

On Aug. 4, the Centers for Medicare & Medicaid Services (CMS) published its fiscal year (FY) 2027 Medicare Inpatient Prospective Payment System (IPPS) final rule. Considering all policy changes, we estimate a final IPPS rate increase of 6.3% relative to FY 2026 for Illinois hospitals. CMS also finalized several policies that will impact hospital reimbursement and operations. This fact sheet outlines ten policies we want IHA members to be aware of.

1. FY 2027 IPPS Wage Index for Illinois: Illinois IPPS hospitals will once again default to the rural floor wage index factor. The final FY 2027 IPPS wage index factor is 1.1719, up from 1.0815 in FY 2026.
2. Expanded CJR Model: CMS finalized the national expansion of its Comprehensive Joint Replacement Model (CJR-X). Participants are acute care hospitals located in any of the 50 United States, District of Columbia, or U.S. Territories that initiates lower extremity joint replacement episodes and is paid under both the IPPS and Outpatient Prospective Payment System (OPPS). Hospitals participating in Transforming Episode Accountability Model (TEAM) are excluded until TEAM ends on Dec. 31, 2030.
3. Change to Off-Campus Provider-Based Departments Definition: CMS made a targeted change to the "same patient population" location criteria. It will limit the referral-based 75% test to outpatient departments only, because the agency believes using a referral relationship to justify distant inpatient sites could create payment advantages that it believes are not warranted. Inpatient facilities seeking provider-based status will still be able to use the alternative "zip-code overlap test," but they will no longer be allowed to use the referral-based test to meet the location requirement.
4. FY 2027 Outlier Fixed-Loss Cost Threshold: CMS finalized an outlier fixed-loss cost threshold of \$49,346 (proposed at \$51,704). This threshold is 23.1% higher than the FY 2026 outlier threshold of \$40,397.
5. Disproportionate Share Hospital (DSH): CMS finalized a \$228 billion increase in DSH and uncompensated care payments. CMS estimates that the percentage of uninsured for FY 2027 will be 9.4%, an increase from the FY 2026 rate of 8.7%.
6. Hospital Readmissions Reduction Program: CMS currently uses six Medicare claims-based readmission measures to assess performance in the program: heart failure, pneumonia, acute myocardial infarction, chronic obstructive pulmonary disease, coronary artery bypass graft procedures and elective total hip/total knee arthroscopy. Beginning with the FY 2030 program year, CMS will also adopt the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization measure.
7. TEAM RFIs: CMS issued two requests for information (RFI) that would potentially expand TEAM. First, CMS solicited feedback on the inclusion of ambulatory surgical center episodes in TEAM, beginning in calendar year 2028 for performance year three at the earliest, since procedures in ambulatory surgery centers would need to be incorporated into TEAM differently than those performed in the outpatient setting. CMS also issued an RFI specific to physician-owned hospitals. Specifically, CMS is considering allowing physician-owned hospitals that are in core-based statistical areas not selected for mandatory TEAM participation to voluntarily opt-in to the model.
8. New and Deleted Medicare Severity Diagnosis Related Groups (MS-DRGs) for FY 2027: CMS created 14 new MS-DRGs and deleted 18 MS-DRGs. These changes are within MDC 05 (Diseases and Disorders of the Circulatory System), MDC 08 (Musculoskeletal System and Connective Tissue) and MDC 13 (Female Reproductive System).
9. New Technology Add-on Payments (NTAP): CMS finalized NTAP policies with modifications to grandfather eligibility for a limited period. Beginning with applications received for NTAPs for FY 2028 and subsequent fiscal years, all applicants will need to demonstrate that the technology meets all three of the current criteria. CMS will allow limited exceptions such that the following technologies remain eligible to apply for NTAP under the alternative pathway through FY 2029: (1) A new medical device that is part of the FDA's Breakthrough Devices Program, has received Breakthrough Device designation as of Sept. 30, 2026, and has received marketing authorization as a Breakthrough Device for the indication covered by the designation by May 1, 2028; (2) A new medical product designated by the FDA as a Qualified Infectious Disease Product as of Sept. 30, 2026, and has received marketing authorization for the indication covered by the designation by May 1, 2028; and (3) A new medical product approved under the FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs and used for the indication approved under the pathway by May 1, 2028.

10. Modifications for the Criteria for New Residency Programs: CMS will no longer consider the previous employment of the faculty or program director to determine whether the program director is new for cap building purposes. In addition, at least 90% of the individual resident trainees (not Full-Time Equivalents) must not have previous training in the same specialty as the new program. It will exclude from this count trainees with previous experience training in another program in the same specialty who enter the new program as first-year residents. It will also exclude displaced residents from the count of the requirement. CMS will also create an exception to the 90% requirement for small residency programs, defined as one accredited for 16 or fewer positions, regardless of whether the program is in an urban or rural area. Based on stakeholder feedback, all these policies will be effective for programs still within their five-year cap-building period as of Oct. 1, 2026, or for programs that begin on or after Oct. 1, 2026.

FY 2027 IPPS facility-specific estimated financial impact reports are available in the [IHA C-Suite](#).

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