



April 17, 2026

CMS Issues FY 2027 Proposed Medicare Inpatient and Long-Term Care Hospital Payment Rule

On Friday (April 10), the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2027 proposed rule for the Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System.

The rule proposes to increase FY 2027 acute care hospital operating payments by about 2.4%, compared with FY 2026. CMS estimates the overall impact of the rule would result in an increase of about \$1.9 billion in payments to acute care hospitals paid under the IPPS in FY 2027.

Medicare uncompensated care payments to disproportionate share hospitals would decrease by 0.2 percent in FY 2027, and additional payments for inpatient cases involving new medical technologies would increase by \$464 million. In the rule, CMS noted that the November 2025 continuing resolution extended additional payments for Medicare-Dependent Hospitals (MDHs) and the temporary change in payments for low-volume hospitals through December 31, 2026. CMS estimated if Congress acts to further extend the funding, payments to those hospitals would increase by \$400 million in FY 2026.

CMS expects the LTCH standard payment rate to increase by 2.4%. CMS said LTCHs can expect to see a \$55 million increase in total payment for FY 2026.

The proposed rule also would expand the Comprehensive Care for Joint Replacement (CJR) Model. The expanded model, called CJR-X, would aim to improve care coordination for Medicare patients undergoing hip, knee and ankle replacements in both inpatient and outpatient hospital settings. CJR-X would be mandatory nationwide and begin on October 1, 2027. In addition, the proposed rule makes several updates to hospital quality and pay-for-performance programs.

The proposed rule is open for public comment through June 9, 2026.

[Press Release](#), [Fact Sheet](#), [Proposed Rule](#)

Summary of key provisions

Payment update. CMS in the rule proposed increasing FY 2027 acute care hospital operating payments by 2.4% compared with FY 2026, for hospitals that are meaningful users of electronic health records and submit quality

measure data. This 2.4% payment update is the summation of a 3.2% hospital market basket increase and a 0.8 percentage point productivity decrease.

However, when other proposed changes are taken into account - including a proposed outlier adjustment, a proposed applicable percentage increase, a projected 0.2% decrease in uncompensated care payments, \$464 million in add-on payments for new medical technologies, and proposed changes to the wage index - CMS estimates that IPPS payments to hospitals would increase by 1.2% for FY 2027, compared with 2026.

CMS also in the rule noted that the estimate assumes the payments for the MDH and low-volume hospitals expire on December 31, 2026, as required under the Congress-passed continuing resolution enacted on November 12, 2025. However, CMS said hospitals would get an estimated \$400 million if those programs are extended before the expiration date.

CMS also proposed a 2.4% payment increase for long-term care facilities. CMS said LTCHs can expect to see a \$55 million increase in total payment for FY 2026.

Table: Proposed FY 2027 Percentage Increases for the IPPS

	Hospital Submitted Quality Data and Is a Meaningful EHR User	Hospital Submitted Quality Data and Is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and Is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and Is NOT a Meaningful EHR User
Proposed Market Basket Rate-of-Increase	3.2	3.2	3.2	3.2
Proposed Productivity Adjustment	-0.8	-0.8	-0.8	-0.8
Proposed Quality Data Adjustment	0.0	0.0	-0.75	-0.75
Proposed Meaningful EHR User Adjustment	0.0	-2.25	0.0	-2.25
Proposed Percentage Change to FY 2027 Standardized Amount	2.4	1.75	1.65	-0.6

Low wage index hospital policy. In the rule, CMS proposed extending the FY 2026 transitional exception for hospitals that saw wage index decreases as a result of the agency discontinuing the 2020 low wage index hospital policy. For FY 2026, the transitional payment exception was equal to the amount that would have been paid if the FY 2026 wage index were equal to 90.25% of its FY 2024 wage index.

GME updates. CMS in the rule proposed adding new non-discrimination requirements for medical residency training programs. The rule proposes that effective October 1, 2026, such programs must “not discriminate, or promote or encourage discrimination, on the basis of race, color, national origin, sex, age, disability, or religion, including the use of those characteristics or intentional proxies for those characteristics as a selection criterion

for employment, program participation, resource allocation, or similar activities, opportunities, or benefits.” CMS proposed similar requirements for nursing and allied health education programs and accreditors.

In addition, CMS proposed changes to the criteria for being considered a “new residency program,” including that at least 90% of the individual residents not have previous experience training in another program in the same specialty. CMS proposed exceptions for small residency programs, displaced residents, and residents admitted via a third-party matching program.

Updates to Organ Procurement policies. CMS in the rule proposed to codify Medicare’s reconciliation of organ acquisition costs for non-renal organs for Independent Organ Procurement Organizations and Histocompatibility Laboratories. The agency also proposed to codify certain instructions on allowable costs under Medicare’s reasonable cost principles for all provider types and rules for allocating overhead costs across all provider types.

Hospital Readmissions Reduction Program. In the rule, CMS proposed to adopt the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization measure. CMS estimated the proposed changes would have no financial impact for FY 2027.

Hospital Acquired-Conditions (HAC) Reduction Program. CMS did not proposal any updates to the HAC program.

Hospital Inpatient Quality Reporting (IQR) Program. In the rule, CMS proposed to adopt three new measures:

- Excess Days in Acute Care After Hospitalization for Diabetes measure beginning with the FY 2029 payment determination.
- Hospital Harm-Postoperative Venous Thromboembolism electronic clinical quality measure (eCQM) beginning with the FY 2030 payment determination.
- Advance Care Planning eCQM beginning with the FY 2030 payment determination.

CMS proposed to remove three measures beginning with the FY 2030 payment determination:

- Venous Thromboembolism Prophylaxis (VTE-1) eCQM.
- Intensive Care Unit Venous Thromboembolism Prophylaxis (VTE-2) eCQM.
- Discharged on Antithrombotic Therapy (STK-02) eCQM.

CMS also proposed to modify five mortality measures beginning with the FY 2028 payment determination to add Medicare Advantage patients and shorten the performance period from three to two years:

- Acute Myocardial Infarction (AMI) Hospitalization measure.
- Heart Failure Hospitalization measure.
- Pneumonia Hospitalization measure.
- Chronic Obstructive Pulmonary Disease (COPD) Hospitalization measure.
- Coronary Artery Bypass Graft (CABG) Surgery measure.

CMS also proposed modifications to three eCQM measures and changes to the data reporting and submission requirements for some eCQMs and structural measures:

- Venous Thromboembolism Prophylaxis (VTE-1) eCQM beginning with the FY 2030 payment determination
- Intensive Care Unit Venous Thromboembolism Prophylaxis (VTE-2) eCQM beginning with the FY 2030 payment determination
- Discharged on Antithrombotic Therapy (STK-02) eCQM beginning with the FY 2030 payment determination.

CMS also requested comment on:

- Potential use of the Emergency Care Access and Timeliness eCQM in the inpatient setting.
- Potential use of the Adult Community-Onset Sepsis Standardized Mortality Ratio measure.
- Updating the scoring methodology associated with the Birthing Friendly Hospital designation.

CMS estimated that the proposed changes for the Hospital IQR Program would add 8,133 hours and \$447,803 to the information collection burden for the FY 2030 payment determination and subsequent years.

Hospital Value-Based Purchasing (VBP) Program. CMS in the rule proposed to adopt the five modified mortality measures proposed in the Hospital IQR program in the Hospital VBP program. CMS estimated the proposed changes would have no net financial impact for FY 2027. The agency also included requests for information on:

- Measuring emergency room access and timeliness in Hospital Inpatient Quality Reporting and Value-Based Purchasing Programs; and
- Potential future use of the Adult Community-Onset Sepsis Standardized Mortality Ratio measure in the Hospital Inpatient Quality Reporting Program.

PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR). In the rule, CMS proposed to adopt two measures beginning with the CY 2028 reporting period/FY 2030 program year:

- The Advance Care Planning electronic clinical quality measure (eCQM)
- Malnutrition Care Score eCQM.

CMS proposed to remove the COVID-19 Vaccination Coverage among Healthcare Personnel measure beginning with the CY 2026 reporting period/FY 2028 program year. CMS estimated that the proposed changes would reduce hospitals' information collect burden by between 88 and 99 hours, saving between \$4,975 and \$5,801 for the FY 2028 payment determination or subsequent years.

Medicare Promoting Interoperability Program. In the rule, CMS proposed to adopt three new measures:

- The Advance Care Planning eCQM beginning with the CY 2028 reporting period;
- The Hospital Harm-Postoperative Venous Thromboembolism (VTE) eCQM beginning with the CY 2028 reporting period;
- The Unique Device Identifiers for Implantable Medical Devices measure beginning with the EHR reporting period in CY 2027.

CMS also proposed to remove two attestations and five measures:

- The Office of the National Coordinator for Health Information Technology (ONC) Direct Review Attestation beginning with the EHR reporting period in CY 2026;
- The optional ONC-Authorized Certification Body (ONC-ACB) Surveillance Attestation beginning with the EHR reporting period in CY 2026;
- The Support Electronic Referral Loops by Sending Health Information measure beginning with the EHR reporting period in CY 2028;
- The Support Electronic Referral Loops by Receiving and Reconciling Health Information measure beginning with the EHR reporting period in CY 2028;
- The Venous Thromboembolism Prophylaxis (VTE) Prophylaxis eCQM beginning with the CY 2028 reporting period;
- The Intensive Care Unit VTE Prophylaxis eCQM beginning with the CY 2028 reporting period; and
- The Discharged on Antithrombotic Therapy eCQM beginning with the CY 2028 reporting period.

CMS also proposed updates to the ONC certification criteria and making the measure an optional bonus measure for the EHR reporting period in CY 2027. The measure would be required in for the CY 2028 reporting period. CMS also proposed modifications to the reporting and submission requirements for the Malnutrition Care Score eCQM and the Hospital Harm eCQMs beginning with the CY 2028 reporting period.

CMS estimated that the proposed changes would add an additional 3,886 hours and \$213,962 to the total information collection burden for the EHR reporting period in CY 2026 and subsequent years.

The Transforming Episode Accountability Model (TEAM). CMS, in the rule, proposed several updates to the TEAMs model, which is a mandatory, 5-year alternative payment model that began in January 1, 2026. CMS proposed updates that would modify policies affecting episode category triggers, quality measure assessment and the construction of target prices. For example, CMS proposed:

- Adding X Medicare Severity Diagnosis Related Groups (MS-DRGs) that would initiate a spinal fusion anchor hospitalization;
- Clarifying quality measure performance periods for certain quality measures;
- Using a rolling historical Composite Quality Score (CQS) baseline period for certain quality measures;
- Adding an Ambulatory Payment Classification (APC) and MS-DRG update factor to target prices;
- Using the full baseline period to construct the prospective normalization factor.

CMS also included two requests for information on ambulatory surgical center episodes and potential voluntary participation of physician owned hospitals in future years of the model.

CJX model. CMS in the rule also proposed a new model that builds on the Comprehensive Care for Joint Replacement Model. The new Comprehensive Care for Joint Replacement CJR Expanded (CJR-X) Model would expand the program nationally in FY 2028. The model would be mandatory for all acute care hospitals, except those participating in TEAM or those located in Maryland.

While the model would still focus on improving post-surgical care for Medicare patients undergoing hip, knee and ankle replacements in both inpatient and outpatient hospital settings, CMS proposes some updates to quality

measures and payment methodology policies. CMS estimates that the proposed CJR-X model would result in \$725 million in Medicare savings across 5 performance years.

If you have questions, please contact [Heather Meade](#) or [Heather Bell](#).

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