What is CMS TEAM?

Transforming Episode Accountability Model (TEAM) is a mandatory, episode-based, alternative payment model (APM) beginning January 1, 2026. Selected acute care hospitals will coordinate care for people with Traditional Medicare undergoing one of the surgical procedures included in the model. The hospital will assume responsibility for cost and quality of care from surgery through the first 30 days after the patient is discharged from the hospital. The TEAM APM is anticipated to run through December 31, 2030.

Purpose: Oftentimes, patients that have surgery experience uncoordinated care, as they transition from the hospital or surgery center, to post-acute settings (such as rehabilitation, skilled nursing, home health, long term acute care hospitals or outpatient therapy facilities), which can lead to breakdowns in communication and poor implementation of best clinical care practices, delayed recovery, suboptimal outcomes, readmissions and/or visits to the emergency department at a hospital.

Goal: To improve the patient experience from surgery through recovery by supporting the coordination and transition of care between providers and promoting successful recovery. This will help reduce avoidable hospital readmissions and emergency department use and improve patient outcomes.

Payment: Participating hospitals will receive a Medicare-determined payment that covers the surgery and care **through 30 days after discharge**, including service following discharge, such as skilled nursing facility (SNF) and provider follow up visits. This is different from the traditional Inpatient Prospective Payment System (IPPS) payment model, where they are paid by the Diagnosis Related Group (DRG) for the inpatient stay or outpatient surgery (the current episode of care) ***not*** the transitions of care between entities during the additional 30 days post-surgery. **This is the first mandatory model to include post-discharge care in the bundled episode payment since the Comprehensive Care for Joint Replacement (CJR) and BPCI Advanced models.**

If the hospital keeps the cost below the target price while maintaining quality, it may receive a reconciliation payment (bonus). If costs exceed the target, and/or quality of care is impacted the hospital may owe repayment to Medicare.

How the Reconciliation Bonus Works

1. Target Price: CMS sets a benchmark cost for each surgical episode, based on historical regional trends usually based on three years of prior data. Then applies a Medicare discount of 1.5-3%.
2. Actual Episode Spending: After the episode concludes (surgery + 30 days post-discharge), CMS calculates the total Medicare spending for that patient's care.

Performance is determined six months after performance year end using claims data to determine actual vs target costs and a composite quality score to reconcile payments.

- Quality metrics included: Hospital readmission rates, Patient-reported outcome measures (PROMs), Complication and infection rates, and Patient Experience (HCAHPS).

3. Bonus Eligibility:
    - If actual spending < target price, and
    - The hospital meets or exceeds quality performance thresholds (e.g., low readmissions, good patient outcomes),
    - Then the hospital is eligible for a reconciliation bonus payment.
4. Bonus Amount:
    - The bonus is the difference between the target price and actual spending, adjusted for quality.
    - There is a risk cap with three stop-gain and stop-less limits:
        - Track 1: Upside only (10%)
        - Track 2: ±5%
        - Track 3: ±20%
    - Track 3 example: If a hospital's annual Medicare payments total $6.4 million, the maximum bonus (or penalty) under a 20% risk cap would be $1.28 million

Only the following surgical procedures are included in TEAM:

- Lower extremity joint replacement (LEJR)
- Surgical hip femur fracture treatment
- Spinal fusion
- Coronary artery bypass graft
- Major small and large bowel procedure

What organizations are impacted?

CMS selected acute care hospitals (see list of hospitals) for mandatory participation based on participation in the IPPS and geographic region. Hospitals not selected, that meet eligibility criteria had the option to opt-in and voluntarily participate by the end of January 2025.

Participating hospitals are expected to coordinate care beyond the acute inpatient stay including: pre-operative planning, post-acute care, rehabilitation and follow-up visits and patient education for patients undergoing one of the five surgical procedures included in TEAM. The LEJR and Spinal Fusion procedures are **also included if performed as outpatient procedures** in the HOSPITAL outpatient setting only.

Preparation: Participating hospitals are educating themselves about the requirements at this time, and identifying the current status and impact of the following:

- Value-based partnerships: Preferred facilities, prepared to commit to the care model, such as:
    - Skilled nursing facilities

    - Rehab facilities
    - Long term care facilities
    - Home health
- Medical management: Review processes and where improvements are needed.
    - Existing and best practice clinical support such as care pathways, policies, and procedures.
    - Care Pathway Optimization
    - Data Infrastructure
    - Staffing/Training
- Patient-centered Metrics: Identify & quantify the following specifically related to the five included surgical procedures:
    - Patient volumes
    - Readmission rates
    - PSI rates
    - Surgical site infection rates
    - HAC rates
    - Patient Satisfaction rates
    - Post discharge ER utilization
    - Patient Reported Outcome Measures (PROMs)

How can Workforce Accelerator support organizations participating in TEAM?

1. Competencies in ALL eight domains of Healthcare Quality Competency Framework are needed to support a successful TEAM model.
2. Organizations should identify competency gaps and provide competency-based upskilling to ensure the staff has the knowledge and skills to interpret requirements, support the program, identify/mitigate risks, and make sustainable improvements.
3. Workforce Accelerator equips the quality and safety team with competencies to help them develop an approach to understand the drivers for the TEAM model and address the drivers at an organizational level, such as
    a. Facilitating data interpretation and visibility: understanding current metrics and their performance and their impact on processes, and competencies related to building structured data reporting integrating with all appropriate metrics and data sources.
    b. Problem solving and applying a performance improvement approach: the ability to identify root causes and contributors to current performance, how to identify current processes, how to develop a project to identify gaps and improve processes/develop standard work, and how to identify and include key stakeholders and facilitate change
    c. Identifying and addressing education needs: the skills and tools needed to understand who and what should be included in education forums
    d. Identifying how quality leadership and stakeholders can be aligned with the work:
        i. Build accountability within the teams that ensures efforts remain prioritized.

ii. Guide teams in long-term integration of competencies within the organization to support quality and safety initiatives outside of TEAM.

Glossary:

Alternative Payment Model (APM): is a payment approach that incentivizes healthcare providers to deliver high-quality coordinated care. They can apply to a specific health condition, care episode, provider type, community, or innovation within Medicare Advantage, Medicare Part D, or Medicaid.

Inpatient Prospective Payment System (IPPS): The IPPS pays a flat rate based on the average charges across all hospitals for a specific diagnosis, regardless of whether that particular patient costs more or less. Under the IPPS, each case is categorized into a diagnosis-related group to determine the base rate.

Diagnosis Related Group (DRG): A system implemented to categorize patients with similar clinical diagnoses in order to better control hospital costs and determine payor reimbursement rates.

Hospital Acquired Condition (HAC): Hospital Acquired Conditions represent instances where the team has introduced harm to patients and typically results in penalties from Medicare/Medicaid. These penalties are aligned with the hospital HAC score as rated against a national average with a lower score being better.

Patient Safety Indicator (PSI): Quality measures that make use of a hospital's available administrative data. The PSIs reflect the quality of inpatient care but also focus on preventable complications and iatrogenic events.

For more information:

List of participating hospitals: TEAM Participant List

Transforming Episode Accountability Model (TEAM) | CMS

TEAM Model Overview Webinar Slides

TEAM Model Frequently Asked Questions | CMS

NAHQ Learning Lab