# Hospitals Warn of Medicare Pilot's Burden on Safety-Net Clinics

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The health agency's rule will hold hospitals in select geographic areas accountable for controlling costs associated with popular procedures.
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## Summary by Bloomberg AI

- A new mandatory payment model, the Transforming Episode Accountability Model, will hold hospitals accountable for controlling costs associated with certain procedures and promises bonuses to hospitals that save money.
- The model will require 741 acute-care hospitals to adopt a strategy to coordinate services for Medicare patients undergoing surgical procedures and will compare their spending against a cost benchmark.
- The American Hospital Association says the model will unfairly burden rural and safety-net facilities that lack the financial resources to implement the changes, including building technical infrastructure and workforce necessary to be successful in the program.

A new mandatory payment model that promises bonuses to hospitals that save money on costly surgeries is facing backlash over concerns it will unfairly burden rural and safety-net facilities that don't have the financial resources to implement the changes.

The **Transforming Episode Accountability Model,** introduced under the Center for Medicare & Medicaid Services fiscal 2026 Inpatient Prospective Payment System **final rule**, will hold hospitals in select geographic areas accountable for controlling costs associated with popular procedures such as coronary artery bypass grafts, lower

extremity joint replacement, major bowel procedures, surgical hip/femur fracture treatments, and spinal fusions.

Starting Jan. 1, 2026, hospitals selected for the five-year program will have their spending on these procedures compared against a cost benchmark. Facilities that meet the CMS's target price will be eligible for supplemental payments. Those who spend above the cost benchmark, however, could face repayments to the CMS.

The move is the latest step that the Trump and previous administrations have taken to curb the meteoric rise in Medicare spending, which according to the **Medicare Payment Advisory Commission** more than doubled between 2010 and 2023, increasing from $500 billion to over $1 trillion per year.

Other alternative payment models have made a modest dent in this spending. For example, Medicare's Shared Savings Program (MSSP), an alternative payment model that pays bonuses to hospitals and doctors that coordinate care and save money on treatments, netted over **$2.1 billion** in savings for the agency in 2023.

Unlike the MSSP, the TEAM model will be mandatory for all hospitals selected for participation, a move the American Hospital Association says will unfairly burden facilities that lack the financial resources to build the technical infrastructure and workforce necessary to be successful in the program.

"While many of our hospitals and health systems have participated in these types of models in the past, there have been barriers for certain hospitals to participate," said Jennifer Holloman, a senior associate policy director at the American Hospital Association.

"There is a significant amount of infrastructure investment that's required to participate and be successful," she said.

## Mandatory Model

TEAM is a trial spearheaded by the Center for Medicare and Medicaid Innovation, a division within the CMS that focuses on developing and testing new models of health-care delivery to improve quality for beneficiaries and save costs for the federal government.

Under the model, 741 acute-care hospitals across 188 geographic regions will be required to adopt a strategy to coordinate services for Medicare patients undergoing "episodes of care" for surgical procedures. This includes assuming responsibility for maintaining the costs and quality of care for patients from the day of surgery through the first 30 days after the Medicare beneficiary is discharged from the hospital.

According to Jeffrey Davis, health policy director at McDermott+ Consulting and former director of regulatory and external affairs at the American College of Emergency Physicians, the mandatory nature of the trial will allow the CMMI to glean insights not found in similar trials due to selection bias.

"I think this administration feels that in many cases, you can get better results from models if they're mandatory," Davis said. "Hospitals that tend to participate voluntarily are those in CMS's view that would do well in that model. But if you force everyone to participate, you actually get more actionable results."

## Industry Pushback

The AHA said in a **letter** to CMS Administrator Mehmet Oz that it was "eager for opportunities to participate in value-based payment arrangements" like TEAM, but the trade organization took issue with the program's selection methodology.

"They created strata based on certain criteria, including whether the hospitals were safety net or whether they had previously participated in models, and they used a higher weighting for those that had not previously participated or were safety net," Holloman said.

Joanna Hiatt Kim, AHA vice president of payment policy, said this selection process would put rural and safety-net facilities at a unique disadvantage because many of them would have to invest already scarce resources into bolstering their care coordination infrastructure.

These investments include strengthening hospitals' analytics capabilities, boosting quality reporting mechanisms, and hiring clinical staff who may not have been in their traditional care workflows, Holloman said.

During the policy's proposed rule stage, affected providers also expressed concern over the model's requirement that hospitals that furnish services above the CMS's target price repay the agency. The providers argued the mandate violated the Constitution's Fifth Amendment and the Medicare statute.

Despite these critiques, Davis of McDermott+ said the CMS has room to defend the policy and has issued other mandatory payment rules.

Davis points to the CMS's response in its **2026 IPPS payment rule**, where the agency noted that the Medicare statute "does not require that models be voluntary or be tested first as a voluntary model, but rather gives the Secretary broad discretion to design and test models that meet certain requirements as to spending and quality."

The CMS also added in its response that TEAM wasn't the first innovation center model that required participation from hospitals. The agency noted its Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals and the Home Health Value-Based Purchasing Model were both mandatory for facilities it selected.