TEAM Administrative Responsibilities Checklist

Numeric References - Federal Register Citations in Appendix A | Key Terms in Appendix B

I. Oversight of Sharing Arrangements and Collaborator Selection

Select TEAM collaborators using written policies and procedures. Selection criteria must include quality of care and anticipated contribution to TEAM performance, and may not be based on the volume or value of referrals or business otherwise generated. (1)	☐
Ensure each sharing arrangement is in writing, signed by the parties, and entered into before care is furnished to TEAM beneficiaries under the arrangement. (2)	☐
Ensure financial arrangements (including gainsharing and alignment payments) are not conditioned directly or indirectly on the volume or value of referrals or business otherwise generated, and do not induce the reduction or limitation of medically necessary items or services. (3)	☐
Maintain accurate current and historical lists of all TEAM collaborators (including names and addresses), update the lists at least quarterly, and publicly report the current list on a web page on the TEAM participant's website. (4)	☐
Maintain readiness to submit the Financial Arrangements List (FAL) and Clinician Engagement List (CEL) to CMS. (5)	☐

II. Audit and Record Retention - Gainsharing and Alignment Payments

Maintain - and require each TEAM collaborator to maintain - contemporaneous documentation for each gainsharing payment or alignment payment, including the nature of the payment, parties, date, and amount. (6)	☐
For any recoupment of all or a portion of a collaborator's gainsharing payment, document the date and amount of the recoupment and the explanation for each recoupment. (7)	☐

III. Beneficiary Protections - Notice Requirements and Freedom of Choice

Provide CMS-developed or CMS-approved beneficiary notification materials that explain the model, confirm beneficiary freedom of choice, address data sharing, and direct beneficiaries to where they can access the list of providers, suppliers, and accountable care organizations (ACOs) with whom the TEAM participant has a sharing arrangement. (Materials may be translated to meet language needs.) (8)	☐
As a condition of each sharing arrangement—defined as a financial arrangement between a TEAM participant and a TEAM collaborator for the sole purpose of making gainsharing payments or alignment payments under the TEAM model—require all ACOs, providers, and suppliers that execute such an arrangement to furnish the beneficiary notification materials prior to discharge from the anchor hospitalization or anchor procedure. (9)	☐
Maintain the ability to generate a list of all beneficiaries who received the beneficiary notification materials (including the date furnished) and provide the list to CMS or its designee upon request. Require collaborators to maintain similar capability for notices they furnish. (10)	☐
Do not restrict beneficiary freedom of choice, including by limiting beneficiaries to a preferred or recommended provider list that is inconsistent with existing Medicare statutes and regulations. (11)	☐
If a TEAM beneficiary is discharged to a SNF without a qualifying 3-day inpatient stay and the SNF is not on the qualified list, provide a discharge planning notice alerting the beneficiary of potential financial liability (otherwise the TEAM participant may be financially liable for the SNF stay). (12)	☐

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IV. Care Coordination Requirement

During discharge planning, make a referral to a supplier of primary care services for the TEAM beneficiary on or prior to discharge from the anchor hospitalization or anchor procedure. (13)	☐

V. Beneficiary Engagement Incentives - Documentation and Technology Safeguards

Maintain contemporaneous documentation of beneficiary engagement incentives that exceed $25 in retail value (including items of technology), including the date provided, the incentive and estimated retail value, and the identity of the beneficiary. (14)	☐
For technology incentives, ensure total retail value does not exceed $75 per TEAM beneficiary per episode and that the technology is the minimum necessary to advance a clinical goal. (15)	☐
For technology items exceeding $75 in retail value, ensure the items remain the property of the TEAM participant and are retrieved at the end of the episode. Document retrieval attempts and the ultimate date of retrieval. (16)	☐

VI. Organizational Change and Regulatory Notifications

If the TEAM participant files a voluntary or involuntary bankruptcy petition, provide notice by certified mail to CMS and the local U.S. Attorney Office within 5 days after the petition is filed, and include a copy of the petition (unless TEAM payment matters have been fully and finally resolved). (17)	☐
Provide written notice to CMS within 30 days of any change in the TEAM participant's legal name becoming effective, including authenticated legal documentation. (18)	☐
Provide written notice to CMS at least 90 days before the effective date of any change in control. (19) A “change in control” generally includes transactions that materially alter who owns or directs the hospital, such as a sale or transfer of substantially all assets, a merger or consolidation where the hospital does not survive, or a transfer of majority ownership or voting rights (see Medicare Managed Care Manual, Ch. 12, §§10.1–10.2). CMS may evaluate such changes for program integrity risks and may require immediate reconciliation of any amounts owed under the TEAM model (42 CFR § 512.595(c)(2))	☐

If you have any questions or seek guidance on how to operationalize these requirements, please contact PYA.

Appendix A

Federal Register Pinpoint Citations

(Numeric Crosswalk)

#	Federal Register pinpoint citation
1	(89 Fed. Reg. 69810-69811 (Aug. 28, 2024)
2	(89 Fed. Reg. 69811 (Aug. 28, 2024)
3	(89 Fed. Reg. 69811-69812 (Aug. 28, 2024)
4	(89 Fed. Reg. 69817 (Aug. 28, 2024)
5	(89 Fed. Reg. 69854-69856 (Aug. 28, 2024)
6	(89 Fed. Reg. 69817 (Aug. 28, 2024)
7	(89 Fed. Reg. 69817 (Aug. 28, 2024)
8	(89 Fed. Reg. 69838-69839 (Aug. 28, 2024)
9	(89 Fed. Reg. 69838 (Aug. 28, 2024)
10	(89 Fed. Reg. 69934-69935 (Aug. 28, 2024)
11	(89 Fed. Reg. 69638 (Aug. 28, 2024)
12	(89 Fed. Reg. 69836-69837 (Aug. 28, 2024)
13	(89 Fed. Reg. 69851 (Aug. 28, 2024)
14	(89 Fed. Reg. 69823 (Aug. 28, 2024)
15	(89 Fed. Reg. 69822 (Aug. 28, 2024)
16	(89 Fed. Reg. 69822 (Aug. 28, 2024)
17	(89 Fed. Reg. 69629 (Aug. 28, 2024)
18	(89 Fed. Reg. 69630 (Aug. 28, 2024)
19	(89 Fed. Reg. 69630 (Aug. 28, 2024)

Appendix B

Key Terms

Anchor: An anchor is either an inpatient hospital stay (anchor hospitalization) or an outpatient procedure (anchor procedure) that initiates a TEAM episode. Anchor hospitalizations are billed through the Inpatient Prospective Payment System (IPPS), while anchor procedures are performed in hospital outpatient departments and billed through the Outpatient Prospective Payment System (OPPS).

Citation: 42 CFR § 512.505; 89 Fed. Reg. 69810–69811 (Aug. 28, 2024)

Beneficiaries: Medicare fee-for-service beneficiaries who receive a qualifying anchor hospitalization or procedure at a TEAM participant hospital for one of the designated surgical episode categories.

Citation: 89 Fed. Reg. 69811–69812 (Aug. 28, 2024)

Clinician Engagement List (CEL): A list of individual clinicians identified by TEAM participants as engaged in the delivery of care during TEAM episodes.

Citation: 89 Fed. Reg. 69817; 69823 (Aug. 28, 2024)

Financial Arrangements List (FAL): A required list maintained by TEAM participants documenting all financial arrangements with downstream collaboration agents related to TEAM episodes.

Citation: 89 Fed. Reg. 69836–69837 (Aug. 28, 2024)

Freedom of Choice: TEAM participants and collaborators must not restrict or interfere with a beneficiary's right to choose any Medicare-enrolled provider or supplier.

Citation: 89 Fed. Reg. 69629–69630; 69638 (Aug. 28, 2024)

Gainsharing and Alignment Payments: Financial payments from TEAM participant hospitals to downstream collaboration agents, made either retrospectively (gainsharing) or prospectively (alignment), to support care coordination and reward performance.

Citation: 89 Fed. Reg. 69838–69839; 69854–69856 (Aug. 28, 2024)

TEAM: Transforming Episode Accountability Model (TEAM) is a Medicare mandatory episode-based payment model under which selected acute care hospitals are financially accountable for the total cost and quality of specified episodes of care across the anchor hospitalization or anchor procedure and the post-acute period.

https://www.cms.gov/priorities/innovation/innovation-models/team-model