

OVERVIEW FACT SHEET

Transforming Episode Accountability Model

MODEL PURPOSE




People who undergo a surgical procedure in an inpatient or outpatient hospital setting may experience fragmented care that can lead to complications in recovery, avoidable hospitalization, and increased spending. Acute care hospitals participating in the Transforming Episode Accountability Model (TEAM) will be accountable for ensuring that people with Medicare receive coordinated, high-quality care during and after certain surgical procedures. CMS released the final rule that established TEAM in August 2024 and finalized additional TEAM policies in August 2025.

MODEL GOALS

TEAM will aim to improve quality of care for people with Medicare undergoing certain high-expenditure, high-volume surgical procedures, reducing rehospitalization and recovery time while lowering Medicare spending. By holding participants accountable for the quality and cost of the episodes in TEAM and ensuring patients are referred to primary care services, the model will promote prevention and support optimal, long-term health outcomes.

MODEL APPROACH

TEAM is a five-year, mandatory, episode-based payment model that will start in January 2026. Hospitals required to participate will be selected based on geographic regions from across the United States. TEAM will have graduated risk through different participation tracks to accommodate different levels of risk and reward and allow participants to ease into full-risk participation.

 TRACK 1	 TRACK 2	 TRACK 3
No downside risk and lower levels of reward for one year for all TEAM participants and up to three years for safety net hospitals.	Lower levels of risk and reward for certain TEAM participants, such as safety net hospitals or rural hospitals, for years two through five.	Higher levels of risk and reward for years one through five.
Episodes of focus will be Lower Extremity Joint Replacement, Surgical Hip Femur Fracture Treatment, Spinal Fusion, Coronary Artery Bypass Graft, and Major Bowel Procedure.		

As a mandatory model, TEAM will advance testing and evaluation of episode-based care as an approach to improve quality of care for patients and lower costs. To encourage other hospitals to maintain momentum in episode-based care, hospitals that participate until the last day of the last performance period of the Bundled Payments for Care Improvement (BPCI) Advanced Model or the last day of the last performance year of the Comprehensive Care for Joint Replacement (CJR) Model will be eligible to voluntarily opt in to TEAM.

TEAM participants will continue to bill Medicare fee-for-service (FFS) but will receive a target price based on all non-excluded Medicare Parts A & B items and services included in an episode. Participants may earn a payment from CMS, subject to a quality performance adjustment, if their spending is below the target price. Participants may owe CMS a repayment amount, subject to a quality performance adjustment, if their spending is above the target price.

MODEL CONTACT INFORMATION

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EVALUATION

TEAM will be evaluated to measure the effects of an episode-based approach on quality of and access to care, utilization patterns, expenditures, and patient experience. Hospital performance will be assessed by:



Comparing spending: a participating hospital's actual Medicare FFS spending vs. their target price



Performance on quality measures: hospital readmission, patient safety, and patient-reported outcomes.

The evaluation will also capture the evolving nature of care delivery transformation. The evaluation design will include a range of analytic methods, including regression and other multivariate methods appropriate to the analysis of stratified randomized experiments.

MODEL PARTICIPATION

- Acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) and located in selected Core-Based Statistical Areas (CBSAs) across the U.S. are required to participate in TEAM.
- Selected CBSAs, published in the FY 2025 IPPS final rule, capture a mix of hospitals with different value-based care experiences.
- Hospitals that participate until the last day of the last performance period of the BPCI Advanced Model or the last day of the last performance year of the CJR Model were eligible to voluntarily opt in to TEAM.
- People with Original Medicare may be in an episode if they are admitted to or receive an outpatient procedure from a participating hospital for one of the five surgical procedures tested in the model.
- New and newly qualifying hospitals in selected CBSAs are required to participate in TEAM after a deferment period of at least one performance year.

ENGAGING HOSPITALS IN VALUE-BASED CARE



A mandatory model design captures a wider variety of providers from across the U.S., including many who have not participated in value-based care.



Risk adjustment for economic factors and comorbidities will ensure target prices properly reflect the additional financial investment needed to care for all beneficiaries.



Certain TEAM participants, such as safety net hospitals and rural hospitals that face greater resource challenges will have the opportunity to participate in TEAM with lower financial risks and rewards, allowing them to take part in value-based care with reduced financial pressure.



TEAM will provide participating hospitals with data to help them track spending, find efficiencies, and achieve positive care outcomes.

MODEL TIMELINE

TEAM is a five-year mandatory model that will begin on January 1, 2026, and end on December 31, 2030.

5-YEAR MODEL	2026	2027	2028	2029	2030
TEAM	PY1	PY2	PY3	PY4	PY5