The NEW ENGLAND JOURNAL of MEDICINE

DECEMBER 5, 2024

Medicare's New Mandatory Bundled-Payment Program — Are We Ready for TEAM?

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In an era of rising U.S. health care spending, the Centers for Medicare and Medicaid Services (CMS) and other payers are increasingly testing alternative payment models that provide incentives for hospitals and physician groups to reduce expenditures. Bundled-payment programs, for example, set a target spending amount for a particular clinical "episode," which begins with a hospitalization or procedure and ends after a predetermined period, usually 30 or 90 days after discharge (see table). If participating organizations spend less than the target amount, they receive a financial bonus; if spending exceeds the target, they must pay a penalty.

Widely anticipated as a promising component of payment reform in Medicare, bundled payments have in reality had mixed results. CMS's flagship Bundled Payments for Care Improvement–Advanced (BPCI-A) initiative, a voluntary program that covers hospitalizations for various medical conditions and a range of procedures, has generated small spending reductions that have been dwarfed by the bonuses it has paid out, thereby leading to large financial losses for CMS.[1] The mandatory Comprehensive Care for Joint Replacement (CJR) program has similarly led to small spending reductions for hip and knee replacements but has disproportionately penalized hospitals serving large numbers of marginalized patients — even though these facilities have reduced spending by an amount similar to that of other hospitals.[2] Moreover, bundled payments haven't been associated with meaningful improvements in clinical outcomes.[3]

Despite these setbacks, CMS in April 2024 announced the newest iteration of bundled payments, the Transforming Episode Accountability Model (TEAM). Slated to launch in January 2026, TEAM will bundle payments for lower-extremity joint replacements, hip and femur fractures, spinal fusions, coronary-artery bypass graft procedures, and bowel procedures. During the model's implementation, it will be important for physicians and policymakers to monitor and potentially address several challenges related to participation rules, health equity, and the position of bundled payments within the broader payment landscape.

One important aspect of TEAM is that participation will be mandatory. The first cohort will consist of all hospitals in the geographic regions that are randomly selected for participation. Although controversial, mandating participation could help advance payment reform. A key limitation of voluntary models such as BPCI-A has been the ability of participants to opt in only when they are fairly certain they can meet spending-reduction targets and thus receive bonuses.

Current Medicare Bundled-Payment Models.*

Model Component	Comprehensive Care for Joint Replacement (CJR)	Bundled Payments for Care Improvement–Advanced (BPCI-A)	Enhancing Oncology Model (EOM)	Transforming Episode Accountability Model (TEAM)
Time frame	April 1, 2016, to December 31, 2024	October 1, 2018, to December 31, 2025	July 1, 2023, to June 30, 2030	January 1, 2026, to December 31, 2030
Participation rules	Mandatory, with voluntary stay-in option	Voluntary	Voluntary	Mandatory, with later voluntary opt-in option
Participants	Hospitals	Hospitals and physician groups	Oncology physician groups	Hospitals
Bundles offered	Hip replacements, knee replacements, and ankle replacements	Cardiac care, cardiac procedures, gastrointestinal surgery, gastrointestinal care, neurologic care, medical and critical care, spinal procedures, and orthopedics	Chemotherapy for breast cancer, chronic leukemia, small-intestine or colorectal cancer, lung cancer, lymphoma, multiple myeloma, or prostate cancer	Lower-extremity joint replacements, hip and femur fracture surgeries, spinal fusions, coronary-artery bypass graft procedures, and major bowel procedures
Episode length	90 days	90 days	6 months	30 days
Separate risk tracks	No	No	Yes	Yes
Conveners allowed	Yes	Yes	No	Yes
Climate change initiative included	No	No	No	Yes

* BPCI-A is the successor to the Bundled Payments for Care Improvement model; EOM is the successor to the Oncology Care Model. Conveners are organizations that contract with participants to provide supportive services, such as data analysis or care navigation; in turn, they share in financial bonuses or penalties that their partners accrue under the model. TEAM is the first payment model to include a climate change initiative, under which the Centers for Medicare and Medicaid Services will calculate energy ratings for hospitals and report on hospital emissions.

This loophole has contributed to financial losses for CMS by shifting the pool of participating hospitals toward those that are likely to earn bonuses and away from those that are likely to have to pay penalties.[1] Because TEAM is mandatory, evaluations of spending outcomes at participating and nonparticipating hospitals could resemble a randomized, controlled trial. By eliminating opportunities for strategic participation, CMS will also increase its chances of achieving savings.

Mandatory participation, however, comes with its own challenges. Spending reductions in the BPCI-A program have been small.[1] Since TEAM will use similar incentive structures, large spending reductions might not be expected among hospitals that are required to participate, given that even those that chose to participate fared poorly under BPCI-A. Participants may have opted in to BPCI-A because they saw opportunities to meet spending-reduction targets without making major practice changes, however.[1,3] By requiring participation, TEAM may offer a more pressing incentive for organizational change.

Second, whereas hospitalizations for medical conditions such as heart failure, sepsis, and stroke account for half the bundles in the BPCI-A program, TEAM focuses solely on procedural bundles. On one hand, patients who undergo procedures tend to be more medically homogeneous than those who are hospitalized for other types of care, and predictable care pathways for procedures can make them easier to bundle into discrete episodes. Procedures are also easier to "nest" within payment models that are designed to cover longitudinal care, such as accountable care organizations. On the other hand, however, once BPCI-A is phased out in 2025, many of the most commonly selected nonprocedural bundles will no longer be included in any alternative payment program, and there will thus be fewer alternative payment models focused on specialty care.

Third, unlike the BPCI-A and CJR programs, TEAM incorporates design components explicitly intended to support health equity. In the first year, all participating hospitals will be eligible to receive bonus payments but won't have to pay penalties. Starting in the second year, safety-net hospitals, which have historically been disproportionately penalized under some bundled-payment programs, will be able to opt in to a lower-risk track in which potential penalties (and bonuses) are smaller than those in the standard track.[2,4]

Supporting equity in TEAM will require more than just limiting losses, however; in particular, it will require paying close attention to target spending amounts. TEAM will assign all hospitals in a geographic region similar target prices, which will be calculated on the basis of the hospitals' collective

historical spending patterns. We believe regional targets merit reconsideration. For hospitals with historically low spending, spending targets would be raised (i.e., made easier to meet) if neighboring hospitals had high historical spending; targets for high-spending hospitals would be lowered (i.e., made harder to meet) if neighboring hospitals had low historical spending. Instead of encouraging spending reductions at all hospitals, regional target prices might therefore allow low-spending hospitals to earn bonuses without improving operations, whereas high-spending hospitals might be penalized despite making improvements. Indeed, regional target prices in the CJR program have had this effect.[2]

Another concern regarding regional target prices is their reliance on risk adjustment. Target spending amounts will be adjusted individually for each participating hospital to account for differences in the medical and social risk factors of the patient populations served by various hospitals in a particular region. Implementing appropriate risk adjustment in payment models has been exceedingly difficult, however, which is one of the primary reasons such models have disproportionately penalized hospitals serving marginalized communities. For example, CJR initially offered hospitals individualized target prices based on their historical spending patterns but eventually shifted to inadequately risk-adjusted regional targets. This policy change correlated with a substantial increase in the proportion of safety-net hospitals being penalized.[4] Although TEAM's target prices will account for patients' age and coexisting conditions as well as income- and geography-based markers of risk, such factors lack the granularity needed for adequate risk adjustment.

An audio interview with Karen Joynt Maddox is available at NEJM.org

CMS could consider providing hospitals in TEAM with individualized target prices based on each hospital's historical spending, a precedent set in the BPCI-A program. This approach could encourage spending reductions at all hospitals and would obviate the need for complex risk adjustment, since spending performance wouldn't be compared among hospitals. BPCI-A stands out as the only payment model that doesn't compare performance among hospitals and the only model that doesn't disproportionately penalize safety-net hospitals.[1] Moving from regional to individualized target prices could therefore support equity in TEAM.

Finally, it will be crucial to consider the positioning of TEAM, and bundled payments in general, within the broader payment landscape. Despite being branded as alternative payment models, bundled-payment programs are built on fee-for-service systems that discourage spending reductions. Hospitals in bundled-payment programs tend to lower per-episode spending by reducing utilization of services not at their own site, which would cause them to forgo fee-for-service revenue, but at postacute care sites, such as skilled nursing and inpatient rehabilitation facilities. This practice is concerning. Large reductions in utilization of and revenue for postacute care facilities during the Covid-19 pandemic and because of payment denials in Medicare Advantage have resulted in staffing cuts and facility closures. Further reducing postacute care utilization could exacerbate these disruptions and strain critical components of the postacute and long-term care systems. Decreasing utilization of postacute care has also had important societal ramifications, including a shift in the burden of providing care from Medicare-reimbursed facilities to nonreimbursed caregivers — most often family and friends — at home.[5]

Physicians and policymakers might reasonably question the role of bundled payments in the broader payment landscape, especially given that such models have led to net financial losses for CMS, have disproportionately penalized safety-net hospitals, and haven't improved clinical outcomes, all while generating small reductions in spending on postacute care at the expense of nonreimbursed caregivers. Is there a viable role for bundled payments in the future of payment reform? TEAM may provide some answers.

Disclosure forms provided by the authors are available at NEJM.org.

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This article was published on November 30, 2024, at NEJM.org.

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DOI: 10.1056/NEJMp2410850