American College of Radiology™

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

On Friday, April 10th, 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 Proposed Rule. The proposed 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). Comments are due to CMS by June 9, 2026.

Proposed Payment for FY 2027

CMS proposes a base FY 2026 update of +2.4%. This is based on a market basket update of 3.2% and the multifactor productivity (MPF) adjustment, which CMS estimates to be a 0.8 percentage point reduction. CMS proposed a neutral adjustment (0 percent update) for hospitals that submit quality data and are not considered "meaningful EHR users," proposed update of 1.6 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 -0.8%. For FY 2027, CMS expects the proposed changes in operating and capital IPPS payment rates will generally increase hospital payments by $1.9 billion.

Data Used in Rate Setting

CMS proposes to use 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.

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

CMS calculated the proposed FY 2027 relative weights 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 proposed 19 national average CCRs for FY 2027 are set forth in Table 5 and are also available on the CMS website:

National Average CCRs	
Group	**CCR**
Routine Days	0.377
Intensive Days	0.324
Drugs and Cellular Therapies	0.18
Supplies & Equipment	0.301
Implantable Devices	0.256
Inhalation Therapy	0.141
Therapy Services	0.258
Anesthesia	0.074
Labor & Delivery	0.37
Operating Room	0.151
Cardiology	0.086
Cardiac Catheterization	0.07
Laboratory	0.095
Radiology	0.122
MRIs	0.065
CT Scans	0.032
Emergency Room	0.133
Blood & Blood Products	0.238
Other Services	0.323

Proposed 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 is proposing 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 welcomes 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.

BriefCase-Triage: CARE (Clinical AI Reasoning Engine) Multi-Triage CT Body
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 flags and communicates suspected positive findings for a wide range of clinically actionable, time-sensitive conditions in the abdominopelvic region.

CMS invites 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.

Proposed Alternative Pathway Repeal for New Technology Add-on Payment and Outpatient Prospective Payment System (OPPS) Device Pass-through
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, we believe it is in the best interest of Medicare patients to refine our 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 is proposing 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 proposed 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

CMS is also interested in information/comments on alternate methods that stakeholders believe would more effectively or efficiently accomplish the goal of aligning payment with value by facilitating payment for innovative, high-value technologies that have demonstrated improved Medicare beneficiary health outcomes, such as alternative strategies for leveraging FDA designations.

Proposed Update to the IPPS Labor-Related Share

For FY 2027, CMS proposes 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 proposes to 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 proposes to apply the wage index to a labor-related share of 62 percent of the national standardized amount.

Proposed 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 proposed total amount of uncompensated care payments is $7.563 billion. This is comprised of uncompensated care payments ($7.46 billion) and supplemental payments to Puerto Rico, Indian Health Service (IHS) and Tribal Hospitals ($102.8 million). This is a decrease of approximately 3.3 percent from FY2026 uncompensated care payments.

Proposed 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 proposes 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. If finalized, these policies would be effective October 1, 2026.

Transforming Episode Accountability Model (TEAM)

The Transforming Episode Accountability Model (TEAM) is a mandatory alternative payment model finalized in the FY2025 IPPS rule. 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 proposed rule, CMS proposes updates to TEAM that would modify policies affecting episode category triggers, quality measure assessment, and the construction of target prices. CMS is soliciting public feedback on two Request for Information (RFIs) regarding ambulatory surgical center episodes and voluntary participation of hospitals with physician ownership.

Comprehensive Care for Joint Replacement Expanded (CJR-X) Model

CMS is proposing to expand the Comprehensive Joint Replacement (CJR-X) model nationwide for eligible acute care hospitals beginning October 1, 2027. This model expands on the earlier CJR program based on positive results from the April 2016 to December 2024 test. The model aims to improve care quality and reduce Medicare spending for lower extremity joint replacement (LEJR) procedures. Participating hospitals would be accountable for cost and quality across the inpatient or outpatient episode and the 90 days post-discharge. If finalized as proposed, participation would be mandatory for most acute care hospitals, except those in the TEAM model and hospitals in Maryland (because of Maryland's unique ratesetting authority). The model includes refinements to quality measures and payment methods, reflecting evaluation findings, stakeholder input, and evolving care delivery patterns.