The New Transforming Episode Accountability Model (TEAM)

A2HA

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Agenda

1. Introductions
2. Bundled Payments Overview
3. TEAM Methodology
4. Strategies to Prepare
5. DataGen Support
6. Q & A

About DataGen®

"Analytics as a Service" for Insights for Healthcare®

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- Legislative and Litigation Trackers
- Culture of Safety Surveys
- Patient Centered Medical Home – NCQA-recognition facilitator

Expert analysis of medical claims data…..

- Medicare's Part A fee-for-service programs – Impact Reports
- Medicare's CMMI value-based programs – Performance Analysis
- Custom analytics to evaluate financial, quality outcomes, and social determinants
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Always There for Healthcare

- Founded 25+ years ago
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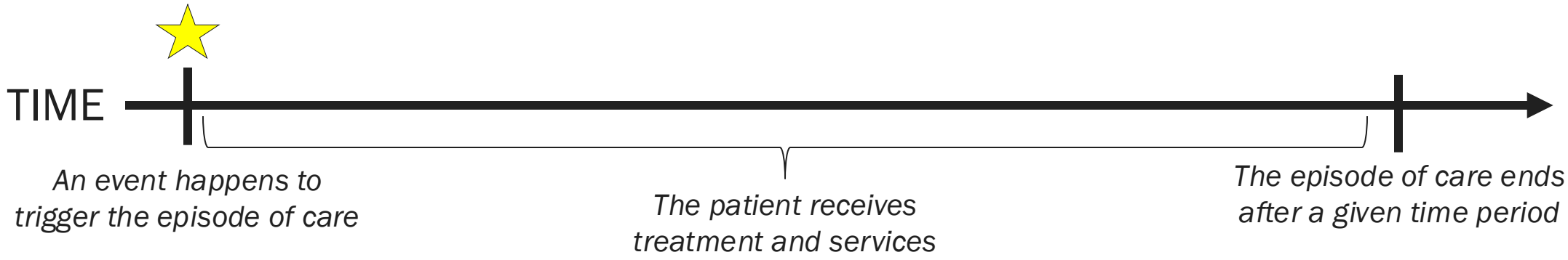
Bundled Payments Overview

What is an Episode of Care?

An episode of care is a patient's entire treatment for an illness or condition, including all services provided to treat a clinical condition or procedure

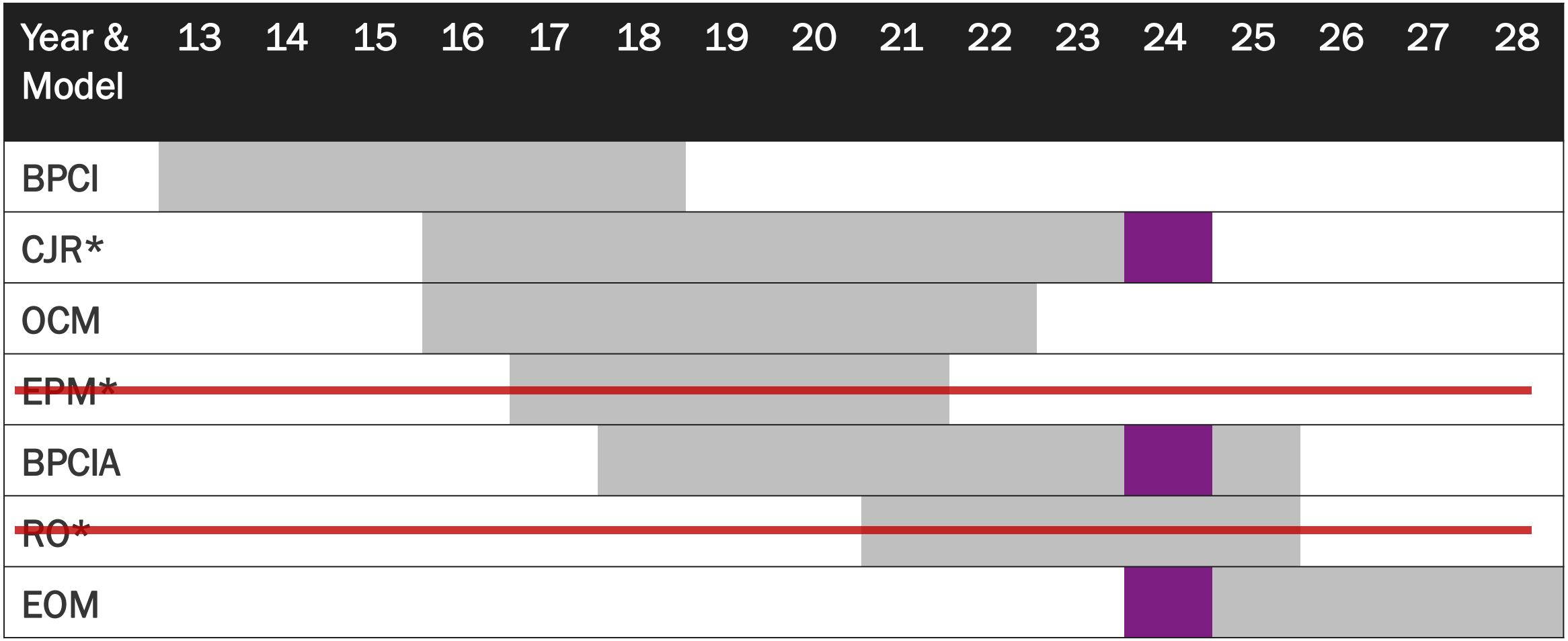


What is a Bundled Payment?

A single target price for the full spectrum of services during an episode of care

Theoretical Simple Example:
Average Baseline Period Medicare Episode Spend: $27,200
Discount factor to incentive/ensure savings: 2%
Target: $27,200 x 0.98 = **$26,656**

Medicare Bundled Payment Evolution



*mandatory model

New Mandatory Bundled Payment Model

Transforming Episode Accountability Model

Mandatory Model: 2026-2030

The Transforming Episode Accountability Model (TEAM) will support people with Medicare undergoing certain surgical procedures by promoting better care coordination, seamless transitions between providers, and successful recovery.

Included procedures: lower extremity joint replacement, surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedure.

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

TEAM Highlights

Criteria	TEAM Specifications
Model Duration	5 years (CY2026–CY2030)
Participants	Acute care hospitals (by CCN)
Participation	Mandatory for hospitals in selected CBSAs One-time voluntary opt-in available for BPCIA and CJR hospitals
Selection	188 CBSAs selected for participation (23.4%)
Patients	Medicare beneficiaries with Part A & B coverage, non-ESRD
Clinical Episodes	30-day episodes of care for 5 surgical procedures
Discount Factor	1.5-2% depending on episode category
Quality	Hospital-Wide AC RDX, CMS PSI-90, THA/TKA PROs PY2+: Falls with Injury, Post-Operative Respiratory Failure, Failure-to-Rescue

TEAM Methodology

Participants

Mandatory Participation

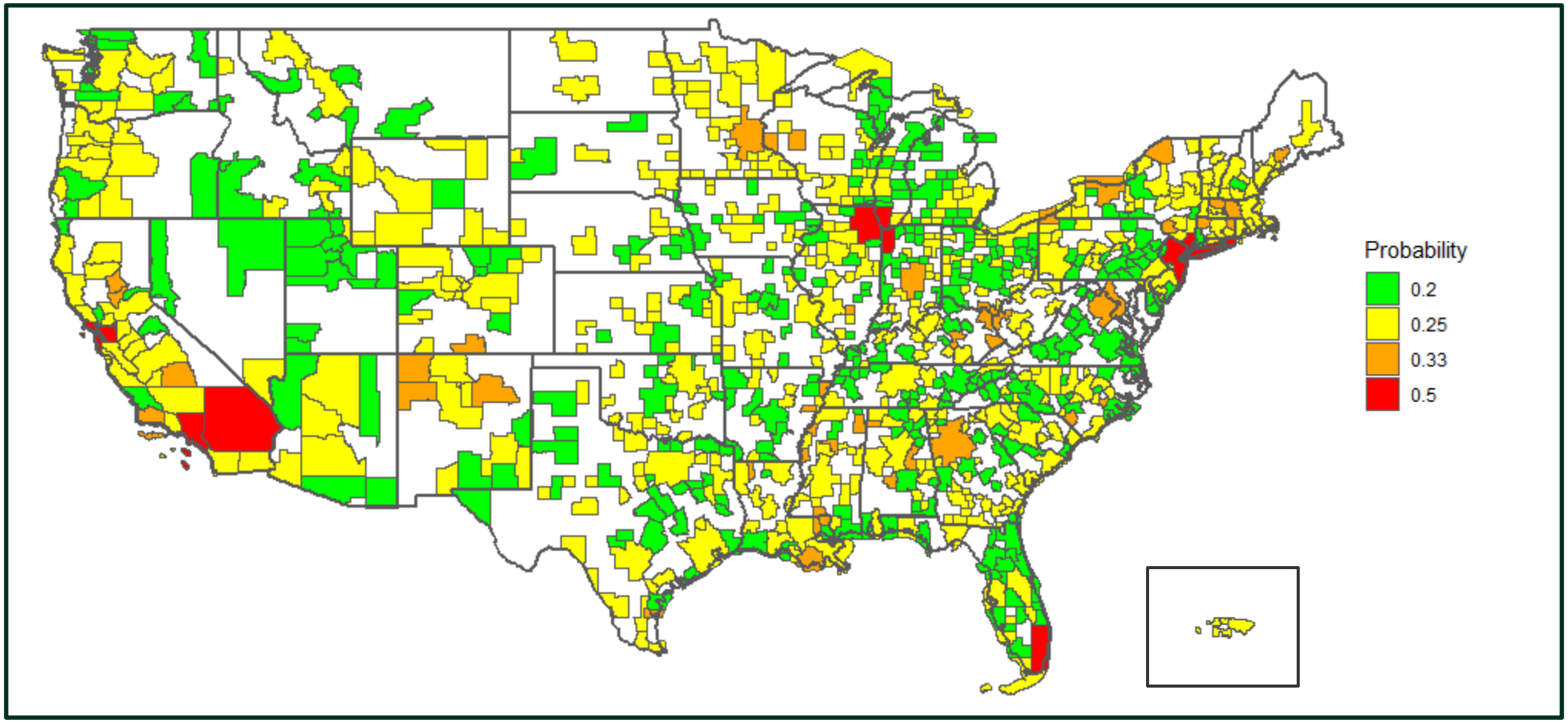
- Acute care hospitals paid under IPPS
- Located in one of 188 selected CBSAs
- Includes hospitals with special designations*
- Proposal for low-volume thresholds not finalized

Voluntary Participation

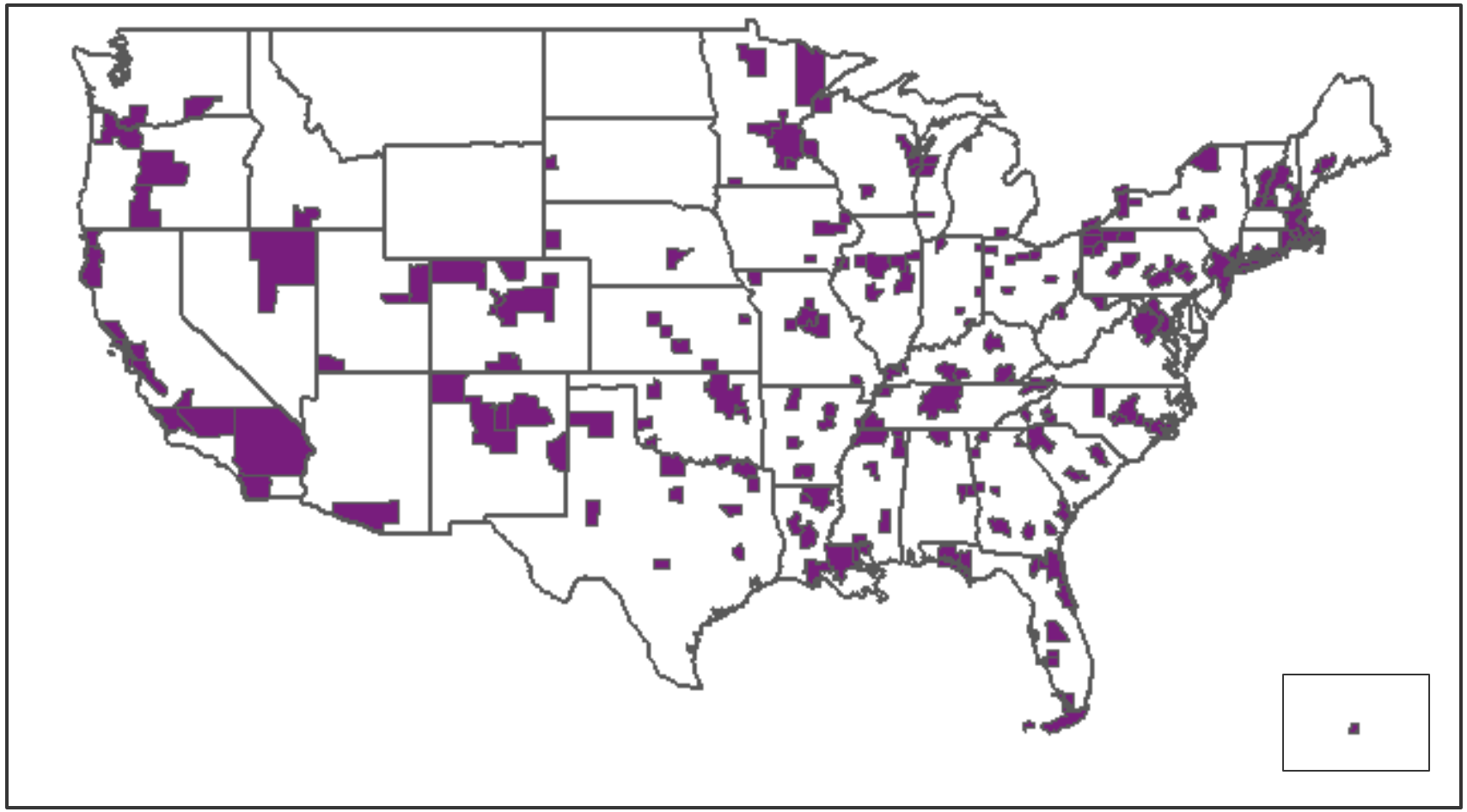
- One-time voluntary opt-in opportunity
- Hospitals currently participating in BPCIA or CJR that are not located in a CBSA selected for mandatory TEAM participation
- Requires submission of a participation election letter in January 2025

*Safety Net Hospitals, Rural Hospitals, Medicare Dependent Hospitals, Sole Community Hospitals, Essential Access Community Hospitals

CBSA Sampling Probability



Final Mandatory CBSAs Selected



188 CBSAs selected

741 hospitals with mandatory participation status

Participation Tracks

Track	Performance Year	Participant Eligibility	Financial Risk
Track 1	PY 1	All TEAM participants	• Upside risk only (10% stop-gain) • Quality adjustment ≤10% for positive reconciliation amounts
	PY 1-3	TEAM participants that are safety net hospitals	
Track 2	PY 2-5	TEAM participants that are: • Safety net hospital • Rural hospital • Medicare Dependent Hospital • Sole Community Hospital • Essential Access Community Hospital	• Upside and downside risk (5% stop-gain/loss) • Quality adjustment ≤10% for positive reconciliation amounts • Quality adjustment ≤15% for negative reconciliation amounts
Track 3	PY 1-5	All TEAM participants	• Upside and downside risk (20% stop-gain/loss) • Quality adjustment ≤10% for positive and negative reconciliation amounts

Episode Specifications

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

Anchor hospital = The acute care hospital that initiates the episode and bears accountability

Triggering event = The inpatient discharge MS-DRG or outpatient procedure HCPCS code that initiates the episode

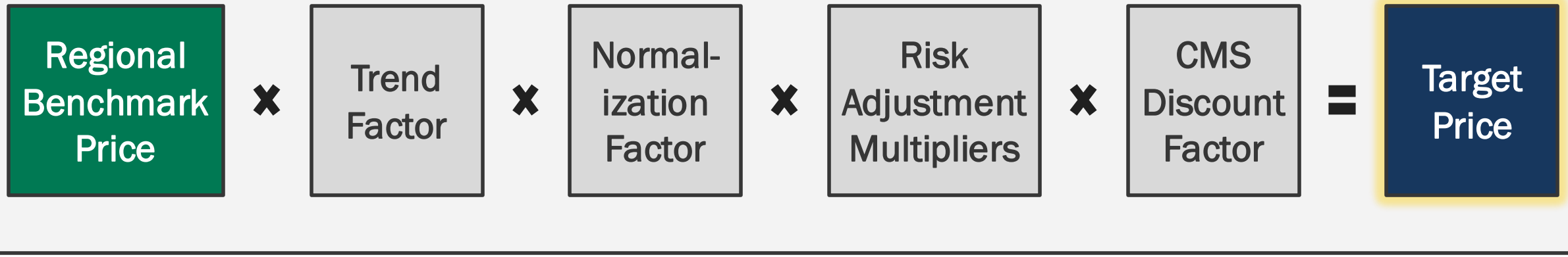
Episode start = Inpatient discharge date or outpatient procedure date

Episode end = 30 days after the episode start date

All Medicare FFS Part A & B payments are included as part of the episode's expenditures, with some exclusions.

Target Price Methodology

Participants will receive for each MS-DRG/HCPCS episode type:



The Preliminary Target Price will use a Prospective Trend Factor and a Prospective Normalization Factor and will not account for Risk Adjustment Multipliers.

The Final Target Price will use a Retrospective Trend Factor (±3% cap) and Normalization Factor (±5% cap).

Risk Adjustment Strategy

Hospital Characteristics

- Bed size
- Safety net status

Beneficiary Social Risk

- Full dual eligibility status
- Qualification for Part D low-income subsidy
- Area deprivation index

Beneficiary Characteristics

- Age group
- Disability
- Dementia
- Prior PAC use
- Institutional LTC
- HCC count
- Specific HCCs
- Other procedure-related variables

Note: Risk adjustments will be calculated for each region and MS-DRG/HCPCS episode type. CMS has not finalized all aspects of the risk adjustment strategy!

Quality Measures

All Episodes		LEJR Only	PY2 Measures		
Hybrid Hospital-Wide All-Cause Readmission Measure	CMS Patient Safety and Adverse Events Composite (PSI-90)	Hospital-Level Total Hip and/or Total Knee Arthroplasty Patient-Reported Outcomes (PRO-PM)	Hospital Harm - Falls with Injury	Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue)	Hospital Harm - Postoperative Respiratory Failure
CMIT ID #356	CMIT ID #135	CMIT ID #1618	MUC 2023-04	MUC 2023-04	MUC 2023-04

The Composite Quality Score (CQS) will be used to adjust positive and negative total reconciliation amounts.

Reconciliation

Annual reconciliation:

- 6 months after the end of the performance year
- Payments and repayments are made as a one-time lump sum

CMS calculations include:

- Application of risk adjusters
- Final retrospective trend and normalization factors
- Quality score adjustments
- Stop loss/gain limits

If Episode Expenditures < Target Amount → Positive NPRA (savings)
If Episode Expenditures > Target Amount → Negative NPRA (losses)

Additional Model Aspects

Health equity

Waivers

Decarbonization

Beneficiary notification

Gainsharing

Strategies to Prepare

Build Your Team

1. **Identify key roles**
   - Multidisciplinary approach
   - Physician champion
2. **Deploy education and training**
   - TEAM specifications
   - Standard care protocols

Analysis Resources

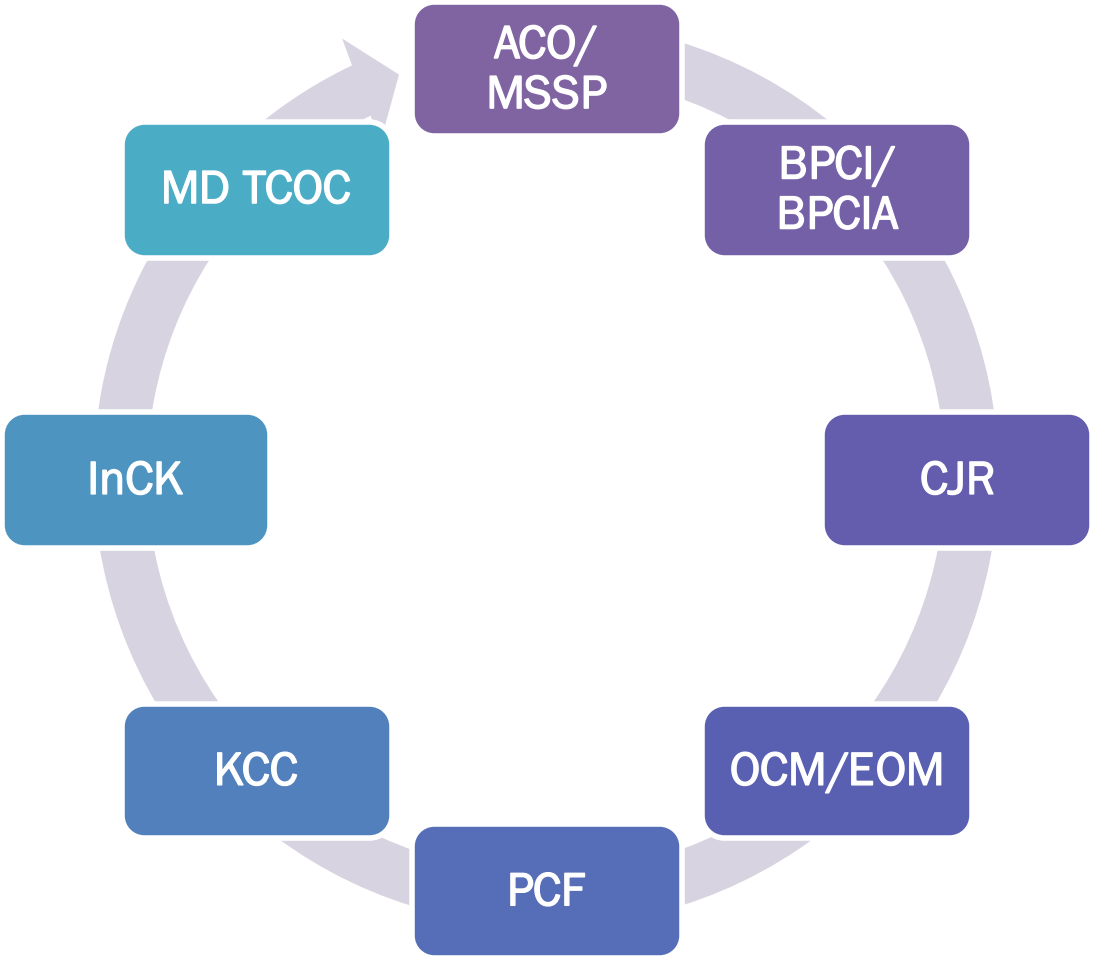
1. **Understand internal resources**
   - Personnel
   - Bandwidth
   - Technology
2. **Partner with data experts**
   - Timely performance metrics
   - Interpretation in context

Prepare for Reconciliation

1. **Depend on your data**
   - Identify deviations from expected performance
   - Respond and plan interventions
2. **Stay in communication**
   - Episode-specific care teams
   - Leadership

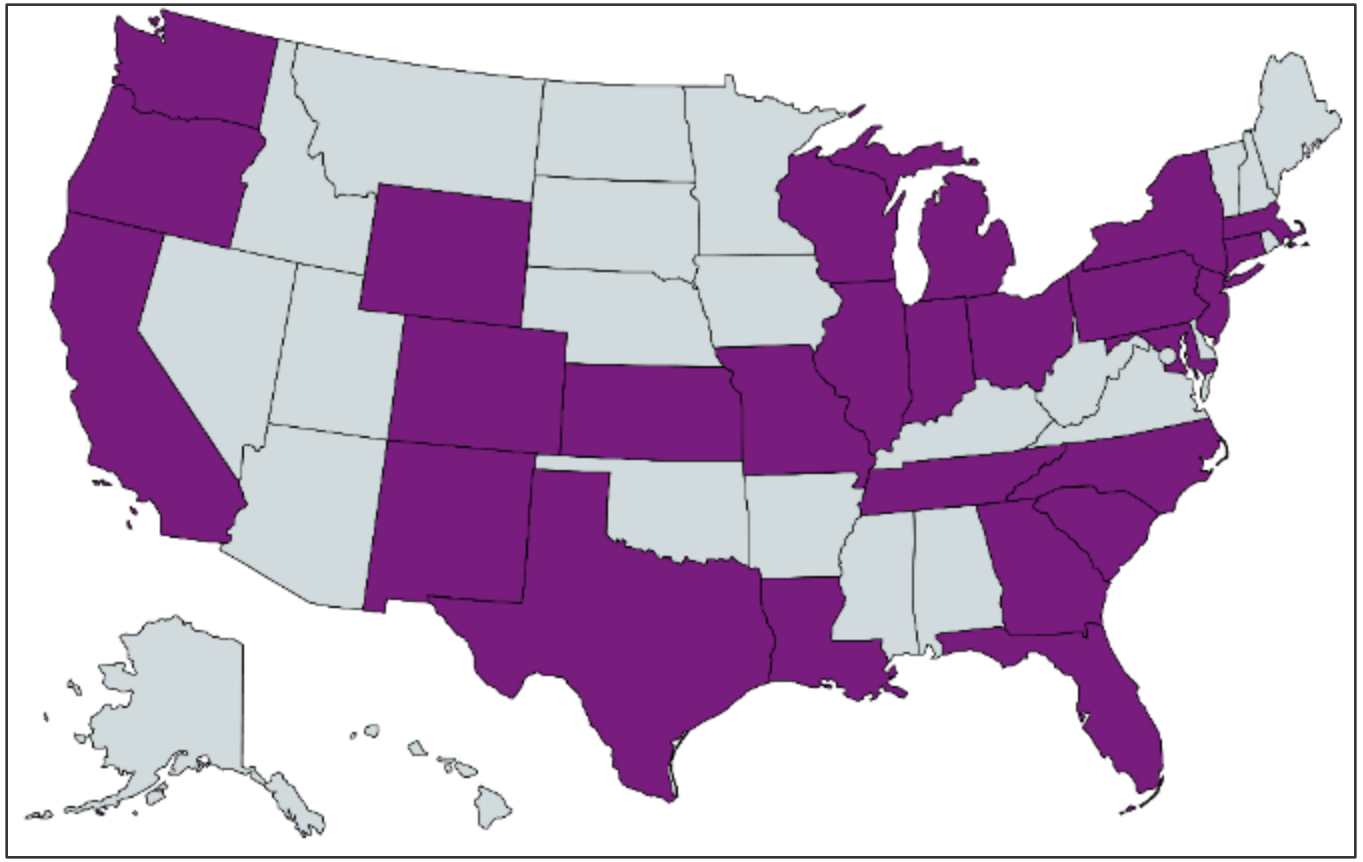
DataGen Support

Medicare APM Analytics



The Making Care Primary (MCP) Model and the Transforming Episode Accountability Model (TEAM) are DataGen's newest Medicare alternative payment models to support.

APM Analytics Across the Country



TEAM Services

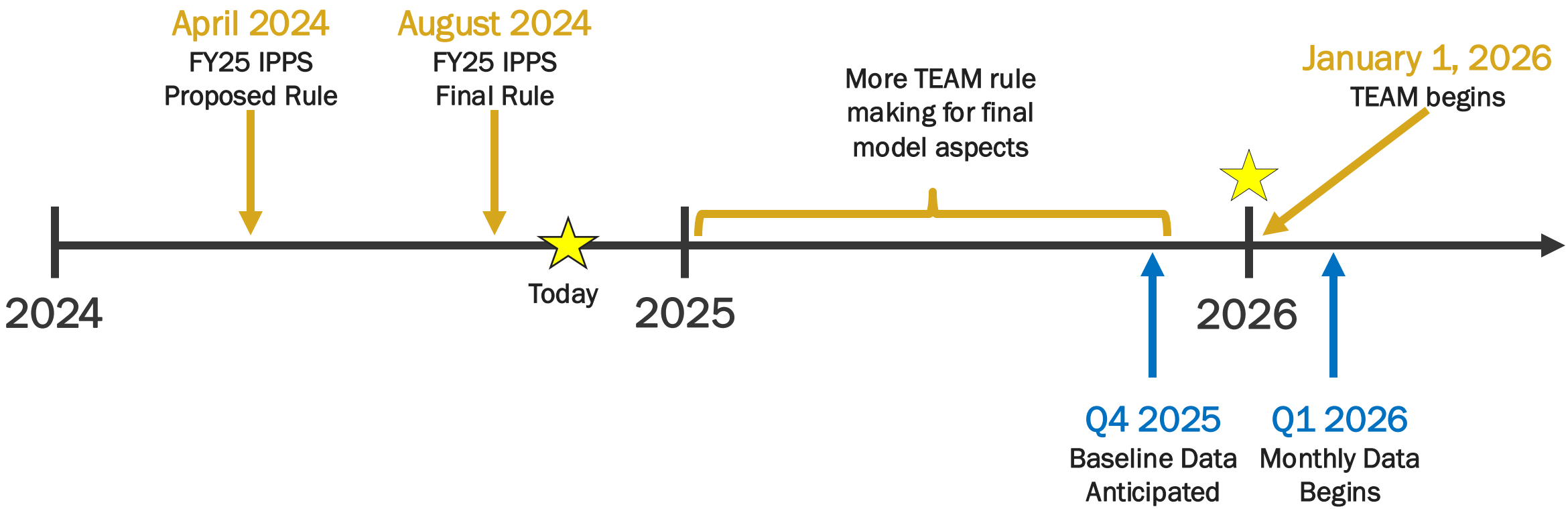
1. **Shadow bundle opportunity analysis**
   - Data source: Medicare SAF LDS files, DataGen generated episodes according to TEAM specifications
   - Licensing now, updated quarterly

Available Now!

2. **TEAM performance data monitoring**
   - Data source: Medicare episode, claim, and target files for TEAM participants
   - Baseline anticipated 2025 Q4
   - Updated monthly once TEAM is live

Available 2025 Q4

Data Timeline



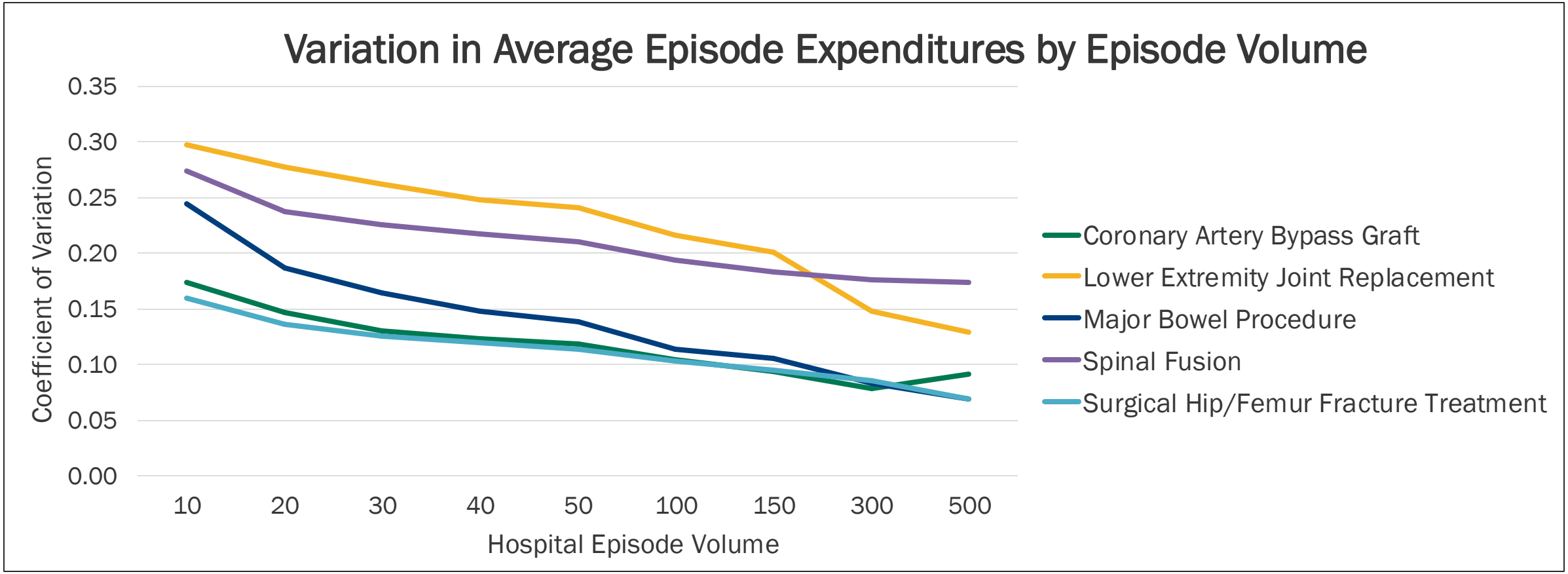
Benefits of Shadow Bundles

- ✓ Assess utilization and performance within procedure or disease-specific bundles
- ✓ Manage episodes within the population prior to the launch of TEAM
- ✓ Enhance provider data transparency
- ✓ Useful for promoting engagement

Build a Strong Analysis Foundation

1. Understand volume & variation
2. Actionable episode spend
3. Post-acute care & readmissions
4. Benchmarks to drive “what if” analyses

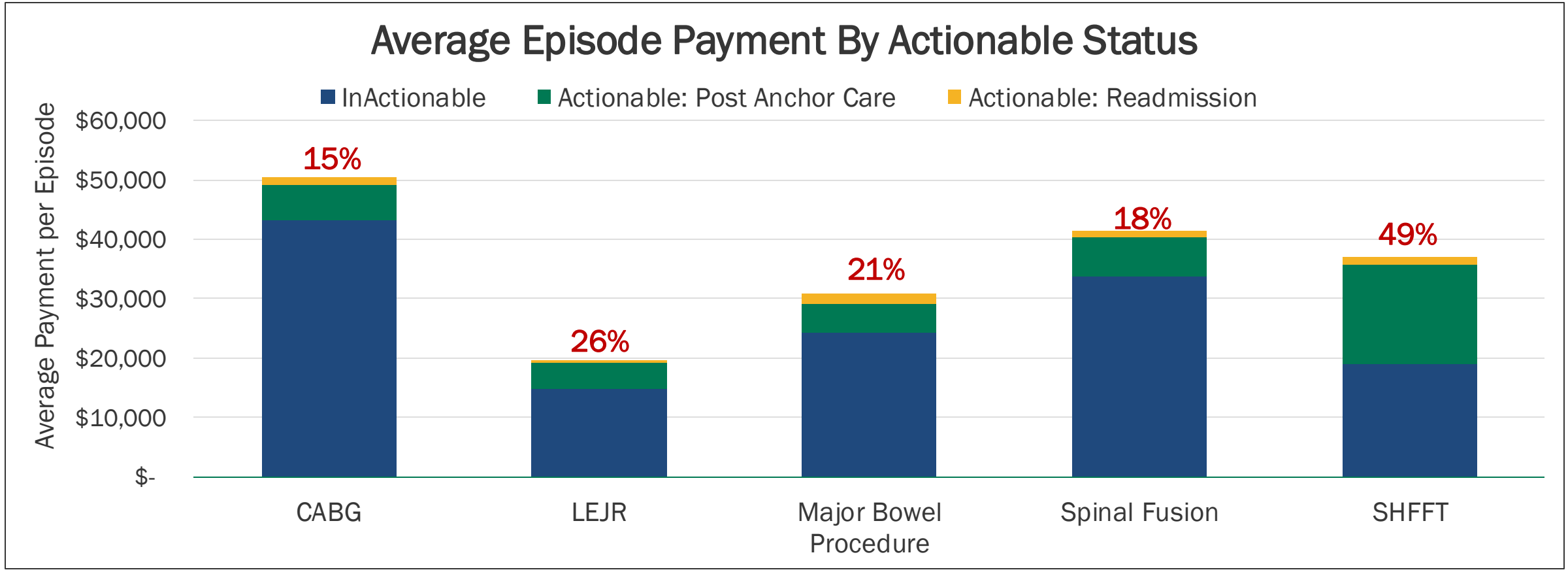
Understand Volume & Variation



Low volume = ↑ cost variability (risk)

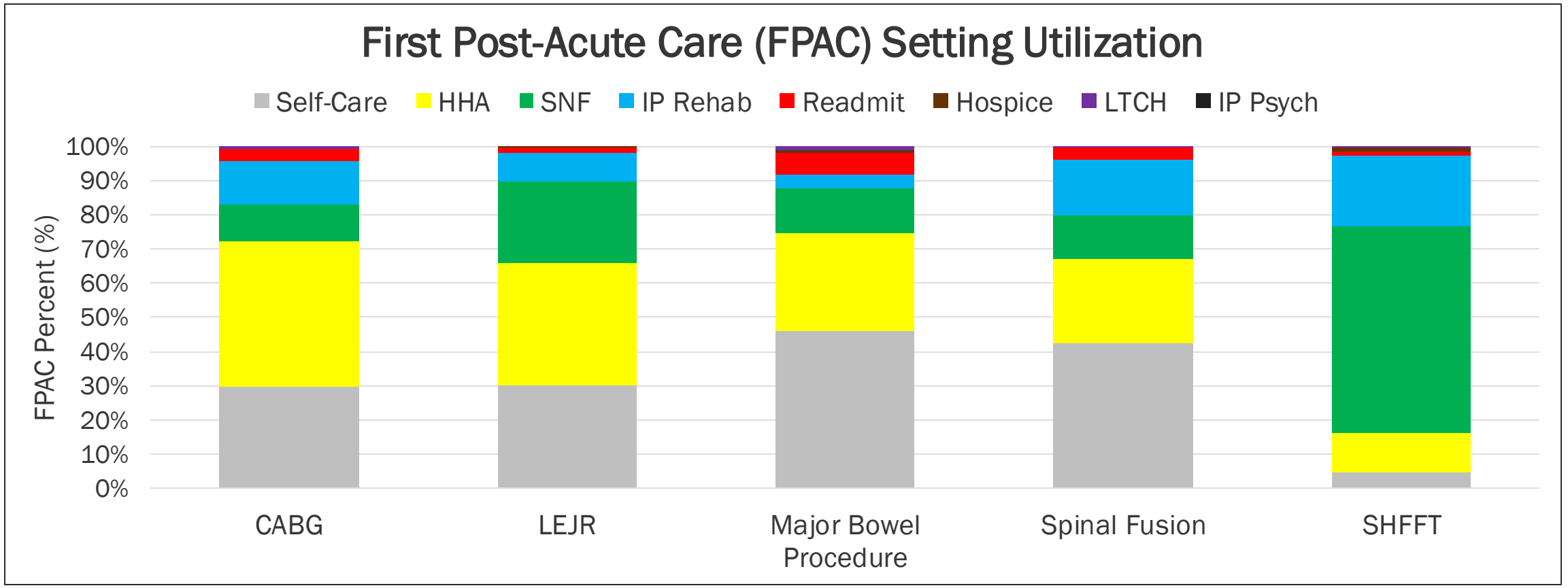
High volume = ↓ cost variability (risk)

Actionable Episode Spend



Percentages indicate proportion of Medicare episode spend that is “actionable”

Post-Acute Care & Readmissions



Assess appropriateness of care, choice of provider, and downstream performance indicators

Benchmarks to Drive "What-if" Analyses

Example: Lower Extremity Joint Replacement

Measure	Hospital	Region	Potential Change
Readmit Rate	0.09	0.05	($433)
SNF Percent	7.4%	15.9%	$887
SNF ALOS	17.3	19.9	$116
HHA Percent	71.0%	50.4%	($420)
HHA Ave Visits	8.6	7.5	($185)
IP Rehab Percent	21.9%	3.5%	($4,388)
Overall Change	-	-	**($4,235)**

How much can this hospital change their Medicare average episode spend if they were performing at the same level as their region?

Questions & Answers

Thank you.

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