Medicare Inpatient Rule: Mandatory Bundled Payment Model

May 1, 2024

California Hospital Association

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Questions

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Moderator

Chad Mulvany
Vice President, Federal Policy

Chad Mulvany is vice president of federal policy for the California Hospital Association (CHA) and is responsible for providing leadership on federal hospital reimbursement issues and contributes on other federal regulatory matters. Based in CHA's Washington, DC Office, Chad collaborates with CHA's federal and state advocacy colleagues and national hospital associations on analysis and policy development for advocacy purposes.

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Meet the Presenters

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FORVIS Knows Healthcare

1,030+	5,200+	175+
team members	Healthcare clients	PPMDDs

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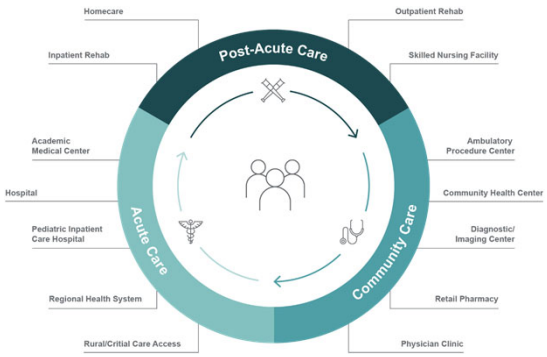
Serving the Entire Continuum of Care



92	9th	1st	2nd
Healthcare Net Promoter Score	Largest Healthcare Consulting Firm	Largest Healthcare Auditor	Largest Healthcare Tax Preparer

Modern Healthcare

Sources: UCX survey NPS score, Modern Healthcare's Largest Management Consulting Firms 2023 ranking, OMB data via the Federal Audit Clearinghouse based on HHS CFDAs for number of Single Audits performed, and Cause IQ based on Form 990s for non-profit healthcare providers

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Agenda

- Why Episodes of Care?
- TEAM Model Specifics
- How to Prepare

The CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care

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Why Episodes of Care?

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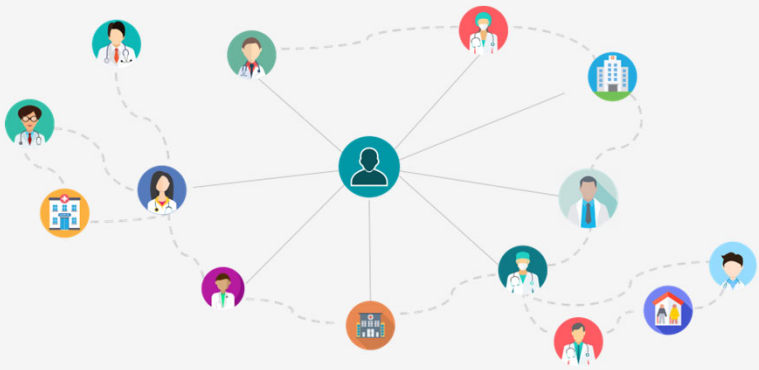
CMMI's Specialty Strategy

CMMI has developed a **comprehensive specialty strategy** to test models that support **person-centered care** across the patient journey. The new strategy focuses on four key elements.

- Enhance Specialty Care Performance Data Transparency
- Maintain Momentum on Episode Payment Models
- Create Financial Incentives within Primary Care for Specialist Engagement
- Create Financial Incentives for Specialists to Move to Value-Based Care

"Medicare beneficiaries often experience fragmented and costly care, distinguished by frequent diagnostics, imaging, tests and other treatment approaches delivered by specialists across sites of care"



The CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care

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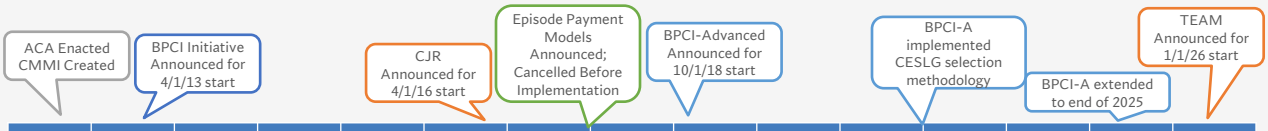
History of Select CMMI Episode of Care Models



ACE

- Medicare saved $585 per episode, however, Increases in PAC spending reduced savings by 45%

BPCI Initiative

- FFS payments were significantly reduced, but CMS experienced net losses after accounting for reconciliation payments to participants

CJR

- First four performance years generated savings to CMS, but COVID pandemic required adjustments to the model that resulted in net losses , results of extension are TBD

BPCI Advanced

- To date, episode payments have been reduced; As of Model Year 3 (2020), CMS experienced net losses after accounting for reconciliation payments to participants

- ACA – Affordable Care Act
- CMMI – Centers for Medicare and Medicaid Innovation
- ACE –Acute Care Episode
- BPCI – Bundled Payments for Care Improvement
- CJR – Comprehensive Joint Replacement
- EPM – Episode Payment Model (Cardiac & Orthopedics)
- TEAM – Transforming Episode Accountability Model

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CMMI Episode of Care Models Overview

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Voluntary Models

Bundled Payments for Care Improvement
- 5-year model focused on 90-day medical & surgical care episodes

Oncology Care Model
- 5-year multi-payer model focused on improving oncology care through 6-month chemotherapy episodes

Bundled Payments for Care Improvement Advanced (Medical & Surgical Care)
- 5-year model focused on 90-day medical & surgical care episodes
- CMS extended model for two more years

Enhancing Oncology Model
- 5-year model focused on 6-month performance periods for cancer care

Mandatory Models

Comprehensive Care for Joint Replacement Model
- 5-year model focused on 90-day episodes of care for patients undergoing a lower extremity joint replacement procedure
- Required for inpatient hospitals located in selected metropolitan statistical areas (MSAs)
- CMS extended the model for three more years

Episode Payment Models
- Focused on 90-day episodes of care for cardiac and orthopedic diagnosis groups
- Canceled by CMMI prior to implementation

Transforming Episode Accountability Model
- 5-year model focused on 30-day episodes of care for patients undergoing certain surgical procedures
- Required for inpatient hospitals located in selected core-based statistical areas

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In which types of CMMI episodic payment models, if any, has your organization participated in previously?

- Voluntary Models
- Mandatory Models
- Both Voluntary and Mandatory Models
- Neither of these

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Why Focus on Episodes of Care?

Episodic care models complement care transformation in other initiatives. Strategic implementation of episode-based models can help fill the geographic and demographic gaps where accountable entities have yet to extend their reach and can keep moving the health system toward accountability for quality and spending outcomes.

	Acute or Specialty Care & Target Population	Primary Care & Population Management
Model Example	CJR, BPCI-A	MSSP
Participants	Hospitals, post-acute care, specialty care, home health	Accountable care organizations (ACO), primary care practices, health plan networks
Interventions	Reduction in or prevention of avoidable institutional care, management of diseases	Prevention, management of diseases, care coordination
Beneficiaries	Moderate to high cost acute-care episodes, chronically ill, and other targeted populations	Mostly healthy, lower cost patients (a few exceptions of models targeting sicker patients)

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Source: The CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care

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TEAM Model Specifics

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What is TEAM?

Transforming Episode Accountability Model was announced in the FFY 2025 IPPS Proposed Rule published on April 10, 2024.

- Mandatory for selected acute care hospitals
- Goal is to improve quality of care for Medicare beneficiaries undergoing certain high-cost surgeries while reducing costs
- Purpose is to address fragmented care that leads to complications in recovery, avoidable hospitalization and increased spending
- Emphasis on improving health equity and access to high-quality care for people in underserved areas

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Transforming Episode Accountability (TEAM) Model

Traditional Medicare FFS Duration: 1/1/2026 – 12/31/2030	Hospitals required to participate will be selected based on geographic regions	Inpatient stay + 30-day total cost of care episodes, incl. Parts A & B; revenue cycle undisrupted	Graduated risk through three participation tracks, with 0% downside risk moving up to 20% in subsequent years*
5 surgical episode groups (inpatient & outpatient settings)	Target prices will be set at the regional level for each DRG/HCPCS with additional patient-level adjustments	Patients attributed to a Medicare ACO are not excluded	Quality measures will be linked to financial gains and losses
One financial reconciliation per model year	Participants required to include referral to primary care in discharge planning	Financial arrangements with providers/ACOs is allowed	Health Equity Plans and Reporting (HRSN) Required

*Some participants will qualify for a 10% downside risk cap

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Participant Selection Criteria

- CMS plans to select approximately a quarter of eligible Core-Based Statistical Areas (CBSAs) for participation in TEAM. A hospital's probability of being required to participate in TEAM depends on the stratum their CBSA is in and ranges from 20% to 50%.
- CMS will select 25% of 803 eligible CBSAs for participation in TEAM.

Selection Strata	Number of safety net hospitals in the CBSA	CBSA's past exposure to CMS' bundled payment models	Average spend for a broad range of episode categories in the CBSA	Number of hospitals within the CBSA	Selection Percentage for CBSAs in strata
1	Low	Low	Low	Low	25%
2	Low	Low	Low	High	25%
3	Low	Low	High	Low	25%
4	Low	Low	High	High	25%
5	Low	High	Low	Low	20%
6	Low	High	Low	High	20%
7	Low	High	High	Low	20%
8	Low	High	High	High	20%
9	High	Low	Low	Low	33%
10	High	Low	Low	High	33%
11	High	Low	High	Low	33%
12	High	Low	High	High	33%
13	High	High	Low	Low	25%
14	High	High	Low	High	25%
15	High	High	High	Low	25%
16	High	High	High	High	25%
17	Very High	High	High	High	50%

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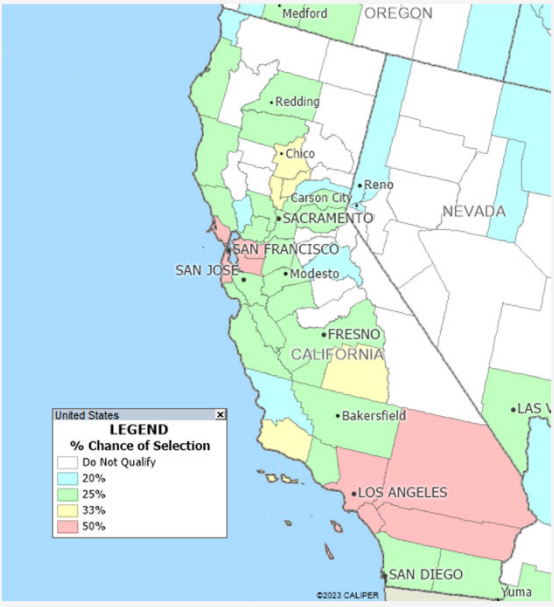
California CBSAs and Probability of Selection

Three CBSAs in California have a 50% chance of selection

CBSA	TEAM Sample Stratum Number	% Chance of Selection
Los Angeles-Long Beach-Anaheim, CA	17	50%
Riverside-San Bernardino-Ontario, CA	17	50%
San Francisco-Oakland-Fremont, CA	17	50%
Chico, CA	12	33%
Santa Maria-Santa Barbara, CA	12	33%
Visalia, CA	12	33%
Yuba City, CA	12	33%
Bakersfield-Delano, CA	16	25%
El Centro, CA	15	25%
Eureka-Arcata, CA	3	25%
Fresno, CA	16	25%
Hanford-Corcoran, CA	13	25%
Merced, CA	15	25%
Modesto, CA	16	25%
Oxnard-Thousand Oaks-Ventura, CA	16	25%
Red Bluff, CA	13	25%
Redding, CA	16	25%
Sacramento-Roseville-Folsom, CA	16	25%
Salinas, CA	16	25%
San Diego-Chula Vista-Carlsbad, CA	16	25%
San Jose-Sunnyvale-Santa Clara, CA	16	25%
Santa Cruz-Watsonville, CA	16	25%
Santa Rosa-Petaluma, CA	16	25%
Stockton-Lodi, CA	16	25%
Ukiah, CA	1	25%
Vallejo, CA	15	25%
Crescent City, CA	5	20%
Napa, CA	8	20%
San Luis Obispo-Paso Robles, CA	8	20%
Sonora, CA	6	20%
Truckee-Grass Valley, CA	5	20%



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Based on the previous slide, what is your organization's chance of being selected for TEAM participation?

- 50%
- 33%
- 25%
- 20%

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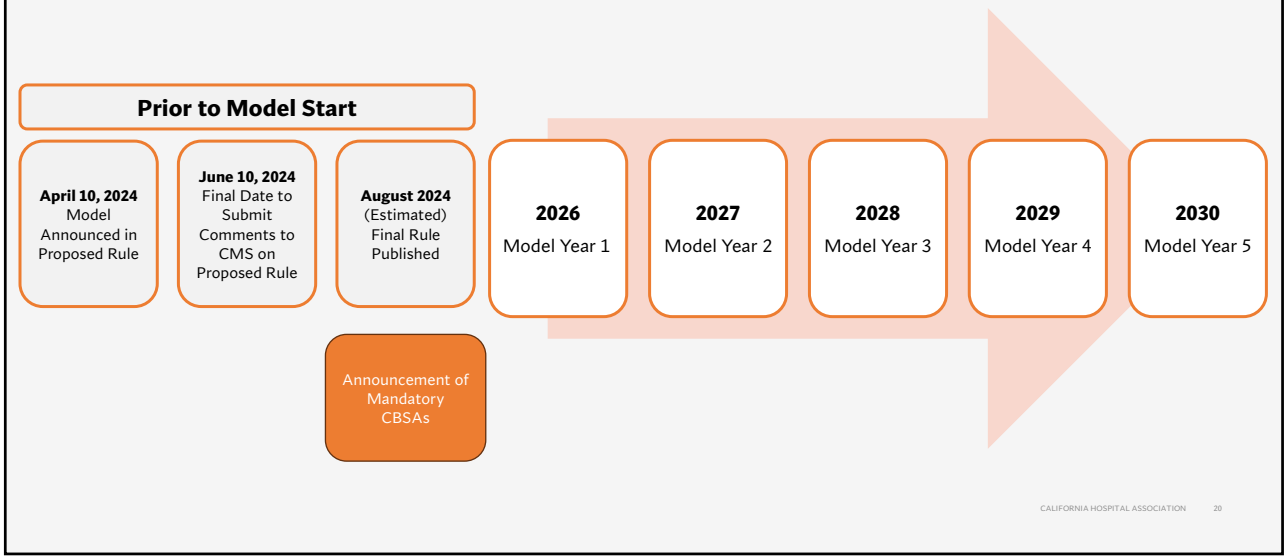
CMS Proposed Timeline



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Episode Groups and Definitions

Episode Category	Billing Codes
Lower Extremity Joint Replacement (Inpatient and Outpatient)	MS-DRG 469,470,521,522 HCPCS 27447, 27130, 27702
Surgical Hip & Femur Fracture Treatment (Inpatient)	MS-DRG 480, 481 482
Coronary Artery Bypass Graft ("CABG") Surgery (Inpatient)	MS-DRG 231, 232, 233, 234, 235, 236
Spinal Fusion (Inpatient and Outpatient)	MS-DRG 453, 454, 455, 459, 460, 471, 472, 473 HCPCS 22551, 22554, 22612, 22630, 22633
Major Bowel Procedure (Inpatient)	MS-DRG 329, 330, 331

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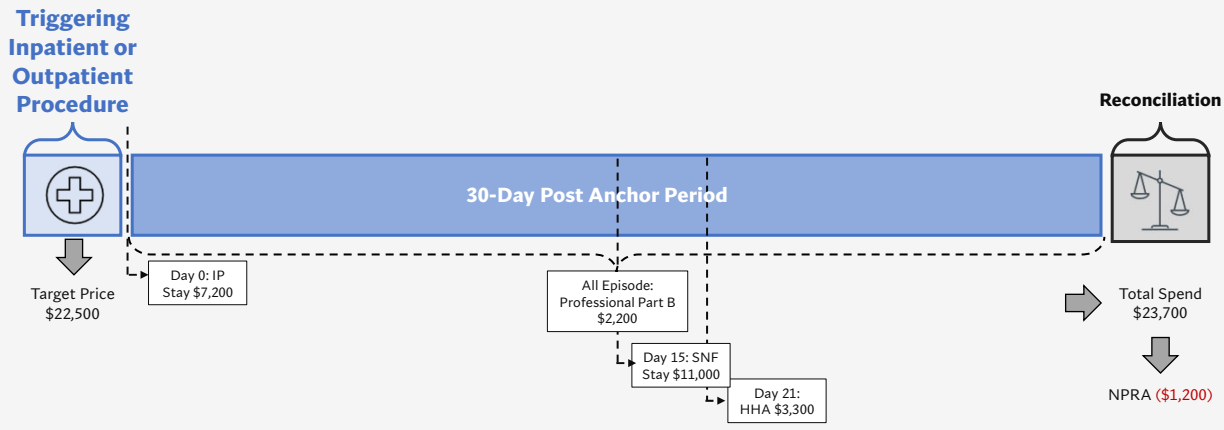
How an Episode of Care Works



- Reconciliation: Target Price – Spend = NPRA (Net Payment Reconciliation Amount)
  - $22,500 - $23,700 = **($1,200)**; therefore, for this specific Episode, the Participant owes **($1,200)**

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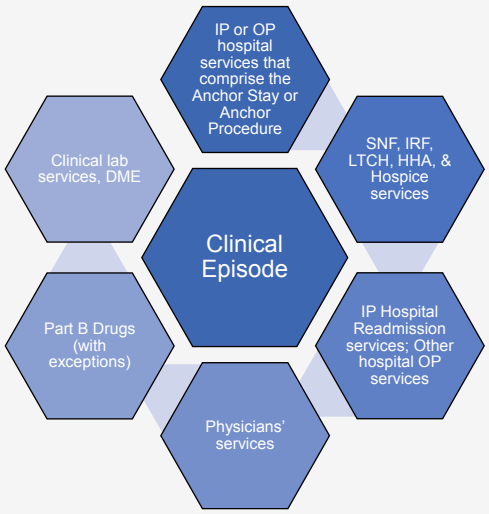
What is Included in the Episode of Care?

- Bundles capture the total cost of care for episodes during the initial hospitalization (or procedure for OP episodes) + 30 days
- Almost all expenditures are included; there are some pre-determined exclusions
- Patients may receive services anywhere & all sites of care are included
- Services are prorated if they straddle episode end dates



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Target Price Calculation

Benchmark price for DRG/HCPCS episode type in census region

- Three-year baseline period used for calculation
  - Year 1 weighted 17%, Year 2 weighted 33%, Year 3 weighted 50%
- CY2022 – CY2024 used for year 1; will roll forward each year
- **LEJR** and **Spinal Fusion** episodes will have site-neutral targets for certain HCPCS/DRG combinations
  - **HCPCS 27130 and 27447 are included in MS-DRG 470**
  - **HCPCS 27702 is included in MS-DRG 469**
  - **HCPCS 22633 is included in MS-DRG 455**
  - **HCPCS 22612 and 22630 are included in MS-DRG 460**
  - **HCPCS 22551 and 22554 are included in MS-DRG 473**

*Limited +/- 5% Retrospective adjustment allowed **For example only, CJR prices and factors will not be used for TEAM

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Target Price Calculation (cont.)

Adjusted for beneficiary-level variables:

- Age Group
- Hierarchical Condition Category Count (90-day lookback)
- Social Risk: Yes or No based on Dual Eligibility, Area Deprivation Index, Part D Low Income Subsidy

Prospective Trend Factor, Normalization Factor*, 3% Discount

LEJR Example: CJR program**

REGION	470/no fracture target price
(1) New England	$19,976.32
(2) Middle Atlantic	$19,863.55
(3) East North Central	$19,408.12
(4) West North Central	$18,935.54
(5) South Atlantic	$19,351.83
(6) East South Central	$19,607.37
(7) West South Central	$20,828.66
(8) Mountain	$18,708.69
(9) Pacific	$18,975.84

Non Dual					
Age Bracket	CMS-HCC Count = 4+	CMS-HCC Count = 3	CMS-HCC Count = 2	CMS-HCC Count = 1	CMS-HCC Count = 0
Age 85+	1.412	1.218	1.163	1.118	1.090
Age 75 to 84	1.360	1.173	1.120	1.077	1.050
Age 65 to 74	1.296	1.118	1.067	1.026	1.001
Age Under 65	1.295	1.117	1.067	1.026	1.000

*Limited +/- 5% Retrospective adjustment allowed **For example only, CJR prices and factors will not be used for TEAM

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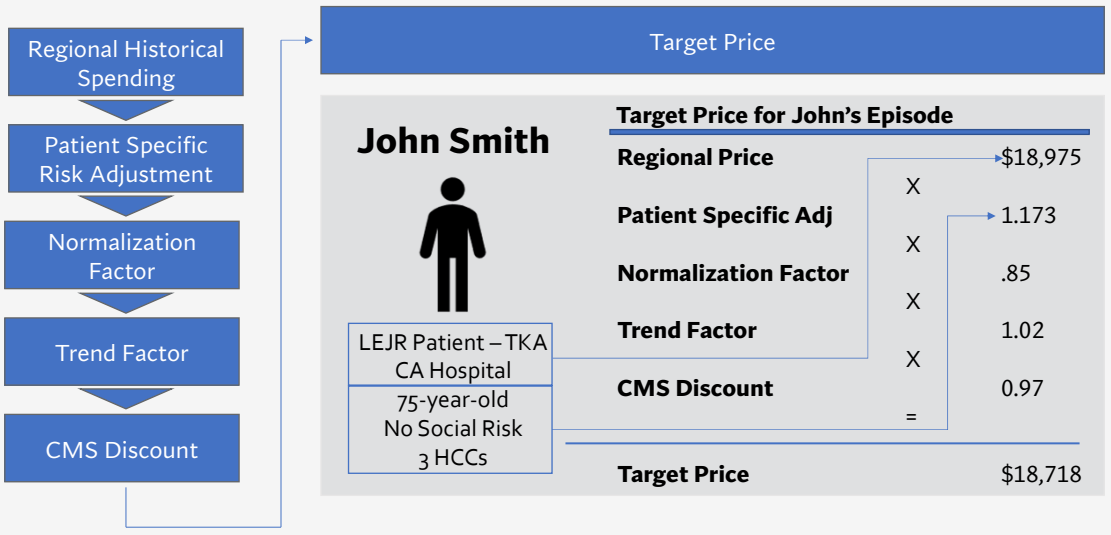
Benchmarking Example – Target Price



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Glide Path to Risk

- TEAM will have graduated risk through different participation tracks to accommodate different levels of risk and reward and allow participants to ease into full-risk participation.

TRACK 1	TRACK 2	TRACK 3
Would be associated with **no downside risk and lower levels of reward** for one year	Would be associated with **lower levels of risk and reward** for certain hospitals, such as safety net hospitals, for years 2 through 5.	Would be associated with **higher levels of risk and reward** for years 1 through 5.
Upside Only (10% Stop Gain)	10% Stop Gain / Stop Loss Limit	20% Stop Gain / Stop Loss Limit

Only Available for Safety net hospitals, rural hospitals, SCH, etc.

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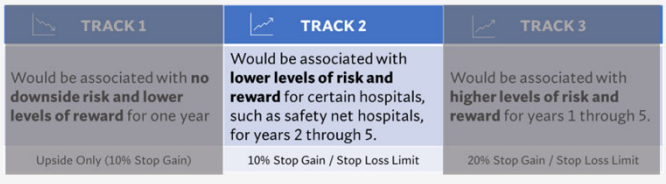
Track 2 Participants

The following types of TEAM participants would be eligible to participate in Track 2 for Performance Years 2-5:

- **Safety net hospitals** that exceed the 75th percentile of the proportion of Medicare beneficiaries across all PPS acute care hospitals in the baseline period for either of the following:
  - Beneficiaries dually eligible for Medicare and Medicaid
  - Beneficiaries eligible to receive Part D low-income subsidies
- **Rural hospitals** that meet at least one of the following criteria:
  - Located in a rural area
  - Located in a rural census tract
  - Has reclassified as a rural hospital
  - Is a rural referral center (RRC)
- **Medicare-dependent hospitals (MDHs)**
- **Sole community hospitals (SCHs)**
- **Essential access to community hospitals**



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Proposed Quality Measures

- Quality measures will be linked to financial gains and losses in TEAM. Measures include:
  - Hybrid All-Cause Readmission Measure
  - CMS PSI-90
  - LEJR Patient Reported Outcomes
- CMS will use these measures to calculate a Composite Quality Score (CQS) similar to those used in BPCI-Advanced and other Medicare alternative payment models
- During reconciliation, the CQS adjustment percentage will be multiplied with the TEAM participant's positive or negative reconciliation amount to produce the CQS adjustment amount, which will then be subtracted from the positive or negative reconciliation amount to create the quality-adjusted reconciliation amount

Track	Reconciliation Amount	CQS Adjustment Percentage Formula
Track 1	Positive Reconciliation Amount	CQS adjustment percentage = (10%-10% * (CQS/100))
Track 2	Positive Reconciliation Amount	CQS adjustment percentage = (10%-10% * (CQS/100))
Track 2	Negative Reconciliation Amount	CQS adjustment percentage = (15% * (CQS/100))
Track 3	Positive Reconciliation Amount	CQS adjustment percentage = (10%-10% * (CQS/100))
Track 3	Negative Reconciliation Amount	CQS adjustment percentage = (10% * (CQS/100))

Reconciliation Amount: $100,000
Amount subject to quality adjustment (10%): $10,000
CQS : 75
Amount earned: 75%*$10,000 = $7,500
Total Quality Adjusted Reconciliation: $92,500

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How to Prepare

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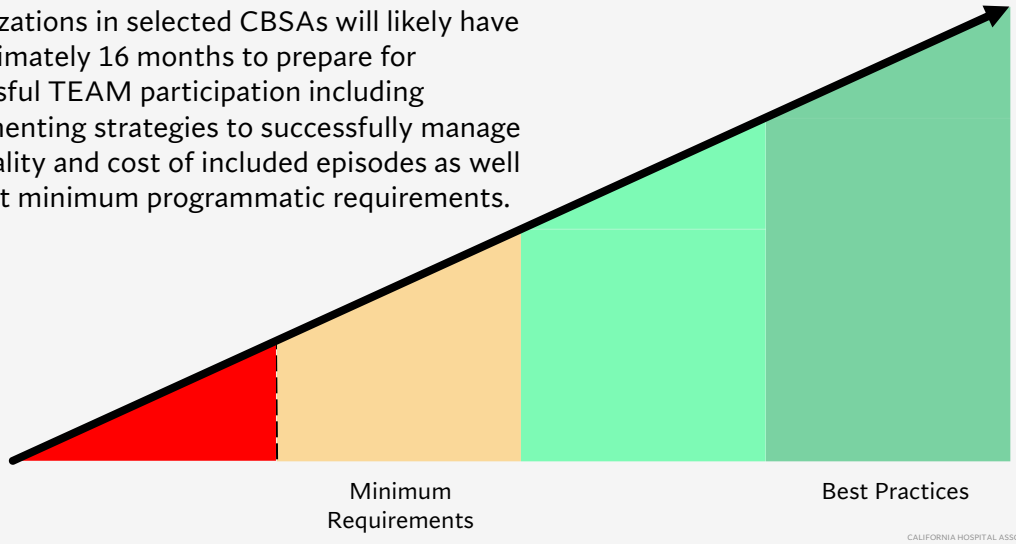
TEAM Implementation Spectrum

Organizations in selected CBSAs will likely have approximately 16 months to prepare for successful TEAM participation including implementing strategies to successfully manage the quality and cost of included episodes as well as meet minimum programmatic requirements.



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Model Requirement / Beneficiary Notification

- As in previous models, TEAM participants must provide written notification of their participation in TEAM to all beneficiaries who meet the eligibility criteria
- Notification must be provided prior to discharge from the anchor hospitalization or anchor procedure
- TEAM participants must be able to generate a list of all beneficiaries who have received notification to CMS upon request

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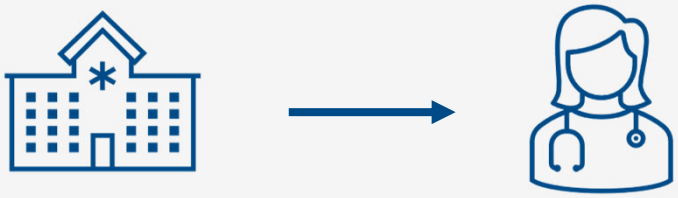
Model Requirement / Referral to Primary Care Provider

What: TEAM participants will be required to refer attributed beneficiaries to a primary care provider prior to discharge from the hospital/outpatient surgical facility

Why: CMS aims to improve the transitions from specialists back to primary care providers following a surgical procedure



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Model Requirement / Health Equity Plans

How CMS Defines Health Equity

"The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes."

TEAM participants will be required to submit a Health Equity Plan starting in the second performance year, with annual updates to the plan thereafter, focusing on the following:

- Identifying health disparities
- Identifying health equity goals
- Describing the equity plan intervention strategy
- Identifying health equity plan performance measures

Source: CMS Proposed Rule

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Model Requirement / HRSN Data Reporting

How CMS Defines Health-Related Social Needs (HRSN)

"The individual-level, adverse social conditions that negatively impact a person's health or healthcare."

- Beginning in PY1, TEAM participants will be required to screen attributed TEAM beneficiaries for at least four HRSN domains, such as food insecurity, housing instability, transportation needs and utilities difficulty
- TEAM participants must also 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

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Model Requirement / Demographic Data Reporting

What: TEAM participants will be required to report demographic data of TEAM beneficiaries beginning in PY2 and all subsequent years

- Demographic data collected may include race, ethnicity, language, disability, sexual orientation, gender identity, sex characteristics, and other demographics

Why: CMS believes this data will provide synergies with goals articulated in the participant's health equity plans and will allow CMS to gain a more nuanced understanding of the expanded demographics of TEAM beneficiaries

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Model Requirement / LEJR Patient Reported Outcomes

What: TEAM participants will be required to submit Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip Arthroplasty/Total Knee Arthroplasty for patients attributed to a Lower Extremity Joint Replacement episode, beginning in Performance Year 1

Why: CMS is working to support a more person-centered quality strategy in accountable care and specialty care models

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Optional / Decarbonization & Resilience Initiative

What: Voluntary initiative allowing TEAM participants to report metrics including carbon emissions data and assessment questions on four potential categories:

- Organizational questions
- Building energy metrics
- Anesthetic gas metrics
- Transportation metrics

- TEAM participants that elect to report all the metrics after a performance year would receive individualized feedback reports and public recognition from CMS
- As part of this initiative, CMS will also provide technical assistance on decarbonization, including guidance in the following areas:
  - Developing approaches to enhance organizational sustainability and resilience;
  - Transitioning to care delivery methods that result in lower GHG emissions and are clinically equivalent to or better than previous care delivery methods
  - Identifying and using tools to measure emissions and associated measurement activities

Why: To help TEAM participants in addressing the threats to the nation's health presented by climate change and the effects of hospital carbon emissions on health outcomes, costs and quality of care

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How to Prepare / Assess

Why: Successful participants will analyze data and assess their readiness for mandatory bundles

What: Determine your organization's total risk, current capabilities and areas for improvement in value-based care activities, including:

Financial Impact & Benchmarking
- Total risk
- Historical performance

Transitions of care
- Discharge planning
- Risk stratification
- Care Coordination

Provider Alignment
- Patient optimization
- Site of care
- Gainsharing/funds flow

Post-Acute Care
- PAC Utilization
- PAC provider performance

Health Equity
- HRSN Screening
- Demographic data

Quality
- Historical performance
- Patient reported outcomes

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How to Prepare / Strategize & Implement

Why: Targeted, data-driven strategies support program success

What: Implement structures and systems to bridge gaps identified through an assessment

- Formalize TEAM governance and management structure
- Consider alignment strategies with providers and post-acute networks
- Implement clinical interventions to improve care and patient experience
- Develop specific plans including care pathways, discharge protocols, patient identification algorithms and waiver utilization guidelines
- Deploy health equity strategy

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If your CBSA were to be selected to participate in TEAM, how ready are you to operationalize a mandatory model with two sided risk?

- Not ready at all
- Somewhat ready
- Very ready
- Unsure

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Questions

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Thank You

Thank you for participating in today's webinar.

For education questions, contact: education@calhospital.org

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