TEAM: CMS Releases the Most Significant Mandatory Bundled Payment Model to Date

WEBINAR: May 14, 2024

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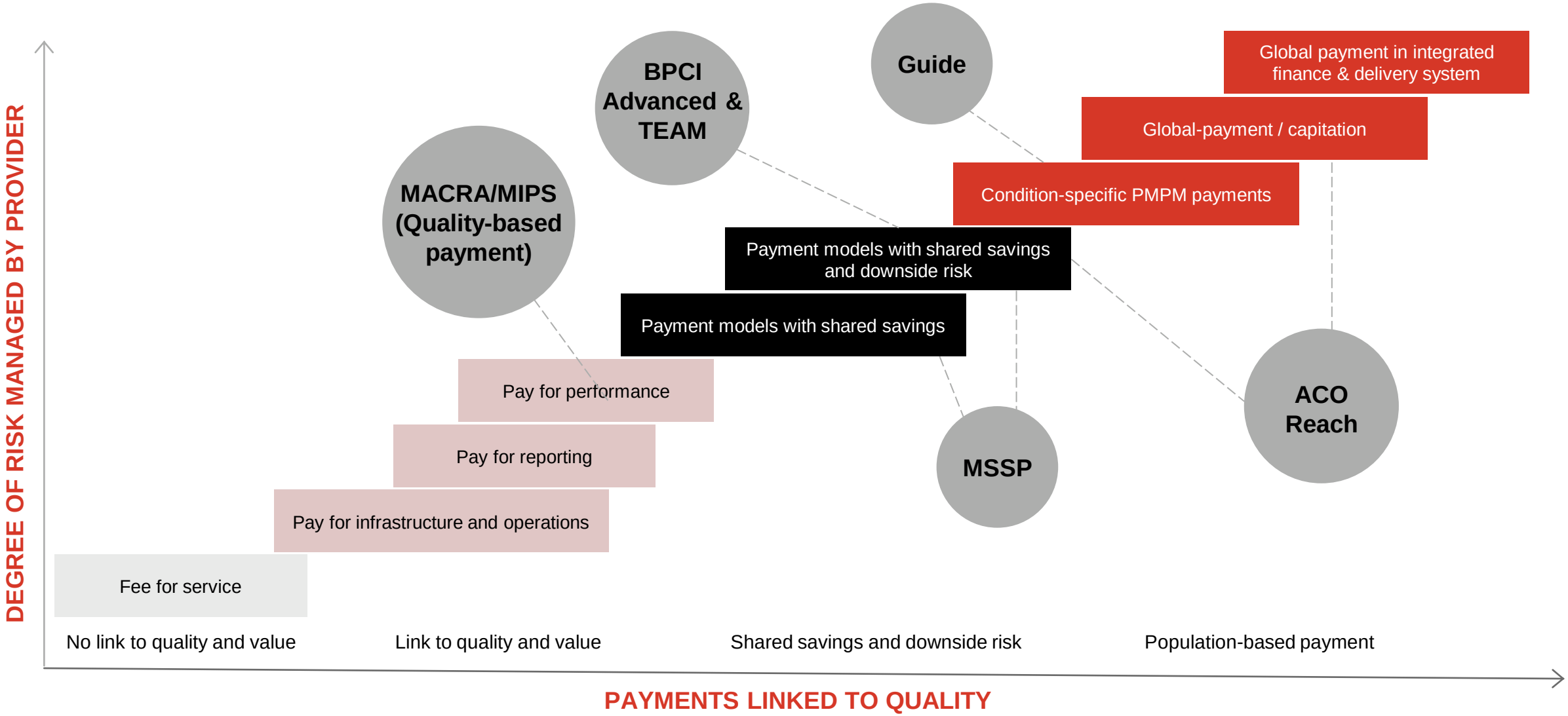
Expertise

- Value-based payment and advanced payment models
- Medicaid policy and operations
- Medicare reimbursement policy
- Medicare Advantage and special needs plans
- Medicare-Medicaid integration
- Post-acute and long-term services and supports/senior living

Qualifications

- Program of All-Inclusive Care for the Elderly (PACE)
- Health equity
- Behavioral health
- Complex care populations
- Prescription drug pricing, Part D, and supply chain redesign
- Financial services
- Healthcare payer and provider organizations
- CMS, OMB, CMMI
- Senate Finance Committee
- Health services research and data science
- Budget analysis and modeling

MEDICARE MODELS SPAN THE CONTINUUM OF RISK & NOW SEEK TO BALANCE VOLUNTARY & MANDATORY PARTICIPATION



TRANSFORMING EPISODE ACCOUNTABILITY MODEL (TEAM) OVERVIEW

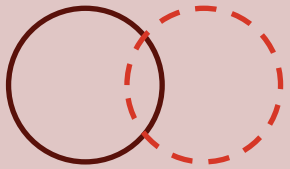
	MODEL OVERVIEW
Payer	Medicare FFS
Type of VBP Model	**Mandatory** Episodic Model: 30-day episodes from surgical procedure in acute care hospital
Method of Payment	Retrospective bundled payment based on comparison to target price (with 3% discount applied) for identified surgical episode
Timeline	January 1, 2026 – December 31, 2030
Episodes	5 major surgical procedures (inpatient only; inpatient + outpatient)
Risk Levels	→ Track 1: upside-only financial risk → Track 2: two-sided financial risk; only available to select participants such as safety net hospitals → Track 3: two-sided financial risk; more risk than Track 2

Sources: Transforming Episode Accountability Model (TEAM). FY2025 Inpatient Prospective Payment System (IPPS) Proposed Rule.

WHO PARTICIPATES IN TEAM?

Acute Care Hospitals

- Participation in TEAM is **mandatory for all hospitals** in CBSAs that CMS selects



Model Overlap and Exclusions

- Hospitals are excluded if they are not paid under the IPPS
  - This includes hospitals in Maryland, as they are testing the Maryland Total Cost of Care (MDTCOC) model
- Hospitals participating in AHEAD **may** be included in mandatory TEAM
- Hospitals that currently participate in BPCI-A or CJR may voluntarily opt in to participate in TEAM
  - However, hospitals that opt in are required to participate in all five years of TEAM
  - CMS will not allow voluntary participation

Sources: Transforming Episode Accountability Model (TEAM). FY2025 Inpatient Prospective Payment System (IPPS) Proposed Rule.

BENEFICIARIES MUST MEET **ALL FIVE CRITERIA** AT THE START OF AN EPISODE TO BE ELIGIBLE FOR INCLUSION IN TEAM

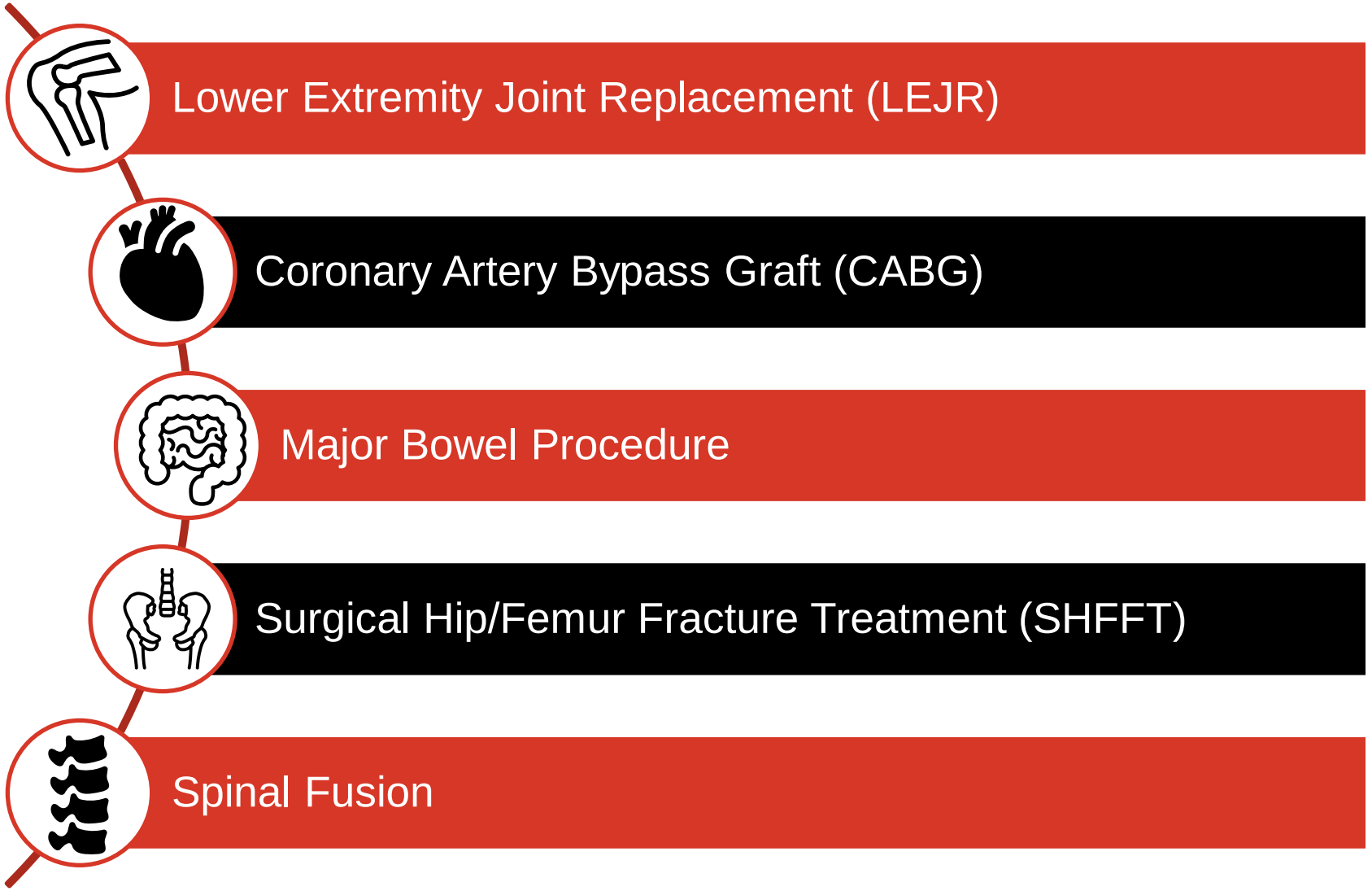
Beneficiary must be

- → Enrolled in Medicare Part A and Part B
- → Have Medicare as their primary payer

Beneficiary must not be

- → Eligible for Medicare due to end-stage renal disease (ESRD)
- → Enrolled in any managed care plan, including Medicare Advantage
- → Covered under a United Mine Workers of America health plan

WHAT ARE THE EPISODES?



Acute care hospitals paid under the IPPS are the only entities that can initiate an episode.

- Episodes can be initiated if a patient had an inpatient admission or if they received the procedure in an outpatient department
- Episodes are 30 days in length, starting from either the **day of the anchor procedure** (for outpatient procedures) or **the date of admission on the IPPS claim** + 30 days from date of discharge (for inpatient procedures)

WHAT COSTS ARE INCLUDED IN AN EPISODE?

Excluded Costs

Similar exclusion restrictions to BPCI-A, such as hospital admissions and readmissions for specific categories of diagnoses, such as oncology, trauma medical admissions, organ transplant, and ventricular shunts determined by MS–DRGs

Included Costs

All other Medicare Part A and Part B costs, including:

- Inpatient hospital services (including Readmissions)
- Clinical laboratory services
- Physician services: specialists
- Durable medical equipment and primary care
- Medications (Part B drugs and biologicals)
- Outpatient therapy services
- Skilled nursing facilities
- Hospice
- Home health services

- Note: Unlike previous episodic models, **the episode is only cancelled due to beneficiary** mortality if the beneficiaries dies during the anchor surgical procedure. For episodes in which the beneficiaries dies after the procedure, **the hospital is still responsible for the costs of the episode.**

EPISODE PROFILE SUMMARY

Condition	Lower Extremity Joint Replacement (LEJR)	Coronary Artery Bypass Graft (CABG)	Major Bowel Procedure (MBP)	Surgical Hip/Femur Fracture Treatment (SHFFT)	Spinal Fusion
Highest Cost / Volume	#1 / #1 (out of all surgical episodes)	#2 / #2 (out of cardiac procedures)	#4 / #5 (out of all surgical episodes)	#2 / #2 (out of all surgical episodes)	#3 / -
Avg. Episode Cost	$24,540	$52,934	$35,553	$46,615	$51,237
% Spending in Post-Hospital Period	40%	22%	37%	63%	27%

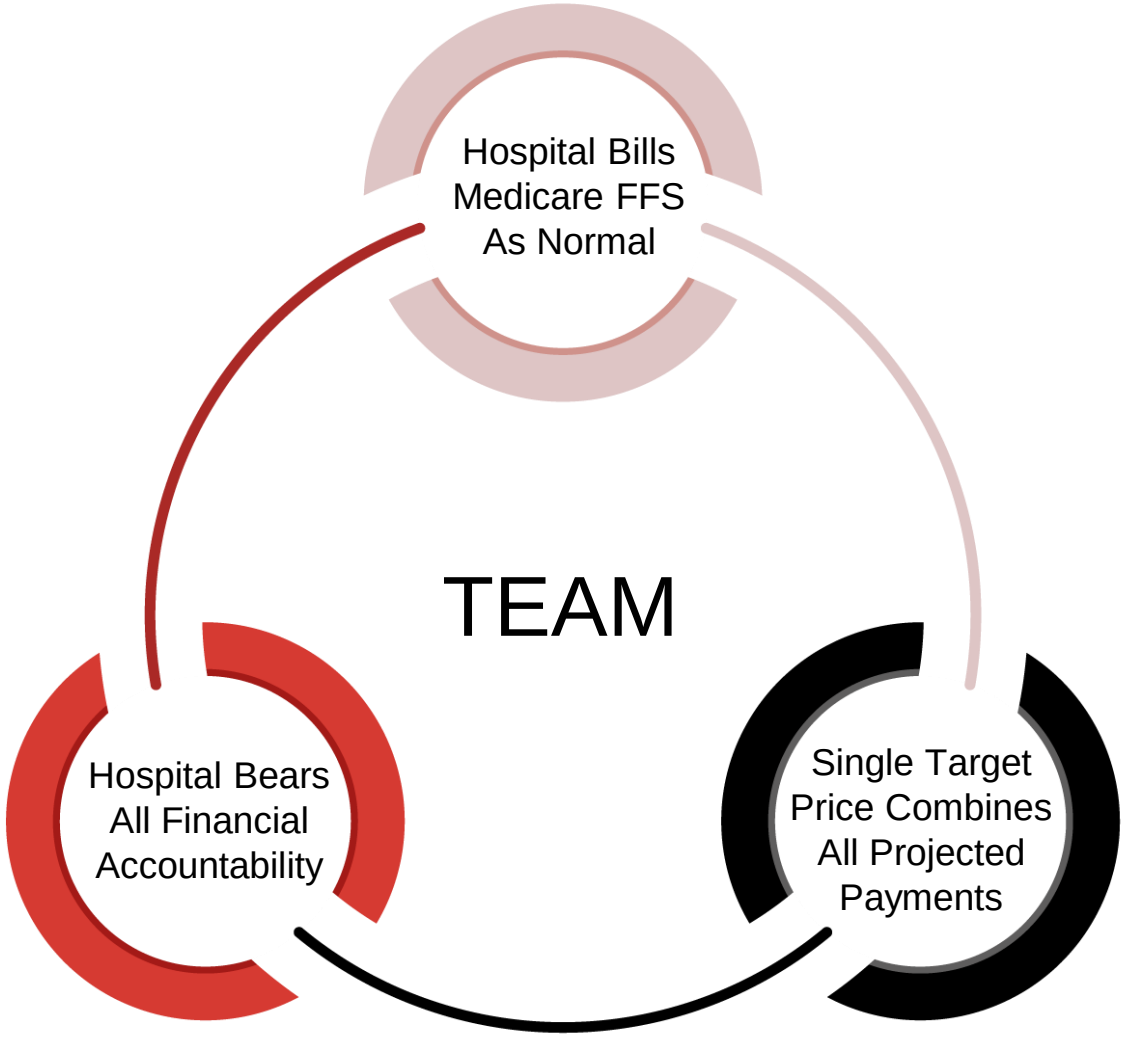
3% Discount Factor

In addition to the 3% discount factor, TEAM also includes several other adjustments for certain participants:

- → Prospective trend factor
- → Prospective normalization factor
- → Track 1 and Track 2 participants have hospital-specific target prices
- → High-cost outlier cap
- → Special considerations and adjustments for low-volume hospitals

Baseline spending is established using three years of baseline spending on each episode.

HOSPITALS CONTINUE TO BILL MEDICARE FFS AND MAINTAINS FINANCIAL ACCOUNTABILITY FOR THE EPISODE



→ **Hospital Bills Medicare FFS As Normal:**
TEAM participants continue to bill Medicare FFS as normal. However, the = participant may also receive a reconciliation payment amount from CMS depending on their CQS and if their performance year spending is less than their reconciliation target price. Since TEAM is a two-sided risk model, TEAM participants may also owe CMS a repayment amount depending on their CQS and if their performance year spending is more than their reconciliation target price.

→ **Single Target Price Combines All Projected Payments:**
All projected payments to the physician, hospital, and other health care provider and supplier services are combined into a target price. This target price represents the expected cost of all items and services furnished to a beneficiary during an episode.

→ **Hospital Bears All Financial Accountability:**
The participating hospital is the single entity that bears financial accountability for the episode, even if the beneficiary stays at another hospital during the episode.

Sources: WBUR. CMS. 2024 MAPD Final Rule.

TEAM CONTAINS THREE TRACKS, WITH DIFFERENT TRACKS AVAILABLE TO DIFFERENT TYPES OF PARTICIPANTS

1 Track 1: One-sided risk

(but only temporarily)

- Track 1 would be available only in PY 1 for all TEAM participants and would have only upside financial risk with quality adjustment applied to positive reconciliation amounts.
- Track 1 would have upside-only financial risk provided through reconciliation payments, subject to a 10% stop-gain limit and a Composite Quality Score (CQS) adjustment percentage of up to 10%,

2 Track 2: Two-sided risk

(for certain participants, such as safety-net hospitals)

- Track 2 would be available in PYs 2 through 5 to a limited set of TEAM participants, including safety net hospitals, and would have two-sided financial risk with quality adjustment to reconciliation amounts.
- Track 2 would have two-sided financial risk in the form of reconciliation payments and repayment amounts, subject to 10% stop-gain and stop-loss limits, a CQS adjustment percentage of up to 10% for positive reconciliation amounts, and a CQS adjustment percentage of up to 15% for negative reconciliation amounts.

3 Track 3: Full Two-sided risk

- Track 3 would be available in PYs 1 through 5 for all TEAM Participants and would have two-sided financial risk with quality adjustment to reconciliation amounts.
- Track 3 would have two-sided financial risk in the form of reconciliation payments or repayment amounts, subject to 20% stop-gain and stop-loss limits and a CQS adjustment percentage of up to 10%

MODEL TIMELINE

April 2024
Proposed IPPS Rule Released, including TEAM Model

Summer 2024
Final IPPS Rule Anticipated, including final TEAM Model + selected CBSAs/Hospitals

Summer 2024 – December 2025
Participant Preparation & Readiness, including data & analytics support, care coordination & care redesign, quality and financial modeling & opportunity analysis, post-acute care network building, etc.

PY2026: Model Begins
Participants may choose Track 1, Track 2 (for certain hospitals such as safety-net hospitals) or Track 3. **After PY2026, Track 1 participants must transition to Track 3 in PY2027 and beyond.**

PY2027 **PY2028** **PY2029** **PY2030**

Track 1: One-sided financial risk

Track 3: Two-sided financial risk

Track 2: Certain participants only, such as safety-net hospitals

Participants who choose Track 1 in PY2026 (Year 1) are required to join Track 3 in PY2027 and remain in Track 3 for the duration of the model.
Participants who choose Track 2 must remain in Track 2 for the duration of the model and do not have the option to switch to Track 3.

HOW WILL PARTICIPATING HOSPITALS BE SELECTED?

- CMS will choose CBSAs based on multiple criteria
- Two main exclusion criteria

1. CBSAs located in Maryland, which is currently covered by the Maryland Total Cost of Care (MDTCOC) model
2. No episodes were initiated at any hospitals in the CBSA for any of the five episode categories

- CMS will stratify CBSAs into groups based on:

Average historical episode spending

Number of hospitals

Number of safety net hospitals

The CBSA's exposure to prior CMS bundled payment models.

- CMS will select approximately 25% of CBSAs from the remaining list

All hospitals in the selected CBSA will be required to participate in TEAM.

Quality measures will focus on:

- Care coordination
- Patient safety
- Patient reported outcomes (PROs)

Three initial quality measures

1. **All TEAM episodes:** Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and Electronic Health Record Data
2. **All TEAM episodes:** CMS Patient Safety and Adverse Events Composite
3. **LEJR only:** Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure

Measures will also be volume weighted (based on the volume of episodes for a TEAM participant) before the Track-specific CQS adjustment is applied

Measures are currently reported through Hospital Inpatient Quality Reporting (IQR) Program, so **there are no additional quality reporting requirements for TEAM.**

HOW WILL THE MODEL INCORPORATE HEALTH EQUITY?

- TEAM will include a broadly-defined beneficiary "social risk adjustment"
- Beneficiaries will receive this social risk adjustment if one or more indicators of social risk apply to them:

1. Beneficiary lives in a state with state-level Area Deprivation Index (ADI) above the 8th decile
2. Beneficiary lives in an area above the 80th percentile of national ADI
3. Beneficiary qualifies for the Medicare Part D Low Income Subsidy (LIS)

- CMS has not yet determined the exact amount of the social risk adjustment or how it will affect reconciliation amounts and target prices

WHAT'S IN IT FOR A HOSPITAL?

Reduce Total Cost of Care and Generate Savings

- Hospitals can reduce their costs for high-cost episodes with support from CMS
- Incentivizes to the continued shift from inpatient to outpatient for certain epsiodes
- By reducing total cost of care (especially compared to peers in their CBSA) and focusing on post-hospital spending, hospitals could reap significant shared savings

Build High-Quality Networks

- To control costs in the post-acute care period, hospitals will have to build networks of high-quality PAC providers
- These networks can help hospitals reduce costs and improve quality for their patients across all types of care, not just the TEAM episodes

Reward for Quality & Serving Vulnerable Populations

- Quality performance bonuses will increase savings (or reduce losses)
- A social risk adjustment will be applied to the model to reward hospitals who more significantly serve vulnerable populations

Transition to Value-Based Care and Build Infrastructure

- Create incentives to continue to build VBC technology, data & analytics and clinical care management capabilities
- Provide experience with another payment model among the VBC portfolio (extrapolate to MA and other payer contracts)
- Enable hospitals to continue the business and operational transition to VBC

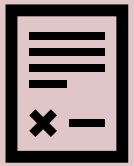
WHAT WILL YOU NEED?

Strategy for success	Clinical, operational & financial strategies
Value-Based contract design	Understand CMS contractual obligations Shared savings agreements with Collaborators
Data analytics	Identify savings opportunities & benchmarks Modeling improvements & track performance
Discharge planning and optimization	PAC network optimization Design other clinical and operational programs

HOW CAN NON-HOSPITAL PROVIDERS, SUCH AS SNFS OR HHAS, PARTICIPATE?

Post-Acute Care Networks

- Hospitals are the only official TEAM participants
- Individuals and entities that have a role in the TEAM participant's performance in the model are known as "TEAM Collaborators"
- Hospitals will look to partner with high-quality SNFs and other PAC providers to help them manage post-acute care costs
- Since participation in the model is mandatory for hospitals in the randomly selected areas, **hospitals in the selected areas will face a lot of pressure to find high quality "downstream" partners, including post-acute care partners**

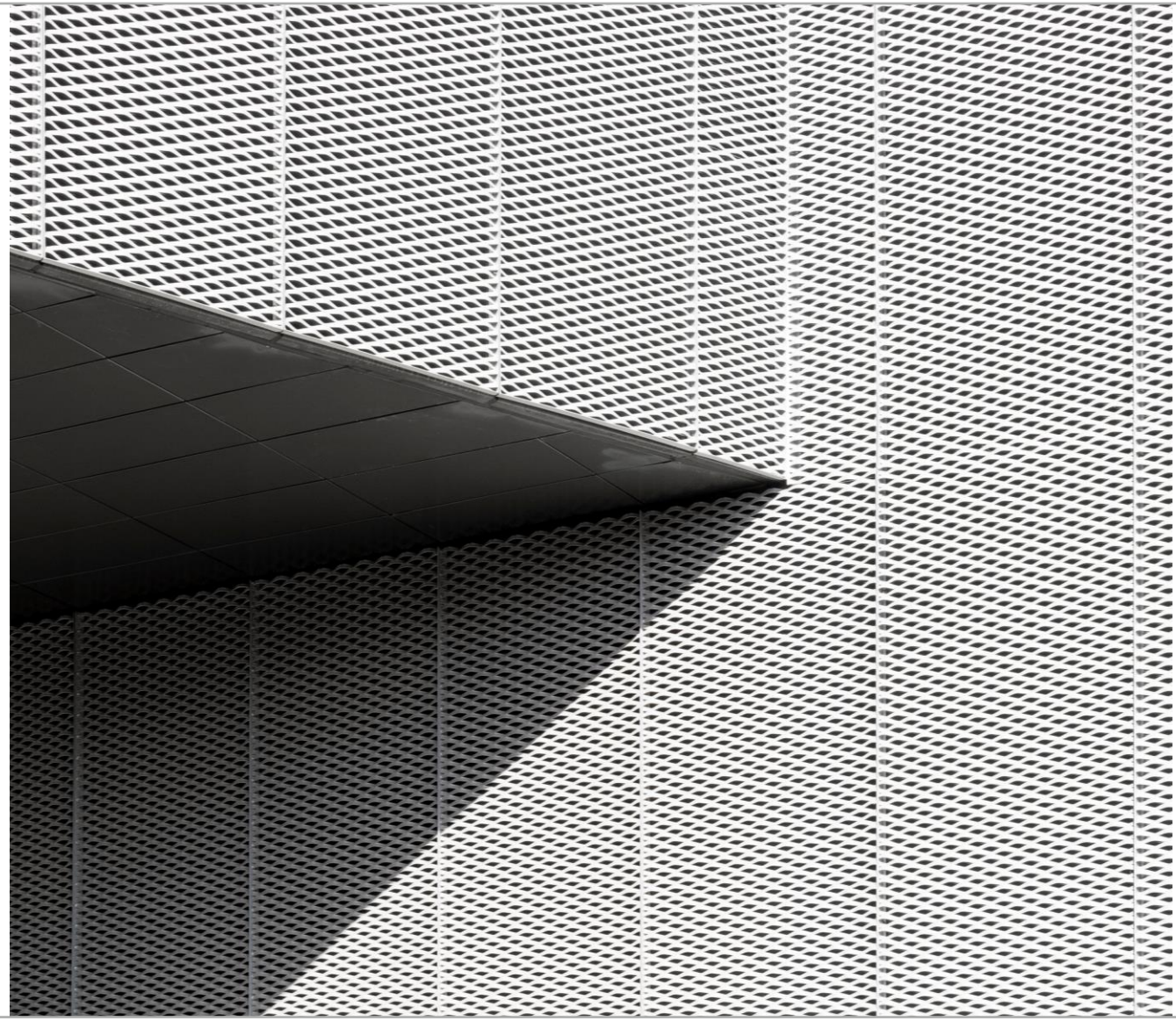


TEAM Collaborators

- Increasing quality, patient-centeredness, and cost-effective care requires collaboration among hospitals, physicians, and post-acute care (PAC) providers
- To encourage this collaboration, CMS will work to further align incentives between hospitals and physicians by **specifying certain types of financial arrangements that participants may use to share reconciliation payments with TEAM Collaborators**

Questions?

ATI Advisory



Additional Resources & Next Steps

- **ATI Website:** atiadvisory.com
- **ATI Webinars:** atiadvisory.com/webinars

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