| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-04 Medicare Claims Processing | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 13930** | **Date: September 11, 2026** |
| | **Change Request 14592** |

**SUBJECT: Fiscal Year (FY) 2027 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 2027 update to the IPPS and LTCH PPS. This recurring update notification applies to chapter 3, section 20.2.3.1.

**EFFECTIVE DATE: October 1, 2026**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: October 5, 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:**
**Recurring Update Notification**

# Attachment - Recurring Update Notification

| Pub. 100-04 | Transmittal: 13930 | Date: September 11, 2026 | Change Request: 14592 |
|---|---|---|---|

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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 2027.

**B. Policy:** The following policy changes for FY 2027 went on display on July 31, 2026, and appear in the Federal Register on August 3, 2026. All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2026, through September 30, 2027, 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, 2026, through September 30, 2027. The newly revised Pricer programs shall be installed timely to ensure accurate payments for IPPS and LTCH PPS claims.

The FY 2027 Final Rule Data Files, FY 2027 Final Rule Tables, and FY 2027 MAC Implementation Files referenced throughout this CR are available on the CMS website (referred to below as the "FY 2027 Final Rule Homepage"). 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-2027-ippsfinal-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 2027 IPPS Final Rule Home Page" or the link titled "Acute Inpatient--Files for Download" (and select 'Files for FY 2027 Final Rule').

**Note:** Unless otherwise instructed, MACs shall use the final rule or if applicable correcting document version of the tables and data files posted on the FY 2027 Final Rule webpage. Information on revisions made to the applicable correcting document tables and data files can be found on the webpage.

## IPPS FY 2027 Update

### A. FY 2027 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 2027 IPPS/LTCH PPS Final Rule, available on the FY 2027 Final Rule 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 2027 Final Rule 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 44.0, software package effective for discharges on or after October 1, 2026. 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 44.0, 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, 2026.

For discharges occurring on or after October 1, 2026, the Fiscal Intermediary Shared System (FISS) calls the appropriate GROUPER based on discharge date. Medicare contractors received the GROUPER documentation in August 2026.

For discharges occurring on or after October 1, 2026, the MCE selects the proper internal code edit tables based on discharge date. Medicare contractors received the MCE documentation in August 2026. Note that the MCE version continues to match the Grouper version.

CMS deleted eighteen MS-DRGs and finalized fourteen new MS-DRGs, decreasing the number of MS-DRGs by four, for a total of 768 for FY 2027.

The ICD-10 MS-DRG V44.0 Definitions Manual Table of Contents and the Definitions of Medicare Code Edits V44 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 2027 ICD-10 MS-DRGs and Medicare Code Edits.

See MAC Implementation File 6 for the complete list of new MS-DRGs for FY 2027.

### 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 2027.

### D. Post-acute Transfer and Special Payment Policy

The changes to MS-DRGs for FY 2027 have been evaluated against the general post-acute care transfer policy criteria using the FY 2025 MedPAR data according to the regulations under Sec. 412.4 (c). As a

result of this review, MS–DRGs 210, 211, 361, 362, 400, 403, 404, 456, 457, 458, 523, 524, and 525 will be added to the list of MS-DRGs subject to the post-acute care policy, and MS–DRGs 361, 362, 400, 403, 404, 456, 457, 458, 463, 464, 465, 616, 617, 618 to the special payment policies.

See Table 5 of the FY 2027 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs available on the FY 2027 Final Rule webpage.

E. New Technology Add-On Payment Policy

For FY 2027, 41 new technology add-on payments will continue and 19 new technology add-on payments are approved to begin. For more information on FY 2027 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 2027 Final Rule webpage. MAC Implementation File 8 also includes information regarding technologies no longer eligible to receive new technology add-on payments.

F. FY 2027 Labor Related Share Percentage

There are no changes to the labor-related share percentages under the IPPS for FY 2027. For reference, the labor related share percentages for FY 2027 can be found in MAC Implementation File 1 available on the FY 2027 Final Rule webpage. No MAC action is necessary as Pricer will apply the labor-related share for FY 2027.

G. Cost of Living Adjustment (COLA) for IPPS Hospitals Located in Alaska and Hawaii.

We have updated the COLA factors for FY 2027. The applicable COLA factors effective for discharges occurring on or after October 1, 2026, can be found in the FY 2027 IPPS/LTCH PPS final rule and in MAC Implementation File 1 available on the FY 2027 Final Rule webpage. MACs shall update the COLAs in Data Element 22 (COLA) of the PSF for hospitals located in Alaska and Hawaii based on the updated COLA factors in MAC Implementation File 1. (We note, the FY 2027 COLA factors for certain areas of Hawaii are unchanged from FY 2026.)

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

MACs shall update the PSF by following the steps in MAC Implementation File 5 ("Instructions to fill out the PSF for the Wage Index and Reclassifications.pdf") available on the FY 2027 Final Rule webpage 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 in MAC Implementation File 5 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 2027, the following policies will apply to the wage index:

- Apply a 5 percent cap for FY 2027 on any decrease in a hospital's final wage index from the hospital's final wage index in FY 2026.

- For FY 2027 ,we are applying a transitional exception to the calculation of FY 2027 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 2027, 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 2026 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 2027 are not eligible for the 5 percent cap. Therefore, for newly opened hospitals in FY 2027, 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 2027) or any other issues, see MAC Implementation File 5 available on the FY 2027 Final Rule webpage for complete instructions.

The transitional exception policy for FY 2027 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 2027 wage index to the hospital's FY 2024 wage index. If the hospital's FY 2027 wage index is decreasing by more than 14.2625 percent from the hospital's FY 2024 wage index, then the transitional payment exception for FY 2027 for that hospital is equal to the additional FY 2027 amount the hospital would be paid under the IPPS if its FY 2027 wage index were equal to 0.857375 percent (95 percent x 95 percent x 95 percent for FYs 2025 - 2027) of its FY 2024 wage index.

In order for Pricer to apply the transitional payment policy in FY 2027, 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 2027 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 2027, per the "FY 2027 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 2027, 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 2027, 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 2027 Final Rule 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. Medicare-Dependent, Small Rural Hospital (MDH) Program Expiration

The special payment provisions provided to a Medicare Dependent Small Rural Hospital (MDH) are not authorized by statute beyond December 31, 2026. Therefore, beginning January 1, 2027, 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 January 1, 2027, and contractors shall update the PSF accordingly to reflect the appropriate provider type with an effective date of January 1, 2027.

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 2027 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 2027. **MACs shall review the urban/rural status of all hospitals located in a "Lugar" county for FY 2027 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 2027, 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 2027

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, are currently effective through December 31, 2026. Under current law, beginning on January 1, 2027, 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 2027, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2026, in order for the applicable low-volume payment adjustment to be applied to payments for its FY 2027 discharges beginning on October 1, 2026 through December 31, 2026. Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment for FY 2026 may continue to receive a low-volume hospital payment adjustment for the portion of FY 2027 beginning on October 1, 2026, through December 31, 2026, without reapplying if it meets both the discharge criterion (that is, less than 3,800 discharges total, including both Medicare and non-Medicare discharges) and the mileage criterion applicable for FY 2026 (that is, located more than 15 road miles from the nearest IPPS hospital). Accordingly, for the portion of FY 2027 beginning on October 1, 2026, through December 31, 2026, such a hospital must send written verification that is received by its MAC no later than September 1, 2026, stating that it meets the mileage criterion applicable for the portion of FY 2027 beginning on October 1, 2026 through December 31, 2026. If a hospital's written request for low-volume hospital status for FY 2027 is received after September 1, 2026, 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 portion of the hospital's FY 2027 discharges beginning on October 1, 2026, through December 31, 2026, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

As noted above, under current law the temporary changes to the qualifying criteria and payment adjustment methodology for certain low-volume hospitals are effective for discharges occurring through December 31, 2026. Beginning January 1, 2027, to qualify for the 25 percent payment adjustment a hospital must have less than 200 total discharges and be located more than 25 road miles from the nearest IPPS hospital, consistent with §412.101(b)(2)(i). A hospital must also submit a written request for low volume hospital status to its MAC that includes sufficient documentation to establish that the hospital continues to meet the applicable mileage and discharge criteria for the portion of FY 2027 beginning on January 1, 2027 through September 30, 2027 (as described earlier). Specifically, for the portion of FY 2027 beginning on January 1, 2027, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than December 1, 2026, in order for the 25-percent, low-volume, add-on payment adjustment to be applied to payments for its discharges beginning on or after January 1, 2027.For FY 2027 discharges occurring before January 1, 2027, 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 the portion of FY 2027 beginning on October 1, 2026, through December 31, 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) with a value greater than 0 and less than or equal to 0.25, determined using the low-volume hospital payment adjustment factor formulas at 42 CFR 412.101(c)(3).

Any hospital that does not meet either the discharge or mileage criteria is not eligible to receive a low-volume payment adjustment for FY 2027 discharges occurring before December 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'.

For FY 2027 discharges occurring on or after January 1, 2027, 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 2027 discharges occurring on or after January 1, 2027, 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 holds the value of 0.25. Likewise, if a hospital qualified for the low-volume hospital payment adjustment for FY 2027 discharges occurring before January 1, 2027, but no longer meets the low-volume hospital definition for FY

2027 discharges occurring on or after January 1, 2027, and therefore the hospital is no longer eligible to receive a low-volume hospital payment adjustment effective January 1, 2027, 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'.

M. Medicare Advantage (MA) Nursing and Allied Health (NAH) Education Payments – Rates for Calendar Year (CY) 2025

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 2027 IPPS/LTCH PPS final rule, we published the final national rates and percentages and their data sources for CY 2025. 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 2025.

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 their full annual adjustment. 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 2027 under the Hospital IQR Program are found in MAC Implementation File 3, available on the FY 2027 Final Rule 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) (email: IQR@hsag.com_) 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 2027 to MACs in September 2026.

Upon receipt of the final list of hospitals that are subject to the HAC Reduction Program for FY 2027, MACs shall update the "HAC Reduction Indicator" field in the PSF with an effective date of October 1, 2026, as follows, and then release the claims:

- For hospitals in the list of hospitals subject to the HAC Reduction Program for FY 2027 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 2027 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 2027, 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 2027. CMS expects to post the final value-based incentive payment adjustment factors for FY 2027 by mid-September in Table 16B of the FY 2027 IPPS/LTCH PPS final rule (which will be available through the Internet on the FY 2027 IPPS/LTCH PPS final rule webpage). (MACs will receive subsequent communication when value-based incentive payment adjustment factors for FY 2027 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 2027 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 2027 in September 2026 in Table 15 of the FY 2027 IPPS/LTCH PPS final rule (which are available via the Internet on the FY 2027 IPPS/LTCH PPS Final Rule webpage). (MACs will receive subsequent communication when the HRRP payment adjustment factors for FY 2027 in Table 15 are available.) Hospitals that are not subject to a reduction under the HRRP in FY 2027 have an HRRP payment adjustment factor of 1.0000. For FY 2027, 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, 2026, 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

***Uncompensated Care Payments***

In the FY 2027 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 2027. 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 2027, which is available via the Internet on the FY 2027 Final Rule 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 2027 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 2076 Factor 3 Calculation (New Hospitals, Uncompensated Care Trim and Newly Merged Hospitals)***

For FY 2027, new hospitals for uncompensated care payment purposes, that is, hospitals with CCNs established after October 1, 2022, 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 2027 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 2027 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 2027 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 2027 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 2027 Final Rule 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 2027, and therefore those would not be available to be listed on the Medicare DSH Supplemental Date File.

In the FY 2027 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 2027 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 2027 cost report's Worksheet S-10 line 30 divided by the national uncompensated care cost denominator.

For FY 2027, newly merged hospitals, e.g., hospitals that have a merger during FY 2027 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 2027, 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 2027 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 2027 Statewide average operating and capital Cost-to-Charge Ratios (CCRs) for urban and rural hospitals. Tables 8A and 8B are available on the FY 2027 Final Rule webpage. Per the regulations in 42 CFR sections 412.84(i)(3)(iv)(C), for FY 2027, 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 2027 operating CCR and capital CCR trim values, refer to MAC Implementation File 1 available on the FY 2027 Final Rule 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 2027 Final Rule webpage for the FY 2027 MS-DRG weighting factor used for such discharges.

Under this policy, a payment adjustment is 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 2027 ESRD PPS base rate will be used for all cost reports beginning during Federal FY 2027 (that is, for cost reporting periods starting on or after October 1, 2026, through September 30, 2027).

The applicable ESRD base rate effective for cost reporting periods beginning on or after October 1, 2026 can be found in the MAC Implementation File 1 available on the FY 2027 Final Rule webpage after the issuance of the CY 2027 ESRD PPS final rule, which is expected by early November 2026.

## LTCH PPS FY 2027 Update

### A. FY 2027 LTCH PPS Rates and Factors

The FY 2027 LTCH PPS Standard Federal Rates are located in Table 1E available on the FY 2027 Final Rule webpage. Other FY 2027 LTCH PPS Factors can be found in MAC Implementation File 2 available on the FY 2027 Final Rule webpage.

The LTCH PPS Pricer has been updated with the Version 44 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2026, and on or before September 30, 2027.

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 2027, 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, 2026, or effective with cost reporting periods that begin on or after October 1, 2026, or upon receipt of an as-filed (tentatively) settled cost report.

***LTCH Statewide Average CCRs***

Table 8C contains the FY 2027 Statewide average LTCH total CCRs for urban and rural LTCHs. Table 8C is available on the FY 2027 Final Rule webpage. Per the regulations in 42 CFR sections 412.525(a)(4)(iv)(C) and 412.529(f)(4)(iii), for FY 2027, 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 2027 LTCH total CCR ceiling, refer to MAC Implementation File 2 available on the FY 2027 Final Rule 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 2027, a 5 percent cap is applied to any decrease in an LTCH's wage index from its FY 2026 wage index. A list of LTCHs whose FY 2027 LTCH PPS wage index decreased by more than 5 percent along with their capped FY 2027 LTCH PPS wage index value can be found on the FY 2027 Final Rule 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 2027 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 2027 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 2027 LTCH PPS wage index, please contact LTCHPPS@cms.hhs.gov for further instructions.

For FY 2027, a 5 percent cap will also be applied to any decrease in an LTCH's applicable IPPS comparable wage index from its FY 2026 applicable IPPS comparable wage index. A list of LTCHs whose FY 2027 applicable IPPS comparable wage index decreased by more than 5-percent along with their capped FY 2027 applicable IPPS comparable wage index value can be found on the FY 2027 Final Rule 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 2027 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 2027 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 2027 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

We have updated the COLAs for FY 2027. The applicable COLA factors effective for LTCH PPS discharges occurring on or after October 1, 2026 can be found in the FY 2027 IPPS/LTCH PPS final rule and are also located in MAC Implementation File 2 available on the FY 2027 Final Rule webpage. MACs shall update the COLAs in Data Element 22 (COLA) of the PSF for LTCHs located in Alaska and Hawaii based on the updated COLA factors in MAC Implementation File 2.

F. LTCH Qualifying Period Average Length of Stay (ALOS) 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 policy in the regulations at 42 CFR 412.23(e)(3) in the FY 2025 IPPS/LTCH PPS Final Rule. We are updating the 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 2027 IPPS/LTCH PPS final rule, we established an update to an extended neoplastic disease care hospital's target amount for FY 2027 of 3.2 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 | |
| 14592.1 | Contractors shall access the IPPS Pricer via the Cloud to pay FY 2027 IPPS payment rates on claims with discharge dates on or after October | X | | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | 1, 2026. | | | | | | | | | |
| 14592.2 | Contractors shall access the LTCH PPS Pricer via the Cloud to pay FY 2027 LTCH payment rates on claims with discharge dates on or after October 1, 2026. | X | | | | | | | | |
| 14592.3 | The Medicare contractor shall install and edit claims with the MCE version 44.0 and Grouper version 44.0 software with the implementation of the FY 2027 October quarterly release. | | | | | X | | | | |
| 14592.4 | 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).<br><br>**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-Payment/HospitalAcqCond/Coding.html. | | | | | X | | | | |
| 14592.5 | Medicare contractors shall inform the Quality Improvement Organization (QIO) of any new hospital that has opened for hospital quality purposes. | X | | | | | | | | |
| 14592.6 | Medicare contractors shall update ALL relevant portions of the PSF in accordance with this CR prior to the implementation of the FY 2027 IPPS and LTCH PPS Pricers. | X | | | | | | | | |
| 14592.6.1 | Medicare contractors shall follow the instructions in the policy section and on the FY 2027 MAC Implementation Files webpage to update the PSF and ensure that the CBSA is assigned properly for all | X | | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | IPPS and LTCH PPS providers.<br><br>**NOTE**: MACs shall follow these instructions for the following: All current IPPS hospitals; any new hospitals that open during FY 2027; or any change of hospital status during FY 2027. | | | | | | | | | |
| 14592.6.2 | 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 2027 applicable IPPS CCR ceilings. Additionally, use of an operating and/or capital CCR of 0.0 requires approval from the CMS Central Office. | X | | | | | | | | |
| 14592.6.3 | 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 2027 total CCR ceiling. Additionally, use of a total CCR of 0.0 requires approval from the CMS Central Office. | X | | | | | | | | |
| 14592.6.4 | Medicare contractors shall ensure they are taking into account the Lugar status of a hospital and apply the payment and/or hospital status appropriately.<br><br>**NOTE:** See instructions in sections H and K for complete details. | X | | | | | | | | |
| 14592.6.5 | 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 | | | | | | | | |
| 14592.7 | Medicare contractors shall be aware that a hospital may request a lower per discharge interim | X | | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | 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. | | | | | | | | | |
| 14592.7.1 | 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 | | | | | | | | |
| 14592.7.2 | 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 2027 cost report. | X | | | | | | | | |
| 14592.8 | Medicare contractors shall ensure that the Fiscal Year Beginning Date field in the PSF (Data Element 4, Position 25) is updated as applicable with the correct date. | X | | | | | | | | |
| 14592.9 | Medicare contractors shall be aware of any manual updates included within this CR. | X | | | | | | | | |
| 14592.10 | 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 | |
| 14592.11 | MACs shall update the COLA factors in Data Element 22 (COLA) of the PSF for IPPS hospitals and LTCHs located in Alaska and Hawaii as described in the | X | | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | respective IPPS and LTCH PPS policy sections of this CR. | | | | | | | | | |
| 14592.12 | 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 | | | | | | | | |
| 14592.13 | For FY 2027 (discharges on or after October 1, 2026), 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 2027 Wage Index".<br><br>**NOTE:** Under the 5 percent cap policy, new hospitals that opened during FY 2027 are not eligible for the 5 percent cap. Therefore, for newly opened hospitals in FY 2027, 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 2027) or any other issues, see MAC Implementation File 5 available on the FY 2027 MAC Implementation Files webpage for complete instructions. | X | | | | | | | | |
| 14592.13.1 | MACs shall use the spreadsheet titled "FY 2027 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 2027. Hospitals eligible for the | X | | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | transition payment policy will have a “1” or “2" in the column titled “Special Payment Indicator field (Data Element 33)”. | | | | | | | | | |
| 14592.13.2 | For hospitals eligible for the transitional payment policy in FY 2027, per the “FY 2027 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.<br><br>**Note:** For hospitals that are not eligible for the transitional payment policy in FY 2027, 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 | | | | | | | | |
| 14592.14 | MACs shall ensure the Special Payment Indicator field (data element 33) and the Special Wage Index field (data element 38) contain the correct values for the FY, and do not include values from the prior FY, for hospitals paid under the LTCH PPS, following the instructions in MAC Implementation File 9 available on the FY 2027 Final Rule webpage. | X | | | | | | | | |
| 14592.14.1 | For FY 2027 (discharges on or after October 1, 2026), for hospitals paid under the LTCH PPS, for all LTCHs, receiving the 5 percent cap on their FY 2027 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 2027 LTCH PPS wage | X | | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | index value in the Special Wage Index field (data element 38).<br><br>For all LTCHs not receiving the 5 percent cap on their FY 2027 LTCH PPS wage index, the MAC shall ensure the Special Payment Indicator field and the Special Wage Index field are blank.<br><br>**NOTE: See MAC Implementation File 9 available on the FY 2027 Final Rule webpage for complete instructions.** | | | | | | | | | |
| 14592.15 | MACs shall ensure the Supplemental Wage Index Flag field (data element 64) and the Supplemental Wage Index field (data element 63) contain the correct values for the FY, and do not include values from the prior FY, for hospitals paid under the LTCH PPS, following the instructions in MAC Implementation File 9 available on the FY 2027 Final Rule webpage. | X | | | | | | | | |
| 14592.15.1 | For FY 2027 (discharges on or after October 1, 2026), for hospitals paid under the LTCH PPS, for all LTCHs receiving the 5 percent cap on their FY 2027 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 2027 applicable IPPS comparable wage index value in the Supplemental Wage Index field (data element 63).<br><br>For all LTCHs not receiving the 5 percent cap on their FY 2027 applicable IPPS comparable | X | | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | wage index, the MAC shall ensure the Supplemental Wage Index Flag field and the Supplemental Wage Index field are blank.<br><br>**NOTE: See MAC Implementation File 9 available on the FY 2027 MAC Implementation Files webpage for complete instructions.** | | | | | | | | | |
| 14592.16 | MACs shall enter a 'Y' in Data Element 58 (Electronic Health Records (EHR) Program Reduction) in the PSF if the hospital (including Puerto Rico hospitals) is subject to a reduction due to NOT being an EHR meaningful user. | X | | | | | | | | |
| 14592.17 | Effective October 1, 2026, 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.<br><br>MACs shall ensure these fields are updated appropriately due to the expiration of the temporary changes to the low-volume hospital policy, effective January 1, 2027, as described in the policy section. | X | | | | | | | | |
| 14592.18 | Due to the expiration of the Medicare dependent hospital (MDH) program, effective January 1, 2027, 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 | X | | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | with a provider type value of '15' shall be updated to '07'. | | | | | | | | | |
| 14592.19 | 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, 2026. | X | | | | | | | | |
| 14592.20 | Medicare contractors shall ensure they are aware of the Average Length of Stay (ALOS) policies under the LTCH PPS at 412.23(e), including the manual update as described in the policy section. Questions on the application of the LTCH PPS ALOS policies should be directed to LTCHPPS@cms.hhs.gov. | 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**