American College of Radiology™

Fiscal Year (FY) 2027 Hospital Inpatient Prospective Payment System Final Rule Detailed Summary

On July 31, the Centers for Medicare and Medicaid Services (CMS) released the fiscal year (FY) 2027 Hospital Inpatient Prospective Payment System (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System Final Rule. The final rule provides updates for Medicare fee-for-service payment rates and policies for inpatient hospitals and long-term care hospitals for FY 2027.

CMS pays acute care for inpatient stays under the IPPS. Under this payment system, CMS sets base payment rates for inpatient stays based on the patient's diagnosis and severity of illness. Subject to certain adjustments, a hospital receives a single payment for the case based on the payment classification assigned at discharge through Medicare Severity Diagnosis-Related Groups (MS-DRGs). These changes take effect on October 1, 2026.

Finalized Payment Updates for FY 2027

CMS finalized a base FY 2026 update of +2.3%. This is based on a market basket update of 3.2% and the multifactor productivity (MPF) adjustment, which CMS estimates to be a 0.9 percentage point reduction. CMS finalized a -0.1% update for hospitals that submit quality data and are not considered "meaningful EHR users," an update of 1.5 percent for hospitals that fail to submit quality data but are considered "meaningful EHR users". For hospitals that fail to submit quality data and are not considered "meaningful EHR users" have a proposed update of -0.9%. For FY 2027.

Impacts of Payment Updates

CMS expects the final changes in operating and capital IPPS payment rates will generally increase hospital payments by $2.1 billion. CMS also estimates that additional payments for inpatient cases involving new medical technologies will increase by approximately $779 million in FY 2027, primarily driven by new approvals for new technology add-on payments.

Data Used in Rate Setting

CMS used the FY 2025 Medicare Provider Analysis and Review (MedPAR) claims file as well as the Medicare cost report data files from the December 2025 update of the FY 2024 Healthcare Cost Report Information System (HCRIS) dataset for purposes of FY 2027 ratesetting. This is consistent with CMS's general policy of utilizing the HCRIS dataset that is 3 years prior to the IPPS fiscal year.

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Market-Based MS-DRG Relative Weight: Finalized Policy Changes

CMS calculated the final relative weights for FY 2027 based on 19 cost-to-charge (CCR) ratios. The proposed methodology uses claims data in the FY 2025 MedPAR file and data from the FY 2024 Medicare cost reports. The charges for each of the 19 cost groups for each claim were standardized to remove the effects of differences in area wage levels, indirect medical education (IME) and disproportionate share hospital (DSH) payments, and for hospitals located in Alaska and Hawaii, the applicable cost-of-living adjustment.

Development of National Average Cost-To-Charge Ratios (CCRs)

The finalized 19 national average CCRs for FY 2027 are as follows:

National Average CCRs	
Group	**CCR**
Routine Days	0.375
Intensive Days	0.320
Drugs and Cellular Therapies	0.178
Supplies & Equipment	0.293
Implantable Devices	0.246
Inhalation Therapy	0.140
Therapy Services	0.253
Anesthesia	0.071
Labor & Delivery	0.379
Operating Room	0.149
Cardiology	0.084
Cardiac Catheterization	0.094
Laboratory	0.093
Radiology	0.120
MRIs	0.063
CT Scans	0.032
Emergency Room	0.132
Blood & Blood Products	0.230
Other Services	0.319

Finalized FY 2027 Applications for New Technology Add-On Payments

Traditional Pathway

CMS received 15 applications for new technology add-on payments for FY 2027 under the new technology add-on payment traditional pathway. Of the 15 applications received under the traditional pathway, 3 applicants were not eligible for consideration for new technology add-on payment because they did not meet these requirements, and 4 applicants withdrew their applications.

Alternative Pathway
CMS finalized the proposal to repeal the alternative pathway for new technology add-on payments beginning with applications received for new technology add-on payments for FY 2028 and require all applicants for new technology add-on payments to demonstrate that they meet all eligibility requirements to receive add-on payments.

CMS received 32 applications for new technology add-on payments for FY 2027 under the new technology add-on payment alternative pathway. Of the 34 applications received under the alternative pathway, 7 applications were not eligible for consideration for new technology add-on payment because it did not meet the FDA approval requirements; and 3 applicants withdrew their applications prior to the issuance of this proposed rule. All the remaining 22 applications received a Breakthrough Device designation from FDA.

CMS received multiple applications for subscription-based technologies for FY 2027. As stated in the FY 2021 IPPS/LTCH PPS final rule (85 FR 58630) and in the FY 2025 IPPS/LTCH PPS final rule (89 FR 69207), CMS noted that there are unique circumstances with respect to determining a cost per case for a technology that utilizes a subscription for its cost and we will continue to consider the issues relating to calculation of the cost per unit of technologies sold on a subscription basis as we gain more experience in this area.

CMS welcomed comments from the public as to the appropriate method to determine a cost per case for such technologies, including comments on whether the cost analysis should be updated based on the most recent subscriber data for each year for which the technology may be eligible for add-on payment.

CMS thanked stakeholders for the feedback. CMS stated they recognize that software-based, subscription-based, EHR-integrated, and artificial intelligence-driven technologies may present differently than technologies that are furnished as a more discrete item or service during an inpatient stay.

<u>BriefCase-Triage: CARE (Clinical AI Reasoning Engine) Multi-Triage CT Body</u>
Aidoc Medical Ltd., Inc. submitted a FY2027 application for new technology add-on payments for BriefCase-Triage: CARE Multi-Triage CT Body (BriefCase-Triage). According to the applicant, BriefCase-Triage is a radiological triage device used for the analysis of contrast and non-contrast CT images that flag and communicates suspected positive findings for a wide range of clinically actionable, time-sensitive conditions in the abdominopelvic region. CMS invited public comments on whether BriefCase-Triage meets the cost criterion and CMS's proposal to approve new technology add-on payments for BriefCase-Triage: CARE Multi-Triage CT Body for FY 2027.

CMS has finalized that the maximum new technology add-on payment for a case involving the use of BriefCase-Triage would be $137.53 for FY 2027 that is 65 percent of the average cost of the technology. Additionally, cases involving the use of BriefCase-Triage that are eligible for new technology add-on payments will be identified by ICD-10-PCS procedure code: XEZ5XKC (Computer-aided triage and notification for imaging abnormalities in computed tomography of chest, abdomen and pelvis, new technology group 12).

Alternative Pathway Repeal for New Technology Add-on Payment and Outpatient Prospective Payment System (OPPS) Device Pass-through
In the FY 2027 IPPS proposed rule, CMS expressed concerns with the limited evaluation process for alternative pathway applications for new technology add-on and OPPS device pass-through payments, and after further consideration, CMS believed that it is in the best interest of Medicare patients to refine their approach, to ensure that all new technologies approved for new technology add-on payment have demonstrated that the technology is not substantially similar to existing technologies and represents an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.

Similarly, CMS believes it is in the best interest of Medicare patients that new technologies approved for OPPS device pass-through payment status have demonstrated a substantial clinical improvement, that is, they substantially improve the diagnosis or treatment of an illness or injury or improve the functioning of a malformed body part, compared to the benefits of a device or devices in a previously established category or other available treatment. Therefore, CMS finalized the proposal to repeal the alternative pathway for new technology add-on payment and OPPS device passthrough applications and require all applicants for new technology add-on payments and OPPS device pass-through payments to demonstrate that they meet the same eligibility requirements to receive add-on payments and/or pass-through payments.

CMS believes this requirement will better align spending and value and ultimately support providers in delivering the best, data driven care possible. By requiring all technologies to demonstrate that they offer a substantial clinical improvement as part of our evaluation process, we believe we will be better able to make evidence-based decisions on which technologies should receive these additional payments

Finalized Update to the IPPS Labor-Related Share
For FY 2027, CMS finalized the proposal to continue to use the national labor-related and nonlabor-related shares (which are based on the 2023-based hospital IPPS market basket) that were used in FY 2026. CMS will use a labor-related share of 66.0 percent for the national standardized amounts for all IPPS hospitals (including hospitals in Puerto Rico) that have a wage index value that is greater than 1.0000. For IPPS hospitals whose wage

index values are less than or equal to 1.0000, CMS will apply the wage index to a labor-related share of 62 percent of the national standardized amount.

Finalized Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs)
Medicare makes DSH payments to IPPS hospitals that serve a high percentage of certain low-income patients. CMS' analysis includes 2,318 hospitals that are projected to be eligible for DSH in FY 2027. For FY2027, the estimated total amount of uncompensated care payments is $7.94 billion, which is an increase of 2.9% compared to CY 2026.

Requirements to Prohibit Unlawful Discrimination by Graduate Medical Education Programs and Nursing and Allied Health Education Programs
To further strengthen the protections against unlawful discrimination finalized in the calendar year (CY) 2026 Outpatient Prospective Payment System (OPPS) Final Rule, CMS finalized the proposal in this rule to require that, in addition to meeting other applicable requirements, an approved medical residency training program must not discriminate, or promote or encourage discrimination, on the basis of race, color, national origin, sex, age, disability, or religion, including the use of those characteristics or intentional proxies for those characteristics as a selection criterion for employment, program participation, resource allocation, or similar activities, opportunities, or benefits. Similar requirements would also apply to approved nursing and allied health education programs and accreditors.

Transforming Episode Accountability Model (TEAM)
The Transforming Episode Accountability Model (TEAM) is a mandatory alternative payment model finalized in the FY2025 IPPS rule. TEAM is a 5-year mandatory alternative payment model tested by the CMS Innovation Center that began on January 1, 2026, and will end on December 31, 2030. It holds hospitals financially accountable for the cost and quality of care for specific surgical episodes, including CABG, joint replacement, major bowel surgery, hip/femur fracture treatment, and spinal fusion. The model tests whether this accountability can lower Medicare spending while maintaining or improving care quality. In this rule, CMS finalized the proposed updates to TEAM that would modify policies affecting episode category triggers, quality measure assessment, and the construction of target prices. CMS finalized changes to a few areas of the model, including: adding three Medicare Severity Diagnosis Related Groups (MS-DRGs) that would initiate a spinal fusion anchor hospitalization; clarifying quality measure performance periods for certain quality measures; using a rolling concurrent Composite Quality Score (CQS) baseline period for certain quality measures; adding an Ambulatory Payment Classification (APC) and MS-DRG update factor to target prices; and using the full baseline period to construct the prospective normalization factor.

Comprehensive Care for Joint Replacement Expanded (CJR-X) Model
In this final rule, CMS expanded the Comprehensive Joint Replacement (CJR-X) model nationwide for eligible acute care hospitals beginning January 1, 2028. CJR-X will be the first expanded mandatory episode-based payment model for hospitals in Original Medicare; findings from CJR-X's predecessor, the Comprehensive Care for Joint Replacement (CJR) Model, showed episode-based payments motivate hospitals, surgeons, and post-acute providers to collaborate to help patients achieve optimal health outcomes while reducing avoidable hospitalizations, complications, and unnecessary costs. Participating hospitals will be accountable for cost and quality across the inpatient or outpatient episode and the 90 days post-discharge.

Participation will be mandatory for most acute care hospitals. Certain hospitals may be exempt from CJR-X, including those participating in the Transforming Episode Accountability Model, those located in Maryland, and those not paid under both the IPPS and Outpatient Prospective Payment System.