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Is Your Cardiac Surgery Program Ready for CMS's TEAM Model?

By Carol Wesley & Michael Church

The Centers for Medicare & Medicaid Services (CMS) continues to accelerate the transition from fee-for-service reimbursement toward value-based care models. The newly finalized Transforming Episode Accountability Model (TEAM) represents one of the most significant steps in this evolution. Unlike voluntary bundled payment programs of the past, TEAM introduces mandatory participation for hospitals in selected regions, requiring them to assume both financial and quality accountability for entire episodes of care.

Under TEAM, hospitals are responsible not only for the index procedure—such as coronary artery bypass graft (CABG)—but also for all related services during the 30-day post-discharge period. This includes inpatient, outpatient, and post-acute care settings, creating a comprehensive accountability framework that spans the continuum of care. The model's design aims to reduce fragmentation, improve care coordination, and incentivize hospitals to deliver high-quality outcomes at lower costs.

For cardiac surgery programs, this mandate introduces a dual challenge: managing clinical complexity while meeting stringent cost and quality benchmarks. CABG patients often require intensive post-operative monitoring, and follow-up care, and some require rehabilitation making them highly susceptible to readmissions and complications—key metrics under TEAM's quality scoring system. At the same time, hospitals face financial risk tied to regional target pricing and risk-adjusted benchmarks, which can significantly impact margins if care pathways are not optimized.

Yet, TEAM also presents opportunities. Hospitals that proactively redesign care processes, strengthen post-acute partnerships, and leverage predictive analytics can not only avoid penalties but also achieve shared savings. By aligning governance structures, clinical protocols, and data-driven strategies, organizations can position themselves as leaders in value-based cardiac care.

Background on TEAM Model

The model introduces a comprehensive structure that spans the index admission or outpatient anchor and a 30-day post-discharge period, incentivizing hospitals to improve care coordination and reduce unnecessary utilization. By combining retrospective financial reconciliation with a robust quality scoring system—including readmissions, emergency department use, patient-reported outcomes, and equity measures—TEAM aims to align clinical excellence with fiscal responsibility. Understanding its design, timeline, and performance metrics is essential for hospital leaders preparing for implementation.

TEAM builds from previous voluntary and mandatory bundled payment projects completed by CMS, including the Bundled Payments for Care Improvement (BPCI and BPCI Advanced), Oncology Care Model (OCM) and Enhancing Oncology Model (EOM), and Comprehensive Care for Joint Replacement (CJR) Model. Thus far, many of these models have shown cost savings in general related to the goals of these bundled payment models—reducing the overall cost of care, advancing continuity of care, expanding accountability for patient outcomes, enhancing patient navigation services. Interestingly, EOM, which will be the only other bundled payment model continuing alongside TEAM after BPCI Advanced concludes on December 31, 2025, demonstrated a net loss to Medicare after accounting for the incentive payments to participants. Other models, such as BPCI, have struggled to demonstrate net savings due to the financial incentives offered by CMS to promote participation.

Bundled payment models have been proposed and tested by CMS for decades, with some of the earliest cardiovascular care bundles dating back to the 1990s with small pilot program studies. These early experiments demonstrated reduced length of stay and hospital charges and increased overall cost savings, though they were very small groups with highly selective participation criteria. TEAM will be the first mandatory bundled payment model for cardiac services enacted by CMS. A previous project was set to launch in 2018, but was canceled in 2017, citing the need for more time to provide input on model design and opportunities to test other model options. With the final FY 2026 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule published on July 31, 2025, it seems that time has finally arrived as of January 1, 2026. Many elements of TEAM are familiar from previous models:

Model Design & Timeline

- Mandatory participation for hospitals in 188 Core-Based Statistical Areas (CBSAs) beginning January 1, 2026
- Covers index admission or outpatient anchor plus 30-day post-discharge episode
- Runs through December 31, 2030

Payment & Quality Structure

- Retrospective reconciliation against CMS-set target prices
- Risk adjustment using HCC v28 and case mix
- Composite Quality Score includes readmissions, ED use, patient-reported outcomes, and equity measures

Implications for Cardiac Surgery Programs

The introduction of TEAM fundamentally changes how hospitals approach cardiac surgery episodes, particularly CABG. Historically, CABG has been among the most resource-intensive procedures, with significant variability in length of stay, complication rates, and post-acute care utilization. These variations translate into unpredictable costs and outcomes—precisely the issues TEAM seeks to address.

Under this new model, hospitals are no longer insulated from the financial consequences of care fragmentation. Instead, they face mandatory financial risk tied to regional target pricing and quality performance metrics. This means that even minor inefficiencies—such as prolonged inpatient stays, unnecessary imaging, or poorly coordinated post-acute transitions—can result in substantial penalties. Moreover, TEAM's quality scoring system incorporates readmissions, emergency department visits, and patient-reported outcomes, placing additional pressure on cardiac programs to deliver seamless, high-quality care across the continuum.

Failure to optimize care pathways and strengthen post-acute coordination could lead to negative reconciliation payments, eroding margins and threatening long-term sustainability. Beyond financial implications, poor performance under TEAM can damage a hospital's reputation, particularly in cardiac care where outcomes are highly visible and often publicly reported. Conversely, hospitals that proactively redesign CABG protocols, invest in care management infrastructure, and leverage predictive analytics have an opportunity to achieve shared savings, enhance patient experience, and position themselves as leaders in value-based cardiovascular care.

While the specific recommendations required at each organization will vary, and should be specifically evaluated and planned for, Corazon generally supports several proactive initiatives which promote high quality and high coordination of care while also maintaining accountability and responsiveness as change is required:

- Strong service line and program leadership to monitor performance and ensure course corrections occur as needed
- Robust internal reporting of operational, financial, and clinical benchmarks with outcomes shared with key stakeholders (in addition to registry participation)
- Patient navigation to support patient needs and proactively follow program performance
- Utilization of external resources (e.g. open heart surgery accreditation) to gain insight from a third party to optimize performance
- Executive team with an active interest and understanding of the program and it's impact on the organization as a whole

Financial Imperatives Under TEAM

The financial stakes for cardiac surgery programs under TEAM cannot be overstated. Hospitals included in the identified CBSAs will be operating in an environment where every dollar spent must align with value-based objectives. Regional target pricing introduces a fixed benchmark, meaning that exceeding cost thresholds, even marginally, can trigger negative reconciliation payments and erode operating margins. Target pricing information will be shared by CMS prior to the beginning of each year (Performance Year 1 has already been emailed to participants that have completed required forms for participation). Reconciliations will occur annually between actual patient care costs to CMS and the target price. Those spending less than the target price may qualify for a reconciliation payment, dependent on quality outcomes and other adjustments, but those spending more may owe a repayment to CMS, also subject to quality and other adjustments.

Furthermore, there are 3 participation tracks in TEAM which affect the level of financial risk for hospitals.

	Track 1	Track 2	Track 3
Eligibility Participants must notify CMS of their track selection prior to each performance year	**PY1:** All TEAM participants **PY1-3:** Safety Net Hospitals	**PY2-5:** Selected hospital types*	**PY1-5:** All TEAM participants
Financial Risk Stop-gain and stop-loss limits cap the total amount that a TEAM participant could owe to CMS as a repayment amount or receive from CMS as a reconciliation payment amount	• Upside risk only • Stop-gain limit: 10% • Stop-loss limit: None	• Upside and downside risk • Stop-gain limit: 5% • Stop-loss limit: 5%	• Upside and downside risk • Stop-gain limit: 20% • Stop-loss limit: 20%
Composite Quality Score Reconciliation amounts are adjusted based on quality measure performance	**Positive** Reconciliation Amounts: Up to 10% **Negative** Reconciliation Amounts: Not applicable (N/A)	**Positive** Reconciliation Amounts: Up to 10% **Negative** Reconciliation Amounts: Up to 15%	**Positive** Reconciliation Amounts: Up to 10% **Negative** Reconciliation Amounts: Up to 10%

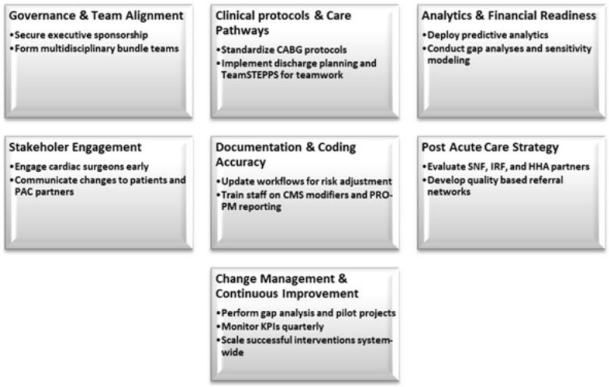
*The following hospital types are eligible for Track 2 in PY2-5: Medicare Dependent Hospitals, Rural Hospitals, Safety Net Hospitals, Sole Community Hospitals, and Essential Access Community Hospitals.

With participation in TEAM mandatory for identified hospitals, key financial pressures include: Bundled Payment Risk: Hospitals assume responsibility for the entire CABG episode, including post-acute care, readmissions, and complications.

Quality-Linked Reimbursement: TEAM ties payment adjustments to performance on metrics such as mortality, readmissions, and patient-reported outcomes, creating a direct link between clinical quality and financial viability.

Capital Allocation Decisions: Investments in care coordination, predictive analytics, and post-acute partnerships are no longer optional and have become strategic imperatives to avoid penalties and capture shared savings.

Failure to act decisively can result in multi-million-dollar losses, while high-performing programs stand to gain through shared savings and reputational advantage. Hospitals that integrate financial modeling with clinical redesign will be best positioned to thrive under TEAM's risk-based framework.



Strategies for Successful Implementation

Successfully navigating the TEAM model requires more than awareness—it demands a deliberate, system-wide transformation. Hospitals must integrate financial, clinical, and operational strategies to meet CMS's cost and quality benchmarks while maintaining excellence in patient care. This involves aligning leadership priorities, standardizing clinical pathways, strengthening post-acute partnerships, and deploying advanced analytics to predict and manage risk. Equally critical is ensuring accurate documentation and coding to support risk adjustment and compliance. The following strategies provide a roadmap for hospital executives and quality leaders to prepare their cardiac surgery programs for TEAM's mandatory requirements and position their organizations for sustainable success.

Conclusion

TEAM introduces mandatory episode-based accountability for CABG and other procedures, fundamentally reshaping how hospitals manage cost, quality, and risk. Success under this model requires more than incremental change—it demands strategic transformation across governance, analytics, care coordination, and documentation. With the model initiating January 1, it is vital to have protocols, tools, dashboards, and analytics established and available to monitor and improve operations in real time under TEAM. Hospitals that act now will not only comply but thrive, capturing shared savings, improving patient outcomes, and securing market leadership in cardiovascular care.

However, navigating TEAM's complexity—regional pricing, quality scoring, and risk reconciliation—requires specialized expertise. This is where we become an indispensable partner. With decades of experience in cardiovascular program development, we offer:

- Data-Driven Insights: Advanced financial modeling and predictive analytics to optimize episode performance.
- Operational Excellence: Proven strategies for care pathway redesign, post-acute coordination, and stakeholder engagement.
- Compliance & Sustainability: Documentation and coding accuracy to safeguard reimbursement and mitigate risk.

Hospitals that partner with us gain a competitive advantage, ensuring not only compliance but long-term financial viability and clinical excellence. In a value-based world, the question isn't whether to adapt—it's how fast and how effectively. We provide the roadmap.

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