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Implementing the Transforming Episode Accountability Model: Skilled Nursing Facility 3-Day Rule Waiver

Related CR Release Date: September 26, 2025	**MLN Matters Number:** MM14098 Revised
Effective Date: January 1, 2026	**Related Change Request (CR) Number:** CR 14098
Implementation Date: January 5, 2026	**Related CR Transmittal Numbers:** R13301DEMO, R13368DEMO, R13399DEMO & R13434DEMO
Related CR Title: Transforming Episode Accountability Model (TEAM) 3-Day Skilled Nursing Facility (SNF) Waiver – Implementation	

What's Changed? We made no substantive changes to the article other than to update the CR release date, transmittal numbers, and transmittal links.

Affected Providers

- Acute care hospitals participating in the model
- Skilled nursing facilities (SNFs)
- Swing bed providers, including critical access hospitals (CAHs)

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Action Needed

Make sure your billing staff knows about the details, participation, and payment for the new Transforming Episode Accountability Model (TEAM) running from January 1, 2026 – December 31, 2030, including:

- CMS will allow acute care hospitals who participate in the model to discharge patients without a 3-day hospital stay to a qualified SNF or swing bed provider, including a CAH
- The patient must meet the eligibility criteria for TEAM and have a qualifying outpatient procedure or hospital inpatient stay prior to admission to the SNF
- The admission date to the SNF must happen no later than 30 days after the hospital or outpatient department discharges the patient
- We'll pay for services when the SNF claim meets certain payment criteria, including submitting the claim with the required TEAM demonstration code A9

Background

The CMS Innovation Center is launching a mandatory, episode-based payment model called TEAM to reduce Medicare spending, improve the quality of care, and further advance care coordination across acute and post-acute care settings. Visit the TEAM webpage to learn more about the model.

Under TEAM, participating acute care hospitals will be accountable for the episode's cost and quality of care for 5 selected surgical procedures in either an inpatient facility or a hospital outpatient department. The hospital's accountability for the episode of care will span from the time of surgery through the first 30 days after the Medicare patient receives an outpatient procedure or leaves the hospital. Each episode includes all items and services related to the initial inpatient stay or outpatient procedure, encompassing both facility and professional services.

TEAM aims to foster greater patient care engagement so providers consider patient needs and preferences that may lead to shorter lengths of stay in both acute care hospitals and post-acute care settings. We anticipate that patients in an episode under TEAM will benefit from:

- Enhanced communication and coordination among health care providers
- Improved discharge planning and facility transfers
- Reduction in unnecessary or redundant procedures
- Fewer avoidable readmissions
- More efficient use of post-acute care services
- Overall higher quality of care through the episode

TEAM will launch on January 1, 2026, and run for 5 years, ending on December 31, 2030. The timeline for the model's performance years (PYs) is:

- **PY1:** January 1, 2026 – December 31, 2026
- **PY2:** January 1, 2027 – December 31, 2027
- **PY3:** January 1, 2028 – December 31, 2028
- **PY4:** January 1, 2029 – December 31, 2029
- **PY5:** January 1, 2030 – December 31, 2030

We've proposed and finalized all TEAM policies through rulemaking, most notably in the FY 2025 and FY 2026 Hospital Inpatient Prospective Payment System (IPPS) final rules. We'll propose and finalize any future TEAM updates through rulemaking.

Participants

TEAM participants are acute care hospitals we pay under the IPPS or Outpatient Prospective Payment System. We selected hospitals based on geographic location, specifically using core-based statistical areas. TEAM also included a one-time voluntary opt-in opportunity for certain hospitals participating in the Bundled Payments for Care Improvement Advanced model or the Comprehensive Care for Joint Replacement model. Participating hospitals are accountable for quality and cost performance for all episode categories in the model.

TEAM includes 3 participation tracks with varying levels of financial risk:

- Track 1, a track with no downside risk, is available to all TEAM participants for the first PY. Safety net hospitals are eligible to remain in Track 1 for the first 3 PYs.
- Track 2, a 2-sided risk track with lower levels of financial risk and reward, is available to certain hospitals, such as rural hospitals, starting in PY2–PY5.
- Track 3, a 2-sided risk track with higher levels of financial risk and reward, is available to all TEAM participants starting in PY1–PY5.

Episodes of Care

Episodes start with a hospital inpatient stay, called an anchor hospitalization, or a hospital outpatient procedure, called an anchor procedure, for one of these 5 surgical procedures:

- Lower extremity joint replacement
- Surgical hip femur fracture treatment
- Spinal fusion
- Coronary artery bypass graft
- Major bowel procedure

In TEAM, submitting a claim for either an inpatient hospital stay that includes 1 of the Medicare Severity Diagnosis-Related Groups or an outpatient procedure claim that contains 1 of the HCPCS codes we've identified in 42 CFR 512.525(d) initiates an episode. Each episode will end on the 30th day following the date of the anchor procedure or the date of discharge from the anchor hospitalization. The admission date to the SNF must happen no later than 30 days after the hospital or outpatient department discharges the patient.

Each episode cost includes all items and services related to the hospital inpatient stay or outpatient procedure and all non-excluded Medicare Part A and Medicare Part B items and services following discharge, for 30 days, such as:

- Follow-up care in SNFs
- Outpatient visits
- Physician services

We exclude certain items and services from the total episode cost, including:

- Certain hospital admissions
- New technology add-on payments
- Transitional pass-through payments
- Certain Part B drugs and biologicals

See 42 CFR 512.525(e) and 42 CFR 512.525(f) for a list of items and services included and excluded from an episode.

Pricing & Payment

TEAM participants, as well as any Medicare provider or supplier that provides items and services to the patient during the episode of care, will continue to bill Medicare under the original Fee-for-Service (FFS) system. Prior to each PY, TEAM will provide participating hospitals with a target price that represents most Medicare spending during an episode of care. TEAM participants can use the target price and other data we provide to identify areas for efficiency and improvements that may promote spending reductions.

After each PY ends, we'll perform a reconciliation calculation to compare each TEAM participant's total PY spending to their final target price for each episode category. We subject reconciliation amounts to adjustments to account for quality performance and limits on gains or losses. After adjusting for post-episode spending, as needed, the TEAM participant will have either a reconciliation payment from CMS or a repayment amount to CMS. We'll process reconciliation payments and repayments directly with the MACs. See 42 CFR 512.540, 42 CFR 512.545, and 42 CFR 512.550 for additional information on TEAM's pricing and payment methodology.

Key Updates

SNF 3-Day Rule Waiver

To enhance care coordination across the post-acute spectrum and support participating hospitals in managing patient care, we're conditionally waiving certain Medicare payment requirements for patients in TEAM episodes starting for dates of service on or after January 1, 2026. Specifically, per regulations at 42 CFR 512.580(b), we're waiving the requirement for a 3-day inpatient hospital stay prior to a Medicare-covered SNF stay for eligible TEAM patients.

Under standard Medicare rules, we cover SNF services if a patient has a qualifying inpatient hospital stay of at least 3 consecutive days (including the day of hospital admission but not the day of discharge). Effective for episodes starting on or after January 1, 2026, until December 31, 2030, patients in a TEAM episode of care may receive SNF or swing bed services without meeting the 3-day hospital stay requirement. Payment of SNF services claims from qualified SNFs or providers with swing bed arrangements will be subject to these criteria:

- The hospital stay wouldn't meet the 3-day rule requirement. If the stay meets the requirement, the waiver isn't necessary.
- The discharge must be from a hospital participating in TEAM. We post and regularly update a list of participating hospitals on the TEAM webpage.
- The participating hospital must have discharged the patient for 1 of the 5 TEAM episode categories prior to the start of SNF services.
- The admission date to the SNF must happen no later than 30 days after the hospital or outpatient department discharges the patient.
- The patient must meet eligibility criteria for TEAM at the time of SNF admission, including:
  - Have Part A and Part B and not be a part of a managed care plan
  - Medicare is the primary payer
  - Not have ESRD as a basis for eligibility
  - Not covered under a United Mine Workers of America health care plan
- The waiver only applies if the SNF is qualified to admit patients under TEAM. We identify qualified SNFs by their star rating and post a list on the TEAM webpage. Qualified SNFs have an overall rating of 3 stars or better for at least 7 of the last 12 months.
- We don't subject providers furnishing SNF services under swing bed arrangements to the star rating requirement.
- Demonstration code A9 is present in the treatment authorization code field (2300 REF02 Segment, where REF01=P4 for electronic claims).
- The type of bill is 21X or 18X (including CAHs).
- Occurrence span code 70 isn't present or is less than 3 calendar days, excluding the day of discharge.
- The admit date is on or after January 1, 2026, and before December 31, 2030.

All other Medicare rules for coverage and payment for Part A-covered SNF services will apply. Your MAC will return to the provider SNF claims if they don't meet these criteria.

If your MAC determines the patient doesn't meet TEAM eligibility criteria but meets all other Medicare rules for coverage and payment for Part A-covered SNF services, they'll remove demonstration code A9 and reprocess it as an FFS claim.

More Information

We issued these transmittals to your MAC as the official instructions for this change:

- R13301DEMO
- R13368DEMO
- R13399DEMO
- R13434DEMO

For more information, find your MAC's website.

We might modify some elements of the model in future years via rule making. See all the TEAM regulations at 42 CFR 512 Subpart E.

Document History

Date of Change	Description
September 29, 2025	We made no substantive changes to the article other than to update the CR release date, transmittal numbers, and transmittal links.
September 5, 2025	We made no substantive changes to the article other than to update the CR release date, transmittal numbers, and transmittal links.
August 27, 2025	Initial article released.

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