Transforming Episode Accountability Model (TEAM) Model Overview Webcast

Center for Medicare and Medicaid Innovation
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Model Purpose

Disclaimer

All information provided in the Transforming Episode Accountability Model (TEAM) Overview is potentially subject to change.

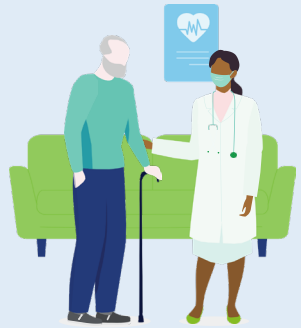
The FY2025 IPPS/Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Final Rule contains final details about TEAM and the participation process.

Model Purpose

In August 2024, CMS finalized a new mandatory model called the **Transforming Episode Accountability Model, or TEAM.**

Some beneficiaries who undergo a surgical procedure in a hospital may experience **fragmented care** that can lead to **complications, avoidable hospitalizations, and increased spending.**

TEAM aims to solve this issue by **holding acute care hospitals accountable for quality and spending performance** during a patient's hospital inpatient stay/hospital outpatient procedure and the 30-day period following hospital discharge.



TEAM encourages hospitals to provide Medicare beneficiaries with **coordinated, high-quality care during and after certain surgical procedures.**

Model Goals

Improve the patient experience from surgery through recovery by supporting the coordination and transition of care between providers and promoting the beneficiary's successful recovery.

Incentivize hospitals to implement care redesign that may lead to:

- Reduced hospital readmissions and emergency department use
- Reduced recovery time for patients
- Reduced Medicare spending
- Improved equitable outcomes

Promote collaboration with Accountable Care Organizations (ACOs) and primary care providers. Participants are required to refer beneficiaries to primary care services. Beneficiaries aligned to an ACO may be included in an episode in TEAM.

Model Snapshot

Model Type: Mandatory Episode-Based Payment Model

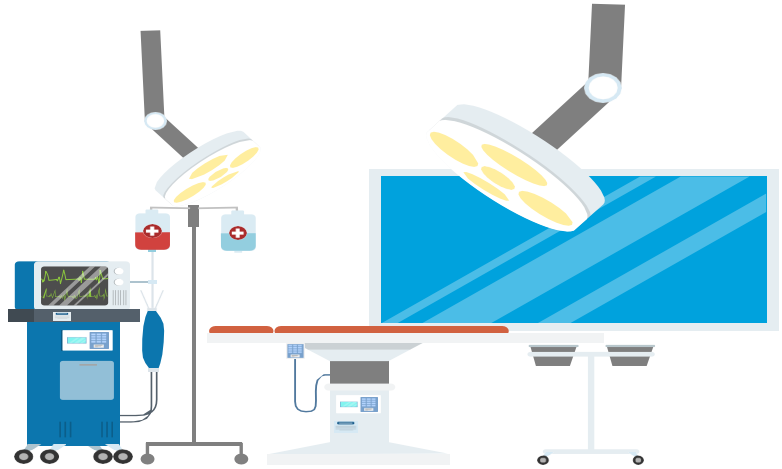
Model Performance Period: Five-year model; five 12-month performance years (PY)

Participants: Acute Care Hospitals in Core-Based Statistical Areas required to participate and eligible Acute Care Hospitals that voluntarily elect to participate in TEAM and are accepted by CMS

Beneficiaries: Traditional Medicare (fee-for-service) beneficiaries with an included episode

Required Episodes:

- Coronary Artery Bypass Graft (CABG)
- Major Bowel Procedure
- Lower Extremity Joint Replacement (LEJR)
- Surgical Hip and Femur Fracture Treatment (SHFFT)
- Spinal Fusion

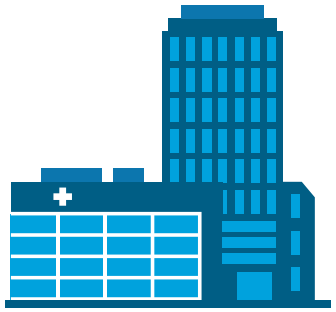


Model Participation

Participants

TEAM participant means an acute care hospital that either:

1. **Initiates episodes and is paid under the Inpatient Prospective Payment System (IPPS)** with a CMS Certification Number (CCN) primary address located in one of the mandatory Core Based Statistical Areas (CBSAs) selected for participation in TEAM in accordance with § 512.515; *or*
2. **Makes a voluntary opt-in participation** election to participate in TEAM in accordance with § 512.510 and is accepted to participate in TEAM by CMS.



The FY2025 IPPS/Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Final Rule identifies **all mandatory CBSAs** selected for participation in TEAM.

The TEAM webpage lists acute care hospitals, identified by CCN, located in one of the mandatory CBSAs selected for participation. After the voluntary opt-in period (January 2025), the webpage will also list opt-in participants. Also in 2025 and prior to the track selection deadline, CMS will update the list to identify hospitals that satisfy the definition of a safety net hospital for performance year one.

The list will be updated periodically to capture hospital status changes.

Voluntary Opt-In

Eligibility to Participate

A hospital must not be in a mandatory CBSA selected for TEAM participation, in accordance with § 512.515, and must satisfy **one of the following criteria to be eligible for voluntary opt-in participation election:**

- Be a hospital participating in the **CJR Model** that participates in CJR until the last day of the last performance year (December 31, 2024); *or*
- Be a hospital participating in the **BPCI Advanced Model**, either as a participant or downstream episode initiator, that participates in BPCI Advanced until the last day of the last performance period (December 31, 2025).

Voluntary Participation Election Period

The voluntary participation election period begins on January 1, 2025, and ends on January 31, 2025.

Voluntary Participation Election Letter

Hospitals that wish to voluntarily opt in to TEAM must submit a written voluntary participation election letter, which serves as the model participation agreement.

CMS will make available a Voluntary Participation Election Letter template to eligible hospitals prior to the election period.

Participation Tracks

TEAM has **3 participation tracks** with varying levels of financial risk.

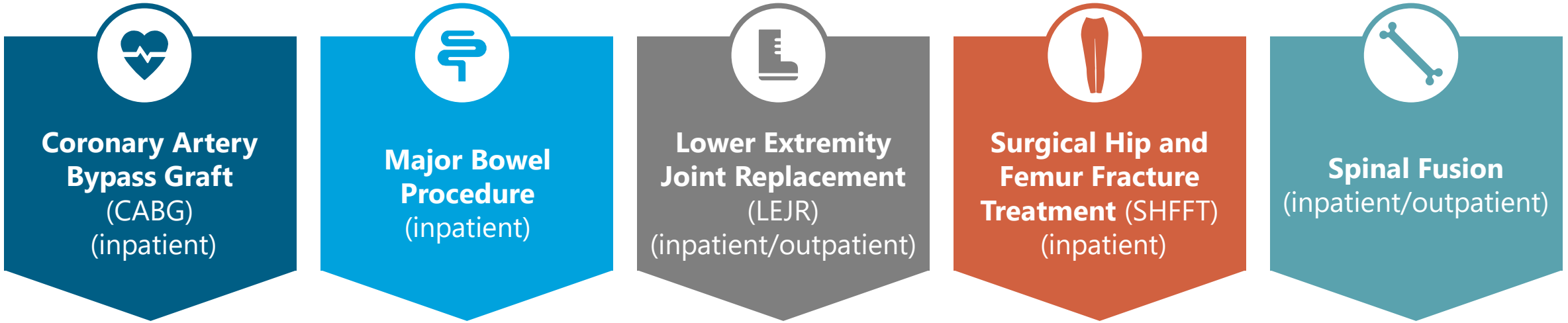
	Track 1	Track 2	Track 3
Eligibility Participants must notify CMS of their track selection prior to each performance year	**PY1:** All TEAM participants **PY1-3:** Safety Net Hospitals	**PY2-5:** Selected hospital types*	**PY1-5:** All TEAM participants
Financial Risk Stop-gain and stop-loss limits cap the total amount that a TEAM participant could owe to CMS as a repayment amount or receive from CMS as a reconciliation payment amount	▪ Upside risk only ▪ Stop-gain limit: 10% ▪ Stop-loss limit: None	▪ Upside and downside risk ▪ Stop-gain limit: 5% ▪ Stop-loss limit: 5%	▪ Upside and downside risk ▪ Stop-gain limit: 20% ▪ Stop-loss limit: 20%
Composite Quality Score Reconciliation amounts are adjusted based on quality measure performance	**Positive** Reconciliation Amounts: Up to 10% **Negative** Reconciliation Amounts: Not applicable (N/A)	**Positive** Reconciliation Amounts: Up to 10% **Negative** Reconciliation Amounts: Up to 15%	**Positive** Reconciliation Amounts: Up to 10% **Negative** Reconciliation Amounts: Up to 10%

*The following hospital types are eligible for Track 2 in PY2-5: Medicare Dependent Hospitals, Rural Hospitals, Safety Net Hospitals, Sole Community Hospitals, and Essential Access Community Hospitals.

Episodes

Episodes

Five surgical episode categories:



All participants are accountable for all episode categories unless an exclusion applies.

Episode Category	MS-DRG and/or HCPCS codes
CABG (inpatient)	MS-DRG: 231, 232, 233, 234, 235, 236
Major Bowel Procedure (inpatient)	MS-DRG: 329, 330, 331
LEJR (inpatient/outpatient)	MS-DRG: 469, 470, 521, 522 HCPCS: 27447, 27130, 27702
SHFFT (inpatient)	MS-DRG: 480, 481, 482
Spinal Fusion (inpatient/outpatient)	MS-DRG: 402, 426, 427, 428, 429, 430, 447, 448, 450, 451, 471, 472, 473 HCPCS: 22551, 22554, 22612, 22630, 22633

Episode Initiation and Length

An **episode is initiated** by a beneficiary's:

- Admission to a TEAM participant hospital for an **anchor hospitalization** (as defined at § 512.505) paid under an included Medicare Severity Diagnosis Related Group (MS-DRG), *or*
- Receipt of an **anchor procedure** (as defined at § 512.505) at a TEAM participant hospital billed under an included Healthcare Common Procedure Coding System (HCPCS) code

Episode Length:

Hospital inpatient stay/hospital outpatient procedure + 30 days

Included Items/Services:

All Medicare Part A and B items and services are included in the episode with limited exceptions (e.g., certain hospital admissions [oncology, transplant], new technology add-on payments, high-cost drugs)

Items Included in Episodes

All Medicare Part A and B items and services are included in the episode unless specifically excluded

Included Items and Services

- Physicians' services
- Inpatient hospital services (including hospital readmissions)
- Inpatient Psychiatric Facilities (IPF) services
- Long-Term Care Hospital (LTCH) services
- Inpatient Rehabilitation Facility (IRF) services
- Skilled Nursing Facility (SNF) services
- Home Health Agency (HHA) services
- Hospital outpatient services
- Outpatient therapy services
- Clinical laboratory services
- Durable Medical Equipment (DME)
- Part B drugs and biologicals, except for those specifically excluded
- Hospice services

Items Excluded from Episodes

The following items, services, and payments are **excluded from the episode:**

Select items and services considered unrelated to the anchor hospitalization/procedure, including, but not limited to, the following:

- Inpatient hospital admissions for MS-DRGs that group to the following categories:
  - Oncology, trauma medical, organ transplant, ventricular shunt
- Inpatient hospital admissions that fall into the following Major Diagnostic Categories (MDCs):
  - MDC 02 (Diseases and Disorders of the Eye), MDC 14 (Pregnancy, Childbirth, and Puerperium), MDC 25 (Newborns), MDC 25 (Human Immunodeficiency Virus)
- Traditional pass-through payments for medical devices
- New technology add-on payments
- Hemophilia clotting factor products
- Part B payments for low-volume drugs, high-cost drugs and biologicals, and blood clotting factors for Hemophilia

Please refer to the FY 2025 IPPS/LTCH PPS Final Rule, § 512.525, for detailed definitions of the excluded items.

Beneficiary Inclusion Criteria and Episode Cancellation

Beneficiary Inclusion Criteria

Beneficiaries who **meet all of the following criteria** upon admission for an anchor procedure or anchor hospitalization may be included in an episode:

- Are enrolled in Medicare Parts A and B
- Are not eligible for Medicare on the basis of having end stage renal disease
- Are not enrolled in any managed care plan (for example, Medicare Advantage, health care prepayment plans, or cost-based health maintenance organizations)
- Are not covered under a United Mine Workers of America health care plan
- Have Medicare as their primary payer

Episode Cancellation

The episode is canceled if any of the following occur:

- ⊗ The beneficiary no longer meets all the inclusion criteria
- ⊗ The beneficiary dies during the anchor hospitalization or the outpatient stay for the anchor procedure
- ⊗ The episode qualifies for cancellation due to extreme and uncontrollable circumstances

Extreme and Uncontrollable Circumstances Policy

TEAM participants **will <u>not</u> be held accountable** for episodes that qualify for cancellation due to **extreme and uncontrollable circumstances**.

An extreme and uncontrollable circumstance occurs if **both** of the following **criteria are met:**

The TEAM participant has a CCN primary address that:

- Is in an emergency area, as those terms are defined in section 1135(g) of the Act, for which the Secretary has issued a waiver under section 1135 of the Act; and
- Is in a county, parish, or tribal government designated in a major disaster declaration or emergency disaster declaration under the Stafford Act.

The date of admission to the anchor hospitalization or the date of the anchor procedure is during an emergency period (as defined in section 1135(g) of the Act) or in the 30 days before the date that the emergency period (as defined in section 1135(g) of the Act) begins.

Model Overlap and Referral to Primary Care Services

Model Overlap

TEAM will **allow both provider and beneficiary overlap** with **most CMS models and initiatives**, including advanced primary care and Accountable Care Organization (ACO) initiatives.

For example:

- A Medicare beneficiary who is aligned to a Medicare ACO initiative, such as the Shared Savings Program, may be included in an episode in TEAM if they receive one of the included surgeries at a TEAM participant hospital.
- CMS will not adjust a TEAM participant's reconciliation amount based on beneficiary ACO alignment.
- Note: The Shared Savings Program takes into consideration "individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program" when calculating an ACO's PY expenditures.

Overlap between TEAM and ACO initiatives and other CMS models and initiatives provides an **opportunity for provider collaboration and smooth transitions of care**.

- A TEAM participant may participate in the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model.
  - Hospitals in Maryland are excluded from being TEAM participants to avoid interference with the Maryland Total Cost of Care Model test.

Referral to Primary Care Services

TEAM encourages **coordination between specialists and primary care providers** to create smooth care transitions and promote beneficiary recovery.

As part of discharge planning, TEAM participants are **required to refer TEAM beneficiaries to a primary care provider** on or prior to discharge from the anchor stay or anchor procedure.

TEAM participants must maintain **beneficiary freedom of choice** when making primary care referrals.

Quality Measures/Assessment and Health Equity

Quality Measures

TEAM incorporates quality measures that focus on **care coordination, patient safety, and patient reported outcomes (PROs).**

PY1

PY1 quality measures include:

- Hybrid Hospital – Wide All-Cause Readmission Measure (CMIT ID #356)
- Hospital-Level Total Hip and/or Total Knee Arthroplasty PRO Performance Measure (CMIT ID #1618) – For LEJR episodes
- CMS Patient Safety and Adverse Events Composite Measure (CMS PSI 90) (CMIT ID #135)

PY2-5

Starting in PY2, the CMS Patient Safety Measure will be replaced with three other safety measures:

- Hospital Harm – Falls with Injury (CMIT ID #1518),
- Hospital Harm – Postoperative Respiratory Failure (CMIT ID #1788),
- Thirty-day Risk – Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue) (CMIT ID #134)

Quality performance will be linked to payment by constructing a composite quality score (CQS). The CQS would adjust a hospital's reconciliation amount based on how well they perform on the quality measures.

Composite Quality Score

CMS uses the Composite Quality Score (CQS) to **adjust reconciliation amounts**, linking quality performance to payment.

The CQS is constructed by **converting quality measures to scaled scores** and then **volume-weighting** the scaled score based on the proportion of attributed episodes for each TEAM participant.

The CQS adjusts reconciliation amounts by applying a **CQS Adjustment Percentage**.

Track	Reconciliation Amount	CQS Adjustment Percentage
Track 1	Positive Reconciliation Amount	Up to 10%
Track 2	Positive Reconciliation Amount	Up to 10%
	Negative Reconciliation Amount	Up to 15%
Track 3	Positive Reconciliation Amount	Up to 10%
	Negative Reconciliation Amount	Up to 10%

Health Equity Strategy

TEAM offers **flexibilities** to certain hospitals, such as safety net hospitals, by **reducing the financial burden** sometimes associated with value-based model participation.

- For example, TEAM participants that are Safety Net Hospitals are eligible to participate in Track 1 with no downside risk for PYs 1 to 3.

TEAM includes **beneficiary social risk adjustment** in target prices to help reflect the additional financial investment necessary to care for underserved populations.

Beneficiary social risk adjustment includes adjustment based on Medicare/Medicaid dual eligibility status, state or national Area Deprivation Index (ADI), and Medicare Part D Low Income Subsidy.

Participants can **voluntarily submit Health Equity Plans** and report on **sociodemographic data** and **screen/report beneficiaries for Social Determinants of Health** (SDoH).

Pricing and Payment Methodologies

Pricing Methodology

Hospitals will continue to bill Medicare FFS but will receive a preliminary target price prior to each performance year.

Preliminary target prices will be based on non-excluded Medicare Parts A and B items and services, and **prospectively trended, normalized**, and **risk adjusted.**

- Target prices include a **discount factor** intended to reflect Medicare's potential savings from TEAM.

Final target prices will be updated to include a **capped retrospective trend** adjustment factor, to capture actual episode spending during the performance year, and a **capped normalization factor** that is intended to ensure that risk adjustment by itself neither increases nor decreases average target prices.

Pricing Methodology (continued)

Target Price Components

- **Baseline Period:** Three-year baseline period that rolls forward by one year each PY. For PY1, the baseline period is January 1, 2022, through December 31, 2024.
- **Regional Target Prices:** Target prices based on 100 percent regional data for each episode category. Regions are defined using the nine U.S. census divisions.
- **High-Cost Outlier Cap:** Episode spending is capped at the 99th percentile at the episode type and region level to protect TEAM participants from especially high payment episodes.
- **Trending Prices:** A prospective trend is used to project baseline spending for preliminary target prices, while a 3% capped retrospective trend adjustment is applied to final target prices to capture actual performance year spending.
- **Discount Factor:** A 1.5% discount is applied to CABG and Major Bowel Procedure episodes, and a 2% discount for LEJR, SHFFT, and Spinal Fusion episodes.
- **Risk Adjustment:** Target prices are risk adjusted based on beneficiary-level factors, such as age and beneficiary social risk adjustment, and hospital-level factors such as hospital bed size.
- **Normalization Factor:** A prospective normalization factor is applied to preliminary target prices, while a 5% capped normalization factor is applied to final target prices based on observed beneficiary case mix.

Reconciliation Process

Reconciliation compares each TEAM participant's **total performance year FFS spending for attributed episodes** for each episode category to their **final target price** for each episode category.

Reconciliation amounts are then **subject to adjustments** to account for **quality performance** and **limits on gains or losses**.

- Positive and negative reconciliation amounts are adjusted by the CQS to create the quality-adjusted reconciliation amount.
- Quality-adjusted reconciliation amounts are adjusted by stop-gain and stop-loss limits.

Track	CQS Adjustment Percentage	Stop-gain/ Stop-loss Limits
Track 1	Up to 10% for positive reconciliation amounts	10% (stop-gain only*)
Track 2	Up to 10% for positive reconciliation amounts Up to 15% for negative reconciliation amounts	5%
Track 3	Up to 10% for positive and negative reconciliation amounts	20%

* Track 1 is upside risk only

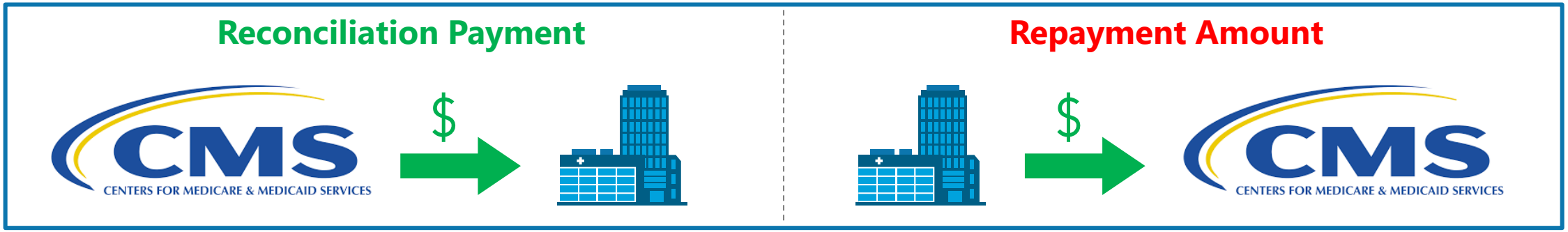
Reconciliation Process (continued)

After the CQS adjustment and stop-gain/stop-loss limits are applied, the resulting figure is the **Net Payment Reconciliation Amount (NPRA)**.

CMS calculates a **post-episode spending amount** for the spending in the 30-day period following the completion of each episode to monitor any shifting of care.

- If a TEAM participant's average post-episode spending is greater than three standard deviations above the regional average, the TEAM participant's spending amount above that value is subtracted from their NPRA.

After adjusting for post-episode spending as needed, the participant will have either a **Reconciliation Payment** or a **Repayment Amount**.



Payment Policy Waivers, Financial Arrangements, and APM Options

Payment Policy Waivers

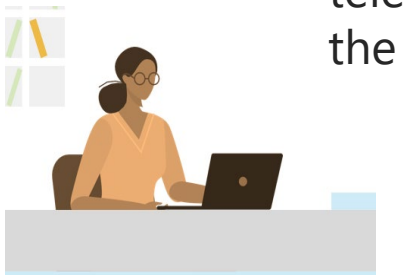
TEAM offers **two types** of **payment policy waivers** for TEAM participants:

The **SNF 3-day rule waiver** removes the requirement that beneficiaries have a minimum three-day inpatient hospital stay before being discharged to a SNF in order for Medicare to cover the SNF stay.

- Medicare will pay for SNF stays at qualifying SNFs for TEAM beneficiaries even if they are discharged from the hospital in under three days.
- To qualify, SNFs must have a CMS rating of at least three stars in the CMS Five-Star Quality Rating System for seven of the past 12 months.

The **telehealth waiver** removes both the geographic site requirements and the originating site requirements for telehealth visits.

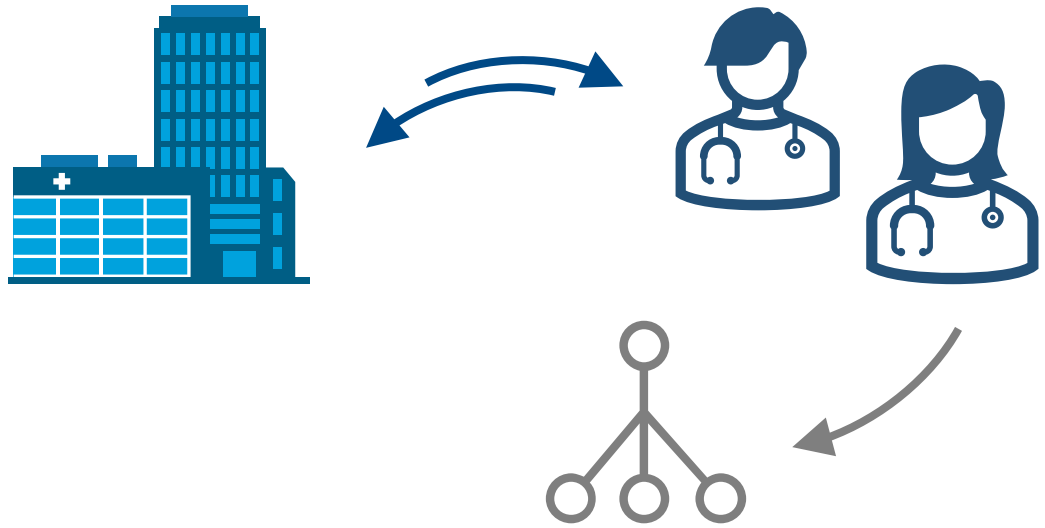
- TEAM beneficiaries can receive telehealth services without being at a particular site or geographic location.
- CMS waives the facility fee for telehealth services originating in the beneficiary's home.



Financial Arrangements

CMS has determined that the **Federal Anti-Kickback Statute Safe Harbor** for CMS-sponsored model arrangements is available to protect remuneration furnished in TEAM.

TEAM participants may enter into a **sharing arrangement** with a TEAM collaborator to make a **gainsharing payment** and/or receive an **alignment payment**.



A TEAM collaborator in a sharing arrangement with a TEAM participant may enter into a **distribution arrangement** with a collaboration agent in order to distribute any **gainsharing payments** it receives.

A collaboration agent in a distribution arrangement with a TEAM collaborator may enter into a **downstream distribution arrangement** with a downstream collaboration agent to distribute any **distribution payments** it receives.

Beneficiary Incentives

CMS has determined that the **Federal Anti-Kickback Statute Safe Harbor** for CMS-sponsored model patient incentives is available to protect TEAM beneficiary incentives.

TEAM participants may offer **in-kind patient engagement incentives** (e.g., technology) to TEAM beneficiaries.

- Subject to certain conditions, including relevance to the beneficiary's care
- Technology-based incentives subject to additional monetary value conditions

Several **clinical goals of TEAM** may be advanced by beneficiary incentives:

- Adherence to drug regimens
- Adherence to care plans
- Reduction of readmissions and complications
- Management of chronic conditions

Alternative Payment Model (APM) Options

For each performance year, TEAM participants may choose one of the following APM options based on their use of **Certified Electronic Health Record Technology (CEHRT)** and their **participation track**:

Advanced Alternative Payment Model (AAPM) Option

- Open to TEAM participants in Track 2 or Track 3
- Participants must attest to their use of CEHRT in a manner specified by CMS

Non-AAPM Option

- For TEAM participants in Track 1 or TEAM participants in Track 2 or Track 3 that do not attest to their use of CEHRT

Data, Monitoring, and Evaluation

Data Sharing Process

CMS offers several types of data to support TEAM participants in evaluating their performance, conducting quality assessment and improvement activities, and conducting population-based activities relating to improving health or reducing health care costs.

TEAM participants must enter into a **TEAM data sharing agreement** and submit a **formal request** annually to receive beneficiary-identifiable data.

TEAM participants that enter into a data sharing agreement can receive:

- **Raw** Medicare Parts A and B beneficiary-identifiable claims data or
- **Summary** Medicare Parts A and B beneficiary-identifiable claims data.

TEAM participants can also receive non-beneficiary-identifiable data: baseline period and performance year **regional aggregate Medicare Parts A and B claims data**.

Monitoring and Compliance

TEAM participants and downstream participants must comply with CMS **evaluation and monitoring activities and applicable laws and regulations**.

CMS may conduct **monitoring and compliance activities**, including:

- Documentation requests, such as surveys and questionnaires
- Audits of data, such as claims, quality measures, and medical records
- Interviews with clinical staff and leadership, beneficiaries, and caregivers
- Site visits
- Monitoring quality outcomes and clinical data
- Tracking patient complaints and appeals

TEAM participants are required to **maintain records for 6 years**.

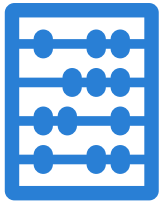
- Includes documents related to compliance, reconciliation, payment, quality measures, utilization, ability to bear financial risk, patient safety, and program integrity.

CMS may take **remedial actions** in the event of noncompliance, falsification, threats to beneficiary health, or program integrity risk.

Evaluation

TEAM's test-oriented design offers unique opportunities for evaluation

- Generating evidence to inform the Secretary's potential decision regarding expansion
- Integration and combined effects of other models including primary care and ACOs
- Capturing broad transformation effects beyond direct impacts
- Investigating the model's ability to narrow health equity gaps



The evaluation will investigate the broad effects of the model through a **mixed methods approach** that allows for capturing the wide-ranging influence of the model and identification of the factors that **account for variation in outcomes** for patients and hospital performance.

Specific Research Topics

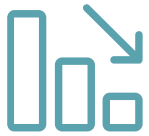
- Payment
- Quality
- Utilization
- Health Equity
- Transformation
- Primary Care Connection
- Model Features and Policy Implications
- Explanations for Variations in Impact
- Unintended Consequences

Decarbonization and Climate Resilience Initiative

Decarbonization and Resilience Initiative

The Decarbonization and Resilience Initiative is designed **to support CMS and HHS efforts to improve quality of care** by bolstering the health system's climate resilience and sustainability.

CMS will provide individualized **benchmarked feedback reports, public recognition, and technical assistance** to help enhance organizational sustainability, support care delivery methods that may lower greenhouse gas emissions, and identify tools to measure emissions.



Hospitals and their corporate affiliates may choose to **voluntarily report** metrics related to greenhouse gas emissions to CMS.

Frequently Asked Questions (FAQs)

Question 1

What is a safety net hospital?

Question 2

What factors does CMS risk adjust for when constructing TEAM's target prices?

Question 3

Please explain TEAM's data sharing process.

Question 4

How can hospitals manage gainsharing or alignment payments with TEAM collaborators that are not tied to volume of episodes?

More Information

More Information

Email: CMMI_TEAM@cms.hhs.gov

Visit: TEAM webpage

Listserv: Sign up for updates on TEAM listserv

TEAM is part of: FY 2025 IPPS/LTCH PPS Final Rule

Thank you for viewing this webcast.

We appreciate your time and interest!

Do you have questions? Contact the model team at CMMI_TEAM@cms.hhs.gov.