Safety Net and Rural Hospitals in the Transforming Episode Accountability Model (TEAM)

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TEAM Goals for Track 2 - Eligible Hospitals

Historically, few hospital types eligible for the Centers for Medicare & Medicaid Services (CMS) Transforming Episode Accountability Model's (TEAM's) Track 2 have participated in **value-based care (VBC).** To promote VBC, CMS selected core-based statistical areas to capture metropolitan and micropolitan areas with a sufficient number of safety net hospitals and hospitals that have not previously participated in CMS' bundled payment models.

Because implementing VBC may be more financially and administratively challenging for hospitals eligible for Track 2, CMS is providing these hospital types with lower-risk participation options with stronger safeguards to protect them from excessive financial harm.

Definitions of Track 2 - Eligible Hospitals

Safety net hospitals are defined according to their patient population by either exceeding the 75th percentile for (a) dually eligible patients for Medicare and Medicaid or (b) Medicare patients eligible for Part D low-income subsidies. Percentiles are created using all inpatient prospective payment system (IPPS) acute care hospitals during a 3-year baseline period. The 3-year baseline period moves forward each year, so a TEAM participant's safety net status can change each year of the model.

Rural hospitals, for the purposes of TEAM, are IPPS hospitals located in (a) a rural area as defined under 42 CFR 412.64 or (b) a rural census tract as defined under 42 CFR 412.103(a)(1). Rural hospital designations can change each year of the model.

Along with safety net and rural hospitals, CMS will also allow select types of hospitals to choose Track 2. The additional Track 2-eligible hospital types are **Medicare-dependent hospital (MDH),**[1] **sole community hospital (SCH),** and **essential access community hospital (EACH).**[2]

CMS will notify TEAM participants annually of their safety net, rural, MDH, SCH, or EACH eligibility status prior to the participation track selection period ahead of each performance year (PY).

TEAM Participation Tracks Offer Different Levels of Risk

TEAM has **three participation tracks.** Track 1 has the lowest risk, Track 2 has intermediate risk, and Track 3 has the highest risk. Notably, Track 3 also has the highest reward. A safety net hospital, rural hospital, MDH, SCH, or EACH can choose a participation track with lower financial risk. The table below summarizes risk and reward across participation tracks. Additional information on participation tracks is available in the *Participation Tracks in the Transforming Episode Accountability Model (TEAM)* fact sheet.

[1] Since the MDH program is scheduled to expire on October 1, 2025, the designation will not qualify for Track 2 if the MDH program is not renewed.
[2] Definitions for Track 2-eligible hospitals can be found at https://www.ecfr.gov/current/title-42/part-512/section-512.520#p-512.520(b)(4).

Participation Track	Risk	Stop-gain limit[3]	Stop-loss limit	Quality adjustment for positive reconciliation[4]	Quality adjustment for negative reconciliation
Track 1	Upside only	10%	N/A	Up to 10%	N/A
Track 2	Upside and downside	5%	5%	Up to 10%	Up to 15%
Track 3	Upside and downside	20%	20%	Up to 10%	Up to 10%

- **All TEAM participants** can select Track 1 or 3 in PY 1.
- **A safety net hospital** can select Track 1, 2, or 3 in PY 2 and PY 3 and Track 2 or 3 in PY 4 and PY 5.
- **A rural hospital, MDH, SCH, or EACH** can select Track 2 or 3 after PY 1.[5]

Hospital type	PY 1 (2026)[6]	PY 2 (2027)	PY 3 (2028)	PY 4-5 (2029-2030)
Safety net hospitals	May select Track 1 or 3	May select Track 1, 2, or 3		May select Track 2 or 3
Rural hospitals, MDH, SCH, or EACH	May select Track 1 or 3	May select Track 2 or 3		
All other hospital types	May select Track 1 or 3	Must select Track 3		

TEAM Target Pricing Relevant to Safety Net and Rural Hospitals

The **risk adjustment model** for all TEAM participants will include hospital-level variables for safety net status, four bed size categories (250 beds or fewer, 251–500 beds, 501–850 beds, and 850 beds or more), and a beneficiary economic risk adjustment variable. The beneficiary economic risk adjustment variable is based on dual eligibility status, low-income subsidy status, and the Community Deprivation Index of the census block group where the beneficiary lives.

- Including these characteristics, among other variables, in the risk-adjustment model will ensure that target prices capture the financial realities of safety net hospitals and smaller hospitals.

TEAM also includes a **low-volume policy** where TEAM participants that have 30 or fewer episodes in a given episode category over the 3-year baseline period will not face downside risk in that episode category for the corresponding PY. TEAM participants that fall below the low-volume threshold for an episode category will still be able to receive a reconciliation payment from CMS if their performance year spending amount is below their aggregated reconciliation target price amount for that episode category.

- The low-volume policy will ensure that hospitals are only facing financial risks for episode categories in which they perform enough procedures to meaningfully evaluate care delivery changes and will protect smaller hospitals from high-cost outlier cases that may skew their costs.

[3] Stop-gain and stop-loss limits reduce the financial risk faced by both TEAM participants and CMS. The reconciliation or repayment amounts for a given participant cannot exceed the participant's aggregated reconciliation target price amount multiplied by their stop-gain or stop-loss limit. For example, the repayment amount owed by a participant in Track 2 could not exceed 5 percent of that participant's aggregated reconciliation target price.
[4] See *Quality Measures in the Transforming Episode Accountability Model (TEAM)* fact sheet for more information on how quality adjustment differs by track.
[5] Hospital types are not mutually exclusive. If a TEAM participant is classified as more than one hospital type, the participant is eligible for all participation tracks available to the hospital types for which it is classified. For example, if a TEAM participant is safety net hospital and a rural hospital, it is eligible for participation tracks available for safety net hospitals and rural hospitals.
[6] Hospitals will be automatically assigned to Track 1 for PY 1 if no selection is made prior to track selection deadline specified by CMS.

Model Aspects for All TEAM Participants That May Be Especially Relevant to Safety Net and Rural Hospitals

TEAM participants can take advantage of **waivers available through TEAM**.

- **TEAM's 3-day skilled nursing facilities (SNF) waiver,** as described in 42 CFR 512.580(b), waives the Medicare program's SNF 3-day rule for coverage of a SNF stay. Therefore, TEAM participants may send a TEAM beneficiary to a qualified SNF[7] within 30 days of the date of discharge from an anchor hospitalization or procedure, and CMS will pay for the SNF stay without the beneficiary needing a 3-day hospital stay. CMS will post to the CMS website the list of qualified SNFs prior to the start of the calendar quarter.
  - The 3-day SNF waivers may be particularly helpful to safety net and rural hospitals that are concerned about discharging patients to homes that are far from a healthcare facility, should the patient need follow-up care.
- CMS amended the waiver requirements such that TEAM participants could utilize the 3-day SNF waiver for TEAM beneficiaries discharged to hospitals providing **post-acute care (PAC) under swing bed arrangements**, as described in 42 CFR 512.580(b)(3)(i).
  - This change should help TEAM participants in rural or underserved areas that may face a shortage of PAC providers.
- **TEAM's telehealth waiver,** as described in 42 CFR 512.580(a), waives the Medicare program's geographic and originating site requirements. TEAM participants may provide telehealth services to a TEAM beneficiary located in any region, and the beneficiary may receive telehealth services at their home if all other Medicare requirements for telehealth services are met.[8]
  - Telehealth waivers may be beneficial in rural settings where obtaining in-person follow-up care can be challenging (e.g., due to lack of transportation).

Data sharing with TEAM participants will enable participants to have data on beneficiary demographics and utilization patterns to guide care improvements.

- The reports may be particularly helpful for hospitals with smaller budgets because they provide information about their population and progress without requiring hospitals to contract with outside vendors or conduct additional analyses.
- CMS will share beneficiary-identifiable claims data and aggregate data summarizing average episode spending for participants and other hospitals within a TEAM participant's region. Data will be available annually at least 1 month before each PY. To receive beneficiary-identifiable claims data, participants will need an approved TEAM data sharing agreement with CMS, as described in 42 CFR 512.562(e).

TEAM participants **do not have additional reporting requirements** for the TEAM quality measures.

- All TEAM quality measures will be obtained directly from existing CMS quality reporting programs, including the Hospital Inpatient Quality Reporting (IQR) Program, Hospital-Acquired Condition (HAC) Reduction Program, and the Hospital Outpatient Quality Reporting (OQR) Program. Therefore, there is no additional reporting burden for TEAM participants, which may particularly benefit safety net, rural, and smaller hospitals that may not have the resources for additional reporting.

[7] CMS determines the qualified SNFs for each calendar quarter based on a review of the most recent rolling 12 months of overall star ratings on the Five-Star Quality Rating System for SNFs on the Nursing Home Compare website. Qualified SNFs are rated an overall of 3 stars or better for at least 7 of the 12 months

[8] Through September 30, 2025, a Medicare beneficiary can get telehealth services at any location in the U.S., including their home. Unless legislation expands the current policy, starting October 1, 2025, telehealth services must be provided in an office or medical facility located in a rural area in the U.S. TEAM participants will be able to use the telehealth waiver beginning on January 1, 2026, as approved in the 2025 IPPS rule.