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Jessica L. Bailey-Wheaton, Esq., Editor
Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, Publisher

CMS Releases FY 2027 IPPS Proposed Rule

On April 10, 2026, the Centers for Medicare & Medicaid Services (CMS) issued the proposed Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) rule for fiscal year (FY) 2027.[1] Perhaps more important than the 2.4% proposed payment update is CMS's announcement of the first mandatory nationwide episode-based payment model in Traditional Medicare, a revived and expanded version of the Comprehensive Care for Joint Replacement (CJR) demonstration. This Health Capital Topics article summarizes the key payment and delivery-reform provisions of the proposed rule.

Proposed Payment Rates

For hospitals that participate in the Hospital Inpatient Quality Reporting (IQR) program and are meaningful users of electronic health records (EHRs), CMS proposes a 2.4% net increase in operating payment rates, reflecting a 3.2% market basket update reduced by a 0.8 percentage point productivity adjustment.[2] CMS estimates that the proposed rule would increase total hospital payments by approximately $1.4 billion in FY 2027 relative to FY 2026.[3] Before accounting for the separate disproportionate share hospital (DSH) and technology add-on policies, the underlying base-rate expansion is estimated to be $1.9 billion.[4]

LTCHs would receive an identical 2.4% standard rate update, and CMS proposes to freeze the LTCH outlier threshold (the dollar amount above which a case qualifies for additional Medicare payment to cover extraordinarily high costs) at the FY 2026 value of $78,936.[5] After layering in reductions to uncompensated care and outlier payments, market analysts estimate the effective update falls closer to 1.2%.[6] The proposed update is 0.2 percentage points below the 2.6% final update CMS adopted for FY 2026, despite CMS projections that the national uninsured rate will rise from an estimated 8.7% in 2026 to 9.1% in 2027.[7]

Disproportionate Share and New Technology Payments

CMS proposes to decrease combined DSH and uncompensated care payments by approximately $564 million in FY 2027, a reversal of the roughly $2 billion DSH increase finalized for FY 2026.[8] In a statement responding to the proposal, Ashley Thompson, senior vice president for public policy analysis and development at the American Hospital Association (AHA), characterized the rule as "another inadequate update to inpatient payment rates, another extremely high productivity cut, and reductions to disproportionate share payments – in the face of rising need for care and higher uninsured rates."[9] Charlene MacDonald, president and CEO of the Federation of American Hospitals, similarly described the update as "a step in the right direction," while stating it "does not negate the compounding effects of rising inflation, record levels of uncompensated care and a growing uninsured population."[10]

Partially offsetting the DSH reduction, CMS proposes to increase new medical technology add-on payments (NTAPs) by approximately $464 million in FY 2027.[11] Additionally, if Congress extends the Medicare-Dependent Hospital (MDH) program and the low-volume hospital adjustment beyond their current expiration at the end of calendar year 2026, CMS estimates affected hospitals would receive approximately $400 million in additional payments.[12]

CJR-X: A Mandatory Nationwide Bundle

The most consequential provision of the proposed rule is the revival and expansion of the CJR Model, which operated as a bundled-payment demonstration from April 2016 through December 2024.[13] CMS proposes to launch the successor "CJR-X" model on October 1, 2027, as a mandatory episode-based payment model covering lower-extremity joint replacement procedures, including hip, knee, and total ankle replacements performed in both inpatient and hospital outpatient settings.[14] Participating hospitals would be held accountable for Medicare spending and quality of care for an episode that begins with the anchor procedure and extends 90 days post-discharge, covering post-acute services such as skilled nursing, home health, and physician follow-up. Under a "quality first" design, hospitals would have to meet a minimum composite quality score before receiving any reconciliation payment.[15]

Unlike the original CJR demonstration, which operated in selected metropolitan statistical areas, CJR-X would apply to most IPPS hospitals across the U.S., with exemptions for hospitals participating in the Transforming Episode Accountability Model (TEAM), hospitals located in Maryland under that state's all-payer hospital rate-setting waiver, and hospitals not paid under either IPPS or the Outpatient Prospective Payment System (OPPS).[16] In response to stakeholder feedback

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that the original CJR disadvantaged safety-net hospitals, CJR-X would apply an updated risk-adjustment methodology with 29 adjusters (over the three adjusters used in the original CJR) and a 5% stop-loss cap on downside risk for hospitals with higher proportions of dual-eligible beneficiaries and for rural and sole community hospitals.[17] CMS cites the original CJR Model's generation of approximately $112.7 million in net Medicare savings during the 2021 through 2023 evaluation period as the basis for expanding the approach nationwide.[18]

The AHA indicated support for continued innovation in Medicare payment models but believes "mandatory participation presents significant challenges, particularly for hospitals that lack the scale or financial capacity to make the necessary investments in care redesign," and urged a "phased or voluntary approach."[19] Separately, market analysts have flagged the "ratchet effect," in which hospital target prices are periodically reset based on prior performance, as a design question that could erode savings potential over the life of the model.[20]

Other Provisions

The proposed rule also includes several additional policy changes. CMS proposes to modify TEAM, a separate mandatory episode-based payment model that began on January 1, 2026, by refining episode category triggers, quality measure assessment, and target pricing methodology. The agency also requests information on potential future rulemaking addressing ambulatory surgical center episodes and voluntary participation of physician-owned hospitals. Separately, the proposed rule addresses non-renal organ acquisition cost reconciliation policies for Independent Organ Procurement Organizations and Histocompatibility Laboratories and clarifies overhead cost allocation rules across provider types.[21]

Conclusion

The FY 2027 IPPS proposed rule continues a trajectory in which incremental rate adjustments are paired with broader structural reforms to Medicare payment. The mandatory scope of the proposed CJR-X model, arriving during TEAM's first performance year, reflects a continued federal preference for alternative payment models as a lever to moderate the growth of Traditional Medicare hospital spending. Public comments on the proposed rule are due to CMS by June 9, 2026, and a final rule is typically issued during the summer.

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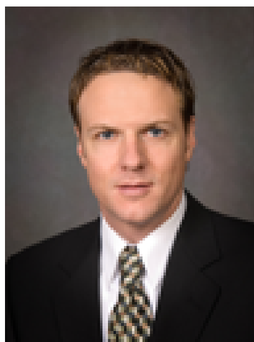
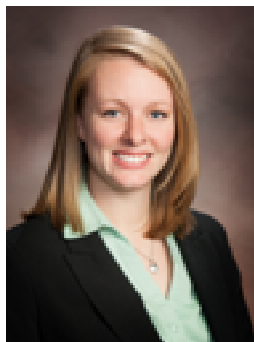


Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 30 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,500 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of "*The Adviser's Guide to Healthcare - 2nd Edition*" [AICPA - 2015], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Guide to Valuing Physician Compensation and Healthcare Service Arrangements* (BVR/AHLA); *The Accountant's Business Manual* (AICPA); V*aluing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies; Business Appraisal Practice*; and, *NACVA QuickRead*. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); the National Association of Certified Valuators and Analysts (NACVA); the American Health Lawyers Association (AHLA); the American Bar Association (ABA); the Association of International Certified Professional Accountants (AICPA); the Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute. He also serves on the Editorial Board of The Value Examiner and QuickRead, both of which are published by NACVA.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Certified Valuation Analyst (CVA) designation from NACVA. Mr. Zigrang also holds the Accredited in Business Valuation (ABV) designation from AICPA, and the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter. He is also a member of the America Association of Provider Compensation Professionals (AAPCP), AHLA, AICPA, NACVA, NSCHBC, and, the Society of OMS Administrators (SOMSA).



Jessica L. Bailey-Wheaton, Esq., is Senior Vice President and General Counsel of HCC. Her work focuses on the areas of Certificate of Need (CON) preparation and consulting, as well as project management and consulting services related to the impact of both federal and state regulations on healthcare transactions. In that role, Ms. Bailey-Wheaton provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services.

Additionally, Ms. Bailey-Wheaton heads HCC's CON and regulatory consulting service line. In this role, she prepares CON applications, including providing services such as: health planning; researching, developing, documenting, and reporting the market utilization demand and "need" for the proposed services in the subject market service area(s); researching and assisting legal counsel in meeting regulatory requirements relating to licensing and CON application development; and, providing any requested support services required in litigation challenging rules or decisions promulgated by a state agency. Ms. Bailey-Wheaton has also been engaged by both state government agencies and CON applicants to conduct an independent review of one or more CON applications and provide opinions on a variety of areas related to healthcare planning. She has been certified as an expert in healthcare planning in the State of Alabama.

Ms. Bailey-Wheaton is the co-author of numerous peer-reviewed and industry articles in publications such as: The Health Lawyer (American Bar Association); Physician Leadership Journal (American Association for Physician Leadership); The Journal of Vascular Surgery; St. Louis Metropolitan Medicine; Chicago Medicine; The Value Examiner (NACVA); and QuickRead (NACVA). She has previously presented before the American Bar Association (ABA), the American Health Law Association (AHLA), the National Association of Certified Valuators & Analysts (NACVA), the National Society of Certified Healthcare Business Consultants (NSCHBC), and the American College of Surgeons (ACS).

Janvi R. Shah, MBA, MSF, CVA, serves as Senior Financial Analyst of HCC. Mrs. Shah holds a M.S. in Finance from Washington University Saint Louis and the Certified Valuation Analyst (CVA) designation from NACVA. She develops fair market value and commercial reasonableness opinions related to healthcare enterprises, assets, and services. In addition she prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services and applies utilization demand and reimbursement trends to project professional medical revenue streams and ancillary services and technical component (ASTC) revenue streams.

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