

INSIGHTS

Fiscal Year 2027

Medicare Hospital

Inpatient Prospective

Payment System (IPPS)

Proposed Rule

Fiscal Year 2027 Medicare Hospital Inpatient Prospective Payment System (IPPS) Proposed Rule

On April 10, 2026, the Centers for Medicare and Medicaid Services (CMS) released the Fiscal Year 2027 Medicare Hospital Inpatient Prospective Payment System (IPPS) Proposed Rule. A fact sheet from CMS is available [here](#). Complete text of the proposal is available [here](#). Comments on the rule are due June 9, 2026.

UPDATES TO IPPS PAYMENT RATES

As part of the proposed rule, CMS would increase payment rates by 2.4% for general acute care hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful users of electronic health records (EHRs) under the Medicare Promoting Interoperability Program. This proposed update reflects a projected FY 2027 hospital market basket increase of 3.2%, reduced by a 0.8% productivity adjustment. Overall, CMS estimates that the proposed changes in IPPS payment rates, together with other policy changes, would increase hospital payments by approximately \$1.4 billion in FY 2027.

CMS also proposes setting the FY 2027 outlier fixed-loss threshold at \$51,704, which would target outlier payments at approximately 5.14% of total operating DRG payments and capital payments, after incorporating an estimate of outlier reconciliation. In its impact analysis, CMS estimates that overall IPPS payments would increase by 1.2% relative to FY 2026, reflecting the combined effects of the proposed update, outlier policies, uncompensated care payments, and wage index changes.

MEDICARE-DEPENDENT HOSPITALS (MDHS) AND LOW-VOLUME HOSPITALS

The MDH program provides enhanced payments to small rural hospitals (≤ 100 beds, not Sole Community Hospitals) where at least 60% of inpatient days or discharges are attributable to Medicare patients, using a blended rate that includes 75% of the federal rate plus 25% of the hospital-specific rate based on historical costs. The low-volume hospital adjustment offers percentage add-ons to IPPS payments for rural hospitals with low annual discharges to offset higher per-case costs, currently on a sliding scale up to 25% for facilities with fewer than 3,800 discharges and more than 15 road miles from another subsection (d) hospital.

In the FY 2027 proposed rule, CMS does not propose substantive policy changes to either the MDH program or the low-volume hospital adjustment. Rather, the agency proposes conforming regulatory changes to reflect current law, under which both policies have been extended through December 31, 2026. As a result, absent further congressional action, the MDH program would expire, and the temporary low-volume hospital policy would revert to permanent law beginning January 1, 2027.

Accordingly, the central issue is less the substance of CMS's proposal than the current appropriations and extender status of these programs. Congress first provided a short-term extension in the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026, and subsequently extended both policies through December 31, 2026, in the Consolidated Appropriations Act, 2026. CMS states that it will revise the regulatory language in the final rule if Congress again extends the programs before the rule is finalized. In practical terms, unless lawmakers enact another extender later this year, both policies will lapse beginning January 1, 2027.

CMS estimates that, if Congress were to extend the MDH and low-volume hospital policies through the end of FY 2027, affected hospitals would receive approximately \$0.4 billion in additional payments. Conversely, under current law, CMS estimates that expiration of the MDH status would reduce payments by approximately \$110 million for roughly 80 affected hospitals, while expiration of the temporary low-volume policy would reduce aggregate payments by approximately \$258 million in FY 2027, with approximately 589 hospitals expected to lose qualification under the stricter post-January 1 criteria.

DISCONTINUATION OF THE LOW-WAGE INDEX HOSPITAL POLICY

The low-wage index hospital policy was established in the FY2020 IPPS final rule as a temporary, budget-neutral initiative to address wage index disparities, benefiting rural hospitals by raising their wage indices to mitigate the impacts of lower payments. This policy adjusted the wage index for hospitals in the bottom quartile, setting a floor at the 25th percentile value, which was offset by a corresponding reduction for higher-wage hospitals. However, in July 2024, the U.S. Court of Appeals for the D.C. Circuit in *Bridgeport Hosp. v. Becerra* ruled that CMS lacked the statutory authority under sections 1886(d)(3)(E) or 1886(d)(5)(I) of the Social Security Act (SSA) to implement this policy, vacating both the policy and its budget neutrality adjustment.

In the FY 2026 final rule, CMS formally discontinued the low-wage index hospital policy and its associated budget-neutrality adjustment for FY 2026 and subsequent fiscal years. At the same time, CMS finalized a narrow, budget-neutral transitional payment exception for FY 2026 for certain hospitals experiencing significant decreases in their wage index resulting from the policy's discontinuation. Under that transition, eligible hospitals could receive additional FY 2026 payments if their wage index otherwise would have fallen by more than 9.75% from their FY 2024 wage index, with payments calculated as if the hospital's FY 2026 wage index were equal to 90.25% of its FY 2024 wage index.

For FY 2027, CMS does not propose to reinstate the low-wage index hospital policy. Instead, it proposes continuing the same transition approach for hospitals that are still significantly affected by the policy's discontinuation. Specifically, CMS proposes a narrow transitional payment exception for hospitals whose FY 2027 wage index would be more than 14.2625% below their FY 2024 wage index, with those hospitals receiving FY 2027 payments as if their wage index were equal to 85.7375% of their FY 2024 wage index. CMS proposes implementing this transition in a budget-neutral manner after applying the 5% cap on wage index decreases.

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

In the FY 2027 proposed rule, CMS proposes a fairly broad set of updates to the Hospital IQR Program. Most notably, CMS would adopt three new measures: the Excess Days in Acute Care After Hospitalization for Diabetes measure beginning with the FY 2029 payment determination, and the Hospital Harm–Postoperative Venous Thromboembolism eQOM and Advance Care Planning eQOM beginning with the FY 2030 payment determination. CMS also proposes to adopt modified versions of five mortality measures beginning with the FY 2028 payment determination – acute myocardial infarction, heart failure, pneumonia, COPD, and CABG mortality – by adding Medicare Advantage patients and shortening the applicable performance period from three years to two years. In addition, CMS proposes similar modifications to three Excess Days in Acute Care measures (for AMI, heart failure, and pneumonia), also beginning with the FY 2028 payment determination.

CMS also proposes to remove three eQOMs beginning with the FY 2030 payment determination: VTE-1, VTE-2, and STK-02. On reporting requirements, CMS proposes to make reporting of the Malnutrition Care Score eQOM mandatory beginning with the FY 2030 payment determination and to establish a policy under which Hospital Harm eQOMs would become mandatory after two years of self-selected reporting. CMS also proposes to update the Maternal Morbidity Structural Measure, beginning with the FY 2028 payment determination, so that hospitals identify which perinatal quality collaborative program they participate in. The proposed rule explains that these reporting changes are intended to continue CMS's move toward a more digital measure set and to standardize hospital quality reporting in several areas.

MEDICARE PROMOTING INTEROPERABILITY PROGRAM

In the FY 2027 proposed rule, CMS proposes a series of changes to the Medicare Promoting Interoperability Program, largely focused on streamlining the program's certification and attestation requirements and shifting hospitals toward newer interoperability functions.

- Most notably, CMS would update the definition of certified electronic health record technology (CEHRT) to align with changes proposed by Office of the National Coordinator for Health Information Technology (ONC), including removing references to several certification criteria from the program's CEHRT definition.
- CMS also proposes to remove the ONC Direct Review and ONC-Authorized Certification Body surveillance attestations beginning with the CY 2026 EHR reporting period, which the agency describes as a burden-reduction step.
- In addition, CMS proposes to remove the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information measures beginning with the CY 2028 EHR reporting period, on the view that newer network-based exchange measures better reflect meaningful health information exchange.
- CMS also proposes several more targeted policy updates.
- The agency would modify the Electronic Prior Authorization measure, including revising the measure language to require that prior authorization be requested electronically using CEHRT and changing the reference from “discharge” to “encounter.”
- CMS further proposes to make that measure optional and worth 10 bonus points for CY 2027, before requiring hospitals to attest “Yes” beginning with the CY 2028 EHR reporting period. CMS indicates the measure would remain unscored in CY 2028 and subsequent years for purposes of point allocation.
- Separately, CMS proposes to add a new Unique Device Identifiers for Implantable Medical Devices measure under the Public Health and Clinical Data Exchange objective beginning with the CY 2027 EHR reporting period.
- Finally, in alignment with the Hospital IQR Program, CMS proposes to adopt two new eQMs (the Hospital Harm-Postoperative Venous Thromboembolism eQm and the Advance Care Planning eQm) beginning with the FY 2030 payment determination, and to remove three eQMs (VTE-1, VTE-2, and STK-02), also beginning with the FY 2030 payment determination.

HOSPITAL READMISSIONS REDUCTION PROGRAM

In the FY 2027 proposed rule, CMS proposes one substantive change to the Hospital Readmissions Reduction Program (HRRP): adoption of the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization measure. CMS would provide hospitals with an early look at performance for the FY 2028 program year and then begin using the measure for payment adjustment purposes in FY 2029. CMS states that it proposes moving the measure directly into HRRP, rather than phasing it in first through a reporting-only program, because sepsis readmissions are associated with significant morbidity. Under the proposal, the FY 2028 early look would be based on an applicable period of July 1, 2024, through June 30, 2026. The measure would first be used for FY 2029 payment adjustments.

HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM

In the FY 2027 proposed rule, CMS does not propose changes to the current Hospital Value-Based Purchasing (VBP) measure set for the FY 2027 program year. CMS instead proposes substantive updates to five existing mortality measures in the Clinical Outcomes domain, beginning with the FY 2032 program year: the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization, Heart Failure Hospitalization, Pneumonia Hospitalization, Chronic Obstructive Pulmonary Disease (COPD) Hospitalization, and Coronary Artery Bypass Graft (CABG) Surgery measures.

For these five measures, CMS proposes adding MA beneficiaries to the measure population and shortening the performance period from three years to two years. The proposed rule also includes a related technical update to the risk adjustment methodology for these measures, replacing the current use of hierarchical condition categories with individual ICD-10 codes. CMS states that these VBP changes would be contingent on first adopting the same refined measures in the Hospital Inpatient Quality Reporting (IQR) Program, consistent with the statutory requirement that measures be publicly reported before being used in the VBP Program.

REQUESTS FOR INFORMATION (RFIS)

CMS includes several RFIs aimed at shaping potential future quality program and model design decisions.

- **Measuring Emergency Care Access and Timeliness in the Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing Programs:** CMS seeks feedback on whether and how the Emergency Care Access & Timeliness eCQM could be used in the inpatient quality programs, including barriers to improving bed availability and ED boarding, whether the outpatient-developed measure specifications fit the inpatient setting, and whether any numerator, denominator, exclusion, or accountability changes would be needed before future adoption.
- **Potential Future Use of the Adult Community-Onset Sepsis Standardized Mortality Ratio Measure in the Hospital Inpatient Quality Reporting Program:** CMS seeks comment on the possible future use of this sepsis mortality measure in IQR, including operational feasibility, workflow and data challenges, how claims and EHR/FHIR data would be reconciled, and what implementation issues hospitals (particularly rural hospitals) might face.
- **Birthing-Friendly Hospital Designation Modification to Expand Designation Criteria:** CMS seeks feedback on expanding the Birthing-Friendly Hospital designation to incorporate the Cesarean Birth eCQM and Severe Obstetric Complications eCQM, as well as on a revised scoring methodology, peer grouping, tiered designation icons, and how the designation should be displayed for consumers.

- Ambulatory Surgical Center (ASC) Episode Request for Information: In the TEAM section, CMS seeks comment on whether and how ASCs could be incorporated into the model in future years, including questions about model structure, participant roles, financial accountability, episode design, target pricing, quality measurement, and whether adding ASCs would require a separate model test.
- Hospital with Physician Ownership Request for Information: Also in the TEAM section, CMS seeks feedback on whether physician-owned hospitals should be allowed to opt into TEAM voluntarily in future years, and, if so, what eligibility criteria, guardrails, and participation requirements should apply to protect model integrity and Medicare savings.

We trust you found this summary useful. Please reach out to [us](#) with any questions.

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