CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13735	**Date: April 14, 2026**
	Change Request 14415

Transmittal 13703 issued March 27, 2026, is being rescinded and replaced by Transmittal 13735, dated April 14, 2026, to change the dates in the CR from March 20, 2026, to April 17, 2026. All other information remains the same.

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 Consolidated Appropriations 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 Consolidated Appropriations Act, 2026.

EFFECTIVE DATE: January 31, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 17, 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 February 3, 2026, President Trump signed into law the Consolidated Appropriations Act, 2026 (Pub. L. 119-75). Division J of this new law includes the extension of certain Medicare IPPS fee-for-service provisions, through December 31, 2026, that expired January 31, 2026. 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 Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026 (Pub. L. 119-37) 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 were extended through January 30, 2026. 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 December 31, 2026, by section 6201 of the Consolidated Appropriations Act, 2026 (Pub. L. 119-75).

Under section 1886(d)(12)(C)(i) of the Act, as amended, for FY 2026 and the portion of FY 2027 beginning on October 1, 2026, and ending on December 31, 2026 (that is, occurring before January 1, 2027), 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).

Under section 1886(d)(12)(C)(i)(III) of the Act, as amended by Public Law 119-75, for FY 2026 and the portion of FY 2027 beginning on October 1, 2026, and ending on December 31, 2026 (that is, occurring before January 1, 2027), 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, 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 after January 30, 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.

Under section 1886(d)(12)(D)(ii) of the Act, as amended by Public Law 119-75, for FY 2026 and the portion of FY 2027 beginning on October 1, 2026 and ending on December 31, 2026 (that is, occurring before January 1, 2027), 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 after January 30, 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).)

As specified in CR 14341, for the extension of the temporary changes to the low-volume hospital payment adjustment for FY 2026 discharges occurring on or before January 30, 2026, consistent with our previously established process, a hospital must have made a written request to its MAC. This request must have contained sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria so that the MAC could determine if the hospital qualifies as a low-volume hospital in accordance with the provisions of Public Law 119-37. A hospital that qualified for the low volume hospital payment adjustment for its FY 2026 discharges occurring on or before January 30, 2026, does not need to notify its MAC and will continue to receive the applicable low-volume hospital payment adjustment for its FY 2026 discharges occurring on or after January 31, 2026, without reapplying, provided it continues to meet the mileage criterion (that is, the hospital continues to be located more than 15 road miles from any other subsection (d) hospital). (This is consistent with the extension of temporary changes to the low-volume hospital payment adjustment for the remainder of FY 2014, for discharges occurring on or after April 1, 2014 (see 79 FR 34446).)

However, for a hospital that did not qualify for the low-volume hospital payment adjustment for its FY 2026 discharges occurring on or before January 30, 2026, in order to receive the low-volume hospital payment adjustment for FY 2026 discharges occurring on or after January 31, 2026, consistent with our previously established procedure, a hospital must notify and provide documentation in writing to its MAC that it meets both the applicable mileage criterion for FY 2026 and the discharge criterion applicable for FY 2026 based upon the most recently submitted cost report. Specifically, for such hospitals, in order for the applicable low-volume percentage increase to be applied to payments for its FY 2026 discharges occurring on or after

January 31, 2026, a hospital's written request must be received by its MAC no later than April 17, 2026. In addition, a hospital that missed the request deadline for FY 2026 discharges occurring on or before January 30, 2026, but qualified for the low-volume payment adjustment in FY 2025 may receive a low-volume payment adjustment for its FY 2026 discharges occurring on or after January 31, 2026, without reapplying if it continues to meet the applicable discharge criterion and mileage criterion. However, the hospital must send written verification that is received by its MAC no later than April 17, 2026, that it continues to meet the mileage criterion, and that it meets the discharge criterion based upon the most recently submitted cost report. If a hospital's written request or written verification for low-volume hospital status for FY 2026 discharges occurring on or after January 31, 2026, is received after April 17, 2026, 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, 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 after January 30, 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 after January 30, 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'.

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

a. General

Prior to the enactment of section 6202 of the Consolidated Appropriations Act, 2026, the MDH program authorized by section 1886(d)(5)(G) of the Act expired on January 31, 2026 (90 FR 36912). Section 6202 of the Consolidated Appropriations Act, 2026 extends the MDH program through December 31, 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 December 1, 2026, (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 January 31, 2026, 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 January 1, 2026* - The regulations at §412.92(b)(2)(v) allowed MDHs to apply for classification as an SCH by January 1, 2026, (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 exceptions listed above will not have its MDH status automatically reinstated retroactively to January 31, 2026. All other hospitals with MDH status as of January 30, 2026, will continue to be classified as MDHs effective January 31, 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 January 30, 2026. 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 January 31, 2026, 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).

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14415.1	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 FY 2026 discharges occurring after January 30, 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								
14415.2	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 January 31, 2026, with an effective date of January 31, 2026, within 2 weeks of the implementation date of this change request.	X								
14415.3	Medicare contractors shall verify that the Hospital-Specific (HSP) amount in the PSF for all	X								

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	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.									
14415.4	Medicare contractors shall notify impacted IPPS hospitals with the letter in Attachment 2.	X								
14415.5	Medicare contractors shall reprocess IPPS claims impacted by this change request with a discharge date on or after January 31, 2026, through the implementation of this change request within 60 days of the implementation date of this change request.	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

Pre-Implementation Contact(s): Dan Ryan, dan.ryan@cms.hhs.gov , Shevi Marciano, shevi.marciano@cms.hhs.gov

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: 2

Examples:

Example 1: Hospital A was classified as an MDH prior to the January 30, 2026 expiration of the MDH program. Hospital A retained its rural classification and did not reclassify as an SCH. Hospital A's MDH status will continue to apply from January 31, 2026.

Example 2: Hospital B was classified as an MDH prior to the January 30, 2026 expiration of the MDH program. In accordance with the regulations at §412.92(b)(2)(v) and in anticipation of the expiration of the MDH program, Hospital B applied for classification as an SCH by January 1, 2026, and was approved for SCH status effective on January 31, 2026. Because the program expired, and a hospital cannot hold SCH and MDH status simultaneously, the hospital will have to reapply for MDH status.

Example 3: Hospital D was classified as an MDH prior to the January 30, 2026 expiration of the MDH program. In anticipation of the expiration of the MDH program, Hospital D requested that its rural classification be cancelled in accordance with the regulations at §412.103(g). Hospital D's rural classification was cancelled effective January 31, 2026. Hospital D's MDH status will therefore be cancelled as of January 31, 2026. In order to reclassify as an MDH, Hospital D must request to be reclassified as rural under §412.103(b) and must reapply for MDH status under §412.108(b).

Example 4: Hospital E was classified as an MDH prior to the January 30, 2026 expiration of the MDH program. In anticipation of the expiration of the MDH program, Hospital E requested that its rural classification be cancelled in accordance with the regulations at §412.103(g). Hospital E's rural classification was cancelled effective March 1, 2026. Hospital E's MDH status will continue to apply but only for the portion of time in which it met the criteria for MDH status. Since Hospital E cancelled its rural status and became urban effective March 1, 2026, MDH status will only continue to apply January 31, 2026 through February 28, 2026 and will be cancelled effective March 1, 2026. In order to reclassify as an MDH, Hospital E must request to be reclassified as rural under §412.103(b) and must reapply for MDH status under §412.108(b).

[DATE]

HOSPITAL
CONTACT
HOSPITAL
NAME
HOSPITAL
ADDRESS
CITY, STATE,
ZIP

Re: Section 6202 Consolidated Appropriations Act, 2026; Extension of the Medicare-Dependent Hospital Program

Provider Name:
CMS Certification Number(CCN): xx-

xxxx Dear {Contact Name},

As part of the Consolidated Appropriations Act, 2026, Congress reinstated the Medicare Dependent Hospital (MDH) program through December 31, 2026. Prior to enactment of that legislation, the MDH program had been set to expire January 31, 2026.
Generally, providers that were classified as MDHs as of January 30, 2026, will continue to be classified as MDHs with no need to reapply for MDH classification. This letter serves as notification regarding {Provider Name's} MDH status.

<Insert any of the following paragraphs, as applicable:>

a) <*{Provider Name}* had requested classification for SCH status and was approved effective with an expiration of the MDH program on January 31, 2026. However, since the MDH program was extended prior to January 31, 2026, and did not in fact expire, the SCH classification will not take effect. *{Provider Name}'s* MDH classification will continue to apply.

b) <*{Provider Name}* requested a cancellation of its rural status under 42 CFR 412.103 and was approved for the cancellation effective January 31, 2026. This cancellation precludes
{Provider Name} from continuing to be classified as a MDH. Therefore, in order to be classified as an MDH, *{Provider Name}* must submit a request for reclassification as a rural hospital under the regulations at 42 CFR 412.103 (b) then and reapply for MDH classification in accordance with the regulations at 42 CFR 412.108(b).>

c) < {*Provider name}* requested a cancellation of its rural status under 42 CFR 412.103 and was approved for the cancellation effective *{effective date - after January 31, 2026}*. *{Provider Name's}* will continue to be classified as a MDH from January 31, 2026 through *{enter date of day immediately prior to effective date of cancellation of rural classification}* and its MDH status will be cancelled effective *{enter effective date of cancellation of rural classification}*. In order to be classified as an MDH, *{Provider Name}* must submit a request for reclassification as a rural hospital under the regulations at 42 CFR 412.103 (b) and then reapply for MDH classification in accordance with the regulations at 42 CFR 412.108(b).>

Per the regulations at 42 CFR 412.108(b)(7), in order to be reclassified as an MDH, a hospital may reapply only after another cost report has been audited and settled.>

If you have any questions, please contact me at *{insert phone number}*.

Sincerely,