CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13399	**Date: September 4, 2025**
	Change Request 14098

Transmittal 13368 issued August 15, 2025, is being rescinded and replaced by Transmittal 13399, dated September 4, 2025, to remove CWF from Business Requirement (BR) 14098.4 and to add BR 14098.7.2 for CWF to bypass the 3-day stay without the other criteria. All other information remains the same.

SUBJECT: Transforming Episode Accountability Model (TEAM) 3-Day Skilled Nursing Facility (SNF) Waiver – Implementation

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to create a mechanism to allow demonstration code A9 to be associated with SNF claims involved in the model. Demonstration code A9 will waive the 3-day hospital stay requirement for SNF claims, allowing hospitals to discharge patients to SNFs after qualifying for outpatient surgeries or inpatient stays.

EFFECTIVE DATE: January 1, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2026

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Demonstrations

Attachment - Demonstrations

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II. GENERAL INFORMATION

A. Background: Section 1115A of the Social Security Act (the Act) authorizes the Centers for Medicare & Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) to test innovative payment and service delivery models to reduce Medicare, Medicaid, and Children's Health Insurance Program (CHIP) expenditures while preserving or enhancing the quality of care furnished to beneficiaries. The CMS Innovation Center is using this authority to test the Transforming Episode Accountability Model (TEAM), an episode-based payment model that aims to reduce Medicare expenditures while preserving or enhancing the quality of care, and to further advance care coordination across acute and chronic medical care settings.

Under TEAM, participating acute care hospitals (TEAM participants) will be responsible for the cost and quality of care for selected surgical procedures. These responsibilities will span from the time of surgery through the first 30 days after a Medicare beneficiary's discharge from an inpatient stay or an outpatient procedure. Each episode includes all items and services related to the initial hospitalization or outpatient procedure, encompassing both facility and professional services.

CMS anticipates that beneficiaries treated under TEAM will benefit from enhanced communication and coordination among healthcare providers, improved discharge planning and facility transfers, a reduction in unnecessary or redundant procedures, fewer avoidable readmissions, more efficient utilization of post-acute care, and an overall higher quality of care throughout the episode. These improvements aim to foster greater patient engagement in their care and shorten the lengths of stay in both acute care hospitals and post-acute care settings.

TEAM is set to launch on January 1, 2026, and will run for five years, concluding on December 31, 2030. The timeline for the model's performance years (PYs) is as follows:

- PY1: January 1, 2026 - December 31, 2026
- PY2: January 1, 2027 - December 31, 2027
- PY3: January 1, 2028 - December 31, 2028
- PY4: January 1, 2029 - December 31, 2029
- PY5: January 1, 2030 - December 31, 2030

As a mandatory model, outlined in regulations at 42 CFR 500-596 (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-H/part-512/subpart-E?toc=1), all policies under TEAM are proposed and finalized through rulemaking, most notably in the Fiscal Year 2025 and Fiscal Year 2026 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) proposed and final rules (https://www.federalregister.gov/documents/2024/08/28/2024-17021/medicare-and-medicaid-programs-and-the-childrens-health-insurance-program-hospital-inpatient).

Future updates to the model would also be proposed and finalized via rulemaking.

As part of this mandatory model, specific provisions of the traditional Medicare Fee-For-Service (FFS) program will be waived with regard to payment for certain SNF stays and certain telehealth services. This CR will focus on allowing demonstration code A9 to be associated with SNF claims involved in the model.

General Model Parameters

Participants

TEAM requires acute care hospitals, paid under the IPPS and the Outpatient Prospective Payment System (OPPS), and those that are located within a Core Based Statistical Areas (CBSA) selected to participate in TEAM, to be participants in the model. TEAM also allowed a one-time opportunity for hospitals that participate until the end of the last day of the last performance period in the BPCI Advanced model or the last day of the last performance year in the Comprehensive Care for Joint Replacement (CJR) model to voluntarily opt-in to TEAM. Hospitals participating in the model, either mandatorily or voluntarily, are held accountable for quality and cost performance for all episode categories in the model.

TEAM includes three participation tracks that allow for a glide-path to full financial risk. Track 1 is an upside only risk track that is available to all hospitals in performance year 1 (CY 2026). Safety net hospitals can remain in Track 1 for the first three performance years. Track 2 is a two-sided risk track, with lower levels of financial risk and reward, that is available starting in performance year 2 (CY2027) and limited to certain hospital types, including safety net hospitals, rural hospitals, Medicare Dependent Hospitals, Sole Community Hospitals, and Essential Access Community Hospitals. Track 3 is a two-sided risk track, with higher levels of risk and reward, that is available starting in performance year 1 (CY 2026). For more information on TEAM participation tracks, see 42 CFR 512.520 (https://www.ecfr.gov/current/title-42/section-512.520).

Episodes

In TEAM, an episode begins with a hospital inpatient stay, called an anchor hospitalization, or a hospital outpatient procedure, called an anchor procedure, for one of the following surgical procedures/episode categories: lower extremity joint replacement, surgical hip femur fracture treatment, spinal fusion, coronary

artery bypass graft, and major bowel procedure. Each episode will end on the 30th day following the date of the anchor procedure or the date of discharge from the anchor hospitalization.

Episodes are identified by Medicare Severity Diagnosis Related Groups (MS–DRGs) for anchor hospitalizations, or by Healthcare Common Procedure Coding System (HCPCS) codes for anchor procedures. For a complete list of MS-DRGs and HCPCS codes associated with TEAM's anchor hospitalization and anchor procedures, see 42 CFR 512.525(d) (https://www.ecfr.gov/current/title-42/part-512/subpart-E#p-512.525(d)).

Each episode includes all items and services related to the initial hospitalization or outpatient procedure, encompassing both facility and professional services. Additionally, all non-excluded Medicare Part A and Part B items and services provided within the 30-day post-discharge period are included, such as follow-up care in SNFs, outpatient visits, and physician services. There are certain items and services excluded from the total episode cost, including certain hospital admissions, new technology add-on payments, transitional pass-through payments, and certain Medicare Part B drugs and biologicals. For a list of items and services included and excluded from an episode, see 42 CFR 512.525(e) (https://www.ecfr.gov/current/title-42/part-512/subpart-E#p-512.525(e)) and 42 CFR 512.525(f) (https://www.ecfr.gov/current/title-42/part-512/subpart-E#p-512.525(f)), respectively.

Pricing and Payment

TEAM participants (the participating acute care hospital) and all Medicare providers and suppliers will continue to bill Medicare as usual under the traditional FFS system for items and services furnished to Medicare FFS beneficiaries. However, prior to each performance year TEAM participants are provided a target price that will represent most Medicare spending during an episode of care. TEAM participants can use the target price and other data provided by CMS to identify areas for efficiency and improvements that can spur spending reductions.

After each performance year concludes, CMS will perform a reconciliation calculation. Reconciliation compares each TEAM participant's total performance year FFS spending for attributed episodes for each episode category to their final target price for each episode category. Reconciliation amounts are subject to adjustments to account for quality performance and limits on gains or losses. After adjusting for post-episode spending as needed, the TEAM participant will have either a Reconciliation Payment from CMS or a Repayment Amount to CMS. For additional information about TEAM's pricing and payment methodology, see 42 CFR 512.540 (https://www.ecfr.gov/current/title-42/section-512.540), 42 CFR 512.545 (https://www.ecfr.gov/current/title-42/section-512.545), and 42 CFR 512.550 (https://www.ecfr.gov/current/title-42/section-512.550).

Reconciliation payments and repayment amounts will be processed directly with the Medicare Administrative Contractors (MACs).

B. Policy:

SNF Waiver

Identifying TEAM claims

CMS is associating the Demonstration Code A9 with the TEAM to identify TEAM episodes that will use the SNF waiver.

To enhance care coordination across the post-acute spectrum and support participant hospitals in managing beneficiary care, CMS is conditionally waiving certain Medicare payment requirements for beneficiaries in TEAM episodes, effective for episodes starting on or after January 1, 2026 (the start of TEAM Performance Year 1). Specifically, CMS is waiving the requirement for a 3-day inpatient hospital stay prior to a Medicare-covered SNF stay for eligible beneficiaries if certain conditions are met, as outlined in regulations at 42 CFR 512.580(b) (https://www.ecfr.gov/current/title-42/part-512/subpart-E#p-512.580(b)).

Under standard Medicare rules, for Medicare to pay for SNF services, a beneficiary must have a qualifying inpatient hospital stay of at least three consecutive days (including the day of hospital admission but not the day of discharge). However, under TEAM, CMS will allow beneficiaries to receive SNF services without meeting this 3-day requirement, facilitating payment of claims for SNF services delivered to beneficiaries at eligible sites. This will be effective for episodes starting on or after January 1, 2026.

Under TEAM, CMS will waive the 3-day hospital stay requirement for SNF services, subject to the following conditions:

- The hospital stay would normally not meet the prerequisite of at least three consecutive days for Part A coverage of SNF services. If the stay would otherwise qualify for covered SNF services, the waiver is not necessary.
- The discharge must be from a hospital participating in TEAM. TEAM participants are listed on the CMS Innovation Center website (https://www.cms.gov/priorities/innovation/innovation-models/team-model) and updated regularly.
- The beneficiary must have been discharged from the TEAM participant hospital for one of the TEAM episode MS-DRGs or HCPCS codes.
- The SNF stay must be within 30 days after the beneficiary is discharged from the hospital or hospital outpatient department.
- The beneficiary must meet the following eligibility criteria for TEAM upon admission for a hospital inpatient stay or hospital outpatient procedure:
  - Are enrolled in Medicare Parts A and B
  - Are not eligible for Medicare on the basis of having end-stage renal disease
  - Are not enrolled in any managed care plan (for example, Medicare Advantage, health care prepayment plans, or cost-based health maintenance organizations)
  - Are not covered under a United Mine Workers of America health care plan
  - Have Medicare as their primary payer
- The waiver applies only if the SNF is qualified to admit beneficiaries under TEAM.
  - CMS determines the qualified SNFs for each calendar quarter based on a review of the most recent rolling 12 months of overall star ratings on the Five-Star Quality Rating System for SNFs on the Nursing Home Compare website. Qualified SNFs are rated an overall of 3 stars or better for at least 7 of the 12 months.
  - CMS will post a list of qualified SNFs on the TEAM website. https://www.cms.gov/priorities/innovation/innovation-models/team-model)
- Providers furnishing SNF services under swing bed agreements will not be subject to the star ratings requirement.
- The SNF must include the appropriate demonstration code (A9) in the Treatment Authorization field on claims that qualify for the waiver under TEAM. The waiver, and more specifically the SNF 3-day Rule waiver, will also apply to swing bed providers (Type of Bill 18X), including Critical Access Hospital (CAH) swing beds.
- All other Medicare rules for coverage and payment of Part A-covered SNF services will continue to apply.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14098.1	Contractors shall utilize Medicare Demonstration Special Processing Number, (demo code), 'A9' to identify TEAM SNF three-day qualifying hospital stay waiver claims.	X				X			X	
14098.2	Contractors shall modify the existing consistency edit to include demo code 'A9'.								X	
14098.3	Contractors shall accept benefit enhancement indicator '4' for the TEAM SNF claims indicating the SNF three-day qualifying hospital stay waiver is applied.								X	
14098.3.1	Contractors shall assign benefit enhancement indicator '4' on claim page 12 with spaces in the ACO ID field when demo code 'A9' is present.					X				
14098.4	Contractors shall bypass all SNF three-day qualifying hospital stay edits on the claim record with the following criteria: o Admit date is on or after January 1, 2026; AND, o Demo code 'A9' is present in the Treatment Authorization Code field; AND, o Type of Bill (TOB) is 21X or 18X (including CAH) AND, o Occurrence Span Code (OSC) 70 is not present OR is less than three calendar days, excluding the day of discharge. **Note**: Example of OSC 70 for a three-day qualifying hospital stay 12/27-12/30					X				NCH
14098.5	Contractors shall assign a reason code to 21X and 18X TOBs when demo code					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	'A9' is present in the Treatment Authorization Code field and an OSC 70 is present with three or more calendar days.									
14098.6	Contractors shall RTP claims for corrections to the provider for removal of demo code 'A9' or correct the OSC days.	X								
14098.7	Contractors shall determine eligibility according to the published (https://www.cms.gov/priorities/innovation/files/team-ovw-webinar-slides.pdf page 18), TEAM Beneficiary Inclusion criteria and return the appropriate error codes on Trailer 8 record if the Beneficiary is ineligible for TEAM Demonstration Model benefits and return the appropriate error codes: -5243 - Beneficiary is covered under UMWA Plan -5244 - Beneficiary does not have Part A and Part B entitlement. -5246 - Beneficiary is in a GHO/Medicare Choices Plan. -524B - Beneficiary's Medicare is not the primary payer. -524S - Beneficiary qualifies for Medicare through the End Stage Renal Disease Benefit plan.								X	
14098.7.1	Contractors shall assign a reason code, append condition code B1, strip the demo code 'A9' and the benefit enhancement					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	indicator '4' from the claim and reprocess the claim as Fee For Service (FFS). Note: Consistent with BPCI Advance									
14098.7.2	Contractors shall bypass the SNF three-day qualifying hospital stay edit on the claim record.								X	
14098.8	Effective for TEAM Demonstration Model with From Dates of Service on or after 1/1/2026. Contractors shall ensure that providers submit the appropriate TEAM Demonstration Code when submitting claims for SNF and Swing Bed services: The Demonstration Code 'A9' shall be submitted by itself for Transforming Episode Accountability Model SNF and Swing Services Claims in the following fields: • Electronic transactions: 2300 REF02 Segment, where REF01=P4. • For DDE or paper Claims, Providers shall be instructed to use fields: 5/MAP1715 (for DDE) or Treatment Authorization field #63 (for paper claims)					X				
14098.9	Contractors shall add Demo Code A9 to the Demo Code 1 field and display the code on claim page 14 when present in the Treatment Authorization field.					X				
14098.10	Contractors shall send the ACO ID ‘T’, Demonstration Code ‘A9’, Benefit Enhancement Indicator ‘4’ to the IDR,					X				IDR

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
14098.4	A/B Crossover Edit '7123'
14098.2	Consistency Edit '0014'

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0