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AAHKS AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

**MEMORANDUM**

**To:** AAHKS **From:** Epstein Becker & Green, P.C.

**Date:** August 15, 2024

**Re:** **Preliminary Summary: 2025 Medicare Inpatient Prospective Payment System Final Rule & New Mandatory "TEAM" Episode-Based Payment Model**

On August 2, 2024, the Centers for Medicare & Medicaid Services (CMS) released its final rule for the fiscal year 2025 Medicare Inpatient Prospective Payment System (IPPS) for acute and long-term care. The rule includes the final policies and parameters for the new mandatory alternative payment model called the Transforming Episode Accountability Model (TEAM). This document contains a preliminary, high-level summary of the 2,987-page final rule while detailed analysis continues.

## I. Changes to Payment Rates

CMS states that the 2025 final rule will increase *average* operating payment rates by 2.9% for general acute care hospitals paid under the IPPS. The payment system's market basket percentage was increased in the final rule to 3.4%, compared to 3% in the proposed rule, in order to reflect 2nd quarter market basket forecast data that became available to CMS while preparing the final rule. The AHA and several large hospital chains nevertheless continue to criticize the final rule as deficient to meet increased inflation and operational costs.

Notwithstanding the overall 2.9% increase, rates for individual procedures are derived from hospital reported costs for those procedures. The final 2025 rates below reflect slight positive or negative DRG weight changes based on hospital reported costs:[1]

| MS-DRG | FY 2024 | | FY 2025 (Proposed) | | FY 2025 (Final) | | % Change from 2024 |
|---|---|---|---|---|---|---|---|
| | Weight | Rate | Weight | Rate | Weight | Rate | |
| **469** | 3.3298 | $21,636.27 | 3.3019 | $22,010.80 | 3.2685 | $21,591.71 | **-0.36%** |
| **470** | 1.8817 | $12,226.85 | 1.9051 | $12,699.59 | 1.8855 | $12,455.61 | **+1.87%** |
| **521** | 2.9942 | $19,455.62 | 2.9240 | $19,491.68 | 2.9146 | $19,253.84 | **-1.01%** |
| **522** | 2.1122 | $13,724.59 | 2.1206 | $14,136.13 | 2.1082 | $13,926.76 | **+1.47%** |

[1] Rates assume a hospital with wage index greater than 1.0 that reported quality data and is a meaningful EHR user. These rates do not include facility-specific calculation of teaching, disproportionate share, capital, and outlier payments for all cases.

## II. Removal of THA/TKA Payment Measure Under the Hospital Inpatient Quality Reporting Program

CMS finalized its proposal to remove four clinical episode-based *payment measures* from the Hospital Inpatient Quality Reporting (IQR) Program beginning with the FY 2026 payment determination, including *Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (CBE #3474)*. This measure assesses hospital risk-standardized payment (including payments made by CMS, patients, and other insurers) associated with a 90-day episode-of-care for elective primary THA/TKA for Medicare FFS patients.

CMS is removing all condition-specific episode-based payment measures from the IQR program because it views them as duplicative of the more broadly applicable measure in the Hospital Value-Based Payment (VBP) Program, *Medicare Spending Per Beneficiary Hospital measure (CBE #2158*). The MSPB Hospital measure evaluates hospitals' efficiency and resource use relative to the efficiency of the national median hospital. The MSPB Hospital measure is a more broadly applicable measure because it captures the same data but for a much larger set of conditions and procedures. CMS noted the arguments of AAHKS and other specialties in support of removing these duplicative measures. CMS received no comments opposing this removal.

## III. New Mandatory Episode-Based Payment Model to Replace CJR and BPCI-A

Based on its experiences with CJR, and in the interest of expanding those savings opportunities to other procedures, CMS finalized a new five-year, mandatory episode-based payment model that would start for hospitals in select regions in January 2026. Under the Transforming Episode Accountability Model (TEAM). Hospitals required to participate would be selected based on geographic regions from across the country.

TEAM participants will continue to bill Medicare under the traditional FFS system for services furnished to beneficiaries. However, the TEAM participant may also receive a reconciliation payment amount from CMS depending on their Composite Quality Score (CQS) and if their performance year spending is less than their reconciliation target price. As TEAM is a two-sided risk model, meaning the model requires TEAM participants to be accountable for performance year spending that is above or below their reconciliation target price, TEAM participants may also owe CMS a repayment amount depending on their CQS and if their performance year spending is more than their reconciliation target price.

Notably, CMS announced in the final rule a one-time opportunity for current hospital participants in CJR and BPCI-A to voluntarily join the TEAM program. The one-time voluntary election period is the month January 2025.

*See the subsequent pages for details on the final model, including the list of all the CBSAs selected for mandatory participation in the TEAM model.*

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**CMS Transforming Episode Accountability Model (TEAM)**
**Final Rule Provisions**

| Category | Summary of Policy | Comment |
|---|---|---|
| **Participants** | Mandatory for all acute care hospitals, with limited exceptions, located within the selected Core-Based Statistical Areas (CBSAs).<br><br>Mandatory CBSAs were selected based on a combination of average historical episode spending, the number of hospitals, the number of safety net hospitals and a mix of a CBSA's exposure to prior Medicare bundled payment models. CMS wanted CBSAs with wide variation in these factors.<br><br>**[See APPENDIX 1 for Final List of Mandatory CBSAs]** | In response to requests from AAHKS and others, CMS will allow a one-time opportunity to voluntarily opt-in to TEAM for acute care hospitals, outside of the mandatory CBSAs, that have completed participation in BPCI-Advanced or CJR.<br><br>The voluntary opt-in window runs from Jan. 1 to Jan. 31, 2025. |
| **Role of Physicians or Other Conveners** | Physicians will be classified as "Downstream participants", meaning individuals or entities in written arrangement with acute care hospitals that engage in TEAM activities.<br><br>Despite many comments in support, CMS declined to allow physician group practices (PGPs) to act as participants or conveners under the model.<br><br>CMS encourages PGPs to collaborate with TEAM participant hospitals and "take advantage of establishing financial arrangements that would align financial incentives to improve quality of care and reduce Medicare spending." | CMS' main reason for excluding PGPs was concern that many, if not most, PGPs lack the resources, care coordination experience, and patient volume to successfully operate in a mandatory two-sided risk model.<br><br>CMS also noted occasional challenges of patient attribution when separate co-located hospitals and PGPs each participate in the same model program. CMS referred to instances under BPCI-Advanced when co-located hospitals and PGPs were each model participants and lacked real-time data to determine which entity was the episode initiator for a particular patient. |
| **Role of ASCs** | Despite requests from AAHKS and other organizations, CMS declined to include ASCs as participants under the model.<br><br>Foremost, CMS states that including ASCs in TEAM would require CMS to also include PGPs, which CMS opposes for the reasons above. | CMS noted that ASC utilization for TKA and THA has slowly been increasing over the years, but overall rates have remained "fairly low".<br><br>CMS disagreed with AAHKS' comment that ASC utilization for TJA may increase due to TEAM participants directing |

**CMS Transforming Episode Accountability Model (TEAM)**
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| | Further, CMS notes the relative lack of Medicare quality measures for ASC settings, which would limit the ability of CMS to generate and compare composite quality scores between hospital and ASC participants. | high-cost, complex beneficiaries to ASCs in order to avoid inclusion of these beneficiaries in the model. CMS says that it believes TEAM participants will work with beneficiaries to make medically appropriate decisions on site of care. |
| **Included Procedures** | Following procedures whether performed on an inpatient or outpatient basis:<br>• Lower Extremity Joint Replacement (LEJR) (hip, knee, or ankle replacement)<br>• Coronary Artery Bypass Grafting (CABG)<br>• Surgical Hip and Femur Fracture Treatment (SHFFT)<br>• Spinal Fusion<br>• Major Bowel Procedure | Final LEJR episode codes:<br>• MS-DRG - 469, 470, 521, 522<br>• HCPCS - 27447, 27130, 27702<br><br>CMS will take into consideration any feedback received should additional clinical episode categories be considered for TEAM in future years. Additional episode categories would be proposed through future rulemaking. |
| **Episode Length** | Admission to 30 days post discharge.<br><br>CMS' rationale for a 30-day episode, as opposed to the 90-day episode used in CJR, is that (1) durations longer than 30 days pose a greater risk for the hospital due to medical events outside the intended scope of the model and (2) the need for care for chronic conditions and other non-anchor conditions becomes much more prevalent in days 31 to 90 following hospital discharge.<br><br>A 30-day episode would position the physician specialist as the principal provider near the anchor event with a hand off back to the primary care provider for longitudinal care management. | CMS declined to include presurgical patient optimization services before admission. CMS believes that starting the episode before the anchor procedure can make it difficult to avoid including unrelated items and is more likely to encompass costs that vary widely among beneficiaries, which would make the episode more difficult to price appropriately.<br><br>CMS believes TEAM is complementary to existing longitudinal, population-based models, such as ACO models and initiatives, which can manage beneficiaries before and after an episode and potentially reduce avoidable procedures that would lead to an admission. |

**CMS Transforming Episode Accountability Model (TEAM)**
**Final Rule Provisions**

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<tr><td>Quality Measures to Determine Composite Quality Score</td><td>• For all TEAM episodes: Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and Electronic Health Record Data (CMIT ID #356)<br><br>• For all TEAM episodes: CMS Patient Safety and Adverse Events Composite (CMS PSI 90) (CMIT ID #135)<br><br>• 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)</td><td>CMS declined to include alternative THA/TKA measures that were not PROMs because CMS wishes to move toward wider adoption of PROMs.</td></tr>
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| **Target Price Methodology** | CMMI finalized its proposal to use 3 years of baseline data, trended forward to the applicable performance year, to calculate target prices at the level of MS-DRG/HCPCS episode type and region. CMMI will risk-adjust episode-level target prices. This approach is consistent with Performance Years 4 – 8 of CJR.<br><br>CMS did not finalize its proposed low-volume threshold policy, noting complications raised by commenters. A new low-volume threshold policy will be established through later rulemaking before 2026. | CMS included the following risk adjustment variables for LEJR episodes:<br>• Age bracket<br>• HCC count<br>• procedure-related (ankle procedure or reattachment, partial hip procedure, partial knee arthroplasty, total hip arthroplasty or hip resurfacing procedure, and total knee arthroplasty)<br>• Disability as the original reason for Medicare enrollment<br>• dementia without complications<br>• beneficiary social risk, prior post-acute care use<br>• hospital bed size<br>• safety net hospital status<br>• and the following 12 HCCs: Metastatic Cancer and Acute Leukemia; Diabetes with Chronic Complications; Morbid Obesity; Major Depressive, Bipolar, and Paranoid Disorders; Parkinson's and Huntington's Diseases; Congestive Heart Failure; : Acute Myocardial Infarction; Hemiplegia/ Hemiparesis; Chronic Obstructive Pulmonary Disease; Fibrosis of Lung and Other Chronic Lung Disorders; Dialysis Status; Hip Fracture/Dislocation |
| **Discount Factor** | CMS originally proposed to apply a 3% discount factor to the benchmark price to serve as the Medicare program's portion of reduced expenditures from the episode. | After consideration of the public comments, CMS is finalizing a discount factor of 1.5% for CABG and Major Bowel episode categories and a discount factor of 2% for LEJR, SHFFT, and Spinal Fusion episode categories. |

**APPENDIX 1:**
**LIST OF MANDATORY CBSAs SELECTED FOR PARTICIPATION IN TEAM**

Adrian, MI
Aguadilla, PR
Alamosa, CO
Albany, GA
Albuquerque, NM
Alexander City, AL
Alexandria, LA
Altus, OK
Amarillo, TX
Anderson Creek, NC
Arcadia, FL
Arkansas City-Winfield, KS
Athens, TX
Auburn, IN
Augusta-Waterville, ME
Bakersfield-Delano, CA
Baraboo, WI
Barnstable Town, MA
Batavia, NY
Batesville, AR
Baton Rouge, LA
Bemidji, MN
Bend, OR
Bogalusa, LA
Boston-Cambridge-Newton, MA-NH
Bowling Green, KY
Bradford, PA
Brattleboro, VT
Breckenridge, CO
Buffalo-Cheektowaga, NY
Burlington, IA-IL
Camden, AR
Cedar Rapids, IA
Celina, OH
Champaign-Urbana, IL
Clovis, NM
Columbia, MO
Columbus, IN
Corbin, KY
Corinth, MS
Cortland, NY
Coshocton, OH
Crescent City, CA
Crestview-Fort Walton Beach-Destin, FL
Dalton, GA
Defiance, OH
Deltona-Daytona Beach-Ormond Beach, FL
Denver-Aurora-Centennial, CO
Douglas, GA
DuBois, PA
Dubuque, IA
Duluth, MN-WI
Durant, OK
Elk City, OK
Elko, NV
Erie, PA
Eureka-Arcata, CA
Faribault-Northfield, MN
Farmington, NM
Findlay, OH
Florence, SC
Forest City, NC
Fort Collins-Loveland, CO
Fort Morgan, CO
Fredericksburg, TX
Galesburg, IL
Glasgow, KY
Goldsboro, NC
Grand Island, NE
Great Bend, KS
Green Bay, WI
Greensboro-High Point, NC
Greenville-Anderson-Greer, SC
Grenada, MS
Hammond, LA
Hanford-Corcoran, CA
Harrisburg-Carlisle, PA
Harrison, AR
Hays, KS
Hermitage, PA
Hot Springs, AR
Huntsville, AL
Huntsville, TX
Hutchinson, KS
Indiana, PA
Jacksonville, FL
Jefferson City, MO
Jesup, GA
Kankakee, IL
Keene, NH
Kennewick-Richland, WA
Kenosha, WI
Key West-Key Largo, FL
Kingsport-Bristol, TN-VA
Kinston, NC
Klamath Falls, OR
Laconia, NH
Lafayette, LA
LaGrange, GA-AL
Lake City, FL
Lakeland-Winter Haven, FL
Las Vegas, NM
Laurel, MS
Lawrence, KS
Lebanon-Claremont, NH-VT
Lewiston-Auburn, ME
Lewistown, PA
Lexington-Fayette, KY
Madison, IN
Manitowoc, WI
Marion, NC
Maryville, MO
Massena-Ogdensburg, NY
McComb, MS
Meadville, PA
Memphis, TN-MS-AR
Michigan City-La Porte, IN
Middlesborough, KY
Midland, TX
Mineral Wells, TX
Minneapolis-St. Paul-Bloomington, MN-WI
Moberly, MO

**LIST OF MANDATORY CBSAs SELECTED FOR PARTICIPATION IN TEAM**

Monroe, LA
Morgantown, WV
Mount Pleasant, TX
Muskogee, OK
Nashville-Davidson--Murfreesboro-Franklin, TN
Natchitoches, LA
New Bern, NC
New Haven, CT
New York-Newark-Jersey City, NY-NJ
Norwalk, OH
Oil City, PA
Oneonta, NY
Orangeburg, SC
Ottumwa, IA
Paducah, KY-IL
Panama City-Panama City Beach, FL
Paris, TX
Parkersburg-Vienna, WV
Peoria, IL
Pontiac, IL
Poplar Bluff, MO
Portland-Vancouver-Hillsboro, OR-WA
Pottsville, PA
Price, UT
Providence-Warwick, RI-MA
Punta Gorda, FL
Raleigh-Cary, NC
Reading, PA
Richmond, IN
Riverside-San Bernardino-Ontario, CA
Rome, GA
Ruston, LA
St. Cloud, MN
St. George, UT
San Diego-Chula Vista-Carlsbad, CA
Sanford, NC
San Francisco-Oakland-Fremont, CA
San Jose-Sunnyvale-Santa Clara, CA
San Luis Obispo-Paso Robles, CA
Santa Fe, NM
Santa Rosa-Petaluma, CA
Savannah, GA
Scottsbluff, NE
Searcy, AR
Sedalia, MO
Spearfish, SD
Springfield, IL
Springfield, OH
Steamboat Springs, CO
Sunbury, PA
Thomaston, GA
Tiffin, OH
Toccoa, GA
Tucson, AZ
Tulsa, OK
Tupelo, MS
Twin Falls, ID
Union City, TN
Vernal, UT
Warren, PA
Washington-Arlington-Alexandria, DC-VA-MD-WV
Waynesville, NC
Weirton-Steubenville, WV-OH
Wichita Falls, TX
Woodward, OK
Worthington, MN