



CMS TEAM | IMPACT REPORT

Inside 721 Hospitals: A Financial Field Guide for the First Mandatory Surgical Episode Model

\$1.2M Average projected Year 1 loss per hospital under the new CMS TEAM mandate. 30% of Medicare revenue at risk by PY5 across 721 mandated hospitals

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What you'll find inside this report

A field guide for hospital and health-system leaders preparing for the first mandatory surgical episode model under CMS TEAM — and the wider wave of accountability that follows through 2030.

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CMS TEAM IMPACT REPORT

The Surgical Reform Decade is Here

American hospitals are entering the most consequential decade of modern surgical care. By 2030, every Baby Boomer will be 65 or older, with nearly 71 million Americans eligible for Medicare.¹ Older adults already drive a disproportionate share of surgical volume that is expected to rise as the population ages. Currently, adults 65 and older account for nearly 40% of inpatient surgeries.²

These are not surgical patients of a generation ago. Multimorbidity is now the norm, affecting roughly 74% of older emergency general surgery patients and more than 80% of those over the age of 85.³

Frailty, dementia, polypharmacy, and social vulnerability are no longer exceptions, they define the modern older adult surgical population as a result.^{4,5,6} The urgency is demographic and systemic. These are the very populations and procedures CMS models target to not only control spending but to improve overall quality of care and the patient experience.

At the same time, the workforce is contracting. The AAMC projects a shortage of up to 121,000 physicians by 2030, including 20,000–30,000 surgeons,⁷ while nursing shortages persist nationwide. Hospitals are being asked to deliver more complex care to a sicker population with fewer clinicians per bed.

This pressure coincides with a sharp compression of inpatient care. Average length of stay for joint replacement has declined from 3.0 days in 2012 to 1.1 days in 2023, and more than half of Medicare total knee arthroplasties are now performed on an outpatient basis.⁸ The surgical episode has shifted beyond the hospital, yet expectations for accountability and care quality now extend across the entire

continuum, from pre-operative care through discharge and into skilled nursing and home recovery. CMS programs such as TEAM formalize this shift, holding hospitals accountable for the full 30-day episode, where a substantial share of costs occurs in the post-acute phase.⁹ Performance is assessed not only on total spending but also on quality measures, including readmissions and patient-reported outcomes. As a result, hospitals may remain within target spending yet still incur penalties if quality benchmarks are not met.⁹

As a result, health systems must robustly operationalize coordinated, continuous, and evidence-based care across the entire perioperative continuum, from preoperative optimization through recovery at home. This level of orchestration is not achievable with traditional manual approaches. AI-enabled platforms such as Rainfall Health are becoming essential, offering real-time visibility into patient progress, care processes, and projected outcomes, replacing delayed, retrospective reporting with actionable insight.

CMS TEAM is the first wave of mandated participation, with a total of 721 hospitals,⁹ but it is not the only one. The CMS Age-Friendly Hospital Measure (IQR attestation began 2025, FY 2027 payment determination) and CJR-X (proposed to launch October 1, 2027 — a mandatory, nationwide 90-day joint replacement episode model with two-sided risk on day one¹⁰) extend the same accountability discipline to the ~2,500+ hospitals not required to participate in TEAM. Within 24 months, virtually every IPPS hospital in the country will sit inside a mandatory surgical episode model. The infrastructure built for TEAM in 2026 is the same infrastructure that will define readiness for the rest of the decade.

≈40%

of U.S. inpatient surgeries are performed on adults 65+

19.4%

of adults 65+ had surgery in the past year

721

TEAM hospitals (2026) - then 2,500+ via CJR-X (2027)

\$1.2M

avg. projected loss per TEAM facility, year 1

01 | THE DEMOGRAPHIC WAVE

More older adults. More surgical episodes. Mandatory accountability.

Adults age 65+ are the fastest-growing segment of the U.S. population — and the fastest-growing segment of surgical demand

The Demographic Wave Driving CMS Surgical Reform

U.S. adults age 65+ will reach ~73M by 2030 and ~86M by 2050 — more than 1 in 5 Americans.

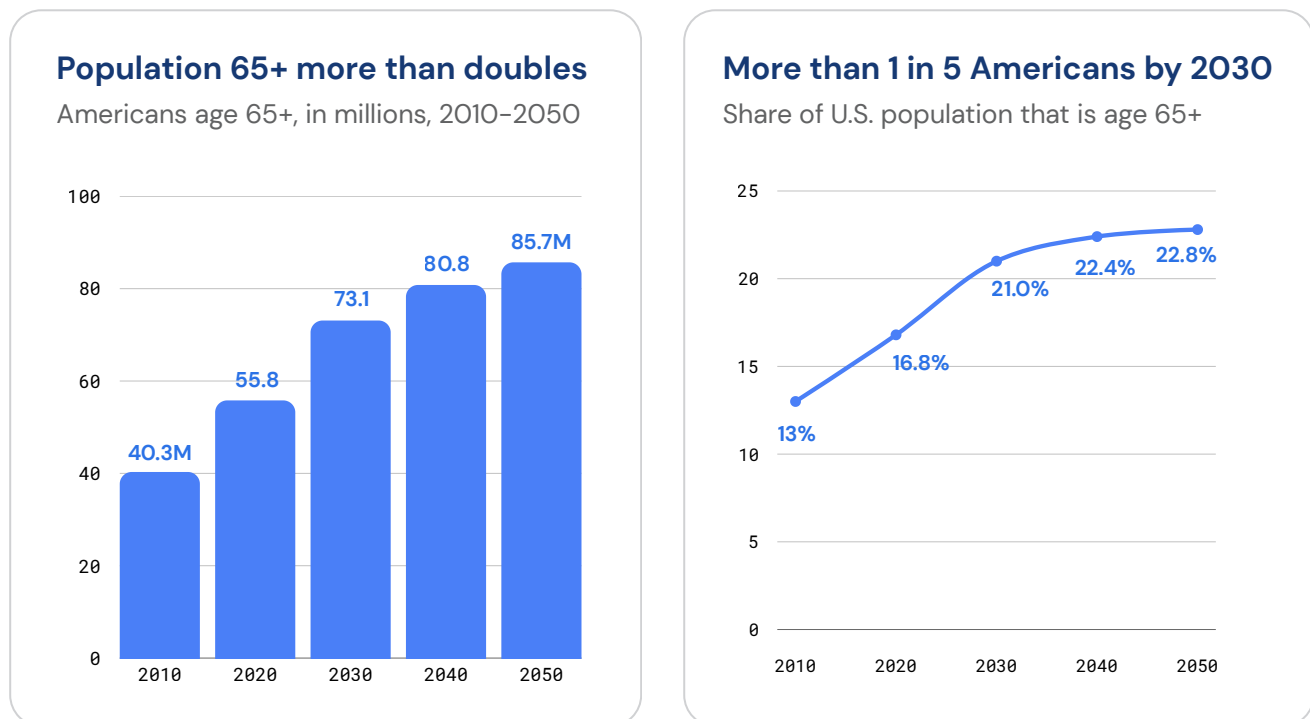


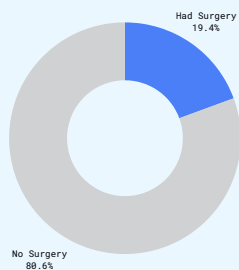
Figure 1. The 65+ population grows from 40.3M (2010) to 85.7M (2050), more than doubling, while the 65+ share of the U.S. population crosses 20% — more than 1 in 5 Americans — by 2030

In 1980 there were roughly 26 million Americans over 65. By 2030, that number will exceed 73 million, and by 2050, 86 million. **The share of the U.S. population that is 65+ will cross 21% before this decade ends. Every major surgical specialty will see its case mix shift towards older and more complex adults.**

02 | SURGERY IS CONCENTRATED IN OLDER ADULTS

Older adults already dominate the procedures CMS is focusing on as part of the TEAM model

Adults 65+ have the highest annual surgery prevalence and account for the majority of all five mandated TEAM procedures



Surgery is concentrated in older adults

Nearly 1 in 5 adults age 65+ underwent surgery in the past year — the highest annual prevalence of any age group. Across CABG, joint replacement, spinal fusion, major bowel, and hip & femur fracture, older adults make up the **majority of all five mandated TEAM procedures**.

■ Had surgery, past year (19.4%) ■ No Surgery (80.6%)

Older adults dominate the five TEAM procedures

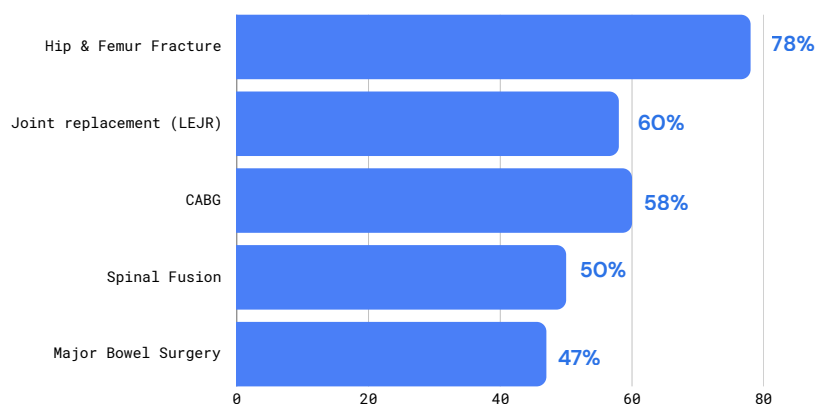


Figure 2. Surgical prevalence in adults 65+ and approximate share of each TEAM procedure performed on older adults

Hip and femur fracture treatment is overwhelmingly an older-adult procedure (~78%); CABG, joint replacement, spinal fusion, and major bowel surgery all draw much of their volume from the 65+ population. This is the operational reality TEAM was written for: the procedures with the highest age skew older with the highest variation in post-acute spending, and the highest readmission rates. **These five surgical focus areas contain the same procedures CMS is now requiring hospitals to manage as full episodes, beyond the hospital inpatient stay, with a focus on reduced spending while optimizing surgical outcomes and the care experience.**

Sources: Annals of Surgery Open (2024) NHIS prevalence; CMS TEAM Final Rule procedure-mix; ACS NSQIP & Medicare claims. Procedure shares approximate.

03 | THE TEAM MANDATE

721 hospitals. \$481M in CMS savings target. Up to 20% of episode revenue at risk.

TEAM is mandatory, performance-based, and stacked on top of other existing CMS pay-for-performance programs.

721

TEAM-mandated hospitals

204,014

annual surgical episodes

\$1.2M

Avg. projected loss per facility

56%

Hospitals projected to lose money

Per-Procedure economic swing under TEAM

Max win/loss per case (\$)

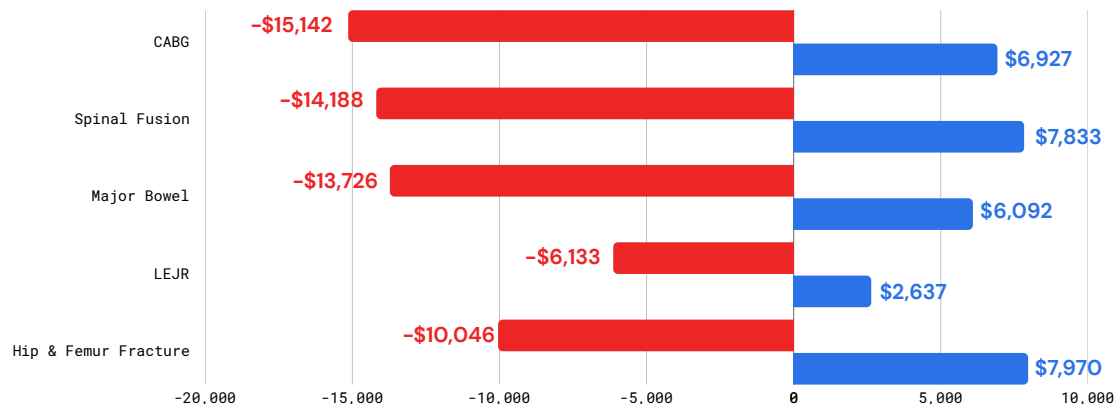
■ Max loss ■ Max win


Figure 3. TEAM scope and per-procedure economic swing. Per-case wins/losses model the full Track 1 / Track 3 range.^{9,12}

TEAM is not a pilot. As of January 1, 2026, 721 acute-care hospitals across 188 CBSAs will be reconciled annually on the cost and quality of every CABG, major bowel, lower extremity joint replacement, surgical hip and femur fracture, and spinal fusion episode across a 30-day post-discharge window. **Industry modeling estimates 56% of mandatory participants will lose money in the first reconciliation cycle, with an average loss of \$1.2M per facility.**¹² For systems performing all five procedures at scale, total exposure across the five-year performance window can exceed \$14M before HRRP, HAC Reduction, and VBP penalties are layered in.¹²

04 | PENALTIES AND INCENTIVES - THE RISK ENVELOPE

Up to $\pm 30\%$ of cumulative target spend on the line by PY5.

721 mandated hospitals, 204k episodes annually, and up to 20% of episode revenue at risk by PY3.

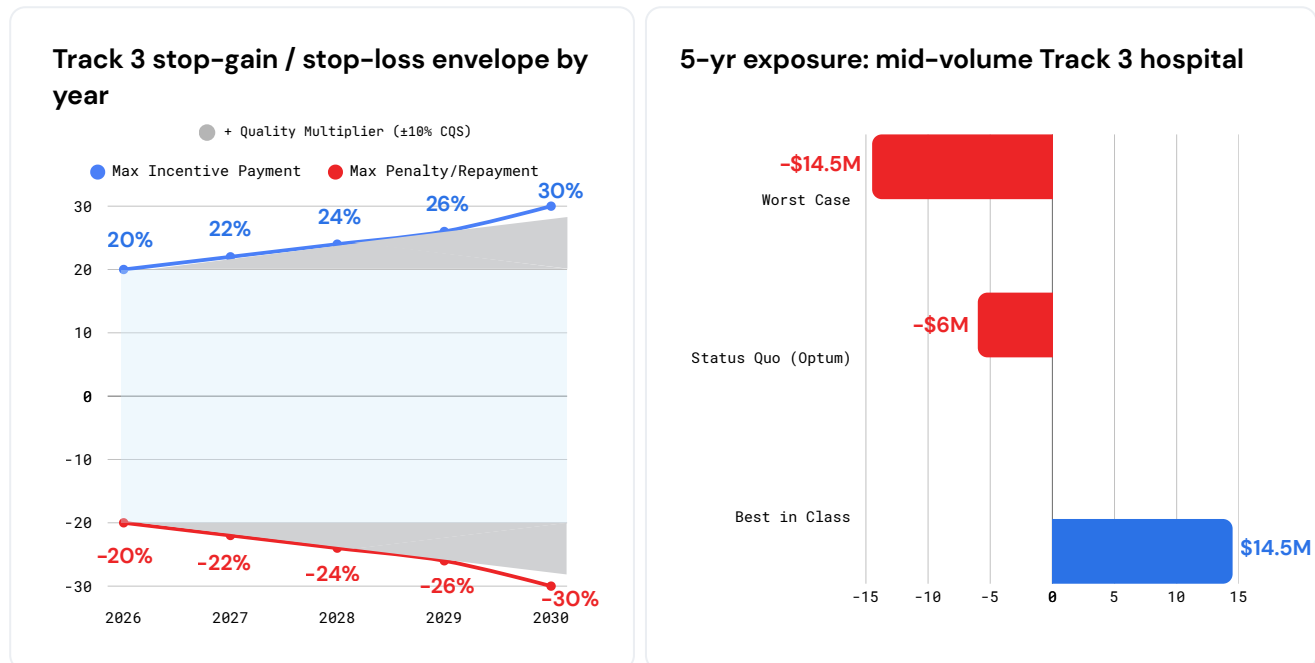


Figure 4. Track 3 stop-gain / stop-loss bands by performance year, plus modeled cumulative 5-year reconciliation impact for a mid-volume hospital — spanning $-\$14.5\text{M}$ (worst case) to $+\$14.5\text{M}$ (best in class), with the Optum status-quo projection at about $-\$6\text{M}$.^{9,12}

Under Track 3 (the default for most TEAM hospitals after PY1), reconciliation is capped at $\pm 20\%$ of cumulative target spend, then adjusted up to an additional $\pm 10\%$ based on the Composite Quality Score.⁹ By PY5, the spread between a worst-case and best-in-class performer at the same hospital can **approach 60 percentage points of episode revenue**. The math is symmetric, but the discipline required to land on the upside is not.



05 | PROVEN RESULTS

What AI-enabled TEAM operations look like in practice

Case examples from California — the largest concentration of TEAM-mandated hospitals in the country.

CALIFORNIA - STATEWIDE

110 mandated hospitals across 26 counties

California has more TEAM-mandated facilities than any other state.¹³ Greater Los Angeles alone hosts 59 facilities; the Bay Area another 22; the Central Valley 17; San Diego 8; Northern California 8; the Central Coast 4. Every one of them must operate the same five-procedure episode model as of January 1, 2026.^{9,13}

110

TEAM-mandated
facilities

26

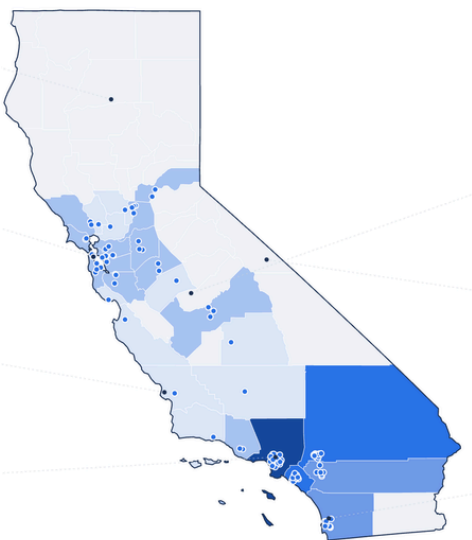
California counties

59

Facilities in Greater
LA

5 yr

Mandatory
performance
period



TEAM-mandated facilities by California region

Greater Los Angeles	59
Bay Area	22
Central Valley	17
San Diego	8
Northern California	8
Central Coast	4

CALIFORNIA - EPISODE ECONOMICS

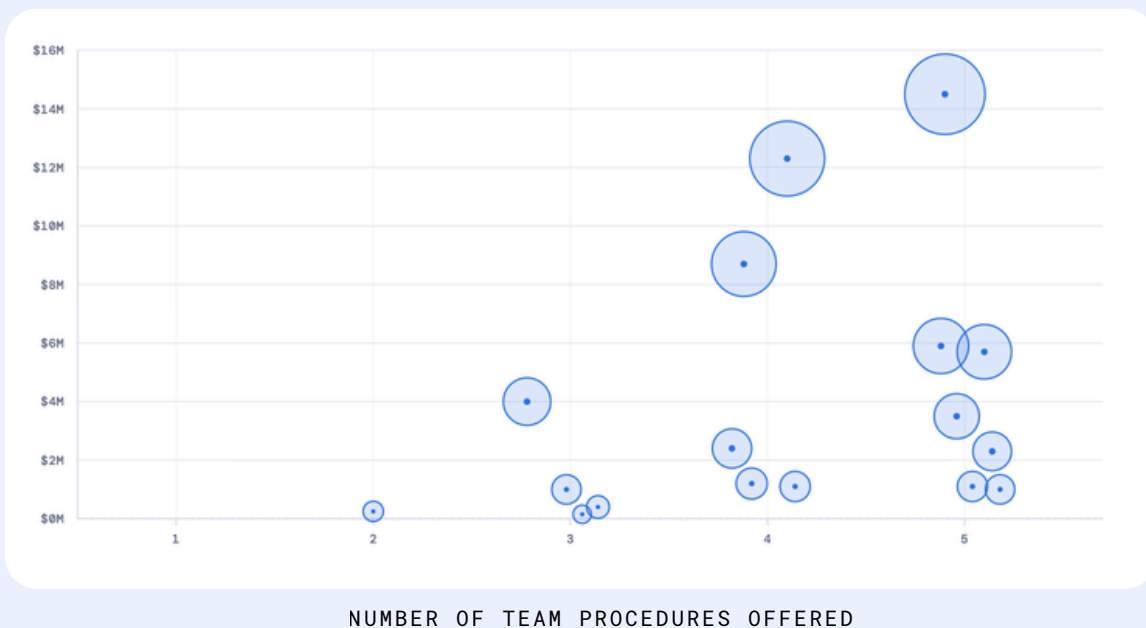
\$2.4M median, \$14.5M peak five-year impact

A Rainfall Health analysis of 17 California health systems modeled five-year financial exposure under TEAM as a function of how many of the five mandated procedures each system performs at meaningful volume.¹⁴ Impact scales nonlinearly: systems performing 4–5 procedures (CABG, major bowel, LEJR, SHFFT, spinal fusion) face exponentially higher risk than single-procedure systems.

Financial impact vs. number of TEAM Procedures

Track 1 Max Amount × 4.5 California Health Systems

FINANCIAL IMPACT (USD)

**\$2.4M**

Median 5-year impact

\$8.7M

Top quartile impact

\$14.5Maximum (5
procedure systems)**17**California Systems
analyzed

RAINFALL HEALTH | PLATFORM RESULTS

Up to 20% Medicare reimbursement impact, \$85M new revenue over 5 years

San Francisco-based Rainfall Health (CEO Eddie Qureshi; \$15M Series A led by Two Bear Capital, February 2026)¹⁵ built an AI-enabled compliance and reimbursement platform specifically for the TEAM mandate. Its capabilities span pre-surgical CDI and PROMs capture, intra-episode cost tracking, post-acute provider matching, and the RAIN Compliant™ verifiable-readiness designation.¹⁴ ROI is anchored to documented per-system Medicare reimbursement gains.

20%Medicare
reimbursement
impact (up to)**\$85M**New Medicare
revenue over 5 yrs**70–80%**

Readmission ID rate

5TEAM
procedures
end-to-end

WHAT THIS MEANS FOR YOU

The window is 2026. The discipline you build for TEAM is the discipline that will define the next decade of surgical care.

AI-enabled TEAM operations are not a revenue-cycle add-on, they are a clinical-AI strategy leveraged to reduce administrative burden on the administrative and clinical teams while optimizing surgical care delivery in a vulnerable patient population, older adults. Documentation, care pathway adherence, post-acute placement, referral coordination, and the integration of evidence-based practices that drive surgical outcomes and patient-reported measures are all critical points along the perioperative continuum where an AI-enabled platform such as Rainfall Health can connect care team members and augment performance in real time. The C-suite question is no longer whether to deploy an AI platform as part of TEAM reporting, but whether to deploy it before or after the first reconciliation cycle, once penalties are realized. Given the compounding-penalty math, the possibility for incentive payments, and the procedure-mix asymmetry shown above, the cost of waiting is materially higher than the cost of acting proactively.

References

Numbered citations correspond to in-text superscripts throughout this brief. Government and peer-reviewed sources are listed first; industry modeling and internal Rainfall Health analyses follow.

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Disclaimer: All figures, analyses, and interpretations in this report were independently compiled by Christina Keny, PhD, MHA, RN, CPHQ for Rainfall Health using publicly available data and published sources available at the time of analysis. Because these external data sources are periodically updated or revised, the findings presented in this report are subject to change. Procedure-share estimates and projections are approximate and intended for strategic planning purposes only and should not be relied upon for individual clinical, financial, regulatory, or operational decision-making.