Physician-Focused Payment Model Technical Advisory Committee

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February 13, 2024

Xavier Becerra, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Becerra:

On behalf of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), we are pleased to submit PTAC's report on improving management of care transitions in population-based models, in the context of Alternative Payment Models (APMs) more broadly and physician-focused payment models (PFPMs). Section 1868(c) of the Social Security Act directs PTAC to: 1) review physician-focused payment models submitted to PTAC by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary.

Within this context, from time to time, it may be beneficial for PTAC to reflect on proposed PFPMs that have been submitted to the Committee to provide further advisement on pertinent issues regarding effective payment model innovation in APMs and PFPMs. In some cases, the importance of an emerging topic may lead PTAC to consider how proposals the Committee has reviewed in the past may inform that emerging topic. For example, PTAC may wish to assess information in previously submitted proposals and other sources that could serve to further inform the Secretary, as well as PTAC itself on these topics. This is the case regarding the topic of improving management of care transitions in population-based models.

From 2016 to 2020, PTAC received 35 proposals for PFPMs and voted on the extent to which 28 of these proposals meet the Secretary's 10 regulatory criteria. Nearly all of the 35 proposals that were submitted to PTAC addressed the proposed model's impact on quality and costs to some degree. Since 2022, PTAC has been conducting a series of theme-based discussions to explore care delivery and payment issues related to developing and implementing population-based total cost of care (PB-TCOC) models, including issues related to specialty

integration. Key themes that emerged from these meetings included the importance of developing care delivery models that include high-touch, multidisciplinary team-based, proactive patient-centered care; balancing the roles and use of primary care providers (PCPs) and specialty care providers; and managing care transitions across settings effectively. Additionally, at least 20 of the proposals that have been submitted to PTAC addressed issues related to facilitating transitions and coordinating care across settings in advanced primary care models (APCMs) and episode-based or condition-specific models.

For this reason, PTAC now sees value in further exploring elements in previously submitted proposals related to this topic, along with current information on improving management of care transitions in the context of population-based models and value-based care transformation. To ensure that the Committee was fully informed, the Committee conducted a theme-based discussion on this topic during PTAC's two-day June 2023 public meeting. The theme-based discussion included an overview presentation by Committee members; as well as listening session presentations and panel discussions with a previous submitter and other subject matter experts (SMEs) on various issues related to improving management of care transitions in population-based models. PTAC also requested public input during the meeting and through a Request for Input (RFI).

This report provides PTAC's findings and valuable information on best practices related to improving management of care transitions in population-based models. The information that PTAC has gleaned from a review of previous PFPM proposals and other literature that addresses this important topic, as well as input received during the theme-based discussion, will help to inform PTAC in its review of future proposals. This material has informed the Committee's comments, which are summarized in the following broad topic areas in this report:

- Topic 1: Importance of Improving Care Management in Population-Based Models;
- Topic 2: Care Delivery Model Features to Improve Management of Care Transitions;
- Topic 3: Enablers to Support Desired Care Delivery Features;
- Topic 4: Payment Model Features to Improve Management of Care Transitions; and
- Topic 5: Enablers to Support Payment Model Features.

Key highlights include:

- Managing transitions in care requires an interdisciplinary team to perform the various functions that are needed, including screening; medication reconciliation; communication and collaboration; timely follow-up visits; patient and caregiver education; and the use of other tools such as checklists and condition-specific red flags.
    - An interdisciplinary team could help to facilitate coordination across settings and could also act as a hub for connecting providers across sectors—including

community organizations that can assist in addressing health-related social needs (HRSNs), such as transportation and housing.

- Population-based models should encourage providers to develop a more holistic view of accountability for ensuring effective care transitions and begin thinking about care transitions earlier in the care delivery process.

- Improving the management of care transitions also requires the development of information technology (IT) solutions that can notify providers when a patient is admitted to a hospital or discharged to home or another setting. While a patient's PCP should function as the "hub" or "quarterback" for managing a patient's care transitions, in many situations, PCPs may not have access to timely data on admissions, transfers, and discharges related to their patients.

- Evidence suggests that the use of Medicare Transitional Care Management (TCM) services is associated with significant improvements in outcomes and substantial cost savings.

    - In 2018 and 2019, the use of TCM services within 30 days of hospital discharge resulted in improvements in hospital readmissions (a 5.6 percent decrease, or -0.6 percentage points), TCOC (a 7.8 percent decrease per episode, or -$236.11/episode), and healthy days at home (a 1.3 percent increase, or +0.32 days) during the 31 to 60 day period following discharge.

    - There was also a significant decrease in TCOC during the 1 to 60 day period following discharge (a 13.7 percent decrease per episode, or -$997.10 per episode).

- Population-based models include inherent global financial incentives that encourage improved management of care transitions across providers and settings.

    - In 2019, practices that were affiliated with an accountable care organization were more likely to bill for TCM services.

    - During the transition to value-based care, increasing uptake of the current TCM codes could help to expand the development of interdisciplinary team-based care delivery approaches and increase provider readiness to participate in models that include accountability for quality and TCOC.

- The design of financial incentives related to providing evidence-based transitional care management services may need to be revisited to incentivize multiple roles within the interdisciplinary care delivery team (rather than focusing on an individual provider) and include additional levels to account for the complexity of team member involvement in managing certain kinds of transitions. Additionally, payment models should explore linking financial incentives for managing care transitions with outcomes.

    - While flexibility is needed to account for variation across health care systems, markets and systems, it may be possible to achieve consistency in the episode definition for the accountable transition period across models.

- Additional best practices include:

    - Allowing for flexibility in transitional care delivery models;
    - Providing actionable data related to managing care transitions;
    - Encouraging the availability of integrated data across settings;
    - Ensuring the availability of information about HRSNs and social determinants of health (SDOH);
    - Developing and strengthening performance measures related to transitions of care;
    - Ensuring parity across the Medicare program regarding providers' ability to transition patients into the appropriate care delivery setting;
    - Improving the harmonization of payment approaches across payers; and
    - Addressing the "ratchet effect," in which providers' baselines are reset based on achieving good performance, including improved outcomes associated with better management of care transitions.

In addition to summarizing the Committee's findings and comments related to these topics, the report also identifies areas where additional research is needed, issues for policy makers, and some potential next steps.

The members of PTAC appreciate your support of our shared goal of improving the Medicare program for both beneficiaries and the providers who care for them. Committee members would be happy to discuss any of these observations with you. However, the Committee appreciates that there is no statutory requirement for the Secretary to respond to these comments.

Sincerely,

//Lauran Hardin//

Lauran Hardin, MSN, FAAN
Co-Chair

//Angelo Sinopoli//

Angelo Sinopoli, MD
Co-Chair

Attachment

Physician-Focused Payment Model Technical Advisory Committee

REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

Improving Management of Care Transitions in Population-Based Models

February 13, 2024

About This Report

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to: 1) review physician-focused payment models (PFPMs) submitted by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary. PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR §414.1465.

Within this context, from time to time, it may be beneficial for PTAC to reflect on proposed PFPMs that have been submitted to the Committee to provide further advisement on pertinent issues regarding effective payment model innovation in Alternative Payment Models (APMs) and PFPMs. Given that, in the past, at least 20 of the proposals that have been submitted to PTAC addressed issues related to facilitating transitions and coordinating care across settings in advanced primary care models (APCMs) and episode-based or condition-specific models, PTAC now sees value in reviewing these elements within these proposals, along with current information on care transitions in population-based models and value-based care transformation. To ensure that the Committee was fully informed, PTAC's June 2023 public meeting included a theme-based discussion on improving management of care transitions in population-based models.

This report summarizes PTAC's findings and comments regarding improving management of care transitions in population-based models. This report also includes: 1) areas where additional research is needed and some potential next steps; 2) a summary of the characteristics relevant for improving management of care transitions in population-based models from proposals that have previously been submitted to PTAC; 3) an overview of key issues relating to care transitions and value-based care transformation; and 4) a list of additional resources related to these theme-based discussions that are available on the Office of the Assistant Secretary for Planning and Evaluation (ASPE) PTAC website.

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SUMMARY STATEMENT

From 2016 to 2020, PTAC received 35 proposals for PFPMs and voted on the extent to which 28 of these proposals meet the Secretary's 10 regulatory criteria. Nearly all of the 35 proposals that were submitted to PTAC addressed the proposed model's impact on quality and costs to some degree. Since 2022, PTAC has been conducting a series of theme-based discussions to explore care delivery and payment issues related to developing and implementing population-based total cost of care (PB-TCOC) models, including issues related to specialty integration. Key themes that emerged from these meetings included the importance of developing care delivery models that include high-touch, multidisciplinary team-based, proactive patient-centered care; balancing the roles and use of primary care providers (PCPs) and specialty care providers; and managing care transitions across settings effectively. Additionally, at least 20 of the proposals that have been submitted to PTAC addressed issues related to facilitating transitions and coordinating care across settings in advanced primary care models (APCMs) and episode-based or condition-specific models.

For this reason, PTAC now sees value in further exploring elements in previously submitted proposals related to this topic, along with current information on improving management of care transitions in the context of population-based models and value-based care transformation. To ensure that the Committee was fully informed, the Committee conducted a theme-based discussion on this topic during PTAC's two-day June 2023 public meeting. The theme-based discussion included an overview presentation by Committee members as well as listening session presentations and panel discussions with a previous submitter and other subject matter experts (SMEs) on various issues related to improving management of care transitions in population-based models. PTAC also requested public input during the meeting and through a Request for Input (RFI).

This report provides PTAC's findings and valuable information on best practices related to improving management of care transitions in population-based models. The information that PTAC has gleaned from a review of previous PFPM proposals and other literature that addresses this important topic, as well as input received during the theme-based discussion, will help to inform PTAC in its review of future proposals. This material has informed the Committee's comments, which are summarized in the following broad topic areas in this report:

- Topic 1: Importance of Improving Care Management in Population-Based Models;
- Topic 2: Care Delivery Model Features to Improve Management of Care Transitions;
- Topic 3: Enablers to Support Desired Care Delivery Features;
- Topic 4: Payment Model Features to Improve Management of Care Transitions; and
- Topic 5: Enablers to Support Payment Model Features.

Key highlights include:

- Managing transitions in care requires an interdisciplinary team to perform the various functions that are needed, including screening; medication reconciliation; communication and collaboration; timely follow-up visits; patient and caregiver education; and the use of other tools such as checklists and condition-specific red flags.
    - An interdisciplinary team could help to facilitate coordination across settings and could also act as a hub for connecting providers across sectors—including community organizations that can assist in addressing health-related social needs (HRSNs), such as transportation and housing.

- Population-based models should encourage providers to develop a more holistic view of accountability for ensuring effective care transitions and begin thinking about care transitions earlier in the care delivery process.

- Improving the management of care transitions also requires the development of information technology (IT) solutions that can notify providers when a patient is admitted to a hospital or discharged to home or another setting. While a patient's PCP should function as the "hub" or "quarterback" for managing a patient's care transitions, in many situations, PCPs may not have access to timely data on admissions, transfers, and discharges related to their patients.

- Evidence suggests that the use of Medicare Transitional Care Management (TCM) services is associated with significant improvements in outcomes and substantial cost savings.

    - In 2018 and 2019, the use of TCM services within 30 days of hospital discharge resulted in improvements in hospital readmissions (a 5.6 percent decrease, or -0.6 percentage points), TCOC (a 7.8 percent decrease per episode, or -$236.11/episode), and healthy days at home (a 1.3 percent increase, or +0.32 days) during the 31 to 60 day period following discharge.

    - There was also a significant decrease in TCOC during the 1 to 60 day period following discharge (a 13.7 percent decrease per episode, or -$997.10 per episode).

- Population-based models include inherent global financial incentives that encourage improved management of care transitions across providers and settings.

    - In 2019, practices that were affiliated with an accountable care organization were more likely to bill for TCM services.

    - During the transition to value-based care, increasing uptake of the current TCM codes could help to expand the development of interdisciplinary team-based care

delivery approaches and increase provider readiness to participate in models that include accountability for quality and TCOC.

- The design of financial incentives related to providing evidence-based transitional care management services may need to be revisited to incentivize multiple roles within the interdisciplinary care delivery team (rather than focusing on an individual provider) and include additional levels to account for the complexity of team member involvement in managing certain kinds of transitions. Additionally, payment models should explore linking financial incentives for managing care transitions with outcomes.

    - While flexibility is needed to account for variation across health care systems, markets and systems, it may be possible to achieve consistency in the episode definition for the accountable transition period across models.

- Additional best practices include:

    - Allowing for flexibility in transitional care delivery models;

    - Providing actionable data related to managing care transitions;

    - Encouraging the availability of integrated data across settings;

    - Ensuring the availability of information about HRSNs and social determinants of health (SDOH);

    - Developing and strengthening performance measures related to transitions of care;

    - Ensuring parity across the Medicare program regarding providers' ability to transition patients into the appropriate care delivery setting;

    - Improving the harmonization of payment approaches across payers; and

    - Addressing the "ratchet effect," in which providers' baselines are reset based on achieving good performance, including improved outcomes associated with better management of care transitions.

In addition to summarizing the Committee's findings and comments related to these topics, the report also identifies areas where additional research is needed, issues for policy makers, and some potential next steps.

I. PTAC REVIEW OF CARE TRANSITIONS IN POPULATION-BASED MODELS

In developing the comments in this report, PTAC considered information from the theme-based discussion during the June 2023 public meeting, an environmental scan developed to provide information on improving management of care transitions in population-based models, and an analysis of the *Impact of Transitional Care Management Services on Utilization, Health Outcomes, and Cost Among Medicare Beneficiaries, 2018-2019*.

PTAC formed a Preliminary Comments Development Team (PCDT) for the June 2023 theme-based discussion, which was comprised of Walter Lin (Lead), Lindsay Botsford, Lauran Hardin, James Walton, and Jennifer Wiler (see Appendix 1 for a list of the Committee members). The PCDT reviewed the environmental scan and delivered a summary presentation to the full Committee during the theme-based discussion. The theme-based discussion included panel discussions with stakeholders from organizations that had previously submitted PFPM proposals that addressed care transitions in APCMs and episode-based or condition-specific models. The theme-based discussion also featured perspectives from a diverse group of SMEs and an opportunity for public comments. At the end of the theme-based discussion, Committee members identified comments to be included in this Report to the Secretary (RTS).

The Committee synthesized information from PTAC proposals, the environmental scan, and panel discussions with a previous submitter and other SMEs during the June 2023 public meeting on improving management of care transitions in population-based models. This RTS summarizes PTAC's comments from its findings, which are organized in five categories:

- Topic 1: Importance of Improving Care Management in Population-Based Models;
- Topic 2: Care Delivery Model Features to Improve Management of Care Transitions;
- Topic 3: Enablers to Support Desired Care Delivery Features;
- Topic 4: Payment Model Features to Improve Management of Care Transitions; and
- Topic 5: Enablers to Support Payment Model Features.

For each topic, relevant issues are highlighted, followed by a summary of PTAC's comments. Appendix 2 provides a list of additional resources related to PTAC's care transitions theme-based discussion that are available on the Assistant Secretary for Planning and Evaluation (ASPE) PTAC website. Appendix 3 includes information about proposals that were previously submitted to PTAC which addressed issues related to facilitating transitions and coordinating care across settings in PFPMs. Appendix 4 includes a complete list of the Committee's comments.

II. BACKGROUND: DEFINITIONS AND CONTEXT RELATED TO CARE TRANSITIONS IN POPULATION-BASED MODELS

As discussed in PTAC's *Report to the Secretary of Health and Human Services: Optimizing Population-Based Total Cost of Care (PB-TCOC) Models in the Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs)*, the Center for Medicare and Medicaid Innovation (CMMI) has set the goal of having all Medicare fee-for-service (FFS) beneficiaries with Parts A and B coverage in a care relationship with accountability for quality and TCOC by 2030.[i] Additionally, the Secretary of HHS has established "*Integration and Care Coordination*" as one of the 10 criteria for proposed PFPMs that PTAC uses to evaluate submitted proposals.

Nearly all of the 35 proposals that were submitted to PTAC between 2016 and 2020 addressed the proposed model's potential impact on quality, costs and care coordination, to some degree. Additionally, at least 20 previous submitters have addressed issues related to facilitating transitions and coordinating care across settings in PFPMs as part of their proposal submissions.[ii]

PTAC is using the following working definition of the term "care transition":

> *Care transitions are **"the movement of a patient from one setting of care…to another."** Care transitions may occur **between settings of the same type or different types, or between the health care system and the community or the patient's home.** Care transitions may take place between different health care professionals within the same facility, for example, between an emergency department (ED) physician and a surgeon in an acute care hospital. Changes in service level, such as from an intensive care unit to a general ward in an acute care hospital, also constitute care transitions.*[iii]

PTAC is using the following working definition of the term "care transition management":

> *Care transition management encompasses "the ongoing support of patients and their families over time as they **navigate care and relationships among more***

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[i] Center for Medicare and Medicaid Innovation. *Innovation Center Strategy Refresh*; 2021:32. https://innovation.cms.gov/strategic-direction-whitepaper

[ii] PTAC determined that sixteen proposals should be assigned the rating of "Meets" or "Meets and Deserves Priority Consideration" for Criterion 7, Integration and Care Coordination. Additionally, four proposals that were not determined to "Meet" Criterion 7 also included components related to facilitating transitions and coordinating care across settings.

[iii] https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/8_transition_of_care_summary.pdf; https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf; Cibulskis CC, Giardino AP, Moyer VA. Care transitions from inpatient to outpatient settings: Ongoing challenges and emerging best practices. *Hosp Practice*. 2011;39(3):128-139. doi:10.3810/hp.2011.08.588.

> ***than one provider and/or more than one health care setting and/or more than one health care service.*** *Care transition management may include a continuum of tailored interventions* ***pre-transition****, including patient/caregiver education and proactive communication with other providers on the patient's care team;* ***during transition****, such as review of discharge instructions; and* ***post-transition****, including follow-up phone calls and post-discharge home visit.*[iv]

These definitions will likely evolve as the Committee collects additional information from stakeholders.

While care transitions can occur between providers, settings (e.g., from a hospital to a SNF) and levels of care (e.g., from an intensive care unit to a general ward in an acute care hospital), PTAC's June 2023 public meeting focused on managing care transitions between settings of care.

Additional information on managing care transitions can be found in PTAC's *Environmental Scan on Improving Management of Care Transitions in Population-Based Models*.

III. CHARACTERISTICS OF PTAC PROPOSALS RELEVANT TO MANAGEMENT OF CARE TRANSITIONS IN POPULATION-BASED MODELS

From 2016 to 2020, PTAC received 35 proposals for PFPMs and voted on the extent to which 28 of these proposals meet the Secretary's 10 regulatory criteria, including Integration and Care Coordination.[v] The goal of this criterion is to "encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM."

At least 20 of the 28 proposals discussed improving care transitions in APCMs and episode-based or condition-specific models. These proposals included:

- Clear delineation of provider responsibilities for all providers involved in care transition activities;
- Proactive referrals and scheduled follow-ups;
- E-consults;
- Care transition management performance measures; and
- Financial incentives to support care transition management activities.

[iv] Zurlo A, Zuliani G. Management of care transition and hospital discharge. Aging Clin Exp Res. 2018;30:263–270. https://doi.org/10.1007/s40520-017-0885-6; Urbanski D, Reichert A, Amelung V. *Discharge and Transition Management in Integrated Care*. Handbook Integrated Care. Springer, Cham; 2021. https://doi.org/10.1007/978-3-030-69262-9_26.

[v] The remaining seven proposals were withdrawn prior to the Committee's deliberation.

PFPMs that focus on improving management of care transitions, such as those proposed to PTAC, can help enhance larger population-based models by improving health care quality and patient outcomes, patient experience, provider experience, and population health, and by lowering spending. Components of effective care transitions include screening, medication reconciliation, communication and collaboration, timely follow-up visits, patient and caregiver education, and other tools and resources such as discharge checklists and patient-centered health records.

A variety of challenges exist related to ensuring the effective management of care transitions. Care delivery challenges include:

- Breakdowns in communication among providers;
- Unplanned discharges from acute settings;
- Disparities in management of care transitions;
- Insufficient HIT infrastructure and data analytic capacity;
- Limited patient awareness of transitional care staff and services; and
- Workforce shortages and turnover.

Some of the most important care delivery challenges relate to providing necessary post-discharge care.

- PCPs are typically accountable for care transition outcomes, yet PCPs often do not know that their patient was admitted to the hospital. An information technology (IT) solution that notifies providers when a patient is admitted to a hospital or discharged to home is needed.
- Providers experience challenges in finding organizations to provide social services to patients and connecting patients to relevant resources and funding sources; and
- Patients experience geographic challenges related to PAC use after hospital discharge. Patients in rural areas also experience challenges related to, transportation, distance to care, lack of broadband, and lack of specialty services.
- PAC providers such as SNFs experience barriers that include, but are not limited to, bed availability, staffing shortages, and technological challenges.

Payment model challenges include:

- A lack of clear accountability among providers;
- Limited and/or conflicting financial incentives;
- Uncertainty around the optimal level of flexibility; and
- The selection of meaningful performance measures.

IV. COMMENTS FOR CONSIDERATION BY THE SECRETARY

Based on findings from the Committee's analysis of PTAC proposals; information in the literature; listening session presentations from Committee members, a previous submitter, and other SMEs during the June 2023 public meeting; and panel discussions with additional SMEs at the June 2023 public meeting; this section summarizes PTAC's comments regarding improving management of care transitions in population-based models. PTAC's comments are organized in four topics:

- Topic 1: Importance of Improving Care Management in Population-Based Models;
- Topic 2: Care Delivery Model Features to Improve Management of Care Transitions;
- Topic 3: Enablers to Support Desired Care Delivery Features;
- Topic 4: Payment Model Features to Improve Management of Care Transitions; and
- Topic 5: Enablers to Support Payment Model Features.

For each topic, relevant issues are highlighted, followed by a summary of PTAC's comments. Additionally, the Committee has identified areas where additional research is needed, as well as some potential next steps related to each topic. Appendix 4 includes a complete list of the Committee's comments.

IV.A. Importance of Improving Care Management in Population-Based Models

Committee members identified several factors related to the importance of improving management of care transitions. These factors include:

- Role of care transition management in care coordination;
- Opportunities for improving care transition management and patient outcomes; and
- Impact of Medicare TCM codes on patient outcomes.

Role of care transition management in care coordination. PTAC's Report to the Secretary on *The Role of Care Coordination in Optimizing Health Care Delivery and Value-Based Care Transformation within Alternative Payment Models and Physician-Focused Payment Models* discussed the need to: 1) broaden the focus of care coordination from managing procedures or visits to managing the patient's journey; 2) coordinate among all providers and CBOs that are involved in the patient's clinical, behavioral health, and SDOH needs; and 3) manage key transitions across specialties and contexts.

The components of effective care transition management include screening; medication reconciliation; communication and collaboration; timely follow-up visits; patient and caregiver education; and the use of other tools and resources such as discharge checklists, transition coaches, patient-centered health records, and condition-specific red flags.

Opportunities for improving care transition management and patient outcomes. Many of the conditions and procedures that have been the focus of the Centers for Medicare & Medicaid Services' (CMS') bundled payment models and ACO models that are designed to help improve care coordination and reduce excess or avoidable utilization and spending can often benefit from enhanced care transitions. This is particularly important for patients who receive acute and post-acute care, and these care transitions are typically evaluated via patient experience, information sharing, and hospital readmission rates.[1,2] Research has found that while CMS has recently emphasized improving care transitions, inefficiencies remain and may be contributing to excess utilization and spending (e.g., due to avoidable hospital readmissions).[3,4]

Several approaches exist for improving care transition management between care settings, which seek to minimize incomplete transference of patients' diagnostic information, and/or the occurrence of patients not receiving and/or understanding full follow-up care information, including:

- Medication management and reconciliation;
- Transition planning and facilitation;
- Patient and family/caregiver engagement;
- Health care provider engagement and shared accountability across health care settings; and
- Coordinated efforts to address physical health, behavioral health, and SDOH.[5]

Research has found that educating patients to promote self-management of their condition is the most common approach for improving the effectiveness of care transitions. Additionally, telehealth allows for earlier detection of clinical deterioration and can also provide patients with increased access to specialty care, both of which reduce the need for transitions.[6,7]

Impact of Medicare Transitional Care Management codes on patient outcomes. In 2013, Medicare introduced two codes for TCM in the Physician Fee Schedule to reimburse providers for assisting patients during the transition from a hospital, SNF, or community mental health hospital stay to a community setting. These new codes: 1) require a provider to communicate with the patient or caregiver within two business days of discharge; 2) make a medical decision of at least moderate or high complexity; and 3) have a face-to-face or telehealth visit within seven days (high complexity) or 14 days (moderate complexity) after discharge. Prior studies have showed low uptake of these codes. Potential barriers contributing to slow uptake of TCM codes could include insufficient payment levels to cover the additional resources needed to deliver TCM services, lack of interoperability of electronic health records (EHRs) across practices and systems, restrictive patient eligibility rules, coinsurance requirements, and documentation requirements that may place excess burden on providers.

In March 2022, an *Analysis of 2019 Medicare Fee-for-Service Claims for Chronic Care Management (CCM) and Transitional Care Management (TCM) Services* was published as a follow-up to PTAC's June 2021 theme-based discussion on care coordination in the context of

APMs.[8] This report described the overall use of TCM and Chronic Care Management (CCM) services in 2019 by patient characteristics, and practice-level use of TCM and CCM codes to provide a baseline assessment of use of these codes prior to the COVID-19 public health emergency (PHE). The report concluded that in 2019, Medicare CCM and TCM services for FFS beneficiaries were likely not used for many beneficiaries who might have benefited from them. However, practices affiliated with a Medicare Shared Savings Program (MSSP) ACO were more likely to bill for providing TCM services to at least one attributed beneficiary who was potentially eligible for TCM services.

In June 2023 an analysis of the *Impact of Transitional Care Management Services on Utilization, Health Outcomes, and Spending Among Medicare Beneficiaries, 2018-2019*[9] was published in preparation for PTAC's theme-based discussion on improving the management of care transitions. This report describes the impact of TCM services on utilization, spending, and health outcomes among Medicare FFS beneficiaries in 2018 and 2019. Compared to beneficiaries who did not receive TCM services, beneficiaries who received TCM services had fewer rehospitalizations, lower total Medicare Parts A and B spending, and almost one-third of an additional healthy day at home. Overall, results from the report suggest that TCM services not only have a positive impact on health outcomes but result in lower total cost of care among Medicare FFS beneficiaries.

- The use of TCM services resulted in improvements in hospital readmissions (a 5.6% decrease, or -0.6 percentage points), TCOC (a 7.8% decrease per episode, or -$236.11/episode), and healthy days at home (a 1.3% increase, or +0.32 days) during the 31 to 60 day period following discharge.

- There was also a significant decrease in TCOC during the 1 to 60 day period following discharge (a 13.7% decrease per episode, or -$997.10 per episode).

PTAC's comments on these issues are listed in Exhibit IV.1.

Exhibit IV.1: PTAC Comments

Topic 1: Importance of Improving Care Management in Population-Based Models

Comment 1A. Evidence suggests that care transition management interventions are associated with achieving substantial cost savings without reducing access or quality. For example, Medicare TCM services within 30 days of hospital discharge in 2018 and 2019 is associated with significant improvements in outcomes related to hospital readmissions, TCOC and healthy days at home.

Comment 1B. Physician practices that were affiliated with an ACO were more likely to bill for providing TCM to at least one attributed Medicare beneficiary who was potentially eligible for TCM services (65.0% vs. 41.3% for practices not affiliated with an ACO); and billed for higher proportions of their beneficiaries who were potentially eligible for TCM.

Comment 1C. Increasing uptake of the current Medicare TCM codes could help to expand the development of interdisciplinary team-based care delivery approaches and increase provider readiness to participate in models that include accountability for quality and TCOC.

V.B. Care Delivery Model Features to Improve Management of Care Transitions

Committee members identified several care delivery model features that would improve the management of care transitions. These features include:

- Supporting PCPs in managing care transitions;
- Supporting interdisciplinary care teams;
- Clearly defining accountable entities;
- Moving from discharge summaries to transition summaries;
- Integrating the "pre-acute" period in the care transition trajectory;
- Leveraging HIT and digital tools;
- Creating data standards;
- Maintaining patient choice;
- Maintaining flexibility in transitional care models; and
- Considering the ability to scale models.

Supporting PCPs in managing care transitions. Several SMEs and Committee members indicated that PCPs are best qualified to facilitate care transitions, citing PCPs' longitudinal and trusted relationships with patients and their insight into their patients' clinical needs and HRSNs. In general, SMEs noted that PCPs should be the "hub" or "quarterback" of a patient's care transitions in many situations. In this role, the PCP or primary care team would initiate and lead handoffs between primary care and other providers (e.g., specialists, hospital discharging providers), and coordinate care transitions among these providers. They would also support patient and caregiver engagement during care transitions.

Related to supporting the PCP as the "quarterback" of a patient's care transitions, one SME noted approaches to generate PCP buy-in to facilitate care transitions. Both approaches involved raising providers' awareness of whether they were completing activities needed to promote continuity of care and coordinate care transitions for their patient panels. One approach involved providers considering and reevaluating goals of care for their patient panel. Another approach was to leverage EHRs to promote patient visibility, for example, by using EHRs to provide an overview of and results for selected metrics (e.g., via a dashboard) for a provider's patient panel.

PCPs may need to address challenges related to facilitating care transitions for their patients. For example, PCPs need to communicate with a large number of other providers and practices, including providers in non-primary care settings, to coordinate care transitions across their patient panels. To facilitate care transitions, PCPs also need timely data related to care transitions among their patients, such as information on admissions, transfers, and discharges.

One SME suggested that 40 to 45 percent of the time, PCPs are not aware that their patient was admitted to the hospital. For patients being treated in an acute care hospital, ideally, the PCP would be notified when the patient is admitted to the hospital. Supporting this level of communication and data sharing may require additional investment in technological infrastructure (e.g., EHRs) or administrative resources.

Another consequence of PCPs lacking access to data on patients' needs for care transitions is the inability to stage patients so that providers can deliver the appropriate amount of services at each stage. For example, providers can currently stage Chronic Kidney Disease (CKD) patients on a five-level scale to identify needs at each phase of the disease progression. Technological tools can predict emergency department (ED) utilization and readmissions among these patients, and identify medication compliance and medication adherence challenges with the patient and patient's family, all supporting more efficient delivery of care.

SMEs and Committee members noted that current FFS payment structures may not adequately support the PCP's role as the "quarterback" of a patient's care transitions. SMEs also indicated that the PCP's ability to act on information is limited in an FFS primary care environment because FFS does not provide financial incentives for a PCP to coordinate care transitions among a patient's providers.

Supporting interdisciplinary care teams. Stakeholders and Committee members noted that managing transitions in care requires an interdisciplinary team to perform the various functions needed. Stakeholders discussed how these teams could act as a hub for connecting providers across sectors, including community organizations to address HRSNs. They noted the importance of including a diversity of roles—including non-physicians, pharmacists and behavioral health providers—in the care transitions workforce. They stated that current payment models do not fully support team-based transitional care as there is often a lack of direct payment to non-physician interdisciplinary team members in FFS programs, and that it is important to include payment to non-physicians because payment can support the management of care transitions. One Committee member suggested that the ability of ACOs and other value-based care payment models to fund non-physician roles could be one reason why the models tend to have better care transition outcomes compared with traditional FFS. Committee members also noted the need to determine the role of PCPs and specialists, and the accountable entity, in building interdisciplinary care teams.

Clearly defining accountable entities. SMEs and Committee members noted that it is important to identify the provider that will be accountable at each stage during a patient's care transitions, regardless of whether the provider is a primary care or specialty provider. One SME indicated that only 15 to 30 percent of the Medicare patients in their hospitals are attributed to a PCP participating in a value-based care program. The remaining patients may not have a usual source of care or may have received non-integrated care in the community, representing a missed opportunity to coordinate care transitions. A few SMEs noted that PCPs may not always be in the best position to manage care transitions, depending on a patient's post-acute needs.

In some cases, the specialist providing the majority of a patient's post-discharge care may be more appropriate to assume responsibility for transitional care.

Moving from discharge summaries to transition summaries. Committee members encouraged a shift from documenting and communicating transitions using a "discharge summary" toward using a "transition summary." A discharge summary implies that one provider's work has ended, whereas a transition summary suggests a provider's continued involvement and potential accountability for post-transition care. When the patient is ready to be discharged, SMEs and Committee members noted that meaningful transition summaries may promote continuity of care during transitions. It is important that transition summaries contain all the relevant clinical and patient safety information needed to ensure effective care transitions.

Integrating the "pre-acute" period in the care transition trajectory. Patients with chronic conditions may experience exacerbations of disease that require hospitalization for more intensive care or treatment. In recent years, some specialties (e.g., gastroenterology) have adopted digital solutions to manage care for these types of patients in the community, prior to them requiring more acute care. One Committee member referred to this period before patients require hospitalization as the "pre-acute" period.

As digital tools are increasingly being used to triage and care for patients in the community, "pre-acute" care transitions may become more widespread. During the "pre-acute" care period, providers can initiate and prioritize transitional care, planning for potential hospitalizations and subsequent transitions to facility- or community-based post-acute care. The "pre-acute" period may offer another opportunity for providers to emphasize longitudinal care, ensure continuity of care, and focus on patient-centered care.

Leveraging HIT and digital tools. HIT and other digital tools may be key for facilitating care transitions and promoting improved communication among providers in a patient's care team. During the June 2023 public meeting, multiple SMEs discussed the centrality of interoperable data in enabling effective care transitions. Health care providers face challenges communicating about patient care across silos in the delivery system, which is particularly problematic during care transitions. Several SMEs and Committee members emphasized the importance of EHR interoperability and bidirectionality, noting that digitizing the post-acute care system may be a priority. Developing a "digital ecosystem" in which all facilities are using the same or compatible EHRs would mean that the same medical record could follow the patient throughout their care transition, promoting continuity of care. SMEs noted different approaches to and reasons for investing in HIT and other digital tools. For example, some SMEs participating in value-based care models have invested their shared savings into improving HIT.

SMEs indicated that digital tool design should emphasize integration across the health care spectrum. One recommendation was to incorporate evidence-based clinical practice guidelines when designing digital tools to ensure that patient care is escalated to a health care practitioner in real time as needed. Another SME recommended comprehensive, inclusive planning during digital tool design to ensure that the tool would enable the flow of communication among all

relevant providers or care team members. Integrated data across ambulatory units, as well as across SNFs, nursing homes, CBOs, and other nonprofit groups, could support improved care for patients during transitions. Current practice relies on manual and burdensome communication, such as through emails, and many PCPs are unaware that their patients have been admitted to the hospital. Timely notification to PCPs when their patients transition to other care settings could improve care management across the continuum of care as patients undergo transitions.

SMEs suggested that to achieve health data utility, a significant investment needs to be made in data infrastructure, with regulations requiring the movement to interoperable data systems following the investment. Similarly, models could incentivize communication between providers in care transition episodes, which could encourage investment into communication technologies. A framework for this kind of data infrastructure does exist, but current data systems are disintermediated and encumbered by various state-level and regional barriers. As data systems are established, it is important to ensure that the available data are informative and helpful for managing care transitions. Committee members echoed the need to avoid being "data rich, information poor, and insight starved."

Creation of data standards. SMEs noted that contrary to standards for inpatient data integration, standards for ambulatory care settings are lacking. Committee members identified the creation of data standards for ambulatory settings as an area of opportunity related to supporting optimal care transitions. One stakeholder pointed toward previous investments and regulations around the Health Information Technology for Economic and Clinical Health (HITECH) Act and meaningful use as positive examples. This investment in a foundational technology infrastructure was essential to increase the number of hospitals and doctors' offices with EHRs. Even with implementation challenges, the investment in meaningful use was successful in digitizing nearly all hospitals and medical practices in the country. However, an additional challenge lies in applying tools retrospectively to enable the silos of data across practices and hospitals to be standardized. Committee members suggested that a similar investment for other ambulatory care settings, PAC settings, and long-term care facilities, is necessary and could facilitate better care transitions across those settings—while acknowledging that such an initiative would be likely to create new challenges. Application of data standards for integration at the outset of the hospitalization could further enable communication during care transitions.

Maintaining patient choice. Committee members emphasized the importance of maintaining patient choice in managing transitions in care. When lacking quality information, patients may make choices about where to seek care based on other factors (e.g., word of mouth, travel time or distance to provider, provider's proximity to family or friends). Several SMEs noted the role of providers in helping patients make informed decisions about where to seek care during care transitions. Hospital discharging providers can share quality information (e.g., on PAC facilities) to support patients' decision-making. When given quality information, patients may be more likely to seek post-discharge care from higher-quality providers, encouraging quality-based competition in the market.

Maintaining flexibility in transitional care models. One SME noted that variation across health care markets, systems, and providers may necessitate differences in transitional care model operations. For example, transitional care models in rural and non-rural markets may require different systems to improve care transitions and related outcomes in their patient populations. Providers may be more inclined to engage with transitional care models that offer flexibilities in patient care, allowing providers to tailor care to their patient populations' specific needs. To support participating organizations, one SME recommended that payers be flexible and adaptable to their contracting organizations' operations.

Considering the ability to scale models. The focus of health care payment reform has remained on identifying payment models that foster good care delivery models, but it is also important for operating models to be sustainable over time. Smaller providers and systems, especially those in rural areas, may have limited resources to invest in transitional care models, due in part to restrictions under current FFS reimbursement mechanisms (e.g., limitations on TCM billing codes, team-based care). Smaller providers and systems may also face challenges in building economies of scale needed to engage in transitional care models.

Providers may have limited resources (e.g., finances, infrastructure, staffing) to invest in model implementation. Payers can support provider engagement in transitional care models by providing financial incentives. For example, up-front payments could be distributed to participating organizations to invest in infrastructure (e.g., HIT, care coordination staff). This kind of funding could allow ACOs and value-based organizations to create the infrastructure needed to succeed in their TCM efforts. Payers may also be able to support care transition improvements on a smaller scale by tailoring payment structures to different provider types.

PTAC's comments on these care delivery model features are listed in Exhibit IV.2.

Exhibit IV.2: PTAC Comments

Topic 2: Care Delivery Model Features to Improve Management of Care Transitions

Comment 2A. PCPs play a pivotal role in managing care transitions. Pre-existing relationships with PCPs are critical for ensuring that an identified provider is ready to assume responsibility when a patient transitions between care settings. Primary care workforce initiatives and payments are necessary to increase the availability of PCPs.

Comment 2B. It is important to identify the provider that will be accountable for continuous treatment after care transitions and whether the provider is a primary care or specialty provider. While it is often appropriate for PCPs to be accountable for continuous treatment following a transition, if a specialist is providing the majority of a patient's post-discharge care, they may be more appropriate to assume responsibility.

Comment 2C. Providers should shift from documenting and communicating transitions using a "discharge summary" toward using a "transition summary" to underscore the need for a provider's continued involvement and potential accountability for post-transition care.

Comment 2D. Care transitions should focus on "pre-acute" care, as well as "post-acute" episodes. Increasing focus on pre-acute episodes can prevent waste and avoid unnecessary utilization.

Comment 2E. HIT and other digital tools may be key for facilitating care transitions, promoting improved communication among providers in a patient's care team, and providing tools for more effective identification of patients who will require transitional care. EHR interoperability and bidirectionality are important for building a "digital ecosystem" in which: all facilities are using the same or compatible EHRs and the same medical record could follow the patient throughout their care transition, promoting continuity of care. It is important to provide access to interoperable data not only among health care providers but also with entities that provide community-based services. Investments in encouraging movement toward interoperable data could support the development of more health information exchange networks. The development of standards for integration of data systems used in ambulatory settings and nursing home settings could further increase the sharing and utility of data.

Comment 2F. It is important to maintain patient choice as a powerful driver for innovation in how care transitions are managed, as patients will select providers offering better care and better patient experiences.

Comment 2G. Variation across health care markets, systems, and providers may necessitate differences in transitional care model operations. Providers may be more inclined to engage with transitional care models that offer flexibilities in patient care, allowing providers to tailor care to their patient populations' specific needs.

Comment 2H. The focus of health care payment reform has remained on identifying payment models to foster good clinical models, but it is also important that operating models be sustainable over time. Consistent standards and support help to reassure providers that investments in the transition to value-based care are related to the goal of implementing sustainable models.

IV.C. Enablers to Support Desired Care Delivery Features

PTAC identified a range of enabling factors to support desired care delivery features in managing transitions in care. These include:

- Extending nested solutions within population-based models that emphasize longitudinal care;
- Establishing common definitions across models for transitional care episodes;
- Increasing access to resources for small practices;
- Incorporating digital providers;
- Addressing provider burnout; and
- Extending the three-day SNF waiver.

Nested solutions within population-based models. Committee members indicated that care transitions extend beyond inpatient episodes. For example, outpatient providers may determine whether an inpatient admission is medical or surgical or whether a readmission occurs. Bundled payments within population-based models that only address inpatient services ignore the reality of care delivery. Instead, Committee members suggested that nested solutions within population-based models extend to address multiple specialties and longitudinal care beyond the inpatient setting. The University of Pennsylvania Transitional Care Model is an example of a model that can be nested in population-based models to help improve care transitions.

Common definitions for transitional care episodes. While Committee members noted that variation across care delivery models needs to exist for models to scale, consistency in episode definitions may be achievable. Identification of the beginning and end of a care transition episode, such as 60 days from a hospital admission, will be useful for expanding care transition models and assessing the most effective approaches to managing transitions. In addition, identifying other meaningful parameters in the episode definition—such as a transition to PAC or a transition home—is an area where PTAC could potentially be helpful in providing additional clarity. The episode definitions could differ based on the nature of the care transition.

Access to resources for small practices. SMEs and Committee members noted that small physician practices may not have the resources needed to build the infrastructure to support effective care transitions. While large networks and integrated health systems can integrate communications across providers and settings through interoperable EHRs, and can benefit from economies of scale, small practices may not have these abilities. Therefore, small practices need help to find ways of communicating and creating partnerships with other organizations in the continuum of care to arrange effective transitions in care.

Additionally, small practices may not have the same access to performance data from payers on topics such as readmission rates, transitions, billing, and ED visits that they would receive in a large integrated system. One stakeholder suggested that Medicare Advantage (MA) plans should provide performance data to small practices for the MA patients they treat.

Digital care providers. Committee members suggested that "digital" care providers can extend the reach of interdisciplinary care teams. Digital care coaches, for example, can help patients manage their transition back to home after acute care, manage care transitions, and escalate patients to the interdisciplinary care team as needed. Committee members noted that there is a need for an organized approach for determining how digital therapies become integrated into care and where the payment goes, as payment will dictate where digital technology is deployed. This technology can support patients with mild conditions or exacerbations of disease during their post-discharge recovery.

Committee members also cautioned that digital care providers could increase fragmentation in care if not properly integrated into population-based models. Digital technologies create new provider entities, and it is important to avoid disintermediating in-person providers and hospital systems when patients are ill. While it is essential to promote innovation in digital technologies, it is also critical to ensure that patients are not left without care when a digital provider does not establish a transition to another provider to meet the patient's needs.

Reducing provider burnout. Committee members discussed the need to prevent and alleviate provider burnout related to managing care transitions. Committee members noted that there is a cognitive burden associated with managing care transitions, and that physicians are increasingly shunning complexity in value-based care models to avoid burnout. They observed that for some providers, financial incentives may be less important compared with non-financial incentives such as administrative or time relief, as it would appeal to their intrinsic motivation to "do the right thing" without causing the practice to lose money. One potential solution is for care transition teams to work "around" the PCP to manage logistical aspects of care transitions. SMEs also mentioned that ancillary staff, including advanced practice nurses, nurse practitioners, physician assistants, and social workers, could support care transition activities and add value to the primary care team. SMEs also discussed the need for compensating other types of ancillary service providers who are helping to facilitate care transitions (such as community health workers).

Three-day SNF waiver. Committee members cited the three-day SNF rule waiver, which is available in MA and in some APMs but not in Medicare FFS, as an opportunity for creating parity between MA and Medicare FFS. This waiver allows hospitals to discharge patients to SNFs before a three-day minimum hospital stay. They suggested that making the three-day waiver available in Medicare FFS could allow for more effective transitions from hospitals to SNFs.

PTAC's comments on these enablers are listed in Exhibit IV.3.

Exhibit IV.3: PTAC Comments

Topic 3: Enablers to Support Desired Care Delivery Features

Comment 3A. Nested solutions within PB-TCOC models should extend beyond inpatient care. Nested models should incorporate multiple specialists, as well as longitudinal and transitional care across settings.

Comment 3C. Identifying common definitions across models for the beginning and end of a transitional care episode (e.g., using 60 days after the start of a hospitalization) would assist in assessing the most effective approaches for managing transitions. The definitions could differ based on the nature of the care transition.

Comment 3E. It is particularly important for stakeholders to explore potential improvements in how small physician practices can access data, as it may be challenging for small practices to access performance data from payers. This could include encouraging ACOs and MA plans to provide performance data to small provider groups for the patients they treat.

Comment 3F. An effective care transition requires an interdisciplinary team to fulfill multiple functions. Interdisciplinary transitional care teams could potentially be used as "hubs" to link patients to necessary services.

Comment 3G. While innovation is leading to the creation of "digital" care providers that provide virtual services and can extend the reach of care teams, having additional providers engage in managing transitions could lead to more fragmented care. It is important that innovations employing digital care providers do so in a way that fully integrates these new provider entities into the care model and transition planning used by in-person care providers.

Comment 3I. Non-financial incentives can help to address provider burnout and workforce shortages—particularly related to providing administrative support and reducing complexity related to transitional care management and population-based models. It is important that the care transition team works "around" the PCP to manage logistical aspects of managing transitions and does not work in a way that overburdens the PCP.

IV.D. Payment Model Features to Improve Management of Care Transitions

Committee members identified several features of payment models that would support care delivery changes to improve care transitions. These features include:

- Increasing the size of existing financial incentives;
- Maintaining flexibility in payment models; and
- Other desirable payment model features.

Size of financial incentives. Some SMEs indicated that the incentives for managing care transitions with population-based models may not be large enough to achieve the desired

adoption of innovative approaches to the management of care transitions. For example, the management of care transitions involves a diverse set of care teams, and there must be large enough incentives to support the interests of and coordination among all involved parties. As accountability for each care team member is established, the financial incentives should be tied to the activities for which the care team member is responsible. In addition, current value-based models require funding for a significant administrative and data infrastructure to operationalize the new payment model, and this is often not feasible for small or medium-sized physician practices. The structure of financial incentives may need to be adjusted for the size of the health care practice.

Maintaining Flexibility in Payment Models. The delivery of transitional care is complex, with a diversity of patient care models and operational models, as discussed in the previous section. Approaching this variety with one payment approach hinders the delivery of transitional care, and instead, flexibility in payment approaches is needed. Similarly, patients requiring transitions in care have diverse health care needs, ranging from the management of acute medical illness to end-of-life care. Additionally, MA and other value-based arrangements provide flexibility to pursue connections with social resources in the community to support management of care transitions and efforts to address HRSNs and SDOH.

Other Desired Payment Model Features. In addition to comments related specifically to care transitions, SMEs and Committee members described desired payment model features of PB-TCOC models in general that also apply to transitional care. Many of these topics were discussed in previous public meetings and the Reports to the Secretary on Population-Based TCOC Models and Integrating Specialty Care in Population-Based Models. These features include:

- **Higher upside risk to incentivize adoption of new payment models**. SMEs reiterated that the payment adjustment percentage of current models, especially in the Merit-based Incentive Payment System (MIPS), is too small to motivate providers given the increased administrative burden of delivering value-based care. One SME suggested a minimum of 30 to 40 percent upside risk to incentivize behavior change, stating that they have seen only slow behavior change using their TCOC model with 100 percent upside and downside risk.

- **Benchmarks that account for the ratchet effect.** The Committee members discussed the ratchet effect that occurs when baselines are reset based on good performance, which limits the ability to achieve continued improvements. The Committee members also noted that this challenge is not present in the MA program. An SME indicated that bundled payment models that set a two or three percent discount that ratchets year after year were sustainable only when there was enough variation in spending to achieve improvements.

- **Mandatory participation.** Committee members echoed sentiments from prior PTAC meetings that identified the need for more mandatory population-based models to increase participation and improve the quality of evaluations. One SME reinforced the idea that transformation in care delivery takes time and shared the example of Diagnosis Related Groups (DRGs), which are mandatory and still required 15 years to achieve a measurable

impact. Another SME recommended instituting mandatory payment bundles to incentivize hospitals that have not yet participated in population payment models.

- **Harmonization across payers.** While recognizing the diversity of patient care needs and need for flexible payment approaches, several SMEs voiced a need to improve the harmonization of payment approaches across payers. One SME shared that from the patient side, the lack of harmonization creates confusion about which services are covered under each type of plan; from the provider side, the cost and quality measures may look different across plans as well. To facilitate the harmonization of services and measures across Medicare plans, for example, an SME recommended structuring the communication lines between the provider and one care manager who coordinates with all payers rather than having different care managers assigned to each payer. Increased movement into MA has created an unlevel playing field between MA and ACOs.

PTAC's comments regarding these payment model features are listed in Exhibit IV.4.

Exhibit IV.4: PTAC Comments

Topic 4: Payment Model Features to Improve Management of Care Transitions

Comment 4A. The design of financial incentives related to providing evidence-based transitional care management services may need to be revisited to incentivize the interdisciplinary care delivery team (rather than focusing on an individual provider), include additional levels to account for the complexity of team members involved, and incorporate a link with outcomes.

Comment 4B. Current models do not have payment incentives that are large enough to trigger the desired behaviors related to care transitions. Because the management of care transitions involves a diverse set of providers, financial incentives need to be sufficient to support the interests of and coordination among all involved parties. Additionally, incentives should be clearly tied to the desired behavior.

Comment 4C. Variation across health care markets, systems, and providers may necessitate differences in care delivery models for managing transitions, which in turn will require flexibility in payment models to account for differences in the operational model.

Comment 4D. Financial incentives in population-based models should include the impact of transitional care management services on patient experience as an element of model success, in addition to the impact of these services on quality and TCOC.

Comment 4E. It is important to address the ratchet effect in transitional care and population-based models (when baselines are reset based on good performance).

Comment 4F. There should be a strategy to harmonize payment approaches across payers in order to consistently incentivize providers to adopt best practices related to managing care transitions.

IV.E. Enablers to Support Payment Model Features

Committee members identified several enablers to support desired payment model features in managing care transitions:

- Promoting the use of TCM codes to encourage value-based transformation;
- Including global incentives and targeted payment mechanisms in population-based models;
- Implementing patient-centric performance metrics; and
- Considering various payment model enablers relevant to PB-TCOC models in general that also apply to care transitions, including prospective payments, payments that address HRSNs, and payments for start-up and operational costs.

Promoting the use of TCM codes to encourage value-based transformation. The Committee members indicated that hybrid solutions are needed to reach CMMI's goal of having all traditional Medicare FFS beneficiaries in a care relationship with accountability for quality and TCOC by 2030. They emphasized that increasing uptake of the current Medicare TCM codes during the transition to value-based care could help to expand the development of interdisciplinary team-based care delivery approaches and increase provider readiness to participate in models that include accountability for quality and TCOC. TCM codes were designed to incentivize practices to develop the infrastructure to furnish transitional care services. The codes account for levels of service, the timing of service, and the medical decision-making aspect of care.

Evidence suggests that the delivery of TCM services is associated with positive patient outcomes and lower cost of care.[10] The Committee members discussed several options that could assist in increasing the uptake of TCM codes, including decreasing coinsurance. The Committee members also discussed the need to address other barriers related to billing for TCM codes. For example, the TCM codes do not incentivize co-ownership of patients across providers or account for the number of team members involved in delivering transitional care management services. Certain care conditions require fluidity in providers' roles; and specialists may have a higher level of engagement at certain points during and after a care transition before scaling back as responsibility for care shifts to the PCP. Additionally, providers experience a substantial administrative burden related to billing for TCM codes.

Rather than incentivizing individual providers to coordinate care transitions, Committee members suggested modifying payments from the TCM codes to incentivize an interdisciplinary team-based approach involving providers working together, including successful handoffs and communication across providers, in order to help encourage the transition toward accountable, patient-centered care. Operationally, this could be implemented through the introduction of a third, highest complexity level TCM code with a three-level gradation of the number of team members involved in the care transition. For example, the code could account for teams of one to two providers, three to four providers, or more than five or six providers. Additionally, the ability to bill for TCM services could potentially be expanded to include other providers, including non-physicians. Additionally, tracking utilization data over time for beneficiaries that

receive TCM services, could help to inform the development of a value-based payment model for transitional care.

The Committee members also suggested further exploration of how outcomes could be linked to the TCM codes, and how population-based models should pay for outcomes rather than services. Tying outcomes to billing TCM codes could not only help to ensure that there are value-based payments tied to usage, but also improve the outcomes associated with the codes and potentially translate into increased use of TCM in ACO models. The TCM payments could either be part of population-based payments in APMs or serve as a bundled payment either separate from or embedded within another APM.

Global incentives and targeted payment mechanisms in population-based models. Global incentives in population-based models create a holistic approach to patient care and can help to address challenges such as complex care transitions. Despite the utility of global incentives in population-based models, such incentives have been slow to improve some health care functions, including care transitions. Committee members suggested that the use of targeted payment mechanisms in combination with global incentives in population-based models may promote more effective transitions in care. Population-based models should consider including separate transitional care management incentives, such as a separate episode-based payment for managing complex transitions involving vulnerable patients. Additionally, nested episodes within population-based models should be extended to address multiple specialties and longitudinal care beyond the inpatient setting.

Patient-centric care transition performance metrics. The impact of transitional care models on patient experience should be an element of model success in addition to the impact of care transitions on cost and quality of care. Assessment of performance metrics on patient experience impacts both patients and providers. Not only will patients seek care where the patient experience is better, but providers can also benefit from evidence showing that their patients are satisfied. Patient-centered metrics for care transitions can be incorporated into systems similar to what is done in the star rating program for MA.

In addition to comments related specifically to care transitions, SMEs and Committee members described enablers for desired payment model features of PB-TCOC models in general that also apply to transitional care. Many of these topics were discussed in previous public meetings and the Reports to the Secretary on *Population-based TCOC Models* and Integrating Specialty Care in Population-Based Models. These features include:

Prospective payments. Just as Committee members support prospective payments for population-based models in general, they noted that prospective payments can promote cost and quality improvement for transitional care. Prospective payments to build infrastructure and monitor implementation, as opposed to future reconciliation, may reduce barriers to participation in value-based care models and accelerate care transformation.

Integration of payments that address health-related social needs. HRSNs can increase the complexity of care transitions and lead to persistent health inequities among some subpopulations of patients. The widespread focus on advancing health equity, addressing HRSNs, and integrating social service and CBOs across sectors in population-based models can also improve care transitions. Consideration should be given to financing the delivery of those services in the community itself, including reimbursements to community organizations.

Recognition of startup and operational costs for implementation and upgrades over time. Committee members noted that when supporting care transition models, including the communication across providers, it is important to recognize the substantial initial startup costs for implementation of care transition management as well as the ongoing operational costs and upgrades that occur over time. Additionally, SMEs and Committee members noted that the goalpost should not be "moved" and financial support should not be abruptly withdrawn when providers start succeeding in their transition to value-based care.

PTAC's comments regarding these enablers are listed in Exhibit IV.5.

Exhibit IV.5: PTAC Comments

Topic 5: Enablers to Support Payment Model Features

Comment 5A. Increasing uptake of current Medicare TCM codes can help to support the transition from FFS to value-based care by increasing provider readiness, expand the development of interdisciplinary team-based care delivery approaches, and increase provider readiness to participate in models that include accountability for quality and TCOC. Decreasing coinsurance and other barriers could help to increase TCM code uptake.

Comment 5B. Global incentives in population-based models are useful for incentivizing a holistic approach to patient care. In addition to global incentives, population-based models should consider including separate transitional care management incentives, such as a separate episode-based payment that may help to target specific transitions in care, such as complex care transitions for vulnerable patients. Additionally, nested episodes within population-based models should be extended to address multiple specialties and longitudinal care beyond the inpatient setting.

Comment 5C. HRSNs can drive complexity in care transitions. Funding sources are needed to finance the delivery of services designed to address HRSNs by CBOs.

Comment 5E. Care transition performance metrics should be patient-centric. Maintaining consumer choice is a powerful driver for innovation because consumers will choose to seek care at places where the patient experience is better. Providers also need signs of success and knowledge that their patients are satisfied. Additionally, the impact of transitional care models on patient experience should be an element of model success in addition to the impact on cost and quality.

Comment 5F. In supporting care transition models, it is important to recognize the initial start-up costs for implementation, as well as ongoing operational costs and upgrades over time.

APPENDIX 1. COMMITTEE MEMBERS AND TERMS

Lauran Hardin, MSN, FAAN, *Co-Chair*
Angelo Sinopoli, MD, *Co-Chair*

Term Expires October 2024

Lawrence R. Kosinski, MD, MBA
SonarMD, Inc.
Scottsdale, AZ

Angelo Sinopoli, MD
Cone Health
Piedmont, SC

Soujanya R. Pulluru, MD
Independent Consultant
Sarasota, FL

Jennifer L. Wiler, MD, MBA
UCHealth Denver Metro and University of Colorado School of Medicine
Aurora, CO

Term Expires October 2025

Lindsay K. Botsford, MD, MBA
One Medical
Houston, TX

James Walton, DO, MBA
JWalton, LLC
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Term Expires October 2026

Jay S. Feldstein, DO
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Walter Lin, MD, MBA
Generation Clinical Partners
St. Louis, MO

Lauran Hardin, MSN, FAAN
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Maysville, KY

Terry L. Mills Jr., MD, MMM
CommunityCare
Tulsa, OK

Joshua M. Liao, MD, MSc
The University of Texas Southwestern Medical Center
Dallas, TX

APPENDIX 2. ADDITIONAL RESOURCES RELATED TO PTAC'S THEME-BASED DISCUSSIONS ON IMPROVING MANAGEMENT OF CARE TRANSITIONS IN POPULATION-BASED MODELS

The following is a summary of additional resources related to PTAC's theme-based discussion on improving management of care transitions in population-based models. These resources are publicly available on the ASPE PTAC website:

Environmental Scan and Additional Analyses

Environmental Scan on Improving Management of Care Transitions in Population-Based Models

Impact of Transitional Care Management Services on Utilization, Health Outcomes, and Spending Among Medicare Beneficiaries, 2018-2019

Request for Input (RFI)

Improving Management of Care Transitions in Population-Based Models Request for Input (RFI)

Materials from the Public Meetings

Materials from the Public Meeting on June 12, 2023

Preliminary Comments Development Team (PCDT) Presentation: Improving Care Transition Management in Population-Based Models

Presentation: Panelist Introduction Slides

Presentation: Subject Matter Expert Listening Sessions

Panelist Biographies

Panel Discussion Guide

Listening Session Facilitation Questions

Materials from the Public Meeting on June 13, 2023

Presentation: Subject Matter Expert Listening Sessions

Panelist Biographies

Listening Session Facilitation Questions

APPENDIX 3. CHARACTERISTICS OF SELECTED PTAC PROPOSALS IDENTIFIED AS BEING RELEVANT TO IMPROVING MANAGEMENT OF CARE TRANSITIONS IN POPULATION-BASED MODELS, DECEMBER 2016 – DECEMBER 2020

Submitter and Proposal	Clinical Focus, Setting, and Payment Mechanism	Specialty Integration Components	Payment Design Features
Broad or Holistic Focus			
American Academy of Family Physicians (AAFP) *Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM)*	**Clinical Focus:** Primary care **Setting:** Primary care practices **Payment Mechanism:** Capitated per beneficiary per month (PBPM)	Primary care medical homes work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange.	Capitated per beneficiary per month (PBPM) payment with shared risk options for accountability
American Academy of Hospice and Palliative Medicine (AAHPM) *Patient and Caregiver Support for Serious Illness (PACSSI)*	**Clinical Focus:** Serious illness and palliative care **Setting:** Inpatient; outpatient; other palliative care settings **Payment Mechanism:** Capitated PBPM	Develop a coordinated care plan with input from all of the patient's physicians and providers, arrange for services from other providers, and maintain ongoing communication with other physicians and providers to ensure care is being delivered consistent with patient's care plans. PCTs encouraged to incorporate clinical and/or non-clinical staff to address the needs of a specific patient community	**Financial Incentives:** Capitated PBPM with shared risk options for accountability
American Academy of Neurology (AAN) *The Patient-Centered Headache Care Payment (PCHCP)*	**Clinical Focus:** Neurology **Setting:** Inpatient or outpatient in primary care; patient home **Payment Mechanism:** One-time payment, PBPM payments, or add-on payments	The proposed model is predicated on a strong internal and/or referral network of providers that involves multiple types of physicians, non-physicians, and other eligible professionals; it allows for the creation of a Headache Care Team, when feasible, establishing accountability or negotiating responsibility to facilitate transitions and coordinate care across settings.	**Financial Incentives:** One-time payment, PBPM payments, or add-on payments (depending upon payment category) with shared risk

Submitter and Proposal	Clinical Focus, Setting, and Payment Mechanism	Specialty Integration Components	Payment Design Features
Coalition to Transform Advanced Care (C-TAC) *Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model*	**Clinical Focus:** Serious illness and palliative care **Setting:** Patient home **Payment Mechanism:** Capitated PBPM	Evidence-based treatments that align with patient preferences, symptom management, 24/7 access to clinical support, comprehensive care plan, support for transitional and PAC, using established reliable handoff processes, and advance care planning	Capitated PBPM with shared risk
Dr. Sobel (Sobel) *Remote specialists and experts on demand improving care and saving costs (Revised version)*	**Clinical Focus**: Broad/not specified **Setting:** Not specified **Payment Mechanism:** Not specified	Regional Referral Centers (RRCs) can provide specialist expertise at any setting, reducing avoidable transitions by leveraging telehealth to consult with specialists.	**Financial Incentives:** Not specified; FFS payment mechanism
University of Chicago Medicine (UChicago) *The Comprehensive Care Physician Payment Model (CCP-PM)*	**Clinical Focus:** Frequently hospitalized patients **Setting:** Home care and rehabilitation **Payment Mechanism:** Add-on PBPM	A single provider is responsible for seeing their patients in both inpatient and outpatient settings, included the patient home or rehabilitation settings.	Add-on PBPM with shared risk
Acute Event Focus			
American College of Emergency Physicians (ACEP) *Acute Unscheduled Care Model (AUCM)*	**Clinical Focus:** Emergency department (ED) services **Setting:** ED **Payment Mechanism:** Episode-based model with continued fee-for-service (FFS)	The proposal calls for facilitating appropriate discharge, informing patients of treatment options, managing unscheduled care episodes by protocol, and arranging post-discharge home visit.	Episode-based model with continued FFS, with shared risk options for accountability
American College of Physicians-National Committee for Quality Assurance (ACP-NCQA) *The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM)*	**Clinical Focus:** PCPs and specialists **Setting:** Primary care practices **Payment Mechanism:** Add-on PBPM	The clinician/practice receives incentives for meeting performance expectations, but does not share losses if costs exceed targets.	Add-on PBPM with shared risk

Submitter and Proposal	Clinical Focus, Setting, and Payment Mechanism	Specialty Integration Components	Payment Design Features
American Society of Clinical Oncology (ASCO) *Patient-Centered Oncology Payment Model (PCOP)*	**Clinical Focus:** Cancer care **Setting:** Inpatient, outpatient **Payment Mechanism:** Episode-based payment with two tracks	To establish accountability or negotiate responsibility and monitoring and follow-up	Episode-based payment with two tracks; add-on payments worth 2-3 percent of total cost of care, including FFS payments; add-on performance payments
Avera Health (Avera) *Intensive Care Management in Skilled Nursing Facility Alternative Payment Model (ICM SNF APM)*	**Clinical Focus:** Primary care (geriatricians) in skilled nursing facilities (SNFs) **Setting:** SNFs and NFs **Payment Mechanism:** Add-on PBPM	The GCT establishes accountability or negotiates responsibility, provides monitoring and follow-up, aligns resources with patient and population needs, develops a care plan, assesses patient needs and goals, facilitates transitions, and coordinates care across settings.	Add-on PBPM with shared risk options for accountability
Icahn School of Medicine at Mount Sinai (Mount Sinai) *HaH Plus (Hospital at Home Plus) Provider-Focused Payment Model*	**Clinical Focus:** Inpatient services in home setting **Setting:** Patient home **Payment Mechanism:** Bundled episode-based payment replacing FFS	Establish accountability and negotiate responsibility; facilitate transitions and coordinate care across settings; provide transition services over a period of 30 days, beginning upon discharge from the acute episode, to complete recovery from the acute episode	Prospective, episode-based payment replacing FFS and with flexibility to support non-covered services; shared risk through retrospective reconciliation
Personalized Recovery Care (PRC) *Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home*	**Clinical Focus:** Inpatient services in home setting **Setting:** Patient home **Payment Mechanism:** Bundled episode-based payment replacing FFS	Hospital-level care being received at home mitigates risk to patients that typically occurs upon discharge from acute care facility.	Bundled episode-based payment replacing FFS, with shared risk
Specialty Care Focus			

Submitter and Proposal	Clinical Focus, Setting, and Payment Mechanism	Specialty Integration Components	Payment Design Features
Community Oncology Alliance (COA) *Oncology Care Model 2.0*	**Clinical Focus:** Oncology/cancer care **Providers:** Individuals or groups of medical oncologists providing services to patients **Payment Mechanism:** Episode-based payment with shared risk	Assess patient needs and goals; facilitate transitions and coordinate care across settings; and establish accountability or negotiate responsibility. Examples include: updating referring physicians and primary care providers; clear communication with consulting physicians and services; arrangement of needed ancillary services, such as home health, hospice, and outside testing services; and expediting patient referrals to outside providers while monitoring the completion of and findings from the referrals.	Episode-based payment with shared risk; trigger code (onset of episode) payment, monthly care management fee, "value-based" cost management for drugs and therapies
Hackensack Meridian Health and Cota, Inc. (HMH/Cota) *Oncology Bundled Payment Program Using CAN-Guided Care*	**Clinical Focus:** Oncology **Setting:** Inpatient and outpatient care **Payment Mechanism:** Bundled episode-based payment replacing FFS	The integration of the various EHRs across Hackensack Meridian Health enables the sharing of key clinical and treatment information across the spectrum of professionals that touch the patient. The investment in analytics aims to standardize and integrate feedback processes on performance on as real-time of a basis as possible. This also requires seamless physician communication to optimize care. There will also be a reorganization of staff from the inpatient to the outpatient divisions as	Prospective, bundled episode-based payments with retrospective reconciliation, replacing FFS; shared risk
Innovative Oncology Business Solutions, Inc. (IOBS) *Making Accountable Sustainable Oncology Networks (MASON)*	**Clinical Focus:** Cancer care **Setting:** Outpatient **Payment Mechanism:** Episode-based	Facilitate transitions and coordinate care settings, delivering evidence-based care and providing early intervention	Episode-based model with continued FFS payments; shared risk for cancer-related expenditures

Submitter and Proposal	Clinical Focus, Setting, and Payment Mechanism	Specialty Integration Components	Payment Design Features
Minnesota Birth Center (MBC) *A Single Bundled Payment for Comprehensive Low-Risk Maternity and Newborn Care Provided by Independent Midwife Led Birth Center Practices that Are Clinically Integrated with Physician and Hospital Services*	**Clinical Focus:** Maternity/newborn care **Setting:** Outpatient **Payment Mechanism:** Additional one-time bundled payment	Establish accountability or negotiate responsibility, facilitate transitions, and coordinate care across settings	**Financial Incentives:** Additional one-time bundled payment
New York City Department of Health and Mental Hygiene (NYC DOHMH) *Multi-provider, bundled episode of care payment model for treatment of chronic hepatitis C virus (HCV)*	**Clinical Focus:** HCV **Setting:** Primary care and specialty care **Payment Mechanism:** Bundled episode-based payment replacing FFS	Facilitate transitions and coordinate care across settings through a wide range of care coordinator services	Bundled episode-based payment replacing FFS, with shared risk
Renal Physicians Association (RPA) *Incident ESRD Clinical Episode Payment Model*	**Clinical Focus:** End-stage renal disease (ESRD) **Setting:** Dialysis centers **Payment Mechanism:** Episode-based model	Patient-centered care coordination; increased upstream chronic kidney disease (CKD) patient education; enhanced access to dialysis modality options, including renal transplant, patient-centered shared decision-making, including advanced care planning, and reductions in hospitalizations	Episode-based model with continued FFS payments and an additional payment for transplant; one- and two-sided risk options
University of New Mexico Health Sciences Center (UNMHSC) *ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Cerebral Emergencies*	**Clinical Focus:** Cerebral emergent care; telemedicine **Setting:** Inpatient; outpatient; or ED **Payment Mechanism:** Additional one-time payment	Telemedicine consults with neurological specialists provide a diagnosis with which a rural hospital can then continue care and treatment at their own facility.	Additional one-time payment without shared risk

APPENDIX 4. SUMMARY OF PTAC COMMENTS ON IMPROVING MANAGEMENT OF CARE TRANSITIONS IN POPULATION-BASED MODELS

The Committee's comments have been summarized in the following broad topic areas:

- Topic 1: Importance of Improving Care Management in Population-Based Models;
- Topic 2: Care Delivery Model Features to Improve Management of Care Transitions;
- Topic 3: Enablers to Support Desired Care Delivery Features;
- Topic 4: Payment Model Features to Improve Management of Care Transitions; and
- Topic 5: Enablers to Support Payment Model Features.

Category 1: Importance of Improving Care Management in Population-Based Models

Comment 1A. Evidence suggests that care transition management interventions are associated with achieving substantial cost savings without reducing access or quality. For example, Medicare Transitional Care Management (TCM) services within 30 days of hospital discharge in 2018 and 2019 is associated with significant improvements in outcomes related to hospital readmissions, TCOC and healthy days at home.

Comment 1B. Physician practices that were affiliated with an accountable care organization (ACO) were more likely to bill for providing TCM to at least one attributed Medicare beneficiary who was potentially eligible for TCM services (65.0% vs. 41.3% for practices not affiliated with an ACO); and billed for higher proportions of their beneficiaries who were potentially eligible for TCM.

Comment 1C. Increasing uptake of the current Medicare TCM codes could help to expand the development interdisciplinary team-based care delivery approaches and increase provider readiness to participate in models that include accountability for quality and TCOC.

Category 2: Care Delivery Model Features to Improve Management of Care Transitions

Comment 2A. Primary care providers (PCPs) play a pivotal role in managing care transitions. Pre-existing relationships with PCPs are critical for ensuring that an identified provider is ready to assume responsibility when a patient transitions between care settings. Primary care workforce initiatives and payments are necessary to increase the availability of PCPs.

Comment 2B. It is important to identify the provider that will be accountable for continuous treatment after care transitions, whether the provider is a primary care or specialty provider. While it is often appropriate for PCPs to be accountable for continuous treatment following a transition, if a specialist is providing the majority of a patient's post-discharge care, they may be more appropriate to assume responsibility.

Comment 2C. Providers should shift from documenting and communicating transitions using a "discharge summary" toward using a "transition summary" to underscore the need for a provider's continued involvement and potential accountability for post-transition care.

Comment 2D. Care transitions should focus on "pre-acute" care, as well as "post-acute" episodes. Increasing focus on pre-acute episodes can prevent waste and avoid unnecessary utilization.

Comment 2E. Health information technology (HIT) and other digital tools may be key for facilitating care transitions, promoting improved communication among providers in a patient's care team and tools for more effective identification of patients who will require transitional care. Electronic health record (EHR) interoperability and bidirectionality are important for building a "digital ecosystem" in which: all facilities are using the same or compatible EHRs; and the same medical record could follow the patient throughout their care transition, promoting continuity of care. It is important to provide access to interoperable data not only among health care providers but also with entities that provide community-based services. Investments in encouraging movement toward interoperable data could support the development of more health information exchange networks. The development of standards for integration of data systems used in ambulatory settings and nursing home settings could further increase the sharing and utility of data.

Comment 2F. It is important to maintain patient choice as a powerful driver for innovation in how care transitions are managed, as patients will select providers offering better care and better patient experiences.

Comment 2G. Variation across health care markets, systems, and providers may necessitate differences in transitional care model operations. Providers may be more inclined to engage with transitional care models that offer flexibilities in patient care, allowing providers to tailor care to their patient populations' specific needs.

Comment 2H. The focus of health care payment reform has remained on identifying payment models to foster good clinical models, but it is also important that operating models be sustainable over time. Consistent standards and support help to reassure providers that investments in the transition to value-based care are related to the goal of implementing sustainable models.

Category 3: Enablers to Support Desired Care Delivery Features

Comment 3A. Nested solutions within population-based total cost of care (PB-TCOC) models should extend beyond inpatient care. Nested models should incorporate multiple specialists, as well as longitudinal and transitional care across settings.

Comment 3C. Identifying common definitions across models for the beginning and end of a transitional care episode (e.g., using 60 days after the start of a hospitalization) would assist in assessing the most effective approaches for managing transitions. The definitions could differ based on the nature of the care transition.

Comment 3E. It is particularly important for stakeholders to explore potential improvements in how small physician practices can access data, as it may be challenging for small practices to access

performance data from payers. This could include encouraging ACOs and Medicare Advantage (MA) plans to provide performance data to small provider groups for the patients they treat.

Comment 3F. An effective care transition requires an interdisciplinary team to fulfill multiple functions. Interdisciplinary transitional care teams could potentially be used as "hubs" to link patients to necessary services.

Comment 3G. While innovation is leading to the creation of "digital" care providers that provide virtual services and can extend the reach of care teams, having additional providers engage in managing transitions could lead to more fragmented care. It is important that innovations employing digital care providers do so in a way that fully integrates these new provider entities into the care model and transition planning used by in-person care providers.

Comment 3I. Non-financial incentives can help to address provider burnout and workforce shortages—particularly related to providing administrative support and reducing complexity related to transitional care management and population-based models. It is important that the care transition team works "around" the PCP to manage logistical aspects of managing transitions and does not work in a way that overburdens the PCP.

Category 4: Payment Model Features to Improve Management of Care Transitions

Comment 4A. The design of financial incentives related to providing evidence-based transitional care management services may need to be revisited to incentivize the interdisciplinary care delivery team (rather than focusing on an individual provider), include additional levels to account for the complexity of team members involved, and incorporate a link with outcomes.

Comment 4B. Current models do not have payment incentives that are large enough to trigger the desired behaviors related to care transitions. Because the management of care transitions involves a diverse set of providers, financial incentives need to be sufficient to support the interests of and coordination among all involved parties. Additionally, incentives should be clearly tied to the desired behavior.

Comment 4C. Variation across health care markets, systems, and providers may necessitate differences in care delivery models for managing transitions, which in turn will require flexibility in payment models to account for differences in the operational model.

Comment 4D. Financial incentives in population-based models should include the impact of transitional care management services on patient experience as an element of model success, in addition to the impact of these services on quality and TCOC.

Comment 4E. It is important to address the ratchet effect in transitional care and population-based models (when baselines are reset based on good performance).

Comment 4F. There should be a strategy to harmonize payment approaches across payers in order to consistently incentivize providers to adopt best practices related to managing care transitions.

Category 5: Enablers to Support Payment Model Features

Comment 5A. Increasing uptake of current Medicare TCM codes can help to support the transition from fee-for-service (FFS) to value-based care by increasing provider readiness, expand the development of interdisciplinary team-based care delivery approaches, and increase provider readiness to participate in models that include accountability for quality and TCOC. Decreasing coinsurance and other barriers could help to increase TCM code uptake.

Comment 5B. Global incentives in population-based models are useful for incentivizing a holistic approach to patient care. In addition to global incentives, population-based models should consider including separate transitional care management incentives, such as a separate episode-based payment that may help to target specific transitions in care, such as complex care transitions for vulnerable patients. Additionally, nested episodes within population-based models should be extended to address multiple specialties and longitudinal care beyond the inpatient setting.

Comment 5C. Health-related social needs (HRSNs) can drive complexity in care transitions. Funding sources are needed to finance the delivery of services designed to address HRSNs by community-based organizations.

Comment 5E. Care transition performance metrics should be patient-centric. Maintaining consumer choice is a powerful driver for innovation because consumers will choose to seek care at places where the patient experience is better. Providers also need signs of success and knowledge that their patients are satisfied. Additionally, the impact of transitional care models on patient experience should be an element of model success in addition to the impact on cost and quality.

Comment 5F. In supporting care transition models, it is important to recognize the initial start-up costs for implementation, as well as ongoing operational costs and upgrades over time.

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