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The next generation of Medicare bundled payments: Considerations regarding TEAM

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The Centers for Medicare and Medicaid Services (CMS) finalized the Transforming Episode Accountability Model (TEAM), a new mandatory five-year model starting January 1, 2026, covering five surgical episodes that include 30 days of post-acute care.

According to CMS, TEAM aims to "improve quality of care for people with Medicare undergoing certain high-expenditure, high-volume surgical procedures, reducing rehospitalization and recovery time, while lowering Medicare spending and driving equitable outcomes."[1] The model (and its mandatory nature) is a key part of CMS's specialty care strategy, which has set a goal of moving 100% of Medicare beneficiaries into accountable care arrangements by 2030.

CMS Episode-Based Models 101

The CMS Innovation Center was established by the Affordable Care Act to develop and implement novel payment and service delivery models intended to improve patient care and lower costs.

Episode-based or bundled payment models are a type of alternative payment model (APM) that set a fixed price for a predefined set of services (an episode), commonly consisting of a procedure and all related services or all care for a medical condition.

Participation in these models can be:

- Voluntary: Any organization that meets certain criteria can opt to participate in the model for a specific length of time.
- Mandatory: Specified organizations, typically those of a certain type (such as hospitals) in selected geographic regions, are required to participate in the model, usually for the entirety of the program.

Participant performance in the model is valuated against quality and financial benchmarks as one of the main goals of these models is to improve quality of care while reducing unnecessary spending.

Model design can be:

- Prospective, which involves setting prices up-front for an episode and concurrently identifying eligible patients.
- Retrospective, which involves identifying episodes based on paid claims and reconciling episode costs against targets after the episodes have ended.

Specifically, CMS is looking to provide continuity in bundled payment/episode-based models given that the Comprehensive Care for Joint Replacement (CJR) and Bundled Payments for Care Improvement Advanced (BPCI Advanced) models are scheduled to end December 31, 2024, and December 31, 2025, respectively. TEAM will be a blend of these models, building on the components of each model that CMS views as successful and refining program methodologies based on lessons learned from recent program experience. Additionally, TEAM will provide "support for safety net providers and underserved beneficiaries, ultimately helping foster a complementary relationship between accountable care organizations (ACOs) and hospital participants."[2] Please refer to the Milliman article What Are Bundled Payments and How Can They Be Used by Healthcare Organizations?" for more information on the specifics of bundled payment programs and episode-based models.[3]

TEAM was finalized in the fiscal year (FY) 2025 Hospital Inpatient Prospective Payment System (IPPS) final rule, CMS-1808-F.[4] Unless otherwise noted, all information contained here describing TEAM is drawn from that final rule, which was released on August 1, 2024.

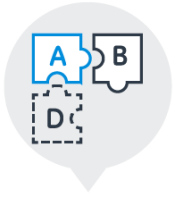
What is TEAM?

TEAM will be a mandatory alternative payment model (APM) with the following key aspects:

Model Length
TEAM is a five-year model that will begin in January 2026 with episodes attributed to calendar year performance periods based on episode end date

Model Participation
TEAM participants are acute care hospitals (ACHs) located in approximately a quarter of all core-based statistical areas (CBSAs) across the country (excluding Maryland)[5]. In addition, ACHs that participated in CJR and/or BPCI Advanced through the end of these programs are eligible to opt in to the model, even if they are in a CBSA that was not selected.

Episode Types
TEAM includes five surgical episodes: coronary artery bypass graft (CABG), lower extremity joint replacement (LEJR), major bowel procedures (BOWEL), surgical hip/femur fracture treatment (SHFFT), and spinal fusion (FUSION).



Episode Construction
TEAM episodes include most Medicare Part A and B services, beginning with the anchor hospitalization or procedure that initiates the episode and ending after a 30-day post-acute period. Part D services are not included.

Reconciliation
Episodes will be retrospectively reconciled annually against target prices based on historical regional spending.
The target prices will account for market trends, beneficiary risk, and performance on quality measures.

Financial Arrangements
Gainsharing with providers who partner with the ACH participant as part of TEAM (with downstream agreements in place) will be allowable, subject to quality and contribution requirements.

Who is required to participate in TEAM and how will they be impacted?

Mandatory model and participation

CMS has tested a variety of episode-based models—the majority of which have been voluntary. Voluntary models are easier to implement and more flexible because they can be implemented without rulemaking; however, they are harder to evaluate due to selection bias and provider attrition. Mandatory models can help prevent (or at least minimize the impact of) these issues, while furthering CMS's accountable care participation goals. Using the mandatory CJR model as a foundation, CMS is expanding the model's geographic scope with a focus on CBSAs. This structure results in selection of a broader set of participants who are more representative of the U.S. population. CBSAs include both micropolitan and metropolitan statistical areas (mSAs and MSAs, respectively) and reflect urban core populations of at least 10,000, whereas in CJR, CMS relied on MSAs, which reflect urban core populations of at least 50,000. In both models, hospitals located in the state of Maryland are excluded.

To select hospitals for participation in TEAM, CBSAs were stratified into 18 cohorts based on the following criteria and assigned a selection percentage:

- Average historical episode spending
- Number of hospitals
- Number of safety net hospitals
- Past exposure to CMS bundled payment models, including the BPCI, CJR, and BPCI Advanced models

This stratification methodology allowed CMS to "oversample CBSAs with low past exposure to CMS' bundled payment models and CBSAs with a high number of safety net hospitals" (pg.69683). Each CBSA had a 20% to 50% chance of selection, which resulted in 188 CBSAs (23.4% of the 803 eligible CBSAs) being selected for participation in TEAM (pg. 69704).

CMS is requiring all ACHs paid under the inpatient prospective payment system (IPPS) within the selected CBSAs to participate, including safety net, rural, Medicare-dependent, sole community, and essential access care hospitals. Historically, these types of hospitals have participated in value-based payment arrangements at lower rates due to a lack of resources or concern with taking on substantial financial risk (pp. 69780, 69794).

As one goal of TEAM is to expand the reach of value-based care to providers that have yet to participate, CMS has acknowledged that TEAM participants will need time to adapt their infrastructures and become familiar with the components of the model. Therefore, CMS is providing a one-year glide path that will ease participants into taking on downside financial risk in TEAM, while allowing certain eligible participants to opt for limited downside financial risk for the entire model.

All TEAM participants will have the option to choose between Tracks 1 and 3 in the first performance year (PY), and eligible participants will have the option to choose between Tracks 2 and 3 throughout the rest of the program, as illustrated in Figure 1. Recognizing the financial barriers and unique care priorities faced by safety net hospitals, in the IPPS final rule for 2025, CMS adjusted the track options for these hospitals and is now allowing them to elect to remain in Track 1 through PY3.

Figure 1: TEAM participation tracks

	Track 1	Track 2	Track 3
Eligible Participant Types	PY1: All participants PY2-3: Safety net hospitals only PY4-5: None	PY1: None PY2-5: Safety net, rural, Medicare-dependent, sole community, and essential access care hospitals only	PY1-5: All participants
Financial Risk	Upside	Limited Two-Sided	Two-Sided
Stop Gain/Loss	10%	5%	20%
Composite Quality Score (CQS) - Positive	Up to 10%	Up to 10%	Up to 10%
CQS - Negative	N/A	Up to 15%	Up to 10%

Note: See the Quality Measures and Reconciliations section below for more information on the how the quality measures and stop gain/loss are calculated and are used to adjust TEAM payments/repayments.

Participants are required to notify CMS of their requested track prior to the start of a PY, with the default tracks being Track 1 for PY1 and Track 3 for PYs 2 to 5. All participation tracks will qualify as a Merit-Based Incentive Payment System (MIPS) APM under the Quality Payment Program, and Tracks 2 and 3 will also qualify as an Advanced APM.

In addition to those ACHs required to participate, CMS is also offering a one-time, voluntary opt-in opportunity for BPCI Advanced or CJR ACHs that remain participants until the final day of the respective program. ACHs eligible to voluntarily opt-in to TEAM had until January 31, 2025 to notify CMS of their intent to participate.

Why this matters: CMS has mandated participation in more geographic regions under TEAM than in CJR, so the model will impact more ACHs, both those familiar and unfamiliar with value-based care. However, the mandated ACHs will have one year to prepare before the model starts in 2026 and the PY Track 1 option will help providers new to value-based care prepare before taking on downside financial risk in the subsequent PYs. Furthermore, safety net hospitals will have the option for an extended glide-path to downside risk through PY3.

Episode selection and length

CMS reviewed the clinical episodes included in the BPCI Advanced model to determine which episodes to test in TEAM. While BPCI Advanced includes both surgical and medical episodes, CMS chose to focus on surgical episodes for TEAM as they "are time-limited with well-defined triggers, have clinically similar patient populations with common care pathways, and have sufficient spending or quality variability, particularly in the post-acute time period, to offer participants the opportunity for improvement" (pg. 69710).

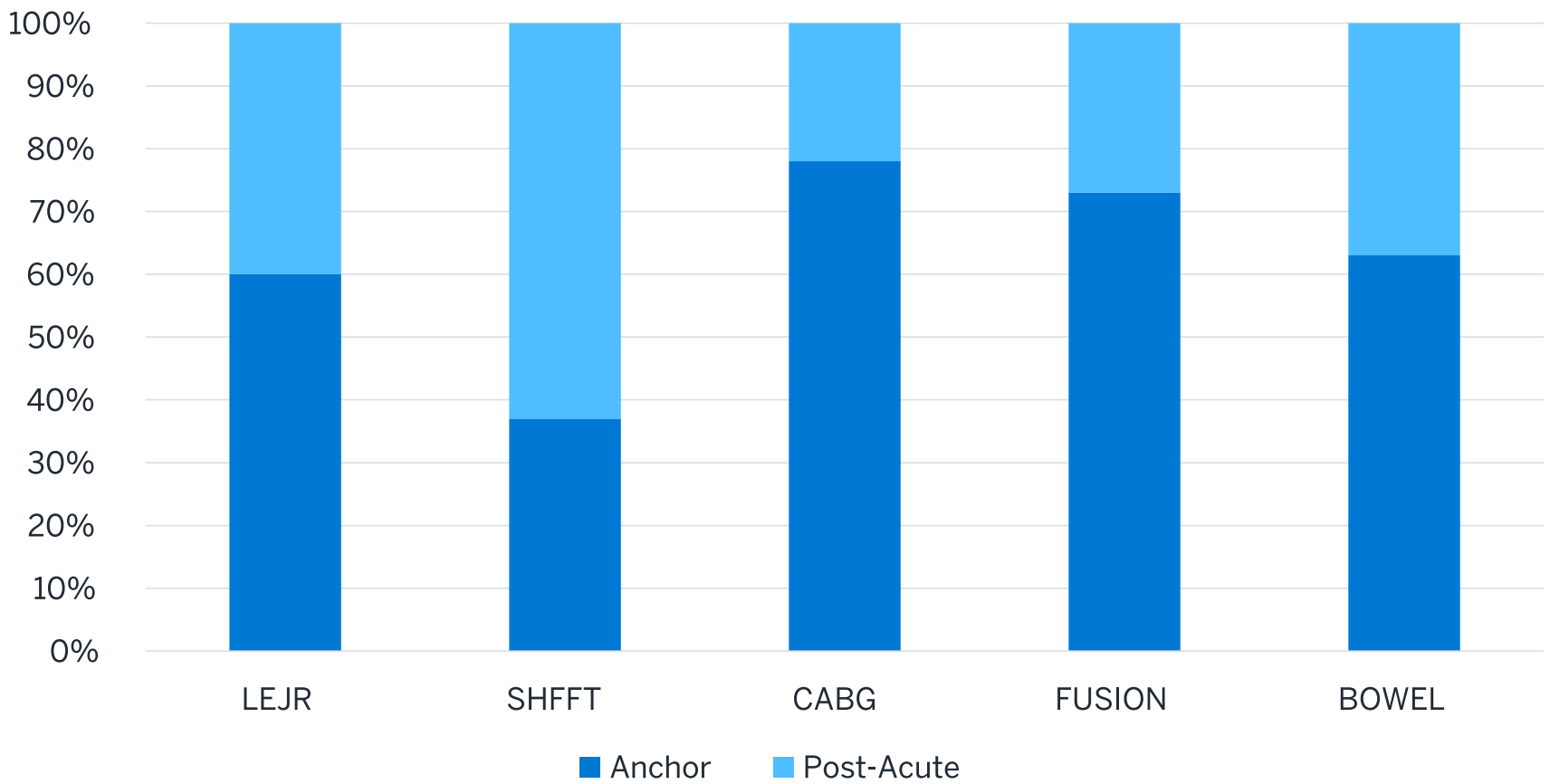
After evaluating 2021 BPCI Advanced experience, CMS chose to include the following five episodes in TEAM:

- Lower extremity joint replacements (LEJR)
- Coronary artery bypass grafting (CABG)
- Surgical hip and femur fracture treatment (SHFFT)
- Spinal fusion (FUSION)
- Major bowel procedures (BOWEL)

CMS believes these episodes reflect the best opportunities for improvement as they are high-volume and high-cost, with post-acute spend ranging from 22% to 63% of total episode costs.

Figure 2 illustrates the proportion of spending during the procedure that initiates the episode (anchor) versus the 30-day post-acute period for the 2021 BPCI Advanced episodes.

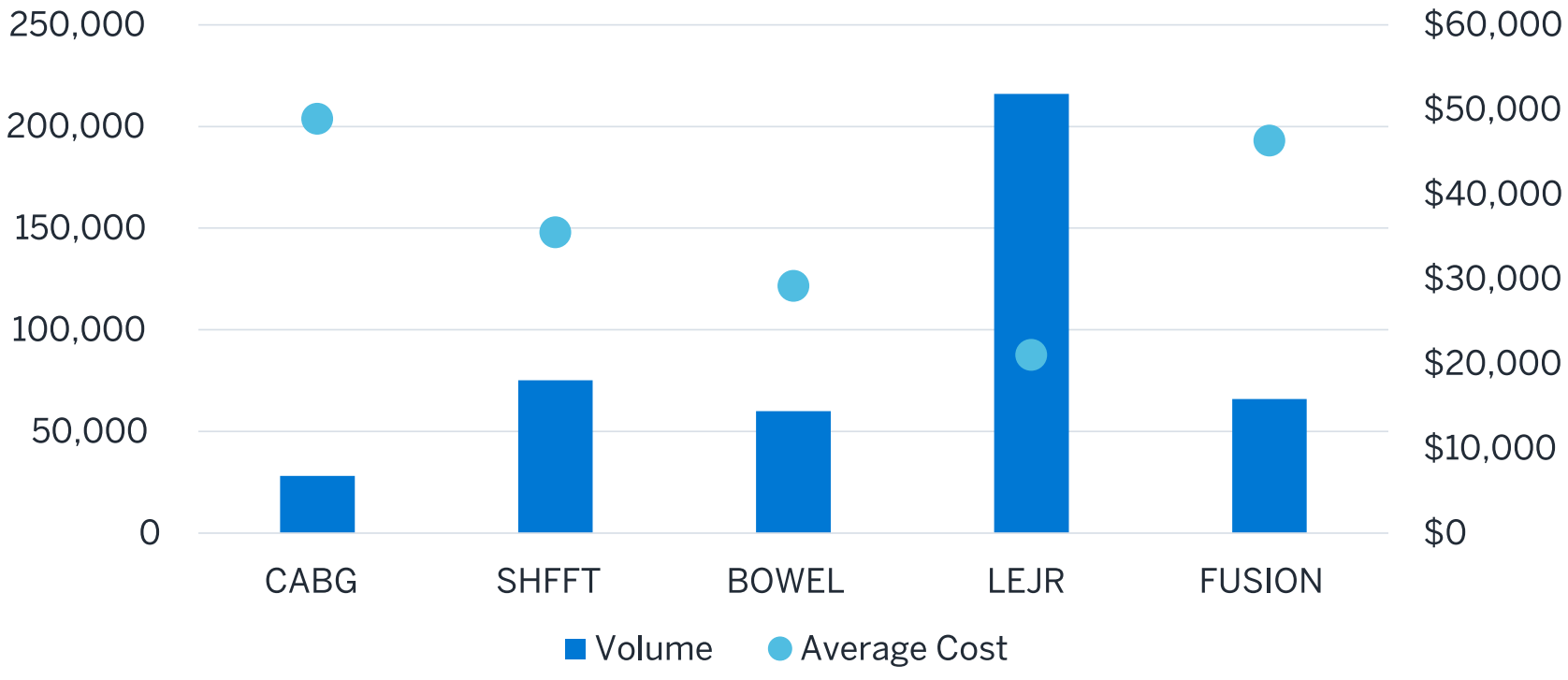
Figure 2: 2021 BPCI Advanced distribution of spending by time period



Source: Pg. 69711.

Using the same 2021 period, CMS estimated national volume and average costs for all TEAM episodes, shown in Figure 3. Altogether, these episodes represent approximately 1.9% of the total Medicare fee-for-service (FFS) spending (Parts A and B only) in 2021, whereas the corresponding 90-day BPCI Advanced episodes accounted for approximately 2.1%.

Figure 3: Estimated historical episodes and costs for CY2021



Source: Pg. 69711.

Similar to both the BPCI Advanced and CJR models, TEAM episodes will be triggered by a surgical procedure that takes place during either an inpatient stay or an outpatient encounter, as identified using the Medicare severity diagnosis-related group (MS-DRG) and Healthcare Common Procedure Coding System (HCPCS) codes listed in Figure 4.

Figure 4: TEAM episode initiating procedures

	Initiating Procedures	
Episode Type	**Inpatient MS-DRGs**	**Outpatient HCPCS**
LEJR	469, 470, 521, 522	27447, 27130, 27702*
CABG	231-236	
SHFFT	480-482	
FUSION	402, 426-430, 447, 448, 450, 451, 471-473	22551*, 22554*, 22612*, 22630*, 22633*
BOWEL	329-331	

** Newly eligible to be performed in the outpatient setting.*

As only ACHs can initiate TEAM episodes, whether mandated or voluntary, episode attribution is simpler than in voluntary models such as BPCI Advanced, which allowed both ACHs and Physician Group Practices (PGPs) to sign up as participants and be attributed episodes. However, ACHs in TEAM will be able to seek administrative or convener support if they choose.

Performing one of these procedures will initiate an episode, whereby the participant ACH will be held accountable for the Part A and B costs associated with the surgery (anchor) and the subsequent 30 days of post-acute care. The first day of the post-acute period is the anchor discharge date for inpatient admissions or the day of the procedure for outpatient surgeries. Like BPCI Advanced, TEAM episodes will include nearly all care that occurs in the post-acute period—there are only a handful of excluded services, including admissions for oncology, trauma, and organ transplantation, as well as high-cost Part B drugs and hemophilia clotting factors (pg. 69921). This means that participants may be exposed to risk for care that is not related or only loosely related to the initiating procedure.

The 30-day post-acute period of TEAM episodes will be significantly shorter than the 90 days included in both BPCI Advanced and CJR. CMS will be shortening the episode length in TEAM because it has found, through analyzing BPCI Advanced episodes between 2020 and 2022, that 75% of post-acute episode spend occurs in the first 30 days of the post-acute period while 90% occurs in the first 60 days. Shorter episodes will also help limit spending for unrelated and chronic conditions that tend to occur in the later stages of longer episodes and minimize potential ACO overlap.

Enhancing the relationship between episode-based models and ACOs appears to be a deciding factor in the episode length, with CMS noting "A 30-day episode would position the specialist as the principal provider near the anchor event with a hand off back to the primary care provider for longitudinal care management and we believe that ACOs are better equipped to address the population health needs of Medicare beneficiaries" (pg. 69727). In addition, eligible Medicare beneficiaries may be attributed to both TEAM and population-based models like ACOs, further promoting the need for collaboration between acute care (TEAM) and primary care (ACOs) providers to address beneficiaries' full spectrums of needs.

Why this matters: TEAM participants will be held responsible for surgical episodes spanning multiple specialties with varying volumes, care patterns, and areas for efficiency. The broader scope and limited number of excluded services from the episodes will allow for more combined potential savings in terms of episode mix; however, the shorter episode length will limit post-acute savings opportunities. Furthermore, CMS believes this episode structure will further promote collaboration between ACH's and Medicare ACOs, which can further enhance care quality while reducing costs across acute and post-acute settings.

TEAM will include only those episodes where care is provided to beneficiaries who meet the following criteria upon admission for an anchor hospitalization or upon receipt of an outpatient anchor procedure:

- Enrolled in Medicare Parts A and B
- Have Medicare as their primary payer
- Not eligible for Medicare based on end-stage renal disease (ESRD)
- Not enrolled in any managed care plan, such as Medicare Advantage, health care prepayment plans, or cost-based health maintenance organizations
- Not covered under a United Mine Workers of America health care plan

An episode will be canceled (and thus excluded from TEAM) if, at any time during the episode, a beneficiary no longer meets all the criteria listed in this section. Furthermore, episodes will not be initiated if the beneficiary dies during the anchor hospitalization or procedure, if the episode occurs at an anchor ACH that is impacted by a natural disaster (under the uncontrolled disasters policy).

Why this matters: These criteria and cancellation policies play an important role in helping TEAM episodes align with Medicare's goals and payment structures. By setting clear eligibility guidelines, CMS aims to include appropriate cases, supporting the integrity of the model and encouraging the efficient use of resources while not holding participants accountable for care associated with cases that they have less ability to effectively manage.

How is performance measured under TEAM?

As a central goal of TEAM is to improve the quality of care while reducing unnecessary spending, participant performance will be evaluated against both quality and financial benchmarks.

Quality measures

Through the quality component of episode-based models, participants have the opportunity for better financial rewards by focusing on their quality performance or quality improvement. CMS will be using the following quality measures, which highlight care coordination, patient safety, and patient-reported outcomes (PROs) and will be relevant to the following applicable episodes:

For Performance Year 1:

1. All TEAM episodes
    1. Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and Electronic Health Record Data (CMS Measure Inventory Tool [CMIT] ID #356) with a calendar year (CY) 2025 baseline period
    2. CMS Patient Safety and Adverse Events Composite (CMS Patient Safety Indicator [PSI] 90, CMIT ID #135) with a CY 2025 baseline period
2. LEJR Episodes
    1. Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM, CMIT ID #1618) with a CY 2025 baseline period

For Performance Years 2-5:

1. All TEAM episodes
    1. Hybrid Hospital-Wide All-Cause Readmission Measure With Claims and Electronic Health Record Data (CMIT ID #356) with a CY 2025 baseline period
    2. Hospital Harm – Falls With Injury (CMIT ID #1518) with a CY 2026 baseline period
    3. Hospital Harm – Postoperative Respiratory Failure (CMIT ID #1788) with a CY 2026 baseline period
    4. Thirty-day Risk-Standardized Death Rate Among Surgical Inpatients With Complications (Failure-to-Rescue) (CMIT ID #134) with a CY 2026 baseline period
2. LEJR Episodes
    1. Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM, CMIT ID #1618) with a CY 2025 baseline period

For PY1, the quality measures are mostly consistent with those used in current and ongoing models. For PY2, CMS is incorporating additional measures that participants will have to familiarize themselves with but are meaningful metrics for the acute surgical procedures in TEAM.

Individual measure performance will be combined during reconciliation to create a composite quality score (CQS), which will adjust the reconciliation payment up to 10% or repayment amount up to 15% (depending on participation track) with higher quality resulting in better financial outcomes.

Why this matters: When TEAM starts, it will include quality measures that are mostly consistent with other models, which will reduce the burden on participants. However, in later model years, participants will have to familiarize themselves with new quality measures that are specific to the surgeries included in TEAM. While there will be a measure that is only applicable to LEJR episodes, the measure was included in both BPCI Advanced and CJR and aligns with the upcoming 2027 mandatory reporting for THA/TKA PRO-PM, which begins prior to the start of TEAM.[6]

Financial

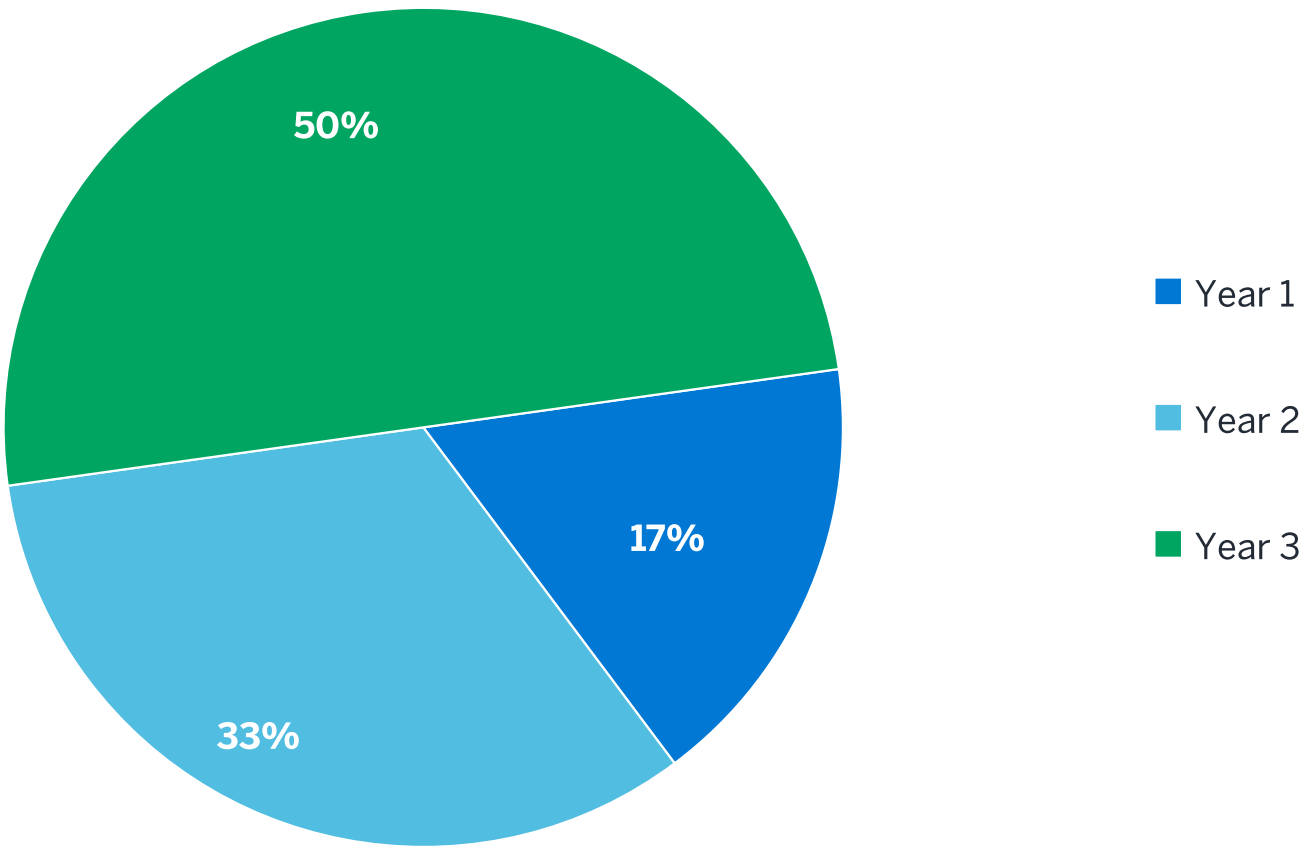
CMS has tested multiple payment methodologies in prior episode-based models, ranging from simple to complex. The goal of the TEAM payment methodology is to combine the most successful components of past models to provide predictable, accurate, and interpretable prospective target prices.

Target prices

The foundation of an episode-based payment methodology is the benchmark data used for the creation of the target prices against which participants will be evaluated, in this case a historical baseline period. There are challenges in choosing an appropriate baseline period. A baseline period that uses an ACH's historical experience may result in hospitals that are less efficient at the start in achieving savings easily, while a baseline period based on regional experience may make it more challenging for these less efficient hospitals to achieve savings at the program start if they need to catch-up to their regional peers. In addition, an older, fixed baseline may fail to accurately represent updated performance care and spending patterns, but updating the baseline period over time may cause target prices to decrease too quickly, potentially penalizing high-performing participants (especially if the baseline period reflects the ACH's historical experience). TEAM will balance these challenges by using a three-year weighted regional baseline period that rolls forward annually. Each individual year of the three-year regional baseline period will be weighted differently, with higher weights for the more recent years that may better predict performance spending.

The first regional baseline period will include episodes starting between January 1, 2022, and December 31, 2024, and reflect the weighting illustrated in Figure 5.

Figure 5: 3-year baseline period weighting



Average spending in the three-year weighted regional baseline period at the MS-DRG/HCPCS and U.S. Census Division levels, capped at the 99th percentile, will result in 261 standardized, regional target prices.

The following factors will be applied to the standardized, regional target prices to create the preliminary target prices, which will be provided to participants prior to the start of each PY in November:

- A prospective trend factor, calculated as the percentage difference between the average regional MS-DRG/HCPCS episode type spending in the last year of the baseline period compared to the first year of the baseline period, with limited retrospective modification at reconciliation to account for the observed market trends between the baseline and PY
- A prospective normalization factor to remove the overall impact of the risk adjustment variables on the national target price based on the last year of the baseline period, with limited retrospective modification at reconciliation to account for the observed case mix in a PY
- A discount factor of 1.5% for CABG and BOWEL episodes and 2% for FUSION, LEJR, and SHFFT episodes.

Risk adjustment

The preliminary target prices will provide a solid foundation for predicting episode spending in the performance period; however, they will require risk adjustment to account for variation driven by the unique characteristics of each beneficiary, TEAM participant, and episode category.

Built upon the risk adjustment methodology used in the CJR three-year extension, TEAM will employ a risk adjustment model based on the following characteristics:

Beneficiary characteristics

- **Age bracket:** Based on the beneficiary's age as of the first day of the episode.
- **Hierarchical Condition Category (HCC) count:** Based on a 90-day look-back period (similar to BPCI Advanced).
- **Social risk:** Based on dual eligibility, area deprivation index, or Part D low-income subsidy eligibility.

Hospital characteristics

- **Hospital bed size:** Classified into four categories (250 beds or fewer, 251-500 beds, 501-850 beds, and 850 beds or more).
- **Safety net hospital status:** Determined by whether the TEAM participant qualifies as a safety net hospital. For the purposes of TEAM, CMS has stated safety net status will be based on meeting one of the following criteria (pg. 69918):

- Exceeding 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.
- Exceeding the 75th percentile of the proportion of Medicare beneficiaries partially or fully eligible to receive Part D low-income subsidies across all prospective payment system (PPS) acute care hospitals in the baseline period.

Episode characteristics

- **Examples include:** Prior post-acute care use, long-term institutional care use, and selected HCCs such as HCC 18 (diabetes with chronic complications), HCC 111 (chronic obstructive pulmonary disease), HCC 85 (congestive heart failure), and HCC 134 (dialysis status)

The addition of variables specific to each episode category in the TEAM risk adjustment methodology is aimed at more accurately capturing the complexity of the patient case mix and its impact on episode costs.

In the final rule, CMS delayed finalizing the proposed 90-day look-back period for determining which HCC flags apply to beneficiaries, citing concerns from commenters about the appropriate length. Similarly, a decision on the policy for low-volume hospitals was postponed following the review of public feedback on the proposed rule. CMS plans to finalize both the lookback period duration and the policy for low-volume hospitals through a notice-and-comment rulemaking process in 2025, so that participants have clarity on the final policies before TEAM begins.

The resulting risk adjustment multipliers calculated using the baseline period will also be broken out at the MS-DRG/HCPCS episode level. They will be provided prospectively and remain fixed at reconciliation, so participants will be able to proactively estimate the finalized target prices prior to reconciliation.

Reconciliation

CMS has tested various reconciliation processes through prior models and has found that there is a need to balance timely feedback on performance, while limiting the administrative burden. Based on its experience, there will be a single annual reconciliation process for TEAM. Mirroring the current CJR process, episodes in a PY will be reconciled once annually in the fall, allowing for six months of claims run-out following the end of a PY. CMS has found through analysis that most claims are received and finalized within six months of the date of service. During the reconciliation process, CMS will apply the stop gain/loss thresholds applicable to a participant's track and adjust the reconciliation payment or repayment amount based on their CQS. This final reconciliation payment or repayment will be the amount the participant will either receive from CMS (reconciliation payment amount) or the amount that they will owe CMS (reconciliation repayment amount).

TEAM participants may dispute calculations related to payment, reconciliation payment amounts, reconciliation repayment amounts, quality measure results, the CQS, or the stop gain/loss by submitting a written notice of the error to CMS within 30 days of receiving the reconciliation report. CMS will then respond within 30 days to either confirm or deny the error, with the option to extend the response time if necessary. If no notice is submitted, the report is considered final, and CMS will proceed with payment or repayment. For disputes not involving reconciliation report calculations, participants would be required to request reconsideration within 10 days, after which the initial decision is deemed final.

Why this matters: CMS's learnings from prior models and participant feedback translates to a payment methodology that it believes focuses on predictability and accuracy. Mostly prospective target prices with an interpretable risk adjustment model will hopefully provide participants with more stable targets as they strive for financial success in TEAM, according to CMS. With target prices built upon regional spending and risk adjustment to account for patient acuity differences, some ACHs may already be below the regional target without making changes while others may be well above the regional target and will have to make significant changes to achieve the required savings. Additionally, purely regional trending means that regions that perform well may see their target prices decrease in future PYs. Finally, the 1.5-2% discount factor for the target price equates to between 4% and 9% of post-acute spending nationally, depending on the episode type. This presents a challenge for participants, as post-acute spending is the primary avenue for reducing episode spend within the TEAM specifications.

Downstream provider financial arrangements

TEAM will be a flexible model, allowing ACH participants to engage in financial arrangements to encourage success in the program. Participants will be allowed to share their reconciliation payments or repayments with providers and suppliers, including Medicare ACOs, which contribute to the ACH participant's performance. These sharing arrangements will require documentation and be subject to several criteria including a quality provision.

Why this matters: While the ACH participant will ultimately be responsible for the cost of an episode, it may not have significant authority over care in the post-acute period. Financial arrangements could allow participants to incentivize downstream providers to focus on optimizing care patterns and reducing unnecessary spending to achieve better model performance.

What support should potential participants consider for TEAM?

TEAM participants, those both familiar with and new to value-based care, should carefully consider their internal capabilities and seek outside support where they see resource limitations. Succeeding in TEAM will not be solely about the participating ACH's quality of care—it will require managing relationships with other providers and understanding how their performance compares to other hospitals.

TEAM participants should consider reaching out to organizations that can provide the following support:

- **CMS bundled payment expertise:** CMS continues to build upon its prior models, incorporating and improving past methodologies and measures. Organizations well-versed in these models can help participants navigate the process while providing insights for achieving success.
- **Analytics:** CMS models provide raw episode- and claim-level data to participants on a regular cadence. Analytical support can help transform the detailed CMS data into reports or interactive tools that provide visibility into program performance in a user-friendly format.
- **Benchmarks:** As key components of the target price methodology are derived by CMS regionally and nationally to achieve policy objectives, it is beneficial to have access to post-acute utilization benchmarks to determine where your hospital ranks among your peers and to identify potential opportunities and risks.

Closing thoughts

TEAM will impact a wide array of ACHs in about a quarter of CBSAs across the United States. These organizations, both those familiar with and new to episode-based models, might not be able to fully realize opportunities and synergies that can be leveraged within the model.

Data alone will not change behavior or solve any inherent issues within a procedure or an ACH. Understanding the data, uncovering possible opportunities, and firmly committing to instituting change are all necessary components of success. Milliman has extensive subject matter expertise and data-driven tools for episode-based programs to help highlight an organization's areas for quality improvements and cost savings. For more information, contact your Milliman consultant.

This paper was updated on 2/11/2025 to reflect updated policies.

[1] CMS. Transforming Episode Accountability Model: Overview Fact Sheet. Retrieved November 12, 2024, from http://www.cms.gov/files/document/team-model-fs.pdf.

[2] Health Affairs Forefront (April 2, 2024). The CMS Innovation Center's Strategy to Support Person-Centered, Value-Based Specialty Care: 2024 Update. DOI: 10.1377/forefront.20240328.868596.

[3] Bazell, C., Alston, M., Pelizzari, P.M., & Sweatman, B.A. (March 27, 2023). What Are Bundled Payments and How Can They Be Used by Healthcare Organizations? Milliman. Retrieved November 12, 2024, from http://www.milliman.com/en/insight/what-are-bundled-payments-and-how-can-they-be-used-by-healthcare-organizations.

[4] The full text of the final rule, 89 FR 68986, Is available at https://www.federalregister.gov/documents/2024/08/28/2024-17021/medicare-and-medicaid-programs-and-the-childrens-health-insurance-program-hospital-inpatient.

[5] The list of CBSAs selected for mandatory TEAM participation is available at https://www.federalregister.gov/d/2024-17021/page-69706.

[6] CMS. THA/TKA PRO-PM. Retrieved November 12, 2024, from http://qualitynet.cms.gov/inpatient/measures/THA_TKA.

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