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

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) is hosting theme-based discussions to inform the Committee on topics that are important for physician-focused payment models (PFPMs). Given the increased emphasis on developing larger population-based Alternative Payment Models (APMs) that encourage accountable care relationships, PTAC has conducted a series of theme-based discussions that examined key definitions, issues and opportunities related to developing and implementing population-based total cost of care (PB-TCOC) models and improving care delivery and integration of specialty care in population-based models.

These theme-based discussions are designed to give Committee members additional information about current perspectives on key issues related to developing and operationalizing PB-TCOC models. This information will be useful to policy makers, payers, accountable care entities, and providers for optimizing health care delivery and value-based transformation in the context of APMs and PFPMs specifically. The theme-based discussions provide an opportunity for PTAC to hear from the public and subject matter experts, including stakeholders who have previously submitted proposals to PTAC with relevant elements.

PTAC's two-day June 2023 public meeting focused on improving management of care transitions in population-based models. During the public meeting, Committee members heard from various subject matter experts, including stakeholders who have previously submitted proposals to PTAC that included components related to care transition management. Specific topics that were addressed included challenges affecting the management of care transitions between different settings of care in population-based models; effective strategies for improving care transition management between various types of settings; approaches for determining provider accountability for managing care transitions; using financial incentives to encourage adoption of best practices related to care transition management; the role of health information technology (HIT); identifying appropriate performance measures; and approaches for addressing disparities in care transition management in population-based models. Stakeholders also had an opportunity to provide public comments. Findings from this theme-based discussion will be included in a report to the Secretary of Health and Human Services (HHS).

Background:

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.[1] 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.

There has been interest in improving care coordination, including management of care transitions, as a potential tool for improving quality and reducing spending while helping to reduce fragmentation of care and duplication of services for Medicare beneficiaries (including dually eligible beneficiaries). Within this context, PTAC has assessed previous submitters' use of model design components related to improving management of care transitions between different kinds of settings.

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.[2]

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) provides an environmental scan for every proposal reviewed by PTAC so that Committee members have an understanding of the clinical and economic circumstances within which a proposed model would be implemented, as well as related resource information that can inform their evaluation of each proposal. To assist PTAC in preparing for the June 2023 theme-based discussion, an environmental scan was developed with background information on topics related to improving care transition management in the context of APMs and PFPMs.

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*

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

[2] PTAC determined that 16 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.

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.[3]

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 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.*[4]*"*

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 skilled nursing facility), 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.

PTAC Areas of Interest:

PTAC is particularly interested in innovative approaches for improving care transition management across different types of settings within the context of value-based care. Particular topics of interest include effective care delivery models that incorporate improvements in care transition management; designing financial incentives to encourage adoption of best practices; determining accountability for care transition management activities; and identifying appropriate performance measures.

PTAC seeks to build upon the insights of stakeholders and use those insights and considerations to further inform the Committee's review of proposals and recommendations that the

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[3] 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 Pract (1995). 2011;39(3):128-139. doi:10.3810/hp.2011.08.588.

[4] Zurlo, A., Zuliani, G. Management of care transition and hospital discharge. Aging Clin Exp Res 30, 263–270 (2018). https://doi.org/10.1007/s40520-017-0885-6; Urbanski, D., Reichert, A., Amelung, V. (2021). Discharge and Transition Management in Integrated Care. In: Amelung, V., Stein, V., Suter, E., Goodwin, N., Nolte, E., Balicer, R. (eds) Handbook Integrated Care. Springer, Cham. https://doi.org/10.1007/978-3-030-69262-9_26.

Committee may provide to the Secretary relating to this topic. PTAC also seeks additional information on stakeholders' experiences related to improving management of care transitions in population-based models. Therefore, PTAC requests stakeholder input on the questions listed below.

Please submit written input regarding any or all of the following questions to PTAC@HHS.gov. Questions about this request may also be addressed to PTAC@HHS.gov.

Questions to the Public:

1. What are the most important challenges that providers face related to managing care transitions between settings of care (e.g., geographic location, workforce availability, technology, payment mechanisms, independent/small providers, rural providers, urban providers, safety net providers, etc.)? Which challenges have the most adverse effects on care transition management?

    a. To what extent do these challenges vary by type of provider (e.g., independent, integrated delivery systems), type of setting, and participation in Accountable Care Organizations (ACOs)? How so?

    b. To what extent do care transition management challenges vary for rural and urban providers?

    c. To what extent do challenges related to improving care transition management vary by specialty (e.g., medical versus surgical), condition or procedure? How so?

    d. To what extent do challenges related to improving care transition management vary depending on whether the provider is making or receiving the transition of the patient from one setting to another?

    e. What are specific challenges related to improving different kinds of care transition management (e.g., ambulatory to acute care, acute to post-acute care, post-acute to ambulatory care)?

    f. To what extent do challenges related to acute care transitions vary depending on whether they are related to unscheduled care or scheduled care?

    g. What are some conditions and procedures where improved management of care transitions between settings could potentially have the greatest impact on quality, patient experience, TCOC, and clinical outcomes?

    h. What are some types of patients for whom improved management of care transitions between settings could potentially have the greatest impact on impact on quality, patient experience, TCOC, and clinical outcomes?

2. What kinds of existing APMs and payers have been effective in integrating care transition management in their model design and using financial incentives to encourage improvements in care transition management?

    a. What existing APMs use financial incentives to encourage improvements in care transition management? What existing APMs integrate care transition management in their model design?

    b. How can APMs address disparities related to care transition management? For what population characteristics are there disparities in care transition management (e.g., rurality, literacy, numeracy, primary language, age, insurance status, behavioral health)?

    c. What payment mechanisms (e.g., capitation, per beneficiary per month [PBPM] payments, bundled payments) are used to incentivize improvements in care transition management? Which payment mechanisms are most effective in incentivizing improvements in care transition management?

    d. What challenges have these APMs and payers faced related to encouraging improvements in care transition management, and how can these challenges be addressed?

    e. What kinds of approaches for incentivizing improvements in care transition management have been most effective for providers in different kinds of payment models (e.g., fee-for-service, shared savings, capitation)? Why?

    f. In addition to financial incentives, what other approaches can APMs use to influence care transition management through their model design (e.g., attribution, benchmarking)? How should attribution approaches account for care transition management? Should benchmarks account for care transition management? If so, how?

3. Are there differences in the quality, effectiveness and outcomes related to care transitions between providers engaged with an accountable care organization and providers that operate within a fee-for-service model? If so, how?

    a. What are the most effective approaches for supporting providers that operate within a fee-for-service model in improving care transition management?

    b. What are the most effective approaches for supporting providers that operate within accountable care organizations and population-based payment models in improving care transition management?

4. How can APMs address disparities related to care transition management?

a. What barriers do underserved populations and providers that serve underserved communities face related to improving management of care transitions?

b. What are examples of organizations that have successfully improved care transition management for different types of underserved populations? What strategies did they implement?

5. What provider/entity activities are associated with best practices for improving care transition management between settings of care (e.g., communication, medication management and reconciliation, transition/discharge planning, shared-decision making, patient/family education, proactive follow-up)?

    a. Does the effectiveness of different types of provider activities vary by the types of care settings involved or the direction of the transition, such as from an acute care hospital to a skilled nursing facility (SNF)?

    b. What is the role of physicians and other members of the care delivery team in improving management of care transitions between settings? How should accountability for care transition outcomes be shared between physicians and facilities?

    c. To what extent does location and/or geography impact best practices for care transition for integrated health care delivery systems? How is this different for independent practices?

    d. How should provider accountability be determined related to conducting various activities related to care transition management between settings?

    e. What are examples of organizations that have implemented effective best practices for improving care transition management in different settings?

6. What kinds of proactive care delivery innovations can improve care transition management for patients?

    a. What are examples of innovative care transition management models that currently exist? What kinds of settings, patients, and diseases/conditions have these models targeted? What approaches have been more effective, or less effective? Why?

    b. How should patient and caregiver preferences be reflected in care transition processes?

    c. What are some conditions and procedures where improved management of care transitions between settings could potentially have the greatest effect on quality, patient experience, and TCOC?

d. How do these innovations address the needs of patients with multiple chronic conditions, patients with issues related to functional ability, patients with health-related social needs (HRSNs), and patients with behavioral health care needs (e.g., serious mental illness and/or substance use disorder)?

7. What kinds of resources or tools do providers need that can assist them in more effectively managing transitions between settings of care?

    a. How can providers most effectively use health information technology (HIT) and data analytics to improve care transition management, such as identifying care patterns or trajectories for certain conditions or procedures?

    b. What kinds of data would help to improve providers' ability to manage transitions between settings of care?

    c. What role can telehealth play in improving various kinds of transitions between care settings?

    d. What data sources, including patient assessment data, are available to inform effective care transitions? How can providers leverage standardized assessment data (e.g., Standardized Patient Assessment Data Elements ([SPADEs])?

8. What financial incentives are likely to be most effective for improving care transition management between care settings?

    a. How do financial incentives inherent in fee-for-service inhibit effective care transition management? How should APMs address these incentives? Are there financial incentives that can be implemented within fee-for-service payment models to improve care transition management?

    b. What kinds of financial incentives and programs currently exist related to improving management of care transitions? What are the pros and cons of these existing financial incentives? What opportunities exist for strengthening these programs?

    c. What incentives have the most potential to improve care transition management for certain conditions or procedures? Does the effectiveness of certain types of incentives vary by specialty (e.g., medical versus surgical), condition or procedure? If so, how?

    d. Do effective financial incentives for encouraging improvements in care transition management vary between population-based and episode-based models? If so, how?

    e. Should financial incentives related to improving management of care transitions be at the organization level or the provider level? Should the incentives be linked

with specific provider/organizational activities or performance, or should providers/organizations have flexibility to use program incentives across a range of approved activities?

f. What kinds of care delivery innovations should financial incentives seek to encourage (e.g., promoting appropriate use of telehealth, discharge planning, employing care managers) to improve the quality of and patient experience with care transition management?

g. What aspects of care transition management are currently being financed or required by payers? Are there additional care transition management services or delivery innovations that should be incentivized or reimbursed? If so, in what contexts?

h. What characteristics of less effective care transition management approaches should financial incentives target to improve quality of and patient experience with care transition management and to reduce TCOC?

i. What kinds of financial incentives have the potential to support health information technology infrastructure enhancements that can help to support improvements in care transition management?

9. What performance metrics should be used to measure the quality and effectiveness of care transition management between different types of settings?

    a. Are there additional considerations that should be made with respect to measuring the quality of care transition management for patients with multifaceted needs, including patients with behavioral health care needs or health-related social needs (HRSNs)?

    b. What are the most relevant patient experience indicators of successful care transition management (e.g., understanding of and ability to implement a care plan, feeling cared for)?

    c. What utilization, quality and outcomes measures are most related to the quality and effectiveness of care transition management (e.g., ED utilization, readmissions)?

    d. For care transitions between settings, what provider or entity should be considered accountable for quality of care and reducing low-value care?

10. What are best practices for improving other types of care transitions?

    a. What approaches are most effective for improving transitions between providers (e.g., primary care and specialty care; care delivery teams; hospitals or integrated delivery systems)?

b. What approaches are most effective for improving transitions between levels of care (e.g., primary and specialty care; ambulatory care to inpatient care; curative to palliative, hospice, and end-of-life care)?

Where to Submit Comments/Input: Please submit written input regarding any or all of the following questions to PTAC@HHS.gov. Questions about this request may also be addressed to PTAC@HHS.gov.

Note: Any comments that are not focused on the topic of care transitions, APMs and PFPMs, and efforts by physicians and related providers caring for Medicare FFS beneficiaries, or are deemed outside of PTAC's statutory authority, will not be reviewed and included in any document(s) summarizing the public comments that were received in response to this request.

Appendix: Working Definitions Related to Population-Based Total Cost of Care (PB-TCOC) Models, Care Coordination, and Management of Care Transitions

PTAC is using the following working definition for population-based models:

> *Population-based models are models that include the entire patient population served by a given accountable entity or a broad subset of the patient population served by an accountable entity (e.g., Medicare-Medicaid enrollees).*[5]

PTAC is using the following working definition for PB-TCOC models:

> *A population-based total cost of care (PB-TCOC) model is an Alternative Payment Model (APM) in which participating entities assume accountability for quality and TCOC and receive payments for all covered health care costs for a broadly defined population with varying health care needs during the course of a year (365 days).*
>
> *Within this context, a PB-TCOC model would not be an episode-based, condition-specific, or disease-specific specialty model. However, these types of models could potentially be "nested" within a PB-TCOC model.*[6]

PTAC is using the following working definition of care coordination that is drawn from the Agency for Healthcare Research and Quality's description of care coordination:

> *Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.*[7]

Within this context, PTAC is using the following working definition of care transitions in the context of value-based care:

> *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*

[5] Assistant Secretary for Planning and Evaluation. Environmental Scan on Care Coordination in the Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs) May 25, 2021; https://aspe.hhs.gov/sites/default/files/documents/b1b55986cfe3016f83b8f48ca2c9b154/PTAC-Mar-2-Escan.pdf

[6] Assistant Secretary for Planning and Evaluation. Environmental Scan on Care Coordination in the Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs) May 25, 2021; https://aspe.hhs.gov/sites/default/files/documents/b1b55986cfe3016f83b8f48ca2c9b154/PTAC-Mar-2-Escan.pdf

[7] Agency for Healthcare Research and Quality. Care Coordination. Accessed May 12, 2023, from https://www.ahrq.gov/ncepcr/care/coordination.html

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.[8]

PTAC is using the following working definition of 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 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.*[9]*"*

Additionally, PTAC is using the following working definition of settings of care in the context of care transition management:

Settings of care represent a broad array of services and places where health care is provided, including (but not limited to):

- *Acute care hospitals,*
- *Urgent care centers,*
- *Ambulance services*
- *Emergency departments,*
- *Specialized outpatient services (rehabilitation, hemodialysis, laboratory, diagnostic tests),*
- *Outpatient surgery centers,*
- *Post-acute care services (e.g., SNF, inpatient rehabilitation facility [IRF}, long-term hospital [LTCH], home health agency [HHA]), and*
- *Nursing homes and other assisted living facilities.*

[8] 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 Pract (1995). 2011;39(3):128-139. doi:10.3810/hp.2011.08.588.

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

In addition, some health care services are provided in private offices or homes.[10]

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

[10] https://www.cdc.gov/eis/field-epi-manual/chapters/Healthcare-Settings.html#:~:text=The%20term%20healthcare%20setting%20represents,%2C%20dentistry%2C%20podiatry%2C%20chemotherapy%2C.