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Healthcare Alert

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CMS finalizes updates to the Transforming Episode Accountability Model Program

By Whitney Phelps and Mukta Chilakamarri

The mandatory Transforming Episode Accountability Model (TEAM) Program will advance the Innovation Center's prior work on alternative payment models.

What's the impact?

- Most of the proposed changes from the proposed rule were finalized without modification.
- These requirements, effective October 1, 2025, will impact the TEAM Program launching on January 1, 2026. Hospitals mandated to participate in TEAM should prepare and begin contracting with post-acute providers.

On July 31, 2025, the Centers for Medicare & Medicaid Services (CMS) issued the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) for Fiscal Year (FY) 2026 (final rule), finalizing many of its suggested changes to the TEAM Program outlined in its proposed rule released on April 11, 2025. As covered in our previous alert, the TEAM Program is a mandatory episode-based payment model for acute care hospitals in selected core-based

statistical areas (CBSA). The program aims to improve care coordination and reduce costs for Medicare beneficiaries undergoing certain surgical procedures, including:

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

Through the final rule, CMS finalized participation requirements, quality measures and assessments, pricing methodology and risk adjustments, the skilled nursing facility (SNF) three-day rule application, and data reporting requirements previously outlined in the proposed rule.

The following compares the changes in the proposed rule to the final rule.

Participation and deferment for new hospitals

Proposed Rule: Provides up to a one-year deferment period for new and newly qualifying hospitals that begin to meet the definition of a "TEAM participant" located in a mandatory CBSA, so that they would have at least one year to prepare for the model. Hospitals that no longer meet the TEAM participant definition will exit the program, effective on the date of the status change.

Final Rule: No modification.

Indian health services/Tribal hospitals

Proposed Rule: Identified certain hospitals that would be ineligible for participation in TEAM due to not being paid under the IPPS and Outpatient Prospective Payment System (OPPS) (89 FR 69643). Specifically, hospitals located in the state of Maryland are precluded from being TEAM participants.

Final Rule: CMS finalized a policy to exclude any entity not paid under both IPPS and OPPS from the model. This means that IHS/Tribal hospitals are no longer mandated as eligible to participate.

Quality measures

Proposed Rule: CMS proposed aligning the hybrid hospital-wide readmission (HWR) measure reporting requirements with the existing Hospital Inpatient Quality Reporting (IQR) Program and permitting certain missing data allowances. The first mandatory reporting period (July 1, 2025, through June 30, 2026) would serve as the baseline for TEAM's performance year one (PY1).

Final Rule: In the Final Rule, CMS is maintaining the policy as finalized in the FY 2025 IPPS/LTCH PPS final rule, which utilizes CY 2025 for the PY1 CQS baseline period and uses July 1, 2024, through June 30, 2025, as the measure performance period for the hybrid HWR measure.

CMS stated that TEAM is maintaining alignment with the Hospital IQR Program. Given that CMS has extended the voluntary reporting of the core clinical data elements and linking variables for the hybrid HWR measure through June 30, 2025, this means that for PY1, it will use the claims-only portion of the hybrid HWR measure in the CQS calculation.

CMS stated that in subsequent TEAM performance years, the complete hybrid HWR measure—incorporating both claims data and core clinical data elements—may be utilized once the core clinical data elements transition from voluntary to required reporting.

Proposed Rule: To capture patient-reported outcomes measures and also to capture care in outpatient settings, CMS proposed to 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).

Final Rule: Finalized without modification.

Approach for when TEAM participant has no quality measure performance data

Proposed Rule: CMS sought to create a neutral quality measure score (50) for TEAM participants with insufficient raw 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.

Final Rule: Finalized without modification.

Accounting for future changes to MS-DRGs and HCPCS

Proposed Rule: Target prices for the episode bundles are based on each Medicare Severity Diagnosis Diagnosis-Related Group (MS-DRG) or Healthcare Common Procedure Coding System (HCPCS). CMS introduced a standard, three-step approach to account for MS-DRG/HCPCS code changes between the baseline and PYs, which would ensure target prices reflected current coding and payment rules (including Hierarchical Condition Categories version 28) and also a scaling factor to account for changes in fee-for-service (FFS) rates between the baseline and PYs.

Final Rule: Finalized without modification.

Calculation and application of normalization factors

Proposed Rule: CMS sought to change the normalization factors from a regional rate for each MS-DRG and HCPCS to a national rate.

Final Rule: Finalized without modification.

Calculation of the prospective trend factor

Proposed Rule: Changed 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.

Final Rule: Finalized without modification.

Replacement of Area Deprivation Index (ADI)

Proposed Rule: Proposed to replace the risk adjustment variable Area Deprivation Index (ADI), a rank indicating a neighborhood's socioeconomic disadvantage, with 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.

Final Rule: Finalized without modification.

Switch to 180-day lookback period

Proposed Rule: Changed the lookback period for the episodic category-specific beneficiary level risk adjustment factors to 180 days from 90 days (the look back is triggered from the day prior to the anchor procedure/hospitalization) to better capture beneficiary acuity, improve the risk adjustment methodology, and better reflect the level of spending outside of the hospital's control.

Final Rule: Finalized without modification.

Low volume hospitals

Proposed Rule: CMS sought comment on how to address low volume episodes for TEAM participants, particularly given the two-sided financial risk.

Final Rule: After considering public comment, CMS imposed a volume threshold of 31 episodes in a given baseline period in order to trigger financial risk for such episodes of care.

Waivers of Medicare program requirements—three-day SNF rule

Proposed Rule: CMS proposed waiving the required three-day inpatient hospital stay prior to a covered Medicare post-hospital extended care service ("3-Day SNF Rule Waiver") to swing bed arrangements in hospitals and critical access hospitals (CAHs).

Final Rule: Finalized without modification.

Health equity plan and health-related social needs data reporting

Proposed Rule: CMS proposed eliminating voluntary health equity plan and health-related social needs data reporting, as well as the Decarbonization and Resilience initiative.

Final Rule: Finalized without modification.

Referral to primary care provider

Proposed Rule: CMS sought comment on requiring a referral to a primary care provider (PCP) on or prior to discharge and alternative approaches to engaging PCPs.

Final Rule: Given the majority of commenters' support for CMS to ensure TEAM beneficiaries are being referred to established suppliers, CMS is modifying the referral to PCP requirement, adding that a TEAM participant must include a referral to an established PCP, as recorded on admission to the hospital or hospital outpatient department, for a TEAM beneficiary, on or prior to discharge from an anchor hospitalization or anchor procedure in the beneficiary's hospital discharge planning. If an established PCP is not recorded on admission to the hospital or hospital outpatient department, the TEAM participant must include a referral to a PCP for a TEAM beneficiary, on or prior to discharge from an anchor hospitalization or anchor procedure.

In other words, if the supplier of primary care services was not recorded on admission to the hospital or hospital outpatient department, the existing referral to primary care services would apply. This ensures that all TEAM beneficiaries, not just those with an established supplier, are connected back to a supplier of primary care services.

Effective Date

The final rule, published in the *Federal Register* on August 4, 2025, will be effective October 1, 2025. Hospitals in selected CBSAs and those that voluntarily opt in to the program should prepare for TEAM Program participation beginning January 1, 2026. This includes identifying

post-acute partners that can help hospitals successfully meet quality measurements and preparing contracts with downstream providers.

For further details or questions about TEAM Program compliance and implementation, please contact your Nixon Peabody team to help strategize and negotiate any gainshare arrangements.

For more information on the content of this alert, please contact your Nixon Peabody attorney or:

Whitney Phelps
518.427.2659
wphelps@nixonpeabody.com

Mukta Chilakamarri
518.427.2665
mchilakamarri@nixonpeabody.com