Healthcare Regulatory Roundup #87 Webinar Transcript

Building Your Dream TEAM – How to Win at Episode Payment Models

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SPEAKERS

Martie Ross, Kathy Reep, Angie Caldwell, Lee Ann Odom, Jason Hardin, PYA Moderator

SUMMARY KEYWORDS

Episodic payment models, care model transformation, collaborator agreements, structuring arrangements, CMS Innovation Center, TEAM model, quality metrics, care coordination, post-acute care, optimization clinics, value-based enterprise, Medicare claims data, cost utilization, patient outcomes, care navigation, telehealth services, financial liability, anchor event, post-anchor event

WEBINAR SUMMARY

The webinar covered the new mandatory episodic payment model launching in January 2026. Key points included the need for hospitals to prepare for the model, which focuses on surgical cases and spans 30 days post-discharge. The model involves three risk tracks: no downside risk, upside with capped stop loss/stop gain, and upside with higher stop loss/stop gain. Collaborator agreements are crucial, with a focus on quality metrics and care coordination. The webinar also emphasized the importance of using claims data to evaluate historical performance and identify areas for improvement.

The webinar focused on 7 key topics:

1. Introduction and TEAM background and context of episodic payment models
2. Details of the TEAM model and participation requirements
3. Risk tracks and preliminary target price calculation
4. Collaborator agreements and structuring arrangements
5. Tactical plan and care model transformation
6. Utilizing claims data for performance evaluation
7. Final thoughts and next steps – voluntary TEAM participation deadlines and list of safety net hospitals

ACTION ITEMS

- ☐ Determine if your organization previously participated in any episodic payment models, either directly or indirectly.
- ☐ Assess if your organization plans to participate in HCRR TEAM, either directly or as part of contracting with a participating hospital.
- ☐ Evaluate if your organization currently participates in any co-management agreements.
- ☐ Determine if your organization plans to leverage claims data to evaluate historical variation in episodic payments.
- ☐ Sign up to receive updates on the HCRR TEAM program from the CMS website.
- ☐ Establish an implementation committee, including legal counsel, to begin planning for the HCRR TEAM program.
- ☐ Map out the current state of care processes for the selected HCRR TEAM episodes.
- ☐ Develop a tactical plan and implementation timeline for the HCRR TEAM program.

TRANSCRIPT

PYA Moderator **00:10**

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

Good morning, everyone. Welcome to the latest episode of PYA is Healthcare Regulatory Roundup compliance webinar series. Today's topic is *Building Your Dream TEAM: How to Win at Episodic Payment Models.* PYA is happy to present today's webinar on this important topic.

Before we get started with the webinar, I'd like to go over a few housekeeping items. As this event is for 1.5 CPE credit hours, there are some additional steps that we will take in order to comply with the NSAB and ASBA requirements. Attendees will be provided five polling questions throughout today's webinar; responses are documented electronically. Attendees must respond to all five polling questions within the allotted time to receive CPE credit for this course. A post-event survey will also be provided for attendees to submit regarding their webinar experience. The polling questions and post-event survey must be submitted for proof of participation today.

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 will be asked to complete a short survey and submit any additional questions, any questions posed after the webinar will be responded to via email.

We've posted a PDF copy of the presentation slides for your reference in the resources pane, you can customize your viewing experience by resizing, moving or minimizing all panes within the webinar.net platform. Your CPE certificates are downloadable via the CPE pane once you have completed the requirements, and are also sent via email after the webinar. 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, Angie Caldwell, Lee Ann Odom, and Jason Hardin.

Martie Ross **02:31**

Thanks, Jennifer. Good morning, everyone, and welcome to our TEAM webinar. I am Martie Ross, a PYA principal in our Kansas City office. Okay, because it's a TEAM webinar, I have to say it, Go Chiefs! But today I'm serving in a different capacity as a point guard to sort of move us between the different topics and call upon our experts to provide some really important insights into this new mandatory episodic payment model that is now set to launch in approximately 11 months. And as we will discuss, there is a lot of work to be done during that 11 months to really position yourself out of the gate for success in this new TEAM model.

In terms of our agenda today, we're going to start with just reviewing the basic TEAM rules. Understanding the implementing regulations that have been published thus far, providing some context for this mandatory payment model, also highlighting the gaps that CMS still has to fill in on the program, and we'll then move into how to work with collaborators. Always, one of the questions and episodic payment models is, how can hospitals move the needle on total cost of care? Because they're paid a DRG or an APC amount, and there's really no opportunities for savings. So, that's all about your relationships with your physicians, your other providers, your post-acute care providers. We'll take a deep dive into how to develop those relationships in compliance with the requirements the program. We'll then move into the TEAM playbook, which is really looking at the technical plan for how to succeed under episodic payment models. And we'll wrap up with analytics and how to make the claims data that will be made available to you by CMS really work for you and inform that tactical plan, as well as those opportunities with collaborators. So, with that, we will go to a first of our five polling questions. And Jennifer, back to you.

PYA Moderator **04:49**

All right. Poll 1, Has your organization previously participated in any episodic payment model, either directly or indirectly? Yes; no; unsure; or, my organization is not a healthcare provider. Remember, you must fill out the polling questions in order to receive CPE credit. You will have 30 seconds to answer.

Martie Ross **05:18**

And again here, I think the distinction between directly would be the hospital, indirectly would be those collaborators, like physician practice groups or post-acute care providers that have worked with hospitals that have been in episodic payment models.

PYA Moderator **05:43**

All right, thank you for participating in our poll. Back to Martie.

Martie Ross **05:48**

So, I sort of have a mix here. Those of you who have gone down this road before, some who are brand new, and some unsure as well. But with that, let's start digging into the rules. For that purpose, we will call upon my colleague, Kathy Reep, who is based in Orlando, Florida. Before joining PYA about five years ago, five and a half years now, Kathy. She worked with the Florida Hospital Association in a number of capacities. She's been an incredible asset here at PYA.

Her face may look very familiar if you have previously attended Healthcare Regulatory Roundup webinars from PYA. Kathy and I are often co-conspirators in that regard. So, Kathy, I'm going to turn it over to you to give us some background and some introduction to these regulations.

Kathy Reep **06:38**

Thanks, Martie. And Martie and I are going to co-present on the issues related to the TEAM rules. I'm going to go through a little bit of background and how you got in this. And then Martie is going to dig a little bit deeper into the process.

So, starting with that, let's just go ahead and make sure that we know where this all came from. This is a program a new model under the CMS Innovation Center, CMMI, Centers for Medicare and Medicaid Innovation. And the goal of CMMI is to develop and test service and payment and service delivery models to improve patient care lower costs and align payments to promote patient centered practices. There have been a number of models that have been implemented through the Innovation Center over the last few years. There are some models that are running fairly parallel to what we're dealing with from a TEAM perspective, the IOTA, the organ transplant model, that kind of thing. So, we do have some models that are in place at the same time that we're dealing with TEAM, but just kind of looking at some of the key programs that have been out since the program was established. The bundled payment for care improvement, or BPCI, was an elective model that ran from 2013 to 2018. But you can see that we then month bumped at the end of 2018 into BPCI advanced, which also was an elective program, and that expires this year. But we also had the comprehensive care for joint replacement, the CJR program that was mandatory for a large number of providers, it was voluntary for others. So, we'll talk a little bit more detail about BPCIA and CJR in a minute.

But the second goal of the innovation center was to have all traditional Medicare beneficiaries in a care relationship with accountability for quality and cost of care by 2030. It is 2025, and we are at 53.4% of Medicare beneficiaries in such a relationship where they are in some sort of an accountable care program.

There are a couple of reports we want to call your attention to, particularly if you are a hospital who is participating in TEAM, and we think you are, if you're with us today, or if you are a provider who is perhaps a post-acute care provider, or other type of provider that could be receiving patients from a TEAM hospital. So, there the reports I want to call your attention to, and we've given you the link for both of those, both of the reports we're going to share. The first one is CMS bundled payments for care improvement advanced models. This was the BPCIA report that came out in May of 2024. It really looks at the overall process, what the hospitals and the providers involved in BPCIA did. It did reduce episode spending by about three and a half percent. And what you can find as you go through this document is a great outline that really addresses some of the steps that providers took to reduce the costs of care. So, I urge you to take a look at this particular document and some of the innovations that the hospitals put in place.

In addition, there was, in December of this year, a report from the Lewin Group on this comprehensive joint replacement model. One thing to remember, and this is maybe a way to head off a question that could wind up being in the chat in a minute, but it I picture someone asking, what will the Trump administration do with the TEAM model? So, let's kind of look at what happened under the prior Trump administration with the CJR model. Again, you've got the information related to the report and where you can find the

report. But when Trump came into office in 2016, the CJR program was launched in 67 metropolitan statistical areas with about 800 hospitals, and it was intended to run for five years, from 2016 to 2020. However, in 2018, participation became voluntary for half of the selected MSAs. So, there were 34 MSAs that were included. And as of 2017, with about 320 hospitals participating. There were some voluntary hospitals as well. So, will we see something like this under the new administration to make this not mandatory, or to make it mandatory for some of those who are required to participate in TEAM? And not for others, allow some to opt in? We don't know. But it is something to keep an eye out on.

From a TEAM overview perspective, just to kind of give you an outline as to how the program is going to work. Martie mentioned that you have about 11 months, little over 11 months to prepare, but it is effective for beginning January 1 of 2026. As we said, it is mandatory. It is a five-year payment model, and the individual hospital is going to be held financially accountable for the cost of a defined episode of care for traditional Medicare beneficiaries. This is not applicable to Medicare Advantage. It is only applicable to your fee-for-service or traditional Medicare beneficiaries. The individual hospital has been selected. You know who you are and those that are required to participate, from mandatory perspective, you were…CMS essentially identified a number of core-based statistical areas or CBS as that are required to participate. However, hospitals that were in BPCIA and in CJR, who are not in a mandatory CBSA, also have the opportunity to voluntarily participate in the new program. So, recognize that for the CJR participants, I believe your time to make your decision to participate is now; there's a little bit more time for the BPCIS participants.

An episode of care, which we're going to be looking at in terms of, we're looking at your cost, the overall cost of care across the episode begins with an anchor event. And because we are talking about inpatient stays and outpatient procedures, the anchor event for the inpatient stay is defined by the date of admission, and for an outpatient procedure, it is the date of surgery. So, we are looking at that anchor event, plus 30 days post discharge, post procedure. We're going to be looking at the cost of care for the anchor and. And then 30 days, post discharge, post procedure, your total cost of care, which will be evaluated against a target, will look at not all nonexempt, Part A and Part B payments, and that those services and the cost will be prorated. Think about a patient who has a major procedure, an applicable procedure, and winds up going into skilled nursing for 35 days. We're going to have to take that 35-day SNF stay, prorate it back to a 30-day stay in order to identify the dollars that will be associated with the actual episode of care.

Martie Ross **15:44**

Kathy, it's a good point, a good time to point out that this 30-day period is significantly lower than either CJR or BPCIA, which both use 90 days exactly. And CMS logic was that it's much easier to manage a 30-day episode, and it typically includes more than 75% of the costs. Extending it out by another 60 days only typically captures another 10 to 15% of the cost. So, CMS said, let's focus on the most immediate opportunities, which are directly following a discharge.

Kathy Reep **16:17**

Thanks, Martie. And then in terms of who's accountable? Yes, it is the hospital. That is, as we said even at the heading, the hospital is financially accountable for the total cost of the episode. If you have, if your total costs exceed the target price, you will owe money. And if you actually have costs that are less than target price, you'll be sharing with CMS in that particular in those savings. Angie is, in a few minutes,

going to go into some details about it. Even though it is the hospital that is accountable, there is the opportunity for you to share both the gain and the loss with partners as we go through this program.

We also wanted to call your attention to a CMS website that I hope that those of you who are participating in TEAM are monitoring on a regular basis. You can go into this website, and you can sign up to receive updates on the program. There are a number of things that we're going to touch base on today that we have questions that still have not been answered. So, as an example, one of the key issues is, I'm a low-volume hospital. Do I have to participate? I've only had 10 of these particular services in the last three years, am I really in this program? Well, right now, until CMS defines low-volume hospitals and who would be excluded, yes, you need to be thinking about this. But if you monitor this website, if you sign up for their emails, all the things like the low-volume hospital definition will be published in a Federal Register for notice and comment. This will kind of keep you aware of when that has happened, so make sure you have signed up for ongoing news from CMS on TEAM.

Okay, so who's in, in terms of the services that I provide? The cases that have been selected, or the services that have been selected? For the TEAM program, are all surgical in nature. It is CMS' belief that it is quote, unquote, "easier to move the needle on surgical cases than it would be on a medical case". So, we are focused on surgical cases. As we look at this, we are looking, as I mentioned before, on both inpatient and outpatient services. And so, the episodes that we are focused on are going to be coronary artery bypass grafts or CABG inpatient only. Obviously lower extremity joint replacements, both inpatient and outpatient. Major bowel procedures, again, inpatient only. Surgical hip and femur fracture treatments, inpatient. And then spinal fusions, both inpatient and outpatient. This is another area, on the spinal fusions that we need to monitor what CMS might do, because there were a number of comments submitted on them that were addressed in the final rule about with a spinal fusion, what about a trauma? And how do those cases fall into this program? And CMS has basically said for right now, they're in, but we will continue to evaluate exclusion of certain cases. So, again, monitoring this, the TEAM website will let you know when CMS does make changes moving forward.

Finally, who all is in? There are 188 core-based statistical areas that have been selected to participate in the program. When CMS made the decision and did their selection, they did seem to focus on some of the CBSA's that had safety net hospitals and that had limited experience with bundled payments, so they were not involved in CJR and the mandatory CJR, for the most part. Martie has noticed that there are two CBSAs that are listed by CMS as participating in the mandatory program. However, there are no eligible hospitals. I believe one became a rural emergency hospital which and then the other one actually closed. Is that correct, Martie? So again, 188 out of 803, eligible CBSAs are required as of now to participate in the program. This includes over 700 hospitals and in excess of 200,000 episodes. CMS has identified savings of about a half a billion dollars over the five-year period. We're going to talk about how that savings comes about, but basically it is some automatic reductions. Discounts that CMS will take off of the target amounts. So, with that, I think it's time for our next polling question.

PYA Moderator **22:06**

All right. The second question is: Do you anticipate your organization will participate in TEAM, either directly, or as a party contracting with a participating hospital? Yes; no; unsure; my organization is not a healthcare provider. Remember, you must fill out all of the polling questions in order to receive CPE

credit, you will have 30 seconds to answer. Thank you for participating in our poll. Now we'll hand it back to the presenters.

Martie Ross **23:07**

Excellent. Well, let's get down into the dirty details of TEAM, starting with the level of risk that hospitals take under this program. And CMS has identified three tracks. Track 1 is no downside risk, only upside, but capped at 10% of the value of the episode. Number 2 is upside/downside, but capped at 5%, either stop-loss or stop-gain. And track 3 is upside/downside, with the stop-loss, stop-win at 20%. Which track you go into depends on what type of hospital you are. If you are a safety net hospital, which, for the purpose of this program, are those that exceed 75th percentile on either dual-eligibles or the Part D low-income subsidy. If you are one of the safety nets, you can remain upside for performance years one, two, and three; and then in performance year four, you'll move to that 5% stop-loss/stop-gain. If you are a rural hospital, and you see here how they define rural to include those that are in a rural census track, but not those that have been reclassified as rural. So, sorry, Miami, you're going to be considered urban for purposes of this program. Also, Medicare-dependent hospitals and small community hospitals fall into this category. They are upside, upside-only for one year; then in years two through five, they go to that Track 2 at 5% stop-loss/stop-gain. For everybody else, it's upside for the first year, and then downside on that Track 3 level of 20% stop-loss/stop-gain. Any hospital, however, can elect at the beginning of any performance year to move from the track they are currently in, to a higher track. So, if you are a safety net hospital, if you figured this game out, beginning of year two, you decide to go to Track 3, you'll have an opportunity to provide notice. If you fail to provide notice, you will be placed in the lowest-risk track that's still available to you. So, no notice. The beginning of 2026, you're going to find yourself in that Track 1 with no downside risk

Kathy Reep **25:13**

And Martie, before you go on, just wanted to comment that there was a question that was posted about the safety net hospitals in a particular state. And what you have here is a definition of safety net hospitals, but what we can do is to get you an actual list of those hospitals after the webinar.

Martie Ross **25:36**

Thanks, Kathy.

Martie Ross **25:39**

Let's move on to the preliminary target price, because remember, that's episodic payment models are actual performance minus anticipated performance equals you owe money back to CMS or CMS is going to pay you money. So, we all have to start with that anticipated cost to CMS of a model.

How do we calculate that? Before the beginning of each performance year, so, five times over the course of this program, CMS is going to calculate what was referred to as price-standardized average hospital spending by DRG or HCPCS for nine census regions. Keyword here is "price-standardized". This is CMS' way of saying we want to eliminate the price differentials that are dependent on something other than hospital efficiency. So, that is the wage index adjustments, it's the geographic adjustments, it's the DSH payments, it's the GME payments, all of that. So, we effectively get ourselves to a national payment rate. Note that CMS price-standardization methodology will take critical access hospital services and price

them into either IPPS or OPPS. What it will not do, however, is reprice a critical access hospital swing bed stay to the SNF methodology. So, CMS says there's not enough data on the claim submitted by a cost swing bed for their post-acute care services, so it's not able to convert it over to the SNF model. Therein is the reason you find, in the final rule, commentary by CMS recommending to hospitals that one way they can save money under these models is, rather than using swing beds to refer patients to skilled nursing facilities. Kind of a continuation of sort of an open hostility CMS has had toward swing bed hospitals historically. And there's been some great analysis done on how this unfairly places costs, swing beds, as a post-acute care provider. It's something that CMS can and should revise in its price standardization, price standardized methodology, but something important to note, as you consider how these are going to be calculated.

Each year, CMS will use three years of historical data. So, for 2026 it's going to be '22, '23, '24. They'll weight that depending on the year to make those calculations. As part of that calculation, they will exclude the outlier episodes, those above the 99th percentile, as well as costs for episodes within specific unrelated items or services. So, preliminarily, CMS has said they're going to exclude, for example, trauma; oncology; pregnancy and childbirth-related expenses, because, yes, Medicare also applies to disabled individuals, not just people over 65; eye and eye disorder services; HIV services; and the like. That's one of these yet to be completely defined by CMS. And one reason we're going to be carefully watching the TEAM website. CMS, then, from that number, will apply a perspective trend to the current performance year that's intended to account for expected changes in healthcare spending between the baseline period and the performance year. So, this is where the actuaries come into play and set that percentage of prospective trend for the target price. And finally, CMS then applies its applicable discount policy. Because how does CMS make money on episodic payments? They assign a mandatory discount to the preliminary target. For major bowel and CABG, it's 1.5%; for the other episodes, it is 2%. Good news here is that they had actually proposed 3% across the board, so they lowered those amounts. But that's how CMS always guarantees it's going to make money on episodic payment models. This is why they like these episodic payment models and continue to try and refine them and expand them in the Medicare program.

The other thing CMS does before each performance year is calculate the risk adjustment factors. They perform a linear regression analysis to produce exponentiated, I can't even say it, coefficients. Which that means, what's the anticipated impact of each of these factors on episodic costs? There are two categories of risk adjustment factors; one are hospital-specific, the others are beneficiary-specific. For hospital-specific, CMS anticipates the that the number of beds a hospital has, the relative size of the hospital, can potentially impact the episode costs. That's one factor they consider. The other is for safety net hospitals, the assumption that the episodic costs are typically higher for safety net hospitals, so they will make an adjustment based on that as well. There are three beneficiary-specific risk adjustment factors, one being the age bracket you're in, so 65 to 75, and so on and so on, because age has an impact on episode costs. The total number of HCCs during a lookback period; this is just a matter of counting up the number of HCCs that have been assigned to a specific patient that, like the lookback period, is yet to be determined. That's HCC doesn't have to be relevant to the specific pre-procedure, it's just a total count. Next up is social need. CMS looks for three things in social need. They look for whether you are a dual-eligible beneficiary; whether you're eligible for that Part D, low-income subsidy; and third, it's those individuals who reside in the top percentile on the area deprivation index. So, they say again, all three of those factors expect to have an impact on the total cost of care. And finally published with the final rule, are lists of

episode-category-specific, beneficiary risk level adjustment factors. So, specific HCCs tied to each of those categories of episodes, and you'll have an adjustment there.

So, next up, don't hit that button. Hit this button. We get to the annual reconciliation process, how CMS will determine if you owe them money or if they're going to pay you money back. And the first step in that process is to determine whether the hospital meets the low-volume hospital policy, as Kathy referenced. We still don't have that criteria, we'll be waiting and bated breath on that one. Next step is, for each qualifying episode, CMS is going to calculate the performance year spend. So, for every episode, they're going to do the exact same thing they did in determining the target price. So, they're going to do the price standardization. They're going to take out the outliers, they're going to extract the costs for certain types of episodes to determine what that actual performance period price is. What is price? Remember, it's not what you get paid. It's what it costs CMS to cover at the Part A and Part B costs within that episode of care. Then for each episode individually, not as a total, but individually, CMS calculates the reconciliation target price. They start that by taking that preliminary target price reference previously and applying those risk adjustment factors. So, every episode is going to have its own target price that's going to be determined, starting with that regional amount and then adjusting it for all of those factors. We just referenced all six of those factors, two hospital-specific, four beneficiary-specific. They then apply a normalization factor to account for changes in beneficiary health status of demographics during the period. And finally, a retrospective trend factor to estimate the realized changes in spending patterns before/during the performance year. And what that is intended to do is address whether the prospective trend factor was accurate or not. So, we true-up the actuarial work in that manner. You then calculate the total reconciliation amount by subtracting the total reconciliation target price from the total performance of your spend. And that gives you the total amount that is then that amount, is then adjusted based on your quality composite score, which is the hospital score across identified quality measures for this program, and you will adjust the reconciliation amount accordingly. And last, but certainly not least, CMS applies the applicable stop-loss or stop-gain limits to determine the actual amount that will be paid to you.

Why do we go into this level of detail? It's to help you appreciate that this isn't as simple as picking a target price and aiming for it. That in fact, there are a number of variables that go into the actual calculation of these amounts, of which you need to be aware, because those are also going to impact how you perform going forward on these particular episodes of care. Areas where you need to focus in on specific patients to address the spend for those individuals.

I referenced the quality composite score. Here are your measures. Okay, performance year one, there are three measures; performance years two through five, we expand that out to five measures. None of these are new measures. These are all currently being measured by CMS as parts of other programs or will soon be measured by CMS. Some of them are just coming online here in 2025/2026, but so there's no separate data collection activity, which you'll need to engage for purposes of this program. This is all behind the scenes with CMS based on other quality payment programs.

Other considerations in this program as you start thinking about how to operationalize the program within your organization; the requirement within TEAM, which is unique to any episodic payment model CMMI has run previously, is a requirement that you make a primary care referral to each TEAM beneficiary. Someone that has gone through one of those identified episodes. They have that referral needs to be made prior to discharge by the anchor admission or the procedure. They don't exactly specify how you make that referral and how you arrange for the referral. It's simply a matter of handing a piece of paper with a

name on it. We'll still look for more clarification there. In doing so, however, you have to comply with beneficiary freedom of choice. You can't require them to go to a certain provider. And interestingly, they know the final rule that if you fail to make those referrals, that's going to be an opportunity for remedial action against the hospital, which can include everything from a corrective action plan to actually recoupment of payments that were made to you under the program.

There are a number of beneficiary protections, which you must adhere to as a program participant. You're going to have to provide notice to beneficiaries that they're in a TEAM episode, that in fact, they are subject to TEAM. They don't, can't opt out, but we at least have to provide them notice of it. As you develop collaborator relationships, you will also need those collaborators to be providing those notices. You'll get more from Angie on that point in a minute. You cannot restrict beneficiary of choice for post-acute care services. You still have to provide a complete list of post-acute care providers to individuals, but you can identify those with whom you are partnering under a sharing arrangement; and you can also make recommendations for preferred providers, highlighting the reasons that we think this is the better opportunity for you as you go through your recovery from these services. And finally, as part of your discharge planning, you must provide patients with notice of any potential financial liability they may have for any non-covered, post-acute care services that they may be considering. That is the scope of the beneficiary protections.

Finally, as is the case with any alternative payment model that has been proposed by CMS, there are certain payment waivers associated, but these are very narrow at this time. The first is telehealth services. That if you provide to health services during the episode, you are not going to be subject to the geographic or originating site restrictions. As you know, where we stand right now is those geographic and originating site restrictions are set to go back into effect on April 1 of this year, absent congressional action. If that would be the worst-case scenario, if you are in TEAM, you will for patients within your episode be able to provide and bill for telehealth services without regard to where the patient is located. The other very common waiver that we see in all of these programs is the waiver of the SNF three-day rule. That thing we enjoyed back in the COVID days, qualifying for SNF coverage even if there was less than a three-day stay in an inpatient facility. So, that is the basics of TEAM. I'm going to turn this over now to Angie Caldwell, my colleague who is based in our Tampa office. Angie has a number of years and years of experience in physician compensation evaluation and has worked on a number of these types of arrangements now become core to TEAM. So, Angie, take us away.

Angie Caldwell **38:46**

Awesome. Thank you, Martie and Kathy. And from an overview perspective of our presentation today, we are transitioning from the what and where into the who and the how. So, when, when we were bringing our information together for this presentation, there's a lot to do between now and January 1, 2026. So, we thought it would be helpful when we are starting to think about the who and the how, to pull a timeline together for our audience, and to help us think through how we're going to accomplish everything that needs to be accomplished prior to January 1, 2026. So, on the screen in front of you, I'm going to stop along the way, but really this timeline is the basis of my section of the presentation. Again, starting with the who, and then getting into the how, and then transitioning over to Leanne to talk even more about the how.

But really, now knowing what you know about TEAM, is when we need to begin forming the implementation committee. So, item number one, think about including your legal team as soon as possible, because in a moment, we're going to talk about collaboration agreements and what needs to be in those, and certain policies and procedures. So, it'll be very important to ensure that your legal team is involved. And then, of course, all of your playbook creators. Which is what Leanne is going to talk about here soon, to ensure, again, buy-in understanding of what's happening and how this is going to work throughout your organization. Determining your own internal timelines. Again, this is just a suggestion, as you think about the upcoming remaining 11 months before this goes into effect in January, and really begin thinking about your data wishlist. So, Martie and Kathy began talking about the metrics, the measurements that are involved, the time periods involved, the DRGs. So, now is the time to begin thinking about your data wishlist. Jason is going to talk about this some more and at the end of the presentation today. But really, begin thinking about what creating that data wishlist, and then begin pulling that together.

So, then, after you have that foundation set, we need to talk about who are the potential collaborators for TEAM. And when we started thinking about this, this is a big list. This is a big group of people that could be potential collaborators under TEAM. It's really anyone who participates in care of a patient in any one of the defined episodes. So, you can see that this is far-reaching, and it is broad across your organizations and across your affiliations, within your care communities, if you will. So, the obvious, of course, are the physicians involved in the care. So, your surgeons down to your anesthesiologist, and then we start thinking about all of the other things that all the other people, all the other who's that participate in this episode of care. DME, SNF provider, swing bed provider, all of these other providers that participate, any one of these groups or any one of these individuals could be a collaborator. So, then we need to begin thinking, okay, if any, if we need to potentially, or want to, as an organization, have a potential collaborator agreement and share in potential savings related to TEAM, then how are we going to bring these parties together in order to accomplish that? Or do we want to have some, how do we want to organize these arrangements? And we're going to talk about that that here in just a moment. So, then, getting back to the timeline, after you determine the potential population of collaborators, you need to begin thinking about the extent to which the collaborators impact the episode of care. So, clearly, some of the individuals, some of the groups that were listed on the previous slide, are going to impact that episode of care more deeply than others within that episode. It doesn't mean that that all shouldn't be considered, but again, we need to think about, again, from a collaborator in a sharing arrangement and a potential physician compensation perspective, how deeply these collaborators are going to impact that care.

So, then to that point, switching, now we're already into May, we're into springtime. Thinking about getting it. You've already created your data wish list; that data wish list has been being worked on for about 60 days, maybe 45 days at this point. And so now you have data to begin creating the opportunity modeling and the dashboard and the framework for this. This is going to change. It's going to be a living, breathing dashboard that's going to flow right up until implementation time in January of 2026. But really starting to create that mechanism to be able to model and build your framework is going to be really important early on, and about halfway through the year.

So, one of the things that is interesting about TEAM, or perhaps unique to TEAM, is that the regulation requires that you create policies and procedures to determine who can be a collaborator under TEAM. So, that policy and procedure should be created in that May/June timeframe, and should document who a collaborator can be. So, a collaborator must be willing and able to contribute to the quality of care. So,

that we've talked about that just a moment ago. How deeply is the collaborator affecting the episode and affecting the care under that episode? The collaborator should demonstrate a commitment to coordinated care, including the time required for planning for all of this. And I had a dear colleague just the other day, we were in a conversation, we were talking about the difference between commitment and being supportive. Commitment means that you're going to do whatever you can possible to make something work. Supportive, perhaps on the sidelines and just, you know, providing a gentle nudge. But these collaborators need to be committed to coordinated care under and within the episode. And then lastly, the criteria for choosing collaborators should be documented within this policy and procedure, and then making sure also then the collaborators are not selected based upon the volume or value of referrals. So, that goes without saying. And determining how much a collaborator is able to affect the episode is not measuring volume or value, it is measuring the collaborators effort within that episode. So, very important distinction. But again, you can't choose a collaborator just because of the number of procedures that they bring to your facility.

So, then, once you have your collaborator P&P established and you are thinking about who your collaborators could be under a sharing arrangement; and you've determined that, yes, these collaborators do meet and qualify under your policies and procedures; it's time to create an inventory of existing arrangements with potential impact. And so, what do we mean by that? And again, we're still talking about the who, we've not even really transitioned into the how yet, because if you think about TEAM and the quality metrics that it brings forth and the requirement to coordinate care across the episode, it is likely that, as an organization, as a participant, you have other arrangements in place where you are paying for performance or paying for quality that now you might want to change. You might want to figure out how to pay within a collaborator agreement under TEAM instead of all of these other, perhaps co-management arrangements or other arrangements where different metrics or measures for quality are currently being utilized. So, we've created and on the screen in front of you, you can see what, and this is not intended to be all-inclusive, but an inventory of potential impact within your organization. So, current ACO participation and initiatives. How is this going to impact if you, as an organization, if you are a participant under TEAM, and you are again working under an ACO, because an ACO can be a collaborator, can be a TEAM collaborator. So, how does that play for your organization co-management arrangements? So, we've listed out some of the most often seen co-management arrangements that that PYA works with. So, cardiac surgery, orthopedic surgery, general surgery, neurosurgery, and there could perhaps be others where there's an opportunity to enhance your current co-management arrangement by morphing that into a TEAM collaborator arrangement. And then also, the structure of performance metrics under other professional services agreements. So, again, thinking about the entire episode of care for these surgical procedures, anesthesia, radiology, hospitalists, others. How can, though the metrics, the performance metrics that you have in those PSAs today, perhaps be enhanced to help you as a participant under TEAM. And then, down to any employed provider arrangements that you might have. Again, how can you potentially align pay for performance within those employment arrangements to help you as a participant under TEAM? So, we have our next polling question before we transition more into the how. Jennifer?

PYA Moderator **49:30**

All right. The third question is: Does your organization presently participate in any co-management agreements? Yes; no; unsure; or, my organization is not a healthcare provider. You must fill out the polling questions in order to receive CPE credit. You will have 30 seconds to answer.

Angie Caldwell **49:55**

And as the responses are coming in, I'm going to chat a little bit about co-management arrangements in general. There are different types of co-management arrangements on the spectrum. Sometimes a co-management arrangement is more an administrative arrangement with some quality metrics, but not a full-blown co-management arrangement where the parties to the arrangement are responsible for the entire clinical service line. And so, you know, when we talk about co-management arrangements, we're really talking about the baby co-management, all the way up to the full-blown service line co-management arrangements. And all of those could really be impacted under TEAM.

PYA Moderator **50:45**

All right, thank you for participating in our poll. I'll hand it back to Angie.

Angie Caldwell **50:50**

Very good. So, I think you know the answers that we're seeing on the screen right now, some of you are unsure if you participate in any co-management arrangements. If you take that inventory, that'll be a helpful step for you in order to be able to determine how TEAM might impact those co-management arrangements.

So, then once you have again created your inventory, we're now into July and August. It's hot, it's summer, it's hurricane season. Down here in Florida, you are working with your data, and you are working with your model and your dashboard to begin really measuring and homing in on how you're going to keep track of this within your organization. And you're also going to, once you've inventoried, once you know who your collaborators might be, and you're starting to look at this opportunity and really determine where your opportunities are, you need to begin thinking about the structure for the arrangements. And you don't have to wait until July to do this. Clearly, you can begin doing this today. But just thinking about determining means you're getting settled. You're really homing in on what those structures might be.

And so, thinking about the structure of that arrangement, we've got VBE question mark and VBE plus. And what do I mean by VBE? I mean a value-based enterprise, and we're going to talk about that more in a moment, but let's generally talk about, before we get into VBEs, let's talk about what is required under a collaborator sharing arrangement, generally. So, first of all, the collaborator is selected by the participant based upon the criteria detailed in that written policy and procedure, which we talked a moment ago about getting that policy of procedure in place. And then the participant selects the collaborators, making sure that the that the collaborators meet the criteria within that PMP. The collaborator has to voluntarily participate. So, this is not a, you have to do this, you have to become a collaborator for us or for a certain participant. It has to be voluntary. The agreement, of course, has to be written, not only because of its requirement, but because it's a good idea. It's just a good business practice to ensure these agreements are in writing, and they should be in place prior to the episode initiation. And so, I would even go so far as to say before January 1, if possible, because, again, you know that you're going to be getting measuring. And depending upon how you structure these arrangements, you want everything to be in place, really, prior to the beginning of that measurement period. Payment terms need to be outlined within a collaborator sharing arrangement, again, specifying on meeting the quality standards of under TEAM for billable

services. And again, the payments cannot be based upon, directly or indirectly, upon the volume or value of referrals. And the sharing arrangement should provide for both gain sharing and alignment payments.

And so, what do we mean by that? There are really three types of payments that should be considered under a collaborator agreement. The first being a game-sharing payment. And everyone participating has probably heard of a game-sharing payment at one time or another in their career. But essentially, this is the payment made by a participant to a collaborator based upon the internal cost savings, based upon the reconciliation payments under TEAM. So, they need to what do those cost savings, and what does that mean, and look like? Well, it needs to be measurable, actual, and verifiable savings realized by the participant from the care redesign. Which, again, we're going to we're going to talk about more of that how, here, in just a moment. The alignment payment is the downside. So, to the extent that the participant has to pay back to CMS, then this is the other side of that. This is the annual payment by a collaborator to a participant to share in that repayment amount. And the last one is a distribution payment, which is where a collaborator is an ACO or a physician group practice, a non-physician provider group practice, really this is where the participant is paying the group, but then the group is making a distribution amongst its ACO members or other members within its practice. So, those types of payments should be considered and defined, to the extent they are applicable, under your collaborator agreement.

So, I mentioned the VBE framework. It's almost like VBE was created for TEAM, or TEAM was created to be fit within a VBE. It is simply uncanny how this all lines up, and there's a lot to creating and establishing a value-based enterprise. Please work with your internal legal counsel or external legal counsel and making sure that this is all compliant, but it seems to be a wonderful framework to work for and within for your chosen collaborators as a participant. First of all, a VBE framework is Stark and Anti-Kickback Statute compliant. And number two, the VBE framework does not require the remuneration between the participant and the physician collaborator, or any of the collaborators to be fair market value. So, you don't have to, you can, but you don't have to meet the same requirements of FMV as you would otherwise under Stark and AKS. That doesn't mean that it shouldn't make business sense or be commercially reasonable. You still want the agreement to make sense for you as a business and as a participant. But again, you can go outside of the requirements to document fair market value that are required for Stark and AKS.

So, briefly on the VBE framework, just as a recap because it's been a while, it's been a few years since this was at the top of everyone's mind. In fact, PYA saw some value-based enterprises established, but not to the extent that we thought we would. And so again, I think this is a wonderful opportunity to consider this as a framework in light of the "who" behind TEAM, the number of collaborators you might have; and again, doing this within a VBE framework affords you some opportunities that you might not have otherwise. For example, VBE support care in-kind contributions. And so care navigators, which I know Lee Ann is going to talk about in a minute, if the participant wants to provide care navigation to its collaborators as part of a VBE framework, they can. This is something that a value-based enterprise allows. So quickly, just to outline the framework, and again, you can reach out to us and counsel on this, but VBE framework has to have the following things outlined on the screen in front of you. One, the participants have to be defined. So, in this case, you have a TEAM participant, and you have TEAM collaborators, and that's defined in your policy and procedure and defined in a collaborator agreement. You have to be under a value-based enterprise collaborating to achieve a value-based purpose. So, what is that here? That's really meeting the TEAM requirements for cost and quality. And you can bring others in as well, since TEAM is a CMS-only reimbursement. But again, there are opportunities to really make

a thing out of this and make it broad, reaching across your organization, and potentially pull in other payers and other payer arrangements. So, you are doing this for a target patient population. And again, if we're just going to talk about TEAM for a minute, your target patient population is anyone receiving one of the episodes or care episodes within and under TEAM. So, your Medicare TEAM beneficiaries become your target population. Within the framework, you have to be engaged in a value-based activity. And what is that? Reducing cost and increasing quality under TEAM, under the episodes defined under TEAM, via a value-based arrangement. So, we've already talked a moment about what that could potentially look like between a TEAM participant and a collaborator, with an accountable body. Again, this is part of the framework for a VBE. This is your TEAM steering committee, or other body composed, which you're going to be forming anyway when you begin aligning and pulling everybody together. This is the body that you've created to really align you as a participant with your collaborators. So, this your this is your accountable body and always memorialized in a governing document. And we've talked about that. So, again, it's almost like a VBE was created for TEAM, and TEAM was created for VBE. There is much opportunity here. Highly recommend that, to the extent that you can, you consider a VBE framework for your collaborators.

So, as I'm wrapping up, and before I turn things over to Lee Ann to talk more about the "how", really, once you are in this and you're measuring and you're gathering your data and you're synthesizing your data, you've thought about the structure of your arrangement, you're really beginning your provider alignment process, right? You're really working, and you're you can start this as soon as your collaborators are identified, but you're working on bringing them to the table and really understanding all the things that have to happen along the way. So, then we're as we're getting into September and October, you're measuring you're modeling, you're documenting your agreements, your ongoing provider alignment activities, and really documenting that playbook. And again, Lee Ann's going to talk about that. And then to the extent that your co-management arrangements become collaborator arrangements, or you have other types of collaborator arrangements that are outside of a VBE, you do need to begin considering if you need fair market value work on those other arrangements. Because, again, outside of a value-based enterprise, Stark, and Anti-Kickback for that physician compensation is still going to be at play.

Wrapping up then in November and December, you're still measuring, you're still modeling, you're still aligning, and you're completing those opinions. And then hopefully by the end of December, you can take a big, deep breath and be ready for that implementation, or the start, on January 1, 2026. So, with that, I'm going to turn things over to my colleague, Lee Ann Odom. So, we are we are coming to you across the country today. Lee Ann is coming to us from in Michigan, outside of Detroit, and Lee Ann is the leader of our performance transformation service line here at PYA, and I'm really looking forward to her part here. Take it away, Leanne.

Lee Ann Odom **1:03:18**

Thank you, Angie. Happy to jump in and start talking about the tactical plan around all of this. So, we heard a lot about the rules so far, we've heard a lot about the individuals involved, what that lineup is. And now we're going to take a few moments to really focus on that care model. We're going to get tactical, and we're going to think about processes that contribute to the path of care that a patient takes. So, we're going to talk about your current care models, and thinking about how well you know the processes, and if they're mapped out, who are your current players, and then touch on the utilization implications. And my colleague Jason will spend a lot of time talking about those TEAM analytics, so that'll be coming soon.

So, thinking about those selected episodes and those five buckets, and considering how to start thinking about transformational tactics, it's always important to know your endzone, right? You need to know where you're going to think about what are the right things to do and processes to put into place to get there. But more importantly, starting with what is that current state mapping is very telling, and can create that really important foundation and infrastructure for starting the journey. So asking some really important questions to kind of start that dialog internally is, what typically happens prior to one of these anchor events? And what we want to do is really be focused on this through the path of a patient, right? The the journey that a patient takes up until these anchor events. When we're talking about this, as you're thinking about the path of the patient, who are they interacting with? Who are the players in the game, up to, during, and after the anchor event? And are there folks that are on the sidelines that could be making a significant contribution to this journey? We'll have to ask ourselves, what resources are we using today? And when we talk about resources, that's all contributing staffing, processes, equipment, we can also look at supply costs. Thinking about some of the selected episodes, particularly the orthopedic or spinal fusion, there are some significant supply costs embedded in there as well. So, again, thinking about those resources. So, you're really going to want to think about what is typically happening while this clock is running from that anchor event through those 30 days following that anchor event.

Thinking about the approach to developing the tactical plan, here's kind of a handy map that maps things out along that journey, right? So, we have some objectives and then expected outcomes. And if we start putting that into, how are you going to approach this and where are you going to start? Again, we've already mentioned that endzone, and it is, what does success look like? So, you've heard a lot about the rules, right? We so everybody wants to ensure that whatever processes or operations ultimately gets put into place they are consistent with the requirements of the program. Angie spoke about a lot of requirements in the collaborator area. And also, really emphasize the goal around increasing quality as well. So, this kind of defining the endzone takes all of that into consideration as you're defining the endzone and thinking about the processes and procedures and the path of the patient, and you're memorializing these objectives and guiding principles around these selected episodes for your organization. This is also your opportunity to put a governance structure in place around standing all of this up. Thinking about these selected episodes, there are multiple, multiple contributors. Thinking about the path a patient takes, the multiple departments that patients touch. There are multiple resources that contribute to the success of this journey, and it is truly a multi- and interdisciplinary approach. So, thinking about a governance structure and how you're going to manage this will be really important. So, once you've got that endzone really defined, moving to mapping the current state, which I had just talked about, will be that next natural step. And oftentimes, really taking the time to document a current state can be really eye opening. This is often the time where we get really internal-looking at processes and procedures, and we find a lot of unnecessary variation. Oftentimes we see variation with preferences, so more preference-driven versus best-in-best class care pathways, as one example. Oftentimes operationally, there could be a tendency to do what might be easy for a department versus what that path of the patient, the best thing for the to have the patient really supported. So, it's understanding that current state and mapping that out that can be a really valuable experience for any organization. So, that current state; so, you will walk away with a mapped portfolio of what does it look like from a patient perspective, for these selected episodes.

So, then we start building the playbook. So, this is where it would get very tactical and very process-oriented, because this is where we're going to do that gap analysis. We're going to really compare the endzone, that goal, with what you've mapped out current state to say, what do we need to do? Where do

we need to fill the gaps to really get to that future state? And this is where you're building that tactical plan. And then naturally, from that tactical plan, you would go into an implementation plan that would have a timeline. So, very similar to what Angie mapped out from a timeline perspective. Thinking about what the focus areas for this activity would be for all of those episodes, obviously, keeping the rule book front and center in your mind will be very important. Thinking about all of those potential collaborators that Angie already talked about, and where do they fit into all of this? This also brings in all of those business and clinical operations. Again, business and clinical operations that support that patient pathway. And then we'll have the data analytics that we'll hear a lot more about. And ultimately, right, we want quality to improve. So, you're measuring, you're really tracking those measures, and how do they fit into these processes? So, if we start thinking about that approach and creating the tactical plan, dividing this work up, probably into the three buckets, if you will, of what happens prior to the anchor event, what's actually happening during that anchor event, and then post-anchor event, would capture that patient pathway, if you will. So, if we start thinking about that anchor event, and everything included in that event, and essentially that's when that clock starts ticking, what we really want to think about is, what can we be doing to optimize patients before they get to that anchor event? Now recognizing the selected episodes are not all elective episodes. So, this, prior to the anchor event, really focuses that concept, really focuses on individuals, where that anchor event is elective in nature, or that you have some time before the anchor event. So, if we start thinking about some of those considerations, particularly around evidence-based care model considerations, they would include things such as optimization clinics. So, for an elective surgery, and I think CJR was a great example of organizations really focusing on total joint replacement patients, it really started to focus on, what can we do with patients to get them ready for surgery in in a way that makes their experience much better, it prepares them, any family members, and also focuses on positive outcomes and positive experiences. So, thinking about therapeutic services for optimizing patients both mobility and strength, prior to that anchor event, it's a great opportunity to work on patient and family education before that anchor event. Oftentimes, discharge delays can happen because it is discovered homes need to be modified, or there's equipment or resources needed. It's great to take care of those items when you can ahead of time. It's also a great time to look at those enhanced recovery after surgery protocols. So, it is, looking at what does the care pathway prior to the surgery look like, and then care navigation. So, already mentioned that, Angie touched on care navigation. So, thinking about throughout these three, this journey again, prior, anchor, and post, is there a role for care navigation, and how do you use that?

It is now time for another polling question, and I'm going to turn that over to Jennifer.

PYA Moderator **1:14:08**

All right. The fourth question is: does your organization presently have any type of optimization clinics? Yes; no; unsure; or, my organization is not a healthcare provider. Remember, you must fill out the polling questions in order to receive CPE credit. You will have 30 seconds to answer.

Lee Ann Odom **1:14:32**

So, as these responses are coming in, talking a little bit more about optimization clinics. Certainly prior to surgery, pre-anesthesia testing can offer a variety of services in most organizations around clearing patients for surgery, the cut. You know, the concept of optimization is not only surgical clearance, but truly, literally, using the word "optimization" to say, how can we ensure that the patient is in the best

shape possible for this elective surgery? Some optimization clinics that I have seen are very diagnosis- or procedure-specific-focused, while others are more general in nature.

So, it looks like we have a handful of organizations that do have active optimization clinics, some that do not, and a variety that are unsure. So, as you're thinking about mapping out that journey, certainly something to look at, a really important tool.

Alrighty. Now we're going to go ahead and dive into that anchor event. Thinking about those selected episodes, you want to take a look at your care pathways, ensuring that they're up to date, evidence-based versus being preference driven. Oftentimes, this requires having care pathway teams put together where you have multiple stakeholders, and all of those individuals that contribute to the care pathway onboard to ensure that everybody has a voice at the table and that implementation goes smoothly. This is the opportunity and the point that is critical to really minimize and/or eliminate that unnecessary clinical variation. It is really important to ensure that patient family-centered care culture is in the forefront of everybody's mind as this work plays out. And you'll see I have a little asterisk there. I mean patient family-centered care culture, unto itself, could be an entirely dedicated topic. Think the important thing here is, as we think about the journey of a patient, we want to ensure that they are highly engaged, because we know that highly-engaged patients are more likely to take meds as instructed, advocate, ask questions, and all of that hard work oftentimes leads to a significant reduction in readmissions and utilization of post-acute care. So, thinking about that 30 days post-anchor event, that part is really, really critical. During that anchor event, we want to ensure that there is smooth throughput and care transition. So, again, thinking about the role of a navigator, and Jason will shortly hear talk to us about more supply utilization and opportunity. So, it's also during that anchor event, what are we looking at for utilization, both people and supplies?

Lee Ann Odom **1:18:05**

And lastly, looking at that post-anchor event, so that 30 days, want to move to a post-acute care, whatever that is determined for the patient, as soon as clinically appropriate, right? We want to keep that care coordination moving, and we want to ensure with that care coordination that there is warm handoffs. Again, a great way that navigators can contribute. Talked about payment waivers, right? Martie talked about that earlier thinking about, how do you utilize either telemedicine or other digital tools to help with that patient communication and transition of care into a warm handoff. As well as the waiver for the three-day qualifying length of stay, should somebody end up going to an SNF for continued care. To the degree possible, again, recognizing that patients will have a choice for their post-acute care services, to the degree that your organization can participate or contribute to the development of those post-acute care pathways is extremely important. And even potentially, if appropriate, deploying resource resources to a post-acute setting to continue with transitions of care, and contributing to that post-30 days is also a great tactic to consider. So, know we talked a lot of tactics quickly here, and I think that Jason will show us a lot of great things on how to measure and some dashboards here. So, Jason Harden a colleague of mine, I will turn it over to him. He is our leader in our Business Intelligence area. Thank you, Jason.

Jason Hardin **1:19:59**

Thanks, Lee Ann. Last but not least, we're going to transition to what your organization can do today, using claims data, to evaluate the historical performance that your organization would have within TEAMs episodes.

So, what we're able to do is use Medicare claims data. And why is Medicare claims data helpful? What it does is it offers valuable insights into historical cost utilization trends, and then it also helps to identify areas of variation and service delivery and patient outcomes. The claims that you're able to obtain from Medicare, it shows services throughout the entire episode of care. And you have a good understanding of what happens within the four walls of your hospital, but I think the real opportunity where you are leveraging Medicare claims data is useful is what happens after they leave the four walls of your hospital. So, to ensure long term outcomes and better care coordination and to be successful in the TEAM model, is understanding what happens after they're discharged and they're in a post-acute care setting.

Since 2014 PYA has purchased the national Medicare Fee for Service claims data, and it's been immensely useful. There are variety of use cases that we able to solve, ranging from evaluating episodic payment models, benchmarking hospital performance, analyzing patient-out migration patterns, and enhancing post-acute care transitions. Related to post-acute care, as I mentioned previously, the claims data provides insight into a variety of metrics related to post-acute care. Just to name a few, you're able to evaluate claims, to identify preferred post-acute care providers by looking at metrics such as the amount of post-acute care spend, average length of stay, readmission rates by episode time, even if that patient is admitted to another inpatient facility. Not ideal, a readmission in general, but having knowledge to understand where they're readmitted to is a benefit of the Medicare claims. Another metric that's useful is when identifying a post-acute care provider that would be preferred is evaluating the occupancy rate. So, if you identify a skilled nursing facility where you have great outcomes, the length of stay is reasonable, readmission rates are low, but they're at 95% occupancy. Perhaps that's not a viable option. So, a lot that you can derive from the claims data when evaluating post-acute care providers.

The remaining slides, I'm going to share a dashboard that we developed for TEAM episodes using our map, our national Medicare claims database. The dashboard you see here shows the episode defined for surgical hit femur fracture treatment episodes. That's a mouthful. We'll refer to it as SHFFT, as the acronym. We selected one at one hospital in particular, in the U.S. and throughout the dashboard, when we refer to Medicare payments as costs. So, when you see costs, those are Part A and Part B payments made by Medicare to the various care settings, so inpatient and post-acute care providers. So, all of the detail that you see here has been anonymized, but it is actual claim data for 2022 is what we're showing here. So, you have 12 months of data, on the top left chart what we see is the average cost of care by month compared to a target price. We have a placeholder of $35,000 listed as the target price for SHFFT episodes. Although CMS is not yet made available what your specific target price would be, the benefit of having this analysis is you can understand the variation in episodic costs by physician and by care setting. The chart we have on the top right shows post-acute care costs as a percent of the total episode costs. What I found interesting based on research and in the claims data, is SHFFT episodes have a very significant amount of post-acute care spend. In this sample of episodes, of the 65 episodes shown here, 44% of the episode cost is related to post-acute care. The bottom two charts show average cost of care by setting for inpatient and the various post-acute care settings. Then, the bottom right chart shows episode volume by month.

To understand variation by physician and the claims data, we have operating physicians. So, this has been anonymized, and you can see that we refer to the physician as Physician C. That's what you see on the first row. We're able to look at the episode, cost on average and volume by operating physician. The rightmost chart is particularly interesting. We're able to segment costs by the inpatient anchor, inpatient

readmission, and then post-acute care related costs. If you compare the first two rows in the rightmost chart, Physician C having 30 episodes, a pretty significant amount of volume. Comparatively, there's an average post-acute care spend of $12,000 per episode, which is higher than Physician F, just below $8,000. So, 50% more on average. To investigate this further, we can drill into all of the details per episode. This allows us to evaluate high-risk patients, and what we see is that 12 of physicians sees 30 episodes, so slightly more than a third, are higher than the target price. This dashboard allows us to understand why. For example, the second episode that you see, the second vertical bar, it shows that total cost is $77,000. Which is $42,000 more than our target price of $35,000. So, what went wrong in this particular episode? This chart provides us insight to see that we have $36,000 related to an inpatient readmission and $16,000 related to an inpatient rehab stay. You can't see from the PowerPoint, but the interactive dashboard, we can see further details and related to what was the length of stay of the readmission, and the inpatient rehab stay, and what facilities were they admitted to.

Jason Hardin **1:26:30**

The last slide, still filtered for Physicians C's 30 shift episodes. We're able to see the variation in post-acute care costs. So, the top right chart is showing the average cost by post-acute care setting, we see that $21,000 on average is the cost of inpatient rehab for episodes that did have inpatient rehab. Skilled nursing on average is $11,000; and home health is only $1,200 on average, which is 5% of inpatient rehab or 10% of the skilled nursing costs, on average.

The bottom chart shows the average cost and episode volume by skilled nursing facility. This is de-identified, but what's really useful in selecting a preferred provider to be in your network is we actually have post-acute care name, so you would know the names of these skilled nursing facilities to further evaluate.

The last slide is related to data sharing. So, CMS will plan to make this data, the claims data, available from CMS either October or November of this year at the earliest. But if you'd like to get a jumpstart on evaluating your organization's episodic performance or identifying areas of opportunity in the TEAM model, feel free to contact us for information on how to obtain Medicare claims data. As another option, if you're interested in learning more about the TEAM model dashboard that we shared today, feel free to contact us for a demo.

And we have our last polling question.

PYA Moderator **1:28:11**

Thank you, Jason. Our fifth and final question is, does your organization plan to leverage claims data to evaluate historical variation in episodic payments? Yes; no; unsure; my organization is not a health care provider. You must fill out the polling questions in order to receive CPE credit, you will have 30 seconds to answer.

Martie Ross **1:28:35**

And Jason in those in those data sets, you're able also to vary by case fix index. So, the argument, oh, we only have, we have the more sick patients, so we have higher costs. You also control that from the data, correct?

Jason Hardin **1:28:50**

Right, we can. Yeah. Bringing in case megs for the DRGs associated with the inpatient procedures.

PYA Moderator **1:28:56**

Absolutely. All right, thank you for participating in our poll. Now I'll hand it back to Jason.

Martie Ross **1:29:08**

Well, I'm going to steal it from Jason, because we have reached the end of our time. Just to highlight for you, our upcoming Healthcare Regulatory Roundup webinar. As Jennifer said, we get together usually twice a month to talk about new and interesting topics. Two weeks from yesterday, we'll be addressing Medicare billing for care management, remote monitoring services. On February 26, our colleague Barry Mathis, will be doing a deep dive into the proposed HIPAA Security Rule. And then on March 5, just a week later, Kathy and I are going to take a way too deep dive into site neutral payments, given how that is one of the targets and the proposed budget reconciliation bill. Really how can hospitals begin appreciating how they're at risk with the loss of site if there's a move towards site-neutral payment, developing strategies along that. Thank you for joining us today. I hope this is helpful, a deeper dive into TEAM. And of course, if we can be of any service, please don't hesitate to reach out. You'll have our contact information. Jennifer, take us home.

Kathy Reep **1:30:09**

Martie, before that, there were several people who asked about who are the safety net hospitals? I put a link in the chat for those who wanted to know the answer to that.

Martie Ross **1:30:20**

And there's also comment about the deadline for a volunteer, at least stated previously, right? At least stated previously. It's tomorrow. But again, we're in this period of the agencies aren't talking to us, so we'll see if there's potentially an extension to that.

Kathy Reep **1:30:36**

But if they aren't talking, we'll see, I would say, don't rely on an extension, because you won't get it by tomorrow. Sorry about that!

PYA Marketing **1:03:36**

No problem, it's a big topic! Thanks to our presenters, Martie, Kathy, Angie, Lee Ann, and Jason. Please remember to stay on the line once the webinar disconnects to complete a short survey for CPE credit. Later today, you'll receive an email with their contact information and a recording of the webinar. Also, the slides and recordings for every episode of PYA is Healthcare Regulatory Roundup series are available on the Insights page of PYA is website, pyapc.com. While at our website, you may register for other PYA webinars and learn more about the full range of services offered by PYA. Please remember to stay on the line once the webinar disconnects, to complete the short survey and post any additional questions you may have. On behalf of PYA, thank you for joining us. Have a great rest of your day.