CAPITOL STREET

April 12, 2026

Hospital Inpatient Pay Proposal +1.0% In 2027

Uncompensated Care Cuts, Wage Index & Outlier Reset Pull Net Pay Down

Relevant Companies

Our Take & Next Up

For profit hospitals would see pay +1.0% in 2027 if the Medicare Inpatient (IPPS) proposal is finalized. The Centers for Medicare and Medicaid Services (CMS) released the draft FY 2027 hospital inpatient rule (IPPS) and long-term acute care hospital (LTCH) payment rules (here). Overall payment changes for all inpatient hospitals are projected at +1.2%, with urban hospitals at +1.2% and rural hospitals at +0.8%. Other policies are described below. New rates start Oct 1, 2026, the start of FY27. We could see modest improvement to the overall update in the final rule, due on or around August 1.

Key Points

Overall payment for all inpatient hospitals is projected to be +1.2%, lower than recent post acute proposals issued over the last week (e.g., IRF, SNF, Hospice, Psych).

- Rural hospitals will see a lower update (+0.8%) than urban facilities (+1.2%) under the CMS proposal.
- This reflects a 2.4% percentage increase, comprising a projected 3.2% MB increase reduced by a 0.8% productivity adjustment.
- Wage index changes and outlier payment corrections are -0.5%, respectively.
- There are other offsets including uncompensated care payment changes (-0.3%), MS-DRG (Medicare Severity Diagnosis Related Group) relative weight changes, and the expiration of the Medicare Dependent Hospital (MDH) program.
- CMS overall payments to inpatient hospitals are projected to increase by $1.9 B in FY 2027.

Additional policies pull down the overall payment update: Disproportionate share hospital (DSH), uncompensated care (UC) at -0.3% and wage index at -0.5%. DSH payments are federal supplemental payments made to hospitals that serve a disproportionately high share of low-income/uninsured patients, and UC payments stem from DSH funding, intended to offset the costs hospitals incur when providing care for which they receive little or no reimbursement. CMS projects that UC and supplemental payments to DSH eligible hospitals will decline from approximately $7.8 B in FY 2026 to $7.6 B in FY 2027, a decrease of about $258 M, or 3.3%.

Proprietary hospitals are hit hardest by DSH and UC cuts, projected to experience an average -5.6% decrease in payments per case in FY 2027. This cut falls unevenly: proprietary hospitals are projected to see a -5.6% change in DSH/UC and supplemental payments, compared to -3.7% for voluntary (nonprofit) hospitals and -1.4% for government hospitals. This is a driver of the for-profit shortfall relative to other ownership types.

Outlier payment corrections (-0.5%) are a driver of the FY 2027 net payment decrease. Medicare sets a target for how much it pays hospitals for unusually expensive cases ("outlier" cases), and that target is roughly 5% of total hospital payments. CMS's modeling suggests hospitals got paid more than the target in FY 2026, with outlier payments reaching approximately 6.0% of total payments, about 0.9 percentage points above the 5.1% target. Therefore in FY 2027, CMS is dialing payments back down to the target. CMS states: "overall, hospitals will experience a 0.7% decrease in payments... primarily due to this -0.9% point correction, in combination with various add-on payment factors." That correction is contributing to the estimated payment decrease across all inpatient hospitals, and it is worth noting it may be partially illusory. If actual FY 2026 outlier payments come in lower than CMS's simulation model estimated, the FY 2027 decrease would be smaller than projected.

CMS introduces the Comprehensive Care for Joint Replacement Expanded (CJR-X) model, **building on the CJR model that ended in December 2024.** The model holds hospitals financially accountable for the cost and quality of care for Medicare patients undergoing lower extremity joint replacements (LEJR) across a 90-day episode spanning surgery through recovery. By aligning incentives for coordination across providers and post-acute care, the model aims to reduce complications and unnecessary spending while improving outcomes. The existing CJR model, currently operating in select markets, would be expanded nationwide, becoming mandatory for all acute care IPPS hospitals except TEAM participants and Maryland hospitals, starting October 1, 2027. CMS estimates $725M in Medicare savings over the first 5 performance years, with no specified end date.

CMS proposes changes to Transforming Episode Accountability Model (TEAM) and seeks comment on two RFIs. TEAM, which began January 1, 2026, creates financial accountability for Medicare beneficiaries undergoing five high-expenditure surgical procedures. Proposed changes include: adding MS-DRGs to trigger spinal fusion episodes; updating quality measure performance periods; revising target price construction; and updating normalization factors. CMS is also soliciting feedback on including ASC episodes and voluntary participation by physician-owned hospitals in future model years.

HEALTH IT

CMS is seeking feedback on the future structure of electronic prior authorization, **as the agency delays implementation and considers moving toward a performance-based measure, with potential inclusion of drugs.** The requirement, previously finalized as mandatory starting CY 2027, is now proposed as optional with bonus points in 2027 and mandatory in 2028. The policy reinforces FHIR-based standards and CMS is soliciting feedback on evolving this into a performance-based measure and whether to expand it to include drugs.

CMS is pivoting away from C-CDA (consolidated clinical document architecture)-based document exchange toward FHIR-based network-driven interoperability. The agency is proposing to retire the long-standing referral loop measures and replace them beginning in 2028 with measures focused on participation in broader exchange frameworks. The shift is intended to move hospitals from point-to-point document exchange to more scalable, interoperable networks, aligning policy with current adoption trends.

Separately, CMS also recently released a proposed rule on modernizing prior authorization for drugs by setting faster decision timelines, expanding FHIR-based electronic workflows, and increasing transparency. These efforts build on a broader federal digital health pledge announced last year by the Trump Administration and CMS to expand a national digital health ecosystem in partnership with companies like Epic, Oracle, Google, and OpenAI (our take here).

Other changes can be found below:

- **Low wage index hospital policy discontinuation:** CMS is winding down the low wage index hospital policy and proposing a narrow transitional exception for FY 2027 to cushion hospitals significantly impacted by its elimination, a structural change to how the wage index operates going forward.
- **Organ procurement payment reforms:** CMS is proposing new payment and oversight infrastructure for IOPOs and histocompatibility labs, including requiring Medicare Administrative Contractors to establish and publish standard acquisition charges for non-renal organ procurement, and codifying longstanding reasonable cost reimbursement policies.
- **Nutrition & MAHA: CMS is proposing to make the Malnutrition Care Score eCQM mandatory.** This would start with the CY 2028 reporting period / FY 2030 payment determination for the Hospital IQR Program, with parallel adoption in the PPS-Exempt Cancer Hospital Quality Reporting Program. The measure evaluates whether adult inpatients receive appropriate malnutrition screening, assessment, diagnosis, and nutrition care planning based on risk and severity. This is a proposal reflecting the administration's stated priority focus on wellness topics.

Ipsita Smolinski
Managing Director I Capitol Street
ipsita@capitol-street.com

202.250.3741 I www.capitol-street.com

900 19th St NW 6th Fl
Washington, D.C. 20006

CAPITOL STREET
