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Healthcare Alert

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CMS proposes updates to the Transforming Episode Accountability Model

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The Centers for Medicare & Medicaid Services (CMS) is moving forward with the Transforming Episode Accountability Model (TEAM).

What's the impact?

- The TEAM program will launch on January 1, 2026, and run for five performance years (each a "PY"), ending in 2030.
- CMS' proposed rule seeks to (i) modify certain aspects of the TEAM program, including participation requirements, quality measurements, pricing, and risk adjustment methodologies, and (ii) eliminate the voluntary health equity plan and health-related social needs data reporting and the Decarbonization and Resilience Initiative.
- In addition to the proposed changes, CMS seeks public comment and input on other key policy areas, including the primary care services referral requirement.

Key takeaways for hospitals and providers

The TEAM program is a mandatory episode-based payment model for select hospitals designed to improve care coordination and reduce costs for Medicare beneficiaries undergoing select surgical procedures through financial incentive arrangements with hospitals and downstream providers.

Background

On April 11, 2025, CMS issued the proposed rule, Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals for Fiscal Year (FY) 2026 (the "Proposed Rule"), which includes suggested changes to the TEAM program as reflected in the FY 2025 IPPS Final Rule (the "Final Rule") and, more importantly, reflects a commitment by the Trump Administration to implementing this model.

CMS established the TEAM program as a mandatory episode-based payment model for the following inpatient and outpatient surgical procedures provided at certain hospitals and those that opt in:

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

Participation in TEAM is mandatory for all acute care hospitals in selected core-based statistical areas (CBSA); however, other hospitals not in a CBSA that participated in either the Bundled Payments for Care Improvement Advanced (BPCI Advanced) or Comprehensive Care for Joint Replacement (CJR) models may voluntarily opt in. Under the TEAM program, all providers will continue to bill Medicare fee-for-service (FFS), but hospitals will receive a preliminary target price for each PY. The target prices will be based on regional spending of Medicare Parts A and B items and services (not otherwise excluded by the regulations) based on the previous three-year, rolling, historical claims experience that is prospectively trended, normalized, and risk-adjusted.

The model includes a risk-sharing component, holding hospitals and their contracted partners accountable for the quality and total cost of care during the episode. There are three participation tracks with varying levels of financial risk that can be shared with other providers treating the patient during the 30-day episode. Depending upon the type of hospital (e.g., rural or safety net) and the PY, hospitals share in gains only or upside and downside risk throughout the five-year model period. Ultimately, the reconciliation process will compare total performance

year FFS spending for attributed episodes to a final target price adjusted for quality performance and stop-gain/stop-loss limits.

As summarized below, the Proposed Rule modifies participation requirements, quality measures and assessments, pricing methodology and risk adjustments, the Skilled Nursing Facility (SNF) three-day rule application, and data reporting requirements. In addition, CMS specifically seeks public comments on certain policy requirements.

PARTICIPATION AND DEFERMENT FOR NEW HOSPITALS

The Proposed Rule provides up to a one-year deferment period for both new hospitals and newly qualifying hospitals that begin to meet the definition of a "TEAM participant" located in a mandatory CBSA so that all new or newly qualifying hospitals would have at least one year to prepare for the model. In addition, hospitals that no longer meet the TEAM participant definition will exit the program, effective on the date of the status change. However, new hospitals that meet the TEAM participant definition resulting from a reorganization begin participation on the date of the reorganization event.

QUALITY MEASUREMENT UPDATES

The Proposed Rule looks to:

- Align the Hybrid Hospital-Wide Readmission (HWR) Measure reporting requirements with the existing Hospital Inpatient Quality Reporting (IQR) Program and permit certain missing data allowances. The first mandatory reporting period (July 1, 2025, through June 30, 2026) would serve as the baseline for TEAM's PY 1. CMS also seeks comments on whether the measure should combine claims data with electronic health record (EHR) data to risk-adjust hospital readmission rates or only use claims-based data.
- Add the Information Transfer Patient Reported Outcome-based Performance Measure (Information Transfer PRO-PM) as a new quality measure for all episodes initiated in the hospital outpatient department, starting in PY 3 (2028). The Information Transfer PRO-PM measurement evaluates how well information is transferred to patients after outpatient procedures and captures the patient viewpoint afforded by patient-reported outcome measures.
- Create a neutral quality measure score for TEAM participants with insufficient quality data to avoid unfair penalties. Once the TEAM participant reaches the threshold for sufficient data to produce raw quality measure data, the data will be converted into a scaled quality measure in the subsequent PY.

PRICING METHODOLOGY ENHANCEMENTS AND RISK ADJUSTMENT MODIFICATIONS

The Proposed Rule introduces a standard, three-step approach to account for Medicare Severity Diagnosis Related Group (MS-DRG) or Healthcare Common Procedure Coding System (HCPCS) code changes between the baseline and PYs, ensuring target prices would reflect current coding and payment rules (including Hierarchical Condition Categories version 28).

In addition, the Proposed Rule changes the normalization factors from a national average for each MS-DRG and HCPCS to a regional rate. The normalization factors ensure that the average benchmark price after risk adjustment does not exceed the average benchmark price prior to risk adjustment. To provide hospitals with complete information to anticipate and manage final reconciliation targets, CMS will provide each hospital participant with two preliminary target prices based on (i) regional averages for each MS-DRG/HCPCS episode before risk adjustment without normalization factors applied and (ii) hospital-specific preliminary target prices after risk adjustment with regional normalization factors applied.

The Proposed Rule would also change the prospective trend factor from a percentage change based between baseline year one (BY1) and baseline year three (BY3) to an annual percentage change calculated using a log-linear model and adding two additional years of episode-spending data in the calculation of the prospective trend factor. These changes are to produce more accurate projections of future FFS costs and more reliable preliminary target prices for TEAM participants.

With respect to the risk adjustment calculations, the Proposed Rule seeks to modify:

- The social needs adjustment to the beneficiary economic risk adjustment factor;
- The Area Deprivation Index (ADI), a rank indicating a neighborhood's socioeconomic disadvantage, to the Community Deprivation Index (CDI), a slightly modified index that updates and standardizes variables in the construction of the ADI to improve accuracy, especially in urban areas; and
- The lookback period for the episodic category-specific beneficiary level risk adjustment factors to 180 days from 90 days to better capture beneficiary acuity, improve the risk adjustment methodology, and better reflect the level of spending outside of the hospital's control.

POLICY AND ADMINISTRATIVE CHANGES

Lastly, the Proposed Rule contains several policy and administrative changes and also seeks comment on certain policy initiatives.

- CMS proposes extending the use of the SNF three-day rule waiver for post-acute care provided under swing bed arrangements in hospitals and critical access hospitals (CAHs).

- CMS also proposes eliminating voluntary health equity plan and health-related social needs data reporting, as well as the Decarbonization and Resilience Initiative.
- The Final Rule requires a referral to a primary care provider (PCP) on or prior to discharge. However, CMS seeks comment on this requirement and alternative approaches to engaging PCPs.

The Proposed Rule also invites healthcare stakeholders to comment on approaches and opportunities to streamline regulations and reduce burdens on those participating in the Medicare program through the Unleashing Prosperity Through Deregulation of the Medicare Program (Executive Order 14192)-Request for Information.

Summary

Hospitals selected to participate in the TEAM program should start forming partnerships with TEAM collaborators to ensure TEAM participant hospitals meet quality measures and achieve financial success, including avoiding penalties and benefiting from shared savings. Stakeholders have until June 10, 2025, to submit comments to CMS. NP is following this proposed rule and its implications for the TEAM program. We also have extensive experience with the CJR model and are available to help strategize and negotiate any gainshare arrangements.

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