STRATEGIC HEALTH CARE

Most Financially Consequential Provisions in the FY 2027 IPPS Final Rule

Page references are to the 2,704-page Public Inspection PDF of CMS-1849-F and CMS-0062-F.
https://www.federalregister.gov/d/2026-15833

1. The 2.3% Rate Update Produces an Estimated 1.7% Overall Payment Increase

Hospitals that successfully participate in the Hospital Inpatient Quality Reporting Program and qualify as meaningful EHR users receive a 2.3% update to the operating standardized amount. The update consists of a projected 3.2% hospital market-basket increase minus a 0.9-percentage-point productivity adjustment. The payment update therefore trails CMS's own estimate of hospital input-cost inflation by 0.9 percentage point.

CMS estimates that ordinary IPPS payment changes will increase hospital payments by approximately $2.1 billion and that increased new-technology add-on payments will add approximately $779 million compared with FY 2026. Including operating, capital, outlier, uncompensated-care, new-technology, and rural-program changes, CMS estimates an aggregate increase of approximately $2.9 billion.

After all modeled changes are incorporated, CMS projects that payments per discharge will rise by only 1.7% across IPPS hospitals. The distribution is uneven:

Hospital category	Estimated FY 2027 change
All hospitals	+1.7%
Urban hospitals	+1.8%
Rural hospitals	+1.1%
Urban hospitals with 500 or more beds	+2.1%
Urban hospitals with fewer than 100 beds	+0.2%
Rural hospitals with fewer than 50 beds	+0.3%
Rural hospitals with 50-99 beds	+0.5%

Hospitals that fail the quality-reporting or meaningful-use requirements receive materially lower updates. The final standardized-amount tables show updates ranging from -0.9% for hospitals failing both requirements to 2.3% for hospitals satisfying both.

Reference pages: 17; 2,538-2,539; 2,553-2,571.

2. Expiration of the MDH and Enhanced Low-Volume Policies Creates a Rural Payment Cliff

Under current law, the Medicare-Dependent Hospital (MDH) program and the temporary enhanced low-volume hospital payment policy expire on December 31, 2026, partway through FY 2027. CMS's estimates assume those expirations occur on January 1, 2027.

The impact is especially severe for MDHs. CMS projects a 6.8% aggregate reduction for the 166 MDHs in its impact analysis. The expiration of MDH status itself accounts for an estimated 8.3% reduction,

partially offset by the general rate update and other payment changes. Small rural hospitals also receive substantially smaller overall increases than larger hospitals, and some rural subgroups are projected to experience net reductions.

For affected rural facilities, congressional extension of the MDH and enhanced low-volume policies is likely to be the most important unresolved FY 2027 financial issue.

Reference pages: 17; 26; 2,553; 2,561; 2,570-2,571; 2,683.

3. Approximately $7.94 Billion in Uncompensated-Care Payments Will Be Redistributed Among DSH Hospitals

CMS finalized approximately $7.939 billion in FY 2027 Medicare DSH uncompensated-care payments. The amount reflects a final Factor 2 of 67.14%.

CMS will allocate the pool using each hospital's share of national uncompensated care, based on a three-year average of audited FY 2021, FY 2022, and FY 2023 Worksheet S-10 data. The multi-year average is intended to reduce annual volatility, but the methodology can still materially redistribute payments among hospitals.

An individual hospital can lose payment even though the national pool increases. Its result depends on how its audited charity-care and non-Medicare bad-debt costs compare with the national audited total. CMS projects a positive aggregate effect for urban hospitals but a slightly negative effect for rural hospitals, with additional variation by teaching status, ownership, and utilization profile.

Reference pages: 681; 693-694; 2,544; 2,579-2,585.

4. The Lower Outlier Threshold Helps High-Cost Cases, but Aggregate Outlier Payments Decline

CMS finalized an FY 2027 fixed-loss outlier threshold of $49,346, below the proposed threshold of $51,704. A case generally qualifies for an inpatient outlier payment when estimated costs exceed the MS-DRG payment and applicable add-ons by more than the fixed-loss amount. The lower threshold makes more exceptionally expensive cases eligible for additional payment.

Despite the lower threshold, CMS projects that recalibration of outlier payments will reduce aggregate hospital payments by approximately 0.6% relative to the FY 2026 baseline. The modeled reduction is approximately 0.7% for urban hospitals, 0.2% for rural hospitals, and 0.8% for hospitals with 500 or more beds. Hospitals with a high concentration of catastrophic-cost cases may benefit from the lower threshold even though the sector-wide outlier effect is negative.

Reference pages: 2,443-2,448; 2,527-2,528; 2,561; 2,570-2,571.

5. FY 2027 New-Technology Add-On Payments Total Approximately $1.74 Billion

CMS estimates total FY 2027 new-technology add-on payments of approximately $1.740 billion:

- Approximately $840.5 million for 41 technologies continuing from prior years;
- Approximately $417.7 million for 16 newly approved alternative-pathway technologies; and
- Approximately $481.5 million for three newly approved traditional-pathway technologies.

The increase in NTAP funding is one of the principal reasons aggregate hospital payments rise by approximately $2.9 billion rather than the roughly $2.1 billion attributable to operating and related payment changes alone.

The rule also eliminates the streamlined alternative pathway for future Breakthrough Devices, Qualified Infectious Disease Products, and certain limited-population antibiotics, subject to transition protections.

After the transition, these technologies generally must demonstrate substantial clinical improvement in addition to meeting the newness and inadequate-payment criteria. The change may reduce future separate reimbursement for emerging technologies and increase hospital risk when adopting expensive products before their costs are fully incorporated into MS-DRG rates.

Reference pages: 285-304; 2,573-2,578.

6. Wage-Index Changes Create Significant Hospital and Regional Winners and Losers

CMS continues the permanent policy limiting any year-to-year wage-index reduction to 5%. It also provides a targeted, budget-neutral transition payment for hospitals substantially affected by the discontinuation of the low-wage-index policy.

A hospital may qualify when its FY 2027 wage index would otherwise be more than 14.2625% below its FY 2024 wage index. CMS will calculate the transition payment as though the hospital's FY 2027 wage index were no lower than 85.7375% of its FY 2024 wage index. Because the policy is budget neutral, its cost is offset through reductions across other IPPS hospitals.

Although the national wage-index effect is approximately neutral, CMS projects substantial regional differences. The wage-index component is positive for Middle Atlantic, East North Central, and South Atlantic urban hospitals, but negative for Pacific, East South Central, West North Central, and Mountain urban hospitals. The wage-index file may therefore matter more to an individual hospital than the national payment update.

Reference pages: 636-640; 2,473-2,474; 2,561.

7. Mandatory CJR-X Creates Nationwide Episode-Payment Risk Beginning January 1, 2028

The final rule establishes the mandatory Comprehensive Care for Joint Replacement Expanded (CJR-X) Model nationwide, including the U.S. Territories, beginning January 1, 2028. Acute-care hospitals participating in TEAM and acute-care hospitals located in Maryland are excluded.

Participating hospitals will be accountable for Medicare spending and quality during the initial lower-extremity joint-replacement admission or outpatient procedure and the following 90-day episode. CMS will use regional, risk-adjusted target prices and a composite quality score. The model includes pricing and risk protections for certain low-volume and safety-net hospitals and permits financial arrangements with collaborating providers and suppliers.

CMS estimates that CJR-X will save Medicare approximately $725 million during its first five performance years. Those federal savings will arise largely from reduced episode spending and hospital repayment obligations. Hospitals with efficient programs may earn reconciliation payments, while hospitals exceeding target prices face downside risk.

Reference pages: 6; 15-17; 1,515-1,584; 2,682.

8. TEAM Changes Alter Target Prices and Expand Accountability for Complex Spinal Fusion Cases

For hospitals already participating in the mandatory Transforming Episode Accountability Model (TEAM), CMS adds MS-DRGs 523, 524, and 525 to the spinal-fusion episode category effective October 1, 2026. These MS-DRGs include relatively complex spinal-fusion cases and may expose participating hospitals to additional episode-level financial risk.

CMS also revises the construction of TEAM target prices by adding APC and MS-DRG update factors, revising normalization and risk-adjustment methodologies, and using the full baseline period to calculate

the prospective normalization factor. It adopts a rolling concurrent Composite Quality Score baseline, under which each performance year is compared with the national distribution for the same measurement period.

CMS does not project a significant aggregate change to its previously estimated TEAM savings. Nevertheless, the revised episode triggers, quality benchmark, and target-price calculations can produce meaningful gains or losses for individual hospitals.

Reference pages: 14-15; 1,440-1,490; 2,681.

9. Organ-Acquisition Reimbursement Changes Create Long-Term Pressure on Transplant Payments

Beginning with cost-reporting periods on or after October 1, 2028, CMS will reconcile independent OPO and histocompatibility laboratory payments for non-renal organ acquisition to actual allowable reasonable costs. CMS estimates savings of $110 million in FY 2029, $380 million over five years, and $1.16 billion over 10 years.

The rule also tightens the manner in which transplant hospitals allocate administrative and general overhead to purchased organs and other high-cost purchased items. Hospitals may not use the full purchase price as an allocation statistic when doing so assigns an inappropriate second layer of hospital overhead to an already fully costed purchased organ.

The policy may reduce reimbursable organ-acquisition costs for some transplant hospitals, recalibrate non-renal OPO standard acquisition charges, increase cost-report audit exposure, and require revisions to hospitals' overhead-allocation methodologies. The impact will vary according to each OPO's charges relative to its allowable reasonable costs and each transplant hospital's current cost-report practices.

Reference pages: 2,028-2,066; 2,134-2,147; 2,631-2,642.

10. New GME Cap-Building Rules Create Financial Risk for Hospitals Opening Residency Programs

For a residency program to be treated as genuinely new for Medicare cap-building purposes, at least 90% of the individual residents entering during the five-year cap-building period generally must not have previously trained in another program in the same specialty.

The rule excludes certain displaced residents and residents entering through qualifying binding matching programs from the calculation, and it exempts programs accredited for 16 or fewer positions from the 90% test. CMS will no longer consider the prior employment of the program director or faculty when deciding whether the program is new.

The policy applies to programs beginning on or after October 1, 2026, and to programs that remain within their cap-building period. A program that fails the test could lose the permanent direct GME and indirect medical education cap increases on which the hospital relied when establishing the program, creating financial exposure that can continue for many years.

Reference pages: 789-811.

11. Quality Programs Create Additional Downside Risk Beyond FY 2027

The final rule adds a sepsis readmission measure to the Hospital Readmissions Reduction Program. Hospitals will receive confidential early-look reports for FY 2028 and FY 2029, and the measure will begin affecting payment adjustments in FY 2030. Hospitals with high sepsis volume, high readmission rates, or weak post-discharge management face the greatest future exposure.

The Hospital Value-Based Purchasing Program remains budget neutral in the aggregate, but approximately $1.9 billion in FY 2027 base operating MS-DRG payments will be withheld and redistributed according to performance. The program therefore creates substantial hospital-level winners and losers even though it does not reduce total industry payment.

Hospitals should treat the new reporting, quality-measure, and interoperability requirements as financial requirements because failure to satisfy applicable conditions can reduce annual payment updates or affect future penalty and incentive calculations.

Reference pages: 11-12; 17; 886-934; 2,589-2,596.

Primary source: FY 2027 IPPS/LTCH PPS Final Rule, CMS-1849-F and CMS-0062-F, Public Inspection version dated July 31, 2026.