

# Top Five Changes in the June 1, 2026 IOTA Final Rule

Medicare Program: Alternative Payment Model Updates and the Increasing Organ Transplant Access Model

## Executive Briefing

### Executive Summary

CMS finalized updates to the Increasing Organ Transplant Access (IOTA) Model, a six-year mandatory CMMI model for selected kidney transplant hospitals. The rule is effective July 1, 2026, and applies beginning in Performance Year 2. For hospital and health system leaders, the rule narrows mandatory participation, expands the financial model to include Medicare Advantage transplants, revises quality scoring, adds patient-notification obligations, and removes the voluntary health equity plan component.

#	Change	Executive Significance
1	Participation narrowed	CMS raises the low-volume threshold and excludes military and VA facilities.
2	Medicare Advantage included	MA kidney transplants now count in both upside and downside risk calculations.
3	Quality scoring revised	CMS adds risk adjustment to the composite graft survival rate.
4	Patient notice obligations added	Participants must notify patients when waitlist status changes from active to inactive; declined-offer notification was not finalized.
5	Health equity plan removed	CMS eliminates the IOTA-specific voluntary health equity plan provisions.

### 1. CMS narrows which transplant hospitals are required to participate.

CMS increased the low-volume eligibility threshold from 11 adult kidney transplants per year during each baseline year to 15 adult kidney transplants per year. CMS also modified eligibility to exclude military medical treatment facilities and VA medical facilities.

**Executive impact:** Fewer low-volume programs will be subject to the mandatory model. CMS has indicated that 95 eligible kidney transplant hospitals will participate at the start of Performance Year 2, down from 103 selected for Performance Year 1.

### 2. Medicare Advantage kidney transplants now count in upside and downside risk calculations.

CMS expanded the definition of “Medicare kidney transplant” to include transplants for attributed patients whose primary or secondary coverage is Medicare fee-for-service or Medicare Advantage.

**Executive impact:** This is financially important for transplant hospitals in high-MA markets. Both upside and downside risk payments will now reflect MA kidney transplant volume; the maximum upside payment remains fifteen thousand dollars per transplant and the maximum downside amount remains two thousand dollars, scaled by performance.

### 3. CMS adds risk adjustment to the quality measure for graft survival.

CMS finalized an updated risk-adjustment methodology for the composite graft survival rate, based on an adapted Scientific Registry of Transplant Recipients framework and intended to account for patient and donor factors that affect graft survival.

**Executive impact:** The change responds to concerns from transplant centers that serve medically complex patients or accept higher-risk organs. Risk adjustment should reduce the incentive to avoid complex candidates solely to protect quality scores.

### 4. CMS adds patient notification requirements for waitlist status changes, but does not finalize broader organ-offer-decline notification.

IOTA participants must notify Medicare beneficiary waitlist patients when their status changes from active to inactive. The notice must include the date and reason for inactivation, the effect on organ-offer eligibility, and how the patient may regain active status.

Participants must deliver notices electronically or by mail, document the notice in the medical record, and, where applicable, share it with the patient’s dialysis facility and nephrologist/managing clinician or referring provider. CMS did not finalize the broader proposal to notify patients about declined organ offers.

**Executive impact:** Hospitals face new communication and documentation obligations, but CMS backed away from the more operationally burdensome declined-offer transparency proposal.

## 5. CMS removes the voluntary health equity plan component.

CMS removed the IOTA Model’s voluntary health equity plan provisions and related definitions to reduce burden on mandatory model participants and allow programs to focus resources on increasing access to kidney transplants.

**Executive impact:** This reduces IOTA-specific planning and reporting expectations. However, transplant programs should still expect scrutiny around access, outcomes, waitlist management, patient communication, and equity-related performance through other oversight channels.

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## Bottom Line for Hospital and Health System Leaders

The final rule makes the IOTA Model narrower and less administratively burdensome, while making the financial methodology more consequential for systems with significant Medicare Advantage transplant volume. Participating transplant hospitals should prioritize payer and MA attribution analysis, performance-score modeling, waitlist-inactivation notification workflows, and clinical governance around complex candidates and higher-risk organs.

**Source:** Federal Register final rule, “Medicare Program; Alternative Payment Model Updates and the Increasing Organ Transplant Access (IOTA) Model,” published June 1, 2026; CMS IOTA Model materials.