Forvis Mazars, LLP

Navigating TEAM: Strategic Positioning for SNFs

June 4, 2026

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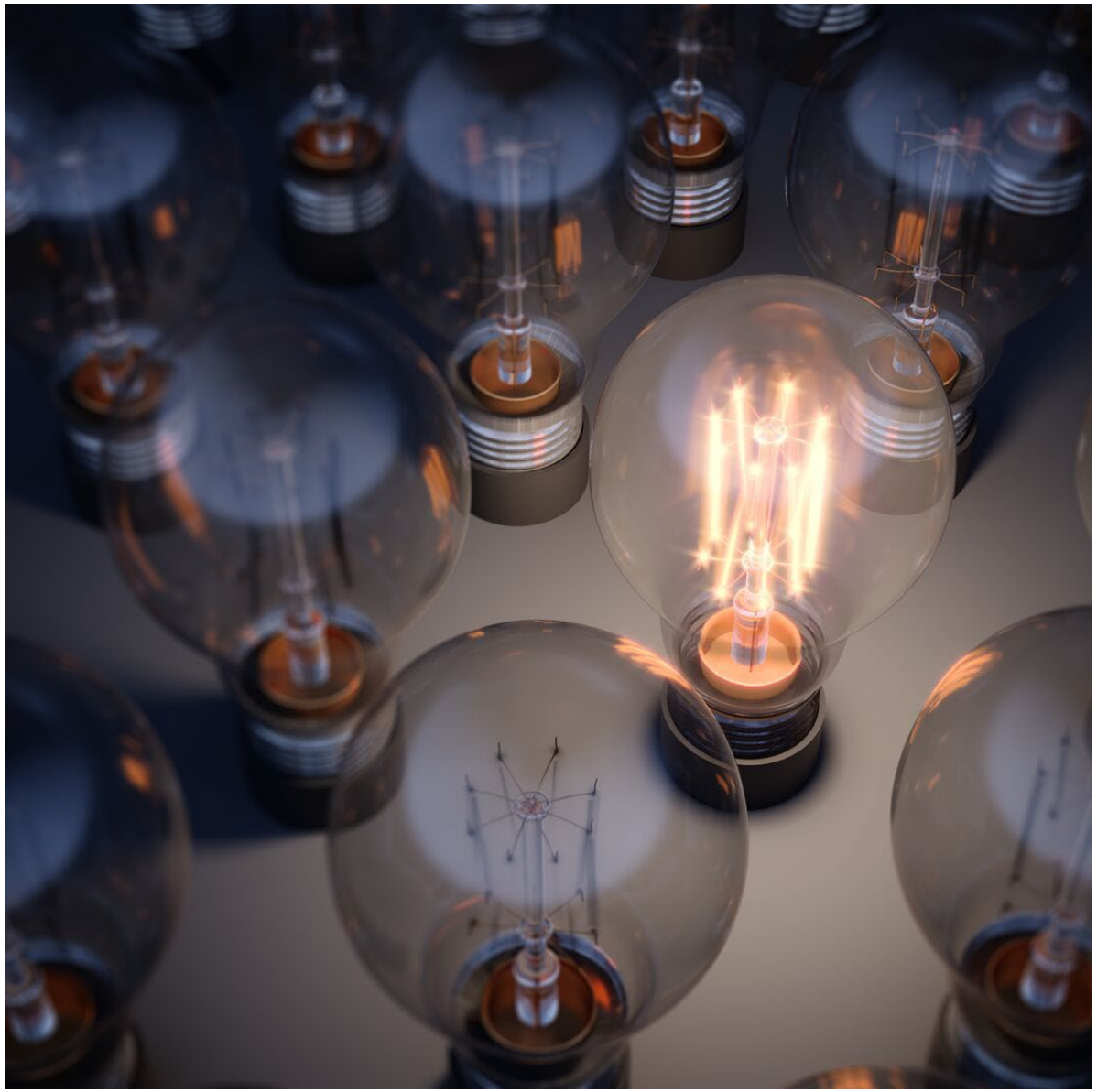
Agenda

1. Explore the value-based care landscape
2. Dig into the TEAM bundled payment model
3. Assess skilled nursing facilities' (SNFs) strategic positioning opportunities presented by TEAM



Navigating TEAM: Strategic Positioning for SNFs

Meet the Presenters

Walter Coleman, MBA

Director

Andy Page, CPA

Partner

David Taylor, CPA

Partner

Value-Based Care Landscape

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Value-Based Care

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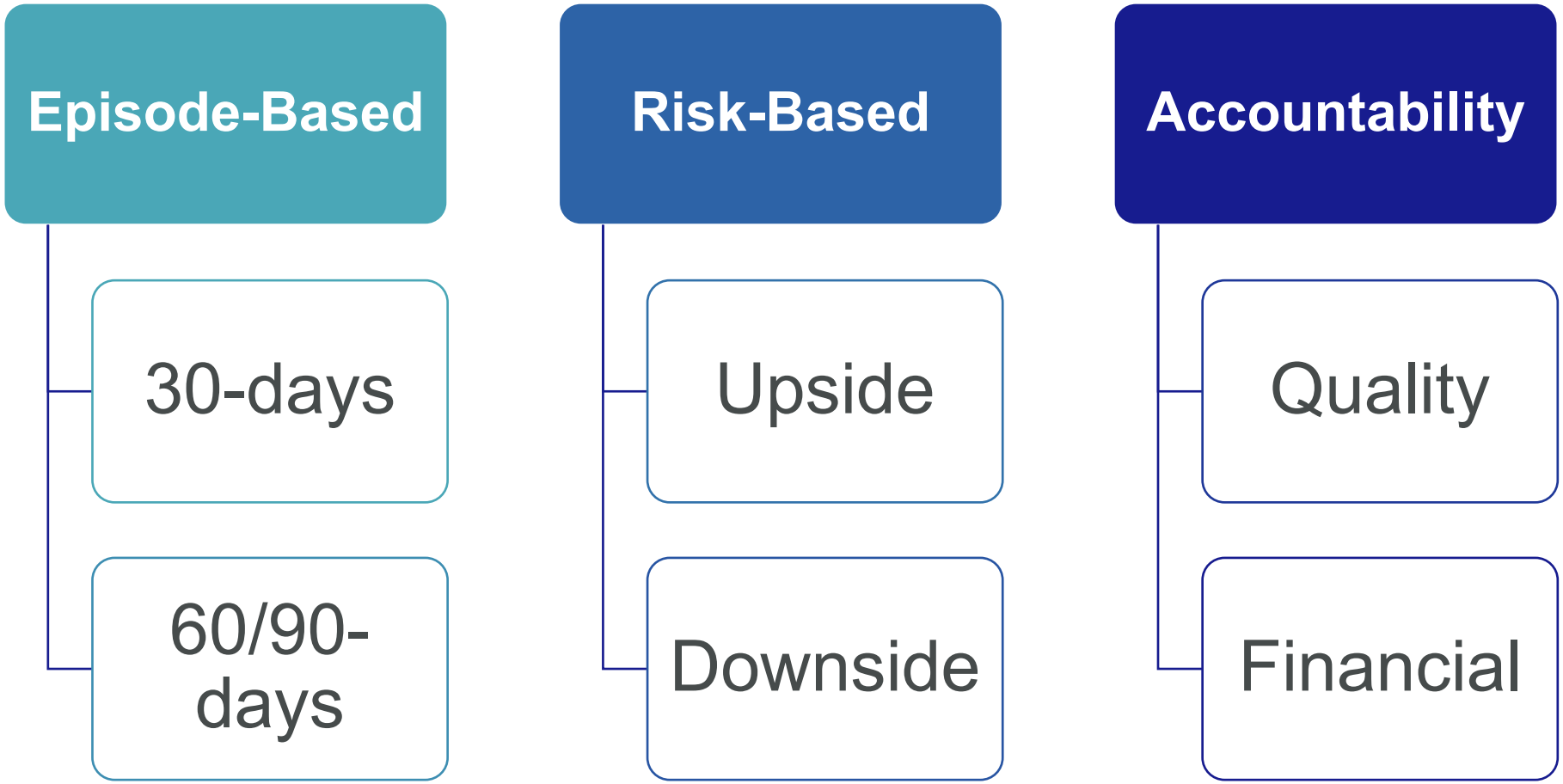
Value-Based Care | Common Model Elements



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Value-Based Care | Common Challenges

Balancing Priorities

Quality vs. Cost

Staying on Target

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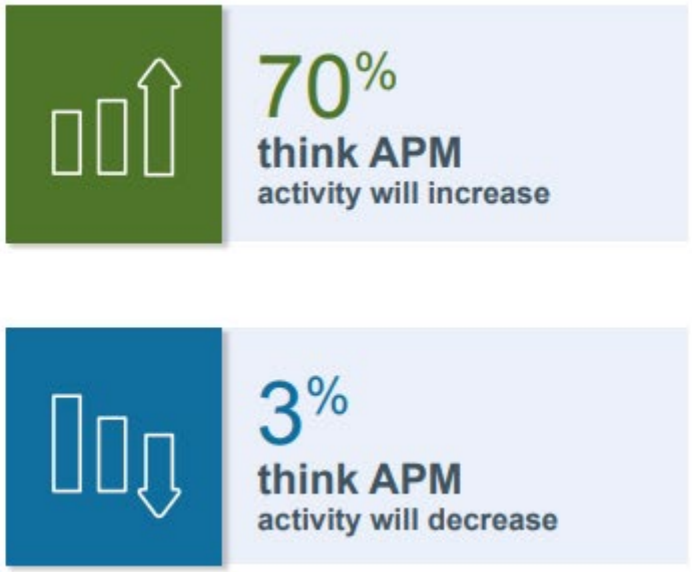
Value-Based Care | Payer Perspectives

Payers have higher expectations that Alternative Payment Model (APM) activity will increase compared to last year

WHAT DO PAYERS THINK ABOUT THE FUTURE OF APM ADOPTION?



Source: HCPLAN 2025 APM Measurement Effort

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Value-Based Care | CMS Innovation Center

Putting all patients at the center of care

The CMS Innovation Center works toward a vision of a health system that achieves optimal outcomes through high quality, affordable, person-centered care.

Innovation Models

Models test ways to achieve better care for patients, smarter spending, and healthier communities. Learn how to participate.

Find models

Where Innovation is Happening

Innovation Center models are implemented across the United States. Locate a participant.

Access map

Strategic Direction

Strategies guide the Innovation Center's efforts to drive our health care delivery system toward meaningful transformation.

Learn more

Source: CMS Innovation Center

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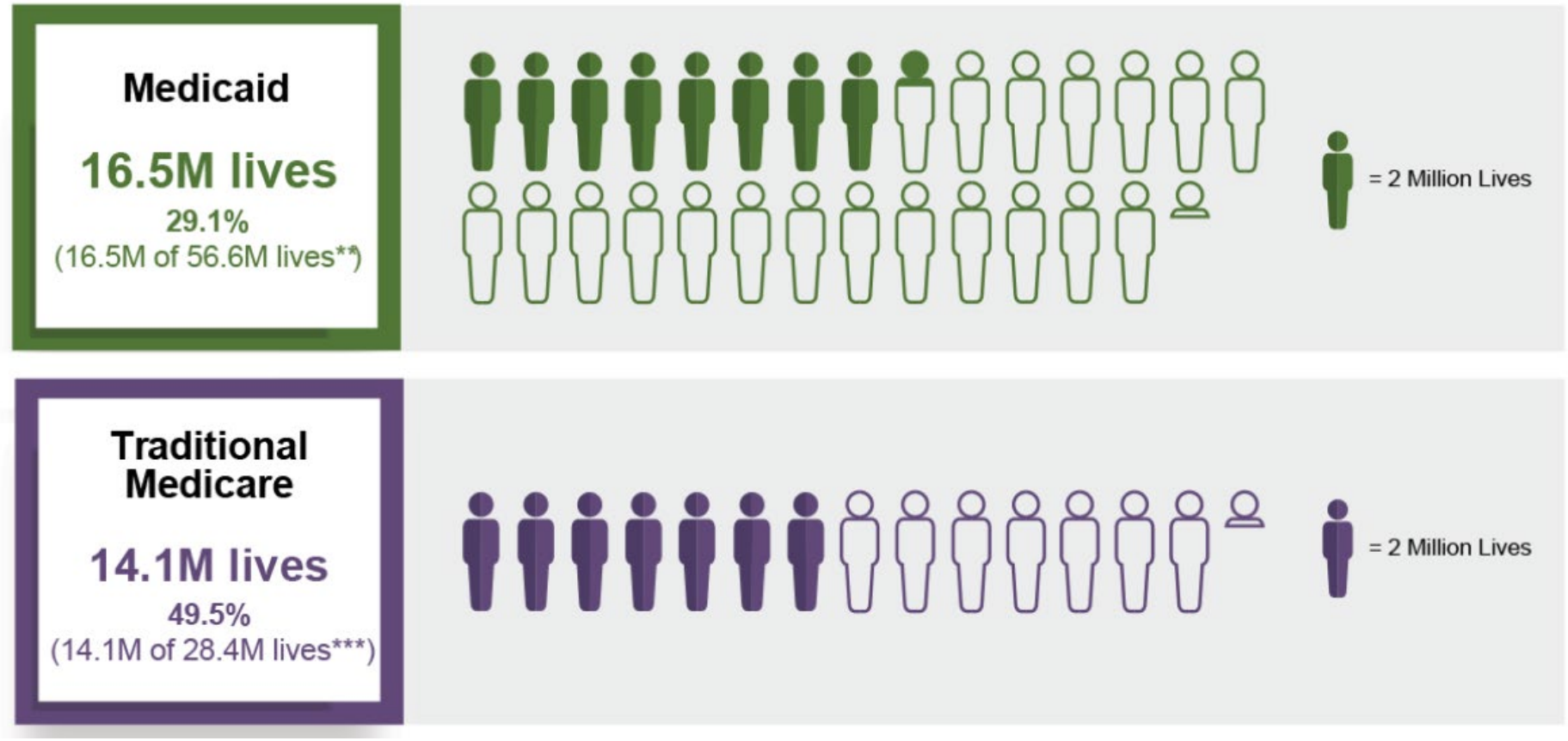
Value-Based Care | CMS Innovation Center

The CMS Innovation Center has set goals to have all Medicare beneficiaries, and the vast majority of Medicaid beneficiaries, in an accountable relationship by 2030.



Source: HCPLAN 2025 APM Measurement Effort

Where do SNFs fit in the value-based care landscape?

Transforming Episode Accountability Model (TEAM)

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TEAM Overview

Five-year mandatory bundled payment model

- Duration: 1/1/2026-12/31/2030
- **Medicare FFS Population Only**
- Selection based on geographic regions

Focus on surgical care

- Five inpatient/outpatient surgical episode groups selected
- Site-neutral target prices for Spinal Fusion and LEJR

30-day episodes

- Participants responsible for total cost of care for the inpatient stay/outpatient procedure plus 30 days post-discharge
- **Revenue cycle not disrupted**

Glide path to risk

- Upside only in year one
- 0% - 20% downside risk in subsequent years based on hospital type
- Gains/losses will be tied to quality performance

Relationship to other APMs

- Medicare ACO beneficiaries can trigger TEAM episodes
  - No recoupment between models

Key Model Requirements

- Notify beneficiaries of participation in TEAM
- Provide referral to primary care before discharge

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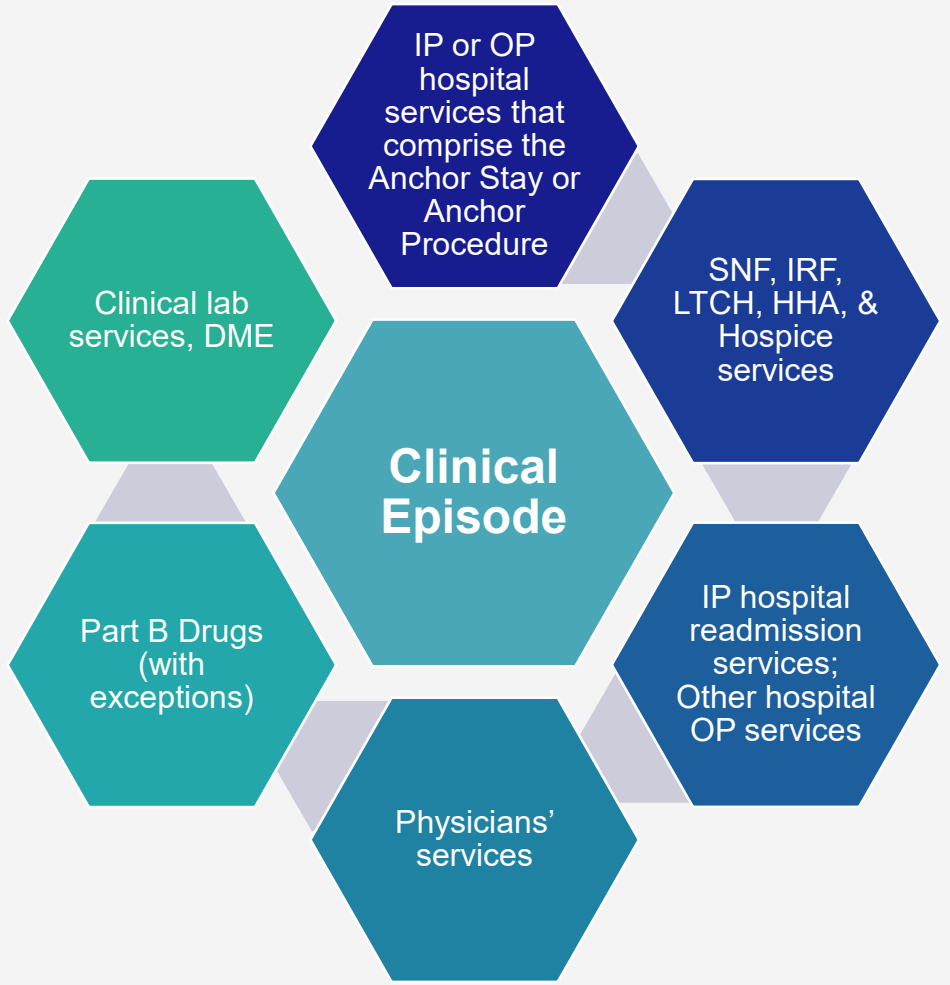
What is Included in an Episode of Care

- Total-cost-of-care for episodes during the initial hospitalization (or procedure for OP episodes)
- Almost all expenditures are included; there are some pre-determined exclusions
- Patients may receive services anywhere & all sites of care are included
- Services are prorated if they straddle episode end dates
- Revenue cycle is typically not disrupted



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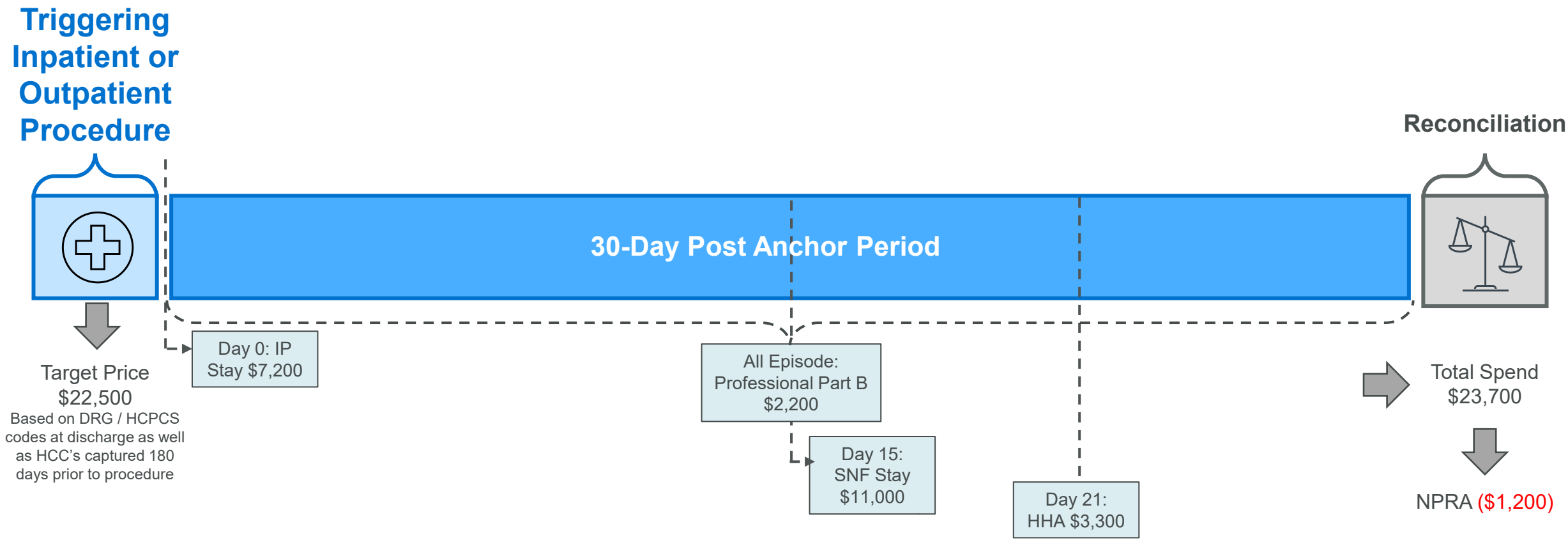
How a TEAM Episode of Care Works



- Reconciliation: Target Price – Spend = NPRA (Net Payment Reconciliation Amount)
  - $22,500 - $23,700 = **($1,200)**; therefore, for this specific Episode of Care, hospital owes **($1,200)**

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Episode Groups & Definitions

Episode Category	Billing Codes
Lower Extremity Joint Replacement (Inpatient & Outpatient)	MS-DRG 469, 470, 521, 522 HCPCS 27447, 27130, 27702
Surgical Hip & Femur Fracture Treatment (Inpatient)	MS-DRG 480, 481, 482
Coronary Artery Bypass Graft ("CABG") Surgery (Inpatient)	MS-DRG 231, 232, 233, 234, 235, 236
Spinal Fusion (Inpatient & Outpatient)	MS-DRG 402, 426, 427, 428, 429, 430, 447, 448, 450, 451, 471, 472, 473, **523, 524, 525 (beg. 10/1/26)** HCPCS 22551, 22554, 22612, 22630, 22633
Major Bowel Procedure (Inpatient)	MS-DRG 329, 330, 331

Episode Group	Avg. NPRA for SNF Discharges*
Lower Extremity Joint Replacement – Fracture	$1,916
Surgical Hip & Femur Fracture Treatment	$1,907

- **NPRA** = *N*et *P*ayment *R*econciliation *A*mount: Calculated as Target Price minus Total Episode Expenditures; if NPRA is positive, Participant is owed reconciliation payments from CMS and vice versa

*Denotes Avg. NPRA for a specific TEAM Participant

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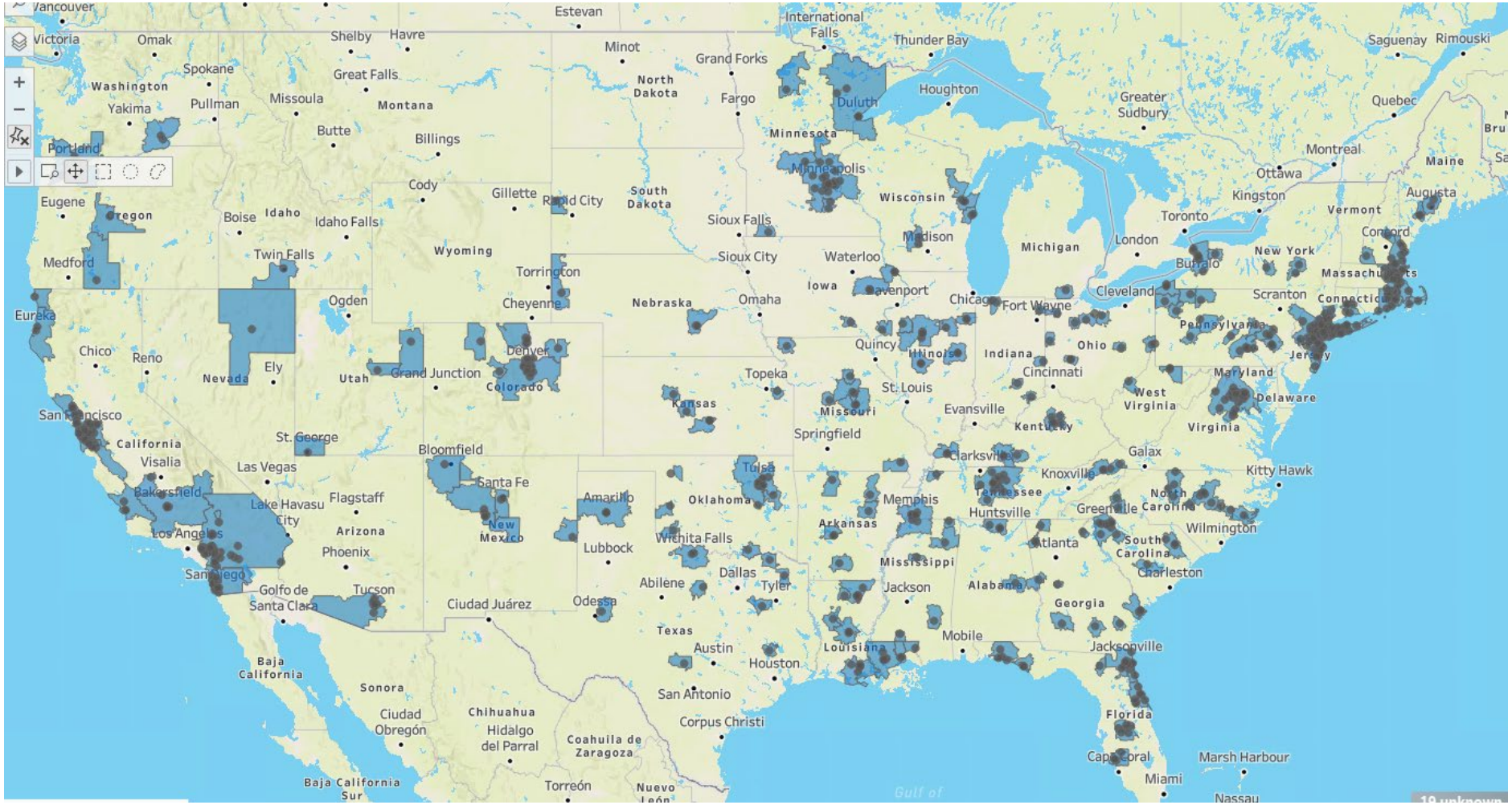
CBSAs Selected for TEAM



- CMS selected 188 of 803 eligible CBSAs for TEAM
- More than 700 hospitals with surgical episodes
- ~200K cases per year
- $481M Expected Savings

Source: https://www.cms.gov/team-model-participant-list

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CMS Episodic Models

	CJR	BPCI-A	TEAM
Model type	Mandatory	Voluntary	Mandatory
Episode length	90 days	90 days	30 days
Episode types	Surgical only (joint replacements)	Medical and surgical	Surgical only
Model Timeline	2016-2024	2018-2025	2026-2030
# of Current Participants	~325 hospitals	~263 hospitals	~734 hospitals
Model Outcomes	Reduced post-acute utilization with little impact on quality or mortality scores	Reduced readmissions and post-acute utilization with no significant change in quality scores	

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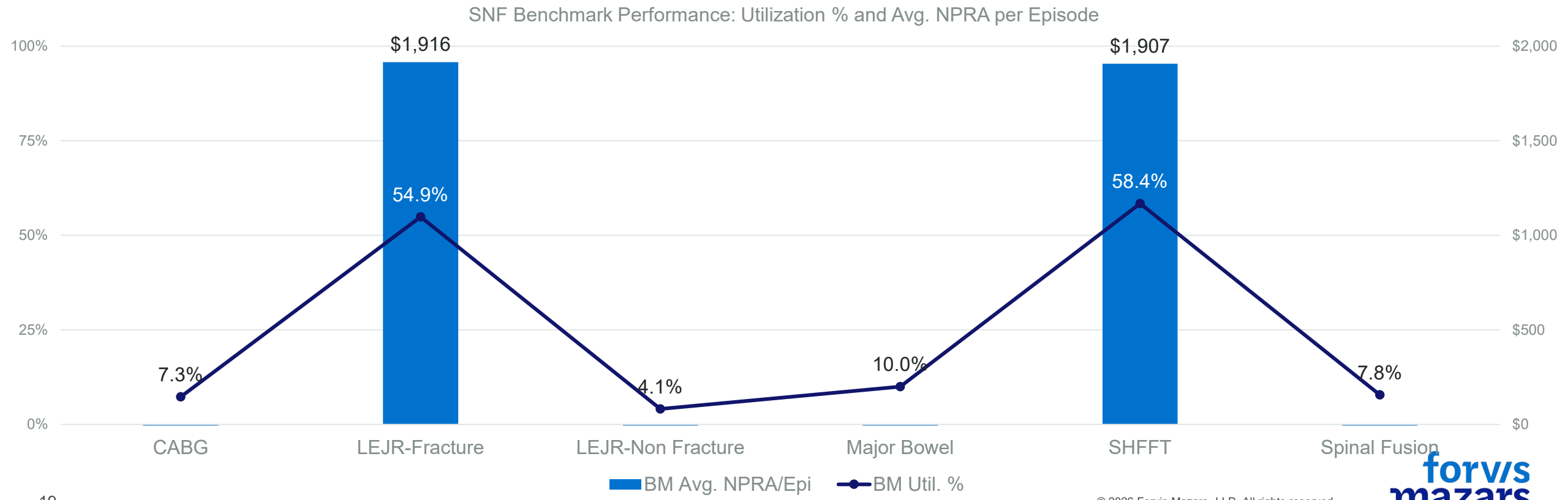
TEAM NPRA Performance by Discharge Destination

	CABG		Lower Extremity Joint Replacement-Fracture		Lower Extremity Joint Replacement-Non Fracture		Major Bowel		Surgical Hip & Femur Fracture Treatment Procedure		Spinal Fusion		TOTAL	
	Benchmark Utilization %	Benchmark NPRA/Episode	Benchmark Utilization %	Benchmark NPRA/Episode	Benchmark Utilization %	Benchmark NPRA/Episode	Benchmark Utilization %	Benchmark NPRA/Episode	Benchmark Utilization %	Benchmark NPRA/Episode	Benchmark Utilization %	Benchmark NPRA/Episode	**Benchmark Utilization %**	**Benchmark NPRA/Episode**
Home	42.1%	$5,104	10.3%	$13,746	63.6%	$1,971	63.6%	$3,695	10.4%	$13,751	63.7%	$4,835	**52.9%**	**$3,560**
HHA	42.1%	$6,601	14.4%	$14,023	30.6%	$658	21.0%	$3,818	11.5%	$13,884	18.6%	$3,483	**24.9%**	**$2,273**
SNF	7.3%	($7,241)	54.9%	$1,916	4.1%	($8,141)	10.0%	($7,198)	58.4%	$1,907	7.8%	($4,044)	**15.1%**	**($1,142)**
IRF	7.9%	($18,763)	15.9%	($9,177)	1.4%	($19,334)	3.0%	($19,629)	15.4%	($10,101)	9.3%	($17,293)	**5.9%**	**($14,115)**



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Key Takeaways for SNFs in TEAM

TEAM Participating Hospitals are looking to:

1. PAC Partners who currently have low readmission rates
2. PAC Partners who are conscious of readmission impact to TEAM and work to avoid them
3. PAC Partners who are willing to grow and expand their patient volumes and populations (take on higher acuity level of patients)
4. PAC Partners with open lines of communication and care coordination
5. PAC Partners that are not overprescribing care

50%

Lower Extremity Joints (nonfracture) is almost 50% of TEAM Episode Volume

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CJR-X | Comprehensive Care for Joint Replacement Expanded Fast Facts

CJR-X is a proposed mandatory, nationwide expansion of the original Comprehensive Care for Joint Replacement (CJR) Model.

Participants

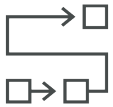
- All IPPS hospitals unless they are already participating in TEAM; Maryland hospitals also excluded
- TEAM participants will begin CJR-X in 2031

Episode Structure

- **90-day total cost of care episodes**, incl. Parts A and B
- Revenue cycle undisrupted

Patient Population

- Medicare FFS only
- Patients can overlap with other Models (i.e. MSSP)



Target Price Calculation

- Starting point for all targets is multistate regional history
- Significant adjustments for patient characteristics and acuity (age group, social risk, specific HCCs)

Risk Exposure

- Two-sided risk in all years for all participants
- ±20% risk for most hospitals (some may qualify for ±5% risk)

Quality Measures

- Five measures in three domains
- Poor quality scores could disqualify hospital from earning bonuses

Why Does CJR-X Matter?

CMS has indicated that more **mandatory alternative payment models with two-sided financial risk for providers is inevitable**.

Successful providers may be able to earn financial incentives; CJR-X also includes unique waivers and provider alignment opportunities.

Episodic strategies **support service line goals**, while also advancing other existing value-based and total-cost-of-care models like ACOs.

The Urgency of CJR-X

61%

Proportion of hospitals in 2023 that paid CMS a penalty for CJR

Oct 2027

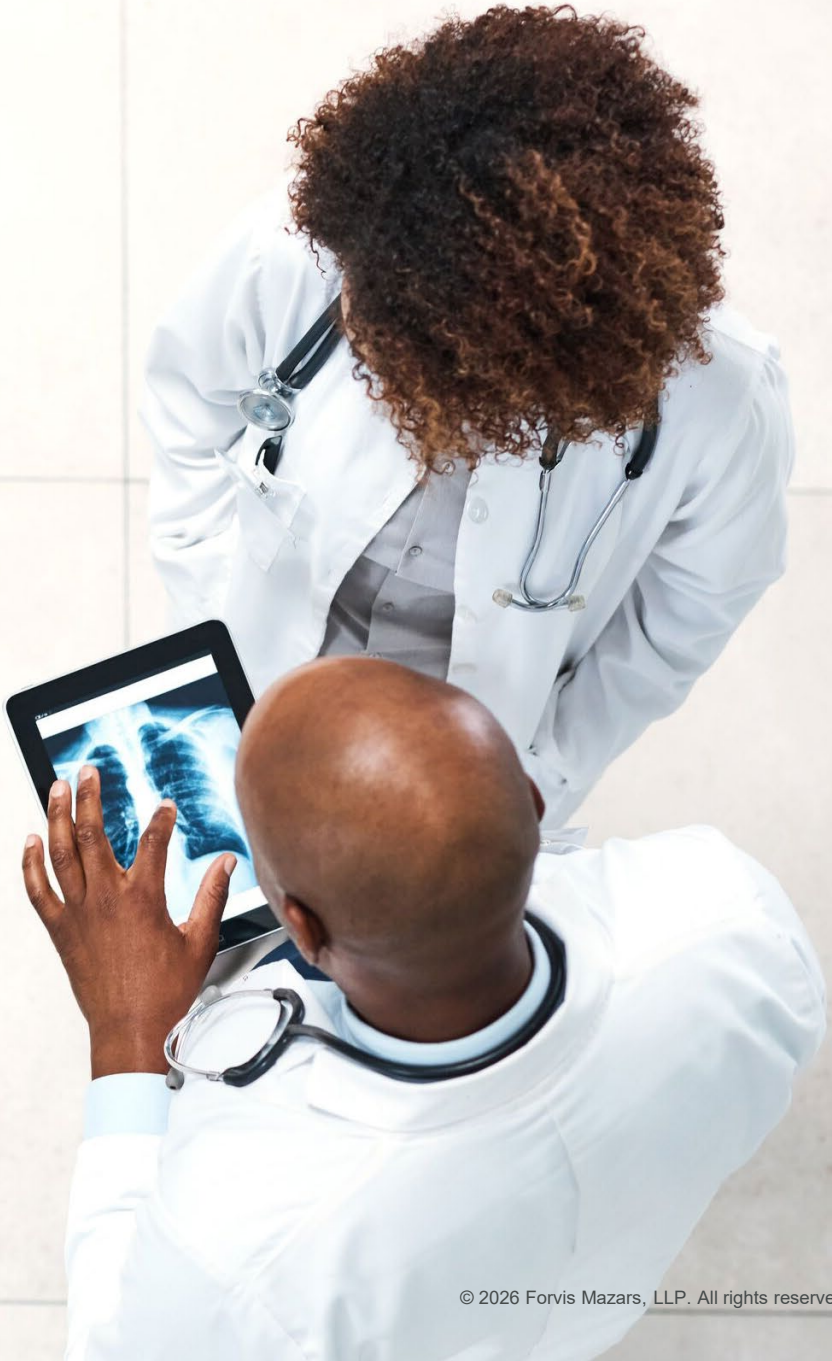
Model start date; deadline to have operational requirements in place

$725M

Projected Medicare savings, PY1–PY5

Two-Sided Risk

Starting year 1 for all participants



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CMS FY 2027 IPPS Proposed Rule

CJR-X vs TEAM

	TEAM	CJR-X
Overview	**30-day** post discharge total cost of care retrospective bundle	**90-day** post discharge total cost of care retrospective bundle
Episodes Included	LEJR, CABG, Spinal Fusion, Major Bowel	LEJR ONLY (Fractures & Non-Fractures)
Participants	Mandatory, in selected CBSAs ~770 hospitals	Mandatory nationwide for hospitals not in TEAM ~2,500 hospitals
Risk Caps	Three different risk tracks with stop loss of (5%, 10% or 20%)	20% for most hospitals with 5% for some protected participants
PY1 Risk	No downside PY 1 2026	Downside starts PY1 October 1, 2027
Quality Impact	Up to a 10% adjustment to reconciliation	Possibility to lose reconciliation if quality is low enough, also affects CMS discount factor

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SNF Positioning Strategies

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TEAM Provides Opportunity for SNFs

- Medicare Referrals – Billing requirements for SNF unchanged
- Opportunity for additional referrals with positive TEAM performance
- 5 Year Model – Current & Future positioning?
- Potential impact of not proactively partnering – referral loss

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Strategies for SNFs

- Assess the impact for your facility / facilities based on your service area on the 723 participating hospitals

Mandatory or Voluntary Participant	Hospital CCN	Hospital Name	CBSA	CBSA Name	CBSA State	Participation Start D	Participation End Da	Newly Iden Participant Previc
Mandatory	010039	HUNTSVILLE HOSPITAL	26620	Huntsville, AL	AL	01/01/2026	12/31/2030	
Mandatory	010052	LAKE MARTIN COMMUNITY HOSPITAL	10760	Alexander City, AL	AL	01/01/2026	12/31/2030	
Mandatory	010065	RUSSELL MEDICAL CENTER	10760	Alexander City, AL	AL	01/01/2026	12/31/2030	
Mandatory	010079	ATHENS LIMESTONE HOSPITAL	26620	Huntsville, AL	AL	01/01/2026	12/31/2030	
Mandatory	010131	CRESTWOOD MEDICAL CENTER	26620	Huntsville, AL	AL	01/01/2026	12/31/2030	
Mandatory	030006	TUCSON MEDICAL CENTER	46060	Tucson, AZ	AZ	01/01/2026	12/31/2030	
Mandatory	030010	ST. MARY'S HOSPITAL	46060	Tucson, AZ	AZ	01/01/2026	12/31/2030	
Mandatory	030011	ST JOSEPH'S HOSPITAL	46060	Tucson, AZ	AZ	01/01/2026	12/31/2030	
Mandatory	030064	BANNER - UNIVERSITY MEDICAL CENTER TUCSON CA	46060	Tucson, AZ	AZ	01/01/2026	12/31/2030	
Mandatory	030085	NORTHWEST MEDICAL CENTER	46060	Tucson, AZ	AZ	01/01/2026	12/31/2030	
Mandatory	030111	BANNER-UNIVERSITY MEDICAL CENTER SOUTH CAMP	46060	Tucson, AZ	AZ	01/01/2026	12/31/2030	
Mandatory	030114	ORO VALLEY HOSPITAL	46060	Tucson, AZ	AZ	01/01/2026	12/31/2030	
Mandatory	030148	NORTHWEST MEDICAL CENTER SAHUARITA	46060	Tucson, AZ	AZ	01/01/2026	12/31/2030	
Mandatory	040014	UNITY HEALTH WHITE COUNTY MEDICAL CENTER	42620	Searcy, AR	AR	01/01/2026	12/31/2030	
Mandatory	040017	NORTH ARKANSAS REGIONAL MEDICAL CENTER	25460	Harrison, AR	AR	01/01/2026	12/31/2030	
Mandatory	040026	CHI ST VINCENT HOSPITAL HOT SPRINGS	26300	Hot Springs, AR	AR	01/01/2026	12/31/2030	
Mandatory	040050	OUACHITA COUNTY MEDICAL CENTER	15780	Camden, AR	AR	01/01/2026	12/31/2030	
Mandatory	040078	NATIONAL PARK MEDICAL CENTER	26300	Hot Springs, AR	AR	01/01/2026	12/31/2030	
Mandatory	040119	WHITE RIVER MEDICAL CENTER	13900	Batesville, AR	AR	01/01/2026	12/31/2030	

Source: https://www.cms.gov/team-model-participant-list

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Assess the Opportunity or Potential Impact

Referral Evaluation Based on TEAM Triggering Surgeries

- Are you getting those types of referrals today?
- How many are you getting?
- Where are you getting them from?
  - What other types of referrals are you getting from the same acute setting? Potential to leverage other referrals to participate in TEAM or other VBC initiatives

What type of publicly reported outcomes does your agency currently have and what is your proactive strategy to improve?

- STAR Ratings
- Potentially Preventable Hospitalizations/Readmissions
- Medicare Spending Per Beneficiary
- Value Based Purchasing performance

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TEAM Participant PAC Network – May be an option

How can post-acute care (PAC) providers become part of a TEAM participant's PAC network?

TEAM's financial incentives are designed to incentivize innovative care delivery methods that focus on improving care and reducing Medicare spending. CMS anticipates TEAM participants and PAC providers, such as skilled nursing facilities and home health agencies, to form partnerships that share financial risk and collaborate on care design strategies. When TEAM participants complete their DSA and DRA forms, CMS provides them with hospital-specific and regional aggregate data. TEAM participants can use this data to guide decision making about PAC providers for TEAM.

TEAM participants may use data and resources to create financial arrangements with TEAM collaborators, such as physicians, PAC providers, and other clinical care providers, to ensure the best quality of care in a cost-effective manner. Depending on the terms of the financial arrangement, TEAM participants may hold other providers and suppliers accountable for upside and downside financial risk.

Source: TEAM Frequently Asked Questions | CMS

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Determine Engagement Strategy

What is your value proposition and how can you differentiate your agency?

Considerations for Partnership Support

- Specific care paths/programs improving outcomes
- Communication and rehospitalization prevention strategies
- Ongoing Reporting

Engagement with Participating Facilities

- Identification of individual(s) involved with TEAM strategy & oversight

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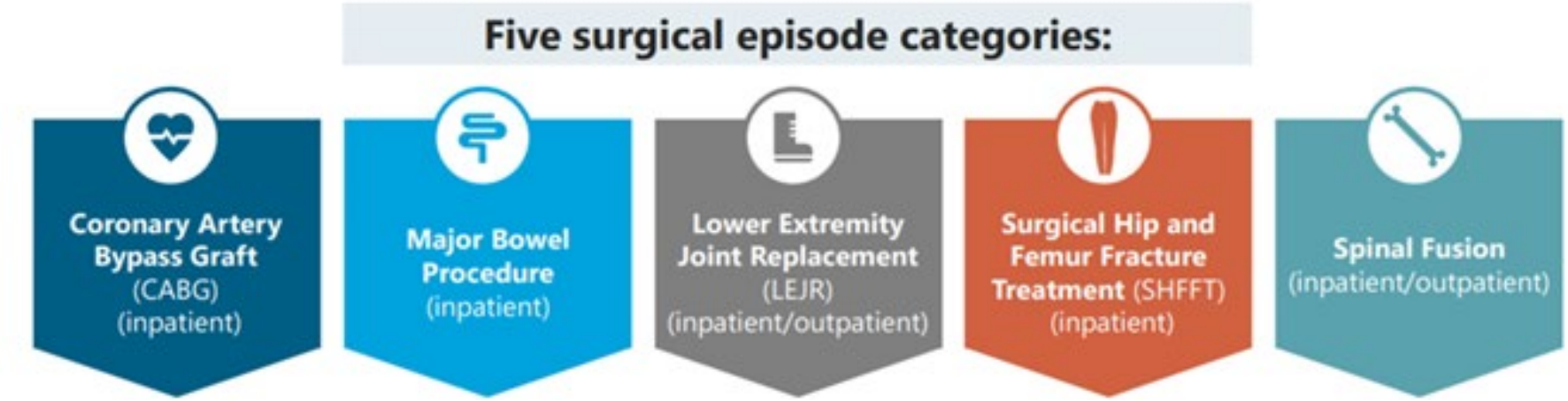
Operational Considerations



TEAM Patient Management

- Patient identification
  - Referral and Intake
  - EMR identification for reporting and visibility
  - Care Management
    - Hospitalization prevention escalations

All Staff Education

- What is TEAM and why does it matter
- Managing TEAM patients

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Monitoring & Compliance Considerations

TEAM participants and downstream participants must comply with CMS **evaluation and monitoring activities and applicable laws and regulations**.

CMS may conduct **monitoring and compliance activities**, including:

- Documentation requests, such as surveys and questionnaires
- Audits of data such as claims, quality measures, and medical records
- Interviews with clinical staff and leadership, beneficiaries and caregivers
- Site visits
- Monitoring quality outcomes and clinical data
- Tracking patient complaints and appeals

TEAM participants are required to **maintain records for 6 years**.

- Includes documents related to compliance, reconciliation, payment, quality measures, utilization, ability to bear financial risk, patient safety, and program integrity.

CMS may take **remedial actions** in the event of noncompliance, falsification, threats to beneficiary health, or program integrity risk.

Source: Transforming Episode Accountability Model (TEAM) Model Overview

Take note even if you are not in a TEAM CBSA-heavy service area

- Value is here to stay and requires intentional monitoring and managing to be successful in other Value-Based Models like current VBP
- CMS innovation models can fluctuate and extend if CMS determines the model is having positive impacts – Example: VBP
- CMS goal for Value-Based Care for Medicare and Medicaid patients

TEAM Resources:

TEAM (Transforming Episode Accountability Model) | CMS

Questions?

Contact

Forvis Mazars

Walter Coleman, MBA
Director
walter.coleman@us.forvismazars.com

Andy Page, CPA
Partner
andy.page@us.forvismazars.com

David Taylor, CPA
Partner
david.taylor@us.forvismazars.com