

## Disclaimer — Review of CMS Annual Rulemaking

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## **FY 2027 IPPS Proposed Rule — Detail on MS-DRG Classifications, Relative Weights, and New Technology Add-Ons**

Detail on the four Section II items from the FY 2027 IPPS/LTCH PPS proposed rule (91 FR 19314). All items are **proposals** open for public comment.

### **1. MS-DRG Classification Changes and Recalibration of Relative Weights**

#### **a. Basis for the classification changes**

CMS conducts an annual review of MS-DRG classifications. Change requests for FY 2027 were due **October 20, 2025**, submitted through the Medicare Electronic Application Request Information System (MEARIS). (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes) The analysis was based on ICD-10 claims data from the **September 2025 update of the FY 2025 MedPAR file** (hospital bills received October 1, 2024 through September 30, 2025), grouped through the proposed **ICD-10 MS-DRG GROUPEL Version 44**. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes) CMS decides whether to modify an MS-DRG by evaluating whether the resource consumption (average costs and length of stay) and clinical characteristics of a patient subgroup are significantly different from the remaining patients in the MS-DRG. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)

#### **b. Examples of proposed classification changes**

The rule proposes numerous specific changes, including:

- **Cardiac pacemaker devices (MDC 05)**. Delete MS-DRGs 258, 259, 260, 261, and 262 and create two new MS-DRGs with a two-way severity split. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)
- **Other circulatory system O.R. procedures (MDC 05)**. Delete base MS-DRG 264 and create new MS-DRGs 361 and 362 (with and without MCC), reassigning 1,447 procedure codes. (Medicare Program; Hospital Inpatient Prospective Payment

- Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)
- **Spinal fusion.** Create new MS-DRGs 523, 524, and 525 (Extensive or Complex Spinal Fusion Procedures Except Cervical, with MCC / with CC / without CC/MCC). (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)
  - **Islet cell / pancreas transplants.** Add 11 ICD-10-PCS codes describing introduction of pancreatic islet cells to MS-DRGs 008, 010, and 019, and retitle MS-DRG 008 to “Simultaneous Pancreas, Islet Cell and Kidney Transplant”. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)
  - **Uterine and adnexa procedures for malignancy.** Delete MS-DRGs 736–741 and create new MS-DRGs 731, 732, and 733. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)

The rule also proposes conforming changes to the ICD-10-CM/PCS coding systems and to the surgical hierarchies across the Pre-MDC and MDCs 05, 08, 10, 11, 12, and 13. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)

### c. Recalibration of the relative weights

CMS proposes to recalibrate the FY 2027 MS-DRG relative weights using two data sources: the **FY 2025 MedPAR** claims file (approximately **6,936,972 Medicare discharges**, excluding Medicare Advantage, CAH, and REH claims) and the **December 2025 update of the FY 2024 HCRIS cost report data**. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes) Weights are computed on a cost basis using **19 cost-to-charge ratios (CCRs)**, standardizing charges to remove wage, IME, DSH, and (for Alaska/Hawaii) cost-of-living effects, trimming statistical outliers at 3.0 standard deviations, and resetting the Present-on-Admission indicator to “Y” for weight-setting. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital

## Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)

Key methodology points:

- **Normalization.** The cost-based weights were normalized by an adjustment factor of **1.944557** so recalibration is payment-neutral overall, as required by statute. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)
- **10-percent cap.** CMS continues the permanent policy capping any MS-DRG's relative-weight reduction at **10 percent** year-over-year (floor of 90 percent of the FY 2026 weight), with a budget-neutrality adjustment to the standardized amount. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)
- **Non-monotonicity.** Cases were combined to address non-monotonic severity levels for MS-DRG 217/218, 504/505, and 582/584. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)

## 2. FY 2027 New Technology Add-On Payment (NTAP) Applicants

### a. Statutory/regulatory criteria

An NTAP applicant must satisfy three criteria under 42 CFR 412.87(b): (1) the technology is **new** (and not “substantially similar” to an existing technology, generally within a 2-to-3-year newness window); (2) it is **costly** such that the otherwise-applicable DRG rate is inadequate (measured against the cost threshold — the lesser of 75% of the standardized amount or 75% of one standard deviation above the geometric mean charge for the MS-DRG); and (3) it demonstrates **substantial clinical improvement** over existing technologies. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes) If approved, the add-on generally pays the lesser of 65% of the technology's cost (or 75% for QIDP/LPAD antimicrobials and certain sickle-cell gene therapies) or 65%/75% of the amount by which case costs exceed the DRG payment. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and

Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)

## **b. Traditional-pathway applications**

CMS received **15 applications** under the traditional pathway for FY 2027. Of these, **3 were ineligible** (did not meet FDA marketing-authorization/request requirements) and **4 were withdrawn**, leaving **8 applications** addressed in the rule (e.g., COBENFY (xanomeline/trospium chloride) for schizophrenia, resubmitted after a prior FY 2026 denial). (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes) For technologies with FDA marketing authorization, CMS makes a proposal to approve or disapprove; it defers a proposal for technologies not yet FDA-authorized. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)

## **c. Alternative-pathway applications**

Under the alternative pathway (42 CFR 412.87(c)–(d)), FDA-designated **Breakthrough Devices, Qualified Infectious Disease Products (QIDPs)**, and drugs approved under the **Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD)** are deemed not substantially similar and are excused from the substantial-clinical-improvement requirement, but must still meet the newness and cost criteria. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)

CMS received **32 applications** under the alternative pathway for FY 2027. Of these, **7 were ineligible** and **3 were withdrawn**, leaving **22 applications** — all Breakthrough Device-designated — on which CMS proposes to approve or disapprove. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes) Examples of alternative-pathway (Breakthrough Device) applicants include the Bayesian Health Sepsis Flagging Device, BriefCase-Triage: CARE Multi-Triage CT Body, the CARA System, In Vision Precision Cardiac Amyloid, PMcardio STEMI AI ECG Model, ViaOne Epicardial Access System, and VUNO Med-DeepCARS. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes) CMS notes it received multiple subscription-based technology applications and continues to solicit comment on determining cost per case for those. (Medicare Program;

Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)

### 3. Proposed Repeal of the Alternative Pathway (NTAP and OPSS Device Pass-Through)

CMS proposes to **repeal the alternative pathway** for both new technology add-on payments and OPSS device pass-through payments. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes) Citing “concerns with the limited evaluation process” for alternative-pathway applications, CMS states that all technologies should have to demonstrate they are not substantially similar to existing technologies **and** represent a substantial clinical improvement, to better align spending with value and strengthen the evidence base for approvals. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)

Specifics of the proposal:

- **NTAP.** For all applications received for **FY 2028 and subsequent years** — including Breakthrough Devices, QIDPs, and LPAD drugs — applicants would have to meet **all three** criteria at § 412.87(b), including substantial clinical improvement. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)
- **Grandfathering.** Technologies currently under review for FY 2027, or previously approved, under the alternative pathway remain eligible under that pathway. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)
- **Deadline change.** The conditional-approval process for antimicrobials (§ 412.87(f)(3)) would be removed; beginning with FY 2028 applications, all applicants would need FDA marketing authorization by **May 1** of the prior year. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)
- **OPSS device pass-through.** For applications received on or after **October 1, 2026** (including the remainder of the CY 2028 cycle ending March 1, 2027), applicants

- would have to demonstrate substantial clinical improvement under § 419.66(c)(2)(i). Applications submitted as of September 30, 2026 for Breakthrough Devices could still be evaluated under the alternative pathway, and existing device category codes remain eligible for their 2-to-3-year window. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)
- **Regulatory amendments.** CMS proposes to revise § 412.87(c), (d), and (f) (removing (f)(3)) and § 419.66(c)(2)(ii), with related technical corrections. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)

CMS emphasizes that a technology denied NTAP or pass-through status is still covered and paid through the normal DRG/APC mechanisms. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes) It invites comment, including on alternative methods for leveraging FDA designations. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)

#### **4. Payment Adjustment for Certain Immunotherapy Cases (§§ 412.85 and 412.312)**

MS-DRG 018 covers CAR T-cell, non-CAR T-cell, and other immunotherapy cases. Because clinical-trial and no-cost/expanded-access cases carry atypically low drug charges, CMS applies a downward **payment adjustor** to those cases so payment reflects their lower cost, while the MS-DRG 018 relative weight reflects the cost of commercially purchased therapy. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)

For FY 2027, CMS proposes to **continue applying the adjustment** — using the methodology as modified in FY 2024 and further modified in FY 2026 — to expanded-access, applicable clinical-trial, and other cases where the immunotherapy product is **not purchased in the usual manner (e.g., obtained at no cost)**. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY)

2027 Rates; Requirements for Quality Programs; and Other Policy Changes) Qualifying cases are identified as those in MS-DRG 018 that (1) contain ICD-10-CM code Z00.6 without payer-only code “ZC,” (2) contain condition code “90,” or (3) have standardized drug charges below the median for clinical-trial cases in MS-DRG 018. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)

The adjustor is calculated by dividing the average cost of those identified cases by the average cost of all other MS-DRG 018 cases. Based on the December 2025 update of the FY 2025 MedPAR file, CMS estimates the average cost of identified cases (**\$71,039**) is **17 percent** of the average cost of the other MS-DRG 018 cases (**\$412,218**). (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes) Accordingly, CMS proposes a **0.17 adjustor**, multiplied against the FY 2027 relative weight for MS-DRG 018 when pricing these claims (and used in budget-neutrality and outlier simulations), with the value to be updated using more recent data in the final rule. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes) The median standardized drug-charge trim value is estimated at **\$25,323** for this proposed rule. (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes)

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*This detail reflects the proposed rule; the individual applicant determinations and all rates/adjustors are subject to comment and may change in the final rule.*