Inpatient & Long-Term Care Hospital Prospective Payment Systems: FY 2027 Changes

Related Change Request (CR) Information	
Number: 14592	**Release Date:** September 11, 2026
Effective Date: October 1, 2026	**Implementation Date:** October 5, 2026
Transmittal Number: R13930CP	
Title: Fiscal Year (FY) 2027 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes	

Affected Providers

- Hospitals
- Long-term care hospitals (LTCHs)

Action Needed

Make sure your billing staff knows about these FY 2027 updates:

- Inpatient Prospective Payment System (IPPS)
- LTCH Prospective Payment System (PPS)
- Certain hospitals that CMS excludes from the IPPS

Key Updates

IPPS FY 2027 Update

FY 2027 IPPS Rates & Factors

Refer to Tables 1A–1D of the FY 2027 IPPS and LTCH PPS final rule for the operating standardized amounts and the federal capital rate.

Refer to the Medicare Administrative Contractor (MAC) implementation file 1 for other IPPS factors, including:

- Applicable percentage increase
- Budget neutrality factors
- High-cost outlier threshold
- Cost-of-living adjustment (COLA) factors

Medicare Severity Diagnosis-Related Group Grouper & Medicare Code Editor Changes

The Medicare Severity Diagnosis-Related Group (MS-DRG) Grouper assigns each case to an MS-DRG based on reported diagnosis and procedure codes and demographic information, such as age, sex, and discharge status. The ICD-10 Medicare Code Editor Version 44.0 validates ICD-10 codes you report on claims for discharges on or after October 1, 2026.

For FY 2027, we deleted 18 MS-DRGs and finalized 14 new MS-DRGs, decreasing the total number of MS-DRGs by 4 to 768. Refer to MAC implementation file 6 for the complete FY 2027 MS-DRG list. Also, refer to MS-DRG Classifications and Software for the ICD-10 MS-DRG V44.0 Definitions Manual Table of Contents and the Definitions of Medicare Code Limits V44 manual for complete Grouper logic documentation.

Replaced Devices Offered Without Cost or With a Credit

For specified MS-DRGs, we reduce a hospital's IPPS payment when the hospital replaces an implanted device without cost or with a credit equal to 50% or more of the cost of the replacement device. We add new MS-DRGs to the list when they're formed from procedures previously assigned to MS-DRGs already on the list. Refer to MAC implementation file 7 for the complete FY 2027 list of MS-DRGs covered under the replaced devices offered without cost or with a credit.

Post-Acute Transfer & Special Payment Policy

We evaluated changes to MS-DRGs for FY 2027 against the general post-acute care transfer policy criteria using the FY 2025 Medicare Provider Analysis and Review data per regulations under 42 CFR 412.4(c).

As a result, we're adding MS-DRGs 210, 211, 361, 362, 400, 403, 404, 456, 457, 458, 523, 524, and 525 to the list of MS-DRGs subject to the post-acute care policy. We're also adding MS-DRGs 361, 362, 400, 403, 404, 456, 457, 458, 463, 464, 465, 616, 617, and 618 to the list of MS-DRGs with special payment policies.

Refer to Table 5 of the FY 2027 IPPS and LTCH PPS final rule for a list of all post-acute and special post-acute MS-DRGs.

New Technology Add-On Payment Policy

For FY 2027, we're continuing 41 new technology add-on payments, and we approved 19 new technology add-on payments. Refer to MAC implementation file 8 for more information on technologies continuing to get payments, technologies newly approved to get payments, and technologies no longer eligible for new technology add-on payments.

Labor-Related Share Percentage

We're not making any changes to the labor-related share percentages under the IPPS for FY 2027. Refer to MAC implementation file 1 for the FY 2027 labor-related share percentages.

COLA for Hospitals Located in Alaska or Hawaii & Paid Under the IPPS

We updated the COLA factors for FY 2027, effective for discharges occurring on or after October 1, 2026. Refer to the FY 2027 IPPS and LTCH PPS final rule and MAC implementation file 1 to review the changes, which apply to hospitals located in Alaska and Hawaii.

Note: The FY 2027 COLA factors remain unchanged from FY 2026 for certain areas of Hawaii.

Updating the Provider Specific File for Wage Index, Reclassifications, and Redesignations & Wage Index Changes and Issues

MACs update the Provider Specific File (PSF) by following steps found in MAC implementation file 5 and the FY 2027 MAC implementation files instructions to:

- Determine the appropriate wage index and other payments
- Update the PSF to ensure we make appropriate IPPS payments for hospitals with reclassifications and redesignations
- Update the PSF and ensure we properly assign the core-based statistical area (CBSA) for all IPPS providers

For hospitals in rural counties that we deem Lugar counties in Table 4B (counties redesignated under section 1886(d)(8)(B) of the Social Security Act), MACs must verify a hospital's Lugar status and apply it appropriately.

For FY 2027, we're applying a:

- 5% cap on any decrease in a hospital's wage index from the hospital's final wage index in FY 2026
- Transitional exception to the calculation of FY 2027 IPPS payments for low-wage index hospitals significantly impacted by our discontinuation of the low-wage index hospital policy

In CR 11707, we created 2 PSF fields:

- Supplemental wage index field (data element 63)
- Supplemental wage index flag (data element 64)

For FY 2027 for all hospitals eligible for the 5% cap, the supplemental wage index flag must be "1" and the supplemental wage index field must equal the wage index in Table 2 in the column labeled FY 2026 Wage Index to implement the 5% cap policy. The Pricer uses these fields to determine the 5% cap on the decrease in a hospital's wage index, if applicable.

Under the 5% cap policy, new hospitals that opened during FY 2027 aren't eligible. These hospitals will have a blank supplemental wage index flag field, and the supplemental wage index field will be zeros. Refer to MAC implementation file 5 for hospitals not listed in Table 2 (other than new hospitals opened in FY 2027).

We apply the transitional exception policy for FY 2027 to certain hospitals that benefited from the FY 2024 low-wage index hospital policy. For these eligible hospitals, we compare the hospital's FY 2027 wage index to its FY 2024 wage index. If the FY 2027 wage index is decreasing by more than 14.2625% from the hospital's FY 2024 wage index, the transitional payment exception for FY 2027 for that hospital is equal to the additional FY 2027 amount the hospital would be paid under the IPPS if its FY 2027 wage index were equal to 85.7375% (95% for FY 2025 * 95% for FY 2026 * 95% for FY 2027) of its FY 2024 wage index.

MACs will use the FY 2027 MAC Table 2 PSF Guide spreadsheet located with MAC implementation file 5 to identify hospitals eligible for the transitional payment policy. Hospitals eligible for the transition payment policy will have a 1 or 2 in the Special Payment Indicator field.

Medicare-Dependent Hospital Program Expiration

We aren't making special payment provisions for Medicare-dependent hospitals (MDHs) beyond December 31, 2026, consistent with the statue. Starting January 1, 2027, all hospitals that qualified previously for MDH status will lose that status, and we'll pay them solely at the federal rate.

Note: Policy in 42 CFR 412.92(b) allows MDHs to apply for sole community hospital status, and we pay them as such under certain conditions once the MDH program expires.

Starting January 1, 2027, provider types 14 and 15 are no longer valid, and MACs should update the PSF accordingly to reflect the appropriate provider type with an effective date of January 1, 2027.

Multicampus Hospitals

We allocate wages and hours to the CBSA in which a hospital campus is located when a multicampus hospital has campuses located in different CBSAs. We base payment to hospitals on the geographic location where the discharge occurred. Therefore, if a hospital has a campus or campuses in different CBSAs, MACs add a suffix to the hospital's CMS Certification Number (CCN) in the PSF to identify and denote a sub-campus in a different CBSA. This helps ensure we can assign the appropriate wage index associated with each campus's geographic location and helps ensure we can pay for Medicare discharges from each respective campus.

Note: Under certain circumstances, we allow individual campuses to reclassify to another CBSA. In those cases, we note the appropriate reclassified CBSA and wage index in the PSF (refer to MAC implementation file 5). Generally, subordinate campuses are subject to the same rules regarding withdrawals and cancellations of reclassifications as main providers.

Treatment of Hospitals Redesignated Under Section 1886(d)(8)(B) of the Social Security Act (Lugar Hospitals) Other Than for Wage Index Purposes

Regulations at 42 CFR 412.64(b)(3)(ii) implement section 1886(d)(8)(B) of the Social Security Act, which redesignates certain rural counties adjacent to 1 or more urban areas as urban for IPPS payment purposes (Lugar counties). We treat hospitals located in Lugar counties as hospitals located in an urban area, and we determine their IPPS payment under section 1886(d) of the Social Security Act based on the urban area to which they're redesignated. Refer to Table 4B for all Lugar counties in FY 2027.

MACs must consider a hospital's Lugar status and determine payment and hospital status appropriately. MACs must verify whether a hospital is in a Lugar county based on the list in Table 4B and whether a hospital has an urban-to-rural 42 CFR 412.103 reclassification that impacts its status. We consider hospitals in Lugar counties with active reclassifications rural for IPPS payment purposes when those payments depend on urban or rural status. We also consider hospitals that waive Lugar status to get the out-migration adjustment rural for IPPS payment purposes.

Low-Volume Hospitals – Criteria & Payment Adjustments for FY 2027

On December 31, 2026, temporary changes to the low-volume hospital payment adjustment provided by the Affordable Care Act and extended by subsequent legislation will expire. Starting January 1, 2027, the low-volume hospital qualifying criteria and payment methodology will revert to what was in effect before the amendments made by the Affordable Care Act and subsequent legislation. Refer to 42 CFR 412.101 for hospital payment adjustment policy regulations.

For FY 2027, MACs must get written requests for low-volume hospital status from hospitals by September 1, 2026, so MACs can apply the applicable adjustment to payments for FY 2027 hospital discharges from October 1, 2026 – December 31, 2026. Hospitals that qualified for the adjustment in FY 2026 may continue to get it in FY 2027 without reapplying if:

- They have fewer than 3,800 total discharges, including both Medicare and non-Medicare discharges
- Their location is more than 15 road miles from the nearest IPPS hospital

If a MAC gets a hospital's written request after September 1, 2026, but the hospital meets mileage criteria, the MAC will apply the low-volume hospital payment adjustment to determine the payment for the hospital's FY 2027 discharges, effective prospectively within 30 days of the date of the MAC's determination.

Starting January 1, 2027, to qualify for the 25% payment adjustment, a hospital must have fewer than 200 total Medicare and non-Medicare discharges and be located more than 25 road miles from the nearest IPPS hospital, consistent with 42 CFR 412.101(b)(2)(i).

No later than December 1, 2026, MACs must also get a hospital's written request for low-volume hospital status that includes sufficient documentation to establish that the hospital continues to meet the applicable discharge and mileage criteria for the portion of FY 2027 starting January 1, 2027 – September 30, 2027, for us to apply the 25%, low-volume, and add-on payment adjustment for hospital discharges on or after January 1, 2027.

A hospital that doesn't meet either the applicable discharge or mileage criteria isn't eligible to get a low-volume payment adjustment for FY 2027 discharges occurring before December 31, 2026. Similarly, a hospital that doesn't meet either the applicable discharge or mileage criteria isn't eligible to get a low-volume payment adjustment for FY 2027 discharges occurring on or after January 1, 2027.

Medicare Advantage Nursing & Allied Health Education Payments – Rates for CY 2025

Under 42 CFR 413.87, hospitals that operate approved nursing and allied health (NAH) education programs and get Medicare reasonable cost reimbursement for these programs also get additional payments if they treat Medicare Advantage (MA) enrollees. We determine a hospital's NAH MA payment by applying a ratio of the hospital-specific NAH Medicare Part A payments, total inpatient days, and MA inpatient days to the national totals of those same amounts from cost reporting periods ending in the FY that's 2 years before the current CY. The formula is:

(((Hospital NAH pass-through payment / Hospital Part A inpatient days) * Hospital MA inpatient days) / ((National NAH pass-through payment / National Part A inpatient days) * National MA inpatient days)) * Current year payment pool

In the FY 2027 IPPS and LTCH PPS final rule, we published the final national rates and percentages and their data sources for CY 2025. MACs will use these rates to make NAH MA payments and Direct Graduate Medical Education payments to applicable providers for portions of cost reporting occurring in CY 2025.

Hospital Quality Initiative

Refer to the list of hospitals that will get the quality initiative bonus. We add providers to the list if they meet the criteria after we publish it. Refer to MAC implementation file 3 for a list of hospitals that will get the statutory reduction to the annual payment update for FY 2027 under the Hospital Inpatient Quality Reporting Program.

Hospital-Acquired Condition Reduction Program

We expect to issue the final list of hospitals subject to the Hospital-Acquired Condition (HAC) Reduction Program for FY 2027 to MACs in October 2026. MACs will use this list to adjust the HAC Reduction Program indicator field in the PSF with an effective date of October 1, 2026.

Hospital Value-Based Purchasing Program

For FY 2027, we're implementing the base operating MS-DRG payment amount reduction and the value-based incentive payment adjustments as a single value-based incentive payment adjustment factor we apply to claims for discharges occurring in FY 2027. We expect to post the final value-based incentive payment adjustment factors for FY 2027 by mid-October in Table 16B of the FY 2027 IPPS and LTCH PPS final rule.

Note: Until we issue the final values in Table 16B, MACs will enter "N" in the value-based purchasing program field.

Hospital Readmissions Reduction Program

We expect to post the Hospital Readmissions Reduction Program (HRRP) payment adjustment factors for FY 2027 in October 2026 in Table 15 of the FY 2027 IPPS and LTCH PPS final rule. Hospitals not subject to a reduction under the HRRP in FY 2027 have an HRRP payment adjustment factor of 1. For FY 2027, hospitals should only have an HRRP payment adjustment factor between 1 and 0.97. MACs will use this file to adjust the HRRP participant (HRR Indicator) and the HRRP adjustment (HRR Adjustment) fields in the PSF with an effective date of October 1, 2026.

Note: The HRR adjustment field in the PSF refers to the HRRP payment adjustment factor.

Once we update the file in Table 15, MACs will update the HRR indicator and HRR adjustment fields in the PSF based on a hospital's eligibility for the reduction. Until we issue the final values, MACs will enter "0" in the HRR indicator field.

Medicare Disproportionate Share Hospital Program: Uncompensated Care Payments

In the FY 2027 IPPS and LTCH PPS final rule, we finalized a Factor 3 for each Medicare disproportionate share hospital (DSH), which represents its relative share of the total uncompensated care payment amount paid to Medicare DSH hospitals along with a total uncompensated care payment amount. We'll continue to pay interim uncompensated care payments on the claim as an estimated per-claim amount to the hospitals projected to get Medicare DSH payments in FY 2027. Refer to the Medicare DSH supplemental data file for FY 2027 for the estimated per-claim amount and projected DSH eligibility for each subsection (d) hospital and subsection (d) Puerto Rico hospital.

For Indian Health Service (IHS) hospitals, tribal hospitals, and hospitals located in Puerto Rico, the amount in the DSH supplemental data file combines the uncompensated care payment per discharge amount and the supplemental payment per discharge amount. At cost report settlement, we'll reconcile the interim estimated uncompensated care payments paid on a per-claim basis with the total uncompensated care payment amount displayed in the Medicare DSH supplemental data file. We'll also reconcile the interim estimated supplemental payments paid on a per-claim basis at cost report settlement using the total supplemental payment displayed in the Medicare DSH supplemental data file.

Hospitals Without Prospective Factor 3 Calculation (New Hospitals, Uncompensated Care Trim & Newly Merged Hospitals)

For FY 2027, we'll calculate Factor 3 for eligible DSH hospitals using the uncompensated care costs from the hospital's FY 2027 cost report, as reported on Line 30 of Worksheet S-10, (annualized, if needed), as the numerator for hospitals with CCNs established after October 1, 2022. We use a denominator in the Factor 3 descriptions found in the first tab of the FY 2027 IPPS and LTCH PPS final rule's Medicare DSH supplemental data file. We then multiply Factor 3 by a scaling factor and by the total uncompensated care payment amount finalized in the FY 2027 IPPS final rule to determine the total uncompensated care payment if we determine the hospital is DSH eligible at cost report settlement.

MACs will apply a scaling factor for the Factor 3 calculation for new hospitals, newly merged hospitals, and hospitals subject to the uncompensated care data trim if we determine a hospital is DSH eligible at cost report settlement. Find the scaling factor in the first tab (file layout) of the FY 2027 IPPS and LTCH PPS final rule's Medicare DSH Supplemental data file. It's also available in MAC implementation file 1.

MACs can refer to the Medicare DSH supplemental data file to confirm whether to treat a hospital as a new hospital for DSH uncompensated care payment purposes. It's possible we'll add new hospitals during FY 2027, and we wouldn't list those on the Medicare DSH supplemental data file.

In the FY 2027 IPPS and LTCH PPS final rule, we continued an additional uncompensated care data trim for hospitals we didn't project as DSH eligible for interim uncompensated care payments. Like new hospitals, those hospitals impacted by this new trim don't have a Factor 3 listed in the FY 2027 Medicare DSH supplemental file. If we determine the hospital, subject to the data trim, is DSH eligible at cost report settlement, the MAC will calculate a Factor 3 from the hospital's FY 2027 cost report's Worksheet S-10 (line 30), divided by the national uncompensated care cost denominator.

For FY 2027, MACs will reconcile interim uncompensated care payments at cost report settlement for newly merged hospitals and those without a merger before final rule development.

Voluntary Request of Per-Discharge Amount of Interim Uncompensated Care Payments

For FY 2027, we use a 3-year average of the number of hospital discharges to produce an estimate of the amount of uncompensated care payment per discharge. Specifically, we divide the hospital's total uncompensated care payment amount by its 3-year historical average of discharges computed using the most recent available data. This results in a per-discharge payment amount that we use to make interim uncompensated care payments to each projected DSH-eligible hospital. We reconcile the interim uncompensated care payments made during the FY at the end of the cost reporting period to ensure the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the FY.

If a hospital submits a request to its MAC for a lower per-discharge interim uncompensated care payment amount, including a reduction to 0, once before the start of the FY or once during the FY, MACs will review the request. The hospital must provide supporting documentation demonstrating there would likely be a significant recoupment (for example, 10% or more of the hospital's total uncompensated care payment or at least $100,000) at cost report settlement if we don't lower the per-discharge amount. Examples include a request:

- Showing a large projected increase in discharges during the FY to support reducing its per-discharge uncompensated care payment amount
- That we reduce its per-discharge uncompensated care payment amount to 0 midyear if the hospital's interim uncompensated care payments during the year have already surpassed the total uncompensated care payment calculated for the hospital

The MAC will evaluate the hospital's request to reduce the per-discharge uncompensated payment amount and the supporting documentation before the start of the FY or with a midyear request when the 2-year average of the discharges is lower than the hospital's projected FY 2027 discharges. If the MAC agrees there likely would be significant recoupment of the hospital's interim Medicare uncompensated care payments at cost report settlement, the only change we would make would be to lower the per-discharge amount either to the amount requested by the hospital or another amount the MAC determines to be appropriate to reduce the likelihood of a substantial recoupment at cost report settlement.

The hospital's request doesn't change how we reconcile the total uncompensated care payment amount at cost report settlement. We still reconcile the interim uncompensated care payments we make to the hospital during the FY at the end of the year to ensure the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the FY.

Supplemental Payment for IHS Hospitals, Tribal Hospitals & Hospitals Located in Puerto Rico

For IHS hospitals, tribal hospitals, and hospitals located in Puerto Rico, we base interim supplemental payment eligibility on a projection of DSH eligibility for the applicable FY. The DSH supplemental data file includes the combined interim uncompensated care payment and interim supplemental payment.

The MAC makes a final determination about a hospital's supplemental payment eligibility in conjunction with its final determination of the hospital's eligibility for DSH payments and uncompensated care payments for that FY. If we deny a hospital's DSH eligibility for a FY, it won't get a supplemental payment for that FY.

The MAC reconciles the interim supplemental payments at cost report settlement to ensure the DSH-eligible hospital gets the full supplemental payment amount we determined before the start of the FY. Projected DSH-eligible hospitals have a total supplemental payment available in the Medicare DSH supplemental data file.

Consistent with the process used for uncompensated care payments cost reporting periods that span multiple FYs, MACs must make a pro rata supplemental payment calculation if the hospital's cost reporting period differs from the FY. The final supplemental payment amounts included on a cost report spanning 2 FYs are the pro rata share of the supplemental payment associated with each FY. We determine this pro rata share based on the proportion of the applicable FY that's included in that cost reporting period.

Outlier Payments: IPPS Statewide Average Cost-to-Charge Ratios

Tables 8A and 8B contain the FY 2027 statewide average operating and capital cost-to-charge ratios (CCRs) for urban and rural hospitals. Per 42 CFR 412.84(i)(3), for FY 2027, we use statewide average CCRs in these instances:

- New hospitals that haven't yet submitted their first Medicare cost report. For this purpose, we define a new hospital as an entity that hasn't accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR 489.18.
- Hospitals with an operating or capital CCR that's more than 3 standard deviations above the corresponding national geometric mean. We calculate this mean annually and publish it in the annual notice of prospective payment rates in accordance with 42 CFR 412.8(b). Refer to MAC implementation file 1 for operating CCR and capital CCR trim values.
- Hospitals where accurate data we use to calculate an operating or capital CCR (or both) isn't available.

Note: Hospitals and MACs can request an alternative CCR to the statewide average CCR per instructions in the Medicare Claims Processing Manual, Chapter 3, section 20.1.2.1.

We require approval from our Central Office if hospitals want to use an operating or capital CCR of 0 or any other alternative CCR.

Payment Adjustment for Certain Immunotherapy Cases in MS-DRG 018

We adjust the payment amount for certain immunotherapy cases that group to MS-DRG 018. Refer to MAC implementation file 1 for the FY 2027 MS-DRG weighting factor used for these discharges.

Under this policy, we apply a payment adjustment to claims that group to MS-DRG 018 and meet 1 of these criteria:

- The claim includes ICD-10-CM diagnosis code Z00.6
- There's an expanded access use of immunotherapy
- The immunotherapy product isn't purchased in the usual manner, such as obtained at no cost

When you purchase Chimeric Antigen Receptor (CAR) T-cell therapy or other immunotherapy products in the usual manner but the case involves a clinical trial of a different product, we won't apply the payment adjustment in calculating the payment for the case.

In cases where there's expanded access to CAR T-cell therapy or other immunotherapy products, you may submit condition code 90 on the claim so the Pricer will apply the payment adjustment in calculating the payment for the case.

To notify your MAC of a case where the CAR T-cell therapy or another immunotherapy product is purchased in the usual manner but the case involves a clinical trial of a different product (with Z00.6 on the claim), enter a billing note NTE02 "Diff Prod Clin Trial" on the electronic claim 837I or a remark "Diff Prod Clin Trial" on a paper claim. The claims processing system will append payer-only condition code ZC so that the Pricer won't apply the payment adjustment in calculating the payment for the case.

To notify your MAC of a case where you don't purchase the CAR T-cell therapy or other immunotherapy product in the usual manner, such as when suppliers give it to you at no cost, enter billing note "PROD NO COST" on the electronic claim 837I or a remark "PROD NO COST" on a paper or direct data entry claim, and the shared system maintainer will populate condition code ZD so the IPPS Pricer applies the payment adjustment in calculating the payment for the case.

IPPS Add-On Payment for Certain End-Stage Renal Disease Discharges

We provide an additional payment to hospitals for inpatient services they render to certain Medicare patients with end-stage renal disease (ESRD) who get dialysis during a hospital stay. We apply this additional payment when the hospital's ESRD patient discharges are 10% or more of its total Medicare charges. This excludes discharges classified into the MS-DRGs listed at 42 CFR 412.104(a) where the patient got dialysis during the inpatient stay.

Per 42 CFR 412.104, we use the annual CY ESRD PPS base rate multiplied by 3 to calculate the ESRD add-on payment for hospital cost reporting periods that start during the FY for the same year. Specifically, we'll use the CY 2027 ESRD PPS base rate for all cost reports starting during FY 2027. The applicable ESRD base rate applies to cost reporting periods from October 1, 2026 – September 30, 2027.

Refer to MAC implementation file 1 for the applicable ESRD base rate effective for cost reporting periods starting on or after October 1, 2026, which we expect to be available by early November 2026.

LTCH PPS FY 2027 Update

FY 2027 LTCH PPS Rates & Factors

Refer to Table 1E for the FY 2027 LTCH PPS standard federal rates. Refer to MAC implementation file 2 for other FY 2027 LTCH PPS factors.

We updated the LTCH PPS Pricer with the Version 44 MS-LTC-DRG table, weights, and factors effective for discharges occurring on or after October 1, 2026, and on or before September 30, 2027.

Discharge Payment Percentage

We must notify LTCHs of their discharge payment percentage (DPP), which is the ratio (expressed as a percentage) of the LTCH's Fee-for-Service discharges that got LTCH PPS standard federal rate payment to the LTCH's total number of LTCH PPS discharges. MACs will continue providing information to LTCHs about their DPP upon settling cost reports using a form letter to notify LTCHs of their DPP.

Section 1886(m)(6)(C)(ii)(I) of the Social Security Act requires us to inform any LTCH with a DPP below 50% for cost reporting periods on or after October 1, 2019. For all discharges in each successive cost reporting period, we pay the LTCH a payment amount that would apply under subsection (d) for the discharge if the hospital were a subsection (d) hospital, subject to the LTCH's compliance with the reinstatement process provided for by section 1886(m)(6)(C)(iii) of the Social Security Act.

LTCH Quality Reporting Program

Under the LTCH Quality Reporting Program (QRP), we'll continue to reduce the FY 2027 annual update to the standard federal rate by 2 percentage points if an LTCH doesn't submit quality reporting data in accordance with the LTCH QRP for that year.

PSF

Refer to the Medicare Claims Processing Manual, Chapter 3, section 20.2.3.1 and Addendum A for PSF-required fields for all provider types. We'll update the inpatient PSF for each LTCH as needed as well as all applicable fields for LTCHs, effective October 1, 2026, with cost reporting periods that start on or after October 1, 2026, or upon getting an as-filed (tentatively) settled cost report.

LTCH Statewide Average CCRs

Refer to Table 8C for the FY 2027 statewide average LTCH total CCRs for urban and rural LTCHs. Per 42 CFR 412.525(a)(4)(iv)(C) and 412.529(f)(4)(iii), for FY 2027, we use statewide average CCRs in these instances:

- New hospitals that haven't yet submitted their first Medicare cost report. For this purpose, we define a new hospital as any entity that hasn't accepted assignment of an existing hospital's provider agreement per 42 CFR 489.18.
- LTCHs with a total CCR more than the applicable maximum CCR threshold (that is, the LTCH total CCR ceiling, which we calculate at 3 standard deviations from the national geometric average CCR). Refer to MAC implementation file 2 for the LTCH total CCR ceiling.
- Any hospital for which data isn't available to calculate a CCR.

Note: Hospitals and MACs can request an alternative CCR to the statewide average CCR per instructions in the Medicare Claims Processing Manual, Chapter 3, section 150.24.

In addition, our Central Office must approve an LTCH using a total CCR of 0 or any other alternative CCR.

LTCH Wage Index

For FY 2027, we applied a 5% cap to any decrease in an LTCH's wage index from its FY 2026 wage index. Refer to the FY 2027 MAC implementation files for a list of LTCHs where the FY 2027 LTCH PPS wage index decreased by more than 5%, along with their capped FY 2027 LTCH PPS wage index value.

Note: Hospitals newly classified as LTCHs during FY 2027 aren't eligible for the 5% cap.

For FY 2027, we applied a 5% cap to any decrease in an LTCH's applicable IPPS comparable wage index from its FY 2026 applicable IPPS comparable wage index. Refer to the MAC implementation files for a list of LTCHs where the FY 2027 applicable IPPS comparable wage index decreased by more than 5%, along with their capped FY 2027 applicable IPPS comparable wage index value.

Note: Hospitals newly classified as LTCHs during FY 2027 aren't eligible for the 5% cap.

In addition, for all LTCHs, MACs will update the County Code field in the PSF (Data Element 60) with the correct Federal Information Processing Series code.

COLA Under the LTCH PPS

We're updating the COLAs for FY 2027. Refer to the FY 2027 IPPS and LTCH PPS final rule or MAC implementation file 2 for the applicable COLA factors for LTCH PPS discharges occurring on or after October 1, 2026. MACs will update Data Element 22 (COLA) of the PSF for LTCHs located in Alaska and Hawaii based on the updated COLA factors in MAC implementation file 2.

LTCH Qualifying Period Policy Manual Update

An LTCH must participate in Medicare as a hospital, typically paid under the IPPS, before getting classification as an LTCH. During this time, we gather average length of stay (ALOS) data and use it to determine whether a hospital's ALOS exceeds the 25 days we require for LTCH classification. We codified this in regulations at 42 CFR 412.23(e)(3) and in the FY 2025 IPPS and LTCH final rule. We're updating the Medicare Claims Processing Manual, Chapter 3, section 150.4 to reflect this policy.

Hospitals Excluded From the IPPS

In the FY 2027 IPPS and LTCH PPS final rule, we established an update to an extended neoplastic disease care hospital's target amount for FY 2027 of 3.2%. 42 CFR 413.40(c)(3) specifies the annual rate of increase percentage, and it's equal to the percentage increase projected by the hospital market basket index.

Background

CR 14592 outlines the annual updates to the IPPS and LTCH PPS for FY 2027 and covers items effective for hospital discharges occurring October 1, 2026 – September 30, 2027, unless otherwise noted. These policy changes went on display on July 31, 2026, and appear in the Federal Register (91 FR 49570) as of August 3, 2026.

We'll release new IPPS and LTCH PPS Pricer software packages that include the updated rates, factors, and policies for FY 2027.

Refer to the FY 2027 final rule home page for the FY 2027 final rule data files, rule tables, and MAC implementation files we reference in this article. MACs use these files unless otherwise specified.

More Information

We issued CR 14592 to your MAC as the official instruction for this change. For more information, find your MAC's website.

Document History

Date of Change	Description
September 14, 2026	Initial article released.