University of California
San Francisco

# TEAMS

## What we can expect from the new Medicare Bundle

Derek Ward, MD
Associate Professor of Orthopaedic Surgery
Division of Adult Reconstruction
UCSF

# Disclosures

- Consulting – Johnson & Johnson
- Stock – Visie
- Previously Orthopaedic Director for UCSF Bundled Payment Program

- Gratitude to UCSF Office of population health and California Hospital Association, Forvis/Mazars for some information on slides

# Outline

- What is a Bundle/History of Bundles at UCSF
- TEAMs
- What to do

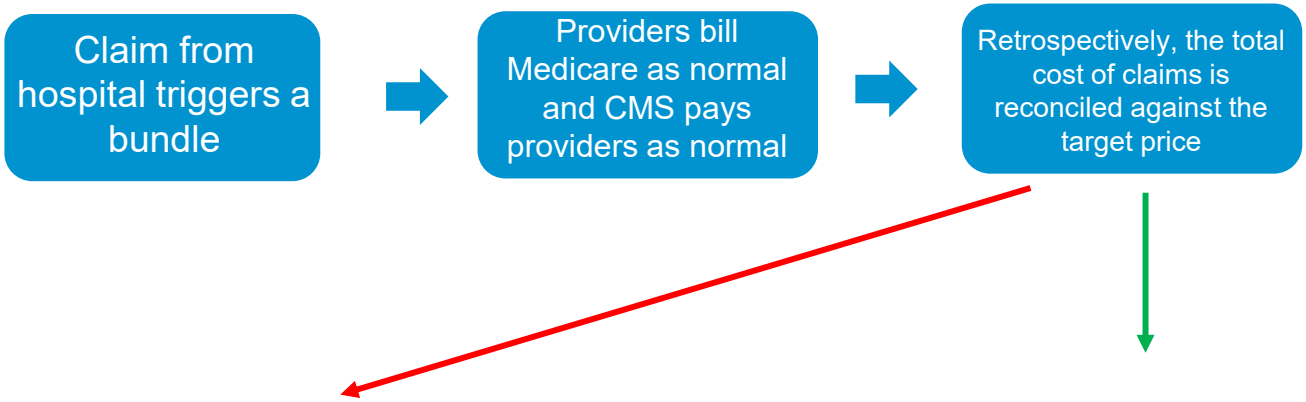
# What is a Bundled Payment

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


- A voluntary Medicare program for Fee-For-Service Medicare A+B
- Incentivized providers to focus on patient costs and outcomes *beyond the inpatient stay* and encouraged close collaboration with post-acute providers

# BPCI Financial Model

Target pricing was derived from historical performance in a selected episode, plus a CMS discount.



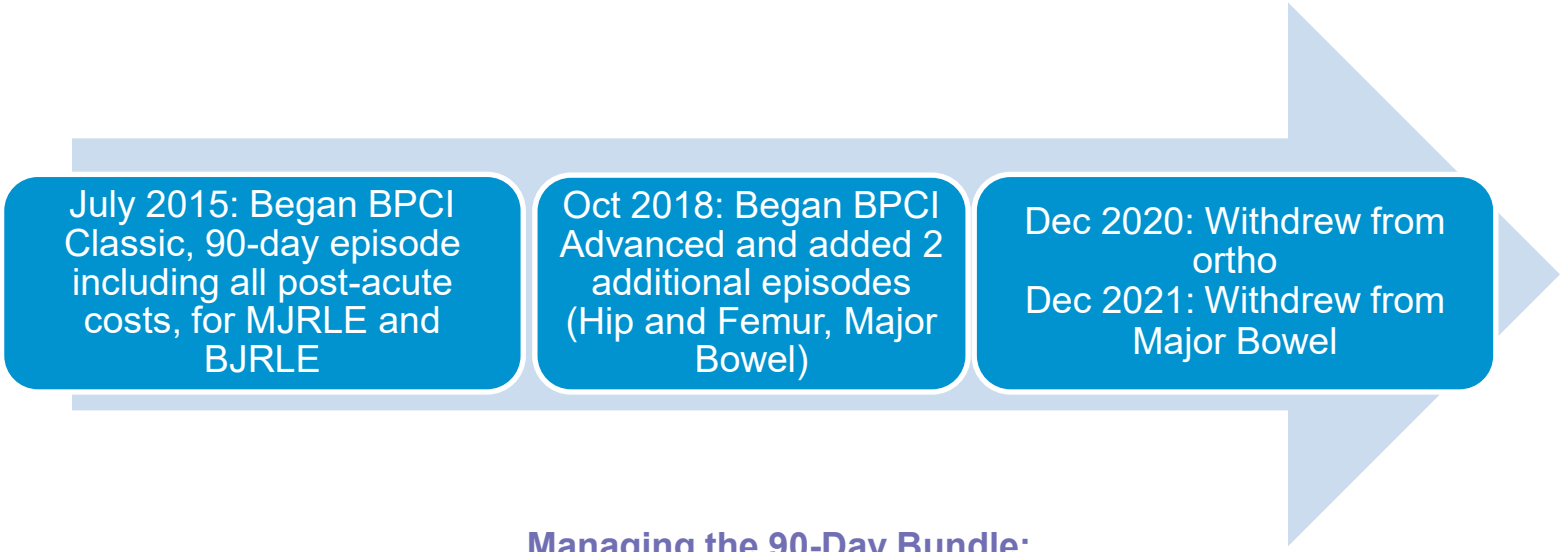

- If a patient's 90-day episode costs **more** than the target price, **Hospital owed** money to CMS for that episode.

- If a patient's 90-day episode costs **less** than the target price, **Hospital received shared savings**.



BPCI = Bundled Payments for Care Improvement Initiative

# UCSF's History with Medicare Bundled Payments




**Managing the 90-Day Bundle:**
**A collaboration between multiple surgery departments & The Office of Population Health**



UCSF

# Past Interventions:

- Health Care Navigator:
  - Round on patients
  - Interdisciplinary huddles
  - Served as direct patient contact
- Triad team (ANS, LCSW, HCN) for high-risk patients
  - Primarily virtual outreach and support
  - Trialed home visits (ortho only)
- SNF and Home Health Coordination
- CipherHealth longitudinal call series

# Lessons Learned

- Significant administrative investment to understand program details and organize efforts
- Supporting complex patients for 90 days required significant resources (particularly in major bowel)
- Unclear cost targets and policy changes hindered program performance
- Complexity of patients limited ability to meet cost targets, even with optimal care
- Cancer care impacted outcomes but was not adequately considered in BPCI-A design

# Lessons Learned

## Drivers for Success


| Leadership & Oversight | Teams & Tools | Cross-Functional Collaboration |
|---|---|---|
| • Strong surgeon/administrative leadership and consistent follow-through<br>• Administrative oversight and management of clinical programs, inpatient protocols, and post-acute care by OPH | • Engaged providers supported by effective engagement tools<br>• Dedicated internal data analyst and collaboration with external data vendor<br>• External consultant for Medicare rules and guidance | • Inpatient and outpatient clinician stakeholders<br>• Clinical Documentation Team<br>• Case Management and Post-Acute Care<br>• SNF and Home Health agency partnerships |



UCSF

# TEAM Model Overview

# What is TEAMS?

- **“Transforming Episode Accountability Model”**

- **”Totally Egregious Ass-whupping from Medicare”**



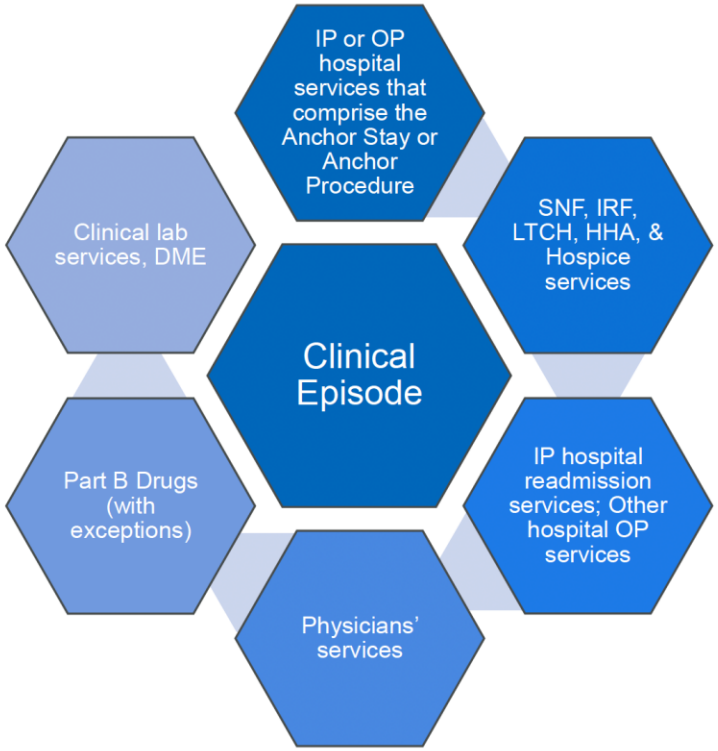

UCSF

# TEAM Key Elements:

| | | |
|---|---|---|
| **Model Design** | • **Mandatory** episode payment model<br>• 30-Day episodes<br>  • Coronary artery bypass graft<br>  • Lower extremity joint replacement<br>  • Major bowel procedure<br>  • Surgical hip/femur fracture treatment<br>  • Spinal fusion | |
| **Duration** | • January 1, 2026 to December 31, 2030 | |
| **Model Tracks** | • **Track 1:** No downside risk & lower levels of reward for one year.<br>  • Safety net hospitals can remain in Track 1 for years 1-3.<br>• **Track 2:** Lower levels of risk & reward for certain hospitals years 2-5.<br>• **Track 3:** Higher levels of risk and reward for entire program. | |
| **Quality** | • 3 quality metrics:<br>  • CMS PSI (90)<br>  • Hospital-Wide All Cause Readmission<br>  • THA/TKA PRO-PM | • 3 additional quality metrics in PY2:<br>  • 2 Hospital Harm measures – Falls with Injury and Postoperative Respiratory Failure<br>  • Failure-to-Rescue |
| **Eligibility** | • ACHs located in 188 selected core-based statistical areas, ACHs who opt-in | |

# What Is Included in an Episode of Care?

- Total-cost-of-care for episodes during the initial hospitalization (or procedure for OP episodes)
- Almost all expenditures are included; there are some pre-determined exclusions
- Patients may receive services anywhere & all sites of care are included
- Services are prorated if they straddle episode end dates
- Revenue cycle is not disrupted




| Episode Category | Billing Codes |
|---|---|
| **Lower Extremity Joint Replacement** (Inpatient & Outpatient) | MS-DRG 469, 470, 521, 522<br>HCPCS 27447, 27130, 27702 |
| **Surgical Hip & Femur Fracture Treatment** (Inpatient) | MS-DRG 480, 481, 482 |
| **Coronary Artery Bypass Graft ("CABG") Surgery** (Inpatient) | MS-DRG 231, 232, 233, 234, 235, 236 |
| **Spinal Fusion** (Inpatient & Outpatient) | MS-DRG 402, 426, 427, 428, 429, 430, 447, 448, 450, 451, 471, 472, 473<br>HCPCS 22551, 22554, 22612, 22630, 22633 |
| **Major Bowel Procedure** (Inpatient) | MS-DRG 329, 330, 331 |

Source: California Hospital Association Webinar/Forvis/Mazars



UCSF

# TEAM Updates
## FY2026 IPPS Final Rule

### Low Volume Policy
- No downside risk for episode groups with fewer than 31 episodes during the baseline period (2022–2024 for PY1)

### HCC Adjustments
- Lengthening the lookback period to 180 days for patient-specific target price adjustments
- Transitioning to HCC Version 28

### Trend Factor Update
- Refining the prospective trend factor to better reflect annual changes in total cost of care

### SNF 3-Day Waiver Expansion
- Now includes swing beds, increasing flexibility in post-acute care

### PCP Referral Requirement
- Moving forward with the requirement; patient must be referred to their established PCP if one exists; if the patient does not have an established PCP, referral to any supplier of primary care services is sufficient

### Spinal Fusion DRG Mapping
- Updating DRG codes to reflect new spinal fusion classifications.

### THA/TKA PRO-PM Reporting
- Starting in Performance Year 3 (2028), includes the Information Transfer PRO-PM to align with Hospital OQR reporting.

### Voluntary Reporting Removal
- HRSN Data Reporting; HRSN screening remains mandatory
- Health Equity Plans
- Decarbonization and Resilience Initiative

17



Source: California Hospital Association Webinar/Forvis/Mazars

# HCC Risk Adjusters

| Episode Group | v22 HCC Risk Adjusters | v28 HCC Risk Adjusters |
|---|---|---|
| Lower Extremity Joint Replacement (LEJR) | • HCC 8: Metastatic Cancer and Acute Leukemia<br>• HCC 18: Diabetes with Chronic Complications<br>• HCC 22: Morbid Obesity<br>• HCC 58: Major Depressive, Bipolar, and Paranoid Disorders<br>• HCC 78: Parkinson's and Huntington's Diseases<br>• HCC 85: Congestive Heart Failure<br>• HCC 86: Acute Myocardial Infarction<br>• HCC 103: Hemiplegia/Hemiparesis<br>• HCC 111: Chronic Obstructive Pulmonary Disease<br>• HCC 112: Fibrosis of Lung and Other Chronic Lung Disorders<br>• HCC 134: Dialysis Status<br>• HCC 170: Hip Fracture/Dislocation | • HCC 17: Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic<br>• HCC 36: Diabetes with Severe Acute Complications<br>• HCC 37: Diabetes with Chronic Complications<br>• HCC 48: Morbid Obesity<br>• HCC 125: Dementia, Severe<br>• HCC 126: Dementia, Moderate<br>• HCC 127: Dementia, Mild or Unspecified<br>• HCC 151: Schizophrenia<br>• HCC 155: Major Depression, Moderate or Severe, without Psychosis<br>• HCC 199: Parkinson and Other Degenerative Disease of Basal Ganglia<br>• HCC 224: Acute on Chronic Heart Failure<br>• HCC 225: Acute Heart Failure (Excludes Acute on Chronic)<br>• HCC 226: Heart Failure, Except End-Stage and Acute<br>• HCC 238: Specified Heart Arrhythmias<br>• HCC 253: Hemiplegia/Hemiparesis<br>• HCC 267: Deep Vein Thrombosis and Pulmonary Embolism<br>• HCC 280: Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders<br>• HCC 326: Chronic Kidney Disease, Stage 5<br>• HCC 327: Chronic Kidney Disease, Severe (Stage 4)<br>• HCC 383: Chronic Ulcer of Skin, Except Pressure, Not Specified as Through to Bone or Muscle<br>• HCC402: Hip Fracture/Dislocation |
| Surgical Hip & Femur Fracture (SHFFT) | • HCC 18: Diabetes with Chronic Complications<br>• HCC 22: Morbid Obesity<br>• HCC 82: Respirator Dependence/Tracheostomy Status<br>• HCC 83: Respiratory Arrest<br>• HCC 84: Cardio-Respiratory Failure and Shock<br>• HCC 85: Congestive Heart Failure<br>• HCC 86: Acute Myocardial Infarction<br>• HCC 96: Specified Heart Arrhythmias<br>• HCC 103: Hemiplegia/Hemiparesis<br>• HCC 111: Chronic Obstructive Pulmonary Disease<br>• HCC 112: Fibrosis of Lung and Other Chronic Lung Disorders<br>• HCC 134: Dialysis Status<br>• HCC 157: Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone<br>• HCC 158: Pressure Ulcer of Skin with Full Thickness Skin Loss<br>• HCC 161: Chronic Ulcer of Skin, Except Pressure<br>• HCC 170: Hip Fracture/Dislocation | • HCC 36: Diabetes with Severe Acute Complications<br>• HCC 37: Diabetes with Chronic Complications<br>• HCC 38: Diabetes with Glycemic, Unspecified, or No Complications<br>• HCC 48: Morbid Obesity<br>• HCC 63: Chronic Liver Failure/End-Stage Liver Disorders<br>• HCC 93: Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders<br>• HCC 109: Acquired Hemolytic, Aplastic, and Sideroblastic Anemias<br>• HCC 125: Dementia, Severe<br>• HCC 126: Dementia, Moderate<br>• HCC 127: Dementia, Mild or Unspecified<br>• HCC 180: Quadriplegia<br>• HCC 181: Paraplegia<br>• HCC 191: Quadriplegic Cerebral Palsy<br>• HCC 198: Multiple Sclerosis<br>• HCC 199: Parkinson and Other Degenerative Disease of Basal Ganglia<br>• HCC 211: Respirator Dependence/Tracheostomy Status/Complications<br>• HCC 213: Cardio-Respiratory Failure and Shock<br>• HCC 226: Heart Failure, Except End-Stage and Acute<br>• HCC 238: Specified Heart Arrhythmias<br>• HCC 249: Ischemic or Unspecified Stroke<br>• HCC 253: Hemiplegia/Hemiparesis<br>• HCC 280: Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders<br>• HCC 326: Chronic Kidney Disease, Stage 5<br>• HCC 383: Chronic Ulcer of Skin, Except Pressure, Not Specified as Through to Bone or Muscle<br>• HCC 402: Hip Fracture/Dislocation |

Source: California Hospital Association Webinar/Forvis/Mazars



UCSF

## Target Price Calculation

### Overview

180-day pre-
ode period
capture

1 Benchmark
DRG/HCPC
type in cens
(three-year b

MS discount
to Major Bowel
ure & CABG;
iscount applied
R, SHFFT, &
Fusion episodes

**Sample Targe**

**$18,975**
Regional Price

**Pacific Division –**
AK, CA, HI, OR, WA

**$18,911**
**Target Price**


s that do not
rticipants,
nary target
gional trend

price."

factor and a national trend factor.

Source: California Hospital Association Webinar/Forvis/Mazars



UCSF

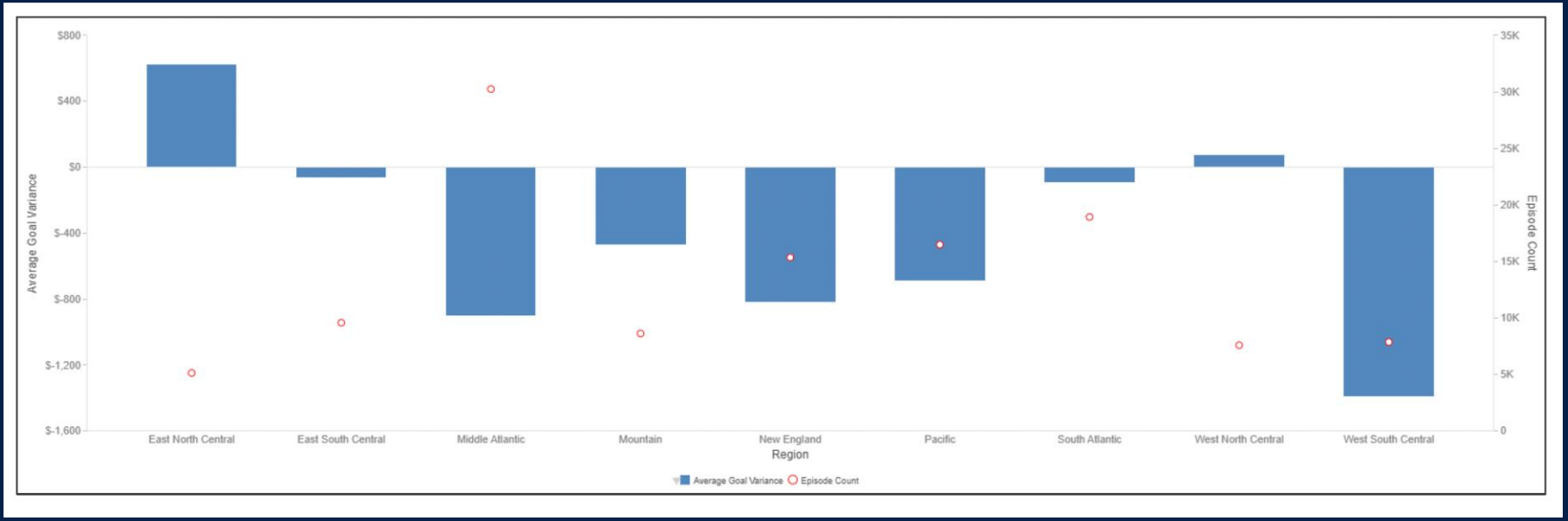
## John Smith

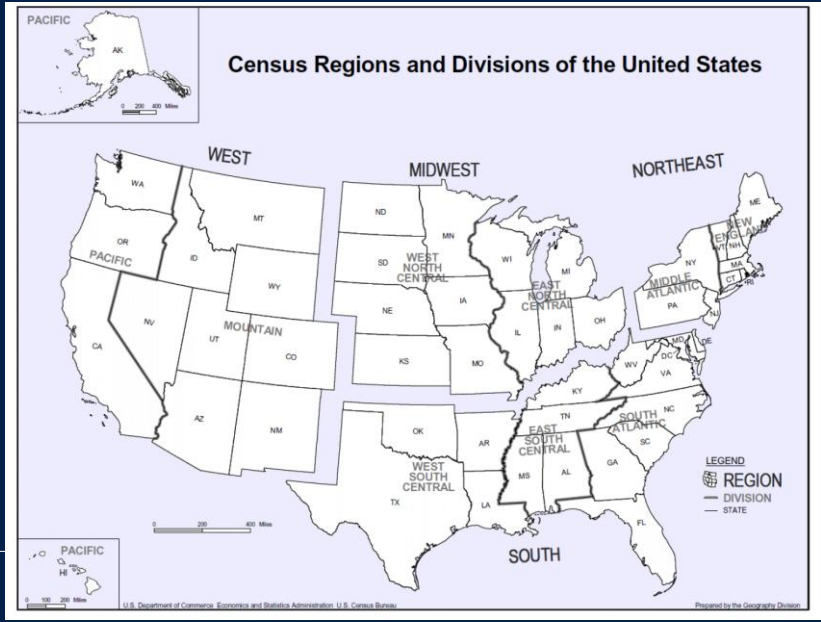
| |
|---|
| Inpatient Non-Fracture Lower Extremity Joint Replacement (DRG 470) |
| Pacific hospital with less than 250 beds |
| 66 years old |
| HCC 22: Morbid Obesity<br>HCC 85: Congestive Heart Failure (CHF) |
| No Social Risk |

## Target Price for John's Episode

| | | |
|---|---|---|
| **Regional Price** | | $19,259 |
| **Hospital Specific Adj** | X | 1.00 |
| **Age** | X | 1.05 |
| **HCC Count** | X | 1.06 |
| **HCC 22: Morbid Obesity** | X | 1.01 |
| **HCC 85: CHF** | X | 1.02 |
| **Normalization Factor** | X | 0.88 |
| **CMS Discount** | X | 0.98 |
| **Target Price** | = | $18,728 |

# Average goal variance and episode by region for expected TEAMs price



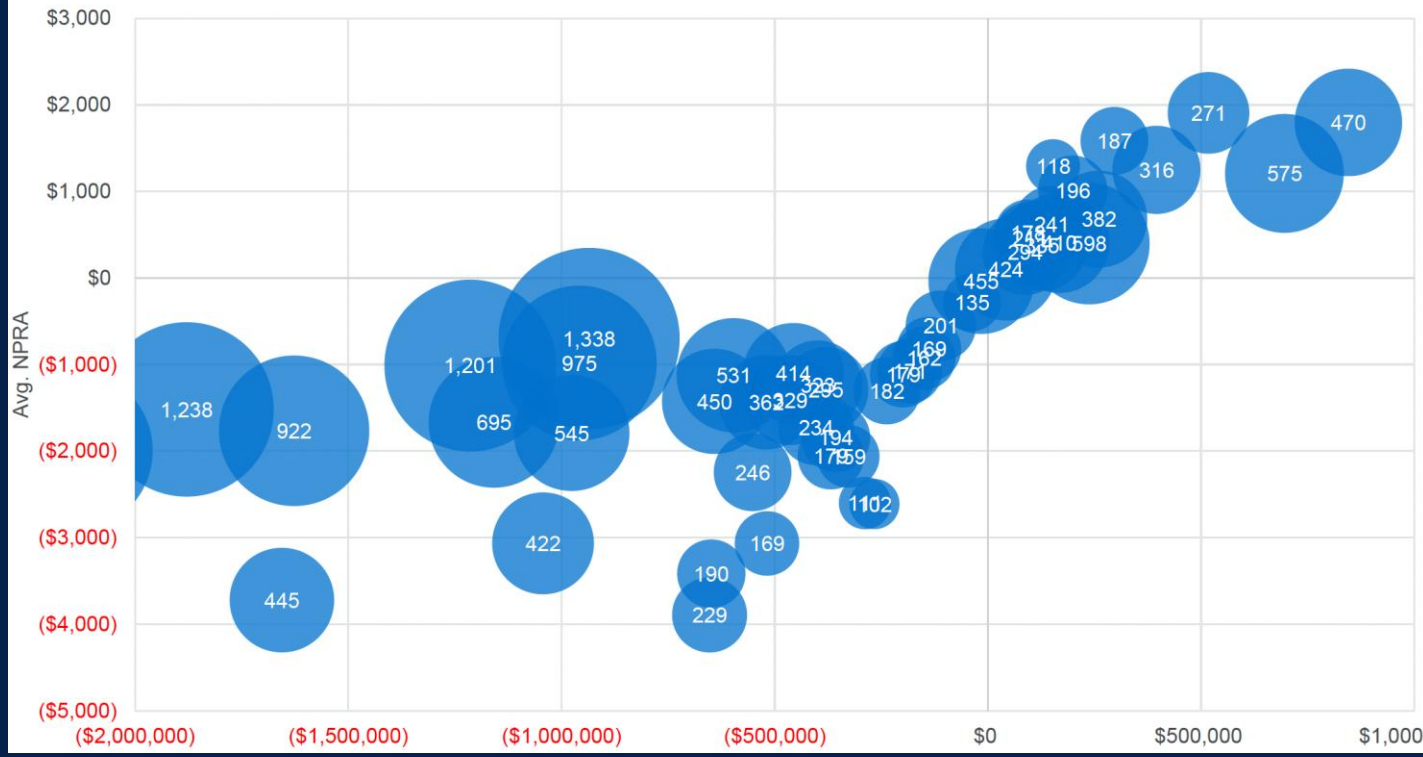



Source Datagen

UCSF

# California TEAM Hospital Performance

## CY2024




- 2024 Average CA Hospital NPRA (Uncapped)= ($669)
- Total Uncapped NPRA per hospitals ranges from ($6M)* - $845K



UCSF

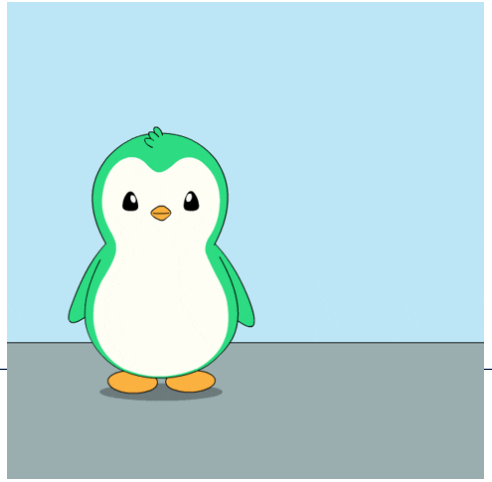
# Quality Measure Updates
## FY2026 IPPS Final Rule

| Finalized TEAM Quality Measures | | |
|---|---|---|
| Performance Year 1 | All Episode Groups | Hybrid Hospital-Wide All-Cause Readmission measure |
| Performance Year 1 | All Episode Groups | CMS Patient Safety and Adverse Events Composite (PSI-90) |
| Performance Year 1 | LEJR | Hospital-Level Total Hip and/or Knee Arthroplasty (THA/THK) Patient Reported Outcome Based Measure |
| Performance Year 2-5 | All Episode Groups | Hospital Harm – Fall with Injury |
| Performance Year 2-5 | All Episode Groups | Hospital Harm – Postoperative Respiratory Failure |
| Performance Year 2-5 | All Episode Groups | Thirty-Day Risk – Standardized Death Rate among Surgical Inpatients with Complications |
| Performance Year 3-5 | Outpatient LEJR and Spinal Fusion | Information Transfer Patient Reported Outcome-based Performance Measure |

PY1 measure period adjusted to June 2025 – July 2026 to align with hospital IQR reporting

Removed after Year 1

Applies to outpatient LEJR and Spinal Fusion episodes only; implementing one year after mandatory OQR reporting



Source: California Hospital Association Webinar/Forvis/Mazars



UCSF

# Glide Path to Risk

- TEAM will have graduated risk through different participation tracks to accommodate different levels of risk & reward & allow participants to ease into full-risk participation.
- All participants will have one year to participate in an upside risk only track unless they opt to participate in a two-sided risk track
- In PYs 2-5, risk track for each participant will vary based on their hospital's classification

| Track 1: Safety Net Hospitals | Track 2: Rural Hospitals, MDH, SCH, or Essential Access Community Hospitals | Track 3: All Other TEAM Participants |
|---|---|---|
| • Upside risk only for PYs 1-3 (**10%** stop-gain limit, Track 1)<br>• Upside & downside risk for PYs 4-5 (**5%** stop-gain/stop-loss limits, Track 2)<br>• Option to move into higher risk track | • Upside risk only for PY 1 (**10%** stop-gain limit, Track 1)<br>• Upside & downside risk for PYs 2-5 (**5%** stop-gain/stop-loss limits, Track 2)<br>• Option to move into higher risk track | • Upside risk only for PY 1 (**10%** stop-gain limit, Track 1)<br>• Upside & downside risk for PYs 2-5 (**20%** stop-gain/stop-loss limits, Track 3) |

Source: California Hospital Association Webinar/Forvis/Mazars



UCSF

# Participants With Reduced Risk

## The following types of TEAM participants would be eligible to participate in tracks with reduced levels of downside risk:

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

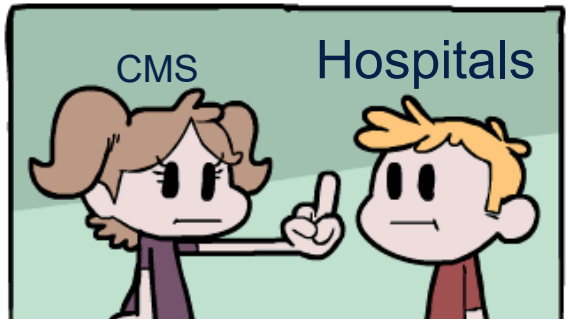
| Safety Net Hospitals | Rural Hospitals, MDH, SCH or Essential Access Community Hospitals |
|---|---|
| • Upside risk only for PYs 1-3 (**10%** stop-gain limit, Track 1)<br>• Upside & downside risk for PYs 4-5 (**5%** stop-gain/stop-loss limits, Track 2)<br>• Option to move into higher risk track | • Upside risk only for PY 1 (**10%** stop-gain limit, Track 1)<br>• Upside & downside risk for PYs 2-5 (**5%** stop-gain/stop-loss limits, Track 2)<br>• Option to move into higher risk track |

Source: California Hospital Association Webinar/Forvis/Mazars



UCSF

# BCPI



# Strategies and Interventions

# My Hospital Has Been Selected?

What now?

- Mandatory means Mandatory -Act NOW, plan ahead
- Pace changes quickly
  - Target prices are designed to constantly lower
- Priorities
  - Outpatient joint replacement
  - Risk Capture Documentation (HCCs)
  - Year 1 Requirements
    - *Beneficiary notification*
    - *Referral to primary care provider*
    - *Health Related Social Needs Screening*

# What to do?

- ***Your Hospital is at Risk – Your Hospital Needs a Plan***

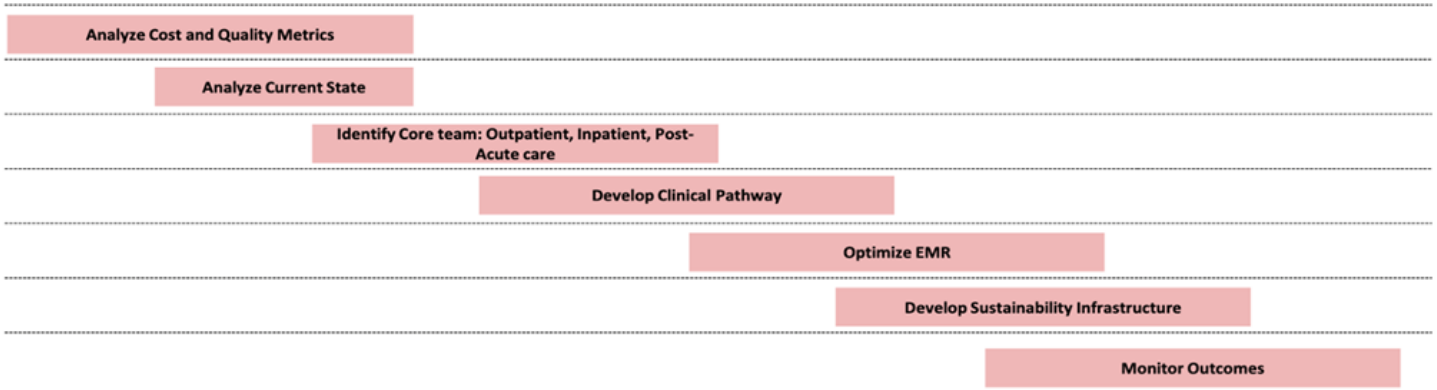
- Align stakeholders and form a leadership council with change powers
  - Work with someone who did this already for BCPI
  - Push the hospital to hire resources to manage this

- Find a data provider


- ED
- PCP/Specialty Clinic

- Acute Care Hospital
- Ambulatory Surgery
- Outpatient Clinic

- Home
- Skilled Nursing Facility
- Home Health
- PCP/ Specialty Clinic



# UCSF - Roles and Responsibilities

- **Division/Department stakeholders**: Define opportunity areas, collaborate with Office of Population Health on solutions, champion on-the-ground initiatives
- **Office of Population Health**: Administer TEAM bundles (episode tracking, coordinate stakeholders, report on performance), lead TEAM Clinical Support with post-acute care focus, lead risk adjustment strategy
- **Department of Quality and Safety**: Care Pathway and Clinical Redesign sponsorship and oversight, CDI, AQI, HEIP, Health Equity Division team involvement with pathways, and quality analytics support
- **Clinical Innovation Center:** Clinical Pathway discovery work, analytics, deployment
- **Close collaborators:** case management, pharmacy, dietary medicine, physical therapy, EIA, IT/informatics, and more

# Conclusions

- TEAMS is here now, it is mandatory
- The government is using this to save money….not improve care
- Leverage your hospitals for resources, be a good partner for them

# Thank you!