STRATEGIC HEALTH CARE

MEMORANDUM

Significant FY 2027 IPPS Final Rule Provisions NOT Included in the CMS Fact Sheet

Page references below correspond to the 2,704-page Public Inspection PDF for CMS-1849-F and CMS-0062-F. https://www.federalregister.gov/d/2026-15833

1. Significant Changes to the Mandatory TEAM Model

The CMS fact sheet does not discuss the changes to the Transforming Episode Accountability Model (TEAM), even though the final rule makes several consequential revisions affecting participating hospitals.

Effective October 1, 2026, CMS is adding MS-DRGs 523, 524, and 525 to the TEAM spinal-fusion episode category. These MS-DRGs capture complex spinal-fusion cases that may involve additional operative time, specialized implants, and greater hospital resource use. CMS declined requests to delay this change, meaning hospitals will assume episode-level accountability for these cases during TEAM's current performance year.

CMS is also replacing the proposed sliding historical quality baseline with a rolling concurrent Composite Quality Score baseline. The applicable quality baseline will advance each performance year with the measurement period. This approach makes the comparison more current, but hospitals will not know the final national comparative benchmark until the concurrent performance data are available.

The final rule also modifies TEAM's target-price methodology by:

- Adding Ambulatory Payment Classification and MS-DRG update factors so that final target prices reflect payment-system weight changes occurring after preliminary prices are developed;
- Applying the APC update factor beginning with TEAM's first performance year;
- Using all three baseline years to calculate the risk-adjustment multiplier and prospective normalization factor beginning with performance year two; and
- Updating final target prices during reconciliation to account for payment-system changes and the participant's realized case mix.

These changes are intended to improve pricing accuracy, but they also introduce the possibility that final target prices will differ from the preliminary amounts hospitals used for budgeting and care-redesign decisions.

Reference pages: Final Rule Public Inspection PDF pp. 1,436-1,446, 1,451-1,461, and 1,472-1,494.

2. New Restrictions on Hospitals Building Medicare GME Caps

The fact sheet discusses the new nondiscrimination requirements for residency programs but omits a separate policy that materially changes when CMS will recognize a residency program as "new" for purposes of building Medicare direct GME and indirect medical education caps.

For a program that is still within its five-year cap-building period as of October 1, 2026, or that begins training residents on or after that date, at least 90 percent of the individual residents entering the program during the five-year period must not have previously trained in another program in the same specialty. CMS will count individual residents rather than resident full-time equivalents when applying the test.

The following residents are excluded from the calculation:

- Residents who meet CMS's definition of a displaced resident;
- Individuals with previous training who enter as first-year residents through the National Resident Matching Program or another binding third-party matching program; and
- Residents in small programs accredited for 16 or fewer positions, because those programs are exempt from the 90 percent requirement.

CMS will no longer consider whether the program director or faculty members were previously employed by another program when determining whether a program is genuinely new. Failure to satisfy the new resident-newness standard could prevent a hospital from receiving the permanent Medicare resident-cap increases it expected when establishing the program.

Reference pages: Final Rule Public Inspection PDF pp. 790-811.

3. Elimination of Streamlined NTAP Eligibility for Certain Technologies

Although the fact sheet reports an increase in FY 2027 new-technology add-on payments, it does not disclose CMS's decision to eliminate the alternative NTAP eligibility pathway for most future FDA-designated Breakthrough Devices, Qualified Infectious Disease Products, and drugs approved under the Limited Population Pathway for Antibacterial and Antifungal Drugs.

Beginning with applications for FY 2028 and subsequent fiscal years, these technologies generally must satisfy all three traditional NTAP criteria:

- The service or technology is new;
- The otherwise applicable MS-DRG payment is inadequate; and
- The service or technology represents a substantial clinical improvement over existing alternatives.

CMS adopted limited grandfathering. A Breakthrough Device or Qualified Infectious Disease Product designated by September 30, 2026, that receives the applicable FDA marketing authorization by May 1, 2028, may continue to use the alternative pathway for FY 2028 and FY 2029. A drug approved and used under the LPAD pathway by May 1, 2028, receives the same limited treatment. CMS also created a corresponding transition through calendar year 2029 for qualifying Breakthrough Devices seeking OPPS device pass-through payment.

The policy creates a more demanding Medicare reimbursement pathway for future devices and antimicrobial products and may delay or reduce hospitals' access to separate payment for emerging technologies.

Reference pages: Final Rule Public Inspection PDF pp. 573-575.

4. Nearly $7.94 Billion in Uncompensated-Care Payments and the Distribution Methodology

The fact sheet does not identify the amount or methodology for FY 2027 Medicare disproportionate-share hospital uncompensated-care payments.

CMS finalized an FY 2027 uncompensated-care pool of approximately $7.939 billion. The amount reflects a final Factor 2 of 67.14 percent, based on CMS's estimate of the change in the uninsured population since 2013. The final pool is approximately $479 million higher than the amount CMS proposed.

CMS will distribute the pool using a three-year average of audited Worksheet S-10 uncompensated-care data from FYs 2021, 2022, and 2023. CMS will calculate each eligible hospital's Factor 3 using the hospital's annualized uncompensated-care costs for those years, subject to the applicable scaling, trimming, new-hospital, and merger policies.

The use of a three-year average is intended to reduce year-to-year volatility, but it can materially redistribute payments among individual DSH hospitals. The effect on a particular hospital depends primarily on its share of the national audited Worksheet S-10 total rather than on the overall size of the uncompensated-care pool. Hospitals therefore should not assume that the aggregate IPPS payment increase will translate into an increase in their individual uncompensated-care payments.

Reference pages: Final Rule Public Inspection PDF pp. 670-705.

5. IPPS Outlier Threshold Lowered to $49,346

The CMS fact sheet does not report the FY 2027 IPPS fixed-loss outlier threshold.

CMS finalized a fixed-loss threshold of $49,346, below the proposed threshold of $51,704. A case becomes eligible for an inpatient outlier payment when its estimated cost exceeds the applicable MS-DRG payment, including specified adjustments and add-on payments, by more than the fixed-loss amount.

The lower final threshold makes unusually expensive inpatient cases somewhat more likely to qualify for outlier payments than under the proposed rule. CMS will also use the $49,346 IPPS fixed-loss amount in determining the high-cost outlier threshold for LTCH site-neutral payment-rate cases.

Reference pages: Final Rule Public Inspection PDF pp. 2,440-2,444 and 2,527-2,528.

6. Targeted Wage-Index Transition Protection

The CMS fact sheet does not identify the final rule's special wage-index transition for certain hospitals affected by the discontinuation of the low-wage-index hospital policy.

CMS will provide a budget-neutral transitional payment exception for hospitals that benefited from the low-wage-index policy in FY 2024 and whose FY 2027 wage index would otherwise be more than 14.2625 percent below their FY 2024 wage index. For a qualifying hospital, CMS will calculate the transitional payment as though the hospital's FY 2027 wage index were no lower than 85.7375 percent of its FY 2024 wage index.

The exception is applied after the permanent five-percent cap on year-to-year wage-index decreases. CMS also finalized a corresponding budget-neutral transition for capital IPPS payments. Because the

protection is narrowly targeted and financed through budget neutrality, it benefits a limited group of hospitals while creating a small offsetting reduction in payments to other IPPS hospitals.

Reference pages: Final Rule Public Inspection PDF pp. 638-643.

7. Operational and Financial Details of the Organ-Acquisition Policies

The fact sheet states that CMS will reconcile non-renal organ acquisition costs beginning with cost-reporting periods on or after October 1, 2028, but it does not explain the new system's operational requirements, transplant-hospital cost-allocation rules, or projected savings.

Under the final rule:

- Independent OPOs will submit proposed organ-specific standard acquisition charges based on prior-year actual costs and reasonable, documented projections for the coming year;
- Independent histocompatibility laboratories will submit comparable proposed organ-specific testing rates;
- Medicare contractors will review and approve the proposed interim rates and disseminate the approved rates to transplant hospitals, OPOs, and other contractors;
- Rates may be adjusted no more frequently than quarterly, either at the contractor's initiative or at the request of the OPO or laboratory;
- Following a rate adjustment, an OPO or laboratory may request a lump-sum payment or repayment to address developing underpayments or overpayments before year-end reconciliation; and
- Payments and amounts payable from transplant hospitals and OPOs will be reconciled directly with the independent OPO or laboratory after the close of its fiscal year.

CMS estimates that the reconciliation policy will reduce Medicare spending by approximately $110 million in FY 2029, $380 million over five years, and $1.16 billion over ten years. CMS's analysis found that, in 2024, 34 independent OPOs had non-renal revenue exceeding reported acquisition costs by approximately $118.8 million, while 10 OPOs had costs exceeding revenue by approximately $19.1 million.

The fact sheet also omits the new cost-allocation requirements affecting transplant hospitals. A hospital generally may not permit the full purchase price of an organ or another high-cost purchased service or supply to inflate the accumulated-cost statistic used to allocate the hospital's administrative and general overhead. Hospitals must correct the allocation through a negative adjustment, by fragmenting or componentizing the A&G cost center, or through a combination of the two methods.

The rule does not eliminate reimbursement for legitimate transplant-program administration, coordination, compliance, contracting, information systems, or finance costs. It requires those costs to be allocated on a statistical basis reflecting the hospital resources actually consumed, rather than treating the price paid for a purchased organ as an automatic proxy for the hospital's internal overhead.

Reference pages: Final Rule Public Inspection PDF pp. 1,999-2,064, 2,135-2,150, and 2,631-2,638.

8. Additional CJR-X Financial and Operational Requirements

The CMS fact sheet identifies CJR-X as a mandatory nationwide model beginning January 1, 2028, but it does not describe several important limitations, pricing features, and hospital obligations.

CJR-X will generally apply to acute-care hospitals paid under the IPPS or OPPS nationwide, including hospitals in the U.S. territories. Hospitals participating in TEAM and acute-care hospitals located in Maryland are excluded. Participating hospitals will be accountable for Medicare spending and quality during the inpatient admission or hospital outpatient procedure and for the following 90 days. The model covers lower-extremity joint replacement involving the hip, knee, and ankle.

CMS will use five quality measures and a composite quality score, together with regional risk-adjusted target prices that include capped normalization and trend adjustments. The rule includes special pricing treatment for low-volume hospitals and a hospital-level safety-net risk-adjustment factor. Low-volume hospitals that do not meet the applicable threshold will be excluded from reconciliation for that performance year rather than being permanently excluded from the model.

Participant hospitals may enter into financial arrangements with eligible collaborators, including physician group practices, to align incentives around care coordination, quality improvement, and episode management. Hospitals must also comply with beneficiary-notification, collaborator-list, data-sharing, monitoring, and program-integrity requirements. CMS estimates that CJR-X will save Medicare approximately $725 million during its first five performance years; the estimate covers only part of the potential savings because the model has no predetermined termination date.

Reference pages: Final Rule Public Inspection PDF pp. 15-17, 1,599-1,604, 1,709-1,795, 1,767-1,773, 1,888-1,904, and 2,629-2,630.

9. CMS Withdrew Mandatory Componentization for Nursing and Allied Health Programs

The fact sheet discusses nondiscrimination requirements for approved nursing and allied health education programs but does not disclose an important administrative change from the proposed rule.

CMS declined to finalize its proposal requiring hospitals to subdivide, or componentize, general service cost centers to distinguish overhead functions that benefit approved nursing and allied health education programs from functions that do not. CMS similarly did not finalize a separate componentization requirement intended to identify related-party costs.

Hospitals therefore will not be required to implement the proposed granular cost-center restructuring. They must, however, continue to ensure that only allowable indirect costs are allocated to nursing and allied health education cost centers, that the allocation statistics reflect a causal and beneficial relationship, and that salary and shared costs are appropriately apportioned and documented. CMS also confirmed that clinical staff salary costs must be reclassified based on documented time devoted to educational activities, not patient-care activities performed in the presence of students.

The decision provides meaningful administrative relief but does not eliminate CMS scrutiny of overhead and salary costs claimed as reimbursable nursing and allied health education expenses.

Reference pages: Final Rule Public Inspection PDF pp. 871-878.