CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13301	**Date: July 10, 2025**
	Change Request 14098

SUBJECT: Transforming Episode Accountability Model (TEAM) 3-Day Skilled Nursing Facility (SNF) Waiver – Implementation

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to create a mechanism to allow demonstration code A9 to be associated with SNF claims involved in the model. Demonstration code A9 will waive the 3-day hospital stay requirement for SNF claims, allowing hospitals to discharge patients to SNFs after qualifying for outpatient surgeries or inpatient stays.

EFFECTIVE DATE: January 1, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2026

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Demonstrations

Attachment - Demonstrations

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II. GENERAL INFORMATION

A. Background: Section 1115A of the Social Security Act (the Act) authorizes the Centers for Medicare & Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) to test innovative payment and service delivery models to reduce Medicare, Medicaid, and Children's Health Insurance Program (CHIP) expenditures while preserving or enhancing the quality of care furnished to beneficiaries. The CMS Innovation Center is testing a bundled payment initiative under this authority to reduce Medicare expenditures while preserving or enhancing the quality of care, and to further advance care coordination across acute and chronic medical care settings.

TEAM is set to launch on January 1, 2026, and will run for five years, concluding on December 31, 2030. As a mandatory model, all policies under TEAM were proposed and finalized through rulemaking; any future updates to the model would also be proposed and finalized via rulemaking. In addition to using insights gained from prior episode-based payment models for its design, TEAM utilized insights gained from prior episode-based payment models and feedback from stakeholders following a Request for Information published in 2023. This CR allows demonstration code A9 to be associated with SNF claims involved in the model. It also allows for the payment of SNF claims without a 3-day hospital stay where the SNF claim is submitted with the A9 demonstration code. Additionally, TEAM will qualify as an Advanced Alternative Payment Model (Advanced APM) as of the model start date under the Quality Payment Program (QPP) criteria. Consistent with the QPP's Advanced APM criteria, TEAM participants will be required to report quality measure data, bear financial risk, and incorporate Certified Electronic Health Record Technology (CEHRT) into their practice. Participants or Participating Practitioners will have the opportunity to meet the threshold requirement for the Qualified APM Participant (QP) determination in order to receive, if eligible, the corresponding incentive payment under the QPP.

TEAM is scheduled to launch on **January 1, 2026** and will run for **five years**, concluding on **December 31, 2030**. The timeline for the model's performance years is as follows:

- **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

Under the TEAM, participating acute care hospitals will be responsible for the cost and quality of care for selected surgical procedures. These responsibilities will span from the time of surgery through the first 30 days after a Medicare beneficiary's discharge from the hospital. Under the model, participant hospitals will continue to bill traditional Medicare Fee-for-Service (FFS) but will be provided target prices that aim to incentivize hospitals to reduce Medicare spending and improve or maintain quality of care. As part of this mandatory model, specific provisions of the traditional Medicare FFS program will be waived with regard to payment for certain SNF stays and certain telehealth services.

TEAM Episodes of Care:

Episodes will begin with a hospital inpatient stay, called an anchor hospitalization, or a hospital outpatient procedure, called an anchor procedure, for one of the following surgical procedures: lower extremity joint replacement, surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedure. Each episode will end on the 30th day following the date of the anchor procedure or the date of discharge from the anchor hospitalization.

An episode will begin when a beneficiary is admitted for an anchor hospitalization or anchor procedure for one of the following Medicare Severity Diagnosis. Related Groups (MS–DRGs), or by the presence of one of the following Healthcare Common Procedure Coding System (HCPCS) codes on an outpatient claim (specifically, a hospital's institutional claim for an included outpatient procedure billed through the Outpatient Prospective Payment System (OPPS)).

Lower Extremity Joint Replacements (LEJR) MS–DRGs and HCPCS codes

• 469 (Major Hip and Knee Joint Replacement or 896 Reattachment of Lower Extremity with Major Complication and Comorbidity (MCC) or Total Ankle Replacement)

• 470 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC).

• 521 (Hip Replacement with Principal Diagnosis of Hip Fracture with MCC).

• 522 (Hip Replacement with Principal Diagnosis of Hip Fracture without MCC).

• 27447 (Total Knee Arthroplasty).

• 27130 (Total Hip Arthroplasty).

• 27702 (Total Ankle Arthroplasty).

Surgical Hip and Femur Fracture Treatment (SHFFT) MS–DRGs

• 480 (Hip and Femur Procedures Except Major Joint with MCC).

• 481 (Hip and Femur Procedures Except 897 Major Joint with Complication or Comorbidity (CC))

• 482 (Hip and Femur Procedures Except Major Joint without CC/MCC).

Coronary Artery Bypass (CABG) MS–DRGs

• 231 (Coronary Bypass with Percutaneous Transluminal Coronary Angioplasty (PTCA) with MCC).

• 232 (Coronary Bypass with PTCA without MCC).

• 233 (Coronary Bypass with Cardiac Catheterization or Open Ablation with MCC).

• 234 (Coronary Bypass with Cardiac Catheterization or Open Ablation without MCC).

• 235 (Coronary Bypass without Cardiac Catheterization with MCC).

• 236 (Coronary bypass without Cardiac Catheterization without MCC).

Spinal Fusion MS–DRGs and HCPCS codes

• 453 (Combined Anterior and Posterior Spinal Fusion with MCC).

• 454 (Combined Anterior and Posterior Spinal Fusion with CC).

• 455 (Combined Anterior and Posterior Spinal Fusion without CC/ MCC).

• 459 (Spinal Fusion Except Cervical with MCC).

• 460 (Spinal Fusion Except Cervical without MCC).

• 471 (Cervical Spinal Fusion with MCC).

• 472 (Cervical Spinal Fusion with CC).

• 473 (Cervical Spinal Fusion without CC/MCC).

• 22551 (Anterior Cervical Spinal Fusion with Decompression Below C2).

• 22554 (Anterior Cervical Spinal Fusion without Decompression).

• 22612 (Posterior or Posterolateral Lumbar Spinal Fusion).

• 22630 (Posterior Lumbar Interbody Lumbar Spinal Fusion).

• 22633 (Combined Posterior or Posterolateral Lumbar and Posterior Lumbar Interbody Spinal Fusion).

Single Level Spinal Fusion Except Cervical with MCC and without MCC Major Small and Large Bowel Procedure MS–DRGs

• 329 (Major Small and Large Bowel Procedures with MCC).

• 330 (Major Small and Large Bowel Procedures with CC).

• 331 (Major Small and Large Bowel Procedures without CC/MCC).

In TEAM, episodes are triggered by the submission of a claim for either an inpatient hospital stay or an outpatient procedure by a TEAM participant. The episode begins on the date of the inpatient admission or the outpatient procedure. Each episode includes a post discharge period, which starts either on the date of discharge from the inpatient hospitalization or the date of the outpatient procedure and extends for 30 days.

Each episode includes all services related to the initial hospitalization or outpatient procedure, encompassing both facility and professional services. Additionally, all non-excluded Medicare Part A and Part B items and services provided within the 30-day post-discharge period are included, such as follow-up care in SNFs, outpatient visits, and physician services. There are certain items and services excluded from the total episode cost, including certain hospital admissions, new technology add-on payments, transitional pass-through payments, and certain Medicare Part B drugs and biologicals.

CMS anticipates that beneficiaries treated under TEAM will benefit from enhanced communication and coordination among healthcare providers, improved discharge planning and facility transfers, a reduction in unnecessary or redundant procedures, fewer avoidable readmissions, more efficient utilization of post-acute care, and an overall higher quality of care throughout the episode. These improvements aim to foster greater patient engagement in their care and shorten the lengths of stay in both acute care hospitals and post-acute care settings.

TEAM Participants

TEAM will require acute care hospitals, paid under the Inpatient Prospective Payment System (IPPS), and who are located within a Core Based Statistical Areas (CBSA) selected to participate in TEAM, to be participants in the model. Hospitals required to participate will be held accountable for quality and cost performance for all episode categories in the model. TEAM will also allow a one-time opportunity for hospitals that participate until the end of the last day of the last performance period in the BPCI Advanced model or the last day of the last performance year in the Comprehensive Care for Joint Replacement (CJR) model to voluntarily opt-in to TEAM. Hospitals that voluntarily opt-in to TEAM will be required to be accountable for all episode categories

tested and must participate for the full duration of the model performance period. In other words, hospitals cannot select the episode categories and they may not prematurely terminate their participation unless terminated by CMS. Therefore, TEAM will capture a variety of hospitals, including those with and without previous value-based care experience.

TEAM will include three participation tracks and offer a glide-path to full financial risk, which acknowledges that certain types of hospitals, such as safety net hospitals, may require different levels of risks and rewards to create equitable participation opportunities in the model. Certain hospitals have the flexibility to choose which track they wish to participate in based on their eligibility for each track during certain years. For example, all hospitals are eligible to participate in Track 1 for Performance Year (PY) 1 or they could choose to participate in Track 3 in PY 1 if they wish to participate in TEAM with greater risk and rewards. We anticipate most hospitals will participate in Track 1 for PY1 given there is no downside risk. We also anticipate that safety net hospitals will choose to remain in Track 1 until the end of PY 3 and then participate in Track 2 for PYs 4-5. Lastly, we anticipate rural hospitals, Medicare Dependent Hospitals, Sole Community Hospitals, and Essential Access Community Hospitals will participate in Track 1 for PY 1 and then Track 2 for PYs 2-5.

TEAM Episode Reconciliation Activities:

TEAM participants will continue to bill Medicare under the traditional FFS system for services furnished to Medicare FFS beneficiaries. Spending reductions, relative to target prices, can be achieved through avoidable hospital readmissions and emergency department use, and reductions in post-acute care, such as reduced institutional length of stay. Performance in the model will be assessed by comparing the hospital's actual Medicare FFS spending to their reconciliation target price as well as assessing quality measure performance. TEAM participants may earn a payment from CMS or owe CMS a repayment amount, subject to certain adjustments, if their spending is below or above the target price, respectively. Reconciliation payments are adjusted by the Composite Quality Score (CQS), stop-gain/stop-loss limits, and a post-episode spending calculation. Reconciliation payments will be funded through Medicare Trust Funds and processed directly with the MACs.

Taking into account the quality performance of the episode, as measured by the composite quality score calculated for each performance year, CMS will determine whether to issue a reconciliation payment to the TEAM participant or to recoup funds from them. To be eligible for a reconciliation payment, participants must achieve the applicable minimum composite quality score. These reconciliation or recoupment amounts will be calculated by a specialty contractor on a semi-annual basis.

Identifying TEAM Claims:

To identify TEAM episodes that will be using the SNF waiver, CMS is associating the Demonstration Code A9 with the TEAM initiative. The participant hospital will be expected to communicate with the SNF to ensure that the SNF claim is submitted to CMS with Demonstration Code A9 in the Treatment Authorization field to use on the SNF waiver.

A9 - Transforming Episode Accountability Model (TEAM)

B. Policy: To enhance care coordination across the post-acute spectrum and support participant hospitals in managing beneficiary care, CMS is allowing to conditionally waive certain Medicare payment requirements for beneficiaries in TEAM episodes, effective for episodes starting on or after January 1, 2026 (the start of TEAM Performance Year 1).

This implementation CR for TEAM is described below:

Skilled Nursing Facility 3-Day Waiver:

Under standard Medicare rules, for Medicare to pay for SNF services, a beneficiary must have a qualifying inpatient hospital stay of at least three consecutive days (including the day of hospital admission but not the day of discharge). However, under TEAM, CMS will allow beneficiaries to receive SNF services without meeting this 3-day requirement, facilitating payment of claims for SNF services delivered to beneficiaries at eligible sites. This will be effective for episodes starting on or after January 1, 2026.

Under TEAM, CMS will waive the 3-day hospital stay requirement for SNF services, subject to the following conditions:

- The hospital stay would normally not meet the prerequisite of at least three consecutive days for Part A coverage of SNF services. If the stay would otherwise qualify for covered SNF services, the waiver is not necessary.
- The discharge must be from a participant hospital in TEAM, and the participant hospitals will be listed on the CMS website and updated regularly.
- The beneficiary must have been discharged from the TEAM participant hospital for one of the TEAM episode DRGs or HCPCS codes within 30 days prior to the initiation of SNF services.
- The beneficiary must meet the eligibility criteria for TEAM at the time of SNF admission, including being enrolled in Part A and Part B, not being enrolled in a managed care plan, not having ESRD as a basis for eligibility, and having Medicare as the primary payer.
- The waiver applies only if the SNF is qualified to admit beneficiaries under TEAM. Qualified SNFs will be identified by their star rating, and this information will be communicated via a list posted on the CMS website.
- The SNF must include the appropriate demonstration code in the Treatment Authorization field on claims that qualify for the waiver under TEAM. The waiver, and more specifically the SNF 3-day Rule waiver, will apply to swing bed providers (Type of Bill 18X), including Critical Access Hospital (CAH) swing bed.
- All other Medicare rules for coverage and payment of Part A-covered SNF services will continue to apply.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14098.1	Contractors shall utilize Medicare Demonstration Special Processing Number, (demo code), 'A9' to identify TEAM SNF three-day qualifying hospital stay waiver claims.	X				X			X	
14098.2	Contractors shall modify the existing consistency edit to include demo code 'A9'.								X	
14098.3	Contractors shall accept benefit enhancement indicator '4' for the TEAM SNF claims indicating the SNF three-day qualifying hospital stay waiver is applied.								X	
14098.3.1	Contractors shall assign benefit enhancement indicator '4' on claim page 12 with spaces in the ACO ID field when demo code 'A9' is present.					X				
14098.4	Contractors shall bypass all SNF three-day qualifying hospital stay edits on the claim record with the following criteria: o Admit date is on or after January 1, 2026; AND, o Admit date is on or before December 31, 2030; AND, o Demo code 'A9' is present in the Treatment Authorization Code field; AND, o Type of Bill (TOB) is 21X or 18X (including CAH) AND, o Occurrence Span Code (OSC) 70 is not present OR is less than three calendar days, excluding the day of discharge. **Note**: Example of OSC 70 for a three-day qualifying hospital stay 12/27-12/30					X			X	NCH
14098.5	Contractors shall assign a reason code to 21X and 18X TOBs when demo code 'A9' is present in the Treatment Authorization Code field and an OSC 70 is present with three or more calendar days.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14098.6	Contractors shall RTP claims for corrections to the provider for removal of demo code 'A9' or correct the OSC days.	X								
14098.7	Contractors shall determine eligibility according to the published (https://www.cms.gov/priorities/innovation/files/team-ovw-webinar-slides.pdf page 18), TEAM Beneficiary Inclusion criteria and return the appropriate error codes on Trailer 8 record if the Beneficiary is ineligible for TEAM Demonstration Model benefits and return the appropriate error codes: -5243 - Beneficiary is covered under UMWA Plan -5244 - Beneficiary does not have Part A and Part B entitlement. -5246 - Beneficiary is in a GHO/Medicare Choices Plan. -524B - Beneficiary's Medicare is not the primary payer. -524S - Beneficiary qualifies for Medicare through the End Stage Renal Disease Benefit plan.								X	
14098.7.1	Contractors shall assign a reason code, append condition code B1, strip the demo code 'A9' and the benefit enhancement indicator '4' from the claim and reprocess the claim as Fee For Service (FFS). Note: Consistent with BPCI Advance					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14098.8	Effective for TEAM Demonstration Model with From Dates of Service on or after 1/1/2026 and before 01/01/2031, Contractors shall ensure that providers submit the appropriate TEAM Demonstration Code when submitting claims for SNF and Swing Bed services: The Demonstration Code 'A9' shall be submitted by itself for Transforming Episode Accountability Model SNF and Swing Services Claims in the following fields: • Electronic transactions: 2300 REF02 Segment, where REF01=P4. • For DDE or paper Claims, Providers shall be instructed to use fields: 5/MAP1715 (for DDE) or Treatment Authorization field #63 (for paper claims)					X				
14098.9	Contractors shall add Demo Code A9 to the Demo Code 1 field and display the code on claim page 14 when present in the Treatment Authorization field.					X				

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
14098.4	A/B Crossover Edit ‘7123’
14098.2	Consistency Edit ‘0014’

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0