

OVERVIEW FACT SHEET

Transforming Episode Accountability Model

MODEL PURPOSE




People with Traditional Medicare who undergo a surgical procedure in a hospital or hospital outpatient department may experience fragmented care that can lead to complications in recovery, avoidable hospitalization, and increased spending. In the proposed Transforming Episode Accountability Model (TEAM), acute care hospitals selected to participate in the model would be accountable for ensuring that people with Medicare receive coordinated, high-quality care during and after certain surgical procedures. Selected hospitals would be required to refer patients to primary care services to support optimal, long-term health outcomes. CMS seeks comment on the proposed TEAM and expects to release a final rule in the fall of 2024.

MODEL GOALS

TEAM would aim 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. By holding TEAM participants accountable for the quality and cost of the episodes in TEAM and ensuring those patients are referred to primary care services, the model would also support CMS' efforts to have all people with Medicare in a care relationship with accountability for quality and total cost of care by 2030.

MODEL APPROACH

TEAM would be a five-year, mandatory episode-based payment model that would start in January 2026. Hospitals required to participate would be selected based on geographic regions from across the United States. TEAM would have graduated risk through different participation tracks to accommodate different levels of risk and reward and allow participants to ease into full-risk participation.

 TRACK 1	 TRACK 2	 TRACK 3
Would be associated with no downside risk and lower levels of reward for one year.	Would be associated with lower levels of risk and reward for certain hospitals, such as safety net hospitals, for years 2 through 5.	Would be associated with higher levels of risk and reward for years 1 through 5.
Episodes of focus would be Lower Extremity Joint Replacement, Surgical Hip Femur Fracture Treatment, Spinal Fusion, Coronary Artery Bypass Graft, and Major Bowel Procedure.		

As a mandatory model, TEAM would advance testing and evaluation of episode-based care as an approach to improve quality of care for patients and lower costs. It would address participation challenges inherent in voluntary models, namely provider attrition and selection bias.

Hospitals required to participate would continue to bill Medicare FFS but would receive a target price based on all non-excluded Medicare Parts A & B items and services included in an episode. Hospitals may earn a payment from CMS, subject to a quality performance adjustment, if their spending is below the target price. Hospitals may owe CMS a repayment amount, subject to a quality performance adjustment, if their spending was above the target price.

MODEL CONTACT INFORMATION

CMMI_TEAM@cms.hhs.gov

EVALUATION

TEAM would be evaluated to measure the effects of an episode-based approach on quality of and access to care, utilization patterns, expenditures, and patient experience. Hospital performance would be assessed by:



Comparing a participating hospital's actual Medicare FFS spending to their target price



Performance on quality measures: hospital readmission, patient safety, and patient-reported outcomes.

The evaluation will also capture the evolving nature of care delivery transformation. The evaluation design will include a range of analytic methods, including regression and other multivariate methods appropriate to the analysis of stratified randomized experiments.

MODEL PARTICIPATION

- Acute care hospitals would be the participants in TEAM, and they would be selected for participation based on selected geographic regions, specifically Core-Based Statistical Areas, from across the United States.
- The selected regions would capture a mix of hospitals with different value-based care experiences.
- People with Traditional Medicare may be in an episode if admitted to or receive an outpatient procedure from a participating hospital for one of the five surgical procedures tested in the model.
- A person with Traditional Medicare receiving care from (aligned to) providers in an ACO may also be in an episode in TEAM by undergoing one of the procedures at a hospital required to participate in the model.

HEALTH EQUITY STRATEGY



A mandatory model design may increase access to high-quality care for people in underserved areas and capture a wider variety of providers from across the US, including many who have not participated in value-based care.



Social risk adjustment would ensure target prices properly reflect the additional financial investment needed to care for underserved beneficiaries.



Certain hospitals, such as safety net hospitals that care for a higher proportion of underserved patients, would have the opportunity to participate in TEAM with lower financial risks and rewards, allowing them to take part in value-based care with reduced financial pressure.



Hospitals would submit health equity plans and report on sociodemographic data and screen beneficiaries for health related social needs to drive continuous quality improvement.

MODEL TIMELINE

TEAM is a five-year mandatory model that would begin on January 1, 2026 and end on December 31, 2030.

5-YEAR MODEL	2026	2027	2028	2029	2030
TEAM	PY1	PY2	PY3	PY4	PY5