



Risk & Insurance | Employee Benefits | Retirement & Private Wealth

WEBINAR

What CMS's Mandatory TEAM Model Means for Hospital Leaders – and What to Do Before 2027



Moderator



Peter Reilly

North American Practice Leader -
Healthcare

HUB International



Chrystina Howard

ERM Leader, Complex Risk Practice
HUB International



Cory Jorbin, Esq.

Director of Compliance Consulting,
National Employee Benefits

HUB International

Agenda

- 1** Setting the Stage
- 2** What TEAM Requires
- 3** The Ripple Effects
- 4** Potential Scenarios
- 5** Readiness Framework

Setting the Stage



The Value-Based Care Trajectory

CMS has been shifting financial risk to providers for over a decade

TEAM represents the next step in CMS's value-based care strategy – and participation is no longer optional

Voluntary models (BPCI, ACOs, shared savings) have paved the way

CMS continues moving providers toward greater accountability for cost and quality outcomes



What is TEAM?

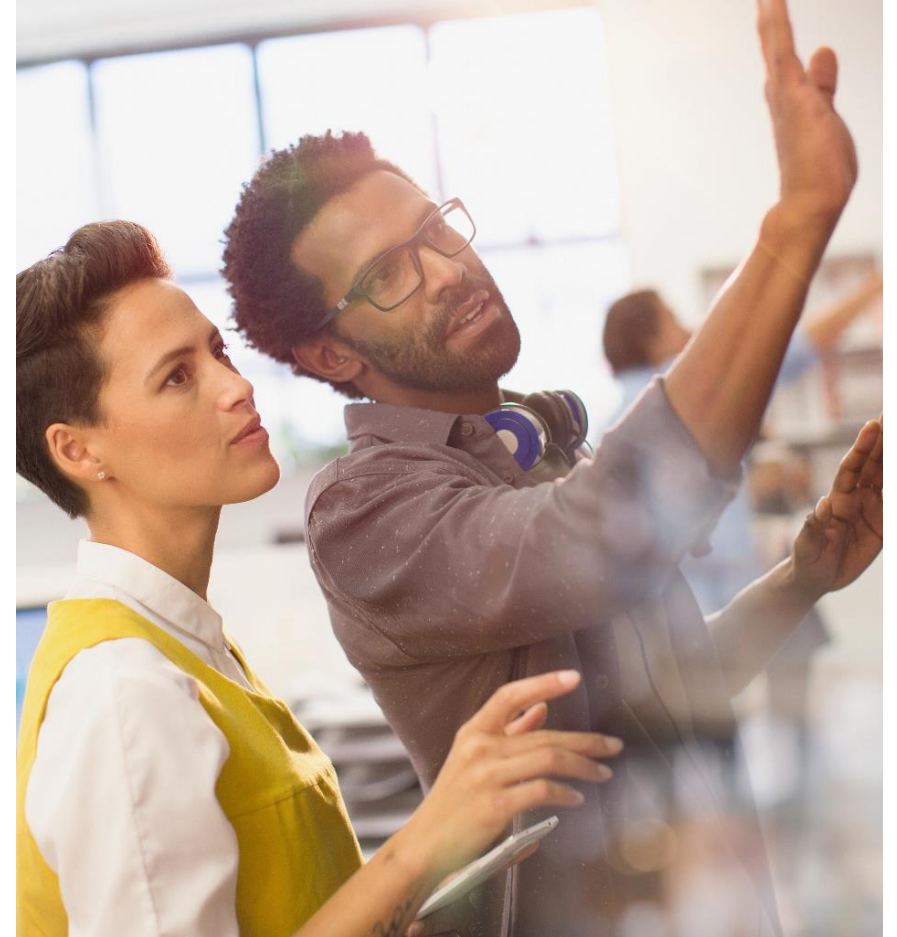
TEAM (Transforming Episode Accountability Model) is CMS's latest mandatory value-based care initiative

Hold hospitals financially accountable for the full cost and quality of care across defined clinical episodes

Covers high-volume, high-cost episodes: joint replacements, cardiac procedures and select surgical episodes

Accountability extends from the anchor hospitalization through post-acute recovery

Participation is determined by geographic designation – MSA-based, rather than organizational opt-in



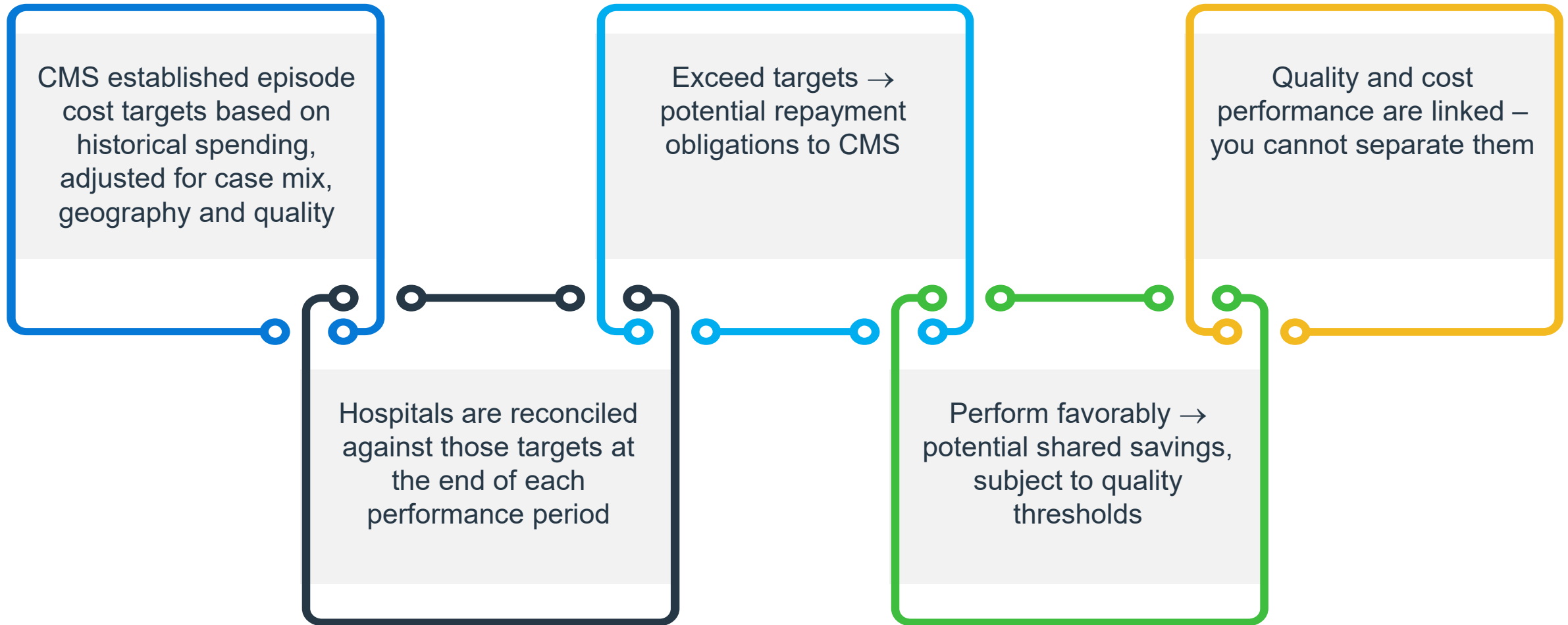
Preparing for 2027 Starts Now

- Participation begins in 2027 for CMS-designated hospitals and health systems
- TEAM preparation may involve operational, financial, compliance and governance coordination
- Preparation activities such as financial modeling, compliance planning and governance alignment require time to implement effectively
- Organizations that begin preparing earlier will have greater flexibility to assess and address gaps

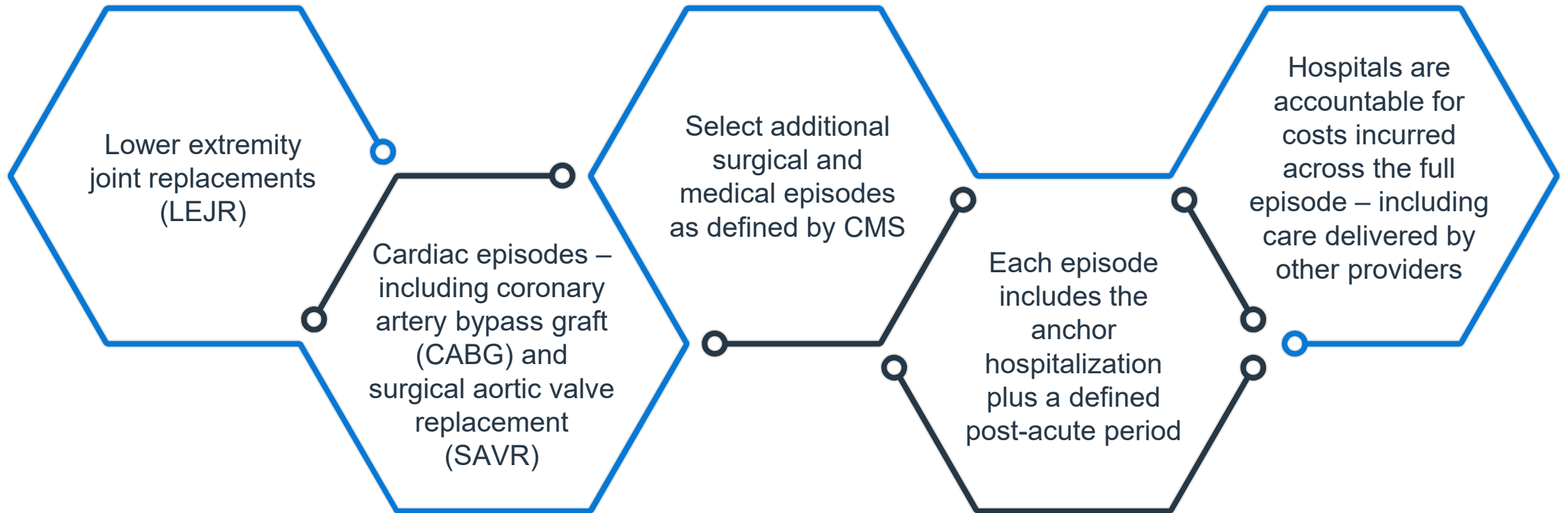
What TEAM Requires



How TEAM Works



What Episodes Are Covered?



Quality Metrics

Performance isn't just about cost

Quality thresholds must be met to access shared savings

Metrics span: clinical outcomes, patient experience, care coordination and process measures

Failure to meet quality thresholds may limit access to shared savings, even with favorable cost performance

Quality underperformance can also trigger additional financial penalties

Reconciliation and Reporting

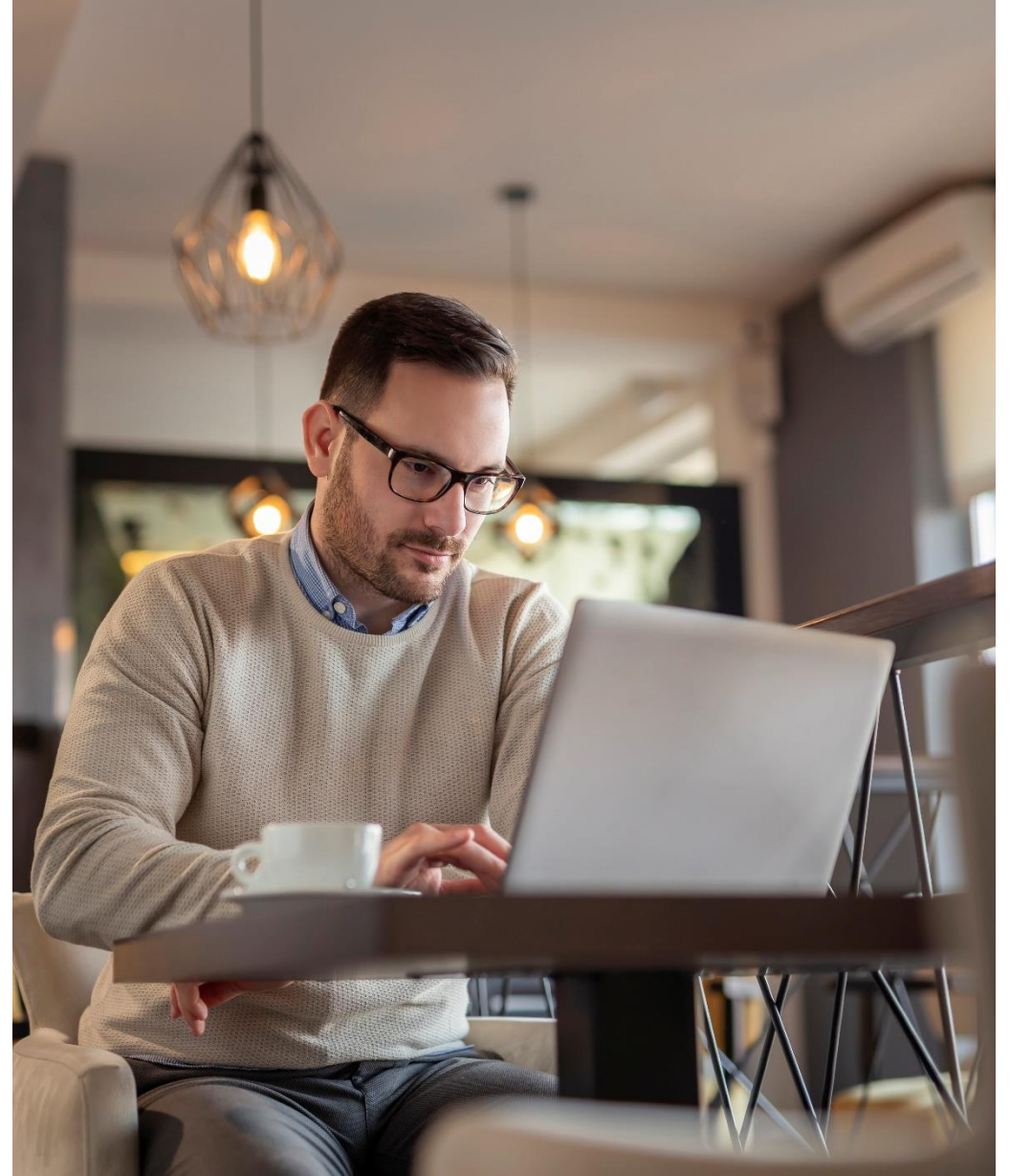
How CMS Measures and Settles Performance

CMS reconciles episode spending against benchmarks periodically throughout the performance year

Reconciliation methodology accounts for risk adjustment, attribution and outlier exclusions

Organizations must understand the methodology to anticipate financial outcomes and identify discrepancies

Dispute resolution processes exist – but require preparation and documentation

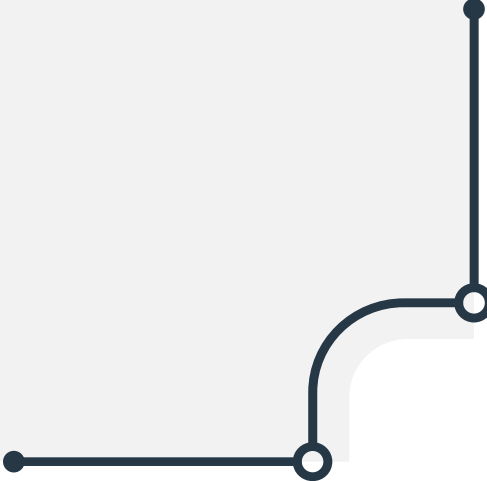


What Mandatory Participation Means in Practice

Participation is determined by MSA designation – not organizational preference

A blue line graphic starting from the bottom left, moving horizontally to the right, then curving upwards and to the right, ending with a solid blue dot.

There is no opt-out for eligible hospitals

A dark blue line graphic starting from the bottom left, moving horizontally to the right, then curving upwards and to the right, ending with a solid dark blue dot.

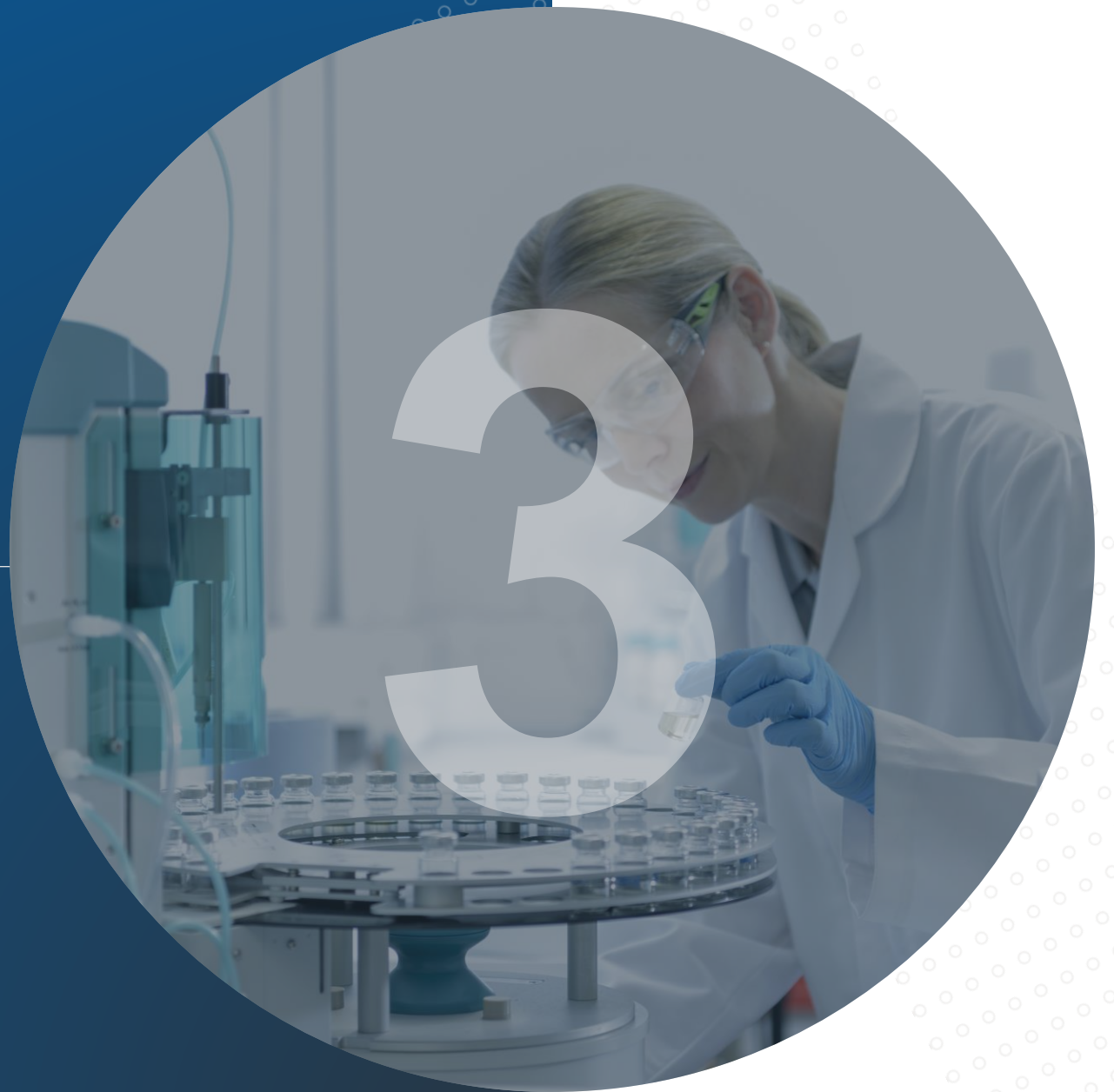
Non-participation is not a neutral position – it carries its own regulatory and financial consequences

A light blue line graphic starting from the bottom left, moving horizontally to the right, then curving upwards and to the right, ending with a solid light blue dot.

The question is not whether to participate – it is how well-prepared your organization will be when participation begins

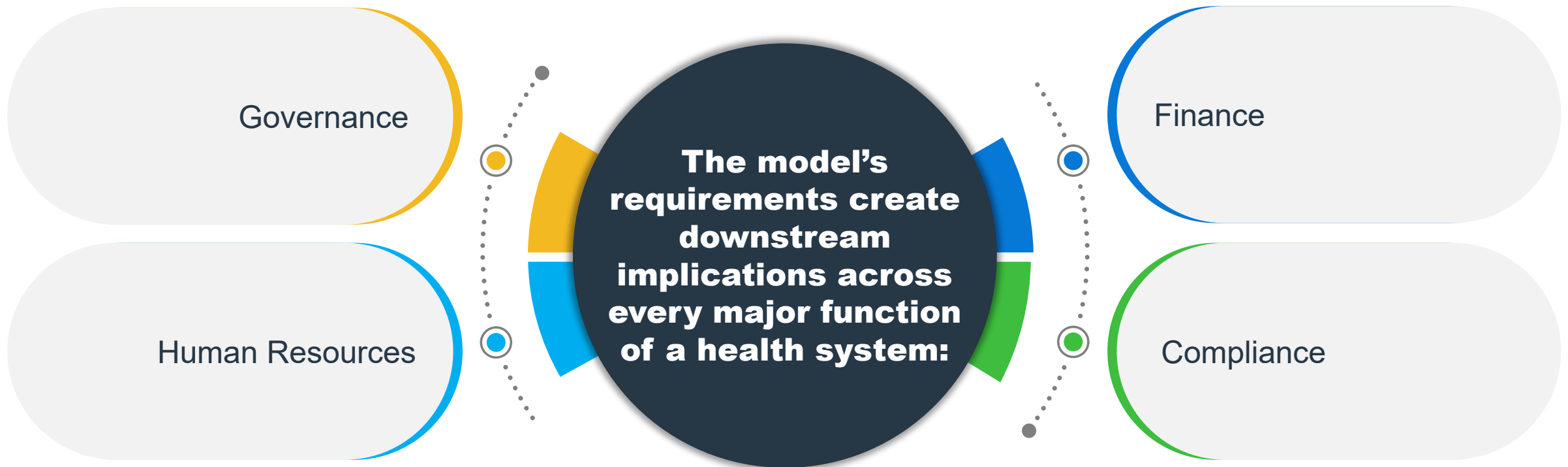
A green line graphic starting from the bottom left, moving horizontally to the right, then curving upwards and to the right, ending with a solid green dot.

The Ripple Effects



TEAM is an Enterprise-Wide Risk. Are You Treating it That Way?

TEAM is not a compliance checkbox – it is an enterprise-wide risk event



Finance and Compliance

Finance

- Budgeting and forecasting must account for potential reconciliation repayments
- Capital planning must reflect performance-based revenue adjustments
- Scenario-based financial modeling will become increasingly important under TEAM

Compliance

- New documentation and reporting requirements demand robust infrastructure
- Coding gaps affect both quality scores and cost calculations
- Audit readiness is a baseline expectation, not an advanced capability

Workforce Stability as a TEAM Performance Driver

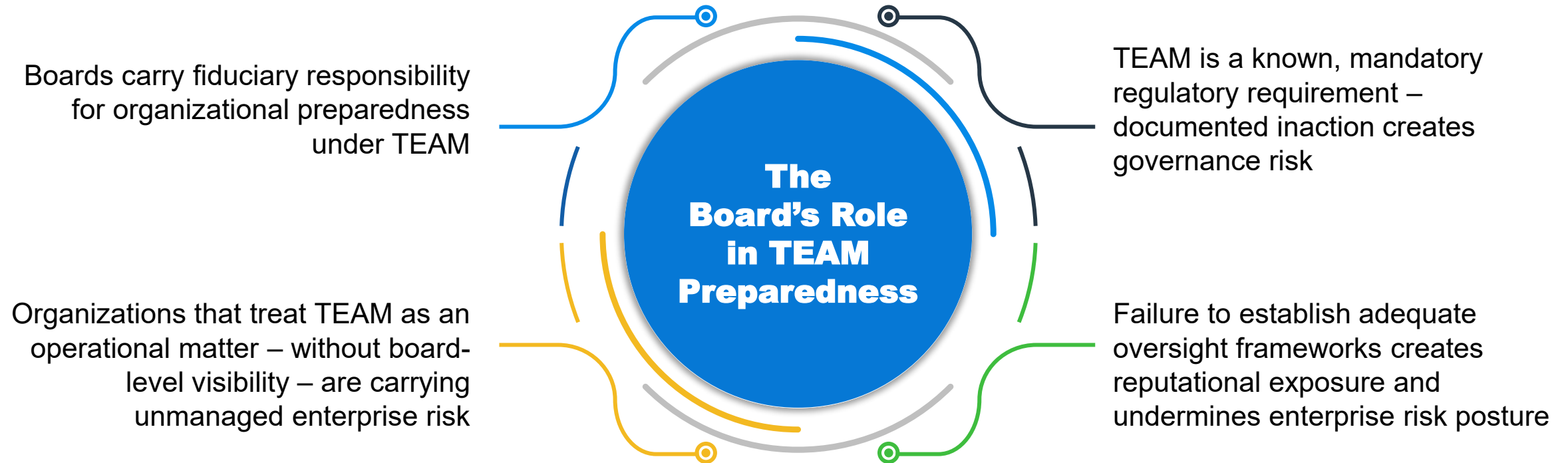
Staffing instability and high turnover directly affect care coordination and episode performance

Burnout reduces the quality and consistency of care across the episode continuum

Post-acute care coordination depends on a stable, engaged clinical workforce

Employee benefits strategy is an underappreciated lever in TEAM readiness

Governance and Legal Liability



Potential Scenarios



Scenario 1: The Financial Modeling Gap

Flying Blind into a Mandatory Risk-Bearing Arrangement

Illustrative scenario – Community Hospital

- A 250-bed community hospital designated MSA performs a high volume of lower extremity joint replacement
- Leadership assumes strong clinical outcomes translate to strong TEAM performance
- No financial modeling has been conducted against CMS episode cost benchmarks
- At first reconciliation, the hospital discovers its post-acute spend – driven by unmanaged SNF utilization – has pushed episode costs 12% above benchmark

Result

A seven-figure repayment obligation to CMS that was not anticipated in the budget – and a compliance conversation the Board was not prepared to have

The gap

No financial exposure modeling. No post-acute care coordination strategy. No board-level awareness of the risk.

Scenario 2: The Governance Blind Spot

When the Board Didn't Know What it Didn't Know

Illustrative scenario – Regional Health System

- A regional health system begins TEAM participation without a formal board briefing on the model's requirements or financial implications
- Senior leadership treats TEAM as an operational matter – delegated to compliance and finance without board responsibility
- During a routine audit, a significant document gap surfaces – affecting both quality scores and cost calculations across multiple episodes
- A payor dispute follows, and the board is asked to respond to questions about its oversight of TEAM compliance
- Board members are unable to demonstrate that adequate governance frameworks were in place

Result

Reputational exposure, a regulatory inquiry and management liability questions that could have been avoided with early governance engagement

The gap

No board briefing. No governance accountability framework. No enterprise risk oversight of TEAM compliance.

Scenario 3: The Compounding Risk Problem

The Aggregate Blind Spot: When TEAM Stacks on Top of Existing VBC Exposure

Illustrative scenario – Multi-Site Health System

- A multi-site health system already participates in two shared savings arrangements and a bundles payment program across its network
- Leadership views TEAM as an incremental compliance requirement – similar to what they’ve managed before
- TEAM is added to the organization’s risk portfolio without modeling the aggregate financial exposure across all risk-bearing arrangements
- A below-average performance year across all programs simultaneously triggers repayment obligations under TEAM, clawbacks under the shared savings arrangements and quality penalties under the bundled payment program

Result

The combined financial impact is significantly larger than any single program would have produced – and exceeds the organization’s contingency reserves

The gap

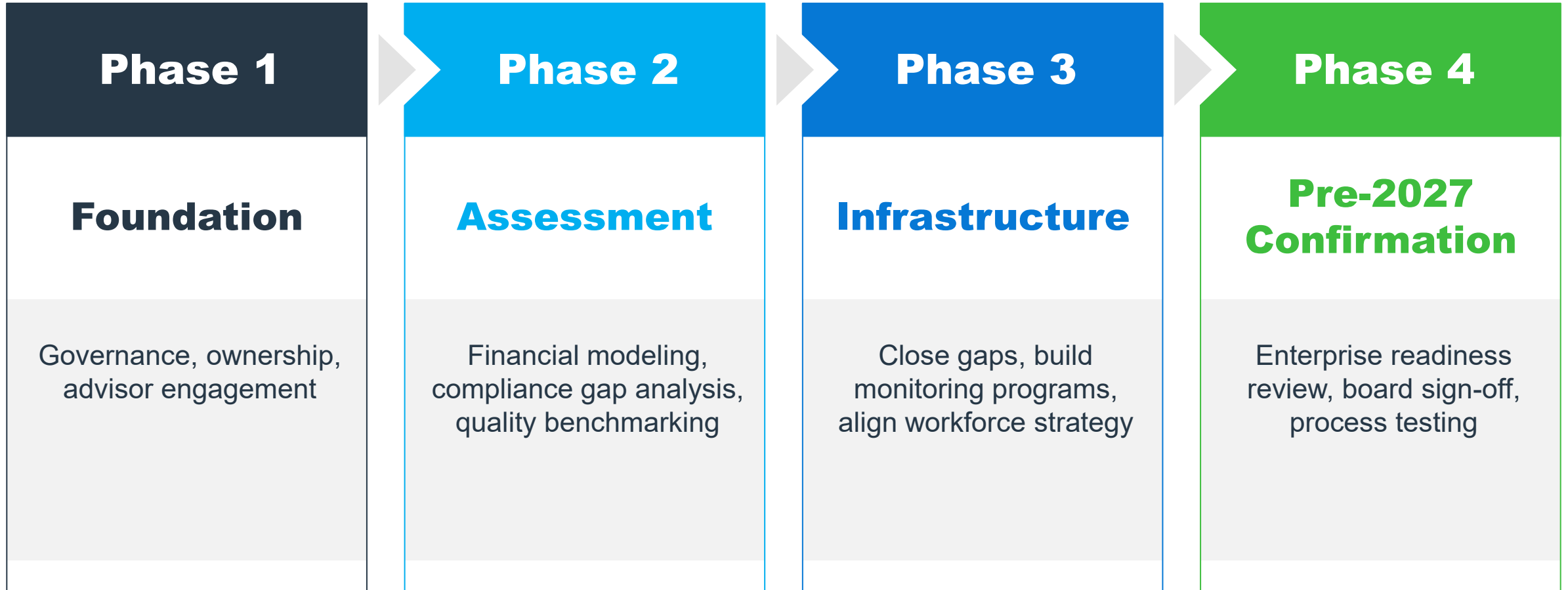
No aggregate VBC risk modeling. No stop-loss or reinsurance strategy. No cross-program risk monitoring.

Readiness Framework

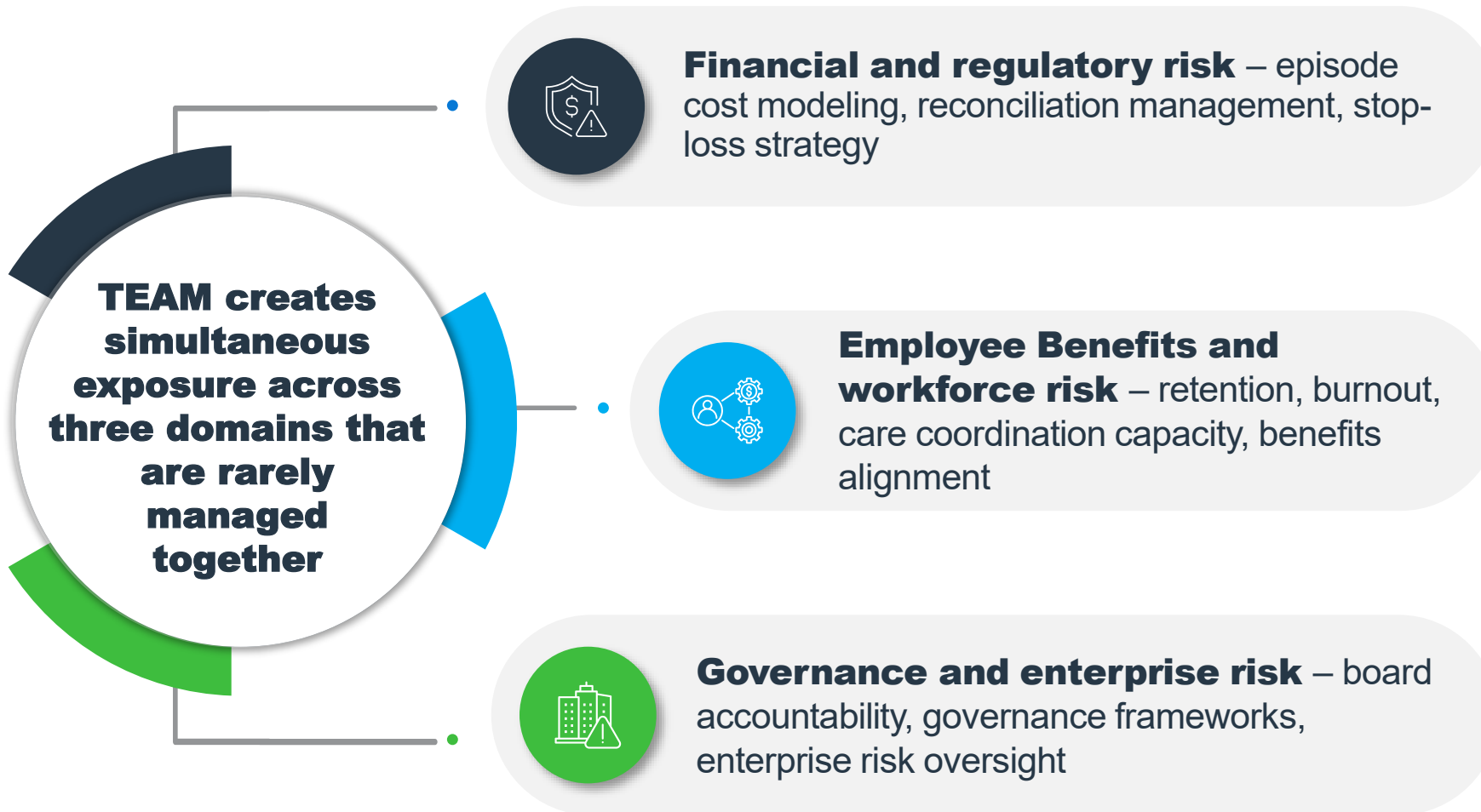


A Four-Phase Readiness Framework

Where to Start – and How to Sequence Your Preparation



TEAM Requires Cross-Functional Coordination



Most organizations manage these through separate advisors – which means no one has a complete picture of their aggregate exposure.

The organizations best positioned to navigate TEAM are those that bring these disciplines together under one roof.

Five Foundational Questions Every Leader Should Ask

01

Have you identified which of your clinical episodes fall within TEAM parameters?

02

Have you modeled your financial exposure under different performance scenarios?

03

Does your Board have visibility into your organization's TEAM readiness status?

04

Do you have cross-functional ownership of TEAM compliance?

05

Have you engaged outside advisors with the right expertise to help you close readiness gaps?

Q&A

UPCOMING EVENTS

hubinternational.com/events/

WEBINAR – Employee Benefits

The State of Global Benefits:

Trends, Risks and What Employers Need to Do

Wednesday, June 10 | 12 PM CT

WEBINAR – Employee Benefits

Breaking the Cost Cycle:

Taking Control of Your Healthcare Cost Strategy

Wednesday, June 24 | 12 PM CT

Thank you

For more information visit www.hubinternational.com



Appendix

Glossary of Terms

- **ACO** — Accountable Care Organization: A group of healthcare providers that coordinate care for a defined patient population, often sharing in savings or losses based on performance.
- **BPCI** — Bundled Payments for Care Improvement: A prior CMS voluntary initiative that bundled payments for defined clinical episodes — a predecessor to mandatory models like TEAM.
- **CABG** — Coronary Artery Bypass Graft: A cardiac surgical procedure included within TEAM episode definitions.
- **CFR** — Contingent Financial Risk: Financial obligations that arise when performance falls short of contractual benchmarks in value-based care arrangements.
- **CMS** — Centers for Medicare & Medicaid Services: The federal agency that administers Medicare, Medicaid and the TEAM model.
- **EB** — Employee Benefits: The benefits and compensation programs offered to employees — a key lever in workforce stability and TEAM readiness.
- **ERM** — Enterprise Risk Management: A framework for identifying, assessing and managing risk across an entire organization.
- **LEJR** — Lower Extremity Joint Replacement: A high-volume surgical episode — including hip and knee replacements — included in TEAM.
- **MPL** — Medical Professional Liability: Insurance and risk management related to professional liability claims against healthcare providers.
- **MSA** — Metropolitan Statistical Area: The geographic designation CMS uses to determine mandatory TEAM participation for eligible hospitals.
- **SAVR** — Surgical Aortic Valve Replacement: A cardiac surgical procedure included within TEAM episode definitions.
- **SNF** — Skilled Nursing Facility: A post-acute care setting whose utilization directly affects episode costs under TEAM.
- **TEAM** — Transforming Episode Accountability Model: CMS's mandatory value-based care initiative holding hospitals financially accountable for the full cost and quality of care across defined clinical episodes.
- **VBC** — Value-Based Care: A healthcare payment model that ties provider reimbursement to quality outcomes and cost efficiency rather than volume of services.