

Transforming Episode Accountability Model (TEAM) Fact Sheet for Post-Acute Care (PAC) Providers



Purpose

The Centers for Medicare & Medicaid Services' (CMS) Transforming Episode Accountability Model (TEAM) is a mandatory model that launched on January 1, 2026, and will continue through December 31, 2030.

This fact sheet is designed to help post-acute care (PAC) providers, such as skilled nursing facilities (SNF), inpatient rehabilitation facilities, and home health agencies, understand TEAM and collaborate effectively with TEAM participant hospitals.¹

This resource provides an overview of TEAM and available resources; roles and benefits for PAC providers engaging in TEAM; opportunities for PAC providers to collaborate on high-quality, well-coordinated patient care across settings; and the SNF 3-Day Rule Waiver.

The recommendations and strategies outlined in this fact sheet are intended solely as optional resources to assist PAC providers who work with TEAM participant hospitals.

Understanding TEAM

TEAM is an episode-based payment model designed to improve care transitions, encourage investment in health care infrastructure, redesign care processes, and incentivize a value-based care collaboration between hospitals and the PAC providers responsible for the care of an Original Medicare beneficiary.

More than 700 acute care hospitals were selected by CMS for this mandatory model and are accountable for all the costs of care for a TEAM episode. A TEAM episode includes an eligible hospital inpatient stay or outpatient procedure (the anchor period) and the 30 days after discharge (the post-discharge period). It captures all Medicare Part A and Part B items and services provided throughout the episode when a beneficiary undergoes one of five surgical procedures initiated by a TEAM-eligible Medicare Severity Diagnosis-Related Groups (MS-DRG) or Healthcare Common Procedure Coding System (HCPCS) code:²

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

A TEAM episode includes all Medicare Part A and B items and services provided during the anchor procedure or hospitalization, as well as items and services delivered by a variety of Medicare providers or suppliers within the 30-day post-discharge period.

If you are viewing a printed version of this fact sheet, you can visit the model's webpage at <https://www.cms.gov/priorities/innovation/innovation-models/team-model>, <https://www.cms.gov/files/document/mm14098-implementing-transforming-episode-accountability-model-skilled-nursing-facility-3-day-rule.pdf>, and <https://www.medicare.gov/care-compare/> to access the resources referenced.

¹ The TEAM [participant hospital list](#) can be found on the TEAM webpage under the Participant Information section.

² For a list of the HCPCS codes and MS-DRGs included in each episode category, please see [42 CFR 512.525\(d\)](#).



Key Resources

- [CMS TEAM Webpage](#)
 - Includes an overview of TEAM, frequently asked questions, and additional reference materials.
- [TEAM Overview Slides](#)
 - An introductory presentation covering the TEAM design, including clinical episode definitions, pricing methodology, and quality components.
- [TEAM Overview Fact Sheet](#)
 - A brief fact sheet detailing the model's goals, financial participation tracks, evaluation metrics, and participation characteristics.
- [TEAM Infographic](#)
 - A one-page CMS visual guide summarizing the TEAM timeline, goals, target surgeries, and care components.
- [Example Patient Journey](#) in TEAM
 - A visual guide following a hypothetical Original Medicare beneficiary through a TEAM care recovery experience, contrasted with a non-TEAM care recovery experience.

Why PAC Providers Matter in TEAM

TEAM encourages participant hospitals and PAC providers to coordinate on patients' needs and preferences throughout treatment and recovery. The goal is to improve patient experiences and provide better care, resulting in fewer complications and readmissions.

PAC providers are critical partners in helping patients:

- **Recover Safely:** Ensure a safe and smooth recovery following the surgical procedure.
- **Reduce Readmissions:** Prevent avoidable hospital readmissions that may compromise patient recovery.
- **Transition Successfully:** Manage the shift from hospital to home or an appropriate PAC setting.
- **Minimize Complications:** Deliver coordinated care after discharge from a hospital when patients may be at an increased risk of complications.

Collaboration with TEAM participants also provides PAC providers with an opportunity to demonstrate their ability to deliver high-quality and efficient care.



Important Note: PAC providers do not bear financial risk under the model unless they opt into risk-sharing financial arrangements with TEAM participant hospitals. See the section below on “How PAC Providers Can Partner With TEAM Participant Hospitals.”

Benefits to PAC Providers Engaging With TEAM Participant Hospitals

PAC providers may benefit from partnering with TEAM participant hospitals as it may provide opportunities to:

- **Strengthen Partnerships:** Build deeper, more collaborative relationships with primary hospital referral partners.
- **Enhance Communication:** Support smoother, more transparent care transitions for shared patients.
- **Expand Data Access:** Gain potential access to relevant Medicare utilization data.
- **Advance Care Quality:** Collaborate on shared clinical quality initiatives.
- **Gain Broader Insights:** Increase visibility into post-acute patient outcomes and total episode performance.
- **Support Quality and Rating Goals:** Target reductions in avoidable readmissions, which could improve CMS Five-Star Quality Ratings over time.
- **Build Value-Based Readiness:** Strengthen operational alignment for current and future Medicare and/or private value-based care models.

How PAC Providers Can Partner With TEAM Participant Hospitals

Engage in care coordination activities

To effectively partner in TEAM, PAC providers should be prepared to:

- Support TEAM participant hospitals' efforts in improving quality of care while reducing Medicare Fee-for-Service (FFS) expenditures.
- Identify Original Medicare beneficiaries who may be at increased risk for complications, extended recovery, or readmission.
- Become familiar with relevant hospital quality measures and reporting priorities to better align care coordination and performance improvement efforts across settings.

PAC providers and TEAM participant hospitals may collaborate on care coordination activities, including:

- Participating in discharge planning discussions (e.g., from a hospital to home, from a PAC facility to home).
- Improving communication about patient status, care needs, and transition to PAC through discharge summaries, medication reconciliation, and intake assessments at the time of hospital discharge.
- Supporting timely follow-up care and continuity of services after discharge.
- Sharing with the interdisciplinary care team information related to patient progress, recovery goals, and ongoing care needs throughout the 30-day post-discharge window.
- Extending evidence-based care plans into PAC settings.

Enter into financial arrangements

- Under TEAM, participant hospitals can enter into voluntary financial arrangements with eligible TEAM collaborators to share in the financial risk of the model.
- The voluntary financial arrangement can include a gainsharing payment, an alignment payment, or both.
 - **A gainsharing payment** is a payment made by the TEAM participant hospital to a TEAM collaborator, and may consist of reconciliation payments received from CMS, internal cost savings, or both.
 - **An alignment payment** is a payment made by a TEAM collaborator to a TEAM participant hospital, after negative reconciliation results. It occurs when the hospital owes money to CMS due to its performance in the model.
- Financial arrangements allow TEAM participant hospitals to align their financial incentives with those of PAC providers, maximizing these partnerships. All financial arrangements must comply with the provisions outlined in [42 CFR 512.565–512.576](#).

Understanding the SNF 3-Day Rule Waiver

Under Medicare FFS rules, CMS will pay for SNF services only if a beneficiary has a qualifying inpatient hospitalization of at least 3 consecutive days, including the day of admission but not the day of discharge.

To enhance care coordination across the post-acute spectrum and support TEAM participant hospitals in managing beneficiary care, CMS is conditionally waiving certain Medicare FFS payment rules for TEAM episodes. For more information on the TEAM SNF 3-Day Rule Waiver, please see [42 CFR 512.580\(b\)](#).

A SNF 3-Day Rule Waiver is available under TEAM, subject to the following conditions:

- The hospital stay does not meet the prerequisite of at least 3 consecutive days for Medicare 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 TEAM participant hospital.
- The beneficiary must have completed an outpatient procedure or been discharged from an acute inpatient hospitalization initiated by a TEAM-qualifying MS-DRG or HCPCS code (see footnote 2 for eligible TEAM-qualifying codes).
- The beneficiary must be admitted to the SNF within 30 days of the outpatient procedure or inpatient hospitalization, bypassing the Medicare FFS requirement of a 3-day inpatient hospitalization.
 - *Readmission Coverage:* The 3-Day Rule Waiver extends to subsequent readmissions or hospital discharges within this 30-day window.
- Long-term care or SNF residents qualify for the SNF 3-Day Rule Waiver if they are discharged to a qualified SNF following a TEAM outpatient procedure or inpatient hospitalization.
- The beneficiary must meet the following TEAM eligibility criteria upon admission for an outpatient procedure or inpatient hospitalization. Beneficiary inclusion criteria are available at [42 CFR 512.535\(a\)](#):
 - Enrolled in Medicare Parts A and B
 - Not eligible for Medicare on the basis of having end-stage renal disease
 - Not enrolled in any managed care plan (for example, Medicare Advantage, health care prepayment plans, or cost-based health maintenance organizations)

- Not covered under a United Mine Workers of America health care plan
- Have Medicare as their primary payer

The SNF 3-Day Rule Waiver applies only if the SNF is qualified based on the following requirements:

- CMS determines that a SNF is qualified through a quarterly review of the most recent rolling 12 months of overall star ratings on the CMS Five-Star Quality Rating System for SNFs on the [Nursing Home Compare webpage](#). To qualify, a SNF must receive an overall rating of at least three stars for 7 or more of the 12 months reviewed.
 - CMS posts a list of qualified SNFs every quarter on the [TEAM webpage](#) under “Additional Information.”
- The waiver also applies to swing bed providers, including Critical Access Hospital (CAH) swing beds.
 - Providers furnishing SNF services under swing bed agreements are not subject to the star ratings requirement.
 - Swing bed providers that are eligible to use the TEAM SNF 3-Day Rule Waiver are included in the quarterly list of qualified SNFs published by CMS.



Important Note: CMS will cover services furnished under the SNF 3-Day Rule Waiver if a beneficiary is later found to be ineligible for TEAM (for example, because of an unexpected coverage change or a non-qualifying final MS-DRG/HCPCS code). Coverage will apply if the hospital and SNF made a good-faith effort based on the data available at admission.

- A screenshot, report, or medical record note showing a working TEAM-qualifying MS-DRG or HCPCS code, or an eligible coverage status at admission, would show a good-faith effort.

How to Bill for Services Using the SNF 3-Day Rule Waiver

Category	Requirement
CMS Payment Policy	Waives the requirement for a 3-day hospital inpatient hospitalization before receiving SNF services. For more information, see the CMS Medicare Learning Network (MLN) Matters® Article MM14098: Implementing the TEAM: SNF 3-Day Rule Waiver . All other Medicare FFS rules for coverage and payment of Part A-covered SNF services still apply.
Type of Claim	Type of Bill (TOB) is 21X for SNF inpatient services or 18X for CAHs.
Who Must Bill	Qualified SNF that provides the service, per the quarterly Qualified SNF List on the TEAM webpage . Services provided by a SNF that is not on the published list will not be paid by Medicare.
Demonstration Code	A9: First Treatment Authorization Code Field (2300 REF02 Segment, where REF01 = P4 for electronic claims).
Required Coding	Occurrence Span Code (OSC) 70 is either not present or reflects a stay of less than 3 calendar days, excluding the day of discharge.
Episode Type	TEAM outpatient or inpatient episodes.



Important Note: The regional Medicare Administrative Contractor (MAC) will return claims to the Qualified SNF or swing bed provider if they do not meet these criteria or if the claim using the SNF 3-Day Rule Waiver is submitted with other Medicare FFS services in the same claim.