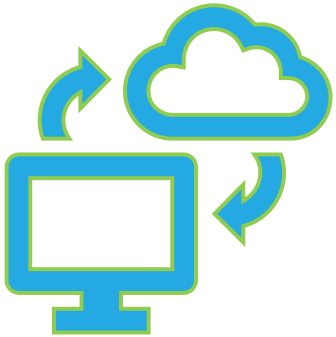
Unpacking CMS's New Mandatory Bundled Payment Model

May 16, 2024



Webinar is being recorded

The recording and slides will be available on the NAACOS website within 48 hours.

Q&A will take place at the end of the program

You can submit written questions using the **“Questions” tab** (not chat) at any time during the webinar.

Speakers

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TEAM

- **Transforming Episode Accountability Model (TEAM)**
  - Included in proposed Inpatient Prospective Payment System (IPPS) rule
  - Comments can be shared with CMS through June 10th
- 5-year mandatory model in specific regions launching Jan. 2026
  - Regions: See Table X.A.-02: List of CBSAs eligible for selection in TEAM p. 1119
- Includes financial accountability for Parts A & B items and services that begin with an anchor hospitalization or procedure and end 30 days post discharge
- Earn payments, subject to a quality adjustment, if spending is below the reconciliation target price (or owe repayment if spending is above the target)
- TEAM website includes additional information & FAQs

TEAM

- Includes 5 specific episodes (more may be added in future years):
  1. Lower extremity joint replacement
  2. Surgical hip/femur fracture treatment
  3. Major bowel procedures
  4. Spinal fusion
  5. Coronary artery bypass graft
- NAACOS comments: Do not require participation in all 5 episodes, do not add episodes during the model period.

Tracks

- 3 participation tracks w/ varying levels of risk:
  - **Track 1-** Available PY 1, upside-only, subject to 10% stop-gain limit and Composite Quality Score (CQS) adjustment percentage of up to 10%
  - **Track 2-** Available PY 2-5 for certain hospitals (safety net, rural hospitals, Medicare dependent hospitals, sole community hospitals, essential access community hospitals), stop-gain and stop-loss limits of 10% and CQS adjustment percentage of up to 10% (15% for negative reconciliation amount)
  - **Track 3-** Two-sided financial risk, subject to 20% stop-gain and stop-loss limits and a CQS adjustment percentage of up to 10%
- Includes safety net hospitals, but provides lower levels of risk PY2-5 for these hospitals
- NAACOS Comments: Do not include safety net hospitals who lack resources to do this effectively. At a minimum, provide additional years in upside only for safety net hospitals. Provide a more gradual on-ramp to risk. Allow all hospitals to participate in Track 2.

Target Prices

- Target prices based on 3 years of baseline data, prospectively trended forward and calculated at the level of MS-DRG/HCPCS episode type and region with a 3% discount factor
  - Propose to incorporate regional pricing data when establishing target prices, similar to CJR model's target prices that are constructed at the regional level
- Will incorporate a prospective normalization factor into preliminary target prices, which would be subject to a limited adjustment at reconciliation
- Seeking comment on including Accountable Care Prospective Trend (ACPT) as a trending approach or other potential ways to increase accuracy of prospective target prices and mitigate the ratchet effect when TEAM target prices are updated
- NAACOS Comments: 3% discount is too aggressive, not sustainable – for some episodes costs have already been reduced w/ prior bundles/episode models and for others the 30-day period is not enough to allow opportunities for savings.
- Provide a lower discount for safety net/rural hospitals.

Low Volume

- Low volume = 30 episodes in 3 years across all episodes
  - Will allow for remaining in Track 2 (or Track 1 for rural/safety net)
- If selected for the model, you must participate in all episodes
- NAACOS Comments: Do not apply one threshold across all episodes. This should be applied for each episode and should be clinically relevant for the particular episode.
- Exclude hospitals with low volumes (instead of adjusting risk track eligibility).

Risk Adjustment

- Proposes to use an HCC count risk adjustment variable, but calculated differently than in CJR
- Using an expanded risk adjustment variable that accounts for multiple potential markers of beneficiary social risk
- Participants will receive risk adjustment multipliers prior to the start of the PY to estimate target prices – calculated at MS-DRG level (separate risk adjustment multipliers for each MS-DRG episode type)
- NAACOS Comments: Risk adjustment not sufficient w/ renormalization policy (renormalization will cancel out risk adjustment) – cap renormalization.

Quality

- Quality Assessments: Starting PY 1 reconciliation amounts will be adjusted based on performance of the following quality measures:
  1. Hospital wide all cause readmission measure with claims and EHR data (all)
  2. CMS patient safety and adverse events composite (all)
  3. Patient reported outcome-based performance measure following elective total hip and/or total knee arthroplasty (PRO-PM) (LEJR)
- TEAM participants must achieve a quality score of 100 to receive the max. quality adjusted reconciliation amount
- NAACOS Comments: Quality approach should not be penalty only (allow for high quality to lower discount, for example).

Reconciliation

- Annual reconciliation of TEAM participant's actual episode payments against the target price(s) will take place 6 months after the end of the performance year
  - Lump sum payments/repayments
- Bonuses/repayments will not be counted in ACO expenditure calculations
- Excluded costs – oncology, trauma medical admissions, organ transplant, ventricular shunts, others
- NAACOS Comments: Excluded costs should be based on clinical appropriateness for each episode (not one set of excluded costs across all 5 episodes).

Financial Arrangements

- CMS allows participants to enter into financial arrangements w/ certain providers/suppliers participating in TEAM activities to share reconciliation payment amounts (and repayments) – team collaborators:
  - SNF, home health, LTCH, IRF, physician, NPP, therapist, outpatient rehab facility, PGP, hospital, CAH, non physician provider group practice, Medicare ACO
- Certain criteria outlined for agreements & downstream distribution payments, including that payments are tied to quality of care criteria and provision of TEAM activities
- NAACOS Comments: With the 3% discount there will not be sufficient savings for downstream arrangements.

Data Sharing

- CMS will provide regional aggregate expenditure data available for all Parts A and B claims associated with episodes in TEAM for the US Census Division in which the TEAM participant is located (similar to what is provided to hospitals in CJR)
  - Regional aggregate data on total expenditures during an anchor hospitalization or procedure and the 30-day post-discharge period for all Medicare FFS benes who have initiated an episode during baseline and performance years

Beneficiary Incentives

- TEAM participants can choose to provide in-kind patient engagement incentives to beneficiaries in an episode, including but not limited to items of technology
  - Items or services involving technology may not exceed $1,000 in retail value for any TEAM beneficiary in any episode (per episode) – must be the minimum necessary to advance a clinical goal as defined in the rule
  - Additional requirements for items of technology exceeding $75 in retail value to safeguard against misuse
- CMS seeks comment on waivers necessary to test this model (include telehealth, 3-day SNF rule)
- NAACOS Comments: Include post discharge home care waivers.

AAPM Status, Others

- CMS is adopting two APM options for TEAM – an AAPM option (TEAM participants required to attest to meeting CEHRT standards) and a non AAPM option (TEAM participants would not meet CEHRT standards)
- Decarbonization and resilience – can voluntarily report greenhouse gas emissions to receive feedback reports and public recognition
- CMS seeks comment on how to promote interoperability in TEAM (focus on participation in TEFCA in the next 1-2 years)
- NAACOS Comments: New AAPM CEHRT standards are unreasonable. Participation in the model (risk tracks) should qualify as AAPM. Do not support requirements to participate in TEFCA.

Equity

- Equity: Must report a health equity plan (voluntary in PY 1), demographic data (starting PY 2), screen attributed TEAM beneficiaries for at least 4 HRSN domains (food insecurity, housing instability, transportation needs, utility difficulty) (starting PY 1), and report aggregated HRSN screening data and screened positive data for each HRSN domain (starting PY 1)
- NAACOS Comments: Provide more guidance on equity plans, limit administrative burdens.

Overlap

- Overlap: Allows for overlap w/ total cost of care models and does not include TEAM's reconciliation payment/repayment amounts in total cost of care models' total expenditures
- CMS also seeks comment on requiring a notification process of the TEAM participant to ensure they alert the total cost of care participant of their aligned beneficiary's episode during the anchor hospitalization or procedure
- NAACOS Comments: Supportive of overlap policies, give an option for carving out patients aligned with full risk models.

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Preliminary Analysis of TEAM Episodes

May 16, 2024

Preliminary Analysis and Discussion of Key Issues

- Model structure
- Selection of regions
- Acute and post-acute spending for TEAM episodes
- Variation in hospital episode spending (sample market)
- Comments on risk adjustment method
- Comment on quality strategy
- Design of analytic reports for TEAM hospitals

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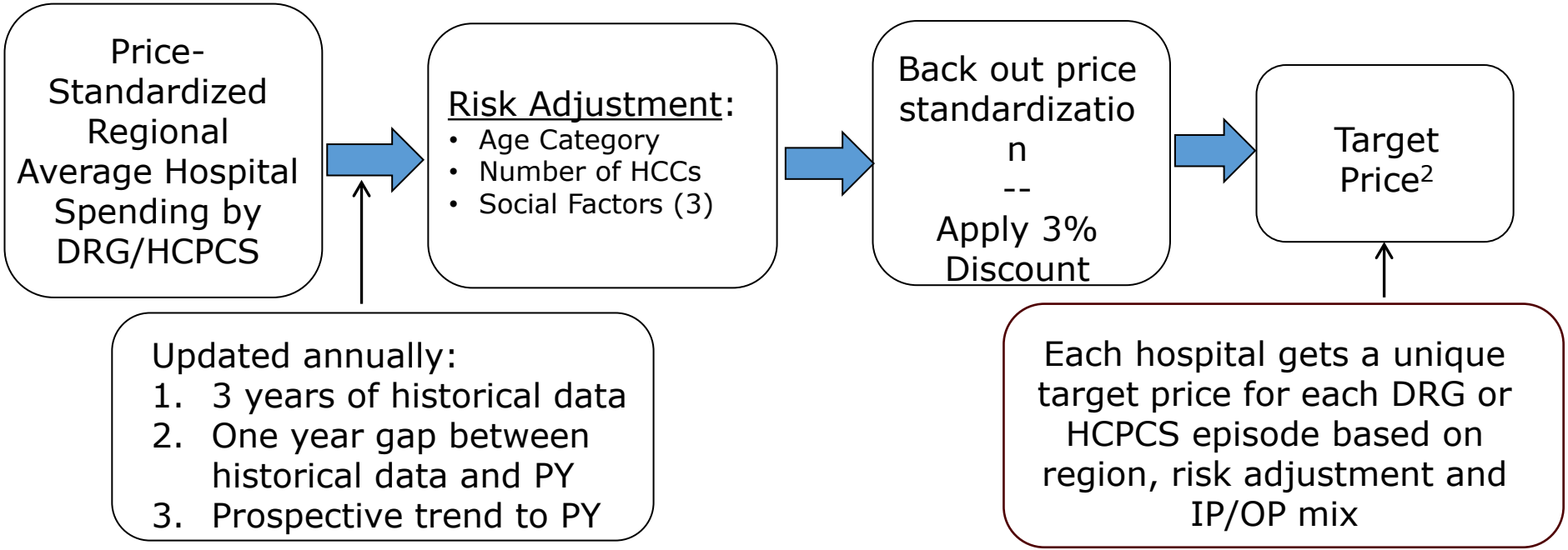
General Approach of TEAM Pricing Model



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TEAM Model: CBSA Selection Criteria

Selection Criteria for CBSAs (802 eligible regions)

- Number of safety net hospitals
- Past exposure to bundled payment models
- Average spending for a range of episodes (high/low)
- Number of hospitals in the CBSA

Probability of TEAMS Selection	20%	25%	33%	50%
Number of CBSAs	312	441	44	5

CBSAs with 50% Probability of Selection

- Los Angeles-Long Beach, CA
- New York-Newark, NY/NJ
- Miami-Fort Lauderdale, FL
- San Francisco-Oakland, CA
- Chicago-Naperville-Elgin, IL

Source: Inpatient PPS Proposed Rule, Table X.a.02

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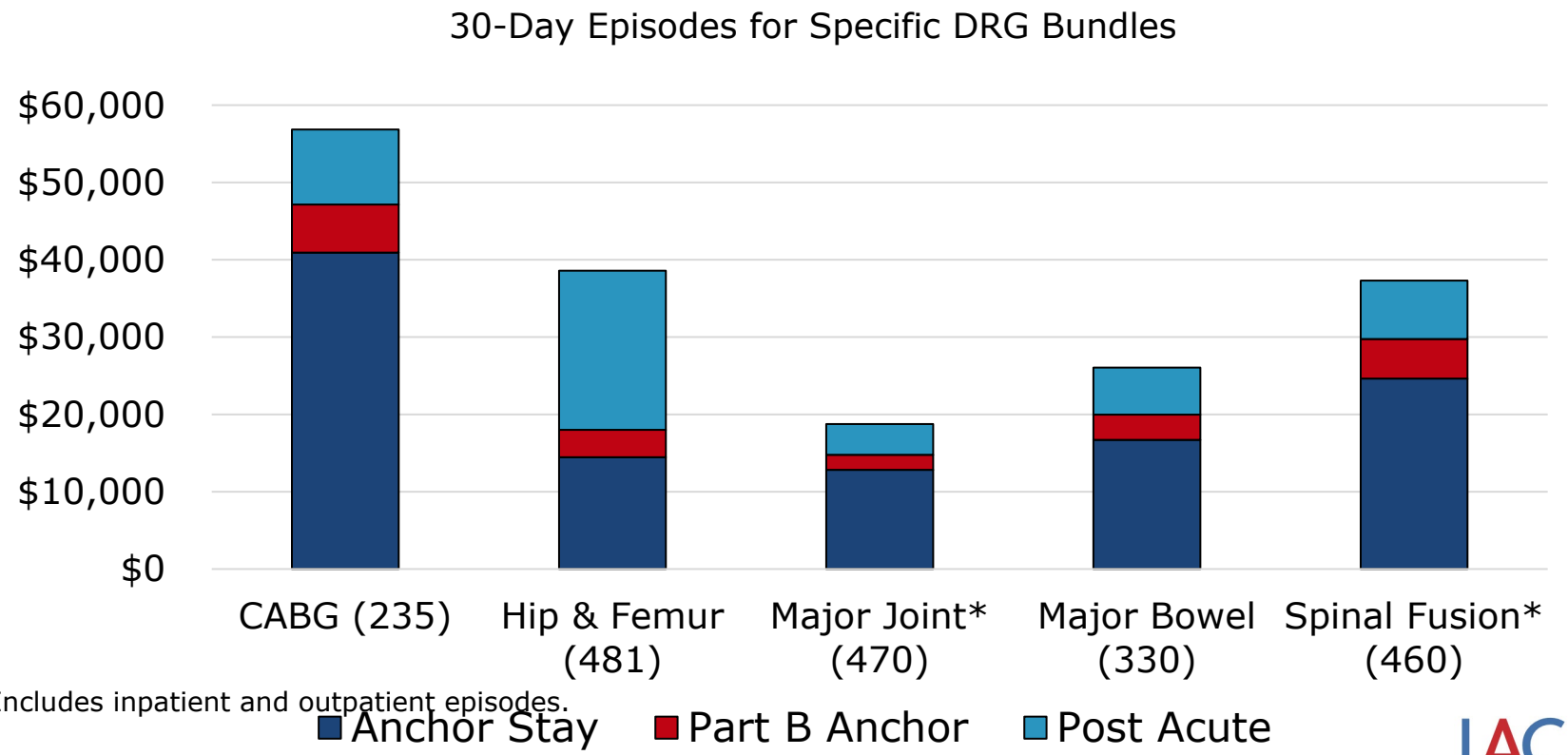
National Average TEAM Episode Cost by Setting



*Includes inpatient and outpatient episodes.

Source: IAC analysis of TEAM episodes 2021-2023 with wage-standardized Medicare claims data (100%) sample.

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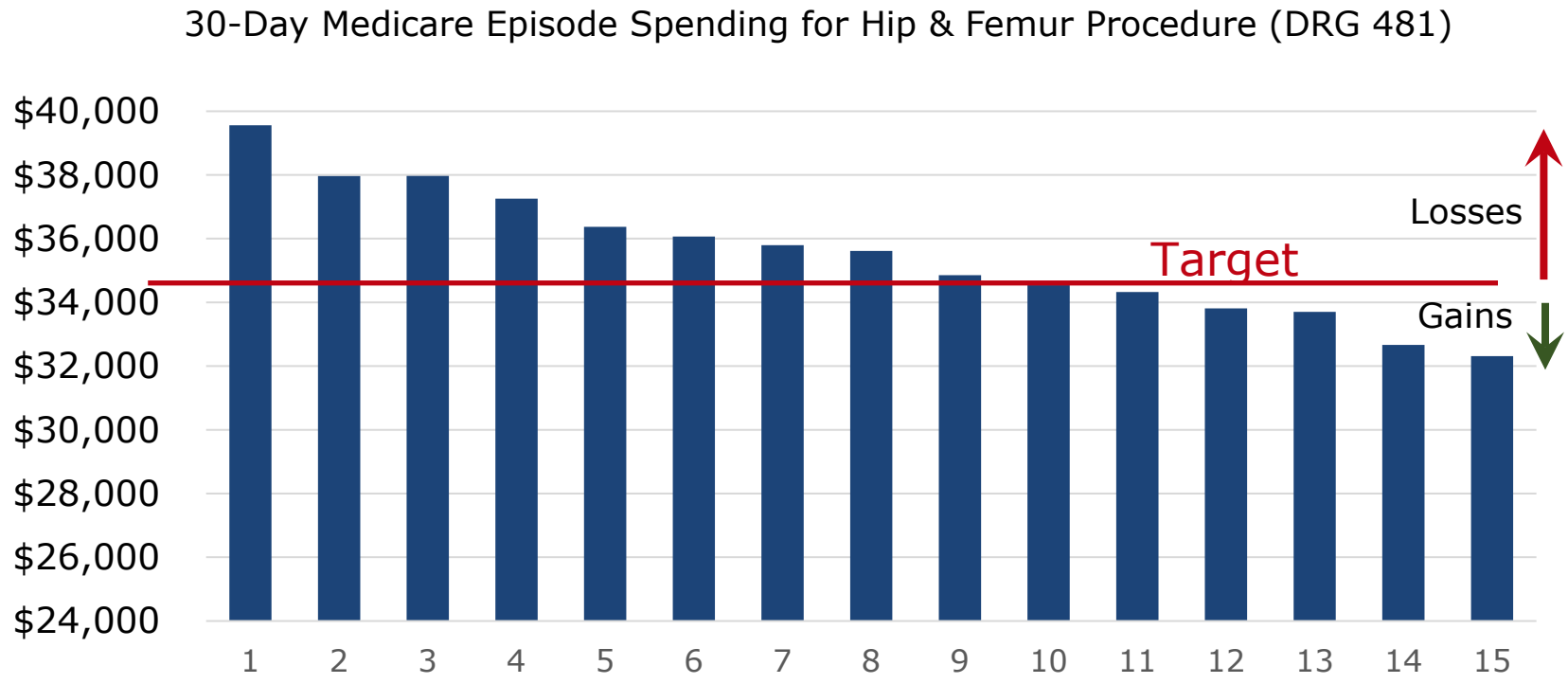
Hospital Spend vs. Target Price in US Metro Market



* Spending adjusted to reflect gain or loss relative to a common target price.

Source: IAC analysis of TEAM episodes 2021-2023 with Medicare claims data (100% sample).

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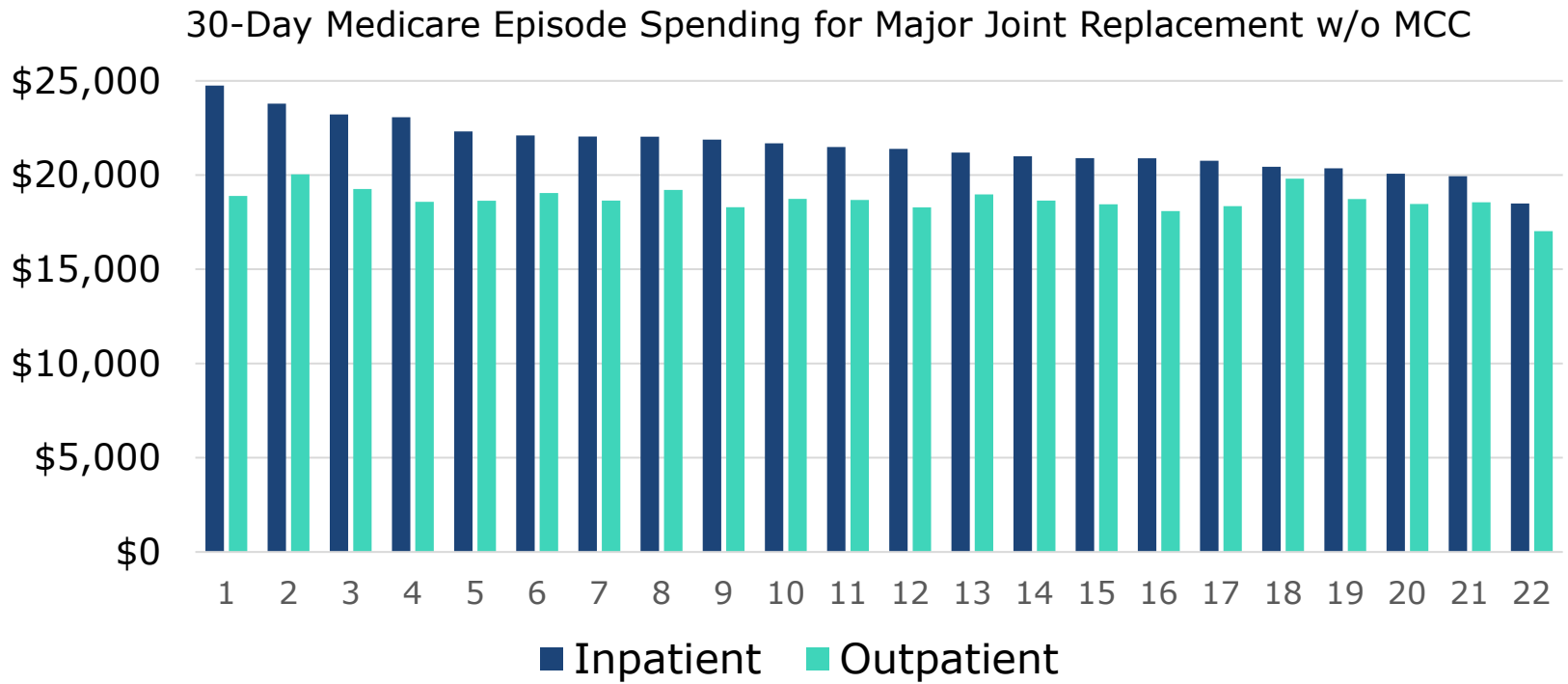
Mean Hospital Cost for IP vs. OP LEJR in US Metro Mkt



Source: IAC analysis of TEAM episodes 2021-2023 with Medicare claims data (100%) sample.

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Risk Adjustment Considerations

- CMS goal: predictability and transparency
- Parsimonious model, similar to CJR
  - Age
  - HCC count (1, 2, 3, 4+)
  - Social risk factors
- A normalization factor is used to ensure the average risk-adjusted target price does not exceed the average base target price.
- Relatively poor model fit – adjusted R-squared = 0.084
- CMS seeks comment on the use of alternative risk models (e.g., BPCI-A with peer group and hospital specific adjusters)

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Quality Considerations

- Composite quality score to adjust payment
- Adjustments
  - Up to 10% increase in positive reconciliation amounts (all Tracks)
  - Up to 10% or 15% reduction on negative reconciliations amounts (T2 or T3)
- Limited measures set, submitted through Hospital IQF Program
  - Hybrid hospital-wide all-cause readmission measure (claims and EHR)
  - Patient Safety and Adverse Events Composite Score
  - For LEJR, total hip or total knee arthroplasty PROM
- More measures to be added in the future
  - Hospital harms - falls without injury
  - 30-day risk-standardized death rate
  - Postoperative respiratory failure

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IAC Analytic Reporting for TEAM Hospitals*

- Target prices, hospital spending, and projected total gains or losses for each TEAM episode
- Breakdown of target prices, spending and gain or loss by DRG and HCPCS trigger codes
- Breakdown of spending by site of care including index admission and post-acute providers (e.g., IRF, SNF etc)
- Breakdown of spending and gain/loss by surgeon
- Profile of readmissions and SNF services by provider
- Support for ongoing analysis of monthly claims feeds provided by CMS to model participants.

* Analytic support services provided for a fee.

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Questions or Comments

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Questions?