Strategies to Successfully Navigate the Transforming Episode Accountability Model

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October 10, 2025

Agenda

- TEAM structure and financial implications
- How health systems are preparing for TEAM
- Steps for ensuring consistent high quality surgical outcomes
- Opportunities to improve performance in TEAM
- Model challenges
- Perspectives on integrating bundled payment into ACO models

Transforming Episode Accountability Model (TEAM)

- **Model Type**: Mandatory episode payment model
- **Duration**: January 1, 2026, through 2030
- **Participants**: 741 acute care PPS hospitals.
- **Episode Length**: Hospital inpatient or outpatient procedure through 30 days post-discharge
- **Pricing**: Risk-adjusted, price standardized regional average prices (9 census divisions)
- **Risk Tracks**: Vary by type of hospital*
  - **Track 1**: 10% upside; 0% downside
  - **Track 2**: 5% upside; 5% downside
  - **Track 3**: 20% upside; 20% downside
- **Financial responsibility**. Hospitals bear financial risk but can gain-share with surgeons and others.

Team Episodes

- Major Bowel Procedure
- Lower Extremity Joint Replacement
- Surgical Hip Femur Fracture Treatment
- Spinal Fusion
- Coronary Artery Bypass Graft

* All hospitals are in Track 1 in 2026. Safety net hospitals in Track 1 for 2026 – 2028 then Track 2. Rural hospitals in Track 2. Urban non-safety net in Track 3.

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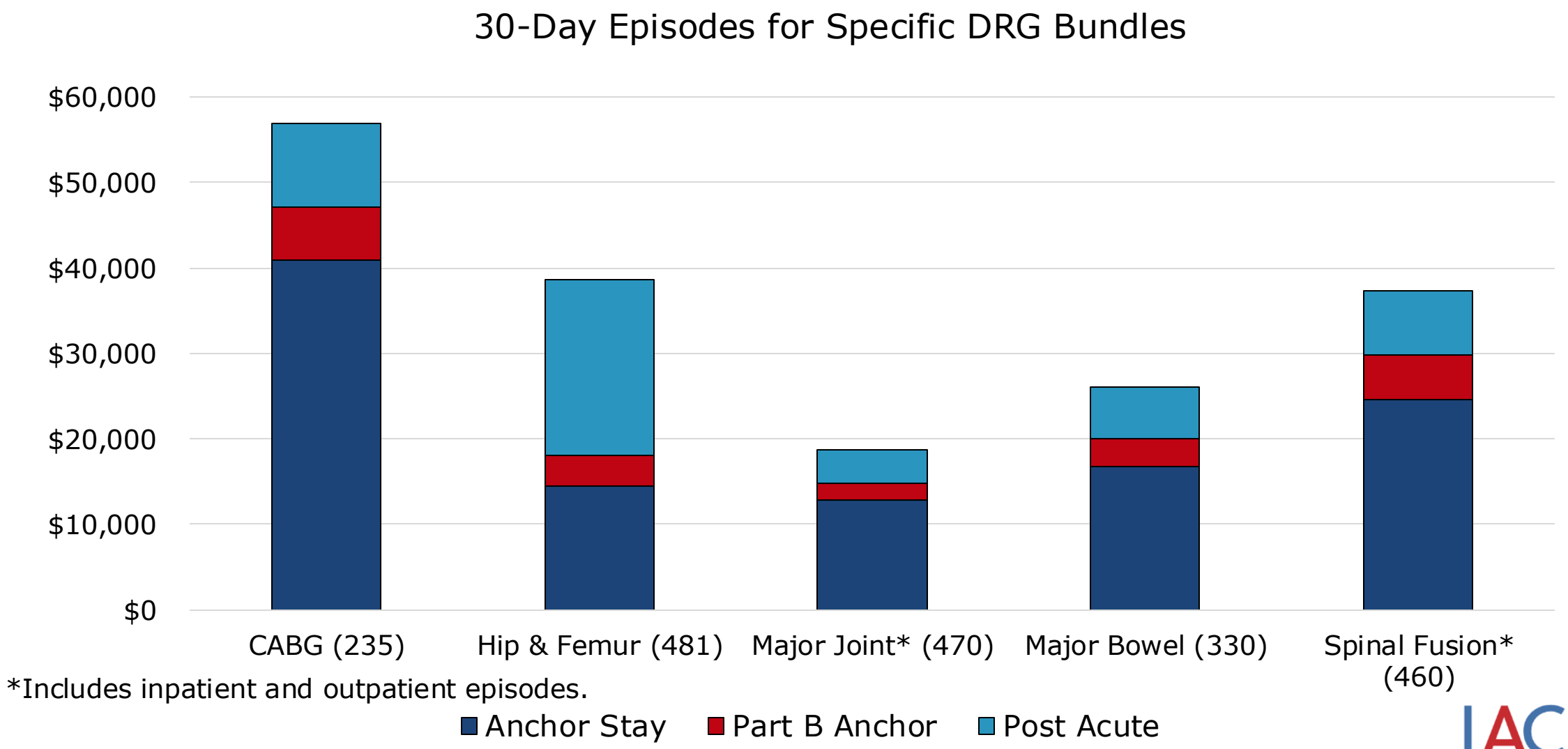
National Average TEAM Episode Cost by Setting



*Includes inpatient and outpatient episodes.

Source: IAC analysis of TEAM episodes 2021-2023 with wage-standardized Medicare claims data (100%) sample.

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Target Price Buildup and Estimated Gain/(Loss)

Sample Hospital: Lower Joint Replacement

All Spending in Standardized Dollars

Lower joint replacement								
DRG	Cases	DRG Index	Regional Base Price	Risk Score	Discount	Episode Target Price	Episode Spending	Episode Gain/(Loss)
469	21	1.715	$31,855	0.959	0.980	$29,934	$29,366	$568
470	503	1.000	$18,586	1.001	0.980	$18,234	$18,809	($576)
521	40	2.527	$46,985	1.031	0.980	$47,459	$53,255	($5,796)
522	105	1.973	$36,680	0.972	0.980	$34,929	$39,942	($5,014)
Total	**669**	**1.267**	**$23,541**	**0.997**	**0.980**	**$22,969**	**$24,517**	**($1,548)**

Source: IAC analysis of TEAM episodes 2021-2023 with Medicare claims data (100% sample) based on specifications in the final 2025 iPPS rule.

Target prices vary substantially by DRG-bundle with this hospital's losses concentrated in hip fracture DRGs .

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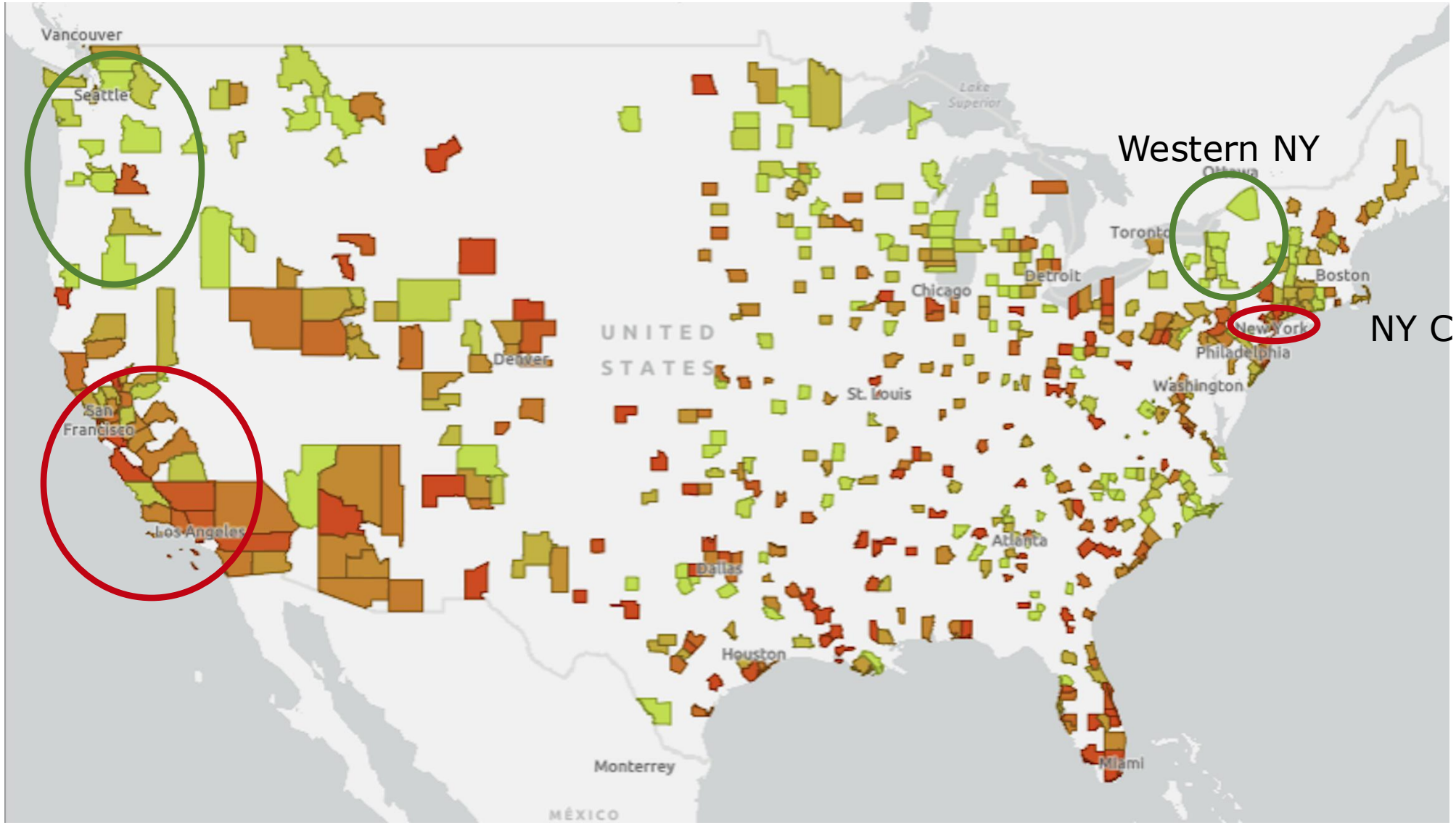
TEAM Gains and Losses Vary by Market

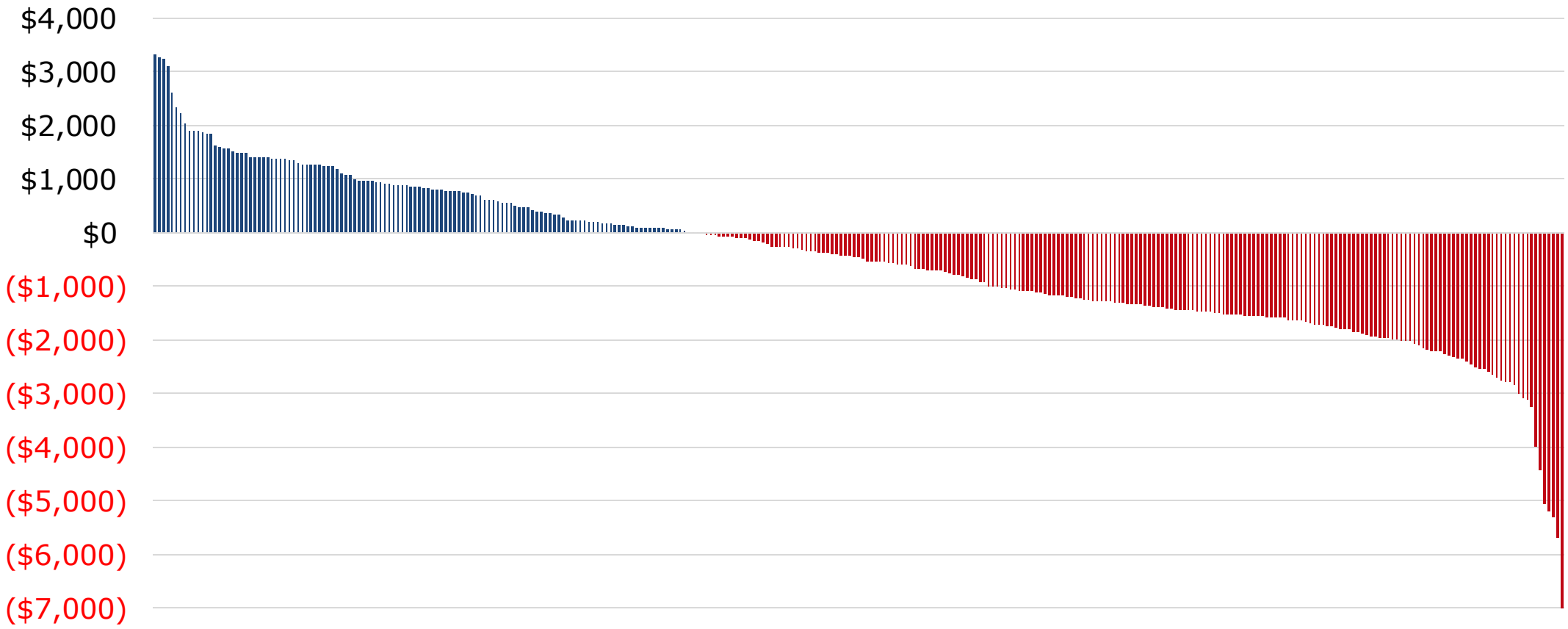
Oregon & Washington

California



Impact of TEAM: Hospitals With 200+ Cases in 2023

2023 Gain or Loss Per Episode



Source: IAC analysis of TEAM episodes using 100% of 2021-2023 Medicare Part A and Part B claims. Analysis is based on final 2025 iPPS rule.

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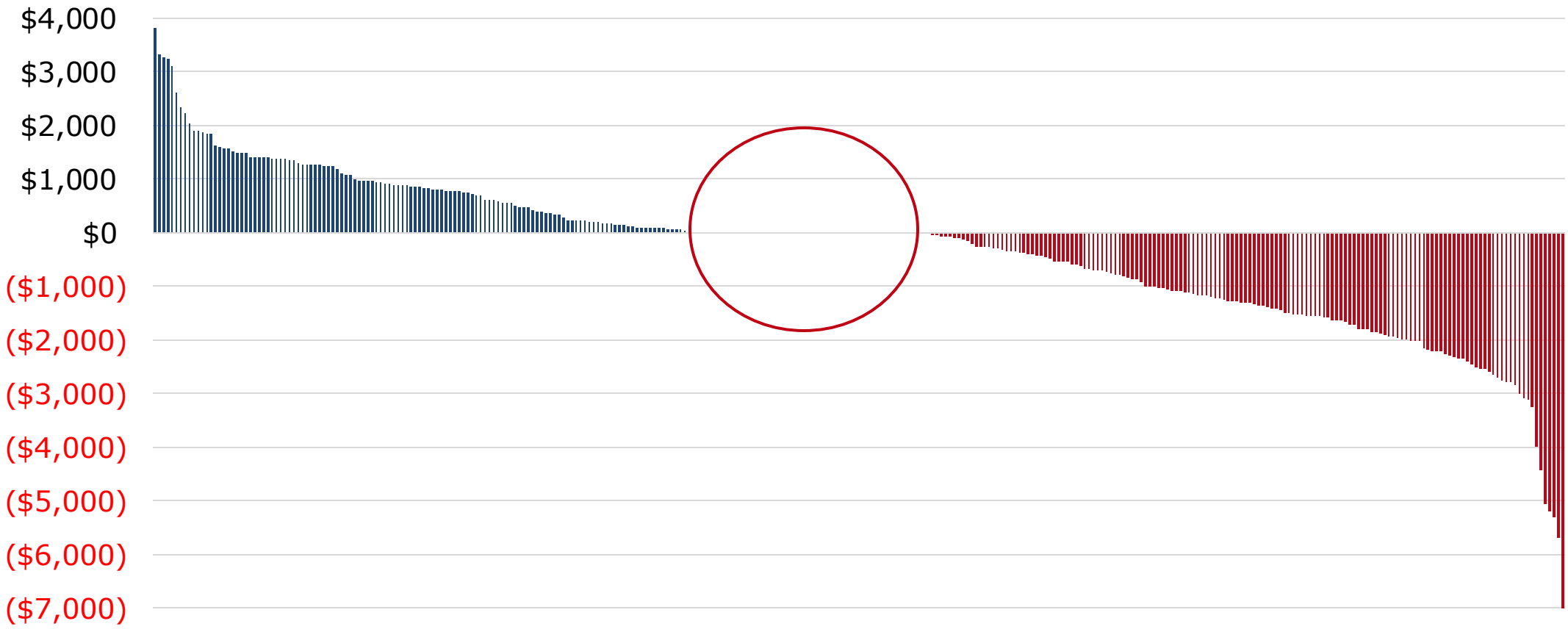
Impact of TEAM: Hospitals With 200+ Cases in 2023

2023 Gain or Loss Per Episode with Safety Net Hospitals in Track 1



Source: IAC analysis of TEAM episodes using 100% of 2021-2023 Medicare Part A and Part B claims. Analysis is based on final 2025 iPPS rule.

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Hospital Strategies for Consideration

- Collaborate with surgical teams on care process improvement
- Support effective care transitions
- Use SNF and IRF services appropriately
- Optimize site of service for multi-setting episodes
- Manage leakage of uncomplicated cases

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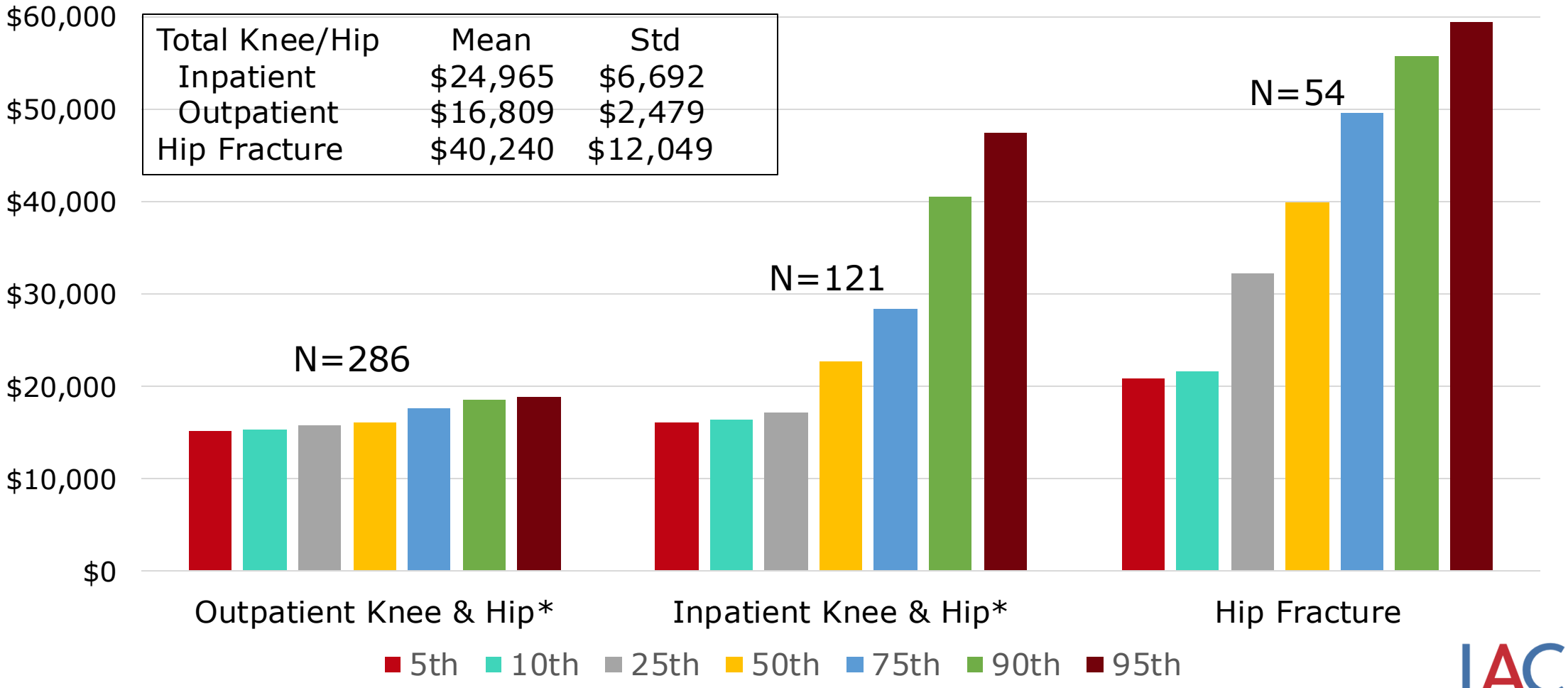
Variation in Spending per Episode by Setting: LEJR

Distribution of Sample Hospital's 2024 Spending Per Episode by Case Characteristics



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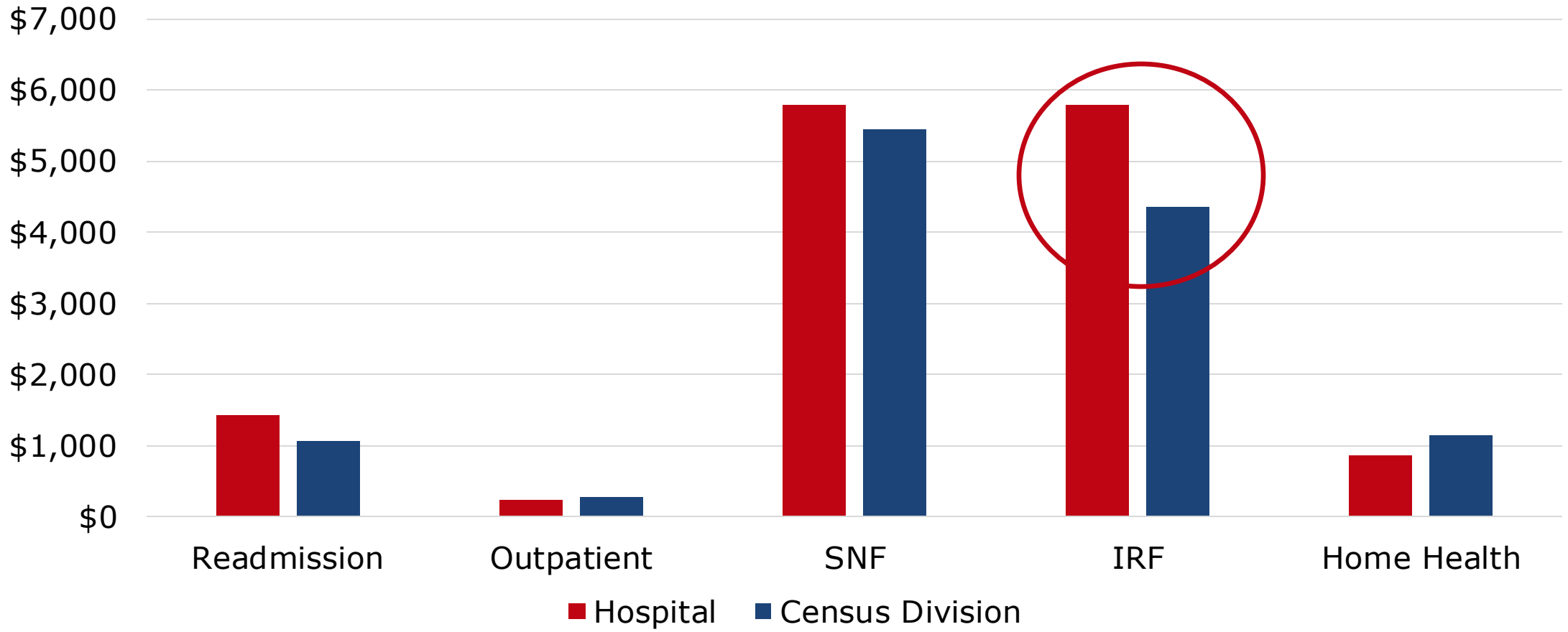
Managing Post-Acute is Key to Success in TEAM

Sample Hospital: Inpatient LEJR (CMI Adjusted) vs. Census Division



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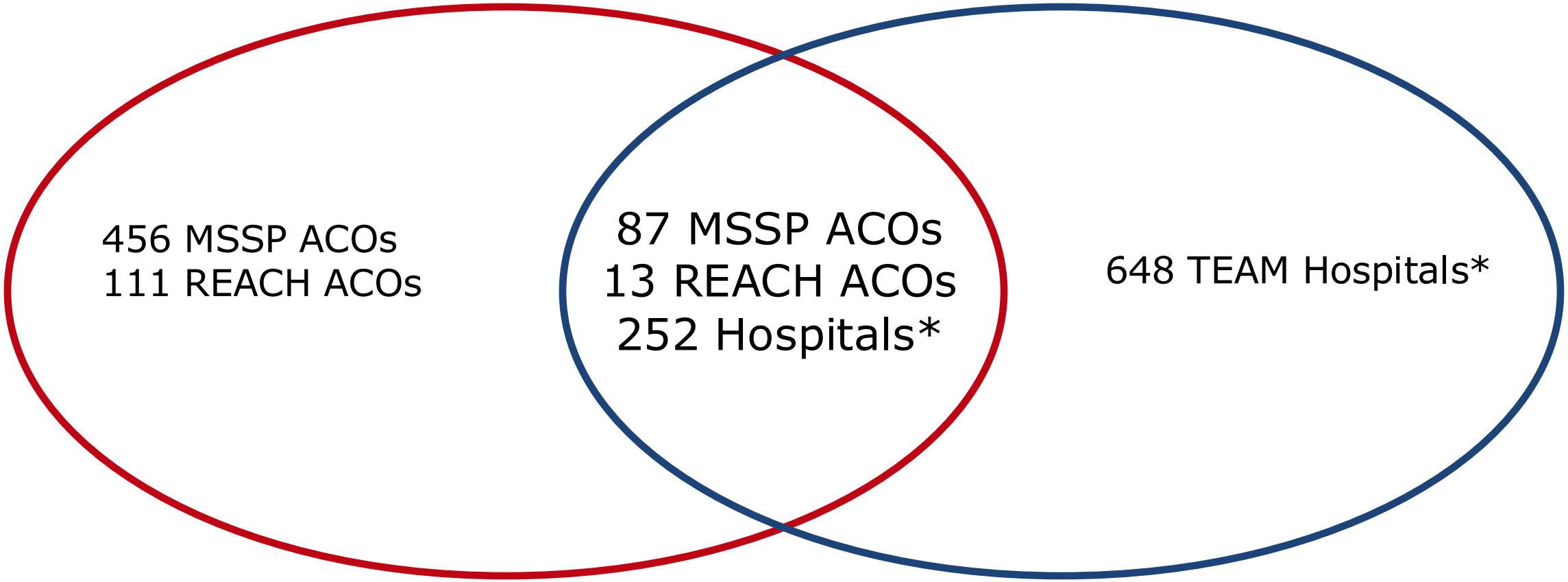
Intersection of TEAM with Medicare ACO Programs



MSSP and TEAM are reconciled separately

* Figure includes 200 MSSP participant hospitals and 52 REACH preferred hospitals.

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Opportunities for ACOs

- Help your affiliated hospitals improve
- Enhance alignment with independent hospitals
- Promote specialist engagement beyond TEAM

ArdentHealth

One TEAM, Many Markets

Ardent's Enterprise Approach to TEAM

About Ardent Health




Founded in **2001**

30 Hospitals in **SIX** states

280 sites of care

24,000+ Team members

1,800+ providers

$5.96B net revenue

ArdentHealth

The last year at Ardent:

Caring for patients in the hospital and beyond

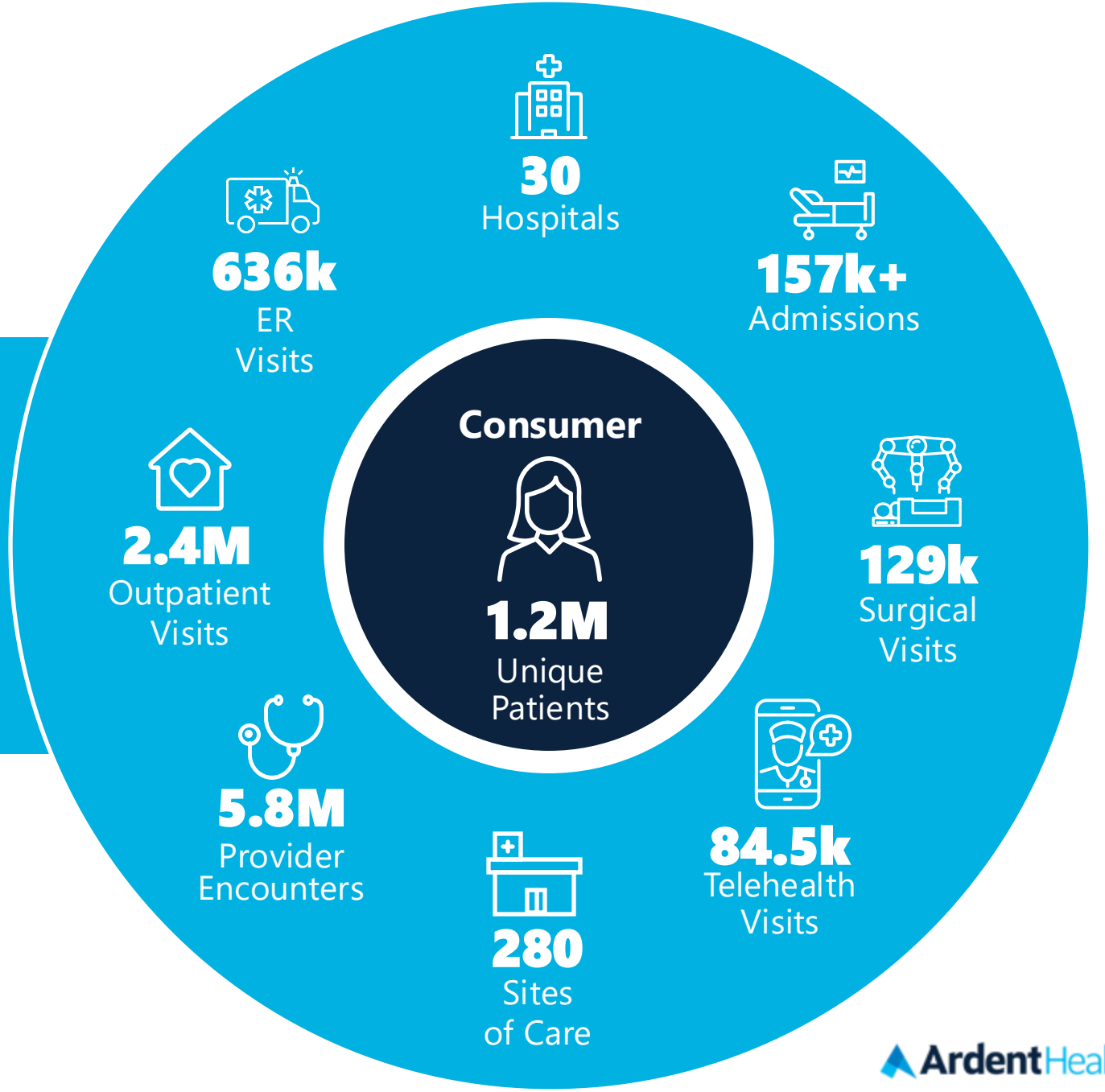
More than
15,000
lives touched
each day

Supported by...

24K+
Team Members

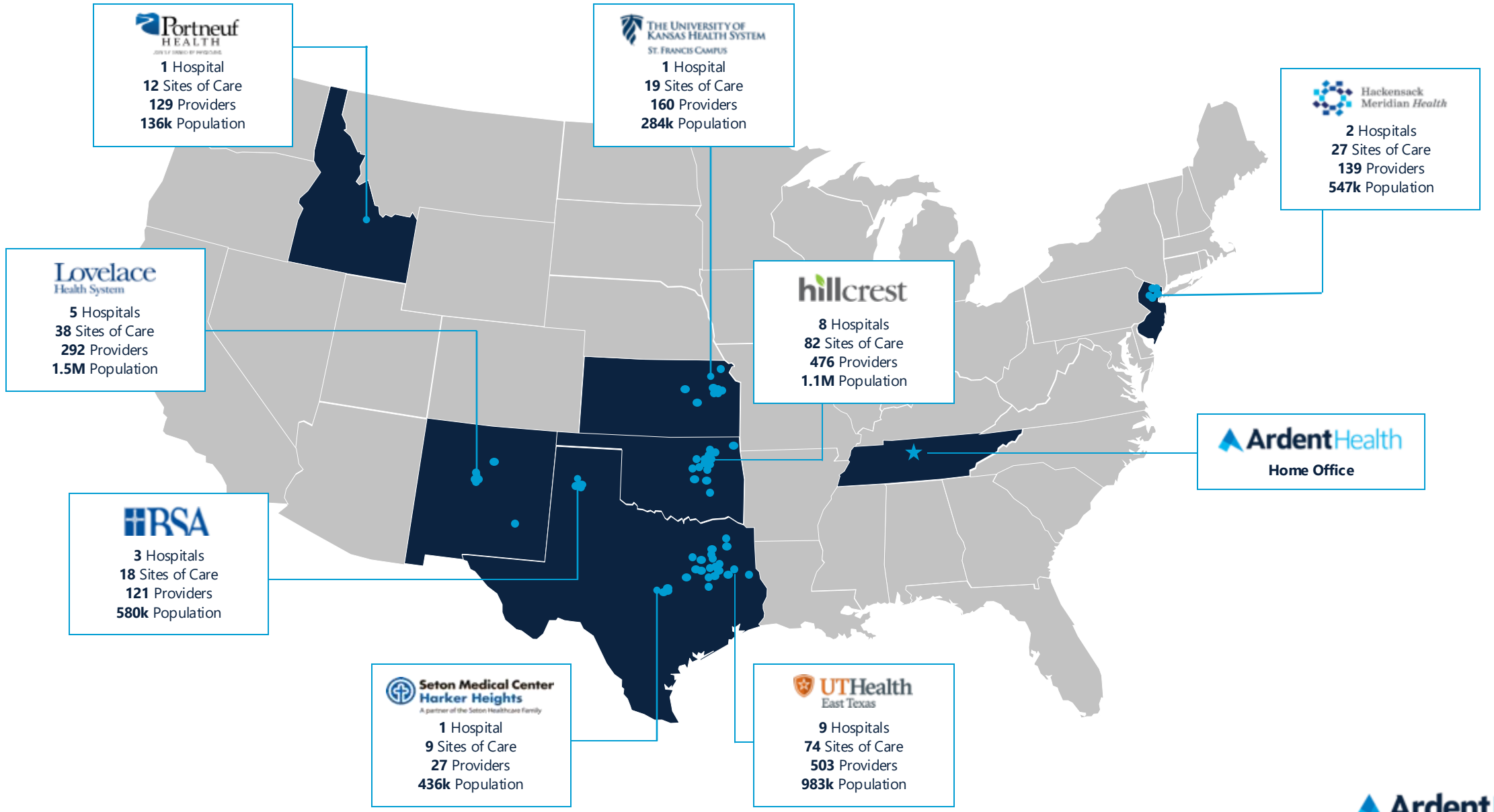
8,200+
Nurses

1,800+
Providers



ArdentHealth

The communities we serve



Portneuf Health
1 Hospital
12 Sites of Care
129 Providers
136k Population

The University of Kansas Health System St. Francis Campus
1 Hospital
19 Sites of Care
160 Providers
284k Population

Hackensack Meridian Health
2 Hospitals
27 Sites of Care
139 Providers
547k Population

Lovelace Health System
5 Hospitals
38 Sites of Care
292 Providers
1.5M Population

hillcrest
8 Hospitals
82 Sites of Care
476 Providers
1.1M Population

ArdentHealth
Home Office

RSA
3 Hospitals
18 Sites of Care
121 Providers
580k Population

Seton Medical Center Harker Heights
A partner of the Seton Healthcare Family
1 Hospital
9 Sites of Care
27 Providers
436k Population

UTHealth East Texas
9 Hospitals
74 Sites of Care
503 Providers
983k Population

ArdentHealth

CMS TEAM Implementation – Enterprise Strategy

Objective: Develop enterprise-wide implementation of CMS TEAM across 14 facilities in 4 states, ensuring scale, alignment, and sustainability.

Enterprise Alignment
Unified program, shared governance, standardized workflows, common goals.

Technology-Driven Execution
Leverage Epic, analytics, automation; scalable infrastructure for reporting & compliance.

Resource Efficiency
No new staff – optimize existing teams and workflows.

ACO & Network Strategy
Leverage ACO and post-acute networks to drive care coordination and manage costs.

By January 1, 2026, Ardent will:

- ❑ Achieve enterprise alignment across facilities and states
- ❑ Be technology-enabled for sustainability
- ❑ Operate resource-efficiently with no added staff
- ❑ Integrate TEAM with ACO/post-acute strategies for stronger VBC outcomes

Implementation Roadmap

Plan

Q1 2025

- Initial Planning & Roadmap Development
- Stakeholder Alignment
- Define strategic pillars: governance, workflows, technology, analytics, provider engagement
- Baseline Assessment: Market readiness reviews, gap identification

Build

Q2-Q3 2025

- Infrastructure Build: Compass Rose workflows, governance forums
- Operational Readiness: Provider engagement, training, technology integration

Launch

Q4 2025

- System testing & workflow validation
- Provider training & user adoption

Execute

Q1 2026

- Program Go-Live across markets
- Ongoing monitoring & compliance tracking

Strategic Pillars

ArdentHealth

Thank You.

Eloy Sena

AVP, Value Based Contracts and Operations

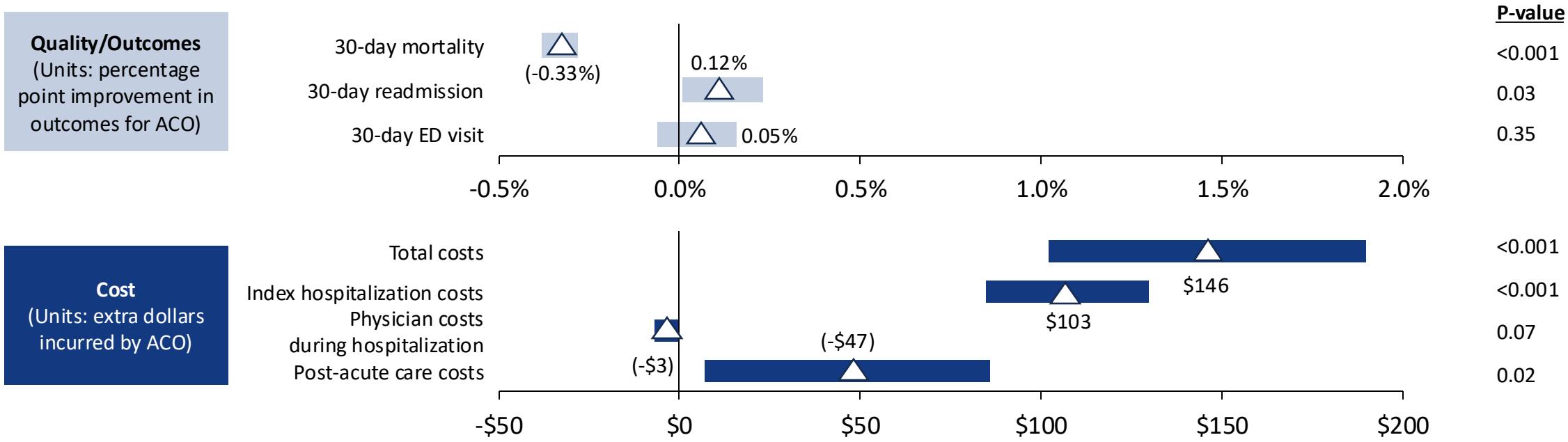
ArdentHealth

The Role of the Surgeon in TEAM

Thomas Tsai, MD, MPH, FACS
Medical Director for Health Policy Research | American College of Surgeons
Co-Director, Healthcare Quality and Outcomes Lab | Harvard University
Associate Professor of Surgery | Mass General Brigham | Harvard Medical School
Associate Professor in Health Policy | Harvard Chan School of Public Health

ACOs and TEAM: Aligning Incentives Could Improve Outcomes but Not Necessarily Savings

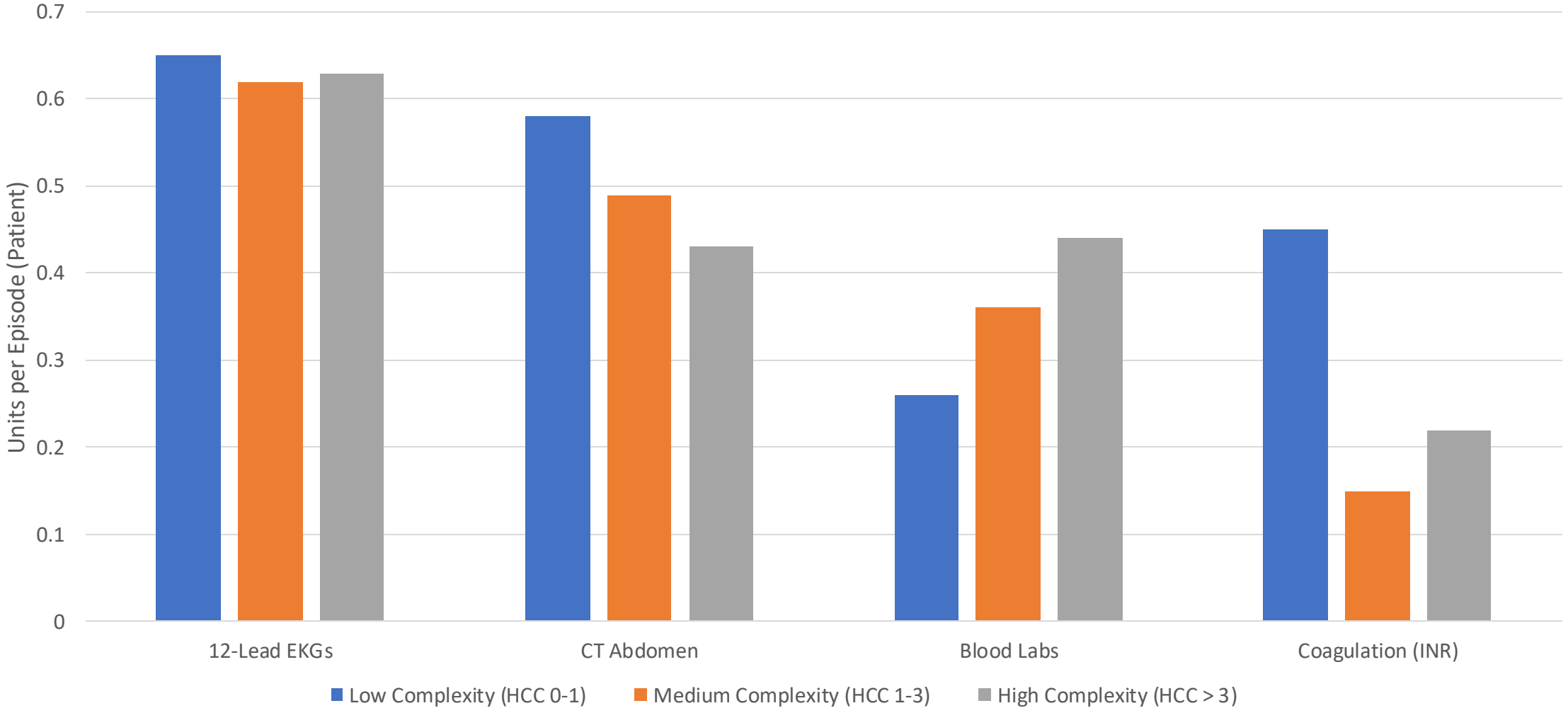
Risk-adjusted clinical and spending outcomes in TEAM surgical conditions by ACO assignment status, 2020-2023



Berlin N et al, *JAMA*, 2025

ACS AMERICAN COLLEGE OF SURGEONS

Diagnostic Services per Episode in the Post-Discharge Period for Colectomy Procedures, Boston Hospital Referral Region, 2012-2015



Perloff J et al (Coffron, Opelka), *Annals of Surgery*, 2023

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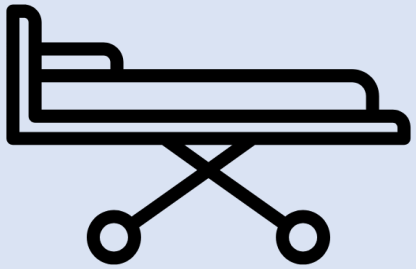
Enhanced Recovery

Savings
-$6,300



Length of Stay
-2.2 days

Major Adverse Events
-28%

Bond-Smith et al, *Cochrane Database Systematic Review*, 2016

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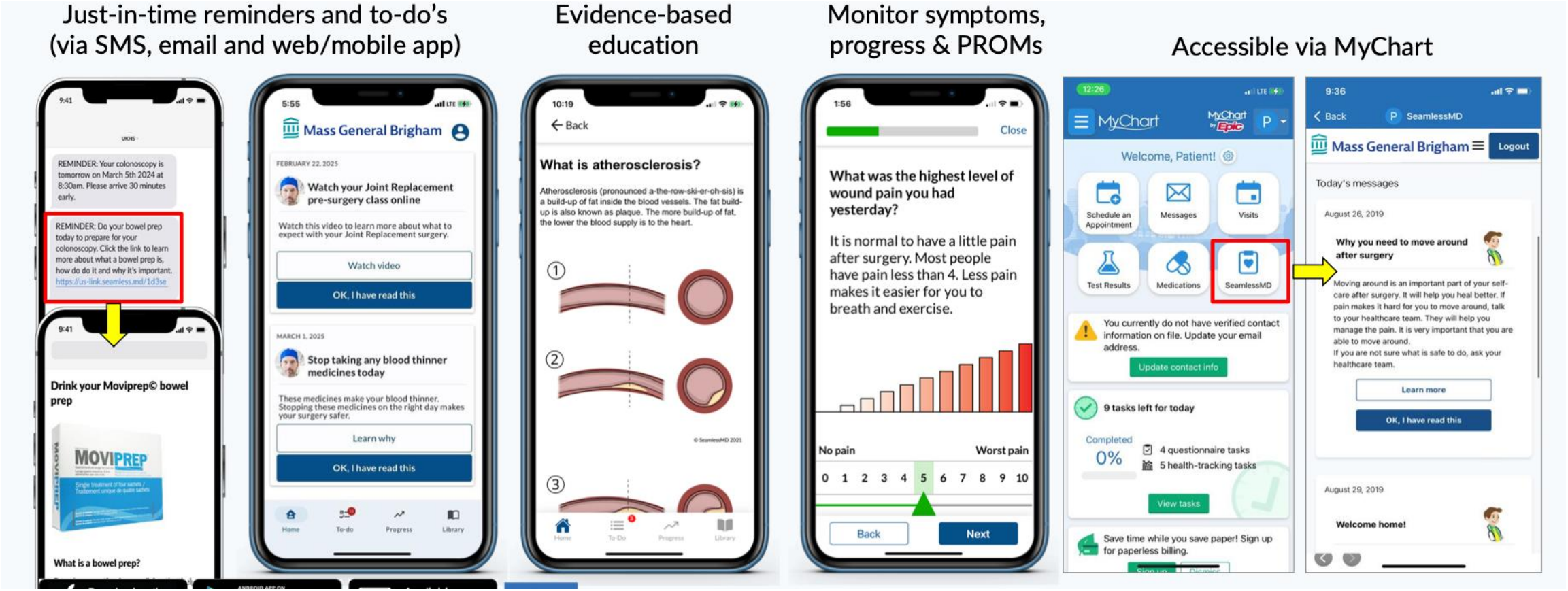
Digital Care Journeys: Streamline Not Complicate Patient Workflows and Experience



Reinvigorating Home Hospital Under TEAM?

Surgical Innovation

Surgical Innovation

Home Hospital for Surgery

Ava Ferguson Bryan, MD, AM; David M. Levine, MD, MPH, MA; Thomas C. Tsai, MD, MPH

What Is the Innovation?

In November 2020, the US Centers for Medicare and Medicaid Services announced the Acute Hospital Care at Home waiver, an innovative payment and delivery system reform focused on the home hospital delivery model (HH). Home hospital delivers monitored at-home treatment that would otherwise require inpatient hospital admission.[1] This care can include nursing and paramedic support, daily clinician and therapist visits, point-of-care laboratory and imaging tests, and administration of IV medications. There is evidence that HH is safer, cheaper, and more effective than traditional inpatient care, particularly for older adults. Home hospital programs have been established as beneficial for a wide range of conditions and are widely used in the United Kingdom, Spain, and Australia. Home hospital for surgery is an emerging option for perioperative care, with uses including preoperative monitoring, postoperative care, and even operation at home. Early efforts for general surgery have focused on ileostomy dysfunction.[2] Routine postoperative care of patients undergoing orthopedic and bariatric surgery may be use cases for HH, and there is a burgeoning industry of private companies offering HH services. In the era of enhanced recovery after surgery (ERAS) and site-of-care optimization as a source of value in alternative payment models, HH is the next step in this progression toward patient-centered, value-based care. Home hospital also carries the potential to reduce surgical inequities by extending care to patients and geographic areas historically deprived

Table. Components of a Surgical Home Hospital Pathway

Phase of care	Components	Quality metrics
Pre-operative	Preoperative home safety evaluation. Surgical prehabilitation and biometric assessment. Multimodal pain and postoperative nausea and vomiting premedication and management. Medication management (eg, anticoagulation).	Adherence to prehabilitation regimen. Equity-focused metrics of access.
Operating room	Multimodal pain management.	Use of totally intravenous and opioid-free anesthesia.
PACU	Observation in PACU. Assessment of nausea and pain control.	Time until discharge to HH from PACU. Nausea and pain medication requirements.
Recovery	Daily visit by surgeon remotely and/or surgicalist/advanced practice clinician. Twice and as-needed visits by nursing or paramedicine, wound care, physical/occupational, and respiratory therapists. Point-of-care postoperative laboratory tests and imaging. Administration of intravenous fluids and medications. Continuous biometric monitoring.	Rate of complications. Rate of safety events, including falls. Escalation of care to inpatient hospitals. Failure to rescue/unanticipated mortality. Steps taken and time spent laying down.
Discharge	Discharge to normal postoperative follow-up.	30-d Postdischarge mortality and readmission. Patient experience.

Abbreviations: HH, home hospital; PACU, postanesthesia care unit.

Bryan AF and Tsai TC, *JAMA Surgery*, 2021

Surgical Home Hospital Outcomes

Escalation of Care

7% of patients required escalation of care during their stay.

Readmission Rate

Readmission rate of 7% rate comparable to brick-and-mortar care.

Average Length of Stay

Patients spent 3 fewer days in the hospital on average, saving 1553 bed days overall.

Ugarte, et al *Annals of Surgery*, 2024

Precision Surgery: Clinical Insights Should Drive Value-Based Care Insights

ACS NSQIP
National Surgical Quality Improvement Program
American College of Surgeons

Surgical Risk Calculator

ACS AMERICAN COLLEGE OF SURGEONS

Procedure: 44140 - Colectomy, partial; with anastomosis
Risk Factors: Age (65), Female, Mild systemic disease, Diabetes (Oral), HTN, BMI (33.28)

Note: Your Risk has been rounded to one decimal point.

Outcomes	Your Risk	Average Risk	Chance of Outcome
Serious Complication	10.5%	16.7%	Below Average
Any Complication	12.8%	18.8%	Below Average
Pneumonia	0.7%	2.4%	Below Average
Cardiac Complication	0.5%	1.3%	Below Average
Venous Thromboembolism	2.0%	2.4%	Below Average
Sepsis	2.9%	4.0%	Below Average
Surgical Site Infection	9.2%	9.8%	Average
Urinary Tract Infection	1.9%	1.5%	Above Average
Renal Failure	1.9%	2.7%	Below Average
Readmission	7.2%	9.5%	Below Average
Return to OR	3.8%	6.4%	Below Average
Death	0.3%	1.5%	Below Average
Discharge to Nursing or Rehab Facility	2.1%	5.7%	Below Average
Colectomy Ileus	9.4%	20.4%	Below Average
Colectomy Anastomotic Leak	2.7%	4.4%	Below Average

Predicted Length of Hospital Stay: 4.5 days

Clinical risk stratification and prediction can augment surgical judgment to identify opportunities to improve quality.

Potential use to identify patients who can have optimal recovery with outpatient vs inpatient surgery.

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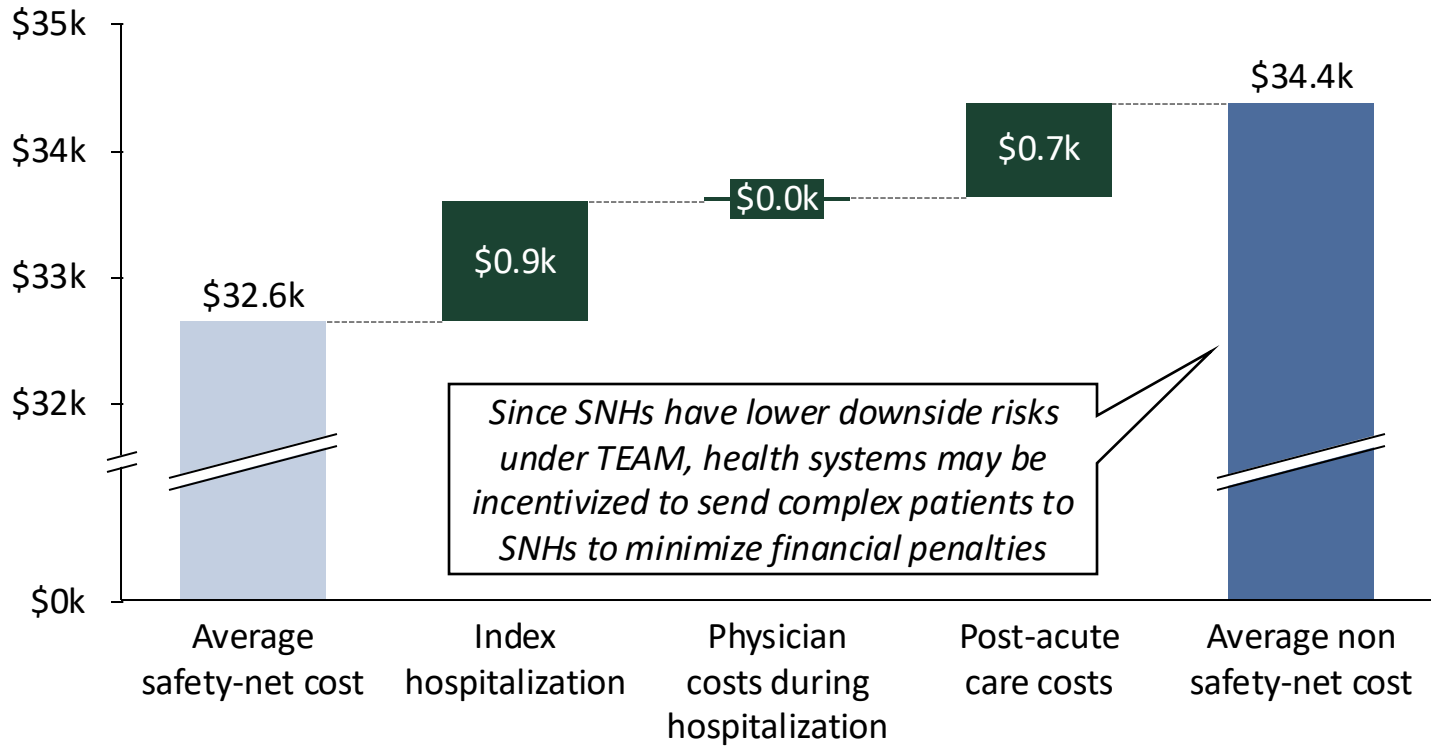
Minimizing Unintended Consequences: Safety Net Hospitals

Potential for Gaming Financial Tracks

1 in 3 surgical episodes under TEAM are performed at safety-net hospitals (SNHs). 2 in 3 healthcare systems under team own a SNH.

Because losses are capped at 5% for SNHs (compared to 20%), healthcare systems may be tempted to game the incentives by shifting high-cost, complex surgical episodes to SNHs.

Increase in average care episode costs for TEAM surgical procedure by non-safety-net hospitals (compared to safety-net hospitals), 2020-2023



Berlin N and Tsai TC (submitted under review)

What is the Role of the Surgeon in TEAM (and Value-Based Care)?

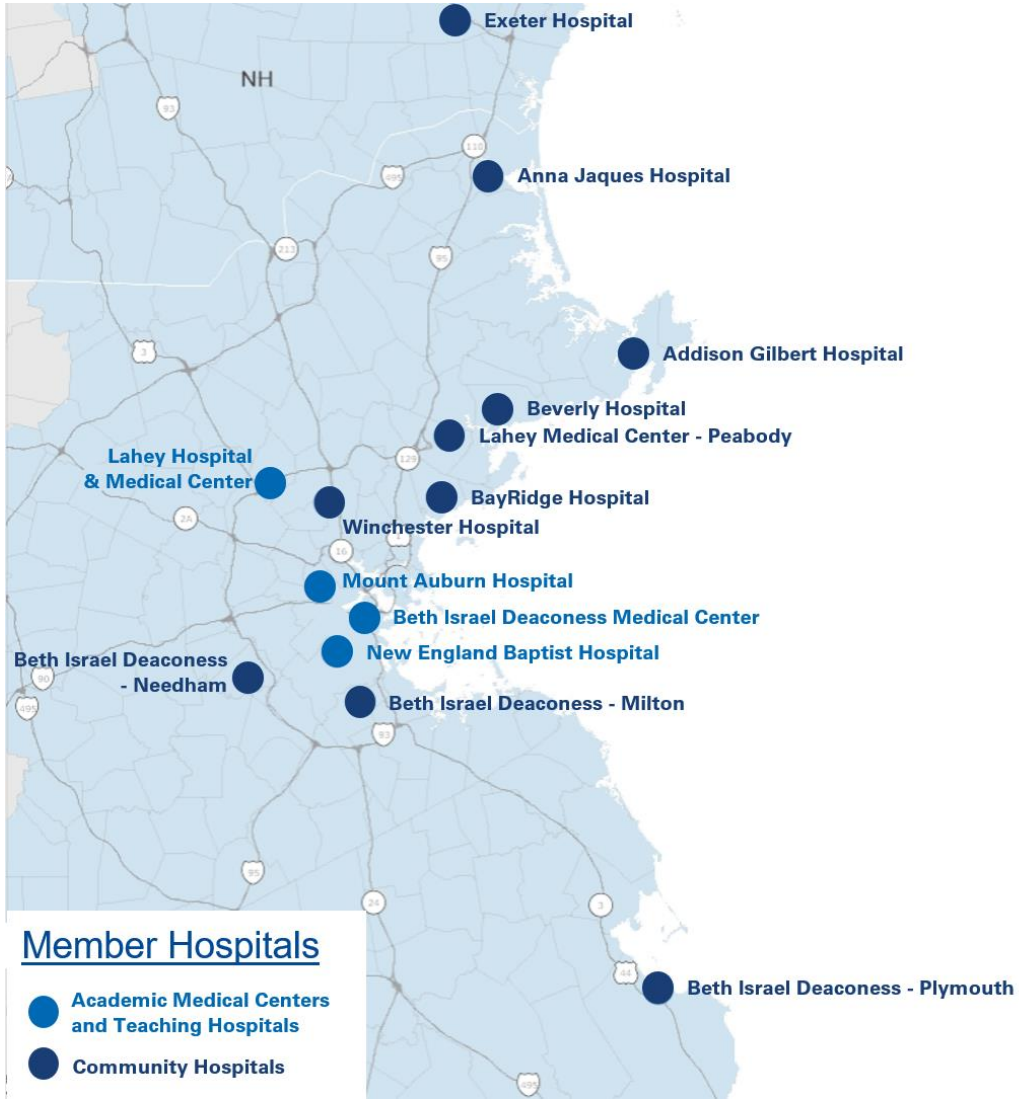
Innovate surgical delivery using evidence-based protocols, digital care journeys, virtual care/remote patient monitoring, precision surgery (risk prediction) to **achieve optimal outcomes for patients**.

Team Model Programming at BILH

Rob Fields, MD MHA
EVP, Chief Clinical Officer, BILH

NAACOs Fall Conference
October 2025

Beth Israel Lahey Health



A Coordinated System of Care

Beth Israel Lahey Health is a comprehensive, high-value system of care across Eastern Massachusetts and Southern New Hampshire. **BILH offers the full continuum of care**, from community and ambulatory care, and post-acute services to advanced tertiary/quaternary care. Our 5,900 physicians and 36,000 employees are committed to our shared purpose to **create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity.**

Together, as a coordinated system of care, we are doing more than we ever could alone. We are solving more problems. Helping more people. Making more breakthroughs. Making a difference.

System Overview
BILH by the Numbers

Beth Israel Lahey Health

1.7M Unique patients annually

39k Employees

$8.3B Operating Revenue

$163M Community Benefit Investment (FY23)

14 Hospitals

100+ Primary Care Locations

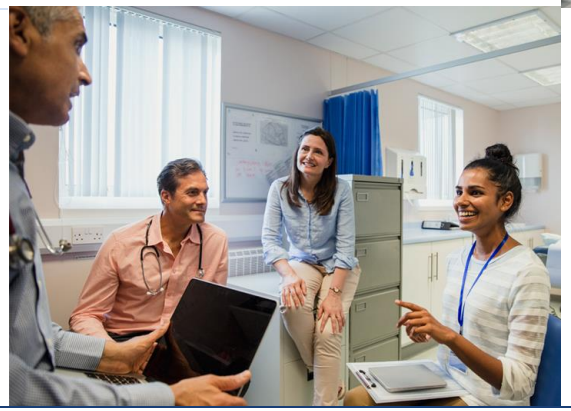
2,500+ Residents & Fellows

2,533 Inpatient Beds

4.1M Outpatient Encounters

1,100+ Medical Students

137k Annual Discharges



$320+ Million in Research Funding

111k Annual Surgeries

3,300+ Active Clinical Research Studies

Every variable in the sustainability function is negatively impacted by these trends.

$$f\left[\frac{(\text{revenue} - \text{cost}) * \text{capacity}}{\text{efficiency}}\right]$$

Example: Lahey Hospital and Medical Center

CMS TEAM Model Approach

Beth Israel Lahey Health

Prework and Preparation

- Webinars (2024)
- Vizient Collaborative (2025)
- Final Rule (2025)

Establishing the Baseline

- BILHPN Collaboration & IAC Data Review
- Divisional Assessments (each Episode + Care Transitions, Primary Care, Hospital Medicine, and Hospital at Home)

Setting up the Structure

- TEAMS Committee (Monthly)
- Targeted Education
- Integration of PY1 Measures in Org Quality Scorecard
- Epic Build

Outlined Strategy (PY1)

- Coding
  - HCC Capture
- Care Transitions
  - Mobility
  - HaH
- Clinical Quality Measures
  - Readmissions
  - THA/TKA PROPM
  - PSI90

Measure Performance

- Directional Trends (Vizient)
- CMS Data (IAC)

Thank You!