

Centers for Medicare and Medicaid Services
Transforming Episode Accountability Model (TEAM)

Frequently Asked Questions

Updated April 2026

Table of Contents

General.....	1
Eligibility	3
Voluntary Opt-in Opportunity	8
Payment Methodology	10
Episode Construction.....	14
Learning System / Technical Assistance	17
Portal and Points of Contact	19
Data Sharing / Participant Reports.....	21
Care Delivery / Quality Strategy.....	23
Financial Arrangements / TEAM Collaborators.....	27
Skilled Nursing Facility Waiver	30
Model Overlap	33

GENERAL

1. What are the Transforming Episode Accountability Model (TEAM)'s goals?

The intent of TEAM is to improve beneficiary care through financial accountability for TEAM participants that initiate at least one of the included episode categories that begin with one of the following procedures: coronary artery bypass graft (CABG), lower extremity joint replacement (LEJR), major bowel procedure, surgical hip and femur fracture treatment (SHFFT), and spinal fusion.

TEAM focuses on improving quality of care and reducing Medicare expenditures for five surgical episode categories. These episode categories represent high-expenditure, high-volume care delivered to Medicare beneficiaries and are evaluable in an episode-based payment model. CMS anticipates that TEAM will:

1. Benefit Medicare patients through improved coordination of items and services paid for through Medicare fee-for-service (FFS)
2. Encourage provider investment in health care infrastructure and redesigned care processes
3. Incentivize higher value care across the inpatient and post-acute care settings

2. How did CMS develop TEAM?

CMS created TEAM using lessons learned from earlier CMS Innovation Center episode-based payment models such as the [Bundled Payments for Care Improvement Advanced \(BPCI Advanced\)](#) and Comprehensive Care for Joint Replacement (CJR) Models, feedback from a [July 2023 Request for Information](#), and consultation with several stakeholders, including providers, health systems, and thought leaders in the field. Additionally, CMS will use public comments received during the rulemaking process to inform any modifications to future policies.

3. How will CMS address policies not yet finalized in a proposed rule for TEAM or make changes to policies in the future?

There may be times that a proposed policy is not finalized or requires a modification, such as needing to further analyze a proposed policy before it is finalized. CMS finalized the majority of TEAM's policy proposals in the [FY 2025 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals \(IPPS\) and the Long-Term Care Hospital \(LTCH\) Prospective Payment Systems \(PPS\) Final Rule](#) and finalized others in the [FY 2026 Hospital IPPS/LTCH PPS Final Rule](#). Additionally, any potential changes to finalized policies before or during the model performance period are subject to undergo notice and comment rulemaking.

4. When will additional updates regarding TEAM be available?

Those interested in remaining up-to-date on model announcements and resources may subscribe to [TEAM's listserv](#).

5. What if we do not perform a certain TEAM-eligible procedure?

Acute care hospitals in mandatory TEAM Core-Based Statistical Areas (CBSAs) that do not meet a TEAM exclusion will trigger a TEAM episode when any one of the five selected clinical episode categories (CABG, LEJR, major bowel procedure, SHFFT, and spinal fusion) is conducted at the hospital. If a hospital only performs two types of episodes, for example, they will trigger TEAM episodes for only those two clinical episode categories. If a hospital does not perform any of the episode types, they will not trigger any TEAM episodes and will not be held financially accountable in the model. Participants will only be held financially accountable for the episodes triggered and reconciled in the model.

6. How can we get involved in TEAM if we are not a participant?

We recommend visiting the [TEAM website](#) and signing up for updates on TEAM using the [TEAM's listserv](#).

Please note that only TEAM participants are given access to the TEAM Participant Portal and Data Portal. Only acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) can be TEAM participants. Other types of providers and suppliers may participate in TEAM as TEAM collaborators, collaboration agents, or downstream collaboration agents, as applicable, if a financial arrangement has been established with a TEAM participant.

ELIGIBILITY

7. Why is participation in TEAM mandatory for selected hospitals?

Mandatory models can improve the generalizability of model findings and capture a wider variety of providers from across the country, including many who have not participated in value-based payment models. Mandatory models also address participation challenges inherent in voluntary models, namely provider attrition and selection bias. As an episode-based payment model that builds on previous voluntary CMMI models, TEAM is well positioned to advance testing and evaluation and aligns with recommendations from federal partners.

A TEAM participant is defined as an acute care hospital that (1) initiates episodes and is paid under the IPPS and Outpatient Prospective Payment System (OPPS) with a CMS Certification Number (CCN) primary address located in one of the mandatory Core-Based Statistical Areas (CBSAs) selected for participation in TEAM in accordance with § 512.515; or (2) Makes a voluntary opt-in participation election to participate in TEAM in accordance with § 512.510 and is accepted to participate in TEAM by CMS.

8. Will hospitals that are newly opened be required to participate in TEAM if located in a mandatory CBSA?

CMS recognizes that new hospitals that open shortly before or during the model performance period, as well as hospitals that begin to satisfy the definition of TEAM participant shortly before or during the model performance period, and that would otherwise be required to participate in TEAM based on their receipt of payment under IPPS and their geographic location, may experience multiple disadvantages relative to other TEAM participants. Therefore, CMS will not immediately require any new hospital, as identified by Medicare ID (CCN) with an initial effective date after December 31, 2024, within the Medicare Provider Enrollment, Chain, and Ownership System (PECOS), excepting any new hospital that is created as part of a reorganization event as defined at § 512.505; these hospitals will have at least one full performance year (PY) of participation deferment before being required to participate in the model.

Specifically, any new hospital located in a mandatory CBSA, and any hospital located in a mandatory CBSA that begins to meet the definition of TEAM participant, are required to participate in TEAM starting on January 1st of the subsequent PY. For example, if a hospital opened in a mandatory CBSA with a Medicare ID (CCN) initial effective date on June 1, 2026, then the hospital would not be required to begin participation until January 1, 2028 (PY 3). Likewise, if a hospital located in a mandatory CBSA terminated their participation in the Rural Community Hospital Demonstration (RCHD) effective on August 1, 2027, then they would not be required to begin participation in TEAM until January 1, 2029 (PY 4).

9. Where will TEAM be tested? What CBSAs have been selected for TEAM participation?

CMS has published a list of the selected mandatory CBSAs in section X.A.3.a.(4) of the preamble of the [FY 2025 Hospital IPPS and LTCH PPS Final Rule](#). By using CBSAs as the unit of selection, CMS is ensuring that the model represents a wide range of markets and requires the participation of many hospitals with diverse characteristics.

10. Is there a list of hospitals selected for TEAM participation?

CMS [published a list of acute care hospitals \(XLSX\)](#), identified by CCN, located in one of the mandatory CBSAs selected for participation. This list also includes eligible hospitals that voluntarily opted in to TEAM participation. CMS will periodically update this list to accurately capture acute care hospitals in the mandatory CBSAs.

11. Will there be updates to the initial TEAM participant list?

CMS may update the TEAM participant list to reflect changes in hospital status (e.g., closures, mergers, and other reorganization events) and accurately capture acute care hospitals in the mandatory CBSAs. CMS will regularly review internal records to identify status changes. A hospital that no longer satisfies the definition of TEAM participant would end TEAM participation effective the date they no longer satisfy the definition. CMS will notify the hospital that it no longer meets this definition within 30 days of the hospital no longer meeting the TEAM participant definition or as soon as is reasonably practicable.

Further, prior to each PY, CMS intends to update the list to identify which hospitals satisfy the definition of a safety net hospital, rural hospital, or other selected hospital types, such as Medicare Dependent Hospitals (MDHs), Sole Community Hospitals (SCHs), and Essential Access Community Hospitals (EACHs) in TEAM, specified under § [512.505](#).

12. What are the safety net hospital criteria for the purposes of TEAM?

For the purposes of TEAM, a safety net hospital is defined as an IPPS hospital that meets at least one of the following criteria:

1. Exceeds the 75th percentile of the proportion of Medicare beneficiaries considered dually eligible for Medicare and Medicaid across all PPS acute care hospitals in the baseline period. The numerator and denominator are as follows:
 1. Numerator: Number of Medicare beneficiaries considered fully eligible for Medicare and Medicaid.
 2. Denominator: Total number of Medicare beneficiaries across all Inpatient Prospective Payment System (IPPS) acute care hospitals that bill Medicare in the baseline period.
2. Exceeds the 75th percentile of the proportion of Medicare beneficiaries partially or fully eligible to receive Part D low-income subsidies across all PPS acute care hospitals in the baseline period.

1. Numerator: Number of Medicare beneficiaries partially or fully eligible to receive Medicare Part D low-income subsidies.
2. Denominator: Total number of Medicare beneficiaries across all Inpatient Prospective Payment System acute care hospitals that bill Medicare in the baseline period.

13. CMS will make redeterminations of safety net hospital qualifications under TEAM annually, meaning that hospital safety net status could vary over the model’s duration. However, we do not expect a significant number of hospitals to experience status changes year after year. What is the definition of a rural hospital in TEAM?

For the purposes of TEAM, ‘rural hospital’ refers to an IPPS hospital that is located in a rural area as defined under [§ 412.64](#) or is located in a rural census tract defined under [§ 412.103\(a\)\(1\)](#).

14. Which hospitals are exempt from mandatory participation?

Acute care hospitals that do not satisfy the definition of TEAM participant are exempt from mandatory participation. For example, hospitals with a CCN primary address not located in a mandatory CBSA and all acute care hospitals in Maryland are exempt from mandatory participation.

Additionally, CMS has excluded Indian Health System (IHS)/Tribal hospitals from TEAM participation by updating the TEAM participant definition in the FY 2026 Hospital IPPS and LTCH PPS Final Rule to state that a TEAM participant must be paid under IPPS and OPSS. Hospitals that are actively participating in the Rural Community Hospital Demonstration (RCHD) are excluded from TEAM participation if their RCHD participation overlaps with TEAM episode window.

15. What policies or flexibilities are available to safety net hospitals that participate in TEAM? Will the policies apply to rural hospitals?

TEAM is a mandatory model that offers a glide path to participation in downside risk for all hospitals, including safety net and rural hospitals. Safety net hospitals are eligible for a longer glide path and therefore will be permitted to participate in Track 1 for PYs 1 through 3, based on their timely notification of participation track selection before the start of each PY. Track 1 limits upside risk with a 10% stop-gain limit, adjusts positive reconciliation amounts for quality performance up to 10%, and offers no downside risk for hospitals as they implement care redesign tactics and build capacity to use data to deliver high-quality care.

Safety net hospitals are also eligible to participate in Track 2 for PYs 2 through 5, based on their timely notification of participation track selection before the start of each PY. Hospitals participating in Track 2 will have upside and downside risk, with a stop-gain and stop-loss limit of 5%. Positive reconciliation amounts will be adjusted for quality performance up to 10%, and negative reconciliation amounts will be adjusted for quality

performance up to 15%. The higher adjustment for negative reconciliation amounts results in a lower repayment amount.

Rural hospitals, MDHs, SCHs, and EACHs located in a mandatory CBSA will participate and may select Track 1 for PY 1. During PYs 2 through 5, these hospitals may select between Tracks 2 and 3, based on their timely notification of participation track selection before the start of each PY. TEAM participants who are classified as MDHs will be eligible for Track 2 participation as long as the MDH program is active at the time that participation track selections are due to CMS.

Hospitals that do not fall into one of these categories will be required to participate in Track 3 for PYs 2 through 5. Hospitals participating in Track 3 will have upside and downside risk, with a stop-gain and stop-loss limit of 20%. Positive and negative reconciliation amounts will be adjusted for quality performance up to 10%.

16. When will hospitals select a participation track?

TEAM participants are required to notify CMS of their track selection prior to the start of each PY. CMS will provide TEAM participants with additional information about the track selection process and deadline, as well as safety net hospital status, prior to each PY. Please note that participants' track selections are subject to eligibility review and approval by CMS.

Participants selected their participation tracks in 2025Q4 in advance of TEAM's start date in 2026. Only points of contact (POCs) with the Authorized Signatory role in the TEAM portal are able to view and submit the Participation Track Selection form to CMS. TEAM participants who failed to notify CMS in advance of the deadline were automatically assigned to Track 1 for PY 1.

In PYs 2 to 5, if a TEAM participant fails to notify CMS of their election to participate in Track 1 or Track 2 by the selection deadline for a given PY, or if the participant is not eligible for Track 1 or Track 2 at the time of the track selection request, they will be assigned to Track 3 for that PY by default.

Please note that all hospitals are eligible to participate in Track 1 in PY1. In PY2 and PY3, Track 1 remains available only to safety net hospitals. Track 2 will become available PY2 onwards to safety net hospitals, Medicare Dependent Hospitals, Sole Community Hospitals, and Essential Access Community Hospitals. TEAM participants will be required to notify CMS of their track selection prior to the start of PY2.

17. Does a hospital have to perform all five-episode categories to participate?

TEAM requires TEAM participants to take part in all five-episode categories. However, if a TEAM participant does not perform a given episode category, then they will not initiate an episode in that episode category in the model.

Additionally, if a TEAM participant does not meet the low volume threshold of at least 31 episodes in a given episode category during the baseline period for a PY, CMS will

still reconcile their episodes but will not hold the TEAM participant accountable for any PY spending that exceeded the reconciliation target price for each of the MS-DRG/HCPCS episode types in that given episode category during that PY—effectively waiving downside risk for episode categories in which the TEAM participant did not meet the minimum baseline episode volume.

CMS may add additional episode categories in future PYs of the model. Any additional episode categories will only be added to TEAM pursuant to notice and comment rulemaking.

18. If a healthcare system has multiple hospitals under the same Tax Identification Number (TIN)/CCN, will hospitals outside the mandatory participation CBSA also be mandated to participate in TEAM?

Acute care hospitals paid under the IPPS and OPSS with a CCN primary address located in a mandatory CBSA are required to participate in TEAM. Therefore, it is possible for a hospital that is located outside of a mandatory CBSA to participate in TEAM if the CCN they use has a CCN primary address located in a mandatory CBSA. CMS has published a list of TEAM participant hospitals on TEAM’s webpage, which was updated to include hospitals that completed a voluntary participation election letter and were accepted for voluntary participation pending their continued fulfillment of the eligibility requirements.

Health systems or other organizations with multiple CCNs can reference the list linked above to understand which hospitals are required to participate in TEAM.

19. Are TEAM participants eligible to move between participation tracks?

Yes, TEAM participants are eligible to move between participation tracks between PYs as long as they meet track eligibility requirements and notify CMS of their track selection in the form and manner and by the deadline set by CMS.

20. Is there an appeal process to be excluded from participation?

No, there is not an appeal process for participation exclusion. In the context of a mandatory model such as TEAM, hospitals located in mandatory CBSAs that meet the TEAM participant definition are required to participate in the model even if they have not had previous episode-based payment model or value-based care experience.

21. Are Ambulatory Surgical Centers (ASCs) or joint venture ASCs located in mandatory participation CBSAs included in TEAM?

No, ASCs do not meet the TEAM participant definition and are not included in TEAM as TEAM participants. However, Medicare spending resulting from services performed at an ASC may be included in episode spending if the ASC services were performed during the episode window.

VOLUNTARY OPT-IN OPPORTUNITY

22. Who is eligible to voluntarily participate in TEAM?

CMS offered a one-time opportunity for select hospitals to opt in to participate in TEAM from January 1-31, 2025. The deadline to submit a voluntary participation election letter was on January 31, 2025. Hospitals not located in a mandatory CBSA that participate until the last day of the last performance period in the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model or the last day of the last PY of the Comprehensive Care for Joint Replacement (CJR) Model (December 31, 2025, and December 31, 2024, respectively) were considered eligible to opt-in to TEAM.

CMS updated [TEAM's participant list \(XLSX\)](#) to include voluntary opt-in participants and shared it on April 7, 2025. CMS does not anticipate allowing additional voluntary opt-in opportunities at this time.

23. Can hospitals eligible to voluntarily participate in TEAM join at any point during the model?

No, CMS offered the voluntary opt-in period as a one-time opportunity for select hospitals to opt in to TEAM participation. CMS required that eligible hospitals notify them of their intent to participate by January 31, 2025.

CMS does not anticipate additional opt-in opportunities at this time.

24. When will previous CJR or BPCI Advanced participants who opted in to participate in TEAM be required to participate?

CMS requires all hospitals that opted in TEAM to participate in all episode categories for the full five-year model performance period (January 1, 2026, through December 31, 2030).

Hospitals that participated until the last day of the last performance period in the BPCI Advanced Model or the last day of the last PY of the CJR Model (December 31, 2025, and December 31, 2024, respectively) were considered eligible to opt in to TEAM.

25. Can acute care hospitals who opted in to TEAM participation opt out of the model after implementation begins?

No, hospitals who opted into TEAM are required to participate for the full five-year performance period and may not withdraw from the model.

26. When and how were eligible hospitals that voluntarily applied to participate in TEAM notified of their participation status?

CMS emailed eligible hospitals and provided them with notification of their eligibility to participate in the model. Acceptance notifications were sent on March 13, 2025. CMS

treats the voluntary participation election letter that hospitals submitted as the participation agreement for TEAM.

PAYMENT METHODOLOGY

27. When will CMS share target prices and baseline data with hospitals participating in TEAM?

TEAM participants that complete a TEAM Data Sharing Agreement (DSA) and a TEAM Data Request and Attestation (DRA) form are eligible to receive target prices and baseline data. These preliminary target prices are calculated using 3 years of baseline data, trended forward to the PY, at the level of MS-DRG/HCPCS episode type and region, with updates to be made using the PY data during reconciliation. CMS provides two types of preliminary target prices for each TEAM participant for each MS-DRG/HCPCS episode type: a region level and a hospital-specific target price.

For PY 1, CMS has distributed the preliminary baseline claims and target pricing data:

- on December 18, 2025, to TEAM participants that completed the required DRA form and DSA in the TEAM Portal by September 22, 2025.
- on March 17, 2026, to additional TEAM participants that completed the required DRA form and DSA in the TEAM Portal by February 6, 2026.

These target prices reflect policies finalized in the FY 2026 IPPS/LTCH PPS Final Rule.

For PYs 2-5, CMS will share preliminary target prices and baseline data prior to the start of each PY.

28. Can you explain TEAM's risk adjustment methodology?

TEAM's risk adjustment methodology uses baseline data to calculate risk adjustment coefficients and holds the coefficients constant at reconciliation. Risk adjustment coefficients will be calculated and made available to TEAM participants, along with the preliminary target prices and baseline data, prior to the start of each PY, so TEAM participants will be able to use them to estimate their episode-level target prices. Risk adjustment factors include age group, Hierarchical Condition Category (HCC) count based on HCC version 28, a beneficiary economic risk adjustment factor, as well as episode category-specific HCC adjusters and hospital-level variables, such as bed size. The comprehensive list of risk adjustment variables can be found in [§ 512.545\(a\)](#).

CMS will use a 180-day lookback period for each TEAM beneficiary who meets the beneficiary inclusion criteria during the entire 180-day lookback period, which ends on the day prior to the anchor hospitalization or anchor procedure, to determine which HCC variables the beneficiary is assigned, the episode category-specific HCC flags, and the TEAM HCC count flag.

The beneficiary economic risk adjustment factor is a single binary variable with a value of yes=1 if the TEAM beneficiary meets one or more of the following criteria: national-level Community Deprivation Index (CDI) above the 80th percentile, eligibility for the low-income subsidy, or eligibility for full dual Medicare-Medicaid benefits.

The risk adjustment coefficients will be calculated at the MS-DRG/HCPCS level using baseline episodes data and a weighted linear regression where episodes are weighed differentially based on whether they occurred in year 1, 2, or 3 of the baseline period. Episodes from baseline year 1 will be weighed at 17 percent, baseline year 2 at 33 percent, and baseline year 3 at 50 percent. The risk adjustment coefficients will be fixed and applied to PY episodes at reconciliation based on the realized patient case mix of the TEAM participant in the PY.

29. How are TEAM's preliminary target prices constructed?

Target prices will be calculated using 3 years of rolling baseline episode spending, trended forward with two additional historical years to the PY, at the level of MS-DRG/HCPCS episode type and region, where region is defined as the nine U.S. Census Divisions, with updates to be made using PY data during reconciliation. Episode spending will be capped using the high-cost outlier cap at the level of MS-DRG/HCPCS episode type and region.

Benchmark prices are calculated using the baseline episode spending data of all TEAM-eligible hospitals in a region, regardless of TEAM participation status. To calculate the regional target prices for each MS-DRG/HCPCS episode type, CMS will apply a prospective trend factor, constructed using five years of data (three baseline years and two trend years), and a discount factor to benchmark prices. CMS will then additionally apply the risk adjustment multiplier and a prospective normalization factor to calculate the hospital-specific preliminary target prices. More information about preliminary target prices is available in [§ 512.540\(b\)](#) as well as the target price specifications shared with participants via email and the [TEAM eDFR platform](#), or published on the [CMS TEAM website](#).

30. What is the prospective normalization factor that will be applied to preliminary target prices?

The prospective normalization factor refers to the multiplier incorporated into the preliminary target prices to ensure that the average total risk-adjusted benchmark price does not exceed the average total unadjusted benchmark price.

CMS will calculate the prospective normalization factor for each MS-DRG/HCPCS episode type and region as the average unadjusted benchmark price divided by the average risk-adjusted benchmark price.

31. What is the prospective trend factor that will be applied to preliminary target prices?

The prospective trend factor refers to the multiplier incorporated into the preliminary target price to account for year-to-year changes in spending patterns between the baseline and the PY. Such changes may result from factors including new technologies, medical advancements, and unexpected changes in health care utilization. To avoid amplifying short-term regional trends that do not represent longer-term cost trends for TEAM

participants, the prospective trend factor applied to preliminary target prices is the average (arithmetic mean) of a regional trend factor and a national trend factor.

The prospective trend factor is calculated as an annual percentage change using a log-linear model that fits the logarithmically transformed values of average regional MS-DRG spending for each of the baseline years. CMS exponentiates the coefficient from this regression to calculate the estimated annual change (where an exponentiated coefficient of 1 signifies no change) in average regional spending for each MS-DRG/HCPCS episode type from year to year. CMS then squares this value to calculate the 2-year prospective trend factor.

Where data is available, CMS will use two additional years of episode spending data (also known as “trend years”, which are the two years immediately prior to the 3-year baseline period) in calculating the prospective trend factor. The national MS-DRG trend factor will be calculated in the same manner as the regional MS-DRG trend factors using a linear regression of logarithmically transformed national average MS-DRG spending.

32. What is the percentage discount factor that will be applied to each of the five-episode categories?

Discount factors by episode category:

1. 1.5% discount factor for the CABG episode category.
2. 1.5% discount factor for the Major Bowel Procedure episode category.
3. 2% discount factor for the Spinal Fusion episode category.
4. 2% discount factor for the LEJR episode category.
5. 2% discount factor for the SHFFT episode category.

33. What is the high-cost outlier cap?

CMS defines the high-cost outlier cap at [§ 512.505](#) to mean the 99th percentile of regional episode spending for a given MS-DRG/HCPCS episode type, region, and baseline/PY. The high-cost outlier cap limits the impact of extremely high episode spending values and is implemented with the aim of protecting participants from getting penalized for the cost of infrequent and potentially nonpreventable complications within each MS-DRG/HCPCS episode type and region.

34. How will TEAM impact Medicare FFS payments?

Episode-based payment models such as TEAM aim to move away from a FFS payment structure by including pay-for-performance methodologies that incentivize improvements in patient outcomes while lowering Medicare spending. TEAM participants and all Medicare providers and suppliers associated with an episode will continue to bill Medicare FFS. Approximately six months after each PY ends, all the spending for items and services that are included in an episode attributed to the TEAM participant will be included in an annual reconciliation process.

TEAM may benefit Medicare beneficiaries by improving the coordination of items paid for through Medicare FFS payments, encouraging provider investment in health care infrastructure and redesigned care processes, and incentivizing higher value care settings for the episode.

35. Please explain TEAM's reconciliation process.

CMS will reconcile, on an annual basis, all the episode spending from the episodes attributed to a TEAM participant against the reconciliation target price. TEAM participants that spend less than the reconciliation target price may earn a reconciliation payment from CMS, which is subject to quality and other adjustments. TEAM participants that spend more than the reconciliation target price may owe CMS a repayment amount, which is subject to quality and other adjustments.

The reconciliation process will begin approximately 6 months after the end of each PY. Each PY will undergo one reconciliation cycle.

36. Please explain how TEAM episodes will be initiated and any cut-off dates for how CMS will calculate reconciliation.

Episodes are initiated when a beneficiary is admitted to a TEAM participant hospital for an anchor hospitalization, as identified by a Medicare Severity Diagnosis Related Group (MS-DRG), or when a beneficiary receives an anchor procedure from a TEAM participant hospital, as identified by a Healthcare Common Procedure Coding System (HCPCS) code, described in [§ 512.525](#).

CMS will use the anchor hospitalization or anchor procedure start date and discharge date to determine how an episode is attributed to a PY. For example, episodes with anchor hospitalization start dates or anchor procedure dates beginning on or after January 1, 2026, and anchor hospitalization discharge dates or anchor procedure dates between January 1, 2026, and December 31, 2026, will be attributed to PY 1.

37. In regard to reconciliation, will all TEAM participants that bill a service to a TEAM beneficiary in an episode be paid through a single bundled payment?

TEAM participants, or any providers/suppliers caring for a TEAM beneficiary, continue to bill Medicare FFS, as usual. They do not receive one single bundled payment. At reconciliation, a TEAM participant hospital's cost and quality performance will be evaluated, which may result in the hospital earning reconciliation payment from or owing a repayment amount to CMS.

EPISODE CONSTRUCTION

38. How were episode categories chosen for the model?

Based on the feedback received from its [2023 Request For Information \(RFI\)](#), CMS selected episode categories with sufficient volume that are clinically similar, have well-defined beginnings and endings, and have demonstrated success in reducing episode payments and achieving net Medicare savings (for instance, in BPCI Advanced and CJR). While the episode categories included in TEAM are surgical, CMS may explore adding additional episode categories to TEAM in the future. Any episode categories added to TEAM would be done through notice and comment rulemaking.

39. What are the codes that would initiate an episode for each of the included TEAM surgical procedures?

Lower extremity joint replacement (LEJR):

- MS-DRG 469, 470, 521, 522
- HCPCS 27447, 27130, 27702

Surgical hip and femur fracture treatment (SHFFT):

- MS-DRG 480, 481, 482

Spinal fusion:

- MS-DRG 402, 426, 427, 428, 429, 430, 447, 448, 450, 451, 471, 472, 473
- HCPCS 22551, 22554, 22612, 22630, 22633

Coronary artery bypass graft:

- MS-DRG: 231, 232, 233, 234, 235, 236

Major bowel procedure:

- MS-DRG 329, 330, 331

Any changes to the codes that would initiate a clinical episode would be updated through notice and comment rulemaking.

40. What is included in the TEAM episode?

An episode of care will include the surgery, including the hospital inpatient stay or outpatient procedure (i.e., anchor period), and items and services in the 30 days following hospital discharge (i.e., post-discharge period), such as skilled nursing facility stays or provider follow-up visits.

As described in [§ 512.525\(e\)](#), episodes include, but are not limited to, the following items and services:

- physicians' services
- inpatient hospital services (including services paid through IPPS operating and capital payments)
- inpatient psychiatric facility (IPF) services
- long-term care hospital (LTCH) services
- inpatient rehabilitation facility (IRF) services

- skilled nursing facility (SNF) services
- home health agency (HHA) services
- hospital outpatient services
- outpatient therapy services
- clinical laboratory services
- durable medical equipment (DME)
- Part B drugs and biologicals
- hospice services
- Part B professional claims date in the 3 days prior to an anchor hospitalization if a claim for the surgical procedure for the same episode category is not detected as part of the hospitalization because the procedure was performed by the hospital on an outpatient basis, but the patient was subsequently admitted as an inpatient.

41. What items or services are excluded from TEAM episodes?

As described in § 512.525(f), TEAM will exclude from episodes all Part A and B items and services, for both the baseline period and PYs, for hospital admissions and readmissions for specific categories of diagnoses, such as oncology, trauma medical admissions, organ transplant, and ventricular shunts determined by MS-DRGs, as well as all the following excluded Major Diagnostic Categories (MDC):

- MDC 02 (Diseases and Disorders of the Eye)
- MDC 14 (Pregnancy, Childbirth, and Puerperium)
- MDC 15 (Newborns and other neonates with conditions originating in perinatal period)
- MDC 25 (Human immunodeficiency virus infections)

Additionally, there are claim-level exclusions of new technology add-on payments (NTAPs) for drugs, technologies, or services approved for add-on payments. Drugs or biologicals that are paid outside of the MS-DRG, specifically hemophilia clotting factors, identified through HCPCS code, diagnosis code, and revenue center on IPPS claims for episodes in the baseline period and PYs are excluded.

42. Which patients are eligible for inclusion in TEAM?

Patients must meet the following criteria throughout the episode window and in the 180-day lookback period to be eligible for inclusion in TEAM:

- Are enrolled in Original Medicare Fee-for-Service (FFS) Parts A and B.
- Are not eligible for Medicare on the basis of having end stage renal disease
- Are not enrolled in any managed care plan (for example, Medicare Advantage, health care prepayment plans, or cost-based health maintenance organizations).
- Are not covered under a United Mine Workers of America health care plan.
- Have Medicare as their primary payer.

To be included in TEAM, the patient's Medicare FFS claim must include the qualifying procedure.

43. Are patients with cancer, trauma, or emergent procedures excluded from TEAM?

Patients with cancer or trauma are included in TEAM. Medicare fee-for-service Part A and B costs attributed to admissions and readmissions for specific categories of diagnoses, including oncology, are excluded from TEAM. However, these exclusions apply to types of care that are unrelated to the TEAM procedure. As noted in the FY2025 IPPS Rule, these services are not unilaterally excluded to encourage comprehensive, patient-centered care coordination. Similarly, patients undergoing emergent procedures are included in TEAM.

Any changes to the episode exclusion criteria for cancer, trauma, or emergent procedures would be updated through notice and comment rulemaking.

44. Does TEAM have a low-volume episode policy?

If a TEAM participant does not meet the low volume threshold of at least 31 episodes in a given PY's baseline period for a given episode category, CMS will still reconcile their episodes. However, the TEAM participant will not be held accountable for any PY episode spending that exceeded the reconciliation target price for each of the MS-DRG/HCPCS episode types in that given episode category during the applicable PY.

This policy, finalized in FY 2026 Hospital IPPS and LTCH PPS Final Rule, effectively waives downside financial risk for the TEAM participant for episode categories in which they did not meet the considered low volume threshold in the baseline period. For example, if a participant had 28 spinal fusion episodes from 2023 through 2025, the baseline period for PY 2, then that participant would not face downside risk for episodes in this category in PY 2.

Note that all PY episodes which are eligible for reconciliation will still be included in determining the Composite Quality Score and stop-loss/stop-gain thresholds, even if downside risk has been waived for those episodes. Additionally, the low volume threshold is recalculated for each PY. A participant may have fewer than 31 episodes for an episode type for PY1, and more than 31 episodes for the same episode type in PY2, and thus, face downside risk for that episode type in PY2.

LEARNING SYSTEM / TECHNICAL ASSISTANCE

45. What education or learning resources will CMS provide to selected hospitals? Is there a calendar of learning resources that will be available?

CMS is taking multiple steps to assist hospitals participating in TEAM with understanding both TEAM's pricing methodology, and how they can use data to help them succeed in the model. CMS provided TEAM participants with resources on various aspects of TEAM including target prices, episode construction and exclusions, participation tracks, collaboration with ACOs, and comparisons with BPCI Advanced and CJR. Participants can review these resources on the [TEAM website](#). CMS has also provided participants with a number of resources, and will continue to do so, through the TEAM Portal Document Library and the Resources tab within the TEAM Custom Export Tool.

CMS will continue to engage with hospitals and provide learning resources and opportunities to help them further understand TEAM policies.

46. What is the purpose of the beneficiary notification letter (BNL) and TEAM beneficiary collaborator notice (BCN)?

TEAM participants are required to share a written beneficiary notification, as described in [§ 512.582\(b\)](#), to all TEAM beneficiaries prior to discharge from the anchor hospitalization or anchor procedure. The BNL is intended to inform TEAM beneficiaries about the model, specifically how it will impact their care, their freedom of choice, their ability to report concerns, and other requirements.

In addition, TEAM requires every TEAM collaborator to provide a written TEAM BCN to TEAM beneficiaries of the existence of its sharing arrangement with the TEAM participant and the basic quality and payment incentives under the model. The notice must be provided no later than the time at which the beneficiary first receives an item or service from the TEAM collaborator during an episode. CMS recognizes that due to the patient's condition, it may not be feasible to provide notification at such time, in which case the notification must be provided as soon as is reasonably practicable. If the participant does not have collaborators, then they are not required to share the BCN.

The BNL/BCN templates are available on the [TEAM website](#) (under "Additional Information"). Please note that these templates should not be edited, with the exception of the editable fields. TEAM participants may translate the templates into other languages. Participants can also create their own templates, in accordance with the requirements described in [§ 512.582\(b\)](#).

47. What are the requirements for distributing the BNL and TEAM BCN?

The BNL must be provided prior to the beneficiary's discharge from the anchor hospitalization or the anchor procedure. Providing the BNL to the patient prior to the initiation of their episode, such as during a pre-surgical testing visit, would also satisfy

the BNL requirement. The BNL only needs to be provided once to each beneficiary during a clinical episode. Additionally, the BCN must be provided once by each TEAM collaborator when they first deliver an item or service to a beneficiary during an episode, or if this is not feasible due to the patient's condition, as soon as it is reasonable to do so.

Please note there are no requirements regarding how the BNL and the BCN are distributed. It can be provided electronically or physically. Each healthcare entity may choose the distribution method that best fits their workflows. However, participants must ensure that the beneficiary receives the required notification and that the hospital maintains a tracking system identifying who received the BNL/BCN and the date on which it was provided.

48. How will the BNL/BCN be monitored for evaluation? Will TEAM participants be required to maintain copies for auditing purposes?

CMS may audit the medical records and claims of TEAM participants to ensure that BNLs/BCNs are provided to beneficiaries in a timely manner using CMS-approved language.

49. How can I sign up for updates about TEAM?

CMS shares updates regarding TEAM via the listserv. If you are not already subscribed, please [use this link](#) and input your email address to receive updates about the model.

50. How can I contact the TEAM model team?

You can reach out to TEAM via email (CMMI_TEAM@cms.hhs.gov).

PORTAL AND POINTS OF CONTACT

51. What are the different portals for TEAM participants, and how can I access them?

The TEAM Portal is an online collaboration platform through [CMS.gov|IDM](https://www.cms.gov/IDM). TEAM participants will be invited to register for the portal via email.

The TEAM Expanded Data Feedback Reporting (eDFR) is an online application through [CMS.gov|Enterprise](https://www.cms.gov/Enterprise) Portal. Within TEAM's eDFR, the Custom Export Tool (CET) will be the mechanism for TEAM participants to receive all data files including preliminary target prices, monthly data, etc. CMS will invite the Data Custodians to register for TEAM's eDFR to obtain access to the platform and the CET. Please note that the data will not be shared until the TEAM participant has completed a DSA and DRA Form.

52. What are the different Point of Contact (POC) types in the TEAM Portal, and what is the role of each type?

TEAM participants may have up to two primary POCs. Primary POCs will receive CMS communications about TEAM, may submit deliverables in the TEAM portal, and have the ability to add and remove POCs from the TEAM portal, including designating POCs as Data Custodians and as Authorized Signatories.

TEAM participants may have multiple Secondary POCs. Secondary POCs will receive CMS communications about TEAM, may submit deliverables in the TEAM portal, and edit their own contact information in the TEAM portal.

Data Custodians are individuals that a TEAM participant will identify to ensure compliance with all privacy and security requirements and for notifying CMS of any incidents relating to unauthorized disclosures of beneficiary-identifiable data. Data Custodians are also the only individuals allowed to access the TEAM eDFR platform where CMS will share target prices and data via the CET. A Data Custodian designation is not mutually exclusive and therefore individuals with this POC designation can also be identified as a primary or secondary POC.

The Authorized Signatory is the only point of contact who can view, complete, and submit the DRA Form, DSA, Track selection form, and APM selection option form. The Authorized Signatory designation is not mutually exclusive and therefore individuals with this POC designation can also be identified as a primary or secondary POC.

53. Can hospital systems designate the same POC for multiple hospitals within a system?

Yes. CMS is requesting at least one Primary POC for each hospital participating in TEAM. Multiple hospitals that are affiliated with each other may select the same Primary POC for TEAM-related communications as appropriate.

54. How can TEAM participants verify their POCs?

TEAM participants can verify their POCs by logging into the TEAM portal and navigating to the Contacts section. Additionally, TEAM participants can also submit an email to CMMI_TEAM@cms.hhs.gov to confirm their POCs.

55. How can I update the POC for our hospital?

Primary POCs for a TEAM participant can log into the TEAM portal, navigate to the Contacts section and update the TEAM participant's POCs. In the event a TEAM participant does not have any active Primary POCs, TEAM participants may submit an email to CMMI_TEAM@cms.hhs.gov with the subject line "Primary Point of Contact", that contains hospital information (e.g., name, CCN), and the contact information (e.g., name, email address, phone number) of the individuals to be added, removed, or changed. It may take up to two weeks for requests to be reflected in the TEAM portal and in TEAM-related communications.

56. Why am I unable to see my facility's data files? Why are the files missing or blank?

Participants will only receive data files if they complete their DRA and DSA by the set deadline for the release. Additionally, participants will only receive the files they elect to receive via their DRA form. Finally, if a participant does not initiate any clinical episodes, they will not receive raw files, or summary reports.

57. How can I request access to the TEAM Portal/CET/eDFR?

The TEAM Portal is located at: <https://app.innovation.cms.gov/TEAM/IDMLogin>. We encourage you to bookmark this page for future convenience.

All TEAM portal users will need a CMS IDM account. If the Primary POC already has a CMS IDM account, because they have participated in any of the CMS Innovation Center models, then they do not have to create a CMS IDM account and only need to register as a "New User" on the landing page of the TEAM Portal. This action will link the CMS IDM account that they have to the TEAM portal. After completing this, you'll be able to simply log in with your CMS IDM credentials for future login attempts.

If you need technical assistance accessing the TEAM portal, please contact the CMMI Help Desk at CMMIForceSupport@cms.hhs.gov or call 1-888-734-6433, option 5.

DATA SHARING / PARTICIPANT REPORTS

58. What types of data will CMS share with hospitals participating in TEAM?

For the purposes of evaluating their performance, conducting quality assessment and improvement activities, conducting population-based activities relating to health or reducing health care costs, or conducting other health care operations, CMS will share preliminary target prices and baseline data, monthly PY data, and reconciliation data for each PY with hospitals in TEAM, pursuant to a complete Data Sharing Agreement (DSA) and Data Request and Attestation (DRA) form. This includes certain beneficiary-identifiable claims data and regional aggregate data.

For the baseline period, hospitals will only receive beneficiary-identifiable claims data for beneficiaries that initiated an episode in their hospital or hospital outpatient department in the 3-year baseline period. CMS will limit the data to items and services included in the episode.

TEAM participants may request to receive summary or raw beneficiary-identifiable claims data for a 3-year baseline period prior to the PY as well as on a monthly basis during the PY to help them engage in care coordination and quality improvement activities for TEAM beneficiaries in an episode.

The DRA form will support a formal data request allowing the TEAM participant to indicate data type preference, like receiving raw or summary level beneficiary identifiable claims data for TEAM beneficiaries. The DSA will ensure TEAM participants comply with applicable laws and safeguards for obtaining the data. To receive beneficiary-identifiable data from CMS, TEAM participants must annually submit a DSA and a DRA form.

59. How often and in what format will claims data be shared?

Baseline period claims data will be shared with TEAM participants prior to each PY. CMS will use a 3-year rolling baseline period as described in [§ 512.540\(b\)\(2\)](#). For example, for PY1, covering the period from January 1, 2026, to December 31, 2026, TEAM participants may be eligible to receive baseline period claims data from January 1, 2022, to December 31, 2024.

In December 2025, CMS shared PY1 baseline period claims data and preliminary target prices with TEAM participants who met the DRA form and DSA submission deadline. PY data will be shared on a monthly basis with TEAM participants who meet the DRA form and DSA submission deadline.

Please note that TEAM participants will be required to complete, sign, and submit a TEAM DSA and DRA form at least annually to receive data from CMS.

60. Will target prices be made publicly available?

CMS published the regional preliminary target prices and will publish the risk adjustment coefficients data for PY1 on the [TEAM website](#). While the regional target prices were made public, the participant-specific preliminary target prices and baseline data were only made available to TEAM participants via the TEAM data portal (also known as the Expanded Data Feedback Reporting or eDFR application).

61. Why did my facility not receive PY1 target prices?

Only participants who submitted a signed DRA form and DSA by February 6, 2026, are eligible to receive PY1 target prices. Additionally, participants will only receive raw files or the baseline spending summary report if they selected to receive those files, via their DRA form. Finally, if a participant does not initiate any clinical episodes, they will not receive raw files, the hospital specific target price summary report, or baseline spending summary report.

CARE DELIVERY / QUALITY STRATEGY

62. Will TEAM qualify as an Advanced Alternative Payment Model (APM)?

Yes, TEAM will qualify as an Advanced APM. TEAM offers two APM options — an Advanced APM (AAPM) option, which requires TEAM participants in Track 2 and Track 3 to attest that they meet the Certified Electronic Health Record Technology (CEHRT) criteria, and a non-Advanced APM (non-AAPM) option, for those who do not meet the CEHRT criteria or participate in Track 1. Only TEAM participants in Track 2 and Track 3 may qualify for the AAPM option, while TEAM participants in Track 1 only qualify for the non-AAPM option. TEAM participants will be asked to make their APM option selection along with their participation track selection prior to each PY.

63. Which quality measures are included in TEAM?

TEAM’s quality measures focus on care coordination, patient safety, and patient reported outcomes (PROs) which we believe represent areas of quality that are particularly important to patients undergoing acute procedures. CMS will use data that hospitals already report through existing CMS quality reporting programs (the Hospital Inpatient Quality Reporting (IQR) Program, the Hospital-Acquired Condition Reduction Program (HACRP), and the Hospital Outpatient Quality Reporting Program (OQR)), to avoid duplicative reporting requirements.

The table below summarizes the quality measures, applicable episodes and PYs, and baseline periods that CMS has finalized:

Measure	CMS Program	Episodes	PYs	Baseline Period
Hospital-Wide All Cause Readmission measure (Claims-only) (CMIT ID #356)	IQR	All inpatient episodes	1	CY 2025
Hybrid Hospital-Wide All Cause Readmission measure (CMIT ID #356)	IQR	All inpatient episodes	2-5	CY 2026
CMS Patient Safety and Adverse Events Composite (CMS PSI) (CMIT ID #135)	HACRP	All inpatient episodes	1	CY 2025

Measure	CMS Program	Episodes	PYs	Baseline Period
Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM) (CMIT ID #1618)	IQR	Inpatient LEJR episodes	1-5	CY 2025
Hospital Harm – Falls with Injury (CMIT ID #1518)	IQR	All inpatient episodes	2-5	CY 2026
Hospital Harm – Postoperative Respiratory Failure (CMIT ID #1788)	IQR	All inpatient episodes	2-5	CY 2026
Thirty-Day Risk-Standardized Death Rate among Surgical Inpatients with Complications (ISCMR) (CMIT ID #134)	IQR	All inpatient episodes	2-5	CY 2026
Information Transfer Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM) (CMIT ID #1797)	OQR	Outpatient LEJR and Spinal Fusion episodes	3-5	CY 2027

64. Are there any specific quality reporting requirements for TEAM?

TEAM does not require participants to report additional quality data beyond those they already submit to CMS for other programs. The TEAM Composite Quality Score (CQS) will be calculated using data already submitted to other CMS programs.

65. Which beneficiaries are included in the quality measures?

Since the quality measures included in the TEAM CQS are obtained from other CMS quality reporting programs, the quality measures used in TEAM include all eligible beneficiaries that meet the numerator and denominator criteria of those measures in their quality reporting programs. Therefore, beneficiaries who do not receive TEAM care may be included in the numerator or denominator of the quality measures.

66. How will CMS score hospitals who do not have sufficient quality measure data for a given measure (e.g., newly established or opened hospitals located in mandatory CBSAs, no beneficiaries meet the denominator criteria)?

TEAM participants that have insufficient quality measure data, such as hospitals that are newly opened will be given a neutral quality measure score for a given quality measure. Specifically, if a TEAM participant does not have a raw quality measure score for a given quality measure during a PY, CMS will assign a scaled quality measure score of 50, which is the midpoint on the CQS scale of 0-100.

67. Does TEAM qualify as a value-based program? Will it be on QualityNet?

TEAM will qualify as an Advanced APM which falls under the Quality Payment Program (QPP). QPP establishes a process to reward clinicians who provide high-quality patient-centered care. QPP aims to improve the quality and safety of care for all individuals and to reduce the administrative burden on clinicians, allowing more time to focus on person-centered care and improving health outcomes.

At this time, CMS will not include TEAM on QualityNet but plans to post TEAM participant quality measure performance on the TEAM webpage.

68. Which quality measures included in TEAM are electronic clinical quality measure(s) (eCQMs)?

TEAM uses the following quality measures as eCQMs:

1. Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and Electronic Health Record Data (CMIT ID #356)
2. Hospital Harm—Falls with Injury (CMIT ID #1518)
3. Hospital Harm—Postoperative Respiratory Failure (CMIT ID #1788)

69. Please explain the referral to primary care services requirement under TEAM.

Since a TEAM episode only lasts 30 days after the TEAM beneficiary is discharged from the hospital, CMS aims to integrate care during the transition from an acute event – an episode – back to longitudinal care relationships, such as primary care. CMS requires TEAM participants to include in hospital discharge planning a referral to an established supplier of primary care services for a TEAM beneficiary, on or prior to discharge from an anchor hospitalization or anchor procedure. TEAM participants must also comply with beneficiary freedom of choice requirements, as codified in § 512.582(a), and not limit a TEAM beneficiary’s ability to choose among Medicare providers or suppliers.

70. What is necessary to fulfill the primary care services referral requirement?

To fulfill this requirement, the beneficiary should be referred to follow-up with a primary care provider (PCP), other practitioner, or entity during the hospital discharge planning process. If the TEAM beneficiary has an established supplier of primary care services, then the participant must refer them to their established supplier. Documentation of the supplier’s name on the referral would be prudent to demonstrate compliance with referring to the TEAM beneficiary’s established supplier of primary care services. The

referral must be made on or prior to discharge from the anchor hospitalization or anchor procedure.

To demonstrate compliance with the requirement for TEAM beneficiaries without an established supplier of primary care services, participants can

- include a list of suppliers in the referral
- provide a phone number or tool for scheduling an appointment
- include a referral in the after-visit summary/discharge

It is not necessary for TEAM participants to schedule an appointment or for the patient to follow up with their PCP to meet the referral to primary care services requirement. The requirement also does not set limits on the time frame for when the PCP visit needs to occur.

71. Are we able to make the primary care referral prior to the anchor hospitalization or procedure?

No. To meet TEAM requirements, the beneficiary must be referred to follow-up with a PCP, other practitioner, or entity during the anchor hospitalization or procedure and prior to hospital discharge.

72. Does every patient require a primary care referral (regardless of setting)?

The referral to primary care services requirement applies to all TEAM beneficiaries, regardless of their TEAM episode type, procedure setting, or where they are discharged following their anchor hospitalization or procedure.

FINANCIAL ARRANGEMENTS / TEAM COLLABORATORS

73. What are the financial arrangements list (FAL) and clinician engagement list (CEL) requirements and how do we determine who should be on each list?

CMS uses the FAL and CEL to track all financial arrangements established under TEAM, including both entity-level and individual-level (i.e., clinician) relationships. In addition, CMS uses the information reported through the FAL/CEL to identify eligible clinicians who may qualify as Qualifying Alternative Payment Model (APM) Participants (QP) based on the services furnished under TEAM (to the extent TEAM is determined to be an Advanced APM). The lists also support APM Performance Pathway (APP) reporting and scoring for MIPS-eligible clinicians (to the extent TEAM is determined to be a MIPS APM). The FAL/CEL is submitted each calendar year-quarter. CMS will notify participants ahead of each quarterly deadline.

The FAL is the list of entities and individuals, including eligible clinicians or MIPS-eligible clinicians, that have a financial arrangement to share reconciliation and repayment amounts with the TEAM participant, their collaborators, or their collaboration agents. These entities and individuals may serve as TEAM collaborators, collaboration agents, or downstream collaboration agents.

Clinicians who are not engaged in financial arrangements, and therefore not included in the FAL, may still participate in TEAM activities that could affect their QP status or their ability to report through the APP. The CEL, which is designed to ensure these clinicians are appropriately recognized, is the list of eligible clinicians or MIPS-eligible clinicians who participate in TEAM activities and have a contractual relationship with the TEAM participant but do not have a financial arrangement.

The TEAM participant is responsible for verifying that clinicians meet the contractual relationship requirements.

74. Where can I find more information on the FAL/CEL?

We recommend participants review the FAL/CEL User Guide, which is available in the Document Library section of the [TEAM Portal under General > Deliverables](#) and provides the following information:

- An overview of the FAL and CEL, including their purpose and key components
- Step-by-step instructions for completing and submitting your FAL/CEL through the TEAM Portal
- Details on both submission methods: individual entry and bulk upload (CSV template)

75. What if our organization does not have any financial agreements or clinician engagements?

If a TEAM participant has no entities that meet the criteria for inclusion in the FAL/CEL, they must submit an attestation within the TEAM Portal, confirming that there are no financial arrangements or clinician engagements to report for the quarter.

76. What is the financial impact on TEAM collaborators performing the procedure or coordinating care if funds are owed?

Hospitals participating in TEAM may choose to enter into financial arrangements with certain providers and suppliers participating in TEAM activities to share their reconciliation payment amount or repayment amount resulting from participation in TEAM. Specifically, TEAM participants may enter into a sharing arrangement with a TEAM collaborator to make a gainsharing payment and/or receive an alignment payment. The board or other governing body of the TEAM participant must have responsibility for overseeing the TEAM participant's participation in the model, its arrangements with TEAM collaborators, its payment of gainsharing payments, its receipt of alignment payments, and its use of beneficiary incentives in the model. The TEAM participant and TEAM collaborator must document this agreement in writing and provide it to CMS upon request as part of TEAM's monitoring and compliance activities (also described in § 512.590).

Practitioners will continue to bill Medicare as normal under fee-for-service. At the end of the PY, CMS reconciles total episode spending against the retrospectively adjusted final target price. CMS adjusts reconciliation amounts for quality performance and applies stop-gain and stop-loss limits (stop-loss limits only apply to Track 2 and Track 3).

A TEAM collaborator in a sharing arrangement with a TEAM participant may enter into a distribution arrangement with a collaboration agent to distribute any gainsharing payments it receives. A collaboration agent in a distribution arrangement with a TEAM collaborator may enter into a downstream distribution arrangement with a downstream collaboration agent to distribute any distribution payments it receives. The final rule in [§ 512.565 \(b\)-\(c\)](#) provides additional details about eligibility requirements and restrictions for financial arrangements in TEAM.

77. How can hospitals manage gainsharing or alignment payments with TEAM collaborators that are not tied to the volume of episodes?

TEAM is designed to encourage participants to make primary care referrals and engage with a patient's aligned total cost of care (or shared savings model), if applicable. In determining the amount of any gainsharing payments, a TEAM participant's gainsharing methodology may take into account the amount of such TEAM activities provided by a TEAM collaborator relative to other TEAM collaborators, however, gainsharing payments and alignment payments should not be based directly on volume or value of referrals. CMS believes this requirement allows flexibility in the determination of gainsharing payments to TEAM collaborators, who have differing contributions to TEAM activities. We understand that this may result in greater differences in the funds available for gainsharing payments and believe that this allows for gainsharing payments

to be made appropriately, without tying them directly or indirectly to the volume or value of referrals.

78. How can post-acute care (PAC) providers become part of a TEAM participant's PAC network?

TEAM's financial incentives are designed to incentivize innovative care delivery methods that focus on improving care and reducing Medicare spending. CMS anticipates TEAM participants and PAC providers, such as skilled nursing facilities and home health agencies, to form partnerships that share financial risk and collaborate on care design strategies. In accordance with [§ 512.562](#), CMS provides participants with hospital-specific and regional aggregate data. TEAM participants can use this data to guide decision making about PAC providers for TEAM.

TEAM participants may use data and resources to create financial arrangements with TEAM collaborators, such as physicians, PAC providers, and other clinical care providers, to ensure the best quality of care in a cost-effective manner. Depending on the terms of the financial arrangement, TEAM participants may hold other providers and suppliers accountable for upside and downside financial risk.

SKILLED NURSING FACILITY WAIVER

79. What is the TEAM Qualified Skilled Nursing Facility (SNF) List?

CMS waives the SNF 3-day rule for coverage of a SNF stay within 30 days of the date of discharge from the anchor hospitalization or date of service of the anchor procedure for a TEAM beneficiary if the SNF is identified on the applicable calendar quarter list of qualified SNFs at the time of the TEAM beneficiary's admission to the SNF.

CMS defines qualified SNFs as those that achieve an overall rating of 3 stars or better for at least 7 of the last 12 months on the Five-Star Quality Rating System for SNFs on the Nursing Home Compare website. In the FY 2026 IPPS Hospital and LTCH rule, CMS amended the waiver requirements such that TEAM participants could also utilize the SNF 3-day rule waiver for TEAM beneficiaries discharged to hospitals and Critical Access Hospitals (CAHs) providing post-acute care (PAC) under swing bed arrangements.

The list of qualifying SNFs is updated every calendar year-quarter and can be found on the [TEAM website](#) under the header "Additional Information.". If a SNF meets the definition of a qualified SNF for a given quarter, then it will qualify for the use of the SNF 3-Day rule waiver for the entirety of that quarter. If a SNF does not meet the definition of a qualified SNF for a given quarter, then it will not qualify for the use of the SNF 3-Day rule waiver for the entirety of that quarter. This means that changes to a SNF's rating during a quarter will not impact its status as a qualified SNF for that quarter.

80. What steps do participants need to take to use the 3-Day Qualified SNF Waiver?

CMS will use Demonstration Code A9 to identify TEAM episodes utilizing the SNF waiver. It will be up to TEAM participants to work with qualified SNFs or CAHs and hospitals providing PAC under swing bed arrangements to ensure that the claim is submitted with this Demonstration Code. There is no paperwork or documentation that needs to be completed by the TEAM participant to utilize the waiver. Similarly, TEAM participants will not need to document specific verbiage in a patient's chart to indicate that the waiver was used.

81. Can patients with outpatient TEAM episodes use the 3-Day Qualified SNF waiver?

The TEAM SNF 3-day rule waiver can be used following an inpatient anchor hospitalization or an outpatient anchor procedure that initiates a TEAM episode, so long as the requirements of the waiver are met. More information on the waiver of the SNF 3-day rule under TEAM can be found at [§512.580\(b\)](#).

82. Which SNF waiver should we use if a patient is included in both TEAM and ACO REACH program or Medicare Shared Savings program (MSSP)?

While TEAM, ACO REACH, and MSSP all offer SNF 3-day rule waivers, the requirements for using the waiver vary across models and programs.

Under TEAM, the 3-day SNF waiver can be used to discharge TEAM beneficiaries with an anchor hospitalization or an anchor procedure to qualified SNFs within 30 days of discharge from an anchor hospitalization or an anchor procedure. The list of qualifying SNFs is updated every calendar year-quarter and can be found on the [TEAM website](#) under the header "Additional Information." Please refer to the TEAM SNF 3-day Rule Waiver Guidance for additional information:

<https://www.cms.gov/files/document/mm14098-implementing-transforming-episode-accountability-model-skilled-nursing-facility-3-day-rule.pdf>

Eligibility for the TEAM waiver of the SNF 3-day rule is not impacted by other programs. If the conditions for the TEAM waiver are met, then TEAM participants can utilize the TEAM waiver and use the TEAM demonstration code regardless of the requirements in other programs.

If a patient's stay qualifies under both TEAM and ACO REACH or MSSP, the waiver could be claimed using the demonstration code for any of the models. However, participants must ensure that the requirements of the relevant program are met before using the corresponding demonstration code.

83. If a patient utilizes the 3-day Qualified SNF waiver, but the SNF is not in a financial arrangement with the TEAM hospital, will the SNF receive payment?

Yes, the SNF will receive FFS payment. SNFs are not required to be TEAM collaborators to utilize the TEAM SNF 3-day rule waiver.

84. What happens if a patient utilizes the 3-day Qualified SNF waiver but is subsequently determined not be eligible for inclusion in TEAM?

TEAM participant hospitals must ensure that beneficiaries meet these criteria prior to the utilization of the 3-day SNF waiver, and more specifically that beneficiaries meet this criteria at the time of discharge from the anchor hospitalization or anchor procedure. Hospitals can use procedure codes and/or diagnosis codes to identify beneficiaries that are likely going to trigger a TEAM Clinical Episode based on the qualifying MS-DRG or HCPCS code.

We recognize that despite good faith efforts by TEAM participants and SNFs to determine a beneficiary's Medicare status for the model, it may occur that a beneficiary is ultimately not eligible to be included in the TEAM at the time the SNF 3-day rule waiver is used. In these cases, CMS will cover services furnished under the waiver when the information available to the provider at the time the services under the waiver were furnished indicated that the beneficiary was included in the model.

85. What if a patient does not meet the requirements for the SNF 3-day rule and voluntarily selects a SNF that does not qualify for the 3-day SNF waiver?

Original Medicare fee-for-service coverage for SNF care is available for beneficiaries who have a prior inpatient hospital stay of 3 consecutive days, which is typically referred

to as the SNF 3-Day Rule. CMS waives the SNF 3-Day Rule for TEAM beneficiaries under some specific circumstances, as described in 512.580(b). In other words, TEAM beneficiaries are eligible for Medicare SNF coverage by either meeting the SNF 3-Day Rule or the TEAM SNF 3-Day Rule Waiver.

However, if a TEAM beneficiary does not have a preceding inpatient hospital stay of at least 3 days, Medicare will only cover the SNF stay if the beneficiary is discharged to a facility that qualifies for the TEAM SNF 3-day waiver (the waiver can also be claimed for TEAM beneficiaries discharged to qualifying SNFs following outpatient procedures).

Finally, if the beneficiary does not have a preceding inpatient hospital stay of at least 3 days and is discharged to a non-qualified SNF, they will be financially responsible for their SNF care. TEAM participants are required to provide beneficiaries with a written discharge planning notice informing them of the financial liability of any services not covered by Medicare that were discussed with the beneficiary as part of the discharge planning process. If a TEAM participant does not inform the beneficiary of the non-covered SNF services within the discharge planning notice, then the TEAM participant will be financially liable for these services.

MODEL OVERLAP

86. How does TEAM overlap with other CMS models or initiatives?

TEAM did not overlap with the CMS Innovation Center's earlier episode-based payment models because they were scheduled to end before the start of TEAM. Specifically, the [Comprehensive Care for Joint Replacement \(CJR\) Model](#) ended in December 2024, and the [Bundled Payments for Care Improvement Advanced \(BPCI Advanced\) Model](#) ended in December 2025.

TEAM allows provider and individual overlap with most CMS models and initiatives, including advanced primary care models and ACO initiatives. For example, a person with Original Medicare receiving care from (aligned to) providers in an ACO may be in an episode if they receive one of the surgeries included in TEAM at a hospital required to participate in TEAM. CMS would not perform any adjustments to a TEAM participant's reconciliation payment amount or repayment amount when there are patients who overlap TEAM and ACO initiatives. Allowing model overlap provides an opportunity for an ACO and TEAM participant to collaborate on shared patients and ensure a smooth transition of care between the TEAM participant and the ACO. ACOs can also participate in TEAM as TEAM Collaborators.

87. How does TEAM impact the shared savings of a Medicare Accountable Care Organization (ACO) initiative when there is model overlap?

A hospital that participates in a Medicare ACO initiative, such as ACO REACH or the Medicare Shared Savings Program (MSSP), and that also participates in TEAM will be accountable for the quality and cost of care for ACO-aligned beneficiaries who have surgeries that would initiate an episode in TEAM. TEAM will not adjust a TEAM's participant's target prices or reconciliation payment amounts and repayment amounts based on model overlap with ACO REACH or the MSSP.

TEAM will not include ACO REACH or the MSSP's shared savings payments or shared loss recoupments when determining episode spending and target pricing calculations.

ACO REACH and the MSSP will not take into consideration TEAM's reconciliation payment amounts or repayment amounts when determining ACO REACH or the MSSP's benchmarks or PY spending because the timing of TEAM's reconciliation process occurs after ACO REACH and the MSSP conducts their calculations.

88. How will TEAM approach model overlap for hospitals that are participating in the AHEAD Model?

As stated in the FY2025 IPPS Final Rule, after consideration of the public comments we received, we finalized our proposals for model overlap to allow overlap between shared savings or total cost of care model or program participants with TEAM episodes. This includes allowing both TEAM participant and total cost of care model or program

participant to retain savings generated from their perspective performance in their model or program without recoupment.