HOSPITAL ACUTE INPATIENT SERVICES PAYMENT SYSTEM

paymentbasics

Revised: October 2026

Medicare beneficiaries receive inpatient care in about 3,100 short-term acute care hospitals paid under the inpatient prospective payment systems (IPPS).[1] Medicare's acute inpatient hospital benefit covers beneficiaries for 90 days of care per episode of illness, with a 60-day lifetime reserve. Illness episodes begin when beneficiaries are admitted and end after they have been out of the hospital or a skilled nursing facility for 60 consecutive days. Beneficiaries are liable for a deductible for the first hospital stay in an episode, for daily copayments on the 61st to 90th day of the episode, a higher daily copayment for lifetime reserve days used beyond the 90th day of the episode, and all costs once lifetime reserve days have been exhausted.[2]

In fiscal year 2024, the Medicare program and its beneficiaries spent $110.5 billion on inpatient services covered under the IPPS. This included $5.9 billion in uncompensated-care payments to IPPS hospitals.

The policies discussed in this document were current as of September 30, 2026. This document does not reflect proposed legislation or regulatory actions.

Defining the inpatient acute care that Medicare buys

Medicare's IPPS primarily pays a predetermined rate intended to cover the operating and capital costs of furnishing an acute hospital inpatient stay. (Certain costs are excluded from IPPS payments and paid separately, such as organ acquisition costs.) Related outpatient department services delivered in the three days before admission are included in the payment for the inpatient stay and may not be separately billed.

Setting the payment rates

Medicare's IPPS payments per stay are derived through a series of adjustments applied to separate operating and capital base payment rates (Figure 1). The two base rates are adjusted to reflect geographic factors, patient case mix, facility characteristics, and other factors.

The base payment amounts—Medicare sets operating and capital IPPS base rates (known as standardized payment amounts). Operating base payments are tied to labor and supply costs; capital base payments are tied to costs for depreciation, interest, rent, and property-related insurance and taxes. For fiscal year 2027, the operating base rate is $6,848 and the capital rate is $540.

Adjustment for geographic factors—The operating and capital IPPS base rates are adjusted by a wage index to reflect the expected differences in local market prices for labor and labor-related costs.[3] To determine the IPPS wage index for each hospital, CMS first calculates an unadjusted hospital wage index for each metropolitan statistical area and statewide rural area, which reflects the average hourly wage for employees of IPPS hospitals in that area relative to the nationwide average. CMS then applies several exceptions, including reclassifying some hospitals from one area to another and applying wage-index floors.

For operating base rates, the wage index is applied to the portion of the base rate attributable to wages and wage-related costs. This operating labor share is set by statute at 62 percent for hospitals with a wage index less than or equal to 1 and is estimated by CMS for those with a wage index above 1. For capital base rates, the wage index raised to a fractional power is applied to 100 percent of the capital base rate.

Adjustment for case mix—For each inpatient stay, the hospital's geographic-adjusted operating and capital rates are then adjusted for case mix to reflect the patient's condition and expected costliness.

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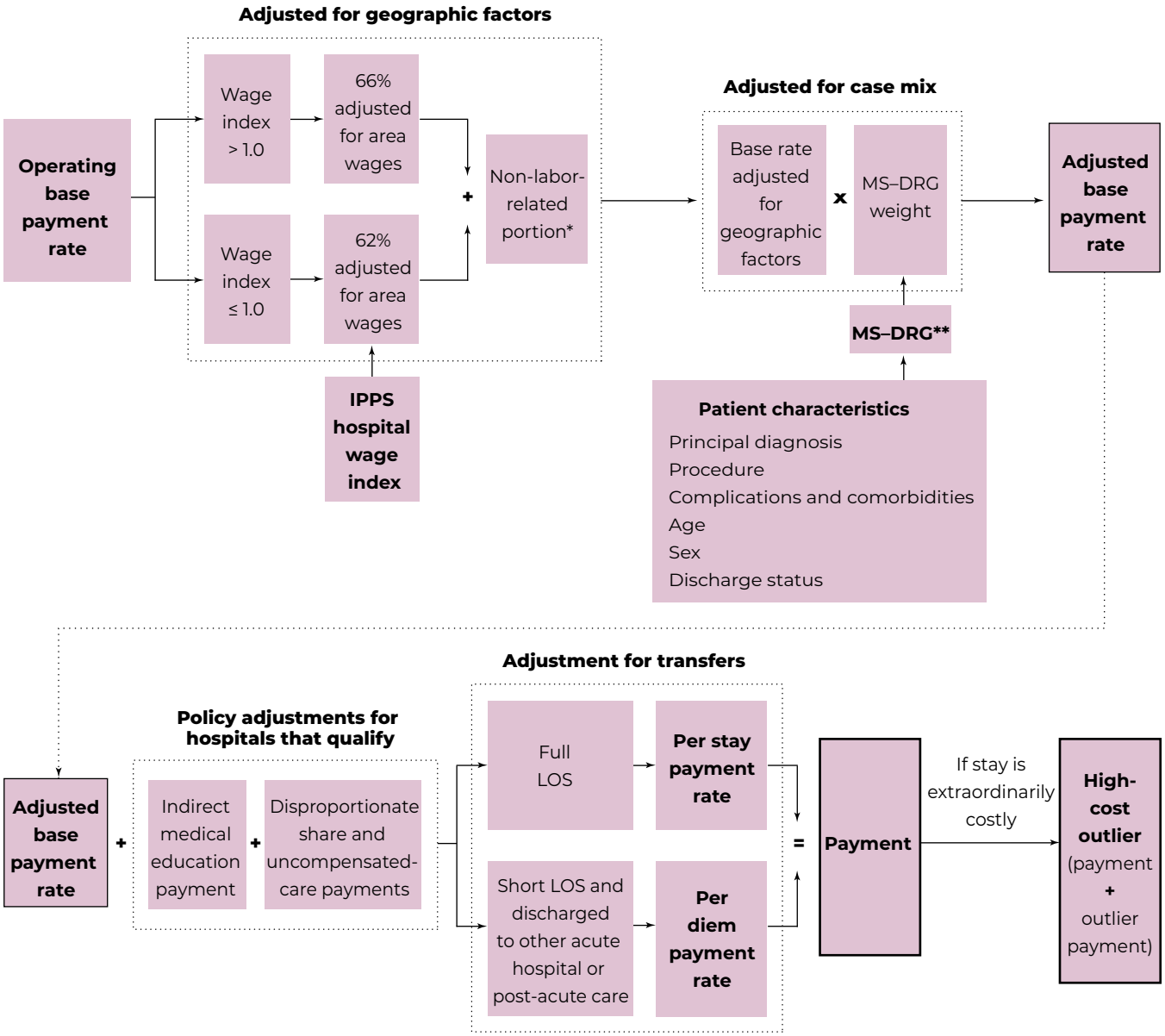
Figure 1 Acute inpatient operating prospective payment system for fiscal year 2027



Note: MS–DRG (Medicare severity diagnosis-related group), IPPS (inpatient prospective payment system), LOS (length of stay). Capital payments are determined by a similar system. Additional payments are also made for certain new technologies and rural or isolated hospitals. Hospitals may receive penalties or additional payments based on their performance on quality standards.
* Hospitals located in Alaska and Hawaii receive a cost-of-living adjustment to the non-labor-related portion of the base rate.
** MS–DRGs comprise base DRGs subdivided into one, two, or three severity levels.

To determine this stay-level case-mix adjustment, Medicare assigns each inpatient stay to a Medicare severity diagnosis-related group (MS–DRG), which is based on patient characteristics, primarily the patient's clinical conditions and treatment strategies. Clinical conditions are defined by the principal diagnosis—the main problem requiring inpatient care—and up to 24 secondary diagnoses indicating other conditions that were present at admission (comorbidities) or developed during the hospital stay (complications). The treatment strategy—surgical or medical—is defined

by the presence or absence of up to 25 procedures performed during the stay. In 2027, the MS–DRG system includes 346 base DRGs, most of which are split into 2 or 3 MS–DRGs based on the presence of either a comorbidity or complication (CC) or major CC, resulting in a total of 768 MS–DRGs.

Each MS–DRG has a weight that reflects the expected costliness of inpatient treatment for patients in that group relative to the expected costliness across all patient groups.

Indirect medical education payments— Hospitals that train residents receive additional operating and capital IPPS payments to offset the additional (indirect) costs of patient care associated with resident training that are not otherwise accounted for under the IPPS. These indirect medical education (IME) payments are calculated as a percentage add-on to geographic– and case-mix–adjusted base rates. The size of the IME percentage add-on depends on the hospital's teaching intensity, defined as the hospital's allowed number of residents per inpatient bed (for operating IME) or allowed residents per average daily inpatient census (for capital IME).

Disproportionate share and uncompensated-care payments—Hospitals that treat a disproportionate share (DSH) of certain low-income patients receive additional operating and capital payments intended to offset the financial effects of treating these patients. DSH payments are calculated as a percentage add-on to geographic– and case-mix–adjusted base rates. The size of the DSH percentage add-on depends on the hospital's low-income patient share, defined as the sum of the proportion of its Medicare inpatient days provided to patients eligible for Supplemental Security Income benefits and the proportion of its total acute inpatient days furnished to Medicaid patients. Any hospital with a low-income share exceeding 15 percent is eligible to receive operating DSH payments. (To be eligible for capital DSH payments, hospitals must also be urban and have 100 or more beds.)

In addition, each DSH hospital receives uncompensated-care payments from a fixed pool of dollars referred to as the "uncompensated-care pool." In fiscal year 2027, the uncompensated-care pool is $7.9 billion dollars and is allocated to DSH hospitals based on their share of reported uncompensated-care costs in 2021, 2022, and 2023 relative to all other hospitals receiving DSH payments.[4] (Capital DSH payments are based on a prior-law DSH formula and do not include a component based on uncompensated care.)

Transfer policy—Facing fixed inpatient payment rates, providers have financial incentives to reduce their inpatient costs by moving some services to another setting. To counter these incentives, IPPS payments for a stay are reduced when patients have a length of stay at least one day less than the geometric mean length of stay for the MS–DRG and:

- are either transferred to another hospital covered by the IPPS or designated as a critical access hospital or,
- for certain DRGs, discharged to a post-acute care setting.[5]

Under this policy, transferring hospitals are paid a per diem rate rather than the full MS–DRG payment. Generally, hospitals receive twice the per diem rate for the first day and the per diem rate for each additional day.[6]

New-technology payments—Hospitals with stays treated using certain new and expensive technologies receive add-on payments to offset the costs of these new technologies. CMS evaluates applications for new-technology add-on payments (NTAPs) submitted by technology firms and others based on criteria of newness, substantial clinical improvement, and the cost of the technology exceeding MS–DRG–specific thresholds.[7] For stays involving eligible new technologies, NTAPs are generally set at 65 percent (or 75 percent for certain technologies) of the lesser of (1) the costs of the new technologies or (2) the amount by which

the costs of the stay exceed the otherwise applicable IPPS operating payment (including IME and DSH).[8]

Outlier payments—Medicare makes extra payments for stays that are extraordinarily costly.

High-cost outlier stays are identified by comparing the cost of that stay to a threshold that is the sum of the hospital's:

- geographic– and case-mix–adjusted base payment for the stay (both operating and capital);
- any IME, DSH, uncompensated care, and NTAP; and
- a fixed loss amount (subject to geographic and transfer adjustments, as applicable).

For each stay that exceeds the threshold, Medicare makes an outlier payment equal to 80 percent of the hospital's costs above the threshold (or 90 percent for burn stays).

Outlier payments are financed by prospective offsetting reductions in the operating base rate and the capital base rate. CMS sets the national fixed loss amount at the level it estimates will result in outlier payments equaling the target operating offset of 5.1 percent (plus a projection for outlier reconciliation, which is 0.04 percentage points in 2027). In 2027, the national fixed loss amount is $49,331 and the offset to the capital base rate is 3.23 percent.

Special payments for rural or isolated hospitals—Medicare makes additional payments to certain rural or isolated hospitals.

Sole community hospital payments—The sole community hospital (SCH) designation is for hospitals that are located at least 35 miles from the nearest short-term acute care hospital or are located in a rural area and meet criteria related to isolation. These hospitals receive inpatient operating payments equal to the higher of payments under the IPPS or payments based on their costs per stay in a base year updated to the current year and adjusted for their current-year case mix.

Medicare-dependent hospital payments—The Medicare-dependent hospital (MDH) program is for small, rural hospitals not designated as SCHs in which Medicare patients comprise at least 60 percent of their admissions or patient days. These hospitals receive inpatient operating payments equal to the higher of standard IPPS rates or a blend of standard IPPS rates (25 percent) and their historical costs updated to the current year and adjusted for changes in their case mix (75 percent). The MDH program is scheduled to expire on January 1, 2027.

Low-volume hospital payments—The low-volume hospital designation is for hospitals that have a low number of inpatient stays and meet criteria related to isolation. Before December 31, 2026, hospitals are eligible if they have less than 3,800 total stays during the fiscal year and are located more than 15 miles from the nearest hospital (excluding critical access hospitals and Indian Health Service hospitals). These hospitals receive up to a 25 percent increase in their IPPS payments (including geographic– and case-mix–adjusted operating and capital base payments and any IME, DSH, uncompensated-care, new-technology, outlier, SCH, or MDH payments). Starting January 1, 2027, eligibility criteria are expected to narrow such that hospitals would only be eligible if they had fewer than 200 total stays and are located more than 25 miles from the nearest hospital.

Quality incentive payments and penalties

Excess readmissions penalty—Under the Hospital Readmissions Reduction Program, hospitals that have excess Medicare readmissions for selected conditions have their adjusted operating base payments reduced by up to 3 percent. In fiscal year 2027, the readmissions policy applies to seven conditions (acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, total hip and knee arthroplasty, coronary artery bypass graft, and sepsis).

Value-based incentive payments—Under the value-based purchasing program, CMS redistributes a pool of dollars equal to 2 percent of adjusted operating base payments based on performance on a set of outcome, patient-experience, safety, and efficiency measures.

Hospital-acquired conditions penalty—Under the Hospital-Acquired Condition Reduction Program, hospitals are ranked on their total rate of preventable conditions such as falls, surgical site infections, and catheter-associated urinary tract infections. The 25 percent of hospitals with the highest rates of preventable conditions generally receive a 1 percent reduction in all inpatient payments.

Payment-rate updates

CMS makes several annual updates to IPPS payment rates, including updates to the base rates, wage indexes, MS–DRG definitions and weights, and the outlier fixed loss amount.

IPPS base rates are updated annually primarily based on the operating and capital market basket indexes—which measure changes in the prices of the inputs hospitals buy—and estimated changes in productivity and other factors. For 2027, the update to the operating base rate was 2.3 percent, and the update to the capital base rate was 3.4 percent.[9] ■

1 The IPPS includes two prospective payment systems: one for inpatient operating costs and one for inpatient capital costs. Approximately 1,400 rural hospitals qualify as critical access hospitals and are paid on a reasonable-cost basis instead of under the IPPS. The Critical Access Hospitals Payment System document in our *Payment Basics* series provides more information on this topic. Short-term acute care hospitals in Maryland and territories other than Puerto Rico, children's hospitals, psychiatric hospitals, and cancer hospitals are also exempt from the IPPS and paid under other rate systems.

2 Medicare pays the approved amount minus any beneficiary liability, such as a deductible or copayment; the provider then needs to collect the remaining amount from the beneficiary or a supplemental insurer. In 2026, the inpatient deductible is $1,736 per episode and the daily copayments are $434 from the 61st to 90th day of an episode and $868 per lifetime reserve day. Medicare reimburses providers for 65 percent of bad debts resulting from beneficiaries' nonpayment of deductibles and copayments after providers have made reasonable efforts to collect the unpaid amounts.

3 For hospitals in Alaska and Hawaii, both the operating and capital rates are boosted by a cost-of-living adjustment, reflecting the higher costs of supplies and other nonlabor resources in those states.

4 Starting in fiscal year 2023, CMS discontinued the use of a low-income day as a proxy with which to measure uncompensated-care costs for hospitals in Puerto Rico and Indian Health Service and tribal hospitals. To protect these hospitals from significant financial disruption, CMS also established new supplemental uncompensated-care payments for these hospitals, which CMS estimates will total $109 million in fiscal year 2027.

5 The post-acute care settings covered by the transfer policy include long-term care hospitals; inpatient rehabilitation, inpatient psychiatric, or skilled nursing facilities; hospice care; and home health care if the patients receive clinically related care that begins within three days after the hospital stay.

6 An exception exists for certain MS–DRGs with high first-day costs. These transfer stays are paid half the full MS–DRG payment plus one per diem payment and half the per diem rate for subsequent days.

7 Beginning in fiscal year 2028, virtually all new applications for new-technology add-on payments—including those that previously could have used an alternative eligibility pathway (i.e., technologies designated by the Food and Drug Administration (FDA) as breakthrough devices or qualified infectious disease products (QIDP), or approved by the FDA under the limited population pathway for antibacterial and antifungal drugs (LPAD))—will need to demonstrate that the technology meets all three of the standard criteria. CMS finalized a limited grandfathering eligibility exception through fiscal year 2029 for certain technologies.

8 Products granted an NTAP that are designated by the FDA as QIDP, approved under the LPAD, or are a gene therapy for sickle cell disease receive a 75 percent NTAP payment instead of 65 percent.

9 Hospitals that fail to provide data on specified quality indicators or to be meaningful users of electronic health records receive only a fraction of the IPPS operating market basket update.