Healthcare Regulatory Round-Up #78 Webinar Transcript

TEAM and Other Key Provisions of the 2025 IPPS Final Rule

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SPEAKERS

Martie Ross, Kathy Reep, Carine Leslie, PYA Moderator

SUMMARY KEYWORDS

Medicare payment rates, wage index, DRG calibrations, budget neutrality, outlier threshold, new DRGs, CBSA changes, low wage index, Medicare disproportionate share, graduate medical education, essential medicines, new technology add-ons, Z codes, value-based purchasing, respiratory infection reporting, TEAM, 2025 IPPS Final Rule, Transferring Episode Accountability Model

WEBINAR SUMMARY

The webinar discussed the 2025 IPPS Final Rule, focusing on payment rates, wage index, and other key provisions. The payment rate increase is 1.67% instead of the reported 2.9%, with adjustments for DRG calibrations, wage index, and budget neutrality. The outlier threshold increased to $46,000. New DRGs were added, and CBSA changes impacted rural and urban designations. The low wage index policy faces legal challenges. Graduate medical education funding increased by $74 million, and new technology add-on payments were introduced. The TEAM episodic payment model, starting in 2026, will affect 700 hospitals, with specific risk and reward structures.

The webinar covered TEAM and other provisions of the 2025 IPPS Final Rule, focusing on 11 key topics:

1. Payment Rates and Wage Index Adjustments
2. Core-Based Statistical Areas (CBSA) and Low Wage Index Policy
3. Graduate Medical Education and Essential Medicines
4. Z Codes for Housing Inadequacy and Instability
5. Inpatient Quality Reporting Program Changes
6. Promoting Interoperability and Respiratory Infection Reporting
7. TEAM Episodic Payment Model Overview
8. Participation and Risk Adjustment in TEAM
9. Quality Composite Score and Collaborator Sharing Arrangements
10. Data Sharing and Payment Waivers

11. Conclusion and Next Steps

ACTION ITEMS

- ☐ Monitor CMS's decision on whether to appeal the court ruling against the low wage index hospital policy.
- ☐ Review the list of TEAM-eligible DRGs and outpatient procedure codes to assess potential impact.
- ☐ Identify potential collaborators and develop written agreements for TEAM gain sharing and alignment payments.
- ☐ Prepare to provide beneficiary notifications and make referrals to primary care providers for TEAM episodes.
- ☐ Analyze lessons learned from BPCI-A program to inform TEAM strategy.

TRANSCRIPT

PYA Moderator **00:05**

Thank you for joining us. The webinar will begin shortly.

Good morning, everyone. Welcome to the latest episode of PYA's Healthcare Regulatory Roundup webinar series. Today's topic is TEAM and Other Key Provisions in the 2025 IPPS Final Rule. PYA is happy to present today's webinar on this important topic.

You may submit questions during the webinar by typing a message into the questions pane of the control panel. Also immediately following the end of the webinar, you'll be asked to complete a short survey and submit any additional questions. We will respond to questions posed after the webinar via email. We have posted in the handouts pane of the control panel, a PDF copy of the slides for your reference. Also, you will receive an email later today with a copy of the slides and a recording of the webinar.

With that, I would like to introduce our presenters, Martie Ross, Kathy Reep, and Carine Leslie.

Kathy Reep **01:40**

Good morning and glad to have you with us on this IPPS and TEAM presentation, although we're also going to talk about some of the other final rules that are out there as well.

We've got Martie, as was mentioned, and I'm Kathy Reep. We've done these webinars a long time. However, we're excited to have Carine Leslie with us today because she's going to jump in and cover some of the additional topics as it relates to the inpatient proposed system I have the inpatient final rule. So, with that, let's just jump into the list of items that we have.

We're trying to save as much time as we can to really address TEAM and go into TEAM, and as much depth as we can. So, I'm going to start off with a discussion of money. I think that's the most one of the most important issues that we deal with. And so, let's talk about the payment rates and wage index.

Everything we have seen published in the media says that we have gotten a 2.9% increase in our payment rates under the Medicare Inpatient Prospective Payment System, moving from 2024 to 2025 you can see a very quick little screenshot related to just a quick Google search of how much did hospitals get? And everyone is saying a 2.9% pay bump. And you can see, even from what was published in the Federal Register, they are looking at a 2.9% increase in our payment rate. But we did not get, or providers did not get that much of an increase at all. It's really closer to 1.67% increase in the rates over 2024.

We've got to start out with the market basket, which published in the rule 3.4% and less. What we knew was the 5.5 percentage points for productivity. That was something that was expected and we knew would happen based upon what market basket was. But as you read through the rule, you wind up with a number of other adjustments to your payment rate, taking you down from that 2.9 the 3.4 minus the point five, we wind up with adjustments related to DRG calibrations and reclassifications, the wage index, budget neutrality. Adjustment, the low wage index, hospital the lowest quartile adjustment, the world demonstration, budget neutrality. So, we wind up with a number of different adjustments to that 2.9 only one being positive. That would be the reclassification budget neutrality. I mean, the world demonstration, budget neutrality is the one that is positive. But you can see that ultimately, by the time we go through all of this calculation, we're winding up with a 1.6% six, 7% increase in our base rate over 2024, so don't spend it thinking that it is 2.9, it won't be.

The other issue that we always run into is what years and what claims did they use, and what cost data did they use? So, we are looking at 2023 claims and using 2022 cost reporting information. So, again, our rate increase, not what has been said but the actual published dollar amounts, are the correct dollar amounts that were in the Federal Register on the next slide, other rate revisions, capital has increased to $510; however, we were expecting, based upon the proposed rule, 516. So, currently we're 503 going up about $7 but not the $14 that we had expected. The outlier threshold was proposed at $49,000 and that your cost would have to exceed that benchmark. However, they moderated that a little bit in the final rule. So, it's a $46,000 threshold for cost outlier. We're currently at 427. So, it's expected, because of this increase in the outlier threshold, that there will be fewer outliers in 2025 than we currently have in 2024 we'll see what happens with that. I think we just need to be very thankful that they did not raise it as much as they had projected to.

They are using a single year of claims data to set the weights for the DRGs. As we go into 2025 they have updated the list of DRGs. Take a look at that. There are 12 new DRGs, and there are three that have been deleted, all within basically the same family. The set, the list of DRGs that are subject to the post acute and transfer policy has been modified. Essentially, they are adding a number several DRGs, 426 through 428, which is the multiple level combined anterior and posterior spinal fusion. And then they are also adding MS-DRGs 447, and 448 which is your multiple level spinal fusion, again, except a cervical. So, one is the combined anterior-posterior, and the other is the multiple-level spinal fusion. Straight, straight spinal fusion. Don't get me talking clinical.

Core-based statistical areas CBS as this was something we had addressed in the proposed rule, and that some markets who are rural were going to become urban and some urban markets were going to become rural. So, they did follow through in the final rule with their revised CBS and moving markets from urban to rural and back and the other way around, and so that you wind up seeing some hospitals who are going to be impacted significantly by those adjustments to the markets that they are in.

CMS believes that their current cap on that went into effect last year on year to year decreases a 5% cap on year-to-year decreases in an area wage index would essentially mitigate any impact of those CVSA changes. Think individual providers need to take a close look at that and to see how this ultimately impacts them, particularly as we move into a discussion in a little bit on some post-acute care situations where there is an add on payment, if you are considered rural, but they do, they are not making any other adjusters related to this CBSA change on the inpatient PPS side, and they also are saying this. They aren't facing this end. This will be effective in 2025 there is an issue related to the wage index. And if you are strictly looking at the Final Rule, CMS has said that they are going to maintain their low wage index hospital policy those that would be the bottom quartile, those hospitals with the lowest wage index.

What CMS did several years ago was to increase the wage index for those hospitals by half of the difference between their actual wage index and the 25th percentile. So, they got a bump in their wage index, an artificial bump, but they received a bump, but it was done in the budget neutral manner, where all of the other hospitals who were not in that bottom quartile actually paid for that increase, and it was an adjustment to your base rate. That is why, when we talked early on about the adjusters to the base rate, we had that adjuster that was tied to the low quartile, budget neutrality. CMS and their final rule has said that they are going to continue this low wage index policy. However, we now have the court stepping in, and we had early on, there was a decision a number of hospitals appealed the decision that CMS had made what they had done, saying that it was not appropriate, and that the actual regulations related to wage index get did not give them the authority to do this, because the actual regulate legislation says that you would be using the wage index within the market to which you are assigned, absent any reclassifications.

These were not reclasses. It was an artificial bump. So, what has now happened is CMS lost on their first court appeal. The hospitals were victorious. CMS appealed that decision, and they have lost again, so that they have basically said, the courts have said, CMS, you can't do this. CMS has until October 21, which is six weeks away, to make a decision as to whether or not they want to take this particular provision to the Supreme Court. Absent Supreme Court, what does CMS do with this particular wage index adjustment that they have made? Will it go through in January of 2025 will there be a mid-year course correction? Will they delay any act response until 2026 and then if they take it to the Supreme Court and lose, or if they don't take it to the Supreme Court, then we've got to look at how will this be addressed by CMS? Will it apply to the hospitals that were outside of the appeal? In other words, those that appealed are saying, “You took money away from me and gave it to these other folks.” Will it address increasing the payment rates to those impacted hospitals or to everyone like they have done with 340B and then, what is the issue? How are they going to address repayment and recoupment, because if it is an issue of repayment, those hospitals that are in the lowest quartile are going to have a very difficult time repaying any dollars that they have received over the last five years under this particular program. So, stay tuned. See what CMS does on October 23 first, or by October 21 first on the issue of Medicare disproportionate share and the uncompensated care pool.

Next slide, I love saying that to her. They are using the three most recent years of audited cost report data, which would be 2019 to 2021. We had expected an increase in the dish and uncompensated care payments of about $568 million based upon the proposed rule, we're actually going to see about a $235 million decrease based upon the final rule formula stays the same. No changes there. But we are looking at a decrease in dollars available under that program for graduate medical education and following section

4122 of the Consolidated Appropriations Act of 2023. We are looking at an increase in funding for graduate medical education, essentially to allow they're providing an additional $74 million that should provide about 200 residency slots from 2026 through 2036 the majority of these slots, 50% of them, at least, will be for psychiatry and psychiatry subspecialty residents. The others would actually be for programs focused on health professional shortage areas. But you can see that they are looking at a significant increase in the slots available for psychiatric programs moving forward. That's probably because of those of us who read these regs. But never mind, there is also a provision within this final rule that ties to something that they had been, that they had proposed, and they are essentially adopting, as they had proposed, additional payments for to cover the buffer stock maintenance of it's what they are calling essential medicines.

They have identified 86 essential medicines that that list will change from one period to the next, but they will be making additional payments similar to what they have done with the mask program under that they, I think they implemented last year, these additional payments will be available only to small meaning fewer than 100 beds, 100 beds or fewer independent hospitals, which means you are not part of a chain organization. They define chain organization to mean more than one hospital, so we are talking small independent hospitals who maintain a six month buffer stock of these essential medicines, and what they will be providing to you is additional payment for the maintenance of these drugs, not paying you additionally for the drugs themselves, but the ventilation that is required, and for storage, managing expiration dates, things like that. The additional resources going into that, that will be the additional payment that you will be able to get, either as a biweekly payment or add a lump sum as a part of your cost report, very similar to what they did last year with the mask availability, new technology add on payments.

We see this from one year to the next, but they are increasing the percentage of estimated costs that will be reimbursed for the new technology related to gene therapy for treatment of sick sickle cell disease. They are increasing the percentage from the current 65% up to 75% and that will be beginning in fiscal year 2025, which will be October, and will go for the period of time that those particular that particular technology is considered new. They are continuing coverage for existing end tabs that are still considered new. They're within that two-to-three-year period and discontinuing seven items. There are five new items that were not in place historically, but that have now been added. And as they propose, they are changing the cutoff date to determine newness, from April 1 to October 1. So, if you are looking at additional years for approval, essentially there is a date change in terms of when they will begin looking at this. And with that, I think I can pass the torch to Carine.

Carine Leslie **18:08**

Thank you, Kathy. So, we're going to talk about Z codes for housing inadequacy and instability. Medicare has had a chance over the past couple of years with the creation of the new SDOH codes under ICD 10 to consider, how do these codes impact the DRG reimbursements? Could they be utilizing more resources or expectations from the hospital system? And so, for 2025, CMS made the decision to finalize the change of the severity designation for these 7z codes for inadequate housing and housing instability. So, essentially, these codes are going from being a non-CC or non-complication or COVID condition code to being a CC, and that's just based on a simple fact that these conditions or these issues that patients have, whether it's inadequate housing or homelessness, does impact the resources that that the hospital has to

utilize in order to care for them. It continues to build on the policy that was created last year when the Z codes for homelessness, the Z59 00, Z59 01, and Z 59 02 were added to that CC list.

I think the main thing to note is that typically, the documentation for this housing instability or housing inadequate housing for a particular patient may not always be documented by a physician, so the documentation could be found within a case managers documentation, nursing documentation, social worker documentation, and from a coding perspective, typically, those are not reviewed and pulled from so as an organization, you want to make sure your team understands that there's other places to look for this documentation and make sure that they're being captured properly.

Kathy Reep **19:54**

The other thing on that grant is that we do have limited fields. Dollars that we can put on a claim. So, you need to make sure that if you're butting up against that, that if this is going to increase your reimbursement for a particular service you get it, you make sure you have it on the claim, as opposed to some of those that are not going to be considered a complication comorbidity, even though they exist.

Carine Leslie **20:19**

Yep, that's a good point. Kathy, thank you.

Value-based purchasing, not much actually changed for value-based purchasing for the 2025 IPPS Final Rule. So, there's no changes to the hospital readmission reduction program and no changes to the hack penalty program. There are some potential future changes coming to the value-based purchasing program. CMS is considering modifying the scoring methodology that's being utilized specifically for the person and community engagement component. And essentially, what they're considering is between the years of 2027 and 2029, they're not going to assess the hospital on the new scoring methodology. They're going to continue to use the six dimensions that are unchanged, and then come 2030, CMS is going to consider one year of data in order to determine how they're going to score the person in community engagement domain. Starting in 2030 and then the years after that, they're going to modify the scoring for that component of the value-based purchasing. So, for now there's no change essentially being made, but understand that that square methodology for that one specific domain will change, and you want to make sure that you're monitoring that as they continue to identify how they're scoring in what they're considering there.

So, the inpatient Quality Reporting Program, a lot has changed for the inpatient Quality Reporting Program. They've added new EQ at EQMS. They have added a new claim-based measure. They've added some structural measures, and they've added some health associated infection measures. So, we'll start with the EQMS. They added two EQMS, a fall with injury, which is a new measure that essentially is assessing if a patient has had a fall during their inpatient stay. Of course, is all measures that are related to the Quality Reporting, it's for patients that are 18 or older. The other measure that they added is related to post op respiratory failure. The distinction here, though, is that it's not for patients that are obstetrical patients. It's only for those that are not obstetrical patients and that they've had they have a respiratory failure within 30 days of having an or procedure. So, that's a that's a unique distinction to be able to make there, excuse me, the structural measure. I think it's interesting in the sense that hospitals are now considering, what is an organization doing to implement strategies and practices that will help strengthen

their culture, their safety and all of that. And so, they've implemented a patient safety structural measure, and also an Age Friendly Hospital structural measure.

So, I'll talk about the first one, the patient safety structural measure. It'll essentially have five different domains that a hospital will be measured on, and those five domains are listed as leadership, strategic planning, culture, safety and learning of the health system, accountability and transparency and patient and family engagement. So, essentially, the hospital will have to consider how they are scoring. They essentially get a score for each of the domains and how they are representing that within their organization.

The second one is the Age Friendly Hospital structure measure, structural measure, and it essentially the goal of it is to see, how is the hospital committing to treating for patients that are 65 years or older? How are they? How's the hospital operating how's the operating room structured? How are they considering the population that is over the age of 65 in all aspects of their organization? Again, this domain has five this measure has five domains. The first domain is, you know, eliciting patient healthcare goals, responsible medication management, screening, frail, frailty screening and intervention, social vulnerability and age, friendly care, leadership and so essentially, what an organization is looking to see is, how are you adjusting making sure your organization is friendly for the population that is over the age of 65, and then measuring against those specific domains.

Lastly, another new measure is there are two measures related to healthcare associated infections. You're probably familiar with, the catheter, UTI standardized ratio and the bloodstream infection standardized ratio that has been around for some time. The two measures here are specific to oncology locations. And so how are, how's the hospital measuring and risk adjusting for services that are being provided within the oncology suite, oncology location of your hospital, and so is the patient getting a UTI catheter associated UTI after they're being admitted? Are they getting a bloodstream infection from a from a central line within the oncology suite? And so, there's similarities there on the risk adjustment requirements and factors for future EQM reporting.

CMS is making specific, significant changes over the next few years. Currently we have six measures. There are three self-reported or self-selected EQMS. There's and then there's three, one for safe use of opioids. Um, C section, birth, and then severe obstetric complications. So, that's where we are currently in 2024 and we will be there again in 2025 However, each year after that, CMS is adding additional measures that a hospital will have to consider for 2026 the measures will increase to eight. So, they're adding two additional measures to the six. The one is hospital harm from severe hyperglycemia, and then hospital harm from severe hypoglycemia. And then in 2027 they're adding one more for opioid related adverse events. And then for 2028 there will be an additional two EQMS that are reported, one for pressure injury and another for acute kidney injury. Essentially, the way that the removals are occurring is that for fiscal year 2026 that will the time period that the data is being utilized for is from 21 to 24 they will remove the AMI, heart failure and pneumonia, and then the hip replacement will be for a different time period of data, and that will also be removed for 2026, but that will be for a time period of April, 1 of 21 through March 31, of 24 Promoting interop interoperability. Say that three times fast.

The main thing here to understand from the program updates is that they instead of having one measure for the anti-microbial Use and Resistance surveillance measure, they're separating them into two separate measures. They're also increasing the performance-based scoring from 70 to 60% for calendar year 2025

and then increasing it for 2026 from 70 to 80% or 80 points. And so, it's just knowing that the measures are now going to be considered separate and not reliant on each other. And then they're working on aligning these program measures with the IQR program, so that there's consistency in the reporting there. So, everything that you just went over as it relates to the IQR program, think about that's going to come into play as a part of promoting interoperability as well, yep.

The last section is respiratory infection reporting requirements. And I think this one's from my personal experiences, is really important. I think if there's one thing that we've learned from the COVID pandemic is that patient safety extends beyond the bedside care that's happening within the health system, it's with it's within the public, and includes the entire health care system, and it also includes public includes public healthcare. And the interest the thing that occurred during COVID is that there was collaboration between the healthcare systems and the public health organizations, and so they were working together, sharing data, identifying when patients had COVID, or they had another respiratory condition that was occurring. The thing is, historically, prior to COVID, the organizations didn't really work together. Health systems were not reporting their data of respiratory infections. The public health was not always consistently reporting the information, and so the data did not always add up as to what the public health was seeing and versus what the healthcare system was seeing. So, the one thing that CMS identified is, with the end of the requirement for the reporting that occurred for April 2024 we would lose all of that data. We would essentially go back to the status quo, the pre-COVID non-collaboration between public health and the hospital health systems. And so, what essentially that, what they have done is to say that starting November 1 of 2024 so prior to 2025 the requirement is that hospitals and critical access hospitals will be required to start submitting date data on a weekly basis related to COVID 19, influenza, RSV to CMS. And essentially, the information is indicating the respiratory infections that are occurring within the specific organization so that it could be better tracked from an overall hospital perspective, but also public health initiative as well. In addition to those specific diagnosis reporting, they will have to report information about the hospital bed census, the capacity of the hospital, the number of patients that are hospitalized, and in some instances, there will be some required or limited patient demographics that are requested, such as the age of a patient. And so, the goal here for CMS is to make sure that we don't lose the momentum that was gained during COVID and the collaboration and the data collection, and monitor that if, by chance, in some very, very distant future, we were to have another pandemic, there's some tracking of what's coming, and there's better collaboration between the organizations.

And with that, I'll turn it back to Kathy.

Kathy Reep **31:42**

Thanks, Carine. And just before we turn it to Martie, just one quick update related to the other payment rules that came out inpatient rehab and patient psych and skilled nursing facility.

Want to not significant changes related to the various programs. So, we wanted to just stress changes in rates, and also the issue of the core based statistical areas, and that those modifications urban to rural, rural to urban, will apply to these post-acute care programs as well. Both inpatient rehab and inpatient psych have a rural add on. So, if you are currently in a rural if you're currently a rural rehab facility, and your area is now going to be considered urban, you are ultimately going to lose that 14.9 14.9% add on payment to your base rate because of the change in your designation, but they're going to phase that out over three

years, so you will get a partial, partial reduction this year, a little bit more next year, and then it will all be gone by 2027 but this will apply to both the inpatient rehab and, inpatient psychiatric facilities. Psychiatric facilities have that 17% add on rehab close to 15% and you can see that for the other payment systems that we're looking at rehab Psych and skilled nursing, we are looking at increases that are greater than what was proposed, as opposed to for hospital inpatient, we got 2.9 they had been proposing something a little bit different than that, but we are looking at a 3% increase for rehab, 2.8 for Psych, and a 4.2% increase for skilled nursing. Why is skilled nursing so high? And it's very simple, is because this was the actual only program that was ever implemented that had a look back. Did we make a mistake last year in terms of our rate adjustment? If so, let's fix it in the in the next year, skilled nursing only program that has that, and you can see what their update is compared to what hospitals are getting. Martie, did anyone ever calculate what hospitals would have received if they applied the same rule?

Martie Ross **34:07**

I'm sure it would be. Goodness gracious, yeah. But we won't go there because it will just upset us all.

Let's talk deep. Go TEAM. If you were wondering why the inpatient rule was significantly longer this year than prior, it is because the number of pages that CMS has devoted to explaining its new mandatory episodic payment model, specifically named Transferring Episode Accountability Model, or TEAM, which is actually a good acronym we decided, as opposed to some of the other tortured acronyms we often see in healthcare. But as you know, this is a mandatory five-year episodic payment model that begins in 2026 under the model, the hospital is financially accountable for the total cost of a defined episode of care for traditional Medicare beneficiaries.

Let's define our terms. Hospital means those selected PPS hospitals, as well as some voluntary participants. Episode of care starts with an anchor event, which is either a specified inpatient admission or an outpatient procedure, plus 30 days post discharge or post procedure. That's a significant change from other episodic payment models that CMS has previously promulgated, which are typically been 90-day episodes. This is a 30-day episode. The explanation is that CMS and analyzing data over the years has determined about 75% of the total cost is incurred within 30 days, 90 days, you only get 15% more up to 90% and so they felt that this is where you want to move the needle. Is in that initial 30-day period, total cost equals all nonexempt Part A and Part B payments. If a service straddles a 30-day period, such as a home health services for a period of time, or a skilled nursing facility admission, they're going to prorate that to accommodate the 30-day period. And accountability means that you will you as a hospital, will owe money if the total cost of care is greater than the target price, but you will receive additional payment if that total cost of care is less than the target price.

There's a lot there to break down. First, beginning with what are the episodes? Here's the list by MSD, MS, DRG, as well as the HCPCS codes for the outpatient procedures. Note that the spinal fusion codes change significantly between the proposed rule and the final rule. Also note these are all surgical procedures, and that, again, is one of the learnings from the bundled payment for care improvement advance model the BP CIA was that CMS saw significantly greater savings in these surgical episodes as compared to the medical episodes. And so, again, to generate the greatest success of this program, they have limited it to surgical procedures.

Kathy Reep **37:02**

Martie, I don't want to ask you to go back, but one of the issues that was raised in the rule is we aren't giving you all the answers. Now we're going to come back with additional guidance over the course of the next 17 months. But one that I thought was real interesting, particularly as it related to the hip and femur fractures, was the fact that a lot of commenters said, What about traumas? And how does this actually fall in here? And I wonder if that's going to be one of those. We're going to get the answers later.

Martie Ross **37:35**

Yeah. And they say this on several occasions, which I'm like, all in favor of, if they don't know they couldn't get it right within the allotted period of time between the proposed and final rule, if they've got time within that 17 months to get things right. I'm all in favor of that, but let's talk about who's in, who's out. CMS started with the list of 803 eligible CBSA's, because we exclude Maryland of that list, 188 were selected for inclusion in TEAM the selection was not random. In fact, it was weighted significantly to include safety net CBSAs that have safety net hospitals as well as CBSAs that have hospitals with limited experience in bundled payments. So, we're certainly trying to be more inclusive, shall we say, in participation.

We have already identified two CBS as that were selected that actually don't have any eligible hospitals in them. So, we're not exactly sure how CMS ended up with those at least two, but there may be more. What we end up with is about 700 hospitals that represent about 200,000 selected episodes per year, you're not going to find anywhere in the rule the list of hospitals. They're not going to send you a notice. Instead, if you are in the CBSA, you are a PPS hospital, and you have done any of these episodes, you are in the TEAM model and will be subject to the payment adjustments appropriately.

Now, for those of you that have hung up on this webinar because you're saying, “Well, I'm not in the CBSA. I don't need to worry about TEAM”, appreciate this is a model that's going to have impact beyond the CBSA, because a lot of these CBSAs are smaller, rural CBSAs that most likely transfer patients to tertiary and quaternary facilities when the cases become more complicated. And so, you're going to have hospitals very closely monitoring their partners in terms of total cost of care. And so certainly, having a working knowledge of this model is going to be critical, but also figuring out how you could be a good partner to these hospitals and become collaborators. We'll talk about what that means, is also going to be important.

CMS believes it's going to say, based again, off its numbers from BP CIA experience, that they're going to save half a billion dollars over five years on this program, in addition to the mandatory participation. CMS will allow certain hospitals to opt into the program, but it's a limited number. If you are currently participating in the comprehensive care for joint replacement, the prior mandatory episodic payment model, and are in that program through the end of this year, that you can elect to stay in the program that represents about 324, hospitals and three four MSAs. There's probably some overlap with the CBS as well. Also, those that are that will continue to be in BP CIA through the end of that program, which is the end of 2025 they also can participate only the hospitals. However, there will not be physician groups or conveners on will not be eligible for participation. You have a short timeline to decide if you're going to opt in to TEAM, because you'll be required to submit a written participation letter during the voluntary

election period, which CMS has identified, is January of 2025. We have not yet seen what that letter looks like, but assume that CMS will be releasing that relatively soon.

Not all TEAM hospitals will be treated the same, specifically in terms of the level of accountability they will assume. So, the risk they take being part of TEAM will vary by the type of hospital. So, begin with safety net hospitals, which they define as those hospitals that exceed the 75th percentile for either dual eligibles or Part D low-income subsidy recipients. If you're in that category of hospital, then you're going to be upside only for the first three performance years, and your stop gain limit will be 10% let's go ahead and talk about stop gain, stop loss. CMS wants to regulate how quickly we make advancements in a reduced total cost of care, and it also wants to prevent hospitals from being too much risk as a result of being in episodic payment models. So, they're going to cap that risk and that reward. The stop gain is the reward, so no more than 10% of the target price. The stop loss is the protection against risk, which is not less than, no more than 10% of the of the target price having to be paid back. Of course, a safety net hospital can elect to be at a higher degree of risk in any year as provided it provides that notice to CMS at the beginning of that performance year.

The second category of hospitals are rural hospitals, not those that have been reclassified, but those that are actually in rural areas. Sorry, Miami, you're not getting any part of this Medicare dependent hospitals and so community hospitals hoping that we still have an MDH program after December 31, of this year, because that's one of the many things on Congress's to do list. But these hospitals will be upside only for year one. They'll go to upside downside in years two through five, but their stop loss, stop gain is going to be narrow. It's going to be limited to 5% and again, these hospitals can elect a higher degree of risk that they choose everybody else. You're going to get one year upside only with the 10% stop loss, and then you go to upside, downside for the rest of the program, with 20% stop gain, stop losses. So, that's where we're going to find the majority of participating hospitals in this program.

Now let's get to the nitty gritty. How could you possibly spend this many pages in the Federal Register talking about something, but how we calculate preliminary target prices. Because in episodic payment models, the target price is the game, because that's where you're trying to figure out where you can reduce costs within that target price. So, this is what CMS says, absent any intervention, this is what we would be expecting to pay for a specific, defined episode of care, so beginning prior to each year of the term of this program. So, for five years prior to the beginning of the performance year, CMS will calculate price, standardized average hospital spending by DRG or HCPCS for nine census regions. So, that was all those 31 these are all 30 listed total DRGs or HCPCS codes. It's going to calculate what is the average cost within nine census regions. Okay, so Southwest, Southeast, Midwest, Upper Midwest. I can't remember the list exactly, but it's going to provide you those similar to the list they've used for CJR throughout that program.

They'll use each year three years of historical data, for example, for 2026 it's going to be based on 22 through 24 data that will be weighted, though. So, the oldest year will be weighted at 17% the most recent year at 50% that looks. Include outlier episodes. They set the outlier at the 99th percentile, so those extremely high-cost cases at top 1% are excluded out of the program. They'll also exclude from the episode costs for specified unrelated items or services. So, certain inpatient admissions that occur during the 30-day episode, like you know, for some reason you're hit by a bus during that 30 day period and you come to the hospital for a trauma admission, those costs are going to be excluded out of the episode as well.

Once we have those targets across all of the MS DRGs and HCPCS as across those nine census regions, we then apply a perspective trend to performance year to account for changes in healthcare spending.

So, we know that between 2024 and 2026 they're going to be changes in healthcare spend attributed to a number of different factors. That perspective trend is intended to account for that. So, we take historical spending and bring it forward to current day activity, and so we'll apply that trend to the target price. Then finally, we apply the discount factor. This is CMS is guaranteed savings from an episodic payment model. These had been proposed at 3% so CMS said, here's the target price, we require you to save at least 3% off that target price. The good news is in the final rule they adjusted those targets is going to be 1.5 for major bowel and cabbage and 2% for the rest of the episodes included. So, some good news in the final rule there.

The other thing that CMS will calculate before each performant year are risk adjustment factors. So, remember, what those target prices give you are the average. And CMS appreciates that the average is really a nonexistent number, and that, in fact, there are a number of different factors that can come into play that impact what the total cost of care for an episode would be. So, they do something fancy called a linear regression analysis. I did not take Calc I don't know what that is, but they produce some coefficients, and that is, in fact, the anticipated impact of these risk factors on the episode costs. And there are two categories of these risk factors. There are hospital specific risk adjustment factors. So, they assume the number of beds in a hospital are going to impact the cost of care, and whether it's a safety net hospital or not, is going to impact the total cost of care during the episode. And then, in addition, we have four beneficiaries, specific risk adjustment factors to come into play. There's an age bracket. The older you are, they assumed, the more expensive, the cost, the number of HCCs assigned to the individual during an assigned look back period. The length of that look back period had been, I can't recall what they had proposed, but this is one of those areas Kathy, where they said, we're not sure yet, so we're going to come back later and determine what that look back factor is for those HCC scores. There's a social need component, which, again, is based off of data available to CMS. And finally, episode-category-specific beneficiary risk adjustment factors.

So, for each of those categories, those five categories of episodes, they've provided a list of HCCs that if that HCC is present on the first day of the episode, then it's going to result in an adjustment to the price. So, example, diabetes, I think, is listed consistently throughout each of those episodes. So, if the patient has a diabetes HCC assigned to them, that's going to be an adjustment to that target price for that specific beneficiary. So, we get all that work done. We have a performance year, and six months after the end of the performance year, we do the reconciliation process and the first so we're going to determine how much does the hospital owe, or how much is the hospital going to receive, and we start that by determining whether the hospital falls within the low volume hospital policy. So, if the hospitals had a very limited number of episodes, CMS will say it's just going to be random chance. So, we're not going to calculate, and there'll be effectively a 0% reconciliation for that hospital. We don't know yet what that number is going to be. It is a to be determined number. Again, one of those things CMS says we're going to work on for the next several months before we get to what those numbers will be for low volume hospitals.

So, again, for now, if you're one of the hospitals, a PPS hospital, and one of the CBS a, assume you're in this model, because we don't know what those low volume numbers are going to be. Then for each qualifying episode for a hospital, CMS will calculate the performance year spend again using the same

methodology that it uses to calculate preliminary target prices, meaning take out the high outlier episodes that top. 1% take out those excluded costs from within the episode. So, you know what you spent. The next step then is, for each of those qualifying episodes, calculate the reconciliation target price. So, again, we're going to start with that preliminary target price we had, which is regionalized. We're going to apply those risk factors that we calculated before the beginning of the performance year, so we adjust that target price for each episode, then we apply a normalization factor to account for changes in beneficiary health status and demographics, because typically you get older and you get sicker as time goes on, and oh my gosh. Can I tell you that one's true, but we make an adjustment there and then.

Last but not least, I wish, we wish they had not made it this decision, but they decided to apply a retrospective trend factor to effectively make up for the fact they may have woofed it on the prospective trend factor, but they did agree that they will not adjust that more than 3% up or down of the prospective trend factor. So, that is a win, at least for providers on that side. So, now I know for every episode, I've got a list of episodes, a list of target prices, a list of actual spend. I then calculate the reconciliation amount by subtracting the total reconciliation target price from the total performance spend. Okay, so I've got a number now I'm going to adjust that's the number of the difference between the target and the actual spend. I'm now going to adjust that by a quality composite score. That is an adjustment percentage that's dictated by your score on specified quality measures. We'll talk about those in just a second, relative to all other hospitals, how they perform. It's a percentile driven composite, and it will give you a percentage by which they'll adjust the reconciliation amount either up or down. If you owe more, if you if you're going to receive payment, it most likely will increase that payment, or if you're going to be owed money, you may owe more due to your performance score.

Finally, after last, but not least, the last thing that CMS does, then, is to apply the stop loss, stop gain limits to determine the final payment or repayment amount for the hospital and set the date by which that payment will be made or will be due from the hospital, the quality scores. They are starting with performance year one. You see these here on the screen, performance years two through five. Excuse me for including that. Two through five. They add some additional measures to those as well. All these are going to either be reported through IQR or they're going to be reported through the hack program, so it's no new reporting requirements, just taking your score on those measures, comparing them to other hospitals, and then assigning a percentile that results in an adjustment factor.

Other fun things about TEAM here in the last seven minutes, other provisions that you're going to learn to master prior to the beginning of 2006 beginning with collaborator sharing arrangements. Yes, the hospital bears all the risk, but obviously needs assistance from physicians and post-acute care providers and other IPPS hospitals to, in fact, be successful in this program, and to accomplish that. CMS provides for collaborator sharing arrangements, and there are two types. They are, gain sharing payments and alignment payments. Gain sharing payments are those made by the hospital to collaborators. And it can be made from one or two, one of two sources, either reconciliation payments, so dollars it receives from CMS, or from internal cost savings realized on the episode of care. And CMS is very clear in saying that an internal cost savings must be measurable, it must be actionable, and it must be verifiable to in fact, have resulted from the activities of that collaborator. What's a collaborator? It's a very kind of amorphous term, but where CMS ends up at is it is a Medicare participating provider or an ACO that participates in some meaningful way in impacting the episodic costs. You have to have a formal policy and procedure to identify who your collaborators are going to be, and you have to have a formal written agreement with

that collaborator that's signed prior to the episode initiation, and you must condition any payment that that collaborator will receive on them meeting specified quality standards and providing billable services to TEAM beneficiaries. And of course, it would not be an episodic payment model without the caution that no payment can be based directly or indirectly on the volume or value of referrals. So, this is certainly going to be something we're going to be working on diligently prior to the beginning of the TEAM performance periods is identifying who are going to be our collaborators. How are we going to formulate these financial arrangements with them? How are we going to develop our agreements to build that cooperation among the continuum of care within the episode?

There are an assortment of beneficiary protections built into TEAM. Of course, we have to have a written notice that are given to beneficiaries regarding the hospital's participation in TEAM, which must be delivered prior to discharge from the acre admission or procedure, I assume, CMS providing us with standard sample notification language. In short order, we have to require our collaborators, as part of that written agreement to provide a similar notification to beneficiaries that they are part of a sharing arrangement that has to be delivered no later than the first delivery of services, or as soon as practical, we have to ensure that we are not restricting beneficiary freedom of choice with respect to post-acute care services. You still have to provide that complete list of post-acute care providers to individuals, but you can identify those, and you must actually require to identify those with which the hospital has a sharing arrangement. And you can, in fact, recommend preferred providers within that list of post-acute care providers. Can't steer, but you can't recommend. And then, as part of the discharge planning process, you must provide notice to beneficiaries that they may have potential financial liability for any non-covered post-acute care services, that the beneficiary may be considered as part of TEAM again to that continuum of care. CMS requires that a hospital as part of the discharge planning process, make a referral for, excuse me, each TEAM beneficiary to a primary care provider that has to be accomplished prior to discharge from the acre, admission, or the performance of the procedure again, have to comply with beneficiary choice. You can't require them to go to a specific provider, care provider, but you do need to make that recommendation.

Interestingly, the regulations actually call out that if a hospital fails to make those referrals, there may be remedial action taken against them in the form of corrective action plan, discontinuation of data sharing, or even recoupment of payments made to the hospital regarding data sharing, you are going to receive the TEAM hospital beneficiary identifiable claims data. But to do that, you'll have to you'll have to complete and submit a data request, a status sharing agreement that will entitle you receive full claims data for the baseline period that'll be made available up here, up the month before the performance year begins, and then on a monthly basis thereafter. CMS will also provide that regional aggregated data from the baseline period, so you always have that comparison you can measure as well.

There are two very minor payment waivers included within one is for telehealth, that if you provide telehealth services during the episode of care, you will not be subject to the geographic or originating site restrictions. Hopefully, that will not be an issue, and Congress on its way again, on its to do list is to extend those telehealth flexibilities. Also, a waiver of the SNF three-day rule for TEAM beneficiaries that are admitted into CMS identified qualified SNPs, not just any SNF. It actually has to be on a list of qualified SNPs that CMS will promulgate prior to the performance year.

The last thing before we get to BPCIA, which we'll just mention very briefly, what's missing, what would have been proposed that I'm not discussing are the health equity requirements. CMS had proposed that from years two through five of the of the performance period, a hospital participating in TEAM would have to submit a health equity plan and would also be required to submit, collect, and submit to CMS certain data regarding its TEAM participants. CMS moved that from a requirement to an option for purposes of TEAM participation. So, again, as you're considering your participation in TEAM, you'll need to make a decision of whether you will participate in those health equity elements.

Finally, as you're looking at TEAM, pay attention to lessons learned from prior programs, specifically from BPCIA. Here I have the link to the evaluation of the most recent completed performance year within BPCIA which be 2021 that is the first year after three years of losing money on this program, CMS actually reduced episodic spending by 3.5% there's a surprising high level of participation within BPCIA, as you see here on the screen. So, there's a lot of information that can be learned from what happened before. Just briefly, we cut from the report issued by Lewin how they viewed through qualitative analysis. Just the impact that these episodic payment models had on care transformation within their organizations. They also discussed within the Lewin report, key care redesign initiatives by successful hospitals. They divide these between pre-hospitalization, hospitalization, and post-hospitalization. Again, not to drill down on those here, but you'll have those slides available as you start considering how TEAM is going to go forward.

Trust us, this isn't the last time we're going to talk about TEAM. We're going to revisit this in January, after we make our way through the full set of final rules. So, as you start really thinking of your one-year strategy for moving to TEAM, hopefully we can provide some additional insights there. More immediately, our next healthcare regulatory Roundup, we're going to go for three weeks between them, this time due to other commitments, but on September 25 Kathy and I will be back, and we're going to talk about Chevron at the end of Chevron deference, really looking back to how hospitals have litigated with CMS previously, and how that will possibly look in the future given this change in the standard for challenging CMS regulations. So, hope you'll be able to join us. Hope this was helpful today, and look forward to talking to you again soon.

PYA Moderator **1:01:17**

Thanks to our presenters, Martie, Kathy, and Carine.

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On behalf of PYA, thank you for joining us, and have a great rest of your day.