Rainfall HEALTH

COMPLIANCE UNDER THE CMS TEAM MANDATE

The compliance risk hiding in plain sight

Gain sharing, data governance, and AI — the unsexy, highest-stakes parts of TEAM implementation, with a legal leader who has lived it from both sides.

FEATURING

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Former Chief Legal & Digital Health Officer, Bassett Healthcare Network

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VP, Compliance & Care Coordination

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INTRODUCTION

The part of TEAM almost no one is talking about publicly

Most conversations about Medicare's Transforming Episode Accountability Model focus on episodes, tracks, and dollars. This one goes somewhere else — to the compliance risk that sits quietly underneath all of it: how you structure gain sharing, how you govern data across the care continuum, and how you adopt AI without creating new exposure.

This guide distills a Rainfall Health webinar with a legal leader who has spent a career at the intersection of healthcare regulation and technology, in conversation with two of Rainfall's implementation and compliance leads. It assumes you already know TEAM is live and mandatory for your hospital.

> **A note:** this is informational, not a Rainfall pitch — and nothing here is legal advice. It's real-world experience, shared to spread awareness on a topic that carries the highest stakes in the game.

FEATURED VOICES

Paul Uhrig
Former Chief Legal & Digital Health Officer, Bassett Healthcare Network

Decades at the intersection of health regulation, interoperability, and technology. Rainfall advisory committee member.

Marla Merkle
VP, Compliance & Care Coordination, Rainfall Health

Oversees internal regulatory compliance and the care coordination team.

Robby Wallace
VP, Clinical Implementation, Rainfall Health

Leads care transformation, clinical compliance, and clinical care design.

01 · THE FRAMING

Unsexy — and the highest stakes in the game

For decades we've said the health system is broken: that we should keep people healthy rather than only treat them when they're sick, and that misaligned incentives are a core problem. TEAM is a real step toward fixing that — its entire design aligns incentives across the care continuum so patients don't come back through the hospital doors.

But every program like this carries compliance risk underneath it. Get the structures wrong and the same alignment that creates value becomes exposure. That's the part almost no one is discussing publicly — and it's exactly where implementation succeeds or fails.

> "This isn't a Rainfall pitch. This conversation is mostly about implementation — the parts that are genuinely unsexy. But we also see these as the highest stakes in the game."
>
> Robby Wallace, VP of Clinical Implementation

Three buckets, one theme

BUCKET 1

Gain sharing & contracts

Sharing incentive payments with downstream providers — on the right criteria, in the right structure.

BUCKET 2

Data governance

Getting the right information to the right place — without letting it be used in ways you never intended.

BUCKET 3

AI

Real efficiency for episode analytics and post-discharge care — governed so it doesn't create new risk.

02 · GAIN SHARING & CONTRACTS

Gain sharing is more than "we'll split the savings"

Gain sharing is one of the arrangements that keeps incentives aligned across the care continuum: when the government pays an incentive for well-managed care, you share it downstream so partners benefit from managing that care appropriately. But it is not simple — and doing it well requires four things working together.

Governance

The committee and decision rights that decide how arrangements are set, monitored, and adjusted.

Data analytics

The measurement that ties shared dollars to real, documented performance — not assumptions.

Contracting

Written agreements with downstream providers, in place *before* care or referrals begin.

Payment infrastructure

The mechanics to actually execute the arrangement and distribute episodic results correctly.

The legal documents and the operational side of the house have to work hand in hand. A perfect agreement means nothing if operations don't match it — and vice versa.

Get everyone in the room early. Create a committee — technology, finance, legal, compliance, population health — and start these discussions before implementation. Legal and compliance need a live view of what's happening operationally.

03 · THE QUESTIONS LEGAL MUST ASK

Five questions before you sign anything

As a health system enters these arrangements, the legal department should be pressing on five things. Each maps to a place where gain sharing quietly goes wrong.

1

What's the regulatory authority?

Always start here. Stark, the Anti-Kickback Statute, and the TEAM regulation — on both federal and state sides.

2

What's the care-redesign objective?

Efficiency, quality, care coordination — or all of them? Name what the arrangement is actually meant to achieve.

3

How is compensation calculated?

What's the methodology, and how are you documenting the sharing of the payments you receive from the government?

4

Could this be viewed as rewarding referrals?

The third rail of every arrangement. The value exchange must fund needed care — never induce referrals.

5

Is it all in a written agreement — up front?

Documented before implementation, before care, before any referrals. Include monitoring and auditing for a later government review.

Where hospitals actually slip

> "You can't have a perfect agreement if your operations are not aligned with what is supposed to happen. That coordination is where most missteps live."
>
> Paul Uhrig, former Chief Legal & Digital Health Officer

The CMS-sponsored model safe harbor

Issued by the OIG in late 2020 / early 2021 — relatively new. You must be in strict compliance with its requirements, and it has to be driving the model you're actually in.

The bright lines

The exchange of value can't be construed to induce referrals. You can't limit services or provide medically unnecessary ones. The point is the best care — not less of it.

THE BIGGEST MISSTEP

Treating the agreement as an afterthought — papering it *after* the operations are already running. Everything must be documented in your downstream agreements before you start providing care or sending patients to referral sources.

Foster the post-acute relationships early. Gain sharing usually means new financial arrangements with ancillary providers and community network partners. Start those communications — and set the right criteria — as early as possible.

05 · DATA GOVERNANCE

The first question is always: who are you sharing data with?

Episodes span the acute setting, the post-acute setting, and everywhere in between — so managing them means moving information across organizations. Where the data goes changes which rules apply.

Clinician to clinician: well-established rails

When you share with other providers for treatment and operations, the frameworks and technical infrastructure already exist — and health systems know them well. This is generally covered by HIPAA or applicable state law.

TEFCA | Epic Care Everywhere | State HIE | HIPAA / state law

Where it gets trickier: vendors

The moment you bring in vendors — to run analytics, or to power AI — is the moment you must stay especially vigilant. Keep your HIPAA business associate agreement in place and your data-use restrictions tight, because episode analytics almost always run through a third party.

The recurring failure mode

A vendor uses the data beyond what they should — or the agreement quietly permits uses broader than what was ever intended. Keep a close eye on data use: is it really being limited to this purpose only?

Know your customer — and know your vendor

> "Scour that agreement to make sure there's no loophole that lets someone use data — identified or de-identified — in a way the health system never intended."
>
> Paul Uhrig, former Chief Legal & Digital Health Officer

The risk often hides one layer down: a vendor with a *downstream* vendor that was never sufficiently vetted. Know what systems they use, and confirm the use is genuinely limited to what was agreed.

Vet the whole chain

Your vendor's vendors matter. Confirm every link in the chain restricts data use to the agreed purpose.

Restrict identified & de-identified data

Both carry risk. The loophole is usually in what the contract quietly allows, not what it obviously states.

The balancing act: information blocking vs. HIPAA

DON'T RELEASE IT

Withhold data and you can be accused of **information blocking** under federal law.

RELEASE IT WRONGLY

Release it inappropriately and you may have **HIPAA** problems instead.

Providers sit between the two — the job is to do right by patients while staying on the correct side of both.

AI belongs in TEAM — under real governance

TEAM needs analytics, and AI helps you understand where your patients are going. Remote patient monitoring will only grow more important for managing post-discharge care, and those tools increasingly run on AI. The question isn't whether — it's how it's governed.

Centralize the governance

Successful systems centralize AI governance while keeping stakeholders involved — if radiology wants AI, radiology is in the room; population health is in the room. Centralization is what keeps every application working seamlessly instead of spawning a bunch of disconnected silos.

Keep a human in the loop

In these early stages, verify reliability and accuracy — while recognizing that if a human always verifies, you never capture the efficiency. Balance it deliberately.

Guard the training data

Ensure your data isn't fed into or used to train LLMs unless you intend it. With ever-increasing data mobility, it comes back to your agreements and what they allow.

A sea change in the past six months: the skepticism of a year ago has given way to genuine enthusiasm among administrators and clinicians alike — which makes disciplined governance more important, not less.

Move deliberately — but move with speed

> "Start incrementally, get some early wins, do your due diligence. Begin on the administrative side, then move into the clinical side."
>
> Paul Uhrig, former Chief Legal & Digital Health Officer

Must-asks before you adopt any AI tool

- **What are our goals?** Anchor every tool to a defined outcome before you evaluate it.
- **Where can we start small?** Pick an incremental use case that can produce an early, credible win.
- **What does our data-use agreement allow?** Confirm the tool can't repurpose or train on your data.
- **Who owns centralized governance?** Name it before adoption, with the right stakeholders attached.

Speed + diligence

We're in an age where health systems need to move with some speed — AI will be very beneficial if it's used correctly. The discipline is doing both at once.

09 · WILL IT BE ENFORCED?

History says: take it seriously

Some hospitals are treating TEAM penalties as hypothetical. But value-based care is a stated priority for this administration — and there's a direct historical parallel that ended exactly one way.

THE PARALLEL · CIRCA 2008-2010

Meaningful use, EHR adoption, and electronic prescribing followed the same playbook: the government offered incentives, then followed them with penalties for hospitals that didn't meet the thresholds.

Incentives offered › **"They'll never enforce it"** › **Penalties came anyway**

The government stayed true to the regulation — and the data shows it worked. Adoption of EHRs and e-prescribing rose because of incentives followed by the credible threat of penalties. History tells us the same will hold for TEAM.

WHAT THAT MEANS FOR TEAM TODAY

A stated priority

Value-based care — keeping people healthy — has been a priority for this administration from the start, per CMS leadership.

Mandatory, not optional

TEAM is a required program. Any policy advancing value-based care should be taken seriously — this one especially.

Don't wait it out

"Maybe they'll waive it" is the same bet hospitals lost last time. The thresholds — and the penalties — arrived on schedule.

Historical parallel drawn from Surescripts-era e-prescribing mandates

10 · THE NEXT 90 DAYS

Make it, no pun intended, a team effort

> "It's a mandatory program — treat it as such. Get everybody together, every function in the hospital working toward the same success, for your patients and your system alike."
>
> Paul Uhrig's advice for the first year of the five-year mandate

Convene the committee

Legal, compliance, finance, technology, population health — together, now.

Paper it up front

Gain-sharing agreements documented before care and referrals begin.

Audit your vendors

Data-use restrictions in place; AI under centralized governance.

WHERE RAINFALL FITS

The end-to-end TEAM solution — compliance included

Rainfall Health is an accountability and accessibility platform powered by AI — the first and only company certified for these Medicare-mandated programs. That certification runs straight through the risks in this guide: compliant gain-sharing structures, disciplined data governance, and AI adopted under real oversight.

Compliance

Gain-sharing structures and downstream agreements built to the CMS-model safe harbor — documented before care begins.

Data governance

Vetted vendors, tight data-use restrictions, and the right rails across the continuum — without tipping into information blocking.

AI-enabled care design

Episode analytics and post-discharge monitoring under centralized governance, with a human in the loop where it counts.

GET CONNECTED

Let's talk about your TEAM compliance

If you're navigating gain sharing, data governance, or AI adoption under the mandate, we'd like to help. Rainfall is the end-to-end solution — technology and services — for hospitals and health systems, and we're glad to spread information and education on the topic.

LEARN MORE
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START A CONVERSATION
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Watch for the next edition of the Rainfall Health webinar series.