GUIDE

# 6 Steps to Mitigate Risk & Uncertainty in the CMS TEAM Program

The Transforming Episode Accountability Model (TEAM) is the most expansive mandatory alternative payment model (APM) to come out of the Centers for Medicare and Medicaid Services (CMS). The program requires just over 700 hospital facilities – and the providers who perform certain procedures in those facilities – to "coordinate care for people with Traditional Medicare undergoing one of the surgical procedures included in the model, and assume responsibility for the cost and quality of care from surgery through the first 30 days after the Medicare beneficiary leaves the hospital."

Key goals of TEAM include:

- Enhancing care quality for Traditional Medicare patients
- Reducing total cost of care for five high-impact surgical procedures
- Incentivizing accountability for cost and quality with risk-sharing options
- Promoting health equity, particularly for underserved patients and populations
- Strengthening care continuity and coordination to improve long-term outcomes

For the past 25 years, healthcare costs have risen at a rate higher than overall consumer prices – an unsustainable track that requires a different approach than historical fee-for-service models that incentivize volume over everything else. CMS and the Center for Medicare and Medicaid Innovation (CMMI) have launched several programs in the last two decades to curb costs. In 2023, nearly half of all Traditional Medicare members participated in an accountable care arrangement. Almost 70% of all Medicare Advantage payments were population-based and included upside reward and downside risk or were linked to quality and value.

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Further, in a survey by Healthcare Payment Learning & Action Network (HCP-LAN), 76% of payers said they expect alternative payment model (APM) activity to increase – nobody said they expect it to decrease. Payers also strongly believe that APMs will result in better quality care, improve coordination, and lead to more affordable care.

## UNDERSTANDING THE RISK LANDSCAPE

As APM participation increases, so does the requirement that providers and hospital systems take on more risk for patient and population outcomes. In TEAM, participants will have to take on financial and operational risk, and for some it will be the first time in this type of arrangement. The uncertainty can lead to concerns and fears that providers or facilities will see a reduction in reimbursement or be subject to financial penalties for not meeting specific benchmarks and goals.

Key to overcoming these concerns and fears is having a solid data foundation, and analytics tools designed specifically for identifying risks and presenting opportunities and options to mitigate them.

## COMMON CONCERNS FOR TEAM PARTICIPANTS

Many providers and facilities mandated to participate in TEAM have concerns about the program. Primary among those concerns is how to manage data around bundled episodes. Data coming from CMS is often slow, which means that participants may not have an accurate picture of their performance during the year. Without those insights, providers and hospitals feel unprepared to adjust in the areas where they are falling short of meeting cost and quality targets.

Other concerns include:

- Staff time required to manually manage care workflows for patients who get one of the five included TEAM procedures
- Limited access to data outside of their own organization, which could hinder collaboration
- Data security worries around sharing protected patient health data with collaborative partners involved in the episode of care
- Lack of advanced technology, such as analytics and care management tools, to meet the demands of a retrospective bundled payment program
- Added administrative burdens that come with new CMS programs
- Education and buy-in so every member of a care team understands the program and their role in controlling costs and improving outcomes

## STEP-BY-STEP FRAMEWORK TO MITIGATE RISK & UNCERTAINTY

It would be difficult to completely eliminate the risk and uncertainty in this type of mandated alternative payment model, but there are steps you can take to mitigate them and feel confident when TEAM launches in January 2026.

 

STEP 1

# Build Robust Data Capabilities

At the heart of any risk-based payment model is your data infrastructure, and TEAM success requires timely access to robust and accurate data. Data coming out of CMS often has a significant lag, which frustrates participants who want to be able to measure progress throughout the year – with plenty of time to course-correct if they are not meeting cost or quality targets.

Another challenge for organizations relying on CMS data is that it only includes claims. That is one piece of the puzzle, but it's certainly not the whole picture. Integrated claims and clinical data can offer a more updated snapshot of patient needs throughout a bundled payment episode.

Successful TEAM participation requires a data management system that can integrate multiple disparate systems into one single source of truth. That data can then inform analysis and care pathways that improve patient experience and outcomes and help participants achieve or exceed cost and quality benchmarks, thus maximizing reimbursement. Additionally, that data infrastructure facilitates optimal performance tracking to understand how your bundled payment contract is structured, what your goals are, and how you can succeed.

 

STEP 2

# Model Scenarios to Anticipate Challenges

For many organizations and providers, the move from fee-for-service to value-based or risk-based contracts is hard because it means venturing into the unknown. Having reimbursement dollars at risk, based on costs and patient outcomes in a system with limited collaboration and data sharing, can be scary, especially if you have never had to think about it before.

But there are tools available today that can alleviate much of that concern before TEAM launches. Modeling applications can paint a picture of how an organization or provider might perform in specific value-based contracts, including bundled payments. The most advanced modeling tools can be fully customized to account for a wide variety of contract variables, reimbursement models, and performance metrics.

AI now offers powerful capabilities to predict potential risks for patients, including those that might be at higher risk for things like hospital readmission or ER visits – costly encounters with the healthcare system that can derail efforts to control and reduce the cost of care.

Predictive analytics can also model best-case, worst-case, and expected outcomes for specific episodes of care based on historical data from past claims. TEAM does include stop-loss and stop-gain limits, capping the amount of financial risk and reward available to participants, so catastrophic scenarios won't impact final performance metrics. However, with these insights available, organizations and providers can put workflows and mechanisms in place to mitigate risks for patients, resulting in better overall outcomes.

## BENEFITS OF MODELING & PREDICTION

**Anticipate and plan for cost-driving scenarios**

**Design proactive workflows and interventions**

**Improve patient outcomes**

**Strengthen financial performance under TEAM**

 

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STEP 3

# Define Clear Care Pathways

Care variation is a big topic in the conversations around improving U.S. healthcare. These variations stem from inconsistent care practices, unnecessary treatments, or inefficiencies in care administration. Bundled payments can remove much of this inconsistency simply by defining what is included in an episode of care – such as covered appointments, imaging, surgical procedures, follow-up care, and physical therapy.

TEAM-participating providers and hospitals can further reduce variations in care in three ways:

1

**Define clear care pathways** for patients in each of the five surgical procedures included in the model. This ensures that each patient receives the same high-quality care.

2

**Tracking provider and facility performance with analytics,** which can help pinpoint outliers with higher-than-average procedure costs, readmission rates, or errors, for example.

3

**Collaborate efficiently on post-acute transitions,** ensuring that patients get the follow-up care they need to understand and safely take post-procedure medications, care for wounds, and recognize the signs of a problem like infection and seek immediate care.

The software tools you use can significantly impact success in these areas. High-performance analytics and integrated care management platforms can help track and objectively report on provider performance, seamlessly translate analytics insights into actionable care team workflows, and securely share patient data with partitioned access and controls to enable better collaboration.

STEP 4

# Audit Your Tracking & Patient Management Capabilities

One of the biggest changes in the transition from traditional fee-for-service to bundled episodes of care is the need to manage patients across multiple providers and facilities – including primary care providers, specialty care providers, surgeons, and hospitals or surgical centers. When everyone involved in the care episode is responsible for meeting specific cost and quality targets, you need a way to track and manage those patients efficiently and accurately through the entire process. Many organizations have only limited capacity to do this within their software system and instead will have to rely on manual processes that take up valuable staff time.

With advanced analytics software designed specifically for bundled payment programs, you can examine all the data surrounding each patient and the care episode to find appropriate care pathways that lead to the best outcomes. The same data can also inform changes to care pathways that will lead to even better results and higher-quality care in future episodes.

STEP 5

# Strengthen Care Coordination Among Participants

U.S. healthcare struggles with siloed care and limited collaboration. APMs like bundled payments require a dramatic shift toward collaborative care. Bundled payments only succeed when every participant:

- Is engaged and actively working toward cost and quality goals
- Understands the benchmarks and metrics the team will be measured against, and the levers they can pull to mitigate unnecessary costs and improve care quality
- Buys into full transparency and data sharing to enable better care coordination

The best way to achieve a high level of coordination among partners is with software designed to facilitate it with:

1

**A strong enterprise data management foundation that can bring together multiple sources of disparate data into a single, homogenized dataset, so everyone is working with the same accurate, up-to-date information.**

2

**Advanced analytics software that can uncover critical insights and align care providers around the key metrics they will be measured against in the bundled payment model.**

3

**Care management tools that translate the insights from your analytics tool into actionable steps that care teams can take to close gaps in care and optimize outcomes.**

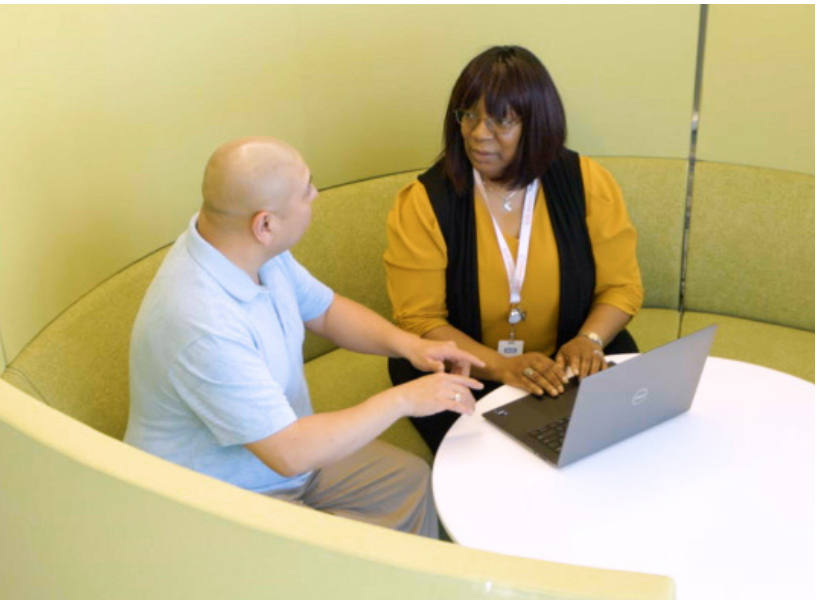
 

STEP 6

## Monitor, Measure, and Improve

Bundled payment programs are not going to be perfect from the start, and TEAM participants new to this alternative payment model are likely to make some mistakes along the way. The key to continued success in this (and future) value-based contracts is to have software to monitor the program, measure key performance indicators, and make improvements over time. Near-real-time data insights allow providers and hospitals to measure performance against benchmarks at regular intervals throughout the year, and pivot quickly to address issues that may impact program results.



## FINDING A STRATEGIC PARTNER FOR YOUR TEAM JOURNEY

TEAM represents the most expansive mandated alternative payment model CMS has implemented so far. As both federal and commercial payers continue to see the benefits of tying healthcare reimbursement to value and outcomes (instead of care volume), these models will only grow. Organizations that embrace the opportunity to excel in TEAM today can build a solid foundation for risk-based payment model success in the future. Investing in the right technology – software platforms purpose-built for value-based care – can help you be proactive and not reactive as the healthcare market continues to shift toward value.

**Ready to get started? Let's talk about your TEAM readiness. Use our checklist to identify the capabilities you need in a TEAM-ready partner and schedule a conversation with our experts to discuss how we can help.**

# About Cedar Gate Technologies

**Cedar Gate enables payers, providers, employers, and service administrators to excel at value-based care with a unified technology and services platform delivering analytics, care, and payment technology on a single data management foundation. From primary care attribution to bundled payments and capitation Cedar Gate is improving clinical, financial, and operational outcomes for every payment model in all lines of business.**

**To learn more, visit cedargate.com.**

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## CHECKLIST: WHAT TO LOOK FOR IN A TEAM-READY TECH PARTNER

Purpose-built tech platforms can build confidence in TEAM participation. If you don't have the tech required to succeed today, here are some things to look for in a TEAM technology partner:

- ☐ Enterprise data management for claims, EHR, SDoH, and CMS Shadow Bundles files, normalizing all into clean, homogenized files for use across your entire software ecosystem
- ☐ Scalable, NoSQL data platform that supports high-volume data processing and enrichment (*e.g.*, ADI feeds)
- ☐ Predictive and prescriptive analytics for pinpointing potential gaps in care and opportunities to improve care in a bundled payment agreement
- ☐ Highly accurate bundle payment modeling to simulate TEAM and other bundled payment performance
- ☐ Clinically focused, episode-based workflows that support best-practice care pathways and reduce variations in care delivery
- ☐ Provider education toolkit to inform patient navigation and administrative workflows
- ☐ Financial settlement validation and clinical optimization with expert-led review of CMS reconciliation documents and recommend clinical enhancements for improved financial performance
- ☐ Composable, modular solutions to build the specific tech stack that meets your needs and integrates easily into legacy technology
- ☐ Proven experience in administering bundled payment programs

 