

<https://www.cms.gov/training-education/medicare-learning-network/resources-training>

MLN6922507 January 2026

# Medicare Payment Systems

This Medicare Payment Systems educational tool explains how each service type payment system works.

A Prospective Payment System (PPS) refers to several payment formulas when reimbursement depends on predetermined payment regardless of the intensity of services provided. Medicare bases payment on codes using the classification system for that service (such as Diagnosis-Related Groups (DRGs) for hospital inpatient services and Ambulatory Payment Classification (APC) for hospital outpatient claims).

This tool explains the payment systems for inpatient hospitals, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, ambulatory surgical centers, durable medical equipment, prosthetics, orthotics, and supplies, home health, and skilled nursing facilities.

Feedback

Print

## Acute Care Hospital Inpatient Prospective Payment System

### What's Changed?

Updated the hospital inpatient prospective payment system for FY 2026

- Updated the hospital market basket increase for FY 2026
- Updated the number of Medicare Severity Diagnosis-Related Groups (MS-DRGs) for FY 2026
- Updated the labor-related share
- Updated dates for the Medicare Dependent Hospitals (MDHs) Program
- Updated information on temporary changes for low-volume hospitals
- Added the FY 2026 qualifications for a hospital to get the 0.25 payment adjustment

Substantive content changes are in dark red.

Hospitals contract with Medicare to deliver acute inpatient hospital care and agree to accept predetermined acute care hospital Inpatient Prospective Payment System (IPPS) rates as full payment.

The IPPS benefit covers Medicare patients for 90 days of care per episode of illness, with a 60-day lifetime reserve. An episode of care starts when the hospital admits the patient and ends after they've been out of the hospital or skilled nursing facility (SNF) for 60 consecutive days.

### ✦ Payment Updates

CMS makes updates to [IPPS payment rates](https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/ipp-s-regulations-and-notice) (<https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/ipp-s-regulations-and-notice>), including updates to base rates, wage indexes, Medicare Severity Diagnosis-Related Group (MS-DRG) definitions and weights, and the outlier fixed-loss amount. We update IPPS base rates annually based on the applicable market basket index and estimates of changes in productivity.

For FY 2026, the increase in IPPS operating payment rates is 2.6% for general acute care hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users. This reflects a projected FY 2026 IPPS hospital market basket update of 3.3%, reduced by the statutorily required 0.7 percentage-point productivity adjustment.

Congress sets the operating rate update by considering the projected increase in the hospital market basket index, which measures the price increases of goods and services hospitals buy to provide patient care.

## ✦ Payment Basis

We pay acute care hospitals an IPPS payment per inpatient case or discharge.

The admitting hospital, or an entity wholly owned or operated by the admitting hospital, must bill all outpatient diagnostic services and admission-related outpatient non-diagnostic services during the 3 days before admitting the patient to the hospital on the inpatient claim. Acute care hospitals can't separately bill Medicare Part B for these services.

Section 1886(d)(1)(B) of the [Social Security Act](https://www.ssa.gov/OP_Home/ssact/title18/1886.htm#act-1886-d-1-b) ([https://www.ssa.gov/OP\\_Home/ssact/title18/1886.htm#act-1886-d-1-b](https://www.ssa.gov/OP_Home/ssact/title18/1886.htm#act-1886-d-1-b)) excludes certain hospitals and hospital units from the IPPS, including:

- Cancer hospitals
- Children's hospitals
- Extended neoplastic disease care hospitals
- Hospitals located outside the 50 states, the District of Columbia, and Puerto Rico, including hospitals in:
  - American Samoa
  - Guam
  - Northern Mariana Islands
  - U.S. Virgin Islands
- Inpatient psychiatric facility hospitals and units
- Inpatient rehabilitation facility hospitals and units
- Long-term care hospitals (LTCHs)
- Religious nonmedical health care institutions

## Medicare Severity Diagnosis-Related Groups

We assign inpatient hospital discharges to MS-DRGs that are used to reflect patients' illness severity, service complexity, and hospital resource use. We don't make additional payments when the present on admission (POA) [indicator \(https://www.cms.gov/medicare/payment/fee-for-service-providers/hospital-acquired-conditions-hac/coding\)](https://www.cms.gov/medicare/payment/fee-for-service-providers/hospital-acquired-conditions-hac/coding) is N, U, or 1 for certain [hospital-acquired conditions \(https://www.cms.gov/medicare/payment/fee-for-service-providers/hospital-acquired-conditions-hac\)](https://www.cms.gov/medicare/payment/fee-for-service-providers/hospital-acquired-conditions-hac) (HACs). We define an MS-DRG by a group of similar clinical conditions and services requiring similar resource use. **There are 772 MS-DRGs for FY 2026.**

The patient's principal diagnosis, secondary diagnoses, procedures performed, sex, age, and discharge status determine MS-DRG assignment. We consider up to 25 diagnoses and 25 procedure codes for MS-DRG assignment. We review MS-DRG classifications annually and make adjustments to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

If our review shows that subsets of clinically similar cases within an MS-DRG use significantly different resources, we may propose reassigning them to different MS-DRGs with similar resource use or creating new MS-DRGs.

The 3 levels of severity in the MS-DRG system based on secondary diagnoses codes are:

1. **Major Complication or Comorbidity (MCC)** — diagnosis with the highest level of severity affecting hospital resource use
2. **Complication or Comorbidity (CC)** — diagnosis with a moderate level of severity affecting hospital resource use
3. **Non-Complication or Comorbidity (Non-CC)** — diagnosis with the lowest level of severity, which doesn't significantly affect illness severity and hospital resource use

Some MS-DRGs are subdivided (or split) into 2 or 3 severity levels according to these CC subgroups. Some MS-DRGs are not subdivided into severity levels; these are known as base MS-DRGs.

## ✦ IPPS Payment Rates

### Base Payment Amounts

We set operating and capital IPPS base rates (known as the standardized payment amounts).

Operating costs cover:

. . .

- Labor
- Supplies

Capital-related costs cover:

- Depreciation
- Interest
- Rent
- Property-related insurance and taxes

We annually adjust these payment rates for:

- The patient's clinical condition and related treatment costs compared to average Medicare case costs (MS-DRG relative weight)
- Market conditions in the hospital's location compared to national conditions (wage index)

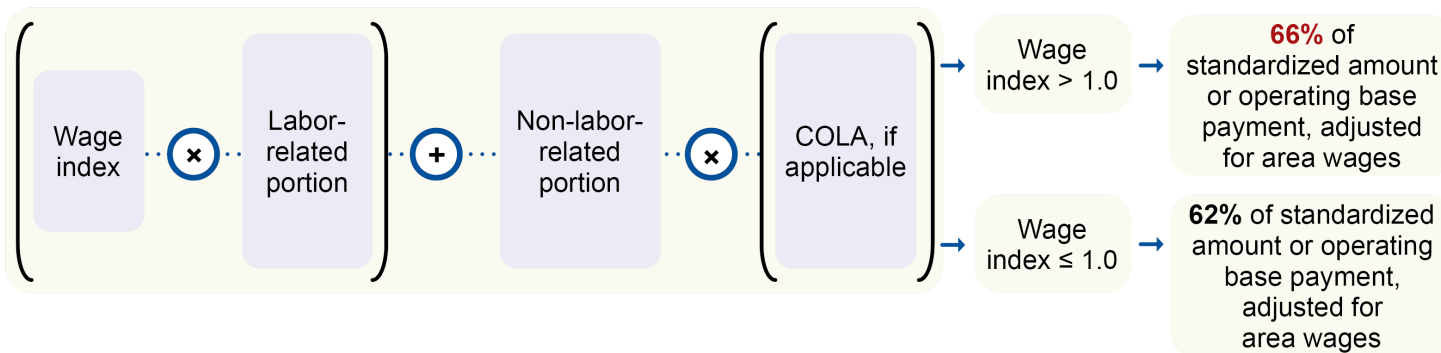
## Other IPPS Hospital Payment Adjustments

- Acute care hospitals' extremely high-cost cases can qualify for outlier payments.
- We pay hospitals that train residents in approved graduate medical education (GME) programs separately for the direct cost of training residents (direct GME). We also increase IPPS hospitals' operating and capital payment rates to reflect teaching hospitals' higher indirect patient care costs compared to those of non-teaching hospitals (indirect medical education (IME)).
- We increase hospitals' operating and capital payment rates for treating a disproportionate share of low-income patients. These hospitals also get uncompensated care payments.
- We may pay acute care hospitals to treat patients with certain newly approved, costly technologies that offer a substantial clinical improvement over existing treatments or that get certain FDA designations for breakthrough devices and antimicrobial products.
- Qualifying rural hospitals and critical access hospitals (CAHs) can get [pass-through payments \(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf#page=162\)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf#page=162) for certain certified registered nurse anesthetist services.
- We pay for nursing and allied health education activities on a reasonable cost basis subject to conditions and limitations in [42 CFR 413.85\(d\) \(https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-F/section-413.85#p-413.85\(d\)\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-F/section-413.85#p-413.85(d)).
- We pay reasonable and necessary costs for a hospital to get an organ as an adjustment to the hospital's IPPS payment.
- We make an add-on payment to hospitals for the costs of administering blood clotting factors to inpatients with hemophilia.
- We make an add-on payment to hospitals participating in a National Institutes of Health-sponsored islet cell transplantation clinical trial for patients with type 1 diabetes.
- We adjust IPPS payment for the added costs of buying U.S.-made, National Institute of Occupational Safety and Health-approved surgical N95 respirators. This applies to cost reporting periods that started on or after January 1, 2023.
- We adjust IPPS payment for certain small, independent hospitals for establishing and maintaining a buffer stock of essential medicines. This applies to cost reporting periods that started on or after October 1, 2024.
- We reduce payment in some cases when a patient has a short length of stay (LOS) and transfers to another acute care hospital or, in certain circumstances, to a post-acute care setting.
- We adjust IPPS payments under the Hospital Value-Based Purchasing (VBP) Program and the Hospital Readmissions Reduction Program (HRRP).
- HAC Reduction Program reduces overall IPPS payments for reasonably preventable HACs

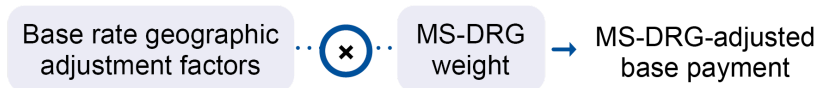
- The MAC Reduction Program reduces overall IPPS payments for reasonably preventable MACs.
- We make an add-on payment to “low-volume” hospitals that meet certain mileage and discharge criteria.

## How We Determine an IPPS Payment

1. The hospital submits a claim to its Medicare Administrative Contractor (MAC) for each patient. Based on the claim information, the MAC assigns the case to an MS-DRG.
2. The base payment rate, or standardized dollar amount, includes the labor-related and non-labor-related shares. We adjust the labor-related share by a wage index to reflect area labor cost differences. **Starting with FY 2026 discharges, the labor-related share equals 66% if the hospital’s wage index is greater than 1.0.** The law requires that the labor-related share equals 62% if the hospital’s wage index is less than or equal to 1.0. We adjust the non-labor-related share by a cost-of-living adjustment (COLA) factor equal to 1.0, except for hospitals in Alaska or Hawaii. This adjustment accounts for the higher cost of living in Alaska and Hawaii.
3. We multiply the wage-adjusted standardized amount by an MS-DRG weighting factor. The weight is specific to each MS-DRG, and each MS-DRG relative weight represents the average resources to treat cases in that MS-DRG compared to the average resources to treat cases in all MS-DRGs.

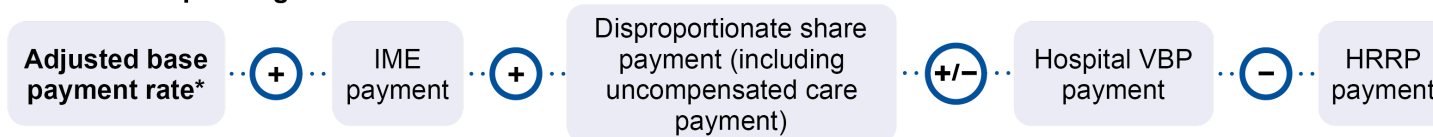


**I. Adjusted for case mix**

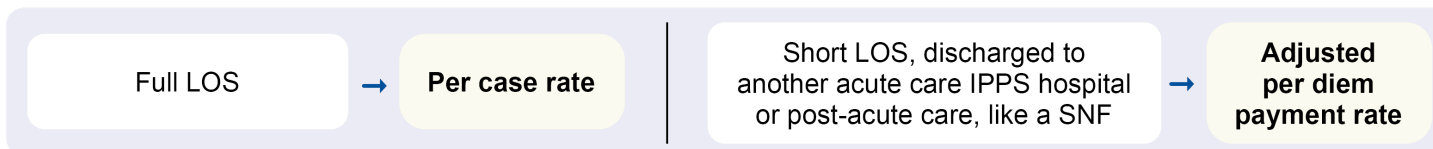


**Qualifying hospitals' policy adjustments:**

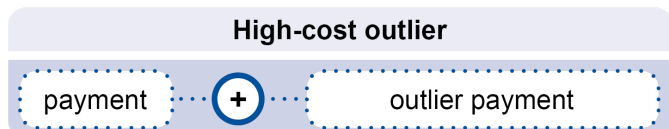
**I. Additional operating amounts**



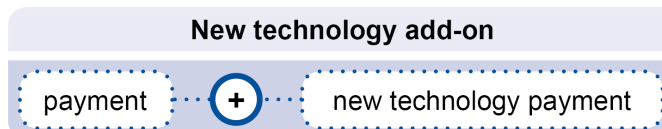
**II. Transfer adjustments**



**III. If the case is extraordinarily costly**



**IV. If the case qualifies for a new technology add-on**



Feedback

---

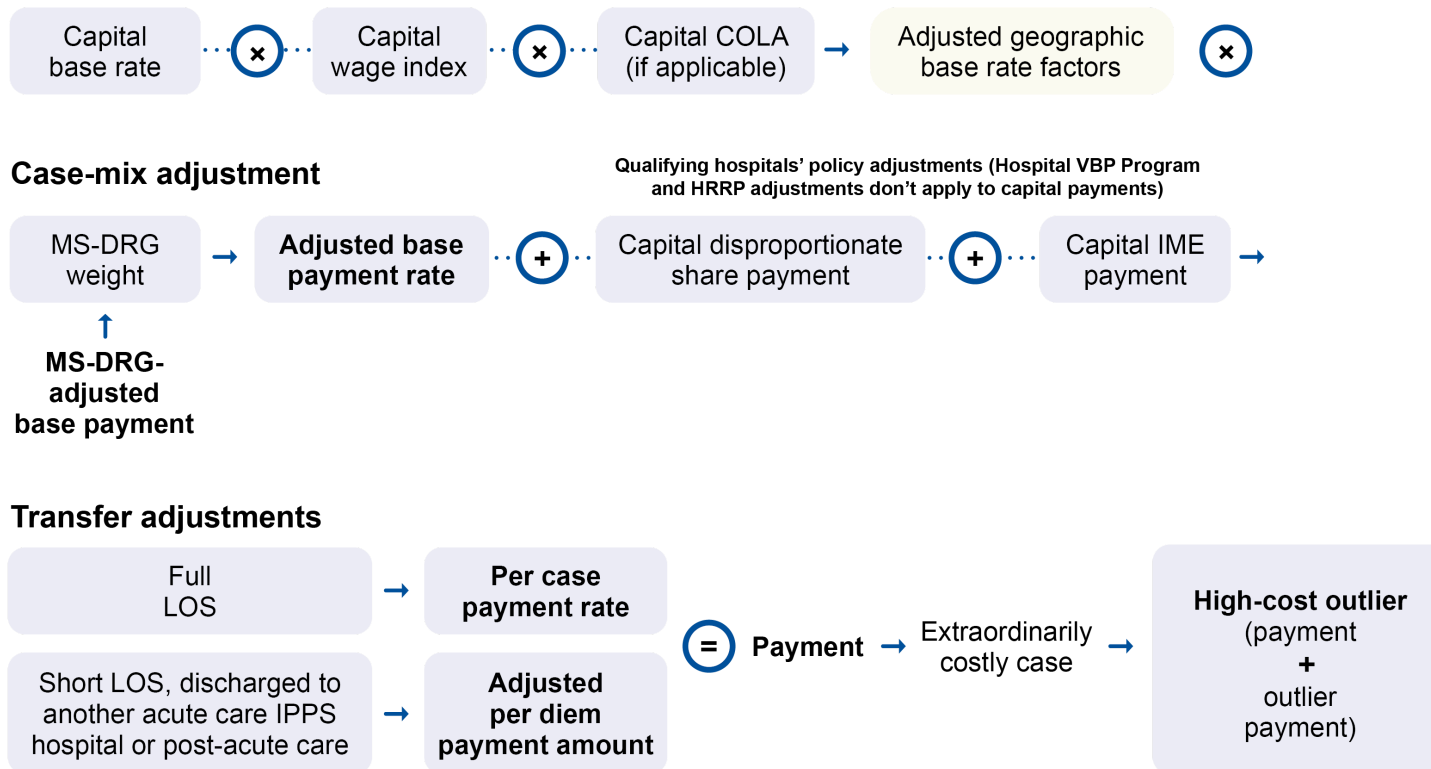
**V. If the hospital ranks in lowest performing HAC quartile**

(overall payment is -1%)

\* Shows the applicable Hospital IQR and Promoting Interoperability Programs payment adjustments.

**Figure 1. Acute Care Hospital IPPS: Operating Base Payment Rate Adjusted for Geographic Factors**

Feedback



Feedback

**Figure 2. Acute Care Hospital IPPS: Capital Base Payment Rate**

**❖ Setting Payment Rates**

## MS-DRG Relative Weights

We assign a weight to each MS-DRG that reflects the average case cost in that group compared to the average Medicare case cost, and we use the same MS-DRG weights for operating and capital payment rates.

We annually adjust the MS-DRG weights without affecting overall IPPS payments, based on standardized charges and all IPPS case costs in each MS-DRG. This adjustment includes a 10% cap on decreases in an MS-DRG relative weight from the previous FY. We standardize hospitals' billed charges to improve comparability by adjusting:

- Charges to remove differences in hospital wage rates across labor markets
- For the size and intensity of the hospital's resident training activities
- For the number of low-income inpatients treated

**Note:** We reduce charges to costs using national average hospital cost ratios to charges for 19 different hospital departments.

## Market Condition Adjustments

We adjust the operating and capital rates by an area wage index to reflect differences in local labor market prices. We measure these differences by comparing the average hourly wage (AHW) for hospital workers in each urban or statewide rural area to the national average.

We use the Office of Management and Budget's Core-Based Statistical Area delineations, with some modifications, to define each labor market area and annually revise the wage index based on IPPS hospital wage data.

If a hospital believes it competes for labor in an area different from its location, it may request geographic reclassification through the [Medicare Geographic Classification Review Board](https://www.cms.gov/medicare/regulations-guidance/geographic-classification-review-board) (<https://www.cms.gov/medicare/regulations-guidance/geographic-classification-review-board>) (MGCRB).

These policies also apply to the wage index:

- We apply a permanent 5% cap on any decrease to a hospital's wage index from its wage index in the previous year, regardless of what caused the decline.
- We apply the wage index to the whole capital base rate and raise it to a fractional power, narrowing the geographic variation in wage index values among labor market areas.
- We apply a COLA, reflecting higher supply and other non-labor resource costs, to the base IPPS operating and capital rates of hospitals in Hawaii and Alaska. We apply the COLA to the non-labor-related portion of the operating base rate and to the whole capital base rate.

## Bad Debts

Bad debts are when a patient doesn't pay their Medicare [coinsurance and deductible](https://www.medicare.gov/basics/costs/medi-care-costs) (<https://www.medicare.gov/basics/costs/medi-care-costs>). We may pay a hospital for Medicare bad debts at 65% of the allowable amount if they meet all requirements under [42 CFR 413.89](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-F/section-413.89) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-F/section-413.89>).

Providers can collect unpaid patient Medicare cost-sharing amounts unless both the:

- State Medicaid agency classifies the patient as categorically or medically needy
- Provider determines the patient is indigent for bad debt purposes

Providers must submit an [acceptable cost report](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-B/section-413.24#p-413.24(f)(5)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-B/section-413.24#p-413.24\(f\)\(5\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-B/section-413.24#p-413.24(f)(5))) with a detailed bad debt listing corresponding to their claimed bad debt amounts.

## ✦ Payment Adjustments

## Direct Graduate Medical Education

We pay teaching hospitals — or hospitals that train residents in approved medical allopathic, osteopathic, dental, or podiatric residency programs — for direct graduate medical education (DGME). These payments are for the approved residency training programs' direct operating costs.

We pay these separately from the IPPS per discharge payment and generally base DGME payments on the:

- Hospital-specific costs per resident in a historical base year, updated for inflation
- Number of residents a hospital trains
- Hospital's Medicare patient load (the proportion of Medicare inpatient days to total inpatient days)

## Indirect Medical Education

Teaching hospitals — or hospitals that train residents in approved medical allopathic, osteopathic, dental, or podiatric residency programs — also get an IME adjustment, which reflects the higher indirect patient care costs of teaching hospitals compared to those of non-teaching hospitals. We calculate the IME adjustment factor using a hospital's intern- and resident-to-bed ratio.

## Medicare Disproportionate Share Hospitals

We also pay for inpatient operating and capital costs to hospitals that serve a [disproportionate share of low-income patients](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.106) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.106>).

Hospitals get 25% of the amount they previously got under the traditional [Medicare disproportionate share hospital](https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/disproportionate_share_hospital.pdf) ([https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/disproportionate\\_share\\_hospital.pdf](https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/disproportionate_share_hospital.pdf)) (DSH) statutory formula. The remainder, equal to 75% of what we otherwise would pay as Medicare DSH operating payments, goes toward an uncompensated care payment after reducing the amount for the uninsured individuals' percentage change.

Each Medicare DSH gets an uncompensated care payment based on its share of uncompensated care costs compared to all Medicare DSHs. We annually update the factor estimates that determine each eligible DSH's uncompensated care payment.

For most Medicare DSHs, we calculate uncompensated care payments from the most recent years of audited [Worksheet S-10 data](https://www.cms.gov/medicare/compliance-and-audits/part-a-cost-report-audit-and-reimbursement/reviews-of-cost-report-worksheet-s-10) (<https://www.cms.gov/medicare/compliance-and-audits/part-a-cost-report-audit-and-reimbursement/reviews-of-cost-report-worksheet-s-10>) to determine each Medicare DSH's share of uncompensated care payments. For FY 2024 and subsequent years, we use an average of the uncompensated care data from the 3 most recent FYs for which audited data is available.

**Note:** For Indian Health Service hospitals, tribal hospitals, and hospitals in Puerto Rico, we use the same multi-year average of Worksheet S-10 data to determine Factor 3 for FY 2024 and subsequent FYs. We also established a new

supplemental payment for these hospitals under [42 CFR 412.106\(h\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G#p-412.106(h)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G#p-412.106\(h\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G#p-412.106(h))).

## Sole Community Hospitals

A Medicare IPPS hospital is eligible for sole community hospital (SCH) classification if it's located more than 35 miles from other like hospitals, or it's located in a rural area (as defined in [42 CFR 412.64](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-D/section-412.64) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-D/section-412.64>)) and meets 1 of the criteria in [42 CFR 412.92](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.92) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.92>).

We don't consider a nearby hospital to be a like hospital if its total inpatient days are less than or equal to 8% of similarly calculated total inpatient days of the hospital seeking SCH status. We base:

- SCH operating payments on the higher of the federal rate payment or its hospital-specific rate payment
- Capital payments on the capital base rate (like all other IPPS hospitals)

SCHs may qualify for a payment adjustment if they experience a [significant volume decrease](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.92#p-412.92(e)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.92#p-412.92\(e\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.92#p-412.92(e))).

For IPPS purposes, we treat certain hospitals formerly designated as [essential access community hospitals \(EACHs\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.109) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.109>) as SCHs.

## Medicare-Dependent Hospitals

A Medicare IPPS hospital is eligible for Medicare-dependent hospital (MDH) classification if it meets the criteria in [42 CFR 412.108](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.108) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.108>).

We base MDH operating payments on the higher of the federal rate payment or the federal rate payment plus 75% of the difference between the federal rate payment and its hospital-specific rate payment.

MDHs may qualify for a payment adjustment if they experience a [significant volume decrease](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.92#p-412.92(e)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.92#p-412.92\(e\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.92#p-412.92(e))).

Section 2202 of the [Full-Year Continuing Appropriations Act, 2025](https://www.congress.gov/119/plaws/publ4/PLAW-119publ4.pdf#page=34) (https://www.congress.gov/119/plaws/publ4/PLAW-119publ4.pdf#page=34), extended the MDH Program through FY 2025. Starting with discharges on or after October 1, 2025, we'll pay MDH hospitals based solely on the federal rate.

## Rural Referral Centers

The Rural Referral Center (RRC) Program supports high-volume rural hospitals. We generally classify a Medicare-participating acute care hospital as an RRC if it's in a rural area for IPPS payment purposes and meets the criteria in [42 CFR 412.96](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.96) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.96).

Current RRCs or hospitals that previously had RRC status get certain advantages:

- **Proximity for MGCRB Reclassification:** A hospital currently or previously designated as an RRC doesn't need to demonstrate proximity to the area where it gets reclassified. A hospital can apply for reclassification to the closest urban or rural area.
- **AHW Data Comparison for MGCRB Reclassification:** A hospital currently or previously designated as an RRC is exempt from the AHW requirement that a hospital's AHW must exceed, by a certain percentage, the AHW of the labor market area where the hospital is located. In addition, regardless of whether located in an urban or rural area, a current or previously designated RRC must only exceed the rural requirement (82%) for the comparison of the hospital's AHW to its desired reclassified area.
- **Medicare DSH Cap:** We exempt hospitals designated as RRCs from the 12% cap on Medicare operating DSH payments applicable to other rural hospitals.

Feedback

## Low-Volume Hospitals

Section 2201 of the [Full-Year Continuing Appropriations Act, 2025](https://www.congress.gov/119/plaws/publ4/PLAW-119publ4.pdf#page=34) (https://www.congress.gov/119/plaws/publ4/PLAW-119publ4.pdf#page=34), extended the temporary changes (the modified definition of low-volume hospital and methodology for calculating the payment adjustment) for low-volume hospitals (under section 1886(d)(12) of the [Social Security Act](https://www.ssa.gov/OP_Home/ssact/title18/1886.htm#act-1886-d-12) (https://www.ssa.gov/OP\_Home/ssact/title18/1886.htm#act-1886-d-12)) through FY 2025.

For FYs 2019 through 2025, we make add-on payments to a qualifying low-volume hospital more than 15 road miles from the nearest [subsection \(d\) hospital](https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/inpatient-reporting-program) (https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/inpatient-reporting-program) if it discharges less than 3,800 total patients during the FY based on its most recently submitted cost report. For each Medicare patient discharge:

- For qualifying low-volume hospitals with 500 or fewer total discharges, the payment adjustment is 0.25
- For qualifying low-volume hospitals with more than 500 but less than 3,800 total discharges, we calculate a low-volume hospital payment adjustment as  $0.25 - [0.25/3,300] \times (\text{number of total discharges} - 500) = (95/330) - (\text{number of total discharges}/13,200)$

For FY 2026, to qualify for the 0.25 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 [42 CFR 412.101\(b\)\(2\)\(i\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.101#p-412.101(b)(2)(i)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.101#p-412.101\(b\)\(2\)\(i\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-G/section-412.101#p-412.101(b)(2)(i))).

## Outlier Payments

We make additional payments for extremely costly outlier cases to promote seriously ill patients' access to high-quality inpatient care. We identify these cases by comparing their estimated operating and capital costs to a fixed-loss threshold.

We annually set the fixed-loss threshold and adjust it to reflect local labor market costs.

We pay outliers by offsetting reductions in the operating and capital base rates (reducing the payment rates to all cases so outlier payments don't increase or decrease estimated aggregate Medicare spending).

We set the national fixed-loss threshold at 5.1% of total FY payments. Our methodology incorporates a projection of operating outlier payment reconciliations for the outlier threshold calculation.

## Transfer Policy

We reduce MS-DRG payments when the patient's LOS is at least 1 day less than the geometric mean MS-DRG LOS and the hospital transfers the patient to 1 of these:

- Another IPPS-covered acute care hospital or, for certain MS-DRGs, a post-acute care setting
- A hospital not participating in Medicare
- A CAH

Our transfer policy includes these post-acute care settings:

~ . . .

- Cancer hospitals
- Children's hospitals
- Home health care, when the patient gets clinically related care that starts within 3 days after a hospital stay
- Hospice care
- LTCHs
- Psychiatric distinct part units located in an acute care hospital or a CAH
- Psychiatric facilities
- Rehabilitation distinct part units located in an acute care hospital or a CAH
- Rehabilitation facilities
- SNFs

## New Technology Add-On Payments

We make an additional payment for [new medical services and technologies](https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/new-medical-services-and-new-technologies) (https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/new-medical-services-and-new-technologies) that meet the criteria in [42 CFR 412.87\(b\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412#p-412.87(b)) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412#p-412.87(b)).

Certain new transformative devices and antimicrobial products may qualify under an alternative inpatient new technology add-on payment pathway discussed in [42 CFR 412.87\(c\) and \(d\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412#p-412.87(c)) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412#p-412.87(c)).

The [Medicare Electronic Application Request Information System™](https://mearis.cms.gov/public/home) (https://mearis.cms.gov/public/home) (MEARIS™) allows users to submit:

- New technology add-on payment applications
- Requests for ICD-10-PCS procedure codes
- MS-DRG classification change requests

**Note:** We accept MS-DRG classification change requests only if they're submitted through MEARIS™. We no longer accept email requests.

## Hospital Readmissions Reduction Program

HRRP is a Medicare VBP program that encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions. HRRP supports the national goal of improving health care for Americans by linking payment to the quality of hospital care.

We include [readmission measures \(https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-readmissions-reduction-program-hrrp\)](https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-readmissions-reduction-program-hrrp) for specific conditions or procedures that significantly affect the lives of many Medicare patients. Under HRRP, we reduce payments to hospitals with higher-than-expected rates of readmission following treatment for select conditions and procedures, encouraging hospitals to provide high-quality care to reduce avoidable returns to the hospital.

## Hospital Value-Based Purchasing Program

The [Hospital VBP Program \(https://www.cms.gov/medicare/quality/value-based-programs/hospital-purchasing\)](https://www.cms.gov/medicare/quality/value-based-programs/hospital-purchasing) delivers upward, downward, or neutral adjustments to participating hospitals' base operating MS-DRG payments based on their quality measure performance. We fund value-based incentive payments by reducing hospitals' base operating MS-DRG payment amounts. The Hospital VBP Program generally applies to all acute IPPS hospitals, with certain exceptions.

The applicable reduction to hospitals' base operating MS-DRG payment amount is 2%. Each hospital then may earn back a value-based incentive payment that's more than, equal to, or less than the 2% reduction, depending on their measure performance.

## Hospital-Acquired Condition Reduction Program

A HAC is a condition a patient gets during hospitalization (the condition wasn't present on admission). The [HAC Reduction Program \(https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-acquired-condition-reduction-program-hacrp\)](https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-acquired-condition-reduction-program-hacrp) is a VBP program that links Medicare payments to health care quality in the inpatient hospital setting.

We reduce overall Medicare IPPS payments by 1% for hospitals that rank in the worst-performing quartile of all hospitals on measures of HACs. Under the HAC Reduction Program, we rank hospitals on their total of [preventable conditions \(http](http://www.cms.gov/medicare/quality/value-based-programs/hospital-purchasing)

[s://www.cms.gov/medicare/payment/fee-for-service-providers/hospital-acquired-conditions-hac](https://www.cms.gov/medicare/payment/fee-for-service-providers/hospital-acquired-conditions-hac)).

## ✦ Inpatient Quality Reporting & Promoting Interoperability Programs

The [Hospital IQR Program](https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/inpatient-reporting-program) provides quality-of-care information so patients can make informed decisions about their health care options. It also encourages hospitals and providers to improve their quality of inpatient care by making sure they're aware of, and reporting on, best practices for their facilities.

Find current quality reporting measures on [IQR Measures](https://qualitynet.cms.gov/inpatient/iqr/measures).

Hospitals that don't meet reporting requirements get a 1/4 reduction to the percentage increase in the market basket index. For hospitals that aren't meaningful EHR users and don't get an exemption, 3/4 of the percentage increase is further reduced by 100%.

### Resources

- [2026 Acute Care Hospital IPPS Final Rule](https://federalregister.gov/d/2025-14681)
- [CMS Acute Inpatient PPS](https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps)
- [CMS Newsroom: FY 2026 Hospital IPPS and LTCH PPS Final Rule](https://www.cms.gov/newsroom/fact-sheets/fy-2026-hospital-inpatient-prospective-payment-system-ipp-pps-and-long-term-care-hospital-prospective-0)
- [Medicare Provider Reimbursement Manual](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929)
- [Web Pricer](https://webpricer.mps.cms.gov)

Feedback

Print

## Ambulatory Surgical Center Payment System & Coverage

## What's Changed?

We updated the:

- Skin substitute coverage information
- Ambulatory surgical center (ASC) Covered Procedures List (CPL)
- CY 2026 payment rates

Substantive content changes are in dark red.

Ambulatory surgical centers (ASCs) provide outpatient surgical services to patients who don't need hospitalization and typically are discharged less than 24 hours after admission. Medicare ASC patients don't typically need active medical monitoring at midnight on the procedure day.

Medicare-certified ASCs must enter into a [legal agreement](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-416/subpart-B) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-416/subpart-B>) with us to get paid. An ASC can be:

- Independent (not part of a service provider or other facility)
- Hospital-operated (under a hospital's common ownership, licensure, or control) if the ASC:
  - Is a separately identifiable and certified facility and is Medicare-enrolled with a supplier approval agreement distinct from the hospital's Medicare provider agreement
  - Is physically, administratively, and financially independent and distinct from other hospital operations, with its costs treated as a non-reimbursable cost center on the hospital's cost report
  - Agrees to the same assignment, coverage, and payment rules as independent ASCs
  - Is surveyed and approved as complying with the ASC conditions for coverage (CfCs)

Feedback

A hospital-operated ASC isn't like a provider-based outpatient surgery hospital department.

A provider-based outpatient hospital department, including an outpatient surgery department:

- May be on or off campus
- Is an integral part of the hospital, subject to the hospital conditions of participation
- Isn't separately Medicare-enrolled or Medicare-certified or subject to the ASC coverage conditions

### ✦ Conditions for Coverage

Each ASC must comply with the [CfCs \(https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-416/subpart-C\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-416/subpart-C), which are health and safety regulations. Each condition has several standards. In general, ASCs must meet established standards for:

Feedback

- Processes to remain compliant with state licensure laws
- A governing body and management
- Safe surgical procedures
- Quality assessment and performance improvement
- A safe and sanitary environment to protect patients' health and safety
- Medical staffing
- Nursing services
- Complete, comprehensive, and accurate medical records
- Pharmaceutical services
- Lab and radiology services
- Patients' rights
- Infection prevention and control to minimize infections and communicable diseases
- Patient admission, assessment, and discharge
- Emergency preparedness

### ✦ ASC Facility Services

The ASC payment system establishes payment rates for eligible ASC procedures.

ASCs get a single payment for each procedure we cover, including these facility items and services:

.. . . . .

- Nursing, technician, and related services
- Facility use for surgical procedures
- Clinical Laboratory Improvement Amendments-waived tests
- Drugs and biologicals (when we make no separate Outpatient Prospective Payment System (OPPS) payment)
- Medical and surgical supplies not on [pass-through status](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419/subpart-G) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419/subpart-G>)
- Equipment
- Surgical dressings
- Implantable prosthetic devices, including intraocular lenses and related accessories and supplies not on pass-through status
- Implanted DME and related accessories and supplies not on pass-through status
- Splints, casts, and related devices
- Radiology services and diagnostic tests or interpretive services for which we don't allow separate payment under the OPPS
- Administrative, record keeping, and housekeeping items and services
- Anesthesia administration and monitoring supplies and equipment
- Anesthetist services supervised by the operating surgeon
- Blood, blood plasma, and platelets, except when the [blood deductible](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf#page=180) (<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf#page=180>) applies

Feedback

### ✦ ASC Ancillary Services

We pay separately for ASC ancillary services that are integral to a surgical procedure we cover. Covered ancillary items and services, which can be provided immediately before, during, or after the procedure, include:

OPPS | | | | |

- OPPS drugs and biologicals paid separately
- OPPS radiology services and diagnostic tests paid separately
- **Groups of skin substitute supply products that are separately payable under the OPPS**
- Brachytherapy sources
- Certain implantable items with OPPS pass-through status
- Corneal tissue acquisition
- Non-opioid pain management drugs, biologicals, and medical devices

[42 CFR 416.164\(c\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-416#p-416.164(c)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-416#p-416.164\(c\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-416#p-416.164(c))) lists ASC items and services we don't cover.

### ✿ Covered Surgical Procedures

We cover surgical procedures that meet [42 CFR 416.166\(a\) – \(e\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-416/subpart-F/section-416.166) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-416/subpart-F/section-416.166>) requirements.

We evaluate the ASC Covered Procedures List (CPL) each year to determine whether we'll add or remove procedures. **For CY 2026, we finalized our proposal to revise the ASC CPL criteria to modify the general standard criteria and to eliminate 5 of the general exclusion criteria, moving them into a new section as nonbinding physician considerations for patient safety. As a result of these criteria changes, we added 289 procedures to the ASC CPL. Additionally, we added 271 codes to the ASC CPL that were removed from the Inpatient Only List for CY 2026.**

### ✿ Payment & Billing

Certified providers or suppliers may provide and bill for [other services in ASCs](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf#page=12) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf#page=12>) that aren't considered ASC services. ASCs should submit claims on the [CMS-1500 or the electronic equivalent, 837P](https://www.cms.gov/files/document/mln006976-medicare-billing-cms-1500-837p.pdf) (<https://www.cms.gov/files/document/mln006976-medicare-billing-cms-1500-837p.pdf>).

We charge the ASC patient their 20% coinsurance payment after they meet their yearly Medicare Part B [deductible](https://www.medicare.gov/basics/costs/medicare-costs) (<https://www.medicare.gov/basics/costs/medicare-costs>). We waive coinsurance and deductibles for certain preventive services.

## ✦ Unit of Payment

Under the ASC payment system, we pay prospectively determined amounts for services connected to covered surgical procedures the ASC provides to patients. CPT and HCPCS codes identify the surgical procedures and ancillary services we cover.

## ✦ Setting Payment Rates

Using the OPPS Ambulatory Payment Classification relative payment weights, we annually revise the ASC relative payment weights for most covered surgical procedures in the ASC payment system, since ASCs don't submit cost reports. We then scale those ASC relative weights for the ASC payment system to ensure budget neutrality. For device-intensive procedures, we set the device amounts of these surgical procedures equal to the device amount under the OPPS (based on the standard ASC rate setting methodology). The device-related portion of device-intensive procedure isn't scaled. To calculate the ASC payment rates for ASC-covered surgical procedures with ASC relative weights, we multiply the [ASC conversion factor](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-416#p-416.171(a)) (CF) by the ASC relative payment weight. Covered surgical procedures that don't have ASC relative weights are those paid at the Physician Fee Schedule (PFS) rate. To calculate the ASC payment rates for procedures paid at the PFS rate, we multiply the PFS CF by the PFS non-facility practice expense relative value unit (PE RVU).

We scale ASC relative payment weights for ASC-covered surgical procedures, covered ancillary radiology services, and certain diagnostic tests.

The weight scalar is the ratio of the current CY expenditures to the upcoming CY total expenditures. We apply it to the upcoming CY relative payment weights to maintain budget neutrality.

We annually adjust the CF for budget neutrality by removing the total expenditures impact from changes in wage index values for the upcoming year compared with the current year through a wage index scalar.

Since CY 2019, we've updated the ASC CF using the productivity-adjusted hospital market basket update factor.

**For CY 2026, we finalized a 2.6% update factor to ASC payment rates for ASCs meeting the quality reporting requirements. We base this update on the final hospital market basket update of 3.3%, reduced by a 0.7 percentage point productivity adjustment.**

We apply a 0.6% hospital market basket update factor to the CY 2025 ASC CF for ASCs not meeting the quality reporting requirements.

For each procedure or service, ASCs get the lesser of the actual charge or the ASC payment rate.

We make a geographic payment adjustment using modified pre-floor and pre-reclassified inpatient hospital wage index values. Any reduction in a geographic area's pre-floor and pre-reclassified inpatient hospital wage index values is capped at a 5% reduction. The ASC wage index value is applied to the 50% labor-related factor for covered surgical procedures and certain covered ancillary services. We make an additional adjustment when the ASC provides multiple surgical procedures in the same encounter or when ASC personnel stop procedures before starting anesthesia.

**Table 1. Alternative Payment Rate Methods**

<b>Surgical Procedure or Ancillary Service</b>	<b>Payment Method</b>
Procedures CMS classifies as office-based and performed in a physician's office at least 50% of the time	Paid at the lower of the ASC rate or the non-facility PE RVU amount of the relevant year's PFS
Device-intensive procedures (ASC-covered surgical procedures which require an insertable or implantable device and the estimated device offset percentage is greater than 30% of the HCPCS code's geometric mean cost based on the most recent data)	Paid with the procedure's device-related portion and a non-device-related portion, calculated according to the standard rate-setting method
Separately payable facility costs for covered ancillary radiology services	Paid at the lower of the ASC rate or the technical component or non-facility PE RVU amount of the same year's PFS (whichever applies)
Separately payable OPPI drugs, biologicals, and radiopharmaceuticals (except non-opioid pain management drugs or biologicals)	Paid at the same amount as OPPI
Non-opioid pain management drugs or biologicals when provided in the ASC setting	Separately paid, generally at the average sales price plus 6%, and subject to a payment limitation (an estimated volume weighted average of 18% of the payment rates of the top 5 primary procedures by volume into which a non-opioid treatment for pain relief would have its payment packaged)

Feedback

Non-opioid pain management devices	Separately paid at the amount of the provider's charges for the device, adjusted to cost, and subject to a payment limitation (an estimated volume weighted average of 18% of the payment rates of the top 5 primary procedures by volume into which a non-opioid treatment for pain relief would have its payment packaged)
Brachytherapy sources	Paid the same as OPSS rates if a prospective OPSS rate is available (otherwise, we pay at contractor-priced rates); we don't adjust payment for geographic wage differences
Skin substitute products	Paid the same amount as the OPSS; we don't adjust payment for geographic wage differences
Low-volume device-intensive procedures	Paid at the ASC rate (including device-intensive adjustments), not to exceed the procedure's OPSS payment rate
Primary surgical procedure and packaged add-on code combinations that are eligible for complexity adjustments under the OPSS and performed in the ASC setting	Paid at the ASC rate through C codes that correspond to each unique code combination, calculated on the basis of the OPSS complexity-adjusted rate

### ❖ ASC Payment System Updates

[ASC Payment](https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc) (<https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc>) explains final ASC payment policies, the ASC CPL and payment rates, and the ASC payment system quarterly addenda updates.

### ❖ ASC Quality Reporting Program

The [ASC Quality Reporting \(ASCQR\) Program](https://data.cms.gov/provider-data/topics/hospitals/ambulatory-surgical-centers) (<https://data.cms.gov/provider-data/topics/hospitals/ambulatory-surgical-centers>) is a pay-for-reporting quality program for the ASC setting. It publicly reports on quality-of-care measures, quality improvement, and information transparency to promote better health outcomes for Medicare patients. Facilities can also view their data and compare their performance with other outpatient settings' through the [ASC Compare](https://www.qualityreportingcenter.com/en/ascqr-program/data-dashboard/asc-compare-tool) (<https://www.qualityreportingcenter.com/en/ascqr-program/data-dashboard/asc-compare-tool>) tool on [Quality Reporting Center](https://www.qualityreportingcenter.com/en) (<https://www.qualityreportingcenter.com/en>).

Eligible ASCs that don't report their quality data according to program requirements get a reduction of 2% from their annual fee schedule update in the next payment determination year.

Find more information about the ASCQR Program on [QualityNet \(https://qualitynet.cms.gov/asc\)](https://qualitynet.cms.gov/asc) and in [42 CFR 416 Subpart H \(https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-416#subpart-H\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-416#subpart-H).

## Resources

- [2026 ASC Final Rule \(https://www.federalregister.gov/d/2025-20907\)](https://www.federalregister.gov/d/2025-20907)
- [ASC Center \(https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/ambulatory-surgical-centers\)](https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/ambulatory-surgical-centers)
- [CMS Newsroom: CY 2026 Hospital OPPS and ASC Payment System Final Rule \(https://www.cms.gov/newsroom/fact-sheets/calendar-year-2026-hospital-outpatient-prospective-payment-system-ops-ambulatory-surgical-center\)](https://www.cms.gov/newsroom/fact-sheets/calendar-year-2026-hospital-outpatient-prospective-payment-system-ops-ambulatory-surgical-center)
- [Guidance for Surveyors: ASCs \(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap\\_1\\_ambulatory.pdf\)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_1_ambulatory.pdf)
- [Medicare Claims Processing Manual, Chapter 14 \(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf\)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf)

Print

## DMEPOS Fee Schedule

---

### What's Changed?

- Added information on the prior authorization exemption process
- Updated the 2026 total factor productivity (TFP) adjustment

Substantive content changes are in dark red.

Medicare Part B (medical insurance) covers various DMEPOS items and services when a qualified provider prescribes them and documents medical necessity that meets Medicare coverage requirements.

We limit our DME coverage to medically necessary items and services used in a Medicare patient's home, including an institution serving as the patient's home. A hospital or skilled nursing facility isn't considered a patient's home.

### ✦ DMEPOS Payments

We pay for DMEPOS items and services through either:

Feedback

- A [fee schedule](https://www.cms.gov/medicare/payment/fee-schedules/dmepos/dmepos-fee-schedule) (https://www.cms.gov/medicare/payment/fee-schedules/dmepos/dmepos-fee-schedule). We update the schedule in January (and in April, July, and October, if needed). We pay 80% of the supplier's actual charge or the fee schedule amount, whichever is lower. The patient pays the remaining 20% [coinsurance](https://www.medicare.gov/basics/costs/medicare-costs) ( https://www.medicare.gov/basics/costs/medicare-costs) after they've paid their deductible.
- The [Competitive Bidding Program \(CBP\)](https://www.cms.gov/medicare/payment/fee-schedules/dmepos-competitive-bidding) (https://www.cms.gov/medicare/payment/fee-schedules/dmepos-competitive-bidding), which requires bidders to compete for supplier contracts that provide DMEPOS items throughout a competitive bidding area. Contract suppliers must accept assignment on all claims for bid items, and we pay a single amount. A temporary gap period in the DMEPOS CBP started on January 1, 2024. During the temporary gap period, any Medicare-enrolled DMEPOS supplier may provide a DMEPOS item, including items that were formerly included in the CBP.

We pay for certain DMEPOS items and services on a fee schedule based on sections 1834(a), (h), and (i) of the [Social Security Act](https://www.ssa.gov/OP_Home/ssact/title18/1834.htm) (https://www.ssa.gov/OP\_Home/ssact/title18/1834.htm) and [42 CFR 414.102](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-C/section-414.102) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-C/section-414.102) for parenteral and enteral nutrition, splints, casts, and intraocular lenses inserted at a physician's office.

The fee schedule files contain certain HCPCS codes that are subject to fee schedule adjustments using payment information from the CBP. We determine the payments for these items under the CBP and adjust the fee schedule amounts for the items using payment information from the program when they're provided outside the program (in non-competitive bidding areas).

The fee schedule adjustment methodologies and regulations at [42 CFR 414.210\(g\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-D/section-414.210#p-414.210(g)) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-D/section-414.210#p-414.210(g)) consider the differences in the costs of items from competitive bidding areas versus non-competitive bidding areas. The fee schedule files also include codes for items and services that aren't subject to the program or fee schedule adjustments.

The [DMEPOS Fee Schedule: CY 2026 Update](https://www.cms.gov/files/document/mm14326-dmepos-fee-schedule-cy-2026-update.pdf) (https://www.cms.gov/files/document/mm14326-dmepos-fee-schedule-cy-2026-update.pdf) has more information on DMEPOS fee schedule amounts and adjustments.

For more payment guidance, see:

- [42 CFR 410.38 \(DMEPOS Scope and Conditions\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.38) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.38>)
- [Medicare Benefit Policy Manual, Chapter 15](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>)
- [Medicare Claims Processing Manual, Chapter 20](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf>)
- [National and Local Coverage Determinations](https://www.cms.gov/medicare-coverage-database/search.aspx) (<https://www.cms.gov/medicare-coverage-database/search.aspx>)

## ✦ Master List

We've streamlined regulatory requirements to help simplify DMEPOS payment requirements and reduce provider and supplier burden through the [Master List of DMEPOS Items Potentially Subject to Conditions of Payment](https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/master-list-dmepos-items-potentially-subject-conditions-payment) (<https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/master-list-dmepos-items-potentially-subject-conditions-payment>). The Master List is a library of Fee-for-Service DMEPOS codes that are flagged as potential vulnerabilities.

Providers and suppliers don't need to act unless an item on the Master List also appears on 1 or both of these lists:

- [Required Prior Authorization List](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/DMEPOS_PA_Required-Prior-Authorization-List.pdf) ([https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/DMEPOS\\_PA\\_Required-Prior-Authorization-List.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/DMEPOS_PA_Required-Prior-Authorization-List.pdf))
- [Required Face-to-Face Encounter and Written Order Prior to Delivery List](https://www.cms.gov/files/document/required-face-face-encounter-and-written-order-prior-delivery-list.pdf) (<https://www.cms.gov/files/document/required-face-face-encounter-and-written-order-prior-delivery-list.pdf>)

## ✦ Prior Authorization

Some DMEPOS items that are frequently subject to unnecessary use require [prior authorization](https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/prior-authorization-process-certain-durable-medical-equipment-prosthetics-orthotics-and-supplies) (<https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/prior-authorization-process-certain-durable-medical-equipment-prosthetics-orthotics-and-supplies>) as a condition of payment, and these items are on the [Required Prior Authorization List](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/DMEPOS_PA_Required-Prior-Authorization-List.pdf) ([https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/DMEPOS\\_PA\\_Required-Prior-Authorization-List.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/DMEPOS_PA_Required-Prior-Authorization-List.pdf)). The prior authorization process ensures you meet all

coverage, coding, and clinical documentation requirements before you provide the item to the patient and submit the claim.

Starting January 1, 2026, we'll offer suppliers an exemption from required prior authorization if they achieve an approval rate of at least 90% of prior authorization requests during an initial or periodic assessment. You can decline this exemption. If we withdraw the exemption because you don't continue to meet the 90% approval rate, we'll notify you at least 60 days before the effective date.

[Prior Authorization and Pre-Claim Review Initiatives \(https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives\)](https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives) has more information.

## ✦ Payment Updates

Along with annual updates in January, we sometimes update fee schedules in April, July, and October when we:

- Add new items (HCPCS codes)
- Make necessary fee schedule corrections
- Apply statute or regulation changes as outlined in the [Medicare Claims Processing Manual, Chapter 23 \(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf#page=73\)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf#page=73), section 60

Section 1834(a)(14)(L) of the [Social Security Act \(https://www.ssa.gov/OP\\_Home/ssact/title18/1834.htm#act-1834-a-14-l\)](https://www.ssa.gov/OP_Home/ssact/title18/1834.htm#act-1834-a-14-l) updates certain DMEPOS fee schedule amounts by the percentage increase in the Consumer Price Index for all Urban Consumers (CPI-U) (U.S. city average) for the 12-month period ending June 30 of the previous year.

We base this adjustment on the economy-wide productivity change equal to the 10-year moving average of changes in annual economy-wide private non-farm business total factor productivity (TFP).

For 2026, the TFP adjustment is 0.7%, and the CPI-U percentage increase is 2.7%. We reduced the 2.7% increase in the CPI-U by the 0.7% increase in the TFP, resulting in a net 2% increase update factor.

## ✦ DMEPOS Refill Policy

We require documentation indicating that the patient confirmed the need for the refill within the 30-day period before the end of the current supply. Delivery of DMEPOS items (in other words, the date of service) can't be sooner than 10 calendar days before the expected end of the current supply.

## Resources

- [42 CFR 414.229 \(Capped Rental Items\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-D/section-414.229) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-D/section-414.229)
- [42 CFR 414 Subpart F \(Competitive Bidding for Certain DMEPOS\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-F) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-F)
- [DMEPOS Order and Face-to-Face Encounter Requirements](https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/dmepos-order-requirements) (https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/dmepos-order-requirements)
- [Medicare DMEPOS Payments While Inpatient](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedDMEPOSInpatient-MLN1541573.pdf) (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedDMEPOSInpatient-MLN1541573.pdf)

## Home Health Prospective Payment System & Coverage

---

Print

Feedback

## What's Changed?

For CY 2026, we updated the:

- Face-to-face encounter requirement
- Market basket increase
- Permanent and temporary payment adjustments
- Case-mix budget neutrality factor
- Fixed-dollar loss ratio
- Home health payment percentage for home health agencies (HHAs) that don't submit the required quality data

Substantive content changes are in dark red.

Medicare pays home health agencies (HHAs) a national, standardized 30-day period payment rate that includes a bundle of home health services, including skilled nursing, physical therapy, speech-language pathology, occupational therapy, medical social services, and home health aides. Periods of care must meet a certain threshold of home health visits. We adjust the payment rate for case-mix and geographic differences in wages. We pay a per-visit payment rate for the care provided during 30-day periods that don't meet the per-visit threshold. The [Patient-Driven Groupings Model](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/HomeHealthPPS/Downloads/Overview-of-the-Patient-Driven-Groupings-Model.pdf) (<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/HomeHealthPPS/Downloads/Overview-of-the-Patient-Driven-Groupings-Model.pdf>) (PDGM) bases payments on 30-day periods and relies on clinical characteristics and other Medicare patient information to place home health care periods into meaningful payment categories.

The 30-day period payment may also include some medical supplies.

## ❖ Home Health Service Qualifications

We cover home health services if:

- The patient meets the criteria outlined in:
  - [Medicare Benefit Policy Manual, Chapter 7](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=23) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=23>), section 30
  - [42 CFR 409.42](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-409/subpart-E/section-409.42) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-409/subpart-E/section-409.42>)
  - Sections [1814\(a\)\(2\)\(C\)](https://www.ssa.gov/OP_Home/ssact/title18/1814.htm#act-1814-a-2-c) ([https://www.ssa.gov/OP\\_Home/ssact/title18/1814.htm#act-1814-a-2-c](https://www.ssa.gov/OP_Home/ssact/title18/1814.htm#act-1814-a-2-c)) and [1835\(a\)\(2\)\(A\)](https://www.ssa.gov/OP_Home/ssact/title18/1835.htm#act-1835-a-2-a) ([https://www.ssa.gov/OP\\_Home/ssact/title18/1835.htm#act-1835-a-2-a](https://www.ssa.gov/OP_Home/ssact/title18/1835.htm#act-1835-a-2-a)) of the Social Security Act
- The HHA providing the services has a valid Medicare Program agreement to participate
- The HHA submits a covered-services claim
- Services provided aren't otherwise excluded from covered services

## Patient Eligibility

Patients are eligible for Medicare home health services if they meet all these criteria:

- Are enrolled in Medicare Part A or B
- Need skilled nursing (SN) care (on an intermittent basis), physical therapy (PT), or speech-language pathology (SLP) services, or continue to need occupational therapy (OT)
- Are under a physician's or allowed practitioner's care
- Get services under a home health plan of care (POC) that a physician or allowed practitioner established and periodically reviews
- Are confined to home (homebound)
- Had a face-to-face encounter with a **physician, nurse practitioner, clinical nurse specialist, physician assistant, or certified nurse-midwife** that was related to the primary reason the patient requires home health services

Occupational therapists can complete the initial and comprehensive patient assessments only when the physician or allowed practitioner orders a therapy service with another rehabilitation therapy service (SLP or PT).

We consider a patient **confined to home (homebound)** if they meet these criteria:

### Criterion 1

The patient must meet **1** of these requirements:

- Because of illness or injury, needs supportive devices like crutches, canes, wheelchairs, or walkers; uses special transportation; or requires another person's help to leave their home
- Has a condition in which leaving their home isn't medically advised

If the patient meets 1 of the requirements in Criterion 1, they must **also** meet **both** requirements in Criterion 2:

### Criterion 2

The patient must **also** meet **both** requirements:

— . . . . .

- The patient normally can't leave home
- Leaving home requires a considerable and taxing effort

We consider a person **confined to home (homebound)** if they don't leave their home often, or if they leave only for a short time for health care services, religious services, adult day care, or other unique or infrequent events (for example, funerals, graduations, barber or hairdresser services).

#### **Confined to home (homebound) examples:**

- A person who's blind or has dementia and needs help to leave home
- A patient who returns home after surgery and whom a physician or allowed practitioner has restricted to specific limited activities (like getting out of bed only for a specified length of time or taking the stairs only once a day)
- A person with a mental health disorder who refuses to leave home or whose physician or allowed practitioner considers it unsafe to leave home unattended, even if they have no physical limitations

### **✦ Home Health Services**

#### **Skilled Therapy**

We cover skilled therapy services (PT, SLP, and OT) to maintain the patient's current condition or to prevent or slow further deterioration. Services must be:

- Performed safely and effectively by, or under the supervision of, a skilled therapist
- Consistent with the nature and severity of the illness or injury and the patient's particular medical needs; the amount, frequency, and duration of services must be reasonable
- Specific, safe, and effective treatment for the patient's condition
- Reassessed at least once every 30 days by a qualified therapist from each involved therapy discipline to compare the patient's resultant measurement against the prior assessment measurement
- Documented in the clinical record to reflect the need for the skilled care provided

## Skilled Nursing

We cover SN care (other than only venipuncture for getting a blood sample) when the patient:

- Needs the specialized judgment, knowledge, and skills of a registered nurse (RN) or licensed practical (vocational) nurse (LPN) (if regulations allow)
- Requires SN services to maintain their current condition or prevent or slow further deterioration

We cover skilled nursing based on the patient's need for skilled care rather than their potential for improvement. We don't consider a service to be a skilled nursing service merely because it's performed by or under the supervision of a nurse. However, in some cases, the patient's condition may cause a service that we'd ordinarily consider unskilled to be considered a skilled nursing service.

## Intermittent Skilled Nursing Care

We define intermittent SN care as care patients need for fewer than 7 days each week or less than 8 hours each day for periods of 21 days or less (with extensions in exceptional circumstances requiring more limited and predictable care).

To meet intermittent SN care requirements, patients must need a medically predictable recurring SN service, which typically occurs when a patient needs an SN service at least once every 60 days. The exception to the intermittent requirement is daily SN services for patients living with diabetes who are unable to administer their insulin, when they don't have an able and willing caregiver.

## Home Health Aide

We cover home health aide services if a patient qualifies for the home health benefit. These services can include:

- Personal care
- Help with activities that directly support skilled therapy services but don't require the skills of a therapist, such as routine maintenance exercises and repetitive practice of functional communication skills
- Simple dressing changes
- Assistance with medications that are ordinarily self-administered and don't require the skills of a licensed nurse
- Prosthetic or orthotic device personal care

To provide these services, a home health aide must meet all these criteria:

- Meet the training and evaluation requirements in [42 CFR 484.80\(a\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-B/section-484.80#p-484.80(a)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-B/section-484.80#p-484.80\(a\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-B/section-484.80#p-484.80(a))); training requirements may vary by state
- Provide hands-on, personal care or services that help treat a patient's illness or injury or maintain a patient's health
- Perform only tasks allowed under state law

Orders for home health aide services must show how often patients need these services. A registered nurse or other skilled professional must supervise the home health aide on-site at least every 14 days if the patient gets SN, PT, OT, or SLP services. In rare instances outside the HHA's control, we allow 1 virtual supervisory visit per 60-day episode of care, which HHAs must document in the patient's medical record.

## Medical Social Services

We cover medical social services when all these criteria are met:

- The patient is eligible for the home health benefit
- The POC explains why only a qualified medical social worker, or social work assistant under a qualified medical social worker's supervision, can safely and effectively provide services the patient needs
- Services resolve social or emotional problems that complicate a patient's medical condition or recovery rate

## Telehealth & Remote Patient Monitoring

The POC must indicate services using telecommunication technology, which can include:

- [Remote patient monitoring](https://www.cms.gov/medicare/coverage/telehealth/remote-patient-monitoring) (<https://www.cms.gov/medicare/coverage/telehealth/remote-patient-monitoring>), defined as collecting physiologic data (for example, electrocardiogram, blood pressure, glucose monitoring) that's digitally stored or transmitted by the patient or caregivers, or both, to the HHAs
- Teletypewriter (TTY)
- Telehealth, defined as real-time interaction between the patient and clinician via 2-way audio-video technology

Telecommunication technology services aren't separately billable and can't be counted as a visit for payment or eligibility requirements. Visits to a patient's home solely to supply, connect, or train them on equipment, without providing another skilled service, aren't separately billable.

Telecommunication technology services must meet patient-specific needs as identified in the comprehensive assessment. HHAs can't substitute telecommunications or audio-only technology for a home visit as part of the POC or for patient eligibility or payment purposes.

See [Telehealth & Remote Patient Monitoring](https://www.cms.gov/files/document/mln901705-telehealth-remote-patient-monitoring.pdf) (<https://www.cms.gov/files/document/mln901705-telehealth-remote-patient-monitoring.pdf>) for more information.

[CMS Telehealth](https://www.cms.gov/medicare/coverage/telehealth) (<https://www.cms.gov/medicare/coverage/telehealth>) helps physicians, practices, and health systems navigate changes to Medicare telehealth policy.

### ❖ Payment Updates

The productivity-adjusted CY 2026 home health market basket update is 2.4% (3.2% market basket increase, reduced by a 0.8 percentage point productivity adjustment).

We applied a remaining permanent adjustment of -1.023% to the CY 2026 home health prospective payment rate to account for the impact of implementing the PDGM. We also applied a -3% temporary adjustment to the CY 2026 base payment rate.

### ❖ Home Health PPS Elements

## PDGM & Home Health Resource Groups

The PDGM case-mix methodology bases 30-day period payment rates on the patient's clinical characteristics and resource needs. It assigns each 30-day period to 1 of 432 case-mix groups called home health resource groups.

We base case-mix payment on these groups, and each group's case-mix weight reflects predicted mean group cost relative to the overall average across all groups.

We apply changes to the PDGM case-mix weights in a budget-neutral manner by multiplying the CY 2026 national standardized 30-day period payment rate by a case-mix budget-neutrality factor. **The final CY 2026 case-mix budget-neutrality factor is 1.0052.**

We base the national, standardized 30-day period payment for case-mix on the patient's condition, care needs, and area wage differences.

## Adjustments to the 30-Day Period Payment Rate

### Case-Mix Adjustments

We use a case-mix methodology that adjusts the 30-day period payment rate based on the patient's characteristics and their corresponding resource needs.

We put the 30-day periods into different subgroups for each of these categories:

- **Admission Source**
  - Community
  - Institutional (acute hospital, inpatient rehabilitation facility, skilled nursing facility, long-term care hospital, inpatient psychiatric facility)
- **30-Day Period Timing**
  - Early (first 30-day care period)
  - Late (all subsequent 30-day care periods, unless there's a gap of more than 60 days between the end of 1 care period and the start of another)
- **Clinical Grouping**
  - Musculoskeletal Rehabilitation
  - Neuro/Stroke Rehabilitation
  - Wounds: Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care
  - Behavioral Health Care
  - Complex Nursing Interventions
  - Medication Management, Teaching, and Assessment (MMTA):
    - MMTA — Surgical Aftercare
    - MMTA — Cardiac/Circulatory
    - MMTA — Endocrine
    - MMTA — Gastrointestinal Tract/Genitourinary System
    - MMTA — Infectious Disease/Neoplasms/Blood-forming Diseases
    - MMTA — Respiratory
    - MMTA — Other
- None
- Low
- **Comorbidity Adjustment Based on Reported Secondary Diagnoses** ◦ High

- Low
  - Medium
- **Functional Impairment Level from OASIS Assessment (based on 30-day care period)**
  - High

## Labor Adjustments

The [labor portion](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=8) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=8) bases each 30-day period payment adjustment on wage levels and wage-related costs of providing patient home health care in different geographic areas.

We cap decreases to the home health wage index in a geographic area so the wage index isn't less than 95% of the wage index in that area in the previous CY. We apply this 5% cap on negative wage index changes in a budget-neutral manner using wage index budget-neutrality factors.

## Continuous 60-Day Recertifications

The Home Health Prospective Payment System (PPS) allows [continuous 60-day patient recertification](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=9) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=9) when the patient remains eligible.

Medicare [conditions of participation](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484#p-484.55(d)(1)) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484#p-484.55(d)(1)) require a recertification assessment during the last 5 days of each certification period (for example, during the initial 60-day certification period, complete the recertification visit on days 56–60).

## Submitting the Notice of Admission

HHAs must submit a one-time [Notice of Admission](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=9) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=9) (NOA) to their Medicare Administrative Contractor (MAC) within 5 days after the start-of-care date to establish that the patient is under a home health period of care that covers all 30-day periods until the patient is discharged from home health services.

HHAs may submit the NOA under these conditions:

- The certifying physician's or allowed practitioner's written or verbal order meets the requirements in [42 CFR 409.43\(d\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-409/subpart-E/section-409.43#p-409.43(d)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-409/subpart-E/section-409.43#p-409.43\(d\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-409/subpart-E/section-409.43#p-409.43(d))) and [42 CFR 484.60\(b\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-B/section-484.60#p-484.60(b)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-B/section-484.60#p-484.60\(b\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-B/section-484.60#p-484.60(b))).
- The initial visit happened within the 60-day certification period, and the patient was admitted to home health care

We may waive the [consequences](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484#p-484.205(j)(3)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484#p-484.205\(j\)\(3\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484#p-484.205(j)(3))) of not submitting an NOA on time if we determine the HHA encountered a circumstance that's exceptional and qualifies for the waiver.

## Plan of Care

The certifying physician or allowed practitioner must periodically review the POC, which must include:

- The services meeting the patient-specific needs identified in the comprehensive assessment
- The responsible disciplines and the frequency and duration of all visits
- The individualized standards listed in [42 CFR 484.60\(a\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-B/section-484.60#p-484.60(a)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-B/section-484.60#p-484.60\(a\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-B/section-484.60#p-484.60(a))) that establish the need for services
- Telehealth, remote patient monitoring, or other services provided through telecommunications technology

If the signed POC isn't available at the time of NOA submission, the HHA must base the submission on 1 of these:

- A physician's or allowed practitioner's verbal order that:
  - Is recorded in the POC
  - Describes the patient's condition and the services the HHA provides
  - Has a responsible registered nurse's or qualified therapist's (as defined in [42 CFR 484.115](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-C/section-484.115) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-C/section-484.115>)) signed and dated attestation for providing or supervising services ordered in the POC
  - Is copied into the POC, which is immediately submitted to the physician or allowed practitioner
- A referral with a detailed order for services the HHA provides that the physician or allowed practitioner signed and dated

Other POC requirements include:

- A physician or allowed practitioner who meets the certification and recertification requirements in [42 CFR 424.22 \(https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-B/section-424.22\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-B/section-424.22) must sign and date the POC or any changes in the POC before submitting the claim for each 30-day period
- The physician or allowed practitioner must review the POC at least every 60 days or more frequently if these apply:
  - The patient wants a transfer
  - There's a change in the patient's condition
  - The patient is discharged with goals met or no expectation they'll need home health care and then returns to home health care within 60 days
- The POC is terminated if the patient doesn't get at least 1 covered SN, PT, SLP, or OT visit in a 60-day period unless the physician or allowed practitioner documents that the interval without this care is appropriate for treating the patient

## Low Utilization Payment Adjustment

We make per-visit payments, called [low utilization payment adjustment \(https://www.cms.gov/Regulations-and-Guidance/Guidance/Materials/Downloads/bp102c07.pdf#page=11\)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Materials/Downloads/bp102c07.pdf#page=11) (LUPA) payments, for 30-day periods with a number of visits below the case-mix group's threshold instead of paying the case-mix adjusted 30-day period payment amount. We updated the CY 2026 LUPA thresholds using CY 2024 data.

Submit appropriate claims and supporting documentation for us to apply the LUPA threshold. Documentation must show the patient's condition and care needs or the case-mix assignment.

**Note:** We may adjust a home health claim based on other claims a provider may or may not bill. Those claims could affect the Common Working File and PPS code already billed or paid.

## Partial-Period Payments

We adjust payments if a patient has an intervening event, which we define as:

• A . . . . .

- A patient choosing to transfer from 1 HHA to another
- An HHA discharging a patient with goals met or no expectation to return and then readmitting them within 30 days of the original 30-day period start date

We prorate case-mix adjusted payments for 30-day periods of that type according to the length of the 30-day period ending in a transfer or discharge and readmission, resulting in partial-period payment.

We recognize a discharge and return to the same HHA during the 30-day period only when a patient reaches treatment goals in the original home health POC.

Terminate the original home health POC if you anticipate that the patient won't need home health services for the rest of the 30-day period.

We base the partial-period payment on how long the patient was under the original HHA's POC before an intervening event (from the first to the last billable service date). We compare the number of days in that period with the full 30-day period to find the proportion of care provided. We then multiply that proportion by the original case-mix and wage index to determine the partial-period payment adjustment.

Partial-period payment adjustments don't apply for transfers among HHAs of common ownership. We consider those situations services that the receiving HHA with ownership interest provides under arrangement on behalf of the originating HHA until the end of the 30-day period.

## Outlier Payments

We allow outlier payments when a 30-day period has unusually large, costly patient home health care needs. We add these outlier payments to the regular 30-day period case-mix and wage-adjusted period payments when estimated costs exceed a threshold amount for each home health resource group.

You can calculate the amount of the outlier payment using steps 1–6 in the [Medicare Benefit Policy Manual, Chapter 7](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=13) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=13>), section 10.8.

**Note:** In CY 2026, the fixed-dollar loss ratio is 0.37 to make sure aggregate outlier payments don't exceed 2.5% of total aggregate payments.

## Consolidated Billing Requirements

We include all HHA services and supplies in the Home Health PPS 30-day period payment rate for patients under a home health POC **except**:

- Certain covered injectable osteoporosis drugs when patients meet specific criteria
- DME, including home infusion drugs and related services
- Negative pressure wound therapy (NPWT) disposable devices

Provide all other covered home health services directly or under arrangement, which is when an outside supplier provides services under contract and looks to the HHA for payment. The HHA bills the MAC for covered home health services.

We subject certain [home health services \(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=16\)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=16) and supplies to the consolidated billing Home Health PPS requirements, and you should bill them with the 30-day period payment rate.

### ✦ Physician or Allowed Practitioner Certification & Recertification Billing

Physicians and allowed practitioners, including clinical nurse specialists, physician assistants, and nurse practitioners, can certify and recertify eligibility, order home health services, and review the POC. Certifying physicians or allowed practitioners must authorize physicians or NPPs to care for the patients in their absence. These physicians or NPPs don't have to be in the same group practice as the certifying physician or allowed practitioner.

For more information:

- [Medicare Benefit Policy Manual, Chapter 7](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=35) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=35), section 30.5.1 explains certifying patient eligibility for Medicare home health services
- [Medicare Benefit Policy Manual, Chapter 7](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=37) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=37), section 30.5.1.1 discusses the home health face-to-face encounter
- [Medicare Benefit Policy Manual, Chapter 7](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=41) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf#page=41), section 30.5.4 outlines billing for certification and recertification
- [Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/ge101c04.pdf#page=11) (https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/ge101c04.pdf#page=11), section 30 discusses certification and recertification by physicians and allowed practitioners

## ❖ Home Health Quality Reporting Program

The [Home Health Quality Reporting Program](https://www.cms.gov/medicare/quality/home-health) (HH QRP) is a pay-for-reporting quality program for the home health setting. It uses public reporting of quality-of-care measurements, quality improvements, and information transparency to promote better health outcomes for Medicare patients.

HHAs must submit admission and discharge OASIS assessments for at least 90% of patients with care episodes occurring during the reporting period. Report data using [OASIS](https://www.cms.gov/medicare/quality/home-health/oasis-data-sets) and the [Home Health Care CAHPS Survey](https://homehealthcahps.org). HHAs use additional quality measures on each claim.

For HHAs that don't submit the required quality data for CY 2026, the home health payment update is 0.4% (2.4% minus 2 percentage points).

HHAs qualify for the full home health update factor by submitting required quality data for specific quality-of-care measures. [Home Health Quality Measures](https://www.hhs.gov/guidance/document/home-health-quality-measures) has more information.

HHAs may qualify for an HH QRP [reconsideration and an extension or exemption](https://www.cms.gov/medicare/quality/home-health/home-health-quality-reporting-reconsideration-and-exception-extension).

The [iQIES](https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/internet-quality-improvement-evaluation-on-system-iques), which includes survey and certification functions, replaces and consolidates the QIES, CASPER, and ASPEN legacy systems.

## Resources

- [2026 Home Health PPS Final Rule](https://www.govinfo.gov/content/pkg/FR-2025-12-02/pdf/2025-21767.pdf) (https://www.govinfo.gov/content/pkg/FR-2025-12-02/pdf/2025-21767.pdf)
- [CMS Home Health PPS](https://www.cms.gov/medicare/payment/prospective-payment-systems/home-health) (https://www.cms.gov/medicare/payment/prospective-payment-systems/home-health)
- [CMS Newsroom: CY 2026 Home Health PPS Final Rule](https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-home-health-prospective-payment-system-final-rule-cms-1828-f) (https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-home-health-prospective-payment-system-final-rule-cms-1828-f)
- [Guide to Home Health Help Desks](https://www.cms.gov/files/document/guide-home-health-help-desksupdated-july-2022.pdf) (https://www.cms.gov/files/document/guide-home-health-help-desksupdated-july-2022.pdf)
- [Web Pricer](https://webpricer.mps.cms.gov) (https://webpricer.mps.cms.gov)

Feedback

[Print](#)

## Hospice Payment System & Coverage

---

### What's Changed?

- Added language clarifying attestation requirement
- Added procedures for terminated hospices
- Updated the FY 2026 payment rates and cap amount
- Added the end date for the hospice benefit component
- Updated details on the transition from the Hospice Item Set (HIS) to the Hospice Outcomes and Patient Evaluation (HOPE) tool

Substantive content changes are in dark red.

Medicare patients who elect hospice must:

- Be eligible for Medicare Part A
- Be certified as terminally ill with a medical prognosis of 6 months or less to live if the illness runs its normal course
- Use a Medicare-approved hospice program
- Sign a hospice election statement
- Waive all coverage rights for terminal illness and related conditions, unless the hospice arranges or delivers the care

Feedback



- Hospice care from a hospice other than the one the patient designates, unless provided under arrangement by the designated hospice
- Room and board, unless the hospice arranges short-term inpatient care
- Emergency department, hospital, or other inpatient facility services; outpatient services; or ambulance transportation, unless the hospice arranges these services or they're services unrelated to the patient's terminal illness and related conditions

## Billing Hospice Attending Physician Services at Certain Facilities

A Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) can bill and get paid under the RHC All-Inclusive Rate (AIR) or FQHC Prospective Payment System (PPS), respectively. This applies when a designated attending physician is an employee of, or has a contract with, RHC or FQHC facilities that provide attending physician services during a patient's hospice election.

To get paid under the RHC AIR or FQHC PPS, the RHC or FQHC must report the GV modifier (attending physician not employed or paid under arrangement by the patient's hospice provider) when a physician, NP, or physician assistant (PA) employed by, or contracted with, an RHC or FQHC provides hospice services to a patient electing hospice.

### ✦ Dually Eligible Veterans

Patients who are dually eligible veterans and live at home in their community may elect and have hospice services paid for under the Medicare hospice benefit. Sections [1853\(c\)](https://www.ssa.gov/OP_Home/ssact/title18/1853.htm#act-1853-c) ([https://www.ssa.gov/OP\\_Home/ssact/title18/1853.htm#act-1853-c](https://www.ssa.gov/OP_Home/ssact/title18/1853.htm#act-1853-c)) and [1814\(d\)](https://www.ssa.gov/OP_Home/ssact/title18/1814.htm#act-1814-d) ([https://www.ssa.gov/OP\\_Home/ssact/title18/1814.htm#act-1814-d](https://www.ssa.gov/OP_Home/ssact/title18/1814.htm#act-1814-d)) of the Social Security Act have more information.

### ✦ Conditions of Participation

[42 CFR 418.52](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C/section-418.52) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C/section-418.52>) requires you to give the patient or representative verbal and written notice of their rights and responsibilities during their initial assessment before providing care.

[42 CFR 418.54](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C/section-418.54) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C/section-418.54>) requires you to complete a patient-specific comprehensive assessment that identifies the patient's need for:

- Hospice care and services
- Physical, emotional, psychosocial, and spiritual care, including a bereavement assessment for the patient's family and other people

[42 CFR 418.56\(c\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C#p-418.56(c)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C#p-418.56\(c\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C#p-418.56(c))) requires the POC to include all services necessary for the palliation and management of the terminal illness and related conditions, including:

- Interventions for pain and symptom management
- Details about the scope and frequency of services necessary to meet specific patient and family needs
- Measurable POC-expected outcomes
- Patient treatment and drug needs
- Patient medical supplies and appliance needs
- The [interdisciplinary group's](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418#p-418.56(a)(1)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418#p-418.56\(a\)\(1\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418#p-418.56(a)(1))) (IDG's) documentation of the patient's or representative's level of understanding, involvement, and agreement with the POC

To minimize fragmented care and improve quality of life, [42 CFR 418.56\(e\)](https://www.ecfr.gov/current/title-42/part-418/subpart-C#p-418.56(e)) ([https://www.ecfr.gov/current/title-42/part-418/subpart-C#p-418.56\(e\)](https://www.ecfr.gov/current/title-42/part-418/subpart-C#p-418.56(e))) requires that the hospice develop and maintain a communication and integration system among all providers delivering care to terminally ill patients. Clearly identify related and unrelated conditions and who's responsible for delivering services for those conditions. Share this information with non-hospice providers delivering services unrelated to the terminal illness.

## Hospice Aide Training & Evaluation

[Hospice aides](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C/subject-group-ECFR74797288a614803/section-418.76) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C/subject-group-ECFR74797288a614803/section-418.76>) deliver a significant portion of direct care. A past employer (for example, a hospice, home health agency, or nursing home) may have trained an aide, allowing the aide to get certified before their current employment. Evaluate new aides' competence, making sure they provide appropriate care.

You may observe and assess an aide's skill competencies with a patient or a [pseudo-patient simulation](https://www.federalregister.gov/documents/2021/08/04/2021-16311/medicare-program-fy-2022-hospice-wage-index-and-payment-rate-update-hospice-conditions-of-p-226) (https://www.federalregister.gov/documents/2021/08/04/2021-16311/medicare-program-fy-2022-hospice-wage-index-and-payment-rate-update-hospice-conditions-of-p-226). If the hospice verifies an area of concern during the on-site visit, it must conduct — and the hospice aide must complete — a [competency evaluation](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C#p-418.76(c)) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C#p-418.76(c)) of the deficient skill and all related skills.

### ❖ Certification Requirements

The hospice's medical director (or designee), or the physician member of the hospice IDG, and the patient's designated attending physician (if they have an attending physician) must certify that the patient is terminally ill no later than 2 calendar days after starting hospice care for their initial 90-day coverage period.

When the patient elects hospice, they may designate an [attending physician](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418#p-418.3(Attending%20physician)) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418#p-418.3(Attending%20physician)), who will have the most significant role in determining and delivering the patient's medical care. The patient may select:

- A doctor of medicine (MD)
- A doctor of osteopathy (DO)
- An NP
- A PA

Only an MD or a DO can certify or recertify that the patient is terminally ill. If a patient's attending physician is an NP or a PA, the hospice medical director, the physician designee, or the hospice IDG physician member certifies the patient as terminally ill. If a patient wants to change attending physicians, they must file a signed statement with the hospice indicating the change.

When a patient chooses hospice care, the hospice must identify an IDG to manage their care. The IDG must include, but isn't limited to, people who are qualified and competent to practice in these professional roles:

- MD or DO (who's an employee or under contract with the hospice)
- Registered nurse (RN)
- Social worker, marriage and family therapist, or mental health counselor
- Pastoral or other counselor

The initial election period certification lasts 90 days. After the initial period, the patient gets another 90-day period and unlimited 60-day election periods. An MD or a DO must certify or recertify each election period.

A hospice must get written certification and document it in the patient's clinical record before submitting a claim to its [Medicare Administrative Contractor](https://www.cms.gov/medicare/coding-billing/medicare-administrative-contractors-macs/who-are-macs) (MAC). Complete certifications include:

- A statement certifying the patient is terminally ill with 6 months or less to live if the terminal illness runs its normal course
- Specific clinical findings and documentation supporting a life expectancy of 6 months or less
- A certified physician's brief narrative explaining clinical findings supporting a life expectancy of 6 months or less
- The certifying physician's signature (or signatures, as appropriate), a certification signature date, and benefit period dates
- Documentation of a physician or an NP face-to-face visit with the hospice patient no more than 30 days before:
  - The third benefit period recertification
  - Each recertification afterward to decide continued hospice benefits eligibility

When you newly admit a patient in their third or later benefit period, [exceptional circumstances](https://www.cms.gov/Regulation-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf#page=8) may prevent a face-to-face encounter before the benefit period starts.

The hospice physician or NP must document that they had a face-to-face patient encounter. The attestation must:

.....

- Include the face-to-face visit date
- State that the certifying physician got face-to-face clinical findings to determine continued hospice care eligibility
- Include the physician's or NP's signature and date they signed

**Note:** Starting October 1, 2025, we'll allow a signed and dated clinical note to fulfill the attestation requirement. Clearly indicate in the medical record that the face-to-face encounter occurred and include the:

- Date of the visit
- Signature of the practitioner who conducted the face-to-face encounter
- Date of the signature

## Hospice Certifying Enrollment

Under section 6405 of the [Affordable Care Act](https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf#page=650) (<https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf#page=650>), these 2 categories of physicians must be [enrolled in Medicare](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/provider-enrolment/Med-Prov-Enroll-MLN9658742.html) (<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/provider-enrolment/Med-Prov-Enroll-MLN9658742.html>) or opt out of Medicare to get paid for hospice services:

- Hospice medical director or the physician member of the hospice IDG who certifies the patient's terminal condition
- Patient-designated attending physician (if they have one) who certifies their terminal condition

Under [42 CFR 418.22\(c\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-B/section-418.22#p-418.22(c)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-B/section-418.22#p-418.22\(c\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-B/section-418.22#p-418.22(c))), either of the 2 categories of physicians listed must certify the patient's terminal condition. For subsequent coverage periods, only the hospice physician may certify the patient's terminal condition.

For detailed information on this requirement, see the [Hospice Certifying Enrollment Q&A](https://www.cms.gov/files/document/hospice-certifying-enrollment-faqs.pdf) (<https://www.cms.gov/files/document/hospice-certifying-enrollment-faqs.pdf>).

## Procedures for Terminated Hospices

We pay for hospice services up to 30 days after a hospice terminates its Medicare provider agreement. We continue paying for claims that extend beyond a provider's termination date if both these statements are true:

- The hospice services are provided under a POC established before that date
- The hospice period of care ends within the 30-day period

## ✦ Election Statement & Notice of Election

Patients meeting eligibility requirements must file an [election statement](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418#p-418.24(b)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418#p-418.24\(b\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418#p-418.24(b))), which must:

- Identify the hospice and attending physician providing care. The patient or representative must acknowledge that they chose the attending physician, if applicable. If a patient wants to change attending physicians, they must file a signed statement with the hospice indicating the change.
- Show that the patient or representative understands that hospice is for palliative care rather than curative care.
- Show that the patient or representative understands that they waive certain Medicare services by electing hospice benefits. Inform the patient that services unrelated to the terminal illness and related conditions are exceptional and unusual; the hospice should provide nearly all care the patient needs. If you find conditions, items, services, or drugs unrelated to the patient's terminal illness and related conditions the hospice won't cover, notify the patient or representative of their right to get an [election statement addendum](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418#p-418.24(c)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418#p-418.24\(c\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418#p-418.24(c))).
- Show the effective election date, which is the first day of hospice care or a later date but no earlier than the election date statement.
- Provide individual hospice cost-sharing information.
- Provide Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) information, including the right to immediate advocacy and [BFCC-QIO contact information](https://www.cms.gov/medicare/quality/quality-improvement-organizations/family-centered-care) (<https://www.cms.gov/medicare/quality/quality-improvement-organizations/family-centered-care>).
- Include the patient's or representative's signature.

**Note:** We require a complete [election statement](https://www.cms.gov/files/document/model-example-hospice-election-statement-march-2024.pdf) (https://www.cms.gov/files/document/model-example-hospice-election-statement-march-2024.pdf) containing all required elements as a condition for payment.

## Notice of Election

Hospice providers must file a [Notice of Election](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418#p-418.24(e)) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418#p-418.24(e)) (NOE) with their MAC through electronic data interchange **within 5 calendar days** after the hospice election date. If you file the NOE after the 5-day period, you're liable for services between the hospice election date and the NOE filing date, and you may not bill the patient for this period.

**Note:** We allow [exceptions](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf#page=5) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf#page=5) when the hospice's inability to file the NOE within 5 calendar days is beyond its control.

Perform an eligibility check immediately before admission so you can reduce potential errors in exception request-related changes to the patient identifier. This confirms that the MBI is active and accurate, since the eligibility inquiry system has an MBI End Date field. If there's a date in that field, the MBI isn't valid after that date. Contact the patient or use an MBI lookup tool to determine the current MBI to use on the NOE.

When you admit patients, inform them in writing that their care is subject to [QIO review](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-F/part-476#p-476.78(b)(3)) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-F/part-476#p-476.78(b)(3)) and discuss potential review results.

## Revoking Hospice Election

A patient or representative may [revoke](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-B/section-418.28) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-B/section-418.28) hospice election at any time. Revoking a hospice election is the patient's or representative's choice, made without undue influence from the hospice provider. To revoke the election, the patient must file a written document with the hospice that includes:

- A signed statement saying they revoke hospice care for the remainder of that election period
- The revocation effective date

The patient gives up their remaining days in that election period, and their previously waived Medicare coverage restarts. A patient may at any time elect to get hospice coverage for any other hospice election periods they're eligible for.

If a Medicare Advantage (MA) enrollee revokes their hospice election, they can continue services through their MA plan or Medicare Fee-for-Service (FFS) providers (subject to the FFS [deductible \(https://www.medicare.gov/basics/costs/medicare-costs\)](https://www.medicare.gov/basics/costs/medicare-costs)) until the start of the next month, when they get services only through their MA plan.

Unless you've already submitted a final claim, file a [Notice of Termination/Revocation \(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf#page=11\)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf#page=11) with your MAC within 5 calendar days after either:

- The patient or their representative revokes hospice election
- The hospice discharges the patient alive

## Hospice Patient Discharge

A hospice may [discharge \(https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-B/section-418.26\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-B/section-418.26) a hospice patient only if:

- The patient moves out of the hospice service area or transfers to another hospice.
- You find the patient is no longer terminally ill.
- There are extraordinary circumstances where the hospice can't continue providing care. These situations include cases where the safety of the patient or hospice staff is at risk. The hospice must:
  - Tell the patient that discharge for cause is under consideration
  - Make a serious effort to resolve the issues
  - Make sure the discharge isn't related to the patient's use of hospice services
  - Document the problem and efforts to resolve the issues in the patient's medical record
  - Notify the MAC and [State Survey Agency \(https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/contact-information\)](https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/contact-information) and make referrals if necessary

Discharging a patient only to avoid exceeding the [cap limit \(https://www.cms.gov/regulations-and-guidance/guidance/manuals/download/s/bp102c09.pdf#page=48\)](https://www.cms.gov/regulations-and-guidance/guidance/manuals/download/s/bp102c09.pdf#page=48) violates these regulations and may cause undue distress and potential harm to terminally ill patients who must find care outside their hospice benefit.

## Change of Designated Hospice

A patient can change their hospice election designation once each election period with a transfer, which we don't consider a revocation. To change the designated hospice, the patient must file a signed statement with the hospice where they got care and with the newly designated hospice. The statement must include the:

- Previous hospice provider name
- New hospice provider name
- Effective date of change

We require home health agencies, skilled nursing facilities, hospices, and comprehensive outpatient rehabilitation facilities to provide a [Notice of Medicare Non-Coverage](https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-nomnc-denc) (NOMNC) to patients ending their Medicare-covered services. The NOMNC tells patients how to request a BFCC-QIO determination and lets them request an expedited determination. A patient gets a [Detailed Explanation of Non-Coverage](https://www.cms.gov/files/document/detailed-explanation-non-coverage-instructions-eff-jan-2025.pdf), which explains specific reasons for ending covered services, only if they ask for an expedited determination.

### ❖ Hospice Level of Care Payment

Even if you don't provide a service on a given day, we pay for hospice care each day a patient is under hospice election. Payments cover service costs in the patient's POC, including services directly from, or arranged by, the hospice. We make payments on 4 levels of care to meet the patient's and family's needs:

- Higher payment rate for days 1–60
1. Routine home care at:
    - Lower payment rate for day 61 and beyond
  2. [Continuous home care](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf#page=34) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf#page=34) to manage a short-term symptom crisis in the home, involving 8 or more hours of care per day, mostly nursing. The 8 or more hours don't need to be continuous; you can provide 4 hours in the morning and 4 hours in the evening. When the patient requires fewer than 8 hours of care, we cover the services as routine home care rather than continuous home care.
  3. Inpatient respite care (facility care for up to 5 days at a time to give an informal caregiver a break).
  4. General inpatient care (provided in a facility on a short-term basis to manage symptoms you can't manage in another setting).

We also pay a **service intensity add-on** with the routine home care rate during the patient's last 7 days of life if their care meets these criteria:

- A routine level-of-health care day
- The hospice discharges the patient as deceased
- An RN or social worker provides direct patient care each day

The service intensity add-on payment is the continuous home care hourly payment rate multiplied by the amount of direct patient care an RN or social worker provides during the 7-day period for a minimum of 15 minutes and up to 4 total hours per day.

### ❖ Hospice Payment Rate Updates & Wage Index

For FY 2026, the final [hospice payment rate](https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice/hospice-regulations-and-notice) (https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice/hospice-regulations-and-notice) update is 2.6% (3.3% inpatient hospital market basket percentage increase minus the 0.7 percentage-point productivity adjustment). The final FY 2026 hospice cap is \$35,361.44.

The base rate for each level of care has a labor share and a non-labor share. We adjust the labor share of the base payment rate by the hospice wage index to account for local differences in wage levels based on where you provided

services.

**Table 2. Hospice Labor Share**

Level of Care	Revised Labor Share	Non-Labor Share
Routine Home Care	66%	34%
Continuous Home Care	75.2%	24.8%
Inpatient Respite Care	61%	39%
General Inpatient Care	63.5%	36.5%

## Wage Index & Cap

We place a permanent 5% cap on any decrease to a geographic area's wage index compared with the previous year. This ensures that a geographic area's wage index won't fall below 95% of its previous year's calculation, regardless of the reasons for the decline.

### ✦ Hospice Payment Caps

Two caps limit the amount and cost of care an individual hospice can provide in a single year. One cap limits the number of inpatient care days that a hospice may provide to 20% of its total patient care days. The other cap is an aggregate cap that limits the total aggregate payments any individual hospice can get in a cap year to an allowable amount, based on an annual per-patient cap amount and the number of patients the hospice serves. We limit this amount to the FY cap amount multiplied by the number of patients the hospice serves.

For accounting years that end after September 30, 2016, and before October 1, 2033, we update the aggregate cap amount each year by the hospice payment update percentage instead of using the Consumer Price Index for Urban Consumers (CPI-U).

Feedback

## ✦ Patient Coinsurance Payments

### Prescription Drugs or Biologicals

When a patient isn't a hospice inpatient but is getting routine or continuous home care, you may bill a [coinsurance](https://www.medicare.gov/basics/costs/medicare-costs) amount for each palliative drug or biological prescription. Coinsurance for each prescription is about 5% of its cost to the hospice. You establish the drug copayment schedule, and the coinsurance for each prescription can't be more than \$5. The patient isn't liable for any coinsurance for hospice-related drugs or biologicals they get during general inpatient or respite care.

### Inpatient Respite Care

You may bill patients a [coinsurance](https://www.medicare.gov/basics/costs/medicare-costs) amount each respite care day equal to 5% of the Medicare respite care day payment. A patient's respite care coinsurance during a hospice coinsurance period can't be more than the inpatient hospital deductible for the year the hospice coinsurance period started.

## ✦ Medicare Advantage & Hospice

MA plans must cover all services Medicare FFS covers, except hospice care. MA enrollees get Medicare FFS hospice benefits and may choose treatment unrelated to their terminal illness and related conditions, including care from their attending physician, from providers outside the MA plan. When MA enrollees get services unrelated to their terminal illness and related conditions from Medicare FFS providers (not through their MA plan), they're subject to the 20% [coinsurance](https://www.medicare.gov/basics/costs/medicare-costs).

For MA plan patients, check with the MA plan for information on eligibility, coverage, and payment. Each plan can have different patient out-of-pocket costs and specific rules for getting and billing for services. Follow the plan's terms and conditions for payment.

MA enrollees needing treatment unrelated to their terminal illness and related conditions may also choose services through their MA plan at the plan cost-sharing level. Benefit costs and coverage may vary by plan. At enrollment and annually thereafter, MA plans must inform enrollees about Medicare hospice option availability and approved hospices in the MA plan's service area, including:

- Those the MA organization owns, controls, or has a financial interest in
- If it's common practice to refer patients to hospice programs outside the plan's service area

### ✦ Value-Based Insurance Design Model Hospice Benefit

When an enrollee in an MA plan elects hospice, the Medicare FFS Program starts covering most of their services, while the MA plan continues covering certain services. After December 31, 2024, we discontinued the [Value-Based Insurance Design Model Hospice Benefit Component](https://www.cms.gov/priorities/innovation/innovation-models/vbid/vbid-hospice-benefit-overview) (<https://www.cms.gov/priorities/innovation/innovation-models/vbid/vbid-hospice-benefit-overview>), where participating MA organizations retained responsibility for all Medicare FFS services, including hospice care. For any hospice election by an MA enrollee on or after January 1, 2025, Medicare FFS pays for Medicare-covered hospice benefits.

### ✦ Hospice Quality Reporting Program

The [Hospice Quality Reporting Program](https://www.cms.gov/medicare/quality/hospice) (<https://www.cms.gov/medicare/quality/hospice>) (HQRP) provides quality-of-care information so patients can make informed decisions about their health care options. It also encourages facilities and providers to improve their quality of inpatient care by making sure they're aware of, and reporting on, best practices.

[Current Measures](https://www.cms.gov/medicare/quality/hospice/current-measures) (<https://www.cms.gov/medicare/quality/hospice/current-measures>) has the current quality reporting measures. [Public Reporting: Key Dates for Providers](https://www.cms.gov/medicare/quality/hospice/public-reporting-key-dates-providers) (<https://www.cms.gov/medicare/quality/hospice/public-reporting-key-dates-providers>) has more information.

To meet the hospital quality reporting requirements, hospices must submit all quality measures. Eligible hospices that don't participate in the HQRP in an FY or don't meet all reporting requirements get a 4% annual market basket update reduction.

Hospices may qualify for a quality reporting program [extension or exemption](https://www.cms.gov/medicare/quality/hospice/hqrp-extensions-and-exemption-requests) (<https://www.cms.gov/medicare/quality/hospice/hqrp-extensions-and-exemption-requests>).

## Hospice Outcomes & Patient Evaluation

Starting October 1, 2025, the [Hospice Outcomes and Patient Evaluation](https://www.cms.gov/medicare/quality/hospice/hope) (HOPE) quality reporting tool replaces the Hospice Item Set (HIS), a retrospective chart review. HOPE can help you understand care needs throughout the patient's dying process and contribute to the patient's POC. It assesses patient interactions in real time. Starting February 15, 2026, the Quality Improvement and Evaluation System won't accept HIS records for hospice admissions and discharges that occurred before October 1, 2025, including any corrections. Submit your HOPE records using [iQIES](https://qtso.cms.gov/news-and-updates/what-expect-hope-assessment-submission-and-reporting-launch-iqies).

## Resources

- [2026 Hospice Wage Index and Payment Rate Update Final Rule](https://federalregister.gov/d/2025-14782)
- [CMS Hospice Center](https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/hospice-center)
- [CMS Newsroom: FY 2026 Hospice Payment Rate Update Final Rule](https://www.cms.gov/newsroom/fact-sheets/fy-2026-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting-program)
- [Hospice Regulations](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418)
- [Medicare Benefit Policy Manual, Chapter 9](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf)
- [Web Pricer](https://webpricer.mps.cms.gov)

Feedback

## Hospital Outpatient Prospective Payment System

---

Print

Feedback

## What's Changed?

- Updated the packaging costs per day
- Updated the CY 2026 payment rates
- Started phasing out the inpatient only (IPO) list over 3 years
- Made permanent a rule allowing some direct supervision through audio-video real-time communications technology (excluding audio-only)
- Reduced future non-drug item and service payments by adjusting the OPPS conversion factor by 0.5% starting in CY 2026

Substantive content changes are in dark red.

The Hospital Outpatient Prospective Payment System (OPPS) under section 1833(t) of the [Social Security Act](https://www.ssa.gov/OP_Home/ssact/title18/1833.htm#act-1833-t) ([https://www.ssa.gov/OP\\_Home/ssact/title18/1833.htm#act-1833-t](https://www.ssa.gov/OP_Home/ssact/title18/1833.htm#act-1833-t)) pays hospitals and community mental health centers (CMHCs) for services they provide to Medicare patients in an outpatient setting.

[Medicare Claims Processing Manual, Chapter 4](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#page=14), (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#page=14>) section 10.1 discusses services we pay for under OPPS.

[42 CFR 419.21](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419/subpart-B/section-419.21) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419/subpart-B/section-419.21>) discusses hospital services subject to the OPPS.

The OPPS applies to designated hospital outpatient services in all hospital classes, [except](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419/subpart-B#p-419.20(b)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419/subpart-B#p-419.20\(b\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419/subpart-B#p-419.20(b))):

- Hospitals providing only inpatient Medicare Part B services
- Critical access hospitals (CAHs)
- Indian Health Service (IHS) and Tribal hospitals
- Hospitals in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, and the U.S. Virgin Islands
- Rural emergency hospitals
- Certain outpatient off-campus provider-based departments (PBDs), which are paid under the Physician Fee Schedule (PFS)
- Maryland hospitals paid under a cost containment waiver according to section 1814(b)(3) of the [Social Security Act \(https://www.ssa.gov/OP\\_Home/ssact/title18/1814.htm#act-1814-b-3\)](https://www.ssa.gov/OP_Home/ssact/title18/1814.htm#act-1814-b-3)

We [exclude payment for certain outpatient services \(https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419#419.22\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419#419.22), like outpatient therapy and screening and diagnostic mammography.

### ✦ Ambulatory Payment Classification Groups

We assign all items and services paid under the OPSS to payment groups called Ambulatory Payment Classifications (APCs), which [GROUP \(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#page=17\)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#page=17) together items and services that are similar clinically and in terms of resource use. Under the OPSS, we make APC payments for items and services that hospital outpatient departments provide.

The OPSS assigns a payment status indicator to every HCPCS code, which identifies whether the service payment falls under the OPSS or under another payment system or fee schedule, and, if so, whether it's paid separately or packaged.

The APC payment rate and calculated copayment apply to each APC service.

Hospitals may get multiple APC payments for patient services on a single day. We [discount \(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#page=25\)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#page=25) multiple surgical procedures performed on the same day.

We pay for some items and services separately, including but not limited to:

• • • • •

- Many surgical, diagnostic, and non-surgical therapeutic procedures
- Blood and blood products
- Most clinic and emergency department visits
- Some drugs, biologicals, and radiopharmaceuticals
- Brachytherapy sources
- Corneal tissue acquisition
- Certain preventive services, including vaccine administration

We pay for partial hospitalization on a per diem basis. The payment represents the expected daily facility care costs in hospital outpatient departments and CMHCs. We expanded the existing rate structure to include 2 partial hospitalization program APCs for each provider type—1 for days with 3 services per day and 1 for days with 4 or more services per day.

## New Technology APCs

We sometimes assign new services to [New Technology APCs](https://www.govinfo.gov/content/pkg/FR-2021-03-02/pdf/2021-04303.pdf) (<https://www.govinfo.gov/content/pkg/FR-2021-03-02/pdf/2021-04303.pdf>) when the service can't be appropriately reported by an existing procedure code assigned to a clinical APC and a new procedure code can't be appropriately assigned to a clinical APC.

## Packaged Costs

Under OPPS, [packaged](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#page=23) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#page=23>) services are items and services that we consider to be an integral part of another primary service paid for under the OPPS. We don't make a separate payment for packaged services, because we include the cost of packaged items and services in the APC payment for the primary service.

[42 CFR 419.2\(b\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419#p-419.2(b)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419#p-419.2\(b\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419#p-419.2(b))) lists some types of packaged items and services. [42 CFR 419.2\(c\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419#p-419.2(c)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419#p-419.2\(c\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419#p-419.2(c))) lists costs we don't include in the hospital OPPS.

## Packaged Drugs, Biologicals & Radiopharmaceuticals

Drugs, biologicals, and therapeutic radiopharmaceuticals below the OPSS drug packaging threshold get packaged payment. In CY 2026, the packaging threshold cost per day for drugs, biologicals, and therapeutic radiopharmaceuticals is \$140.

Diagnostic radiopharmaceuticals below the diagnostic radiopharmaceutical packaging threshold get packaged payment. In CY 2026, the packaging threshold cost per day for diagnostic radiopharmaceuticals is \$655.

Several categories of nonpass-through drugs, biologicals, and radiopharmaceuticals, regardless of the cost of the products, get packaged payment. Because the products are packaged according to the policies in [42 CFR 419.2\(b\)](http://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419/subpart-A/section-419.2#p-419.2(b)) ([http://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419/subpart-A/section-419.2#p-419.2\(b\)](http://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419/subpart-A/section-419.2#p-419.2(b))), we refer to them as policy-packaged drugs, biologicals, and radiopharmaceuticals.

## Separately Paid Drugs, Biologicals & Radiopharmaceuticals

Section 1833(t) of the [Social Security Act](https://www.ssa.gov/OP_Home/ssact/title18/1833.htm#act-1833-t) ([https://www.ssa.gov/OP\\_Home/ssact/title18/1833.htm#act-1833-t](https://www.ssa.gov/OP_Home/ssact/title18/1833.htm#act-1833-t)) provides for temporary additional payments or transitional pass-through payments. Payments for qualifying or non-packaged drugs, biologicals, and radiopharmaceuticals are generally based on the average sales price (ASP) methodology or other similar payment methodologies.

### ✦ Setting APC Payment Rates

We determine separately payable medical and surgical rates by multiplying the service's clinical APC's prospectively established scaled relative weight by a conversion factor (CF) to get a national unadjusted APC payment rate. The relative APC weight measures the resource service needs based on the APC geometric mean services cost.

The CF translates the scaled relative weights into dollar payment rates. [Hospital Outpatient Regulations and Notices](http://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notice) (<http://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notice>) has the national unadjusted payment rates and copayments for each HCPCS code in each rulemaking page's addenda.

To account for geographic price differences, we further adjust the labor portion of the national unadjusted payment rate (60%) by the hospital wage index for the area where we make payment. We don't adjust the remaining 40%.

For CY 2026, we use the Inpatient Prospective Payment System (IPPS) post-reclassified wage index for urban and rural areas to determine the wage adjustments for both the OPSS payment rate and the standardized copayment amount. Most copayments are 20% of the APC payment rate.

In addition to standard OPSS payments, we pay hospitals:

- [Pass-through payments](https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/pass-through-payment-stat-us-new-technology-ambulatory-payment-classification-apc) (https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/pass-through-payment-stat-us-new-technology-ambulatory-payment-classification-apc) for specific drugs, biologicals, and devices that meet pass-through status criteria (generally, these items are too new to produce payment rate-setting data).
- [Outlier payments](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#page=33) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#page=33) for individual services that cost hospitals much more than the services' APC group rates. CMHCs get a separate, capped hospital outlier threshold.
- Transitional outpatient payments for certain cancer hospitals and children's hospitals.
- An adjustment for [certain cancer hospitals](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#page=32) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#page=32).
- [Rural adjustments](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#page=26) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#page=26) (currently a payment increase of 7.1%) for most services at rural sole community hospitals (SCHs), including essential access community hospitals (EACHs) located in rural areas.

The annual review of APCs and their relative weights considers:

- Changes in hospital and medical practices
- Changes in technology
- Adding new services and removing obsolete services
- New cost data
- Hospital Outpatient Payment Panel recommendations
- Other relevant information

For CY 2026, we increased the OPSS payment rates by a 2.6% outpatient department fee schedule factor, based on the hospital inpatient market basket of 3.3% for inpatient services paid under the hospital IPPS reduced by a 0.7 percentage-point productivity adjustment.

We create other item and service category payment rates through alternative methods, like:

• [Rural adjustments](#) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#page=26)

- Separately payable drugs, biologicals, and radiopharmaceuticals
- Brachytherapy sources
- Services assigned to New Technology APCs

We update OPPS payment files quarterly to account for midyear changes, like:

- Adding new pass-through drugs or devices
- Adding new services and procedures to clinical and New Technology APCs
- Removing inpatient only (IPO) list procedures
- Adding new HCPCS codes
- Updating payment rates for separately payable drugs and biologicals based on the most recently available ASP data

We base payment for items and services on the annual scaled relative weights and generally don't update them quarterly. [Medicare Claims Processing Manual, Chapter 4](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#page=21) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#page=21>), section 10.3 has more APC payment adjustment information.

We exempt rural SCHs from the site-specific Medicare PFS-equivalent payment for the clinic visit service when an off-campus PBD provides the service.

## Revenue Code Selection

Hospital outpatient facilities may determine the most appropriate cost center and revenue code when billing for certain services. If Medicare hasn't provided specific instructions, hospital outpatient departments should report their charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report. [Medicare Claims Processing Manual, Chapter 4](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf#page=59) (<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf#page=59>), section 20.5 has more information.

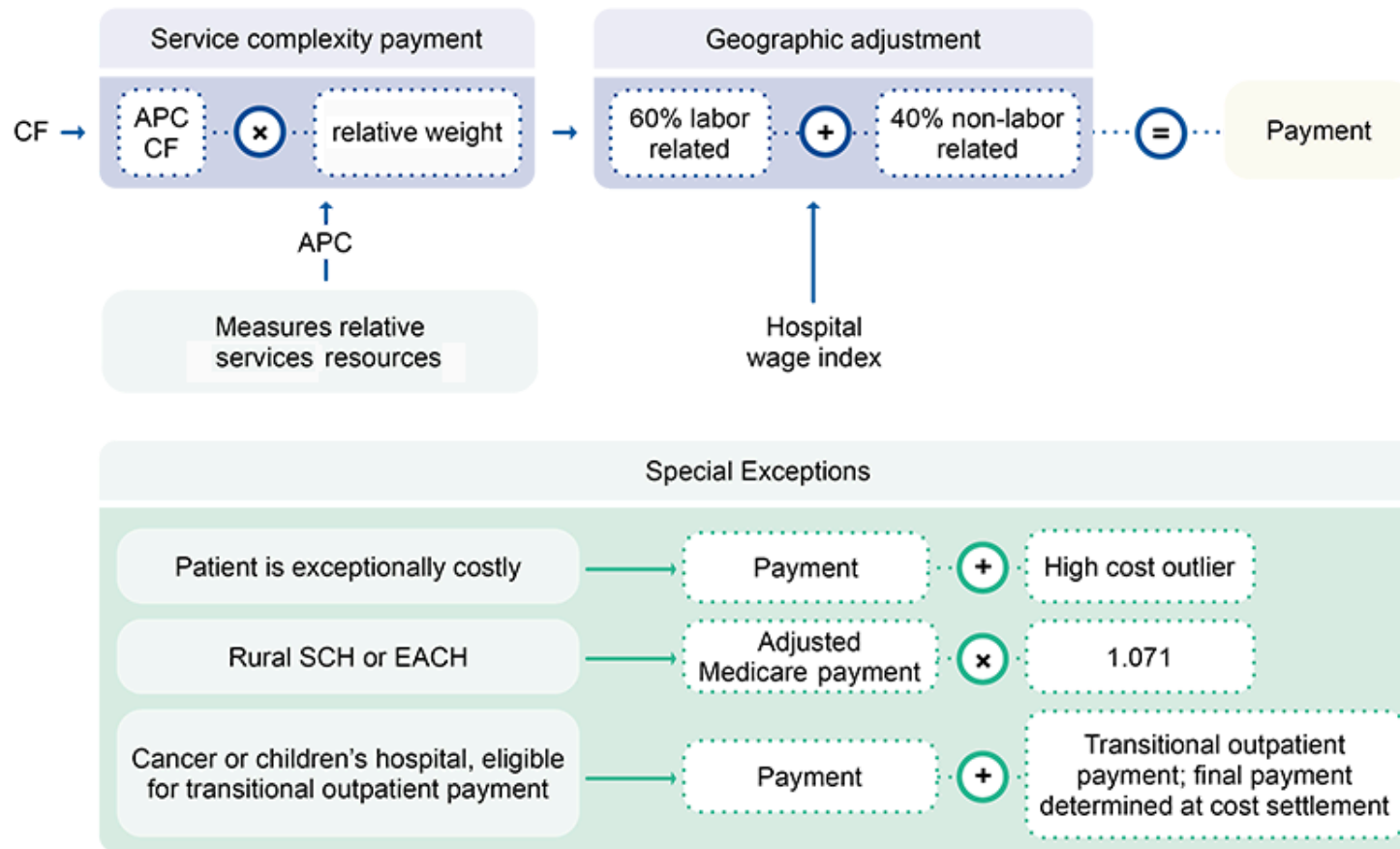
If you get claim denials with "Invalid Revenue Code" errors that you believe are due to an outdated edit, contact your [MAC](https://www.cms.gov/mac-info) (<https://www.cms.gov/mac-info>).

## Outlier Payments

Along with the APC payment, the OPPS provides outlier payments to hospitals to help mitigate the financial risk associated with high-cost and complex procedures, where a very costly service could present a hospital with significant financial loss. Outlier payments are provided on a service basis when the cost of a service exceeds both:

- The APC payment amount multiplier threshold, which is the APC payment amount multiplied by a certain amount
- The APC payment amount plus a fixed-dollar amount threshold, which is the APC payment plus a certain dollar amount

### ✦ **OPPS Payment Rates**



Feedback

**Figure 3. Calculating OPSS Payments**

[✦ IPO List](#)

We created the IPO list as part of the initial implementation of the OPSS in 2000. **We're phasing out the IPO list over 3 years, starting with removing 285 mostly musculoskeletal services in CY 2026.**

### ✦ General Supervision vs. Direct Supervision

For most hospital and CAH outpatient therapeutic services, the minimum required level of supervision is general supervision for each hospital outpatient service "incident to" a physician's service.

Under [42 CFR 410.28\(e\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.28#p-410.28(e)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.28#p-410.28\(e\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.28#p-410.28(e))), we allow these non-physician practitioners (NPPs) to supervise cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR), pulmonary rehabilitation (PR), and diagnostic services as authorized under their scope of practice and applicable state law:

- Nurse practitioners
- Physician assistants
- Clinical nurse specialists
- Certified nurse-midwives
- Certified registered nurse anesthetists

Under [42 CFR 410.28\(e\)\(2\)\(iii\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.28#p-410.28(e)(2)(iii)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.28#p-410.28\(e\)\(2\)\(iii\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.28#p-410.28(e)(2)(iii))), we permanently allow the physician or NPP to directly supervise CR, ICR, PR, and diagnostic services through audio-video real-time communications technology (excluding audio-only), **except for diagnostic services that have a global surgery indicator of 010 or 090.**

### ✦ Prospective Adjustment to Payments for Non-Drug Items and Services

The [340B Final Remedy rule](https://www.federalregister.gov/documents/2023/11/08/2023-24407/medicare-program-hospital-outpatient-prospective-payment-system-remedy-for-the-340b-acquired-drug) (<https://www.federalregister.gov/documents/2023/11/08/2023-24407/medicare-program-hospital-outpatient-prospective-payment-system-remedy-for-the-340b-acquired-drug>) finalized changes to the calculation of the OPSS CF applicable to non-drug items and services starting in CY 2026. **It also codified a 0.5% reduction in the OPSS CF applicable to non-drug items and services, excluding hospitals that enrolled in Medicare after January 1, 2018.**

## ❖ Hospital Price Transparency

We increased the penalty for some hospitals that don't comply with the [CY 2020 Hospital Price Transparency final rule \(https://www.federalregister.gov/d/2019-24931\)](https://www.federalregister.gov/d/2019-24931). We set a maximum civil monetary penalty, \$300 per day, for smaller hospitals with a bed count of 30 or less and a \$10 per bed per day penalty for hospitals with a bed count greater than 30, not to exceed a maximum of \$5,500 daily.

## ❖ Medical Device Pass-Through

Transformative devices with an FDA Breakthrough Device designation can still qualify for [device pass-through \(https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419/subpart-G/section-419.66\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419/subpart-G/section-419.66) payment status even if the substantial clinical improvement criterion doesn't apply. These devices must have pass-through payment status and must meet the other pass-through status criteria.

[Pass-Through Payment Status and New Technology APC \(https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/pass-through-payment-status-new-technology-ambulatory-payment-classification-apc\)](https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/pass-through-payment-status-new-technology-ambulatory-payment-classification-apc) has more information on the requirements for device pass-through payment applications.

## ❖ Prior Authorization

Request prior authorization for these outpatient department services:

- Blepharoplasty
- Botulinum toxin injections
- Cervical fusion with disc removal
- Facet joint interventions
- Implanted spinal neurostimulators
- Panniculectomy
- Rhinoplasty
- Vein ablation

Medical necessity documentation requirements remain the same. The current standard review time for prior authorization requests for outpatient department services is 7 calendar days.

### ✦ Hospital Outpatient Quality Reporting Program

The [Hospital Outpatient Quality Reporting \(OQR\) Program](https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hospital-outpatient-quality-reporting-program) (<https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hospital-outpatient-quality-reporting-program>) is a hospital outpatient department pay-for-reporting quality program. Hospitals that don't report quality data get a 2% reduction in their annual payment update.

Hospitals qualify for the full OPSS update factor by submitting required quality data for specific quality-of-care measures. [QualityNet Hospital OQR Program](https://qualitynet.cms.gov/outpatient/oqr) (<https://qualitynet.cms.gov/outpatient/oqr>) has more information.

Feedback

## Resources

- [2026 OPSS Final Rule \(https://federalregister.gov/d/2025-20907\)](https://federalregister.gov/d/2025-20907)
- [42 CFR 419—Prospective Payment System for Hospital Outpatient Department Services \(https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419)
- [CMS Hospital Outpatient PPS \(https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient\)](https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient)
- [CMS Newsroom: CY 2026 Hospital OPSS and ASC Payment System Final Rule \(https://www.cms.gov/newsroom/fact-sheets/calendar-year-2026-hospital-outpatient-prospective-payment-system-opss-ambulatory-surgical-center\)](https://www.cms.gov/newsroom/fact-sheets/calendar-year-2026-hospital-outpatient-prospective-payment-system-opss-ambulatory-surgical-center)
- [Hospital Outpatient Overview \(https://qualitynet.cms.gov/outpatient\)](https://qualitynet.cms.gov/outpatient)
- [Prior Authorization for Certain Hospital Outpatient Department Services \(https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/prior-authorization-certain-hospital-outpatient-department-opd-services\)](https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/prior-authorization-certain-hospital-outpatient-department-opd-services)

## Inpatient Psychiatric Facility Prospective Payment System

---

Print

Feedback

## What's Changed?

- Updated rural location adjustment factor
- Added a link to the FY 2026 teaching and rural adjustment factors
- Updated the FY 2026 market basket increase
- Updated the FY 2026 labor-related share

Substantive content changes are in dark red.

Medicare pays for covered psychiatric services in inpatient psychiatric facilities (IPFs) under a prospective payment system (PPS). IPFs include inpatient psychiatric hospitals and Medicare-certified distinct part (DP) psychiatric units in acute care hospitals and critical access hospitals (CAHs).

We cover 90 benefit days per benefit period for patients' psychiatric conditions. There's also a 60-day lifetime reserve. The total amount we pay for inpatient psychiatric hospital services over a patient's lifetime is limited to 190 days. This 190-day lifetime limit applies to psychiatric services in freestanding psychiatric hospitals but not to:

- Inpatient psychiatric services in general hospitals
- Medicare-certified DP psychiatric units in acute care hospitals
- CAHs

When a Medicare patient gets covered psychiatric services during an IPF stay, the facility may charge the patient only the appropriate [deductible and coinsurance](https://www.medicare.gov/basics/costs/medicare-costs) amounts.

### ✦ Certifications & Recertifications

Medicare Part A pays for services in an inpatient psychiatric facility only if a physician certifies and recertifies the need. Certification starts with an inpatient admission order. A certification statement helps us pay only for appropriate services.

Part A pays for IPF services if both:

- The [physician certifies](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-B#p-424.14(b)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-B#p-424.14\(b\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-B#p-424.14(b))), at the time of admission or as soon as possible, that the patient needs inpatient psychiatric services that they reasonably expect to improve the patient's condition, or for diagnostic study. Inpatient psychiatric services require [active treatment](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c02.pdf#page=10) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c02.pdf#page=10>) documented in the patient's hospital records.
- The order meets [these requirements](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-A/section-412.3) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-A/section-412.3>):
  - A qualified, licensed physician orders the patient's admission and has admitting privileges at the hospital as permitted by state law
  - The admitting practitioner is knowledgeable about the patient's hospital course, medical plan of care, and current condition
  - The decision (order) isn't delegated to another person on the hospital's medical staff who isn't state-authorized to admit patients or has no patient-admitting privileges

Complete and document certification in the patient's medical record before they're discharged.

If a patient continues to need active inpatient psychiatric treatment, follow this timeline for recertification:

- **First recertification:** By the 12th hospitalization day
- **All other required certifications:** At least every 30 days, but a utilization review committee can create different review intervals on a case-by-case basis (for example, every third day)

Recertification must include:

- Documentation that inpatient treatment since the last certification or recertification was, and continues to be, required
  - Treatment you reasonably expect to improve the patient's condition
- for:
  - Diagnostic study
- Proof the patient still needs daily active treatment directly from or under supervision of IPF personnel
  - Intensive treatment services
  - Admission or related services necessary for diagnostic study
- Hospital records showing the services are:
  - Equivalent services

The physician responsible for the case, or another physician with case knowledge authorized by the responsible physician or the hospital's medical staff, must sign certifications and recertifications.

### ❖ IPF PPS Payment Rates

Under the IPF PPS, IPFs get a predetermined [federal per diem base rate](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-N/section-412.422) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-N/section-412.422) for inpatient hospital services. The federal per diem base rate covers all IPF patient costs, including inpatient operating and capital-related costs (routine and ancillary services). It doesn't include pass-through costs, like bad debts and graduate medical education.

We calculate the IPF PPS per diem payment after adjusting the IPF PPS per diem base rate for facility and patient characteristics.

The IPF must provide all necessary Medicare-covered services directly or under arrangement. The IPF PPS payment is [payment in full](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-N/section-412.422#p-412.422(b)) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-N/section-412.422#p-412.422(b)), subject to applicable [deductible and coinsurance](https://www.medicare.gov/basics/costs/medicare-costs) (https://www.medicare.gov/basics/costs/medicare-costs), for Medicare-covered inpatient operating and capital-related costs associated with providing Medicare-covered services in an IPF; it doesn't cover the costs of providing an approved medical education program's hospital services in an IPF.

[Inpatient hospital services](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-409/subpart-B/section-409.10#p-409.10(b)) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-409/subpart-B/section-409.10#p-409.10(b)) don't include [physician services](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-415/subpart-C/section-415.102#p-415.102(a)) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-415/subpart-C/section-415.102#p-415.102(a)) or services provided by:

- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified nurse-midwives
- Qualified psychologists
- Certified registered nurse anesthetists

We pay for these covered professional services separately under Medicare Part B.

## Facility-Level Adjustments

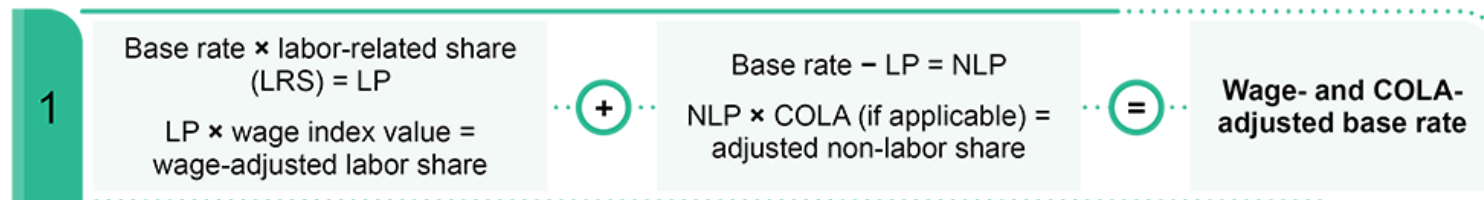
- We adjust the labor portion of the federal per diem base rate to account for geographic differences with an appropriate [IPF wage index](https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility/wage-index) (<https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility/wage-index>)
- We apply an **18% payment adjustment** for IPFs in rural locations, and IPFs whose delineations changed from rural to urban in FY 2025 get a 3-year budget-neutral phase-out of their FY 2025 rural adjustment to reduce this financial impact
- We apply a 54% payment adjustment for the first day's stay for IPFs with a qualifying emergency department (ED); we make a 28% payment adjustment for the first day's stay for IPFs [without a qualifying ED](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf#page=327) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf#page=327>)
- We pay IPFs that train interns and residents a facility-level adjustment to the federal per diem rate
- For IPFs in Alaska and Hawaii, we adjust the federal per diem base rate non-labor portion (NLP) by a cost of living adjustment (COLA) factor

Feedback

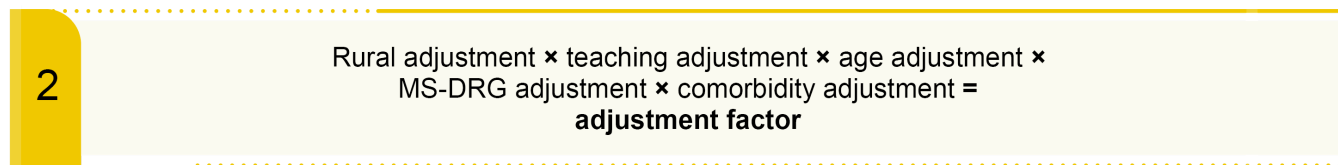
## Patient-Level Adjustments



- Full federal per diem base rate
- Reduced federal IPF per diem base rate for IPFs that don't report quality data



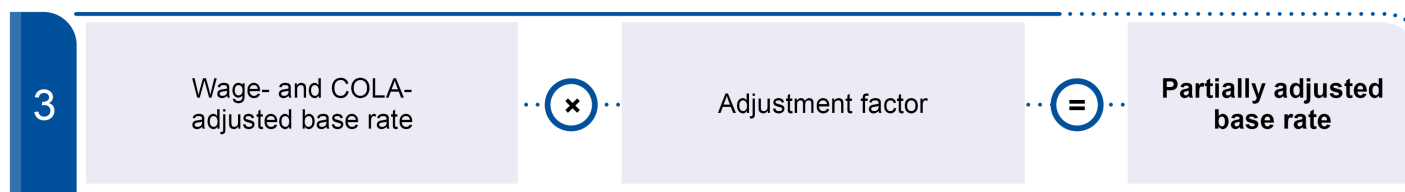
**Step 2.** Calculate the total facility- and patient-level adjustment factors, except the variable per diem and ED adjustments.



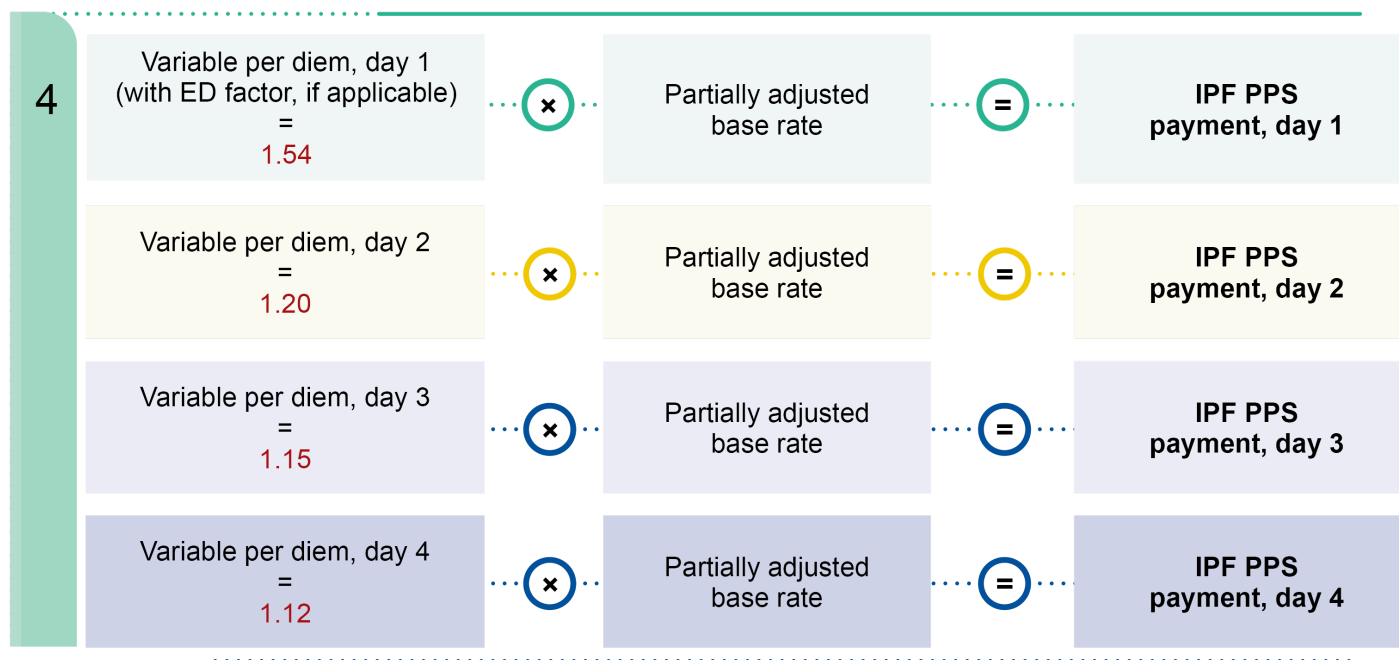
Feedback

**Note:** View the [FY 2026 teaching status or rural adjustment factors \(https://www.cms.gov/files/document/fy-2026-addendum-ipf-pps-final-payment-updates.pdf\)](https://www.cms.gov/files/document/fy-2026-addendum-ipf-pps-final-payment-updates.pdf).

**Step 3.** Multiply Step 2's **adjustment factor** by Step 1's **wage- and COLA-adjusted base rate** to get a partially adjusted federal per diem base rate, without variable per diem and ED adjustments.



**Step 4.** Multiply the partially adjusted federal per diem base rate for each day of the stay by its applicable variable per diem adjustment factor. For day 1, the factor is 1.54 if the IPF has a qualifying ED or 1.28 if the IPF has no qualifying ED.



Feedback

**5**

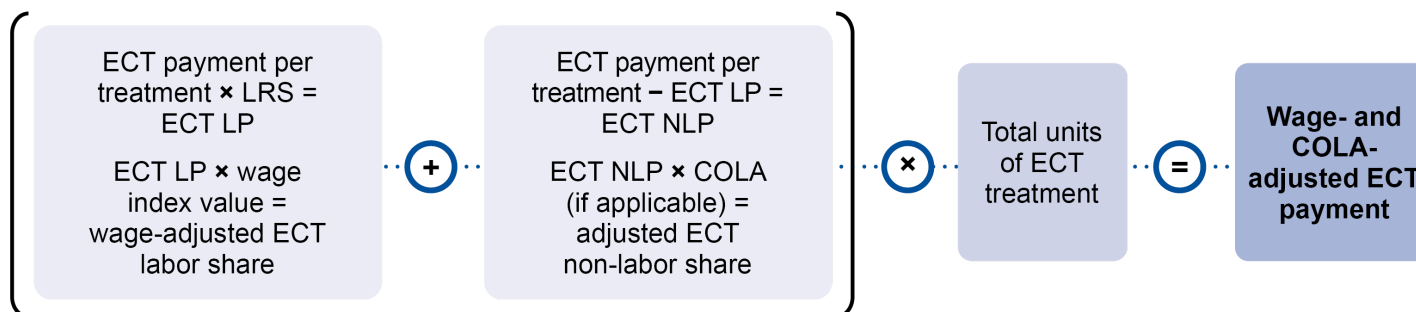
Total = sum of IPF PPS payments for each day of stay

**Step 5.** Add the IPF PPS payments for each day of the stay to get the total IPF PPS payment amount.

### Calculating ECT Treatment Payment

Multiply ECT treatment units provided during the stay by the appropriate wage- and COLA-adjusted ECT per treatment amount to get the total ECT payment. The appropriate ECT per treatment amount is the full ECT per treatment amount or

the reduced ECT per treatment amount for IPFs that don't report quality data.



When submitting claims, reasonably and consistently record the items and services patients got during an IPF stay. Even though IPFs get a per diem payment, you must completely and accurately report claims charges. This information helps us accurately calculate outlier payments and periodically refine the [IPF PPS](https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility) (<https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility>).

### ✿ Payment Updates

The FY 2026 IPF factor increase is 2.5%, which is a 3.2% market basket update reduced by a 0.7 percentage point productivity adjustment.

[IPF PPS Regulations and Notices](https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility/ipf-pps-regulations-and-notices) (<https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility/ipf-pps-regulations-and-notices>) has more information.

### Cost Report Data

Cost report data from Medicare freestanding and hospital-based IPFs helps calculate the major market basket stand-alone IPF cost weights. We calculate:

- Average freestanding IPF length of stay (LOS) from data reported on Worksheet S-3, Part I, Line 14
- Average hospital-based IPF LOS from data reported on Worksheet S-3, Part I, Line 16

[Provider Reimbursement Manual - Part 2, Chapter 40 \(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935\)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935) explains these worksheets.

## Market Basket Updates

- The FY 2026 LRS is 79.0%.
- We continue to base the IPF wage index on the concurrent pre-floor, pre-reclassified Inpatient Prospective Payment System (IPPS) hospital wage index. We determine IPF labor market areas based on the core-based statistical area established by the Office of Management and Budget.
- We apply, in a budget-neutral manner, a permanent 5% cap on any decrease to a provider's wage index from its wage index in the previous year.

## Cost-to-Charge Ratios

National median cost-to-charge ratios (CCRs) apply to these IPFs:

- New IPFs that haven't submitted their first Medicare cost report
- IPFs with an overall operating or capital CCR that exceeds 3 standard deviations above the corresponding national urban or rural average (the ceiling)
- Other IPFs that give the Medicare Administrative Contractor inaccurate or incomplete data for calculating a CCR

## ❖ IPF Quality Reporting Program

The [Inpatient Psychiatric Facility Quality Reporting \(IPFQR\) Program \(https://qualitynet.cms.gov/ipf\)](https://qualitynet.cms.gov/ipf) provides quality-of-care information so patients can make informed decisions about their health care options. It also encourages hospitals and providers to improve their quality of inpatient care by making sure they're aware of, and reporting on, best practices for their facilities.

[Quality Net \(https://qualitynet.cms.gov/ipf/measures\)](https://qualitynet.cms.gov/ipf/measures) and [IPFQR \(https://qualitynet.cms.gov/ipf/ipfqr/measures\)](https://qualitynet.cms.gov/ipf/ipfqr/measures) have the current quality reporting measures.

To meet the IPFQR Program requirements, IPFs must submit all quality measures. Eligible IPFs that don't participate in the IPFQR Program in an FY or don't meet all reporting requirements get a 2% annual market basket update reduction.

## Resources

- [2026 IPF PPS Final Rule \(https://federalregister.gov/d/2025-14781\)](https://federalregister.gov/d/2025-14781)
- [CMS Newsroom: FY 2026 Medicare IPF PPS and Quality Reporting Final Rule \(https://www.cms.gov/newsroom/fact-sheets/fy-2026-medicare-inpatient-psychiatric-facility-prospective-payment-system-ipf-pps-and-quality\)](https://www.cms.gov/newsroom/fact-sheets/fy-2026-medicare-inpatient-psychiatric-facility-prospective-payment-system-ipf-pps-and-quality)
- [IPF PPS Regulations \(https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-N\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-N)
- [Medicare Benefit Policy Manual, Chapters 2–4 \(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673\)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673)
- [Medicare Claims Processing Manual, Chapter 3 \(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf#page=312\)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf#page=312), section 190
- [Web Pricer \(https://webpricer.mps.cms.gov\)](https://webpricer.mps.cms.gov)

Feedback

Print

## Inpatient Rehabilitation Facility Prospective Payment System

### What's Changed?

We updated the FY 2026 market basket increase.

Substantive content changes are in dark red.

Medicare pays inpatient rehabilitation hospitals and inpatient rehabilitation units, known as inpatient rehabilitation facilities (IRFs), on a per-discharge [prospective payment system](https://www.ssa.gov/OP_Home/ssact/title18/1886.htm#act-1886-j) (PPS).

We use the [IRF-Patient Assessment Instrument](https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-pai-and-irf-grp-manual) (IRF-PAI) to classify Medicare patients into clinical, demographic, and payment groups that reflect their expected resource needs. We also use the IRF-PAI information to monitor quality of care.

IRFs must complete the appropriate IRF-PAI sections when admitting and discharging each Medicare Fee-for-Service (FFS) and Medicare Advantage (MA) patient.

### ✿ IRF Payment Rates

Under the IRF PPS, IRFs get a predetermined payment for goods and services they provide during each patient's IRF stay. Federal rates reflect all IRF patient care costs, including routine, ancillary, and capital costs. Federal rates don't include:

Feedback

- Operating-approved educational activities` costs described in [42 CFR 413.75\(a\)\(1\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-F/section-413.75#p-413.75(a)(1)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-F/section-413.75#p-413.75\(a\)\(1\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-F/section-413.75#p-413.75(a)(1))) and [42 CFR 413.85\(c\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-F/section-413.85#p-413.85(c)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-F/section-413.85#p-413.85\(c\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-F/section-413.85#p-413.85(c)))
- Bad debts
- Hemophilia blood product costs

To determine the federal payment amount for each IRF patient, we group patients by clinical condition and expected resource use. We assign patients to:

- Rehabilitation impairment categories according to the primary IRF admitting condition.
- Case-mix groups (CMGs) according to their functional status (motor and cognitive scores) and age. An unweighted motor score determines a patient's CMG placement. The 18 items scored have an equal weight of 1. Within each CMG:
  - We categorize cases into 1 of 4 tiers based on the patient's comorbidities (conditions secondary to the principal admitting diagnosis)
  - We make 1 tier payment for the case based on the patient's highest-paying tier comorbidity

We adjust for:

- Interrupted stays
- Short stays less than 3 days
- Short-stay transfers (transfers to another institutional setting with an IRF length of stay less than the average CMG length of stay)
- Deaths
- High-cost outlier cases

We apply a permanent 5% cap in a budget-neutral manner on any decrease to a provider's wage index from their previous year's wage index.

## Facility Characteristics

We adjust the hospital wage index to reflect geographic wage rate differences.

We apply an adjustment to the base rate for IRFs that treat a higher proportion of low-income patients.

IRFs with residency training programs get higher payment rates based on the number of interns and residents trained compared with their average daily census. We cap this adjustment.

We annually update rates to reflect:

- Inflation costs for IRF goods and services using a market basket index calculated for freestanding and hospital-based IRFs
- Changes in local wage rates

The FY 2026 IRF market basket increase factor is 2.6%, which is a 3.3% market basket update reduced by a 0.7 percentage point productivity adjustment.

## Compliance Threshold

A facility must meet [IRF classification requirements](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-B/section-412.29) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-B/section-412.29>) to get IRF PPS payment. At least 60% of the facility's total inpatient population must need intensive IRF treatment for 1 or more of [13 medical conditions](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-B/section-412.29#p-412.29(b)(2)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-B/section-412.29#p-412.29\(b\)\(2\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-B/section-412.29#p-412.29(b)(2))). We include comorbidities in the compliance threshold if they meet certain criteria.

## Medicare Administrative Contractor Compliance Percentage

An IRF's compliance percentage is the percentage of the total inpatient population requiring intensive IRF treatment for 1 or more of 13 medical conditions. Medicare Administrative Contractors (MACs) use compliance review period data to calculate the compliance percentage.

Except in the case of new IRFs, each compliance review period is 1 continuous 12-month period, starting 4 months before starting a cost reporting period and ending 4 months before the next cost reporting period.

MACs calculate the compliance percentage using:

- **Presumptive Methodology:** MACs use CMS software to analyze IRF PPS impairment group codes and etiologic diagnosis and comorbidity codes. IRFs send these ICD-10-CM codes on the IRF-PAIs to us through [iQIES \(https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/internet-quality-improvement-evaluation-system-iques\)](https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/internet-quality-improvement-evaluation-system-iques).
  - If at least 60% of the IRF's inpatient population requires IRF treatment for 1 or more of the 13 medical conditions, then the IRF meets the 60% rule.
  - If the IRF doesn't meet the 60% rule requirements based on the first part of the process, MACs must perform reviews of cases from the IRF Arthritis Verification Report to make sure they meet regulatory requirements for inclusion in the IRF's presumptive methodology compliance percentage, as explained in the [Medicare Claims Processing Manual, Chapter 3 \(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf#page=178\)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf#page=178), section 140.1.3.
  - If at least 50% of your inpatient population is Medicare FFS or MA patients, then your MAC may use the presumptive methodology to determine if you meet the 60% compliance threshold. Your MAC may also review a random medical records sample if it believes that's a more accurate way of calculating your compliance percentage. MACs must conduct a manual medical review if the IRF doesn't meet the 60% compliance threshold using the presumptive methodology. A MAC-calculated, random medical record sample always replaces the presumptive compliance percentage review.
- **Medical Records Review:** MACs analyze a random medical records sample representing IRF inpatients during the compliance review period.

MACs must use the random medical record sample method to calculate the compliance percentage when both conditions are met:

- The facility's presumptive compliance percentage is less than the required 60% compliance threshold
- The facility's Medicare population (Medicare FFS plus MA patients) is less than half its total patient population

MACs must send results to the appropriate CMS Survey & Operations Group (CMS Location), which determines an IRF's classification for the next cost reporting period. The classification status is effective for the entire cost reporting period.

If the CMS Location doesn't classify a Medicare provider as an IRF, the provider isn't eligible for payment under the IRF PPS. We pay them under the Inpatient PPS.

## New IRF Units

We allow a hospital to open a new IRF unit anytime within the cost reporting year if the hospital notifies the [Office of Program Operations & Local Engagement](https://www.cms.gov/leadership/office-program-operations-local-engagement) (<https://www.cms.gov/leadership/office-program-operations-local-engagement>) and their [MAC](https://www.cms.gov/MAC-info) (<https://www.cms.gov/MAC-info>) in writing of the change at least 30 days before opening the new unit. In this circumstance, this change remains in effect for the rest of the cost reporting year.

## Documentation Requirements

When determining if an IRF admission is reasonable and necessary, MACs must consider these items in a patient's IRF medical record:

- [Preadmission screening](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P#p-412.622(a)(4)(i)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P#p-412.622\(a\)\(4\)\(i\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P#p-412.622(a)(4)(i)))
- Individual [overall plan of care](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf#page=33) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf#page=33>) completed within 4 days of IRF admission
- Physician admission order
- Physician visit notes
- Patient's in-house medical record [IRF-PAI](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf#page=34) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf#page=34>) forms (electronic or paper format)
- Medical necessity criteria

Submit IRF-PAI admission and discharge assessments together after a patient's discharge. We won't accept and process a Medicare Part A FFS IRF payment claim until we get and accept a corresponding IRF-PAI.

## Medical Necessity Criteria

For Medicare to pay an IRF claim, the patient's IRF stay must be reasonable and necessary according to [42 CFR 412.622\(a\)\(3\)\(4\)\(5\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P#p-412.622(a)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P#p-412.622\(a\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P#p-412.622(a))) and the [Medicare Benefit Policy Manual, Chapter 1](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf#page=30) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf#page=30>), section 110.

We require a history and physical under the [conditions of participation](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C#p-482.24(c)(4)(i)(A)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C#p-482.24\(c\)\(4\)\(i\)\(A\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C#p-482.24(c)(4)(i)(A))).

Within the 48 hours before IRF admission, licensed or certified clinicians must complete a **preadmission patient screening**. This is a detailed, comprehensive evaluation of each patient's condition, need for medical therapy, and need for rehabilitation, including:

- Prior function level
- The patient's ability to actively participate in treatment
- Expected improvement level and time expected to reach it
- Clinical complications risk
- Conditions requiring rehabilitation
- Required treatments (physical therapy, occupational therapy, speech-language pathology, prosthetics, or orthotics); 1 of the therapies must be physical therapy or occupational therapy
- Anticipated discharge destination

A preadmission screening completed **more than 48 hours** before IRF admission is acceptable if the IRF assesses the patient's updated medical and functional status — by phone or in person — and documents it in the patient's medical record **in the 48 hours** immediately before admission.

We deny the claim if the rehabilitation physician doesn't document that they reviewed and agreed with the preadmission screening findings before the IRF admission.

Hold **interdisciplinary team meetings** ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P/section-412.622#p-412.622\(a\)\(5\)\(i\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P/section-412.622#p-412.622(a)(5)(i))) at least **once each week** ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P/section-412.622#p-412.622\(a\)\(5\)\(ii\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P/section-412.622#p-412.622(a)(5)(ii))) throughout the IRF stay. A rehabilitation physician may lead the weekly interdisciplinary team meetings in person, by video, or by phone. All team members must have current knowledge of the patient's medical and functional status.

Team meetings must involve a:

- Rehabilitation physician
- Registered nurse with rehabilitation training or experience
- Social worker or case manager (or both)
- Licensed or certified therapist from each therapy discipline involved in the patient's care

Keep the meetings' results and findings, along with the rehabilitation physician's agreement with those results and findings, in the patient's medical record.

Interdisciplinary team meetings should include participant names and professional titles. You don't need signatures from interdisciplinary team meeting participants other than from the rehabilitation physician, whose signature indicates their agreement.

To meet medical necessity requirements, the patient must:

- Need active and ongoing therapeutic intervention in **multiple** therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics or orthotics therapy), 1 of which must be physical or occupational therapy.
- Start the required therapy treatments within 36 hours from midnight on the day of admission.
- Generally need and get at least 3 hours of therapy per day at least 5 days per week and show measurable improvement in functional capacity or adapting to impairments. In certain well-documented cases, this intensive rehabilitation therapy program might instead be at least 15 hours per week within a period of 7 consecutive calendar days, starting with the IRF admission date.
- Be stable enough to benefit from intensive IRF services at admission. Patients who are unable to actively participate in, and benefit from, the intensive rehabilitation therapy services because they're still completing their treatment course in the referring hospital should stay there until they can participate.

The rehabilitation physician must:

- Document that they reviewed and agree with the findings and results of the preadmission screening before the IRF admission.
- Document an individualized plan of care by day 4.
- Have at least 3 face-to-face meetings with the patient to assess their medical and functional status within the first week of admission. Starting the second week after admission, a non-physician practitioner with specialized training and experience may conduct 1 of the 3 required face-to-face visits per week.

[IRF Rules and Related Files](https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation/rules-related-files) (<https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation/rules-related-files>) has more information.

### ❖ IRF Quality Reporting Program

The [Inpatient Rehabilitation Facility Quality Reporting Program](https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility) ([IRF QRP](https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility)) provides quality-of-care information so patients can make informed decisions about their health care options. It also encourages hospitals and providers to improve their quality of inpatient care by making sure they're aware of, and reporting on, best practices for their facilities.

[IRF QRP FAQs](https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-faqs) (<https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-faqs>) has more information.

To meet the IRF QRP requirements, IRFs must submit all quality measures. Eligible IRFs that don't participate in the IRF QRP in an FY or don't meet all reporting requirements get a 2% annual increase factor reduction.

IRFs may qualify for a [reconsideration and an exception or extension](https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-reconsideration-and-exception-extension) (<https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-reconsideration-and-exception-extension>).

Starting with the FY 2026 IRF QRP, we're expanding the IRF quality data reporting requirements, which currently apply to all IRF patients with Part A FFS and MA plans, so that IRFs start collecting data on all IRF patients, regardless of payer. This policy will make sure that:

- All IRF patients get the same quality of care
- All provider metrics reflect performance across the IRF patient network

Providers started collecting the IRF-PAI assessment on all patients getting IRF care, regardless of payer, on October 1, 2024.

## Resources

- [2026 IRF PPS Final Rule \(https://federalregister.gov/d/2025-14780\)](https://federalregister.gov/d/2025-14780)
- [CMS IRF PPS \(https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation/rules-related-files\)](https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation/rules-related-files)
- [CMS Newsroom: FY 2026 IRF PPS Final Rule \(https://www.cms.gov/newsroom/fact-sheets/fy-2026-inpatient-rehabilitation-facilities-prospective-payment-system-final-rule-cms-1829-f\)](https://www.cms.gov/newsroom/fact-sheets/fy-2026-inpatient-rehabilitation-facilities-prospective-payment-system-final-rule-cms-1829-f)
- [Web Pricer \(https://webpricer.mps.cms.gov\)](https://webpricer.mps.cms.gov)

Feedback

[Print](#)

## Long-Term Care Hospital Prospective Payment System

### What's Changed?

We updated the FY 2026 market basket increase factor.

Substantive content changes are in dark red.

Long-term care hospitals (LTCHs) generally treat medically complex patients who need longer hospital stays than they could get at short-term acute care hospitals. LTCHs must meet the same Medicare certification requirements as short-term acute care hospitals. For Medicare payment classification purposes, LTCHs must average an inpatient length of stay (LOS) greater than 25 days.

Feedback

#### ✦ Payment Updates

CMS updates the [LTCH payment rates \(https://www.cms.gov/medicare/payment/prospective-payment-systems/long-term-care-hospital/regulations-notices\)](https://www.cms.gov/medicare/payment/prospective-payment-systems/long-term-care-hospital/regulations-notices) annually based on the market basket index. Per federal regulations, we then reduce the rates through a productivity adjustment.

The FY 2026 LTCH Prospective Payment System (PPS) market basket increase factor is 2.7%, which is a 3.4% market basket update reduced by a 0.7 percentage point productivity adjustment.

For LTCHs that don't report quality data, we further reduce the market basket rate by 2 percentage points.

### Medicare Severity Long-Term Care Diagnosis-Related Group Patient Classifications

We pay LTCHs under the LTCH PPS. Under this payment system, we set base payment rates for inpatient stays based on:

- Patient's diagnosis
- Services or treatment provided
- Illness severity

A hospital gets a single payment for each case depending on the payment classification assigned at discharge. The classification systems are:

- **Inpatient Prospective Payment System (IPPS):** Medicare Severity Diagnosis-Related Groups (MS-DRGs)
- **LTCH PPS:** Medicare Severity Long-Term Care Diagnosis-Related Groups (MS-LTC-DRGs)

We group each patient stay using:

- One principal diagnosis
- Up to 24 secondary diagnoses
- Up to 25 procedure codes
- Age
- Sex
- Patient discharge status

We annually update each MS-LTC-DRG based on the latest LTCH discharge data and its predetermined average length of stay (ALOS). We pay LTCHs for each discharge based on the MS-LTC-DRG if it meets exclusion requirements from the site neutral payment rate. We pay for cases assigned to an MS-LTC-DRG based on the federal payment rate, including payment and policy adjustments.

### ✦ Site Neutral Payment Rate

When a patient doesn't meet specific criteria, we pay LTCH discharges at a site neutral payment rate, which is generally the lower of these:

- IPPS comparable per diem amount (calculated under the [short-stay outlier](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-O/section-412.529) (SSO) policy, including the applicable [high-cost outlier](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-F/subject-group-ECFRaa270bfd7fcbe5c/section-412.83) (HCO) payment)
- Estimated case costs calculated by multiplying allowable charges by the LTCH's [cost-to-charge ratio](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-F/subject-group-ECFRf893c5ca33a904b/section-412.84#p-412.84(i)(3)) (CCR)

We exclude discharges from the site neutral payment rate and pay based on the standard federal payment rate if the provider directly admits the patient from the IPPS hospital and the patient had:

- At least 3 days in an intensive care or coronary care unit at the IPPS hospital but no psychiatric or rehabilitation MS-LTC-DRG care at the LTCH
- At least 96 hours of respiratory ventilation services at the LTCH but no psychiatric or rehabilitation MS-LTC-DRG care at the LTCH

## ✦ Payment Policy Adjustments

SSO, HCO, fixed-loss amount, and [interrupted stay](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-O/section-412.531) payment policy adjustments all apply to site neutral and standard federal payment rate discharges except where noted.

### Short-Stay Outlier

The [SSO policy](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-O/section-412.529#p-412.529(a)) helps prevent inappropriately paying for cases without a full episode of care. SSO payment adjustments apply only to the standard federal payment rate discharges and may happen when a patient:

- Experiences an acute condition that needs urgent treatment or more intensive rehabilitation and the LTCH discharges them to another facility
- Doesn't need an LTCH care level and the LTCH discharges them to another facility
- Is discharged to their home
- Dies within the first several days after LTCH admission
- Exhausts LTCH benefits during the stay

We apply an adjustment when the LOS ranges from 1 day through 5/6 of the ALOS for the MS-LTC-DRG where we group that case. We subject the MS-LTC-DRG payment to the SSO adjustment.

We don't apply an adjustment when the LOS is more than 5/6 of the ALOS for the MS-LTC-DRG where we group that case. In this situation, the LTCH gets the full MS-LTC-DRG payment.

**Note:** When calculating the SSO adjustment, we cap the SSO threshold (5/6 of the ALOS for the MS-LTC-DRG) at 25 days. We never subject stays of 25 days or more to the SSO policy.

Feedback

This policy doesn't apply to site neutral discharges.

We blend the MS-LTC-DRG per diem amount with what we would pay under the IPPS, calculated as a per diem and capped at the full IPPS comparable amount.

### SSO Payments When Patient Benefits Exhaust During an LTCH Stay

We base LTCH payments on the patient's covered benefit days until the LOS triggers a full MS-LTC-DRG payment. This means a patient's remaining benefit days and length of hospital stay affect LTCH payments and may result in an SSO payment adjustment.

**Table 3. Benefits Exhaust & LOS is Below MS-LTC-DRG Threshold**

If	Then	Example
----	------	---------

<p>The patient uses regular episode benefit days during an LOS below the SSO MS-LTC-DRG threshold</p>	<ul style="list-style-type: none"> <li>• The patient pays for non-covered days</li> <li>• The LTCH gets SSO payment for the patient's covered hospital stay</li> </ul>	<p>The MS-LTC-DRG SSO threshold is 25 days, and the patient's LOS is 20 days; the LTCH gets SSO payment. The patient's benefit days end on day 15.</p> <ul style="list-style-type: none"> <li>• We pay for 15 covered days under the LTCH SSO policy</li> <li>• The patient pays for days 16–20</li> </ul>
---	--	--

**Table 4. Benefits Exhaust & LOS Exceeds MS-LTC-DRG Threshold**

If	Then	Example
<p>The patient uses all episode benefit days during an LOS exceeding the SSO MS-LTC-DRG threshold</p>	<ul style="list-style-type: none"> <li>• The patient doesn't pay for non-covered days (until they reach HCO threshold)</li> <li>• The LTCH gets full MS-LTC-DRG payment</li> </ul>	<p>The MS-LTC-DRG SSO threshold is 25 days, and the patient's benefit days end on day 30; the patient's LOS is 35 days.</p> <ul style="list-style-type: none"> <li>• The patient doesn't pay for days 31–35 (the SSO policy doesn't apply)</li> <li>• The LTCH gets full MS-LTC-DRG payment; the patient pays for the first day the stay qualifies as an HCO through discharge</li> </ul>

Feedback

**Note:** We allow 90 covered episode benefit days of care under the inpatient hospital benefit. Each patient has 60 lifetime reserve days, which the patient may use to cover non-covered episode days of care exceeding 90 days.

### High-Cost Outlier

The [HCO policy](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-O#p-412.525(a)) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-O#p-412.525(a)) adjusts the applicable LTCH PPS payment rate (site neutral rate or standard federal rate) for LTCH stays with costs exceeding typical cases of similar case-mix costs. To qualify for an HCO payment, an LTCH's estimated treatment costs must exceed the outlier threshold. We calculate the applicable outlier threshold as the case's applicable LTCH PPS payment plus the applicable fixed-loss amount.

The HCO payment equals 80% of the difference between the estimated case cost and the outlier threshold.

For SSO cases, we calculate the outlier threshold by adding the applicable fixed-loss amount to the adjusted SSO MS-LTC-DRG payment. If the estimated SSO case cost exceeds the outlier threshold, it qualifies for an HCO payment.

We set 2 fixed-loss amounts:

- Site neutral payment rate
- Standard federal rate

The HCO adjustment:

- Improves LTCH PPS hospital- and patient-resource cost accuracy
- Cuts LTCH financial losses from treating patients needing more costly care
- Limits LTCH loss to fixed-loss amount and cost percentages above the marginal cost factor
- Discourages underserving high-cost patients

Medicare Administrative Contractors (MACs) use PRICER software to determine if enough medically necessary benefit days are in the outlier period. If a patient has enough benefit days, the MAC processes the claim as usual and the LTCH takes no other action. If a patient doesn't have enough benefit days, the MAC returns the claim to the LTCH for correction, indicating the correct HCO threshold amount.

Feedback

### HCO Payments When Patients Exhaust Benefits During an LTCH Stay

We make HCO payments for:

- Days the patient has Medicare coverage (regular, [coinsurance \(https://www.medicare.gov/basics/costs/medicare-costs\)](https://www.medicare.gov/basics/costs/medicare-costs), or lifetime reserve days) for part of the stay beyond the HCO threshold
- Medically necessary covered cost days when the patient has a benefit day available

**Table 5. Patient Benefits Exhaust Before Qualifying for Full LTCH PPS Standard Federal Rate Payment**

If	Then	Example
----	------	---------

<ul style="list-style-type: none"> <li>• The patient's benefits are exhausted before qualifying for the full MS-LTC-DRG payment</li> <li>• Covered care costs exceed the standard federal rate HCO threshold for an SSO-adjusted payment</li> </ul>	<p>The LTCH gets HCO payment with SSO-adjusted payment for covered medically necessary benefit days</p>	<p>The LTCH admits a standard federal rate patient with 5 remaining benefit days grouped to an MS-LTC-DRG with a 30-day ALOS.</p> <ul style="list-style-type: none"> <li>• The patient doesn't have enough regular benefit days to trigger a full MS-LTC-DRG standard federal rate payment (5/6 of MS-LTC-DRG ALOS), qualifying the case for an SSO-adjusted payment.</li> <li>• The LTCH cost for covered services during the 5 benefit days exceeds the standard federal rate HCO threshold. The case also qualifies for an HCO payment for all costs above the HCO threshold days 1–5.</li> <li>• The patient pays for day 6 through discharge.</li> </ul>
---	---	---

**Table 6. Patient Benefits Exhaust After Qualifying for Full Applicable LTCH PPS Payment**

If	Then	Example
<ul style="list-style-type: none"> <li>• The patient's benefits are exhausted after qualifying for the full applicable LTCH PPS payment</li> <li>• Covered care costs exceed the applicable HCO threshold</li> </ul>	<p>The LTCH gets HCO payment with the full LTCH PPS payment for covered medically necessary benefit days</p>	<p>The LTCH admits a standard federal rate patient with 36 remaining benefit days grouped to an MS-LTC-DRG with a 30-day ALOS.</p> <ul style="list-style-type: none"> <li>• On day 33, the patient's care cost exceeds the standard federal rate HCO threshold, qualifying the case for the full MS-LTC-DRG standard federal rate payment and the HCO payment for all covered costs (available benefit days) above the HCO threshold</li> <li>• The patient pays for day 37 through discharge</li> </ul>

Feedback



“Full applicable LTCH PPS payment” means the standard federal rate (including SSO adjustment) or the site neutral payment rate, based on the LTCH case. “Applicable HCO threshold” means the HCO threshold determined from the standard federal rate fixed-loss amount or site neutral fixed-loss amount based on the LTCH case.



**Table 7. Patient Exhausts Benefits Before Exceeding Applicable HCO Threshold**

If	Then	Example
<ul style="list-style-type: none"> <li>• The patient qualifies for the full applicable LTCH PPS payment</li> <li>• The patient uses all regular benefit days for the stay before exceeding the applicable HCO threshold</li> </ul>	<ul style="list-style-type: none"> <li>• The LTCH gets the full LTCH PPS payment (and doesn't get the HCO payment)</li> <li>• The patient pays costs incurred the day after the case exceeds the applicable HCO threshold</li> </ul>	<p>The LTCH admits a standard federal rate patient with 36 remaining benefit days grouped to an MS-LTC-DRG with a 30-day ALOS.</p> <ul style="list-style-type: none"> <li>• The patient care cost exceeds the standard federal HCO threshold on day 45</li> <li>• The patient exhausted all benefit days before reaching the HCO threshold; the case isn't eligible for HCO payment</li> <li>• The patient doesn't pay covered costs for days 37–45</li> <li>• The patient pays for day 46 through discharge</li> </ul>

Feedback

If the patient's benefits are exhausted during the LTCH stay, determine the:

- Day when the case cost reaches the applicable HCO threshold (use charges per day and CCR)
- Number of benefit days the patient has left

To calculate the HCO, use the costs for the days after the patient's case cost reaches the HCO threshold of available benefit days. If the patient remains under care after benefits are exhausted, they pay the costs of those remaining days.

Any changes to HCO payments under the LTCH PPS outlier reconciliation policy don't retroactively affect a patient's lifetime reserve days or coverage status, benefits, or payments under Medigap or Medicaid.

## HCO Fixed-Loss Amounts

The fixed-loss amount for standard federal payment rate cases is the amount allowing yearly projected total HCO payments to equal 7.975% of the total LTCH PPS standard federal payment rate payments estimated for that year (full MS-LTC-DRG payments or adjusted SSO amount plus HCO payments).

We include estimated uncompensated care payments in the outlier fixed-loss cost threshold calculation. Specifically, in all cases, we use the estimated per-discharge uncompensated care payments to hospitals eligible for these payments.

The applicable HCO threshold for site neutral payment rate cases is the sum of the case's site neutral payment rate and the IPPS fixed-loss amount. We set the site neutral case fixed-loss amount to the same value as the IPPS fixed-loss amount.

We estimate each case's cost using provider-specific file CCRs.

Use the applicable statewide average CCR when the LTCH's provider-specific file CCRs aren't available.

MACs estimate a case's cost by multiplying the Medicare-covered charges by the LTCH's overall CCR, based on the most recently settled or tentatively settled cost report.

These CCR revisions or determinations may also apply:

- We may ask MACs to use an alternative CCR showing recent substantial increases or decreases in a hospital's charges
- LTCHs may ask their MAC to use a higher or lower CCR based on substantial evidence when their CMS Regional Office approves it
- MACs annually assign the statewide average CCR to LTCHs with CCRs above the maximum ceiling
- MACs use an LTCH's actual CCR rather than the statewide average LTCH CCR with CCRs below the minimum floor
- MACs may use the statewide average CCR when the LTCH CCR is undetermined (for example, before a new LTCH submits its first Medicare cost report or when data isn't available to calculate the CCR because it's missing or incorrect)

The LTCH PPS outlier policy allows for reconciling HCO payments at cost report settlement and accounts for differences between the estimated and actual CCR for the period when the discharge occurs.

## Interrupted Stay

An [interrupted stay](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-O/section-412.531) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-O/section-412.531>) happens when an LTCH discharges a patient to an acute care hospital, inpatient rehabilitation facility (IRF), skilled nursing facility (SNF), swing bed, or home, and the same LTCH readmits the patient for more medical treatment within a specified period. For example, an LTCH discharges the patient for treatment because the services are unavailable in the LTCH.

The 2 types of interrupted stays are:

- 3 days or less
- Greater than 3 days

The interruption day count starts the day of discharge (the first day the patient is away from the LTCH at midnight).

### 3-Day or Less Interruption Example

If an LTCH discharges a patient on September 2, the [3-day or less interrupted stay](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-O/section-412.531#p-412.531(a)(1)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-O/section-412.531#p-412.531\(a\)\(1\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-O/section-412.531#p-412.531(a)(1))) policy determines payment if the LTCH readmits the patient to the same LTCH on September 2, 3, or 4.

If an LTCH discharges a patient and readmits them to the same LTCH within 3 days, the patient may:

- **Get outpatient or inpatient tests, treatment, or care at an inpatient acute care hospital, IRF, SNF, or swing bed.** Outpatient or inpatient care during interruption is part of a single LTCH care episode and bundled into the LTCH payment. If a patient gets tests or procedures during a 3-day interruption and the LTCH pays the provider under [arrangements](https://www.ecfr.gov/current/title-42/part-409/section-409.3#p-409.3) (<https://www.ecfr.gov/current/title-42/part-409/section-409.3#p-409.3>), the total patient day count includes all interrupted days.
- **Have an intervening patient stay at home for up to 3 days with no tests, treatment, or care.** If the patient doesn't get care during the 3-day interruption, the LTCH can't use days away in the total LOS. However, if the patient gets care during an interruption the LTCH pays for under arrangements, the LTCH uses all interruption days in that patient's LOS.

### Greater Than 3-Day Interruption Example

If a patient is discharged from an LTCH on September 2, the [greater than 3-day interrupted stay](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-O/section-412.531#p-412.531(a)(2))) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-O/section-412.531#p-412.531\(a\)\(2\)\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-O/section-412.531#p-412.531(a)(2))) policy determines payment if the patient is readmitted to the same LTCH between September 5 and the applicable provider's fixed-period threshold.

For a greater than 3-day interruption, the LTCH must:

1. Discharge the patient
2. Admit them directly to an inpatient acute care hospital, IRF, SNF, or swing bed
3. Readmit them to the original LTCH within a specified period

**Table 8. Greater Than 3-Day Interruption**

Discharge To	Interrupted Stay Fixed Period
Inpatient acute care hospital	Between 4 and 9 consecutive days
IRF	Between 4 and 27 consecutive days
SNF or swing bed	Between 4 and 45 consecutive days

We treat an interrupted stay episode as 1 discharge for payment and make 1 LTCH PPS payment. Interrupted stays are eligible for HCO payments.

We pay separately for an intervening inpatient stay at the acute care hospital, IRF, SNF, or swing bed.

These examples don't qualify as interrupted stays:

- The patient's stay at an acute care inpatient hospital, IRF, SNF, or swing bed exceeds the fixed-day period
- The patient is discharged to a facility type other than an acute care inpatient hospital, IRF, SNF, or swing bed
- The patient is discharged to more than 1 facility or goes home between LTCH stays

If the stay disruption doesn't meet the interrupted stay definition, the original discharge ends the patient's first stay. If an LTCH readmits the patient, the second admission starts a new stay. The LTCH gets 2 LTCH PPS payments (full MS-DRG payment or adjusted SSO payment, as applicable) for 2 patient stays:

- Payment for the first stay
- Payment for the stay after an LTCH readmission

### **Interrupted Stay Billing Requirements**

- The **from** date is the original admission date
- Report the stay's dates in **Statement Covers Period**:
  - The **through** date is the final discharge date
- Report payable days in the **Covered Days** field (value code 80)
- Report interrupted days in the **Non-Covered Days** field (value code 81)
- Report occurrence span code (OSC) 74 with the dates the patient is absent at midnight (interruptions of more than 1 day):
  - OSC **from** date is the initial LTCH discharge date
  - OSC **through** date is the last LTCH date the patient isn't present at midnight
- Don't change the principal diagnosis when the patient is readmitted to the LTCH; if the patient has other medical conditions when they return, report the diagnosis codes on the claim
- Use revenue code 018X to show the number of interruption days

## Discharge Payment Percentage Adjustment

An LTCH's discharge payment percentage is the ratio of the LTCH's discharges that got the standard federal rate payment to its total Medicare discharges under the LTCH PPS. If an LTCH's discharge payment percentage for a cost reporting period isn't at least 50%, this payment adjustment policy applies after we calculate the percentage and notify the LTCH. For cost reporting periods subject to this adjustment, the discharge payment percentage adjustment is:

- An amount equivalent to the hospital IPPS payment
- An added HCO-cases payment based on the fixed-loss amount for an IPPS hospital in effect at the time of the LTCH discharge

The payment adjustment ends when the calculated cost reporting period's discharge payment percentage is at least 50%. We may subject the LTCH to this adjustment again if, after reinstatement, the discharge payment percentage falls below 50%.

LTCHs subject to a cost reporting period payment adjustment can get a special probationary reinstatement. They can do this by getting the payment adjustment delayed if, for at least 5 consecutive months of the 6 months before the cost reporting period, they calculate the discharge payment percentage to at least 50%.

For any cost reporting period where the payment adjustment would have applied without a delay, the payment adjustment will be applied for all discharges in the cost reporting period if the discharge payment percentage isn't at least 50%.

### ✦ LTCH Quality Reporting Program

The [Long-Term Care Hospital Quality Reporting Program](https://www.cms.gov/medicare/quality/long-term-care-hospital) (LTCH QRP) makes quality-of-care information available so patients can make informed decisions about their health care options. It also encourages hospitals and providers to improve their quality of inpatient care by making sure they're aware of, and reporting on, best practices for their facilities and type of care.

[LTCH QRP Measures Information](https://www.cms.gov/medicare/quality/long-term-care-hospital/lrch-quality-reporting-measures-information) has the current quality reporting measures. Find more information in the [LTCH QRP FAQs](https://www.cms.gov/files/document/fy2024-lrch-qrp-faqs.pdf).

Eligible LTCHs that don't participate in the LTCH QRP in an FY or don't meet all reporting requirements get a 2.0% reduction in their annual payment update.

LTCHs may qualify for a [reconsideration and an exception and extension](https://www.cms.gov/medicare/quality/long-term-care-hospital/lrch-quality-reporting-reconsideration-and-exception-extension).

Feedback

## Resources

- [2026 LTCH PPS Final Rule](https://federalregister.gov/d/2025-14681)
- [CMS LTCH PPS](https://www.cms.gov/medicare/payment/prospective-payment-systems/long-term-care-hospital)
- [CMS Newsroom: FY 2026 Hospital IPPS and LTCH PPS Final Rule](https://www.cms.gov/newsroom/fact-sheets/fy-2026-hospital-inpatient-prospective-payment-system-ipp-pps-and-long-term-care-hospital-prospective-0)
- [Web Pricer](http://webpricer.mps.cms.gov)

[Print](#)

## Skilled Nursing Facility Prospective Payment System

### What's Changed?

- Updated the FY 2026 market basket increase
- Updated the skilled nursing facility (SNF) Value-Based Purchasing (VBP) Program measures

Substantive content changes are in dark red.

Medicare pays skilled nursing facility (SNF) services per diem under a prospective payment system (PPS). The SNF PPS per diem payment covers all Medicare Part A SNF services (routine, ancillary, and capital-related costs), except operating-approved educational activities and services excluded from SNF consolidated billing (CB) costs under section 1888(e)(4) (E) of the [Social Security Act](https://www.ssa.gov/OP_Home/ssact/title18/1888.htm#act-1888-e-4-e) ([https://www.ssa.gov/OP\\_Home/ssact/title18/1888.htm#act-1888-e-4-e](https://www.ssa.gov/OP_Home/ssact/title18/1888.htm#act-1888-e-4-e)).

### ✦ SNF Payment Rates

We determine SNF payments by adjusting base payment rates for geographic differences in labor costs and case-mix, and we calculate separate base rates for urban and rural areas.

Payment rates include an add-on to the Medicare Part B services cost estimate. We pay this add-on for SNF patients during a Part A-covered stay.

Feedback

We base the standardized per diem rates on national data from urban and rural areas. Case-mix and wage adjustments apply to these per diem rates. We pay SNFs at the full federal rate.

There are 2 federal rate adjustments that reflect a SNF's reimbursement:

1. A permanent 5% cap on any decrease to a SNF's wage index from its previous year's wage index
  - This provision aims to provide stability and predictability in a SNF's reimbursement by limiting sudden, significant drops in its wage index. The wage index adjusts payments based on geographic variations in labor costs.
  - A SNF's wage index for FY 2026 wouldn't be less than 95% of its final FY 2025 wage index regardless of whether the SNF is part of an updated core-based statistical area (CBSA).
  - For subsequent years, a SNF's wage index wouldn't be less than 95% of its previous FY's wage index.
  - We pay a new SNF the wage index for the area where it's geographically located for its first full or partial FY with no cap applied, because a new SNF wouldn't have had a wage index in the previous FY.
2. The patient case mix (showing the number of resources typically needed for each patient's clinical condition identified during the resident assessment process) using the [Patient Driven Payment Model](https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/patient-driven-model) (<https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/patient-driven-model>) (PDPM) patient classification system

We update [federal rates](https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/list-federal-regulations) (<https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/list-federal-regulations>) annually to reflect changes in:

- Cost of goods and services SNFs purchase to provide care using the SNF market basket index
  - We include a forecast error adjustment when the difference between forecast and actual changes in the market basket exceeds a 0.5% threshold for the most recently available final FY data.
  - We adjusted the FY 2026 3.3% market basket increase upward to account for the forecast error adjustment of 0.6%, resulting in a SNF market basket percentage increase of 3.9%, which we reduced by the 0.7 percentage-point productivity adjustment. This results in an FY 2026 SNF market basket update of 3.2%.
- Local wage rates using the latest hospital wage index
- Facility performance in the SNF Value-Based Purchasing (VBP) Program

## ✦ PDPM Case-Mix Provision

PDPM classifies patients into 5 case-mix index (CMI)-adjusted components, and each component uses different measures.

**Table 9. CMI-Adjusted Components & Measures**

Component	Measure
Physical therapy (PT)	Clinical category, functional score
Occupational therapy (OT)	Clinical category, functional score
Speech-language pathology (SLP)	Presence of acute neurologic condition, SLP-related comorbidity or cognitive impairment, mechanically altered diet, or swallowing disorder
Non-therapy ancillary (NTA)	NTA comorbidity score
Nursing	Functional score

**Note:** We apply a variable per diem (VPD) resource-use adjustment rate for PT, OT, and NTA payments.

To [calculate each payment component](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/SNF_PDPM_Classification_Walkthrough_v2.pdf) ([https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/SNF\\_PDPM\\_Classification\\_Walkthrough\\_v2.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/SNF_PDPM_Classification_Walkthrough_v2.pdf)), multiply the CMI linked to the patient's case-mix group by the wage-adjusted component base rate and then by the VPD schedule-specific day, when applicable. Add each component payment to the non-case-mix component payment rate to create the patient's PDPM per diem rate.

Feedback

$PT = PT \text{ Base Rate} \times PT \text{ CMI} \times VPD \text{ Adjustment Factor}$	<b>Plus (+)</b>
$OT = OT \text{ Base Rate} \times OT \text{ CMI} \times VPD \text{ Adjustment Factor}$	<b>Plus (+)</b>
$SLP = SLP \text{ Base Rate} \times SLP \text{ CMI}$	<b>Plus (+)</b>
$Nursing = Nursing \text{ Base Rate} \times Nursing \text{ CMI} \times 18\% \text{ Nursing Adjustment Factor (Only for Patients with AIDS)}$	<b>Plus (+)</b>
$NTA = NTA \text{ Base Rate} \times NTA \text{ CMI} \times VPD \text{ Adjustment Factor}$	<b>Plus (+)</b>
$Non\text{-Case Mix} = Non\text{-Case Mix Base Rate}$	<b>Equals (=)</b>
	<b>PDPM Rate</b>

Feedback

#### Figure 4. Calculating PDPM Classification

##### Clinical Category & Functional Status

PT and OT components use 2 classifications:

- Clinical category
- Functional status

##### Clinical Category

We base the clinical category on the primary SNF stay diagnosis code by mapping the ICD-10-CM codes coded on the [Minimum Data Set](https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual) (https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual) (MDS) in Item I0020B to a PDPM clinical category.

A surgical procedure during the previous inpatient stay may adjust the clinical category and map to 1 of these primary diagnosis clinical categories:

- Acute Infections
- Acute Neurologic
- Cancer
- Cardiovascular and Coagulations
- Major Joint Replacement or Spinal Surgery
- Medical Management
- Non-Orthopedic Surgery
- Non-Surgical Orthopedic/Musculoskeletal
- Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)
- Pulmonary

Mapping the ICD-10-CM diagnosis or surgical category classifies a SNF resident into each of the clinical categories. Each year we consider stakeholder ICD-10-CM mapping suggestions.

## PDPM PT & OT Clinical Categories

Given similar costs among certain PT and OT clinical categories, we grouped certain patient clinical classification categories together:

- Major Joint Replacement or Spinal Surgery
- Non-Orthopedic Surgery and Acute Neurologic
  - Non-Surgical Orthopedic/Musculoskeletal
- Other Orthopedic ◦ Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)
  - Acute Infections
  - Cancer
  - Cardiovascular & Coagulations
  - Medical Management
- Medical Management ◦ Pulmonary

## Functional Status

We calculate the PDPM PT and OT functional score in Table 10 using MDS 3.0 data based on 10 Section GG items that proved highly predictive of PT and OT costs per day:

- 1 eating item
- 1 oral hygiene item
- 1 toileting item
- 2 bed mobility items
- 3 transfer items
- 2 walking items

**Table 10. Section GG Items Included in PT & OT Functional Score**

Section GG Item	Functional Score Range
GG0130A1 — Self-care: Eating Admission Performance	0–4

GG0130B1 — Self-care: Oral Hygiene Admission Performance	0–4
GG0130C1 — Self-care: Toileting Hygiene Admission Performance	0–4
GG0170B1 — Mobility: Sit to Lying Admission Performance	0–4 (average of 2 items)
GG0170C1 — Mobility: Lying to Sitting on Side of Bed Admission Performance	0–4 (average of 2 items)
GG0170D1 — Mobility: Sit to Stand Admission Performance	0–4 (average of 3 items)
GG0170E1 — Mobility: Chair- or Bed-to-Chair Transfer Admission Performance	0–4 (average of 3 items)
GG0170F1 — Mobility: Toilet Transfer Admission Performance	0–4 (average of 3 items)
GG0170J1 — Mobility: Walk 50 Feet with 2 Turns	0–4 (average of 2 items)
GG0170K1 — Mobility: Walk 150 Feet	0–4 (average of 2 items)

Feedback

**Table 11. Section GG Items Included in Nursing Functional Score**

<b>Section GG Item</b>	<b>Functional Score Range</b>
GG0130A1 — Self-care: Eating	0–4
GG0130C1 — Self-care: Toileting Hygiene	0–4
GG0170B1 — Mobility: Sit to Lying	0–4 (average of 2 items)
GG0170C1 — Mobility: Lying to Sitting on Side of Bed	0–4 (average of 2 items)

GG0170D1 — Mobility: Sit to Stand	0–4 (average of 3 items)
GG0170E1 — Mobility: Chair- or Bed-to-Chair Transfer	0–4 (average of 3 items)
GG0170F1 — Mobility: Toilet Transfer	0–4 (average of 3 items)

These 12 SLP-related comorbidities predict higher SLP costs:

- Amyotrophic lateral sclerosis (ALS)
- Aphasia
- Apraxia
- Cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke
- Dysphagia
- Hemiplegia or hemiparesis
- Laryngeal cancer
- Oral cancers
- Speech and language deficits
- Tracheostomy care (while a resident)
- Traumatic brain injury
- Ventilator or respirator (while a resident)

[PDPM](https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/patient-driven-model) (<https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/patient-driven-model>) has more information about mapping between ICD-10-CM diagnoses and SLP comorbidities.

Under the PDPM, we assess a patient’s cognitive status using the [Brief Interview for Mental Status](https://www.youtube.com/watch?v=SajJKdi3B3U) (<https://www.youtube.com/watch?v=SajJKdi3B3U>) (BIMS). In cases where you can’t complete the BIMS, complete a Staff Assessment for Mental Status. We use the Cognitive Performance Scale (CPS) to score patients based on the staff assessment responses. We base the new PDPM cognitive score on the Cognitive Function Scale, which combines scores from the BIMS and CPS into 1 scale that compares cognitive function across all patients.

After completing the BIMS or CPS, use the cognitive measure classification methodology in Table 12 to determine the BIMS and CPS scores.

**Table 12. Cognitive Measure Classification**

<b>PDPM Cognitive Level</b>	<b>BIMS Score</b>	<b>CPS Score</b>
Cognitively Intact	13–15	0
Mildly Impaired	8–12	1–2
Moderately Impaired	0–7	3–4
Severely Impaired	N/A	5–6

## NTA Comorbidity Score

We found NTA costs increase with 50 conditions and extensive services. Providers report these conditions and extensive services on the MDS 3.0 with the ICD-10-CM codes identified in MDS Item I8000.

The PDPM NTA accounts for the relative costliness of some comorbidity scores and comes from a patient's weighted comorbidities count, rather than a simple comorbidities count.

To get this weighted count, we assign points between 1 and 8 to each of the 50 PDPM comorbidities to classify the patient's NTA based on its relative costliness.

To determine the patient's [NTA comorbidity score](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_NTAComorbidityScoring_v2_508.pdf) ([https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM\\_Fact\\_Sheet\\_NTAComorbidityScoring\\_v2\\_508.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_NTAComorbidityScoring_v2_508.pdf)):

1. Identify all the patient's qualifying comorbidities
2. Add each comorbidity's points

This sum is the patient's NTA comorbidity score, putting that patient into an NTA component classification group.

## ✦ Minimum Data Set

### Streamlined Assessment Schedule

PDPM PPS assessments include:

- Initial 5-day PPS assessment
- Interim Payment Assessment (IPA), an optional assessment completed at any point during the patient's stay when clinical change occurs
- Discharge assessment

For late assessments, providers:

- Bill the default [Health Insurance Prospective Payment System \(https://www.cms.gov/medicare/payment/prospective-payment-systems/hipps-codes\)](https://www.cms.gov/medicare/payment/prospective-payment-systems/hipps-codes) (HIPPS) late assessments code for non-compliant days
- Use the 5-day assessment HIPPS code for the rest of the stay unless the provider completes an IPA

Late assessments affect VPD. For example, if a 5-day assessment is 2 days late, we adjust VPD for days 1 and 2 and calculate it using the default HIPPS code. The 5-day assessment HIPPS code controls payment starting on day 3 of the VPD schedule.

### PDPM HIPPS Coding

Each PDPM HIPPS code follows this structure:

- **Character 1:** PI and OT Payment Group
- **Character 2:** SLP Payment Group
- **Character 3:** Nursing Payment Group
- **Character 4:** NTA Payment Group
- **Character 5:** Assessment Indicator

## IPA Item Set

Providers may complete the IPA to report the patient's PDPM classification change with no VPD schedule change. The IPA changes payment starting on the assessment review date, ending when the Part A stay stops, unless the provider completes another IPA.

## State Assessments

States can choose PDPM item sets to calculate Medicaid payments. Each state determines if providers use PDPM comparisons and payment data for Medicaid. If so, states may require Omnibus Budget Reconciliation Act PDPM assessment data, like comprehensive and quarterly assessments. These item sets use Section GG, Items I0020B (primary medical condition) and J2100 (recent surgery requiring active SNF care).

[MDS 3.0 Technical Information](https://www.cms.gov/medicare/quality/nursing-home-improvement/minimum-data-set-technical-information) (<https://www.cms.gov/medicare/quality/nursing-home-improvement/minimum-data-set-technical-information>) has more information.

## MDS Items

**Section I: SNF Primary Diagnosis:** Code Item I0020 as any response 1–13; then enter the ICD-10-CM code in I0020B to report a patient's primary diagnosis. This item asks, "What's the main reason for admitting this person to the SNF?" We retired Item I0020A; use only I0020 and I0020B.

**Section J: Patient Surgical History:** Items J2100 – J5000 capture major surgical procedures during the hospital stay immediately before SNF admission. We use these items with the diagnosis captured in I0020B to classify patients into PT and OT case-mix categories.

**Section O: Discharge Therapy Items:** Items O0425A1 – O0425C5 record each therapy discipline mode (for example, individual, group, or concurrent therapy) and therapy amount (in minutes) the patient gets. Users get an error message if that discipline's group and concurrent minutes total more than 25% of total therapy.

**Section GG: Interim Performance:** To get a patient's interim performance, use MDS Section GG items, column 5, for patient functional assessments. The new column look-back period is a 3-day window before the IPA's assessment reference date.

Swing Bed PPS PDPM Assessment uses several existing MDS items:

- K0100: Swallowing Disorder
- I1300: Inflammatory Bowel Disease
- I4300: Active Diagnosis: Aphasia
- O0100D2: Special Treatments & Programs: Suctioning Post-Admit Code

I1300: Inflammatory Bowel Disease is an existing MDS item added to the 5-day PPS Assessment and IPA.

For information on swing beds, see [MDS 3.0 for Nursing Homes and Swing Bed Providers](https://www.cms.gov/medicare/quality/nursing-home-improvement/minimum-data-sets-swing-bed-providers) (<https://www.cms.gov/medicare/quality/nursing-home-improvement/minimum-data-sets-swing-bed-providers>) and [Minimum Data Set \(MDS\) – Version 3.0](https://www.cms.gov/filings/document/finalmids-30-rai-manual-v11811october2023.pdf#page=1170) (<https://www.cms.gov/filings/document/finalmids-30-rai-manual-v11811october2023.pdf#page=1170>).

## Concurrent & Group Therapy Limit

The PDPM combined limit for both concurrent therapy (1 therapist with 2 patients doing different activities) and group therapy (1 therapist with 2–6 patients doing the same or similar activities) can't equal more than 25% of the therapy that SNF patients get for each therapy discipline.

The PPS Discharge Assessment checks therapy limit compliance and includes the number of minutes per mode, per discipline, for the entire PPS stay.

## Interrupted SNF Stay Policy

An interrupted SNF stay happens when a patient leaves Part A-covered SNF care and then readmits to Part A-covered SNF care **in the same SNF** (not a different SNF) within the interruption window.

**Note:** If a resident drops to a non-skilled level of care or leaves Part A SNF care, we consider the patient discharged because of the interrupted stay policy, even if the patient remains in the facility.

The interruption window is a 3-day period starting on the first non-covered day after a Part A-covered SNF stay and ending at 11:59 pm on the third consecutive non-covered day.

The first non-covered day is:

- The departure day if the patient leaves the SNF
- The day after the final Part A coverage day if the patient stops Part A coverage but stays in the SNF

If the patient returns to a covered Part A stay within 3 days, we consider the subsequent stay a continuation of the last interrupted stay and:

- The VPD schedule continues from the last discharge day.
- The assessment schedule continues from the Part A discharge day. We don't require a new 5-day assessment when the patient readmits, but the provider may decide to complete the IPA.

For example, if the SNF patient discharges from Part A on day 17 (in other words, day 17 is the last covered SNF day), payment rates start on day 18 upon readmission.

The interrupted stay policy doesn't apply and we consider the subsequent stay a new stay if the patient readmits to either:

- The same SNF outside the interruption window
- A different SNF (regardless of the length of time between stays)

In these cases, the VPD schedule resets to day 1 payment rates, and the assessment schedule also resets to day 1, requiring a new 5-day assessment.

## Administrative Level-of-Care Presumption Under PDPM

SNF PPS [administrative presumption](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_AdminPresumption_v6_508.pdf) ([https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM\\_Fact\\_Sheet\\_AdminPresumption\\_v6\\_508.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_AdminPresumption_v6_508.pdf)) automatically classifies a patient who's correctly assigned 1 of the designated, more intensive case-mix classifiers on the 5-day PPS assessment to a SNF level of care through the assessment reference date.

Patients not assigned to a designated classifier get an individual determination using existing administrative criteria. This doesn't automatically classify the patient as meeting or not meeting the level-of-care definition.

PDPM classifiers designated under this administrative presumption include:

- Nursing groups covered by Extensive Services, Special Care High, Special Care Low, and Clinically Complex nursing categories
- PT and OT groups TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO
- SLP groups SC, SE, SF, SH, SI, SJ, SK, and SL
- NTA component's uppermost (12+) comorbidity group

## PDPM Payment for AIDS Patients

PDPM focuses [AIDS patient costs](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_AIDS_v3_508.pdf) ([https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM\\_Fact\\_Sheet\\_AIDS\\_v3\\_508.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_AIDS_v3_508.pdf)) by assigning the highest classification point value (8 points) of any condition or service under its NTA component and adds 18% to the nursing component.

### ❖ Consolidated Billing Provision

The [CB](https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/consolidated-billing) (<https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/consolidated-billing>) provision is like hospital bundling and requires SNFs to include all Medicare-covered services a patient gets during a covered Part A stay on the Part A bill, except a small list of excluded services billed separately under Part B by an outside entity.

For Part A-covered patient stays, the CB provision requires SNFs to bill us for all patient PT, OT, and SLP services. Submit all Part A stay claim services performed by an outside entity, except specifically excluded services outside the PPS bundle, which are separately billable under Part B.

We [exclude some services](https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/consolidated-billing) (https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/consolidated-billing) from CB. The CB exclusion doesn't apply to a physician's "incident to" services provided by someone else as incident to the practitioner's professional service. When someone else provides an incident to service to a SNF resident, we treat it as a CB item, so the SNF must bill us for it. The [Consolidated Appropriations Act, 2023](https://www.congress.gov/117/plaws/publ328/PLAW-117/publ328.pdf#page=1444) (https://www.congress.gov/117/plaws/publ328/PLAW-117/publ328.pdf#page=1444), excludes coverage for marriage and family therapists and mental health counselors from CB.

Learn more about CB in the [SNF Consolidated Billing](https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN5568033-SNF-CB/PaymentPolicy/snf/index.html) (https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN5568033-SNF-CB/PaymentPolicy/snf/index.html) web-based training.

## ❖ Place of Service Codes

[Place of service](https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets) (https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets) (POS) codes identify where a patient gets a service. Enter the correct 2-digit code on Medicare claims to ensure proper payment for physician services provided to patients in inpatient facilities like SNFs and hospitals. POS codes frequently associated with SNF services include:

- Inpatient hospital: 21
- SNF (with Part A coverage): 31
- Nursing facility (or SNF patient with no Part A coverage): 32

A recent [Office of Inspector General report](https://oig.hhs.gov/reports/all/2023/medicare-paid-millions-more-for-physician-services-at-higher-nonfacility-rates-rather-than-at-lower-facility-rates-while-enrollees-were-inpatients-of-facilities) (https://oig.hhs.gov/reports/all/2023/medicare-paid-millions-more-for-physician-services-at-higher-nonfacility-rates-rather-than-at-lower-facility-rates-while-enrollees-were-inpatients-of-facilities) revealed that physicians sometimes enter POS code 32, indicating they provided patient services in a nursing facility or during a non-covered SNF stay when, in fact, the patient was covered under Part A. Use POS code 31 for services you provide during a Part A stay in a SNF.

Additionally, if a patient is seen in a physician's office but is also:

- An [inpatient of a hospital](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c26pdf.pdf#page=33) (https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c26pdf.pdf#page=33), use POS code 21 for inpatient hospital
- A patient of a SNF (with Part A coverage), use POS code 31 for SNF
- A patient of a nursing facility or SNF (without Part A coverage), use POS code 32 for nursing facility

[MLN Matters® article MM13767 \(https://www.cms.gov/files/document/mm13767-improving-payment-accuracy-physician-services-skilled-nursing-facilities.pdf\)](https://www.cms.gov/files/document/mm13767-improving-payment-accuracy-physician-services-skilled-nursing-facilities.pdf) has more information.

## ❖ SNF Quality Reporting Program

The [SNF Quality Reporting Program \(QRP\)](https://www.cms.gov/medicare/quality/snf-quality-reporting-program) provides quality-of-care information so patients can make informed decisions about their health care options. It also encourages facilities and providers to improve their quality of inpatient care by making sure they're aware of, and reporting on, best practices.

The SNF QRP applies to freestanding SNFs, SNFs affiliated with acute care facilities, all non-critical access hospitals, and non-swing bed rural hospitals.

[SNF QRP Measures and Technical Information \(https://www.cms.gov/medicare/quality/snf-quality-reporting-program/measures-and-technical-information\)](https://www.cms.gov/medicare/quality/snf-quality-reporting-program/measures-and-technical-information) has the current quality reporting measures. Find more information in the [SNF QRP FAQs \(https://www.cms.gov/medicare/quality/snf-quality-reporting-program/faqs\)](https://www.cms.gov/medicare/quality/snf-quality-reporting-program/faqs).

To meet the SNF QRP requirements, SNFs must submit Resident Assessment Instrument MDS quality data and the CDC National Healthcare Safety Network summary data. Any SNF we determine to be non-compliant with the quality reporting requirements may be subject to a 2 percentage-point reduction in their annual payment update for the applicable year.

SNFs may qualify for a QRP [reconsideration and an exception or extension \(https://www.cms.gov/medicare/quality/snf-quality-reporting-program/reconsideration-and-exception-extension\)](https://www.cms.gov/medicare/quality/snf-quality-reporting-program/reconsideration-and-exception-extension).

## ❖ SNF Value-Based Purchasing Program

Through the [SNF VBP Program \(https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing\)](https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing), we award incentive payments to encourage SNFs to improve the quality of care they provide to patients.

We reduce the adjusted federal per diem rate by 2% and adjust the resulting rate by the earned FY SNF amount.

For the FY 2026 Program year, the SNF VBP will use 4 [quality measures \(https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing/measures\)](https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing/measures) to update the scoring methodology. Starting FY 2027, the SNF VBP will expand to 8 measures.

For FYs 2019–2025 Program years, we used only the SNF 30-Day All-Cause Readmission Measure (SNFRM) to evaluate SNFs in the SNF VBP Program. The Program ties portions of SNFs' payments to their performance on this measure. We calculate this measure by assessing the risk-standardized rate of all-cause, unplanned hospital readmissions for Medicare Fee-for-Service SNF patients within 30 days of discharge from a previous nearby hospitalization.

We're **replacing** (<https://www.federalregister.gov/d/2023-16249/p-1361>) the SNFRM with the SNF Within-Stay Potentially Preventable Readmission (SNF WS PPR) starting with the FY 2028 Program year. FY 2027 will be the last Program year we include the SNFRM.

SNFs get quarterly and annual performance reports, which we use to publicly report SNF performance information on [Care Compare](https://www.medicare.gov/care-compare/?providerType=NursingHome) (<https://www.medicare.gov/care-compare/?providerType=NursingHome>).

[42 CFR 413.338](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-J#p-413.338(a)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-J#p-413.338\(a\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-J#p-413.338(a))) has more information.

## Resources

- [2026 SNF PPS Final Rule](https://federalregister.gov/d/2025-14679) (<https://federalregister.gov/d/2025-14679>)
- [CMS Newsroom: FY 2026 SNF PPS Final Rule](https://www.cms.gov/newsroom/fact-sheets/fy-2026-skilled-nursing-facility-snf-prospective-payment-system-final-rule-cms-1827-f) (<https://www.cms.gov/newsroom/fact-sheets/fy-2026-skilled-nursing-facility-snf-prospective-payment-system-final-rule-cms-1827-f>)
- [Medicare Claims Processing Manual, Chapters 6–7](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912>)
- [Web Pricer](https://webpricer.mps.cms.gov) (<https://webpricer.mps.cms.gov>)

Feedback

View the [Medicare Learning Network® Content Disclaimer and Department of Health & Human Services Disclosure \(https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Product-Disclaimer\)](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Product-Disclaimer).

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).

Copyright © 2025, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. The American Hospital Association (the "AHA") has not reviewed, and isn't responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.

Feedback