Transforming Episode Accountability Model (TEAM) Overview Webcast
December 3, 2024

>>Jen Lippy, CMS: Good afternoon, and thank you for tuning in to the Overview Webcast for the Transforming Episode Accountability Model, or TEAM, for short. We have several CMS subject matter experts on the line with us today, and we are excited to share a presentation about TEAM.
Before we dive into the agenda for today's presentation, I will introduce our presenters. My name is Jen Lippy, and I'm the Deputy Director of the CMS Innovation Center's Division of Payment Models. Sacha Wolf is a Technical Advisor within the Division of Payment Models, leading TEAM. Aaron Broun is a Social Science Research Analyst within the Division of Payment Models, helping to lead TEAM's learning system efforts.

In addition to listening to this recording, please don't hesitate to reach out with questions you have about the model. TEAM's email address is **CMMI_TEAM@cms.hhs.gov**. The email address is also provided at the end of this presentation. In today's recording, we will review several elements of TEAM, as illustrated on this slide. To support user experience, CMS has provided timestamps in the description to allow you to reference specific sections of the presentation, as needed. Please refer to the description for more information.

This recording will present TEAM's purpose and participation specifications. We will identify the different episode categories tested in TEAM, and review how episodes are defined. We will also describe model overlap policies and the primary care services referral requirement. Next, we will review the quality measures and assessment process, as well as pricing and payment methodologies under TEAM. We will also go over TEAM's health equity goals. Then, we will describe the payment policy waivers, and financial arrangements available to TEAM participants. Additionally, we will describe the alternate payment model options for TEAM participants. Next, we will review TEAM's data sharing, monitoring, and evaluation requirements. We will discuss the voluntary Decarbonization and Resilience Initiative, which is the first of its kind in an Innovation Center model.

Finally, we will close with a brief review of some additional resources available to TEAM participants and the public. With that, I will pass to Sacha, who will describe TEAM's purpose. Sacha, the mic is yours.

>>Sacha Wolf, CMS: Thank you, Jen. I'm Sacha Wolf, and I will now review TEAM's purpose. First, we have a reminder for our listeners: All information provided in the Transforming Episode Accountability Model, or TEAM Overview, is subject to change based on future notice-and-comment rulemaking.

The *Fiscal Year 2025 Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System Final Rule* contains final policies for TEAM, including the type of participant, the geographic regions required to participate, the types of episodes and quality measures in the model, how target prices are constructed, and other model policies and requirements. For your reference, we've provided a link to the final rule on this slide, and on TEAM's webpage.

It's important to have a strong model purpose in order to test the outcomes that may improve quality of care and reduce Medicare spending. For TEAM, we are aware that 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, or hospital outpatient procedure, and the 30-day period following discharge.

TEAM will build on lessons learned in previous episode-based payment models to incentivize participants to coordinate care across care settings. Previous models TEAM has drawn from include the

Bundled Payments for Care Improvement Advanced model, or BPCI Advanced model, and the Comprehensive Care for Joint Replacement model, or CJR model.

TEAM will test and evaluate the impact of a mandatory model in selected geographic areas for improved care quality and efficiency, as well as reduce healthcare costs within acute care hospitals that initiate certain surgical procedures. TEAM encourages hospitals to provide Medicare beneficiaries with coordinated, high-quality care during and after certain surgical procedures. We will highlight in an upcoming section how TEAM's pricing methodology and payment structure may help to financially incentivize high-quality, coordinated care for the episodes tested in the model.

TEAM's goals are designed to drive the CMS Innovation Center's advancements in episode-based payment models and support care transformation following acute medical events. First, TEAM aims to improve the patient journey from surgery through recovery by ensuring seamless coordination and transition of care between providers, ultimately promoting successful recovery for beneficiaries. Second, TEAM incentivizes hospitals to adapt and implement innovative care redesign tactics to improve patient care experience.

Participating hospitals use data to select and perform care transformation activities that may lead to reduced hospital readmissions, decreased emergency department use, shortened recovery times, lower Medicare spending, and improved equitable outcomes. TEAM will work to promote collaboration with Accountable Care Organizations, or ACOs, and primary care providers. TEAM participants are required to refer beneficiaries to primary care services to create smooth transitions and promote recovery. Beneficiaries aligned with an ACO may be included in TEAM's episodes.

The benefit of these strategies are multifaceted: patient experience and health outcomes may improve; providers receive support for adopting best practices; and both Medicare and participants achieve cost savings through more efficient care delivery.

This slide presents an overview of TEAM's implementation approach. TEAM will launch on January 1st, 2026, and run for five years, ending on December 31st, 2030. As a mandatory model, all model policies are proposed and finalized through rulemaking. Participants include acute care hospitals located in selected core-based statistical areas, or CBSAs, that are required to participate. CMS will also allow a one-time voluntary opt-in opportunity for hospitals participating until the last day of the last performance period in the BPCI Advanced Model or the last day of the last performance year in the CJR Model, to participate in TEAM. We have more information for the voluntary opt-in on an upcoming slide.

TEAM addresses a defined population, specifically fee-for-service Medicare beneficiaries who initiate an anchor hospitalization or anchor procedure for specific episode categories. The surgical procedures included in the model will be: lower extremity joint replacement, or LEJR; surgical hip femur fracture treatment, or SHFFT; spinal fusion; coronary artery bypass graft, or CABG, and major bowel procedure.

And next, I will pass the event to Aaron, to review participation details.

>>Aaron Broun, CMS: Hi all, thanks for tuning in for the TEAM Overview Webcast. I'm Aaron Broun. And in the next section, we will share more information about participation options available in TEAM.

A TEAM participant is defined as an acute care hospital that either initiates episodes and is paid under the Inpatient Prospective Payment System with a CMS Certification Number, or CCN, primary address located in one of the mandatory core-based statistical areas, or CBSAs, selected for participation in TEAM, or makes a voluntary opt-in participation election to participate in TEAM, and is accepted to participate in TEAM by CMS. Essentially, hospitals can participate in TEAM through two pathways:

mandatory participation, if they are in selected CBSAs, or voluntary participation, if they choose to opt in and are approved by CMS.

On September 5th, 2024, CMS published a list of acute care hospitals located in one of the core-based statistical areas selected for mandatory participation in TEAM. This list will be updated periodically to capture status changes. We will also update this list to capture hospitals that have voluntarily opted in to TEAM, as well as update this list to identify whether a hospital meets the safety net hospital definition used in the model.

CMS will offer a one-time opportunity for hospitals that participate in the BPCI Advanced or CJR Model to opt-in to TEAM participation. This option is only available to BPCI Advanced hospital participants who participate until the last day of the last performance period, or CJR participant hospitals who participate until the last day of the last performance year. Previous BPCI Advanced and CJR participants are not eligible to opt-in. Hospitals choosing to voluntarily opt-in to TEAM must do so between January 1st, 2025, and January 31st, 2025. These hospitals must submit a voluntary participation election letter, which serves as the model participation agreement. CMS will make a template available to eligible hospitals prior to January 1st, 2025.

We have received a couple of requests for baseline period data to support eligible hospitals as they make the decision to participate in TEAM during the voluntary participation election period of January 2025. Although CMS will provide baseline period data to TEAM participants prior to the start of the model on January 1st, 2026, CMS will not be able to provide baseline period data to hospitals before the voluntary participation election period ends on January 31st, 2025. Eligible hospitals are encouraged to use their experience and data from the BPCI Advanced or CJR models to determine the right path for your organization. More information on TEAM data sharing will be provided on a later slide.

TEAM will have three participation tracks that come with varying levels of financial risk. The table on this slide demonstrates the potential adjustments based on track selection. As TEAM continues, and hospitals build capacity, they will take on greater financial responsibility. CMS has included certain safeguards, such as Track 1 and Track 2 eligibility to support certain types of hospitals, like safety net hospitals, as they build infrastructure and capabilities. The track options are responsive to public feedback around the importance of creating a glide path in CMS models to smooth out the transition to risk.

During Performance Year 1, TEAM participants will select from Track 1 or Track 3, depending on their risk preferences. TEAM participants will notify CMS of their track selection prior to the start of Performance Year 1 in a form and manner specified by CMS. TEAM participants who fail to timely notify CMS will be automatically assigned to Track 1 for Performance Year 1.

Track 1 will be available for all TEAM participants in Performance Year 1, and through the third performance year for TEAM participants that meet the definition of a safety net hospital. For the purposes of TEAM, to be considered a safety net hospital, the hospital must meet at least one of two criteria: A) Exceed the 75th percentile of the proportion of Medicare beneficiaries considered duly eligible for Medicare and Medicaid across all prospective payment system acute care hospitals in the baseline period; or B) Exceed the 75th percentile of the proportion of Medicare beneficiaries, partially or fully eligible to receive Part D low income subsidies across all PPS acute care hospitals in the baseline period.

For Performance Year 1, the baseline period is January 1st, 2022, through December 31st, 2024. Track 1 features only upside financial risk, with a quality adjustment applied to positive reconciliation amounts,

which are subject to a 10% stop-gain limit and a Composite Quality Score, or CQS, adjustment percentage of up to 10%.

Beginning in Performance Year 2, and through Performance Year 5, certain TEAM participants will be able to select Track 2. Track 2 will feature two-sided financial risk with a quality adjustment applied to reconciliation amounts, subject to 5% stop-gain and stop-loss limits. A CQS adjustment percentage of up to 10% for positive reconciliation amounts and a CQS adjustment percentage of up to 15% for negative reconciliation amounts. The higher CQS adjustment for negative reconciliation amounts results in a lower repayment amount. The following hospital types will be eligible for Track 2 in Performance Years 2-5: Medicare dependent hospitals, rural hospitals, safety net hospitals, sole community hospitals, and essential access community hospitals.

Track 3 will be available in Performance Years 1-5. Track 3 features two-sided financial risk, with a quality adjustment applied to reconciliation amounts subject to 20% stop-gain and stop-loss limits and a CQS adjustment percentage of up to 10% for positive and negative reconciliation amounts. TEAM participants that meet track-specific criteria, such as safety net hospitals for Track 1 and hospitals eligible for Track 2, will be required to notify CMS of their track preference on an annual basis prior to the start of each performance year.

I will now pass the event to Jen, who will share more information about episodes included in TEAM. Jen, the floor is yours.

>>Jen Lippy, CMS: Thanks, Aaron. Next, I'm going to walk us through some content that defines and describes the episodes included in TEAM.

As stated earlier, the five surgical episode categories included in TEAM will be: coronary artery bypass graft, or CABG; major bowel procedure; lower extremity joint replacement, or LEJR; surgical hip and femur fracture treatment, or SHFFT; and spinal fusion. All TEAM participants will be accountable for the included episode categories, unless an exclusion applies. We have a table with the MS-DRG and HCPCS, or HCPCS codes, for each included episode category on the slide for quick reference.

There are two ways an episode is initiated. The first is by a beneficiary's admission to a TEAM participant for an anchor hospitalization paid under MS-DRG. This would initiate an inpatient episode. The second way an episode is initiated is by a beneficiary's receipt of an anchor procedure billed under a HCPC code. This would result in the initiation of an outpatient episode. An episode ends on the 30th day following the date of the anchor procedure, or the 30th day following the date of the discharge from the anchor hospitalization. Included items and services are described at a high level on this slide, however, we will go into more detail for this next.

All Medicare Parts A and B items and services are included in the episode, except specific exclusions in the code of federal regulations at 42 CFR 512.525(e). Included items and services are listed on this slide. These are physician services; inpatient hospital services, including hospital readmissions; inpatient psychiatric facility services; long-term care hospital services; inpatient rehabilitation facility services; skilled nursing facility services; home health agency services; hospital outpatient services; outpatient therapy services; clinical laboratory services; durable medical equipment; Part B drugs and biologicals, except for those included under exclusions in the final rule and hospice services.

Items excluded from the episode are briefly described on this slide. For more detailed information about excluded items refer to 42 CFR 512.525(f), or section X.B of the Final Rule, linked at the bottom of this slide. A copy of these slides is available on TEAM’s webpage. These exclusions include select items and services considered unrelated to the anchor hospitalization or the anchor procedure for episodes in the baseline period and performance year, including, but not limited to, inpatient hospital

admissions for MS-DRGs that group to the following categories: oncology, trauma medical, organ transplant, ventricular shunt, or inpatient hospital admissions that fall into certain Major Diagnostic Categories, or MDCs. Additionally, exclusions will also include traditional pass-through payments for medical devices, new technology add-on payments, hemophilia clotting factor products, and Part B payments for low-volume drugs, high-cost drugs and biologicals and blood clotting factors for hemophilia.

Episodes tested in TEAM include only those in which care is furnished to beneficiaries who meet all the following criteria upon admission for an anchor procedure or anchor hospitalizations: are enrolled in Medicare Parts A and B; are not eligible for Medicare based on having End Stage Renal Disease; are not enrolled in any managed care plan; are not covered under a United Mine Workers of America health care plan; have Medicare as their primary payer.

Episodes are cancelled if the following occur: the beneficiary no longer meets all the inclusion criteria; the beneficiary dies during the anchor hospitalization for an inpatient episode or dies during the anchor procedure for an outpatient episode; or the episode qualifies for cancellation due to extreme and/or uncontrollable circumstances. When an episode is canceled, the services furnished to the beneficiary prior to and following the episode, cancellation would continue to be paid by Medicare as usual, and there would be no episode spending calculation that would be reconciled against the target price.

TEAM participants will not 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 first is that the TEAM participant has a CCN primary address that is in an emergency area and is in a county, parish, or tribal government designated in a major disaster declaration, or emergency disaster declaration, under the Stafford Act. And the second, is that the date of admission to the anchor hospitalization or the date of the anchor procedure is during an emergency period, or in the 30-days before the date that the emergency period begins. A hypothetical example of this would be if TEAM were implemented in 2024, then hospitals located in emergency areas impacted by Hurricane Helene would have had their episodes canceled.

I will pass the event over to Sacha, who will present the next section.

>>Sacha Wolf, CMS: Thanks, Jen. The next slides reviews TEAM Model overlap policies and collaboration requirements.

TEAM will allow both provider and beneficiary overlap with most CMS models and initiatives, including advanced primary care and 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 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 a beneficiary ACO alignment. CMS believes overlap between TEAM and ACO initiatives and other CMS models and initiatives provides an opportunity for provider collaboration and improved transitions of care.

For example, a TEAM participant may participate in the States Advancing All-Payer Health Equity Approaches and Development or AHEAD Model. We believe a hospital participating in the AHEAD Model and in an episode-based payment model like TEAM could help hospitals to achieve the best outcomes in patient care and cost reductions broadly and for specific beneficiaries. We note that while TEAM allows overlap with AHEAD Model, hospitals in Maryland are excluded from being TEAM participants, even though Maryland participates in the AHEAD Model.

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 supplier of primary care services on or prior to discharge from the anchor hospitalization or anchor procedure. By requiring a referral to primary care services, this creates an opportunity for the patient's specialists and primary care providers to engage and support the patient with more collaborative care.

It's important to note that TEAM participants must maintain beneficiary freedom of choice when making primary care referrals. This is described in further detail in the "Beneficiary Choice and Notification" section of the final rule.

I will pass the event back to Aaron, who will share more information about TEAM's quality measures. Aaron, the floor is yours.

>>Aaron Broun, CMS: Thanks, Sacha. With the next few slides, I will walk us through TEAM's quality measures and assessment process.

TEAM uses the lessons learned in previous episode-based payment models to incorporate quality measures that focus on care coordination, patient safety, and patient reported outcomes, or PROs.

The measures proposed for TEAM are ones currently being reported through the Hospital Inpatient Quality Reporting Program and Hospital Acquired Condition Reduction Program. CMS may propose changes to TEAM's measures and the methodology for constructing the Composite Quality Score through future notice and comment rulemaking. Performance Year 1 quality measures will include three measures: the Hybrid Hospital-Wide All-Cause Readmission Measure, the Hospital-Level Total Hip and/or Total Knee Arthroplasty PRO Performance Measurement, and the CMS Patient Safety and Adverse Events Composite Measurement.

Starting in Performance Year 2, the CMS Patient Safety Measure will be replaced with three other safety measures: the Hospital Harm–Falls with Injury Measure, the Hospital Harm–Postoperative Respiratory Failure Measure, and the Thirty-day Risk–Standardized Death Rate Among Surgical Inpatients with Complications, also known as the Failure-to-Rescue Measure. Quality performance will be linked to payment through the Composite Quality Score (CQS). The CQS will adjust a hospital's reconciliation amount based on how well they perform on the quality measures. CMS uses the Composite Quality Score to adjust reconciliations, 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.

Track 1 participants will have no downside risk and may have a CQS adjustment percentage of up to 10% for positive reconciliation amounts.

Track 2 participants may have a CQS adjustment percentage of up to 10% for positive reconciliation amounts and up to 15% for negative reconciliation amounts. The higher CQS adjustment for negative reconciliation amounts will result in lower repayment amounts.

Track 3 participants may have a CQS adjustment percentage of up to 10% for positive and negative reconciliation amounts.

As mentioned on the previous slide, 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 will be eligible to participate in Track 1 with no downside risk for Performance Years 1-3. In addition, TEAM includes beneficiary social risk adjustment in target pricing to help reflect the additional financial investment necessary to care for underserved populations. TEAM will include adjustments for Medicare and Medicaid dual eligibility

status, state, or national Area Deprivation Index (or ADI), and Medicare Part D Low Income Subsidy status.

TEAM participants can voluntarily submit a Health Equity Plan to receive technical assistance on care transformations that support improved outcomes. TEAM participants will be invited to report on sociodemographic data and screen and refer beneficiaries for Social Determinants of Health.

I will now pass the event over to Sacha, who will walk us through TEAM's pricing and payment methodologies. Sacha, the floor is yours.

>>Sacha Wolf, CMS: Thanks, Aaron. The next several slides review TEAM's pricing and payment processes.

During the performance year, hospitals participating in TEAM will continue to bill Medicare fee-for-service. These hospitals will receive a preliminary target price prior to each performance year. Hospitals may use the preliminary target price as a way to gauge their spending during the 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 will include a discount factor intended to reflect Medicare's potential savings from TEAM. Final target prices will be updated at reconciliation to include a capped retrospective trend adjustment factor that helps to capture actual episode spending during the performance year, as well as a capped normalization factor that is intended to ensure that risk adjustment by itself neither increases nor decreases average target prices.

We have listed some TEAM target price terms and definitions on this slide. The baseline period will be the three-year baseline period that rolls forward by one year each performance year. For Performance Year 1 the baseline period is January 1st, 2022, through December 31st, 2024. TEAM's regional target prices are based on 100% regional data for each episode category. Regions are defined using the nine U.S. census divisions. The high-cost outlier cap describes the cap that TEAM will place on episode spending above the 99th percentile at the episode type and region level to protect TEAM participants from especially high-cost episodes. TEAM uses both prospective and retrospective trending for determining target prices. The prospective trend factor 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.

As mentioned earlier, the discount factor is intended to reflect Medicare's potential savings from TEAM. The discount factor will vary based on the episode category. A 1.5% discount will be applied to CABG and Major Bowel Procedure episode categories, and a 2% discount factor for LEJR, SHFFT, and Spinal Fusion episode categories. TEAM's target prices include risk adjustment based on beneficiary-level factors such as age, beneficiary social risk adjustment, as well as hospital level factors, such as hospital bed size and safety net hospital status.

Lastly, TEAM includes a normalization factor that is intended to ensure that risk adjustment by itself neither increases nor decreases average target prices. The 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.

These slides briefly review TEAM's reconciliation process. Reconciliation compares each TEAM participant's total performance year fee-for-service spending for attributed episodes for each episode category to their final target price for each episode category. Reconciliation amounts will be 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. The table that

illustrates CQS adjustment percentages and stop-loss and stop-gain limits by track is displayed again on this slide. As a reminder, TEAM participants in Track 1 will be subject to upside risk only, and therefore will not owe CMS any repayment amounts.

After the CQS adjustment and stop-gain/stop-loss limits are applied the resulting figure is the Net Payment Reconciliation Amount, or 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 target average, the TEAM participants spending amount above that value is subtracted from their NPRA. After adjusting for post-episode spending as applicable, the participant will have either a reconciliation payment or a repayment amount.

Now Jen will review the payment policy waivers and financial arrangements in TEAM. Take it away, Jen.

>>Jen Lippy, CMS: Thanks, Sacha. The following section describes TEAM's payment policy waivers and financial arrangements.

TEAM will offer two types of payment policy waivers for TEAM participants. First, 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 for Medicare to cover the SNF stay. Medicare will pay for SNF stays at qualifying SNF's for TEAM beneficiaries, even if they are discharged from the hospital in under three days. To qualify, SNF's must have a CMS rating of at least three stars in the CMS Five-Star Quality Rating System for seven of the past twelve months.

Second, 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.

CMS has determined that the Federal Anti-Kickback Statute Safe Harbor for CMS-sponsored model arrangements is available to protect remuneration furnished in TEAM. This slide includes a simple diagram of TEAM's permissible financial arrangements. First, 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.

CMS has determined that the Federal Anti-Kickback Statute Safe Harbor for CMS-sponsored model payment incentives is available to protect TEAM beneficiary incentives. TEAM participants may offer in-kind payment engagement incentives to TEAM beneficiaries. For example, technology to encourage adherence to recommended treatment. These are subject to certain conditions, including relevance to beneficiary's care. Technology-based incentives are subject to additional monetary value conditions. Several of TEAM's clinical goals may be advanced by beneficiary incentives, including adherence to drug regimens, adherence to care plans, reduction of readmissions and complications, and management of chronic conditions.

For each performance year, TEAM participants may choose one of the following Alternative Payment Model, or APM, options based on their use of Certified Electronic Health Record Technology, or CEHRT, and their participation track. The Advanced Alternative Payment Model, or AAPM, option is open to TEAM participants that select Track 2 or Track 3. Participants must attest to their use of CEHRT in a

manner specified by CMS. The Non-AAPM Option is open to TEAM participants in Track 1 or TEAM participants in Tracks 2 or 3 that do not attest to their use of CEHRT.

In the next section, Aaron will review several of TEAM's operational processes. Aaron, the floor is yours.

>>Aaron Broun, CMS: Thanks, Jen. I will review data sharing, monitoring, and evaluation processes under TEAM.

This slide outlines TEAM's process for sharing data with participants. 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 healthcare costs. CMS intends to make baseline data available to TEAM participants in advance of the model start date of January 1st, 2026. CMS also intends to make monthly performance year data available to TEAM participants on a monthly cadence during the performance year. To receive baseline period and performance year beneficiary-identifiable data, TEAM participants must enter into a TEAM data sharing agreement and submit a formal data request annually. TEAM participants that enter into a data sharing agreement can receive Medicare Parts A and B beneficiary-identifiable claims data in raw format, summary format, or both. TEAM participants can also receive non-beneficiary-identifiable data, such as baseline period and performance year regional aggregate Medicare Parts A and B claims data.

TEAM participants and downstream participants, for example, TEAM collaborators, 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, and tracking patient complaints and appeals. TEAM participants are required to maintain records for six years. This includes documents related to compliance, reconciliation, payment, 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.

The displayed slide describes TEAM's evaluation process. TEAM's test-oriented design offers unique opportunities for evaluation, such as 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 and 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 include payment, quality, utilization, health equity, transformation, primary care, connection, model features and policy implications, explanations for variations in impact, and unintended consequences. Similar to other CMS Innovation Center models, we anticipate publicly releasing reports on the TEAM webpage demonstrating the evaluation findings.

And now I will pass the event back to Sacha, who will share more information on the Decarbonization and Climate Resilience Initiative and close out today's webcast. Take it away, Sacha.

>>Sacha Wolf, CMS: Thanks, Aaron. This section will cover TEAM's voluntary Decarbonization and Resilience Initiative. This initiative aims to assist hospitals in addressing the threats to the nation's

health and its healthcare system presented by climate change and the effects of hospital carbon emissions on health outcomes.

The voluntary Decarbonization and Resilience Initiative has two elements. The first is technical assistance for all interested TEAM participants, and the second is a voluntary reporting option to capture information related to Scope 1 and Scope 2 emissions as defined by the Greenhouse Gas Protocol framework. CMS will provide individualized benchmark 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.

We would like to use the remaining time to review a few common questions that we have received in TEAM's help desk inbox. CMS will update TEAM's FAQ webpage soon. Now that I have my colleagues joined, the first question we will address is: "What is a safety net hospital?"

>>Aaron Broun, CMS: Thanks, Sacha. TEAM defines safety net status based on its Medicare beneficiary population relative to all other PPS hospitals in the baseline period. A safety net hospital is one that exceeds the 75th percentile in either the proportion of Medicare beneficiaries considered duly eligible for Medicare and Medicaid, or the proportion of Medicare beneficiaries, partially or fully eligible to receive Part D low-income subsidies. The baseline period for Performance Year 1 runs from the start of 2022 through the end of 2024. So, safety net hospital status for Performance Year 1 has not yet been determined. CMS will identify and share a list of hospitals that satisfy the definition of a safety net hospital prior to Performance Year 1. CMS will make redeterminations of safety net qualifications under TEAM annually, meaning that hospital safety net status could vary over the model's duration. However, we do not expect a significant number of hospitals will experience status changes year over year.

>>Sacha Wolf, CMS: Thanks for that answer, Aaron. The next question we will answer is: "What factors does CMS risk adjust for when constructing TEAM's target prices?"

>**>Jen Lippy, CMS:** Thanks, Sacha. I'd be happy to take that one. CMS risk adjusts the preliminary episode target prices at both the beneficiary level and the hospital level. At the beneficiary level, CMS risk adjusts for age bracket, comorbidities, as measured by Hierarchical Condition Category counts, and social need, as measured by Area Deprivation Index, low-income subsidy eligibility, and/or full Medicaid eligibility. At the hospital level, CMS adjusts for hospital bed size and safety net status. Additional details on episode category-specific risk adjustment factors can be found in section 512.545 of the final rule. Thanks, Sacha.

>**>Sacha Wolf, CMS:** Great response, Jen. The next question we have is: "Please explain TEAM's data sharing process."

>>Aaron Broun, CMS: Thanks, Sacha. So, CMS will make available to TEAM participants certain beneficiary-identifiable claims data regarding Medicare fee-for-service beneficiaries who may initiate an episode and be attributed to them in the model for the purposes of evaluating their performance, conducting quality assessment and improvement activities, conducting population-based activities relating to health or reducing healthcare costs, or conducting other healthcare operations. For the baseline period, hospitals will only receive beneficiary-identifiable claims data for beneficiaries that initiated an episode in their hospital or hospital outpatient department in the three-year baseline period, and data would be limited to items and services included in the episode.

Hospitals participating in TEAM may request summary or raw beneficiary-identifiable claims data for a three-year baseline period, as well as on a monthly basis during the performance year, to help them engage in care coordination and quality improvement activities for TEAM beneficiaries in an episode. And as a reminder, the receipt of beneficiary-identifiable data is contingent on the TEAM participants'

submission of a data sheet sharing agreement and a formal data request, on an annual basis. More information on the data request process will be provided in 2025.

>>Sacha Wolf, CMS: I appreciate that thorough response, Aaron. The last question we have time for today, in today's webcast is: "How can hospitals manage gain sharing or alignment payments with TEAM collaborators that are not tied to volume of episodes?" Jen?

>>Jen Lippy, CMS: Thanks, Sacha. TEAM is designed to encourage participants to make primary care service referrals and engage with a patient's aligned total cost of care, or shared savings model, if applicable. A TEAM participant's gain sharing methodology may take into account the amount of such TEAM activities provided by a TEAM collaborator relative to other TEAM collaborators. However, it should not be based fully on volume of referrals. CMS believes this proposed requirement allows flexibility in the determination of gain sharing payments to TEAM collaborators who have differing contributions to TEAM activities. We understand that this may result in greater differences in the funds available for gain sharing payments and believe that this allows for gain sharing payments to be made appropriately, without tying them directly, or indirectly, to volume or value of referrals.

And now I'll pass the event back to Sacha to close out this session.

>>Sacha Wolf, CMS: Thank you, Jen.

As we close, we'd like to share some additional information and resources with you. We have a reminder of TEAM's email address here on the slide, which is **CMMI_TEAM@cms.hhs.gov**. For more information on the model, please visit TEAM's webpage. To stay up to date on TEAM, please sign up for TEAM's listserv using the link on this slide. We will announce upcoming events, resources, and more information about updates to the model using the listserv, and you can learn about these as they become available by signing up.

Thank you for tuning in to learn more about TEAM. We appreciate your time and interest, and we welcome questions about the model, at the model's inbox at **CMMI_TEAM@cms.hhs.gov**. We will use the questions you share to prepare additional materials, such as frequently asked questions, or FAQs.

Thank you, again. The webcast is now complete. We hope you enjoy the rest of your day.

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