# TEAM: The new mandatory CMS model replacing CJR

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# Model overview

The Transforming Episode Accountability Model is a proposed mandatory episode-based alternative payment model. **Under TEAM, acute care hospitals located in selected core-based statistical areas would be responsible for coordinating care for traditional Medicare beneficiaries undergoing specified surgical procedures in inpatient and outpatient settings.**

These hospitals would be responsible for the cost and quality of care from surgery through the first 30 days post-discharge. TEAM aims to improve care transitions, enhance patient outcomes and reduce avoidable readmissions by fostering better coordination between hospitals and primary care providers.

## The surgical procedures included in TEAM:

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

Participating hospitals would receive regional target prices from CMS encompassing most Medicare spending during the episode, including surgery and post-discharge services such as skilled nursing facility stays and follow-up visits. By holding hospitals accountable for the total costs of care, TEAM incentivizes improved care coordination and patient outcomes.

*TEAM is a proposed five-year, mandatory model for acute care hospitals located in selected CBSAs, starting January 2026.*

# Model highlights

- Traditional Medicare beneficiaries undergoing surgery often experience fragmented care, leading to complications and avoidable readmissions.
- TEAM aims to improve patient experience from surgery through recovery by enhancing care coordination and transitions, thus reducing hospital readmissions and emergency department visits.
- Hospitals would be required to refer patients to primary care services to support continuity of care and long-term health outcomes.
- Health equity is prioritized in TEAM, offering flexibilities such as lower risk and reward tracks for safety net hospitals and pricing adjustments for underserved populations.

# Model purpose

In the current Medicare fee-for-service payment system, providers are paid separately for each service, leading to fragmented care and potentially higher costs. TEAM proposes an episode-based payment approach where hospitals receive target prices covering all costs associated with the episode of care, with limited exclusions. This approach holds hospitals accountable for spending and quality performance, motivating better care coordination and improved quality.

By including lower extremity joint replacement, surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft and major bowel procedures, TEAM aims to enhance care transitions and incentivize higher value care across inpatient and post-acute settings for these specific high-volume surgical procedures.

# Model design: Goals and participation tracks

**TEAM is a proposed five-year, mandatory episode-based payment model starting January 2026.** The model includes a one-year glide path for participants to ease into full financial risk.

CMS intends to use a stratified random sampling methodology to select 25% of the CBSAs that it has identified as eligible for TEAM. Using this approach, eligible CBSAs have between a 20% and 50% probability of being selected based on their assigned stratum.

Hospitals would be required to participate in TEAM if they're located in any of the estimated 200 CBSAs across the United States that will be selected, exposing hospitals in these regions to mandatory two-sided risk for the five included surgical episodes of care. These episodes will span 30 days and can be triggered in both the inpatient and outpatient settings.

## Model goals as defined by CMS:

- ✓ quicker recovery after surgery;
- ✓ fewer avoidable hospital and ED visits;
- ✓ shorter hospital/post-acute care stays;
- ✓ smoother transitions back to primary care;
- ✓ lower costs; and
- ✓ more equitable health outcomes.

# TEAM has three participation tracks

Track 1: **No downside risk and 10% stop-gain limit** for Performance Year 1. Quality adjustment ≤10% for positive reconciliation amounts.

Track 2: **Upside and downside risk with 10% stop-gain/stop-loss limits** for Performance Years 2-5, available to hospitals that meet certain criteria (Safety Net, Rural, Medicare Dependent, Sole Community or Essential Access Community). Quality adjustment ≤10% for positive reconciliation amounts ≤15% for negative reconciliation amounts.

Track 3: **Upside and downside risk with 20% stop-gain/stop-loss limits** for Performance Years 1-5, available for all TEAM participants. Quality adjustment ≤10% for positive and negative reconciliation amounts.

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Episodes begin with a hospital stay or outpatient procedure for the included surgeries and end 30 days post-discharge. Hospitals would continue to bill Medicare FFS but receive regional target prices based on all non-excluded Medicare Parts A and B items and services, risk-adjusted based on beneficiary-level factors.

Performance is assessed by comparing actual Medicare FFS spending to regional, risk-adjusted target prices and evaluating three quality measures: hospital readmissions, patient safety and patient-reported outcomes.

TEAM aligns with the CMS Innovation Center strategy to drive accountable care and integrate specialty and primary care. It allows beneficiaries receiving care from Accountable Care Organizations to participate in TEAM episodes, promoting collaboration to improve care quality and reduce costs. Hospitals are required to refer patients to primary care services to support long-term health outcomes.

# Additional model objectives

## Health equity strategy

TEAM supports CMS' broader efforts to promote health equity by increasing access to high-quality, coordinated care across the continuum. The model offers flexibility to hospitals serving underserved populations, such as participating in lower risk and reward tracks.

The target price methodology includes a social risk adjustment to account for the additional financial investment needed for underserved individuals. TEAM's beneficiary-level social risk adjustment includes consideration for full dual eligibility status, residential Area Deprivation Index percentile and qualifying for the Medicare Part D Low Income Subsidy.

Participating hospitals must submit health equity plans, report sociodemographic data to CMS and screen individuals for health-related social needs to address disparities and support continuous quality improvement.

## Decarbonization and resilience initiative

TEAM also supports federal efforts to improve care quality by enhancing a health systems' climate resilience and sustainability. Participating hospitals can voluntarily report greenhouse gas emissions metrics and receive individualized feedback and public recognition. Hospitals would have access to technical assistance and learning systems to improve organizational sustainability, support care delivery methods that lower emissions and identify tools to measure emissions.

# TEAM participation: Are you prepared?

By implementing TEAM, CMS aims to create a more integrated, efficient and equitable healthcare system for traditional Medicare beneficiaries undergoing significant surgical procedures. The model's approach addresses both healthcare delivery and broader environmental sustainability, fostering a holistic improvement in patient care and health system resilience.

## Start planning now before you enter mandatory participation status

Feel confident that your acute care hospital can tackle the mandatory TEAM program. With over a decade of experience in CMS alternative payment models, we'll provide you with the data analytics and professional support you need to thrive.

We make it easy for you to navigate complicated CMS methodology and payment structures. Our experts will walk you through Medicare payment policies, the TEAM-specific methodology and the reconciliation process to position you for potential savings and prepare your leadership for factors that could impact incentives.

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