



## Executive Summary: FY 2027 Hospital Inpatient Prospective Payment System (IPPS) and LTCH PPS Proposed Rule

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*CMS-1849-P | Proposed rule displayed April 10, 2026*

**Bottom line.** This proposed rule provides only a modest base payment increase for inpatient hospitals, but it is strategically more important for what it signals: tighter pressure on quality accountability, more scrutiny on graduate medical education and cost reimbursement practices, and a major expansion of mandatory episode-based payment through the proposed national CJR-X model. For CEOs, the near-term financial headline is manageable, but the medium-term message is clear: Medicare continues to push hospitals toward stronger clinical standardization, better post-acute performance, and broader accountability for total episode cost.

### 1. What the rule does

**CMS proposes to update FY 2027 inpatient payment rates and related policies for acute care hospitals and LTCHs.** The rule also includes proposals on hospital quality programs, graduate medical education and nursing/allied health payments, new technology add-on payments, organ acquisition and reasonable cost reimbursement policies, and Innovation Center models including TEAM and CJR-X.

### 2. Financial impact: positive but limited

**The core payment update is modest.** CMS proposes a 2.4 percent increase in IPPS payment rates, reflecting a 3.2 percent market basket update less a 0.8 percentage point productivity adjustment. CMS estimates the combined payment and policy changes would increase hospital payments by about \$1.4 billion in FY 2027. Additional payments tied to inpatient cases involving new medical technologies are estimated to increase by about \$464 million.

**Implication.** This is not a rule that materially expands inpatient margins. Most systems should view the 2.4 percent update as a partial inflation offset, not a source of net margin relief. Hospitals with meaningful Medicare volume may see nominal revenue growth, but labor cost pressure, supply inflation, and utilization mix changes are likely to absorb much of the gain.

**Important caveat for rural hospitals.** Under current law, the Medicare-Dependent Hospital program and temporary low-volume hospital payment changes expire on December 31, 2026. CMS notes that if Congress extends them through the end of FY 2027, affected hospitals would receive about \$0.4 billion in additional payments. For rural systems and affiliated community hospitals, this is a material watch item outside the four corners of the proposed rule.

### 3. Strategic issues

#### A. Mandatory bundled payment is expanding again

**The biggest strategic development in the rule is CJR-X.** CMS proposes to expand the Comprehensive Care for Joint Replacement model nationally beginning October 1, 2027. Unlike the original CJR model, the expanded model would be mandatory nationwide for acute care hospitals, except hospitals participating in TEAM and those in Maryland. It would hold hospitals accountable for spending and quality for lower extremity joint replacement episodes spanning the inpatient or hospital outpatient procedure and the 90 days after discharge.

**Implication.** This is a major operational signal. Hospitals should treat orthopedic episode management, preferred post-acute networks, implant governance, and care navigation as enterprise priorities now rather than waiting for finalization. The proposed model also indicates that CMS remains willing to use mandatory models when prior tests show savings and stable quality.

#### B. TEAM remains an important near-term operating model

The rule proposes updates to the Transforming Episode Accountability Model, which began January 1, 2026, affecting episode triggers, quality measure assessment, and target price construction for CABG, lower extremity joint replacement, major bowel procedures, surgical hip/femur fracture treatment, and spinal fusion episodes.

**Implication.** For systems in TEAM markets, this is not just a reimbursement rule. It is a care redesign rule. Finance, physician leadership, case management, post-acute strategy, and analytics teams need to operate from one playbook because episode leakage and variable post-acute utilization will increasingly show up as margin loss.

#### C. Quality programs continue to move toward outcome and digital measures

CMS proposes to add the Advance Care Planning eCQM across the Hospital Inpatient Quality Reporting Program, the PPS-Exempt Cancer Hospital Quality Reporting Program, and the Medicare Promoting Interoperability Program. CMS also proposes to adopt five modified claims-based risk-standardized mortality measures in IQR and then modify those measures in the Hospital Value-Based Purchasing Program. In the Hospital Readmissions Reduction Program, CMS proposes a new 30-day all-cause risk-standardized readmission measure following sepsis hospitalization.

**Implication.** The direction of travel is unmistakable: CMS wants more digitally extractable measures and more focus on meaningful patient outcomes. Hospitals that still treat quality reporting as a compliance function rather than a clinical operations function will be disadvantaged. Advance care planning performance, sepsis transitions of care, and mortality-sensitive care pathways deserve executive oversight.

#### D. GME and education policy changes raise governance and compliance stakes

CMS proposes to require that approved residency programs, as well as nursing and allied health education programs and accreditors for those programs, not discriminate or promote or encourage discrimination based on protected characteristics or intentional proxies for those characteristics.

**Implication.** Teaching systems should expect heightened scrutiny of program governance, admissions or selection practices, policy documentation, and institutional oversight. This is as much a compliance and reputational matter as a reimbursement issue.

## E. Cost reimbursement and organ acquisition proposals matter for specialized providers

The rule would codify aspects of organ acquisition cost reconciliation for non-renal organs for independent organ procurement organizations and histocompatibility laboratories, while also clarifying longstanding reasonable-cost principles and overhead allocation rules.

**Implication.** For systems with transplant programs, this is a technical but potentially important area. Leaders should confirm that finance and reimbursement teams understand whether any codified interpretations could alter cost reporting positions, audit exposure, or appeals strategy.

## 4. What is not changing is also important

CMS says it is not proposing updates to the Hospital Value-Based Purchasing Program beyond the cross-program mortality measure changes, and it is not proposing updates to the Hospital Acquired Condition Reduction Program in this rule. That relative stability matters because it allows organizations to focus on the more significant proposed changes in bundled payment expansion, readmissions, eCQM reporting, and education program compliance.

## 5. Risk assessment

- **Margin risk remains real.** The proposed inpatient rate update is positive, but not large enough to offset structural cost growth for many systems.
- **Orthopedic episode risk is rising.** CJR-X would make lower extremity joint replacement a national enterprise issue, with direct consequences for surgeons, care coordination, post-acute strategy, and finance.
- **Readmissions and mortality exposure are broadening.** New and modified measures, especially sepsis readmissions and mortality-focused proposals, will put more pressure on clinical reliability and care transitions.
- **Compliance risk is expanding beyond billing.** GME, nursing, and allied health program requirements elevate governance and documentation risk for academic health systems.
- **Operational fragmentation will be more costly.** The rule rewards hospitals that can link acute care, physicians, IT, quality, and post-acute management into a coherent operating model.

## 6. Recommended actions for health system leadership

- **Run a system-level FY 2027 impact estimate.** Quantify the effect of the 2.4 percent update, NTAP continuation, expected case-mix changes, and any exposure tied to rural hospital payment extenders.
- **Stand up an enterprise CJR-X readiness effort.** Even though CJR-X would not begin until October 1, 2027, the orthopedic and post-acute capabilities required to succeed take time to build.
- **Tighten sepsis and transition-of-care performance.** If the sepsis readmission measure is finalized, organizations with uneven discharge planning, SNF coordination, or ambulatory follow-up will be exposed.
- **Audit quality data infrastructure.** Advance care planning and other eQMs require reliable EHR workflows, documentation, extraction logic, and physician adoption.
- **Review academic program policies.** Teaching hospitals should review residency, nursing, and allied health program standards and governance processes with legal and compliance leadership.
- **Assess transplant and cost-reporting implications.** Systems with transplant services should examine whether proposed organ acquisition and cost allocation codifications create financial or audit risk.

## 7. Bottom line

For most health systems, the FY 2027 proposed inpatient rule is less about a dramatic payment surprise and more about strategic direction. CMS is offering a manageable inpatient rate increase while continuing to move hospitals toward stronger episode accountability, more outcomes-based measurement, tighter digital reporting, and closer scrutiny of program governance. The most consequential proposal is the nationwide mandatory CJR-X expansion, which signals that CMS still views bundled payment as a core tool for hospital accountability. Health systems that respond early by standardizing orthopedic episodes, strengthening post-acute performance, hardwiring quality workflows, and tightening academic program compliance will be better positioned whether the rule is finalized largely as proposed or revised after comment.

## References

1. Centers for Medicare & Medicaid Services. FY 2027 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Proposed Rule - CMS-1849-P fact sheet. April 10, 2026.
2. Centers for Medicare & Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2027 Rates; Requirements for Quality Programs; and Other Policy Changes. CMS-1849-P, public inspection version, displayed April 10, 2026.
3. Centers for Medicare & Medicaid Services. FY 2027 IPPS Proposed Rule Home Page. Accessed April 11, 2026.