ALTERNATIVE PAYMENT MODELS

Navvis' New CEO on What It Will Take to Succeed in the TEAM Model

Tim Elliott says the CMMI model will help health systems shine a light on unwarranted variations in care

David Raths • March 23, 2026 • 7 min read

Key Highlights

- Tim Elliott, a founding member of Navvis, now serves as CEO to lead the company's strategic initiatives in value-based care.
- Navvis is working with clients on the TEAM model, which requires hospitals to coordinate care for specific surgical episodes with financial risk starting in 2027.
- Successful implementation requires physician champions, aligned care models, and advanced analytics to monitor outcomes and drive continuous improvement.

Value-based care enablement company Navvis recently appointed Tim Elliott as its CEO. Elliott was one of Navvis' founders and has served the company in several roles, including president, chief corporate development officer, and executive vice president and general counsel. He recently spoke with *Healthcare Innovation* about his company's engagement with health systems such as Hackensack Meridian on the newly launched mandatory TEAM model from the Center for Medicare & Medicaid Innovation (CMMI).

The TEAM model mandates 741 hospitals to coordinate care for specific surgical episodes, with financial risk starting in 2027. The model puts an emphasis on improved patient outcomes and cost control.

Healthcare Innovation: We have written before about TEAM (Transforming Episode Accountability Model), and most of our readers probably know something about it. But can you summarize what the goals are from CMS's perspective, and what it means for the health systems that Navvis works with? What are some of the opportunities, but also challenges that they face as they as they go into it?

Elliott: I view TEAM as CMMI really trying to get the specialists involved in value-based care. The MSSP ACO model really focuses on primary care physicians and their attributed members. There's a lot of impact that can be driven there, but it really is hard to engage the specialists in a model like that. CMMI is being very active. I was listening in to a conference last week and Abe Sutton said they're going to release nine new models. Even today they announced the MAHA Elevate model.

But TEAM is an integrated payment model for specialists to focus on the pre-procedure, the actual care in the hospital, and then the care post-op for a period of time. It's really meant to align the specialists around a value-based care construct. It's a form of bundled payment. This is just expanding it into different clinical settings.

HCI: And it's mandatory rather than voluntary, so that's a big shift, too.

Elliott: That's exactly right. It is mandatory for certain procedures. So I think it's foretelling where the government's going. They are seeing the benefit of aligning folks in a way that's different than just a fee-for-service Medicare model.

You asked about some of the challenges that organizations face. I will tell you there are two schools of thoughts. Even though it's mandatory for institutions, we've come across some facilities where they've said, 'You know what, we're going to do the best we can, and if we have to pay a penalty, so be it; we're just not going to do anything related to TEAM.'

HCI: And in the first year, there's no downside risk, right? The downside part starts after the first year. So people might be thinking they will worry about that later.

Elliott: I think that's right, although I will tell you that this isn't something where you can flip a switch, right? They may think they can do it fast later, but they'll find out the hard way that that's not the case.

The is complicated. You have to align independent specialists and all the providers who are involved in these procedures around a common care model to ensure the patient is in a very seamless way cared for and doesn't readmit and has a great outcome. In our experience, that's not something that happens overnight or without a real physician champion, a work plan, a view of a common care model that you start with and then evolve through input from the various providers — and then implementing that and reporting and monitoring it.

HCI: We talk to chief medical officers of multi-hospital health systems, and they talk about wanting to standardize evidence-based care across a health system, so maybe this is an opportunity to do that for order sets and care pathways.

Elliott: I think that what you said is spot on. There's always going to be variation in care, because every patient is not the same, but it's the unwarranted variation in care, right? Why are we seeing drastically different outcomes across the group of physicians or drastically different utilization of certain pharmaceuticals or certain imaging or testing? That's the type of unwarranted variation that a model like this will shine a light on, and then you can work with the providers to ask, why is it different?

HCI: For this program you may also need visibility into post-acute care, and that's something that a lot of health systems have struggled with once patients leave the hospital and aren't directly in their care anymore, right?

Elliott: Yes. We spend a lot of time creating high-performing post-acute networks. We contract around a set of quality indicators that they agree to follow. Sometimes patients are discharged, and they sit in the SNF for 28 days and they really aren't getting that much better care. I think everyone would rather be at home when it's medically appropriate to do so. Bad things happen in facilities — infections and older patients get disoriented, so managing that length of stay is really important. The other problem that a lot of health systems are facing is the throughput within their facilities. Identifying processes to get patients out of the inpatient setting and to the post-acute setting or to the home is a key part. There are so many things that are interrelated, and done right, you can get multiple benefits.

HCI: I understand that you are working with Hackensack Meridian on TEAM. Are there some things that you've been addressing first with them?

Elliott: So much of what we do is about change management. So where we started with them was identifying the right physician champions around what needed to be accomplished and engaging with them. We could come in and say, 'here's the care model you need to adopt for this procedure,' but if the physicians don't have their fingerprints on it, if they don't really buy into it, if we don't have the right champions for it, it's going to be very hard to get it adopted across the house.

So I would say that identifying the physician leaders, and then collaborating with them around a care model, and then using those leaders as champions of the effort to socialize it throughout the health system is key. That was work that we did to stand up a go-live at the first of the year with them. Now it's a lot about tracking. Were we thinking about it correctly? Is the patient flow working like we thought it would? What are the outcomes? We are collecting the data and reporting out on the outcomes and then doing constant improvement based on that type of information.

HCI: With these health systems — not just in in Hackensack Meridian's case — do they need new kinds of analytics tools to track this? Or can they use ones they already have?

Elliott: I would say it varies. Some of the organizations that we work with are relatively sophisticated in that way. And it's just a matter of adopting data capture and reporting that they're doing. For others, it's really creating it from the ground up. They've never thought about exactly what their costs are across all these different providers.

About the Author

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