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Driving Value Through TEAM: How Hospitals Can Prepare for the 2026 Launch

With the Centers for Medicare & Medicaid Services (CMS) set to launch the Transforming Episode Accountability Model (TEAM) on January 1, 2026, hospitals across the country are evaluating their readiness to participate. The TEAM model includes five surgical episodes: coronary artery bypass graft (CABG), lower extremity joint replacement (LEJR), major bowel procedures, spinal fusion, and surgical hip and femur fracture treatment (SHFFT). The goal of TEAM aims to drive value-based care through improved cost efficiency and quality outcomes.

A recent analysis from *JAMA Health Forum offers a compelling snapshot of the financial impact of TEAM participation. Hospitals, mandated to participate in TEAM demonstrated notably higher overall 30-day episode spending across all five categories compared to non-participants. For example, TEAM participants spent $28,135 for LEJR episodes compared to $25,914 for non-participants, a nearly $2,200 in additional costs. Similarly, in SHFFT episodes, TEAM participants saw costs of $38,271 versus $35,447 for non-participants. These trends were consistent across postacute care categories as well.

Key Takeaways from the TEAM Cost Data

While higher total spending was evident overall for hospitals participating in TEAM, the most significant differences emerged in perioperative services spending, post acute care (PAC) utilization, including skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and home health agencies (HHAs). For example:

Overall Adjusted 30-Day Episode Spending

Episode	TEAM Hospital Participant	Nonparticipant Hospital	Variance % of Spending
CABG	$49,551	$46,968	5.50%
LEJR	$28,315	$25,914	9.27%
Major Bowel Procedure	$31,820	$29,326	8.50%
Spinal Fusion	$34,092	$31,587	7.93%
SHFFT	$38,271	$35,447	7.97%

A few highlights driving episode costs:
- Skilled Nursing Facility (SNF) spending for SHFFT was 17.6% higher, $11,951 for participants vs. $10,157 for non-participants.
- Post-Acute Care (PAC) spending for spinal fusion was 5.4% higher, $6,763 for participants versus. $6,416 for non-participants.
- Home Health Agency (HHA) costs for LEJR were 40.3% higher, $1,051 vs. $749.

These findings underscore a crucial insight: successful TEAM participation requires thoughtful management of efficient perioperative services, surgical care, and downstream care. Hospitals need to closely align their surgical care pathways for the five surgical episodes and strengthen transitions (from hospital to postacute care settings) to avoid unnecessary costs and readmissions.

Strategic Focus Areas for TEAM Success

To position for success under TEAM, participating hospitals should prioritize the following activities.

1. Perioperative Episode Standardization and Pre-Operative Evaluation: Create standardized, evidence-based clinical pathways for all five procedures. Focus on reducing variability in OR efficiency, pre-operative evaluation, discharge planning, and post-acute referrals.

2. Post-acute Network Optimization: Build high-performance SNF, IRF, and HHA partnerships. Implement data-sharing agreements and performance metrics to track outcomes and manage total cost of care.

3. Data-Driven Performance Measurement: Utilize real-time data to monitor episode costs, readmissions, transition in care, and PAC utilization. Benchmark performance against TEAM national trends and internal historical baselines.

4. Multidisciplinary Governance: Establish surgical episode governance committees that include perioperative leaders, OR surgical leaders, care coordinators, financial analysts, and PAC liaisons to monitor progress and intervene quickly when performance lags.

5. Patient Engagement and Education: Proactively prepare patients for discharge expectations with pre-operative evaluation protocols and post-surgical recovery pathways to reduce complications, readmission rates, costs, and inappropriate PAC utilization.

Organizational Readiness Assessment for TEAM

With the January 2026 go-live fast approaching, hospitals should conduct a readiness assessment by the last quarter of2025. The readiness assessment should include a review of:

- Pre-operative processes and OR operations
- Clinical protocols for the five episodes
- Transitions of care integrating PAC providers in discharge planning
- The historical performance of 30-day readmission rates and PAC costs
- Reporting capabilities and access to claims data
- Surgeon and primary care physician alignment and governance structures

TEAM represents a significant shift in how CMS expects hospitals to deliver surgical care. The shift is less focused on the standalone procedure and more focused on the episode of care with cost and quality accountability. For hospitals to succeed, early investments in perioperative services, post-acute integration, surgical governance, and analytics will ensure compliance and more importantly, deliver measurable clinical and financial value.

For more information on how Lumina Health Partners can assist your participating hospital, reach out for information on our TEAM Readiness Assessment and TEAM Compliance Checklist.

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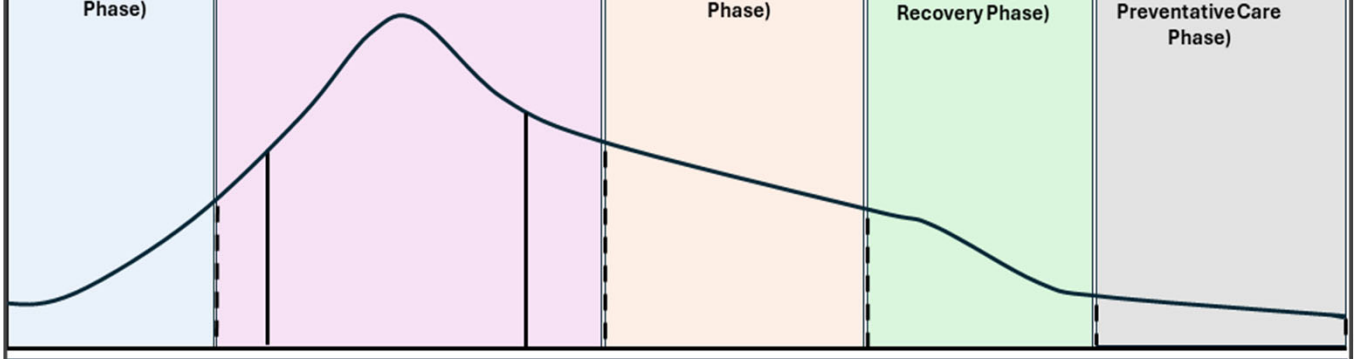
TEAM Model Perioperative Services Value Stream



	Preoperative Evaluation (Pre-Surgical Phase)	Surgical Episode (Intraoperative Phase)	Postoperative Care (Acute Care Phase)	Postoperative Recovery (30-90 day Recovery Phase)	Ambulatory Management (Maintenance and Preventative Care Phase)
Value Drivers	• Risk stratification • Early identification of comorbidities • Prehabilitation to improve surgical readiness • Advance postop. care coordination • Patient education and engagement	• Use of standardized clinical pathways and ERAS (Enhanced Recovery After Surgery) protocols • Minimization of surgical complications • Efficient OR use and anesthesia time • Early mobilization and discharge planning initiated Day 0	• Seamless coordination across care team members (nurses, PT, case managers) • Pain management that reduces opioid use • Early discharge planning with goal-directed therapy • Avoiding unnecessary consults or imaging	• Early post-discharge follow-up (virtual/in-person) • Proactive symptom monitoring and medication reconciliation • Reinforcement of rehabilitation/therapy adherence • Reduction of preventable readmissions	• Long-term rehab adherence and chronic disease control • Reintegration into daily life and work • Primary care handoff to maintain continuity • Capture of long-term PROMs to inform future care
Performance Metrics	• % of patients with documented preoperative risk stratification • % of high-risk patients receiving prehabilitation or optimization • Time from surgical referral to preoperative clearance • Patient comprehension (via surveys) of surgical risks and post-op expectations • Cancellation/delay rates due to avoidable clinical factors	• Intraoperative complication rate • Surgical site infection (SSI) rate • Average LOS (risk-adjusted) • Use of evidence-based surgical checklists and protocols • 30-day readmission rate post-surgery (early signals)	• % of patients mobilized within 24 hours post-op • Pain control effectiveness (e.g., VAS scores, opioid consumption) • Complication index (DVT, delirium, pneumonia) • % discharged to home vs. SNF (favoring home when clinically appropriate) • Cost per episode (inclusive of post-acute services)	• 30-day readmission rate • ED visit rate without admission • % of patients receiving follow-up within 7 days • Patient-reported outcomes (PROMs) for function and satisfaction • Home health utilization and outcomes	• % of patients returning to baseline function or work status • Longitudinal PROMs (e.g., HOOS/KOOS for LEJR, Oswestry for spine) • Long-term complication rates (e.g., implant failure, cardiac issues) • Primary care follow-up documented within 90 days post surgical episode
Risk Stratification Role	• Identifies patients likely to have extended length of stay (LOS), readmission, or discharge to higher-cost post-acute settings • Informs surgical planning (e.g., setting: inpatient vs. outpatient) • Enables risk-adjusted benchmarking of outcomes and cost • Identify ICD-10 risk adjustment variables • HCC capture including exclusions	• Determines expected LOS, potential for ICU use, and discharge disposition • High-risk patients may need real-time care coordination to prevent complications	• Refine risk score and potential post-surgical recovery complication factors • Drives realistic discharge targets and appropriate post-acute planning • Influences selection of SNF vs. home health vs. outpatient rehab)	• High-risk patients enrolled in transitional care models (e.g., nurse navigator, CHW check-ins) • Adjusts expectations for resource use and recovery trajectory • Customer rehabilitation plan based on risk stratification • Design rehab facility or in-home rehab based on risk assessment plan	• Supports intensity/duration of rehab plans • High-risk patients need ongoing surveillance to prevent downstream costs (reoperations, chronic disability)