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CMS Finalizes 2.3% FY 2027 IPPS Payment Update, Increases Uncompensated Care Payments, Expands Mandatory Episode-Based Payment, & Revises GME and Cost-Reporting Policies

On July 31, 2026, the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2027 Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System final rule. CMS also released a fact sheet accompanying the rule.

Finalized policies include:

- increase IPPS operating payment rates by 2.3 percent with approximately $2.9 billion in total payment growth,
- recalibrate MS-DRG weights using updated claims and cost data,
- increase uncompensated care (DSH) payments by approximately 2.9 percent to an estimated $7.94 billion,
- discontinue the low-wage index policy and implement a budget-neutral transition for affected hospitals, while maintaining other wage index adjustments,
- tighten provider-based status criteria,
- establish non-discrimination requirements and new criteria for residency programs,
- continue New Technology Add-on Payments (NTAPs) while eliminating alternative pathways beginning with FY 2028 applications,
- establish the nationwide mandatory Comprehensive Care for Joint Replacement Expanded Model,
- refine the Transforming Episode Accountability Model (TEAM),
- reconcile non-renal organ acquisition costs and codify appeals processes, and
- increase LTCH payment rates by 2.3 percent, with continued reliance on quality reporting penalties and budget neutrality adjustments.

This rule is scheduled to be published in the *Federal Register* on August 4, 2026, and regulations are effective October 1, 2026.

CMS FINALIZES 2.3% IPPS UPDATE FOR FY 2027

FINALIZED WITH MODIFICATION

Pages 723-743[1], 643-647, 2467-2471, 2682-2683

The Inpatient Prospective Payment System (IPPS) per-discharge payment is based on two national standardized base payment rates, one for operating costs and the other for capital-related costs. CMS adjusts each of these rates for geographic, case-mix, and other factors.

For FY 2027, CMS finalizes a **2.3 percent increase**[2] in operating payment rates for general acute care hospitals that successfully submit quality data and are meaningful electronic health record (EHR) users. This update reflects a projected 3.2 percent market basket increase, reduced by a **0.9 percentage point productivity adjustment**, consistent with statutory requirements under the Affordable Care Act.[3] **The productivity adjustment increased from the proposed 0.8 percentage point reduction based primarily on updated Bureau of Labor Statistics historical productivity data.**

Hospitals that do not meet applicable quality reporting or EHR requirements will receive lower updates. **Hospitals that fail to submit quality data but are meaningful EHR users will receive a 1.5 percent update; hospitals that submit quality data but are not meaningful EHR users will receive a –0.1 percent update; and hospitals that meet neither requirement will receive a –0.9 percent update.**[4,5]

CMS continues to use the 2023-based IPPS market basket, which was rebased and revised in FY 2026. For FY 2027, CMS finalizes a national labor-related share of 66 percent for hospitals with a wage index greater than 1 (and 62 percent for those with a wage index less than or equal to 1).[6] For capital-related payments, CMS finalizes a **3.4 percent update**[7] to the federal capital rate.

Overall, CMS estimates that acute care hospital operating and capital payments IPPS will increase by approximately $2.9 billion in FY 2027 relative to FY 2026. The estimate includes an approximately $2.1 billion increase in operating payments, including outlier and uncompensated care payments; a $240 million increase in capital payments; and approximately $520 million associated with other changes, including new technology add-

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[1] All page numbers reference the unpublished final rule.

[2] Down from proposed payment update of 2.4% due to the increased productivity adjustment based on updated BLS data.

[3] The MFP adjustment is a 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity.

[4] **Proposed:** +1.6 percent, 0.0 percent, or –0.8 percent respectively

[5] See Table V.B-01 on page 738 of the unpublished rule.

[6] For FY 2027 standardized operating amounts, see Table 1B in the FY 2027 Table 1A-1E Addenda File.

[7] **Proposed:** 3.1%; updated based on forecast error adjustment of 0.3%

on payments and the January 1, 2027 expiration of the Medicare-Dependent Hospital program and temporary low-volume hospital payment adjustments.[8]

Although CMS projects a $2.9 billion aggregate payment increase, that estimate includes capital and other policy changes and may obscure uneven impacts across hospitals, particularly those affected by the expiration of the MDH and temporary low-volume payment provisions.

CMS FINALIZES FY 2027 MS-DRG RECALIBRATION TO ADVANCE MORE PRECISE COST-BASED WEIGHTS WHILE LIMITING PAYMENT VOLATILITY

FINALIZED AS PROPOSED

Pages 266-283 of the unpublished rule

CMS finalizes its proposal to recalibrate the MS-DRG relative weights for FY 2027 using FY 2025 Medicare Provider Analysis and Review (MedPAR) claims data (approximately 6.9 million discharges) and FY 2024 Medicare cost report (HCRIS) data. The methodology continues to rely on a cost-based approach using 19 cost center cost-to-charge ratios (CCRs) to standardize hospital charges and convert them to estimated costs.

Consistent with prior policy, CMS excludes Medicare Advantage claims, Critical Access Hospitals (CAHs), Rural Emergency Hospitals (REHs), and other non-IPPS providers, and applies a series of data cleaning and trimming steps, including removal of statistical outliers and invalid claims. CMS also continues to reset Present on Admission (POA) indicators to "Y" for purposes of weight-setting to avoid distortions from hospital-acquired condition (HAC) payment policies and preserve budget neutrality.

Additional refinements include adjustments for transplant acquisition costs, continued handling of non-monotonicity across DRG severity levels, and application of the permanent 10 percent cap on reductions in MS-DRG relative weights. CMS also maintains its normalization process to ensure that recalibration does not change overall aggregate payments.

For FY 2027, CMS finalizes its proposal to continue its refined methodology for MS-DRG 018 (CAR-T and related immunotherapies), including exclusion of clinical trial and non-purchased product cases from cost calculations and application of an adjustment factor to appropriately reflect resource use.

[8] CMS notes that its estimate of operating payment changes generally does not account for changes in hospital admissions or real case-mix intensity, which could also affect aggregate payments.

Updates reflect a balance between capturing emerging high-cost therapies and limiting year-over-year volatility.

UNCOMPENSATED CARE PAYMENTS TO DSH HOSPITALS TO INCREASE 2.9% IN FY 2027

FINALIZED WITH MODIFICATION

Pages 648-708 of the unpublished rule

Hospitals that receive Medicare disproportionate share hospital (DSH) receive two separate payments:

1. 25 percent of the amount they previously would have received under Section 1886(d)(5)(F) of the Social Security Act (Act) for DSH; and
2. An additional payment for uncompensated care (UC) as determined by the product of three factors:
    - **Factor 1**: 75 percent of the payments that would otherwise be made under Section 1886(d)(5)(F) of the Act,
    - **Factor 2**: 1 minus the percent change in the percent of individuals who are uninsured, and
    - **Factor 3**: a hospital's UC amount relative to all DSH hospitals expressed as a percentage.

CMS finalizes its calculations for Factor 1 and Factor 2 and methodological approach for Factor 3 in this rule which are updated from the proposed rule based on more recent data.

1. **Factor 1:** CMS finalizes that Factor 1 for FY 2027 will be **$11,825,250,000**.[9]
2. **Factor 2:** CMS finalizes that Factor 2 for FY 2027 will be **67.14 percent**.[10]
3. **Factor 3:** For FY 2027, for calculating Factor 3, CMS finalizes the use of data from the three most recent years of audited cost reports: FY 2021, FY 2022, and FY 2023. The methodology for Factor 3 is the same as used in FY 2025 and FY 2026.

Final estimated FY 2027 uncompensated care payments and supplemented payments total approximately **$7.94 billion**,[11] a **2.935% increase**[12] from FY 2026.

The increase in total uncompensated care payments as opposed to the proposed decrease is largely attributable to utilization of more recently available data.

[9] **Proposed:** $11.477 billion.
[10] **Proposed:** 65.00 percent.
[11] **Proposed:** $7.46 billion
[12] **Proposed:** 3.279% decrease

CMS FINALIZES FY 2027 WAGE INDEX UPDATES, INCLUDING CONTINUED LOW-WAGE INDEX TRANSITION

FINALIZED WITH MODIFICATION

Pages 578-647

The wage index reflects the relative hospital wage level in the hospital's geographic area compared to the national average. CMS determines each hospital's labor market area using Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget (OMB). For FY 2027, CMS finalizes annual updates to the wage index using wage data from the FY 2023 cost reporting period, along with several budget-neutral wage index policies.

Wage index policies with a budget-neutral impact include:[13]

- ***Discontinuation of the low-wage index policy*:** Under the FY 2020 IPPS/LTCH PPS final rule, CMS finalized a temporary policy to address wage index disparities affecting low-wage index hospitals, many of which are rural hospitals. Consistent with the FY 2026 policy, CMS finalizes a narrow, budget-neutral transitional exception for FY 2027 for hospitals that benefited from the FY 2024 low-wage index policy and are significantly impacted by its discontinuation. Eligible hospitals will receive a transitional payment adjustment if their FY 2027 wage index falls below 85.7375 percent of their FY 2024 wage index after applying the 5-percent cap policy. CMS also finalizes a budget-neutral equivalent exception under the capital IPPS to help mitigate the impact of the policy change. **The budget neutrality adjustment associated with this policy is 0.999777.**[14]
- ***The permanent cap policy*:** Finalized in the FY 2023 IPPS/LTCH PPS final rule, this permanent policy limits annual decreases in a hospital's wage index to no more than 5 percent from the previous fiscal year. For FY 2027, **the budget neutrality adjustment associated with this policy is 0.999379.**[15]
- ***The rural floor*:** Established by the Balanced Budget Act of 1997, the rural floor ensures that an urban hospital's wage index cannot be lower than the rural wage index for its state.[16] For FY 2027, the budget neutrality adjustment associated with this policy would be 0.985465.
- ***Medicare Geographic Classification Review Board (MGCRB) reclassifications*:** Implemented as part of the Omnibus Budget Reconciliation Act of 1989, this policy allows hospitals to apply for reclassification to a higher wage index area. For FY 2027, **the associated budget neutrality adjustment is 0.949363.**[17]

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[13] See page 2,403 of the unpublished final rule for a summary of the FY 2027 budget neutrality factors.
[14] **Proposed:** 0.999782; updated based on more recent data.
[15] **Proposed:** 0.991972; updated based on more recent data.
[16] As of FY 2024, CMS also treats rural reclassified hospitals the same as geographically rural hospitals for wage index calculation purposes.
[17] **Proposed:** 0.972154; updated based on more recent data.

CMS largely continues existing wage index policies for FY 2027, extending the transitional payment adjustment for hospitals most affected by the discontinuation of the low-wage index policy. The final rule otherwise maintains longstanding wage index policies that govern annual payment adjustments.

REFERRAL-BASED PATHWAY FOR PROVIDER-BASED STATUS LIMITED TO OUTPATIENT FACILITIES

FINALIZED AS PROPOSED

Pages 1,507-1,514

Current law identifies the types of facilities that qualify as providers of services but does not explicitly define the term "provider-based." CMS uses provider-based criteria under 42 C.F.R. 413.65 to determine whether a facility operates as part of a "main provider" for Medicare payment and coverage purposes. To qualify, a facility must meet the "same patient population" requirement by demonstrating either that: (1) at least 75 percent of its patients reside in the same ZIP code areas as at least 75 percent of the main provider's patients; or (2) at least 75 percent of its patients who require services furnished by the main provider receive those services from that provider. These criteria must be met during the preceding 12 months and on an ongoing basis.

For FY 2027, CMS finalizes its proposal to limit the second pathway to outpatient facilities and organizations. As a result, off-campus inpatient facilities may no longer rely on the referral-based test to satisfy the "same patient population" requirement for provider-based status and instead must meet the geographic ZIP code test. CMS states the change is intended to preserve the original purpose of the referral-based exception while reducing the potential for unintended payment advantages for certain inpatient facilities.

While CMS characterizes the policy as a limited refinement with minimal impact on existing facilities, the change narrows the circumstances under which off-campus inpatient facilities may qualify for provider-based status by eliminating the referral-based pathway.

GRADUATE MEDICAL EDUCATION AND NURSING AND ALLIED HEALTH EDUCATION

Pages 772-880

Prohibition on Unlawful Discrimination in Medical Education Programs

FINALIZED AS PROPOSED

Hospitals may receive direct graduate medical education (GME) and indirect medical education (IME) payments for residents training in "approved medical residency programs."

CMS finalizes its proposal to establish additional nondiscrimination requirements for approved medical residency programs, nursing and allied health education (NAHE) programs, and NAHE accrediting organizations. Effective October 1, 2026, these programs and organizations may not discriminate, or promote or encourage discrimination, based on race, color, national origin, sex, age, disability, or religion.

CMS consolidates the applicable GME- and NAHE-related nondiscrimination requirements under a new 42 C.F.R. 413.84. CMS directs programs to the Attorney General's guidance regarding potentially unlawful policies and proxies and advises programs to review their selection criteria for compliance.

Criteria for New Residency Programs

FINALIZED WITH MODIFICATION

CMS also revises the criteria for determining whether a residency program qualifies as "new" for purposes of building additional direct GME and indirect medical education FTE caps. The policy **applies to programs still within their five-year cap-building period as of October 1, 2026, and to programs beginning thereafter**.[18] A program must receive initial accreditation and generally must ensure that at least 90% of the individual residents entering during the five-year period have not previously trained in the same specialty. CMS removes restrictions on hiring experienced faculty and program directors.

Allowable NAHE Direct and Indirect Costs

FINALIZED WITH MODIFICATION

For cost-reporting periods beginning on or after October 1, 2026, hospitals must deduct tuition and other program revenue from NAHE direct costs before allocating overhead. Hospitals must then use the Worksheet B-1 reconciliation column to restore the deducted revenue to the accumulated-cost statistic solely for purposes of allocating indirect costs.

CMS further clarifies that allowable NAHE overhead is limited to costs incurred by the provider that are **directly attributable** to and proportionately benefit the approved educational activity. **CMS does not finalize mandatory componentization of general service cost centers**, but hospitals must use appropriate allocation methods to prevent unrelated overhead from flowing to NAHE cost centers. Personnel costs must also be apportioned between education and patient care when employees perform both functions.

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[18] **Proposed:** CMS proposed to apply revised criteria to programs beginning on/after 10/1/26; CMS expands the policy to include programs within 5 year cap building period as of 10/1/26.

NEW TECHNOLOGY ADD-ON PAYMENTS

FINALIZED AS PROPOSED

Pages 284-577

The new technology add-on payment (NTAP) program allows for an additional payment for medical services or technologies that are found to be: (1) new; (2) disproportionately costly to the existing MS-DRG; and (3) a substantial clinical improvement. CMS has also established alternative pathways for certain technologies with different criteria.

Applicants Approved for Traditional NTAP Pathway for FY 2027 and Finalized Changes to Commercial Availability

Pages 303-433

Under the traditional NTAP pathway, CMS finalizes its proposal to continue NTAPs for 41 technologies and discontinue NTAPs for 13 technologies.[19] Of 15 new applications, CMS approves three, denies four, does not consider three, and notes five withdrawals.

CMS also finalizes that any documented delay in commercial availability may extend a technology's newness period only until the NTAP becomes effective. If the technology is still unavailable at that time, the newness period begins on September 30 before the NTAP start date.

Applicants Approved for Alternative Pathways for FY 2027 and Finalized Removal of Alternative Pathways Beginning FY 2028

Pages 434-577

CMS considered and approved 16 applications under the alternative pathways, all of which received the Breakthrough Device designation. CMS did not consider any applications with Qualified Infectious Disease Product (QIDP) designation or the Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD) pathway.

Beginning with FY 2028 applications, CMS eliminates the NTAP alternative pathways and generally requires all applicants to meet the standard eligibility criteria, including substantial clinical improvement, unless grandfathered.

Changes may impact manufacturers' planning related to application pathways, application timing, and product launch. Changes may reduce the number of products granted NTAPs in future years.

[19] See Table II.E.-01 beginning on page 325 and Table II.E.-02 beginning on page 335.

EXPANSION OF THE COMPREHENSIVE CARE FOR JOINT REPLACEMENT MODEL

FINALIZED WITH MODIFICATION

Pages 1515-1996

The Comprehensive Care for Joint Replacement (CJR) Model was intended to improve care for Medicare patients undergoing lower extremity joint replacements (LEJR) in the inpatient or outpatient setting and for total ankle replacements in the inpatient setting. This model became mandatory in 2021 with the performance period beginning on April 1, 2016, and ending on December 31, 2024.

The finalized Comprehensive Care for Joint Replacement Expanded Model (CJR-X) will expand the CJR Model as it produced strong evidence of cost savings while maintaining quality of care. This expanded, mandatory model will be nationwide and include U.S. territories and begin on **January 1, 2028, as opposed to the proposed October 1, 2027, start date, in response to comments voicing concerns about readiness**.[20] This model will be the first nationwide test of a mandatory episode-based payment model with most hospitals paid under IPPS being required to participate.[21]

CJR-X episodes will generally include related Medicare Parts A and B services from the qualifying procedure through 90 days after discharge. CMS will compare actual episode spending with a hospital-specific target price, and participating hospitals may receive reconciliation payments or owe repayments based on their quality and financial performance.

The CRJ-X model will create incentives for hospitals to coordinate care in a more effective manner and enhance communication among providers while preventing unnecessary utilization and avoidable readmissions.

CHANGES TO THE TRANSFORMING EPISODE ACCOUNTABILITY MODEL

FINALIZED WITH MODIFICATION

Pages 1436-1506

The Transforming Episode Accountability Team Model (TEAM) is a five-year, episode-based payment model that is mandatory for selected hospitals. The model started on January 1,

[20] **Proposed:** October 1, 2027.
[21] **Excluded**: hospitals participating in the TEAM Model, those not paid under both the IPPS and OPPS, and certain hospitals located in Maryland.

2026, and will end on December 31, 2030, and aims to improve patient experience from surgery through recovery by facilitating care coordination and transition. TEAM will test five surgical episodes including Coronary Artery Bypass Graft Surgery (CABG), Lower Extremity Joint Replacement (LEJR), Major Bowel Procedure, Surgical Hip/Femur Fracture Treatment (SHFFT), and Spinal Fusion.

CMS finalizes the following TEAM modifications:

- **Spinal Fusion Episode Category:** Adds three MS-DRGs to better reflect patient acuity and resource use for certain spinal fusion procedures.
- **Episode Attribution:** Excludes TEAM participants from CJR-X to preserve distinct episode-duration comparisons.
- **Measurement Performance Periods for Certain Quality Measures:** Aligns two hospital-harm measures with the Hospital IQR Program's one-year reporting period and the ISCMR measure with its two-year rolling period.
- **CQS Baseline Period Methodology:** Adopts a **concurrent CQS baseline methodology** effective Team PY1.
- **APC and MS-DRG Update Factors:** Adds APC and MS-DRG update factors to better align target prices with performance-year payment weights and spending trends.
- **Prospective Normalization Factor Construction:** Beginning in PY2, calculates prospective normalization factors by episode type and region using applicable baseline episodes and applies risk-adjustment coefficients across the baseline period.

Through RFIs, CMS sought feedback on potential TEAM expansions, including model design, financial accountability, episode construction, quality measurement, and voluntary participation by physician-owned hospitals. CMS intends to propose allowing physician-owned hospitals outside mandatory CBSAs to participate in future rulemaking.

CMS FINALIZES ITS RECONCILIATION OF NON-RENAL ORGAN ACQUISITION COSTS AND CODIFICATION OF REIMBURSEMENT APPEALS

FINALIZED WITH MODIFICATION

Pages 1997-2065

Currently, independent organ procurement organizations (IOPOs) and histocompatibility laboratories (HCLs) are reimbursed on a reasonable cost basis for non-renal organ acquisition, without a formal reconciliation process. CMS cites findings from Medicare contractors and the Office of Inspector General (OIG) indicating that reported non-renal charges may exceed reasonable costs.

In response, CMS is finalizing with modifications its proposal to reconcile non-renal organ acquisition costs for IOPOs and HCLs, aligning the approach with existing policies for kidney acquisition costs. However, **instead of the initial 1-year delay originally proposed, CMS is finalizing a 2-year implementation delay, effective for cost reporting periods beginning on or after October 1, 2028.**

CMS finalizes modified procedures for IOPO non-renal SACs and independent HCL testing rates. IOPOs and HCLs will submit documented rate estimates and adjustments to Medicare contractors for reasonableness review and approval, after which contractors will publish the approved rates.

CMS also codifies the Administrator's discretionary authority to review appeals under 413.420(g), either at the request of an IOPO or HCL or on the Administrator's own initiative.

The policy strengthens program integrity and payment accuracy for non-renal organ acquisition, while the two-year delay gives IOPOs and HCLs additional time to implement the new reconciliation and rate-setting requirements.

CMS PROVIDES CLARIFICATION AND CODIFICATION OF REASONABLE COST PAYMENT POLICIES FOR ALL PROVIDERS

FINALIZED AS PROPOSED

Pages 2066-2150

Some providers are reimbursed by Medicare for all or some of their services on a reasonable cost basis such as critical access hospitals (CAHs), rural health clinics (RHCs), and OPOs and HCLs. In response to OIG audits which have identified instances in which certain providers have claimed unallowable costs on their Medicare Cost Reports (MCRs), CMS finalizes its proposals to clarify and codify key reasonable cost reimbursement policies.

CMS also clarifies policies related to the prudent buyer principle, allowable OPO outreach and education costs, and non-allowable expenses such as entertainment and alcohol, while reaffirming allowable professional education costs.

Finally, CMS finalizes its proposals to codify overhead cost allocation requirements currently reflected in cost reporting guidance, to ensure costs are accurately assigned and to prevent inappropriate cost shifting that could overstate or understate Medicare reimbursement.

The clarification and codification of the reasonable cost payment policies may help safeguard program integrity.

CMS FINALIZES 2.3% INCREASE IN LONG TERM CARE HOSPITAL PAYMENTS FOR FY 2027

FINALIZED WITH MODIFICATION

Pages 1011-1023

LTCHs are excluded from the IPPS and are paid under their unique payment system because of the difference in complexity, resource utilization and length of stay factors.

For FY 2027, CMS finalizes a **2.3 percent** update to the LTCH PPS standard Federal payment rate, based on a 3.2 percent market basket increase **reduced by a 0.9 percentage point productivity adjustment**, consistent with Affordable Care Act requirements.[22] LTCHs that fail to submit required data under the LTCH Quality Reporting Program (QRP) will receive a reduced update of **0.3 percent** (a 2.0 percentage point penalty). CMS continues to use the 2022-based LTCH market basket, adopted in FY 2025, to reflect LTCH-specific cost structures.

CMS also finalizes continued application of applicable budget-neutrality adjustments, including the area wage-level budget-neutrality factor. The finalized rates apply to LTCH PPS payments for FY 2027.

The FY 2027 LTCH payment update pairs modest baseline updates with meaningful compliance-driven penalties, particularly through the LTCH QRP.

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This Applied Policy® Summary was prepared by Meghan Basler with support from the Applied Policy team of health policy experts. If you have any questions or need more information, please contact her at mbasler@appliedpolicy.com or at (908) 752-9875.

[22] **Proposed:** 2.4 percent update; updated due to change in productivity adjustment based on updated BLS data.