Transforming Episode Accountability Model (TEAM)
What to Know & How to Prepare

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Today’s Learning Objectives

1

Describe the history of CMS’ value-based care strategies, current alternative payment models, & goals

2

Identify the structure of TEAM, model timeline, & geographies required to participate

3

Explain model requirements, key considerations for compliance, & best practices for operationalizing a mandatory bundled payment model

Agenda

1. Episodes of Care Overview
2. Transforming Episode Accountability Model (TEAM) Overview
3. Preparing for Participation in TEAM

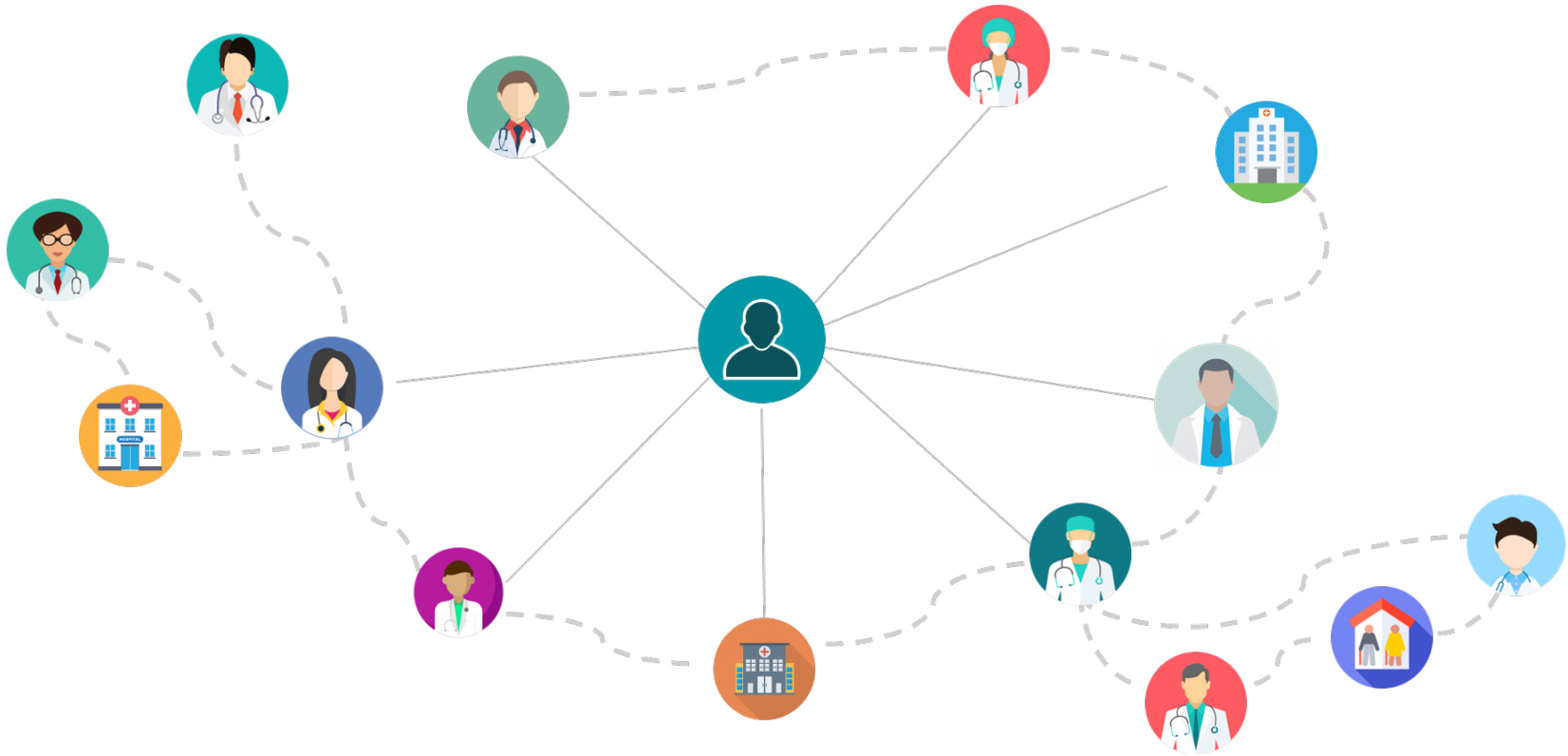
Episodes of Care Overview

CMMI's Specialty Strategy

CMMI has developed a **comprehensive specialty strategy** to test models that supports **person-centered care** across the patient journey. The new strategy focuses on four key elements.

- Enhance Specialty Care Performance Data Transparency
- Maintain Momentum on Episode Payment Models
- Create Financial Incentives Within Primary Care for Specialist Engagement
- Create Financial Incentives for Specialists to Move to Value-Based Care

"Medicare beneficiaries often experience fragmented and costly care, distinguished by frequent diagnostics, imaging, tests and other treatment approaches delivered by specialists across sites of care"



Why Focus on Episodes of Care?

Episodic care models complement care transformation in other initiatives. Strategic implementation of episode-based models helps fill geographic & demographic gaps where accountable entities have yet to extend their reach & keeps healthcare providers moving toward accountability for quality & cost outcomes.

	Acute or Specialty Care & Target Population	Primary Care & Population Management
Model Example	CJR, BPCI-A	MSSP
Participants	Hospitals, post-acute care, specialty care, home health	Accountable care organizations (ACOs), primary care practices, health plan networks
Interventions	Reduction in or prevention of avoidable institutional care, management of diseases	Prevention, management of diseases, care coordination
Beneficiaries	Moderate to high cost acute-care episodes, chronically ill, & other targeted populations	Mostly healthy, lower cost patients (a few exceptions of models targeting sicker patients)

Source: The CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care

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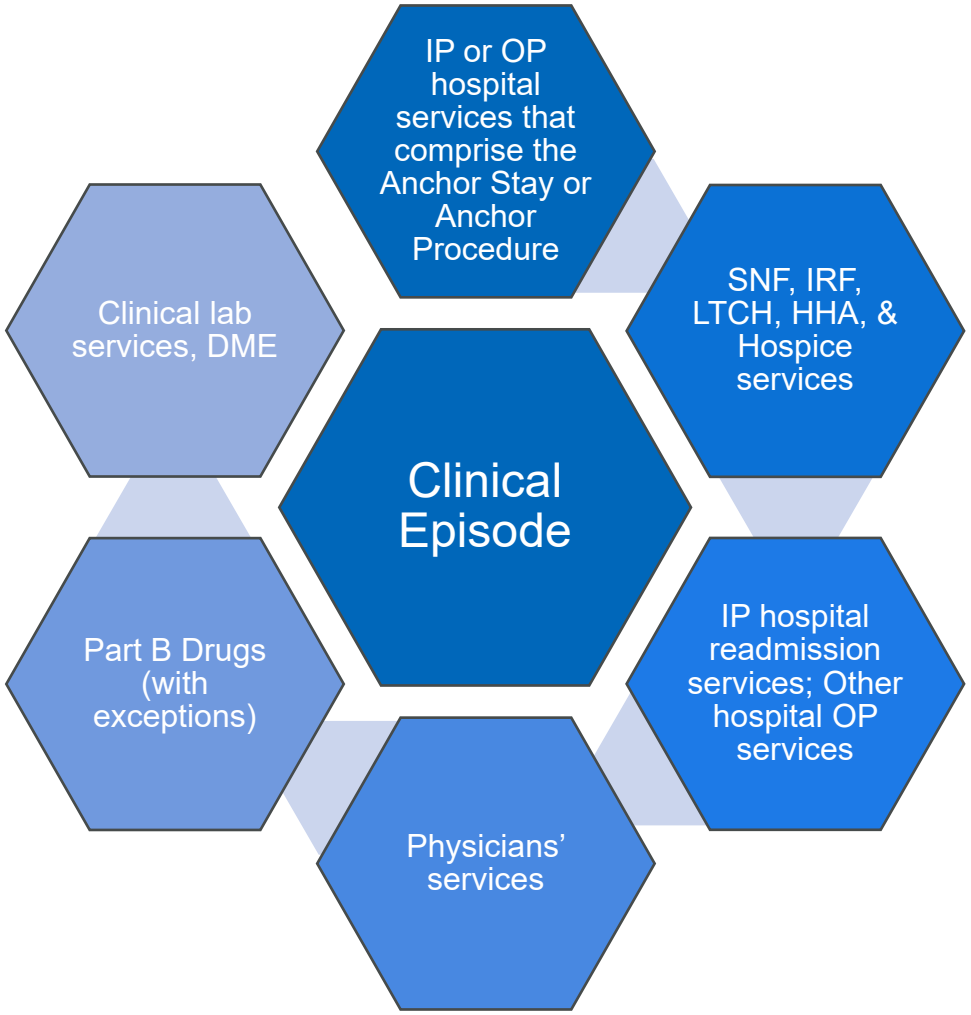
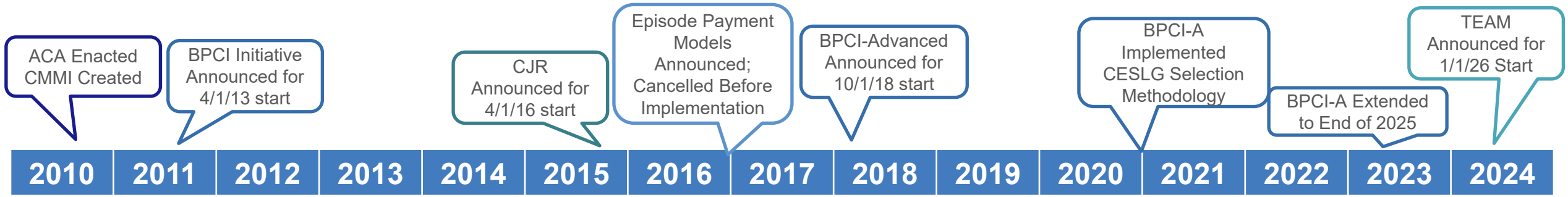
What Is Included in an Episode of Care?

- Total-cost-of-care for episodes during the initial hospitalization (or procedure for OP episodes)
- Almost all expenditures are included; there are some pre-determined exclusions
- Patients may receive services anywhere & all sites of care are included
- Services are prorated if they straddle episode end dates
- Revenue cycle is typically not disrupted



History of Select CMMI Episode of Care Models



ACE

- Medicare saved $585 per episode; however, increases in PAC spending reduced savings by 45%

BPCI Initiative

- FFS payments were significantly reduced, but CMS experienced net losses after accounting for reconciliation payments to participants
- Post-acute utilization & readmissions reduced with limited changes in quality or patient experience

CJR

- First four performance years generated savings to CMS, but COVID pandemic required adjustments to the model that resulted in net losses, results of extension are TBD
- Little impact on quality or mortality scores while reducing utilization of post-acute care

BPCI Advanced

- Through Model Year 3 (2020), CMS experienced net losses after accounting for reconciliation payments to participants
- **In Model Year 4 (2021), CMS saved $465M**

- ACA – Affordable Care Act
- CMMI – Centers for Medicare & Medicaid Innovation
- ACE – Acute Care Episode
- BPCI – Bundled Payments for Care Improvement
- CJR – Comprehensive Joint Replacement
- EPM – Episode Payment Model (Cardiac & Orthopedics)
- TEAM – Transforming Episode Accountability Model

Benefits of Participating in Episodes of Care

Patients

- Improved experience & clinical outcomes through more coordinated care
- Reduction in readmissions & length of stay in hospital &/or post-acute facility
- Emphasis on treating conditions at home when clinically appropriate
- Increased communication between primary care providers & specialists
- Incentives available for healthy habits, *i.e.*, providing a scale to track weight, wearable fitness tracker, blood pressure cuff, etc.

Providers

- Financial benefits if total costs are lower than set target prices
- Access to claims data that is often elusive
- Vehicle to drive coordination of care across primary care & post-acute providers
- Mechanism to engage service lines & specialists in value-based care

Payors

- Revenue stream diversification through value-based incentives
- Lowered total costs through reduction of unnecessary services
- Improved quality performance through increased provider accountability

Transforming Episode Accountability Model (TEAM) Overview

What Is TEAM?

- Transforming Episode Accountability Model was finalized in the FFY 2025 IPPS Final Rule displayed on August 1, 2024.

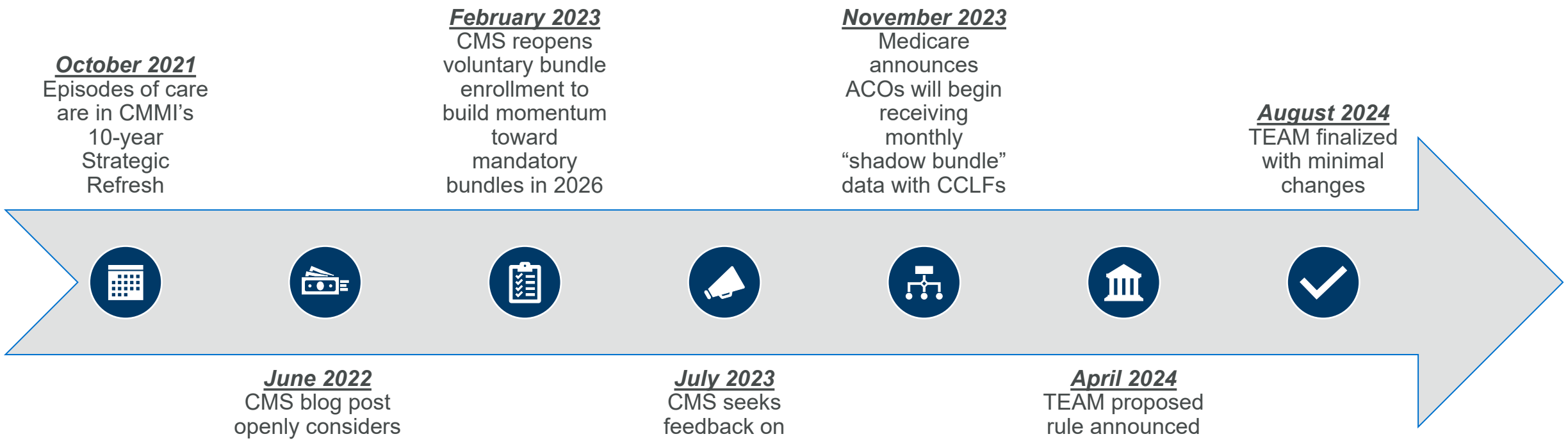
Mandatory for selected acute care hospitals

Goal is to improve quality of care for Medicare beneficiaries undergoing certain high-cost surgeries while reducing costs

Purpose is to address fragmented care that leads to complications in recovery, avoidable hospitalization, & increased spending

Emphasis on improving health equity & access to high-quality care for people in underserved areas

The industry saw this coming…



TEAM Overview

Traditional Medicare FFS Duration: 1/1/2026 – 12/31/2030	Hospitals required to participate were selected based on geographic regions	Current BPCI-A & CJR participants can opt in to participation if their region was not selected	Inpatient stay + 30-day total cost of care episodes, incl. Parts A & B; revenue cycle undisrupted
Graduated risk through three participation tracks, with 0% downside risk moving up to 5% or 20% in subsequent years*	5 surgical episode groups (inpatient & outpatient settings)	Target prices will be set at the regional level for each DRG/HCPCS with additional adjustments	Patients attributed to a Medicare ACO are still included in TEAM
Quality measures will be linked to financial gains and losses	One financial reconciliation per model year	Participants are required to screen patients for health-related social needs (HRSN) and include referral to primary care in discharge planning	Gainsharing is allowed

*Some participants will qualify for a 5% downside risk cap

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Significant Updates in TEAM Final Rule

- Some of the proposed ruling was adapted based on public comment, below are the most significant changes from Proposed to Final Rule:

1. **Voluntary Opt-In**: available for current BPCI-A or CJR participants who complete their current agreement periods
2. **Spinal Fusion Final MS-DRG's**: CMS removed MS-DRG's 453, 454, 455, 459, 460, & ADDED MS-DRG's 402, 426, 427, 428, 429, 430, 447, 448, 450
3. **Safety Net Hospital Participation**: will now be allowed to participate in Track 1 for Performance Year 1-3
4. **Track 2 Financial Risk**: Track 2 will be available for a limited number of participants for Performance Year 2-5 & financial risk has been reduced from 10% stop-gain & stop-loss to 5% stop-gain & stop-loss
   - ➢ Quality adjustment for Track 2 will be up to 10% for positive reconciliation & up to 15% for negative reconciliation
5. **Retrospective Trend Factor**: CMS will now apply a retrospective trend factor to the reconciliation target prices (capped at 3%)
6. **Updated Discount Factors**: proposed Discount Factor was 3% reduction from Target Price: Final Discount Factors:
   - ✓ CABG & Major Bowel = 1.5% Discount Factor
   - ✓ LEJR, SHFFT, & Spinal Fusion = 2.0% Discount Factor
7. **Risk Adjustment**: expanded Risk Adjustment from original 3 factors to include episode specific Risk Adjustment Factors
8. **Rural Hospital Definition**: will no longer include hospitals that have reclassified as a rural hospital or hospitals that are Rural Referral Centers (RRCs)

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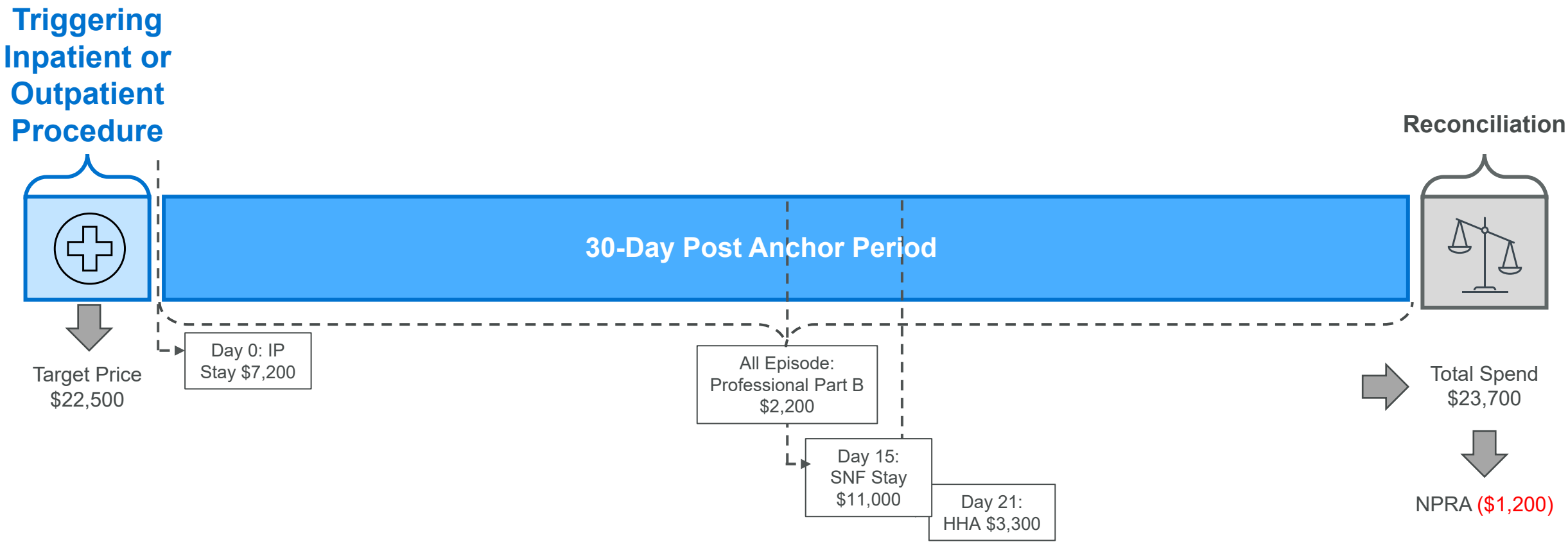
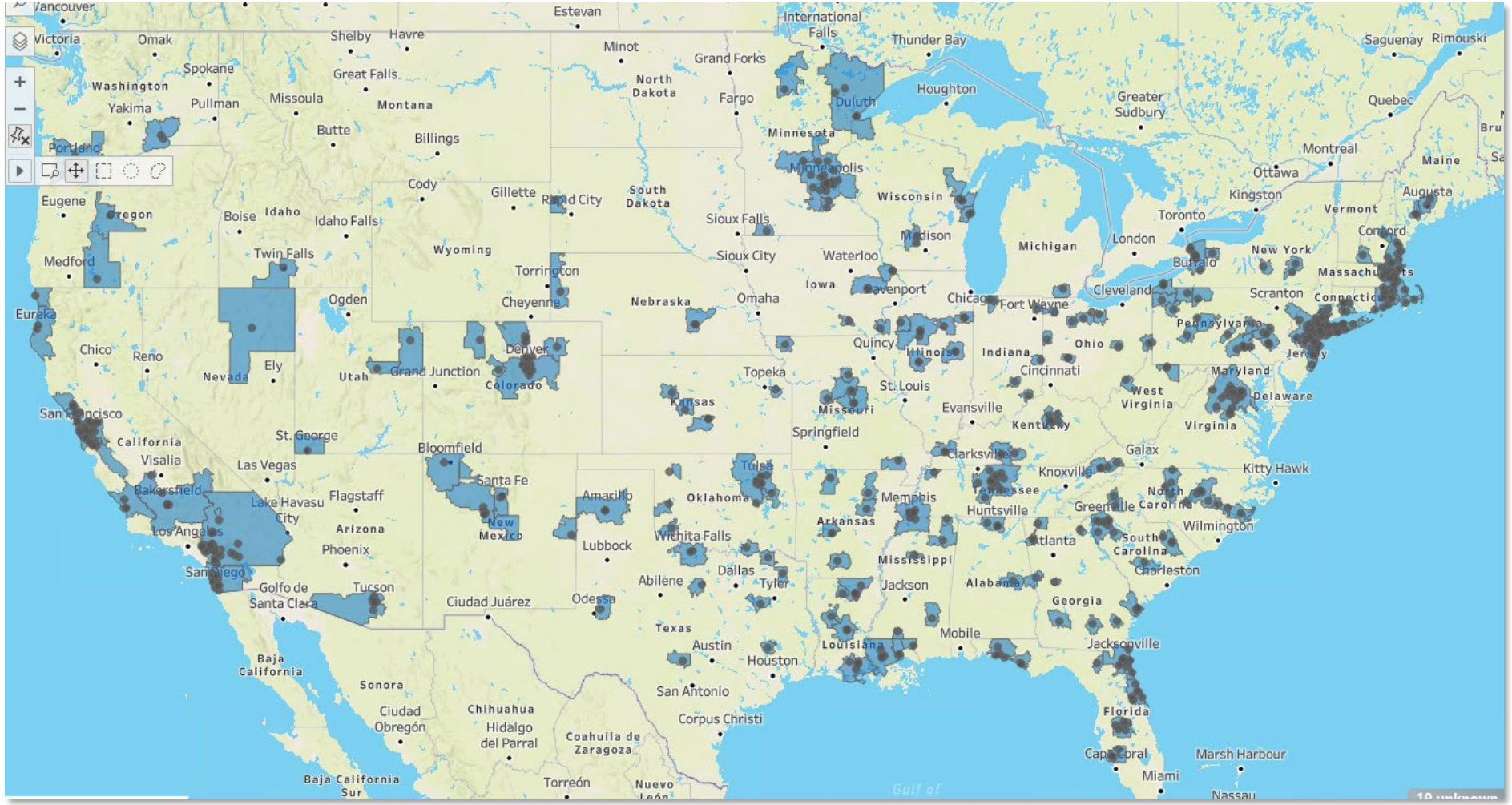
How a TEAM Episode Works



- Reconciliation: Target Price – Spend = NPRA (Net Payment Reconciliation Amount)
  - $22,500 - $23,700 = **($1,200)**; therefore, for this specific Episode, Participant owes **($1,200)**

CBSAs Selected for TEAM



- CMS selected 188 of 803 eligible CBSAs for TEAM
- More than 700 hospitals with surgical episodes
- ~200K cases per year
- $481M Expected Savings

CBSAs NOT Selected for TEAM
Optional Participation

CMS finalized a decision to allow a one-time option for hospitals not selected for TEAM to participate in the Model

Option to participate is ONLY allowed for hospitals currently participating in **BPCI-Advanced or CJR**

In order to be eligible for TEAM, hospital must continue participating in BPCI-Advanced &/or CJR until the last date of the Model

- CJR ends on December 31st, 2024
- BPCI-Advanced ends on December 31st, 2025

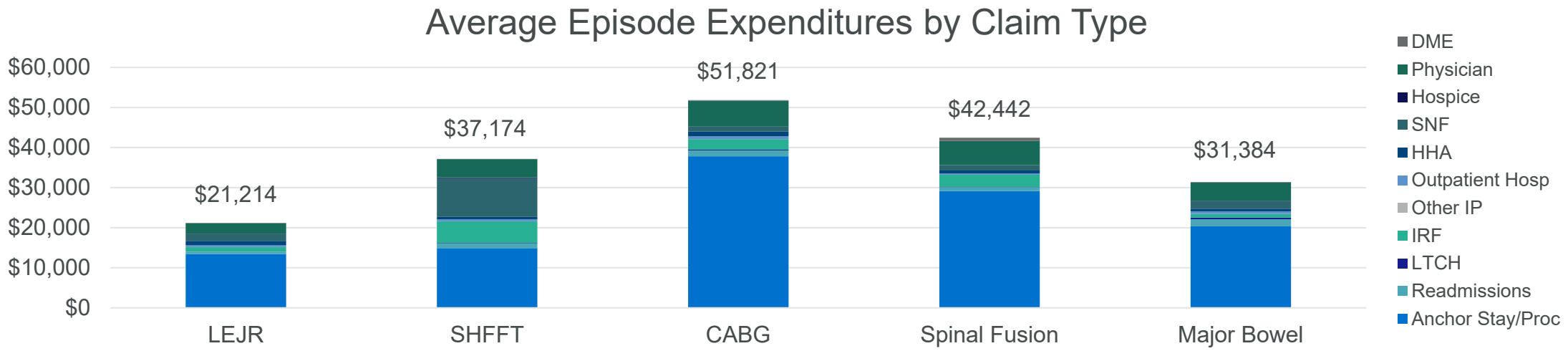
Hospitals opting in must participate in all five episode groups & for the full five years

Voluntary withdrawal after the Model begins is NOT allowed

To opt in, hospitals must submit a written participation letter to CMS in **January 2025**

Episode Groups & Definitions

Episode Category	Billing Codes
Lower Extremity Joint Replacement (Inpatient & Outpatient)	MS-DRG 469, 470, 521, 522 HCPCS 27447, 27130, 27702
Surgical Hip & Femur Fracture Treatment (Inpatient)	MS-DRG 480, 481, 482
Coronary Artery Bypass Graft ("CABG") Surgery (Inpatient)	MS-DRG 231, 232, 233, 234, 235, 236
Spinal Fusion (Inpatient & Outpatient)	MS-DRG 402, 426, 427, 428, 429, 430, 447, 448, 450, 451, 471, 472, 473 HCPCS 22551, 22554, 22612, 22630, 22633
Major Bowel Procedure (Inpatient)	MS-DRG 329, 330, 331



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Target Price Calculation
Overview

1 Benchmark price for DRG/HCPCS episode type in census region (three-year baseline)

2 Site-neutral targets for certain HCPCS/DRG combinations within LEJR & Spinal Fusion episode groups

3 Adjusted for hospital-level variables (hospital bed size, safety net hospital), beneficiary-level variables (age group, HCC count, social risk), & episode-group specific variables (individual HCCs, etc.)

4 1.5% CMS discount applied to Major Bowel Procedure & CABG; 2.0% discount applied to LEJR, SHFFT, & Spinal Fusion episodes

Sample Target Price Calculation

$18,975 Regional Price **x** **1.173** Patient/Hospital Specific Adjustment **x** **0.85** Normalization Factor **x** **1.02** Trend Factor **x** **0.98** CMS Discount **=** **$18,911 Target Price**

Can be adjusted by up to 3% retrospectively

For illustrative purposes only

Risk Adjustment

CMS will utilize the following risk adjusters for patient specific target price adjustment:

- Age Bracket
- HCC Count
- Social Risk
- Hospital Bed Size
- Safety Net Hospital Status

Coronary Artery Bypass Graft (CABG)

- Prior PAC Use
- HCC 18: Diabetes with Chronic Complications
- HCC 46: Severe Hematological Disorders
- HCC 58: Major Depressive, Bipolar, and Paranoid Disorders
- HCC 84: Cardio-Respiratory Failure and Shock
- HCC 85: Congestive Heart Failure
- HCC 86: Acute Myocardial Infarction
- HCC 96: Specified Heart Arrhythmias
- HCC 103: Hemiplegia/Hemiparesis
- HCC 111: Chronic Obstructive Pulmonary Disease
- HCC 112: Fibrosis of Lung and Other Chronic Lung Disorders
- HCC 134: Dialysis Status

Major Bowel Procedure

- Long-Term Institutional Care Use
- HCC 11: Colorectal, Bladder, and Other Cancers
- HCC 18: Diabetes with Chronic Complications
- HCC 21: Protein-Calorie Malnutrition
- HCC 33: Intestinal Obstruction/Perforation
- HCC 82: Respirator Dependence/Tracheostomy Status
- HCC 85: Congestive Heart Failure
- HCC 86: Acute Myocardial Infarction
- HCC 103: Hemiplegia/Hemiparesis
- HCC 111: Chronic Obstructive Pulmonary Disease
- HCC 112: Fibrosis of Lung and Other Chronic Lung Disorders
- HCC 134: Dialysis Status
- HCC 188: Artificial Openings for Feeding or Elimination

Surgical Hip & Femur Fracture (SHFFT)

- HCC 18: Diabetes with Chronic Complications
- HCC 22: Morbid Obesity
- HCC 82: Respirator Dependence/Tracheostomy Status
- HCC 83: Respiratory Arrest
- HCC 84: Cardio-Respiratory Failure and Shock
- HCC 85: Congestive Heart Failure
- HCC 86: Acute Myocardial Infarction
- HCC 96: Specified Heart Arrhythmias
- HCC 103: Hemiplegia/Hemiparesis
- HCC 111: Chronic Obstructive Pulmonary Disease
- HCC 112: Fibrosis of Lung and Other Chronic Lung Disorders
- HCC 134: Dialysis Status
- HCC 157: Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
- HCC 158: Pressure Ulcer of Skin with Full Thickness Skin Loss
- HCC 161: Chronic Ulcer of Skin, Except Pressure
- HCC 170: Hip Fracture/Dislocation

Lower Extremity Joint Replacement (LEJR)

- Dementia Without Complications Variable
- Prior PAC Use
- HCC 8: Metastatic Cancer and Acute Leukemia
- HCC 18: Diabetes with Chronic Complications
- HCC 22: Morbid Obesity
- HCC 58: Major Depressive, Bipolar, and Paranoid Disorders
- HCC 78: Parkinson's and Huntington's Diseases
- HCC 85: Congestive Heart Failure
- HCC 86: Acute Myocardial Infarction
- HCC 103: Hemiplegia/Hemiparesis
- HCC 111: Chronic Obstructive Pulmonary Disease
- HCC 112: Fibrosis of Lung and Other Chronic Lung Disorders
- HCC 134: Dialysis Status
- HCC 170: Hip Fracture/Dislocation

Spinal Fusion

- Prior PAC Use
- HCC 18: Diabetes with Chronic Complications
- HCC 46: Severe Hematological Disorders
- HCC 58: Major Depressive, Bipolar, and Paranoid Disorders
- HCC 84: Cardio-Respiratory Failure and Shock
- HCC 85: Congestive Heart Failure
- HCC 86: Acute Myocardial Infarction
- HCC 96: Specified Heart Arrhythmias
- HCC 103: Hemiplegia/Hemiparesis
- HCC 111: Chronic Obstructive Pulmonary Disease
- HCC 112: Fibrosis of Lung and Other Chronic Lung Disorders
- HCC 134: Dialysis Status

Glide Path to Risk

- TEAM will have graduated risk through different participation tracks to accommodate different levels of risk & reward & allow participants to ease into full-risk participation.
- All participants will have one year to participate in an upside risk only track unless they opt to participate in a two-sided risk track
- In PYs 2-5, risk track for each participant will vary based on their hospital's classification

Safety Net Hospitals	Rural Hospitals, MDH, SCH, or Essential Access Community Hospitals	All Other TEAM Participants
• Upside risk only for PYs 1-3 (**10%** stop-gain limit, Track 1) • Upside & downside risk for PYs 4-5 (**5%** stop-gain/stop-loss limits, Track 2) • Option to move into higher risk track	• Upside risk only for PY 1 (**10%** stop-gain limit, Track 1) • Upside & downside risk for PYs 2-5 (**5%** stop-gain/stop-loss limits, Track 2) • Option to move into higher risk track	• Upside risk only for PY 1 (**10%** stop-gain limit, Track 1) • Upside & downside risk for PYs 2-5 (**20%** stop-gain/stop-loss limits, Track 3)

Participants With Reduced Risk

The following types of TEAM participants would be eligible to participate in tracks with reduced levels of downside risk:

- **Safety net hospitals** that exceed the 75th percentile of the proportion of Medicare beneficiaries across all PPS acute care hospitals in the baseline period for either of the following:
  - Beneficiaries dually eligible for Medicare & Medicaid
  - Beneficiaries eligible to receive Part D low-income subsidies
- **Rural hospitals** that meet at least one of the following criteria:
  - Located in a rural area
  - Located in a rural census tract
- **Medicare dependent hospitals (MDHs)**
- **Sole community hospitals (SCHs)**

Safety Net Hospitals	Rural Hospitals, MDH, SCH or Essential Access Community Hospitals
• Upside risk only for PYs 1-3 (**10%** stop-gain limit, Track 1) • Upside & downside risk for PYs 4-5 (**5%** stop-gain/stop-loss limits, Track 2) • Option to move into higher risk track	• Upside risk only for PY 1 (**10%** stop-gain limit, Track 1) • Upside & downside risk for PYs 2-5 (**5%** stop-gain/stop-loss limits, Track 2) • Option to move into higher risk track

Proposed Quality Measures

- Quality measures will be linked to financial gains & losses in TEAM. Measures include:
  - Hybrid All-Cause Readmission Measure
  - CMS PSI-90
  - LEJR Patient Reported Outcome-Based Performance Measure
  - Hospital Harm & Failure to Rescue Measures (beginning in PY2)
- CMS will use these measures to calculate a Composite Quality Score (CQS) similar to those used in BPCI-Advanced & other Medicare alternative payment models

Track 3 Reconciliation Calculation Examples

Negative Financial Reconciliation

Reconciliation Amount: ($100,000)
Amount subject to quality adjustment (10%): $10,000
CQS : 75
Amount earned: 75%*$10,000 = $7,500
Total Quality Adjusted Reconciliation: ($92,500)

Positive Financial Reconciliation

Reconciliation Amount: $100,000
Amount subject to quality adjustment (10%): $10,000
CQS : 75
Amount earned: 75%*$10,000 = $7,500
Total Quality Adjusted Reconciliation: $97,500

Preparing for Participation in TEAM

Preparing for Participation in TEAM

If your hospital was selected for TEAM or is eligible to opt in:

- Determine your organization's current state in TEAM episodes & areas for improvement to develop an outlook of performance in the model
- Implement strategies to improve performance in areas identified in current state assessment & comply with model requirements
- Track performance & identify areas for improvement across the care continuum

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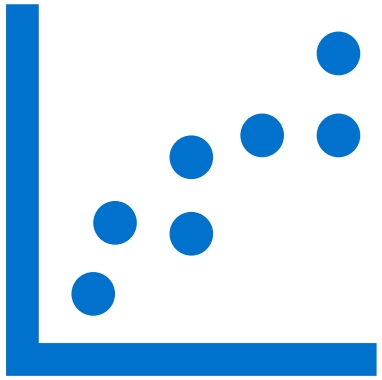
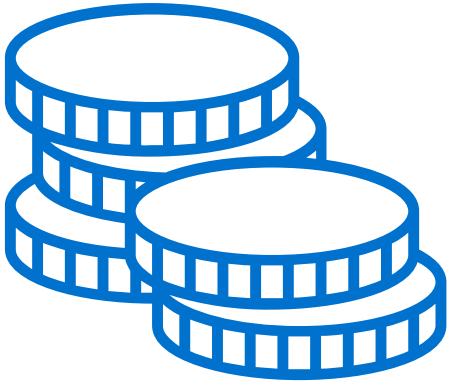
Why Preparing for TEAM Matters
… and the time to act is now!

Mandatory means mandatory



CMS won’t provide data until late 2025

Pace of change and implementation matters



CMS projects netting $481M over five-year model

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Organizations Selected for TEAM
Recommended Action Plan to Prepare

Fall 2024 ▶ **2025** ▶ **2026**

Current State Assessment

Purpose: Determine your organization's current state in TEAM episodes & areas for improvement to develop an outlook of performance in the model.

TEAM Outlook

- Financial Projections
- Risk Adjustment/Stratification
- Care Setting Optimization
- Provider Alignment/Intelligence
- Discharge Planning
- Coordination of Care
- Outcomes Management
- Quality Measure Results
- Model Requirement Readiness

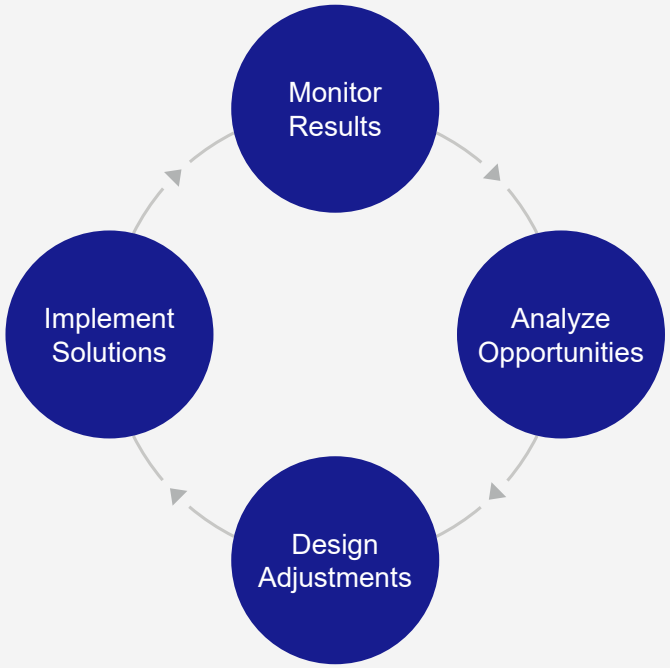
Playbook Development

Purpose: Implement strategies to improve performance in areas identified in current state assessment & comply with model requirements.

- Financial Performance
- Model Requirements
- Clinical Transformation
- Optional Strategies

Ongoing Monitoring

Purpose: Track performance & identify areas for improvement across the care continuum.



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Current State Assessment
TEAM Performance Outlook

Sample Data, For Illustrative Purposes Only

Hospital-Level Outlook

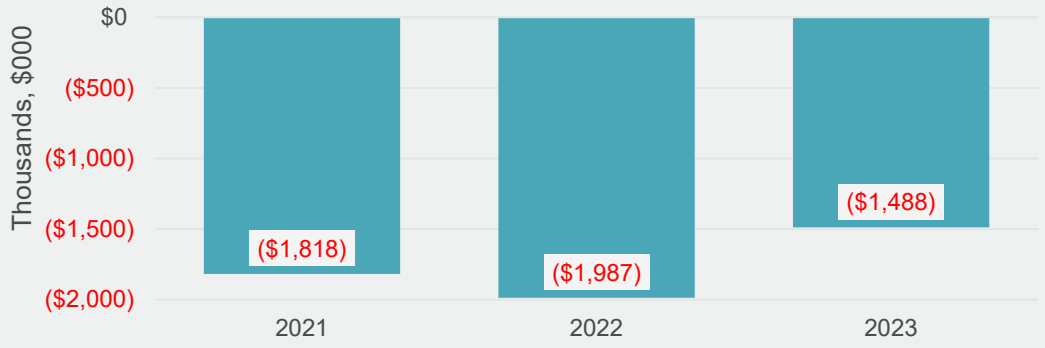
Annual Volume: 614 Cases

Total Program Size: $22M

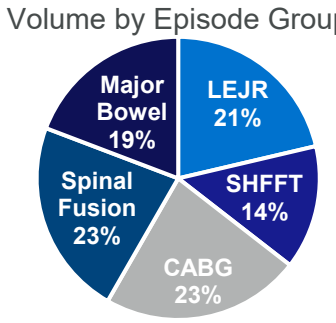
Annual Stop Gain/Loss: $4.4M

Financial Snapshot // Historical Performance (FFY2023)

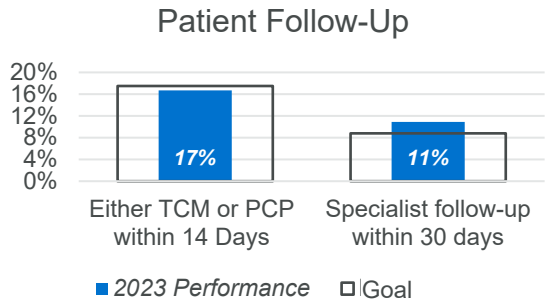
Average Target Price	$35,902
Average Episode Spend	$38,325
Net Payment per Episode	($2,423)
Total Net Payment Recon Amt (NPRA)	**($1,488,004)**



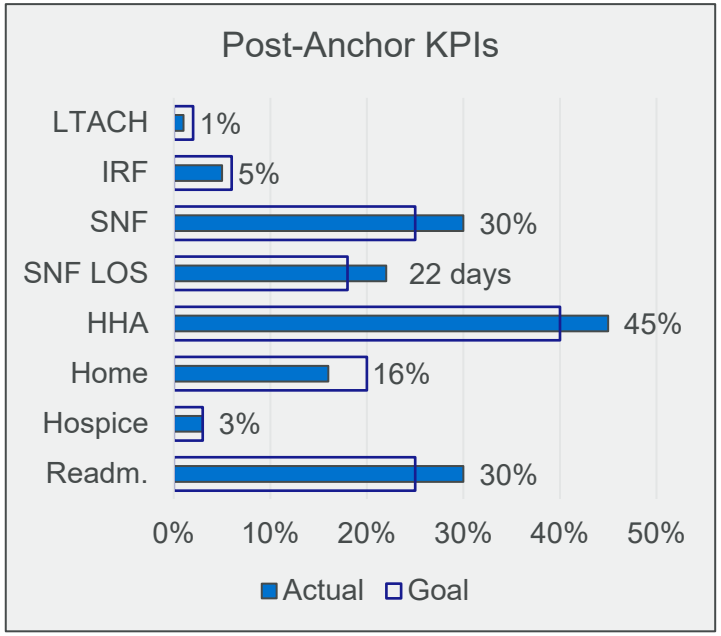
Episode Group Summary



Episode Group	Volume	Avg. NPRA per Case	Total Annual NPRA
LEJR	131	($3,665)	($480,177)
SHFFT	87	($611)	($53,182)
CABG	140	($1,709)	($239,293)
Spinal Fusion	138	($4,374)	($603,679)
Major Bowel	118	($946)	($111,673)
Total	**614**	**($2,423)**	**($1,488,004)**



Episode Type	Volume	NPRA/Epi	Total NPRA
Elective	305	($712)	($217,160)
Emergent	147	($6,153)	($904,491)
Urgent	74	($3,374)	($249,676)
Other	88	($1,327)	($116,776)



Key: LEJR = Lower Extremity Joint Replacement; SHFFT = Surgical Hip and Femur Fracture Treatment; CABG = Coronary Artery Bypass Graft

TEAM Playbook Development
Model Requirements

Starting in PY1

Beneficiary notification – Attributed beneficiaries must receive written notification of their participation in TEAM

Referral to primary care provider – Referral to a primary care provider prior to discharge from the hospital/outpatient surgical facility must be provided to all beneficiaries

HRSN Screening – Each beneficiary must be screened for at least four health-related social needs (HRSNs) such as food insecurity, housing instability, transportation needs, & utilities difficulty

LEJR patient reported outcomes – Hospital-Level, Risk-Standardized Patient-Reported Outcomes must be submitted for patients attributed to a Lower Extremity Joint Replacement episode

Voluntary Reporting

Health equity plans – Participants may submit plans that identify health disparities, health equity goals, & strategies for improving health equity

HRSN Screening & Screened Positive Data – Participants may report aggregated HRSN screening data & screened positive data for each HSRN domain that received screening

Demographic data reporting – Participants may report demographic data of attributed beneficiaries which may include race, ethnicity, language, disability, sexual orientation, gender identity, sex characteristics, & other demographics

TEAM Playbook Development
Optional Strategies

Provider Alignment & Gainsharing

Participants may develop formalized provider alignment strategies such as gainsharing agreements to share financial gains &/or losses with individual providers (surgeons, primary care providers).

Incentives & Waivers

Participants may utilize model flexibilities such as certain types of beneficiary incentives & waivers, *e.g.*, SNF 3-Day Waiver, to support the achievement of clinical goals.

Existing Value-Based Care Initiatives

Organizations participating in other value-based care models (such as the Medicare Shared Savings Program) may benefit from integration with TEAM operations through shared resources, governance structure, etc.

Post-Acute Network Formation

To improve alignment & coordination with post-acute providers, participants may form post-acute networks based on performance metrics such as ALOS, spend, readmissions, etc.

Decarbonization & Resilience Initiative

CMS will provide individualized feedback reports & public recognition to participants who voluntarily report carbon emissions data & metrics to track emissions reduction.

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Next Steps
Pursuing Value-Based Care

- Evaluate your organization's performance in value-based care models:
  - Understand areas of opportunity
  - Improve alignment with specialists, service lines, & hospitals
  - Increase collaboration between primary care & specialty care
  - Prepare for future mandatory alternative payment models
- Build value-based capabilities to manage patients
- Evaluate data on an ongoing basis to identify performance trends

- Value-based care is permanent & growing with a CMS goal of having 100% of Medicare beneficiaries in a value-based arrangement by 2030
- Despite this, less than 30% of healthcare executives believe their value-based care aspirations align with their operating model & organizational capabilities

Questions?

The information set forth in this presentation contains the analysis and conclusions of the author(s) based upon his/her/their research and analysis of industry information and legal authorities. Such analysis and conclusions should not be deemed opinions or conclusions by Forvis Mazars or the author(s) as to any individual situation as situations are fact-specific. The reader should perform their own analysis and form their own conclusions regarding any specific situation. Further, the author(s)' conclusions may be revised without notice with or without changes in industry information and legal authorities.

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