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Leadership in the Transforming Episode Accountability Model

Beginning January 1, 2026 the Centers for Medicare & Medicaid Services (CMS) will transition how many hospitals perform total joint arthroplasty in the United States. Depending on the core based statistical area you reside in, your hospital may transition from a fee for service model into an episodic bundled care or alternative payment model (APM). This will apply to all patients enrolled in Medicare part A and B with Medicare as the primary payer, but exclude those patients with Managed Medicare/Medicare Advantage or Medicare eligibility due to end-stage renal disease. The Transforming Episode Accountability Model (TEAM) program for total joint arthroplasty or lower extremity joint replacement (LEJR) will establish regionally based target prices for 30-day episode of care for LEJR performed electively, encompassing current procedural terminology (CPT) codes 27130, 27447, 27702 as well as MS DRG 469 and 470, and LEJR performed non-electively for femoral neck fractures to include MS DRG 521 and 522. Services bundled in the 30-day episode of care include physician fees, acute care stay fees (and hospital readmissions), post-acute care (home health, skilled nursing, inpatient rehabilitation, long-term care, hospice) and inpatient psychiatric facility fees. In addition, outpatient physical therapy, emergency department care, laboratory services, durable medical equipment (DME) and Medicare part B drugs and biologics we will be included in the 30-day target price ((CMS), 2024)

Target Price and Reconciliation Price Determination

The target price is the benchmark price determined for a region. In order to determine the target prices for a region, CMS examines historical Medicare DRG and CPT claims over a three-year period starting four years prior to the target year. CMS weights later years heavier, with the first baseline year weighted 17%, the second year 33% and the third year 50%. CMS then excludes 99th percentile regional spending and incentive program payments and applies a prospective normalization factor that works to standardize the risk adjustment of the target price at a national level. After considering these factors, CMS then discounts the calculated value by 2% to determine the target price.

The reconciliation price is the risk adjusted target price after taking into account hospital risk bonuses and/or penalties. Risk adjustment at the institutional level will take into account bed size and hospital safety net status. Risk adjustments at the beneficiary level will include age (broken up into 4 brackets < 65, 65-75, 75-85, >85), beneficiary economic risk (using the Community Deprivation Index) and Hierarchical Condition Category (HCC) count risk adjustment factor (beneficiaries with 0, 1, 2, 3, 4+ HCCs), found on a 180-day look back ending one day prior to the initiation of the bundle. Furthermore, episode category-specific risk adjustment will be taken into account utilizing episode specific factors as noted in the table below for LEJR. These factors/HCC codes will follow the same 180-day look back period and will act as an additional risk adjustment factor to the reconciliation price. (Centers for Medicare and Medicaid Services, 2025)

HCC	Description	Common ICD-10 Code Blocks*
17	Metastatic Cancer & Acute Leukemia	C78.00–C79.9, C77.0–C77.9, C92.00–C92.02
36	Diabetes with Severe Acute Complications	E10.10, E10.11, E11.10, E11.11

37	Diabetes with Chronic Complications	E10.21–E10.29, E10.31–E10.39, E10.40–E10.49, E11.21–E11.29, E11.31–E11.39, E11.40–E11.49, E10.51–E10.59, E11.51–E11.59, E10.65, E11.65, E10.69, E11.69, E10.8, E11.8
48	Morbid Obesity	E66.01, E66.2
125	Dementia, Severe	F03.91, F02.81
126	Dementia, Moderate	F03.90, G30.1, G31.1
127	Dementia, Mild or Unspecified	G30.0, G30.9
151	Schizophrenia	F20.0–F20.9
155	Major Depression, Moderate or Severe, without Psychosis	F32.1, F32.2, F33.1, F33.2
199	Parkinson's and Other Basal Ganglia Disorders	G20, G21.0–G21.9, G23.1
224	Acute on Chronic Heart Failure	I50.23, I50.33, I50.43
225	Acute Heart Failure (Excludes Chronic)	I50.21, I50.31, I50.41
226	Heart Failure, Except End-Stage and Acute	I50.22, I50.32, I50.9
238	Specified Heart Arrhythmias	I48.0–I48.92, I47.1, I49.01
253	Hemiplegia/Hemiparesis	G81.90–G81.94, G81.11–G81.14, G81.01–G81.04
267	DVT/PE	I82.4x, I82.6x, I26.0x–I26.99
280	COPD and Chronic Lung Disease	J44.0, J44.1, J44.9, J84.10–J84.89
326	CKD Stage 5	N18.5
327	CKD Stage 4	N18.4
383	Chronic Skin Ulcer (Not Pressure)	L97.101–L97.929
402	Hip Fracture/Dislocation	S72.001A–S72.92xA
Ankle procedure or reattachment, partial hip procedure, partial knee arthroplasty, total hip arthroplasty or hip resurfacing procedure, and total knee arthroplasty		
Dementia without complications		
Disability as the original reason for Medicare enrollment		
Prior post-acute care use		

* https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/risk-adjustment/2025-model-software/icd-10-mappings

At the completion of a program year, CMS will retrospectively reconcile the hospital's actual claims against the target price. This reconciliation process will happen six months after the program year to allow for late claims. Adjustments to the reconciliation amount are based on the institution's Composite Quality Score (CQS). Three quality measures will influence the final reconciliation amount.

These include the Hybrid Hospital-Wide All-Cause Measure with Claims and Electronic Health Record Data, the CMS Patient Safety and Adverse Events Composite, and for LEJR the Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient Reported Outcome-Based Performance Measure (PRO-PM). (Archives, 2024)

Participation in TEAM

Program participation will follow three tracks. Track one will be available to all participants with no downside risk and upside risk capped at 10%. After the first program year, all participants will transition to track 3 except for safety net hospitals that can remain in track one for the first three years. Track two is available for years two through five for hospitals that meet certain criteria as noted in the figure below. This track has a lower risk profile with upside and downside risk capped at 5%. Finally, track three is available to all programs in all five years, but has the highest upside and downside risk capped at 20%. CQS adjustments to positive and negative reconciliation amounts are included in all three tracks.

TRACK	TEAM PARTICIPANT ELIGIBILITY	FINANCIAL RISK
Track 1 Program year 1	All TEAM participants	● Upside risk only (10% stop-gain limit) ● CQS adjustment percentage of up to 10% for positive reconciliation amounts
Track 1 Program years 1-3	TEAM participants that are safety net hospitals	● Upside risk only (10% stop-gain limits) ● CQS adjustment percentage of up to 10% for positive reconciliation amounts
Track 2 Program years 2-5	TEAM participants that meet one of the following criteria: ● Safety net hospital ● Rural hospital ● Medicare dependent hospital ● Sole community hospital ● Essential access community hospital	● Upside and downside risk (5% stop-gain limit) ● CQS adjustment percentage of up to 10% for positive reconciliation amounts and up to 15% for negative reconciliation amounts
Track 3 Program years 1-5	All TEAM participants	● Upside and downside risk (20% stop-gain/stop-loss limit) ● CQS adjustment percentage of up to 10% for positive and negative reconciliation amounts

Convenors of the TEAM program will be limited to hospital systems and will not include private orthopaedic surgeons or groups. That said, it is still critical for orthopaedic surgeons to recognize their role as leaders in their healthcare system in order to ensure program participation success. Total joint arthroplasty as a subspecialty has a wealth of experience participating in APMs from Bundled Payment for Care Improvement (BPCI), Comprehensive Care for Joint Replacement (CJR) and Bundled Payment for Care Improvement Advanced (BPCI-Advanced) compared to other physician specialties. Lessons learned from our participation in these programs demonstrated that surgeon-led, multidisciplinary care had the greatest level of improvement in overall patient outcomes. Surgeon-led collaboration with hospital stakeholders demonstrated decreases in length of stay, increased proportion of discharge to

home, reduction in 90-day readmission rates and reduction in complication rates over the duration of the CJR program (Dennis Q. Chen, 2023).

The role of the surgeon-leader in the upcoming TEAM program will be similar to that of previous APMs. While orthopaedic surgeons' part B payments represent only 12% of the total reimbursement for LEJR, we control approximately 90% of the cost of care through clinical decision-making and orders (Iorio R, 2020). Surgeons are uniquely positioned at the nexus of clinical decision-making and orders to enact the most meaningful changes to patient care that will also have the greatest impact on cost of care.

It is important to distinguish that the TEAM program will not take into account direct and indirect costs of care, but actual claims made to CMS for care delivered during the 30-day episode. Direct costs of care are those incurred by a health care system for direct patient care. This includes such things as implants, non-implantable supply, labor costs, laboratory services, DME and medications. Indirect costs of care are those costs incurred by a health care system for services provided to support patient care. Examples include information technology support, health care administration and human resource benefits. Revenue generated by a health care system, minus both direct and indirect costs represent the contribution margin. While these concepts are important in successfully navigating TEAM, CMS is looking only at claims submitted for care delivered. As previously mentioned, at the end of a program year, those claims will be reconciled against the target price independent of actual cost of care. Those institutions that submitted claims below the target price will see an additional payment from CMS, whereas those institutions that submit claims above the target price may receive a financial penalty. The goal for health care systems will be to keep both claims and the costs of care below the target price.

Preparing for TEAM

Historically, physician led APMs have outperformed those led by hospitals (Sullivan & Feore, 2019), (Murphy, et al., 2019). As TEAM only allows hospitals to be the conveyors of the program, physician leadership in this APM requires collaboration with hospital administrators to maximize both financial and clinical success.

Clinical Pathways

Reducing claims for services starts prior to the anchor stay through effective presurgical optimization pathways. Physician led perioperative orthopaedic surgical home (POSH) clinics can provide multidisciplinary care to patients prior to surgery. Use of these clinics have shown to drive value by reducing length of stay, increasing home discharges, improving functional outcomes and reducing the cost of care (Chimento & Thomas, 2017) (Kim, et al., 2019). With the expansion of principal care management (PCM) codes by CMS in 2022 (Center for Medicare and Medicaid Services, 2022), non-face-to-face time performed by physicians, advanced practice providers (APPs), and clinical staff can be billed, providing a financial foundation to further develop POSH clinics. The new ability to bill for the time that clinical staff such as registered nurses (RNs), licensed practical nurses (LPNs) and medical assistants (MAs) spend performing patient care means that nurse run, physician developed care pathways can be leveraged to provide reimbursable preoperative optimization work while limiting opportunity cost of APPs and physicians being pulled away from higher reimbursed clinical work.

Standardization of evidence based clinical pathways during the hospitalization and post-acute care period can eliminate variations in care while improving outcomes, and reducing cost (Featherall, Brigati, Faour, Messner, & Higuera, 2018), (Ellis, et al., 2018). Standardization of pathways can also allow simultaneous system wide changes to protocols and can facilitate compliance tracking through order set usage. With the incorporation of arthroplasty for the treatment of femoral neck fractures through DRG

521 & 522, additional pathways need to be developed for the efficient treatment of femoral neck fractures. Standardization of such interventions such as fascia iliaca blocks, booking priority of <24 hours for the operating room, consensus with hospitalist and anesthesia services on hard stops to surgery to avoid unnecessary preoperative tests, and specific criteria for home versus facility discharge are examples of ways to reduce length of stay, 30-readmission and spiraling post-acute care costs, while improving outcomes.

Operational Efficiency

Optimizing claims submitted to CMS will help hospitals participating in TEAM keep reconciliation prices below the regional target price. However, health care systems still need to maintain direct costs of care (as well as indirect costs) below the reimbursement provided by CMS for the LEJR bundle. Understanding every step along the patient journey at a granular level from preoperative preparation, acute care stay, and the 30-day post-acute care period will allow surgeon-leaders to identify unnecessary costs and improve operational efficiency. The easiest place a surgeon-leader can reduce direct costs of care is the operating room. Strategies include surgical instrument leaning, standardization of drape packs, and eliminating unnecessary non-implantable supply costs. The cost of processing a single reusable instrument for surgery can range from $0.59-$11.52 (Lonner, et al., 2021). The “leaning methodology” outlined by Al-Abbasi et al is an excellent approach to reducing overall tray burden by eliminating rarely used items and separating them into “accessory trays” that can be opened only on an as needed basis (Al Abbasi, Brennan, Ohly, & Gee, 2024). In addition to instrument leaning, non-implantable supply can be reduced with the same leaning methodology applied to surgical drapes. Standardizing drape packs across surgical procedures instead of surgeons can streamline purchasing and supply storage, as well as providing an opportunity to reduce waste and turnover time in the operating room. Once the optimal drape pack contents are decided, surgical teams should also decide on the most efficient architecture of the pack to facilitate faster instrument table setup. Beyond processing and setup, non-implantable supply costs can be significant for total joint arthroplasty cases. Bipolar electrosurgical devices may make surgical approaches for hip replacements easier, but come at a substantial cost and are often unnecessary. Surgical gown choice is a controversial topic amongst surgeons, but evidence for selection of one type over another is often based on intraoperative culture results as a proxy for infection and not on actual infection rates (Konopitski, 2024). The cost difference between different styles of helmeted and non-helmeted gowns can range substantially, with helmetless gowns costing around $10 and Toga style gowns costing around $75 per gown. Even saw blade selection can save $20-$30 per case.

Beyond the operating room, it is also important to limit non-critical consultations or procedures during the episode of care. These include such things as routine femoral head pathology and preoperative nerve blocks. Historically bone specimens taken during total joint arthroplasty have been routinely sent for histopathologic examination order to screen for possible malignancy. These consultations can result in a claim to CMS of around $75.98-$97.54 (Services, 2025) per specimen and are controversial in their effectiveness as a screening tool when applied to hips and knees replaced for primary or post-traumatic osteoarthritis (Moschetti, Schilling, & Jevsevar, 2022). Eliminating routine pathologic specimens for all total joint arthroplasty cases and reserving it only for arthroplasty performed in the setting of fracture or avascular necrosis could reduce unnecessary claims and costs of care while maintaining quality. Nerve blocks have been identified as effective components of a multimodal pain pathway for total joint arthroplasty (Fillingham, Regional Nerve Blocks in Primary Total Hip Arthroplasty: The Clinical Practice Guidelines of the American Association of Hip and Knee Surgeons, American Society of Regional Anesthesia and Pain Medicine, American Academy of Orthopaedic Surgeons, Hip Society, 2022; Fillingham, Regional Nerve Blocks in Primary Total Knee Arthroplasty: The Clinical Practice Guidelines of

the American Association of Hip and Knee Surgeons, American Society of Regional Anesthesia and Pain Medicine, American Academy of Orthopaedic Surgeons, Hip Society, 2022). However, not all blocks are equivalent in their effectiveness and can represent a substantial cost to the episode of care. Specific to total knee arthroplasty, CPT has separate billable codes for adductor canal, IPACK and genicular nerve blocks. The CMS physician fee schedule for these blocks amount to between $61.54 – $212.52 depending on which blocks are billed (Services, 2025). These blocks are also associated with a facility charge through the CMS outpatient prospective payment system (OPPS) that can range between approximately $600 -$1200 per episode of care.

Clinical Documentation Initiatives

While most clinical pathways and operational efficiency initiatives are designed to reduce cost of care and/or claims delivered to CMS, clinical documentation initiatives are the only effective way to drive increases in reimbursement by improving the reconciliation price for an episode of care. Effective documentation starts prior to the admission through collaboration with primary care providers (PCPs) in your network. Orthopaedic surgeons only see a patient needing LEJR procedures during a brief window of their healthcare lifetime. This provides a very limited opportunity to document HCC codes into patient's charts, such as during a preoperative surgical appointment or during a preoperative admission testing visit. PCPs have a significantly greater amount of time to diagnose and document specific medical comorbid conditions that will ultimately influence the reconciliation price. Collaboration with the PCP networks, optimizing the use of preoperative appointments to incorporate HCC code hygiene into their workflow, and leveraging information technology (IT) teams to make documentation easier can help improve preoperative HCC documentation in electronic medical records. This will ultimately increase the number of patients with higher-level HCC count risk adjustment factors as well as greater number of episode category specific HCC codes, driving a higher reconciliation price.

Implementation

As previously mentioned, surgeon-led initiatives historically demonstrate better outcomes compared to those led by hospital administrators. Leadership for these initiatives should be driven by a medical director, division chief or department chairperson, but have to be supported through surgical group consensus. Consensus driven changes where collaboration between department faculty and agreement on how to proceed with both clinical and operational changes to care have a greater chance of being successfully enacted by administrators than if just driven by a single surgeon-leader. Beyond a core group of surgical faculty that helps develop evidence based and fiduciary initiatives, individual surgeon participation in committee appointments ensures a seat at the table where many care delivery decisions are made.

Summary

TEAM represents a significant shift in how CMS reimburses hospitals for LEJR, moving from a fee-for-service model to an APM that demands both clinical and operational efficiency. While hospitals are the official conveyors of TEAM, surgeon leadership will ultimately determine program success. Orthopaedic surgeons, through their ability to influence clinical decision-making, standardize care pathways, reduce unnecessary costs, and strengthen documentation practices, hold the leverage to align patient outcomes with financial sustainability. Through collaboration with hospital administrators, surgeon-leaders can position themselves and their institutions to not only to thrive under TEAM but also to deliver higher quality care. With TEAM, CMS has made it clear that the future in care delivery will require deliberate leadership, multidisciplinary collaboration and a commitment to evidence-based practice.

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