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Advancing Toward Bundled Payments

What to Know and How to Prepare

May 19, 2024

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Agenda

- Value-Based Care: Episodic Payment Models
- Mandatory TEAM Announcement
- How to Prepare if Selected
- Bundled Payment Best Practices

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*"A 2022 study examining fragmentation of ambulatory care for Medicare fee-for-service beneficiaries found that **four in ten** beneficiaries experience highly fragmented care, with a mean of **13 ambulatory visits across 7 practitioners in one year**."*

In 2021, this goal was announced:

"CMS expects <u>100%</u> of traditional Medicare beneficiaries to be treated by a provider in value-based care relationship by 2030."

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

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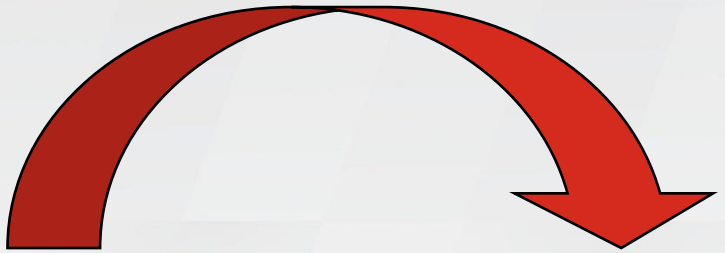
Goals of Value-Based Programs

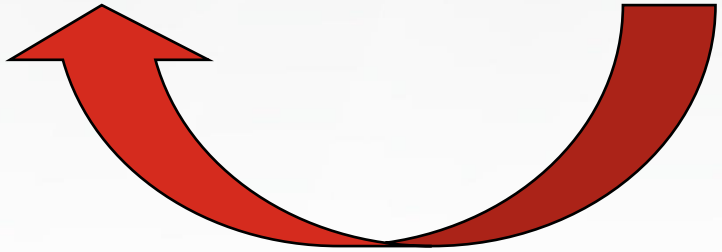


Cost Containment Goals

- Reverse the FFS incentive to provide more services
- Provide Incentives for efficiency
- Manage financial risk
- Align payment incentives to support quality goals

Quality Goals

- Increase or maintain appropriate and necessary care
- Decrease inappropriate care (redundancies)
- Make care more responsive to patients
- Promote safer care



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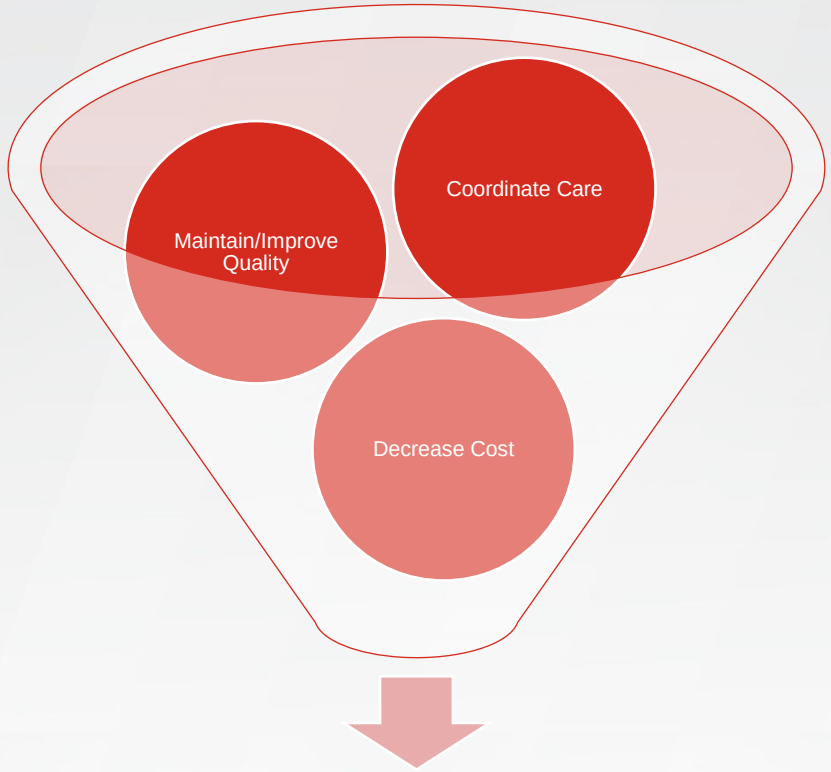
Alternative Payment Models (APMs): What Are They?

- An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.
- Focus today: EPISODIC Payment Models aka BUNDLED Payments



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Why Focus on Episodes of Care?

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

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

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

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CMMI's Specialty Strategy

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

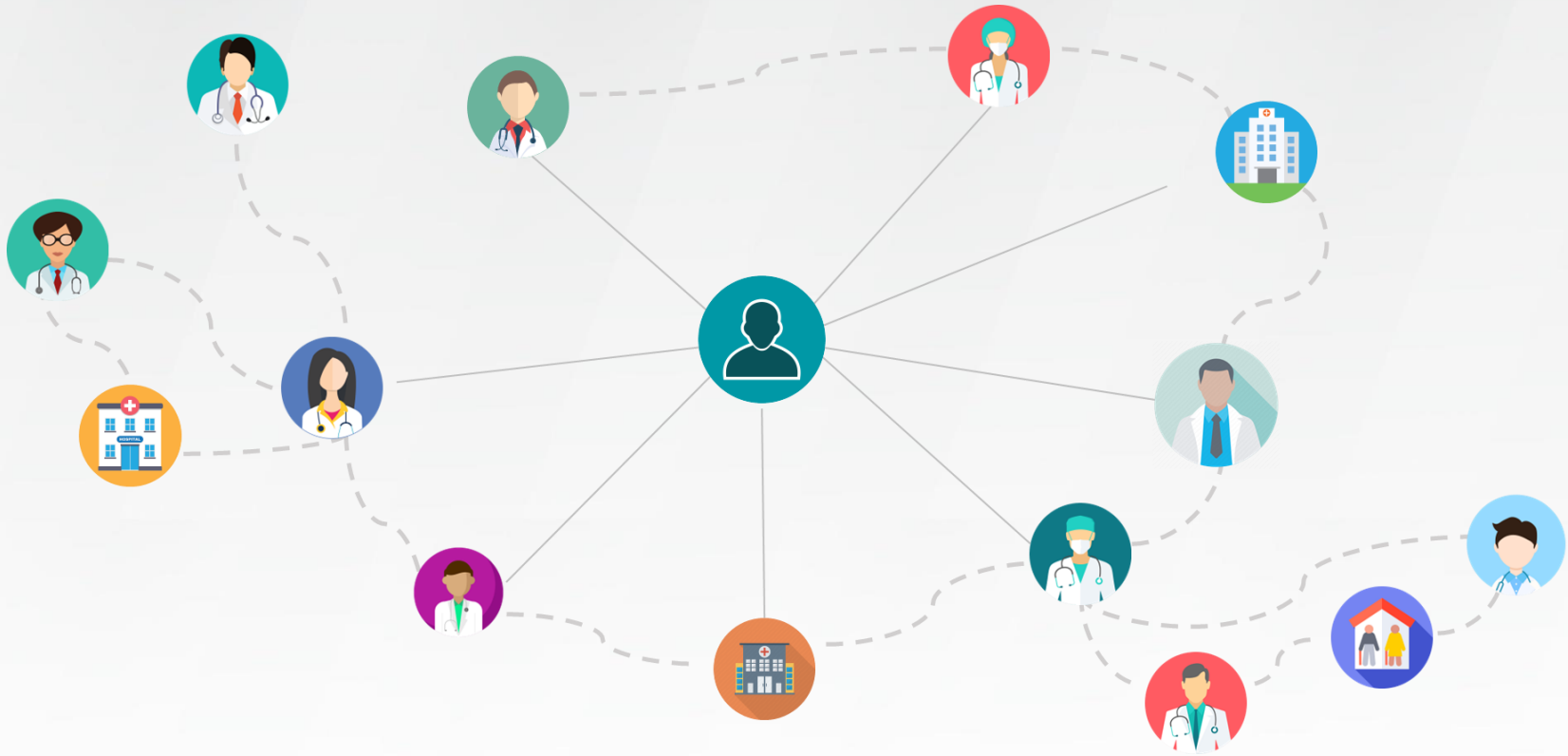
Enhance Specialty Care Performance Data Transparency

Maintain Momentum on Episode Payment Models

Create Financial Incentives within Primary Care for Specialist Engagement

Create Financial Incentives for Specialists to Move to Value-Based Care

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



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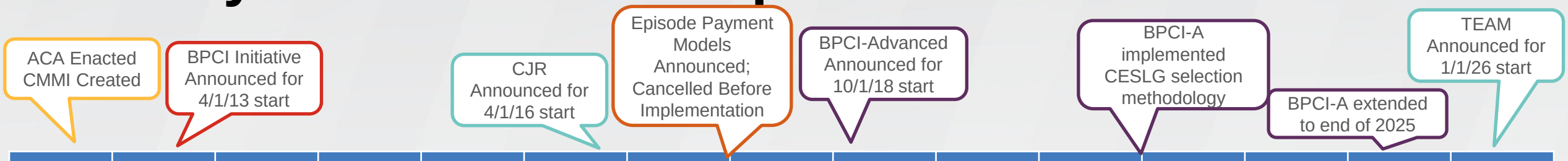
History of Select CMMI Episode of Care Models



ACE

- Tested bundled payments for cardiac and orthopedic inpatient surgical procedures
- Medicare saved $585 per episode and $7.3M total
- Increases in PAC spending reduced savings by 45%; quality remained unchanged

BPCI Initiative

- Tested whether linking payments during an episode following an inpatient hospitalization could reduce costs while maintaining quality
- FFS payments were significantly reduced, but CMS experienced net losses after accounting for reconciliation payments to participants

CJR

- Mandatory episode-based model focused on encouraging providers to work together to improve the quality and coordination of care for patients undergoing a joint replacement surgery
- First four performance years generated savings to CMS, but COVID pandemic required adjustments to the model that resulted in net losses
- CMS made changes to the model following the pandemic and extended the model until Dec 2024

BPCI Advanced

- Tested whether linking payments during an episode incentivizes providers to improve care and reduce costs
- To date, episode payments have been reduced and quality has been maintained
- As of Model Year 3 (2020), CMS experienced net losses after accounting for reconciliation payments to participants
- CMS made changes in 2021 with the goal of generating net savings and extended the model until Dec 2025

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

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CMMI Episode of Care Models Overview

Voluntary Models

Bundled Payments for Care Improvement

- 5-year model focused on 90-day medical & surgical care episodes

Oncology Care Model

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

Bundled Payments for Care Improvement Advanced (Medical & Surgical Care)

- 5-year model focused on 90-day medical & surgical care episodes
- CMS extended model for two more years

Enhancing Oncology Model

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

Mandatory Models

Comprehensive Care for Joint Replacement Model

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

Episode Payment Models

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

Transforming Episode Accountability Model

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

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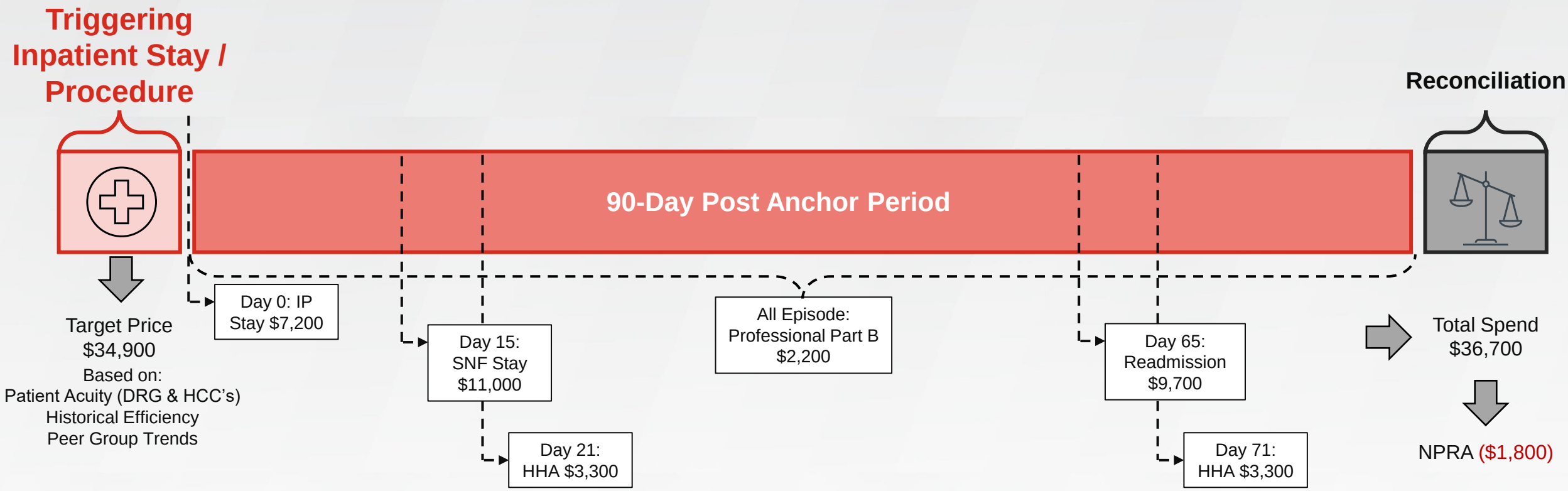
CMS *Current* Bundled Payments: How It Works



- Reconciliation: Target Price – Spend = NPRA (Net Payment Reconciliation Amount)
  - $34,900 - $36,700 = **($1,800)**; therefore, for this specific Episode, Participant owes **($1,800)**

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** NPRA is subject to adjust upward or downward based on Composite Quality Score (CQS)*

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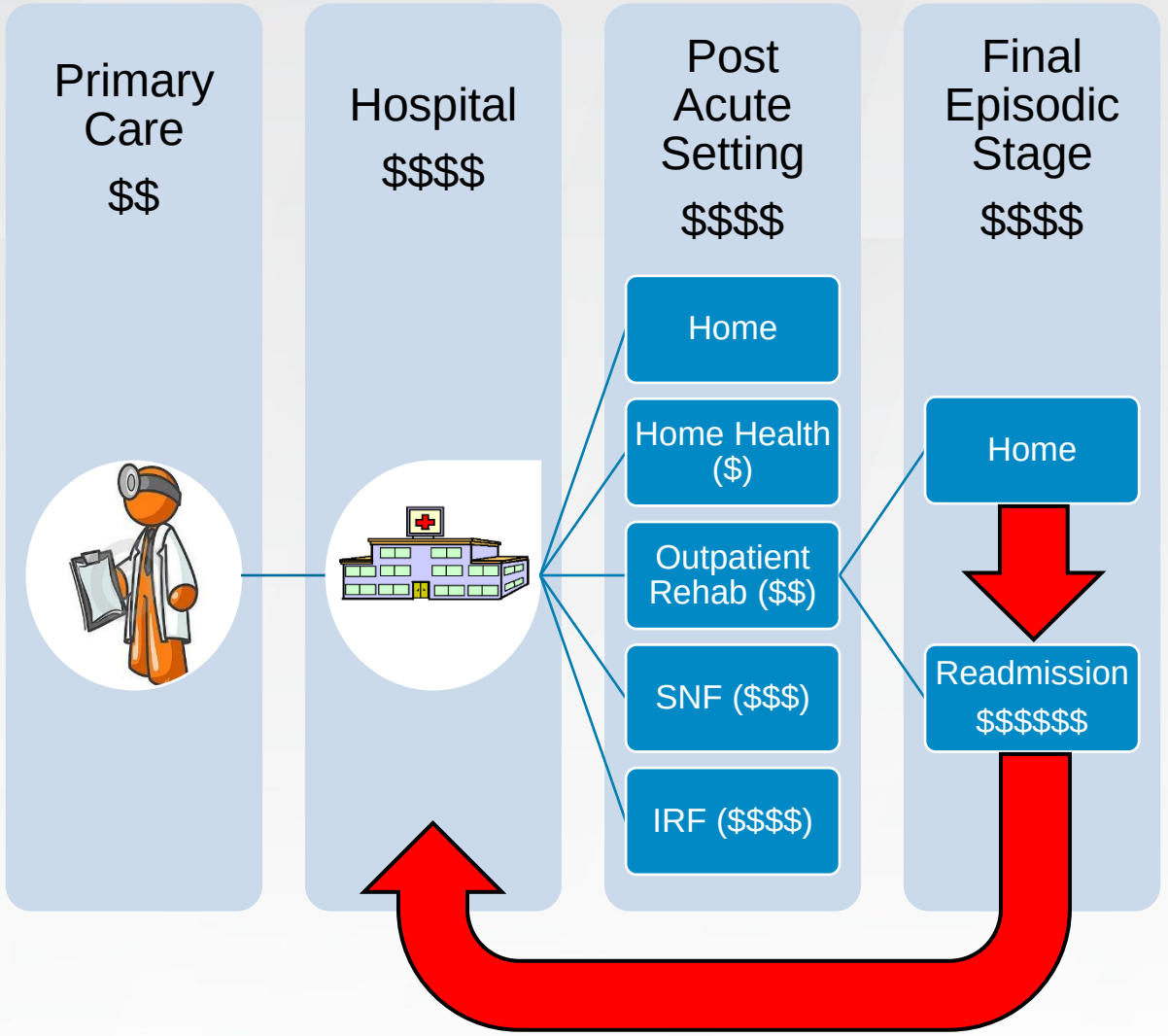
How to Succeed in Bundled Payments

- Acknowledge settings of care and readmissions scenarios that could lead to expenditure reduction



Up to **60%** of patient spend occurs post-acute

- PAC Setting Costs
- Readmission Opportunity

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Fundamental Challenges to APM Adoption Persist

- 89% of senior healthcare executives believe that engaging in more APMs is a "strategic need" for their organization, yet **fewer than half** (48%) of respondents agreed that their organization was "capable" of meeting this strategic need
- In short, many providers' fundamental capabilities fall short of their goals and needs

Source: MINDSETS: FORVIS Executive Leadership Survey Results (November 2021)

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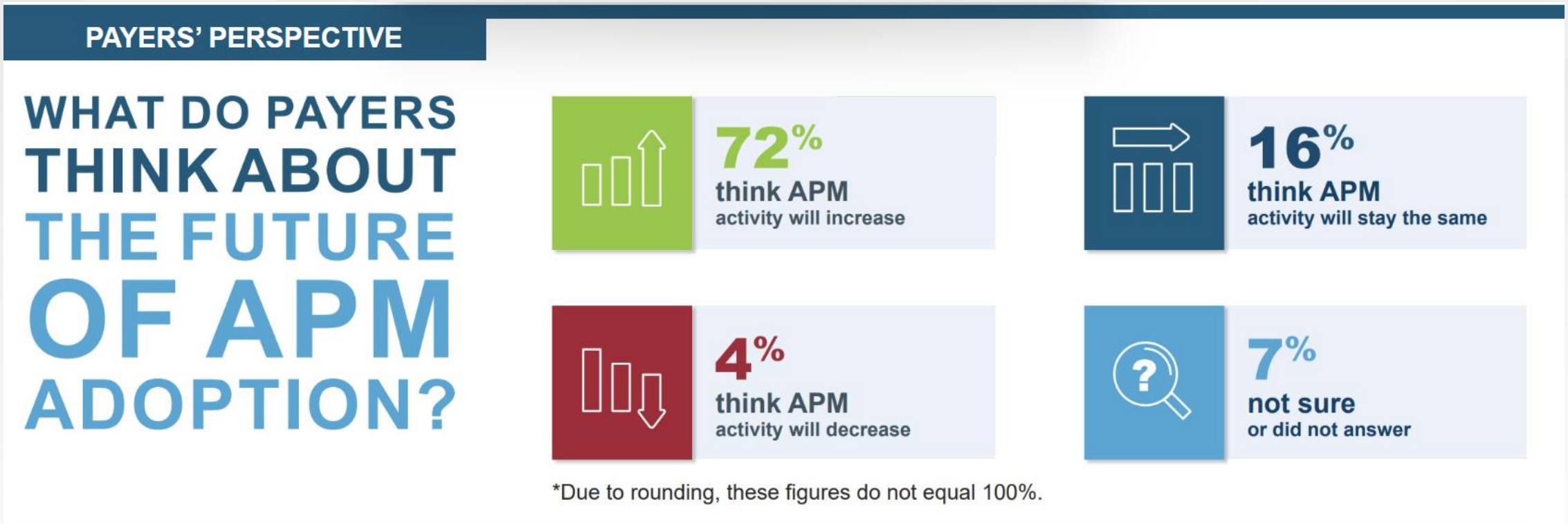
Payers' Perspective on APMs



Source: HCPLAN 2023 APM Measurement Effort

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TEAM: Recently Announced Mandatory Bundled Payment Program

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What is TEAM?

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

Mandatory for selected acute care hospitals

Goal is to improve quality of care for Medicare beneficiaries undergoing certain high-cost surgeries while reducing costs

Purpose is to address fragmented care that leads to complications in recovery, avoidable hospitalization and increased spending

Emphasis on improving health equity and access to high-quality care for people in underserved areas

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Transforming Episode Accountability (TEAM) Model

- CMS has announced a new mandatory episode-based alternative payment model focusing on surgical procedures

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

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

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CMS Proposed Timeline

Prior to Model Start

April 10, 2024
Model Announced in Proposed Rule

June 10, 2024
Final Date to Submit Comments to CMS on Proposed Rule

August 2024
(Estimated) Final Rule Published

Announcement of Mandatory CBSAs

2026
Model Year 1

2027
Model Year 2

2028
Model Year 3

2029
Model Year 4

2030
Model Year 5

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Episode Groups and Definitions

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

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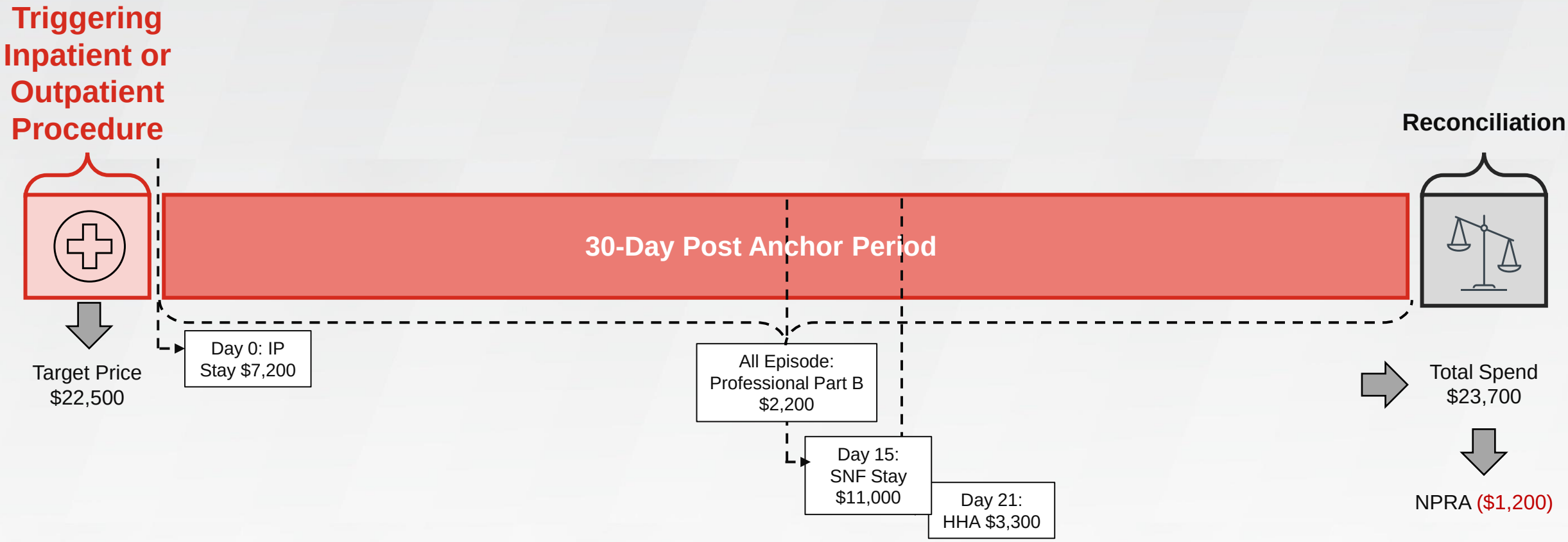
How an Episode of Care Works



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

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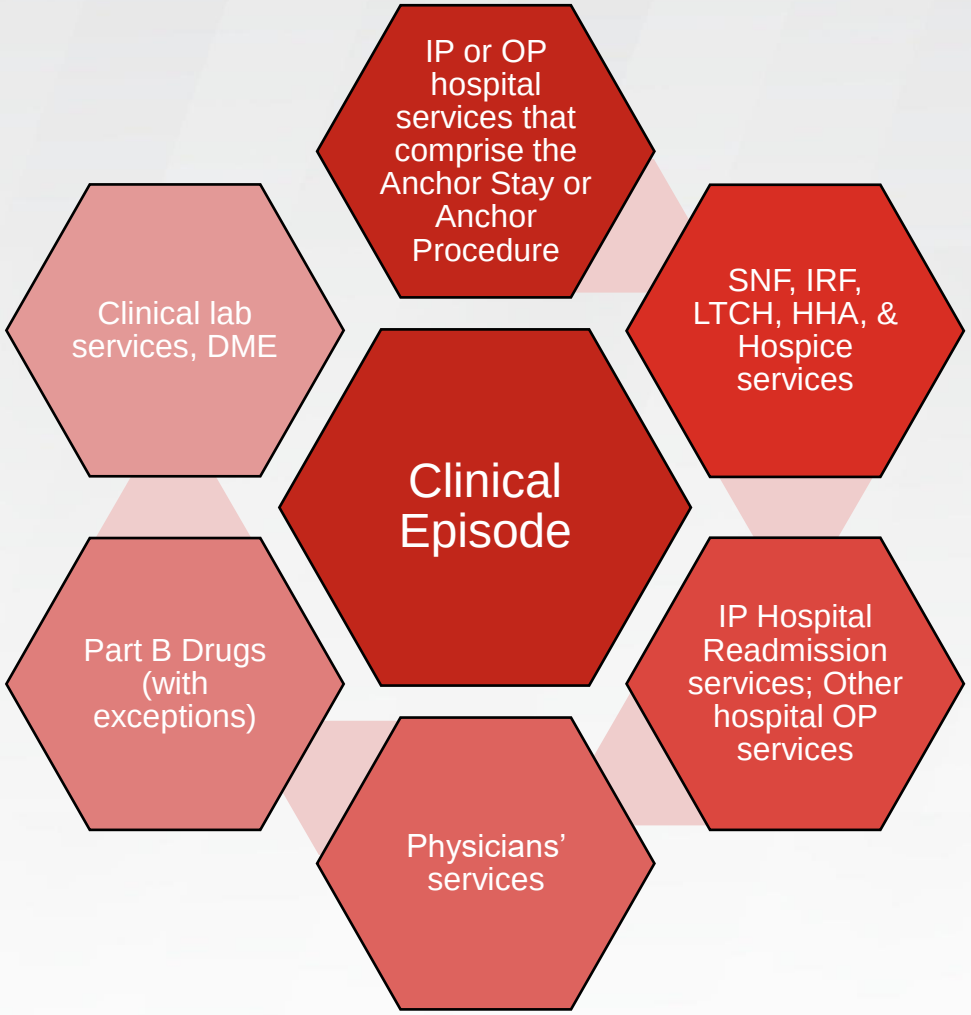
What is Included in the Episode of Care?

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



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Target Price Calculation

- Benchmark price for DRG/HCPCS episode type in census region
  - Three-year baseline period used for calculation
    - Year 1 weighted 17%, Year 2 weighted 33%, Year 3 weighted 50%
  - CY2022 – CY2024 used for year 1; will roll forward each year
  - **LEJR** and **Spinal Fusion** episodes will have site neutral targets for certain HCPCS/DRG combinations
    - **HCPCS 27130 and 27447 are included in MS-DRG 470**
    - **HCPCS 27702 is included in MS-DRG 469**
    - **HCPCS 22633 is included in MS-DRG 455**
    - **HCPCS 22612 and 22630 are included in MS-DRG 460**
    - **HCPCS 22551 and 22554 are included in MS-DRG 473**
- Adjusted for beneficiary-level variables:
  - Age Group
  - Hierarchical Condition Category Count (90-day lookback)
  - Social Risk: Yes or No based on Dual Eligibility, Area Deprivation Index, Part D Low Income Subsidy
- Prospective Trend Factor, Normalization Factor*, 3% Discount

LEJR Example: CJR program**

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

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

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

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Benchmarking Example – Target Price

Target Price

John Smith

LEJR Patient – TKA
TX Hospital

75-year-old
No Social Risk
3 HCCs

Target Price for John's Episode

Regional Price		$18,975
	X	
Patient Specific Adj		1.173
	X	
Normalization Factor		.85
	X	
Trend Factor		1.02
	X	
CMS Discount		0.97
	=	
Target Price		$18,718

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Glide Path to Risk

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

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

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

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How to Prepare If Selected

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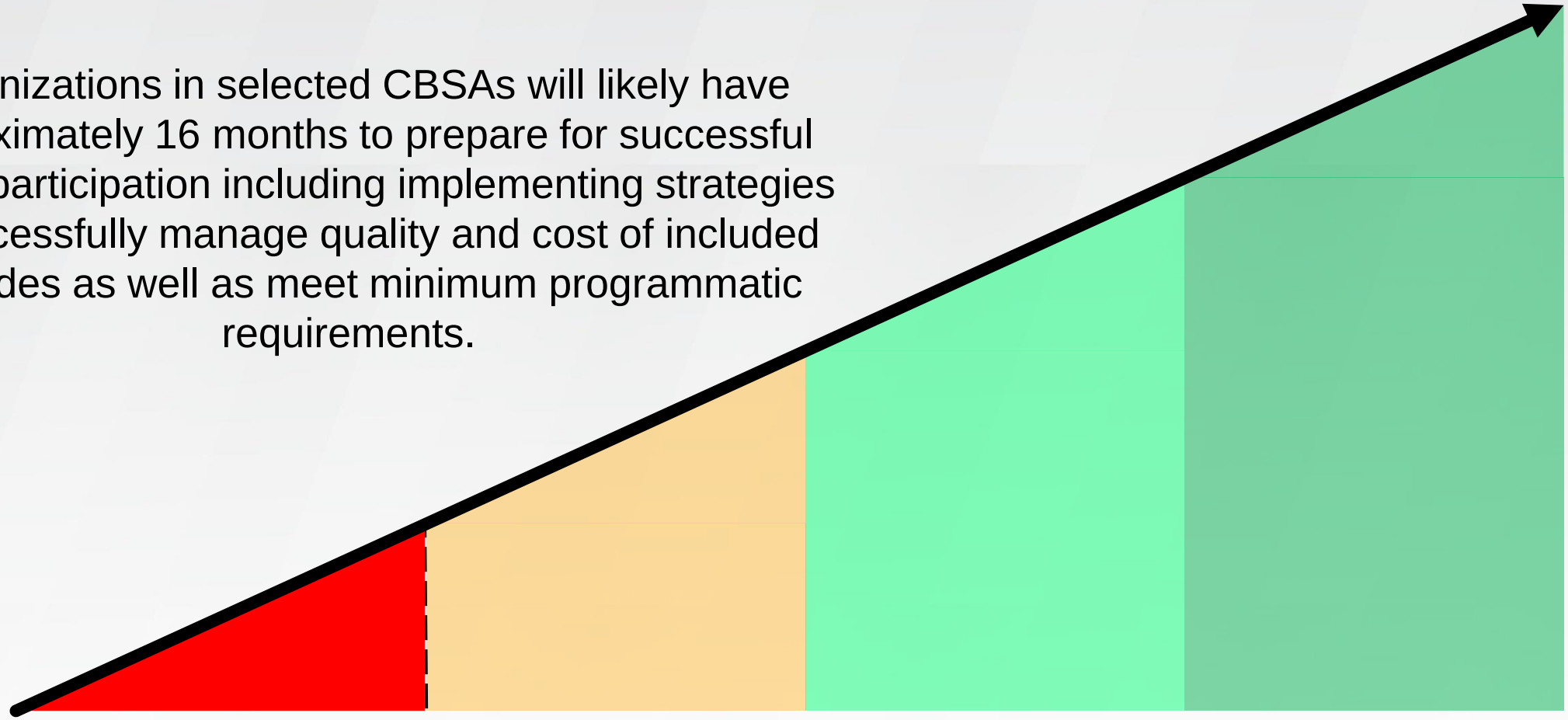
TEAM Implementation Spectrum

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



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How to Prepare // Assess

- **Why:** Successful participants will analyze data and assess their readiness for mandatory bundles
- **What:** Determine your organization's total risk, current capabilities and areas for improvement in value-based care activities, including:

Financial Impact & Benchmarking
- Total risk
- Historical performance

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

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

Post-Acute Care
- PAC Utilization
- PAC provider performance

Health Equity
- HRSN Screening
- Demographic data

Quality
- Historical performance
- Patient reported outcomes

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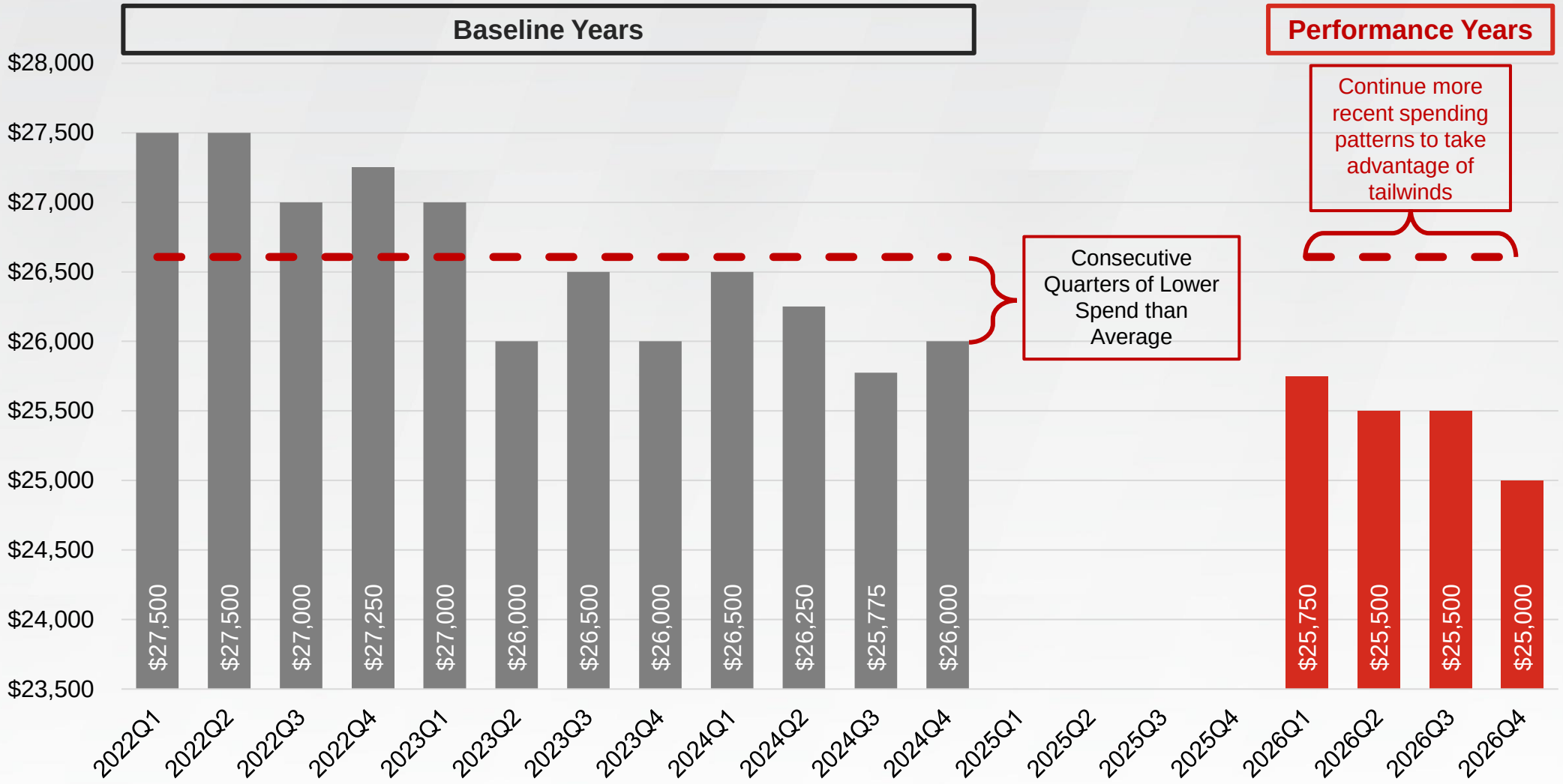
Recognize Episode Performance in Baseline



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Classify & Quantify the Upside

Data Analysis Process

- Identify trends and outliers
- Understand utilization categories that drive increased levels of expenditures
- Validate data and perform Root Cause Analyses when appropriate

Measuring Success

Understand Utilization Effects on Cost Reduction

Identify Opportunities for Improvement

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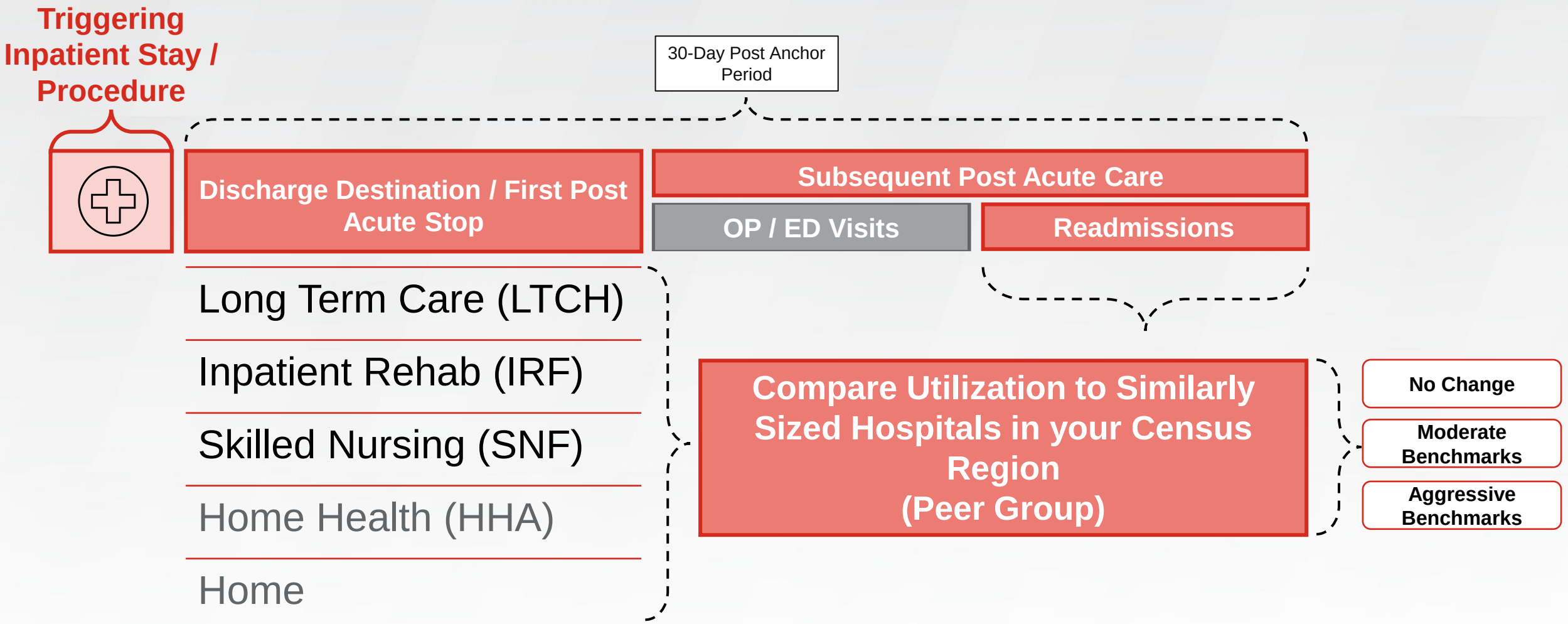
Quantify the Upside



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Recognize Organizational Change Ability

- Are you able to address the following strategies for your organization?

Physician Engagement	Care Coordination	Post Acute Setting	Readmissions

• Physicians influence utilization and post-acute spending with wide variations
• What are specific factors that motivate change and performance improvement within your physician population?
• Can you embrace an interdisciplinary team approach in managing care for BPCI-A patients?
	• Ensuring an appropriate, established care coordination network is vital
	• What is your level of influence to patient care outside of the facility's four walls?
	• Can you leverage existing population health strategies to Episodic Strategies?
	• Is your Care Coordination strategy scalable and sustainable?
		• PAC Setting is crucially important to manage
		• At what levels can you evaluate and understand impact of change on:
		  • Owned PAC facilities
		  • Existing PAC Partners
		  • Potential PAC Partners
		  • PAC KPI's: Length of Stay, Readmission Rate, etc.
		• Can your organization intervene to ensure appropriate PAC pathways are followed?
			• A single readmission is often more than 2x's the "spend" of an entire 90-day episode of a non-readmitted patient
			• Is "leakage," readmissions to other Acute Care Hospitals in your area a significant hurdle to overcome?
			• What is your ability to reduce readmissions within your organization?
			• Can you leverage existing population health strategies to combat readmissions?

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Model Requirement // Beneficiary Notification

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

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Model Requirement // Referral to Primary Care Provider

- **What:** TEAM participants will be required to refer attributed beneficiaries to a primary care provider prior to discharge from the hospital/outpatient surgical facility
- **Why:** CMS aims to improve the transitions from specialists back to primary care providers following a surgical procedure

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Model Requirement // HRSN Data Reporting

How CMS Defines Health Related Social Needs (HRSN)
“The individual-level, adverse social conditions that negatively impact a person’s health or healthcare.”

- Beginning in PY1, TEAM participants will be required to screen attributed TEAM beneficiaries for at least four HRSN domains, such as food insecurity, housing instability, transportation needs and utilities difficulty
- TEAM participants must also report on policies and procedures for referring beneficiaries to community-based organizations, social service agencies, or similar organizations that may support patients in accessing services to address unmet social needs

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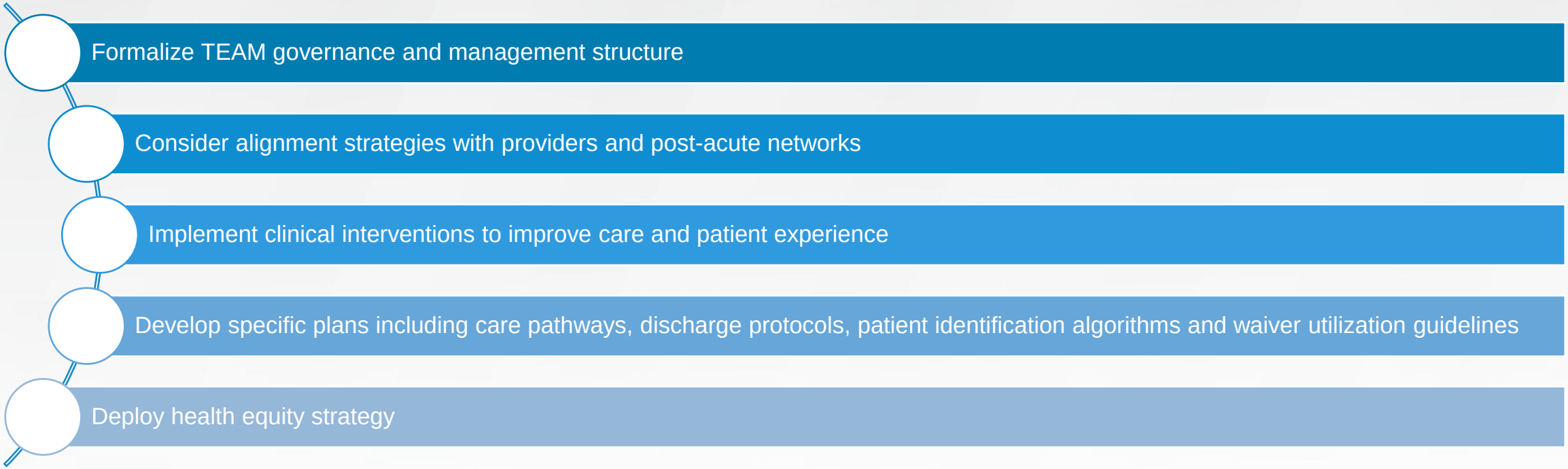
How to Prepare // Strategize & Implement

- **Why:** Targeted, data-driven strategies support program success
- **What:** Implement structures and systems to bridge gaps identified through an assessment



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Questions for Your Organization to Consider

Does your organization currently have a workflow in place to reach out to patients for ongoing follow-up?

How are Care Management services outside the acute setting integrated into the care team?

Have you previously conducted an analysis of your post-acute utilization and spend comparing yourself to your peers and/or region?

Do you have any existing formal post acute provider networks in place?

Does your organization train providers on proper coding and documentation practices?

Do you have referral tracking and follow up systems in place and a workforce to support those systems in care coordination including addressing SDOH/HRSN?

Are clinical care paths utilized across the care continuum?

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Coding and Documentation Impact on Value Based Care Models

Target Price Adjustment Model

Patient 1			Patient 2		
IP / Congestive heart failure / Reset Patient 1 Selections		$30,648	IP / Congestive heart failure / Reset Patient 2 Selections		$26,685
☐	HCC8-Metastatic Cancer and Acute Leukemia in the 90-days pre-Clinical Episode period		☐	HCC8-Metastatic Cancer and Acute Leukemia in the 90-days pre-Clinical Episode period	
☐	HCC9-Lung and Other Severe Cancers in the 90-days pre-Clinical Episode period		☐	HCC9-Lung and Other Severe Cancers in the 90-days pre-Clinical Episode period	
☐	HCC10-Lymphoma and Other Cancers in the 90-days pre-Clinical Episode period		☐	HCC10-Lymphoma and Other Cancers in the 90-days pre-Clinical Episode period	
☐	HCC11-Colorectal, Bladder, and Other Cancers in the 90-days pre-Clinical Episode period		☐	HCC11-Colorectal, Bladder, and Other Cancers in the 90-days pre-Clinical Episode period	
☐	HCC12-Breast, Prostate, and Other Cancers and Tumors in the 90-days pre-Clinical Episode period		☐	HCC12-Breast, Prostate, and Other Cancers and Tumors in the 90-days pre-Clinical Episode period	
☐	HCC17-Diabetes with Acute Complications in the 90-days pre-Clinical Episode period		☐	HCC17-Diabetes with Acute Complications in the 90-days pre-Clinical Episode period	
☑	HCC18-Diabetes with Chronic Complications in the 90-days pre-Clinical Episode period		☐	HCC18-Diabetes with Chronic Complications in the 90-days pre-Clinical Episode period	
☐	HCC19-Diabetes without Complication in the 90-days pre-Clinical Episode period		☐	HCC19-Diabetes without Complication in the 90-days pre-Clinical Episode period	
☐	HCC21-Protein-Calorie Malnutrition in the 90-days pre-Clinical Episode period		☐	HCC21-Protein-Calorie Malnutrition in the 90-days pre-Clinical Episode period	
☑	HCC22-Morbid Obesity in the 90-days pre-Clinical Episode period		☐	HCC22-Morbid Obesity in the 90-days pre-Clinical Episode period	
☐	HCC23-Other Significant Endocrine and Metabolic Disorders in the 90-days pre-Clinical Episode period		☐	HCC23-Other Significant Endocrine and Metabolic Disorders in the 90-days pre-Clinical Episode period	
☐	HCC27-End-Stage Liver Disease in the 90-days pre-Clinical Episode period		☐	HCC27-End-Stage Liver Disease in the 90-days pre-Clinical Episode period	
☐	HCC28-Cirrhosis of Liver in the 90-days pre-Clinical Episode period		☐	HCC28-Cirrhosis of Liver in the 90-days pre-Clinical Episode period	
☐	HCC29-Chronic Hepatitis in the 90-days pre-Clinical Episode period		☐	HCC29-Chronic Hepatitis in the 90-days pre-Clinical Episode period	
☐	HCC33-Intestinal Obstruction/Perforation in the 90-days pre-Clinical Episode period		☐	HCC33-Intestinal Obstruction/Perforation in the 90-days pre-Clinical Episode period	
☐	HCC34-Chronic Pancreatitis in the 90-days pre-Clinical Episode period		☐	HCC34-Chronic Pancreatitis in the 90-days pre-Clinical Episode period	
☐	HCC35-Inflammatory Bowel Disease in the 90-days pre-Clinical Episode period		☐	HCC35-Inflammatory Bowel Disease in the 90-days pre-Clinical Episode period	
☐	HCC39-Bone/Joint/Muscle Infections/Necrosis in the 90-days pre-Clinical Episode period		☐	HCC39-Bone/Joint/Muscle Infections/Necrosis in the 90-days pre-Clinical Episode period	
☐	HCC40-Rheumatoid Arthritis and Inflammatory Connective Tissue Disease in the 90-days pre-Clinical Episode period		☐	HCC40-Rheumatoid Arthritis and Inflammatory Connective Tissue Disease in the 90-days pre-Clinical Episode period	
☐	HCC46-Severe Hematological Disorders in the 90-days pre-Clinical Episode period		☐	HCC46-Severe Hematological Disorders in the 90-days pre-Clinical Episode period	
☐	HCC47-Disorders of Immunity in the 90-days pre-Clinical Episode period		☐	HCC47-Disorders of Immunity in the 90-days pre-Clinical Episode period	
☐	HCC48-Coagulation Defects and Other Specified Hematological Disorders in the 90-days pre-Clinical Episode period		☐	HCC48-Coagulation Defects and Other Specified Hematological Disorders in the 90-days pre-Clinical Episode period	
☐	HCC54-Drug/Alcohol Psychosis in the 90-days pre-Clinical Episode period		☐	HCC54-Drug/Alcohol Psychosis in the 90-days pre-Clinical Episode period	
☐	HCC55-Drug/Alcohol Dependence in the 90-days pre-Clinical Episode period		☐	HCC55-Drug/Alcohol Dependence in the 90-days pre-Clinical Episode period	
☐	HCC57-Schizophrenia in the 90-days pre-Clinical Episode period		☐	HCC57-Schizophrenia in the 90-days pre-Clinical Episode period	
☑	HCC58-Major Depressive, Bipolar, and Paranoid Disorders in the 90-days pre-Clinical Episode period		☐	HCC58-Major Depressive, Bipolar, and Paranoid Disorders in the 90-days pre-Clinical Episode period	
☐	HCC70-Quadriplegia in the 90-days pre-Clinical Episode period		☐	HCC70-Quadriplegia in the 90-days pre-Clinical Episode period	
☐	HCC71-Paraplegia in the 90-days pre-Clinical Episode period		☐	HCC71-Paraplegia in the 90-days pre-Clinical Episode period	

- Capturing HCC's enables CMS and Payers to better estimate what they will spend on a beneficiary and what target / expectation your organization will be held to

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Bundled Payment Best Practices

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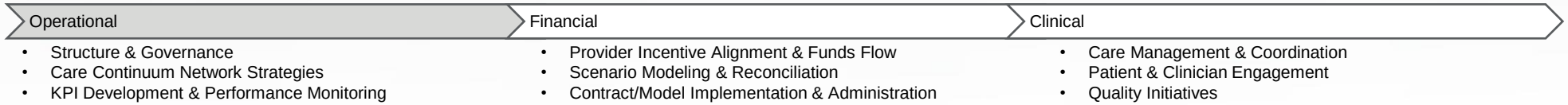
Operational Recommendations & Best Practices

Recommendations

- Establish TEAM Steering Committee that meets monthly to review performance, KPIs and examine strategy
- Identify TEAM program leader responsible for correspondence with CMS and model compliance
- Utilize BPCI-A monthly claims data to monitor performance and identify benchmarking methodology for tracking

Best Practices

- Identify a physician champion(s) with relevant clinical expertise for these procedures
- Maintain multi-disciplinary representation on TEAM steering committee including physicians, administrators, nurses and other support staff
- Develop a formal network of post-acute providers with high degrees of alignment



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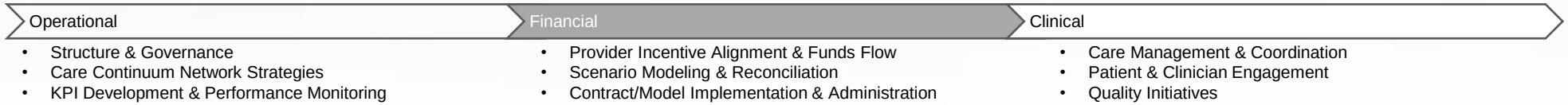
Financial Recommendations & Best Practices

Recommendations

- Utilize CMS provided claims data to estimate targets, aggregate expenditures and track performance in advance of financial reconciliation
- Quantify the impact of additional claims runout, retrospective adjustments to targets and their impact on potential NPRA payments

Best Practices

- Develop a gainsharing structure and methodology with defined metrics to measure cost savings improvement and set a baseline to measure against
- Explore value-add and/or revenue generating opportunities through new care coordination services (chronic care management, transitional care management, disease management, etc.)



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Clinical Recommendations & Best Practices

Recommendations

- Identify TEAM patients ASAP (before discharge) and establish working DRG code with high accuracy (>98%)
- Screen patients for appropriate discharge setting/provider determination and communicate anticipated 90-day care plan with patient, family and providers
- Risk stratify patients for readmission or adverse events and connect high-risk patients with appropriate care navigator

Best Practices

- Implement daily multidisciplinary rounds/huddles with focus to include TEAM patients and their Expected LOS, Barriers to discharge, CDI, DCP, Medical Necessity, Readmissions Risk
- Utilize care pathways based on patient risk level that extend into care continuum to ensure successful care transitions throughout 90-day episode
- Deploy a facility care navigator to focus on opportunities with post-acute providers and lead weekly care conferences

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Thank You

Walter Coleman
Director
Walter.Coleman@forvis.com
804.347.7535

forvis.com

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Assurance / Tax / Advisory

Appendix

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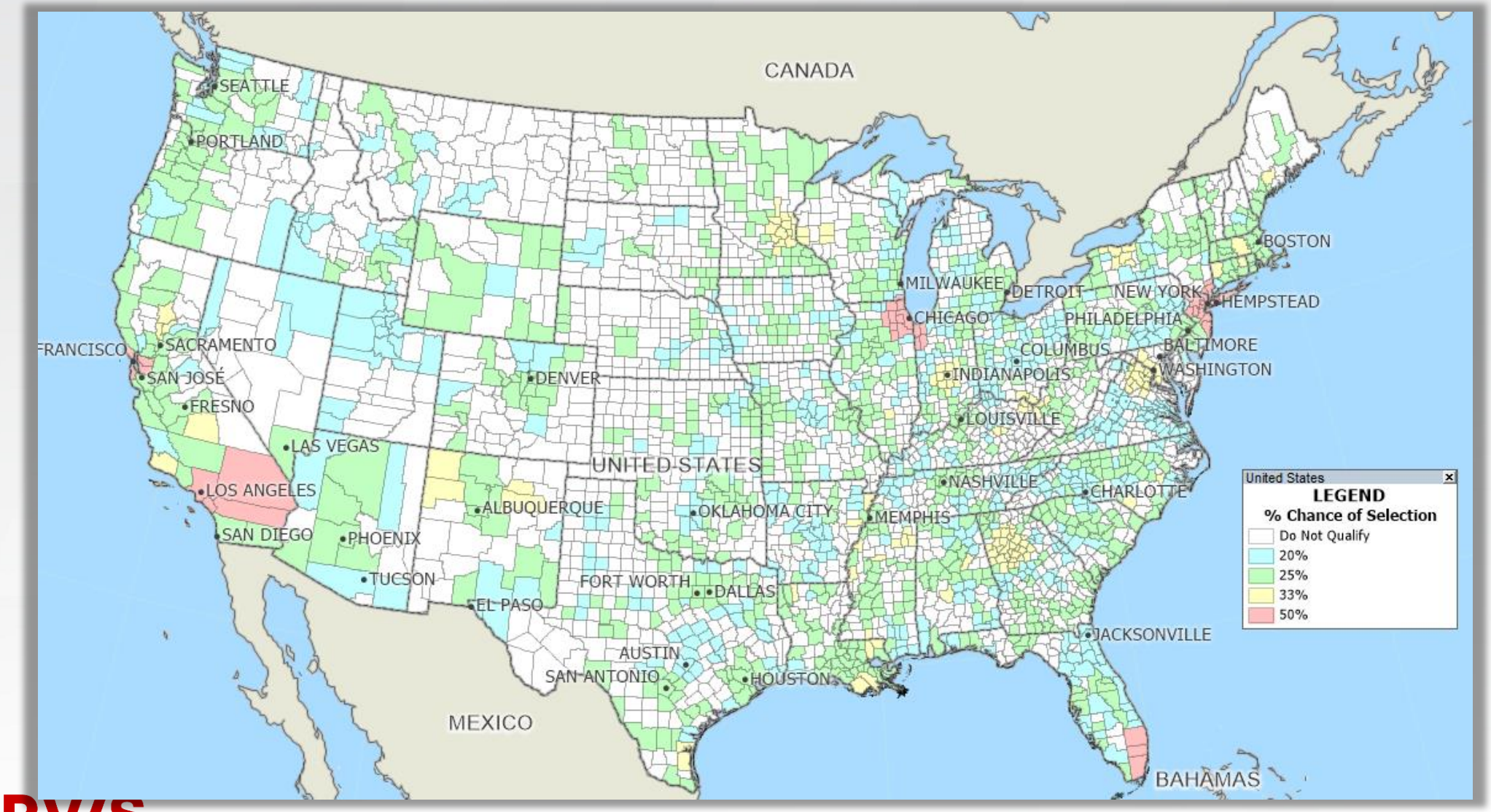
Selection Probability



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Proposed Quality Measures

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

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

Reconciliation Amount: $100,000
Amount subject to quality adjustment (10%): $10,000
CQS : 75
Amount earned: 75%*$10,000 = $7,500
Total Quality Adjusted Reconciliation: $97,500

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Track 2 Participants

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

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

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

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Model Requirement // Health Equity Plans

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

- TEAM participants will be required to submit a Health Equity Plan starting in the second performance year, with annual updates to the plan thereafter, focusing on the following:
  - Identifying health disparities
  - Identifying health equity goals
  - Describing the equity plan intervention strategy
  - Identifying health equity plan performance measures

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Source: CMS Proposed Rule

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Model Requirement // Demographic Data Reporting

- **What:** TEAM participants will be required to report demographic data of TEAM beneficiaries beginning in PY2 and all subsequent years
  - Demographic data collected may include race, ethnicity, language, disability, sexual orientation, gender identity, sex characteristics, and other demographics
- **Why:** CMS believes this data will provide synergies with goals articulated in the participant's health equity plans and will allow CMS to gain more nuanced understanding of the expanded demographics of TEAM beneficiaries

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Model Requirement // LEJR Patient Reported Outcomes

- **What:** TEAM participants will be required to submit Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip Arthroplasty/Total Knee Arthroplasty for patients attributed to a Lower Extremity Joint Replacement episode, beginning in Performance Year 1
- **Why:** CMS is working to support a more person-centered quality strategy in accountable care and specialty care models

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