

CMS' New CJR-X Model, Proposed Changes to TEAM Model and Updated Inpatient Hospital Payments and Policies

Summary Prepared for AAHKS from the 2027 Medicare Inpatient Prospective
Payment System Proposed Rule

April 16, 2026

Contents of Summary

- **Overview of Proposed Rule & Next Steps**
- **CJR-X and Proposed Changes to TEAM**
- **2027 IPPS Payment Rates for LEJR**
- **Graduate Medical Education Policies**

2027 Medicare IPPS Proposed Rule

- CMS released the FY2027 *Medicare Inpatient Hospital Prospective Payment System Proposed Rule* on Friday, April 10
- Included in the 576-page Rule are significant polices from the CMS Innovation Center (CMMI)
 - Proposed changes to the Transforming Episode Accountability Model (TEAM), which began in 2026
 - Proposed nationwide, mandatory indefinite expansion of the CJR, to be known as “CJR-X”, beginning 2028
 - CMS says “*The [CJR-X] presents an opportunity to further improve the quality of care for [LEJRs] furnished to Medicare beneficiaries nationwide by incentivizing hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization or procedure through recovery.*” Even though CJR achieved some savings, cost reduction is not an explicit CMS goal for CJR-X
- This document summarizes the major CJR-X parameters, compares them to TEAM, and also notes proposed changes to TEAM
- CMS raises important questions about the future role of ASCs and physician-owned hospitals in LEJR episode payment models
- Comments on the proposed rule are due June 9, 2026

Timeline of Next Steps

IPPS AND CJR-X

- **May 2026** – AAHKS develops substantive comments and feedback on IPPS proposed rule
- **June 9, 2026** – Public comments on the proposed rule due to CMS
- **May-June 2026** – CMS meets with stakeholders, like AAHKS, to hear directly about comments and questions, though CMS cannot answer questions or provide feedback until the Final Rule is published
- **June-July 2026** – CMS reviews public comments and drafts IPPS Final Rule internally
- **Late July/Early Aug. 2026** – CMS publishes IPPS Final Rule with any changes based upon public comments
- **Oct. 1, 2026** – FY 2027 payment rates go into effect; changes to TEAM go into effect
- **Oct. 1, 2027** – CJR-X performance year 1 begins

CJR-X and Proposed Changes to TEAM

MODEL OVERVIEW

	TEAM Model – With Proposed Changes	CJR-X Model (Proposed)	Notes
Performance Years (PY)	Jan. 1, 2026 - Dec. 31, 2030	Indefinite, beginning Oct. 1, 2027	Original CJR ran April 1, 2016 – Dec. 31, 2024
Model Type	Mandatory – Phase 1 test for select facilities	<p>Mandatory – Phase 2 nationwide expansion of CJR</p> <p>ACA grants the Sec. of HHS authority to expand a CMMI model nationwide if the following findings are made:</p> <ul style="list-style-type: none"> • expansion is expected to reduce spending w/o reducing quality of care, or improve the quality w/o increasing spending; • the CMS Chief Actuary certifies that such expansion would reduce (or hold level) net program spending; • expansion would not deny or limit the coverage or provision of benefits 	CMS reports that the Original CJR achieved savings to Medicare of \$112.7 million from 2022-2023 while maintaining quality of care as measured by ED visits, unplanned readmission rates, mortality rates, and LEJR complication rates
Participants	<ul style="list-style-type: none"> • All acute inpatient hospitals in approximately 190 randomly selected Core Based Statistical Areas (CBSAs) • Hospitals outside the select CBSAs that participated in the CJR or BPCI-A were given a one-time chance to opt-into TEAM • 722 hospitals total participating 	All acute inpatient hospitals in the nation, except for facilities already participating in TEAM and hospitals in Maryland.	The Original CJR was mandatory for hospitals in select in select Metropolitan-Based Statistical Areas (MBSAs)

CJR-X and Proposed Changes to TEAM

THE ROLE OF HOSPITALS, SURGEONS & ASCS

	TEAM Model – With Proposed Changes	CJR-X Model (Proposed)	Notes
Conveners	Only acute care hospitals act as Participants and model conveners that manage the episode	Only acute care hospitals will act as Participants and model conveners that manage the episode	<p>CMS notes:</p> <ul style="list-style-type: none"> Hospitals already manage discharge and placement recommendations Hospitals are more likely to have access to resources and capital necessary to appropriately manage and coordinate care through the episode
Role of Physicians	<ul style="list-style-type: none"> Physicians are “Downstream participants” with written arrangement with acute care hospitals that engage in TEAM activities Physicians and providers continue to bill Medicare as normal. At the end of the year, CMS reconciles total episode spending for the Participant Hospital against the retrospectively adjusted final target price Despite many comments in support, CMS declined to allow physician group practices to act as participants or conveners 	<ul style="list-style-type: none"> Physicians are “Downstream participants” with written arrangement with acute care hospitals for CJR-X activities Physicians and providers continue to bill Medicare as normal. At the end of the year, CMS reconciles total episode spending for the Participant Hospital against the retrospectively adjusted final target price Physicians may participate in gainsharing with Participant hospitals 	<p>CMS also notes:</p> <ul style="list-style-type: none"> It is more administratively feasible to manager fewer hospital Participants as opposed to physician groups CMS wants to test mandatory participation, and many physician groups lack resources, volume, or experience to succeed under the model
Role of ASCs	Despite requests from AAHKS and other organizations, CMS declined to include ASCs as convening Participants. Foremost, CMS states that including ASCs in TEAM would require CMS to also include PGPs	ASCs are not included as convening Participants. As CMS did not include ASCs in the Original CJR, CMS says it lacks basis to certify a national mandatory expansion to ASCs at this time	

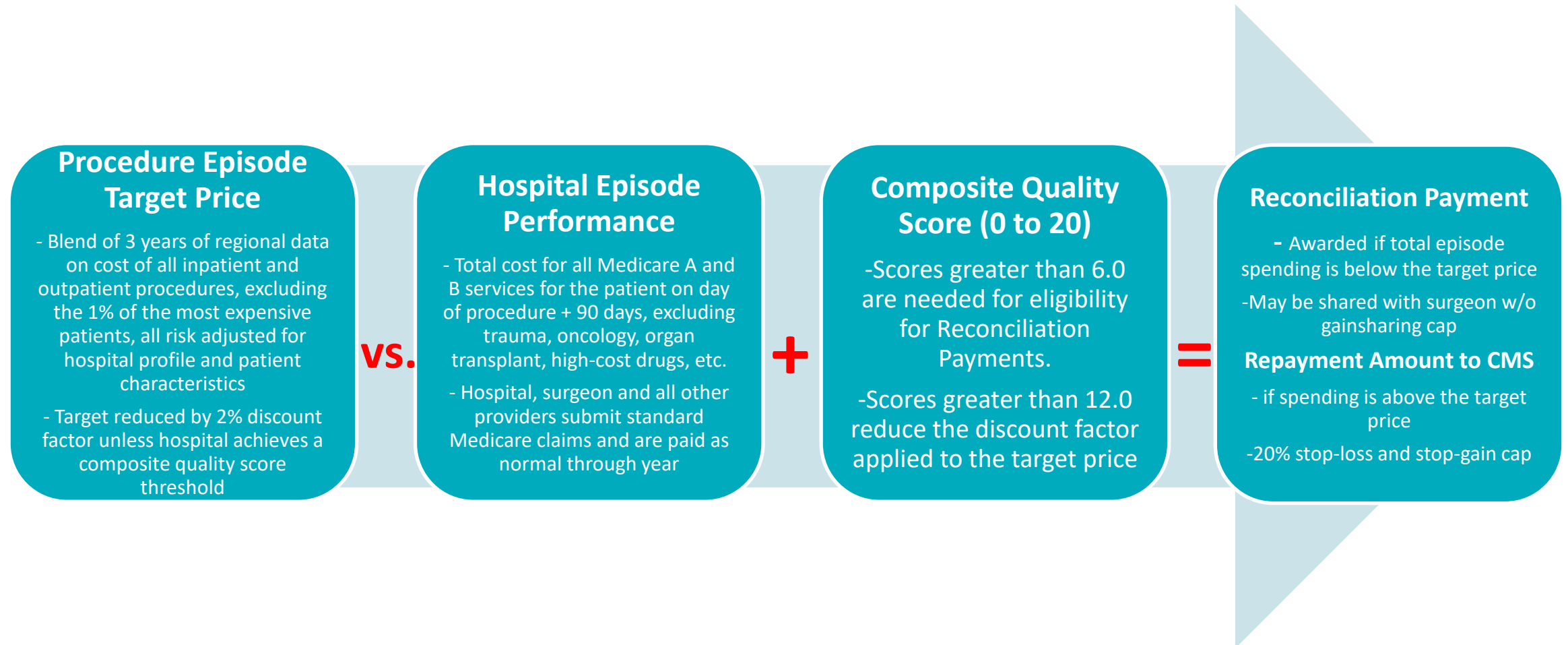
CJR-X and Proposed Changes to TEAM

SCOPE OF EPISODE

	TEAM Model – With Proposed Changes	CJR-X Model (Proposed)	Notes
Covered Procedures	<ul style="list-style-type: none"> LEJR: DRGs 469, 470, 521, 522; CPTs 27447, 27130, 27702 Surgical Hip/Femur Fracture Treatment (SHFFT): DRGs 480, 481, 482 Coronary Artery Bypass Graft Surgery (CABG) Major Bowel Procedure Spinal Fusion - CMS proposes expanding anchor spinal procedures to include DRGs 523, 524, 525 	<p>LEJR:</p> <ul style="list-style-type: none"> DRG 469 DRG 470 DRG 521 DRG 522 CPT 27447 CPT 27130 	<p>Unicompartmental (Partial) Knee Replacement is not included</p> <p>Also, CMS proposes to exclude total ankle arthroplasty (CPT 27702) from CJR-X as this was not previously tested under BPCI-A or CJR</p>
Services Included in Episode Costs	<p>Included: All <i>inpatient</i> and <i>outpatient</i> procedures and all Medicare Part A and Part B items and services during the episode, including physicians, SNF, home health, hospice, Part B drugs or biologics, DME and lab services, therapy, etc.</p> <p>Excluded: Trauma, oncology, organ transplant, diseases of the eye, pregnancy & childbirth, HIV, pass-through payments for medical devices, new technology add-on payments, hemophilia clotting factors, Part B payments for low-volume drugs, high-cost drugs and biologics, and blood clotting factors</p>	<p>Included: All <i>inpatient</i> and <i>outpatient</i> procedures and all Medicare Part A and Part B items and services during the episode, including physicians, SNF, home health, hospice, Part B drugs or biologics, DME and lab services, therapy, etc.</p> <p>Excluded: Trauma, oncology, organ transplant, diseases of the eye, pregnancy & childbirth, HIV pass-through payments for medical devices, new technology add-on payments, hemophilia clotting factors, Part B payments for low-volume drugs, high-cost drugs and biologics, and blood clotting factors</p>	<p>CMS expanded the Original CJR to include outpatient LEJR in 2022</p> <p>CMS notes that outpatient THA/TKA accounted for nearly 75% of episodes “at the end of the Original CJR”</p>
Episode Length	Anchor hospitalization + 30 days post-discharge	Anchor hospitalization + 90 days post-discharge	Despite more spending variability due to unrelated conditions, CMS still believes a 90-day episode generated savings under Original CJR. 90-day episode also aligns with the surgeon global payment timeframe

CJR-X Model Overview

PAYMENT DETERMINATION PROCESS



CJR-X and Proposed Changes to TEAM

PAYMENT – RECONCILIATION & ADJUSTMENTS

	TEAM Model – With Proposed Changes	CJR-X Model (Proposed)	Notes
Payments & Reconciliation	<p>All providers and suppliers furnishing care under TEAM are still paid under existing Medicare payment systems</p> <p>Following the end of a year, actual total spending for the episode would be compared to the Participant hospital’s risk adjusted target price for that procedure</p> <p>Participants may achieve a reconciliation payment if their total episode spending (adjusted by the Composite Quality Score) is below the target price, or they may owe a repayment amount if their spending is above the target price</p>	<p>All providers and suppliers furnishing LEJR care would continue to be paid under existing Medicare payment systems</p> <p>Following the end of a year, actual total spending for the episode would be compared to the Participant hospital’s risk adjusted target price</p> <p>Participants may achieve a reconciliation payment if their total episode spending is below the target price and they achieve a threshold Composite Quality Score. Or they may owe a repayment amount if their spending is above the target price</p>	
Risk Tracks	<p>TEAM offers 3 different participation tracks with varying levels of financial risk based on increasing stop-gain and stop-loss limits (capping total amount that a TEAM participant could owe to CMS as a repayment amount or receive from CMS as a reconciliation payment amount) for varying levels of participant experience and resources</p>	<p>CJR-X has only one financial risk track, though adjusted based on Composite Quality Score</p> <p>20% stop-loss and 20% stop-gain related to the target price would be applied to most Participants. Medicare-dependent, small rural hospitals and safety-net hospitals would have a stop-loss of 5%</p>	

CJR-X and Proposed Changes to TEAM

PAYMENT – TARGET PRICE/BENCHMARK

	TEAM Model – With Proposed Changes	CJR-X Model (Proposed)
Target Price Methodology	Target price is calculated using 3 years of rolling baseline episode spending, trended forward to the applicable performance year, to calculate target prices for each MS-DRG/HCPCS episode type by region. This approach is consistent with Performance Years 2019-2024 of Original CJR	<p>CMS proposes using 3 years of baseline data, rebased annually, trended forward to the performance year, to calculate target prices at the level of MS-DRG/HCPCS episode type within the region.</p> <p>Baseline data for procedure costs will be based wholly on regional data. CMS believes now that basing target prices on hospital-specific data makes a hospital compete against itself in a downward spiral of target prices. Use of regional prices is meant to ensure hospitals compete only against their peers in the region</p> <p>Both inpatient and outpatient costs will be grouped together for the purposes of pricing a procedure</p>
High-Cost Outlier Cap	<p>The high-cost outlier cap is the amount at which episode spending would be capped for the purposes of determining baseline and performance year episode spending.</p> <p>CMS defines the high-cost outlier cap the 99th percentile of regional spending for a given DRG/HCPCS episode type, region, and baseline year</p>	CMS proposes a high-cost outlier cap of 99% for each of the 4 procedures in each region when calculating the target price
Discount Factor	To capture savings for CMS, a 2% discount factor is applied to the target price for LEJR and SHFT episodes	<p>To capture savings for CMS, a 2% discount factor is applied to the target price for all procedures</p> <p>The discount factor is reduced to 1% for a Composite Quality Score above 12.0 and no discount factor is applied for a CQS of 17.0 or above</p>

CJR-X and Proposed Changes to TEAM

FINANCIAL ARRANGEMENTS & GAINSHARING

	TEAM Model – With Proposed Changes	CJR-X Model (Proposed)	Notes
Financial Arrangements	<p>Hospitals participating in TEAM have the option, but are not required, to enter into financial arrangements with certain providers and suppliers, such as surgeons, participating in TEAM activities to share their reconciliation payment amount or repayment amount resulting from participation in TEAM</p> <p>CMS encourages physician group practices to collaborate with TEAM Participant hospitals and “take advantage of establishing financial arrangements that would align financial incentives to improve quality of care and reduce Medicare spending”</p>	<p>CJR–X participants may wish to enter into financial arrangements with entities that support CJR–X activities to share their reconciliation payment amount or repayment amount. Partners could include providers and suppliers, as well as entities that assist with data analytics, provider engagement, care redesign planning, and other model related activities</p>	<p>CMS has declined to incorporate AAHKS’ request to require Participant hospitals to share savings with surgeons</p>
Physician Gainsharing	<p>In determining the amount of any gainsharing payments, a TEAM Participant’s gainsharing methodology may take into account the amount of such TEAM activities provided by a TEAM collaborator relative to other TEAM collaborators, however, gainsharing payments and alignment payments should not be based directly on volume or value of referrals</p> <p>Regulations detail strict provisions for establishing gainsharing agreements between Participant hospitals and surgeons</p>	<p>Proposed regulations detail strict provisions for establishing gainsharing agreements between Participant hospitals and surgeons</p> <p>No gainsharing cap</p>	<p>In 2021, CMS granted the AAHKS request to eliminate the cap on gainsharing amounts in Original CJR</p>

CJR-X and Proposed Changes to TEAM

RISK ADJUSTMENT OF PARTICIPANT TARGET PRICES

	TEAM Model – With Proposed Changes	CJR-X Model (Proposed)	Notes
Risk Adjustment Model	<p>-Risk adjust target prices at the hospital level using a bed size risk factor and a safety-net risk factor;</p> <p>-Risk adjust target prices at the beneficiary level using a 180-day lookback period to construct:</p> <ul style="list-style-type: none"> • “HCC count risk adjustment factor” • “age bracket risk adjustment factor” • “beneficiary economic risk adjustment factor” • certain conditions: <p>++ Ankle procedure or reattachment, partial hip procedure, partial knee arthroplasty, THA or hip resurfacing procedure, and TKA;</p> <p>++ Disability as the original reason for Medicare enrollment;</p> <p>++ Prior post-acute care use;</p> <p>++ HCC 17: Metastatic Cancer, Acute Myeloid Leukemia</p> <p>++ HCC 36: Diabetes with Severe Acute Complications; HCC 37: Diabetes with Chronic Complications; HCC 48: Morbid Obesity;</p> <p>++ HCC 125: Dementia, Severe; HCC 126: Dementia, Moderate; HCC 127: Dementia, Mild or Unspecified; HCC 151: Schizophrenia; HCC 155: Major Depression, Moderate or Severe, without Psychosis;</p> <p>++ HCC 199: Parkinson and Other Degenerative Disease of Basal Ganglia;</p> <p>++ HCC 224: Acute on Chronic Heart Failure; HCC 225: Acute Heart Failure; HCC 226: Heart Failure, Except End-Stage and Acute; HCC 238: Specified Heart Arrhythmias;</p> <p>++ HCC 253: Hemiplegia/ Hemiparesis;</p> <p>++ HCC 267: Deep Vein Thrombosis and Pulmonary Embolism;</p> <p>++ HCC 280: Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders;</p> <p>++ HCC 326: Chronic Kidney Disease, Stage 5; HCC 327: Chronic Kidney Disease, Severe (Stage 4);</p> <p>++ HCC 383: Chronic Ulcer of Skin, Except Pressure</p> <p>++ HCC402: Hip Fracture/Dislocation</p>	<p>-Risk adjust target prices at the hospital level using a bed size risk factor and a safety-net risk factor;</p> <p>-Risk adjust target prices at the beneficiary level using a 180-day lookback period to construct:</p> <ul style="list-style-type: none"> • “HCC count risk adjustment factor” • “age bracket risk adjustment factor” • “beneficiary economic risk adjustment factor” • certain conditions: <p>++ Ankle procedure or reattachment, partial hip procedure, partial knee arthroplasty, THA or hip resurfacing procedure, and TKA;</p> <p>++ Disability as the original reason for Medicare enrollment;</p> <p>++ Prior post-acute care use;</p> <p>++ HCC 17: Metastatic Cancer, Acute Myeloid Leukemia</p> <p>++ HCC 36: Diabetes with Severe Acute Complications; HCC 37: Diabetes with Chronic Complications; HCC 48: Morbid Obesity;</p> <p>++ HCC 125: Dementia, Severe; HCC 126: Dementia, Moderate; HCC 127: Dementia, Mild or Unspecified; HCC 151: Schizophrenia; HCC 155: Major Depression, Moderate or Severe, without Psychosis;</p> <p>++ HCC 199: Parkinson and Other Degenerative Disease of Basal Ganglia;</p> <p>++ HCC 224: Acute on Chronic Heart Failure; HCC 225: Acute Heart Failure; HCC 226: Heart Failure, Except End-Stage and Acute; HCC 238: Specified Heart Arrhythmias;</p> <p>++ HCC 253: Hemiplegia/ Hemiparesis;</p> <p>++ HCC 267: Deep Vein Thrombosis and Pulmonary Embolism;</p> <p>++ HCC 280: Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders;</p> <p>++ HCC 326: Chronic Kidney Disease, Stage 5; HCC 327: Chronic Kidney Disease, Severe (Stage 4);</p> <p>++ HCC 383: Chronic Ulcer of Skin, Except Pressure</p> <p>++ HCC402: Hip Fracture/Dislocation</p>	<p>In response to AAHKS comments, CMS added risk adjustment to Original CJR beginning in 2021. CJR adjusted only for age, HCC count, and “dually-eligible” status</p> <p>CMS acknowledged in later analysis that the original lack of risk adjustment was a barrier to access to value-based care for minority and disabled populations</p> <p>CMS proposes to use the TEAM risk adjustment model in CJR-X</p>

CJR-X and Proposed Changes to TEAM

CALCULATING THE COMPOSITE QUALITY SCORE (CQS) FROM EXISTING QUALITY MEASURES

	TEAM Model – With Proposed Changes	CJR-X Model (Proposed)	Notes
Quality Measures	<p>For all <i>inpatient episodes</i>:</p> <ul style="list-style-type: none"> Hybrid Hospital-Wide All Cause Readmission (Hybrid HWR) Measure with Claims and Electronic Health Record Data (CMIT ID #356); <p>For all <i>inpatient episodes</i> in PY1:</p> <ul style="list-style-type: none"> CMS Patient Safety and Adverse Events Composite (CMS PSI-90) (CMIT ID #135); <p>For all <i>inpatient LEJR episodes</i> in PY1–PY5:</p> <ul style="list-style-type: none"> Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient Reported Outcome-Based Performance Measure (PRO-PM) (CMIT ID #1618); <p>For all <i>inpatient episodes</i> in PY2–PY5:</p> <ul style="list-style-type: none"> Hospital Harm—Falls with Injury (CMIT ID #1518); (CMS proposes to align this reporting period with those under the Inpatient Quality Reporting System (IQR)) Hospital Harm— Postoperative Respiratory Failure (CMIT ID #1788); (CMS proposes to align this reporting period with those under the IQR) Thirty-day Risk— Standardized Death Rate among Surgical Inpatients with Complications (ISCMR) (CMIT ID #134); (CMS proposes to align this reporting period with those under the IQR) and <p>For all <i>outpatient LEJR</i> and Spinal Fusion episodes PY3–PY5:</p> <ul style="list-style-type: none"> Information Transfer Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM) (CMIT ID #1797) 	<ul style="list-style-type: none"> Hospital-level Risk-Standardized Complication Rate (RSCR) following elective primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (CMIT ID #350) Hospital Visits Within 7 days of Hospital Outpatient Department (HOPD) Surgery(CMIT ID #344 OP-36) Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)(CMIT ID #338) Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey (OAS CAHPS) (CMIT ID# 162) Hospital-Level Total Hip and/or Knee Arthroplasty (THA/TKA) Patient Reported Outcome (PRO) (CMIT ID # 1618) 	<p>Under CJR-X:</p> <ul style="list-style-type: none"> Complications measure performance will count for 50% of CQS Patient experience measures will be weighted at 40% of CQS PROs will be weighted at 10% of CQS, more heavily than under CJR <p>Unlike Original CJR, CJR-X will not reward hospitals for quality <i>improvement</i>. Rather, CMS will value actual level of quality performance achieved in CJR-X</p> <p>Participants receive a weighted CQS of up to 20 points based on percentile performance. Scores greater than 6.0 are needed for eligibility for Reconciliation Payments. Also, the Discount Factor is reduced for scores above 12.0</p>

CJR-X and Proposed Changes to TEAM

WAIVERS & EXCEPTIONS

	TEAM Model – With Proposed Changes	CJR-X Model (Proposed)	Notes
Safety Net & Rural Hospitals	<p>Eligibility for a participation track with less financial risk for:</p> <ul style="list-style-type: none"> • Medicare Dependent Hospitals (MDHs) • Rural Hospitals • Safety Net Hospitals • Sole Community Hospitals • Essential Access Community Hospitals 	<p>CJR-X would apply a 5% stop loss protection to:</p> <ul style="list-style-type: none"> • hospitals with a high proportion of dually eligible Medicare and Medicaid patients • “geographically rural” hospitals that do not necessarily fit the statutory definition of a rural hospital • MDHs • Rural Hospitals • Sole Community Hospitals 	
CMS Policy Waivers	<ul style="list-style-type: none"> • SNF 3-day rule waiver removes requirement that beneficiaries have a minimum 3-day inpatient hospital stay before being discharged to a SNF • Telehealth waiver removes both the geographic site requirements and the originating site requirements for telehealth visits 	<ul style="list-style-type: none"> • Home Visits – CMS will allow up to 9 post-discharge home visits to be billed during each 90-day episode. This limit on the number of visits is based on the average post-acute care LOS of approximately 30 to 45 days for original CJR episodes and the incentives under original CJR to improve efficiency, which may shorten post-acute care stays • SNF 3-day rule waiver removes requirement that beneficiaries have a minimum 3-day inpatient hospital stay before being discharged to a SNF • Telehealth waiver removes both the geographic site requirements and the originating site requirements for telehealth visits 	

CJR-X and Proposed Changes to TEAM

REQUESTS FOR INFORMATION

	TEAM Model – With Proposed Changes	CJR-X Model (Proposed)	Notes
ASCs as Participants	<p>As more LEJRs are being performed in ASCs, CMS seeks public input on the parameters under which ASCs could be incorporated into TEAM, including, model structure, participant roles and financial accountability, episode and target price construction, and quality measurement</p>	<p>CMS is not asking for information on ASCs’ potential role in CJR-X. CMS notes that, as TEAM is still in the Phase I testing, it has more flexibility in changing fundamental elements. Whereas, ASCs were not tested as participants in the Original CJR, therefore CMS feels it is constrained from considering a national policy to include them in CJR-X</p>	
Physician Owned Hospitals (POHs)	<p>Current law limits expansion of POHs. However, CMS says there is some evidence to suggest that POHs may help control costs, maintain or improve patient outcomes, and prevent hospital consolidation</p> <p>CMS is considering a future voluntary opt-in period to allow POHs in CBSAs not selected for TEAM participation, to participate in the model</p> <p>CMS seeks input on model design and operationalization for the inclusion of POHs</p>	<p>CMS is not asking for information on POHs’ potential role in CJR-X. CMS notes that, as TEAM is still in the Phase I testing, it has more flexibility in changing fundamental elements. Whereas, POHs were not tested as separate participants in the Original CJR, therefore CMS feels it is constrained from considering a national policy to include them in CJR-X</p>	

2027 Medicare Rates for Inpatient Hospital Procedures

PROPOSED RATES FOR LEJR PROCEDURES

- Proposed increase in all IPPS payment rates for FY 2027 is projected as +2.4% on average
- This reflects a projected FY 2027 hospital market basket percentage increase of 3.2%, reduced by a 0.8 percentage point productivity adjustment
- CMS expects the proposed changes in IPPS payment rates — in addition to other changes — will generally increase hospital payments by approximately \$1.4 billion.

MS-DRG	FY 2025		FY 2026		% Change from 2025	FY 2027 (Proposed)		% Change from 2026
	Weight	Rate	Weight	Rate		Weight	Rate	
469	3.2685	\$21,591	3.0332	\$20,483	-5.1%	3.1294	\$21,805	+6.4%
470	1.8855	\$12,455	1.9289	\$13,025	+4.6%	1.9700	\$13,726	+5.4%
521	2.9146	\$19,253	2.8702	\$19,382	+0.6%	2.8571	\$19,907	+2.7%
522	2.1082	\$13,926	2.1177	\$14,300	+2.7%	2.1237	\$14,767	+3.2%

NOTE: National Payment Amount – Projected by CMS as the baseline amount that will be paid nationally for the MS-DRG. This amount DOES NOT INCLUDE facility-specific calculation of teaching, disproportionate share, capital, and outlier payments for all cases. Assumes hospital with wage index greater than 1.0 that reported quality data and is a meaningful EHR user.

Graduate Medical Education (GME)

NEW PROGRAM REQUIREMENTS

Prohibit Unlawful Discrimination in Approved Medical Residency Programs

- Last year, CMS finalized new rules to state that residency program accrediting organizations may not use accreditation criteria that 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
- For 2027, CMS proposes 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

Modifications to the Criteria for New Residency Programs

- Medicare pays hospitals for the direct costs of approved GME programs on a per-resident basis. Statute requires CMS to apply a direct GME cap in medical residency training programs established since 1995
- CMS proposes that, effective for programs started on or after Oct. 1, 2026, in order for a residency program to be considered new, in addition to receiving initial accreditation from the appropriate accrediting body, at least 90% of the individual resident trainees (not FTEs) must not have previous training in the same specialty as the new program
- CMS would no longer consider the previous employment of the faculty or program director in determining whether a residency program should be considered genuinely new for cap-building purposes. That is, a hospital would no longer have to demonstrate that the faculty and program director in a new program have not previously been employed in an existing program in the same specialty