Evolution in Value-Based Care: How CMS TEAM Creates a Framework for Success

April 8, 2026

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Speakers

Anant Vasudevan, MD, MBA
Chief Medical Officer
Radial

Ross Armstrong
Chief Commercial Officer
Bamboo Health

Frank Winegar
Partner
Guidehouse

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Learning Objectives

- Describe the structure of the CMS TEAM program as well as the key levers for success
- Analyze the difference between a personnel-enabled vs. tech-enabled approach to managing quality of care and total cost of care for specific populations
- Evaluate how AI-driven tools and workflow engineering could be combined to create a scalable and successful strategy for CMS TEAM

Background

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TEAM: How It Works

What it is:

A mandatory Medicare episode-based payment model that launched January 1, 2026, running for five performance years (through 2030).

Who it affects:

Acute Care Hospitals in mandatory Core-Based Statistical Areas (CBSAs) selected by CMS.

How it works:

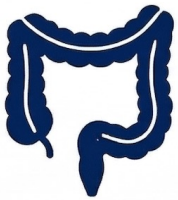
CMS sets a target price for all Medicare Part A and B services, starting with a qualifying surgery and extending 30 days onward.

Why it's challenging:

Target prices are based on your past performance and regional peers, and they roll forward annually.

Source: https://www.cms.gov/priorities/innovation/team-frequently-asked-questions

Five Surgical Episodes

					
Episode Name	CABG	Major Bowel	LEJR	SHFFT	Spinal Fusion
Setting	Inpatient Only	Inpatient Only	IP & Outpatient	Inpatient Only	IP & Outpatient
CMS Discount Factor	1.5%	1.5%	2.0%	2.0%	2.0%
Target MS-DRGs	231-236	329-331	469, 470, 521, 522	480-482	402, 426-430, 447-451, 471-473

Sources: https://www.cms.gov/priorities/innovation/team-frequently-asked-questions
https://www.cms.gov/files/document/team-overview-updated.pdf

By Design, CMS will Realize Savings

In short, CMS savings under the TEAM model are essentially funded by a collective reduction in provider pay.

Sources: https://www.cms.gov/priorities/innovation/team-frequently-asked-questions
https://www.cms.gov/files/document/team-risk-adj-prelim-target-specs.pdf
https://www.cms.gov/files/document/team-overview-updated.pdf

The “Sneaky Baseline”

1. REGIONAL VS. NATIONAL FOCUS.

TEAM target prices are set using Regional Benchmarks.

Compete against neighbors in your Census Division, not nationally.

2. THE NINE CENSUS DIVISIONS.

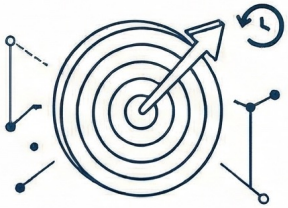
CMS groups providers with similar cost structures into nine U.S. Census Divisions.

(e.g. New England, Pacific etc.)

3. HISTORICAL COST BASELINE.

Your region’s historical average costs directly influence your target price.

4. THE ROLLING BENCHMARK.



Target price updates **every year** based on a rolling benchmark.

Over time, compete against your own past performance, and everyone else’s too.

5. RELATIVE OUTPERFORMANCE.

Staying ahead of your region drives savings.

Falling behind amplifies losses.

THE CRITICAL TAKEAWAY: Start slow with TEAM, and you risk never catching up.

Sources: https://www.cms.gov/priorities/innovation/team-frequently-asked-questions
https://www.cms.gov/files/document/team-overview-updated.pdf

Downside Risk Starts in January 2027

Track 1 (PY1 Only)	Track 2 (PY2-PY5)	Track 3 (PY1-PY5)
Risk: **Upside only** (No downside risk).	**Risk:** Two-sided (Upside and Downside).	**Risk:** Two-sided (High Risk/Reward).
Limits: 10% stop-gain limit.	**Limits:** 5% stop-gain / 5% stop-loss.	**Limits:** 20% stop-gain / 20% stop-loss.
Eligibility: All TEAM participants in Year 1. Safety Net hospitals through Year 3.	**Eligibility:** Safety Net, Rural, Sole Community, and Medicare Dependent Hospitals.	**Eligibility:** All TEAM participants.

Source: https://www.cms.gov/files/document/team-overview-updated.pdf

Key Clinical Levers for Success

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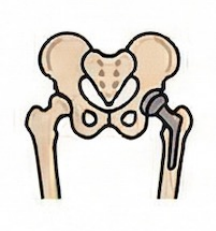
Highest-impact TEAM KPIs

1. Site of Care
% Inpatient vs. Hospital Outpatient Department
(only for LEJR Non-Fracture and Spinal Fusion)

2. Post-Acute
% discharged to facility-based care vs. home
SNF LOS

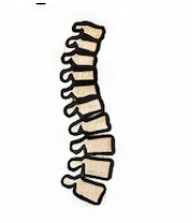
3. Utilization
% of episodes with a post-discharge ED visit
% of episodes with a readmission
Inpatient LOS

1. Outpatient is Safe and Appropriate for Many Patients



LEJR

- **Outpatient:** Similar readmission rates[1,2], adverse events[1,2] (even with propensity matching); higher patient satisfaction[1,3], lower costs[1,4]
- **Inpatient:** Preferred for patients at higher risk of readmission and complications (e.g. age > 70, cardiac history, smoking history, diabetes, poor nutritional status)[5]



Spinal fusion

- **Outpatient:** Similar readmission rates[5,6,7], lower costs[7,8]
- **Inpatient:** Preferred for patients with high rates of complication (e.g. age > 65, CHF, lack of functional independence, increased operative time)[9]

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2. Post-Acute Care at Home can Benefit the Right Patients

For many common conditions, **seniors can achieve the same or better functional outcomes with homecare**[1,2,3]

Facility post-acute care **may be unnecessary or even harmful** – secondary infections, delirium, venous thromboembolism[4]

Readmissions data from home health vs. skilled nursing facility is mixed - however, key subpopulations including those with dementia show **similar readmission rates**[5,6]

Mortality rates are similar at home vs. facilities[5,6]

Post-acute costs and costs within 60 days of admission are significantly lower with home health vs. post-acute facility[5]

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3. Evidence-Based Interventions to Reduce Utilization

Early Mobilization

- **Increases** likelihood of **home discharge**[1,2]
- Improved **functional outcomes** and **steady** state recovery[1, 3, 4, 5, 6]
- Reduces **risk** of adverse events (**deconditioning**[1], clots[5], pneumonia,[7] etc.)
- Reduces inpatient length of stay[2,3], 30-day readmission rates[2]

Patient-specific interventions

- **ERAS protocols adherence associated with decreased inpatient LOS**[8]
- **Individually tailored discharge planning:**[7, 9]
  - –Reduces inpatient length of stay and readmissions for older patients with at least one comorbidity, improves satisfaction and emotional well-being

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The Key to TEAM Success: Optimize Every Phase of the Surgical Journey

Personnel-driven vs. Tech-Enabled Approaches

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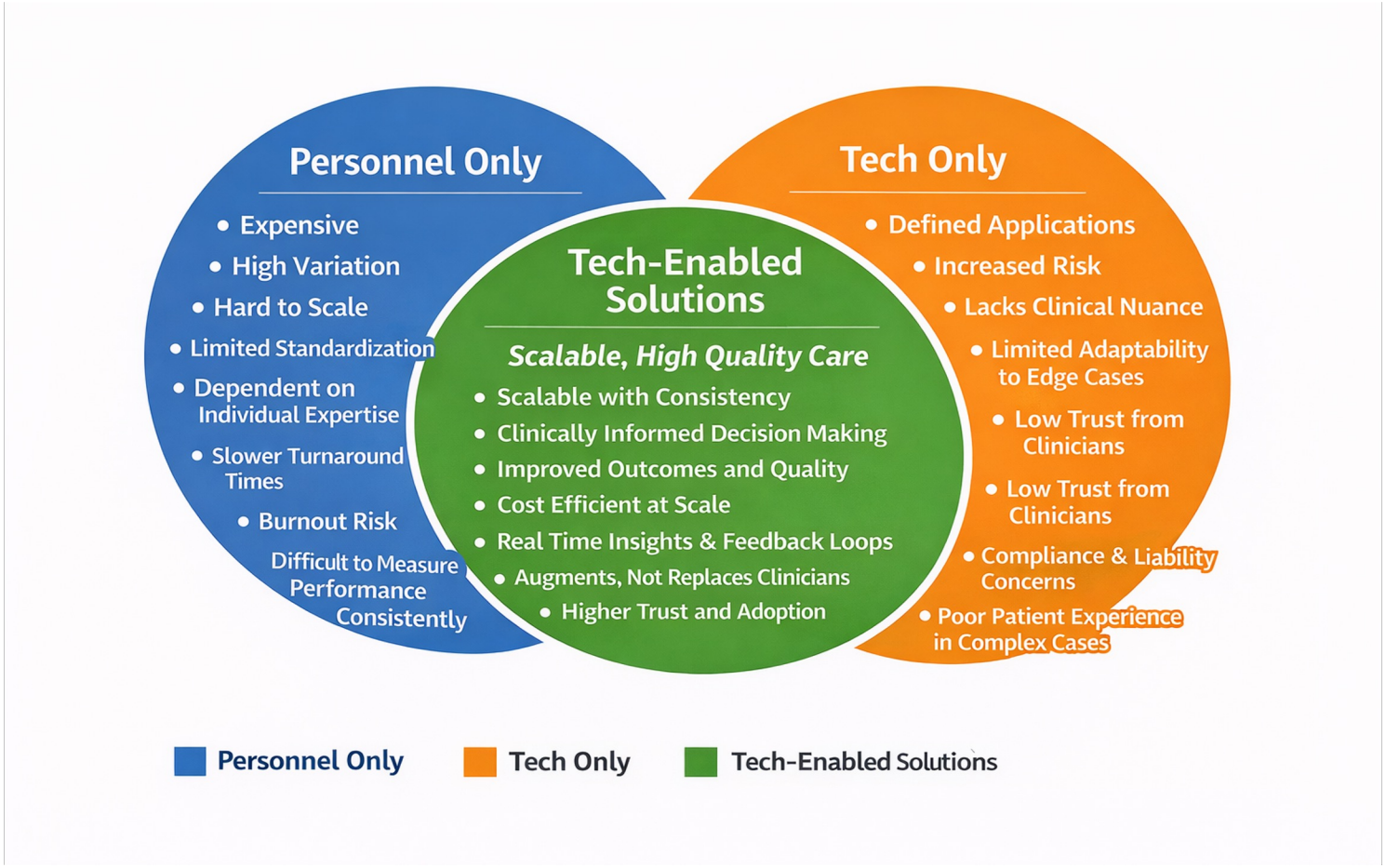
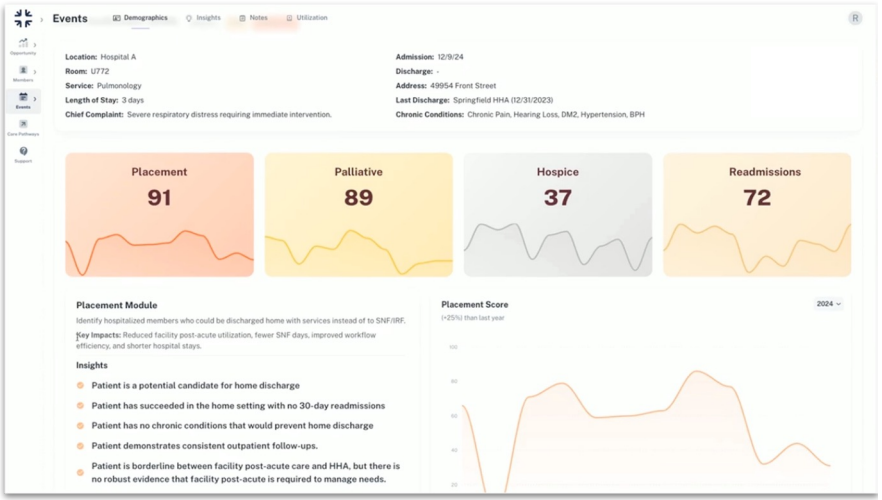
Tech-enabled Approach



Real-Time Decision Support

Driving consistent results requires real-time decision support in the workflow.

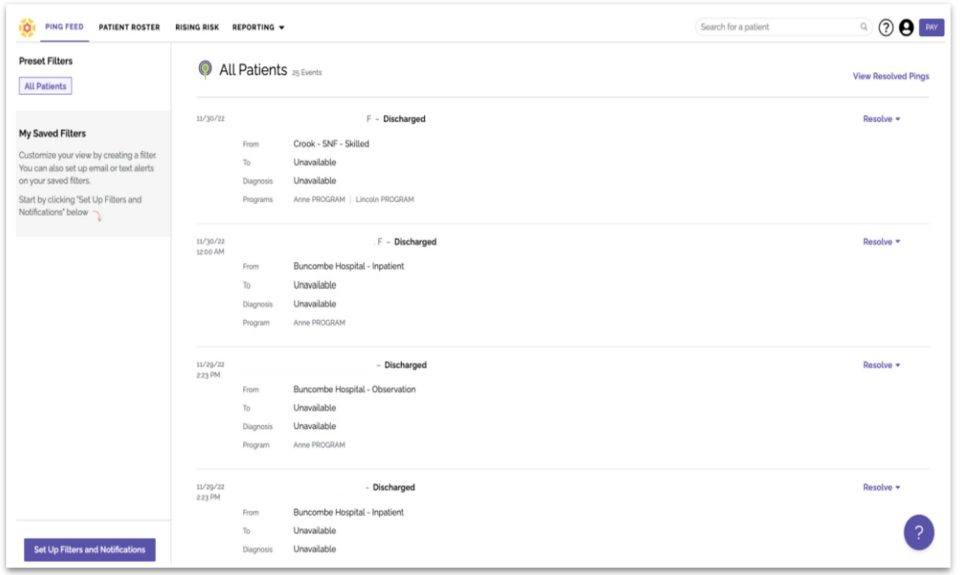
- Aligns team on next-site-of-care to drive care plan prior to surgery
- Retrospective analysis doesn't drive consistent behavior change
- Needed for consistency across specialties, care teams, locations
- Requires a consistent tool whether or not existing clinical record exists
- Developing "standard" patient profiles doesn't work



Real-Time Data Across the Care Continuum

- Care management teams require real-time information to efficiently manage patients and generate the highest impact.

- Use Cases:
  - Post-acute care plan initiation
  - Post-acute start times
  - Managing SNF LOS
  - ED diversion
  - Reduction in analytics lag



Areas to Deploy AI

AI use cases that exist today:

Pre-surgical

- Agent conducts assessments (e.g.,SDOH, BH conditions, pre-existing conditions)
- Assign risk prior to procedure (clinical data, assessments, etc.)
- AI copilots for drafting care plans

Post-surgical

- Agent outreaches with interactive questionnaires / assessments
- Scheduling /nudging to attend appointments or compliance with discharge plan of care
- Real-time encounter tracking and outreach

Analytics

- Real-time assessment of risk throughout the episode (clinical data, assessments, etc.)
- Provider variation

Workflow Engineering

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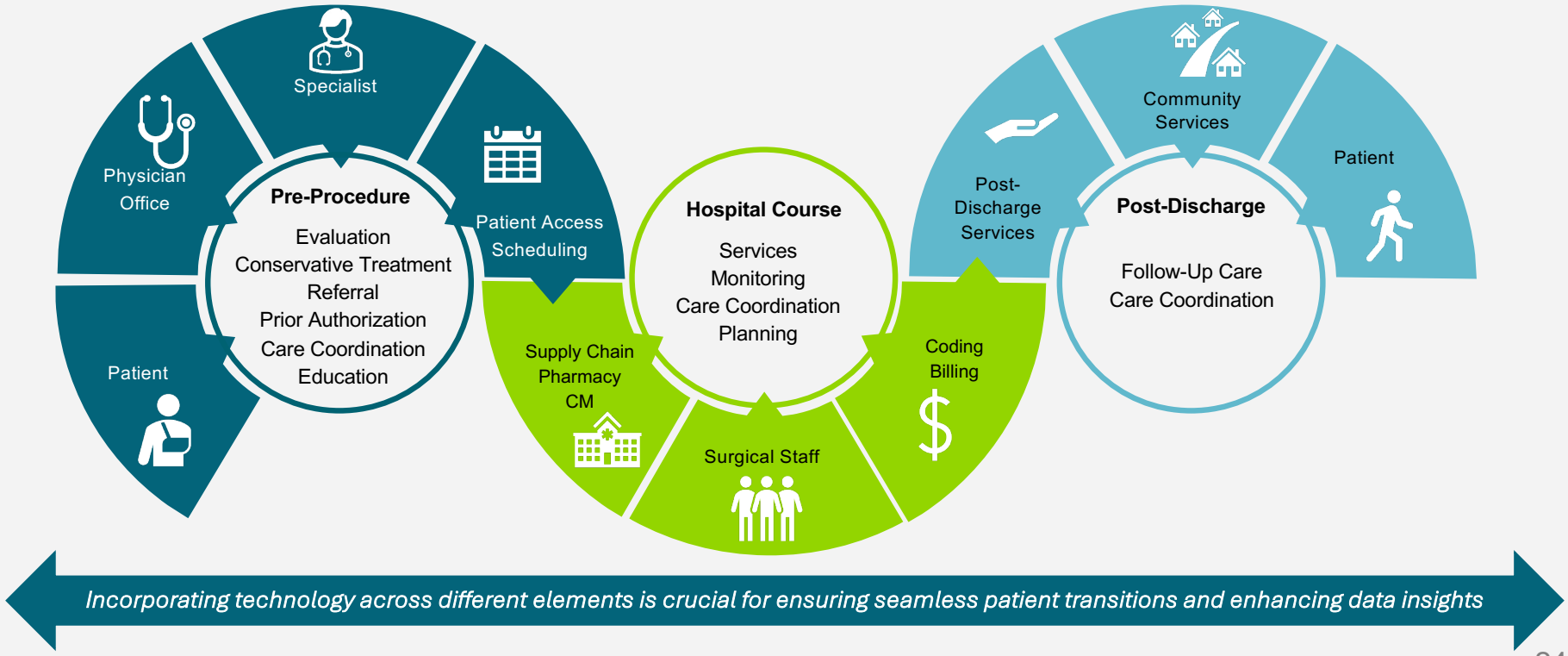
Redesigning the Surgical Episode: From Fragmented Care to System Accountability

How TEAM incentivizes end-to-end coordination across pre-procedure, inpatient, and post-discharge care



Looking Forward

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Episodic Risk Programs are Growing

TEAM begins the renewed expansion of episodic risk; ASM follows quickly in ambulatory specialty care. These models create sustained, multi-year accountability across the continuum — making early readiness a strategic advantage.

BPCI Advanced (Voluntary bundles)
• Episode-based payments continue through 12/31/2025

ASM (Mandatory ambulatory specialty risk)
• Mandatory for specialists treating heart failure or lower back pain

CJR (Episode-based foundation)
• Hip/knee replacement episode accountability

TEAM (Mandatory hospital episodic risk)
• Mandatory, 30-day surgical episodes

TEAM

Near-term expansion of mandatory episodic risk

- **Mandatory episode-based model** running **Jan 1, 2026–Dec 31, 2030**
- Episodes include **anchor stay/procedure + 30 days post-discharge for five surgical categories (e.g., LEJR, SHFFT, CABG, spinal fusion, major bowel)**
- TEAM holds hospitals accountable for **quality + total episode spend, with downside risk beginning in PY2**

ASM

Next wave (ambulatory specialties brought into risk)

- CMS is extending accountability into **ambulatory specialty care via ASM**
- **Mandatory** for specialists treating **Original Medicare** patients with **heart failure or low back pain** in selected regions
- Runs **Jan 1, 2027–Dec 31, 2031**

Why this matters now

- CMS is moving from "pilot/voluntary" bundles toward **multiple concurrent mandatory models spanning Part A (hospital episodes) and Part B (specialist performance)**
- These models are **multi-year by design**, so readiness investments compound over time (care redesign, analytics, alignment)

Preparing for CMS TEAM

CMS TEAM is not just a payment model—when approached strategically, it becomes a launchpad for enterprise value-based care capabilities.

TEAM as a Standalone Mandate

- Point-in-time analytics and reporting
- Isolated episode workflows
- Limited physician and post-acute alignment
- Reactive performance management

TEAM as a catalyst for broader value

Enterprise Care Redesign

- ✓ Standardized clinical pathways across settings
- ✓ Improved transitions and care coordination
- ✓ Scalable models for future episodes

Physician & Post-Acute Alignment

- ✓ Stronger hospital-physician collaboration
- ✓ Preferred PAC networks and shared accountability
- ✓ Durable relationships that support multiple models

Data, Analytics & Performance Management

- ✓ Episode-level cost and quality visibility
- ✓ Infrastructure reusable for ACOs, MSSP, ASM, and commercial bundles
- ✓ Ongoing performance monitoring, not episodic review

Value-Based Care Foundation

- ✓ Readiness for additional CMS and commercial models
- ✓ Improved quality scores and market reputation
- ✓ Sustainable financial performance beyond TEAM reconciliation

Value-based care readiness across programs

Reduced variation and total cost of care

Improved quality, access and patient experience

Stronger positionings for future CMS and commercial models

A Unified Approach to Operational & Population Health Priorities

Aligning operational throughput and population health priorities through a unified framework enables health systems to solve today's access challenges while building sustainable, population-wide impact.

Operational Priorities

- ED & inpatient throughput
- Capacity and flow management
- Length of stay & discharge efficiency
- Workforce productivity

Unified, Enterprise Framework

- ✓ **Shared data & analytics across ops and pop health**
- ✓ **Care models spanning episodic and longitudinal needs**
- ✓ **Enterprise care coordination & transitions**
- ✓ **Scalable infrastructure reusable across populations**

Why this works:

- ✓ ***Optimizes across both near-term operational pressure and long-term population outcomes.***

Population Health Priorities

- Preventable utilization reduction
- Chronic & high-risk population management
- Total cost of care
- Health equity & access

Unified Solutions are:

- ✓ Cost-effective
- ✓ Flexible across populations
- ✓ Scalable across service lines
- ✓ Sustainable over time

Lessons Learned from Conversations with Health Systems

The most successful TEAM conversations shift the focus from compliance to enterprise performance—using TEAM to strengthen care delivery, physician alignment, and value-based care readiness.

Initial Health System Perspective

TEAM Is viewed as a compliance risk

- Health systems first frame TEAM as a mandatory model with downside exposure
- Early focus is on avoiding CMS payback, not performance transformation

What TEAM Reveals in Practice

Fragmentation across the care continuum

- Siloed inpatient, ambulatory, and post-acute teams
- No clear owner for the full 30-day episode

Data exists but is not operationalized

- Retrospective analytics
- Limited translation to frontline action

Physician alignment drives outcomes

- Practice variation materially impacts performance
- Engagement matters more than incentives alone

Post-acute care is a major opportunity

- Limited visibility into SNF/IRF/HHA performance
- Anxiety around patient experience

What Leaders Want Instead

TEAM that does ‘double duty”

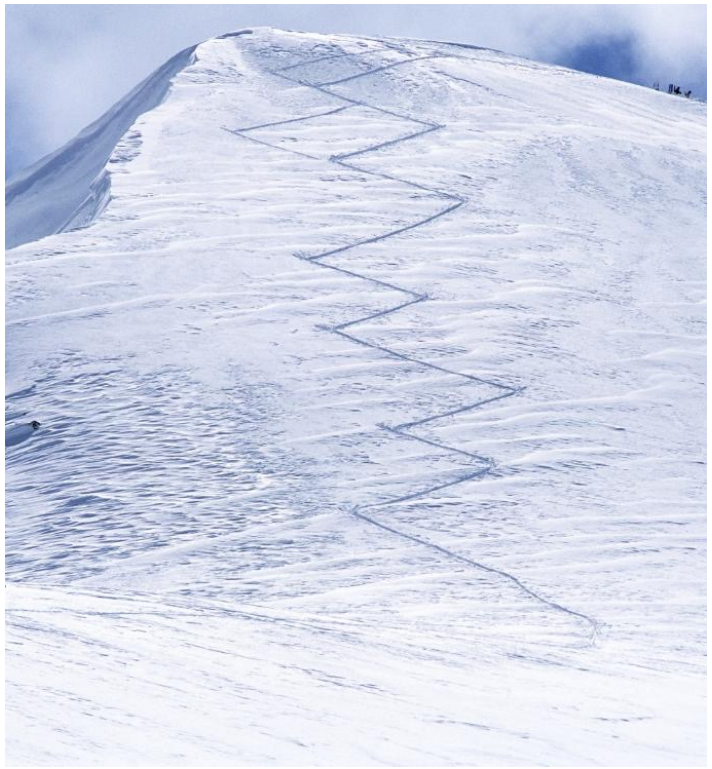
- Reusable analytics and care models
- Foundation for future CMS and commercial programs

Operating model, not a project

- Ongoing governance and accountability
- Embedded change management

Wrap-Up: CMS TEAM as a Strategic Advantage

- Why CMS TEAM matters from your role or experience
- What organizations should prioritize now
- One insight or lesson learned from work with health systems



Clinical/Operational Takeaways

- **Finalize Strategy:** Lock in your TEAM approach now to stay ahead of January's downside risk.
- **Success Is:** Proactive care planning, robust risk mitigation, practical expectation setting.
- **"Tech-Enabled":** Consider approaches that blend clinical expertise with automated efficiency.
- **"Risk x Actionability":** The tech formula to identify and manage high-impact patients upstream.
- **Strategic Advantage:** By design, CMS will generate savings under TEAM. Use TEAM to master episodic risk management today and build a long-term edge as mandatory models expand.

Parting Thoughts

1. **Early movers** will have a **compounding advantage**. Top decile performance requires the deployment of **robust systems**.

2. The real decision is not whether to act, but how aggressively to **redesign care delivery** and whether to **deploy to broader populations**.

   - **Win for today**: Unify efforts into one operating model
     - ↑ Access / throughput
     - ↓ Readmissions
     - ↑ Provider alignment
     - ↑ Outcomes in other VBC programs
   - **Win for tomorrow**: Get a head start as more episodic risk models are coming

3. Leading organizations will:

   - Embed **decision support** to drive early actions
   - **Leverage Real-time network data**
   - Have robust **Care coordination** workflows
   - Drive efficiencies and effectiveness by **leveraging AI**

Questions?

Thank you for joining.

A recording will be sent following the webinar
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