Assessing the Impact: TEAM Model

This brief provides a succinct overview of the AHEAD Model. Access additional Task Force Model Impact Briefers here.

Introduction

Beginning January 1, 2026, the Centers for Medicare & Medicaid Services (CMS) will implement the Transforming Episode Accountability (TEAM) Model. This is a five-year, mandatory, episode-based payment model for hospitals in specific geographic areas. It builds on previous CMS programs such as the Bundled Payments for Care Improvement Advanced and the Comprehensive Care for Joint Replacement models. Medicare beneficiaries often face fragmented and costly care, frequently moving between different doctors, clinics, and tests without coordination. This disjointed approach negatively impacts both patient outcomes and overall health care costs. CMS aims to address this by creating financial incentives for hospitals to improve care coordination across providers and ultimately deliver better health outcomes.

Model Goals

Improve care quality for Traditional Medicare patients undergoing major surgeries by reducing rehospitalizations and recovery time, lowering costs, and promoting equitable outcomes.

Eligibility & Participation

The TEAM model is mandatory for acute care hospitals that are located in selected Core Based Statistical Areas (CBSAs), which are roughly analogous to ZIP codes. Unlike previous models, safety net and rural hospitals will be required to participate, including Medicare Dependent Hospitals, Sole Community Hospitals, and Essential Access Community Hospitals.

Participants will receive episode-based payments for five procedures:

1. Coronary Artery Bypass Graft
2. Lower-Extremity Joint Replacement
3. Major Bowel Procedure
4. Surgical Hip/Femur Fractures
5. Spinal Fusion

The episodes will include nearly all costs provided during the procedure and for 30 days after the patient leaves the hospital. Episodes will be triggered when a patient with Traditional Medicare coverage receives inpatient or outpatient care for one of the five procedures.

Financial Methodology

TEAM has three participation risk tracks, offering a one-year glide path to financial risk:

Track 1	Track 2	Track 3
Available for all participants in performance year (PY) 1 and to safety net and rural hospitals for up to three years. No downside risk, with a 10% stop-gain limit. Up to 10% upside for quality performance.	Available starting in PY2 for safety net and rural hospitals. Lower levels of downside risk, with 5% stop-gain/stop-loss limits. Up to 10% upside for quality performance if hospitals earn savings, and 15% mitigation of losses based on quality.	Available in PY 1-5 for all participants. Highest level of downside risk, with 20% stop-gain/stop-loss limits. Up to 10% upside for quality performance if hospitals earn savings, and 10% mitigation of losses based on quality.

TEAM model participants will continue to bill Medicare fee-for-service (FFS) as usual but will receive prospective target prices for the five episodes. These target prices are based on three years of baseline data, adjusted based on region and patient complexity.

CMS will reconcile actual spending relative to the target once for each performance year. To encourage collaboration between hospitals and physicians, the TEAM model allows hospitals to share reconciliation payments with other providers involved in the episode.

Performance & Quality Measurement

Hospital performance will be assessed by:

- **Episode Cost:** Comparison of the participant's actual Medicare FFS spending vs. the target price.
- **Quality:** Participant performance will be assessed by three metrics: hospital readmissions, patient safety, and patient-reported outcomes. These quality measures will be used to calculate a Composite Quality Score, which is used to increase savings or mitigate losses. All measures rely on claims or quality data that the hospital is already required to report to CMS.

In PY1, the patient safety metric is based on the composite metric called Patient Safety Indicator 90 (PSI-90).

Beginning in PY2, PSI-90 will be replaced with three measures that will be adopted by the Hospital Inpatient Quality Reporting Program:

- Hospital Harm – Falls with Injury
- 30-day Risk – Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue)
- Hospital Harm – Postoperative Respiratory Failure

Health Equity

To help address disparities and promote continuous quality improvement, participants may voluntarily submit health equity plans and report demographic data to CMS (e.g., race, ethnicity, language, disability, sexual orientation, and gender identity).

Additionally, TEAM participants may voluntarily report data on health-related social needs screening to CMS. The four domains include:

- Food insecurity
- Housing instability
- Transportation
- Utility needs

Decarbonization and Resilience Initiative

The CMS Voluntary Decarbonization and Resilience Initiative aims to mitigate the health care system risks posed by climate change.

Participants may voluntarily report data on hospital carbon emissions and their impact on health outcomes, costs, and quality of care.

Established in 2014, the Health Care Transformation Task Force brings together patients, payers, providers, and purchaser representatives to act as a private sector driver, coordinator, and facilitator of delivery system transformation. In addition to serving as a resource and shared learnings convener for members, the Task Force is also a leading public voice on value-based payment and care delivery transformation.