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INSIGHTS

Fiscal Year 2027 Medicare Hospital Inpatient Prospective Payment System Final Rule

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On July 31, 2026, the Centers for Medicare and Medicaid Services (CMS) released the Fiscal Year 2027 Medicare Hospital Inpatient Prospective Payment System (IPPS) Final Rule. A CMS fact sheet is available here. The complete text of the final rule is available here. The final rule takes effect on October 1, 2026.

UPDATES TO IPPS PAYMENT RATES

As part of the final rule, CMS increases payment rates by 2.3% 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. The final update is 0.1% lower than the 2.4% update in the proposed rule. It reflects the same projected FY 2027 hospital market basket increase of 3.2%, reduced by a 0.9% productivity adjustment rather than the 0.8% adjustment in the proposed rule.

Overall, CMS estimates that the final changes in IPPS payment rates, together with other policy changes, will increase hospital payments by approximately $2.1 billion in FY 2027, up from the $1.4 billion estimate in the proposed rule. CMS separately estimates that payments for inpatient cases involving new medical technologies will increase by approximately $779 million in FY 2027, primarily driven by new approvals for new technology add-on payments. Including operating, capital, new technology, uncompensated care, and other payment changes, CMS estimates that acute care hospital payments will increase by $2.9 billion in FY 2027.

CMS finalized the FY 2027 outlier fixed-loss threshold at $49,346, lower than the proposed $51,704, based on updated data. The final threshold continues to target outlier payments at approximately 5.14% of total operating DRG payments, after incorporating an estimate of outlier reconciliation. In its final impact analysis, CMS estimates that total FY 2027 operating payments, including uncompensated care payments, will increase by 1.7% relative to FY 2026, up from the 1.2% estimate in the proposed rule.

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

The MDH program provides enhanced payments to small rural hospitals with 100 or fewer beds that are not Sole Community Hospitals and that derive at least 60% of inpatient days or discharges from Medicare patients. Qualifying hospitals are paid the higher of the federal rate or a blended rate composed of 75% of the federal rate and 25% of a hospital-specific rate based on historical costs. The low-volume hospital adjustment offsets the higher per-case costs of rural hospitals with low annual discharge volumes through a percentage add-on to IPPS payments. The add-on currently follows a sliding scale of up to 25%.

As in the proposed rule, the final rule makes no substantive policy changes to either the MDH program or the low-volume hospital adjustment. CMS finalized, as proposed, the conforming regulatory changes reflecting current law, under which both policies were extended through December 31, 2026, first by the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026, and then by the Consolidated Appropriations Act, 2026. CMS had stated in the proposed rule that it would revise the regulatory language if Congress extended the programs before the rule was finalized; no further extension was enacted, and the final rule reflects current law without revision. Absent further congressional action, the MDH program will expire beginning January 1, 2027, and formerly qualifying hospitals will be paid solely under the federal rate. The temporary low-volume hospital policy will revert on that date to the permanent statutory criteria, under which a hospital must have fewer than 200 total discharges and be located more than 25 road miles from another subsection (d) hospital to receive the 25% adjustment.

The final rule updates the impact estimates. CMS now estimates that extending both policies through the end of FY 2027 would provide affected hospitals with approximately $0.3 billion in additional payments, down from the $0.4 billion estimate in the proposed rule. Under current law, CMS estimates that 81 of the 166 current MDHs would otherwise be paid under the blended rate and will experience an overall payment reduction of approximately $94 million, compared with the proposed rule estimate of approximately $110 million for roughly 80 hospitals. CMS continues to estimate that expiration of the temporary low-volume policy will 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. The final rule notes that approximately 55 of those 589 hospitals have 200 or fewer total discharges and could continue to qualify if they also meet the 25-road-mile criterion, but CMS is unable to estimate how many will do so because the distance determination is made by each hospital's Medicare Administrative Contractor.

DISCONTINUATION OF THE LOW-WAGE INDEX HOSPITAL POLICY

The low-wage index hospital policy was established in the FY 2020 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 finalized the proposed transition policy without modification and did not reinstate the low-wage index hospital policy. Hospitals whose FY 2027 wage index would be more than 14.2625% below their FY 2024 wage index will receive FY 2027 payments as if their wage index were equal to 85.7375% of their FY 2024 wage index. CMS will implement the transition in a budget-neutral manner after applying the 5% cap on wage index decreases, along with a budget-neutral equivalent exception under the capital IPPS. CMS estimates that 54 hospitals, out of the more than 3,000 hospitals paid under the IPPS, will receive FY 2027 transitional exception payments. In response to commenters challenging its authority to apply the transition in a budget-neutral manner, CMS maintained that section 1886(d)(5)(I)(i) of the SSA provides that authority. CMS declined requests to extend the transition beyond FY 2027 but stated that it may consider an extension in future rulemaking.

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

CMS finalized the broad set of updates to the Hospital IQR Program from the proposed rule, in nearly all respects as proposed. CMS adopted 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 electronic clinical quality measure (eCQM) and Advance Care Planning eCQM beginning with the FY 2030 payment determination. CMS also finalized the adoption of modified versions of five mortality measures beginning with the FY 2028 payment determination (acute myocardial infarction (AMI), heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), and coronary artery bypass grafting (CABG) mortality) adding Medicare Advantage patients and shortening the applicable performance period from three years to two years, together with a technical update replacing hierarchical condition categories with individual ICD-10 codes in the risk adjustment methodology. CMS finalized the same modifications to the three Excess Days in Acute Care measures (for AMI, heart failure, and pneumonia), also beginning with the FY 2028 payment determination, and finalized the removal of three eCQMs beginning with the FY 2030 payment determination: VTE-1, VTE-2, and STK-02.

On reporting requirements, CMS finalized mandatory reporting of the Malnutrition Care Score eCQM beginning with the FY 2030 payment determination and the policy under which Hospital Harm eCQMs become mandatory after two years of self-selected reporting, beginning with the FY 2030 payment determination. CMS modified the latter policy in one respect relative to the proposed rule: data will be publicly reported on the Provider Data Catalog for the first year of mandatory reporting before being reported on the Care Compare tool at Medicare.gov, including the Hospital Star Ratings, beginning with the second year of mandatory reporting. CMS also finalized, as proposed, the update to the Maternal Morbidity Structural Measure, beginning with the FY 2028 payment determination, requiring hospitals to identify which perinatal quality collaborative program they participate in.

MEDICARE PROMOTING INTEROPERABILITY PROGRAM

CMS finalized the proposed changes to the Medicare Promoting Interoperability Program, with one timing modification affecting the electronic referral loops measures.

- CMS finalized, as proposed, the updated definition of certified electronic health record technology (CEHRT), aligning with changes proposed by Office of the National Coordinator (ONC), including removing references to several certification criteria from the program's CEHRT definition. CMS stated that ONC need not finalize its proposed rule for CMS to finalize these revisions.
- CMS finalized, as proposed, the removal of the ONC Direct Review and ONC-Authorized Certification Body surveillance attestations beginning with the CY 2026 EHR reporting period.
- CMS finalized removal of the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information measures with a modification: in response to comments on operational readiness and transition timing, removal takes effect with the CY 2029 EHR reporting period, one year later than the proposed CY 2028 period.

CMS also finalized the more targeted policy updates as proposed.

- CMS finalized the modifications to the Electronic Prior Authorization measure, including revising the measure language to require that prior authorization be requested electronically through a Prior Authorization API using CEHRT and changing the reference from "discharge" to "encounter."
- CMS finalized making that measure optional and worth 10 bonus points for the CY 2027 EHR reporting period, with hospitals required to attest "Yes" beginning with the CY 2028 EHR reporting period. The measure will remain unscored in CY 2028 and subsequent years for purposes of point allocation. CMS stated that it is strongly considering proposing, in the FY 2028 IPPS rulemaking, to require use of the functionality in the three ONC electronic prior authorization certification criteria.
- CMS finalized adoption of the 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. Hospitals will attest "Yes" or "No" or claim an applicable exclusion to fulfill the measure requirements.
- In alignment with the Hospital IQR Program, CMS finalized adoption of two new eCQMs (the Hospital Harm–Postoperative Venous Thromboembolism eCQM and the Advance Care Planning eCQM) and removal of three eCQMs (VTE-1, VTE-2, and STK-02), each beginning with the FY 2030 payment determination.

HOSPITAL READMISSIONS REDUCTION PROGRAM

CMS finalized adoption of the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization measure in the Hospital Readmissions Reduction Program (HRRP), but modified the implementation timeline relative to the proposed rule. The proposed rule provided for a single early look for the FY 2028 program year, with the measure used for payment adjustment beginning in FY 2029. The final rule instead provides two years of confidential early look reports, which will include estimated HRRP payment adjustments with the sepsis measure added, for the FY 2028 program year (applicable period of July 1, 2024 through June 30, 2026) and the FY 2029 program year (applicable period of July 1, 2025 through June 30, 2027).

The measure will first be used for payment adjustment beginning with the FY 2030 program year (applicable period of July 1, 2026 through June 30, 2028). During the early look periods, data will not be publicly reported or used for payment adjustment. CMS retained its position, over commenter objections, that the measure should enter HRRP directly rather than first passing through a reporting-only program, citing the morbidity, mortality, and cost associated with sepsis readmissions. CMS estimates no financial impact from the HRRP changes for the FY 2027 payment determination.

HOSPITAL-ACQUIRED CONDITION (HAC) REDUCTION PROGRAM

Consistent with the proposed rule, the final rule makes no changes to the HAC Reduction Program for FY 2027. Under the existing statutory framework, hospitals in the worst-performing quartile of Total HAC Scores receive a 1% reduction in overall Medicare fee-for-service payments. In its impact analysis, CMS estimates that 721 of the 2,891 non-Maryland hospitals with an estimated FY 2027 Total HAC Score would be in the worst-performing quartile and subject to the payment reduction, with actual results to be determined in the fall of 2026 following a 30-day review and corrections period.

HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM

As proposed, the final rule makes no changes to the current Hospital VBP measure set for the FY 2027 program year. CMS estimates that the total amount available for value-based incentive payments for FY 2027 is approximately $1.9 billion under the program's budget-neutral structure. CMS finalized, as proposed, the 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 AMI Hospitalization, Heart Failure Hospitalization, Pneumonia Hospitalization, COPD Hospitalization, and CABG Surgery measures.

For these five measures, CMS finalized adding MA beneficiaries to the measure population and shortening the performance period from three years to two years, along with the related technical update replacing hierarchical condition categories with individual ICD-10 codes in the risk adjustment methodology. Consistent with the statutory requirement that measures be publicly reported before use in the VBP Program, CMS finalized adoption of the modified measures in the Hospital IQR Program for the FY 2028 through FY 2031 payment determinations, with the measures then removed from the IQR Program and modified in the VBP Program beginning with the FY 2032 program year (initial VBP performance period of July 1, 2028 through June 30, 2030). CMS noted that the performance standards established for the FY 2032 program year do not yet reflect the finalized modifications and that updated standards will be provided in the FY 2028 IPPS rulemaking.

COMPREHENSIVE CARE FOR JOINT REPLACEMENT EXPANDED (CJR-X) MODEL

The final rule finalizes the expansion of the Comprehensive Care for Joint Replacement (CJR) Model into CJR-X, a mandatory nationwide bundled-payment model for Medicare fee-for-service beneficiaries undergoing lower extremity joint replacements (hip, knee, and ankle procedures) performed in inpatient or hospital outpatient settings, tested under section 1115A of the SSA. Participating acute care hospitals will be accountable for the cost and quality of care from the inpatient admission or outpatient procedure through 90 days after discharge. The model applies to acute care hospitals paid under the IPPS and Outpatient Prospective Payment System (OPPS), with limited exclusions; CMS finalized, as proposed, the exclusion of hospitals participating in TEAM and hospitals located in Maryland.

CMS modified the start date relative to the proposed rule: in response to comments on implementation readiness, CJR-X will begin on January 1, 2028, rather than the proposed October 1, 2027. Hospitals will be assessed on five quality measures combined into a composite quality score. Target prices will be regional and risk-adjusted, incorporating capped normalization and trend factors, with separate pricing accommodations for low-volume and safety net hospitals. CMS will permit overlap with most other models and will allow participant hospitals to enter financial arrangements. The final rule also waives certain Medicare program requirements, provides for beneficiary-identifiable and regional aggregated data sharing, and gives participants options for Alternative Payment Model participation. Hospitals may earn reconciliation payments if episode spending is below the applicable target price and quality requirements are met or owe repayments to CMS if spending exceeds the target.

REQUESTS FOR INFORMATION (RFIS)

CMS did not finalize policy through the RFIs included in the proposed rule. The final rule summarizes the comments received on each RFI and describes CMS's response as follows.

- Measuring Emergency Care Access and Timeliness in the Hospital IQR and VBP Programs: Commenters were largely opposed to including the Emergency Care Access & Timeliness eCQM in the VBP Program, citing factors outside hospital control such as behavioral health patients awaiting placement, lack of post-acute or supportive housing options, and non-deferrable trauma volume, and stated that any adoption should follow at least two years of reporting in the IQR Program. CMS responded that it is not responding to specific comments in the final rule but will take the input into account in future development and consideration of the measure for both programs.

- Potential Future Use of the Adult Community-Onset Sepsis Standardized Mortality Ratio Measure in the IQR Program: Commenters generally supported the transition from process to outcome measures but raised concerns regarding feasibility and implementation burden, particularly for rural hospitals; the need for further pilot testing, clear technical specifications, and risk adjustment methodology detail; and the influence of transfer patterns and factors outside the inpatient facility's control on sepsis outcomes. CMS responded that it is not responding to specific comments in the final rule but will take the input into account in future development and consideration of the measure.

- Birthing-Friendly Hospital Designation Modification to Expand Designation Criteria: Commenters supported moving beyond a binary scoring structure but raised concerns with the potential scoring framework, including the interpretability of k-means clustering, the combined effects of clustering and peer grouping, and the possibility that hospitals performing poorly on the Cesarean Birth or Severe Obstetric Complications eCQMs could receive a designation icon; several recommended a z-score methodology, minimum thresholds, or absolute criteria, and many urged that any updates be fair to rural, safety net, and other hospitals serving complex patient populations. CMS responded that it is not responding to specific comments in the final rule but will take the input into account in the future development of the designation.

- Ambulatory Surgical Center (ASC) Episodes in TEAM: CMS stated that, due to the breadth of topics covered and the variety of viewpoints expressed, it is not responding to specific comments. CMS acknowledged the input on the parameters under which ASCs could be incorporated into TEAM, including the degree to which adding ASCs would necessitate a separate model test, and stated that it is conducting an in-depth review of the comments, which may inform potential future rulemaking proposals.

- Hospitals with Physician Ownership in TEAM: CMS responded to comments in detail and stated that it intends to propose in future rulemaking a policy allowing physician-owned hospitals (POHs) not located in mandatory TEAM Core-Based Statistical Areas to participate voluntarily in TEAM. In responding to commenters' concerns regarding patient selection, referral patterns, beneficiary choice, and model evaluation, CMS stated that it intends to address beneficiary protections, monitoring requirements, and the potential for remedial action or participant termination in that future rulemaking, and that it may align the terms of POH participation with existing TEAM participation requirements where possible and appropriate.

We trust you found this summary useful. Please reach out to us with any questions.