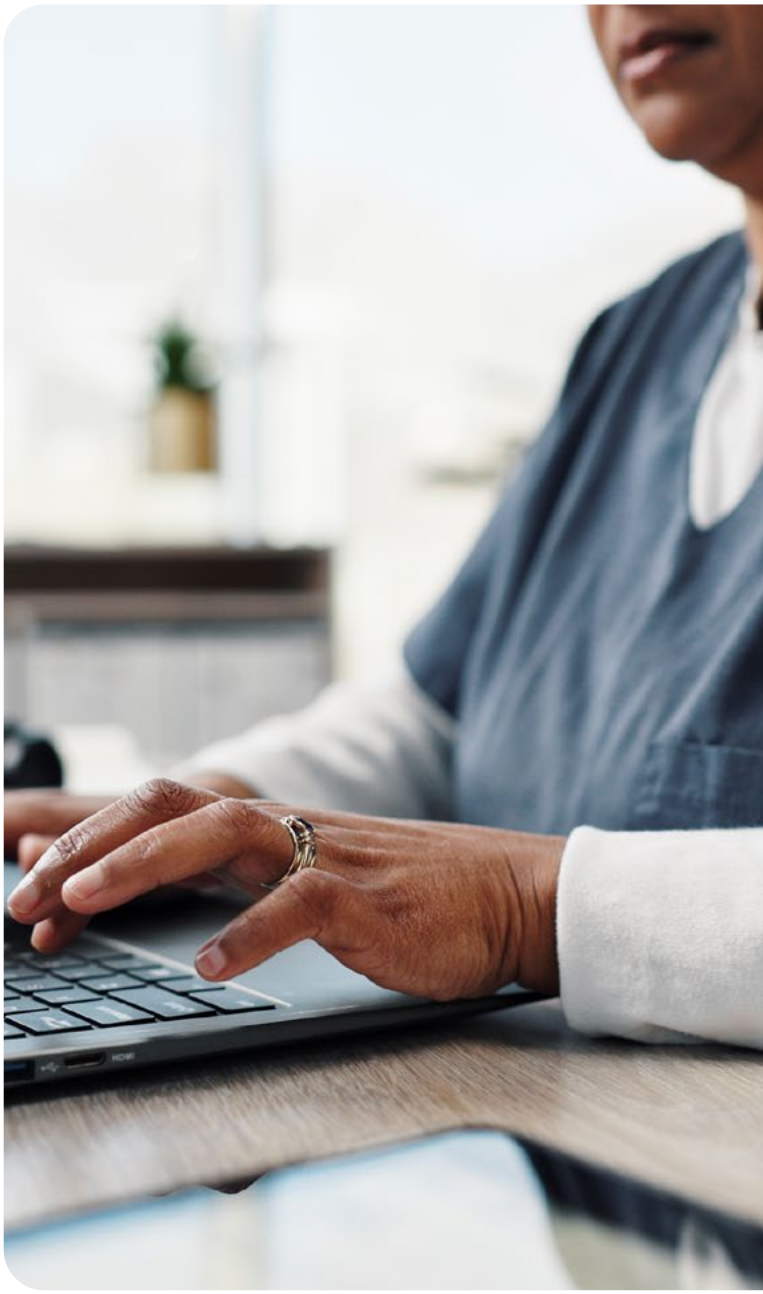
Clarify

# Navigating CMS's Transforming Episode Accountability Model (TEAM)

A Strategic Guide for Hospital and Health System Leaders

# Background and History: The Road to TEAM

## The TEAM model is not an isolated initiative but rather the latest phase in CMS's longstanding push toward value-based care and alternative payment models (APMs).

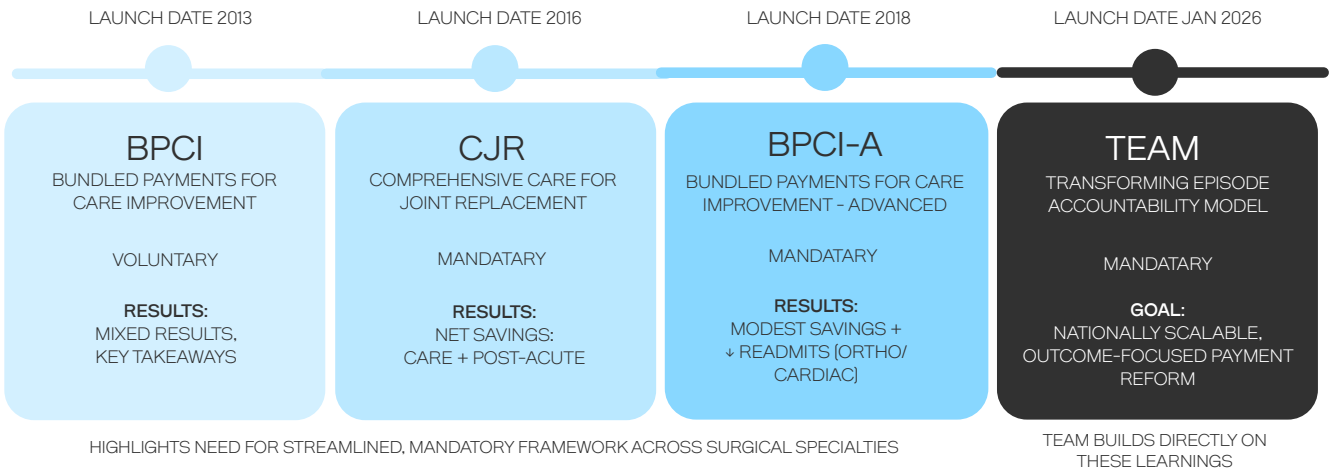


Over the past decade, bundled payment programs have served as a bridge between fee-for-service and population health, incentivizing providers to deliver more coordinated, efficient, and high-quality care within defined episodes. The Bundled Payments for Care Improvement (BPCI) initiative launched in 2013 as a voluntary model, followed by BPCI-Advanced and the Comprehensive Care for Joint Replacement (CJR) model, which tested mandatory participation in select regions.

While these programs demonstrated mixed results, key lessons emerged. BPCI-A showed modest savings and reduced readmissions for orthopedic and cardiac procedures, while CJR yielded net savings primarily through standardized care pathways and post-acute optimization. However, participation remained fragmented, particularly among hospitals with limited resources or data infrastructure.

CMS's decision to sunset both BPCI-A (ended December 2025) and CJR (ending December 2024) underscores the need for a more streamlined, mandatory framework with greater alignment across surgical specialties

TEAM builds directly on these learnings. Unlike prior programs, it incorporates a narrower post-discharge window (30 days instead of 90), standardized episode definitions, and risk-adjusted benchmarks to promote fair comparisons across hospitals. It also introduces a more nuanced quality overlay, reinforcing CMS's broader goal of tying payment to outcomes, not volume. In doing so, TEAM marks a policy evolution: moving from pilot experiments toward a nationally scalable approach for surgical accountability.

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# Overview of the CMS TEAM Program

The TEAM model is scheduled to begin on January 1, 2026, and will run through December 31, 2030. Approximately 700 hospitals located in 188 randomly selected Core-Based Statistical Areas (CBSAs)—including both metropolitan and micropolitan regions—will be required to participate (Maryland excluded). Participation is mandatory for acute care hospitals reimbursed under the Inpatient Prospective Payment System (IPPS), reinforcing CMS's shift away from voluntary value-based models.

**TEAM is designed with four overarching goals:** to improve surgical outcomes for Medicare beneficiaries, reduce avoidable readmissions, lower total episode spending, and promote equity in surgical care delivery.

By focusing on standardized payment and quality-linked performance, CMS aims to create a more predictable, accountable, and data-driven framework for managing surgical care.

At its core, TEAM holds hospitals financially accountable for five common and costly surgical episodes: **lower-extremity joint replacement (LEJR), coronary artery bypass grafting (CABG), spinal fusion, surgical hip/femur fracture treatment (SHFFT), and major bowel procedures.** These episodes are triggered either during inpatient stays or outpatient procedures, with a fixed accountability window of 30 days post-discharge.

**CMS applies a weighted methodology: 50%** of the benchmark is derived from the most recent year, **30%** from the year prior, and **20%** from the earliest year in the baseline period.

CMS chose these conditions for their high volume, significant post-acute cost variation, and strong opportunity for improvement in care coordination.

## Episodes and Benchmarking

Reimbursement under TEAM is benchmarked against prospectively set target prices that reflect a three-year regional historical baseline. CMS applies a weighted methodology: 50% of the benchmark is derived from the most recent year, 30% from the year prior, and 20% from the earliest year in the baseline period. To account for spending trends, CMS includes a prospectively calculated trend factor, while a normalization factor limits the volatility introduced by risk adjustment.

Each episode is discounted to incentivize savings: CABG and bowel procedures carry a 1.5% discount, while LEJR, spinal fusion, and SHFFT are discounted by 2.0%. This preliminary target price is then risk-adjusted to reflect patient- and hospital-specific factors, such as case mix, comorbidities, and social risk. The final benchmark is the reference against which each hospital's actual episode spending is reconciled.

**Hospitals will also choose one of three participation tracks, with escalating financial risk:**

- **Track 1 (Upside Only):** Provides shared savings without downside financial risk, offering the lowest potential rewards and no penalties. Available to all hospitals in the first performance year and extendable through year three for safety-net hospitals.
- **Track 2 (Limited Two-Sided Risk):** Introduces moderate upside gains and moderate downside losses, balancing limited risk with incremental reward. Applies to certain hospitals, including safety-net, rural, Medicare-dependent, and sole-community hospitals. Available for years two through five.
- **Track 3 (Full Two-Sided Risk):** Requires hospitals to take on both substantial upside gains and downside losses, offering the highest potential rewards and penalties. Available to all hospitals from year one through year five.

Importantly, all payment outcomes are modified by performance on three quality measures, which together form the Composite Quality Score (CQS). These are:

1. **Hybrid Hospital-Wide All-Cause Readmission Measure** (CMS ID #356), which incorporates claims and electronic health record data;
2. **CMS Patient Safety and Adverse Events Composite** (PSI-90) (CMS ID #135), which reflects a hospital's rate of avoidable complications and adverse events;
3. **Additional condition-specific measures and patient-reported outcomes** will be introduced in later performance years.

Hospitals that perform well on these quality indicators may see their reconciliation payments **boosted by up to 10%**. Conversely, underperformance can deepen **repayment obligations by as much as 15%,** depending on the risk track selected.

# TEAM STRUCTURE

## DESIGNED WITH FOUR OVERARCHING GOALS:

1. Improve surgical outcomes for Medicare beneficiaries
2. Reduce avoidable readmissions
3. Lower total episode spending
4. Promote equity in surgical care delivery

## HOLDS HOSPITALS FINANCIALLY ACCOUNTABLE FOR FIVE COMMON AND COSTLY SURGICAL EPISODES:

1. Lower-extremity joint replacement (LEJR)
2. Coronary artery bypass grafting (CABG)
3. Spinal fusion
4. Surgical hip/femur fracture treatment (SHFFT)
5. Major bowel procedures

## HOSPITALS CHOOSE FROM THREE TRACKS WITH INCREASING FINANCIAL RISK:

### TRACK 1
(Upside Only):

Shared savings only
no losses

Available to all in Year 1; Safety-net hospitals through Year 3

Lowest risk/reward

### TRACK 2
(Limited Two-Sided Risk):

Moderate upside/downside financial exposure

Available Years 2–5

Limited risk/ modest reward

### TRACK 3
(Full Two-Sided Risk):

Hospitals take on full financial risk

Available Years 1–5

Highest rewards and penalties.

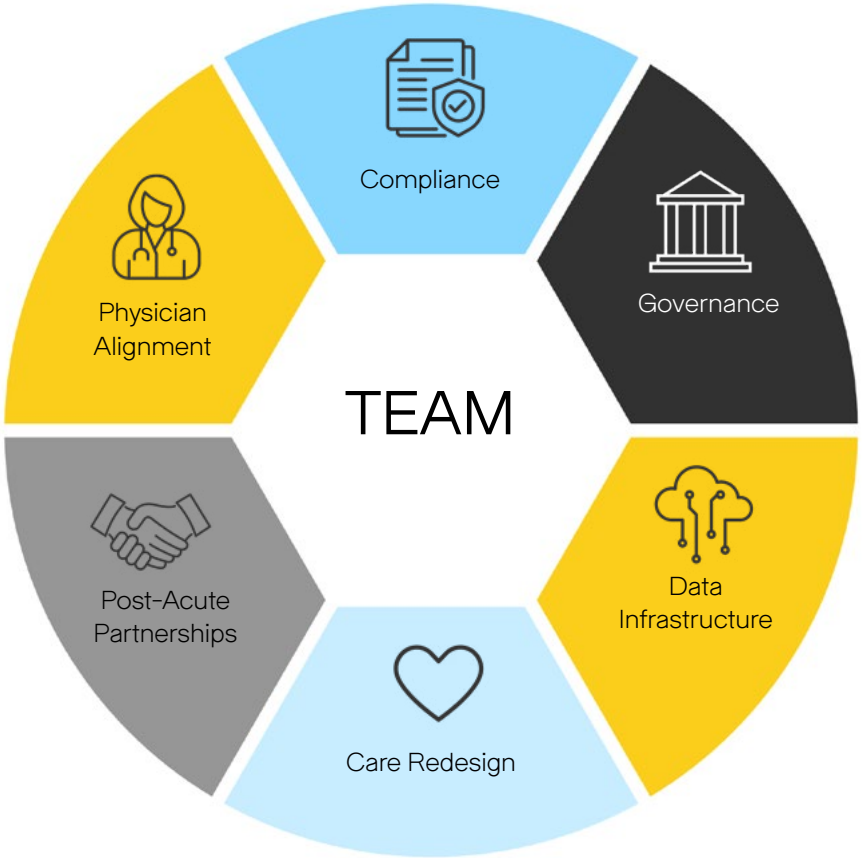
# How Hospitals Can Best Prepare

Preparation for TEAM requires a proactive, cross-functional approach that goes beyond episodic clinical care. Success will hinge on whether hospitals can establish new governance models, realign their care processes, and make strategic investments in analytics and post-acute partnerships.

Operationally, hospitals must first establish a clear governance structure for TEAM implementation. This means forming a multidisciplinary steering committee that includes representation from finance, perioperative leadership, care management, physician leadership, and analytics.

Roles and responsibilities must be clearly defined to ensure timely decision-making around target pricing, care redesign, and reconciliation tracking.

Data infrastructure is another foundational requirement. Hospitals should work toward integrating monthly CMS claims feeds into their internal analytics environment to monitor episode costs in near real-time. Effective preparation includes modeling target prices under various risk tracks, estimating potential exposure, and identifying areas of high variation across the 30-day post-discharge window. Without these capabilities, organizations risk being reactive, rather than strategically proactive, in managing financial risk.



Clinically, hospitals must double down on surgical care pathways and discharge planning. Evidence from BPCI-A and CJR suggests that pre-operative optimization programs, ERAS protocols, and nurse navigator models can all drive down variation and prevent costly readmissions. Given the compressed episode length under TEAM, immediate post-discharge care will matter more than ever. Hospitals must coordinate with post-acute partners to ensure timely follow-up, rapid transitions, and aligned incentives.

Physician alignment is equally important. Surgeons must be made aware of how their decisions impact episode costs and quality outcomes. Gainsharing models—permitted under TEAM—offer a powerful tool for engagement. Hospitals should consider implementing dashboards to show surgeons their performance relative to peers and create financial incentives that reward reductions in avoidable utilization.

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# Looking Forward: What's at Stake, and What's Possible

CMS has made it clear that TEAM is not just a one-off program but a potential blueprint for the future of surgical accountability in Medicare. If successful, it could lead to broader adoption of bundled payments, expanded condition coverage, and even integration into total-cost-of-care models.

**For health systems, this creates a dual imperative: mitigate risk today while building capabilities for tomorrow.** TEAM can serve as a catalyst for care transformation, forcing organizations to finally break down silos between inpatient and post-acute care, align clinicians to common quality goals, and modernize their approach to cost management. Hospitals that treat TEAM as a compliance exercise will likely underperform. But those who view it as a strategic opportunity stand to gain—clinically, financially, and competitively.

At a time when margins are tight and competition is fierce, TEAM offers a chance to create operational discipline, elevate care standards, and demonstrate readiness for future value-based models. The organizations that embrace TEAM not just as a mandate but as a movement will be the ones defining the next generation of accountable care.

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# Conclusion

The TEAM model is more than just another CMS pilot—it is the clearest signal yet that Medicare intends to institutionalize episode-based accountability at scale. Hospitals that prepare now—by investing in data infrastructure, aligning care teams, and embedding analytics into their decision-making—will not only perform well under TEAM but will also future-proof their organizations for what comes next.

This is a moment of transformation. For health systems willing to lead, TEAM presents a rare opportunity to build a new foundation for surgical care; that is, one that rewards value, prioritizes outcomes, and positions hospitals as true stewards of patient journeys beyond the hospital walls.

# About Clarify Health

Clarify Health empowers customers to deliver better care and therapies through more actionable insights from all the world's patient-level data.

With an integrated enterprise analytics platform, Clarify helps customers select the best providers, map and predict care journeys, and understand the use and impact of therapy on patients.

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Clarify Health is an enterprise data and analytics platform company that enables providers, payers, and other healthcare organizations to improve access, affordability, and outcomes. Clarify translates one of the largest healthcare datasets into actionable insights to incentivize and engage providers, optimize their performance, and contain cost. Clarify's solutions are built on the Clarify Atlas Platform® which maps 300M+ patient journeys to deliver 20B+ AI-powered predictions and surface insights with speed and precision.