CAPITOL STREET

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CMS Slips Mandatory Surgical Demo ‘26 In Hospital Rule

Savings to FFS are Minimal (<$1 B) & Arise Via Post-Acute Versus Surgery Techniques

Relevant Companies

Our Take & Next Up

CMS announced (here) a mandatory surgical demo (2026 start) in select regions of the country with minimal savings (<$1B) expected over five years, largely from post-acute care savings. CMMI is under pressure to provide concrete savings to the Medicare program as only a handful of demonstrations (out of ~60 programs at CMMI) have saved the program dollars while maintaining or improving quality. We note that the savings come primarily from post-acute care savings versus better techniques for Medicare beneficiaries undergoing expensive surgeries. The agency is asking for comments before finalizing the program. Link to IPPS here.

Key Points

Last week, CMS announced the Transforming Episode Accountability Model (TEAM), a mandatory 5-year, episode-based program starting in 2026 that has minimal savings (<$1B). The model requires acute care hospitals to coordinate care for FFS beneficiaries who undergo one of the surgical procedures below.

- lower extremity joint replacement,
- surgical hip and femur fracture treatment,
- spinal fusion,
- coronary artery bypass graft, and
- major bowel procedures.

The model is set to start on January 1, 2026, and run for five years, ending on December 31, 2030. Hospitals required to participate would be based on selected geographic regions, Core-Based Statistical Areas (CBSAs). Selected hospitals would be required to participate even if they have not had previous episode-based payment model or value-based care experience.

Selected acute care hospitals would assume responsibility for the cost and quality of care from surgery through the first 30 days post discharge. All participating hospitals would be required to refer patients to primary care services. Notably, Maryland is excluded as it participates in the Maryland Total Cost of Care Model. CMS is proposing to oversample CBSAs that have limited previous exposure to CMS' bundled payment models and CBSAs with a higher number of safety net hospitals. Eligible localities range from upstate New York, parts of Pennsylvania & Georgia, smaller localities in Texas, and parts of California, among others.

CBSAs with the highest number of safety net hospitals have 50% odds of being selected. These CBSAs include San Francisco-Oakland-Fremont, CA; Riverside-San Bernardino-Ontario, CA; New York-Newark-Jersey City, NY-NJ; Miami-Fort Lauderdale-West Palm Beach, FL; Los Angeles-Long Beach-Anaheim, CA; Chicago-Naperville-Elgin, IL-IN.

Post acute generates the savings and target price generation can be found below. CMS estimates that TEAM would result in net savings of $705 M across the 5 performance years. On the net, TEAM participants are expected to pay CMS $403 M. A majority of the additional savings likely come from decreases in post-acute rather than change in the costs of the procedures as CMS pushes for primary care referrals to lower post-surgical costs. CMS believes that the effect of TEAM on episode spending will be a reduction of 0 to 3%.

- **CMS will provide participating hospitals with a target price that would represent most Medicare spending during an episode of care**, which would include the surgery (including the hospital inpatient stay or outpatient procedure) and items and services following hospital discharge.
- **Target prices would be based on all non-excluded Parts A & B items and services included in an episode and would be risk-adjusted based on beneficiary-level factors.** Performance in the model will be assessed by comparing TEAM participants' actual Medicare FFS spending during a performance year to their reconciliation target price as well as by assessing performance on three quality measures.

There are 3 participation tracks based on risk, along with a one-year glide path, to on-ramp hospitals to ease into full financial risk.

- Track 1 would have no downside risk and lower levels of reward for the first year (10% stop-gain limit)
- Track 2 would be associated with lower levels of risk and reward for certain hospitals, such as safety net hospitals, for years 2 through 5 (10% stop-gain/stop-loss limit)
- Track 3 would be associated with higher levels of risk and reward for years 1 through 5 (20% stop-gain/stop-loss limit)

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