| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-20 One-Time Notification | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 13564** | **Date: December 23, 2025** |
| | **Change Request 14341** |

**SUBJECT: Extensions of Certain Temporary Changes to the Low-Volume Hospital Payment Adjustment and the Medicare-Dependent Hospital (MDH) Program under the Inpatient Prospective Payment System (IPPS) Provided by the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to direct the A/B Medicare Administrative Contractors (MACs) to ensure the provider specific file (PSF) is updated to reflect the provisions of sections 6201 and 6202 of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026.

**EFFECTIVE DATE: October 1, 2025**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: January 14, 2026**

***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 |
|---|---|
| N/A | N/A |

**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:**

**One Time Notification**

# Attachment - One-Time Notification

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## II. GENERAL INFORMATION

**A. Background:** On November 12, 2025, President Trump signed into law the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026 (Pub. L. 119-37). Division F of this new law includes the extension of certain Medicare IPPS fee-for-service provisions, through January 30, 2026, that expired October 1, 2025. Specifically, section 6201 provides an extension of increased inpatient hospital payment adjustment for certain low-volume hospitals and section 6202 provides an extension of the MDH program.

### B. Policy: 1. Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2026

The regulations implementing the low-volume hospital payment adjustment policy are at § 412.101. The Full-Year Continuing Appropriations and Extensions Act, 2025, extended the temporary changes to the low-volume hospital qualifying criteria and payment adjustment under the IPPS. That is, the modified definition of a low-volume hospital and the methodology for calculating the payment adjustment for low-volume hospitals under section 1886(d)(12) of the Act through FY 2025. Under these changes, to qualify a hospital must have less than 3,800 total discharges and be located more than 15 road miles from the nearest IPPS hospital, and the applicable percentage increase is based on a continuous, linear sliding scale ranging from an additional 25 percent payment adjustment for low-volume hospitals with 500 or fewer discharges to a zero percent additional payment for low-volume hospitals with more than 3,800 discharges. (For additional information, refer to the FY 2026 IPPS/Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) final rule (90 FR 36908 through 36912).) These temporary changes were further extended through January 30, 2026, by section 6201 of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026 (Pub. L. 119-37).

Section 1886(d)(12)(C)(i) of the Act, as amended by Public Law 119-37, provides that for the portion of FY 2026 beginning on October 1, 2025 and ending on January 30, 2026 (that is, occurring before January 31, 2026), a low-volume hospital must be more than 15 road miles from another subsection (d) hospital. In

accordance with the existing regulations at § 412.101(a), the term "road miles" is defined to mean "miles" as defined at § 412.92(c)(1) (75 FR 50238 through 50275 and 50414).

Section 1886(d)(12)(C)(i)(III) of the Act, as amended by Public Law 119-37, provides that for the portion of FY 2026 occurring before January 31, 2026, a low-volume hospital must have less than 3,800 discharges during the fiscal year. Consistent with the requirements of section 1886(d)(12)(C)(ii) of the Act, the term "discharge" for purposes of this provision refers to total discharges, regardless of payer (that is, Medicare and non-Medicare discharges). Under § 412.101(b)(2)(iii), for FYs 2019 through 2025, the hospital's most recently submitted cost report is used to determine if the hospital meets the discharge criterion to receive the low-volume payment adjustment in the current year. For purposes of the low-volume hospital adjustment for FY 2026 discharges occurring before January 31, 2026, the number of total discharges is determined in a manner consistent with how it was determined for FY 2019 through FY 2025. That is, to implement the extension of these temporary changes in the low-volume hospital payment policy for FY 2026 discharges occurring before January 31, 2026, in accordance with the existing regulations at § 412.101(b)(2)(iii) and consistent with our implementation of the changes in FYs 2019 through 2025, the hospital's most recently submitted cost report is used to determine if the hospital meets the discharge criterion to receive the low volume payment adjustment in the current year. We use cost report data to determine if a hospital meets the discharge criterion because this is the best available data source that includes information on both Medicare and non-Medicare discharges.

Section 1886(d)(12)(D)(ii) of the Act, as amended by Public Law 119-37, provides that for the portion of FY 2026 occurring before January 31, 2026, the low-volume hospital payment adjustment is determined using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 500 or fewer discharges to 0 percent for low-volume hospitals with greater than 3,800 discharges. To implement the extension of these temporary changes in the low-volume hospital payment policy for FY 2026, discharges occurring before January 31, 2026, in accordance with the existing regulations at § 412.101(c)(3) and consistent with our implementation of those changes in FYs 2019 through 2025:

- For low-volume hospitals with 500 or fewer total discharges, the low-volume hospital payment adjustment is 0.25.
- For low-volume hospitals with more than 500 total discharges but less than 3,800 total discharges, the low volume hospital payment adjustment is calculated as 0.25 - [0.25/3300] × (number of total discharges - 500) = (95/330) - (number of total discharges/13,200).

(For additional information, refer to the FY 2026 IPPS/LTCH PPS final rule (90 FR 36908 through 36912).)

In order to receive a low-volume payment adjustment for FY 2026 discharges occurring before January 31, 2026, consistent with our previously established process, a hospital must make a written request to its MAC. This request must contain sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria so that the MAC can determine if the hospital qualifies as a low-volume hospital in accordance with the provisions of section 6201 of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026, and consistent with existing requirements set forth in the regulations at § 412.101(b)(2)(iii) (in conjunction with § 412.101(e) as applicable). (For additional information on our established process, refer to the FY 2026 IPPS/LTCH PPS final rule (90 FR 36908 through 36912).) Under this procedure, a hospital that received the low-volume hospital payment adjustment in FY 2025 may continue to receive a low-volume hospital payment adjustment for FY 2026 discharges occurring before January 31, 2026 without reapplying if it continues to meet both the applicable discharge criterion and the mileage criterion (described above). However, such a hospital must send written verification stating that it continues to meet the applicable mileage criterion for FY 2026 discharges occurring before January 31, 2026, and that, based upon the most recently submitted cost report, the hospital meets the discharge criterion applicable for FY 2026 discharges occurring before January 31, 2026. (Note, if a hospital submitted a written request for low-volume

hospital status for FY 2026 under the process described in the FY 2026 IPPS/LTCH PPS final rule prior to the enactment of Public Law 119-37 and that request was approved, it is not necessary for such a hospital to provide any additional written notification to its MAC in order to receive the low-volume hospital payment adjustment under the provisions of Public Law 119-37.)

In order for the applicable low-volume percentage increase to be applied to payments for its FY 2026 discharges occurring before January 31, 2026, a hospital's written request or verification must be received by its MAC no later than 14 days from the date of issuance of this CR. If a hospital's written request or written verification for low-volume hospital status for FY 2026 discharges occurring before January 31, 2026 is received after this date, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the low-volume hospital payment adjustment to determine the payment for the hospital's FY 2026 discharges occurring before January 31, 2026, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

The Pricer applies the applicable low-volume hospital payment adjustment factor from the Provider Specific File (PSF) for hospitals that have a value of 'Y' in the low-volume hospital indicator field on the PSF. Therefore, for hospitals that meet both the discharge criterion and the mileage criterion applicable for FY 2026 discharges occurring before January 31, 2026, MACs shall enter a value of 'Y' for the low-volume payment adjustment factor field in the PSF (position 74) and shall update the low-volume adjustment factor field in the PSF (positions 252-258) with a value greater than 0 and less than or equal to 0.250000 calculated in accordance with the existing regulations at § 412.101(c)(3) as described above.

Any hospital that does not meet either the discharge or mileage criteria is not eligible to receive a low-volume payment adjustment for FY 2026 discharges occurring before January 31, 2026, and the MAC must ensure the low-volume hospital indicator field on the PSF contains a value of 'blank' and shall update the low-volume payment adjustment factor field on the PSF to hold a value of 'blank'.

As noted above, the provisions of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026 extended the low-volume hospital qualifying criteria and payment adjustments through January 30, 2026. Consistent with current law, the low-volume hospital definition and payment adjustment methodology will revert back to the policy established under statutory requirements that were in effect prior to the amendments made by the Affordable Care Act and extended through subsequent legislation. Therefore, for FY 2026 discharges occurring on or after January 31, 2026, to qualify for the low-volume hospital payment adjustment of 25 percent a hospital must have less than 200 total discharges and be located more than 25 road miles from the nearest IPPS hospital. For hospitals that meet both the discharge criterion and the mileage criterion for the low-volume hospital payment adjustment applicable for FY 2026 discharges occurring on or after January 31, 2026, the MAC shall ensure the low-volume indicator field on the PSF continues to hold a value of 'Y' and the low-volume payment adjustment factor field on the PSF continues to hold the value of 0.25. Likewise, if a hospital qualified for the low-volume hospital payment adjustment for FY 2026 discharges occurring before January 31, 2026, but no longer meets the low-volume hospital definition for FY 2026 discharges occurring on or after January 31, 2026, and therefore the hospital is no longer eligible to receive a low-volume hospital payment adjustment effective January 31, 2026, the MAC shall update the low-volume indicator field to hold a value of 'blank' and shall update the low-volume payment adjustment factor field on the PSF to hold a value of 'blank'.

2. Extension of the Medicare-Dependent Hospital (MDH) Program

a. General

Prior to the enactment of section 6202 of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026, the MDH program authorized by section 1886(d)(5)(G) of the Act expired at the end of FY 2025 (90 FR 36912). Section 6202 of the Continuing

Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026 extends the MDH program through January 30, 2026. The regulations governing the MDH program are found at §412.108.

b. Continuity of MDH Status

The regulations at § 412.92(b)(2)(v) allow MDHs to apply for classification as a Sole Community Hospital (SCH) by September 1, 2025, (that is, 30 days prior to the anticipated expiration of the MDH program), and if approved, to be granted such status effective with the expiration of the MDH program.

Consistent with previous implementations of the MDH program extension, generally, providers that were classified as MDHs as of the date of expiration of the MDH provision will be reinstated as MDHs effective October 1, 2025 with no need to reapply for MDH classification. There are two exceptions:

- *MDHs that requested a cancellation of their rural classification under §412.103(b)* - In order to meet the criteria to become an MDH, generally a hospital must be located in a rural area. To qualify for MDH status, some MDHs may have reclassified as rural under the regulations at §412.103. With the anticipated expiration of the MDH provision, some of these providers may have requested a cancellation of their rural classification.
- *MDHs that classified as Sole-Community Hospitals (SCHs) on or after October 1, 2025* - The regulations at §412.92(b)(2)(v) allowed MDHs to apply for classification as an SCH by September 1, 2025, (that is, 30 days prior to the anticipated expiration of the MDH program), and if approved, to be granted such status effective with the expiration of the MDH program.

Any provider that falls within the exception listed above will not have its MDH status automatically reinstated retroactively to October 1, 2025. All other hospitals with MDH status as of September 30, 2025 will continue to be classified as MDHs effective October 1, 2025 through January 30, 2026. Providers that fall within the exceptions mentioned above would have to reapply for MDH classification in accordance with the regulations at 42 CFR 412.108(b) and meet the classification criteria at 42 CFR 412.108(a) in order to be classified as a MDH.

The existing Provider Type field on the PSF (position 55 – Provider Type) must be updated by the MAC to hold a value of “14” or “15” (as applicable) if the provider was classified as an MDH as of September 30, 2025. Any hospital that requested SCH status under §412.92(b)(2)(v) or a cancellation of its rural classification under §412.103(b) will not be eligible for MDH classification as of October 1, 2025, and the MAC must ensure the Provider Type field on the PSF (position 55 – Provider Type) has been updated to hold a value of “00”or “07” (as applicable).

As described above, the amendments provided by section 6202 of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026, extend the MDH program through January 30, 2026. Therefore, beginning on January 31, 2026, all hospitals that previously qualified for MDH status will no longer have MDH status. Accordingly, for FY 2026 discharges occurring on or after January 31, 2026, Provider Types 14 and 15 will no longer be valid. MACs shall update the PSF to the appropriate provider type with an effective date of January 31, 2026.

c. MAC Implementation Files

In conjunction with this CR, we have published files to assist the MACs in implementing the requirements of this CR. These files can be found in MAC Implementation File 10 available on the FY 2026 MAC Implementation Files webpage at: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page#MAC

The following attachments will be available in MAC Implementation File 10:

- Attachment 1 outlines the various possible actions to be followed for each former MDH and the corresponding examples for each scenario.
- Attachment 2 contains a draft letter with text corresponding to the applicable scenarios outlined in Attachment 1. Each MAC shall add to each letter information specific to that provider regarding how it is affected by the MDH program extension; that is, notifying the provider of its status under the extension of the MDH program.

Notification to providers is necessary only if (1) the provider applied for SCH classification per the regulations at §412.92(b)(2)(v) or (2) the provider cancelled its rural reclassification under §412.103.

d. Hospital Specific (HSP) Rate Update for MDHs

In CR 14203 (Transmittal 13398; September 4, 2025), MACs were instructed to to expire October 1, 2025 under current law at that time, MACs were directed to update the HSP rates for purposes of having rates for SCHs and MDHs in the PSF that were uniformly updated. Therefore, for the payment of FY 2026 discharges occurring on or after October 1, 2025 and before January 31, 2026, MACs shall verify that the HSP amount for MDHs in the PSF was entered in FY 2025 dollars per the instructions in CR 14203. The Pricer will apply the update and DRG budget neutrality factors to the HSP amount for FY 2026.

## 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 | |
| 14341.1 | Medicare contractors shall update the Provider Specific File (PSF), Low-Volume Indicator (File Position 74) with a 'Y' and Low-Volume Adjustment Factor (File Positions 252-258) for those IPPS hospitals that meet both the discharge and mileage criteria for a low-volume hospital for Fiscal Year (FY) 2026 discharges occurring before January 31, 2026 (as described in the policy section) within 2 weeks of the implementation date of this CR or the receipt of the hospital's notification, whichever is later. | X | | | | | | | | |
| 14341.2 | Medicare contractors shall update the PSF, Provider Type (File Position 55) with a '14' or '15' for those IPPS hospitals that qualify as an MDH for discharges on or after October 1, 2025, with an effective date of October 1, 2025, within 2 weeks of the implementation date of this change request. | X | | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 14341.3 | Medicare contractors shall verify that the Hospital-Specific (HSP) amount in the PSF for all MDHs has been updated in accordance with Business Requirement 14203.11 as described in section B.2.d. of the policy section of this CR within 2 weeks of the implementation date of this change request. | X | | | | | | | | |
| 14341.4 | Effective January 31, 2026, Medicare contractors shall remove both the 'Y' in the Low-Volume Indicator in the PSF (position 74) and the value in the Low-Volume Adjustment Factor field in the PSF (positions 252 - 258) for providers that no longer qualify as a low volume hospital as described in the policy section. | X | | | | | | | | |
| 14341.5 | Medicare contractors shall notify impacted IPPS hospitals with the letter in Attachment 2. | X | | | | | | | | |
| 14341.6 | Due to the statutory expiration of the MDH program, effective January 31, 2026, 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 | | | | | | | | |
| 14341.7 | Medicare contractors shall reprocess IPPS claims impacted by this change request with a discharge date on or after October 1, 2025, through the implementation of this change request within 60 days of the implementation date of this change request. | X | | | | | | | | |

## IV. PROVIDER EDUCATION

None

**Impacted Contractors:** None

## 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**