

Providers: Collaborate or Lose Under TEAM Risk-Based Payment for Specialty Procedures

written by Theresa Hush | August 15, 2025



Surgery will be a financial winner or loser under TEAM (Transforming Episode Accountability Model), a mandatory episodic payment model beginning in January 2026. Let's be clear: TEAM requires a tectonic plate shift in managing cost and outcomes of surgical procedures for five types of procedures. To be on the winning side of this model, your hospital and physicians must prepare now to manage patients undergoing certain high-cost surgeries, defined by *episodes starting from surgery to 30 days afterwards*. Cost management will require collaboration between the hospital, specialists, primary care physicians, and post-surgical providers.

A large model, with 743 hospitals currently involved and that covers high profile procedures (CABG, upper and lower extremity joint replacements, spinal fusion, femur fracture reduction, and major bowel surgeries), TEAM will likely thrust hospitals

and practices into the spotlight for performance, good or bad. You do not want to be on the losing end of TEAM.

TEAM Facts and Context

CMS will pay the five types of high-cost surgical procedures under a model that estimates a target cost. While all providers get payments under the normal fee-for-service system, hospitals under the target cost get a payback, while those whose costs exceed the target must pay back CMS. Since TEAM is the first episodic payment model that involves both hospitals (the key “participants”) and physicians (“collaborators”) who treat a Medicare patient in a TEAM episode at the participating hospital, the total costs will include everything:

- Facility costs, including the operating room and other units;
- Specialty physicians and associated costs;
- Anesthesia;
- Medications;
- Related care that occurs within the 30 days after surgery—rehabilitation or skilled nursing, equipment, home services, and costs of treating post-surgical complications.

However, hospitals are specifically targeted for risk-based reimbursement, and they must take action to hold physicians and other providers accountable for their care under collaborative arrangements, as allowed under TEAM. There are many cost-spurring variables in procedures, especially the five types in TEAM. Patients have a variety of risks going into surgery that

need special attention. Surgeons have different surgical approaches, techniques, equipment or preferred prostheses, or even volumes of surgery, all of which generate cost variations. Surgical complications—which can occur during or after surgery—raise the cost. Anesthesia varies between types and may complicate outcomes. Time itself is a factor; the hospital operating room (OR) now costs an average of \$46 per minute. Each variation to the norm runs up the cost, driven by each and every participant in the process

The complexity of costs under procedures is why the optimal arrangement for TEAM providers is to create a collaboration to align incentives and economics. And it pays to create that collaboration now, because after the one-year grace period in 2026, there is a downside financial risk for costs above the CMS target.

Every TEAM Stakeholder Needs Tools for Accountability

Up to now, facility and surgical team activities have been functioning on a semi-separate basis, with hospitals more focused on physical needs and scheduling to keep patients moving through the system in order to support physicians, and physicians calling most of the shots on what happens in the OR.

TEAM makes that untenable. Hospitals will be responsible for poor outcomes generated by physicians, or incorrect anesthesia, or after-care. Outcomes and costs are interconnected, and if

there are continued barriers to communication between stakeholders, there will be no improvement in cost performance or patient outcomes.

TEAM hospitals and physicians must structure their processes and platforms for evaluation of TEAM procedural episodes and reach agreement on major points of the patient's care process. Start now to avoid losing opportunities to make gains before risk payments hit just one year later.

Your platform for evaluating costs and moderating them in the future rests on data and an open, collaborative process. How can TEAM hospitals implement such a platform and set of agreements? You can follow these six steps to create the tools needed for accountability.

1. Analyze history.

Adopt technology to replicate TEAM procedural episodes and use it to Identify historical costs, cost drivers, and quality issues in each case. All costs present in TEAM episodes should be in historical episodes. Patient EHR data and claims data should be integrated to ensure there is enough depth of clinical information for clinicians to analyze the historical events in light of new requirements. These episodes will boost your ability to avoid cost overruns.

2. Calculate cost variation for each procedure and attributable causes.

Just review of data alone can result in changes to improve clinical practice. But it is critically important for clinicians to understand what is behind variable costs. While

we expect that cases will differ, extreme cost variation might reveal lack of a good patient risk assessment, lengthy anesthesia, sub-optimal surgical approaches, or underlying complexity due to patient status and comorbidities, among other factors. You must collectively examine every part of the pre-surgical and surgical process for opportunities, with clinical teams involved in that discovery process. Clinician review and feedback of episode findings is essential.

3. Evaluate all complications and unexplained events, in particular.

With complications driving 20 percent of total episode cost increases, it is crucial to analyze what caused those issues in order to assess clinical quality and identify other factors driving costs. Episodes should report complications both during and after procedures to improve understanding of causes and how to mitigate them going forward.

4. Establish an improved pre-surgical process.

While some of the TEAM procedures will be scheduled emergently (e.g. femur fracture repair, CABG), the others potentially have wait-time to accomplish three tasks that can reduce complications and improve outcomes. These should all happen *prior to the day of surgery*:

Improve your patient risk assessment by including anesthesia and primary care for a full assessment of existing patient risks. This should include a visit with the anesthesiologist prior to surgery and discussion between the surgeon and anesthesiologist with the patient's primary care physician.

Begin patient strengthening therapy prior to joint replacements, if indicated, to improve patient pain and recovery after surgery.

Prepare patient for the post-surgical period, including set-up of physical therapy and rehabilitation, diet and nutrition regimen, home modification or equipment, and patient training prior to surgery.

5. Adjust or adopt clinical and patient process pathways for surgeries.

TEAM hospitals will undoubtedly want to standardize care in an effort to find economies and to reduce complications.

Negotiations around the use of specific prostheses, anesthesia, medications, surgical approaches or procedures are expected.

This is the time to agree on the use of robotics and AI as tools in specific surgeries or with specific proceduralists.

6. Establish interoperable communication of the episode in the hospital EHR to be shared with all providers involved, including primary care physicians, regardless of their affiliation or access to the hospital system at present.

Most likely, not all principals on the patient's team are in one organization or one system. Nevertheless, the hospital will need to ensure access to the patient's episode to everyone on the patient's team. Likewise, TEAM requires arrangements with primary care physicians, who also need to be included in this system, and later, with post-surgical providers

Now is the time to [aggregate data](#) and to look at your

experience and costs through replicated TEAM episodes. Don't settle for just making your first year of TEAM a practice year. Take the initiative in 2026 to test and document improvement. TEAM requires a major shift in who is involved in patient surgery, and your health system must be up to the task. Your sustainability will depend on it.

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Image: Jackalope West