

CMS Proposes 2.4% IPPS Update for FY 2027 with Targeted Payment Adjustments, DSH Reductions, and Expanded Oversight Across Hospital Policies

On April 10, 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 [proposed rule](#). CMS released a [fact sheet](#) and a [press release](#) on the Comprehensive Care for Joint Replacement Expanded (CJR-X) Model accompanying the rule.

This rule proposes to:

- increase IPPS operating payment rates by 2.4 percent with approximately \$1.9 billion in total payment growth,
- recalibrate MS-DRG weights using updated claims and cost data,
- decrease uncompensated care (DSH) payments by approximately 3.3 percent (~\$7.46 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 NTAPs while proposing to eliminate alternative pathways beginning FY 2028,
- expand mandatory episode-based payment through the proposed nationwide CJR-X Model,
- refine Transforming Episode Accountability Model (TEAM) and solicit information on its potential expansion,
- reconcile non-renal organ acquisition costs and codify appeals processes, and
- increase LTCH payment rates by 2.4 percent, with continued reliance on quality reporting penalties and budget neutrality adjustments.

This proposed rule is scheduled to be published in the *Federal Register* on April 14, 2026, and comments are due by 5:00 pm EDT on June 15, 2026.



CMS PROPOSES MODEST 2.4% IPPS UPDATE FOR FY 2027

Pages 400-403, 449-452, and 1390-1405 of the unpublished rule

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 proposes a 2.4 percent increase 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 0.8 percentage point productivity adjustment, consistent with statutory requirements under the Affordable Care Act.¹ Hospitals that fail to meet quality reporting or EHR requirements would receive lower updates of +1.6 percent, 0.0 percent, or -0.8 percent, depending on compliance.²

CMS continues to use the 2023-based IPPS market basket, which was rebased and revised in FY 2026, and proposes to maintain 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).³

For capital payments, CMS proposes a 3.1 percent update to the capital federal rate, resulting in an overall 4.02 percent increase in capital payments after accounting for budget neutrality adjustments, outlier policy, and wage index-related changes.

Overall, CMS estimates that total IPPS payments will increase by approximately \$1.9 billion in FY 2027.⁴ Payments for new medical technologies are projected to increase by approximately \$464 million, reflecting continued use of new technology add-on payments (NTAP).

Finally, under current law, special payment adjustments for Medicare-Dependent Hospitals (MDHs) and low-volume hospitals are extended only through December 31, 2026, after which they are scheduled to expire absent further congressional action. If extended, these payments are projected to total approximately \$0.4 billion in FY 2027.

CMS continues to pair modest baseline updates with targeted adjustments, relying on quality compliance, meaningful use of EHRs, technology adoption, and select payment

¹ The MFP adjustment is a 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity.

² See Table V.B-01 on page 451 of the unpublished rule.

³ For FY 2027 standardized operating amounts, see the Table 1B in [FY 2027 Proposed Rule Table 1A-1E Addenda File](#).

⁴ See pg. 18 of the unpublished rule, *“acute care hospitals are estimated to experience a \$1.9 billion increase in payments in FY 2027, primarily driven by the changes in FY 2027 operating payments, including outlier payments, uncompensated care payments, capital payments, new technology add-on payments, and the expiration of the temporary changes in the low-volume hospital program and the expiration of the MDH program on January 1, 2027.”*

policies—rather than broad increases—to drive reimbursement, resulting in greater variability across hospitals.

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

Pages 192-206 of the unpublished rule

CMS proposes 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 proposes 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.

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

UNCOMPENSATED CARE PAYMENTS TO DSH HOSPITALS PROPOSED TO DECREASE 3.3% IN FY 2027

Pages 404-438 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 proposes its calculations for Factor 1 and Factor 2 and methodological approach for Factor 3 in this rule.

1. **Factor 1:** CMS proposes that Factor 1 for FY 2027 will be \$11.477 billion.⁵
2. **Factor 2:** CMS proposes that Factor 2 for FY 2027 will be 65.00 percent.
3. **Factor 3:** For FY 2027, for calculating Factor 3, CMS proposes to use 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.

Proposed FY 2027 uncompensated care payments and supplemented payments total approximately \$7.46 billion, a 3.279% decrease from FY 2026.⁶

The decrease in total proposed uncompensated care payments is largely due to the decrease in Factor 1 of \$11.477 billion in FY 2027 (compared to \$11.761 billion in FY 2026).

CMS PROPOSES TRANSITION FOR THE DISCONTINUATION OF THE LOW WAGE INDEX POLICY

Pages 344-404 of the unpublished rule

The wage index reflects the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. To determine a hospital's labor market area, CMS uses Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget (OMB). For FY 2027, CMS proposes revisions to implement its annual update of the wage index, including proposing to use wage data from cost reporting periods beginning in FY 2023, and other adjustments and applications related to calculating the FY 2027 wage index.

Wage index policies with a budget neutral impact include:

⁵ OACT will plan to update the Factor 1 estimates for the final rule, if more recent data becomes available.

⁶ Dollar difference in UC payments FY 2026-FY2027 is a decrease of \$258M

- **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. Similar to FY 2026, for FY 2027 CMS proposes to discontinue this low wage index policy and proposes a budget-neutral narrow transitional exception for low-wage index hospitals that would be significantly impacted by the removal of this policy for FY 2027.⁷ CMS also proposes a similar budget neutral exception under the capital IPPS, which is adjusted based on local cost variation, to help offset the impact. The budget neutrality adjustment associated with this policy is 0.999782.
- **The permanent cap policy:** Finalized in the FY 2023 IPPS/LTCH PPS final rule and prevents any hospital from having a wage index below 95 percent of its wage index for the previous fiscal year. For FY 2027, the budget neutrality adjustment associated with this policy would be 0.991972.
- **The rural floor:** Implemented as part of the Balanced Budget Act of 1997 and mandates that wage indexes for urban hospitals in a state cannot be lower than said state’s rural area wage index. In the FY 2024 IPPS/LTCH PPS final rule, CMS finalized that rural reclassified hospitals be treated the same as geographically rural hospitals for wage index calculation purposes. 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 and allow hospitals to apply to be reclassified to a higher wage index area. For FY 2027, the budget neutrality adjustment associated with this policy would be 0.972154.

CMS proposes to update data and maintain budget neutrality while continuing the transitional exception amid the discontinuation of the low-wage index policy.

CRITERIA FOR PROVIDER-BASED STATUS

Pages 900-904

Current law outlines types of facilities that are identified as providers of services but does not explicitly define the term “provider-based.” In practice, CMS distinguishes between standalone facilities and those operating as part of a “main provider,” where multiple locations function as a single entity for Medicare payment and coverage purposes. CMS has established criteria under 42 C.F.R. § 413.65 to determine eligibility for provider-based status.

⁷ If the hospitals FY 2027 wage index decreased by more than 14.2625% from the FY 2024 hospital wage index.

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 codes 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.

Citing concerns that inpatient facilities may receive unintended payment advantages, CMS proposes to limit use of the second pathway (§ 413.65(e)(3)(iii)(B)) to outpatient departments only, which could restrict the ability of certain inpatient facilities to qualify for provider-based status.

If finalized, this policy may make it more challenging for inpatient facilities to receive provider-based status.

CMS PROPOSES NON-DISCRIMINATION REQUIREMENTS FOR ACCREDITING ORGANIZATIONS AND MEDICAL RESIDENCY PROGRAMS

Pages 476-523 of the unpublished rule

Hospitals may receive direct graduate medical education (GME) and indirect medical education (IME) payments for residents training in “approved medical residency programs.” To ensure compliance with federal law, CMS proposes to require that accrediting organizations and residency programs certify that they do not discriminate on the basis of race, color, national origin, sex, age, disability, or religion. CMS states this policy is intended to prevent programs from implementing practices that could constitute unlawful discrimination under federal law. The proposal would also apply to approved nursing and allied health education programs and accreditors. If finalized, the policy would be effective October 1, 2026.

In addition, CMS proposes new criteria for new residency programs established on or after October 1, 2026, requiring that at least 90 percent of residents have not previously completed training in the same specialty, alongside existing requirements for initial accreditation by the appropriate accrediting body.

By tying GME eligibility to non-discrimination requirements and more prescriptive program criteria, CMS is advancing a trend toward greater oversight of training program structure and eligibility, with potential implications for how hospitals design, expand, and certify residency programs.

NEW TECHNOLOGY ADD-ON PAYMENTS

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 Considered for Traditional NTAP Pathway for FY 2027 and Proposed Changes to Commercial Availability

Pages 226-289

Under the traditional NTAP pathway, CMS proposes to continue NTAPs for 41 technologies, and discontinue NTAPs for 13 technologies.⁸ For new application under the traditional pathway, CMS received 15 applications. Of those applications, three were not considered because they did not meet requirements and four withdrew their applications. Of the remaining eight, CMS proposes to approve one technology and disapproves six, and does not propose approval or disapproval for one.

In general, CMS uses the FDA marketing authorization date to determine when a technology becomes available for the purposes of NTAP timing, but there are some cases where CMS recognizes a later date. Citing concerns that applicants' assertions of delays in commercial availability have increasingly occurred and become more complex, CMS proposes that it may consider a documented delay in the beginning of a technology's newness period due to commercial availability only until the NTAP becomes effective for the FY for which the applicant applied for the NTAP. If finalized, for a technology that is not yet available for sale at the time of its NTAP becoming effective, the newness period would begin on September 30 before the technology's NTAP start date.

Applicants Considered for Alternative Pathways for FY 2027 and Proposed Removal of Alternative Pathways Beginning FY 2028

Pages 290-343

CMS considered and proposed to approve 22 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.

CMS proposes to repeal these alternative pathways beginning with applications received for FY 2028 and to require that these applicants demonstrate they meet all eligibility requirements under either the traditional NTAP pathway or pass-through payment for medical devices requirements. CMS cites concern about the limited evaluation process and value of meeting the substantial clinical improvement criterion as reasons for the removal

⁸ See Table II.E.-01 beginning on page 232 and Table II.E.-02 beginning on page 235.

of the alternative pathways. If the proposal is not finalized, CMS indicates it will continue to review applications under these pathways.

CMS invites public comment on the proposal, as well as other ways the agency could more effectively align payment with value for innovative technologies.

Proposed 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 if alternative pathways are repealed.

PROPOSED EXPANSION OF THE COMPREHENSIVE CARE FOR JOINT REPLACEMENT MODEL

Pages 905-1094 of the unpublished rule

The Comprehensive Care for Joint Replacement (CJR) Model is 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 proposed Comprehensive Care for Joint Replacement Expanded Model (CJR-X) would expand the CJR Model as it produced strong evidence of cost savings while maintaining quality of care. This expanded model, if finalized, would be nationwide, mandatory, and begin on October 1, 2027. This model would be the first nationwide test of a mandatory episode-based payment model with most hospitals paid under IPPS being required to participate.

This expanded model would test an episode-based payment approach in which participating hospitals would ensure patients receive quality, coordinated, affordable care through the first 90 days of recovery following their procedure. Participating acute care hospitals would be assessed against a target price that assumes all costs associated with an LEJR episode of care, starting with the procedure through 90 days following discharge. With some exceptions, the episode would include total related items and services paid under Medicare Parts A and B for eligible CJR-X patients. Following the end of a model PY, actual total spending for the episode would be compared to the participating hospital's target price, and depending on the quality and spending performance, the hospital may receive an additional payment from Medicare or be required to repay a portion of the spending on the episode.

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

PROPOSED CHANGES TO THE TRANSFORMING EPISODE ACCOUNTABILITY MODEL (TEAM)

Pages 859-892 of the unpublished rule

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, 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.

The proposed modifications involve adding MS-DRGs to initiate spinal fusion anchor hospitalization; adjusting episode attribution; clarifying quality measure performance periods for certain measures; utilization of a rolling historical Composite Quality Score (CQS) baseline period for particular measures; adding an APC and MS-DRG update factor to target prices; and using the full baseline period to construct the prospective normalization factor.

- **Spinal Fusion Episode Category:** CMS proposes adding three new MS-DRGs to better classify acuity and resource utilization by beneficiaries for a set of spinal fusion procedures.
- **Episode Attribution:** Given the similarities between TEAM and the proposed CJR-X Model and CMS's intent to assess different outcomes between the two episode durations, CMS proposes to exclude TEAM participants from participating in CJR-X.
- **Measurement Performance Periods for Certain Quality Measures:** TEAM aims to align with existing reporting requirements wherever possible, so as to not introduce additional participant burdens. CMS is proposing to establish measurement performance periods for three quality measures: Hospital Harm – Falls with Injury, Hospital Harm – Postoperative Respiratory Failure, and Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (ISCMR). For the first two, CMS proposes alignment with the Hospital IQR Program's CY reporting requirements with a one-year measurement performance period. For ISCMR, CMS proposes to align with the Hospital IQR Program's two-year rolling measurement performance period.
- **CQS Baseline Period Methodology:** CMS proposes to establish a historical sliding CQS baseline methodology effective Team PY1, although CMS seeks comment as to whether this would be preferable in TEAM PY2. CMS also proposes to align CQS baseline periods with the CMS hospital reporting program timeframes for measures

that are not aligned at this time. While not proposing a concurrent QOS baseline methodology, CMS is considering this approach and seeks comment on potential implementation.

- **APC and MS-DRG Update Factors:** CMS proposes to add an APC update factor for the calculation of the prospective and retrospective trend factor. CMS proposes to define this update factor as the component applied to the prospective trend factor, thus ensuring the APC weights corresponding to the PY are incorporated into the final target price calculations. CMS also proposes to update the pricing methodology to add a MS-DRG update factor to the calculation of the prospective trend factor for episodes with anchor end dates in the fourth quarter of the PY. CMS further proposes to define the updated prospective trend factor as the multiplier used in the preliminary target price to allow estimation of changes in spending patterns between the baseline period and the corresponding CY and FY in the performance year.
- **Prospective Normalization Factor Construction:** Starting with PY₂, CMS proposes to update the calculation of prospective normalization factor at the MS-DRG/HCPCS episode type and region level dependent on applicable episodes in the baseline period. CMS proposes updates to apply the risk adjustment coefficients to all applicable baseline year episodes.

CMS also issued two Requests for Information (RFI) seeking stakeholder input on potential future expansions of TEAM. Specifically, CMS is exploring the incorporation of ambulatory surgical centers (ASCs) into the model and is requesting feedback on model design, financial accountability, episode construction, and quality measurement. In addition, CMS is considering whether to allow physician-owned hospitals (POHs) to voluntarily participate in TEAM, particularly in markets not currently selected for mandatory participation. CMS notes that any such expansion would require appropriate guardrails to address risks related to utilization, patient selection, and program integrity, and would be pursued through future rulemaking.

Through these proposals, CMS signals a shift towards alignment and updating calculations to enhance TEAM operations.

CMS PROPOSES RECONCILIATION OF NON-RENAL ORGAN ACQUISITION COSTS AND CODIFICATION OF REIMBURSEMENT APPEALS FOR IOPOS AND HCLS

Pages 1095-1119 and 1531-1533 of the unpublished rule

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 proposes—beginning in FY 2028—to reconcile non-renal organ acquisition costs for IOPOs and HCLs, aligning the approach with existing policies for kidney acquisition costs. Under this proposal, Medicare Administrative Contractors would review reported costs to ensure they are reasonable, necessary, and patient care-related, and reconcile them to payments made by transplant hospitals and other OPOs. CMS would also require contractors to establish and publish standard acquisition charges (SACs) and HCL testing rates.

CMS further proposes to codify the Administrator’s discretionary authority to review appeals decisions under § 413.420(g), allowing IOPOs and HCLs to request review and confirming the Administrator’s ability to initiate review independently.

Implementation would be delayed by one year to allow for operational readiness, with no savings in FY 2027, but estimated savings of \$100 million in FY 2028, \$500 million over five years, and \$1.28 billion over ten years. CMS also anticipates a modest administrative burden of approximately 10 additional reporting hours per entity beginning in FY 2028.

If finalized, while the proposals would result in significant savings for CMS, they may increase the result in decreased reimbursement and increased reporting burden for IOPOs and HCLs for non-renal organ acquisition.

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

Pages 1119-67 and 1532-1533 of the unpublished rule

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 Office of Inspector General (OIG) audits which have identified instances in which providers including CAHs, transplant hospitals, and OPOs have claimed unallowable costs on their Medicare Cost Reports (MCRs), CMS proposes to clarify and codify key reasonable cost reimbursement policies.

CMS’s proposals include clarification of 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.

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

If finalized, the proposals may help safeguard program integrity regarding reasonable cost payment policies.

CMS PROPOSES 2.4% INCREASE IN LONG TERM CARE HOSPITAL PAYMENTS

Pages 643-648 of the unpublished rule

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 proposes a 2.4 percent update to the LTCH PPS standard Federal payment rate, based on a 3.2 percent market basket increase reduced by a 0.8 percentage point productivity adjustment, consistent with Affordable Care Act requirements. LTCHs that fail to submit required data under the LTCH Quality Reporting Program (QRP) would receive a reduced update of 0.4 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. As under IPPS, the statute allows for payment updates to be less than zero depending on applicable adjustments.

The proposed rule applies to approximately 330 LTCHs nationwide for discharges occurring on or after October 1, 2026. CMS also proposes to continue applying budget neutrality adjustments, including wage index-related policies, to maintain overall spending neutrality within the system.

The FY 2027 LTCH proposal mirrors broader CMS policy trends, pairing modest baseline updates with meaningful compliance-driven penalties, particularly through the LTCH QRP.

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.