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FY 2027 Hospital IPPS & LTCH Proposed Rule: Key Provisions and Implications

The recently issued proposed rule introduces updates to inpatient payment rates, quality programs, graduate medical education, and alternative payment models. The rule reflects continued movement toward prospective payment refinement, quality-based reimbursement, and episode-based accountability.

Key Takeaways

- 2.4% payment rate update for both IPPS and LTCH
- Mandatory participation in Comprehensive Joint Replacement model for acute care hospitals beginning in FY 2028
- Quality measurement continues to evolve
- Rural hospitals face increased financial risk due to expiring programs.

Payment Rate Updates

Generally, hospitals are paid a set rate based on a patient's diagnosis. Acute care hospitals use Medicare Severity Diagnosis-Related Groups (MS-DRGs), while LTCHs utilize Medicare Severity Long-Term Care Diagnosis-Related DRGs (MS-LTC-DRGs) to classify patients upon discharge. The payment rates for MS-DRGs and MS-LTC-DRGs are updated annually to reflect changes in the cost of rendering services to patients, known as the "market basket" adjustment, and other factors.

The fiscal year (FY) 2027 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Proposed Rule reflects a projected **payment rate increase of 2.4%** for acute care hospitals that are meaningful electronic health record users and participants in the Hospital Inpatient Quality Reporting (IQR) Program. This rate reflects a market basket increase of 3.2%, reduced by a .8% productivity adjustment. Overall, CMS estimates that the rate increase, in addition to other changes reflected in the Proposed Rule, will **increase hospital payments by $1.4 billion in FY 2027**. Additional payments for cases involving new technologies are expected to provide another $464 million.

The proposed standard payment rate for LTCHs reflects an **increase of 2.4%** from the FY 2026 rate. This reflects a market basket increase of 3.2%, reduced by a .8% productivity adjustment. Overall, **payments to LTCHs are expected to increase by $55 million**.

Payments to Disproportionate Share Hospitals (DSH) are estimated to be $15.3 billion in FY 2027, an increase of around 4% from estimated FY 2026 amounts.

Two programs that currently provide enhanced payments to rural hospitals are set to expire at the end of 2026. Both the Medicare-Dependent Hospital (MDH) Program and the Low-Volume Hospital (LVH) adjustment will expire on December 31, 2026, without legislative intervention.

Innovation Center Models

Transforming Episode Accountability Model (TEAM)

TEAM is a mandatory model that began on January 1, 2026, and will continue through December 31, 2030. It focuses on five categories: Coronary Artery Bypass Graft Surgery (CABG), Lower Extremity Joint Replacement, Major Bowel Procedure, Surgical Hip/Femur Fracture Treatment, and Spinal Fusion. The proposed rule seeks to make several modifications, including updates to episode triggers, quality measurement, and pricing methodology.

Comprehensive Joint Replacement Expanded (CJR-X) Model

The CJR Model was implemented in 2016 on a limited basis as a mandatory test of quality and spending accountability related to hip and knee replacements. CMS is proposing to expand the program nationwide to all eligible acute care hospitals. (Notably, hospitals participating in TEAM would be exempt from participation in CJR-X until the end of the TEAM test period.) Critical Access Hospitals, Rural Emergency Hospitals, and certain other facilities not paid under IPPS would be exempt. Ambulatory Surgery Centers (ASCs) are also excluded, although CMS is seeking feedback on whether they should be included in the future. CMS estimates this model will generate $725 million in Medicare savings over a five-year period.

The first performance year of the CJR-X model is proposed to be October 1, 2027, through September 30, 2028. While TEAM tests 30-day episodes of care, CJR-X would test 90-day episodes. CJR-X would generally include patients who have Medicare as their primary provider but are not enrolled in any managed care plan, such as Medicare Advantage. CJR-X participants must provide written notice to Medicare beneficiaries of their inclusion in the model, although patients do not have the option to opt out. The notification should identify any CJR-X collaborator – any provider, supplier, or other entity that is a financial partner of the hospital for purposes of participation in CJR-X. Participants must also ensure that each collaborator provides written notice to beneficiaries describing the basic quality and payment incentives under the model.

The CJR-X model would include inpatient hip, knee, and ankle replacement procedures paid through the IPPS under select Medicare Severity Diagnosis Related Groups (MS-DRG 469, 470, 521, or 522) and outpatient hip and knee replacement procedures billed under select Healthcare Common Procedure Coding System codes (HCPCS 27130 or 27447) through the outpatient prospective payment system (OPPS). The model would include all services provided during the 90-day period beginning with the date of procedure (outpatient) or admission (inpatient), including but not limited to:

- Physician services
- Hospital services (inpatient, outpatient, and long-term care)
- Inpatient rehabilitation facility services
- Inpatient psychiatric facility services
- Skilled nursing facility services
- Home health services
- Outpatient therapy services
- Clinical laboratory services
- Durable medical equipment (DME)
- Part B drugs and biologics

Proposed quality measures focus on patient safety, patient experience, and health outcomes and are intended to incentivize hospitals to better coordinate care across various care settings. The measures largely mirror those used in the CJR test model. However, two additional measures are proposed due to the high percentage of outpatient procedures. Quality measure results would be publicly displayed on the CMS website.

The proposed rule also addresses financial arrangements between CJR-X participants and collaborators.

Specifically, CMS is proposing that certain "sharing arrangements" would fall under the Federal anti-kickback statute safe harbor for CMS-sponsored model arrangements if they meet established criteria. Such gainsharing arrangements must be in writing, signed by the parties, and entered into before care is furnished. Further, participation must be voluntary.

Quality Reporting and Value-Based Programs

Hospital Inpatient Quality Reporting (IQR) Program

The Proposed Rule includes several changes to the Hospital IQR program, which hospitals must participate in to receive the full IPPS rates. The proposal includes three new measures, as well as modifications of several current measures and removal of others. The proposed changes are as follows:

- ***New Measures*:**
  - **Excess Days in Acute Care After Hospitalization for Diabetes** (beginning with FY 2029 payment determination)
  - **Hospital Harm-Postoperative Venous Thromboembolism electronic clinical quality measure (eCQM)** (beginning with FY 2030 payment determination)
  - **Advance Care Planning eCQM (**beginning with FY 2030 payment determination)
- ***Modified* Mortality Measures:** Modifications include adding Medicare Advantage (MA) patients and reducing the measurement period from three years to two. The modified measures would be implemented beginning with the FY 2028 payment determination and relate to mortality measures following hospitalization for the following conditions:
  - Acute Myocardial Infarction (AMI)
  - Heart Failure
  - Pneumonia
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Coronary Artery Bypass Graft (CABG)
- ***Modified* Utilization Measures:** Modifications include adding MA patients and shortening the measurement period from three years to two. The modified measures would be implemented beginning with the FY 2028 payment determination and relate to excess days in acute care following hospitalization for the following conditions:
  - AMI
  - Heart Failure
  - Pneumonia
- ***Removal* of Measures:** Beginning with the FY 2030 payment determination, the following measures would be removed:
  - Venous Thromboembolism Prophylaxis (VTE-1)
  - Intensive Care Unit Venous Thromboembolism Prophylaxis (VTE-2)
  - Discharged on Antithrombotic Therapy (STK-02)

Hospital Readmission Reduction Program

The proposed rule would add a measure relating to 30-day readmissions following sepsis hospitalization, with an initial measurement period from July 1, 2025, to June 30, 2027, for the FY 2029 program year.

Key Implications for Hospitals

Several hospital industry groups expressed concern over the proposed rule. The American Hospital Association (AHA) described the payment update as "inadequate." Further, "AHA and its members support

continued innovation in Medicare payment models that align incentives, promote coordinated care, and reward prevention and wellness." However, AHA disagreed with the proposal for mandatory participation in value-based models, noting "significant challenges, particularly for hospitals that lack the scale or financial capacity to make the necessary investments in care redesign." The Federation of American Hospitals (FAH) noted that the proposed payment update "does not negate the compounding effect of rising inflation, record levels of uncompensated care and a growing uninsured population." FAH also expressed concern regarding the use of mandatory models, stating that this "further destabilizes the system by interfering with clinical decision-making, failing to reflect how care is delivered across providers, and limiting providers' ability to determine the best course of care for each patient."

Hospitals are also facing uncertainty from broader economic and legislative factors. The "One Big Beautiful Bill Act" (OBBA) enacted in 2025 is expected to reduce federal Medicaid spending by more than $900 billion over a ten-year period. The reductions stem from restrictions on state-directed payments and provider taxes, as well as implementation of work requirements for Medicaid eligibility. Additionally, the expiration of enhanced Affordable Care Act premium tax credits at the end of 2025 is expected to drastically increase the uninsured population, which will increase uncompensated care for hospitals. The shift of more procedures – many of which have historically been high-margin services – to outpatient settings is already drastically impacting hospitals. This will only increase with the three-year phase-out of the Inpatient Only List (IPO) introduced in the Calendar Year 2026 Outpatient Prospective Payment System and Ambulatory Surgery Center (ASC) Payment System Final Rule. In 2026 alone, close to 300 services were removed from the IPO and almost 550 procedures were added to the ASC Covered Procedures List. "Site neutrality," where Medicare payment for certain services would be consistent regardless of where the service is performed, is another concept that continues to gain traction.

Resources:

- **CMS Resources:**
  - Fact Sheet: *FY 2027 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Proposed Rule — CMS-1849-P* (April 10, 2026)
  - Proposed Rule: *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; Correction* (April 14, 2026.)
- American Hospital Association. (April 10, 2026.) *"Policies Must Keep Pace with the Real Cost of Delivering Care" – FAH Statement on IPPS/LTCH Proposed Rule.* https://www.aha.org/press-releases/2026-04-10-aha-statement-fy-2027-proposed-ipps-ltch-payment-rule
- Federation of American Hospitals. (April 10, 2026.) *CMS Releases 2024 Final Payment Rule.* https://fah.org/blog/policies-must-keep-pace-with-the-real-cost-of-delivering-care-fah-statement-on-ipps-ltch-proposed-rule/

For a brief recap of key provisions, click here.