FY 26 Key Proposals and Policies for TEAM Participants

Quick Reference Guide

A. Limited Deferment Period for Certain Hospitals

- **Deferment for New Hospitals**:
  - New hospitals and those that begin to meet TEAM participant criteria in mandatory CBSAs will have a deferment period before participation.
  - Deferment lasts **at least 1 full performance year**, not exceeding **2 years**.
- **Loss of TEAM Participant Status**:
  - Hospitals that no longer meet TEAM criteria (e.g., convert to CAH) will end participation on the date they no longer qualify.

B. Linking Track 2 Participation to Medicare Dependent Hospital (MDH) Status

- **MDH Definition**:
    - Hospital that is in a rural area, ≤100 beds, non-Sole Community Hospital, a high Medicare discharge percentage.
- **MDH Program Ending**:
    - MDH program is set to expire 9/30/25, affecting Track 2 eligibility.
        - Historically, Congress has extended the MDH program and in some instances retroactively reinstated the program
    - Propose that TEAM participants who are classified as MDHs would still be eligible for Track 2 participation as long as the MDH program is active at the time Track participation selections are due to CMS.
    - As of the latest estimates, there are 741 TEAM participants, with 25 holding MDH designation.
    - Estimated impact: 4 out of 741 hospitals

C. Quality Measurement Updates

- **Hybrid Hospital-Wide All-Cause Readmission Measure (Hybrid HWR)**:
    - 2025 IPPS continued voluntary reporting for hospitals until 6/30/25.
    - Proposing alignment with the **Hospital IQR program**, specifically using the first mandatory reporting period of 7/1/25 - 6/30/26 as the TEAM PY1 quality measure performance period for the Hybrid HWR measure
        - This change means that the first year of hospitals' mandatory reporting of this measure in the IQR program will serve as the baseline period for TEAM's PY1
    - CMS seeks comment on whether TEAM should **not** align with the Hospital IQR program and, as during the voluntary reporting period, only use claims-based elements of the Hybrid HWR for quality measurement
- **Information Transfer Patient Reported Outcome-based Performance Measure (PRO-PM)**:
    - CMS aims to incorporate more patient-reported outcome measures into TEAM and quality measures that capture care in the outpatient setting, given the LEJR & spinal fusion episodes can initiate in the HOPD setting.

- CMS looked at quality measures from CMS Hospital Outpatient Quality Reporting Program to identify a single measure that would be clinically meaningful for both LEJR & spinal fusion categories
    - **Information Transfer PRO-PM** becomes mandatory in the Hospital OQR program in CY2026 (PY2 of TEAM)
        - Evaluates how well post-procedure information is transferred to patients.
- CMS proposes the addition of **Information Transfer PRO-PM for all episode categories initiated in the HOPD in TEAM in 2028**
    - Propose to include Information Transfer PRO-PM starting in PY3 with a CY2027 baseline period
    - **TABLE XI.A.-03: PROPOSED QUALITY MEASURE PERFORMANCE PERIODS BY TEAM PERFORMANCE YEAR**

Measure	TEAM Performance Year				
	1st	2nd	3rd	4th	5th
Information Transfer PRO-PM	Not Applicable	Not Applicable	CY 2028 (January 1, 2028 – December 31, 2028)	CY 2029 (January 1, 2029 – December 31, 2029)	CY 2030 (January 1, 2030 – December 31, 2030)

D. Handling Insufficient Quality Data

- **New Hospitals & Incomplete Data**:
    - New hospitals that began seeing Medicare beneficiaries in 2025 may have incomplete quality data.
    - Hospitals self-selecting eCQMs for the Hospital IQR Program that are not Falls and/or Hospital Harm measures may not have a quality score for TEAM.
    - Proposing a **neutral quality measure score** of **50** for a given quality measure for hospitals with insufficient data.
    - Once the participant reaches the threshold for sufficient data to produce raw quality measure data, it will be converted into a scaled quality measure in the subsequent performance year

E. Methodology for Constructing Target Prices with Coding Changes

- **Adjusting for MS-DRG/HCPCS Changes**:
    - To account for any future MS-DRG/HCPCS changes and construct preliminary target prices, CMS proposes a three-step approach to account for MS-DRG and HCPCS changes by remapping and adjusting relevant MS-

DRG/HCPCS episode types during the baseline period to estimate performance year costs

- **Three-step approach**:
  - **Identify Code Changes**: Remap codes to new/updated DRG/HCPCS.
  - **Construct Episodes Using Remapped Code Triggers**: Map baseline episodes to the updated DRG/HCPCS.
  - **Adjust Standardized Allowed Amounts**: Account for FFS rate changes between baseline and performance years due to changes in MS-DRG/HCPCS weights

F. Reconstructing the Normalization Factors

- **Normalization Factor**:
  - Normalization Factor is the ratio of the average benchmark price divided by the average risk-adjusted benchmark price
  - Factor adjusts to ensure fairness in pricing adjustments
  - CMS proposes to update the language at § 512.505 to clarify that the **prospective normalization factor** will be calculated using the benchmark prices rather than using preliminary target prices
  - Specifically, CMS proposes to revise the definition for **prospective normalization factor** to mean the multiplier incorporated into the preliminary target price to ensure that the average of the total risk-adjusted benchmark price does not exceed the average of the total non-risk adjusted benchmark price
  - Similarly, CMS proposes to revise the definition for **final normalization factor** to mean the benchmark price for each MS-DRG/HCPCS episode type and region divided by the mean of the risk-adjusted benchmark price for the same MS-DRG/HCPCS episode type and region

G. Community Deprivation Index (CDI)

- **Replacing ADI**:
  - Proposing to rename the social needs risk adjustment factor to be the **beneficiary economic risk adjustment factor**

- Proposing to replace the use of the ADI in the construction of the beneficiary economic risk adjustment variable, with a similar but slightly modified census block group deprivation index, the **Community Deprivation Index** (CDI)
- Proposing to use only national-level CDI rankings in the construction of the beneficiary economic risk adjustment factor

H. Beneficiary Risk Adjustment with 180-Day Lookback Period

- **180-Day Lookback:**
  - Propose to use the beneficiary's Medicare FFS claims from the previous 180 days to determine which HCC variables (or flags) the beneficiary is assigned and determine the HCC episode-specific flags as well as the TEAM HCC count flag
    - The TEAM beneficiary would need to meet beneficiary inclusion criteria, as described in § 512.535, during the entire 180-day lookback period
  - Provides more accuracy for episode attribution and target price calculations
  - The section proposes using HCC version 28 (v28) for risk adjustment, replacing the previously finalized version 22 (v22).
  - The proposed HCC v28 includes approximately 30 risk adjusters per episode category, compared to about 25 in the previous version.
  - TEAM participants must meet specific beneficiary inclusion criteria during the entire 180-day lookback period.

I. Episode Attribution Date Range Alignment

- **Modifying Attribution of Episodes to Baseline Years**:
  - Proposing to modify the approach to attribution of episodes to baseline years for the purposes of calculating preliminary target prices
  - Proposing that an episode with an anchor hospitalization beginning in a given baseline year and an anchor hospitalization discharge date in the subsequent baseline year would be attributed to the baseline year when the anchor hospitalization discharge date occurred.

        - For example, an episode with an anchor hospitalization beginning in December 2022 with an anchor hospitalization discharge date in January 2023 would be included in the baseline for both PY 1 (as baseline year 2 of a baseline period from January 1, 2022, to December 31, 2024) and PY 2 (as baseline year 1 of a baseline period from January 1, 2023, to December 31, 2025)
    - Propose to reconcile an episode based on the episode's anchor hospitalization or anchor procedure discharge date.
    - Examples:

Anchor Hospitalization/ Procedure Start Date	Anchor Hospitalization/ Procedure Discharge Date	Episode End Date	Performance Year (PY) for Target Price	Reconciliation Time Period
November 1, 2026	November 15, 2026	December 15, 2026	PY 1	Fall 2027
November 1, 2026	December 15, 2026	January 15, 2027	PY 1	Fall 2027
January 5, 2027	January 10, 2027	February 10, 2027	PY 2	Fall 2028

J. Removal of Health Equity Plans

- **Health Equity Plans**:
    - CMS proposes **removal** of health equity plans and associated social needs data policies from TEAM.
    - CMS will consider adding elements that are consistent with the new Administration's focus on Making America Healthy Again

K. SNF 3-Day Waiver Expansion

- **SNF Waiver**:
    - Proposed expansion to include **hospitals and CAHs with swing bed arrangements** for SNF 3-day Waiver eligibility
    - Aligns with MSSP regulations

L. Removal of Decarbonization & Resilience Initiative

- **Policy Update**:
    - Removal of the decarbonization and resilience initiative due to a shift in Administration priorities.

Soliciting Comments On:

- **Indian Health Service Outpatient Episodes**
- **Low Volume Hospitals**: Seeking comment on several potential policies to address concerns about low volume providers participating in TEAM
- **Standardized Prices and Reconciliation Amounts**
- **Primary Care Services Referral Requirement**:
    - Current policy requires referrals to primary care suppliers, regardless of existing relationships.
    - CMS seeks comment on whether referrals should prioritize existing primary care relationships.