The TEAM Model Framework

Financial Incentives, Risks, and Quality Measures

June 26, 2025

Presenters

Erin Heilman

SVP, Regulatory Affairs, CPHQ

Erin Heilman is a distinguished leader in the healthcare quality regulatory space, known for her innovative approach to simplifying complex regulations. For over a decade, Erin has developed award-winning content, including articles, guides, and tools that empower quality leaders to excel in their reporting obligations.

Kristen Beatson

SVP Clinical Quality Improvement, BSN, RN

Kristen Beatson is an accomplished Healthcare IT leader with over 30 years of clinical, informatics and quality improvement experience. As the Senior Vice President of Clinical Quality Improvement at Medisolv, she is highly focused on helping customers harness the transformative power of digital data to optimize operational efficiencies and more importantly, to empower the delivery of superior healthcare.

Meet Mrs. Carter

- 74-year-old Medicare FFS beneficiary
- Medical history: hypertension, diabetes, mild heart disease
- Presents to the ER with chest pain, admitted for CABG

Inpatient Experience

- Undergoes multiple tests and evaluations
- CABG performed after 2 days
- Post-op confusion and medication concerns
- Multiple consults, little coordination

- Post-op confusion
- Medication concerns
- Multiple consults, little coordination

Post-Acute Care

- Discharged to SNF, delayed records
- PCP not notified
- Referred to outpatient cardiac rehab but missed appointments

Post-Acute Care Chaos

- 13 different ambulatory visits to 7 different providers
  1. Cardiologist
  2. PCP
  3. Surgeon
  4. SNF Staff
  5. Rehab Team
  6. Endocrinologist
  7. Neurologist
- Duplicated imaging
  - Echocardiogram ordered by cardiologist and by PCP
- Medication errors
  - Three blood pressure meds prescribed by different doctors which cause dizziness and a fall
- ER visits for fall & dizziness

What's Driving This Experience?

- Fee-for-service rewards volume, not coordination
- No single entity accountable for the episode of care
- Communication gaps across care settings

Transforming Episode Accountability Model (TEAM)

- Financial accountability to incentivize care coordination
- Reduction of unnecessary or duplicate services
- Enhancing overall care experience for beneficiaries

Agenda

01. TEAM Overview

02. How Costs Are Considered

03. Which Quality Measures are Used

04. How CMS Calculates Your Payment or Penalty

05. What to do Now to Prepare

Q&A handled during *The Medisolv Minute Radio Show*
July 17th at 10:00 AM EST

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If TEAM proves successful, it could pave the way for "managing episodes as a standard practice in Traditional Medicare."

TEAM Model Performance Period

- TEAM is a 5-year program that starts January 1, 2026, and ends on December 31, 2030. Final data submission of clinical data elements and quality measures in CY 2031.

5 Performance Years (Calendar Years) PY 1-PY 5

Performance Year 1 (PY 1)	January 1, 2026 – December 31, 2026
Performance Year 2 (PY 2)	January 1, 2027 – December 31, 2027
Performance Year 3 (PY 3)	January 1, 2028 – December 31, 2028
Performance Year 4 (PY 4)	January 1, 2029 – December 31, 2029
Performance Year 5 (PY 5)	January 1, 2030 – December 31, 2030

How Does TEAM Work?

Patient has a procedure – inpatient or outpatient department

- An eligible patient has an eligible procedure during the Performance Year as an inpatient or in your outpatient department.

Calculating Cost

- CMS will track all items and services for that beneficiary within 30 days of that procedure.
- CMS provides your hospital with a target price for each episode.
- Your spending will be compared to your target price. Underspending is better.

Modifying Cost with Quality

- CMS adds together the total cost of all services from all eligible procedures for all eligible patients for that 30-day window and adds those costs together. They compare it with what you should have spent based on your target prices.
- CMS will use your scores on certain quality measures to adjust your payment (for low cost) or penalty (for high cost).

Payment or Penalty

- CMS will either give you a bulk payment or you will owe CMS a bulk penalty.

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TEAM Participation Tracks

Track	Performance Year (PY)	Eligible Participants	Quality Adjustment Limits	Stop-Gain and Stop-Loss Limits
Track 1	PY 1	All TEAM participants	**Up to 10% +Adjustment**	**Up to 10% +Stop-Gain**
			N/A	N/A
Track 1	PY 1-3	Safety net hospital	**Up to 10% +Adjustment**	**Up to 10% +Stop-Gain**
			N/A	N/A
Track 2	PY 2-5	• Safety net hospital • Rural hospital • Medicare Dependent Hospital • Sole Community Hospital • Essential Access Community Hospital	**Up to 10% +Adjustment**	**Up to 5% +Stop-Gain**
			Up to 15% -Adjustment	**Up to 5% -Stop-Loss**
Track 3	PY 1-5	All TEAM participants	**Up to 10% +Adjustment**	**Up to 20% +Stop-Gain**
			Up to 10% -Adjustment	**Up to 20% -Stop-Loss**

For each performance year you must notify CMS which track you want to be part of, even if you are a special designation hospital.

How Costs Are Considered

Eligible Episodes, Eligible Beneficiaries, and Eligible Items & Services

Which Episodes Are Eligible for TEAM?

Procedure	Defined As	Exclusions	Initiated In	Applicable Codes
Lower Extremity Joint Replacement (LEJR)	Hip, knee, and ankle replacement	Arthroplasty of the small joints in the foot	Inpatient Outpatient	MS-DRG Codes: • 469, 470, 521, 522 HCPCS Codes: • 27447, 27130, 27702
Surgical Hip/Femur Fracture Treatment (SHFFT)	Hip fixation procedure in the presence of a hip fracture (both open and closed surgical hip fixation) with or without fracture reduction	Joint replacement	Inpatient	MS-DRG Codes: • 480, 481, 482
Coronary Artery Bypass Graft (CABG)	Coronary revascularization by CABG	None	Inpatient	MS-DRG Codes: • 231, 232, 233, 234, 235, 236
Spinal Fusion	Spinal fusion procedures for cervical, thoracic, or lumbar	None	Inpatient Outpatient	MS-DRG Codes: • 402, 426, 427, 428, 429, 430, 447, 448, 450, 451, 471, 472, 473 HCPCS Codes: • 22551, 22554, 22612, 22630, 2263
Major Bowel Procedure	Major small or large bowel surgery	None	Inpatient	MS-DRG Codes: • 329, 330, 331

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Setting Target Prices For Each Episode

Before the Performance Year starts hospitals will receive target prices for each eligible episode.

- CMS will provide your hospital a specific target price for each of the MS-DRG/HCPCS codes for each episode by using the following process:
  - Determine regional target prices based on spending for all hospitals in your region (even non-TEAM hospitals).
  - Apply a prospective trend and normalization factor.
  - Apply a discount factor according to episode.
    - CABG & Major Bowel: 1.5%
    - LEJR, SHFTT, Spinal Fusion: 2%

- Regional target prices are based on 3 years of baseline data.
  - PY 1: January 1, 2022 – December 31, 2024
  - PY 2: January 1, 2023 – December 31, 2025
  - PY 3: January 1, 2024 – December 31, 2026
  - PY 4: January 1, 2025 – December 31, 2027
  - PY 5: January 1, 2026 – December 31, 2028

How do Episodes Qualify Under TEAM?

Episodes begin with:

anchor hospitalization (an admission to an acute care hospital)

OR

anchor procedure (an outpatient procedure at a hospital outpatient department)

Episodes in TEAM may be associated with multiple hospitalizations through readmissions or transfers. When more than one hospitalization occurs during a single episode, CMS will hold the hospital to which the episode is initiated accountable.

Episodes end:

30 days after hospital discharge or anchor procedure

30 days starts:

on day of admission or day of procedure

unless

- the admission is the same day of the procedure for the same episode category
  OR
  within three days of the procedure for the same episode category. In that case, it's the date of the procedure.

What Beneficiaries are Included in TEAM?

Beneficiaries who meet all the following criteria at the time of admission or procedure:

- Have Medicare as their primary payer
- Enrolled in Medicare Part A and Part B
- Are not eligible for Medicare on the basis of end-stage renal disease
- Are not enrolled in any managed care plan (for example, Medicare Advantage)
- Are not covered under a United Mine Workers of America health plan

Episode Cancellation

- The episode is canceled if any of the following occur:
  - The beneficiary no longer meets all inclusion criteria
  - The beneficiary dies during the inpatient or outpatient stay
  - The episode qualifies for cancellation due to extreme and uncontrollable circumstances.
    - The date of hospital admission or procedure is during the emergency period or in the 30 days before it starts

Which Costs Are Included?

Included: All Medicare Part A & B items and services

- Physicians' services
- Inpatient hospital services (including hospital readmissions)
- Inpatient Psychiatric Facilities (IPF) services
- Long-Term Care Hospital (LTCH) services
- Inpatient Rehabilitation Facility (IRF) services
- Skilled Nursing Facility (SNF) services
- Home Health Agency (HHA) services
- Hospital outpatient services
- Outpatient therapy services
- Clinical laboratory services
- Durable Medical Equipment (DME)
- Part B drugs and biologicals, except for those specifically excluded
- Hospice services

Excluded: These select items and services

- Inpatient hospital admissions for MS-DRGs that group to the following categories:
  - Oncology, trauma medical, organ transplant, ventricular shunt
- Inpatient hospital admissions that fall into the following Major Diagnostic Categories (MDCs):
  - MDC 02 (Diseases and Disorders of the Eye), MDC 14 (Pregnancy, Childbirth, and Puerperium), MDC 25 (Newborns), MDC 25 (Human Immunodeficiency Virus)
- Traditional pass-through payments for medical devices
- New technology add-on payments
- Hemophilia clotting factor products
- Part B payments for low-volume drugs, high-cost drugs and biologicals, and blood clotting factors for Hemophilia

Mrs. Carter Example

Is she an Eligible Beneficiary? YES

- Medicare as primary payer
- Medicare Part A & B
- Not ESRD or managed care

Did she have an Eligible Episode? YES

- Admitted to the hospital
- CABG MS-DRG: 234

How much is my hospital aiming to spend?

- CMS-Established Target Price for this DRG: $48,905

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Mrs. Carter's Estimated 30-Day Costs

	Service / Setting	Estimated Medicare Cost
3 Days Prior to Admission	**Emergency Department Visit** (initial presentation)	$1,200
	Acute Care Stay	
Anchor Hospitalization	**Inpatient Stay & CABG Surgery** (DRG 234)	$55,000
30 days Post Anchor Hospitalization	**ICU & Stepdown Care (post-op)**	Included in DRG
	Consultations (Cardiology, Surgery, Hospitalist)	$1,500
	Imaging & Diagnostics (EKG, Echo, Labs, CT)	$2,500
	Post-Acute	
	Skilled Nursing Facility Stay (14 days)	$6,800
	Home Health (visits, wound care, monitoring)	$2,200
	Primary Care Follow-up Visit	$100
	Cardiology Follow-up Visit	$180
	Cardiac Rehab (initial sessions)	$600
	Duplicate Echo Test (redundant)	$500
	ER Visits x2 (fall and medication complications)	$2,400
	Neurology Consult (cognitive concerns)	$300
	Medication Errors (management, reconciliation)	$300
	TOTAL (30-day episode)	**$73,580**

EXAMPLE
CMS-established Target Price
$48,905

Aggregating the Annual Costs

CMS will gather and aggregate all your actual spending and compare that to your target prices.

Procedure	Annual FFS Volume	Target Price	Total Allowable Spending	Actual Spending	Variance
CABG	144	$48,905	$7,042,320	$7,204,237	$161,917
SHFFT	117	$35,501	$4,153,617	$3,803,423	($350,194)
Major Bowel	111	$29,184	$3,251,872	$3,537,482	$285,610
LEJR	231	$21,063	$4,865,553	$4,654,342	($211,211)
Spinal Fusion	121	$46,326	$5,639,468	$5,553,346	($86,122)
TOTALS	**720**	—	**$24,952,830**	**$24,752,830**	**($200,000)**

The hospital underspent by $200k, which is good.

Performance Period	PY 1	PY 2	PY 3	PY 4	PY 5
	2026	2027	2028	2029	2030

Episodes All 5 Every Year	PY 1	PY 2	PY 3	PY 4	PY 5
	 Lower Extremity Joint Replacement (LEJR)	 Surgical Hip/Femur Fracture Treatment (SHFFT)	 Coronary Artery Bypass Graft (CABG)	 Spinal Fusion	 Major Bowel Procedure

Risk Tracks	PY 1	PY 2	PY 3	PY 4	PY 5
Acute	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
Safety Net	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
Special Status	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3

Measures	PY 1	PY 2	PY 3	PY 4	PY 5
HWR	✓	✓	✓	✓	✓
THA/TKA	✓	✓	✓	✓	✓
PSI 90	✓				
HH-FI		✓	✓	✓	✓
HH-RF		✓	✓	✓	✓
FTR		✓	✓	✓	✓
Info Transfer			✓	✓	✓

Quality Measures: And now for something completely different

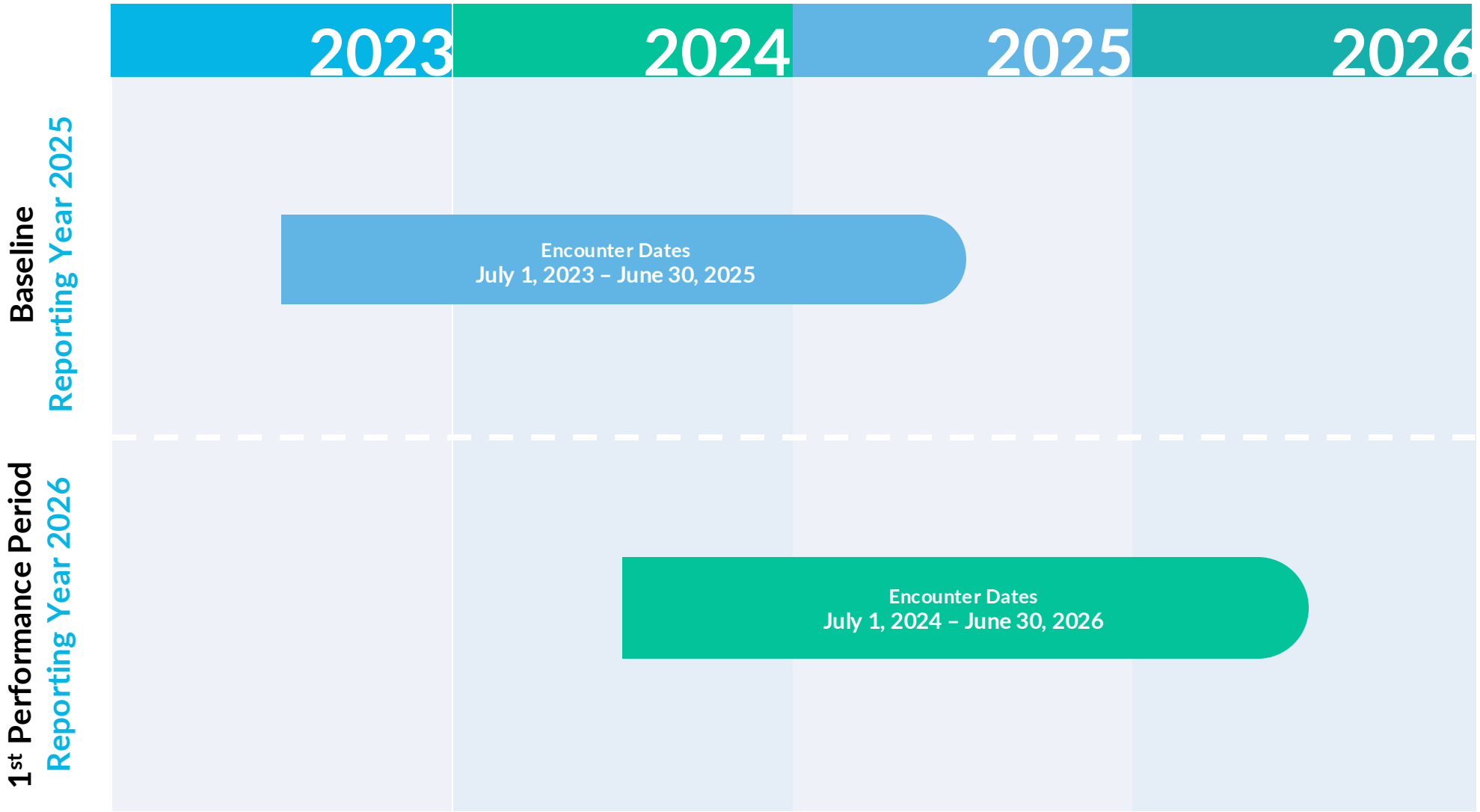
Not really, but these Quality measures have nothing to do with the beneficiaries who qualify for TEAM…well, mostly.

TEAM Quality Measures

Measure Title	Eligible Episodes	Performance Years (PY)	Sourced From
Hybrid Hospital-Wide Readmission	All	PY 1-5	Inpatient Quality Reporting (IQR)
THA/TKA PRO-PM	LEJR episodes only	PY 1-5	Inpatient Quality Reporting (IQR)
PSI 90	All	PY 1	HAC Reduction Program
HH-Falls w/ Injury	All	PY 2-5	Inpatient Quality Reporting (IQR)
HH-Postoperative Respiratory Failure	All	PY 2-5	Inpatient Quality Reporting (IQR)
Failure to Rescue	All	PY 2-5	Inpatient Quality Reporting (IQR)
Information Transfer PRO-PM	HOPD – LEJR + Spinal Fusion	PY 3-5	Outpatient Quality Reporting (OQR)

Patient Safety and Adverse Events Composite Measure (PSI-90)
PY 1 Only

PSI-90 Baseline & Performance Periods



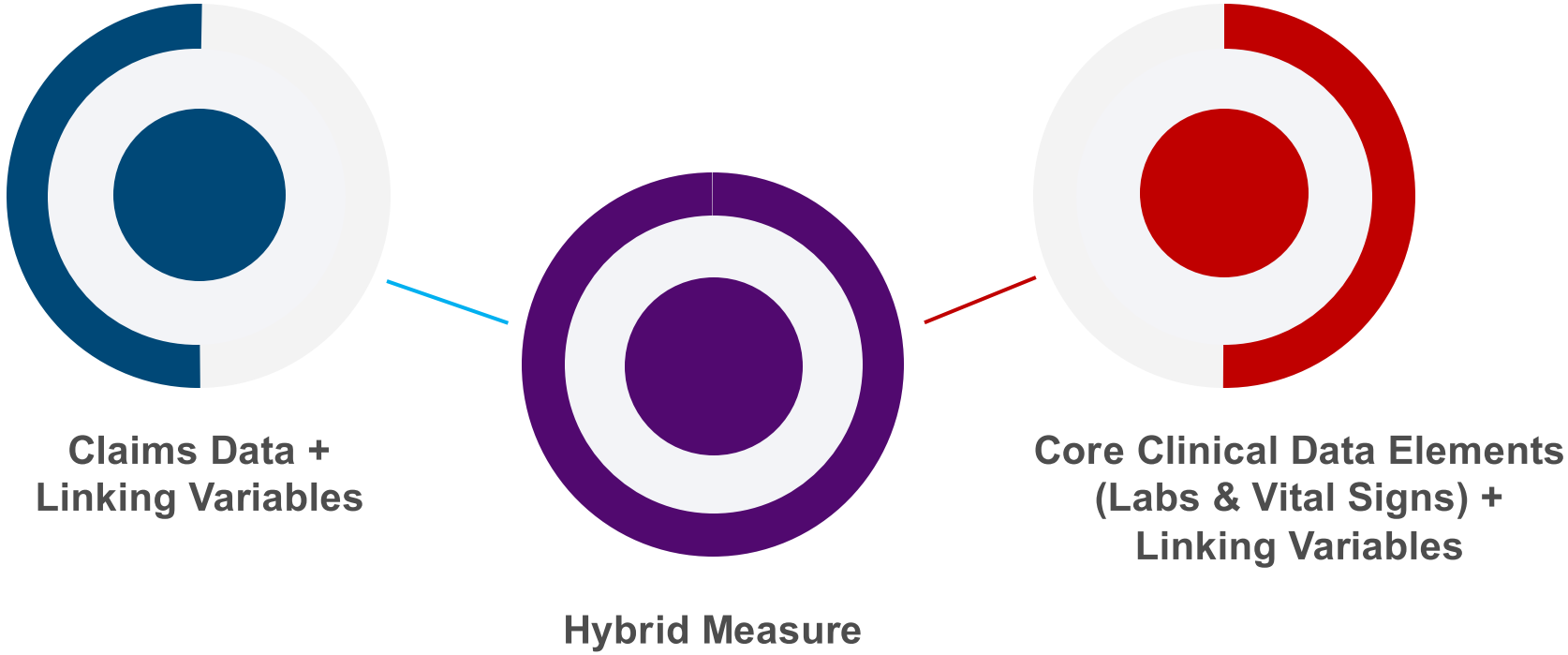
How the measure is evaluated under TEAM

PSI-90

- Baseline Period: July 1, 2023 – June 30, 2025
- Performance Period: July 1, 2024 – June 30, 2026
- Measure Type: Claims-based
- Submitted Under: Hospital Acquired Condition Reduction Program (HACRP)
- Episode Eligibility: All
- Performance rate you should aim for: the median score is **0.964** (July 1, 2021 to June 30, 2023) per Partnership for Quality Measurement. Patient Safety Indicator (PSI) 90: Patient Safety and Adverse Events Composite | Partnership for Quality Measurement

Hybrid Hospital-Wide All-Cause Readmission Measure (HWR) PY 1 - 5

Hybrid Hospital-Wide Readmission Measure (HWR)



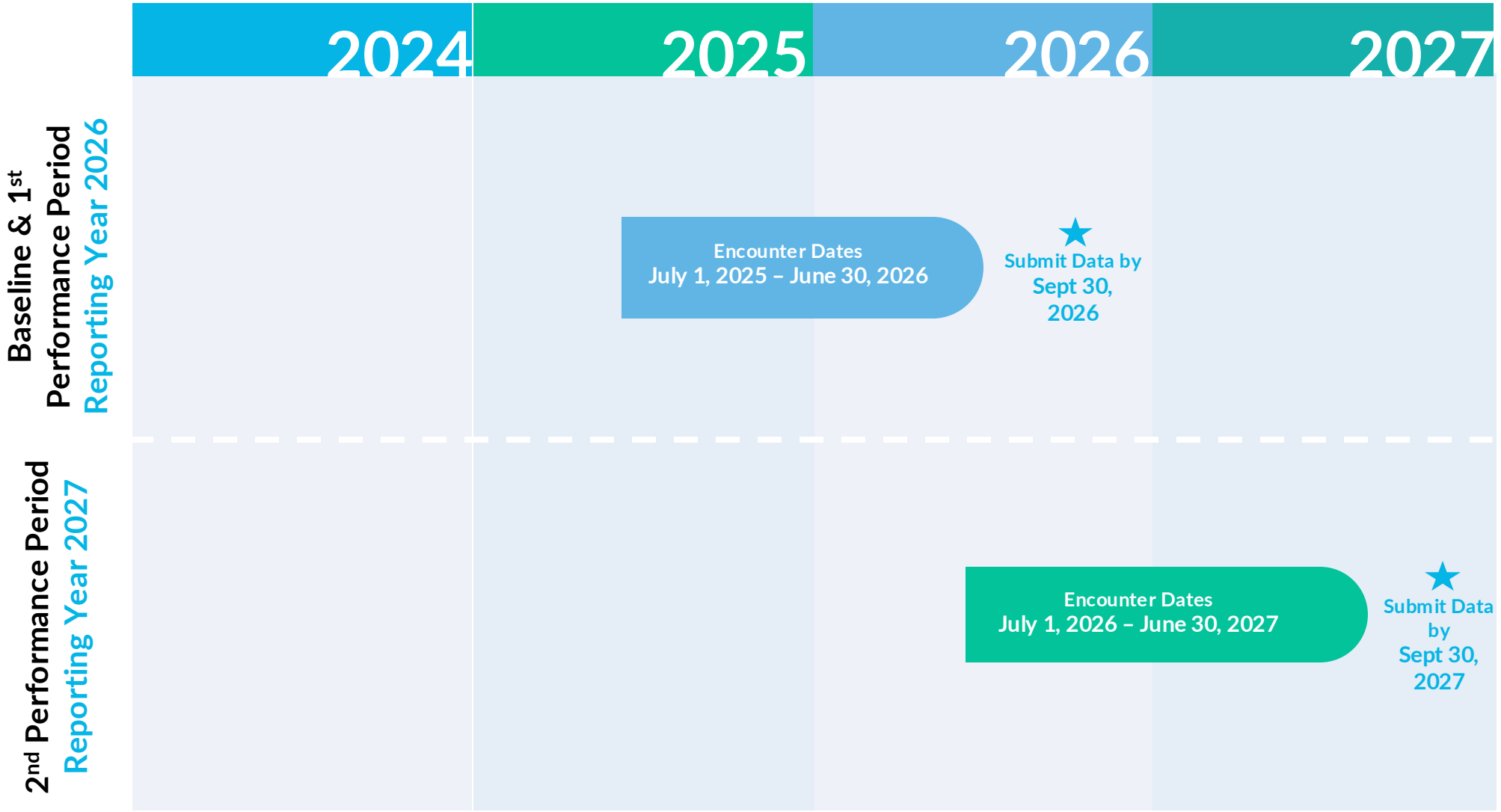
HWR Threshold Changed

Proposed Changes

- Reduce submission thresholds for both CCDEs and linking variables to ≥70%

- Lower the number of required CCDE data elements to allow for up to two missing laboratory results and up to two missing vital signs.

Hybrid Readmission Baseline & Performance Periods



How the measure is evaluated under TEAM

Hybrid Readmission Measure

- Baseline Period: July 1, 2025 – June 30, 2026
- Performance Period: July 1, 2025 – June 30, 2026
- Measure Type: Claims based + EHR Data
- Submitted Under: The Inpatient Quality Reporting Program
- Episode Eligibility: All
- Performance rate you should aim for: the national result from Care Compare for the comparable claims-based measure is **14.6%**

Hospital-Level Total Hip and/or Total Knee Arthroplasty PRO Performance Measure (THA/TKA PRO-PM) PY 1 - 5

THA/TKA PRO-PM

Hospital-Level Total Hip Arthroplasty/Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure (THA/TKA PRO-PM)

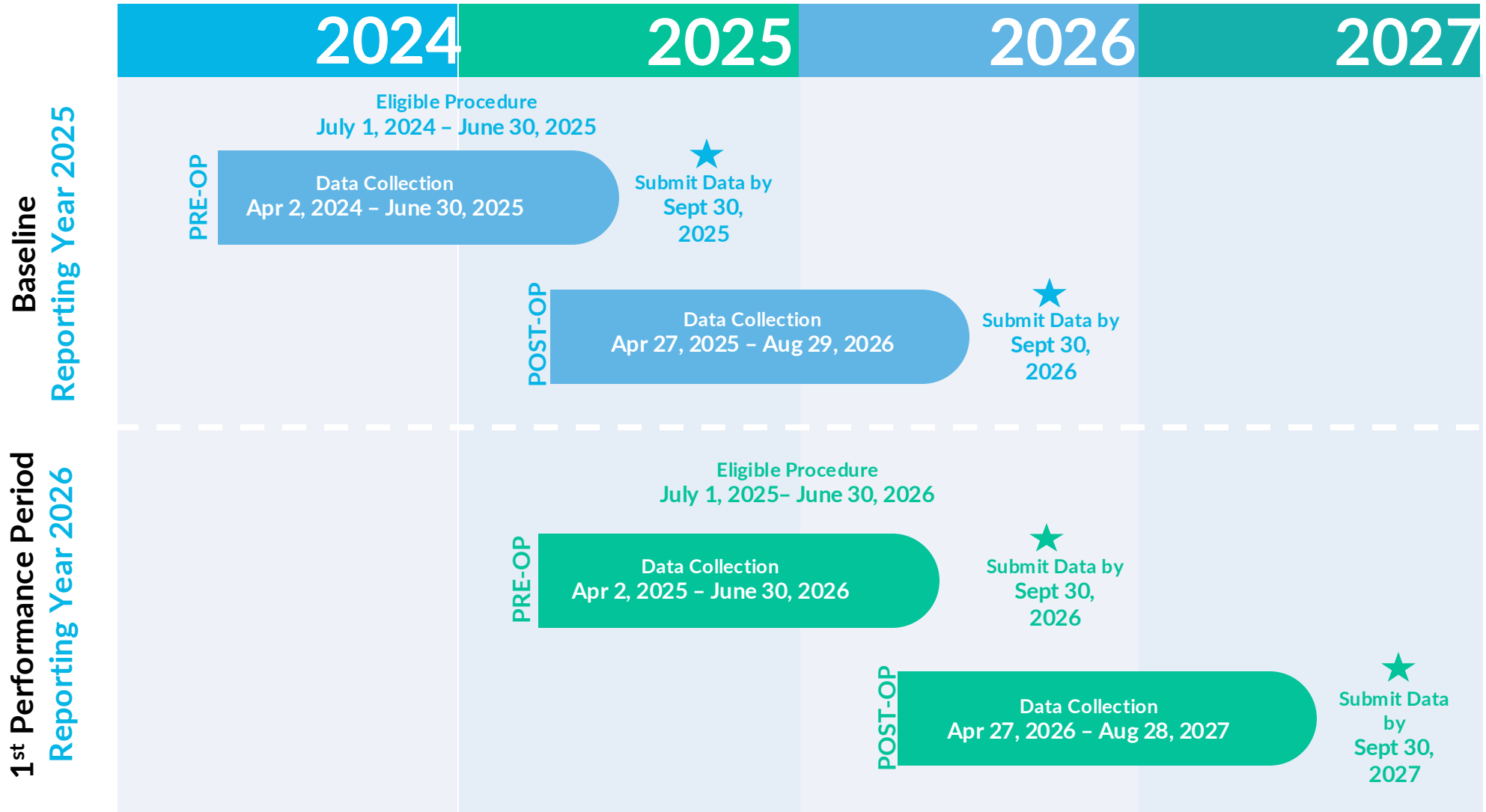
Measure Intent:

- To measure your hospital's rate of improvement in patients' self-reported pain and function following elective primary THA/TKA.

Goal:

- Demonstrate an improved patient-reported score for your patients who underwent elective THA/TKA surgery.

THA/TKA PRO-PM Baseline & Performance Periods



How the measure is evaluated under TEAM

THA/TKA PRO-PMs

- Baseline Period: July 1, 2024 – June 30, 2025
- Performance Period: July 1, 2025 – June 30, 2026
- Measure Type: Survey
- Submitted Under: The Inpatient Quality Reporting Program
- Episode Eligibility: LEJR Only

Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue)
PY 2 - 5

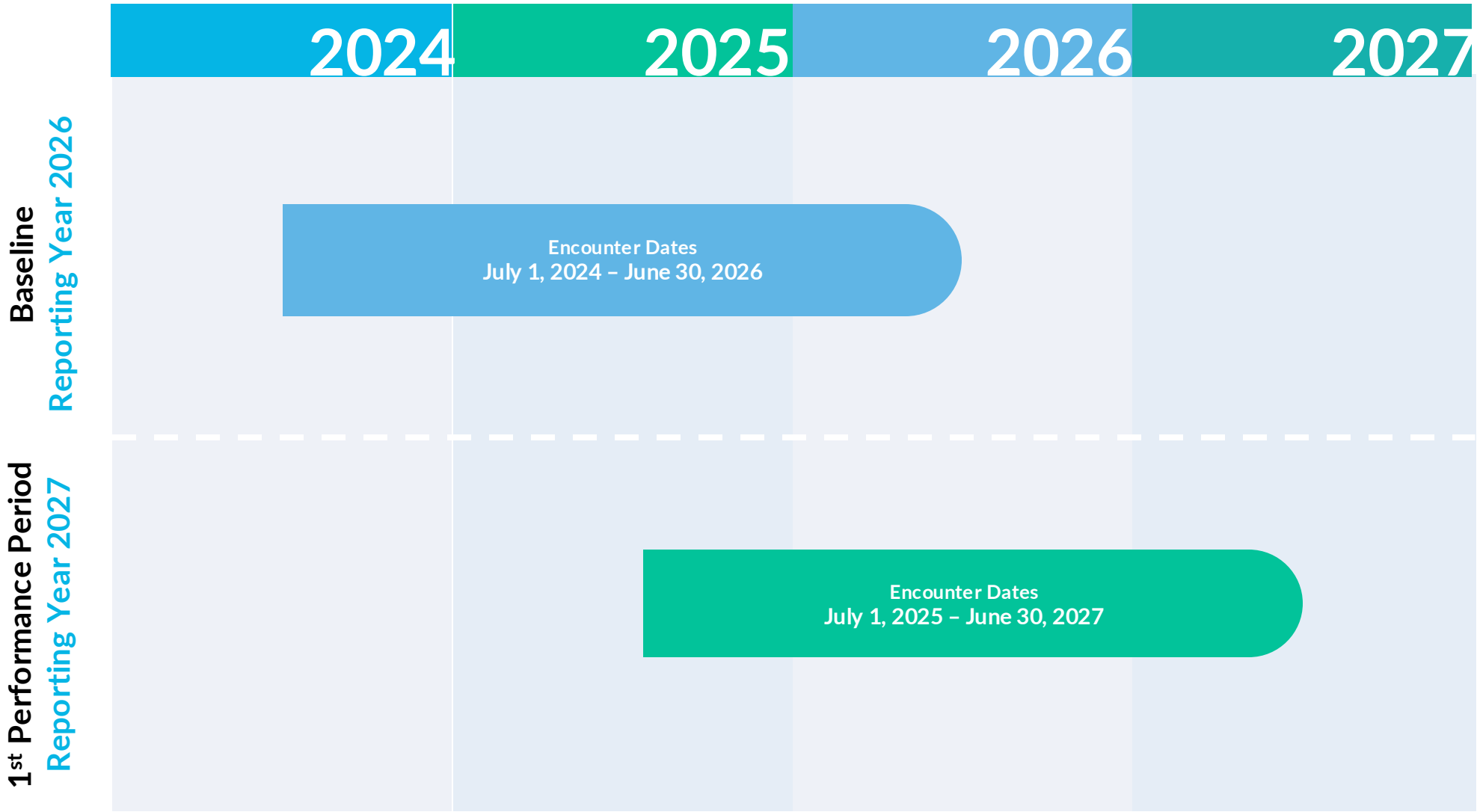
PSI-04 to FTR

- CMS is replacing the PSI-04 Death Among Surgical Inpatients with Serious Treatable Complications claims measure with a new claims measure called the Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue)

Thirty-Day Risk-Standardized Death Rate Among Surgical Inpatients with Complications (Failure-to-Rescue - FTR)

- Measure Description: This is a claims-based risk-standardized measure of death after hospital-acquired complication, defined as the probability of death given a postoperative complication.
- Denominator: Patients 18 years old and older admitted for certain procedures in the General Surgery, Orthopedic, or Cardiovascular Medicare Severity Diagnosis Related Groups who were enrolled in the Medicare program and had a documented complication that was not present on admission.
- Numerator: Patients who died within 30 days from the date of their first “operating room” procedure, regardless of site of death.

FTR Baseline & Performance Periods



How the measure is evaluated under TEAM

FTR

- Baseline Period: July 1, 2024 – June 30, 2026 (Reporting Year 2026)
- Performance Period: July 1, 2025 – June 30, 2027 (Reporting Year 2027)
- Measure Type: Claims-based
- Submitted Under: The Inpatient Quality Reporting Program
- Episode Eligibility: All
- Performance rate you should aim for: AHRQ (Agency for Healthcare Research and Quality) PSI-04 benchmark is **151.17 per 1000 discharges** PSI Benchmark Data Tables, v2024

Hospital Harm – Falls with Injury (HH-FI)
PY 2 - 5

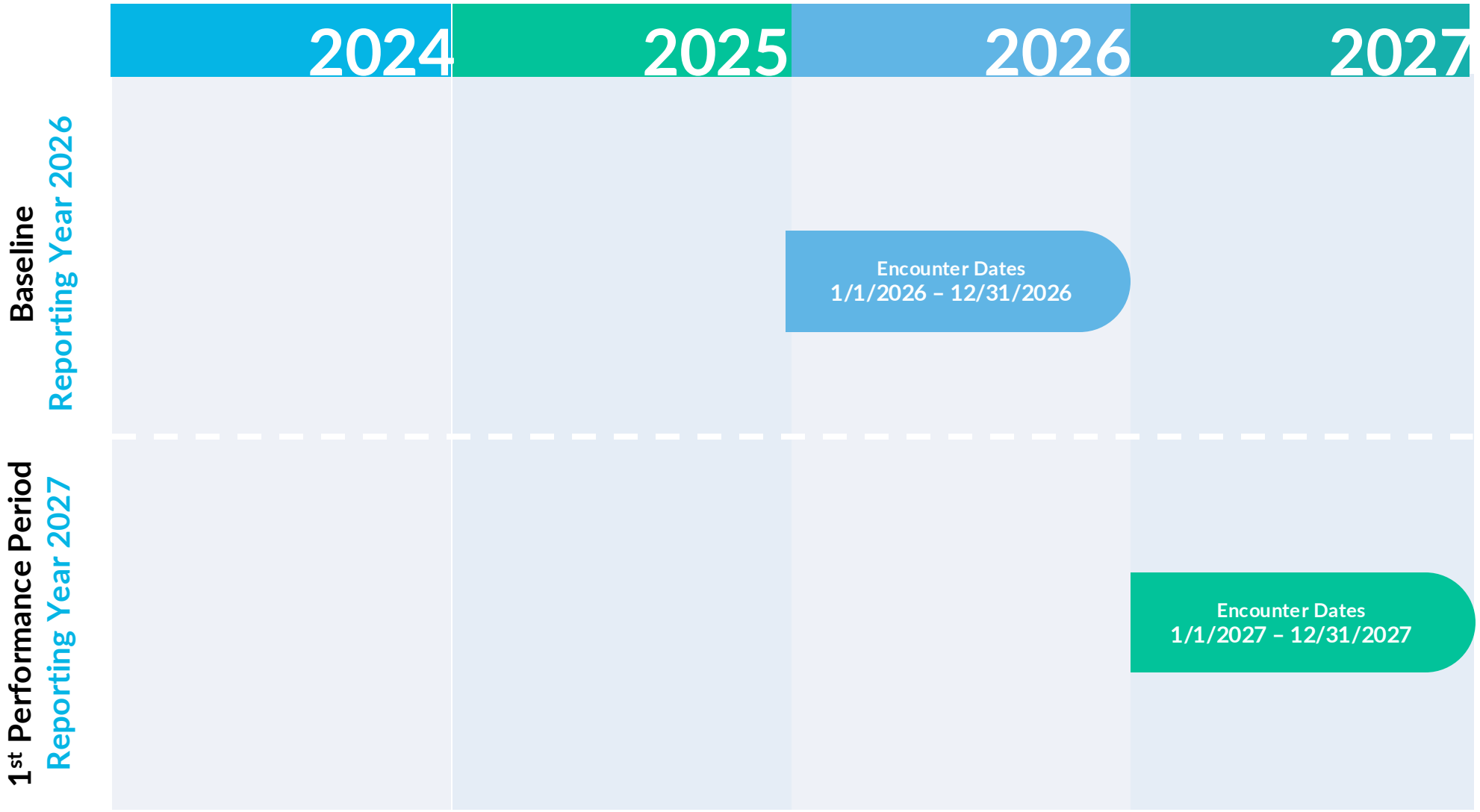
Hospital Harm: Falls with Injury

HH-FI

- This risk adjusted measure assesses the number of inpatient hospitalizations where at least one fall with a major or moderate injury occurred among the total qualifying inpatient hospitalizations 18 years and older.

- Available for submission to meet IQR eCQM Requirements in 2026

HH-FI Baseline & Performance Periods



How the measure is evaluated under TEAM

Falls with Injury

- Baseline Period: January 1, 2026 – December 31, 2026
- Performance Period: January 1, 2027 – December 31, 2027
- Submitted Under: The Inpatient Hospital Reporting Program
- Episode Eligibility: All
- Performance rate you should aim for:
  - ❑ NDNQI (National Database of Nursing Quality Indicators) benchmark for falls with injury on general medicine units ranges from **0.62 to 0.68 falls with injury per 1000 patient days.**
  - ❑ AHRQ (Agency for Healthcare Research and Quality) PSI-08 (In hospital falls associated fracture rate) benchmark is **0.27 per 1000 discharges** PSI Benchmark Data Tables, v2024

Hospital Harm – Postoperative Respiratory Failure (HH-RF) PY 2 - 5

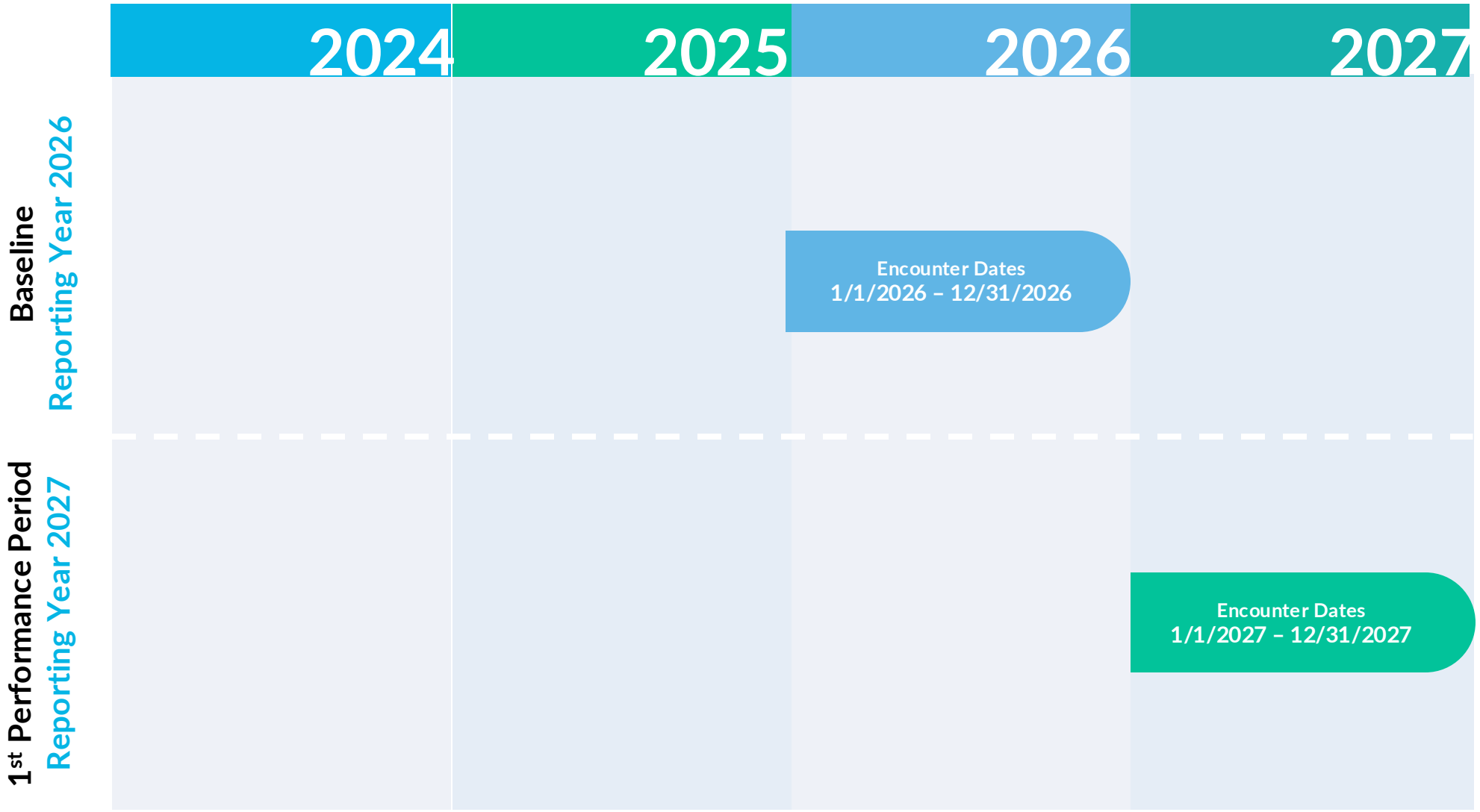
Hospital Harm – Postoperative Respiratory Failure

HH-RF

- This risk adjusted measure assesses the number of elective inpatient hospitalizations for patients aged 18 years and older without an obstetrical condition who have a procedure resulting in postoperative respiratory failure.

- Available for submission to meet IQR eCQM Requirements in 2026

HH-RF Baseline & Performance Periods



How the measure is evaluated under TEAM

HH-RF

- Baseline Period: January 1, 2026 – December 31, 2026
- Performance Period: January 1, 2027 – December 31, 2027
- Submitted Under: IQR
- Episode Eligibility: All
- Performance rate you should aim for: AHRQ (Agency for Healthcare Research and Quality) PSI-11 benchmark is **7.32 per 1000 discharges** PSI Benchmark Data Tables, v2024

Information Transfer Patient Reported Outcome-based Performance Measure (Information Transfer PRO-PM) PY 3 - 5

Information Transfer PRO-PM

Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery

*2026 IPPS Proposed Rule - add the new Information Transfer PRO-PM to TEAM

Measure Intent:

- To measure how well patients got clear, personal information about their recovery after an outpatient procedure.

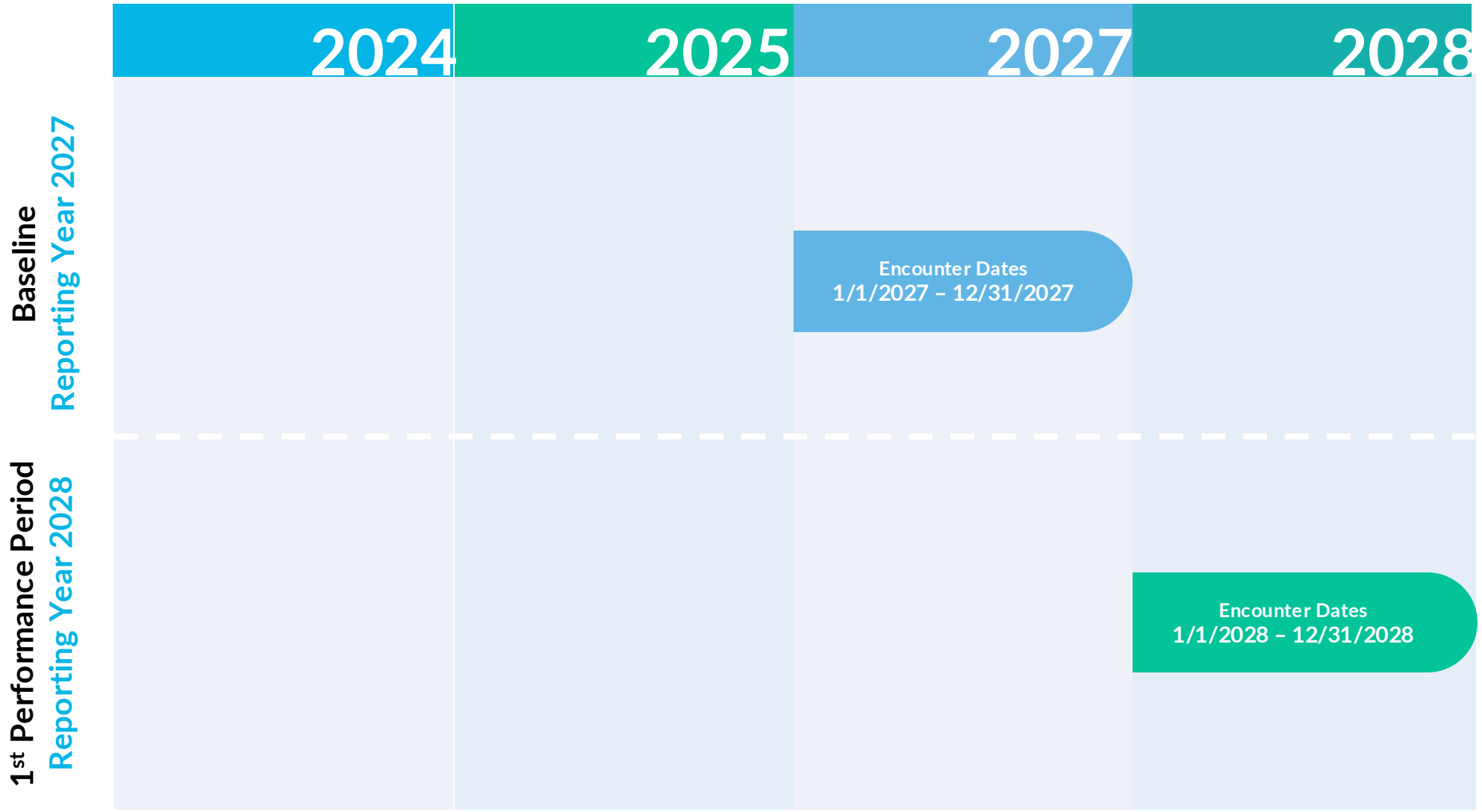
Goal:

- Hospitals should use the results to learn about patient experience and make changes to improve.

Information Transfer PRO-PM

- **Denominator:** Patients aged 18 or older who underwent a procedure or surgery in a hospital outpatient department (HOPD) and completed the survey.
- **Numerator:** Sum of all individual scores from eligible respondents calculated by taking the sum of items to which the respondent gave a positive response of “Yes” or “Very Clear” and dividing by the number of items the respondent deemed applicable to their procedure or surgery.
- Hospitals must sample and submit 300 completed surveys. If the hospital doesn’t have 300 eligible cases, they must submit all survey data.
- This measure is not risk-adjusted.

Information Transfer PRO-PM Baseline & Performance Periods



How the measure is evaluated under TEAM

Information Transfer PRO-PM

- Baseline Period: January 1, 2027 – December 31, 2027
- Performance Period: January 1, 2028 – December 31, 2028
- Measure Type: Survey
- Submitted Under: The Outpatient Quality Reporting Program
- Episode Eligibility: LEJR & Spinal Fusion

How CMS Calculates Your Payment or Penalty

Calculating TEAM Model Reimbursement Amount

Step 1 Convert your Quality Measure Performance into a Useable Score

Step 2 Calculate your Hospital Reconciliation Amount (add up your costs)

Step 3 Adjust your Cost amount using your Quality Score

Step 4 Finalize your Net Payment Reconciliation Amount

Procedure	Annual FFS Volume
CABG	144
SHFFT	117
Major Bowel	108
LEJR	231
Spinal Fusion	120
TOTALS	**720**

Quality Measure	Scaled Quality Measure Score	Volume Weighting	Normalized Weight	Weighted Scaled Score
Hybrid Hospital-Wide Readmission	60	720	0.43	25.8
THA/TKA/ PRO-PM	40	231	0.14	5.6
PSI 90	50	720	0.43	21.5
Composite Quality Score				52.9

Calculating TEAM Model Reimbursement Amount

Step 1 Convert your Quality Measure Performance into a Useable Score

Step 2 Calculate your Hospital Reconciliation Amount (add up your costs)

Step 3 Adjust your Cost amount using your Quality Score

Step 4 Finalize your Net Payment Reconciliation Amount

Procedure	Annual FFS Volume	Annual Aggregated Target Price	Aggregated Final Reconciliation Target Price	Actual Spending	Hospital Reconciliation Amount
TOTALS	**720**	**$90,000**	**$100,000**	**$70,000**	**$30,000**

Calculating TEAM Model Reimbursement Amount

Step 1 Convert your Quality Measure Performance into a Useable Score

Step 2 Calculate your Hospital Reconciliation Amount (add up your costs)

Step 3 Adjust your Cost amount using your Quality Score

Step 4 Finalize your Net Payment Reconciliation Amount

Track	Quality Adjustment Limits	Calculated Reconciliation Payment or Repayment	CQS	CQS Adjustment Formula	CQS Adjustment Percent	Subtracted $$	Quality-Adjusted Reconciliation Amount
Track 3	Up to 10% +Adjustment	$30,000	53	(0.1-0.1*(53/100))	4.70%	$1,410	$28,590

Calculating TEAM Model Reimbursement Amount

Step 1 Convert your Quality Measure Performance into a Useable Score

Step 2 Calculate your Hospital Reconciliation Amount (add up your costs)

Step 3 Adjust your Cost amount using your Quality Score

Step 4 Finalize your Net Payment Reconciliation Amount

Track	Stop-Gain and Stop-Loss Limits
Track 3	Up to 20% +Stop-Gain
	Up to 20% -Stop-Loss

Aggregated Reconciliation Target Price	Actual Spending	Hospital Reconciliation Amount	Quality-Adjusted Reconciliation Amount	Apply Stop-Gain Limit
$100,000	$70,000	$30,000	$28,590	$20,000

What to do now

Next Steps

1. Determine ownership - complete point of contact form
2. Subscribe to TEAM Listserv
3. Identify TEAM Stakeholders - Partner with participants – SNF, Rehab, Providers
4. Consider financial agreements to share reconciliation payment or repayment
5. Analyze current performance
6. Standardize & implement oversight and monitoring of processes

TEAM Point of Contact Form

TEAM Listserv

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Next Steps

1. Review discharge planning process – identify gaps, areas for improvement

2. Enable case managers to support care coordination – PCP referrals, communication + patient health information exchange with facilities and providers responsible for post-acute care.

3. Tracking tools and analytics – start now

4. Set cost and quality measure performance goals

5. Data sharing agreement - evaluate performance, support improvement initiatives.
   - Submit a formal request annually to receive beneficiary-identifiable data.
     - Raw Medicare Parts A and B beneficiary-identifiable claims data or
     - Summary Medicare Parts A and B beneficiary-identifiable claims data
   - TEAM participants can also receive *non-beneficiary-identifiable* data: baseline period and performance year regional aggregate Medicare Parts A and B claims data.

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Model Readiness Assessment & Strategic Planning

Plan Smart.
Align Early.
Report with Confidence.

Benefits

- Enhanced Compliance
- Improved Performance
- Strategic Alignment
- Long-Term Success

A detailed session covering program and reporting requirements and their application to your organization.

An in-depth analysis of your performance history and current state.

Detailed review of each selected measure.

Understanding gaps and developing plans to address them; Planning for subsequent reporting years, including future measure identification

The Medisolv Minute

The Medisolv Minute: The TEAM Model Framework, will air on July 17th at 10:00 AM EST

- Reviewing questions asked during today's webinar
- **Click here** to Join Us

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Appendix

Step 1: Convert Quality Measure Performance into a Useable Score

Convert Raw Score

- Compare the hospital's score against all other hospitals' performance on each measure (not just TEAM-eligible hospitals.) CMS will convert a hospital's raw quality measure scores into scaled quality measures scores based on national distribution of raw scores.

- Example: if a hospital's raw quality hybrid measure score was 15% in PY 1 and that is equivalent to the 60th percentile during the baseline period, their scaled quality measure score for that measure will be 60 in the performance year.

Step 1: Convert Quality Measure Performance into a Useable Score

Apply Volume Weighting

- CMS will then apply a volume weighting to the score based on the volume of episodes for a hospital.

Procedure	Annual FFS Volume
CABG	144
SHFFT	117
Major Bowel	108
LEJR	231
Spinal Fusion	120
TOTALS	**720**

Quality Measure	Volume of Episodes	Normalized Weight
Hybrid Hospital-Wide Readmission	720	0.43
THA/TKA/ PRO-PM	231	0.14
PSI 90	720	0.43
	1,671	1.00

Step 1: Convert Quality Measure Performance into a Useable Score

Multiply standardized score and volume weighting

- Finally, CMS will multiply your quality score and weight to get your weighted score. Each score is added up to give you a Composite Quality Score (CQS).

Quality Measure	Scaled Quality Measure Score	Normalized Weight	Weighted Scaled Score
Hybrid Hospital-Wide Readmission	60	0.43	25.8
THA/TKA/ PRO-PM	40	0.14	5.6
PSI 90	50	0.43	21.5
Composite Quality Score			52.9

Step 2: Calculate Hospital Reconciliation Amount

Determine an individual Hospital Reconciliation Amount

- Those who provide items and services for the beneficiary included in the episode bill Medicare as they usually do.
- Six months after the end of each performance year, CMS uses claims data to determine how much you spent for each episode.
- At the end of the year, CMS will update your target prices to account for risk factors as well as market fluctuation.
  - CMS will adjust your target price using the risk-adjusted variables on the next slide.
  - Then they will adjust the normalization factor up or down (as applicable) +/- 5%.
- Total spend – aggregated finalized prices:
  - The dollar amount difference between the finalized price and a hospital's actual spending.

Procedure	Annual FFS Volume	Aggregated Target Price	Aggregated Final Reconciliation Target Price	Actual Spending	Hospital Reconciliation Amount
TOTALS	**720**	**$24,980,348**	**$25,000,000**	**$24,772,482**	**–$227,518**

Risk Adjustment Multiples (Coefficients) By Episode

Episode	Age Bracket	HCC Count	Prior post-acute care use	Beneficiary social risk	Bed-size	Safety Net Hospital status	Prescence of these HCCs*	Long-term institutional care use	Procedure-related Variable	Disability as original reason for Medicare enrollment	Dementia w/o complication
CABG	X	X	X	X	X	X	18, 46, 58, 84, 85, 86, 96, 103, 111, 112, 134				
SHFFT	X	X		X	X	X	18, 22, 82, 83, 84, 85, 86, 96, 103, 111, 112, 134, 157, 158, 161, 170				
Major Bowel	X	X		X	X	X	11, 18, 21, 33, 82, 85, 86, 103, 111, 112, 134, 188	X			
LEJR	X	X	X	X	X	X	8, 18, 22, 58, 78, 85, 86, 103, 111, 112, 134, 170		X	X	X
Spinal Fusion	X	X	X	X	X	X	8, 18, 22, 40, 58, 85, 86, 96, 103, 111, 112, 134				

Step 3: Adjust Cost amount using Quality Score

CQS: Composite Quality Score | CQS Adjustment

- Once CMS has a hospital's Composite Quality Score (CQS) and Reconciliation Amount they will adjust the dollar amount up or down based on your CQS. (i.e., CQS Adjustment)

- A better quality score will always help you, but the adjustment will always mean a subtraction from your Reconciliation Amount.

- There are 3 tracks in TEAM and each track has a different positive and negative CQS Adjustment percentage.

Step 3: Adjust Cost amount using Quality Score

CQS: Composite Quality Score | CQS Adjustment

- Once CMS has a hospital's Composite Quality Score (CQS) and Reconciliation Amount they will adjust that amount up or down based on the CQS.

Track	Quality Adjustment Limits	Calculated Reconciliation Payment or Repayment	CQS	CQS Adjustment Formula	CQS Adjustment Percent	Subtracted $$	Quality-Adjusted Reconciliation Amount
Track 1	Up to 10% +Adjustment	$24,000	72	(0.1-0.1*(72/100))	2.80%	$672	$23,328
Track 2	Up to 10% +Adjustment	$10,000	45	(0.1-0.1*(45/100))	5.50%	$550	$9,450
Track 2	Up to 15% -Adjustment	($7,500)	66	(0.15*(66/100))	9.90%	$743	($6,757)
Track 3	Up to 10% +Adjustment	$227,518	53	(0.1-0.1*(53/100))	4.70%	$10,693	$216,825
Track 3	Up to 10% -Adjustment	($26,500)	93	(0.1*(93/100))	9.30%	$2,465	($24,035)

Mrs. Carter Example

Step 4.1: Finalize Net Payment Reconciliation Amount

Apply Stop-Gain & Stop-Loss Limits

- Depending upon the track you are in, CMS will apply a limitation on the amount you can gain or a limitation on the amount you lose.

Limitation on gain

The reconciliation payment amount cannot exceed a certain percentage above the aggregated reconciliation target price amount.

Example

- I'm in Track 3
- If my aggregated reconciliation target amount was $100k
- I only spent $70k (under by $30k)
- My CQS Adjusted reconciliation payment amount is $25k
- I only get back $20k (20% of $100k – stop gain)

Limitation on loss

The repayment amount cannot exceed a certain percentage below the aggregated reconciliation target price amount.

Example

- I'm in Track 2
- If my aggregated reconciliation target amount was $100k
- I spent $110k (over by $10k)
- My CQS Adjusted reconciliation payment amount is negative -$7k
- I only have to pay $5k (5% of $100k – stop loss)

Step 4.1: Finalize Net Payment Reconciliation Amount

Track	Stop-Gain and Stop-Loss Limits
Track 1	Up to 10% +Stop-Gain
	N/A
Track 2	Up to 5% +Stop-Gain
	Up to 5% -Stop-Loss
Track 3	Up to 20% +Stop-Gain
	Up to 20% -Stop-Loss

Aggregated Reconciliation Target Price	Actual Spending	Hospital Reconciliation Amount	Quality-Adjusted Reconciliation Amount
$25,000,000	$24,772,482	–$227,518	$216,825

Stop Gain: $5,000,000
Quality-Adjusted Reconciliation Amount: $216,825
Hospital Receives Full Reconciled Amount

Step 4.2: Finalize Net Payment Reconciliation Amount

Apply post-episode adjustment

- If the average post-episode (after the 30 days is up) spending is greater than three standard deviations above the regional average post-episode spending amount, then you'll get a post adjustment. CMS will subtract from your total the amount of post-episode spending exceeding the limit.

- The post-episode spending calculation amount is not subject to the limitation on loss or gain.

Finally! Your hospital will either get a payment from CMS or you'll owe CMS money.

Performance Year (PY)	PY1		PY2		PY3		PY4		PY5	
Anchor Procedures or Admissions that Start within these dates	January 1, 2026 – December 31, 2026		January 1, 2027 – December 31, 2027		January 1, 2028 – December 31, 2028		January 1, 2029 – December 31, 2029		January 1, 2030 – December 31, 2030	
Episodes	1. Lower Extremity Joint Replacement (LEJR) 2. Surgical Hip/Femur Fracture Treatment (SHFFT) 3. Coronary Artery Bypass Graft (CABG) 4. Spinal Fusion 5. Major Bowel Procedure									
Target Prices Calculated Using Episode Data From	January 1, 2022 - December 31, 2024		January 1, 2023 - December 31, 2025		January 1, 2024 - December 31, 2026		January 1, 2025 - December 31, 2027		January 1, 2026 - December 31, 2028	
Available Tracks	Short-term Acute Care Hospital	Safety Net	Short-term Acute Care Hospital	Safety Net	Short-term Acute Care Hospital	Safety Net	Short-term Acute Care Hospital	Safety Net	Short-term Acute Care Hospital	Safety Net
	1 or 3	1 or 2	3	1 or 2	3	1 or 2	3	2	3	2
Quality Measures	Evaluated	Performance Period:	Evaluated	Performance Period:	Evaluated	Performance Period:	Evaluated	Performance Period:	Evaluated	Performance Period:
Hybrid Hospital-Wide Readmission	✓	July 1, 2025 – June 30, 2026	✓	July 1, 2026 – June 30, 2027	✓	July 1, 2027 – June 30, 2028	✓	July 1, 2028 – June 30, 2029	✓	July 1, 2029 – June 30, 2030
THA/TKA PRO-PM (LEJR Episodes only)	✓	July 1, 2025 – June 30, 2026	✓	July 1, 2026 – June 30, 2027	✓	July 1, 2027 – June 30, 2028	✓	July 1, 2028 – June 30, 2029	✓	July 1, 2029 – June 30, 2030
PSI 90	✓	July 1, 2023 – June 30, 2025								
HH-Falls w/ Injury			✓	January 1, 2027 – December 31, 2027	✓	January 1, 2028 – December 31, 2028	✓	January 1, 2029 – December 31, 2029	✓	January 1, 2030 – December 31, 2030
HH-Post-Respiratory Failure			✓	January 1, 2027 – December 31, 2027	✓	January 1, 2028 – December 31, 2028	✓	January 1, 2029 – December 31, 2029	✓	January 1, 2030 – December 31, 2030
Failure to Rescue			✓	July 1, 2025 – June 30, 2027	✓	July 1, 2026 – June 30, 2028	✓	July 1, 2027 – June 30, 2029	✓	July 1, 2028 – June 30, 2030
Information Transfer PRO-PM					✓	January 1, 2028 – December 31, 2028	✓	January 1, 2029 – December 31, 2029	✓	January 1, 2030 – December 31, 2030

Acronym & Term Definitions

- **CQS:** Composite Quality Score
- **CQS adjustment amount:** the amount subtracted from the positive or negative reconciliation amount to generate the reconciliation payment or repayment amount.
- **CQS adjustment percentage:** the percentage CMS applies to the positive or negative reconciliation amount based on the TEAM participant's CQS performance. Hospitals must achieve a CQS of 100 to get the maximum quality-adjusted reconciliation amount.
- **Reconciliation amount:** the dollar amount representing the difference between the reconciliation target price and performance year spending, prior to adjustments.
- **Quality-adjusted reconciliation amount:** the dollar amount representing the difference between the reconciliation target price and performance year spending, after adjustments for quality, but prior to application of stop-gain/stop-loss limits and the post-episode spending adjustment.
- **NPRA:** Net Payment Reconciliation Amount – the dollar amount representing the difference between the reconciliation target price and performance year spending, after adjustments for quality and stop-gain/stop-loss limits, but prior to the post-episode spending adjustment.
- **Reconciliation payment amount:** the amount that CMS may owe to a TEAM participant after reconciliation as determined in accordance with § 512.550(g).
- **Repayment amount:** the amount that the TEAM participant may owe to Medicare after reconciliation as determined in accordance with § 512.550(g).
- **Reconciliation target price:** the target price applied to an episode at reconciliation, as determined in accordance with § 512.545.

Understanding CMS Years

REPORTING YEAR

The reporting year is a specific period during which data is collected and reported to CMS. It is often referenced when talking about what is required in a reporting year.

Example: We are in Reporting Year 2025. The THA/TKA PRO-PM has a Measurement Period of July 1, 2024 – June 30, 2025. Submission of this data completes your 2025 Reporting Year Requirements.

FISCAL YEAR

The fiscal year is a 12-month period used for financial accounting and budgeting purposes. Unlike the calendar year, the fiscal year can start on a different date, such as October 1st and end on September 30th of the following year. Most commonly (but not always) the CMS Fiscal Year is two years after the Reporting Year.

Example: We are in Reporting Year 2025 which affects payments for Fiscal Year 2027. CMS will sometimes refer to FY 2027 for your reporting requirements.

PERFORMANCE PERIOD

Throughout this presentation we referenced the measure type's Performance Period to help you understand the timeframes of data that you must submit or are considered to fulfill that Reporting Year's requirements.

CALENDAR YEAR

The calendar year is the most commonly used year in everyday life. It follows the standard January 1st to December 31st timeframe. Sometimes CMS says Calendar Year to indicate Reporting Year.

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