Preparing for TEAM: The New Mandatory Bundled Payment Model

Sept 5, 2024

Agenda

- Housekeeping and Introductions
- Detailed review of TEAM
- Modeling and analysis
- Questions from the audience

Housekeeping

Webinar is being recorded

The recording and slides will be available on the NAACOS website within 48 hours.

Q&A will take place at the end of the program

You can submit written questions using the **"Questions" tab** (not chat) at any time during the webinar.

Speakers

Rob Mechanic
Executive Director
Institute for Accountable Care

Aisha Pittman
SVP of Government Affairs
NAACOS

Jen Perloff
Director of Research
Institute for Accountable Care

Jennifer Gasperini
Director of Regulatory & Quality Affairs
NAACOS

Overall Impressions

- Bundled payments have proven to drive care transformation and lower overall costs
- TEAM model design is structured as a payment cut: target price methodology and episode duration does not offer much cost reduction opportunity beyond DRG
- CMS made only slight modifications to the proposed policies despite significant pushback across various stakeholder groups
- Election may have an impact on the model
- With implementation of TEAM beginning in 2026, there is little time to prepare

TEAM Overview

- **Transforming Episode Accountability Model (TEAM)**
  - Included in final Inpatient Prospective Payment System (IPPS) rule
  - NAACOS submitted detailed comments on the proposed rule – only minor modifications made in the final rule
- 5-year mandatory model in specific regions launching Jan. 2026
  - Regions: See Table X.A.-05: Final List of CBSAs eligible for selection in TEAM p. 69687
  - One-time voluntary opt-in available for BPCI-A, CJR participants (regardless of region)
- Includes financial accountability for Parts A & B items and services that begin with an anchor hospitalization or procedure and end 30 days post discharge
- Earn payments, subject to a quality adjustment, if spending is below the reconciliation target price (or owe repayment if spending is above the target)
- TEAM website includes additional information & FAQs

Summary of key policies

NAACOS Comments	CMS Final Policy
Including safety net hospitals – CMS should make safety net participation voluntary or at a minimum no risk for the full duration of the model.	Required participation from safety net hospitals, providing up to 3 years of participation with no financial downside risk (Track 1) and 2 additional years in lower levels of risk (Track 2).
Financial discount – NAACOS advocated for a more sustainable financial discount.	CMS finalized a lower discount factor to minimize overall financial risk in the model.
Overlap policies – Supportive of overlap policies and ask to provide an option for carving out patient aligned with full risk models.	No significant changes.

TEAM Episodes

- Includes 5 specific episodes (more may be added in future years):
  1. Lower extremity joint replacement (LEJR)
  2. Surgical hip/femur fracture treatment (SHFFT)
  3. Major bowel procedures
  4. Spinal fusion
  5. Coronary artery bypass graft (CABG)
- CMS did not make changes to allow for selection of episodes, noting this would introduce selection bias and make evaluation of TEAM more difficult

Participation Tracks

	Track 1	Track 2	Track 3
Years Available	Available PY 1 Available PY 1-3 for certain safety net and rural hospitals	Available PY 2-5 for safety net, rural, Medicare dependent, sole community and essential access community hospitals	Available PY 1-5
Financial Risk	No downside financial risk Subject to 10% stop-gain limit and Composite Quality Score adjustment percentage of up to 10%	Lower levels of risk Stop-gain and stop-loss limits of 5% and quality adjustment percentage of up to 10% (15% for negative reconciliation amount)	Highest levels of risk Stop-gain and stop-loss limits of 20% and a quality adjustment percentage of up to 10%

Target Prices

- In response to stakeholder concerns, CMS finalized:
  - **1.5% discount factor for CABG and Major Bowel Procedure episodes**
  - **2% discount factor for LEJR, SHFFT and Spinal Fusion episodes**
- CMS finalized application of a 3% capped retrospective trend factor used at reconciliation

Risk Adjustment

- CMS finalized, with changes, use of an HCC count risk adjustment variable.
- **CMS finalized changes the proposed risk adjustment model to include additional clinically relevant risk adjusters.**
  - CMS believes these changes will result in higher target prices for emergent procedures – so that a hospital with a trauma center would have a higher target price at reconciliation for emergent episodes as compared to a community hospital that only performed elective procedures.
- In response to stakeholder concerns, CMS is not yet finalizing the length of the lookback period to determine which HCC flags the beneficiary is assigned, or their policy on low volume hospitals.

Quality

- Reconciliation amounts will be adjusted based on performance on the following quality measures:
  1. Hospital wide all cause readmission measure with claims and EHR data
  2. CMS patient safety and adverse events composite (CMS PSI 90) (for PY 1)
  3. Patient reported outcome-based performance measure following elective total hip and/or total knee arthroplasty (PRO-PM) – LEJR episode only
  4. Hospital Harm – Falls with Injury (for PY 2 and subsequent years)
  5. Hospital Harm – Postoperative Respiratory Failure (for PY 2 and subsequent years)
  6. 30 Day Risk Standardized Death Rate Among Surgical Inpatients with Complications (Failure to Rescue) (for PY 2 and subsequent years)
- TEAM participants must meet established performance thresholds to earn an increase of up to 10% to a positive net payment reconciliation amount (NPRA)
- CMS discusses addition of potential measures in future program years to align with other hospital quality reporting requirements

Reconciliation

- Annual reconciliation of TEAM participant's actual episode payments against the target price(s) will take place 6 months after the end of the performance year
  - Lump sum payments/repayments
- CMS notes they are not able to provide provisional reconciliation results but will consider ways of providing more updated performance and trend data throughout the performance year to help gauge performance in the model prior to reconciliation
- CMS will release beneficiary identifiable claims data on a monthly basis
- Bonuses/repayments will not be counted in ACO expenditure calculations

Data Sharing

- CMS will provide regional aggregate expenditure data available for all Parts A and B claims associated with episodes in TEAM for US Census Division in which the TEAM participant is located (similar to what is provided to hospitals in CJR)
  - Regional aggregate data on total expenditures during an anchor hospitalization or procedure and the 30-day post-discharge period for all Medicare FFS benes who have initiated an episode during baseline and performance years

AAPM Status, Other Issues

- CMS is adopting two APM options for TEAM – an AAPM option (TEAM participants required to attest to meeting CEHRT standards) and a non AAPM option (TEAM participants would not meet CEHRT standards)
- Decarbonization and resilience – can voluntarily report greenhouse gas emissions to receive feedback reports and public recognition

Equity

- CMS finalized requirements that participants must:
  - Report a health equity plan (voluntary)
  - Report demographic data (starting PY 2)
  - Screen attributed TEAM beneficiaries for at least 4 HRSN domains (food insecurity, housing instability, transportation needs, utility difficulty) (starting PY 1), and
  - Report aggregated HRSN screening data and screened positive data for each HRSN domain (starting PY 1)
- CMS will provide sub-regulatory guidance to provide additional information such as demographic data elements that can be used

Overlap

- Allows for overlap w/ total cost of care models and does not include TEAM's reconciliation payment/repayment amounts in total cost of care models' total expenditures
- As CMS develops the structure of the raw claims files that will be provided on a regular basis to TEAM participants, they will explore the ability to add model overlap assignment info when feasible

Appeals

- CMS will allow a first level appeal process for contesting:
  - Calculation of the TEAM participant's reconciliation amount or repayment amount
  - Calculation of net payment reconciliation amount (NPRA)
  - Composite Quality Score (CQS)
- CMS will also enable TEAM participants to contest determinations made by CMS through a reconsideration process

Institute for Accountable Care Analysis of TEAM Episodes

Robert Mechanic
Jennifer Perloff
Daniel Koppel

September 5, 2024

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Today’s Discussion

- Target pricing overview
- Selected regions
- Characteristics of participating hospitals.
- Profile of hospital gains and losses in TEAM
- Intersection of TEAM with Medicare ACO programs
- Opportunities for ACOs

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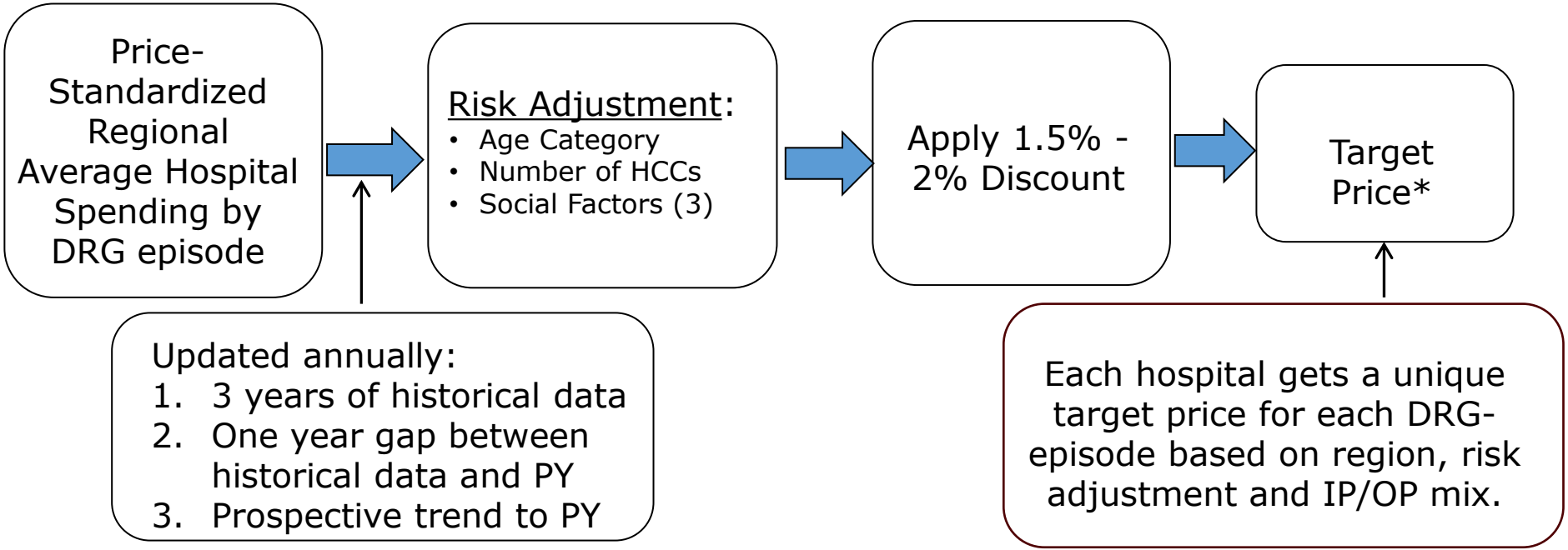
Important Changes in Final iPPS Rule

- Reduced episode discount rate
- Reduced stop-loss caps for rural and safety net hospitals
- Enhanced risk-adjustment model

General Approach of TEAM Pricing Model



*Final target price subject to retrospective trend adjustment capped at +/- 3%.
*Payment reconciliation is conducted in standardized dollars.

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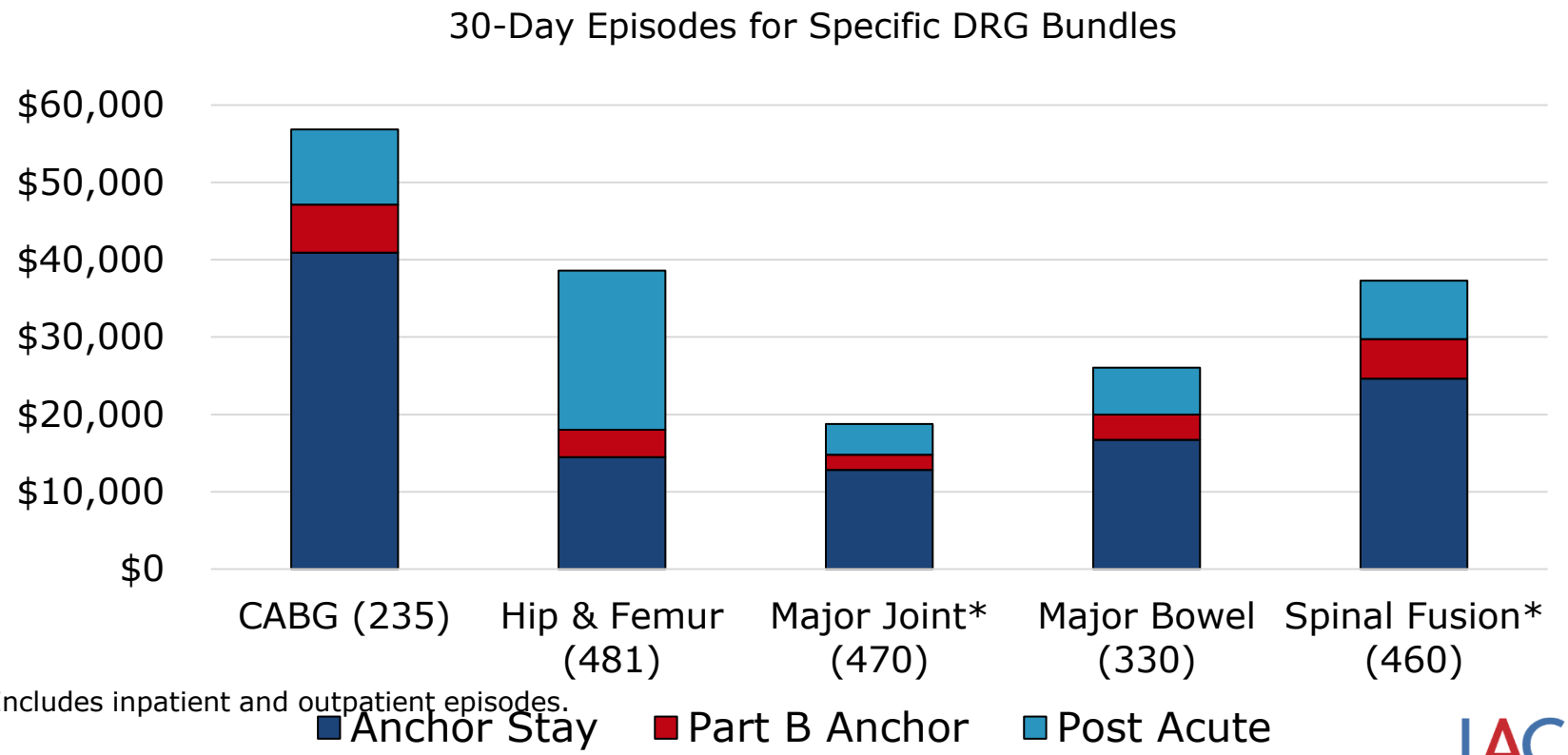
National Average TEAM Episode Cost by Setting



*Includes inpatient and outpatient episodes.

Source: IAC analysis of TEAM episodes 2021-2023 with wage-standardized Medicare claims data (100%) sample.

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20 Largest Markets Selected for TEAM

Metro Area	State	Hospitals	Cases
New York	NY	97	40,669
Boston	MA	34	17,139
Washington	DC	22	9,083
San Francisco	CA	28	7,755
Nashville	TN	16	7,523
Minneapolis	MN	21	5,955
Jacksonville	FL	12	5,761
Denver	CO	20	5,712
San Diego	CA	14	5,216
Tulsa	OK	12	3,735
Riverside	CA	23	3,698
Providence	RI	13	3,520
Raleigh	NC	5	3,356
Portland	OR	17	3,279
Tucson	AZ	8	2,950
Greenville	SC	6	2,887
Memphis	TN	6	2,863
San Jose	CA	6	2,816
Huntsville	AL	3	2,562
Harrisburg	PA	5	2,129

These 20 markets account for 69% of cases across the 188 regions

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TEAM Hospital Characteristics

Urban/Rural	Safety Net	Track	Number of Hospitals	Total Cases	Percent with Gains	Percent with Losses
Urban	No	3	315	139,718	34%	66%
Urban	Yes	2	205	41,557	35%	65%
Rural	No	2	64	14,270	52%	48%
Rural	Yes	2	57	5,872	49%	51%

Safety Net Hospitals

(1) Exceed the 75th percentile of the proportion of Medicare dually eligible beneficiaries across all PPS acute care hospitals in the baseline period.

(2) Exceed the 75th percentile of the proportion of Medicare beneficiaries partially or fully eligible to receive Part D low-income subsidies across all PPS acute care hospitals in the baseline period.

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Distribution of TEAM Hospitals by Surgical Volume

2023 Case Volume	Number of Hospitals	Percent of Hospitals	Total TEAM Spending	Percent of TEAM Spend
All	**641**	**100%**	**$5.9**	**100%**
At least 500	129	20%	$3.2	54%
At Least 300	226	35%	$4.4	75%
At least 200	320	50%	$5.1	86%
Less than 200	321	50%	$0.8	14%

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TEAM Markets with Largest Initial Gains and Losses

Metro Area	State	2023 Cases	Gain or Loss Per Case
Portland	OR	3,279	$1,981
Lafayette	LA	1,567	$1,408
Buffalo	NY	1,863	$1,370
Minneapolis	MN	5,955	$915
Raleigh	NC	3,356	$785
US Total		**201,742**	**($572)**
New York	NY	40,669	($1,078)
Memphis	TN	2,863	($1,259)
Denver	CO	5,712	($1,348)
Riverside	CA	3,698	($1,535)
San Jose	CA	2,816	($2,703)

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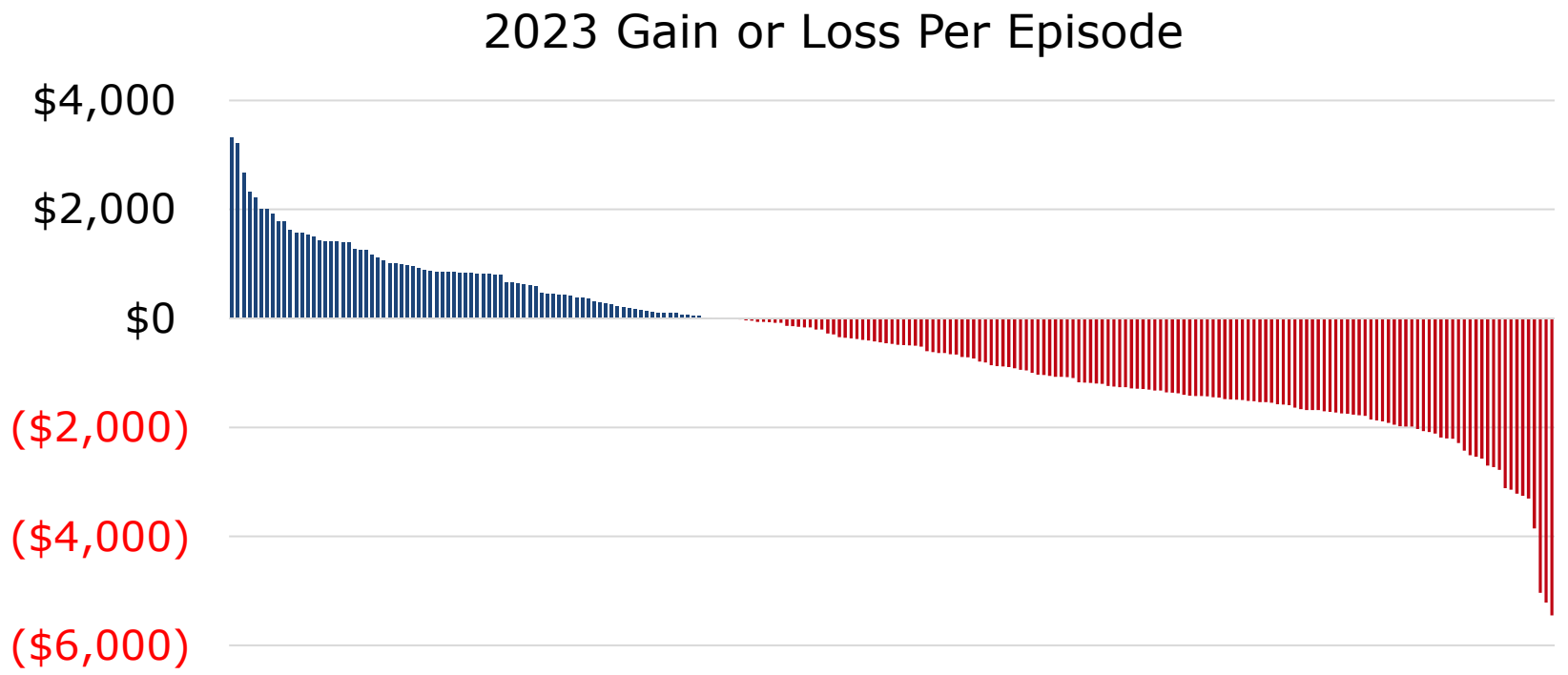
Impact of TEAM: Hospitals With 300+ Cases in 2023



Source: IAC analysis of TEAM episodes using 100% of 2021-2023 Medicare Part A and Part B claims. Analysis is based on final 2025 iPPS rule.

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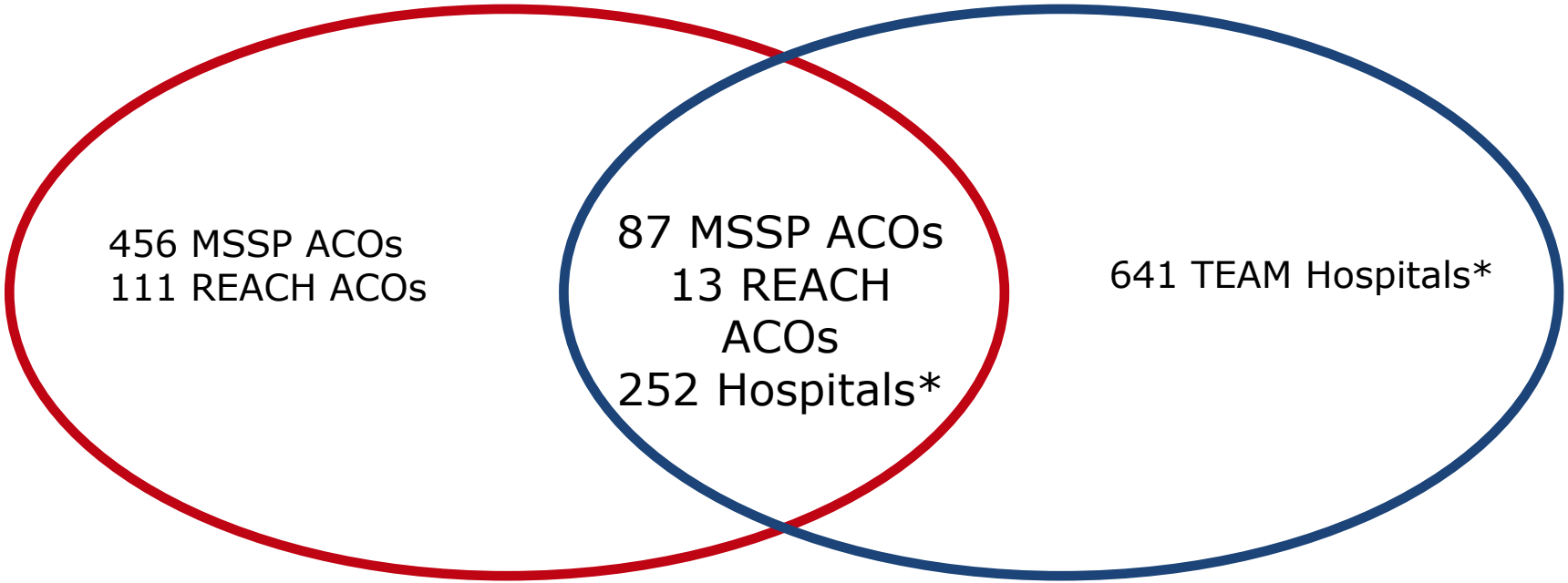
Intersection of TEAM with Medicare ACO Programs



MSSP and TEAM are reconciled separately

* Figure includes 200 MSSP participant hospitals and 52 REACH preferred hospitals.

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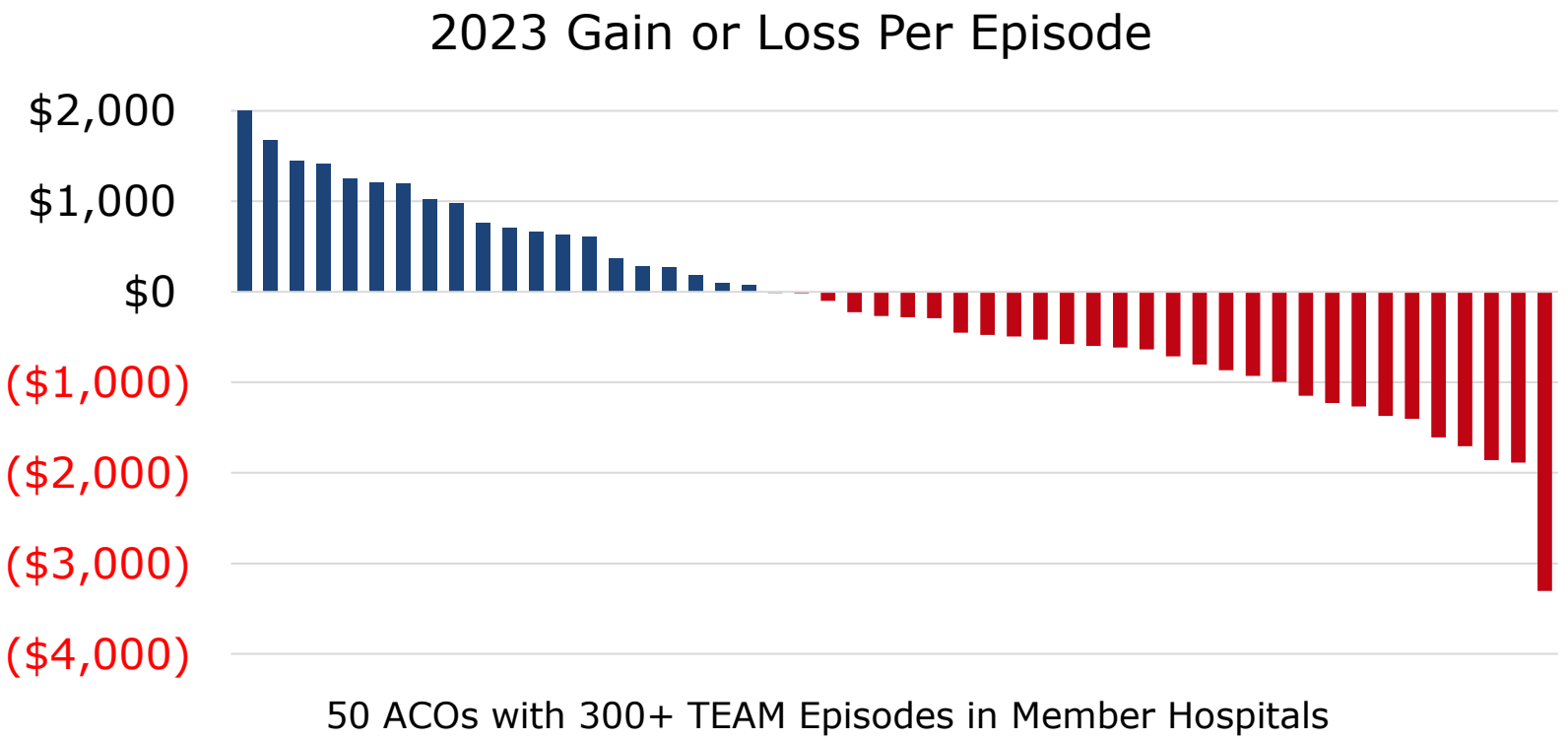
Impact of TEAM for MSSP ACOs with Hospitals



Source: IAC analysis of TEAM episodes with 100% Medicare 2021-2023 claims data based on iPPS final rule.

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Opportunities for ACOs

- Help your affiliated hospitals improve
- Improve alignment with independent hospitals
- Opportunities to contract with hospitals to support their programs?

IAC TEAM Resource Page

ARE YOU READY FOR MEDICARE'S NEW MANDATORY BUNDLED PAYMENT MODEL?

Medicare's new mandatory bundled payment model, the Transforming Episode Accountability Model (TEAM) is finalized. Starting in 2026, approximately 640 hospitals in 188 markets will be required to take financial risk for five 30-day surgical episodes. The Institute for Accountable Care can help you prepare to succeed.

Learn About IAC's In-Depth Opportunity Analysis Report

Schedule a Complimentary Briefing with Our Policy Experts

Learn About TEAM

- How does the model work?
- What are the mandatory regions?
- Which hospitals must participate?
- What services are included?
- How does risk adjustment work?
- What hospitals must do now to get ready for TEAM

https://www.institute4ac.org/team-resources/

IAC Analytic Reporting for TEAM Hospitals*

- Target prices, hospital spending, and projected total gains or losses for each TEAM episode
- Breakdown of target prices, spending and gain or loss by DRG and HCPCS trigger codes
- Breakdown of spending by site of care including index admission and post-acute providers (e.g., IRF, SNF etc)
- Breakdown of spending and gain/loss by surgeon
- Profile of readmissions and SNF services by provider
- Support for ongoing analysis of monthly claims feeds provided by CMS to model participants.

* Analytic support services provided for a fee.

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Questions or Comments

Rob Mechanic (rmechanic@institute4ac.org)
Jen Perloff (perloff@brandeis.edu)
Dan Koppel (dankopp@institute4ac.org)

Questions?