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Transforming Episode Accountability Model (TEAM) Summary from the Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes

May 2, 2024

Key Takeaways

In conjunction with the release of the Fiscal Year 2025 Inpatient Prospective Payment System (IPPS) Proposed Rule (hereinafter, Proposed Rule), on April 10, the Centers for Medicare and Medicaid Services (CMS) Innovation Center announced a new mandatory 5-year, episode based alternative payment model known as the Transforming Episode Accountability Model (TEAM). Generally, the TEAM would test whether an episode-based pricing methodology linked with quality measure performance for select acute care hospitals reduces Medicare program expenditures while preserving or improving the quality of care for Medicare beneficiaries who initiate certain episode categories.

Comments are due June 10, 2024 by 5PM, and the final rule is expected to be released by early August. Vizient looks forward to working with members to help inform our letter to the agency.

Transforming Episode Accountability Model (TEAM)

The CMS Innovation Center ("Innovation Center") designs and tests alternative payment and care delivery models that can include specific payment, quality and other policies. While the models vary, there are some general provisions that are similar across programs. Under an episode-based payment structure (e.g., Bundled Payments for Care Improvement (BPCI) Initiative, BPCI Advanced Model, Comprehensive Care for Joint Replacement (CJR) Model), all the projected payments to the physician, hospital and other health care provider and suppliers are combined into a target price. Also, health care providers may realize financial gains or losses based on quality measure assessments and management of resources and costs for each episode.

To implement the model, the Innovation Center provides additional information alongside the Proposed Rule.

Model Performance Period

CMS proposes a 5-year "model performance period" which is the 60-month period from January 1, 2026 to December 31, 2030. Each "performance year" (PY) would begin on January 1 and end on December 31 of each year during TEAM's model performance period. CMS indicates it considered a 3-year or 10-year model performance period, but determined that 5 years would provide enough data and time to evaluate whether the model is successful for the included episode categories. In addition, CMS considered beginning TEAM later in 2026 (e.g., April 1, July 1, October 1) but decided that January 1, 2026 would still provide sufficient time for participants to prepare, and it would provide continuity between models as BPCI Advanced concludes on December 31, 2025. **CMS seeks comment on the proposed model performance period of 5 years and proposed**

model start date of January 1, 2026, for PY 1, and on the alternative considered start dates. Should the start date be moved, CMS seeks feedback on the adjustment to the model performance period.

TEAM Participants

CMS proposes that acute care hospitals would be the TEAM participant and the only entity able to initiate an episode in TEAM. Specifically, CMS proposes defining a TEAM participant as an acute care hospital[1] that initiates episodes and is paid under the IPPS with a CMS Certification Number (CCN) primary address located in one of the geographic areas selected for participation in TEAM. **CMS seeks comment on the proposed definition of TEAM participant and hospital.**

In the Proposed Rule, CMS clarifies that all acute care hospitals in Maryland would be excluded from being TEAM participants because Maryland hospitals are not currently paid under the IPPS and Outpatient Prospective Payment System (OPPS). Also, CMS proposes that payment to Maryland acute care hospitals would be excluded from the pricing calculations associated with TEAM. **CMS seeks comment on this proposal and whether there are potential approaches for including Maryland acute care hospitals as TEAM participants. In addition, CMS seeks comment on whether Maryland hospitals should be TEAM participants in the future.**

Regarding the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model (a State-based voluntary total cost of care (TCOC) model that will incorporate hospital global budgets and may include up to 8 states participating), CMS indicates it is hesitant to propose excluding hospitals that participate in the AHEAD Model from being TEAM participants. CMS acknowledges that allowing overlap may introduce model complexities (e.g., constructing TEAM prices or the AHEAD global budgets and statewide total cost of care calculations). **CMS seeks comment on whether there may be potential approaches for including hospitals participating in the AHEAD Model as TEAM participants, or other approaches that may not result in participation in both models but support the integration of episodes and hospital global budgets. Since the AHEAD Model would be voluntary for participating states and hospitals, CMS seeks comment on whether hospitals located in AHEAD states should be required to participate in TEAM if they either do not participate in the AHEAD Model or it they terminate their participation in the AHEAD model before the AHEAD model ends.**

CMS also considered including physician group practices (PGPs) in the definition of a TEAM participant in the future, based on a PGP's participation in BPCI Advanced, but declined to do so. The agency notes that there are other meaningful opportunities for PGPs, such as engaging in financial arrangements with TEAM participants or future PGP-specific opportunities under development through the Innovation Center's specialty care strategy. **CMS seeks comment on whether it should include PGPs in the definition of a TEAM participant through future rulemaking, or if there are other ways, beyond financial arrangements, that CMS could incorporate PGPs to promote collaboration between TEAM participants and other providers who may care for a TEAM beneficiary over the course of an episode.**

Proposed Mandatory Participation

CMS proposes to require hospitals located in selected geographic areas that meet the proposed TEAM participant definition to participate in TEAM. **Given some TEAM participants may have limited or no value-based care experience, CMS seeks comment on whether 1 year is**

[1] CMS proposes that the term "hospital" has the same meaning as hospital as defined in section 1886(d)(1)(B) of the Social Security Act; this definition includes only acute care hospitals paid under the IPPS.

adequate time for hospitals to prepare or whether a longer timeframe (e.g., 18 months) or a shorter timeframe (e.g., 6 months) would be sufficient.

CMS also indicates that it considered making participation in TEAM voluntary but was concerned that this would not lead to meaningful evaluation findings, among other reasons. **However, CMS seeks comment regarding a potential voluntary opt-in participation arm in the proposed TEAM.** Specifically, CMS is considering limiting voluntary opt-in participation to TEAM for hospitals that currently participate in the BPCI Advanced or CJR model, that are not located in an area mandated for TEAM participation (hospitals would continue to participate in their current model until completion). CMS clarifies that a potential voluntary opt-in would be a one-time opportunity to join TEAM participation and those hospitals would need to complete and submit an application to CMS, prior to the first PY of TEAM.

Financial Accountability

Consistent with the CJR model, CMS proposes to make TEAM participants financially accountable for the episode. CMS clarifies that an episode in TEAM may be associated with multiple hospitalizations through readmissions or transfers. CMS proposes that when one hospitalization occurs during a single episode, then it will hold the TEAM participant to which the episode is initiated financially accountable for the episode (e.g., a hospital admission that is preceded by an emergency room visit and subsequent transfer to a tertiary or other hospital facility, as patient may wish to be near home for post-acute care). **CMS seeks comment on the proposal to require TEAM participants to be financially accountable for episodes in TEAM. CMS also seeks comment on approaches for splitting financial accountability when multiple providers care for a single beneficiary in an episode.**

TEAM Participation Tracks

Based on previous feedback that CMS offer a glide path to smooth the transition to risk in its models, CMS proposes three tracks in TEAM, each with differing financial risk and quality performance adjustments. **CMS seeks comments the following tracks and whether there are alternative approaches for constructing a glide path in TEAM. Also, CMS seeks comment on the requirement that TEAM participants notify CMS of their track selection and whether the agency should automatically assign TEAM participants to Track 1 if they fail to timely notify CMS of their desired track selection.**

- Track 1:
  - Available only in PY 1 for all TEAM participants
  - Only upside financial risk with quality adjustment applied to positive reconciliation amounts
    - Subject to a 10% stop-gain limit and a Composite Quality Score (CQS) adjustment percentage of up to 10%
  - Automatically assigned to Track 3 for PY 2 (remain in Track 3 for PYs 2-5)
- Track 2:
  - Available in PYs 2-5 to a limited set of TEAM participants (e.g., safety net hospital, rural hospital, Medicare Dependent Hospital, Sole Community Hospital, Essential Access Community Hospital)[2]

[2] Hospitals that are safety net hospitals. For purposes of TEAM, CMS proposes that a TEAM participant must meet at least one of the following criteria in order to be considered a safety net hospital:

- Exceeds the 75th percentile of the proportion of Medicare beneficiaries considered dually eligible for Medicare and Medicaid across all PPS acute care hospitals in the baseline period.
- Exceeds 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. (Footnote continued on the following page).

    - Two-sided financial risk with quality adjustment to reconciliation amounts
        - Subject to 10% 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
    - TEAM participants that meet Track 2 hospital criteria could switch between Track 2 and Track 3 on an annual basis (notice to CMS would be required)
        - **CMS seeks comment on whether it should prohibit TEAM participants from switching tracks after PY 2 or if there are other options CMS should consider to mitigate evaluation challenges.**
- Track 3:
    - Available in PYs 1-5 for all TEAM participants
    - Two-sided financial risk with quality adjustment to reconciliation amounts
        - Subject to 20% stop-gain and stop-loss limited and a CQS adjustment percentage of up to 10%

Proposed Approach to Select TEAM Participants

CMS proposes to select geographic areas and require all hospitals in those selected areas to participate in TEAM to help minimize the risk of TEAM participants shifting higher cost cases to hospitals not participating in TEAM. CMS proposes to group these geographic areas according to certain characteristics and then to randomly select geographic areas from within those groups (also known as strata) for model implementation. Regarding the geographic regions, CMS proposes to require that all hospitals within a Core Based Statistical Area (CBSA), that CMS selects through a stratified random sampling methodology, participate in TEAM.

CMS proposes to stratify CBSAs into groups based on average historical episode spending, the number of hospitals, the number of safety net hospitals and the CBSA's exposure to prior CMS bundled payment models. To reach more beneficiaries, including those in underserved communities, CMS proposes to oversample CBSAs that have limited previous exposure to CMS' bundled payment models and CBSAs with a higher number of safety net hospitals (Table X-A.-03 of the Proposed Rule at pg. 1135-1136 includes the selection strata and their proposed selection percentages; CMS would select approximately 25% of eligible CBSAs in the table). **CMS seeks comment on the proposed approach to selecting TEAM participants.**

Given CBSAs are updated periodically, CMS proposes to use the CBSA designations in OMB Bulletin 23-01 issued on July 21, 2023 as the CBSA designations for purposes of the model, even if such designations change during the model performance period. In the Proposed Rule, CMS provides exclusion criteria for CBSAs (e.g., Maryland hospitals, CBSAs where no episodes were initiated at hospitals for any of the five categories of episodes). Table X.A.-02 of the Proposed Rule (pg. 1119-1132) lists the CBSAs eligible for selection in TEAM.

Hospitals that are rural hospitals. For purposes of TEAM, CMS proposes that a TEAM participant must meet at least one of the following criteria in order to be considered a rural hospital:

- Is located in a rural area as defined under § 412.64.
- Is located in a rural census tract defined under § 412.103(a)(1).
- Has reclassified as a rural hospital under § 412.103.
- Is a rural referral center (RRC), which has the same meaning given this term under § 412.96.

Hospitals that are Medicare dependent hospitals (MDH) as defined under 42 CFR 412.108.
Hospitals that are sole community hospitals (SCHs) as defined under 42 CFR 412.92.
Hospitals that are essential access community hospitals as defined under 42 CFR 412.109.

Proposed Episodes

CMS proposes to test five categories of surgical episodes in the model: Coronary Artery Bypass Grafting (CABG),[3] Lower Extremity Joint Replacement (LEJR),[4] Surgical Hip and Femur Fracture Treatment (SHFFT),[5] Spinal Fusion,[6] and Major Bowel Procedure.[7] Based on the agency's analysis using 2021 data, CMS indicates that the proposed episodes were selected because they represent the highest volume and highest cost surgical episodes performed in the inpatient setting. The agency also provides estimates regarding the number of episodes TEAM would capture.[8]

CMS notes that it intends to add additional episode categories in future PYs of the model through future notice and comment rulemaking. **CMS seeks comment on the five proposed episode categories and any additional episode categories it should consider for the model.**

CMS proposes to identify episodes with Medicare Severity Diagnosis Related Groups (MS-DRGs) and Healthcare Common Procedure Coding System (HCPCS) codes for inclusion in TEAM and seeks comment on this approach. Table X.A.-04 (Proposed Rule at pg. 1147) includes the proposed episode categories and billing codes.

Also, CMS proposes to define episodes as including all Medicare Part A and Part B items and services,[9] with some exceptions, beginning with an admission to an acute care hospital stay ("the anchor hospitalization") or an outpatient procedure at a hospital outpatient department (HOPD) ("anchor procedure"), and ending 30 days following hospital discharge or anchor procedure.

CMS proposes that items and services for episodes would include the following items and services under Medicare Part A and Part B (subject to certain exclusions). **CMS seeks comment on the items and services it proposes to include in TEAM:**

- Physicians' services
- Inpatient hospital services, including services paid through IPPS operating and capital payments
- Inpatient psychiatric facility (IPF) services
- Long-Term Care Hospital (LTCH) services
- Inpatient Rehabilitation Facility (IRF) services
- Skilled Nursing Facility (SNF) services
- Home Health Agency (HHA) services

[3] The proposed CABG episode category would include beneficiaries undergoing coronary revascularization by CABG. CMS proposes to define the CABG episode category as any coronary revascularization procedure that is paid through the IPPS under MS-DRG 231–236, including both elective CABG and CABG procedures performed during initial acute myocardial infarction (AMI) treatment.
[4] CMS clarifies the proposed LEJR episode category would include hip, knee, and ankle replacements, including total ankle arthroplasty (TAA), performed in either the hospital inpatient or outpatient setting. CMS proposes to define the LEJR episode category as a hip, knee, or ankle replacement that is paid through the IPPS under MS-DRG 469, 470, 521, or 522 or through the OPPS under HCPCS code 27447, 27130, or 27702.
[5] CMS clarifies the proposed SHFFT episode category would include beneficiaries who receive a hip fixation procedure in the presence of a hip fracture. It would not include fractures treated with a joint replacement. CMS proposes to define the SHFFT episode as a hip fixation procedure, with or without fracture reduction, but excluding joint replacement, that is paid through the IPPS under MS-DRG 480–482. The SHFFT episode would include beneficiaries treated surgically for hip and femur fractures, other than hip arthroplasty. SHFFT procedures include open and closed surgical hip fixation, with or without reduction of the fracture.
[6] The proposed Spinal Fusion episode category would include beneficiaries who undergo certain spinal fusion procedures in either a hospital inpatient or outpatient setting. CMS proposes to define the spinal fusion episode category as any cervical, thoracic, or lumbar spinal fusion procedure paid through the IPPS under MS–DRG 453-455, 459-460, or 471-473, or through the OPPS under HCPCS codes 22551, 22554, 22612, 22630, or 22633.
[7] The proposed Major Bowel Procedure episode would include beneficiaries who undergo a major small or large bowel surgery. CMS proposes to define the Major Bowel Procedure episode category as any small or large bowel procedure paid through the IPPS under MS-DRG 329-331.
[8] Based on the agency's analysis of Medicare fee-for-service claims data, beginning in CY 2021, CMS estimates the number of episodes that TEAM would capture to be approximately 28,088 for CABG; 75,254 for SHFFT; 59,983 for Major Bowel Procedure; 215,957 for LEJR; and 65,968 for Spinal Fusion. The average episode cost for these historical episodes was approximately $48,905 for CABG, $35,501 for SHFFT, $29,184 for Major Bowel Procedure, $21,063 for LEJR, and $46,326 for Spinal Fusion.
[9] Items and services as described in § 512.525(e)

- Hospital outpatient services
- Outpatient therapy services
- Clinical laboratory services
- Durable medical equipment
- Part B drugs and biologicals except for those excluded under §512.525 (f) as proposed
- Hospice services
- Part B professional claims dated in the 3 days prior to an anchor hospitalization if a claim for the surgical procedure for the same episode category is not detected as part of the hospitalization because the procedure was performed by the TEAM participant on an outpatient basis but the patient was subsequently admitted as an inpatient

CMS proposes to exclude from episodes certain Part A and B items and services that are clinically unrelated to the anchor hospitalization or anchor procedure, in addition to other items and services. Additional information regarding exclusions is available in the Proposed Rule (pg. 1149-1153) and CMS indicates that completed lists of proposed excluded MS-DRGs for readmissions and proposed excluded HCPCS codes for Part B services furnished during TEAM episodes after TEAM beneficiary discharge from an anchor hospitalization will be posted on the CMS TEAM website at https://innovation.cms.gov/initiatives/TEAM. The lists would apply to all PYs of the model until and unless the lists are updated. CMS proposes that revisions to the exclusion lists would be initiated through rulemaking to allow for public input. **CMS seeks comment on the proposed excluded services, the list of excluded services, and the process for updating the lists of excluded services for TEAM.**

CMS also proposes circumstances in which an episode may be cancelled (e.g., beneficiary no longer meets criteria for inclusion, beneficiary death during the anchor hospitalization or anchor procedure, episode subject to extreme and uncontrollable circumstances).

Beneficiary Inclusion Criteria

CMS proposes to begin an episode with an anchor hospitalization or anchor procedure and that all services that are included in the IPPS (e.g., 3-day payment window payment policies) would be included in the episodes. Also, CMS proposes that Medicare beneficiaries whose care would be included in TEAM would be those beneficiaries who meet all of the following criteria at the time of admission to the anchor hospitalization or anchor procedure:

- Enrolled in Medicare Part A and Part B.
- Not eligible for Medicare on the basis of end-stage renal disease.
- Not enrolled in any managed care plan (for example, Medicare Advantage, Health Care Prepayment Plans, cost-based health maintenance organizations).
- Not covered under a United Mine Workers of America health plan, which provides health care benefits for retired mine workers.
- Have Medicare as their primary payer.

CMS proposes that if a beneficiary meets the inclusion criteria, an episode would begin when a beneficiary is admitted for an anchor hospitalization or anchor procedure for certain MS-DRGs, or by the presence of certain HCPCS codes on an outpatient claim. A complete list of proposed MS-DRGs and HCPCS codes is available in the Proposed Rule (pg. 1154-1155).

Quality Measures and Reporting

CMS proposes to use the following measures to determine hospital quality of care and eligibility for a TEAM reconciliation payment.

- For all TEAM episodes: Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and Electronic Health Record Data (CMIT ID #356);
- For all TEAM episodes: CMS Patient Safety and Adverse Events Composite (CMS PSI 90) (CMIT ID #135); and
- For LEJR episodes: Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM) (CMIT ID #1618).
- Note: Table X.A.-05 of the Proposed Rule (pg. 1178) includes a summary of proposed quality measure performance periods by year of TEAM.

CMS also identifies three measures on the 2023 Measures Under Consideration (MUC) List that have been proposed for inclusion in the Hospital Inpatient Quality Reporting (IQR) Program for FY 2025 that may be more clinically meaningful and specific to the episodes in TEAM.[10] **CMS seeks further comment on the three proposed measures and the three MUC measures. Also, CMS seeks feedback on potentially replacing the CMS PSI 90 measure beginning in 2027, TEAM's second PY.**

CMS proposes to collect quality measure data through the existing mechanisms of the Hospital IQR and Hospital-Acquired Conditions (HAC) Reduction Program. Also, CMS proposes to display quality measure results on the publicly available CMS website, but CMS would share each TEAM participant's quality metrics with the hospital prior to being publicly displayed.

Pricing and Payment Methodology

CMS details the TEAM pricing and payment methodology in the Proposed Rule and specifically addresses the following topics (Proposed Rule at pg. 1179-1234) with several additional questions posed for stakeholder feedback, some of which are noted below.

Topic	Additional Information
Prices (Proposed Rule at pg. 1184-1202)	CMS seeks comment on the proposal to use 3 years of baseline episode spending, rolled forward each PY, with more recent baseline years weighted more heavily, to calculate TEAM target prices. CMS also seeks comment on calculating target prices at the region/episode category level, among other topics related to target prices (e.g., services that extend beyond an episode, episodes that span PYs; high-cost outlier cap; trending prices; discount factor, low volume hospitals, preliminary target prices).
Risk Adjustment and Normalization (Proposed Rule at pg. 1202-1210)	CMS seeks comment on proposals for risk adjusting episodes.
Proposed Process for Reconciliation (Proposed Rule at pg. 1210-1218)	CMS seeks comment on the proposed process for reconciliation
Calculating the Reconciliation Payment Amount or Repayment Amount (Proposed Rule at pg. 1218-1220)	CMS seeks comment on these proposals.
Incorporating the Composite Quality Score (CQS) into the Reconciliation Amount (Proposed Rule at pg. 1220-1223)	Table X.A.-08 (Proposed Rule at pg. 1221) includes the TEAM proposed CQS adjustment percentage formulas. CMS seeks feedback on the proposed methodology to calculate and apply the TEAM CQS and the proposed definition of quality-adjusted reconciliation amount.

[10] The three measures are: Hospital Harm – Falls with Injury (MUC2023-048); Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue) (MUC2023-049); and Hospital Harm - Postoperative Respiratory Failure (MUC2023-050)

Limitations on Net Payment Reconciliation Amount[11] (Proposed Rule at pg. 1223-1225)	CMS seeks comment on the proposal for differential stop-gain and stop-loss limits for TEAM participants by Track and PY.
Participant Responsibility for Increase Post-Episode Payments (Proposed Rule at pg. 1225-1226)	CMS seeks comment on the proposal to make TEAM participants responsible for making repayments to Medicare based on high spending in the 30 days after the end of the episode. Also, CMS seeks feedback on the proposed methodology to calculate the threshold for high post-episode spend.
Reconciliation Payments and Repayment (Proposed Rule at pg. 1226-1230)	CMS seeks comment on the proposal to make reconciliation payments to, and collecting repayment amounts from, TEAM participant as a one-time, lump sum payment or whether to implement a value-based purchasing approach where CMS makes payment adjustments to future fee-for-service (FFS) claims in lieu of lump sum payments.
Proposed Appeals Process (Proposed Rule at pg. 1230-1235)	CMS seeks comments on the first level appeals process, reconsideration review process and CMS administrator review process.

Referral to Primary Care Services

CMS proposes that TEAM participants include in patient discharge planning (prior to discharge from an anchor hospital or anchor procedure) a referral to a supplier of primary care services for a TEAM beneficiary. CMS also proposes that the TEAM participant must not limit a TEAM beneficiary's ability to choose among Medicare providers or suppliers. If a TEAM participant fails to comply with requiring a referral to a supplier of primary care services during hospital discharge planning, then CMS proposes that the TEAM participant would be subject to remedial action. **CMS seeks comments on these requirements.**

Model Overlap

CMS acknowledges the potential overlap of Medicare beneficiaries participating in different Medicare models and initiatives (e.g., accountable care organizations, TCOC models, other Innovation Center models, the Shared Savings Program). CMS indicates that beneficiaries may be involved in multiple models simultaneously and provides proposals to manage this overlap. For example, CMS proposes to allow any savings generated on an episode in TEAM and any contribution to savings in the total cost of care model be retained by each respective participant.

However, CMS acknowledges that certain Accountable Care Organizations (ACOs) may prefer for their aligned beneficiary population to not be included in TEAM and that other circumstances may warrant additional consideration. **As such, CMS seeks comment on prohibiting aligned beneficiaries from full-risk population-based care relationships (for example, Shared Savings Program Enhanced Track) from being in an episode in TEAM. Also, CMS seeks comment specifically on non-condition specific care relationships (that is, this would exclude condition-specific models such as the Enhancing Oncology Model (EOM)). In addition, CMS seeks comment on the use of supplemental data (for example, shadow bundles data[12]) as providing a total cost of care or shared savings model participant with the ability to utilize episodes to improve care coordination and reduce cost.**

[11] CMS proposes to define NPRA as the dollar amount representing the different between the target price and performance year spending, after adjustments for quality and stop-gain/stop-loss limits, but prior to the post-episode spending adjustment.
[12] Shadow bundles are claims data for services, supplies, and their associated payments grouped into discrete procedural- and/or condition-specific episodes of care. Episodes are constructed based on a consistent set of rules for ACO-attributed beneficiaries who meet the criteria to trigger an episode. Target prices are incorporated to measure performance and provide opportunity for sharing savings with providers.

In the Proposed Rule, CMS also requests comment on ways to implement a notification process for shared savings or TCOC participants so that they are aware one of their aligned beneficiaries has initiated an episode in TEAM.

CMS also indicates that as new models are announced, the agency plans to assess each new model to determine if the structure of payment and savings calculation are subject to the current proposed overlap policy or if there would be a need to bring forward additional overlap requirements.

Health Equity

In the Proposed Rule, CMS aims to use the TEAM to improve disparities in surgical outcomes by transforming infrastructure and care delivery processes, particularly for hospitals that serve higher proportions of historically underserved populations.

To identify safety net providers in TEAM, CMS discusses multiple methodological options (e.g., CMS Innovation Center Strategy Refresh Definition; Medicare Safety Net Index; Area Deprivation Index). Based on the agency's review, it proposes to use the CMS Innovation Center's Strategy Refresh's definition for identifying safety net hospitals within TEAM.[13] **CMS seeks comment on the proposal to identify safety net hospitals using the CMS Innovation Center's Strategy Refresh's definition in TEAM.**

To identify rural hospitals, CMS proposes that a rural hospital means an IPPS hospital that is located in a rural area[14]; is located in a rural census tract[15]; has reclassified as a rural hospital[16]; or is designated a rural referral center (RRC).[17] **CMS seeks comment on the proposal to identify rural hospitals. Also, CMS indicates it is not proposing to include a measure of hospital rurality within the risk adjustment model but seeks comment on whether inclusion of this risk adjustor would be warranted.**

Social Risk Adjustment

Regarding beneficiary social risk adjustment, CMS proposes to incorporate and equally weight three social risk indicators in TEAM's target price methodology (i.e., state and national ADI indicators, the Medicare Part D LIS indicator, and dual-eligibility status for Medicare and Medicaid). CMS believes that including these social risk indicators would ensure TEAM participants that serve disproportionately high numbers of underserved beneficiaries are not inadvertently penalized when setting TEAM target prices. **CMS seeks comment on the proposed beneficiary social risk adjusters for TEAM and whether there are potential beneficiary social risk indicators CMS should consider in TEAM's target price methodology.**

Health Equity Plan

CMS also proposes that TEAM participants can voluntarily submit to CMS, in a form and manner and by the date(s) specified by CMS, a health equity plan for the first PY. Beginning in PY 2, CMS proposes that TEAM participants would be required to submit a health equity plan in a form and manner and by the date(s) specified by CMS. CMS also proposes the following elements to be included in health equity plans (more information available in the Proposed Rule (pg. 1257): identifies health disparities; identifies health equity goals and describes how the TEAM participant

[13] The CMS Innovation Center's Strategy Refresh defined safety net hospitals as short-term hospitals and critical access hospitals (CAHs) that serve above a baseline threshold of beneficiaries with dual eligibility or Part D Low-Income Subsidy (LIS), as a proxy for low income status. Under the CMS Innovation Center's Strategy Refresh definition, hospitals are identified as safety net when their patient mix of beneficiaries with dual eligibility or Part D LIS exceeds the 75th percentile threshold for all congruent facilities who bill Medicare.
[14] As defined under § 412.64 of this chapter
[15] Defined under § 412.103(a)(1) of this chapter.
[16] 42 CFR 412.103
[17] 42 CFR 412.96

will use the health equity goals to monitor and evaluate progress in reducing identified health disparities; describes the health equity plan intervention strategy; identifies health equity plan performance measure(s), the data sources used to construct the health equity plan performance measures, and an approach to monitor and evaluate the health equity plan performance measures. **CMS seeks comment on the proposed health equity plan submission proposal and the proposed elements of the health equity plan.**

Demographic Data Reporting

Regarding demographic data reporting, CMS proposes that TEAM participants could voluntarily report to CMS demographic data of TEAM beneficiaries in PY 1. Beginning in PY 2 and all subsequent PYs, CMS proposes that TEAM participants would be required to report demographic data of TEAM beneficiaries to CMS in a form and manner and by a date specified by CMS. The demographic data would also be required to conform to USCDI version 2 data standards, at a minimum. **CMS seeks comments on the demographic data reporting requirement and seeks comments on how reporting of this demographic data could be minimized if it could be collected from multiple data sources.**

Screening

Beginning in PY 1, CMS proposes that TEAM participants would be required to screen attributed TEAM beneficiaries for at least four Health-Related Social Needs (HRSN) domains (e.g., food insecurity, housing instability, transportation needs, and utilities difficulty). Also, TEAM participants would need to report aggregated HRSN screening data and screened-positive data for each HRSN domain for TEAM beneficiaries who received screening to CMS in a form and manner and by date(s) specified by CMS. As part of this reporting to CMS, TEAM participants would report on policies and procedures for referring beneficiaries to community-based organizations, social service agencies, or similar organizations that may support patients in accessing services to address unmet social needs. **CMS seeks comment on reporting processes that would streamline reporting of aggregated HRSN screening data for attributed TEAM beneficiaries, including potential use of the Hospital IQR Program measures related to HRSN screening.**

Upfront Infrastructure Payments

Lastly, CMS seeks comment on possibly providing upfront infrastructure payments to qualified safety net hospital participants to further support safety net hospitals in the transformation of care delivery. The TEAM participant would also submit a detailed plan that describes their intended use of the funds and how those funds would support the goals of the model and improve the care of underserved beneficiaries. **CMS also seeks comment on the proposed methodology and/or parameters that could be used in a formula to determine the infrastructure payment amounts for qualifying TEAM participants.**

Financial Arrangements

In the Proposed Rule, CMS proposes several flexibilities to help TEAM participants, including the ability to engage in financial arrangements to share a TEAM participant's reconciliation payment amounts and repayment amounts. In addition, CMS also provides information for TEAM participants to offer beneficiary incentives to encourage adherence to recommended treatment and beneficiary engagement in recovery. CMS proposes to use the term "TEAM collaborator" to refer to individuals and entities who have a role in the TEAM participant's performance in the model. CMS proposes a list of providers and suppliers that are Medicare-enrolled and eligible to participate in Medicare or entities that are participating in a Medicare ACO initiative that may be TEAM collaborators (Proposed Rule at pg. 1270-1271). **CMS seeks comment on the proposed definition of TEAM collaborators and any additional Medicare-enrolled providers or suppliers, such as Rural Emergency hospitals, Rural Health Clinics, and Federally Qualified Health Centers, that should be included in this definition.**

Sharing Arrangements

Similar to the CJR Model, CMS proposes that certain financial arrangements between a TEAM participant and a TEAM collaborator be termed “sharing arrangements.” For purposes of the Federal anti-kickback statute safe harbor for CMS-sponsored model arrangements, CMS proposes that a sharing arrangement would be to share reconciliation payment amounts or repayment amounts. Where a payment from a TEAM participant to a TEAM collaborator is made pursuant to a sharing arrangement, CMS proposes to define that payment as a “gainsharing payment.” Where a payment from a TEAM collaborator to a TEAM participant is made pursuant to a sharing arrangement, CMS proposes to define that payment as an “alignment payment.” CMS provides that a TEAM participant must not make a gainsharing payment or receive an alignment payment except in accordance with a sharing arrangement. In the Proposed Rule, CMS provides additional requirements regarding the sharing agreement (e.g., compliance with other laws and regulations, agreement documents in writing, agreement made available to CMS upon request, TEAM participant oversight of sharing agreements, agreement must not pose a risk to beneficiary access).

In the Proposed Rule, CMS proposes specific requirements for the written agreement (pg. 1274) and documentation requirements (pg. 1282-1283).

Also, CMS proposes several conditions and limitations for gainsharing payments and alignment payments as program integrity protections for the payments to and from TEAM collaborators. More information on these conditions and limitations is available in the Proposed Rule (pg. 1276-1281).

In the Proposed Rule, CMS also addresses other financial arrangements between TEAM collaborators and other individuals or entities called “collaboration agents” which are to be termed “distribution arrangements.” Additional information regarding distribution arrangements is available in the Proposed Rule (pg. 1283-1288).

In addition, CMS addresses certain financial arrangements between a collaboration agent that is both a physician group practice (PGP), non-physician provider group practice (NPPGP), or therapy group practice (TGP) and an ACO participant and other individuals termed ‘‘downstream collaboration agents’’ which are to be termed a ‘‘downstream distribution arrangement.’’ More information regarding downstream collaboration agents is available in the Proposed Rule (pg. 1288-1291).

Beneficiary Incentives

In the Proposed Rule, CMS indicates that TEAM participants may provide in-kind patient engagement incentives to beneficiaries in an episode, subject to certain conditions. CMS provides that these incentives should directly relate to the beneficiary's medical care and advance clinical goals (e.g., medication adherence or reducing readmissions). CMS proposes requirements for the provision of technology items, including a maximum value of $1,000 per episode and enhanced safeguards for items exceeding $75 in value. CMS also proposes documentation requirements when incentives are provided (e.g., date the incentive was provided, the item or service, and the beneficiary's identity). **CMS seeks feedback on these requirements and whether further safeguards are needed for program integrity.**

Enforcement Authority

In the Proposed Rule, CMS clarifies that Office of the Inspector General (OIG) authority is not limited or restricted by the provisions of the model, including the authority to audit, evaluate, investigate, or inspect the TEAM participant, TEAM collaborators, collaboration agents, downstream collaboration agents, or any other person or entity or their records, data, or information, without limitations.

Additional information regarding Fraud and Abuse waiver and OIG Safe Harbor Authority is in the Proposed Rule (pg. 1298-1299).

Proposed Waivers of Medicare Program Requirements

CMS proposes waivers of certain program rules for providers and suppliers furnishing services to TEAM beneficiaries to offer more flexibility than under existing Medicare rules. **CMS seeks comments on possible waivers (beyond those specifically discussed in the Proposed Rule) that might be necessary to test in this model.**

In the Proposed Rule, CMS further addresses post-discharge home visits and the homebound requirement for access to home health services[18] in the context of a waiver, however CMS does not propose to waive the homebound requirement under TEAM. **CMS seeks comment on this proposal, including whether the agency should waive the ''incident to'' rule, similar to the BPCI Advanced and CJR models.**

In addition, like the telehealth waivers in the BPCI Advanced and CJR models, CMS proposes to waive the geographic site requirements that limit telehealth payment to services furnished within specific types of geographic areas or in an entity participating in a federal telemedicine demonstration project approved as of December 31, 2000. CMS clarifies that any service on the list of Medicare approved telehealth services and reported on a claim that is not excluded from the proposed episode definition (see section X.A.3.b. of the preamble of the Proposed Rule) could be furnished to a TEAM beneficiary, regardless of the beneficiary's geographic location. Also, for TEAM, CMS proposes to create a specific set of nine HCPCS G-codes to describe the evaluation and management (E/M) services furnished to TEAM beneficiaries in their homes via telehealth. If the proposed TEAM is finalized, we would specify the precise G-code created for TEAM and share them to TEAM participants prior to the first PY (Table X.A.-10, Proposed Rule at pg. 1310-1311 provides the proposed TEAM telehealth waiver G-code crosswalk). CMS proposes to develop payment rates for these new telehealth G-codes for E/M services in the patient's home that are similar to the payment rates for the office/outpatient E/M services, since the codes will describe the work involved in furnishing similar services. Additional information regarding telehealth waivers is included in the Proposed Rule (pg. 1305-1314).

Also, CMS addresses the 3-day SNF rule in the context of a waiver (Proposed Rule at pg. 1314-1323). **CMS seeks comment on whether it is reasonable to: (1) cover services furnished under the SNF waiver based on TEAM participant knowledge of beneficiary eligibility for the TEAM as determined by Medicare coverage status at the time the services under the waiver were furnished; and (2) to hold the TEAM participant financially responsible for rejected SNF claims if a TEAM beneficiary is discharged to a SNF without a qualifying 3-day inpatient stay, but the SNF is not on the qualified list as of the date of admission to the SNF, and the TEAM participant has failed to provide a discharge planning notice. Finally, CMS seeks comment on any other related issues that it should consider in connection with these proposals to protect beneficiaries from significant financial liability for non-covered SNF services related to the waiver of the SNF 3-day rule under the proposed TEAM.**

[18] Traditional Medicare currently provides reimbursement for home health care services if a beneficiary meets the following criteria: 1. The beneficiary either (a) must need the assistance of a supportive device, special transportation, or another person to leave their residence OR (b) have a condition that makes leaving his or her home medically contraindicated; and 2. There must be a normal inability to leave the home AND leaving home must require a considerable and taxing effort. More information available at Social Security Act Secs. 1814(a)(2)(c) and 1835(a)(2)(a).

Monitoring and Beneficiary Protections

In the Proposed Rule, CMS notes concern that the model could result in efforts to steer beneficiaries into lower cost services. As a result, CMS believes some additional safeguards may be necessary under the TEAM for program integrity purposes. CMS proposes that TEAM participants must require all ACOs, providers, and suppliers who execute a Sharing Arrangement with a TEAM participant to share beneficiary notification materials (to be developed or approved by CMS) that detail this proposed payment model with the beneficiary prior to discharge from the anchor hospitalization, or prior to discharge from the anchor procedure for a Medicare FFS patient who would be included under the model. CMS indicates that TEAM participants must require this notification as a condition of any Sharing Arrangement. **CMS invites comment on ways in which the timing and source of beneficiary notification could best serve the needs of beneficiaries without creating unnecessary administrative work for providers and suppliers.**

Also, CMS indicates it will monitor for access to care, quality of care, and delayed care of beneficiaries.

Access to Records and Record Retention

CMS proposes that the TEAM participant and its TEAM Collaborators must maintain and give the Federal Government, including, but not limited to, CMS, HHS, and the Comptroller General, or their designees, access to all documents (including books, contracts, and records) and other evidence sufficient to enable the audit, evaluation, inspection, or investigation of the CMS Innovation Center model. CMS proposes that TEAM participants must maintain the documents and other evidence for a period of 6 years from the last payment determination for the TEAM participant under the CMS Innovation Center model or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless certain circumstances occur (e.g., allegation of fraud, CMS determines a special need to retain a group of records). **CMS seeks comment on whether it should instead require hospital participants and TEAM Collaborators to maintain records for fewer than 10 years, which would be more consistent with historical Innovation Center requirements.**

Data Sharing

CMS proposes to make certain beneficiary-identifiable claims data and regional aggregate data available to participants in TEAM regarding Medicare FFS beneficiaries who may initiate an episode and be attributed to them in the model. CMS notes that since TEAM participants are hospitals who are covered entities and are the only entity able to request the beneficiary identifiable data and with whom CMS would share the beneficiary-identifiable data, it believes that the proposed disclosure of the beneficiary claims data for an anchor hospitalization or an anchor procedure plus 30-day post-discharge for episodes included under the TEAM model would be permitted by the HIPAA Privacy Rule under the provisions that permit disclosures of PHI for ‘‘health care operations’’ purposes.

CMS also clarifies that it proposes to disclose beneficiary-identifiable data to only the hospitals that are bearing risk for episodes and not with their collaborators. In addition, CMS proposes that TEAM participants must limit their beneficiary-identifiable data requests, for TEAM beneficiaries who are in an episode during the baseline period or PY, to the minimum necessary to accomplish a permitted use of the data.

CMS proposes that if a TEAM participant wishes to receive beneficiary-identifiable claims data, they must submit a formal request for data on an annual basis in a manner, form, and by a date specified by CMS indicating if they want summary beneficiary-identifiable data, raw beneficiary-identifiable

data, or both, and sign a TEAM data sharing agreement.[19] CMS also includes specific attestations in the Proposed Rule (pg. 1341).

In addition, CMS proposes to provide TEAM participants with regional aggregate data on the total expenditures during an anchor hospitalization or anchor procedure and the 30-day post-discharge period for all Medicare FFS beneficiaries who would have initiated an episode under the baseline period and PYs.

CMS proposes to make 3 years of baseline period data available to TEAM participants who enter into a TEAM data sharing agreement with CMS for beneficiaries who would have been included in an episode had the model been implemented during the baseline period. CMS intends to make these data available upon request prior to the start of each PY and in accordance with applicable privacy and security laws and established privacy and security protections.

CMS proposes to make beneficiary-identifiable data and regional data available on a monthly basis and for up to 6 months after a PY.

Alternative Payment Model Considerations

CMS aims to align the design of TEAM with the Advanced Alternative Payment Model (APM) criteria in the Quality Payment Program (QPP) and enable CMS to have the necessary information on eligible clinicians to make the requisite Qualifying APM Participant (QP) determinations. CMS proposes that the TEAM Participant would be considered the APM entity, but that the TEAM participant's eligible clinicians may be assessed for QP determinations depending on which track the TEAM participant is in and whether the CEHRT criteria are met. CMS also proposes to adopt two different APM options for TEAM – an Advanced APM (AAPM) (TEAM participants attest to meeting the CEHRT standards and in which the TEAM participant's eligible clinicians may be assessed for QP determinations) and a non-AAPM option (TEAM participants would not meet CEHRT or financial risk standards and the TEAM participant's MIPS eligible clinicians may be assessed for reporting and scoring through the APM Performance Pathway (APP)).

CMS also proposes that each TEAM participant would be required to submit information about the eligible clinicians or merit-based incentive payment (MIPS) eligible clinicians who enter into financial arrangements with the TEAM participant for purposes of supporting the TEAM participant's cost or quality goals. CMS further details proposals regarding the financial arrangements list and clinical engagement list in the Proposed Rule, including submission requirements (Proposed Rule at pg. 1357-1361).

Termination of the TEAM

In the event CMS terminates the TEAM, the agency would provide written notice to TEAM participants specifying the grounds for termination and the effective date of such termination.

Key Evaluation Research Questions

CMS provides a list of key evaluation questions for the TEAM (Proposed Rule at pg. 1368-1370). CMS plans to evaluate the TEAM on an annual basis.

[19] More information regarding the TEAM Data Sharing Agreement is available in the Proposed Rule (pg. 1348-1353).

Decarbonization and Resilience Initiative

In the Proposed Rule, CMS proposes a voluntary Decarbonization and Resilience Initiative within TEAM. The voluntary initiative would have two elements: technical assistance for all interested TEAM participants and a proposed voluntary reporting option (annual) to capture information related to Scope 1 (e.g., direct emissions related to healthcare operations) and Scope 2 (e.g., indirect emissions from purchased energy) emissions as defined by the Greenhouse Gas Protocol (GHGP) framework,[20] with the potential to add Scope 3 (e.g., other GHG emissions) in future years.

CMS proposes that TEAM participants could voluntarily report on organizational questions and Scopes 1 and 2 metrics, as participants in TEAM would have direct oversight of these items. **CMS seeks feedback regarding how the agency may be able to standardize and collect this information in the future.**

Also, CMS notes that TEAM participants could elect to report metrics including emissions data and assessment questions on four potential categories: organizational questions, building energy metrics, anesthetic gas metrics, and transportation metrics, to CMS. CMS proposes that the building metrics would be reported to CMS using the ENERGY STAR® PortfolioManager® and all other metrics would be reported to CMS in a manner and form specified by CMS. TEAM participants that elect to report all the metrics after a PY would receive individualized feedback reports and public recognition from CMS.

CMS also proposes a set of organizational questions (Proposed Rule at pg. 1386-1387) regarding the TEAM participant's sustainability team and sustainability activities.

CMS seeks additional information regarding potential future voluntary reporting of Scope 3 emissions. For example, CMS is interested in learning what metrics or data collection elements would be appropriate for TEAM participants to accurately report Scope 3 emissions, and how CMS and hospitals can engage other parts of supply chain that contribute to Scope 3 emissions or incentivize their reduction of Scope 3 GHGs?

CMS also proposes to establish a publicly reported hospital recognition badge for the TEAM participant's commitment to decarbonization; CMS would post a hospital recognition badge on a CMS website and the recognition badge would be reevaluated each year. **CMS seeks comment on potentially expanding to tiered recognition approach in future years. CMS also requests information on ways the agency could structure potential payments, bonuses, or payment adjustments for participation in the Decarbonization and Resilience Initiative. CMS provides examples of potential incentives in the Proposed Rule (pg. 1399).**

What's Next?

Vizient's Office of Public Policy and Government Relations will be commenting to CMS regarding the Proposed Rule. If you have any questions or would like to share feedback, please reach out to Jenna Stern, Associate Vice President, Regulatory Affairs and Public Policy in Vizient's Washington, D.C. office.

[20] Janet Ranganathan, Laurent Corbier, Pankaj Bhatia, Simon Schultz, Peter Gage, & Kjeli Oren. The Greenhouse Gas Protocol: A Corporate Accounting and Reporting Standard (Revised Edition). World Business Council for Sustainable Development and World Resources Institute. 2004. https://ghgprotocol.org/sites/default/files/standards/ghg-protocol-revised.pdf