AAOS
American Association of Orthopaedic Surgeons

TEAM Model Proposed Rule Summary

On April 10, 2024, the Centers for Medicare and Medicaid Services (CMS) released a proposed implementation and testing of the Transforming Episode Accountability Model (TEAM). This mandatory model would begin on January 1, 2026, and end on December 31, 2030. TEAM is considered the successor to BPCI-A and CJR, with episode-based pricing linked to quality measure performance for five surgical episode categories, three of which are orthopedic. This model is being released following CMS' Innovation Center's (CMMI) review of comments submitted in response to the July 2023 Request for Information on Episode-Based Payment Models. ***AAOS strongly opposes any mandatory model and will be working to make the necessary changes prior to the model implementation date.***

Background

CMS believes that an episode-based payment methodology creates an incentive for participants to coordinate across care settings as the participating entity, in this case acute care hospitals, takes responsibility for the quality and cost outcomes of the entire episode.

All the projected payments to the physician, hospital, and other health care provider and supplier services will be combined into a target price.

If successful, CMS hopes that the TEAM model will establish the framework for managing episodes as a standard practice in traditional Medicare.

To encourage this collaboration, TEAM proposes to align incentives between hospitals and physicians by specifying certain types of financial arrangements that participants can use to share the reconciliation payment amounts received from CMS. The thinking here is that TEAM participants would be able to share incentives downstream with providers and suppliers when they achieve higher quality and more cost-effective care through collaboration.

The full rule text can be found here.

Model Details (pg. 1093)

Participants will continue to bill Medicare using the fee-for-service (FFS) system. In addition, TEAM participants will receive a reconciliation payment from CMS depending on their Composite Quality Score (CQS) and if their performance year spending is less than their reconciliation target price.

TEAM is a two-sided risk model, meaning that the model requires participants to be accountable for their performance year spending that is above or below their target price. If the performance year spending is more than the participant's reconciliation target price and depending on the CQS score, the participant may owe CMS a repayment amount.

CMS seeks "comment on the proposed model performance period of 5 years and proposed model start date of January 1, 2026, for Performance Year 1, and on the alternatively considered start dates (April 1, 2026, July 1, 2026, and October 1, 2026), and the subsequent adjustment to dates of the model performance period if we were to change the model start date."

TEAM Participant Definition: To simplify episode attribution and make it easier for the single entity to identify beneficiaries that may be included in the model, acute care hospitals would be the TEAM participant and the only entity available to initiate an episode.

CMS does not include physician group practices (PGPs) and believes that there are other meaningful opportunities for PGPs to engage in TEAM through financial arrangements with TEAM participants. **CMS also notes opportunities for PGPs to engage through other value-based care initiatives, including future PGP-specific opportunities under development through CMMI's specialty care strategy.**

CMS considered making participation voluntary, but they are concerned that a fully voluntary model would not lead to meaningful evaluation findings. (pg. 1101)

Since the episodes being tested in this model have been used on a voluntary basis in BPCI-A and BPCI, CMS has significant data on the performance of these episode categories in a voluntary structure. However, CMS is seeking comments on a voluntary opt-in to the model for hospitals currently participating in CJR or BPCI-A.

CMS "considered splitting financial accountability between the TEAM participant and other providers and suppliers that provide items and services to the TEAM beneficiary. For example, they considered the TEAM participant being financially accountable for a majority of the episode spending, such as all Medicare Part A spending, and other suppliers, such as PGPs, being accountable for a portion episode spending related to Medicare Part B spending. However, they have concerns about how to accurately determine a reasonable sharing methodology that reflects the portion of spending either the TEAM participant or the PGP should be financially accountable for. Further, they have concerns about requiring PGPs to be financially accountable given practices can vary by size and resources."

CMS seeks "comment on approaches to splitting financial accountability when multiple providers care for a single beneficiary in an episode."

CMS is not proposing to require convener entities in this model, and they do not intend to identify or require Medicare-enrolled nor non-Medicare providers or suppliers to be convener entities given the resources that would be required to convene over one or more TEAM participants.

"As with the CJR model, CMS does not intend to restrict the ability of TEAM participants to enter into administrative or risk sharing arrangements related to TEAM with entities that may provide similar support as

a convener, except to the extent that such arrangements are already restricted or prohibited by existing law. CMS is also not proposing to require TEAM participants to partner with convener entities and are not proposing to require any entities, providers, or suppliers to serve as conveners for purposes of TEAM." (Pg. 1107)

Participation Tracks

CMS is proposing that there will be three tracks in TEAM, each with different financial risk and quality performance adjustments.

- Track 1 would be available only in PY1 for all TEAM participants and would have only upside financial risk with quality adjustment applied to positive reconciliation amounts.
- Track 2 would be available in PYs 2-5 to a limited set of TEAM participants, including safety net hospitals, and would have two-sided financial risk with quality adjustment to reconciliation amounts.
- Track 3 would be available in PYs 1-5 for all TEAM participants and would have two-sided financial risk with quality adjustment to reconciliation amounts.

CMS is proposing a one-year glide path to two-sided risk to ensure that participants have time to prepare. All participants can select between Track 1 or Track 3.

For PY 1, Track 1 would have only upside financial risk provided through reconciliation payments, subject to a 10% stop-gain limit and a Composite Quality Score adjustment percentage of up to 10%.

Track 2 would have two-sided financial risk in the form of reconciliation payments and repayment 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.

CMS "believes the CQS adjustment percentage of up to 15% for negative reconciliation amounts, is appropriate for Track 2 because it further limits a TEAM participant's financial risk given that a higher CQS adjustment percentage for negative reconciliation amounts results in a lower repayment amount."

Track 3 would have two-sided financial risk in the form of reconciliation payments or repayment amounts, subject to a 20% stop-gain and stop-loss limit and a CQS adjustment of up to 10%.

TEAM participants would be required to notify CMS of their track selection prior to the start of PY 1. If participants do not self-select, CMS will automatically assign them to Track 1 for PY 1.

If TEAM participants select Track 1 for PY 1, they would be automatically assigned to Track 3 for PY 2-5. However, certain participants may benefit from a participation option with limited two-sided risk. CMS is therefore proposing that certain participants may elect to participate in Track 2 beginning in PY 2 and stay in Track 2 for the remainder of the model.

Only the below types of TEAM participants would be eligible to participate in Track 2 for PYs 2-5:

Safety net hospitals, based on the following criteria:

- 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.
- Hospitals that are rural, as defined by CMS statute.
- Hospitals that are Medicare dependent hospitals
- Hospitals that are sole community hospitals
- Hospitals that are essential access community hospitals

CMS "proposes that TEAM participants that meet the Track 2 hospital criteria described above would be required to notify CMS on an annual basis prior to the start of every performance year, beginning for PY 2, of their desire to participate in Track 2. CMS proposes that TEAM participants that meet the Track 2 hospital criteria could switch between Track 2 and Track 3 on an annual basis."

TABLE X.A.-01 – SUMMARY OF PROPOSED TEAM PARTICIPATION TRACKS

Track	Performance Year (PY)	TEAM Participant Eligibility	Financial Risk
Track 1	PY 1	All TEAM participants	• Upside risk only (10% stop-gain limit)
			• CQS adjustment percentage of up to 10% for positive reconciliation amounts
Track 2	PYs 2-5	TEAM participants that meet one of following hospital criteria: • Safety net hospital • Rural hospital • Medicare Dependent Hospital • Sole Community Hospital • Essential Access Community Hospital	• Upside and downside risk (10% stop-gain/stop-loss limits) • CQS adjustment percentage of up to 10% for positive reconciliation amounts and CQS adjustment percentage of up to 15% for negative reconciliation amounts
Track 3	PYs 1-5	All TEAM participants	• Upside and downside risk (20% stop-gain/stop-loss limits) • CQS adjustment percentage of up to 10% for positive and negative reconciliation amounts

CMS proposes to select geographic areas with all hospitals included to test the effects of the episode-based payment approach more broadly across an accountable care community. This method will also minimize the risk of TEAM participants shifting higher cost cases to hospitals not participating.

"Instead of taking a simple random sampling where all geographic areas have the same chance for selection, CMS would group these geographic areas according to certain characteristics and then randomly select geographic areas from within those groups, also known as strata, for model implementation. Such a stratified random sampling method based on geographic area would provide several benefits."

CMS "expects that this method would allow them to observe the experiences of hospitals in geographic areas with various characteristics, such as variations in the number of hospitals, average episode spending, number of hospitals that serve a higher proportion of historically underserved beneficiaries, and differing experience with previous CMS bundled payment models. CMS could then examine whether these characteristics impact the effect of the model on patient outcomes and Medicare expenditures within episodes of care. Using a stratified random sampling based on geographic area would also substantially reduce the extent to which the selected hospitals would differ from other hospitals on the characteristics used for stratification, compared to a simple random sample."

"Simple randomization may ensure similarity between the selected hospitals and hospitals that are not selected, but simple randomization can also lead to differences if enough units are drawn in a group-randomized design where the number of available groups is relatively small. Finally, using a stratified random sampling of geographic areas would improve the statistical power of the subsequent model evaluation improve our ability to reach conclusions about the model's effects on episode spending and the quality of patient care." (pg. 1115)

CMS proposes to use a stratified random sampling method to select 25% of the 803 eligible CBSA's. See Table X.A.-02: List of CBSAs Eligible for Selection in TEAM for the complete list (pg. 1119)

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. CMS proposes to oversample CBSAs with a higher number of safety net hospitals.

CMS is proposing to stratify the eligible CBSAs into mutually exclusive groups corresponding to 16 unique combinations of high and low values for the following CBSA-level characteristics, based on the median values across all CBSAs:

- ***Average spend for a broad set of episode categories in the CBSA:*** Using the episode categories included in BPCI-A from January 1, 2022-June 30, 2023 to determine the average spend for a broad set of episode categories for each CBSA. These include Chronic obstructive pulmonary disease; bronchitis, asthma, Renal failure; Sepsis; Simple pneumonia and respiratory infections; Urinary tract infection;

Seizures; Stroke; Double joint replacement of the lower extremity; Fractures of the femur and hip or pelvis; Hip & femur procedures except major joint; Lower extremity and humerus procedure except hip, foot, femur; Major joint replacement of the lower extremity; Major joint replacement of the upper extremity; Back & neck except spinal fusion; Spinal fusion; Back & neck except spinal fusion.

- ***Number of hospitals within the CBSA:*** CMS will select CBSAs which include mSA areas in addition to MSAs, meaning that TEAM would be representative of the U.S. by including areas with a single hospital and areas with a high number of hospitals.
- ***CBSA's past exposure to CMS' bundled payment models:*** CMS believes that the extent of previous participation in bundled payment models in a CBSA may be a factor in how successful participants will be at reducing costs and improving quality.
- ***Number of safety net hospitals in the CBSA:*** CMS notes that safety net providers have historically had lower participation rates in voluntary episode-based payment models as frequently as other providers. CMS is creating an additional stratum from one of these 16 strata for a total of 17 to select CBSAs into TEAM. CMS proposes to move these CBSAs with a very high number of safety net hospitals into a new 17th stratum to prevent an asymmetrical distribution when stratifying CBSAs by this characteristic.

CMS' proposed method of random selection combined with oversampling CBSAs with certain characteristics will result in the following selection probabilities:

- 33.3% (one out of three) CBSAs will be selected in strata with high number of safety net hospitals and low past exposure to CMS' bundled payment models. Four strata have this selection probability.
- 25% (1 out of 4) CBSAs will be selected in strata with either high number of safety net hospitals or low past exposure to CMS' bundled payment models (but not both). Eight strata have this selection probability.
- 20% (1 out of 5) CBSAs will be selected in strata with neither high number of safety net hospitals nor low past exposure to CMS' bundled payment models. Four strata have this selection probability.
- 50% (1 out of 2) CBSAs will be selected with the highest number of safety net hospitals (One strata has this selection probability: the 17th stratum).

TABLE X.A.-03: SELECTION STRATA AND THEIR PROPOSED SELECTION PERCENTAGES

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	1/4
2	Low	Low	Low	High	1/4
3	Low	Low	High	Low	1/4
4	Low	Low	High	High	1/4
5	Low	High	Low	Low	1/5
6	Low	High	Low	High	1/5
7	Low	High	High	Low	1/5
8	Low	High	High	High	1/5
9	High	Low	Low	Low	1/3
10	High	Low	Low	High	1/3
11	High	Low	High	Low	1/3
12	High	Low	High	High	1/3
13	High	High	Low	Low	1/4
14	High	High	Low	High	1/4
15	High	High	High	Low	1/4
16	High	High	High	High	1/4
17	Very High	High	High	High	1/2

CMS used power analyses to "identify detectable changes in episode spending between a potential group of CBSAs selected for the model and a potential control group of CBSAs using a Type I error of 0.05 and Type 2 error of 0.2 (implying a power of 0.8). The analysis shows that, if a quarter of eligible CBSAs are selected for TEAM, they will be able to detect 1.5% changes in episode spending, all else being equal. This change in episode spending is within the savings range that CMS might expect to achieve given estimates for surgical episodes from previous episode-based payment models, including BPCI Model 2, CJR, and BPCI Advanced. This is critical to ensuring that CMS is able to assess the model's impact on Medicare spending." (pg. 1136)

Proposed Episodes

CMS is considering adding medical episodes in future years of the model and are soliciting comments on including medical episodes in TEAM, as well as input on which specific model episodes would best support the goals of the model.

CMS selected episodes for this proposed model with a great proportion of spending in the post-acute period relative to the anchor hospitalization or procedure as such episodes may reflect a greater opportunity to improve care transitions for beneficiaries and reduce unnecessary hospitalizations and emergency care. (pg. 1138)

CMS is proposing to test these specific surgical episodes because they are time-limited with well-defined triggers, have clinically similar patient populations with common care pathways, and have sufficient spending or quality variability, particularly in the post-acute period, to offer participants the opportunity for improvement. They also represent the highest volume and highest cost surgical episodes performed in the inpatient setting.

"Although CABG and SHFFT episodes were finalized in the Advancing Care Coordination through Episode Payment Models (Cardiac and Orthopedic Bundled Payment Models) Final Rule (CMS-5519-F) on December 20, 2016, that mandatory test was not implemented. The proposed TEAM is the next logical step for applying lessons learned from BPCI Advanced in a mandatory model. TEAM would enable CMS to capture a more diverse population of providers, and potentially beneficiaries."

- **Lower Extremity Joint Replacement:** this episode category would include hip, knee, and ankle replacements performed in either the hospital inpatient or outpatient setting. LEJR was selected because it is the highest volume, highest cost BPCI-A surgical episode category according to 2021 data with 204,160 episodes costing $5.01 billion, with more than 40% of spending occurring in the post-acute period.
- **SHFFT:** this episode category, referred to as Hip and Femur procedures except Major Joint in BPCI-A, would include beneficiaries who receive a hip fixation procedure in the presence of a hip fracture. It would exclude fractures treated with a joint replacement. SHFFT was selected because it was the second highest volume and second-highest cost BPCI-A surgical episode performed in the inpatient setting based on 2021 data with 69,076 episodes costing $3.22 billion, with more than 63% of spending occurring in the post-acute period.
- **Spinal Fusion:** this episode category would include beneficiaries who undergo certain spinal fusion procedures in either the inpatient or outpatient setting. It was selected because it was the third-highest cost BPCI-A surgical episode performed in the inpatient setting based on 2021 data, with 62,345 episodes costing $3.2 billion, with more than 27% of spending occurring in the post-acute period.

Based on Medicare FFS claims data analysis beginning in CY 2021, CMS estimates the following number of episodes that TEAM would capture: 75,254 for SHFFT, 215,957 for LEJR, and 65,968 for Spinal Fusion. The average episode cost for these historical episodes that extended 30 days post-hospital discharge were $35,501 for SHFFT, $21,063 for LEJR, and $46,326 for Spinal Fusion.

Clinical Dimension of Episodes

Hospitals participating in TEAM would identify beneficiaries in included episodes through their MS-DRG during the anchor hospitalization or through the HCPCS codes for outpatient procedures. The MS-DRG for inpatient procedures would determine the ultimate MS-DRG assignment for the hospitalization, unless additional surgeries higher in the MS-DRG hierarchy are also reported. This is the same method as was used in BPCI-A and CJR.

CMS proposed to define episodes with a clinical dimension defining which conditions and associated services are included in the episode category as well as a temporal dimension that describes episode length, start and endpoints, and conditions under which the episode may be cancelled prior to the end of the episode.

All episodes will begin with an admission to an acute care hospital stay (anchor hospitalization) or an outpatient procedure at a hospital outpatient department (anchor procedure), and end 30 days following hospital discharge or anchor procedure.

- **LEJR:** Include hip, knee, and ankle replacements, but exclude arthroplasty of the small joints in the foot. It would include both hospital inpatient and outpatient procedures paid under MS-DRG 469, 470, 521, or 522 or HCPCS code 27447, 27130, or 27702. Both inpatient and outpatient Total Ankle Arthroplasty would trigger an episode in TEAM. The estimated annual number of potentially eligible beneficiary discharges for LEJR would be 226,000.
- **Surgical Hip & Femur Fracture Treatment (Excluding LEJR):** Defined as a hip fixation procedure, with or without fracture reduction, but excluding joint replacement paid under MS-DRG 480-482. The episode would include beneficiaries treated surgically for hip and femur fractures, other than hip arthroplasty, including open and closed surgical hip fixation, with or without reduction of the fracture. The estimated annual number of potentially eligible beneficiary discharges for SHFFT would be 85,000. While a small number of SHFFT procedures are performed in the HOPD setting, TEAM would only include inpatient procedures as that conforms with hip and femur procedure except major joint episodes under BPCI-A.
- **Spinal Fusion:** Any cervical, thoracic, or lumbar spinal fusion procedure paid under MS-DRG 453-455, 459-460, or 471-473, HCPCS codes 22551, 22554, 22612, 22630, or 22633. The estimated annual number of potentially eligible beneficiary discharges for Spinal Fusion would be 94,000.

TABLE X.A.-04: PROPOSED EPISODE CATEGORIES AND BILLING CODES

Episode Category	Billing Codes (MS-DRG/HCPCS)
LEJR	MS-DRG 469, 470, 521, 522 HCPCS 27447, 27130, 27702
SHFFT	MS-DRG 480, 481, 482
CABG	MS-DRG 231, 232, 233, 234, 235, 236
Spinal fusion	MS-DRG 453, 454, 455, 459, 460, 471, 472, 473 HCPCS 22551, 22554, 22612, 22630, 22633
Major bowel procedure	MS-DRG 329, 330, 331

Items and Services Included in Episodes

All items and services paid under Medicare Part A and Part B during the performance period would be included in the episodes. The full list includes:

- 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.
- 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.

Items and Services Excluded (pg. 1150)

CMS proposes to exclude from episodes certain Parts A and B items and services that are clinically unrelated to the anchor hospitalization or procedure.

The proposed exclusions would be applicable to episodes including during the baseline period, the three-year historical period used to construct target prices, and episodes initiated during a performance year. The proposed exclusions are similar to those for BPCI-A. These include:

- Oncology
- Trauma medical admissions
- Organ transplant
- Ventricular shunts determined by MS-DRG
- Major Diagnostic Category (MDC) 02 (Diseases and Disorders of the Eye)
- MDC 14 (Pregnancy, Childbirth, and Puerperium)
- MDC 15 (Newborns)
- MDC 25 (Human Immunodeficiency Virus)

- The IPPS new technology add-on payments (NTAP) for drugs, technologies, and services identified by value code 77 on IPPS hospital claims for episodes in the baseline period and performance years. This is similar to the policy in CJR.
- The OPPS transition pass-through payments for medical devices as identified through OPPS status indicator H for episodes in the baseline period and performance years. This is similar to the policy with BPCI-A and CJR.
- Drugs or biologics that are paid outside of the MS-DRG, specifically hemophilia clotting factors as identified by HCPCS code, diagnosis code, and revenue center on IPPS claims for episodes in the baseline period and performance years.
- Certain Part B payments for high-cost drugs and biologicals, low-volume drugs, and blood clotting factors for hemophilia patients billed on outpatient, carrier, and DME claims for episodes in the baseline period and initiated in the performance years.

Beneficiary Inclusion Criteria

CMS explains that they are beginning an episode with the anchor hospitalization or procedure because of the challenges related to clinical variability leading up to the episodes and identifying unrelated services, given the MCCs experience by TEAM beneficiaries.

CMS proposes that all services included in the IPPS, such as the 3-day payment window payment policies, would be included in the episodes. Beneficiaries eligible for the TEAM must meet all the below criteria at the time of admission:

- 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 the episode start date will be the day of the anchor procedure for outpatient or the date of admission on the IPPS claim associated with the anchor hospitalization that triggered the episode.

If an anchor hospitalization is initiated on the same day as or within 3 days of an outpatient procedure for the same episode category, CMS proposes to begin the episode on the date of the outpatient procedure rather than the date of the inpatient admission. This is different from BPCI-A, where there could be episodes initiated at one hospital and continued at another following a transfer, but like CJR where there would be two separate hospitalizations resulting in an episode initiation depending on the hospital participation in the model and the MS-DRGs involved in the hospital admissions.

Episode Length (pg. 1158)

CMS believes that the 30-day episode length is appropriate to "both sustain the spending reductions demonstrated in BPCI-A and CJR and mitigate some of the current challenges experienced between ACOs, hospitals, and other providers.

The 30-day episode length would "position the specialist at the principal provider near the anchor event with a hand off back to the primary care provider for longitudinal care management." CMS believes that "ACOs are better equipped to address the population health needs of Medicare beneficiaries."

CMS proposes that, for episodes where a Medicare payment for services included in the episode spans a period of care extending beyond the 30-day episode duration, the payments would be prorated so that only the portion attributable to care during the fixed duration of the episode is attributed to episode spending.

CMS seeks input from stakeholders on potentially making the episode length 60 or 90 days.

Cancelling Episodes

CMS believes it will be appropriate to cancel an episode given the following circumstances:

- When the beneficiary's status changes during the episode "such that they no longer meet the criteria for inclusion because the target price reflects full payment for the episode, yet CMS would not have full Medicare episode payment data for the beneficiary to reconcile against the target price.
- In cases where a beneficiary has a subsequent admission for an episode on the same day or within 3 days of an outpatient procedure from the same episode category, the outpatient episode would instead initiate an anchor hospitalization. The anchor hospitalization start date would be the date of the outpatient procedure.
- If a beneficiary dies during the anchor hospitalization or anchor procedure, rather than at any point during the post-discharge period of the episode as is the case in BPCI-A.
- Episodes subject to extreme and uncontrollable circumstances (EUC) would be canceled, therefore the services associated with the episode would continue to be paid through Medicare FFS but the episode would not be reconciled against a target price.

Quality Measures and Reporting

CMS is beginning with a limited set of quality measures that are being tied to payment. **They plan to incorporate more PRO-PMs in the future of the model.**

CMS "considered including generic PRO data to support the collection and reporting of PROs, similar to the CJR model requiring voluntary submission of the Veterans RAND 12 Item Health Survey (VR-12) or the PROMIS Global-10 generic PRO survey."

CMS recognizes that "PRO collection and reporting may increase participant and patient burden and we do not want to impose this on TEAM participants for generic PRO data since it may be less clinically meaningful to the episodes that would be tested in TEAM."

"The CQS would be combined with the TEAM participants' reconciliation amount during the reconciliation process to tie quality performance to payment." Future measures will be added or removed through notice and comment rulemaking.

To "encourage greater care collaboration among the providers of TEAM beneficiaries, CMS propose three measures." These would be used to determine hospital quality of care and eligibility for TEAM reconciliation payment. These measures are:

- **For all TEAM episodes: Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and Electronic Health Record Data (CMIT ID #356)-pg. 1168**
- **For all TEAM episodes: CMS Patient Safety and Adverse Events Composite (CMS PSI 90) (CMIT ID #135)-pg. 1169**
- **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)-pg. 1171**

Beginning in PY 1 and continuing for the duration of the model, CMS proposes to adjust reconciliation amounts by the TEAM participants' CQS based on their performance of quality measures previously listed.

CMS is proposing these three measures for the following reasons:

- Alignment with the goals of TEAM
- Hospitals' familiarity with the measures due to their use in other CMS hospital quality programs, including the Hospital IQR and HAC Reduction Programs
- Alignment to CMS priorities, including the CMS National Quality Strategy which has goals that support safety, outcomes, and engagement

CMS is seeking feedback on the opportunity for shared decision making to be captured with the model. CMS specifically seeks comment "on whether such a measure concept or any existing measures would be appropriate for TEAM."

CMS is also seeking comment on the three 2023 measures under consideration (Hospital Harm – Falls with Injury (MUC2023-048); Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue) (MUC2023-049); Hospital Harm - Postoperative Respiratory Failure (MUC2023-050)) and possibly replacing the CMS PSI 90 measure beginning in 2027. These measures, if finalized and included in TEAM, would also be reported via the Hospital IQR HAC Reduction program. (pg. 1174)

CMS proposes that data submission for the Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data (CMIT ID #356), CMS Patient Safety and Adverse Events Composite (CMS PSI 90) (CMIT ID #135), Hospital-Level, and Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA) (CMIT ID #1618) be accomplished through existing Hospital IQR Program processes.

TABLE X.A.-05– SUMMARY OF PROPOSED QUALITY MEASURE PERFORMANCE PERIODS BY YEAR OF TEAM

Measure Title	TEAM Performance Year				
	1st	2nd	3rd	4th	5th
Hybrid Hospital-Wide Readmission Measure *	July 1, 2024 – June 30, 2025	July 1, 2025 – June 30, 2026	July 1, 2026 – June 30, 2027	July 1, 2027 – June 30, 2028	July 1, 2028 – June 30, 2029
CMS PSI 90 **	July 1, 2023 – June 30, 2025	July 1, 2024 – June 30, 2026	July 1, 2025 – June 30 - 2027	July 1, 2026 – June 30, 2028	July 1, 2027 – June 30, 2029
THA/TKA PRO-PM ***	July 1, 2024 – June 30, 2025	July 1, 2025 – June 30, 2026	July 1, 2026 – June 30, 2027	July 1, 2027 – June 30, 2028	July 1, 2028 – June 30, 2029

* Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data (CMIT ID #356).
** CMS Patient Safety and Adverse Events Composite (CMS PSI 90) (CMIT ID #135).
*** Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA) (CMIT ID #1618).

CMS is "aware that the Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA) PRO-PM is new to the Hospital IQR Program, although it has been used in the CJR model for several years and are seeking comment on the use of this measure for TEAM."

Pricing and Payment Methodology (pg. 1179)

Target prices: baseline period for benchmarking will be 3 years, rolled forward each year. This is similar to the initial CJR methodology.

- To determine baseline episode spending for PY1, CMS would use baseline episode spending for episodes that started between January 1, 2022 and December 31, 2024
- To determine baseline episode spending for PY2, CMS would use baseline episode spending for episodes that started between January 1, 2023 and December 31, 2025
- To determine baseline episode spending for PY 3, CMS would use baseline episode spending for episodes that started between January 1, 2024 and December 31, 2026
- To determine baseline episode spending for PY 4, CMS would use baseline episode spending for episodes that started between January 1, 2025 and December 31, 2027
- To determine baseline episode spending for P Y 5, CMS would use baseline episode spending for episodes that started between January 1, 2026 and December 31, 2028

CMS acknowledges participant concerns with the "ratchet effect" of being penalized for achieving lower spending by having lower target prices in subsequent years, but they prefer to "balance this concern against the likelihood of having inaccurate target prices" if older baseline episode spending data is used or if it is rebased less frequently.

CMS will use a 3-year baseline period and rebase annually and adjust baseline episode spending to trend all episode spending to the most recent year of the baseline period. This proposed adjustment would reflect the impact of inflation and changes in episode spending due to a variety of factors in the baseline period.

Baseline year 1 for PY 1 is CY 2022, baseline year 2 is CY 2023, and baseline year 3 is CY 2024. CMS proposes "to calculate the adjustment factors for baseline years 1 and 2 by dividing average episode spending for baseline year 3 episodes by average episode spending for episodes from baseline years 1 and 2, respectively. They would then apply the applicable adjustment factors to the episode spending of each episode in baseline years 1 and 2. This adjustment would bring all baseline episode spending forward to the most recent baseline year, so that baseline year 1 and 2 spending would be expressed in baseline year 3 dollars. This method would be consistent with how they calculated the baseline trend factor for CJR in the performance years that used the 3-year baseline period." These baseline trend factor adjustments will be calculated at the MS-DRG/HCPCS episode type and region level. (pg. 1186)

CMS proposes to "weight episode spending from baseline year 1 at 17%, baseline year 2 at 33%, and baseline year 3 at 50%. This method of weighting would mean that the most recent episode spending patterns, expected to be the most accurate predictor of performance year spending, would contribute most strongly to the benchmark price at 50%. The remaining 50% would be divided into thirds, with baseline year 2 contributing approximately 2/3, while baseline year 1, which is likely to be the least accurate predictor of performance year spending, would contribute 1/3."

Regional Target Prices

CMS is proposing to provide TEAM participants with target prices for each proposed MS-DRG/HCPCS episode type and region based on 100% regional data for all TEAM participants prior to each performance year, consistent with PY 4-8 of the CJR model.

CMS seeks comment on the proposal to provide regional target prices to all TEAM participants for each PY during the model performance period. CMS also seeks comment on other potential ways to set target prices for Track 1 and 2 participants.

Services that Extend Beyond an Episode

"An example would be a beneficiary in an episode who is admitted to a SNF for 15 days, beginning on Day 26 post-discharge from the TEAM anchor hospitalization or anchor procedure. The first 5 days of the SNF admission would fall within the episode, while the subsequent 10 days would fall outside of the episode."

CMS proposes that, to the extent that a Medicare payment for included episode services spans a period of care that extends beyond the episode period, the payments would be prorated so that only the portion attributable to care during the episode is attributable to the episode payment when calculating the actual Medicare payment for the episode. This method is similar to that of the CJR model.

"For non-IPPS inpatient hospital (for example, CAH) and inpatient PAC (for example, SNF, IRF, LTCH, IPF) services, CMS proposes to prorate payments based on the percentage of actual length of stay (in days) that falls within the episode window. For HHA services that extend beyond the episode, CMS proposes that the payment proration be based on the percentage of days, starting with the first billable service date ("start of care date") and through and including the last billable service date, that fall within the episode. This proposed policy would ensure that TEAM participants are not held responsible for the cost of services that did not overlap with the episode period."

"For IPPS services that extend beyond the episode (for example, readmissions included in the episode definition), CMS proposes to separately prorate the IPPS claim amount from episode target price and actual episode payment calculations, called the normal MS-DRG payment amount for purposes of this proposed rule. The normal MS-DRG payment amount would be prorated based on the geometric mean length of stay, comparable to the calculation under the IPPS PAC transfer policy."

For episodes that begin in one performance year and end in the subsequent performance year, CMS proposes to remain consistent with the policy in BPCI-A by having all episodes receive the target price associated with the date of discharge from the anchor hospitalization or procedure, regardless of the episode end date.

"Annual reconciliation is based on episodes that end during a performance year, so if an episode extends past the end of a performance year, that episode would factor into the next performance year's reconciliation, when the episode ends, which is consistent with both CJR and BPCI Advanced. Accordingly, if an episode were to end after the final performance year of the model, CMS proposes that it would not be reconciled." (pg. 1192)

High-cost Outlier Cap

CMS proposes "to cap both baseline episode spending and performance year episode spending at the 99th percentile of spending at the MS-DRG/HCPCS episode type and region level, referred to as the high-cost outlier cap. CMS proposes to determine the 99th percentile of spending at the MS-DRG/HCPCS episode type and region level during the applicable time period, and then set spending amounts that exceed the high-cost outlier cap to the amount of the high-cost outlier cap."

For example, "if the high-cost outlier cap was set at $30,000, an episode that had actual episode spending of $45,000 would have its spending amount, for purposes of the model, reduced by $15,000 when the cap was applied and therefore, the spending for that episode would be held at $30,000."

When calculating the performance year episode spending at reconciliation, CMS proposes to use capped episode spending so that a TEAM participant would not be held responsible for catastrophic episode spending amounts that they could not reasonably have been expected to prevent.

Trending Prices

CMS is proposing to provide preliminary target prices that incorporate a prospective trend factor to TEAM participants. This will be calculated as the percent difference between the average regional MS-DRG/HCPCS episode type expenditures computed using the most recent year of the applicable baseline period, and the comparison average regional MS–DRG/HCPCS episode type expenditures during the first year of the baseline.

"By comparing baseline year 3 to baseline year 1, the prospective trend would capture changes across a two-year period, which CMS believes is appropriate given that they would be projecting spending patterns in the performance year which would be 2 years after baseline year 3. This proposed trend factor calculation would be similar to how the market trend factor is currently calculated in the CJR extension, but instead of retrospectively comparing average regional MS-DRG/HCPCS episode type spending during the performance year to spending during the baseline year, the calculation would be performed prospectively, so that performance year expenditures would not be considered. A fully prospective trend factor would give participants more certainty about what their reconciliation target prices would be, although reconciliation target prices as proposed would incorporate both beneficiary-level risk adjustment and an adjustment to the prospective normalization factor." (pg. 1196)

CMS is "requesting comment on alternative ways to calculate the trend factor to both increase accuracy of prospective target prices and to mitigate the ratchet effect. CMS recognizes that spending on some episodes, such as Lower Extremity Joint Replacement, has been decreasing over time and may reach a point where further decreases in spending could compromise quality and patient safety." (pg. 1197)

Discount Factor

CMS proposes to apply a 3% discount factor to the benchmark price when calculating the preliminary target prices to serve as Medicare's portion of reduced expenditures from the episode. This is similar to what is applied in CJR and in the surgical episode target prices in BPCI-A.

Low Volume Hospitals

CMS proposes a low volume threshold for reconciliation purposes that would apply to total episodes across all episode categories in the baseline period for a given performance year.

"If a TEAM Participant did not meet the proposed low volume threshold of at least 31 total episodes in the baseline period for PY1, CMS would still reconcile their episodes, but the TEAM participant would be subject to the Track 1 stop-loss and stop-gain limits for PY1. If a TEAM Participant did not meet the proposed low volume threshold of at least 31 total episodes in the applicable baseline periods for PYs 2-5, the TEAM Participant would be subject to the Track 2 stop-loss and stop-gain limits for PY 2-5."

Preliminary Target Prices

CMS proposes to provide preliminary target prices to the TEAM participants by the end of November prior to each performance year. The preliminary target prices would be based on regional episode spending during the baseline period and participants would receive the preliminary target prices for each MS-DRG/HCPCS episode type that corresponded to their region.

Risk Adjustment and Normalization

To simplify the risk adjustment methodology for TEAM and allow participants to more easily calculate an episode level estimated target price, CMS proposes to base the methodology on the CJR extension with several differences.

- The risk adjustment coefficients will be calculated at the MS-DRG/HCPCS episode type level. The same age bracket risk adjustment variable (less than 65 years, 65 to less than 75 years, 75 to less than 85 years, and 85 years or more) that is used in the CJR extension, based on the participant's age on the first day of the episode, as determined through Medicare enrollment data will be used.
- There will also be an HCC count risk adjustment variable (TEAM HCC count), which would have a 90-day lookback for each beneficiary, beginning with the day prior to the anchor hospitalization or anchor procedure. Consistent with BPCI-A, CMS proposes use the beneficiary's Medicare FFS claims from that lookback period to determine which HCC flags the beneficiary is assigned and created a count of them.

CMS also proposes "to use an expanded risk adjustment variable that accounts for multiple potential markers of beneficiary social risk. Although it would function as a single, binary (yes=1 or no=0) variable in the risk adjustment model, the variable would represent the union of three different potential markers of beneficiary social risk."

- The first would be full Medicare/Medicaid dual eligibility status, which is currently used in both CJR and BPCI Advanced.

CMS further proposes "to incorporate two additional elements to the beneficiary social risk adjustment variable."

- "CMS proposes that beneficiaries would also be assigned the value of yes=1 for the social risk adjustment variable if they either fall into a state or national Area Deprivation Index percentile beyond

a certain threshold, or if they qualify for the Medicare Part D Low Income Subsidy. The beneficiary would be assigned a value of yes=1 on this single, binary social risk variable if one or more of these three indicators of social risk applied to the beneficiary. CMS proposes to use a threshold of the 80th percentile for the national ADI and the 8th decile for the state ADI. Across other CMS Innovation Center models, as well as peer reviewed publications, CMS did not find a consensus on a specific threshold that is universally used. For example, the Making Care Primary Model uses 75th percentile for the national ADI and in existing literature, some papers use a continuous measure, and some use a 75%, an 80%, or 85% cut-off. Therefore, CMS feels that an 80% threshold is comparable to other risk adjustment methodologies." (pg. 1207)

- CMS also proposes "to provide a prospective normalization factor with preliminary target prices. The prospective normalization factor would be subject to a limited adjustment at reconciliation based on the observed case mix, up to +/- 5%."

CMS seeks comment on "the utility of including standardized patient assessment data in TEAM's risk adjustment methodology or whether there is other functional status data CMS should consider and whether standardized patient assessment data or other functional status data should be included in TEAM's risk adjustment methodology in future performance years." (pg. 1209)

Process for Reconciliation

CMS proposes "to adjust the reconciliation amount for quality based on the TEAM participant's CQS, which would be constructed from their quality measure performance, to calculate the quality-adjusted reconciliation amount."

CMS "proposes to apply stoploss/stop-gain limits to the quality-adjusted reconciliation amount to determine the TEAM participant's Net Payment Reconciliation Amount (NPRA)."

CMS proposes "to adjust the NPRA for post-episode spending, when applicable, to determine the reconciliation payment or repayment amount."

The annual reconciliation calculation would compare performance year spending on episodes that ended during that performance year with reconciliation target prices for those episodes to calculate a reconciliation amount for each TEAM participant.

Annually, CMS would reconcile all episodes attributed to a TEAM participant that end in a given calendar year during the model performance period. This is consistent with CJR and other CMS value-based programs.

The reconciliation would be conducted 6 months after the end of the performance year, as with CJR for performance years 6-8. CMS will capture claims submitted by July 1st following the end of the performance

year and carry out the NPRA calculation to make the payment or hold participants responsible for repayment in quarters 3 or 4 of that calendar year. (pg. 1212)

TEAM Participants that Experience a Reorganization Event

CMS proposes to define a reorganization event as a merger, consolidation, spin off, or other restructuring that results in a new hospital entity under a given CCN. This would result in the TEAM participant billing under a difference CCN, or an additional entity could be incorporated into the TEAM participant's existing CCN, resulting in a new hospital entity.

For example, "TEAM participant A may merge with, or be purchased by, TEAM participant B and begin billing under TEAM participant B's CCN. In this case, CMS proposes to perform separate reconciliation calculations for TEAM participant A and TEAM participant B for those episodes where the anchor hospitalization admission or the anchor procedure occurred before the effective date of the merger or purchase. CMS proposes to reconcile episodes where the anchor hospitalization admission or the anchor procedure occurred on or after the effective date of the merger or purchase under the new or surviving CCN that applies to the blended entity."

"If a TEAM participant merges into or is purchased by a non-TEAM participant and begins billing under the CCN on the non-TEAM participant, CMS proposes to reconcile episodes for the TEAM participant where the anchor hospitalization admission or the anchor procedure occurred before the effective date of the merger or purchase. This policy would allow for the TEAM participant to earn a reconciliation payment or owe a repayment for the episodes that occurred during the portion of the performance year that they were in the model. However, once the TEAM participant begins to bill under the non-TEAM participant's CCN, the blended entity would not be considered a TEAM participant and CMS would not reconcile episodes where the anchor hospitalization admission or the anchor procedure occurred on or after the effective date of the merger or purchase under the new or surviving CCN that applies to the blended entity."

Updating Preliminary Target Prices to Create Reconciliation Target Prices

"In some cases, the final target price applied to an episode in a given performance year at reconciliation will not change. In addition, in some cases the reconciliation target price will increase from the preliminary target price provided prior to the performance year, potentially benefiting TEAM participants. For instance, if the prospective normalization factor were calculated as 0.85, but the beneficiary case mix during the performance year differed from the case mix during the final year of the baseline such that the final normalization factor were calculated as 0.89, the reconciliation target price would incorporate the final normalization factor and therefore be higher than the preliminary target price."

Composite Quality Score

The CQS is one component of the reconciliation process. CMS proposes it would be calculated based on the TEAM participant's performance on the quality measures proposed for the model. Quality measures that apply to more episode categories will be volume-weighted more heavily in the CQS.

"Similar to the BPCI Advanced model, for each TEAM performance year CMS proposes for each quality measure to convert raw quality measure scores into scaled quality measure scores by comparing the raw quality measure score to the distribution of raw quality measure score percentiles among the national cohort of hospitals, which would consist of TEAM participants and hospitals not participating in TEAM, in the CQS baseline period, so that each measure has a scaled quality measure score between 0 and 100 for each episode category."

"For example, if a TEAM participant's raw quality measure score of 71% in PY 1 is equivalent to the 60th percentile during the CQS baseline period, their scaled quality measure score for that measure will be 60 in the performance year."

CMS recognizes "there may be instances where the raw quality score may fall between percentiles or may be higher or lower than the raw quality scores in the CQS baseline period. Therefore, they propose if the raw quality measure score could belong to either of two percentiles in the CQS baseline period, then they would assign the higher percentile."

CMS would also assign a scaled score of 100 if the TEAM participant has a raw quality measure score greater than the maximum of the raw quality measure scores in the CQS baseline period and assign a scaled quality measure score of zero if the TEAM participant has a raw quality score less than the minimum of the raw scores in the CQS baseline period. CMS would not assign a scaled quality score if the TEAM participant has no raw quality measure score.

The CQS baseline period will be CY 2025 for the duration of TEAM. This is similar to the method for BPCI-A.

"If new episodes categories or quality measures are introduced to TEAM, CMS would reassess the CQS baseline period and implement any changes in future notice and comment rulemaking."

To volume weight the quality measures, CMS will base them on the volume of episodes for a participant. (pg. 1218)

TABLE X.A.-06 – EXAMPLE QUALITY MEASURE NORMALIZED WEIGHTS CALCULATION

Quality Measure	Volume of Episodes	Normalized Weight
Hybrid Hospital-Wide Readmission (CMIT ID 356)	650	0.38
CMS Patient Safety and Adverse Events Composite (CMIT ID 135)	650	0.38
Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (CMIT ID 1618)	400	0.24
	1,700	1.00

CMS "would then take the quality measures normalized weights and combine it with the scaled quality measure scores to determine the weighted scaled score. Specifically, CMS proposes to calculate a weighted average by multiplying each quality measure's scaled quality measure score by its normalized weight to create weighted scaled scores for a TEAM participant. The weighted scaled scores would then be added together to construct the CQS for the TEAM participant."

TABLE X.A.-07 – EXAMPLE WEIGHTED SCALED SCORE AND CQS CACLULATION

Quality Measure	Scaled Quality Measure Score	Normalized Weight	Weighted Scaled Score
Hybrid Hospital-Wide Readmission (CMIT ID 356)	60	0.38	22.8
CMS Patient Safety and Adverse Events Composite (CMIT ID 135)	50	0.38	19
Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (CMIT ID 1618)	40	0.24	9.6
Composite Quality Score			51.4

Calculating the Reconciliation Payment Amount or Repayment Amount

CMS proposes "to apply the high-cost outlier cap to episodes in the performance year similarly to how they propose to apply it to baseline episodes, using the 99th percentile for each MS-DRG/HCPCS episode type and region as the maximum. Any performance year episode spending amount above the high cost outlier cap would be set to the amount of the high cost outlier cap. CMS will then compare each TEAM participant's performance year spending to its reconciliation target prices. The reconciliation amount will be defined as the dollar amount representing the difference between the reconciliation target price and performance year spending, prior to adjustments for quality, stop-gain/stop-loss limits, and post-episode spending." (pg. 1219)

Once this has been calculated, CMS will adjust the amount for quality performance, apply the stop-loss and stop-gain limits, and then combine the Net Payment Reconciliation Amount with the results of the post-episode payment calculation.

CMS "proposes to not have the reconciliation amount for a given performance year be impacted by TEAM Medicare repayments or reconciliation payments made in a prior performance year."

Incorporating the Composite Quality Score into the Reconciliation Amount

Like BPCI-A, CMS proposes that a TEAM participant's quality performance would be linked to payment by translating the CQS into a CQS adjustment percentage and apply that to any positive or negative reconciliation amount.

- Track 1: The CQS adjustment percentage would adjust a positive reconciliation amount up to 10%, and because Track 1 does not have downside risk, there would be no CQS adjustment percentage for negative reconciliation amounts. In the event a TEAM participant in Track 1 would have earned a

negative reconciliation amount, their CQS would still be reported in their reconciliation report so that they may use this information to improve their quality measure performance in the next performance year.

- Track 2: The CQS adjustment percentage would adjust a positive reconciliation amount up to 10% and a negative reconciliation amount up to 15%. The CQS adjustment percent would not adjust the positive reconciliation amount down by more than 10%, nor would it adjust the negative reconciliation amount up (meaning more towards a positive amount) by more than 15%.
- Track 3: The CQS adjustment percentage would adjust a positive reconciliation amount up to 10% and a negative reconciliation amount up to 10%.

TABLE X.A.-08 – TEAM PROPOSED CQS ADJUSTMENT PERCENTAGE FORMULAS

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))

CMS proposes to define the quality-adjusted reconciliation amount as 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.

In Track 2, CMS believes an asymmetric application of the adjustment percentage may help "mitigate some of the negative financial burden that may be associated with caring for underserved beneficiaries who tent to be higher cost and have worse health outcomes."

TABLE X.A.-09 – EXAMPLE OF PROPOSED CQS APPLICATION

Participant Track	Reconciliation Amount	CQS	CQS Adjustment Percentage	CQS Adjustment Amount	Quality-Adjusted Reconciliation Amount
Track 1	$24,000	72	2.8%	$672	$23,328
Track 1	-$19,500	88	0.0%	$0	$0.00
Track 2	$10,000	45	5.5%	$550	$9,450
Track 2	-$7,500	66	9.9%	$743	-$6,757
Track 3	$38,000	51	4.9%	$1,862	$36,138
Track 3	-$26,500	93	9.3%	$2,465	-$24,035

Limitations on NPRA

Similar to CJR, CMS proposes to phase in risk in TEAM.

- Track 1: TEAM participants would not be subject to downside risk in PY 1. CMS also proposes a stop-gain limit of 10% for Track 1 TEAM participants in PY 1.
- Track 2: TEAM participants would be subject to downside and upside risk with a symmetric stop-gain and stop-loss limits of 10% for PY 2-5. CMS believes a 10% stop-gain and stop-loss limit of 10% is appropriate for Track 2 participants who can gain value-based care experience but have less financial risk.
- Track 3: TEAM participants that opt into Track 3 of the model would be subject to both upside and downside risk, with symmetric stop-gain and stop-loss limits of 20% for all performance years. The greater level of downside risk in Track 3 would be balanced by higher stop-gain limits for Track 3 compared to Track 1 or Track 2, which CMS proposes to continue for all performance years.

CMS also proposes to apply the stop-loss and stop-gain limits after application of the CQS. Thus, they propose to define the NPRA "as 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." This is like both BPCI-A and CJR.

Participant Responsibility for Increased Post-Episode Payments

"While the proposed episodes would extend 30 days post-discharge from the anchor hospitalization or post-procedure (for outpatient episodes), some hospitals may have an incentive to withhold or delay medically necessary care until after an episode ends to reduce their actual episode payments. CMS does not believe this would be likely, but in order to identify and address such inappropriate shifting of care, they propose to calculate for each performance year the total Medicare Parts A and B expenditures in the 30-day period following completion of each episode for all services covered under Medicare Parts A and B, regardless of whether the services are included in the proposed episode definition." (pg. 1225)

To address this, CMS proposes "to identify whether the average 30-day post-episode spending for a TEAM participant in any given performance year is greater than three standard deviations above the regional average 30-day post-episode spending, based on the 30-day post-episode spending for episodes attributed to all TEAM regional hospitals in the same region as the TEAM participant. CMS proposes that beginning with PY1 for Track 3 TEAM participants, and PY2 for Track 2 TEAM participants, if the TEAM participant's average post-episode spending exceeds this threshold, the amount above the threshold would be subtracted from the reconciliation amount or added to the repayment amount for that performance year. The amount above the threshold would not be subject to the stop-loss limits."

Reconciliation Payments and Repayments

For PY 1/Track 1 participants, CMS will combine the NPRA and post-episode spending amount. If positive, the participant would receive the amount as a one-time lump sum payment from Medicare. If negative, they would not be responsible for repayment.

For participants in Track 3 for PY 1, and Track 2 or 3 for PY 2-5, if the amount is positive then the participant would receive the amount as a one-time lump sum payment from Medicare. If negative, Medicare would collect the one-time lump sum repayment in a "manner that is consistent with all relevant federal debt collection laws and regulations."

CMS is "not proposing to require financial guarantees or change existing Medicare recoupment or offsetting policies, but they are seeking comment on whether they should consider these options further or if there are other ways to reduce financial hardship for TEAM participants that owe a repayment amount. CMS also seeks comment on whether they should consider a Medicare payment policy waiver to reduce financial hardship, what the waiver would waive, and if the waiver is necessary to avoid undue burden on TEAM participants." (pg. 1229)

Proposed Appeals Process

First Level Appeal Process: The calculation of the TEAM participant's reconciliation amount or repayment amount as reflected on a TEAM reconciliation report; the calculation of NPRA; and the calculation of the CQS. CMS proposes that participants review their reconciliation report and be required to provide a notice of calculation error that must be submitted per CMS rules. If such notice is not provided, CMS will deem the report final within 30 calendar days after it is issued.

- "If CMS receives a timely notice of an error in the calculation, CMS will respond in writing within 30 calendar days to either confirm or refute the calculation error, although CMS would reserve the right to an extension upon written notice to the TEAM participant. CMS proposes that if a TEAM participant does not submit timely notice of calculation error in accordance with the timelines and processes specified by CMS, the TEAM participant would be precluded from later contesting any element of the TEAM reconciliation report for that performance year."
- "If a TEAM participant contests a matter that does not involve an issue contained in, or a calculation that contributes to, a TEAM reconciliation report, a notice of calculation error is not required. A notice of calculation error form would not be an appropriate format for addressing issues other than calculation errors, given that it is tailored specifically to calculation errors. In these instances, they propose that if CMS does not receive a request for reconsideration from the TEAM participant within 10 calendar days of the notice of the initial reconciliation, the initial determination is deemed final and CMS proceeds with the action indicated in the initial determination."

Reconsideration Review Process: CMS is proposing that only TEAM participants may utilize the dispute resolution process being proposed, and it would be used in the case that a determination has been made and the participant disagrees with that decision. Statute would include specific details regarding this process and the criteria. The reconsideration determination would be issued within 60 days of CMS's receipt of the filed position papers and supporting documentation. CMS's determination made by the reconsideration official

would be final and binding 30 days after its issuance, unless the participant or CMS were to request review of the reconsideration determination by the CMS Administrator. (pg. 1234)

CMS Administrator Review Process: It is proposed that either the participant or CMS may request that the CMS Administrator review the reconsideration determination.

- "The request to the CMS Administrator would have to be made via email, within 30 days of the reconsideration determination, to an email address specified by CMS. The request would have to include a copy of the reconsideration determination, as well as a detailed written explanation of why the model participant or CMS disagrees with the reconsideration determination."
- "Promptly after receiving the request for review, the CMS Administrator would send the parties an acknowledgement of receipt that outlines whether the request for review was granted or denied and, should the request for review be granted, the review procedures and a schedule that would permit both CMS and the TEAM participant an opportunity to submit a brief in support of their positions for consideration by the CMS Administrator."
- "Should the request for review be denied, the reconsideration determination would be final and binding as of the date of denial of the request for review by the CMS Administrator. Should the request for review by the CMS Administrator be granted, the record for review would consist solely of timely submitted briefs and evidence contained in the record before the reconsideration official and evidence as set forth in the documents and data; the CMS Administrator would not consider evidence other than information set forth in the documents and data. The CMS Administrator would review the record and issue to CMS and the TEAM participant a written determination that would be final and binding as of the date the written determination was sent." (pg. 1234)

Model Overlap

CMS acknowledges that they "need to consider how to promote meaningful collaboration between providers and TEAM participants. In prior models, overlap policies were intended to be simple by avoiding duplicative incentive payments or giving precedence to a single accountable entity. However, what resulted were confusing methodologies or misaligned incentives which were difficult to navigate. Participants from prior models have also cited confusion with identifying to which model(s) a beneficiary may be aligned or attributed."

"For the purposes of this proposed rule, "total cost of care" models or programs refer to models or programs in which episodes or performance periods include participant financial responsibility for all Part A and Part B spending, as well as some Part D spending in select cases. CMS uses the term "shared savings" in this proposed rule to refer to models or programs in which the payment structure includes a calculation of savings (that is, the difference between FFS amounts and program or model benchmark) and CMS and the model or program participant each retain a particular percentage of that savings."

"For example, a beneficiary may be attributed to a provider participating in the Shared Savings Program for an entire performance year, as well as have initiated an episode in TEAM during the ACO's performance year. Each model or program incorporates a reconciliation process, where total included spending during the performance period or episode are calculated, as well as any potential savings achieved by the model or program. 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. This would mean the episode spending in TEAM would be accounted for the in the total cost of care model's total expenditures, but TEAM's reconciliation payment amount or repayment amount would not be included in the total cost of care model's total expenditures. Likewise, the total cost of care model's savings payments or losses would not be included in the episode spending in TEAM." (pg. 1238)

"CMS believes that allowing overlap and the retention of savings by ACOs and TEAM participants will encourage providers to collaboratively deliver coordinated care and yield improved outcomes to beneficiaries. This aligns with broader agency goals to foster increased beneficiary alignment to value-based care and allows CMS to learn from experience and avoid creating challenges managing shared beneficiaries between ACOs and episodes of care participants."

CMS notes additional potential benefits of this overlap, such as strengthening the volume of episodes a TEAM participant is responsible for. Alternatively, 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."

Further, they "seek comment on the use of supplemental data (for example, shadow bundles data) 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." (pg. 1240)

Considerations for Notification Process for Shared Savings or Total Cost of Care Model

CMS acknowledges that many ACOs use their market's Health Information Exchange to provide admission, discharge, and transfer (ADT) alerts while others use fax or telephone. CMS seeks comments on what timeframe should be required to issue the notification and what processes should be used to provide the notification with limited burden on the TEAM participants.

Health Equity

CMS proposes to use the CMS Innovation Center's Strategy Refresh's safety net definition for identifying safety net hospitals within TEAM. The definition uses two recognized measures of social risk to identify hospitals serving a higher proportion of beneficiaries that may face barriers to care.

These are dual-eligible beneficiaries and the incorporation of the proportion of patients with Part D Low-Income Subsidy (LIS) as a proxy for income. (pg. 1251)

Identification of Rural Hospitals

A rural hospital will be defined as "an IPPS hospital that is located in a rural area; is located in a rural census tract defined; has reclassified as a rural hospital, or is designated a rural referral center (RRC). This definition would be an expanded version of the rural hospital definition used by the CJR model."

For PY 1, rural designations for TEAM would be based on the participant's rural classification as of the model start date. CMS proposes that model rural designations will occur only once at the beginning of each model performance year regardless of when a TEAM participant's rural classification may change within a given performance year.

Beneficiary Social Risk Adjustment

"To align with other CMS Innovation Center models, CMS proposes to incorporate and equally weight three social risk indicators in TEAM's target price methodology--specifically state and national ADI indicators, the Medicare Part D LIS indicator, and Dual-eligibility status for Medicare and Medicaid."

Health Equity Plans and Reporting

CMS is "proposing that TEAM participants can voluntarily submit to CMS, a health equity plan for the first performance year. This proposal to make submission of a health equity plan voluntary in PY1 recognizes that constructing a health equity plan may require significant time and effort by the TEAM participant."

Beginning in PY 2, CMS proposes that TEAM participants would be required to submit a health equity plan. This would begin in PY 2 for those TEAM participants that voluntarily submitted a health equity plan in PY 1 and beginning in PY 3 for those TEAM participants that first reported a health equity plan in PY 2, CMS proposes that the TEAM participant would submit updates to their previously submitted health equity plans. (pg. 1256)

All health equity plans must include the following elements:

- Identifies health disparities, defined as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health, health quality, or health outcomes that are experienced by one or more "underserved communities" within the TEAM participant's population of TEAM beneficiaries that the participant will aim to reduce. Underserved communities will be defined as "populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life."

CMS proposes that the data sources used to inform the identification of health disparities should also be noted in the plan.

- Identifies health equity goals and describes how the participant will use the goals to monitor and evaluate progress in reducing the identified health disparities.
- Describes the health equity plan intervention strategy.
- Identifies health equity plan performance measures, the data sources used to construct the health equity plan performance measures, and an approach to monitor and evaluate the health equity plan performance. These measures are proposed to be defined as "one or more quantitative metrics that the TEAM participant will use to measure changes in health disparities arising from the health equity plan interventions."

Demographic Data Reporting

CMS is "proposing that TEAM participants could voluntarily report to CMS demographic data of TEAM beneficiaries in PY 1. Beginning in PY 2 and all subsequent performance years, 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."

Health Related Social Needs Data Reporting

"Beginning in PY 1, CMS proposes that TEAM participants would be required to screen attributed TEAM beneficiaries for at least four HRSN domains—such as but not limited to food insecurity, housing instability, transportation needs, and utilities difficulty— because they believe these areas are most pertinent for the TEAM beneficiary population."

"TEAM participants would need to report aggregated HRSN screening data and screened-positive data for each HRSN domain for TEAM beneficiaries that received screening to CMS beginning in PY 1 and for all following performance years. As part of this reporting to CMS, they also propose that 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." (pg. 1262)

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 Inpatient Quality Report Program measures related to HRSN screening."

CMS is considering offering payments to offset the upfront costs of health IT investments for safety net hospitals.

"To receive an infrastructure payment, CMS could consider the following requirements and seek comment on any changes:

- Require TEAM participants to be a safety net hospital.
- 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. With respect to use of funds for technology investments that involve implementing, acquiring, or upgrading health IT, the hospital would also be required to ensure such technology is certified under the ONC Health IT Certification Program or utilizes nationally recognized, consensus-based standards, where such criteria or standards are available for the health IT-related activity. Use of these standards and certification criteria ensure that technology investments would support interoperability across systems.
- Should CMS make an infrastructure payment to a safety net hospital, they would need to monitor the spending of infrastructure payments to prevent funds from being misdirected and ensure they are used for activities that constitute a permitted use of the funds (for example, health IT/EHR enhancements to the extent those involve population health analytics and support for referrals to address HRSNs, in addition to costs associated with recruiting and hiring dedicated staff).
- In addition to the initial plan of anticipated spending, should a safety net hospital participant receive upfront funds, they could also be required to submit annual reports that includes an itemization of how infrastructure payments were actually spent during the performance year, including expenditure categories, the dollar amounts spent on the various categories, any changes to the spend plan, and such other information as may be specified by CMS. This itemization could include expenditures not identified or anticipated in the submitted spend plan and any amounts remaining unspent.
- Any infrastructure payments that are spent for unauthorized purposes or are unspent at the end of a specified timeframe, that is, 3 years, must be repaid to CMS."

Financial Arrangements

CMS "expects that TEAM participants would identify key providers and suppliers caring for beneficiaries in the surrounding communities, and then could establish partnerships with these individuals and entities to promote accountability for the quality, cost, and overall care for beneficiaries, including managing and coordinating care; encouraging investment in infrastructure, enabling technologies, and redesigning care processes for high quality and efficient service delivery; and carrying out other obligations or duties under TEAM. These providers and suppliers may invest substantial time and other resources in these activities, yet they would not be the direct recipients of any reconciliation payment amounts or repayment amounts as they are not the risk bearing entity and do not directly participate in TEAM."

CMS believes "it is possible that a TEAM participant that may receive a reconciliation payment amount or repayment amount may want to enter into financial arrangements with other providers or suppliers to share

this reconciliation payment amount or repayment amount with the TEAM participant. CMS expects that all financial relationships established between TEAM participants and providers or suppliers for purposes of TEAM would be those permitted only under applicable law and regulations, including the applicable fraud and abuse laws and all applicable payment and coverage requirements." (pg. 1269)

TEAM Collaborators

"For purposes of the Federal anti-kickback statute safe harbor for CMS-sponsored model arrangements, CMS proposes that the following types of providers and suppliers that are Medicare-enrolled and eligible to participate in Medicare or entities that are participating in a Medicare ACO initiative may be TEAM collaborators:

- Skilled Nursing Facility (SNF)
- Home Health Agency (HHA)
- Long-Term Care Hospital (LTCH)
- Inpatient Rehabilitation Facility (IRF)
- Physician
- Nonphysician practitioner
- Therapist in a private practice
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- Provider or supplier of outpatient therapy services
- Physician Group Practice (PGP)
- Hospital
- Critical Access Hospital (CAH)
- Non-physician provider group practice (NPPGP)
- Therapy group practice (TGP)
- Medicare ACO

Sharing Arrangements

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."
- "A TEAM participant must not make a gainsharing payment or receive an alignment payment except in accordance with a sharing arrangement. The TEAM participant and TEAM collaborator must document this agreement in writing."

CMS proposes "that the TEAM participant must develop, maintain, and use a set of written policies for selecting individuals and entities to be TEAM collaborators. To safeguard against potentially fraudulent or abusive practices, CMS proposes that **the selection criteria determined by the TEAM participant must include the quality of care delivered by the potential TEAM collaborator**. Moreover, the selection criteria cannot be based directly or indirectly on the volume or value of referrals or business otherwise generated by, between or among the TEAM participant, any TEAM collaborator, any collaboration agent, or any individual or affiliated with a TEAM participant, TEAM collaborator, or collaboration agent."

"In addition to including quality of care in their selection criteria, TEAM participants must also consider selection of TEAM collaborators based on criteria that include the anticipated contribution to the performance of the TEAM participant in the model by the potential TEAM collaborator to ensure that the selection of TEAM collaborators takes into consideration the likelihood of their future performance."

CMS further proposes that "if a TEAM participant enters a sharing arrangement, its compliance program must include oversight of sharing arrangements and compliance with the applicable requirements of the model. Requiring oversight of sharing arrangements to be included in the compliance program provides a program integrity safeguard."

Requirements

CMS proposes "that the sharing arrangement must be in writing, signed by the parties, and entered into before care is furnished to TEAM beneficiaries under the sharing arrangement. In addition, participation in a sharing arrangement must be voluntary and without penalty for nonparticipation."

"It is important that providers and suppliers rendering items and services to beneficiaries during the model performance period have the freedom to provide medically necessary items and services to beneficiaries without any requirement that they participate in a sharing arrangement to safeguard beneficiary freedom of choice, access to care, and quality of care."

"The sharing arrangement must set out the mutually agreeable terms for the financial arrangement between the parties to guide and reward model care redesign for future performance toward model goals, rather than reflect the results of model performance years that have already occurred and where the financial outcome of the sharing arrangement terms would be known before signing."

CMS proposes that "the sharing arrangement must require the TEAM collaborator and its employees, contractors, and subcontractors to comply with certain requirements that are important for program integrity under the arrangement."

CMS proposes that "the sharing arrangement must not pose a risk to beneficiary access, beneficiary freedom of choice, or quality of care so that financial relationships between TEAM participants and TEAM collaborators

do not negatively impact beneficiary protections under the model. The sharing arrangement as proposed must require the TEAM collaborator to have a compliance program that includes oversight of the sharing arrangement and compliance with the requirements of the model, just as CMS requires TEAM participants to have a compliance program that covers oversight of the sharing arrangement for this purpose as a program integrity safeguard."

CMS "proposes that the board or other governing body of the TEAM participant have responsibility for overseeing the TEAM participant's participation in the model, its arrangements with TEAM collaborators, its payment of gainsharing payments, its receipt of alignment payments, and its use of beneficiary incentives in the model." (pg. 1274)

CMS "proposes that the written agreement memorializing a sharing arrangement must specify the following parameters of the arrangement:

- The purpose and scope of the sharing arrangement.
- The identities and obligations of the parties, including specified TEAM activities and other services to be performed by the parties under the sharing arrangement.
- The date of the sharing arrangement.
- Management and staffing information, including type of personnel or contractors that will be primarily responsible for carrying out TEAM activities.
- The financial or economic terms for payment, including the following:
    - Eligibility criteria for a gainsharing payment.
    - Eligibility criteria for an alignment payment.
    - Frequency of gainsharing or alignment payment.
    - Methodology and accounting formula for determining the amount of a gainsharing payment that is solely based on quality of care and the provision of TEAM activities.
    - Methodology and accounting formula for determining the amount of an alignment payment.

Gainsharing Payment and Alignment Payment Conditions and Limitations

CMS "proposes to require that gainsharing payments be derived solely from a TEAM participant's reconciliation payment amounts, internal costs savings, or both; that they be distributed on an annual basis, not more than once per calendar year; that they not be a loan, advance payment, or payment for referrals or other business; and that they be clearly identified as a gainsharing payment at the time they are paid."

CMS believes that gainsharing payment eligibility for TEAM collaborators should be conditioned on the quality-of-care criteria and the provision of TEAM activities. (pg. 1277)

- Quality of Care Criteria: "To be eligible to receive a gainsharing payment, the TEAM collaborator must meet quality of care criteria during the performance year for which the TEAM participant earned a

reconciliation payment amount that comprises the gainsharing payment. CMS proposes that this quality-of-care criteria will be included in the sharing arrangement and mutually agreed upon by the TEAM participant and TEAM collaborator."

- Provision of TEAM Activities: "To be eligible to receive a gainsharing payment, or to be required to make an alignment payment, a TEAM collaborator other than a PGP, NPPGP, or TGP must have directly furnished a billable item or service to a TEAM beneficiary during the same performance year for which the TEAM participant earned a reconciliation payment amount or repayment amount. For purposes of this requirement, CMS considers a hospital, CAH or post-acute care provider to have "directly furnished" a billable service if one of these entities billed for an item or service for a TEAM beneficiary in the performance year for which the TEAM participant earned a reconciliation payment amount or repayment amount."

"To be eligible to receive a gainsharing payment or required to make an alignment payment for a given performance year, a PGP, NPPGP or TGP must have billed for an item or service that was rendered by one or more members of the PGP, NPPGP or TGP to a TEAM beneficiary during the episode that is attributed to the same performance year for which the TEAM participant earned a reconciliation payment amount or repayment amount. Like the proposal for TEAM collaborators that are not PGPs, these proposals also require a link between the TEAM collaborator that is the PGP, NPPGP or TGP and the provision of items and services to beneficiaries during the episode by PGP, NPPGP or TGP members."

CMS proposes that "the amount of any gainsharing payments must be determined in accordance with a methodology that is solely based on quality of care and the provision of TEAM activities…the methodology for determining alignment payments may not directly take into account the volume or value of referrals or business generated by, between or among the parties."

CMS "proposes that for each performance year, the aggregate amount of all gainsharing payments that are derived from a reconciliation payment amount by the TEAM participant must not exceed the amount of the reconciliation payment amount."

CMS proposes "that alignment payments from a TEAM collaborator to a TEAM participant may be made at any interval that is agreed upon by both parties. Alignment payments must not be issued, distributed, or paid prior to the calculation by CMS of the repayment amount, and cannot be assessed in the absence of a repayment amount. The TEAM participant must not receive any amounts under a sharing arrangement from a TEAM collaborator that are not alignment payments."

Consistent with CJR, CMS proposes that "for a performance year, the aggregate amount of all alignment payments received by the TEAM participant from all of the TEAM participant's TEAM collaborators must not exceed 50 percent of the repayment amount."

Additionally, "the aggregate amount of all alignment payments from a TEAM collaborator to the TEAM participant for a TEAM collaborator other than an ACO may not be greater than 25 percent of the TEAM participant's repayment amount. The aggregate amount of all alignment payments from a TEAM collaborator to the TEAM participant for a TEAM collaborator that is an ACO may not be greater than 50 percent of the TEAM participant's repayment amount."

Distribution Arrangements

Similar to CJR, CMS proposes that certain financial arrangements between TEAM collaborators and other individuals or entities called "collaboration agents" be termed "distribution arrangements."

- Collaboration agent: an individual or entity that is not a TEAM collaborator and that is a PGP, NPPGP, or TGP member that has entered into a distribution arrangement with the same PGP, NPPGP, or TGP in which he or she is an owner or employee.
- Distribution arrangement: a financial arrangement between a TEAM collaborator that is a PGP, NPPGP or TGP and a collaboration agent for the sole purpose of sharing a gainsharing payment received by the PGP, NPPGP or TGP. Where a payment from a TEAM collaborator to a collaboration agent is made pursuant to a TEAM distribution arrangement, we define that payment as a "distribution payment."

As with the gainsharing payments, CMS proposes that the amount of any distribution arrangements must be determined in accordance with a methodology that is solely based on quality of care and the provision of TEAM activities. (pg. 1284)

CMS proposes that "a collaboration agent is eligible to receive a distribution payment only if the collaboration agent furnished or billed for an item or service rendered to a beneficiary during an episode that occurred during the same performance year for which the TEAM participant accrued the internal cost savings or earned a reconciliation payment amount that comprises the gainsharing payment being distributed. CMS notes that all individuals and entities that fall within our proposed definition of collaboration agent may either directly furnish or bill for items and services rendered to beneficiaries."

CMS "proposes that the TEAM collaborator may not enter into a distribution arrangement with any individual or entity that has a sharing arrangement with the same TEAM participant. This proposal ensures that the proposed separate limitations on the total amount of gainsharing payment and distribution payment to PGPs, NPPGPs, TGPs, physicians, and nonphysician practitioners that are solely based on quality of care and the provision of TEAM activities are not exceeded in absolute dollars by a PGP, NPPGP, TGP, physician, or nonphysician practitioner's participation in both a sharing arrangement and distribution arrangement for the care of the same TEAM beneficiaries during the performance year." (pg. 1287)

CMS "recognizes there could be instances where an individual or entity could have distribution arrangements with multiple TEAM collaborators."

"For example, a physician may practice with and have reassigned their Medicare billing rights to multiple PGPs, and those PGPs may each be TEAM collaborators. CMS seeks comment on allowing an individual or entity to have distribution arrangements with multiple TEAM collaborators and whether there are additional program integrity safeguards that should be established in those scenarios."

Downstream Distribution Arrangements

CMS proposes that certain financial arrangements between a collaboration agent that is both a PGP, NPPGP, or TGP and an ACO participant and other individuals termed ''downstream collaboration agents'' be termed a ''downstream distribution arrangement.''

- Downstream distribution arrangement: a financial arrangement between a collaboration agent that is both a PGP, NPPGP, TGP and an ACO participant and a downstream collaboration agent for the sole purpose of sharing a distribution payment received by the PGP, NPPGP, or TGP.
- Downstream collaboration agent: an individual who is not a TEAM collaborator or a collaboration agent and who is a PGP member, a NPPGP member, or a TGP member that has entered into a downstream distribution arrangement with the same PGP, NPPGP, or TGP in which he or she is an owner or employee, and where the PGP, NPPGP, or TGP is a collaboration agent.

When a payment from a collaboration agent to a downstream collaboration agent is made pursuant to a downstream distribution arrangement, CMS will define that payment as a downstream distribution payment.

CMS proposes that "all downstream distribution arrangements must be in writing and signed by the parties, contain the effective date of the agreement, and entered into before care is furnished to TEAM beneficiaries under the downstream distribution arrangement."

Participation must be voluntary and without penalty for nonparticipation, and the downstream distribution arrangement must require the downstream collaboration agent to comply with all applicable laws and regulations.

As with the proposals for gainsharing and distribution payments, CMS proposes that the opportunity to make or receive a downstream distribution payment must not be conditioned directly or indirectly on the volume or value of referrals or business otherwise generated by, between or among the TEAM participant, any TEAM collaborator, any collaboration agent, any downstream collaboration agent, or any individual or entity affiliated with a TEAM participant, TEAM collaborator, collaboration agent, or downstream collaboration agent. (pg. 1290)

Beneficiary Incentives

"TEAM participants may choose to provide in-kind patient engagement incentives to beneficiaries in an episode, which may include but not be limited to items of technology."

This would be subject to the following proposed conditions:

- The incentive must be provided directly by the TEAM participant or by an agent of the TEAM participant under their direction and control to the TEAM beneficiary during an episode.
- The item or service provided must be reasonably connected to the TEAM beneficiary's medical care and be a preventive care item or service or an item of service that advances a clinical goal, by engaging the TEAM beneficiary in better managing their own health.

Consistent with CJR, items or services involving technology may not exceed $1,000 in retail value for any TEAM beneficiary in any episode (per episode). Additional enhanced proposed requirements for items or technology exceeding $75 in retail value are that they must remain the property of the TEAM participant and be retrieved from the beneficiary at the end of the episode.

Clinical Goals of TEAM

CMS is "proposing to allow TEAM participants to offer in-kind beneficiary engagement incentives, where such incentives must be closely related to the provision of high-quality care and advance a clinical goal for a TEAM beneficiary and should not serve as inducements for TEAM beneficiaries to seek care from the TEAM participants or other specific suppliers and providers. CMS proposes that beneficiary incentives must advance one of the following clinical goals of TEAM:

- Beneficiary adherence to drug regimens.
- Beneficiary adherence to a care plan.
- Reduction of readmissions and complications resulting from treatment during the episode.
- Management of chronic diseases and conditions that may be affected by treatment for the TEAM clinical condition.

TEAM participants must maintain documentation of items and services furnished as beneficiary engagement incentives that exceed $25 in retail value including items of technology.

CMS proposes to require that the documentation established contemporaneously with the provision of the items and services must include at least the following:

- The date the incentive is provided.
- The incentive and estimated value of the item or service.
- The identity of the beneficiary to whom the item or service was provided.

CMS also proposes that the documentation regarding items of technology exceeding $75 in retail that are required to be retrieved from the beneficiary at the end of an episode must also include contemporaneous documentation of any attempt to retrieve technology.

Proposed Waivers of Medicare Program Requirements

CMS "believes it may be necessary and appropriate to provide flexibilities to hospitals participating in TEAM, as well as other providers and suppliers that furnish services to beneficiaries in episodes."

"Waivers of certain program rules for providers and suppliers furnishing services to TEAM beneficiaries may be appropriate to offer more flexibility than under existing Medicare rules for such providers and suppliers, so that they may provide appropriate, efficient care for beneficiaries."

"An example of such a program rule that could be waived to potentially allow more efficient inpatient episodes would be the 3-day inpatient hospital stay requirement prior to a covered skilled nursing facility (SNF) stay for beneficiaries who could appropriately be discharged to a SNF after less than a 3-day inpatient hospital stay."

Post-Discharge Home Visits and Homebound Requirement

"A beneficiary is considered to be confined to the home if the beneficiary has a condition, due to an illness or injury, that restricts his or her ability to leave home except with the assistance of another individual or the aid of a supportive device (that is, crutches, a cane, a wheelchair or a walker) or if the beneficiary has a condition such that leaving his or her home is medically contraindicated. While a beneficiary does not have to be bedridden to be considered confined to the home, the condition of the beneficiary must be such that there exists a normal inability to leave home and leaving home requires a considerable and taxing effort by the beneficiary."

"However, CMS is not proposing to waive the homebound requirement under TEAM for several reasons. Based on the typical clinical course of beneficiaries after certain surgical procedures, CMS believes that many beneficiaries would meet the homebound requirement for home health services immediately following discharge from the anchor hospitalization or following discharge to their home or place of residence from a SNF that furnished PAC services immediately following the hospital discharge, so they could receive medically necessary home health services under existing program rules."

Telehealth

As with the telehealth waivers for BPCI-A and CJR, 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. Waiver of this requirement would allow beneficiaries located in any region to receive services related to the episode to be furnished via telehealth, as long as all other Medicare requirements for telehealth services are met. Any service on the list of Medicare approved telehealth services and reported on a claim that is not excluded from the proposed episode definition could be furnished to a TEAM beneficiary, regardless of the beneficiary's

geographic location. Under TEAM, this waiver would support care coordination and increasing timely access to high quality care for all TEAM beneficiaries, regardless of geography. Additionally, we propose for TEAM waiving the originating site requirements that specify the particular sites at which the eligible telehealth individual must be located at the time the service is furnished via a telecommunications system."

CMS proposes to waive the requirement **only when the telehealth services are being furnished in the TEAM beneficiary's home or place of residence during the episode.** (pg. 1309)

"For TEAM, CMS proposes to create a specific set of nine HCPCS G-codes to describe the E/M services furnished to TEAM beneficiaries in their homes via telehealth. If the proposed TEAM is finalized, CMS would specify the precise G-code created for TEAM and share them to TEAM participants prior to the first performance year."

TABLE X.A.-10 – PROPOSED TEAM TELEHEALTH WAIVER G-CODE CROSSWALK

TEAM G-Code (used for illustrative purposes. Specific G-codes will be created if TEAM is finalized)	Short Descriptor	Corresponding Office/Outpatient E/M CPT Code
GXX01	Remote E/M new pt 10mins	99201
GXX02	Remote E/M new pt 20mins	99202
GXX03	Remote E/M new pt 30 mins	99203
GXX04	Remote E/M new pt 45mins	99204
GXX05	Remote E/M new pt 60mins	99205
GXX12	Remote E/M est. pt 10mins	99212
GXX13	Remote E/M est. pt 15mins	99213
GXX14	Remote E/M est. pt 25mins	99214
GXX15	Remote E/M est. pt 40mins	99215

CMS "would include final RVUs under the CY 2026 Medicare Physician Fee Schedule for PY 1. Additionally, CMS proposes to update these values each performance year to correspond to final values established under the Medicare Physician Fee Schedule."

3-Day SNF Rule

Given "the potential benefits CMS sees for TEAM participants, their provider partners, and beneficiaries, CMS proposes to waive the SNF 3-day rule for coverage of a SNF stay following the anchor hospitalization or anchor procedure under TEAM."

"To ensure protection to TEAM beneficiary safety and optimize health outcomes, CMS proposes to require that TEAM participants may only discharge a TEAM beneficiary under this proposed waiver of the SNF 3-day rule to a SNF rated an overall of three stars or better by CMS based on information publicly available at the time of hospital discharge from an anchor hospital stay or anchor procedure." (pg. 1316)

CMS is "proposing to align with the CJR model policy and require TEAM participants to keep a record of discharge planning notice distribution to TEAM beneficiaries."

"CMS will monitor TEAM participants' use of discharge planning notices to assess the potential for their misuse. To protect TEAM beneficiaries from being charged for non-covered SNF charges in instances when the waiver was used inappropriately, and similar to the CJR model, CMS is proposing to add certain beneficiary protection requirements that would apply for SNF services that would otherwise have been covered except for lack of a qualifying hospital stay." (pg. 1322)

Monitoring and Beneficiary Protection

CMS is proposing "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."

"TEAM participants must require this notification as a condition of any Sharing Arrangement. Where a TEAM participant does not have Sharing Arrangements with providers or suppliers that furnish services to beneficiaries during an episode, or where the anchor hospitalization or anchor procedure for a Medicare FFS patient who would be included under the model was ordered by a physician who does not have a Sharing Arrangement, the beneficiary notification materials must be provided to the beneficiary by the TEAM participant." (pg. 1326)

CMS also proposes "that TEAM participants must require every TEAM collaborator to provide written notice, to be developed by CMS, to applicable TEAM beneficiaries of the existence of its sharing arrangement with the

TEAM participant and the basic quality and payment incentives under the model. CMS proposes that the notice must be provided no later than the time at which the beneficiary first receives an item or service from the TEAM collaborator during an episode. CMS recognizes that due to the patient's condition, it may not be feasible to provide notification at such time, in which case the notification must be provided to the beneficiary or his or her representative as soon as is reasonably practicable."

Monitoring for Access to Care and Quality of Care

CMS "intends to monitor the claims data from TEAM participants—for example, to compare a hospital's case mix relative to a pre-model historical baseline to determine whether complex patients are potentially being systematically excluded. CMS will publish these data as part of the model evaluation to promote transparency and an understanding of the model's effects."

CMS proposes "to require that TEAM participants must, as part of discharge planning, account for potential financial bias by providing TEAM beneficiaries with a complete list of all available post-acute care options in the Medicare program, including HHAs, SNFs, IRFs, or LTCHs, in the service area consistent with medical need, including beneficiary cost-sharing and quality information (where available and when applicable). This list should also indicate whether the TEAM participant has a sharing arrangement with the post-acute care provider. CMS expects that the treating surgeons or other treating practitioners, as applicable, will continue to identify and discuss all medically appropriate options with the beneficiary, and that hospitals will discuss the various facilities and providers who are available to meet the clinically identified needs." (pg. 1329)

Monitoring for Delayed Care

As with CJR, CMS "proposes as part of the reconciliation process that TEAM participants would be financially accountable for certain post-episode payments occurring in the 30 days after conclusion of the episode. CMS believes that including such a payment adjustment would create an additional deterrent to delaying care beyond the episode duration. In addition, CMS believes the data collection and calculations used to determine such adjustment would provide a mechanism to check whether providers are inappropriately delaying care."

Data Sharing

CMS "believes that it is necessary for the purposes of this model to offer TEAM participants the ability to request summary or raw beneficiary-identifiable claims data for a 3- year baseline period as well as on a monthly basis during the performance year to help TEAM participants engage in care coordination and quality improvement activities for TEAM beneficiaries in an episode."

"For the 3-year baseline period, TEAM participants would only receive beneficiary-identifiable claims data for beneficiaries that initiated an episode in their hospital or hospital outpatient department in the 3-year

baseline period, and the beneficiary identifiable claims data shared with the TEAM participant would be limited to the items and services included in the episode."

"In other words, the TEAM participant would not receive beneficiary-identifiable claims data for beneficiaries that were admitted to their hospital or hospital outpatient department and did not initiate an episode in the baseline period. Nor would the TEAM participant receive beneficiary-identifiable claims data, for beneficiaries who did initiate an episode in their hospital or hospital outpatient department during the baseline period, for items and services that are not included in an episode, such as a primary care visit 5 days before the episode or a hospital readmission 1 day after the episode ends. CMS is proposing to apply a similar approach for the beneficiary-identifiable claims data sharing during the performance year."

CMS "proposes to make beneficiary-identifiable claims data for episodes in TEAM available through two formats, summary and raw, both for the baseline period and on an ongoing monthly basis during their participation in the model as they do for BPCI-A and CJR." (pg. 1339)

"TEAM participants must limit their beneficiary-identifiable data requests, for TEAM beneficiaries who are in an episode during the baseline period or performance year, to the minimum necessary to accomplish a permitted use of the data. CMS proposes the minimum necessary Parts A and B data elements may include but are not limited to the following data elements:

- Medicare beneficiary identifier (ID).
- Procedure code.
- Gender.
- Diagnosis code.
- Claim ID.
- The from and through dates of service.
- The provider or supplier ID.
- The claim payment type.
- Date of birth and death, if applicable.
- Tax identification number.
- National provider identifier.

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 proposed episode definitions during the baseline period and performance years. This data would be provided at the regional level; that is, CMS proposes to share regional aggregate data with a TEAM participant for episodes initiated in the U.S. Census Division where the TEAM participant is located."

CMS "proposes that the 3-year period utilized for the baseline period match the baseline data used to create TEAM participants target prices every performance year, and roll forward one year every performance year. Specifically, CMS proposes that the baseline period data for the summary and raw beneficiary-identifiable data reports and regional aggregate data report would be shared annually at least 1 month prior to the start of a performance year and available for episodes for each of the following performance years:"

- Performance Year 1: Episodes that began January 1, 2022 through December 31, 2024
- Performance Year 2: Episodes that began January 1, 2023 through December 31, 2025
- Performance Year 3: Episodes that began January 1, 2024 through December 31, 2026
- Performance Year 4: Episodes that began January 1, 2025 through December 31, 2026
- Performance Year 5: Episodes that began January 1, 2026 through December 31, 2027

"If a TEAM participant wishes to retrieve the beneficiary-identifiable data, the TEAM participant would be required to first complete, sign, and submit—and thereby agree to the terms of—a data sharing agreement with CMS, which CMS would call the TEAM data sharing agreement." (pg. 1348)

Referral to Primary Care Services

"Under TEAM, CMS is proposing that TEAM participants be required to include in hospital discharge planning a referral to a supplier of primary care services for a TEAM beneficiary, on or prior to discharge from an anchor hospitalization or anchor procedure. CMS also proposes that the TEAM participant must comply with beneficiary freedom of choice requirements and 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 the TEAM participant would be subject to remedial action." (pg. 1353)

Alternative Payment Model Options

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 "seeks to ensure the design of TEAM meets the Merit-based Incentive Payment System (MIPS) APM criteria and that CMS has the necessary information on MIPS eligible clinicians, so that they may be eligible for certain scoring benefits under MIPS."

CMS therefore proposes "to adopt two different APM options for TEAM—an AAPM option in which TEAM participants would attest to meeting the CEHRT standards and in which the TEAM participant's eligible clinicians may be assessed for QP determinations (to the extent TEAM is determined to be an Advanced APM for Track 2 and Track 3), and a non-AAPM option in which TEAM participants would not meet CEHRT or

financial risk standards and in which the TEAM participant's MIPS eligible clinicians may be assessed for reporting and scoring through the APM Performance Pathway (APP) (to the extent the TEAM is determined to be a MIPS APM for all tracks)." (pg. 1357)

CMS "proposes that each TEAM participant would be required to submit information about the eligible clinicians or MIPS eligible clinicians who enter into financial arrangements with the TEAM participant for purposes of supporting the TEAM participants' cost or quality goals. This information would enable CMS to make determinations as to eligible clinicians who could be considered QPs based on the services furnished under TEAM (to the extent the model is determined to be an AAPM) and would be necessary for APP reporting and scoring for MIPS eligible clinicians (to the extent the model is determined to be a MIPS APM)." (pg. 1359)

Interoperability

CMS is "seeking comment on how CMS can promote interoperability in the proposed TEAM, in particular, to what extent TEAM participants are planning on participating in TEFCA in the next 1-2 years, as well as other means by which interoperability may support care coordination for an episode. Any further proposals related to interoperability included in TEAM would be done in future notice and comment rulemaking."

Evaluation Approach

CMS' "evaluation would assess the impact of the TEAM on the aims of improved care quality and efficiency as well as reduced health care costs. This would include assessments of patient experience of care, utilization, outcomes, Medicare expenditures, provider costs, quality, and access. CMS' key evaluation questions would include, but are not limited to, the following:

- Payment. Is there a reduction in Medicare expenditures in absolute terms? By subcategories? Do the TEAM participants reduce or eliminate variations in expenditures that are not attributable to differences in health status? If so, how have they accomplished these changes? Did TEAM result in net savings to the Medicare program, after accounting for the financial incentives distributed under the model?
- Utilization. Are there changes in Medicare utilization patterns overall and for specific types of services? How do these patterns compare to historic patterns, regional variations, and national patterns of care? How are these patterns of changing utilization associated with Medicare payments, patient outcomes and general clinical judgment of appropriate care?
- Referral Patterns and Market Impact. How has provider behavior in the selected CBSAs changed under the model? Is there evidence of broader changes to the market? Are provider relationships changing over the course of the model? Is the model facilitating continuity of care by connecting beneficiaries with new or existing primary care providers?

- Outcomes/Quality. Is there either a negative or positive impact on quality of care and/or better patient experiences of care? Did the incidence of relevant clinical outcomes such as complications remain constant or decrease? Were there changes in beneficiary outcomes under the model compared to appropriate comparison groups?
- Equity. Were there notable impacts by subgroups based on beneficiary characteristics such as race/ethnicity, dual status, rurality, or other measures of socio-economic disadvantage? How did TEAM participants address health disparities in care? Did the financial performance differ for hospitals furnishing a substantial share of services to uninsured and low-income patients?
- Transformation. Is there evidence that the participants' changes in care delivery, that were made in the response to the model, will be sustained? Did TEAM enable positive spillover effects to other episodes of care, or other providers across the local market of the health system?
- Unintended Consequences. Did TEAM result in any unintended consequences, including adverse selection of patients, access problems, cost shifting beyond the agreed upon episode, evidence of stinting on appropriate care, anti-competitive effects on local health care markets, evidence of inappropriate referrals practices? Is so, how, to what extent, and for which beneficiaries or providers?
- Potential for Extrapolation of Results. What was the typical patient case mix in the participating practices and how did this compare to regional and national patient populations? What were the characteristics of participating practices and to what extent were they representative of practices treating Medicare FFS beneficiaries? Was the model more successful in certain types of markets? To what extent would the results be able to be extrapolated to similar markets and/or nationally?
- Explanations for Variations in Impact. What factors are associated with the pattern of results (previously)? Specifically, are they related to:
    - Characteristics of the model including variations by year and factors such as presence of downside risk or track assignment? The TEAM participant's specific features and structure, including such factors as the number of relevant cases, provider mix, and health system affiliation?
    - The TEAM participant's organizational culture and readiness
    - The TEAM participant's care redesign interventions and their ability to carry out their proposed intervention?
    - Characteristics and nature of interaction with partner providers including PAC provider community?
    - Characteristics of market and CBSA such as resources, care infrastructure and supply of physicians and associated providers?
    - Characteristics associated with the patient populations served?

Evaluation Period and Anticipated Reports

"The evaluation period would encompass this entire 5- year model performance period and up to 2 years after. CMS plans to evaluate the TEAM on an annual basis. However, they recognize that interim results are subject to issues such as sample size and random fluctuations in practice patterns. Hence, while CMS intends to conduct periodic summaries to offer useful insight during the course of the model test, a final analysis after the end of the 5-year model performance period will be important for ultimately synthesizing and validating results." (pg. 1370)

Decarbonization and Resilience Initiative

CMS also proposes a voluntary a "Decarbonization and Resilience Initiative within TEAM to assist hospitals in addressing the threats to the nation's health and its health care system presented by climate change and the effects of hospital carbon emissions on health outcomes, health care costs and quality of care. The voluntary initiative would have two elements: technical assistance for all interested TEAM participants and a proposed voluntary reporting option to capture information related Scope 1 and Scope 2 emissions as defined by the Greenhouse Gas Protocol (GHGP) framework, with the potential to add Scope 3 in future years."

Since "hospital activities (such as surgical procedures) impact emissions and the work of hospitals requires uninterrupted service delivery, CMS believes TEAM presents an opportunity for CMS to learn more about key strategies for decarbonization (for example, clinical decarbonization approaches, approaches to reducing low-value services and physical waste) and improving resiliency in the health care system. It is hoped that this initiative would help bring savings to the health system and the Medicare Program, consistent with TEAM's goals." (pg. 1372)

- "Scope 1: Direct emissions. Direct GHG emissions occur from sources that are owned or controlled by an organization or company. For health care, Scope 1 captures health care operations such as direct facilities emissions, anesthetic gases, and GHG emissions from leased or owned vehicles."
- "Scope 2: Indirect emissions from purchased energy. GHG emissions from the generation of purchased electricity consumed by the organization or company. For health care facilities, Scope 2 includes purchased or acquired electricity, and steam, heat, or cooling consumed by the reporting organization or company."
- "Scope 3: Other indirect GHG emissions. Scope 3 allows for the treatment of all other indirect emissions. Scope 3 incorporates upstream and downstream emissions in the supply chain. For health care, Scope 3 may include purchased pharmaceuticals and chemicals, medical devices and supplies, food, water, waste, employee and patient transportation, and additional emissions outside of Scopes 1 and 2. In Scope 3, all purchased and sold goods have an estimated emissions factor for their production, transportation, and life cycle. For example, in a health care setting, Scope 3 emissions may include prescribed medicine such as metered dose inhalers (MDI). Scope 3 uniquely incorporates intangible emissions through the organization's reported investments."

"The proposed decarbonization initiative could directly lead to lower emissions through: (1) sharing benchmarkable data back to TEAM participants, which will support identification of opportunities to improve energy efficiency; (2) supporting their GHG emissions reporting activities, which will support TEAM participants in better understanding their current state energy consumption, GHG emissions, and opportunities to improve energy efficiency; and (3) providing technical assistance related to reporting, identifying, and accessing resources for and undertaking activities to reduce GHG emissions."

"For the technical assistance portion of the Decarbonization and Resilience Initiative CMS is proposing that they would provide three types of support to interested TEAM participants: (pg. 1383)

- 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 (for example, switching from Desflurane to alternative inhaled anesthetics)
- Identifying and using tools to measure emissions and associated measurement activities."