Transforming Episode Accountability Model (TEAM)

What to Know

About TEAM

On August 1, 2024, CMS displayed the Medicare Inpatient Prospective Payment Systems (IPPS) final rule, which included specifications for a new mandatory bundled payment program focused on beneficiaries undergoing certain high-expenditure, high-volume surgical procedures. CMS has **finalized** that the Transforming Episode Accountability Model (TEAM) will begin on January 1, 2026, with a duration of five years. This model supports CMS' efforts to have all Medicare beneficiaries in care relationships with accountability for quality and total cost of care by 2030.

Why does TEAM matter?

- **Mandatory:** Participation in all CMS selected TEAM episodes will be required for every IPPS hospital within a CBSA that has been selected.
- **Future:** The two-sided risk imperative is only accelerating for CMS, with the goal of all Medicare FFS beneficiaries being in an accountable care relationship by 2030.
- **Incentives:** Financial incentives, unique provider alignment strategies, and policy waivers are available for participants.
- **Complementary:** Episodic strategies support service line goals, while also benefiting other existing value-based and total cost of care models.

Who will participate in TEAM?

CMS has selected a cohort of participants grouped by their core-based statistical area (CBSA). In total, 188 of 803 (23.4%) eligible CBSAs were selected. This subset represents more than 700 hospitals accounting for over 200,000 annual episodes of care. CMS has also made available a one-time, voluntary opt-in option for those hospitals not selected for TEAM but who are current participants in the Bundled Payment for Care Improvement-Advanced (BPCI-A) or Comprehensive Joint Replacement (CJR) models and complete their existing programs.

Fast Facts

Duration	January 2026 to December 2030
Patient Population	Medicare FFS only
Risk Arrangement	Graduated risk through three participation tracks, with possible 0% downside risk in the first year moving up to 20% in subsequent years. Some participants will qualify for a 5% downside risk cap.
Episode Inclusion	30-day total cost of care episodes, incl. Parts A and B; revenue cycle undisrupted
Benchmark Calculation	Determined by: • Regional pricing based on historical baseline • Hospital bed size, safety net status, and prior post-acute use • Patient characteristics (age group, social risk) • Patient acuity (DRG/HCPCS, HCC count, and episode-specific HCC capture)
Program Overlap	Allowed with several APMs including MSSP/PTS
Target Price Data	CMS to provide in late **November 2025**

Episode Groups & Definitions

Lower Extremity Joint Replacement*	Coronary Artery Bypass Graft Surgery	Major Bowel Procedure	Spinal Fusion*	Surgical Hip & Femur Fracture Treatment

*Inpatient and outpatient

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Action Plan

Fall 2024 → 2025 → 2026

Current State Assessment

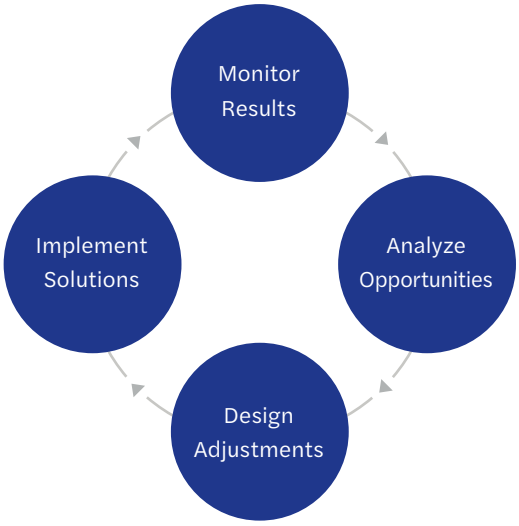
TEAM Performance Outlook

- Financial Projections
- Risk Adjustment/Stratification
- Care Setting Optimization
- Provider Alignment/Intelligence
- Discharge Planning
- Coordination of Care
- Outcomes Management
- Quality Measure Results
- Model Requirement Readiness

Playbook Development

- Financial Performance
- Model Requirements
- Clinical Transformation
- Optional Strategies

Ongoing Monitoring



Value-Based Care (VBC) & Forvis Mazars

- Working with hospitals and physicians on VBC since 2012
- Current VBC clients in 28 states
- 58% market share in supporting Medicare voluntary bundles
- Several claims-based Medicare analysis models
- Monthly support for ACOs with aggreg. >300K beneficiaries
- Elusive access to TEAM pre-risk claims data
- Exclusive sponsor of HFMA's VBC council since 2016
- Experienced financial, operational, and clinical professionals

Michael Wolford | Principal | 216.798.8593 | michael.wolford@us.forvismazars.com
Craig Tolbert | Principal | 205.907.9247 | craig.tolbert@us.forvismazars.com
Stephen Kitterman | Director | 864.417.8506 | stephen.kitterman@us.forvismazars.com
Walter Coleman | Director | 804.347.7535 | walter.coleman@us.forvismazars.com

forvismazars.us

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