APPLIED POLICY®

CMS Proposes Changes to the Transforming Episode Accountability Model (TEAM)

On April 11, 2025, the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2026 Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System proposed rule. CMS released a fact sheet and a press release accompanying the rule. The rule includes proposed modifications to the mandatory Transforming Episode Accountability Model (TEAM). These modifications address participation, quality measurement, target pricing, and care delivery. TEAM was previously finalized and hospitals were selected for participation in the (FY) 2025 Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System final rule.

OVERVIEW

TEAM is a mandatory, episode-based payment model set to begin on January 1, 2026, and run through December 31, 2030. It applies to acute care hospitals reimbursed under the Hospital Inpatient Prospective Payment System (IPPS). The model's episodes are initiated by select inpatient and outpatient procedures, including lower extremity joint replacement (LEJR), surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft (CABG), and major bowel procedure, and extend 30 days post patient discharge. During this episode window, hospitals are accountable for the cost and quality of the care across Medicare Parts A and B.

Hospitals will continue to bill under traditional Medicare Fee for Service (FFS), but financial incentives are tied to cost containment and quality. CMS will set price targets based on predicted spending, and hospitals may either receive bonus payments or be subject to repayments depending on whether actual costs fall below or exceed these targets. This model also includes a pay-for-performance quality adjustment based on a Composite Quality Score (CQS), and features stop-gain and stop-loss limits to manage financial exposure, similar to past episode-based models like the Comprehensive Care for Joint Replacement (CJR) Model and the Bundled Payments for Care Improvement (BPCI).

EPISODE DEFINITIONS

Each TEAM episode begins either on the day of a qualifying outpatient procedure or the date of admission associated with an inpatient hospitalization. The episode continues for 30 days following the patient's discharge. During this window, all Medicare Part A and B services are included, unless they fall under specifically excluded categories intended to ensure the model only captures services directly related to the anchor procedure or hospitalization.

Bundled items and services under the TEAM model include durable medical equipment (DME) and most Part B drugs and biologicals. The Medical Severity- Diagnosis Related Groups (MS-DRGs) and HCPCS codes that trigger a TEAM episode are outlined in Table 1., and the services excluded from episode calculations[1] are listed in Table 2.

Table 1. Proposed Categories and Billing Codes[2]

Episode Category	Billing Codes (MS-DRG/HCPCS)
LEJR	MS-DRG 469, 470, 521, 522 HCPCS 27447, 27130, 27702
SHFFT	MS-DRG 480, 481, 482
CABG	MS-DRG 231, 232, 233, 234, 235, 236
Spinal fusion	MS-DRG 453, 454, 455, 459, 460, 471, 472, 473 HCPCS 22551, 22554, 22612, 22630, 22633
Major bowel procedure	MS-DRG 329, 330, 331

Table 2. Services Excluded from TEAM Episode Calculations

Category	Excluded Items/Services	Details/Criteria
Unrelated Services	Inpatient hospital admissions for select MS–DRGs and MDCs	- MS–DRGs grouped into the following diagnosis categories: (A) Oncology (B) Trauma medical (C) Organ transplant (D) Ventricular shunt - Admissions in the following Major Diagnostic Categories (MDCs): (A) MDC 02 – Eye disorders (B) MDC 14 – Pregnancy/childbirth (C) MDC 15 – Newborns (D) MDC 25 – HIV
NTAP	New Technology Add-on Payments	As defined in 42 CFR part 412, subpart F
Device Pass-Through	Transitional pass-through payments for medical devices	As defined in 42 CFR § 419.66

[1] 89 FR 69921

[2] TABLE X.A.-04 in the unpublished FY 2025 IPPS/LTCH PPS final rule.

Category	Excluded Items/Services	Details/Criteria
Hemophilia Inpatient	Hemophilia clotting factors	Per 42 CFR § 412.115
Part B Drugs (Baseline)	Low-volume, high-cost drugs/biologicals and hemophilia clotting factors (Baseline Period)	- HCPCS billed in <31 episodes across TEAM - HCPCS billed in ≥31 episodes and mean cost >$25,000/episode - HCPCS for clotting factors (identified in ASP files or newly introduced)
Part B Drugs (Performance Year)	Low-volume, high-cost drugs/biologicals and hemophilia clotting factors (Performance Year)	- HCPCS not in baseline & ≤10 episodes in PY - HCPCS not in baseline & >10 episodes in PY & cost >$25,000/episode - HCPCS not in baseline & >10 episodes in PY & cost ≤$25,000 & correspond to a drug from baseline but with new code - HCPCS for new hemophilia clotting factors

PAYMENT METHODOLOGY

Annually, CMS will reconcile each participant's spending on episodes against target prices, applying several adjustments:

1. Risk adjustment at the beneficiary level
2. CQS-based quality adjustment
3. Stop-loss and stop-gain caps
4. Post-episode spending review

Consistent with the CJR model, reconciliation will occur 6 months after the end of the performance year to allow for half a year of claim runout. This reconciliation produces a Net Payment Reconciliation Amount (NPRA), which includes any penalty or bonus based on cost, quality, and outlier spending. To mitigate gaming incentives, CMS will assess post-episode spending and penalize outlier activity beyond three standard deviations of the regional norm. If post-episode spending is greater than three standard deviations above the regional average, then the difference between this three standard deviation threshold and the post episode spend would be either added to the repayment amount the hospital owed CMS or subtracted from the reconciliation amount CMS owed the hospital.

Additionally, CMS proposes using the 99th percentile of episode costs within each MS-DRG/HCPCS and region pair to cap extreme outlier cases and seeks feedback on including the model's baseline year in this cap calculation.

RISK TRACKS AND PARTICIPATION FLEXIBILITY

TEAM participants will enter one of three financial risk tracks.

Track 1 will have no downside risk and be available to all participants in the first year of the model. Safety net hospitals will be allowed to remain on this track for three years to allow them more time to adjust to episode-based payment models.

Track 2 will only be available in years 2-5 of the model, and only for the following types of participants: safety net hospitals, rural hospitals, Medicare dependent hospitals (MDHs), sole community hospitals (SCHs), and essential access community hospitals. To reduce the risk taken on by these participants, Track 2 will have lower stop-loss and stop-gain limits, and allow for larger reductions to repayment amounts owed to CMS via CQS adjustments.

Beginning in the second year of the model, Track 2 participants will have the option to switch between Track 2 and Track 3 on an annual basis.

Track 3 will be used by all participants who do not qualify for Track 2 after the first year of the model.

The stop-gain/stop-loss limits and CQS adjustment limits for each track are outlined in Table 3.

Table 3. Financial Risk Tracks Under TEAM

Track	Financial Risk
Track 1	• Upside risk only (10% stop-gain limit) • CQS adjustment percentage of up to 10% for positive reconciliation amounts
Track 2	• Upside and downside risk (5% stop-gain/stop-loss limits) • CQS adjustment percentage of up to 10% for positive reconciliation amounts and CQS adjustment percentage of up to 15% for negative reconciliation amounts
Track 3	• Upside and downside risk (20% stop-gain/stop-loss limits) • CQS adjustment percentage of up to 10% for positive and negative reconciliation amounts

CMS PROPOSES CHANGES TO PARTICIPATION IN THE TEAM MODEL IN THE FY 2026 IPPS PROPOSED RULE

CMS utilized a stratified random sampling methodology to select Core Based Statistical Areas (CBSAs) for required participation in the TEAM model. All hospitals within a selected CBSA are mandated to participate. In total, CMS selected 188 CBSAs for TEAM, representing approximately 23.4 percent of eligible CBSAs. A list of selected CBSAs can be found in Table X.A.-07 of the FY 2025 IPPS /LTCH PPS final rule.

Additionally, hospitals that participated in either BPCI Advanced or CJR model and remained active through the end of those models (December 31, 2025, and December 31, 2024, respectively) were offered the opportunity to voluntarily opt-in to TEAM regardless of whether their CBSA was selected for participation. Hospitals that opted in by January 31, 2025, cannot opt-out of the model after joining.

In the FY 2026 proposed IPPS rule, CMS introduces a limited deferment period for hospitals that are newly established or newly meet the criteria for TEAM. These hospitals would not be required to participate for at least one performance year. CMS defines "new hospitals" as those with new Medicare certification numbers (CCN), issued after December 31, 2024.

CMS also proposes that a hospital no longer meets the qualification criteria for TEAM, its participation would terminate effective the date the criteria are no longer met. Under this proposal, CMS would notify the hospital that it no longer meets the definition of TEAM within 30 days, or as soon as reasonably practical.

To address the scheduled expiration of the Medicare Dependent Hospital (MDH) designation on September 30, 2025, CMS proposes a transition policy. If the MDH program is not extended by Congress, affected hospitals will be reimbursed under the standard IPPS rate starting in FY 2026. However, CMS proposes that MDH hospitals remain eligible for Track 2 participation in TEAM as long as the MDH designation is active at the time track selections are due.

CMS is seeking comment on all of the above participation proposals. In addition, CMS requests feedback on related issues such as:

- Indian Health Service (IHS) hospital outpatient episodes
- Low-volume hospitals
- Standardized pricing and reconciliation methodologies
- Primary care referral requirements
  However, no policy changes are proposed at this time for these topics.

CMS PROPOSES MODIFICATIONS TO TARGET PRICING AND BENCHMARK CALCULATION

If finalized as proposed, the benchmark price for each episode would be calculated separately by MS-DRG/HCPCS type and region. This benchmark would be based on the average standardized spending for each episode type/region combination over a rolling three-year baseline period.

For the first performance year of the model (beginning January 1, 2026), CMS will use data from episodes initiated between January 1, 2022, and December 31, 2024. In subsequent years, the baseline period would roll forward one year, with heavier weighting given to more recent data. The first two years of data will be adjusted to reflect third-year dollars. This approach allows participants to be rewarded for greater efficiency relative to their regional peers. CMS will use geographically standardized allowed amounts to prevent local cost variation from distorting benchmarks.

Table 4. Target Price Weights by Baseline Year

Performance Year	Baseline Year 1 (17% weight)	Baseline Year 2 (33% weight)	Baseline year 3 (50% weight)
PY 1	CY 2022	CY 2023	CY 2024
PY 2	CY 2023	CY 2024	CY 2025
PY 5	CY 2026	CY 2027	CY 2028

CMS also proposes applying a discount factor to benchmark prices to reflect Medicare's share of expected savings. Although the original proposal called for a 3% discount, the final model features episode-type specific discounts ranging from 1.5% to 2% in response to stakeholder concerns about financial risk. Preliminary target prices would be shared with participants by the end of November before the start of each performance year.

PROPOSED CHANGES TO RISK ADJUSTMENT METHODOLOGY

To account for patient-level variation, CMS proposes comprehensive risk adjustment across all episode types. This includes:

- Beneficiary-level variables including age bracket, Hierarchical Condition Category (HCC) count, and beneficiary economic risk,
- Hospital-level factors such as bed size and safety-net status, and
- Episode-specific adjustors tailored to care complexity

CMS proposes renaming the existing social needs risk measure to "beneficiary economic risk adjustment" and replacing the Area Deprivation Index (ADI) with the Community Deprivation Index (CDI) to align with the ACO REACH model. The CDI includes 18 standardized variables, avoiding overemphasis on any single factor like income or home value. Risk will be measured nationally, not at the state level.

Under this revised approach, beneficiaries will be flagged for social risk if they:

- Are eligible for Medicaid,
- Receive the Medicare Part D Low Income Subsidy (LIS), or,

- Live in a census tract with a national CDI ranking in the 80th percentile or above

CMS also proposes extending the HCC lookback period from 90 to 180 days to better capture chronic conditions prior to the anchor procedure. HCC counts will be grouped into five tiers (0, 1, 2, 3, and 4+), while age will be categorized as less than 65 years, 65-75 years, 75-85 years, or above 85 years.

CMS seeks comments on both the transition from ADI to CDI and the proposed 180-day HCC lookback.

Other Target Pricing Proposals

CMS proposes several additional refinements to target price construction:

- A three-step process for handling MS-DRG/HCPCS coding changes, including remapping and adjustments,[3]
- Updates to the normalization and trend factors to better reflect available data, and
- Alignment of episode attribution date ranges across baseline and performance years to streamline methodology.

CMS PROPOSES QUALITY MEASURE ENHANCEMENTS

CMS emphasizes that TEAM payment adjustments should reflect not only lower costs but also improved patient outcomes. Accordingly, the agency will link payments to quality of care via payment adjustments via the Composite Quality Score (CQS).[4]

Under this proposal, initially TEAM would include three quality measures already reported under the Hospital Inpatient Quality Reporting (IRQ) and/or Hospital-Acquired Condition (HAC) Reduction programs, avoiding additional reporting program. Quality measures for TEAM participants would be publicly available online starting in 2027. The three measures are:

- Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and Electronic Health Record Data (CMIT ID #356), which would apply to all episode types,
- CMS Patient Safety and Adverse Events Composite (CMS PSI 90) (CMIT ID #135), which would apply to all episode types, and

[3] Table XI.A.-06, Table XI.A.-07, Table XI.A.-08, and Table XI.A.-09 in the FY 2026 IPPS proposed rule demonstrates these steps.
[4] The finalized set of TEAM quality measures are outlined in Table XI.A.-02 on page 979 of the unpublished FY 2026 proposed rule.

- Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM) (CMIT ID #1618), which would only apply to LEJR episodes.

In this proposed rule, CMS proposes several changes and clarifications to the TEAM measure set:

- The addition of a fourth measure- the Information Transfer Patient Reported Outcome-based Performance Measure (Information Transfer PRO-PM)- to the quality measure set beginning in Performance Year 2, focused on outpatient care transitions,
- Assigning a neutral CQS score of 50 for hospitals with insufficient data, and,
- Setting the PY 1 baseline period for the Hybrid Hospital-Wide All-Cause Readmission Measure as July 1, 2025 – June 30, 2026, due to delayed Outpatient Prospective Payment System (OPPS) reporting requirements.

CQS IMPACT ON PAYMENT CALCULATION

The CQS score for a given measure will be the percentile of the participant's score among a national cohort of hospitals. This cohort score distribution will be calculated for CY 2025, and this CY 2025 data would be used to determine percentiles for the duration of the model. Therefore, despite the use of percentiles, it will be theoretically possible for all TEAM participants to score 100 on CQS if each participant scored higher on all quality measures than any hospital in CY 2025.

The amount that the CQS score would influence reconciliation amounts would vary based on the participant's track. The CQS adjustment percentage will then be multiplied by a participant's reconciliation amount to determine the CQS adjustment amount, which will then be subtracted from the participant's reconciliation amount to create their quality-adjusted reconciliation amount. This means that, for participants receiving a positive reconciliation amount, the quality-adjusted reconciliation amount will always be lower than their original reconciliation amount unless they receive a score of 100. Similarly, for participants who owe a repayment to CMS, quality-adjusted repayment amount will always be lower than their original repayment amount unless they receive a score of zero.

CMS PROPOSES REMOVAL OF HEALTH EQUITY AND ENVIRONMENTAL REPORTING REQUIREMENTS

While there was no mandatory reporting of health disparities for TEAM participants, in prior rulemaking, participants could voluntarily report elements including health equity plans, demographic data, and health related social needs. CMS proposes to remove the health equity plan and health related social needs data reporting, stating that the removal of these policies is to align with the new Administration's priorities and to reduce the burden on TEAM participants. Likewise, CMS also proposes to remove the Decarbonization and Resilience Initiative.

Hospitals may still submit voluntary demographic data, and CMS welcomes suggestions for alternative data elements.

CMS PROPOSES EXPANSION OF THE 3-DAY SNF WAIVER

Building on the FY 2025 IPPS/LTCH PPS final rule, which waived the 3-day SNF rule for discharges to SNFs meeting certain quality standards, CMS now proposes extending the waiver to discharges to swing-bed hospitals and Critical Access Hospitals (CAHs) that provide post-acute care. Feedback is requested on this proposal.

STAKEHOLDER RESPONSES

Stakeholder perspectives remain largely unchanged from the FY 2025 IPPS final rule. The American Hospital Association (AHA) reaffirmed its support for value-based care but reiterated concerns about financial risk. AHA continues to urge CMS to make the TEAM model voluntary rather than mandatory.[5]

***

This Applied Policy® Summary was prepared by Annie Tuttle with support from the Applied Policy team of health policy experts. If you have any questions or need more information, please contact her at atuttle@appliedpolicy.com or at (713) 625-2928.

[5] https://www.aha.org/news/headline/2025-04-11-cms-issues-hospital-ipps-proposed-rule-fy-2026