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Inpatient & Long-Term Care Hospital Prospective Payment Systems: FY 2026 Changes

Related CR Release Date: September 4, 2025	**MLN Matters Number:** MM14203
Effective Date: October 1, 2025	**Related Change Request (CR) Number:** CR 14203
Implementation Date: October 6, 2025	**Related CR Transmittal Number:** R13398OTN
Related CR Title: Fiscal Year (FY) 2026 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes	

Affected Providers

- Hospitals
- Long-term care hospitals (LTCHs)

Action Needed

Make sure your billing staff knows about these FY 2026 updates:

- Inpatient Prospective Payment System (IPPS)
- LTCH Prospective Payment System (PPS)
- Certain hospitals that CMS excludes from the IPPS

Background

CR 14203 outlines the annual updates to IPPS and LTCH PPS for FY 2026. All items covered in this CR are effective for hospital discharges occurring on or after October 1, 2025 – September 30, 2026, unless otherwise noted. These policy changes went on display on August 1, 2025, and appear in the Federal Register (90 FR 36536) on August 4, 2025.

We'll release new IPPS and LTCH PPS Pricer software packages that include the updated rates, factors, and policies for FY 2026.

See the FY 2026 final rule home page for the FY 2026 final rule data files, rule tables, and Medicare Administrative Contractor (MAC) implementation files referenced in this article. MACs use these files unless otherwise specified.

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Key Updates

IPPS FY 2026 Update

FY 2026 IPPS Rates & Factors

See Tables 1A–D of the FY 2026 IPPS and LTCH PPS final rule for the operating rules, standardized amounts, and the federal capital rate.

See the MAC implementation file 1 for other IPPS factors, including:

- Applicable percentage increase
- Budget neutrality factors
- High-cost outlier threshold
- Cost-of-living adjustment (COLA) factors

Medicare Severity Diagnosis-Related Group Grouper & Medicare Code Editor Changes

The Medicare Severity Diagnosis-Related Group (MS-DRG) Grouper assigns each case into an MS-DRG based on the reported diagnosis and procedure codes and demographic information, such as age, sex, and discharge status. The ICD-10 Medicare Code Editor Version 43.0 uses edits for the ICD-10 codes reported to validate correct coding on claims for discharges on or after October 1, 2025.

We deleted 6 MS-DRGs and finalized 5 new MS-DRGs, decreasing the number of MS-DRGs by 1, for a total of 772 for FY 2026. See MAC implementation file 6 for the complete MS-DRG list for FY 2026. Also, see the MS-DRG Classifications and Software webpage for the ICD-10 MS-DRG V43.0 Definitions Manual Table of Contents and the Definitions of Medicare Code Edits V43 manual for the complete documentation of the Grouper logic.

Replaced Devices Offered Without Cost or with a Credit

For specified MS-DRGs, we reduce a hospital's IPPS payment when they replace an implanted device without cost or with a credit equal to 50% or more of the cost of the replacement device. We add new MS-DRGs to the list subject to the policy for payment under the IPPS for replaced devices offered without cost or with credit when they're 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.

Post-Acute Transfer & Special Payment Policy

We evaluated changes to MS-DRGs for FY 2026 against the general post-acute care transfer policy criteria using the FY 2024 Medicare Provider Analysis and Review data per regulations under 42 CFR 412.4(c). As a result, we won't add or remove any MS-DRGs from the list of those subject to either the post-acute care or the special payment policies. See Table 5 of the FY 2026 IPPS and LTCH PPS final rule for a list of all post-acute and special post-acute MS-DRGs.

New Technology Add-On Payment Policy

For FY 2026, 27 new technology add-on payments will continue, and we approved 26 new technology add-on payments. We granted 1 additional technology conditional approval pending FDA marketing authorization. We'll issue more instructions if FDA grants marketing authorization in time for FY 2026 payments under the conditional approval policy. See MAC implementation file 8 for more information on technologies either continuing to receive payments or those starting to receive payments as well as information regarding technologies no longer eligible to receive new technology add-on payments.

Labor-Related Share Percentage

We use the labor-related share under the IPPS to determine the proportion of the national IPPS base operating payment rate to apply to the area wage index. Under current law, hospitals receive payment based on either a 62% labor-related share or the labor-related share estimated from time to time by the HHS Secretary, depending on which labor-related share results in a higher payment.

For FY 2026, we finalized an update to the labor-related share for discharges occurring on or after October 1, 2025. For all IPPS hospitals (including those in Puerto Rico) with wage indexes greater than 1 for FY 2026, we'll apply the wage index to the labor-related share of the operating national standardized amount using the updated labor-related share found in MAC implementation file 1.

COLA for Hospitals Paid Under the IPPS

There are no COLA factor changes for FY 2026. See the FY 2026 IPPS and LTCH PPS final rule or MAC implementation file 1 for the applicable COLAs effective for discharges occurring on or after October 1, 2025.

Updating the Provider Specific File for Wage Index, Reclassifications & Redesignations and Wage Index Changes & Issues

MACs update the Provider Specific File (PSF) by following steps found in the MAC implementation file 5 and FY 2026 MAC implementation files instructions to:

- Determine the appropriate wage index and other payments
- Update the PSF to ensure we make appropriate IPPS payments for hospitals with reclassifications and redesignations
- Update the PSF and ensure we properly assign the core-based statistical area (CBSA) for all IPPS providers

For hospitals located in rural counties deemed Lugar counties in Table 4B (counties redesignated under section 1886(d)(8)(B) of the Social Security Act), MACs must verify and ensure a hospital's Lugar status is applied appropriately.

For FY 2026, we're applying a 5% cap on any decrease in a hospital's wage index from its final wage index in FY 2025. For FY 2026 and subsequent FYs in the FY 2026 IPPS and LTCH final rule, we're finalizing the discontinuation of the low wage index hospital policy. We're also finalizing a transitional exception to the calculation of FY 2026 IPPS payments for low wage index hospitals significantly impacted by the low wage index hospital policy discontinuation.

In CR 11707, we created 2 PSF fields:

- Supplemental wage index field (data element 63)
- Supplemental wage index flag (data element 64)

For FY 2026 for all hospitals eligible for the 5% cap, the supplemental wage index flag must be "1" and the supplemental wage index field must equal the wage index in Table 2 in the column labeled FY 2025 Wage Index to implement the 5% cap policy. The Pricer uses these fields to determine the 5% cap on the decrease in a hospital's wage index, if applicable.

Under the 5% cap policy, new hospitals opened during FY 2026 aren't eligible. Such hospitals will have a blank supplemental wage index flag field, and the supplemental wage index field will be zeroes. See MAC implementation file 5 for hospitals not listed in Table 2 (other than new hospitals opened in FY 2026).

We apply the transitional exception policy for FY 2026 to certain hospitals that benefitted from the FY 2024 low wage index hospital policy. For these eligible hospitals, we compare the hospital's FY 2026 wage index to its FY 2024 wage index. If the FY 2026 wage index is decreasing by more than 9.75% from the hospital's FY 2024 wage index, 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% (95% for FY 2025 * 95% for FY 2026) of its FY 2024 wage index.

MACs will use the FY 2026 MAC Table 2 PSF Guide spreadsheet located 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 Special Payment Indicator field.

Sole Community Hospitals & Medicare-Dependent, Small Rural Hospital Program: Updating the Hospital-Specific Rate in the PSF

For FY 2026, MACs must update the hospital-specific (HSP) amount in the PSF for all sole community hospitals (SCHs) and Medicare-dependent hospitals (MDHs). Despite the MDH program expiring under current law as of October 1, 2025, we're instructing MACs to update the HSP rates so SCH and MDH rates in the PSF are uniform. We update the HSP amount from FY 2018 to FY 2025 dollars by applying an update factor of 1.18513 to the current HSP amount in the PSF before entering the final amount in the PSF effective October 1, 2025. The 1.18513 factor represents the product of all annual market basket updates and the MS-DRG budget neutrality factors from FY 2019–2025. The Pricer will apply the update and MS-DRG budget neutrality factor to the HSP amount for FY 2026.

MDH Program Expiration

We aren't authorizing special payment provisions provided to MDHs beyond FY 2025. Starting October 1, 2025, all hospitals that previously qualified for MDH status will lose that status, and we'll pay them solely on the federal rate.

Note: Policy at 42 CFR 412.92(b) allows MDHs to apply for SCH status and be paid as such under certain conditions once the MDH program expires.

Starting with FY 2026, provider types 14 and 15 are no longer valid, and MACs will update the PSF accordingly to reflect the appropriate provider type with an effective date of October 1, 2025.

Multicampus Hospitals

We allocate wages and hours to the CBSA in which a hospital campus is located when a multicampus hospital has campuses located in different CBSAs. We base payment to hospitals on the geographic location where the discharge occurred. Therefore, if a hospital has a campus or campuses in different CBSAs, MACs add a suffix to the hospital's CMS Certification Number (CCN) in the PSF to identify and denote a sub-campus in a different CBSA. This helps ensure 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.

Note: Under certain circumstances, we allow individual campuses to reclassify to another CBSA. In those cases, we note the appropriate reclassified CBSA and wage index in the PSF (see MAC implementation file 5). Generally, subordinate campuses are subject to the same rules regarding withdrawals and cancellations of reclassifications as main providers.

Treatment of Hospitals Redesignated Under Section 1886(d)(8)(B) of the Social Security Act (Lugar Hospitals) Other than for Wage Index Purposes

Regulations at 42 CFR 412.64(b)(3)(ii) implement section 1886(d)(8)(B) of the Social Security Act, which redesignates certain rural counties adjacent to 1 or more urban areas as urban for the purposes of payment under the IPPS (Lugar counties). Accordingly, hospitals located in Lugar counties are deemed as located in an urban area, and their IPPS payment under section 1886(d) of the Social Security Act is determined based on the urban area to which they're redesignated. See Table 4B for all Lugar counties in FY 2026.

MACs must consider the Lugar status of hospitals and determine payment and hospital status appropriately. MACs must verify whether a hospital is in a Lugar county based on the list in Table 4B. MACs must also verify whether a hospital has an urban-to-rural 42 CFR 412.103 reclassification that impacts its status. We consider hospitals in Lugar counties with active reclassifications rural for IPPS payment purposes when those payments depend on urban or rural status. We consider hospitals that waive Lugar status to receive the out-migration adjustment rural for IPPS payment purposes.

Low-Volume Hospitals – Criteria and Payment Adjustments

On September 30, 2025, temporary changes to the low-volume hospital payment adjustment provided by the Affordable Care Act and extended by subsequent legislation will expire. Starting October 1, 2025, the low-volume hospital qualifying criteria and payment methodology will revert to what was in effect prior to the amendments made by the Affordable Care Act and subsequent legislation. See 42 CFR 412.101 for hospital payment adjustment policy regulations.

For FY 2026, MACs must receive written requests for low-volume hospital status from hospitals by September 1, 2025, so MACs can apply the applicable 25% low-volume payment adjustment to payments for hospital discharges starting on or after October 1, 2025. Under this procedure, hospitals that qualified for the low-volume hospital payment adjustment in FY 2025 may continue to receive the adjustment in FY 2026 without reapplying if it meets both the discharge (less than 200 total, including both Medicare and non-Medicare discharges) and mileage criteria (25 miles) for FY 2026.

If a MAC receives a hospital's written request after September 1, 2025, but that hospital meets mileage criteria, the MAC will 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 determination.

Note: Due to a change in the definition of low-volume hospitals starting in FY 2026, MACs will update the low-volume indicator field and the low-volume adjustment factor field on the PSF to hold a value of blank for any current low-volume hospitals that no longer meet the applicable criteria starting in FY 2026.

Medicare Advantage Nursing & Allied Health Education Payments – Rates for CY 2024

Under 42 CFR 413.87, hospitals that operate approved nursing and allied health (NAH) education programs and receive Medicare reasonable cost reimbursement for these programs also receive additional payments if they treat Medicare Advantage (MA) enrollees. We determine a hospital's NAH MA payment by applying a ratio of the hospital-specific NAH Medicare Part A payments, total inpatient days, and MA inpatient days to the national totals of those same amounts from cost reporting periods ending in the FY that's 2 years prior to the current CY. The formula is:

(((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 and LTCH PPS final rule, we published the final national rates and percentages and their data sources for CY 2024. MACs will use these rates to make NAH MA payments and Direct Graduate Medical Education payments to applicable providers for portions of cost reporting occurring in CY 2024.

Hospital Quality Initiative

See the list of hospitals that will receive the quality initiative bonus. We'll add providers to the list if they meet the criteria after we publish it. See MAC implementation file 3 for a list of hospitals that will receive the statutory reduction to the annual payment update for FY 2026 under the Hospital Inpatient Quality Reporting Program.

Hospital-Acquired Condition Reduction Program

We expect to issue the final list of hospitals subject to the Hospital-Acquired Condition (HAC) Reduction Program for FY 2026 to MACs in mid-September 2025. MACs will use this list to adjust the HAC Reduction Program indicator field in the PSF with an effective date of October 1, 2025.

Hospital Value-Based Purchasing Program

For FY 2026, we're implementing 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. We expect to post the final value-based incentive payment adjustment factors for FY 2026 by mid-September in Table 16B of the FY 2026 IPPS and LTCH PPS final rule.

Note: Until we issue the final values in Table 16B, MACs will enter "N" in the value-based purchasing program field.

Hospital Readmissions Reduction Program

We expect to post the Hospital Readmissions Reduction Program (HRRP) payment adjustment factors for FY 2026 in mid-September 2025 in Table 15 of the FY 2026 IPPS and LTCH PPS final rule. Hospitals not subject to a reduction under the HRRP in FY 2026 (such as Maryland hospitals and non-subsection (d) hospitals) have an HRRP payment adjustment factor of 1. For FY 2026, hospitals should only have an HRRP payment adjustment factor between 1 and 0.97.

Note: The HRR adjustment field in the PSF refers to the HRRP payment adjustment factor.

Once we update the file in Table 15, MACs will update the HRR indicator and HRR adjustment fields in the PSF accordingly based on a hospital's eligibility for the reduction. Be aware that until we issue the final values, MACs will enter "0" in the HRR indicator field.

Medicare Disproportionate Share Hospital Payment Adjustment Implementation of New Office of Management and Budget Labor Market Delineations

Hospitals located in urban counties becoming rural under adopting the new Office of Management and Budget delineations in the FY 2025 IPPS and LTCH PPS final rule are subject to a transition for their Medicare disproportionate share hospital (DSH) payment. A hospital with more than 99 beds and less than 500 beds that was redesignated from urban to rural would be subject to a DSH payment adjustment cap of 12%.

Under the transition and per regulations at 42 CFR 412.102, for the first year that a hospital loses urban status, it will receive an additional payment equaling 66.67% of the difference between the DSH payment before its redesignation from urban to rural and the DSH payment otherwise applicable after its redesignation.

In the second year after a hospital loses urban status, it will receive an additional payment equaling 33.33% of the difference between the applicable DSH payments before its redesignation from urban to rural and the DSH payments otherwise applicable after its redesignation. We'll determine this adjustment at cost report settlement. In determining the claim payment, the Pricer will only apply the DSH payment adjusted based on its urban or rural status according to the redesignation.

Uncompensated Care Payments

In the FY 2026 IPPS and LTCH PPS final rule, we finalized a Factor 3 for each Medicare DSH hospital representing its relative share of the total uncompensated care payment amount paid to Medicare DSH hospitals along with a total uncompensated care payment amount. We'll continue to pay interim uncompensated care payments on the claim as an estimated per-claim amount to the hospitals projected to receive Medicare DSH payments in FY 2026. See the Medicare DSH supplemental data file for FY 2026 for the estimated per-claim amount and projected DSH eligibility for each subsection (d) hospital and subsection (d) Puerto Rico hospital.

For Indian Health Service (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. We'll reconcile the interim estimated uncompensated care payments paid on a per-claim basis at cost report settlement with the total uncompensated care payment amount displayed in the Medicare DSH supplemental data file. We'll reconcile the interim estimated supplemental payments paid on a per-claim basis at cost report settlement using the total supplemental payment displayed in the Medicare DSH supplemental data file.

Hospitals Without Prospective Factor 3 Calculation (New Hospitals, Uncompensated Care Trim & Newly Merged Hospitals)

For FY 2026, we'll calculate Factor 3 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 for hospitals with CCNs established after October 1, 2021, that we determine are eligible for Medicare DSH at cost report settlement. We use a denominator for this calculation found in the FY 2026 IPPS and LTCH PPS final rule Medicare DSH supplemental data file's first tab (file layout) in the variable Factor 3 description. We multiply Factor 3 by a scaling factor and multiply by the total uncompensated care payment amount finalized in the FY 2026 IPPS final rule to determine the total uncompensated care payment amount we pay to the hospital if we determine the hospital to be DSH eligible at cost report settlement.

MACs will apply a scaling factor for the Factor 3 calculation for new hospitals, newly merged hospitals, and hospitals subject to the uncompensated care data trim if we determine a hospital is DSH eligible at cost report settlement. Find the scaling factor in the first tab (file layout) of the FY 2026 IPPS and LTCH PPS final rule's Medicare DSH Supplemental data file. It's also available in MAC implementation file 1.

MACs can refer to the Medicare DSH supplemental data file to confirm whether a hospital should be treated as a new hospital for DSH uncompensated care payment purposes. It's possible there will be new hospitals added during FY 2026, and those wouldn't be available to be listed on the Medicare DSH supplemental data file.

In the FY 2026 IPPS and LTCH PPS final rule, we continued an additional uncompensated care data trim for hospitals we didn't project as DSH eligible for interim uncompensated care payments. Like new hospitals, those hospitals impacted by this new trim don't have a Factor 3 listed in the FY 2026 Medicare DSH supplemental file. If we determine the hospital, subject to the data trim, is DSH eligible at cost report settlement, the MAC will 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, MACs will reconcile interim uncompensated care payments at cost report settlement for newly merged hospitals and those without a merger prior to final rule development.

Voluntary Request of Per Discharge Amount of Interim Uncompensated Care Payments

For FY 2026, we use a 3-year average of the number of hospital discharges to produce an estimate of the amount of uncompensated care payment per discharge. Specifically, we divide the hospital's total uncompensated care payment amount by its 3-year historical average of discharges computed using the most recent available data. This results in a per-discharge payment amount that we use to make interim uncompensated care payments to each projected DSH eligible hospital. We reconcile the interim uncompensated care payments made during the FY at the end of the cost reporting period to ensure the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the FY.

If a hospital submits a request to its MAC for a lower per-discharge interim uncompensated care payment amount, including a reduction to 0, once before the beginning of the FY or once during the FY, then MACs will review the request. The hospital must provide supporting documentation demonstrating there would likely be a significant recoupment (for example, 10% or more of the hospital's total uncompensated care payment or at least $100,000) at cost report settlement if we don't lower the per-discharge amount. Examples include:

- A request showing a large projected increase in discharges during the FY to support reducing its per-discharge uncompensated care payment amount
- A request we reduce its per-discharge uncompensated care payment amount to 0 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 will evaluate the hospital's request for strictly reducing the per-discharge uncompensated payment amount and the supporting documentation before the beginning of the FY or with a midyear request when the 2-year average of discharges is lower than the hospital's projected FY 2026 discharges. If the MAC agrees there likely would be significant recoupment of the hospital's interim Medicare uncompensated care payments at cost report settlement, the only change made would be to lower the per-discharge amount either to the amount requested by the hospital or another amount the MAC determines to be appropriate to reduce the likelihood of a substantial recoupment at cost report settlement.

The hospital's request doesn't change how we reconcile the total uncompensated care payment amount at cost report settlement. We still reconcile the interim uncompensated care payments made to the hospital during the FY at the end of cost reporting period to ensure the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the FY.

Supplemental Payment for IHS Hospitals, Tribal Hospitals & Hospitals Located in Puerto Rico

For IHS hospitals, tribal hospitals, and hospitals located in Puerto Rico, we base interim supplemental payment eligibility 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 makes a final determination about a hospital's supplemental payment eligibility in conjunction with its final determination of the hospital's eligibility for DSH payments and uncompensated care payments for that FY. If we deny a hospital DSH eligibility for a FY, it won't receive a supplemental payment for that FY.

The MAC reconciles the interim supplemental payments at cost report settlement to ensure 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 FYs, MACs must make a pro rata supplemental payment calculation if the hospital's cost reporting period differs from the FY. The final supplemental payment amounts included on a cost report spanning 2 FYs are the pro rata share of the supplemental payment associated with each FY. This pro rata share is determined based on the proportion of the applicable FY that's included in that cost reporting period.

Outlier Payments: IPPS Statewide Average Cost-to-Charge Ratios

Tables 8A and 8B contain the FY 2026 statewide average operating and capital cost-to-charge ratios (CCRs) for urban and rural hospitals. Per 42 CFR 412.84(i)(3), for FY 2026, we use statewide average CCRs in these instances:

- New hospitals that haven't yet submitted their first Medicare cost report. For this purpose, we define a new hospital as an entity that hasn't accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR 489.18.
- Hospitals with an operating or capital CCR that's more than 3 standard deviations above the corresponding national geometric mean. We calculate this mean annually and publish it in the annual notice of prospective payment rates in accordance with 42 CFR 412.8(b). See MAC implementation file 1 for operating CCR and capital CCR trim values.
- Hospitals where accurate data used to calculate an operating or capital CCR (or both) isn't available.

Note: Hospitals and MACs can request an alternative CCR to the statewide average CCR per instructions in the Medicare Claims Processing Manual, Chapter 3, section 20.1.2.1.

We require approval from our Central Office if hospitals want to use an operating or capital CCR of 0 or any other alternative CCR.

Payment Adjustment for Certain Immunotherapy Cases in MS-DRG 018

We adjust the payment amount for certain immunotherapy cases that group to MS-DRG 018. See MAC implementation file 1 for the FY 2026 MS-DRG weighting factor used for these discharges.

Under this policy, we'll apply a payment adjustment to claims that group to MS-DRG 018 and meet 1 of these criteria:

- Includes ICD-10-CM diagnosis code Z00.6
- There's an expanded access use of immunotherapy
- The immunotherapy product isn't purchased in the usual manner, such as obtained at no cost

When you purchase Chimeric Antigen Receptor (CAR) T-cell therapy or other immunotherapy products in the usual manner but the case involves a clinical trial of a different product, we won't apply the payment adjustment in calculating the payment for the case.

In cases where there's expanded access to CAR T-cell therapy or other immunotherapy products, you may submit condition code 90 on the claim so the Pricer will apply the payment adjustment in calculating the payment for the case.

To notify your 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 (with Z00.6 on the claim), 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. The claims processing system will append payer-only condition code ZC so that the Pricer won't apply the payment adjustment in calculating the payment for the case.

To notify your MAC of a case where the CAR T-cell therapy or other immunotherapy product isn't purchased in the usual manner, such as provided at no cost, you 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 claim, and the shared system maintainer will populate condition code ZD so the IPPS Pricer applies the payment adjustment in calculating the payment for the case.

IPPS Add-On Payment for Certain ESRD Discharges

We provide an additional payment to hospitals for inpatient services provided to certain Medicare patients with ESRD who receive a dialysis treatment during a hospital stay if the hospital's ESRD patient discharges, excluding discharges classified into the MS-DRGs listed at 42 CFR 412.104(a) where the patient received dialysis services during the inpatient stay, are 10% or more of its total Medicare charges.

Per 42 CFR 412.104, we use the annual CY ESRD PPS base rate multiplied by 3 to calculate the ESRD add-on payment for hospital cost reporting periods that start during the FY for the same year. Specifically, we'll use the CY 2026 ESRD PPS base rate for all cost reports starting during FY 2026. The applicable ESRD base rate is effective for cost reporting periods starting on or after October 1, 2025 – September 30, 2026.

See MAC implementation file 1 for the applicable ESRD base rate effective for cost reporting periods starting on or after October 1, 2025, which we expect to be live in early November 2025.

LTCH PPS FY 2026 Update

FY 2026 LTCH PPS Rates & Factors

See Table 1E for the FY 2026 LTCH PPS standard federal rates. See MAC implementation file 2 for other FY 2026 LTCH PPS factors.

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

Discharge Payment Percentage

We're required to notify LTCHs of their discharge payment percentage (DPP), which is the ratio (expressed as a percentage) of the LTCH's fee-for-service discharges that received LTCH PPS standard federal rate payment to the LTCH's total number of LTCH PPS discharges. MACs will continue providing information to LTCHs of their DPP upon settling cost reports using a form letter to notify LTCHs of their DPP.

Section 1886(m)(6)(C)(ii)(I) of the Social Security Act requires that, for cost reporting periods on or after October 1, 2019, any LTCH with a DPP for the cost reporting period that isn't at least 50% be informed. For all discharges in each successive cost reporting period, we pay the LTCH a 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 reinstatement process provided for by section 1886(m)(6)(C)(iii) of the Social Security Act.

LTCH Quality Reporting Program

Under the LTCH Quality Reporting Program (QRP), we'll continue to reduce the FY 2026 annual update to the standard federal rate by 2 percentage points if an LTCH doesn't submit quality reporting data in accordance with the LTCH QRP for that year.

PSF

See the Medicare Claims Processing Manual, Chapter 3, section 20.2.3.1 and Addendum A for PSF-required fields for all provider types. We'll update the inpatient PSF for each LTCH as needed as well as all applicable fields for LTCHs effective October 1, 2025, effective with cost reporting periods that begin on or after October 1, 2025, or upon receiving an as-filed (tentatively) settled cost report.

LTCH Statewide Average CCRs

See Table 8C for the FY 2026 Statewide average LTCH total CCRs for urban and rural LTCHs. Per 42 CFR 412.525(a)(4)(iv)(C) and 412.529(f)(4)(iii), for FY 2026, we use statewide average CCRs in the following instances:

- New hospitals that haven't yet submitted their first Medicare cost report. For this purpose, we define a new hospital as any entity that hasn't accepted assignment of an existing hospital's provider agreement per 42 CFR 489.18.
- LTCHs with a total CCR more than the applicable maximum CCR threshold (that is, the LTCH total CCR ceiling, which we calculate at 3 standard deviations from the national geometric average CCR). See MAC implementation file 2 for the LTCH total CCR ceiling.
- Any hospital for which data isn't available to calculate a CCR.

Note: Hospitals and MACs can request an alternative CCR to the statewide average CCR per instructions in the Medicare Claims Processing Manual, Chapter 3, section 150.24.

In addition, our Central Office must approve LTCH using a total CCR of 0 or any other alternative CR.

LTCH Wage Index

For FY 2026, we applied a 5% cap to any decrease in an LTCH's wage index from its FY 2025 wage index. See the FY 2026 MAC implementation files for a list of LTCHs where the FY 2026 LTCH PPS wage index decreased by more than 5%, along with their capped FY 2026 LTCH PPS wage index value.

Note: Hospitals newly classified as LTCHs during FY 2026 aren't eligible for the 5% cap.

For FY 2026, we applied a 5% cap to any decrease in an LTCH's applicable IPPS comparable wage index from its FY 2025 applicable IPPS comparable wage index. See the MAC implementation files for a list of LTCHs where the FY 2026 applicable IPPS comparable wage index decreased by more than 5%, along with their capped FY 2026 applicable IPPS comparable wage index value.

Note: Hospitals newly classified as LTCHs during FY 2026 aren't eligible for the 5% cap.

In addition, for all LTCHs, MACs will update the County Code field in the PSF (Data Element 60) with the correct Federal Information Processing Series code.

COLA Under the LTCH PPS

See MAC implementation file 2 for COLAs effective for discharges occurring on or after October 1, 2025. There are no updates for FY 2026.

LTCH Qualifying Period Policy Manual Update

An LTCH must participate in Medicare as a hospital (typically paid under the IPPS) prior to receiving classification as an LTCH. During this time, we gather average length of stay (ALOS) data, which we use to determine if a hospital's ALOS is greater than the 25 days we require for LTCH classification. We codified this in regulations at 42 CFR 412.23(e)(3) and in the FY 2025 IPPS and LTCH final rule. We're updating the Medicare Claims Processing Manual, Chapter 3, section 150.4 to reflect this policy.

Hospitals Excluded from the IPPS

In the FY 2026 IPPS and LTCH PPS final rule, we established an update to an extended neoplastic disease care hospital's target amount for FY 2026 of 3.3%. The update is the annual rate of increase percentage specified in 42 CFR 413.40(c)(3), and it's equal to the percentage increase projected by the hospital market basket index.

More Information

We issued CR 14203 to your MAC as the official instruction for this change. For more information, find your MAC's website.

Document History

Date of Change	Description
September 22, 2025	Initial article released.