Transforming Episode Accountability Model (TEAM)

Clinical Episode Construction Specifications

Centers for Medicare & Medicaid Services (CMS)
Center for Medicare and Medicaid Innovation
(Innovation Center)

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1 INPUTS

Table 1: Clinical Episode Inputs

#	Name	Source	Description
Clinical Episode Construction Datasets			
1	Medicare Part A and B Claim-Level Files	CMS	TEAM national clinical episodes are constructed using all Medicare Part A and B claims (inpatient, carrier, outpatient, home health agency services, skilled nursing facility, durable medical equipment, and hospice) with a service date in the given baseline period or performance year.
2	TEAM Participant List	CMS	The file records information such as CMS Certification Number (CCN for all TEAM participants.
3	Common Medicare Enrollment (CME) file	CMS	The CME file includes age, disability as the reason for Medicare entitlement, sex, race, enrollment status, low-income subsidy status, and dual eligibility for Medicare and Medicaid.
4	Official CMS Standardized Allowed Amounts	CMS	Payments from the claims taken from the claim-level files are standardized using the official CMS payment standardization algorithm.
5	Geometric Mean Length of Stay (GMLOS) data	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html	The GMLOS data are used to prorate non-outlier payments for the Inpatient Prospective Payment System (IPPS) as per the most recent Final Rule and Correction Notice tables available on this page.
6	Blood clotting factors HCPCS codes list	https://www.cms.gov/medicare/payment/fee-for-service-providers/part-b-drugs/average-drug-sales-price	List of HCPCS codes to identify blood clotting factors to control bleeding for hemophilia patients can be found in the TEAM Exclusions List file.

2 OUTPUTS

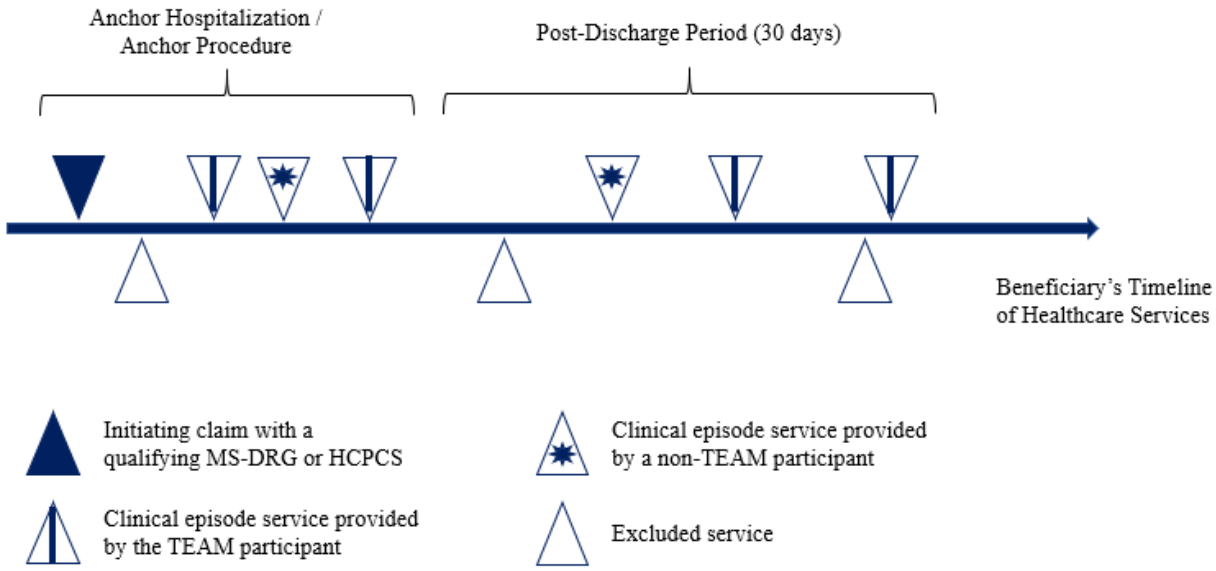
Table 2: Clinical Episode Outputs

#	Name	Description
1	TEAM National and Participant Baseline Period Clinical Episodes	The national and participant set of clinical episodes used to construct preliminary target prices for TEAM.
2	TEAM National and Participant Performance Year Clinical Episodes	The national and participant set of clinical episodes used to construct final target prices and determine reconciliation amounts, repayment amounts, and post-episode spending amounts for TEAM.

3 CLINICAL EPISODE CONSTRUCTION OVERVIEW

The following document describes the specifications used to construct clinical episodes for the Transforming Episode Accountability Model (TEAM). Clinical episodes are constructed using all of the inputs in Table 1. The main components of clinical episodes are Medicare Parts A and B claims. Figure 1 below outlines the basic principles of a clinical episode.[1]

Figure 1: Clinical Episode Window and Services



Notes:
1) Triangles above the Beneficiary's Timeline of Healthcare Services represent services included in the clinical episode.
2) If an anchor hospitalization is initiated on the same day as or within 3 days of an outpatient procedure for the same episode type, the episode begins on the date of the outpatient procedure rather than the date of the inpatient admission.

The three inpatient and two multi-setting (MS) TEAM episode types are "triggered" or "initiated" by an admission to the inpatient setting with specific Medicare Severity Diagnosis Related Groups (MS-DRG) code or by a procedure performed in an outpatient setting with specific Healthcare Common Procedure Coding Systems (HCPCS) code.[2] Hospitals will be accountable for all the MS-DRG or HCPCS codes within an episode type.

Clinical episodes are constructed to include all items and services that overlap with the clinical episode window, with some exceptions for items and services such as readmissions,

[1] All terms used in Figure 1 are defined in **Section 6**. Define Clinical Episode Shells.
[2] A complete list of the MS-DRGs and HCPCS codes per episode type that trigger a TEAM clinical episode can be found in the Code of Federal Regulations here: https://www.ecfr.gov/current/title-42/section-512.525.

which are defined by MS-DRG or Major Diagnostic Categories (MDCs); Part B drugs, which are defined by HCPCS codes; and hemophilia clotting factors, which are defined by HCPCS codes.[3] Clinical episode-level payments are created by summing official CMS standardized allowed amounts for all non-excluded services.[4] These *standardized payments* reflect the cost of items and services after removing variation in spending arising from geographical adjustment of reimbursement in CMS payment systems (e.g., hospital wage index and geographic practice cost index (GPCI)) and from policy-driven adjustments (e.g., indirect medical education (IME) adjustments). This process produces spending for each clinical episode; henceforth, all references to spending are assumed to be in standardized allowed amounts. This specifications document uses the following key terms for clinical episode construction:

- **Anchor hospitalization:** an inpatient hospitalization at an acute care hospital (ACH) with a qualifying MS-DRG, which in turn initiates an inpatient clinical episode shell. Anchor hospitalizations start on admission to the ACH and end upon discharge.
- **Anchor procedure:** an outpatient procedure performed at an ACH with a qualifying HCPCS code, which in turn initiates an outpatient clinical episode shell. Anchor procedures start and end on the revenue center date of the qualifying procedure.
- **Post-discharge period:** starts on the day the anchor hospitalization/anchor procedure ends and is 30 days long. It encompasses all the relevant spending incurred for that beneficiary during that period.

The specifications are divided into nine sections that correspond to detailed descriptions of the sequential stages of the clinical episode construction process. This document contains specifications for constructing clinical episodes in both the baseline period and applicable performance year. The steps in **Section 5** and **Section 6** discuss general specifications used in the construction of baseline period and performance year clinical episodes. The steps in **Section 7** describe the process of determining which items and services are included in clinical episodes. The steps in **Section 4** and **Section 8** are applied to construct baseline period clinical episodes, which are the inputs used to construct preliminary target prices. The steps in **Section 9** are applied to construct performance year clinical episodes, which are inputs used to construct final target prices and performance year clinical episode spending.

- **Section 4** describes the mapping of MS-DRG and Ambulatory Payment Classification (APC) changes over time
- **Section 5** describes scaling payments from the baseline period to the performance year

[3] A complete list of clinical episode exclusions can be found in the "TEAM Exclusions List" file.
[4] "CMS Standardization Methodology for Allowed Amount, Version 14." Centers for Medicare & Medicaid Services (CMS), October 2024. Available at the ResDAC CMS Payment Standardization website.

- **Section 6** describes defining clinical episode shells
- **Section 7** describes assigning payments and services to clinical episodes
- **Section 8** describes finalizing baseline period clinical episodes
- **Section 9** describes finalizing performance year clinical episodes

Table 3 below contains the baseline periods and the performance years for TEAM.

Table 3: Clinical Episode Period Date Ranges

Clinical Episode Period	Date Range
Performance Year 1	Baseline Period: Clinical episodes that have an anchor hospitalization or anchor procedure with a start date on or after 1/1/2022 and an anchor hospitalization or anchor procedure end date between 1/1/2022 and 12/31/2024. In other words, the PY1 baseline period includes clinical episodes with anchor start dates on or after 1/1/2022 and anchor end dates between CY2022 and CY2024. Performance Year: Clinical episodes with anchor start dates on or after 1/1/2026 and anchor end dates between 1/1/2026 and 12/31/2026.
Performance Year 2	Baseline Period: Clinical episodes that have an anchor hospitalization or anchor procedure with a start date on or after 1/1/2023 and an anchor hospitalization or anchor procedure end date between 1/1/2023 and 12/31/2025. In other words, the PY2 baseline period includes clinical episodes with anchor start dates on or after 1/1/2023 and anchor end dates between CY2023 and CY2025. Performance Year: Clinical episodes with anchor end dates between 1/1/2027 and 12/31/2027.

Clinical Episode Period	Date Range
Performance Year 3	Baseline Period: Clinical episodes that have an anchor hospitalization or anchor procedure with a start date on or after 1/1/2024 and an anchor hospitalization or anchor procedure end date between 1/1/2024 and 12/31/2026. In other words, the PY3 baseline period includes clinical episodes with anchor start dates on or after 1/1/2024 and anchor end dates between CY2024 and CY2026. Performance Year: Clinical episodes with anchor end dates between 1/1/2028 and 12/31/2028.
Performance Year 4	Baseline Period: Clinical episodes that have an anchor hospitalization or anchor procedure with a start date on or after 1/1/2025 and an anchor hospitalization or anchor procedure end date between 1/1/2025 and 12/31/2027. In other words, the PY4 baseline period includes clinical episodes with anchor start dates on or after 1/1/2025 and anchor end dates between CY2025 and CY2027. Performance Year: Clinical episodes with a anchor end dates between 1/1/2029 and 12/31/2029.
Performance Year 5	Baseline Period: Clinical episodes that have an anchor hospitalization or anchor procedure with a start date on or after 1/1/2026 and an anchor hospitalization or anchor procedure end date between 1/1/2026 and 12/31/2028. In other words, the PY5 baseline period includes clinical episodes with anchor start dates on or after 1/1/2026 and anchor end dates between CY2026 and CY2028. Performance Year: Clinical episodes with anchor end dates on or after 1/1/2030 and a clinical episode end date on or before 12/31/2030.

4 MAP MS-DRG AND APC CHANGES OVER TIME

When a MS-DRG or APC[5] associated with initiating a TEAM episode changes in an annual update, such as fiscal year IPPS Final Rule updates, comparing clinical episode spending between different time periods requires mapping between existing codes and new codes. Such a mapping ensures that comparisons of clinical episode spending across different time periods represent the same clinical content. This mapping aids in the consistent construction of clinical episodes between historical baseline periods and subsequent performance years.

As the model progresses, mappings for MS-DRG and APC will be incorporated in accordance with the most recent IPPS/OPPS Final Rules. These steps are applicable to baseline period clinical episodes to ensure consistency with the performance year clinical episodes.

Table 4: Section 4 Inputs and Outputs

Inputs
• IPPS Final Rules (Fiscal Year 2020 – Fiscal Year 2030)
• OPPS Final Rule Addendums B and J (Calendar Year 2020 – Calendar Year 2030)
• IPPS and Outpatient claims
Outputs
• IPPS and Outpatient claims with applicable mapped MS-DRGs and APCs

- **Step 1. Map MS-DRG and APC changes over time:**
  - **Step 1a.** For all MS-DRGs that are or will be mapped to TEAM eligible MS-DRGs in the baseline period, map the changes in MS-DRG between the baseline year and the appropriate fiscal year (in the performance year) using annual addendums to IPPS Final Rules.
    i. Assign each IPPS stay the mapped MS-DRG[6] for the performance year.
  - **Step 1b.** For all TEAM eligible HCPCS codes, map all APC changes using the OPPS Final Rules.[7]

[5] Effective 1/1/2015, CMS established Comprehensive-APC (C-APCs) to provide all-inclusive payments for certain procedures. All sections of this document use APCs to refer to both APCs and C-APCs.
[6] If there are no changes in the MS-DRG between the years, assign the original MS-DRG as the mapped MS-DRG for the relevant year.
[7] The HCPCS-APC mapping also takes into account APCs that undergo complexity adjustments in the presence of a secondary J1 or add-on HCPCS code, if any.

i. Assigns each outpatient claim the mapped APC, if any, for the performance year.[8]

ii. If the combination of HCPCS codes on the baseline claim would be complexity adjusted under the performance year OPPS Final Rules, then the claim is mapped to the complexity adjusted APC. Otherwise, it is not.

[8] If APC performance year weights are not available, use the APC weights from the most recent calendar year.

5 SCALE PRICES FROM BASELINE TO PERFORMANCE YEAR DOLLARS

This section describes the process of scaling historical prices from the baseline period to the performance year. Prior to estimating the clinical episode spending based on data from the baseline period, the standardized payments of each clinical episode are inflated to performance year dollars using MS-DRG-specific price scaling factors for initiating inpatient (i.e., IPPS) stays and HCPCS-specific price scaling factors for initiating outpatient procedures. These price scaling factors ensure that clinical episodes in the baseline period are comparable to performance year clinical episodes, by accounting for changes to payment rates and MS-DRG/APC mapping updates.

Table 5: Section 5 Inputs and Outputs

Inputs
• IPPS and outpatient claims with applicable mapped MS-DRGs and APCs
• MS-DRG and APC weights
Outputs
• MS-DRG and HCPCS Scaling Factors
• IPPS and outpatient claims with performance year scaled payment rates

- **Step 2. Scale payments from the initiating IPPS stay during the anchor hospitalization:** For payments from the IPPS stay that initiates the anchor hospitalization, the scaling factor is calculated as a ratio of MS-DRG rates, calculated as the ratio of the re-mapped fiscal year MS-DRG relative weight to the original MS-DRG relative weight (based on the discharge date of the stay).[9]
    - To update the payments from an anchor hospitalization, use the following equation:
        i. Calculate the scaling factor for the MS-DRG in the anchor hospitalization using the following equation:

$$\textbf{\textit{Scaling Factor}}_{IPPS\ stay} = \frac{\textbf{\textit{DRG weight}}_{remapped}}{\textbf{\textit{DRG weight}}_{original}}$$

        ii. Apply the scaling factor to the base MS-DRG portion of the cost of the stay by multiplying the MS-DRG standardized allowed amount by the corresponding

[9] MS-DRGs in the baseline period are mapped forward to the performance year using the methodology described in Section 4.

scaling factor applicable to the fiscal year. The scaled spending will be used for both the triggering portion of the episode as well as any eligible claims with TEAM MS-DRGs included in the post-discharge period.

- Payments included in IPPS stay standardized allowed amount beyond the base MS-DRG portion of the cost (e.g., add-on or outlier payments) are not scaled. In the first step, for a given IPPS stay, remove the allowed amount for outliers or any add-on payments:

$$\textbf{Std Allowed Amount}_{DRG} = \textbf{Std Allowed Amt}_{IPPS\ stay} - \textbf{Std Allowed Amount}_{Outliers/AddOns}$$

- Second, apply the scaling factor to the base MS-DRG portion of the cost of the IPPS stay:

$$\textbf{Scaled Std Allowed Amt}_{DRG} = (\textbf{Std Allowed Amt}_{DRG} \times \textbf{Scaling Factor}_{IPPS\ stay})$$

- To calculate the total adjusted cost for the IPPS stay, add back in the standardized allowed amount for any outlier payments: [10]

$$\textbf{Total Adjusted Cost}_{IPPS\ stay} = \textbf{Scaled Std Allowed Amt}_{DRG} + \textbf{Std Allowed Amount}_{Outliers/AddOns}$$

- **Step 3. Scale payments from the initiating outpatient claim during the anchor procedure:** For payments from the initiating outpatient claim during the OP anchor procedure, use a separate approach to adjust baseline costs for APC changes between the baseline and performance year:
  - **Step 3a.** Update HCPCS payments for the anchor procedure in the baseline year for HCPCS codes that consistently map to APCs in the baseline and performance year:[11]
    i. Calculate a scaling factor which is the ratio of the performance year APC relative weight to the baseline year APC relative weight (based on the revenue center date).[12,13]

$$\textbf{Scaling Factor}_{OP\ procedure} = \frac{\textbf{APC weight}_{PY}}{\textbf{APC weight}_{BY}}$$

    ii. Once the scaling factor is calculated, multiply the anchor procedure outpatient clinical episode costs by the scaling factor:

[10] Note that this does not include add-on payments which are removed during the payment standardization process (NTAP, Clotting factors).
[11] If APC performance year weights are not available, use the APC weights from the most recent calendar year.
[12] The APCs in the baseline period are mapped forward to the performance year using the methodology described in **Section 4**.
[13] The APC payment weights can be found in the OPPS Final Rule Addendums B and J.

$$\textbf{\textit{Scaled Std Allowed Amt}}_{OP\ episode} = \left(\textbf{\textit{Std Allowed Amt}}_{OP\ episode} \times \textbf{\textit{Scaling Factor}}_{OP\ procedure}\right)$$

At the end of **Step 3,** the claim level dataset in the baseline period will have payments inflated to performance year dollars using the most recently available fee schedules. This dataset will be used as an input to **Section 7** when assigning services from Medicare Part A and B claims to clinical episodes.

6 DEFINE CLINICAL EPISODE SHELLS

This section describes the specifications to define national inpatient and outpatient clinical episodes shells. Clinical episode shells start with the admission to an inpatient anchor hospitalization or the revenue center date of an outpatient anchor procedure and end 30 days after the end of the anchor hospitalization/anchor procedure, including the day on which the anchor hospitalization/anchor procedure ends. The clinical episode shells define the period for which services can be included in the clinical episode spending and are comprised of anchor hospitalization/anchor procedure and post-discharge period. There is a 180-day lookback period before the start of the clinical episode shell. This period will include risk adjusters defined by beneficiary clinical history as observed in claims in the 180-day period prior to the start of the clinical episode shell, and will be used solely for risk adjusting target prices.

- **Section 6.1** explains the methodology to identify potential national anchor procedures for outpatient clinical episode shells.
- **Section 6.2** describes the methodology to identify potential national anchor hospitalizations for inpatient clinical episode shells.
- **Section 6.3** describes the process of creating the clinical episode shell for the post-discharge period.
- **Section 6.4** describes the clinical episode-level exclusions.

These steps of constructing clinical episode shells are identical for the baseline period and performance year.

Table 6: Section 6 Inputs and Outputs

Inputs
• TEAM MS-DRGs and HCPCS Codes
• Inpatient and outpatient claims with applicable mapped MS-DRGs and APCs
• Beneficiary Enrollment Datasets (EDB and CME)
Outputs
• Clinical episode shells

6.1 Identify Potential National Anchor Procedures for Outpatient Clinical Episode Shells

The following steps are used to identify potential national anchor procedures from the universe of outpatient claims. National anchor procedures include all potential outpatient clinical

episodes, and not just those initiated by TEAM participants. Anchor procedures initiate outpatient clinical episodes.

- **Step 4. Limit to outpatient lines with positive standardized allowed amounts.**
- **Step 5. Apply same day, tie-breaking precedence rules:** For cases where multiple potential anchor procedures are possible on the same day for the same beneficiary, apply the following steps in the order listed until the ties are broken.
  - **Step 5a.** Select the outpatient line with the higher standardized line allowed amount.
  - **Step 5b.** Select the outpatient line with the later processing date.
  - **Step 5c.** Select the outpatient line with the higher charge amount.
  - **Step 5d.** Select the outpatient line with the smaller claim identifier number.
  - **Step 5e.** Select the outpatient line with the smaller line item number.
- **Step 6. Construct anchor procedures:** Take all outpatient lines at an ACH that are initiated by HCPCS code for the two multi-setting episode types. Set the start and end of the anchor procedure equal to the revenue center date.

6.2 Identify Potential National Anchor Hospitalizations for Inpatient Clinical Episode Shells

The following steps are used to identify potential national anchor hospitalizations from the universe of IPPS claims. National anchor hospitalizations include all potential inpatient clinical episodes, not just those initiated by TEAM participants. Anchor hospitalizations initiate inpatient clinical episodes.

- **Step 7. Limit to IPPS stays with positive standardized allowed amounts.**
- **Step 8. Construct Anchor Hospitalizations:** Restrict to IPPS stays at an ACH that are initiated by a qualifying MS-DRG.[14] The start and end dates of the anchor hospitalization are the admission date and discharge date, respectively.

6.3 Construct Clinical Episode Shells for Post-Discharge Period

The following steps are used to define the second component of the clinical episode shell, the post-discharge period.

- **Step 9. Define post-discharge period:** Inpatient and outpatient clinical episodes' post-discharge periods begin on the day anchor hospitalizations and anchor procedures end, respectively, and extend for 30 days.[15]

[14] Uses MS-DRGs mapped to the applicable fiscal year in the performance year as described in **Section 4**.
[15] The discharge date and the procedure completion date are both day one of the post-discharge period.

- **Step 10. Define clinical episode shells where a beneficiary dies during the post-discharge period**: For clinical episode shells where a beneficiary dies during the post-discharge period, set the clinical episode end date as the beneficiary death date.[16]
- **Step 11. Update anchor start date for inpatient clinical episode which occurs on the same day or within three days of an outpatient procedure.** Using a unique identifier for each beneficiary with an IP clinical episode shell, check if the anchor hospitalization is initiated on the same day or within three days of a TEAM eligible outpatient procedure in the same episode type at the same ACH.
    - If so, set the anchor start date of the episode to be that of the outpatient procedure (i.e., OP revenue center date). The anchor end date will remain the hospitalization discharge date.

6.4 Exclude Clinical Episode Shells

Implement the following exclusions for clinical episode shells.

- **Step 12. Enact clinical episode-level exclusions:** Exclude clinical episode shells where:
    - The clinical episode shell is not in the relevant baseline period or performance year.
        i. In the baseline period, exclude inpatient and outpatient clinical episodes with an anchor hospitalization discharge date or anchor procedure completion date, respectively, before January 1st of the first baseline year or after December 31st of the final baseline year.
        ii. In the performance year, exclude clinical episodes that have anchor hospitalization discharge dates or anchor procedure completion dates outside of the calendar year for clinical episode construction purposes.
    - The clinical episode is initiated at an ineligible ACH.[17]
    - The clinical episode is initiated in ineligible states.[18]

[16] Beneficiary death date is taken from the CME.
[17] ACH provider numbers include those with the last four digits of the CCN in 0001-0899. Ineligible ACHs include PPS-exempt cancer hospitals (CCN in 05-0146, 05-0660, 10-0079, 10-0271, 22-0162, 33-0154, 33-0354, 36-0242, 39-0196, 45-0076, and 50-0138), critical access hospitals (the last four digits of the CCN in 1300-1399), hospitals in Maryland (CCN begins with "21" or "80"), psychiatric hospitals, rehabilitation hospitals, children's hospitals, long-term care hospitals, emergency hospitals, veteran hospitals, and Indian Health System (IHS)/Tribal hospitals. Also, RCH hospitals will be excluded if their participation in the RCH demonstration overlaps with the episode window. Finally, episodes initiated at hospitals that open in a mandatory CBSA or hospitals located in a mandatory CBSA that begin to satisfy the definition of TEAM participant after December 31, 2024 are also excluded from PY1 but can be eligible in later PYs.
[18] Ineligible states include the state of Maryland.

- The outpatient clinical episode has an inpatient clinical episode occurring on the same day or within three days in the same episode type and same ACH.
- The beneficiary is not continuously enrolled in Medicare Part A and Part B during the clinical episode period or the 180-day lookback period.
- The beneficiary is covered through managed care plans (such as Medicare Advantage) during the clinical episode period or the 180-day lookback period.
- The beneficiary is eligible for Medicare based on a diagnosis for End-Stage Renal Disease (ESRD).[19]
- The beneficiary has a primary payer other than Medicare during the clinical episode period or the 180-day lookback period.[20]
- The beneficiary dies during the anchor hospitalization or anchor procedure.
- The anchor procedures initiated by outpatient lines do not have the highest ranking J1[21] status indicator on the claim.
- The clinical episode shell is initiated at an ACH impacted by extreme and uncontrollable circumstances (EUC) during the performance year.[22] The TEAM EUC policy applies to clinical episodes that have an anchor hospitalization or anchor procedure begin date in the period up to and including 30 days before the major disaster or emergency disaster-designated disaster start date and up to the disaster end date.[23]

[19] ESRD eligibility is taken from the CME.
[20] As a result of this restriction, clinical episodes where the beneficiary is covered through United Mine Workers of America Health and Retirement Funds are excluded.
[21] J1 indicates Hospital Part B services paid through C-APC.
[22] For an EUC to be included under the TEAM EUC policy, the Secretary of Health and Human Services must have issued a Section 1135 Waiver, and Federal Emergency Management Agency (FEMA) needs to have issued an accompanying Major Disaster Declaration. Additionally, the ACH should be located in a Federal Information Processing Standard (FIPS) county designated by FEMA as a disaster-impacted area.
[23] See the Code of Federal Regulations for the EUC policy here: https://www.ecfr.gov/current/title-42/part-512/subpart-E#p-512.537(b)(3)

7 ASSIGN SERVICES AND ASSOCIATED PAYMENTS TO CLINICAL EPISODES

This section describes the process of determining which items and services are included in clinical episodes. It is intended to provide a general understanding of the payment aggregation methodology for TEAM.

- **Section 7.1** describes the general rules for payment aggregation.
- **Section 7.2** discusses payments that are excluded from clinical episodes.
- **Section 7.3** describes the process for prorating payments from claims.
- **Section 7.4** discusses calculating the total clinical episode spending.

All steps in this section are the same for construction of both baseline period and performance year clinical episodes.

Table 7: Section 7 Inputs and Outputs

Inputs
• Clinical episode shells
• All Medicare Part A and B claims and related standardized payments for the following: inpatient, carrier, outpatient, home health agency services, skilled nursing facility, durable medical equipment, and hospice
• GMLOS data
• PFS
• Quarterly Average Sales Price (ASP) Drug Pricing Files
• TEAM exclusion lists (Refer to **Step 16** below)
Outputs
• National set of clinical episodes with overall clinical episode spending calculated

7.1 General Rules for Payment Aggregation

This section describes the methodology to determine which items and services are included in the clinical episode (i.e., grouped claims) and how payments from those services are allocated to the clinical episode. The methodology identifies all qualifying items and services occurring concurrent to at least one day of a clinical episode to determine if all payments, or a

subset of payments, are grouped to the clinical episode.[24] Regardless of the setting, all non-excluded payments are assigned if they occur during the clinical episode.[25]

- **Step 13. Consider Medicare Parts A and B claims for payment aggregation:** Consider payments from claims in all Medicare Part A and B care settings, including inpatient, carrier, outpatient, home health agency services, skilled nursing facility, durable medical equipment, and hospice.
- **Step 14. Limit to eligible claims:** Restrict to claims that satisfy the following criteria:
  - Have a standardized payment amount greater than zero, and
  - The claim's service start dates overlap at least one day of the clinical episode.
- **Step 15. Assign claims as occurring during the clinical episode:** Assign all claims that have service dates during the clinical episode and all payments from the initiating anchor hospitalization or anchor procedure.

7.2 Excluded Payments

Although TEAM operates under a total-cost-of-care concept, in which all Medicare FFS payments for services furnished during the clinical episode are generally included, payments from the following claims are removed from clinical episodes.

- **Step 16. Apply TEAM exclusions logic:** Remove payments for the following TEAM specific exclusions:
  - Claim is initiated in ineligible states.[26]
  - Part B payments for high-cost drugs, low-volume drugs[27] and blood clotting factors for hemophilia patients billed on outpatient, carrier, and durable medical equipment claims. Specifically in the baseline period, this list includes:
    i. Drug HCPCS codes that are billed in fewer than 31 clinical episodes in the national set of baseline period clinical episodes;
    ii. Drug HCPCS codes that are billed in at least 31 clinical episodes in the baseline period, have a mean cost of greater than $25,000 per clinical episode in the baseline period, and are flagged for exclusion after clinical review;

[24] Grouped claims refer to all the items and services that are included while aggregating the total cost associated with the clinical episode. Ungrouped claims refer to the claims that are excluded due to the payment exclusion criteria outlined in **Section 7.2**.
[25] Services and payments are also aggregated to the post-episode spending monitoring period (i.e., days 31 to 60 after the anchor hospitalization discharge date or anchor procedure completion date). Costs in the post-episode spending monitoring period is not included in the reconciliation amount/repayment amount calculations.
[26] Ineligible states include the state of Maryland.
[27] To determine if a drug HCPCS meets the cost or volume thresholds for exclusion, the clinical episodes are pooled across all clinical episode types.

iii. HCPCS codes corresponding to clotting factors for hemophilia patients, identified in quarterly ASP file as HCPCS codes with clotting factor equal to 1, and other HCPCS codes identified as hemophilia by clinicians;

In the performance year, the exclusion list will be broadened to include:

- Drug HCPCS codes that were not in the baseline period, and appear in fewer than or equal to 10 clinical episodes per annum in the performance year;
- Drug HCPCS codes that were not in the baseline period, appear in more than 10 clinical episodes per annum in the performance year, have a mean cost of greater than $25,000 per clinical episode in the performance year, and are clinically reviewed;
- Drug HCPCS codes that were not in the baseline period, appear in more than 10 clinical episodes per annum in the performance year, have a mean cost less than or equal to $25,000 per episode, and correspond to a drug that appears in the baseline period list but was assigned a new HCPCS code between the baseline and performance year;
- HCPCS codes for new hemophilia clotting factors not in the baseline period.

- New technology add-ons, identified through value code 77 on IPPS hospital claims.[28]
- All Medicare Part A and B payments that occur during an inpatient readmission based on the following excluded MDC list:
  i. MDC 02 (Diseases and Disorders of the Eye)
  ii. MDC 14 (Pregnancy, Childbirth, and Puerperium)
  iii. MDC 15 (Newborns)
  iv. MDC 25 (Human Immunodeficiency Virus).
- All Medicare Part A and B payments that occur during an inpatient readmission based on the excluded readmission MS-DRGs list.[29]
- Pass-through payments for medical devices on OPPS hospital outpatient claims, identified through OPPS status indicator H.

7.3 Prorate Claims

This section describes the methodology used to prorate claims and payments that span beyond the clinical episode so as to appropriately allocate the payments to the clinical episode.

[28] This exclusion is applied during the payment standardization process.
[29] A complete list of excluded readmission MS-DRGs can be found in the "TEAM Exclusions List" file on the CMMI TEAM website.

Table 7 lists all claim and payment types and their respective proration methodologies. For a full description of the various proration methodologies, refer to **Steps 17 – 19**.

Table 8: Proration Methodology by Claim and Payment Type

Claim Type	Proration Methodology
Carrier	Never prorate
Critical access hospitals	Per diem
Durable medical equipment	Never prorate
Home health agency	Per visit
Hospice	Per diem
Inpatient psychiatric facility	Per diem
Inpatient rehabilitation facility (outlier and non-outlier payments)	Per diem
IPPS (non-outlier payments)	GMLOS method
IPPS (outlier payments)	Per diem
Long-term care hospital (outlier and non-outlier payments)	Per diem
OPPS	Never prorate
Skilled nursing facility	Per diem

- **Step 17. Identify claims to prorate:** Identify all claims that overlap with the clinical episode but end after the clinical episode to determine if all or a subset of payments are assignable to the clinical episode.
    - Never prorate OPPS, carrier and durable medical equipment claims. Assign them to the clinical episode.
- **Step 18. Identify and prorate applicable claims based upon a per-diem rate:** To prorate on a per diem basis, assign payments to the clinical episodes based on the number of days in the claim that occur during the clinical episode. Prorate the following types of claims on a per diem basis:
    - critical access hospitals
    - hospice
    - inpatient psychiatric facilities

- inpatient rehabilitation facilities
- long-term care hospital
- skilled nursing facilities

- **Step 19. Identify and prorate remaining claims:** For the remaining IPPS claim types, prorate outlier and non-outlier payment amounts separately.
  - **Step 19a.** Prorate outlier payments. Prorate outlier payments on a per-diem basis using the methodology described in **Step 18**.
  - **Step 19b.** Prorate IPPS non-outlier payments. For IPPS non-outlier payments, compare the number of days of the inpatient stay (that needs to be prorated) overlapping the post-discharge period with the GMLOS by MS-DRG and the fiscal year of the discharge date.
    i. If the number of days overlapping the post-discharge period is greater than or equal to the GMLOS-1, assign the full non-outlier payment amount to the post-discharge period.
    ii. Otherwise, prorate on a per diem basis, giving double weight to the first day of the overlap.

7.4 Calculate Total Clinical Episode Spending

After assigning payment amounts to clinical episodes for all non-excluded claim payments across all settings, sum payment amounts at the clinical episode level.

- **Step 20. Calculate the overall clinical episode spending:** Sum all payments assigned to the clinical episode to calculate total clinical episode spending.

For the baseline period, the clinical episode dataset created at the end of **Step 20** is used as an input in **Section 8** to create the final set of baseline period clinical episodes. For the performance year, the clinical episodes from **Step 20** are used as an input in **Section 9** to create the final national and participant set of clinical episodes.

8 FINALIZE BASELINE PERIOD CLINICAL EPISODES

This section describes the methodology to create a final set of inpatient and outpatient clinical episodes for national and participant populations in the baseline period. The first step is to limit only one clinical episode for an individual beneficiary to occur at a given time. That is, if a beneficiary has multiple clinical episodes with overlapping dates, only one of these clinical episodes is retained. Next, map HCPCS for outpatient clinical episodes to MS-DRGs. Finally, winsorize clinical episode spending on the upper bound and subset clinical episodes to participants. This final set of clinical episodes are the inputs to the risk adjustment model used to construct the preliminary target prices.

Table 9: Section 8 Inputs and Outputs

Inputs
• National set of clinical episodes
• TEAM participant list
Outputs
• Final national set of clinical episodes with winsorized prices
• Participant set of baseline period clinical episodes

- **Step 21. Allow no more than one clinical episode to occur at a given time for a beneficiary:** For clinical episodes where a beneficiary has a secondary anchor stay or anchor procedure any time during the clinical episode period after the first day of the anchor hospitalization or anchor procedure, retain the first clinical episode. The second clinical episode, and any subsequent clinical episode, will be counted as a readmission and included in the costs of the first episode.[30]

- **Step 22. Map HCPCS for outpatient clinical episodes to MS-DRGs.** For outpatient clinical episodes, map the triggering HCPCS to a MS-DRG for MS-lower extremity joint replacement (LEJR) and MS-spinal fusion.

[30] Overlapping episode resolution for the baseline period involves a more comprehensive set of episodes. Specifically, overlap is resolved across trend year (refer to Appendix A) and baseline period clinical episodes.

Table 10: OP Clinical Episodes MS-DRG Mapping

Episode Type	Original HCPCS	Mapped MS-DRG
MS-LEJR	27447, 27130	470
MS-LEJR	27702	469
MS-Spinal Fusion	22551, 22554	473
MS-Spinal Fusion	22612, 22630	451
MS-Spinal Fusion	22633	402

- **Step 23. Winsorize clinical episode spending**: To limit extreme values, winsorize Clinical Episode spending at the 99th percentile for each MS-DRG episode type, region, and calendar year across the baseline period.
  - Set all values above the 99th percentile to the 99th percentile.

- **Step 24. Subset clinical episodes to TEAM participants:** Subset the national set of clinical episodes to those initiated by a participating TEAM ACH. This will be referred to as the TEAM baseline period participant set of episodes.[31]

[31] Participation in TEAM is mandatory for ACHs located in one of the mandatory Core Based Statistical Areas (CBSAs) selected for participation. Voluntary participants include ACHs which were participants through the completion of the Comprehensive Joint Replacement (CJR) or Bundled Payments for Care Improvement Advanced (BPCI Advanced) models and have accepted voluntary election letters.

9 FINALIZE PERFORMANCE YEAR CLINICAL EPISODES

This section describes the methodology to create a final set of inpatient and outpatient clinical episodes for national and participant populations in the performance year. The first step is to limit only one clinical episode for an individual beneficiary to occur at a given time. That is, if a beneficiary has multiple clinical episodes with overlapping dates, only one of these clinical episodes is retained. Next, map HCPCS for outpatient clinical episodes to MS-DRGs. Finally, winsorize clinical episode spending on its upper bound and subset clinical episodes to participants.

Table 11: Section 9 Inputs and Outputs

Inputs
• National set of clinical episodes
• TEAM participant list
Outputs
• Final national set of clinical episodes with winsorized prices
• Participant set of performance year clinical episodes

- **Step 25. Allow no more than one clinical episode to occur at a given time for a beneficiary:** For clinical episodes where a beneficiary has a secondary anchor stay or anchor procedure any time during the clinical episode period after the first day of the anchor hospitalization or anchor procedure, retain the first clinical episode. The second clinical episode, and any subsequent clinical episodes, will be counted as a readmission and included in the costs of the first episode.

- **Step 26. Map HCPCS for outpatient clinical episodes to MS-DRGs.** For outpatient clinical episodes, map the triggering HCPCS to a MS-DRG for MS-Lower extremity joint replacement and MS-Spinal fusion (refer to Table 10 for mappings).

- **Step 27. Winsorize clinical episode spending:** To limit extreme values, winsorize clinical episode spending at the 99th percentile for each MS-DRG/HCPCS episode type and region in the performance year.[32] Set all values above the 99th percentile to the 99th percentile.

[32] For the MS-LEJR and Spinal Fusion clinical episodes, treat outpatient clinical episodes as having MS-DRGs for the clinical episode since winsorization will be done at the MS-DRG level and not the APC level.

- **Step 28. Subset clinical episodes to TEAM participants:** Subset the national set of clinical episodes to those initiated by a participating TEAM ACH. This will be referred to as the TEAM performance year participant set of clinical episodes.

This dataset is used to calculate performance year spending for reconciliation purposes.

APPENDIX A TREND YEARS

Per the FY2026 IPPS Final Rule, the prospective trend factor, which represents the expected changes in average spending patterns between the baseline period and the performance year, is calculated using the baseline period and trend year clinical episodes. The trend years include clinical episodes with anchor hospitalization or anchor procedure dates two years immediately prior to the 3-year baseline period.

Table A1. Trend Years and Trend Periods Date Ranges

Clinical Episode Period	Date Range
Performance Year 1	Trend Years: Clinical episodes that have an anchor hospitalization or anchor procedure with a start date on or after 1/1/2020 and an anchor hospitalization or anchor procedure end date before or on 12/31/2021. Trend Period: Clinical episodes that have an anchor hospitalization or anchor procedure with a start date on or after 1/1/2020 and an anchor hospitalization or anchor procedure end date before or on 12/31/2024.
Performance Year 2	Trend Years: Clinical episodes that have an anchor hospitalization or anchor procedure with a start date on or after 1/1/2021 and an anchor hospitalization or anchor procedure end date before or on 12/31/2022. Trend Period: Clinical episodes that have an anchor hospitalization or anchor procedure with a start date on or after 1/1/2021 and an anchor hospitalization or anchor procedure end date before or on 12/31/2025.
Performance Year 3	Trend Years: Clinical episodes that have an anchor hospitalization or anchor procedure with a start date on or after 1/1/2022 and an anchor hospitalization or anchor procedure end date before or on 12/31/2023. Trend Period: Clinical episodes that have an anchor hospitalization or anchor procedure with a start date on or after 1/1/2022 and an anchor hospitalization or anchor procedure end date before or on 12/31/2026.
Performance Year 4	Trend Years: Clinical episodes that have an anchor hospitalization or anchor procedure with a start date on or after 1/1/2023 and an anchor hospitalization or anchor procedure end date before or on 12/31/2024. Trend Period: Clinical episodes that have an anchor hospitalization or anchor procedure with a start date on or after 1/1/2023 and an anchor hospitalization or anchor procedure end date before or on 12/31/2027.

Clinical Episode Period	Date Range
Performance Year 5	Trend Years: Clinical episodes that have an anchor hospitalization or anchor procedure with a start date on or after 1/1/2024 and an anchor hospitalization or anchor procedure end date before or on 12/31/2025. Trend Period: Clinical episodes that have an anchor hospitalization or anchor procedure with a start date on or after 1/1/2024 and an anchor hospitalization or anchor procedure end date before or on 12/31/2028.

The methodology for trend year episode construction and baseline episode construction is aligned. At a high-level, the following steps are used to construct trend year episodes:

- **Step A1. Construct clinical episode shells and apply eligibility criteria,** as described in Steps 1 to 12.
- **Step A2. Aggregate clinical episode spending, apply overlap resolution, and map OP clinical episodes to MS-DRGs** as described in Steps 13 to 22.
- **Step A3. Winsorize clinical episode spending,** as described in Step 23.

The resulting output is a final national set of episodes used to calculated the prospective trend factor.