HEALTHCARE REGULATORY ROUND-UP #87

Building Your Dream TEAM

How To Win At Episodic Payment Models

January 30, 2025

Housekeeping

- Slides, handouts, and forms available in **Resources Panel**
- Enter questions in **Q&A Panel**
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  - **Remain logged in for entire webinar**
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Introductions

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Today's Agenda

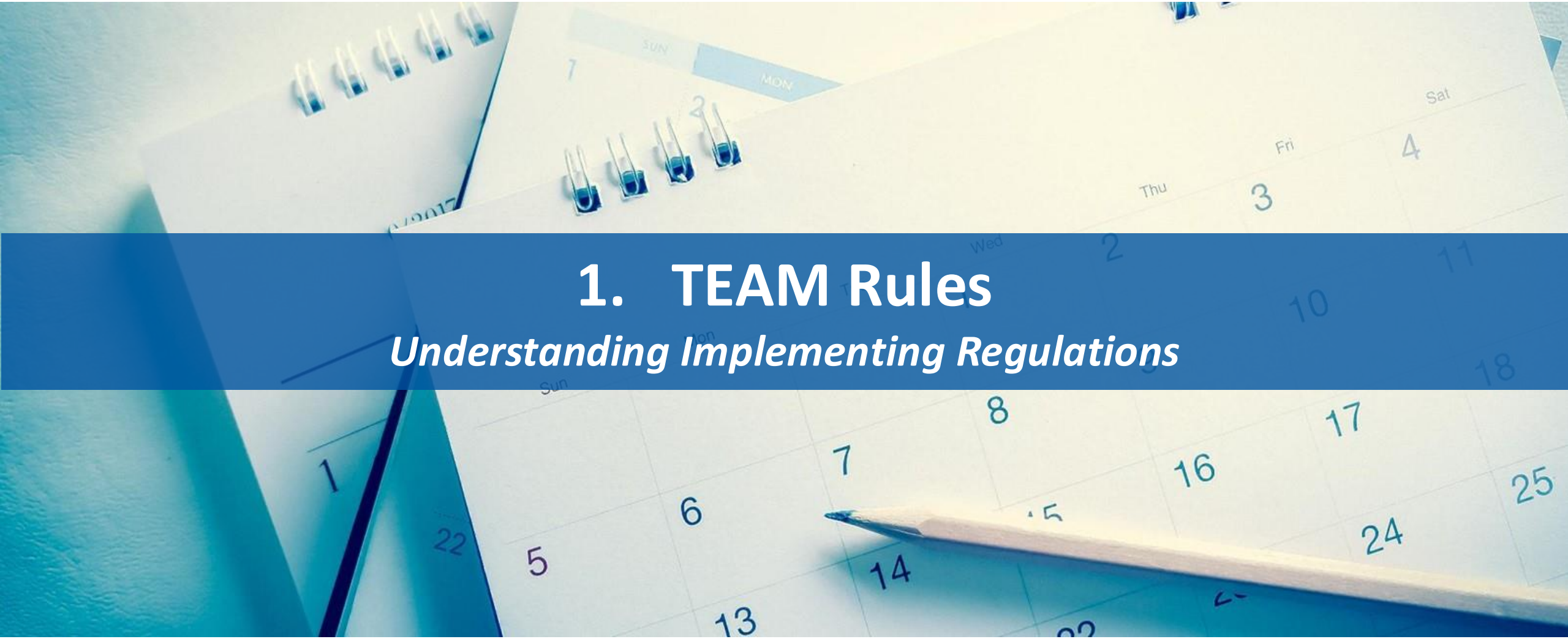
1. **TEAM Rules** – *Understanding implementing regulations*

2. **TEAM Line-Up** – *Working with Collaborators*

3. **TEAM Playbook** – *Developing your tactical plan*

4. **TEAM Analytics** – *Making claims data work for you*

Polling Question #1



1. TEAM Rules

Understanding Implementing Regulations

Background – CMS Innovation Center

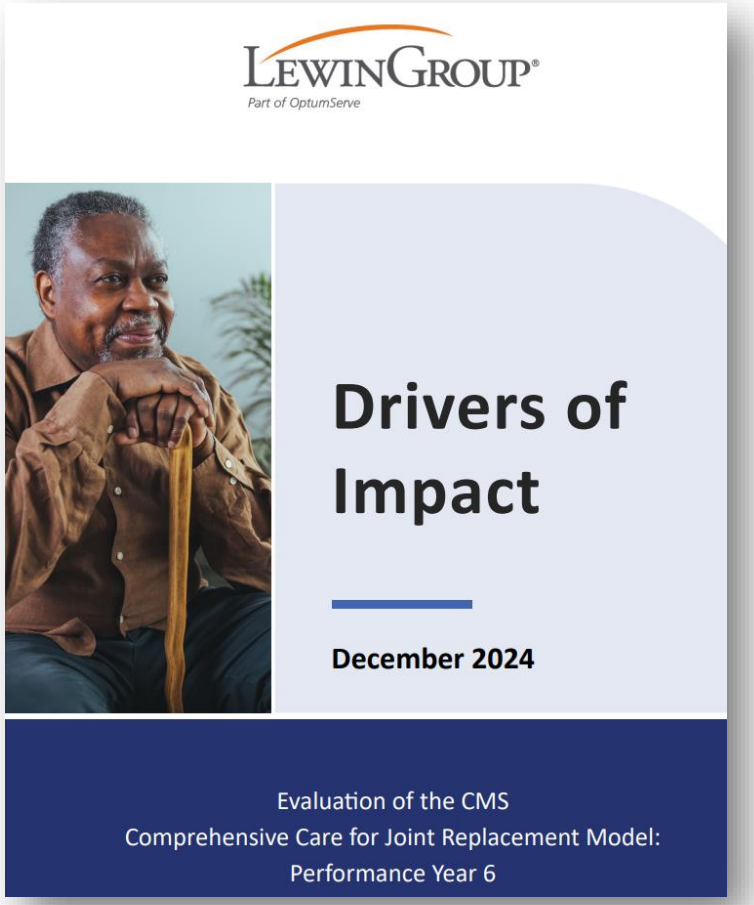
- Goal: to develop and test payment and service delivery models to improve patient care, lower costs, and align payment systems to promote patient-centered practices
  - Bundled Payment for Care Improvement (BPCI) (elective) (2013 – 2018)
  - Comprehensive Care for Joint Replacement (CJR) (mandatory) (2016 – 2024)
  - BPCI Advanced (elective) (2018- 2025)
- Goal: to have all traditional Medicare beneficiaries in a care relationship with accountability for quality and total cost of care by 2030
  - At 53.4% (as of January 2025)

Lessons from BPCI-A

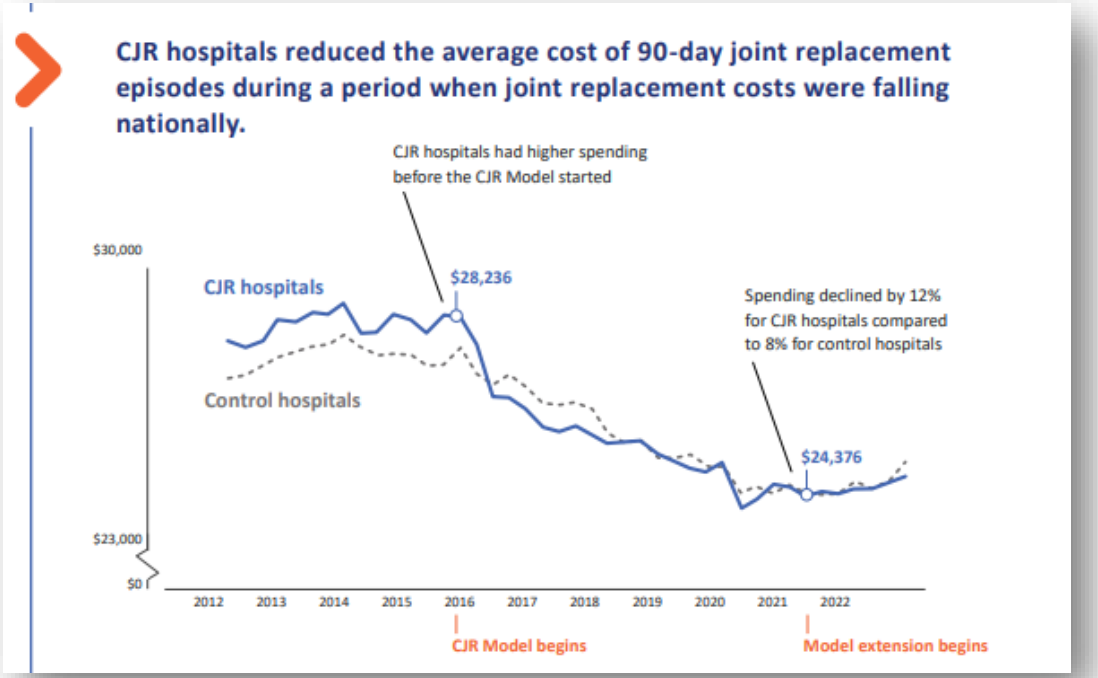
- In Model Year 4 (2021), BPCI-A reduced episode spending by 3.5%
- Level of participation
  - 1 in 5 eligible hospitals participated
  - 1 in 4 eligible clinicians triggered a BPCI-A episode
  - 1 in 5 hospitalizations/outpatient procedures were under BPCI-A

https://www.cms.gov/priorities/innovation/data-and-reports/2024/bpci-adv-ar5

Lessons from CJR



Launched in April 2016 in 67 MSAs with ~800 hospitals; reduced to 34 MSAs in 2017 with ~320 hospitals

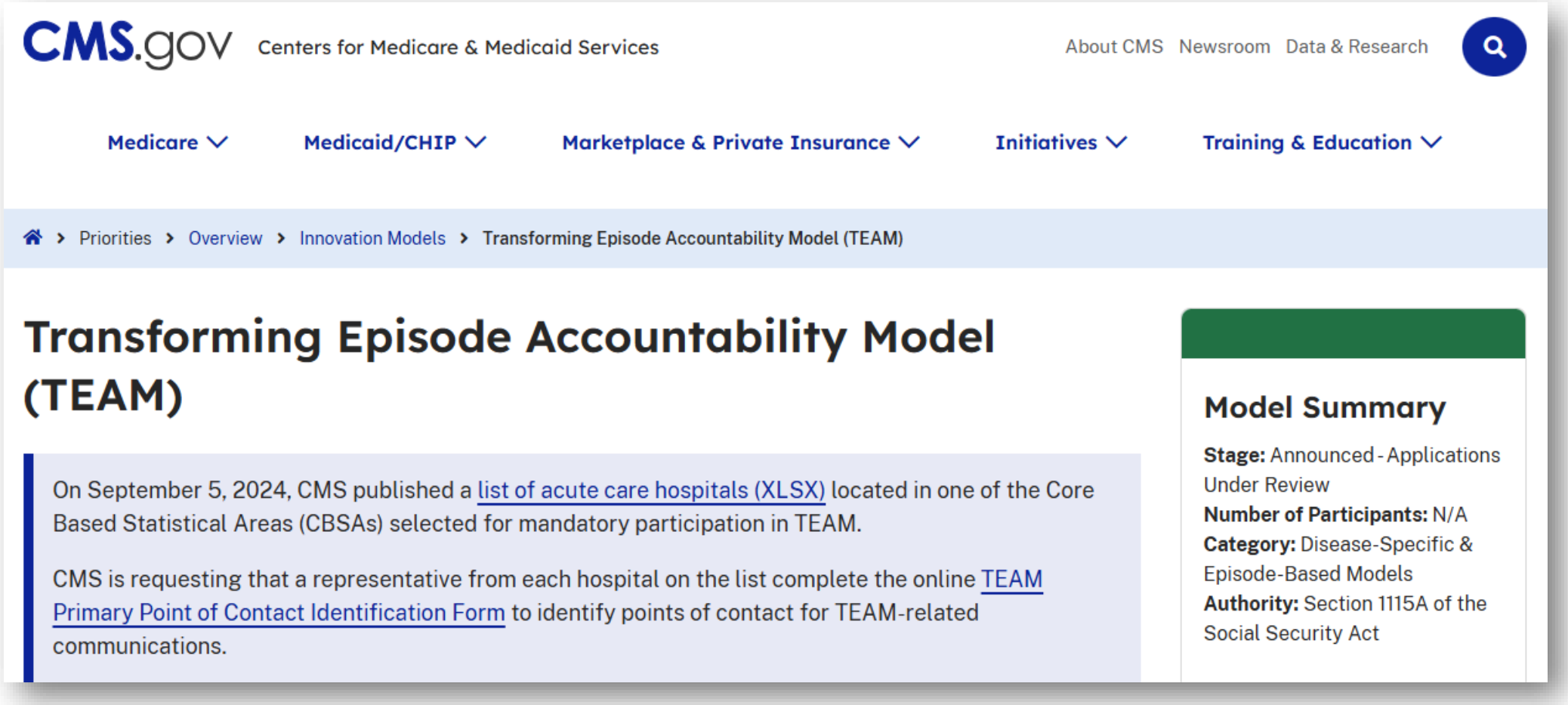


https://www.cms.gov/priorities/innovation/data-and-reports/2024/cjr-py6-ar-drivers-impact

TEAM Overview

- Mandatory 5-year episodic payment model beginning 01/01/2026 under which hospital financially accountable for total cost of defined episode of care for traditional Medicare beneficiaries
  - Hospital = Selected PPS hospitals + voluntary participants
  - Episode of care = Anchor event (specified inpatient stay/outpatient procedure) + ***30 days*** post-discharge/post-procedure
  - Total cost = All non-exempt Part A & B payments (prorated if service staddles episode)
  - Accountable = Owe money if total cost > target price, receive additional payment if total cost < target price

CMS TEAM Website



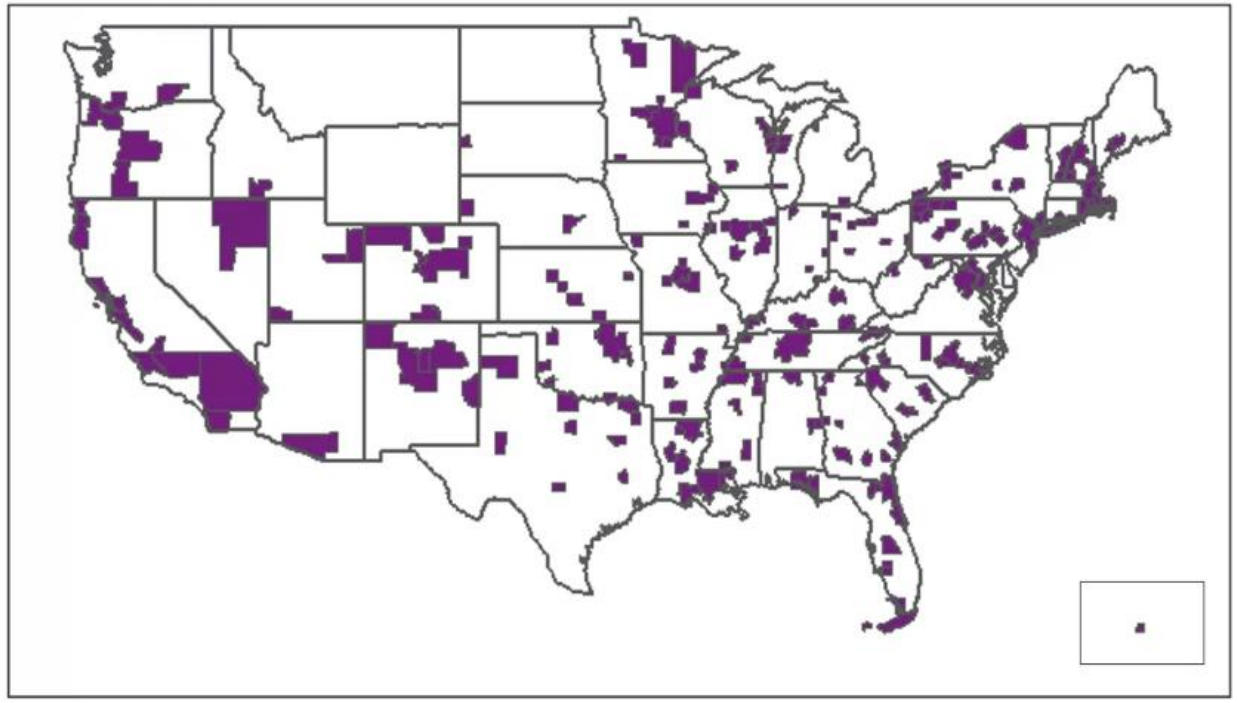
https://www.cms.gov/priorities/innovation/innovation-models/team-model

Selected Episodes: Focus on Surgical Care

Surgical Episode	Inpatient MS-DRGs	Outpatient HCPCS Codes
Coronary Artery Bypass Graft	231-236	
Lower Extremity Joint Replacement	469, 470, 521, 522	27447, 27130, 27702
Major Bowel Procedures	329-331	
Surgical Hip/Femur Fracture Treatment	480-482	
Spinal Fusion	402, 426-430, 447-448, 450-451, 471-473	22551, 22554, 22612, 22630, 22633

PPS Hospitals in Selected CBSAs

- 188 of 803 eligible CBSAs
  - Weighted towards CBSAs with safety net hospitals and hospitals with limited bundled payment experience
  - At least 2 CBSAs with no eligible hospitals
- Includes 700+ hospitals representing 200,000+ episodes/year
- CMS anticipates nearly $0.5 billion in savings over 5 years



Polling Question #2

Level of Risk Based on Hospital Classification

- Safety net hospitals (exceed 75th percentile for either dual eligibles or Part D low-income subsidy recipients)
  - Upside only for PY 1-3 (10% stop-gain limit)
  - Upside/downside for PY 4-5 (5% stop-loss/stop-gain limits)
  - May elect higher degree of risk at beginning of performance year
- Rural hospitals (located in rural area/rural census tract, not hospitals reclassified as rural), Medicare-dependent hospitals, and sole community hospitals
  - Upside only for PY 1 (10% stop-gain limit)
  - Upside/downside for PY 2-5 (5% stop-loss/stop-gain limits)
  - May elect higher degree of risk at beginning of performance year
- All other hospitals
  - Upside only for PY 1 (10% stop-gain limit)
  - Upside/downside PY 2-5 (20% stop-gain and stop-loss limits)

Preliminary Target Prices

- Prior to the start of each performance year, calculate price-standardized average hospital spending by DRG/HCPCS for 9 census regions
  - Use 3 years of historical data (e.g., 2026 based on 2022-24 data)
    - Year 1 = 17%; Year 2 = 33%; Year 3 = 50%
  - Exclude outlier episodes (≥ 99th percentile) and costs within episodes for specified unrelated items/services (e.g., certain inpatient admissions)
  - Apply prospective trend to performance year to account for changes in healthcare spending between baseline period and performance year
  - Apply applicable discount factor (CMS' guaranteed savings)
    - 1.5% for major bowel and CABG
    - 2.0% for LEJR, SHFFT, and spinal fusion

Risk Adjustment Factors

- Prior to start of each performance year, perform linear regression analysis to produce exponentiated coefficients (anticipated impact of each factor on episode costs)
  - Hospital-specific risk adjustment factors
    - Number of beds
    - Safety net hospital
  - Beneficiary-specific risk adjustment factors
    - Age bracket
    - Number of HCCs during look-back period (length to be determined)
    - Social need
    - Episode category-specific beneficiary level risk adjustment factors (specified HCCs present as of first day of episode)

Annual Reconciliation Process

- Determine if low volume hospital policy applies
  - If hospital has less than to-be-determined number of episodes, no reconciliation performed
- For each qualifying episode, calculate performance year spend
  - Same methodology used to calculate preliminary target prices
- For each qualifying episode, calculate reconciliation target price
  a. Adjust preliminary target price by applying risk adjustment factors
  b. Apply normalization factor to account for changes in beneficiary health status/demographics
  c. Apply retrospective trend factor to estimate realized changes in spending patterns during performance year (not to exceed +/- 3% of prospective trend factor)
- Calculate reconciliation amount by subtracting total reconciliation target price from total performance year spend
- Calculate Quality Composite Score (QCS) adjustment percentage and adjust reconciliation amount accordingly, subject to applicable percentage cap
- Apply stop loss/stop gain limits to determine final payment/re-payment amount

TEAM Quality Measures

- Performance Year 1
  - Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and EHR Data
  - CMS Patient Safety and Adverse Events Composite
  - Hospital-Level Total Hip and/or Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure (LEJR episodes only)
- Performance Year 2 – 5
  - Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and EHR Data
  - Hospital Harm – Falls with Injury
  - Hospital Harm – Postoperative Respiratory Failure
  - 30-day Risk Standardized Death Rate Among Surgical Inpatients with Complications
  - Hospital-Level Total Hip and/or Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure (LEJR episodes only)

Primary Care Referrals

- For each TEAM beneficiary, hospital must make referral to primary care provider prior to discharge from anchor admission/procedure
- Comply with beneficiary freedom of choice
- Failure to provide such referrals may result in remedial action against hospital
  - E.g., corrective action plan, discontinuation of data sharing, recoupment of payments

Beneficiary Protections

- Provide written beneficiary notification regarding hospital's participation in TEAM prior to discharge from anchor admission/procedure
- Require collaborators to provide written beneficiary notification regarding sharing arrangement no later than first delivery of services (or as soon as practical)
- Do not restrict beneficiary freedom of choice for post-acute services
  - Provide complete list of post-acute care providers, identifying those with which hospital has sharing arrangement
  - May recommend preferred providers
- As part of discharge planning, provide notice of potential financial liability for any non-covered post-acute care services beneficiary may be considering

Payment Waivers

- Telehealth furnished during episode not subject to geographic and originating site restrictions
- Waiver of SNF 3-day rule for TEAM beneficiary admission to CMS-identified qualified SNF

2. TEAM Line-Up

Working with Collaborators

2025 Timeline

JAN – FEB	MAR – APR	MAY – JUN	JUL – AUG	SEPT – OCT	NOV – DEC
EDUCATE					
WHO			HOW		

• Form TEAM Implementation Committee
  • Legal
  • TEAM Playbook creators
• Determine internal timelines
• Name responsible parties
• Create data wish list
	• ***Determine population of potential Collaborators***
	• Determine the extent to which the potential Collaborators impact the episode of care
		• Create opportunity modeling framework/ dashboard
		• Create Collaborator P&P
		• Prove potential Collaborators meet the P&P
		• Create inventory of existing arrangements with potential impact
			• Measure/model
			• Determine agreement(s) structures(s)
			  • VBE?
			  • VBE+
			• Provider alignment
				• Measure/model
				• Create Collaborator Sharing Arrangements or other structures
				• Provider alignment
				• Begin FMV opinions, if required
					• Measure/model
					• Provider alignment
					• Complete FMV opinions, if required
					• Finalize

Potential Collaborators

- Potentially any provider who participates in care of patient in one of defined episodes:
  - Cardiothoracic or Cardiac Surgeon
  - Orthopedic Surgeon (including spine)
  - Colorectal Surgeon
  - General Surgeon
  - Neurosurgeon (spine)
  - Anesthesiologist/Anesthesiology Group
  - Hematologist
  - Advanced Practice Provider
  - Ambulance
  - Emergency Medicine
  - Physical Therapist/Physical Therapy Group (outpatient)
  - DME Provider
  - SNF Provider
  - Swing Bed Provider
  - Inpatient Rehabilitation Provider
  - Home Health Provider
  - Pathologist/Lab Provider
  - Radiologist/Radiology Provider
  - Hospitalist/Hospitalist Provider

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Collaborator P&P

- Participant selects Collaborators who must meet requirements outlined in Participant's written policy and procedures (P&P)
- Collaborator must be:
  - Willing and able to contribute to quality care within episode of care
  - Demonstrate commitment to coordinated care, including time required for planning
  - Chosen based on ability to demonstrate criteria set forth in P&P
    - Not based on the value or value of referrals

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Inventory of Impact

- Current ACO participation and initiatives
- Current co-management arrangements:
  - Cardiothoracic/Cardiac Surgery
  - Orthopedic Surgery
  - General Surgery
  - Neurosurgery
  - Others
- Structure of performance metrics under professional services agreements:
  - Anesthesia
  - Radiology
  - Hospitalist
  - Others
- Structure of performance metrics under provider employment agreements

Polling Question #3

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Requirements for Collaborator Sharing Arrangements

- Collaborator selected by participant based on criteria detailed in written P&P
- Collaborator participates voluntarily
- Written agreement between participant and collaborator signed ***prior to episode initiation*** (i.e., before January 1, 2026)
- Payment conditioned on meeting specified quality standards plus provision of billable services to TEAM beneficiaries; cannot be based directly/indirectly on volume/value of referrals
- Must provide for gainsharing *and* alignment payments

Three Types of Payments

- *Gainsharing payment*: annual payment *by Participant to Collaborator* made exclusively from reconciliation payments and/or internal cost savings
  - Internal cost savings = measurable, actual, and verifiable savings realized by Participant from care redesign
- *Alignment payment*: annual payment *by Collaborator to Participant* to share in Participant's repayment amount
- *Distribution payment*: annual payment *by Collaborator ACO, physician group practice, non-physician provider group practice, or therapy group practice* under a distribution arrangement (e.g., payment by group practice to physician member of group practice)

VBE Framework Aligns Neatly with TEAM

- Stark Law and AKS compliant
- Do not require remuneration to be fair market value
- **VBE framework recap:**
  - *VBE Participants* (TEAM Participant and TEAM Collaborators)
  - Collaborating to achieve a *Value-Based Purpose* (TEAM requirements for cost and quality)
  - For a *Target Patient Population* (Medicare TEAM beneficiaries)
  - Engaged in a *Value-Based Activity* (taking action to reduce cost and increase quality under TEAM)
  - Via a *Value-Based Arrangement* (TEAM Participant and Collaborators)
  - With an *Accountable Body* (TEAM Steering Committee or other body composed of Participant and Collaborators)
  - Memorialized by a *Governing Document*

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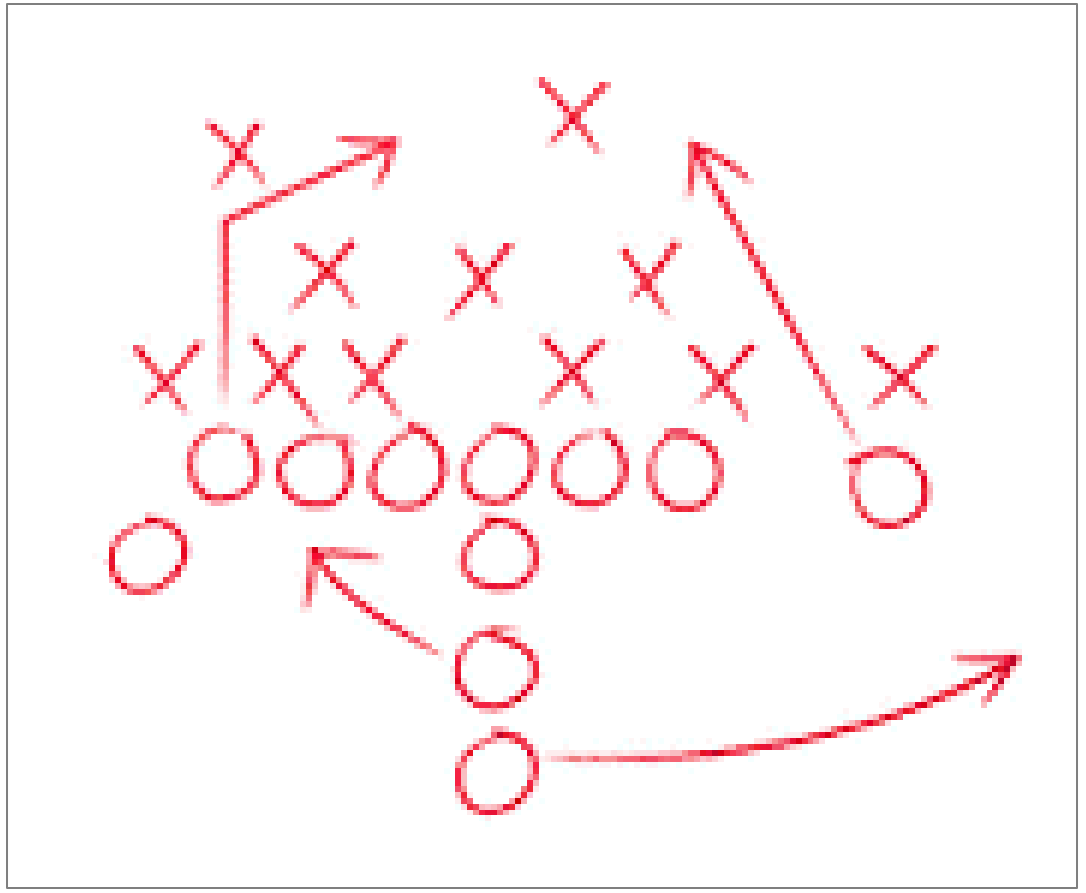
3. TEAM Playbook

Developing Your Tactical Plan

Playbook: Let's Get Tactical

Care Model

- Do you know and understand:
  - ✓ Your current care models?
  - ✓ Your current players?
  - ✓ Utilization implications?
    (*more about that during TEAM ANALYTICS*)



Selected Episodes: Transforming the Tactics

- **Current State Mapping**
  - What is typically happening prior to anchor event? Is that information available?
  - What players are in the game during anchor event and is there anyone on the sidelines?
  - What resources are you using?
  - What is typically happening while clock is running for 30 days following anchor event? ?
- **Know the Endzone**
  - ✓ Identify what could be happening prior to anchor event to optimize patient outcomes
  - ✓ Ensure all players involved in anchor event are running toward same goal post
  - ✓ Identify optimal resource utilization
  - ✓ Transform care model to provide high quality and efficient care before, during, and after anchor event

Approaching the Tactical Plan

	Define the End Zone	Understand Current State	Build Your Playbook	Implement The Plan
OBJECTIVES	• Define what success looks like	• Understand and document current state	• Compare current state to end zone using gap analysis • Use identified gaps as framework to move from current state to desired future state	• Implement your tactical plan through collaboration and project management • Ensure objectives are measurable
OUTCOMES	✓ Objectives, Guiding Principles, and Governance Structure	✓ Current State Documents	✓ Tactical Plan	✓ Measurable progress for accomplished objectives

FOCUS AREAS

- Rule Book
- Line Up: Potential Collaborators, business and clinical operations, data analytics, score board

Tactical Plan – *Prior to Anchor Event*

- Evidence-based care model considerations prior to anchor event
  - Optimization clinics
  - Therapeutic services for optimization
  - Patient and family education
  - Home modifications and equipment planning
  - Enhanced recovery after surgery protocols (ERAS)
  - Care navigation

Polling Question #4

Tactical Plan – *Anchor Event*

- Evidence-based care pathways
- Minimize and eliminate unnecessary clinical variation
- Ensure patient family centered culture to drive patient engagement and outcomes*
- Emphasize smooth throughput and care transitions
- Understand supply utilization and opportunities (opportunity to formalize value analysis teams)

**Patient Family centered care culture can be a dedicated transformational journey that positively affects outcomes broadly*

Tactical Plan – *Post Anchor Event*

- Begin as soon as clinically appropriate (care coordination as part of anchor event clinical pathway)
- Warm hand-offs
- Participate or contribute to development of post acute care pathway, as appropriate
- Deploy resources to post acute setting, as appropriate

4. TEAM Analytics

Making Claims Data Work for You

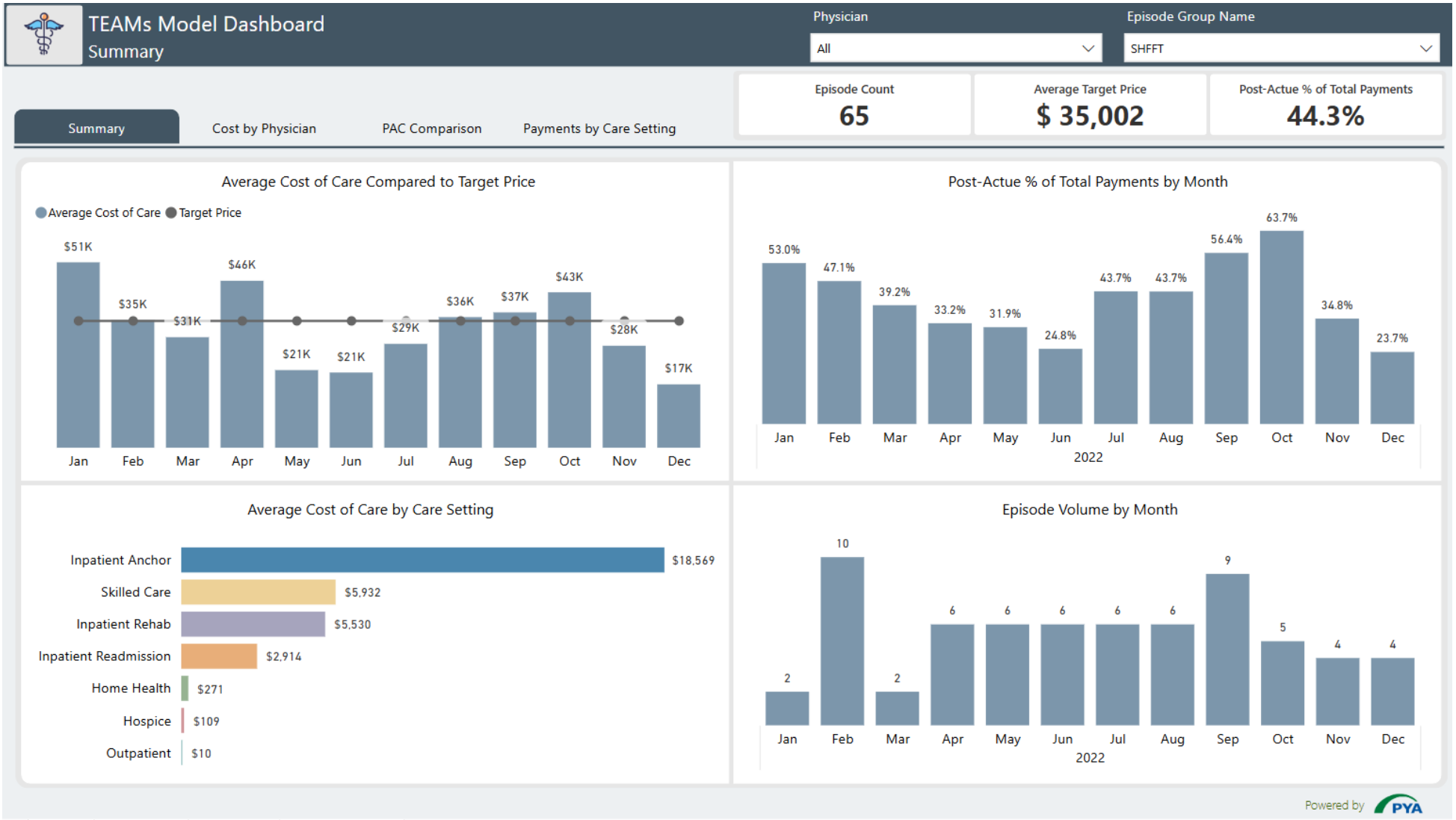
The Role of Claims Data in Episodic Payment Models

- **Why Medicare claims data matters**
  - Comprehensive source of historical cost and utilization patterns
  - Identifies trends in service delivery and outcomes
  - Covers all services provided to a patient across the entire episode of care
  - This full-spectrum view allows hospitals to track care patterns, understand cost drivers, and identify inefficiencies.

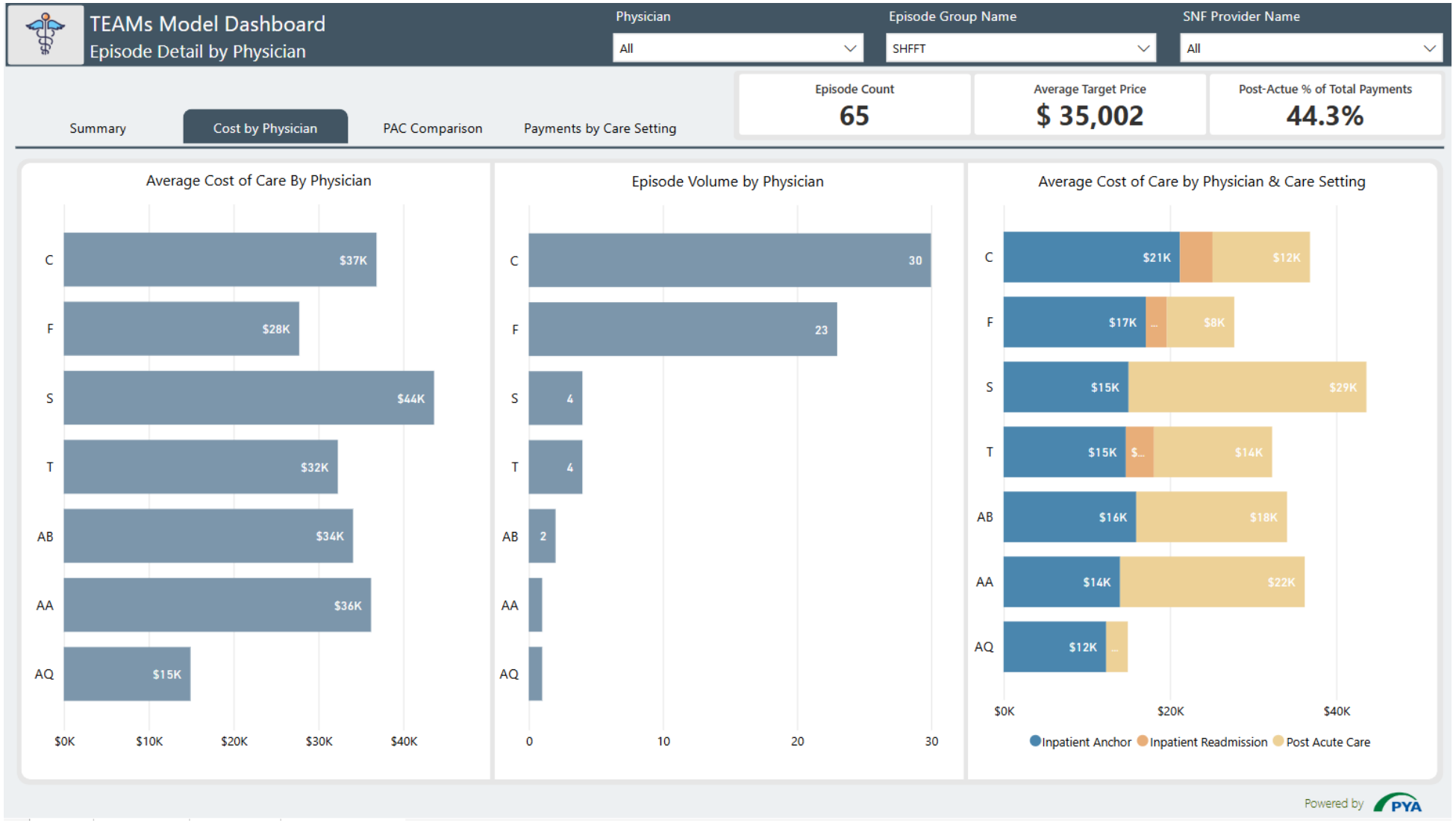
The Role of Claims Data in Episodic Payment Models

- **Optimizes post-acute care and care coordination**
  - Medicare claims data provides insights into **post-acute care utilization**, helping hospitals:
    - Identify **high-performing skilled nursing facilities (SNFs), home health agencies, and inpatient rehab facilities**
    - Reduce **unnecessary post-acute care spending** by ensuring patients receive the right level of care
    - Improve **care transitions** to prevent rehospitalizations
  - Hospitals can create **preferred provider networks** based on quality and cost-effectiveness of post-acute care providers.

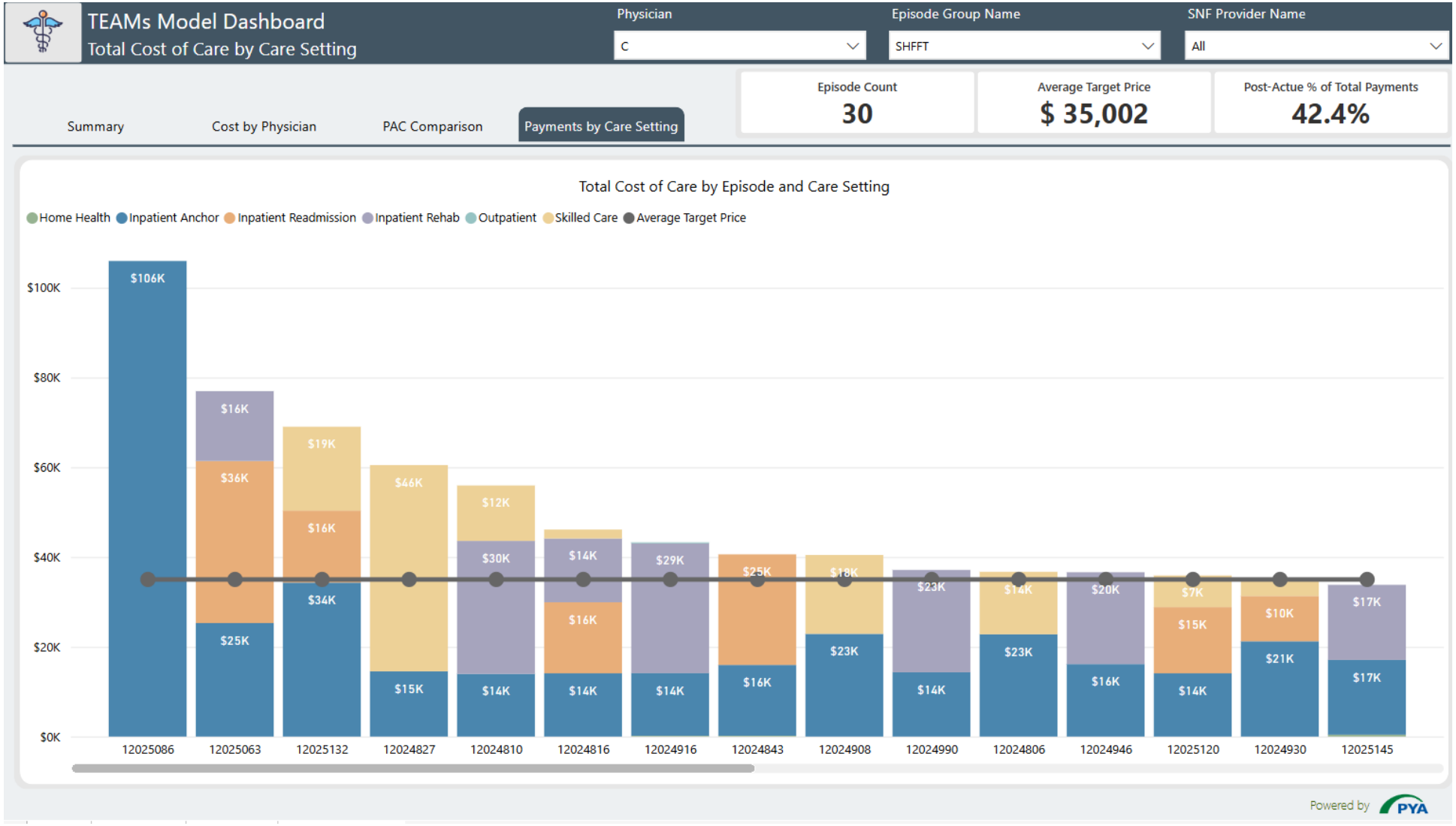
Cost vs. Target: Key Insights from Episode Analysis



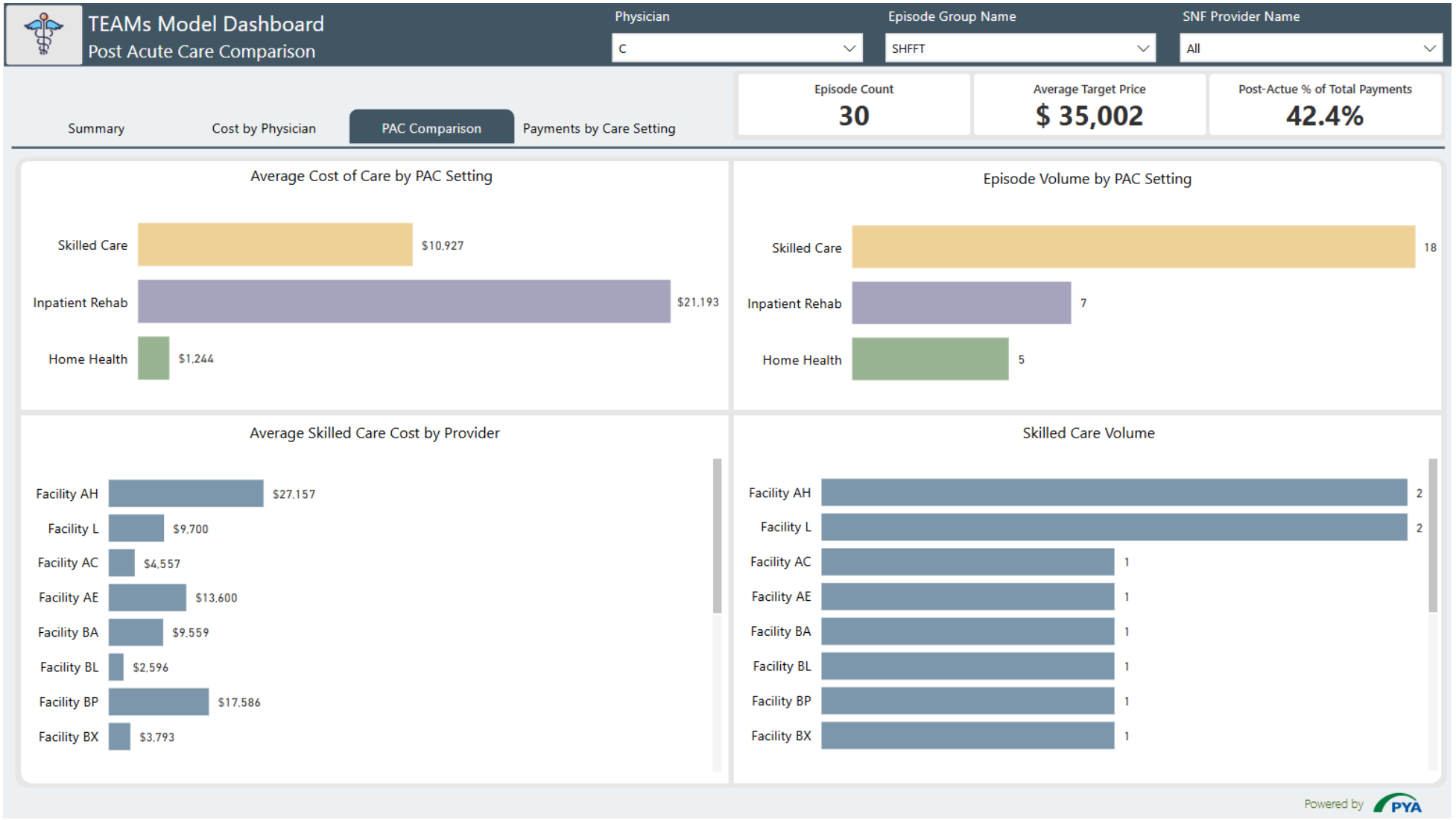
Physician Performance: Understanding Variation



Evaluate High-Risk Patients



Post-Acute Care Optimization



Data Sharing

- To receive beneficiary-identifiable claims data, hospital must submit annual request in manner required by CMS and sign formal data sharing agreement
  - Claims data for baseline period then made available at least one month prior to start of PY and monthly during PY
- CMS will provide regional aggregate data for 3-year baseline period at least one month prior to start of performance year and monthly during PY

Polling Question #5

Our Upcoming Healthcare Regulatory Round-Up Webinars

- **February 12, 11 am – 12 pm ET**
  Providing and Billing Medicare For Care Management and Remote Monitoring Services
- **February 26, 11 am – 12 pm ET**
  Deep Dive Into Proposed HIPAA Security Rule Changes
- **March 5, 11 am – 12 pm ET**
  Tightening Your Belt: Prepare for Site Neutral Payment Reforms

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