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Implementing the Transforming Episode Accountability Model: Telehealth Waiver

Related CR Release Date: November 20, 2025	**MLN Matters Number:** MM14215
Effective Date: January 1, 2026	**Related Change Request (CR) Number:** CR 14215
Implementation Date: April 6, 2026	**Related CR Transmittal Number:** R13479DEMO
Related CR Title: Transforming Episode Accountability Model (TEAM) Telehealth Waiver – Implementation	

Affected Providers

- Acute care hospitals participating in the model
- Physicians
- Other providers delivering telehealth services to Transforming Episode Accountability Model (TEAM)-eligible patients

Action Needed

Make sure your billing staff knows about the details, participation, and payment for telehealth services under TEAM with dates of service on or after January 1, 2026, including:

- CMS will waive geographic and originating site requirements for patients receiving these services
- The patient must meet the eligibility criteria and have a qualifying outpatient procedure or hospital inpatient stay
- The service must happen no later than 30 days after the start of the episode of care
- We added 9 new HCPCS codes G0660–G0668 for evaluation and management (E/M) services
- We'll pay for services when the claim meets certain payment criteria, including submitting the required demonstration code A9

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Background

The CMS Innovation Center is launching a mandatory, episode-based payment model 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 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 Hospital 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 1 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 stay that includes 1 of the Medicare Severity Diagnosis-Related Groups (MS-DRGs) 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.

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 for 30 days following discharge, such as:

- Follow-up care in skilled nursing facilities
- Outpatient visits
- Physician services

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

- Certain hospitals 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 initiate 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 Medicare Administrative Contractors (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

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(a), we're waiving the geographic site and originating site requirements for telehealth services.

Under standard Medicare rules, we cover telehealth services when patients are in specific geographic areas. Within those areas, patients must be in 1 of the health care settings the statute specifies as an eligible originating site. The service you provide must be on the list of Medicare-approved telehealth services. We pay a facility fee to the originating site and provide separate payment to the distant site provider for the service. We'll apply patient coinsurance and deductible to all TEAM telehealth services. See the Medicare Claims Processing Manual, Chapter 12, section 190, for more information on Medicare telehealth services.

Aligning with other CMS Innovation Center episode-based payment models, we'll allow patients in any geographic area to receive telehealth services during a TEAM episode. We'll also permit a home or place of residence to serve as an originating site for patients in a TEAM episode. We'll pay claims for telehealth services you deliver to patients at home or place of residence, regardless of location, under these conditions:

- A participating hospital must have discharged the patient who's receiving telehealth services for one of the TEAM episode MS-DRGs or HCPCS codes
- You must provide the telehealth services within 30 days after the patient receives an outpatient procedure or leaves the hospital
- The participating hospital must bill for the telehealth services
- Telehealth services can't replace in-person home health visits for patients under a home health episode of care
- We won't cover telehealth services performed by social workers for patients under a home health episode of care
- The telehealth geographic waiver and allowing the home as an originating site don't apply when a physician or approved non-physician practitioner conducts a face-to-face visit to certify patient eligibility for the Medicare home health benefit
- If the patient is at home, you can't provide a telehealth service with a descriptor that prevents delivering the service in a home (for example, a hospital visit code)
- If you provide an E/M visit through telehealth to a patient at home, you must bill the visit using 1 of the TEAM-specific G codes listed in Business Requirement 28 of this CR, which corresponds to different levels of time-based E/M services
- For level 4 and 5 TEAM telehealth home visits, you must document in the medical record that licensed auxiliary clinical staff were available on-site in the patient's home during the visit or document the reason why such a high-level visit didn't require such personnel to be present
- We'll waive the facility fee we pay to an originating site for a telehealth service if the service originated from the patient's home and billed with place of service code 10
- The patient receiving telehealth services must meet eligibility criteria for TEAM at the time of admission for an anchor procedure or anchor hospitalization:
  - Have Part A and Part B and not be part of a managed care plan
  - Medicare is the primary payer
  - Not have ESRD as a basis for eligibility
  - Not have a United Mine Workers of America health care plan
- The claim contains:
  - Demonstration code A9 in the treatment authorization code field (2300 REF02 Segment, where REF01 = P4 for electronic claims)
  - Type of bill 13X
  - HCPCS code G0660–G0668 as the only service on revenue code 0780

Your MAC will return to provider telehealth claims if they don't meet these criteria or if you submit a TEAM telehealth claim with other Medicare FFS services.

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

More Information

We issued CR 14215 to your MAC as the official instruction for this change. 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
November 21, 2025	Initial article released.