

## Preliminary Comments Development Team (PCDT) Presentation Reference Deck:\*

### **Improving Care Transition Management in Population-Based Models**

Walter Lin, MD, MBA (Lead)  
Lindsay Botsford, MD, MBA  
Lauran Hardin, MSN, FAAN  
James Walton, DO, MBA  
Jennifer Wiler, MD, MBA

\* This reference deck includes additional details on some topics that were not included in the presentation deck that was discussed during the public meeting.

# Objectives of This Theme-Based Meeting

*The goal for this meeting is to better understand how financial incentives in Alternative Payment Models (APMs) can be structured to incentivize improvements in care transition management between settings throughout the Medicare program, and how various experts and providers have sought to address barriers to improving care transition management through financial incentives. Topics that will be covered include:*

- **Opportunities and barriers** related to improving care transition management between settings in population-based models.
- Effective **care delivery model innovations** and strategies for improving care transition management between different kinds of settings.
- **Payment strategies** for incentivizing improvements in care transition management in population-based models.
- **Performance metrics** for measuring care transition management.

# Background About This Theme-Based Meeting

- Proposals submitted to PTAC
  - PTAC has deliberated on the extent to which 28 proposed physician-focused payment models (PFPMs) met the Secretary’s 10 regulatory criteria, including *Integration and Care Coordination*.\*
  - Many of these proposals described issues and proposed payment design solutions related to improving care transition management.
- Previous PTAC public meetings
  - June 2021 public meeting covered the role care coordination can play in optimizing health care delivery and value-based transformation, in the context of APMs and physician-focused payment models specifically.
  - June 2022 public meeting addressed care delivery model design for population-based total cost of care (PB-TCOC) models.
  - March 2023 public meeting focused on improving care delivery and integrating specialty care in population-based models.

\* Nearly all of the 35 proposals that have been submitted to PTAC addressed the potential impact on costs and care coordination, to some degree – including at least 20 proposals that addressed issues related to facilitating transitions and coordinating care across settings in advanced primary care models (APCMs) and episode-based or condition-specific models. Please see the Appendix for additional information.

# Preliminary Working Definition of Care Transitions\* in the Context of Value-Based Care

PTAC is using the following working definition of *care transitions*:

- 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.

\* This definition will continue to evolve as the Committee collects additional information from stakeholders.

References: [https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/8\\_transition\\_of\\_care\\_summary.pdf](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.

# Preliminary Working Definition of Care Transition Management\* in the Context of Value-Based Care

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

- Care transition management is “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 visits.

\* This definition will continue to evolve as the Committee collects additional information from stakeholders.

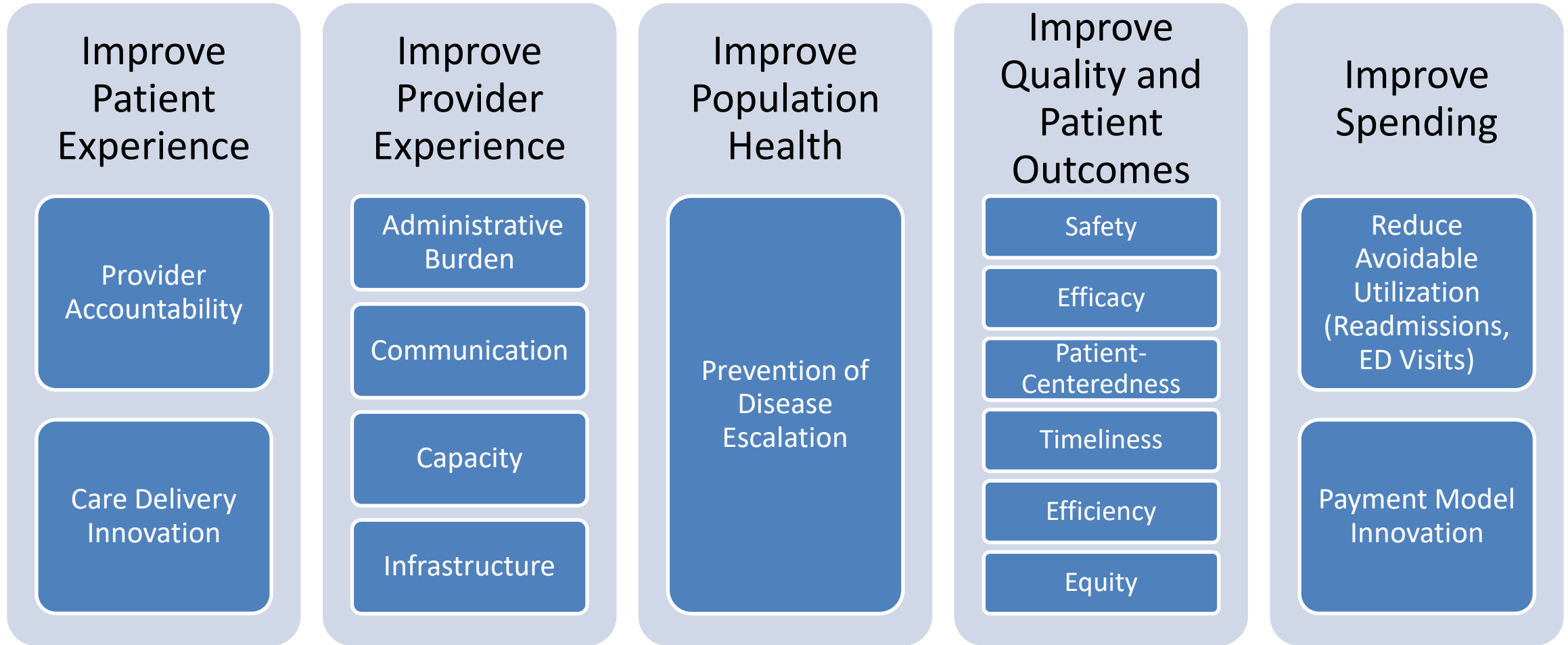
References: Zurlo, A., Zuliani, G. Management of care transition and hospital discharge. *Aging Clin Exp Res* 30, 263–270 (2018). <https://doi.org/10.1007/s40520-017-0885-6>; Urbanski, D., Reichert, A., Amelung, V. (2021). Discharge and Transition Management in Integrated Care. In: Amelung, V., Stein, 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](https://doi.org/10.1007/978-3-030-69262-9_26); <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/improving-care-transitions/index.html>

# Preliminary Working Definition of Settings of Care in the Context of Care Transition Management

PTAC is using the following working definition of *settings of care*:

- 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., skilled nursing facilities [SNFs], inpatient rehabilitation facilities [IRFs], long-term care hospitals [LTCHs], and home health agencies [HHAs]), and
  - Nursing homes and assisted living facilities.
- In addition, some health care services are provided in private offices or homes.

# Objectives of Effective Care Transitions



References: Bodenheimer T, Sinsky C. From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *Ann Fam Med*. 2014;12(6):573-576. doi:10.1370/afm.1713; Prior M, McManus M, White P, Davidson L. Measuring the “Triple Aim” in Transition Care: A Systematic Review. *Pediatrics*. 2014;134(6):e1648-e1661. doi:10.1542/peds.2014-1704; 1. Campagna V, Nelson SA, Krsnak J. Improving Care Transitions to Drive Patient Outcomes: The Triple Aim Meets the Four Pillars. *Professional Case Management*. 2019;24(6):297. doi:10.1097/NCM.0000000000000387.

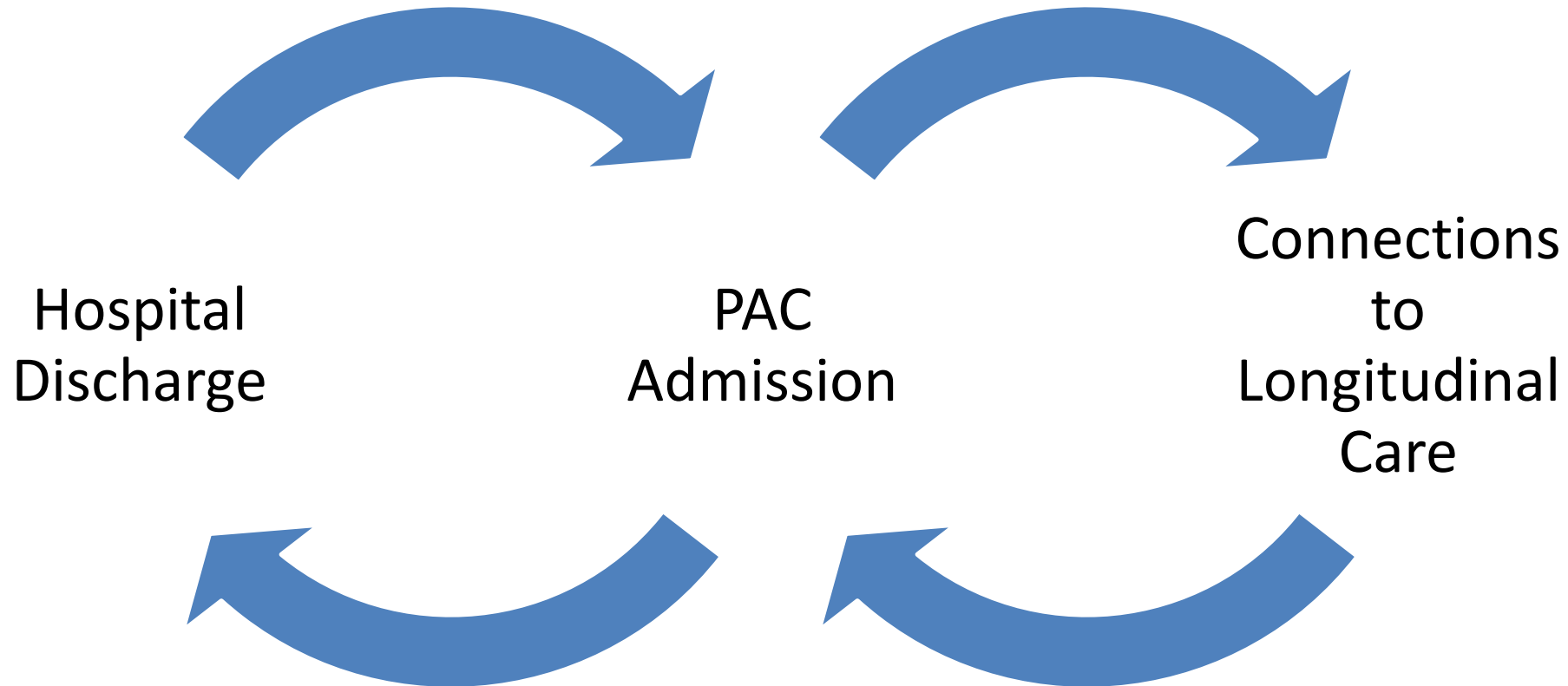
# Components of Effective Care Transition Management Models

- Screening
- Medication reconciliation
- Communication and collaboration
- Timely follow-up visits
- Patient and caregiver education
- Other tools and resources
  - *Discharge checklist, transition coach, patient-centered health record, condition-specific red flags*



# Patient Handoffs During Care Transitions

Effective transfer of health information is key to successful patient handoffs.



# Example of Selected Care Transitions for a Patient with Stroke\*



EMS transports patient to hospital



Patient admitted to hospital



Patient discharged to post-acute care (PAC) facility



Patient discharged to home (*with or without home health services*)

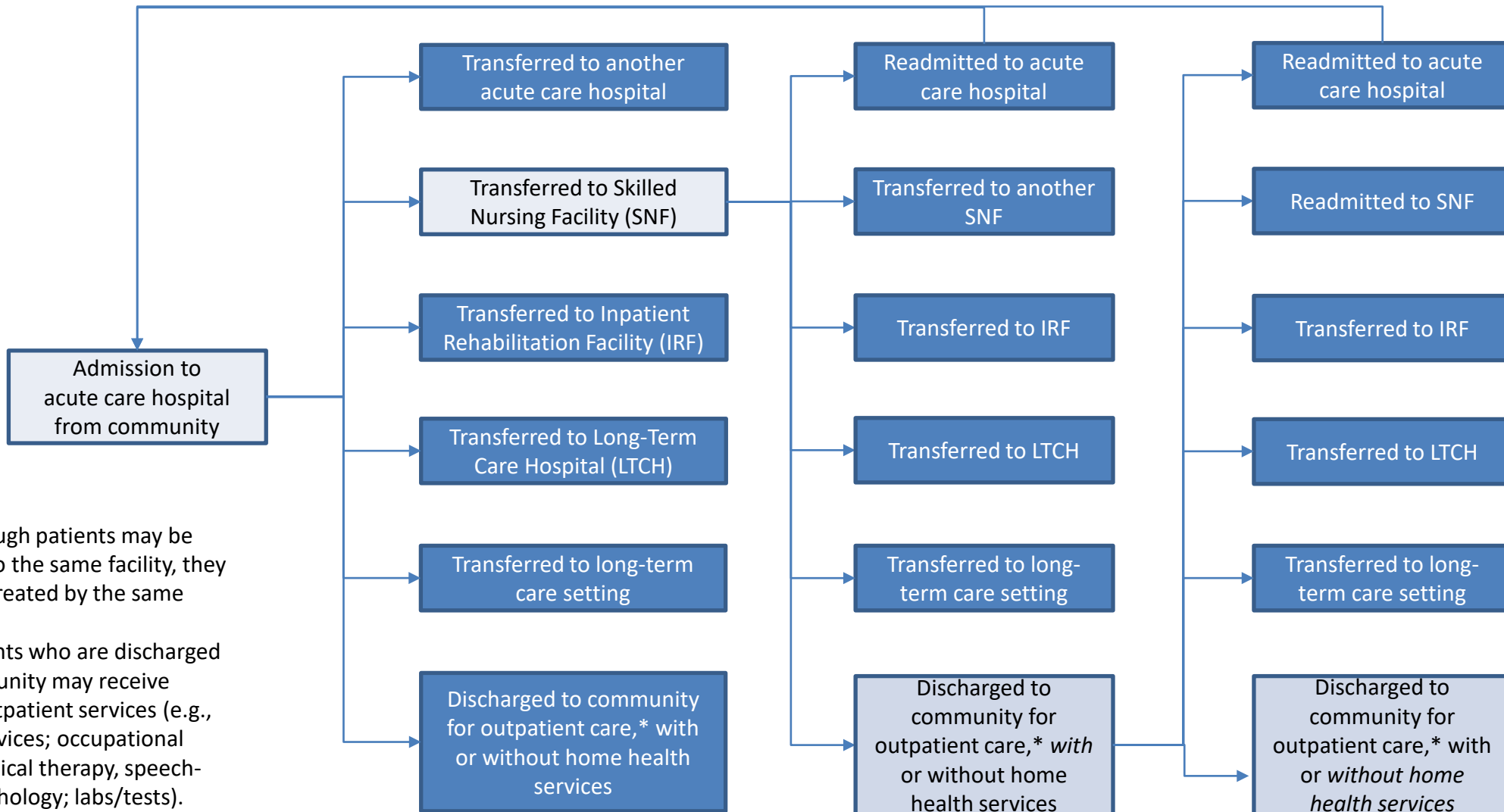


Patient receives ongoing outpatient care in the community



• Some patients may experience care transitions to additional settings (e.g., hospital readmissions to the same or a different acute care hospital from a post-acute care facility or home, transitions between post-acute care settings of the same or different types), as well as follow-up outpatient care.

# Care Setting Transitions Represent Risk of Patient Harm: Example Options for a Patient with Stroke



Notes: Although patients may be readmitted to the same facility, they may not be treated by the same provider.

\*Some patients who are discharged to the community may receive follow-up outpatient services (e.g., physician services; occupational therapy, physical therapy, speech-language pathology; labs/tests).

# Background: Medicare Enrollment Overview, 2021

Total Medicare Beneficiaries: ~64 million

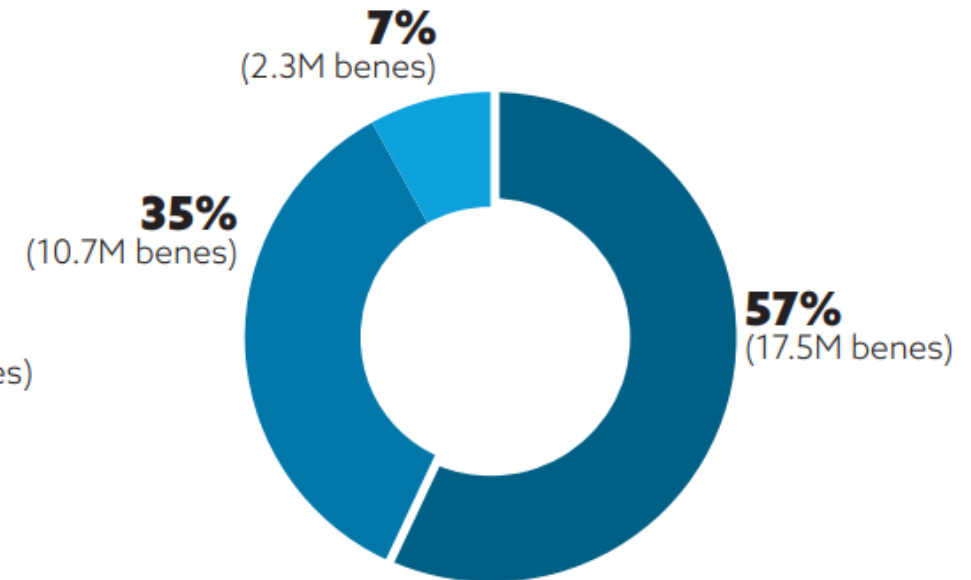
- 58 million with both Part A and Part B
- 53% in Traditional Medicare
- More than half (17.5 million) of the beneficiaries in Traditional Medicare were not in ACOs or similar models

Part A and B Traditional Medicare & Medicare Advantage Beneficiaries



■ Traditional Medicare (Part A & B)  
■ Medicare Advantage and Other Health Plan Enrollment

Accountable Care in Traditional Medicare



■ Medicare FFS benes not in an ACO  
■ Medicare FFS benes in a MSSP ACO\*  
■ Medicare FFS benes in other ACOs and ACO-like models

# Takeaways from Prior Studies on Care Transition Interventions

- Evidence suggests that care transition interventions are associated with substantial cost savings without sacrificing access or quality.
  - The Care Transitions Intervention, a patient-centered coaching intervention, was associated with 22% lower total health care costs at six months.
  - The University of Pennsylvania Transitional Care Model was associated with lower average costs per patient, even when accounting for costs of transitional care services.
    - At 30 days after discharge, lower average post-acute (~\$800/patient) and total care costs (~\$1,400-\$2,100/patient).
    - At 180 days after discharge, lower average post-acute (~\$600-\$1,600/patient) and total care costs (~\$2,200-\$4,000/patient).

References: Wieczorek E, Kocot E, Evers S, Sowada C, Pavlova M. Do financial aspects affect care transitions in long-term care systems? A systematic review. *Archives of Public Health*. 2022;80(1):90. doi:10.1186/s13690-022-00829-y; Saenger PM, Ornstein KA, Garrido MM, et al. Cost of home hospitalization versus inpatient hospitalization inclusive of a 30-day post-acute period. *Journal of the American Geriatrics Society*. 2022;70(5):1374-1383. doi:10.1111/jgs.17706; Gardner R, Li Q, Baier RR, Butterfield K, Coleman EA, Gravenstein S. Is Implementation of the Care Transitions Intervention Associated with Cost Avoidance After Hospital Discharge? *J Gen Intern Med*. 2014;29(6):878-884. doi:10.1007/s11606-014-2814-0; <https://ldi.upenn.edu/our-work/research-updates/cost-impact-of-the-transitional-care-model-for-hospitalized-cognitively-impaired-older-adults/>.

# Low Uptake of Medicare Transitional Care Management (TCM) Services Among Fee-For-Service (FFS) Providers

- 2013: Medicare introduced two TCM codes to reimburse for assisting patients when moving from inpatient to the community.
- Prior studies show that uptake of TCM codes has been slow.
- Factors influencing TCM code uptake may include:
  - The relative cost vs. financial incentives of providing TCM services.
  - Lack of interoperability between electronic health records.
  - Eligibility and coinsurance requirements.

# Higher Use of Medicare TCM Services by ACO-Affiliated Physician Practices

In 2019, of all practices in the U.S. with at least one attributed beneficiary potentially eligible for TCM, 45.6 percent billed TCM for at least one potentially eligible beneficiary, and these practices billed for an average of 22.6 percent of their potentially eligible beneficiaries.

Primary care practices and larger practices were more likely to bill for providing TCM services.

## Practices that were affiliated with an ACO:

- Were **more likely to bill for providing TCM** to at least one attributed beneficiary who was potentially eligible for TCM services (65.0% vs. 41.3% for practices not affiliated with an ACO).
- **Billed for higher proportions of their beneficiaries** who were potentially eligible for TCM.\*

Medicare TCM services were likely not provided to many FFS beneficiaries who might have benefitted from them.

\* In the analysis, potential eligibility was determined based on analysis of claims-identified chronic conditions or discharges from hospitals, skilled nursing facilities, and community mental health centers, and does not include physician assessment of patient suitability or appropriateness for TCM services.

Reference: *Analysis of 2019 Medicare Fee-for-Service (FFS) Claims for Chronic Care Management (CCM) and Transitional Care Management (TCM) Services, March 1, 2022*, available at <https://aspe.hhs.gov/sites/default/files/documents/41fd0a9affdc5f36bca0656b4f4ca6b/CCM-TCM-Descriptive-Analysis.pdf>.

# Impact of Medicare TCM Services on Hospital Readmissions, Total Cost of Care (TCOC), and Healthy Days at Home

Although uptake of TCM services may be suboptimal, use of TCM services in 2018 and 2019 is associated with significant improvements in outcomes 31 to 60 days following discharge for:

- Hospital readmissions – a 5.6% decrease;
- TCOC – a 7.8% decrease per episode; and
- Healthy days at home – a 1.3% increase.\*

Measure	Difference between Treatment Group and Comparison Group	Treatment Group	Comparison Group
Hospital readmissions	0.60%	10.09%	10.69%
Total cost of care (31 to 60 days)	\$236.11/episode	\$2,803.15/episode	\$3,039.26/episode
Total cost of care (1 to 60 days)	\$997.10/episode	\$6,303.53/episode	\$7,300.63/episode
Healthy days at home	0.32 days	25.88 days	25.56 days

Future direction: strategies for improving TCM uptake.

Note: Study conducted using 2018 and 2019 Medicare fee-for-service claims. For this analysis, the Treatment Group included patients who received TCM service within 30 days of acute care hospital inpatient discharge, and the Comparison Group included patients who did not receive TCM service within 30 days of acute care hospital inpatient discharge.

\* Unless otherwise noted, measures capture spending, utilization, and healthy days at home in days 31-60 following acute care hospital inpatient discharge. Unit of analysis: episodes that begin from a qualifying discharge eligible for TCM after a short-term acute care hospital stay and end 60 days after discharge. Results are statistically significant at  $P \leq 0.01$ . Report forthcoming.



# Takeaways from Studies on Medicare TCM Services

- Practices that were affiliated with a MSSP ACO were more likely to bill for TCM services.
- Use of TCM services within 30 days of hospital discharge in 2018 and 2019 is associated with significant improvements in outcomes.

## Implications?

# Examples of Care Delivery Models for Transitional Care

Model and Organization	Components
Transitional Care Model <i>University of Pennsylvania School of Nursing</i>	The Transitional Care Model originally focused on chronically ill older adults and reducing readmissions, but it has more recently been adapted for use among Medicaid patients and those with psychiatric conditions. This model has nine core components: screening, staffing, maintaining relationships, engaging patients and caregivers, assessing/managing risks and symptoms, educating/promoting self-management, collaborating, promoting continuity, and fostering coordination.
Better Outcomes for Older Adults through Safe Transitions (BOOST) <i>American Hospital Association</i>	BOOST provides a toolkit to participating hospitals that these hospitals can tailor to their local context. The toolkit includes implementation guidance; a diagnostic tool to identify patients at high risk for readmissions; a discharge checklist, patient education materials, and information for providers; guidance for post-discharge follow-up care and medication reconciliation; and additional resources to identify and manage patients at high risk of readmission.
Care Transitions Intervention <i>University of Colorado School of Medicine</i>	CTI begins when a patient is in the hospital and meets with a transition coach. The transition coach conducts a follow-up home visit and three additional phone calls to provide consistency across the transition and help the patient manage their condition. The transition coach focuses on CTI's four pillars of transition care: medication self-management, a dynamic patient-centered health record, primary and specialist provider follow-up, and knowledge of condition-specific red flags (e.g., symptoms and drug reactions) so that patients know when their condition is worsening. A range of personnel can fill the role of transition coach.
Project Re-engineered Discharge (RED) <i>Boston University Medical Center</i>	Project RED develops and tests strategies to improve the hospital discharge process, promoting patient safety and reducing readmission rates. Activities include diagnosis-related education, post-discharge follow-up (e.g., appointments, tests), written discharge plan, discharge plan reconciliation, and phone communication.

# Selected Facilitators of Care Transition Management

- **Collaborating within and across organizations**
  - Interdisciplinary, team-based care (including the care coordination nurse)
  - Coordination between health care and community services supporting care transition management
  - Efficient information transfer and management
  - Effective face-to-face communication
- **Tailoring services to patients and caregivers**
  - Comprehensive, tailored patient/caregiver education
  - Patient/caregiver involvement in care planning
  - Evaluation and modification of care transition management activities
- **Generating staff buy-in**
  - Prioritizing and championing care transition management services

# Care Delivery Challenges Related to Improving Management of Transitions Between Settings

- Communication breakdown
- Unplanned discharges
- Disparities in care transition management
- Insufficient health information technology (HIT), infrastructure, and data analytics to identify utilization patterns and provide patient-centered transition planning
- Gaps in access to post-discharge care
- Limited patient awareness of care coordination staff and services
- Workforce availability and staffing turnover
- Lack of accountability

References: Evaluation of the Community-Based Care Transitions Program: Final Evaluation Report. Econometrica, Inc. 2017. <https://downloads.cms.gov/files/cmmt/cctp-final-eval-rpt.pdf>; Environmental Scan on Care Coordination in the Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs). Office of the Assistant Secretary for Planning and Evaluation. 2021. <https://aspe.hhs.gov/sites/default/files/private/pdf/261946/Jun-2021-CC-Escan.pdf>; Friedman A, Howard J, Shaw EK, Cohen DJ, Shahidi L, Ferrante JM. Facilitators and Barriers to Care Coordination in Patient-centered Medical Homes (PCMHs) from Coordinators' Perspectives. The Journal of the American Board of Family Medicine. 2016;29(1). doi:10.3122/jabfm.2016.01.150175; Rattray NA, Sico JJ, Cox LM, Russ AL, Matthias MS, Frankel RM. Crossing the Communication Chasm: Challenges and Opportunities in Transitions of Care from the Hospital to the Primary Care Clinic. The Joint Commission Journal on Quality and Patient Safety. 2017;43(3):127-137. doi:10.1016/j.jcjq.2016.11.007; <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/improving-care-transitions/index.html>.

# Enablers of Effective Care Transitions

## Policy Goals

- Value-based care
- Shared risk
- Increased accountability
- Delivery system transformation

## Payment Policy

- Addressing limitations of current FFS billing
- APMs
- Financial incentives (capitated payments, per beneficiary per month [PBPM] payments, episode-based payments)



## Patients, Providers, and Care Delivery Processes


- Knowledge of high-quality providers at the point of referral
- Tailored discharge instructions
- Medication reconciliation
- Remote monitoring and timely follow-up
- Communication
- Patient and family/caregiver education
- Closing the referral loop



## Desired Quality and Health Outcomes

- Utilization – improve access/reduce barriers to care, reduce emergency department visits
- Quality – reduce readmissions, reduce mortality, increase healthy days at home
- Spending – reduce TCOC by shifting care to more appropriate settings and reduce avoidable utilization
- Equity – reduce disparities

# Examples of Payment Models for Supporting Care Transitions



Model and Organization	Components
Medicare Transitional Care Management (TCM) Services <i>Centers for Medicare &amp; Medicaid Services (CMS)</i>	The 30-day TCM period begins on a patient’s inpatient discharge date and continues for the next 29 days. Services include: supporting a patient’s transition to a community setting; health care professionals who accept patients at the time of post-facility discharge, without a service gap; health care professionals taking responsibility for a patient’s care; and moderate or high complexity medical decision-making for patients with medical or psychosocial problems.
Bundled Payments for Care Improvement (BPCI) Advanced Model <i>Center for Medicare and Medicaid Innovation (CMMI)</i>	Single retrospective bundled payment and one risk track, with a 90-day Clinical Episode duration. Participants lead engagement and coordination efforts. Aims to address fragmented and inefficient care by encouraging physicians to redesign care delivery, reduce variations in standards of care, and provide clinically appropriate services. The BPCI Advanced Model promotes seamless, patient-centered care throughout each clinical episode and encourages providers from all health care settings to collaborate and communicate on quality and total cost of care.
Accountable Care Organizations (ACOs) <i>CMS, Commercial Payers</i>	Groups of doctors, hospitals, and other health care providers, who come together voluntarily to provide coordinated high-quality care to their patient populations. These arrangements can improve transitional care through improved provider-provider communication, shared infrastructure for real-time information transfer, and centralized and/or embedded staff supporting care coordination. Specific flexibilities supporting transitional care may be granted under specific ACO models.
Medicare Advantage <i>CMS → Commercial Payers</i>	Medicare pays a fixed monthly amount for beneficiary coverage, with health plan flexibility to charge different out-of-pocket costs, set different rules, or provide additional services not covered or with limited coverage under traditional Medicare FFS.

References: <https://innovation.cms.gov/innovation-models/bpci-advanced>; <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/transitional-care-management-services-fact-sheet-icn908628.pdf>; [https://innovation.cms.gov/innovation-models/aco#:~:text=Accountable%20Care%20Organizations%20\(ACOs\)%20are,the%20Medicare%20patients%20they%20serve](https://innovation.cms.gov/innovation-models/aco#:~:text=Accountable%20Care%20Organizations%20(ACOs)%20are,the%20Medicare%20patients%20they%20serve;); <https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf>.

# Overview of Payment Model Challenges Related to Improving Care Transition Management\*

- Limited and/or conflicting financial incentives for providing care transition management activities between settings in traditional fee-for-service (FFS) environment
- Assigning accountability for care transition quality and spending when multiple providers and settings participate in care transitions
- Establishing optimal degree of flexibility in participation requirements related to care transition management, and structuring financial incentives for participating providers
- Implementing meaningful performance measures to evaluate quality of care transition management

\* Representative list; this will continue to evolve as the Committee collects additional information from stakeholders.

# Limited and/or Conflicting Financial Incentives

- Limitations on who can provide Transitional Care Management
  - Primary care providers (PCPs) vs. specialists
- TCM services reimbursement vs. costs
- Pressures to reduce lengths of stay, discharge patients to less intensive settings, and reduce readmissions
- FFS TCM reimbursement not tied to outcomes

References: <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/transitional-care-management-services-fact-sheet-icn908628.pdf>; Agarwal SD, Barnett ML, Souza J, Landon BE. Adoption of Medicare's Transitional Care Management and Chronic Care Management Codes in Primary Care. JAMA. 2018;320(24):2596-2597. doi:10.1001/jama.2018.16116



# Assigning Accountability for Care Transitions

- No accountability for outcomes or spending under FFS
- Multiple providers may contribute to care transitions.
- Existing Center for Medicare and Medicaid Innovation (CMMI) Models vary in their approaches to determine accountability for care transition management when multiple providers and settings are involved.
- Some ACO models base accountability on plurality of services.
  - Attribution based on plurality of services or “first touch” may not account for all providers who contribute to a beneficiary’s health care spending, utilization, and outcomes related to care transitions. For example, the Next Generation ACO (NGACO) Model used the majority of a beneficiary’s Evaluation and Management (E&M) visits to determine their usual source of care.
  - Although not required, ACOs may share financial incentives or performance data with participating providers to encourage downstream quality improvements.

## Assigning Accountability for Care Transitions, Continued

- Some episode-based models also base accountability on plurality of services.
  - Under the Oncology Care Model (OCM), chemotherapy care episodes were aligned to the practice that provided the majority of that beneficiary's cancer-related E&M visits.
- Some episode-based models base accountability on the setting that provided care for the index or anchor event.
  - Under the Comprehensive Care for Joint Replacement (CJR) Model, the participating hospital that provided a beneficiary's joint replacement surgery is held accountable for their care transition management.
  - Under the Bundled Payments for Care Improvement Advanced (BPCI-A) Model, clinical episodes beginning with an Anchor Stay (inpatient acute care hospital admission with qualifying Medicare Severity Diagnosis Related Group [MS-DRG] code) or Anchor Procedure (start of outpatient procedure with qualifying Healthcare Common Procedure Coding System [HCPCS] code) are aligned to participating hospitals, practices, or providers.
- Beneficiaries who are not attributed may experience worse management of care transitions and have poorer outcomes related to care transitions.

# Establishing Optimal Degree of Flexibility

Patient-centered care may necessitate different approaches to care transition management, including patients:

- With multiple chronic conditions
- With high or rising risk
- With conditions requiring acute or chronic management
- In underserved areas or with issues in access to care

Patient panel mix may vary substantially across providers and regions.

# Possible Care Transitions Performance Measures

Different types of performance measures are relevant to an evaluation of the effectiveness of care transitions.

- Care process measures
  - Medication reconciliation, communication about discharge information, receipt of complete written discharge instructions.
- Utilization
  - ED visits, avoidable hospital readmissions, post-acute care stays, home health visits, advance care planning.
- Spending
  - Total cost of care, setting-specific spending measures (e.g., acute care, hospital outpatient, post-acute care, and home health spending).
- Health care outcomes
  - Mortality, frailty, change in functional status, receipt of follow-up care, healthy days at home.
- Patient-reported outcomes
  - Patient experience with care (e.g., understanding of and ability to implement a care plan, feeling cared for).

# Examples of Technical Issues Affecting Implementation Meaningful Performance Measures

- Balancing specificity and useability
  - Sample size issues
    - Lower-volume providers
    - Some condition-specific measures
- Data collection burden
  - Capturing patient experience in key domains
    - For example, understanding, preferences, preparedness, care planning
  - Proximity to event and recall bias
- Defining person-centered goals and indicators
- Applicability of absolute or relative scales for providers serving certain populations

# Options for Addressing Selected Payment Model Challenges

- Sharing benchmarked financial and performance data in a timely manner
  - Predictive algorithms / risk-stratification data
- Payment design features that shift risk to providers in the traditional fee-for-service environment
  - Tying TCM payments and/or bonuses to outcomes
  - Shifting FFS providers to risk-based relationships
- Creating care models supporting TCM innovation
  - Granting waivers, expanding non-physician roles
- Defining and disseminating TCM best practices
  - Associated requirements and participants' voluntary activities
- Flexibilities and lessons learned (e.g., coverage of additional benefits and Special Needs Plan care transition protocols under Medicare Advantage)

# PTAC Care Transitions Public Meeting Focus Areas

- Improving care transitions under FFS
  - Is it possible to tie outcomes related to care transition management under Medicare FFS?
- Exploring why providers in value-based care organizations perform better care transition services
- Improving care transitions under value-based care models
  - Leveraging performance measurement and financial incentives

Appendix A  
Options for Addressing Selected Payment  
Model Challenges



# Options for Addressing Selected Payment Model Challenges

The following are examples of payment design features that shift risk to providers in the traditional fee-for-service environment.

Payment Design Feature	How Payment Design Feature Supports Care Transition Management Activities in Selected Center for Medicare and Medicaid Innovation (CMMI) Models
Bundled payments	<p><b>Comprehensive Care for Joint Replacement (CJR) Model</b> – hospitals are responsible for quality and spending within 90 days of discharge, emphasizing discharge planning, post-discharge care/recovery, and coordination between hospitals and ambulatory care providers (e.g., physical therapists).</p> <p><b>Bundled Payments for Care Improvement (BPCI) Advanced Model</b> – participants are responsible for ensuring that the entire health care team (from all care settings) communicates and collaborates on quality and TCOC.</p>
Per beneficiary per month (PBPM) payments	<p><b>Next Generation Accountable Care Organization (NGACO) Model</b> – NGACOs used data analytics to identify prospectively aligned beneficiaries at risk of hospitalization and engage them through care management, managing care transitions to prevent readmission.</p>
Capitated payments	<p><b>Global and Professional Direct Contracting (GPDC)/ACO Realizing Equity, Access, and Community Health (REACH) Model</b> – participating and preferred providers can fund non-covered care transition management activities by assuming varying degrees of risk for total care or primary care.</p>

# Options for Addressing Selected Payment Model Challenges, Continued

Innovative payment approaches to support care transition management activities may be allowed through:

- Granting waivers
- Distributing shared savings/losses among care team members
- Expanding non-physician roles
  - Allowing additional providers to bill care transition management activities
  - Permitting additional providers to furnish telehealth services, which can support remote monitoring

Lessons learned from other payment systems (e.g., Medicare Advantage):

- Flexibility to provide benefits not covered under Medicare FFS
- Potential for cost efficiency

# Options for Addressing Selected Payment Model Challenges, Continued

- Some existing models have requirements related to care transition management activities, including:
  - Practicing person-centered care;
  - Designating a single individual or organization to assume full responsibility for facilitating care continuity, communication, and coordination across all health settings;
  - Enhancing primary care, home health, and long-term care services;
  - Designing and providing resources aligned with patient/population needs; and
  - Increased access to educational programs and services targeting prevention, early identification, and treatment of chronic diseases.

# Options for Addressing Selected Payment Model Challenges, Continued

- Participants in APMs may also engage in self-directed care transition activities tailored to their patient populations, such as:
  - Building relationships with other health care organizations;
  - Employing care navigators or embedding staff in post-acute care and rehabilitation facilities;
  - Developing and implementing communication plans;
  - Establishing interdisciplinary teams to provide patient-centered care; and
  - Investing in technological advancements and enhanced data infrastructure, and developing predictive algorithms.
- Examples of flexibilities and lessons learned:
  - Care delivery innovations (for example, Hospital at Home [HaH] programs)
  - Medicare Advantage: Coverage of additional benefits, Special Needs Plan (SNP) care transition protocols

**Appendix B**  
**Examples of Components of Effective Care**  
**Transitions**

# Examples of Components of Effective Care Transitions

- Improve patient experience
  - Provider Accountability – Shared co-management between discharging and admitting providers; patient/caregiver education
  - Care Delivery Innovation – Implementation of effective, evidence-based care models
- Improve provider experience
  - Administrative Burden – Non-physician staff enter some or all documentation in medical record.
  - Communication – Clearly defined roles, responsibilities, and communication plans
  - Capacity – Physicians as coaches providing care team oversight, expanding non-physician staff roles
  - Infrastructure – Standardize and synchronize workflows for prescription refills
- Improve population health
  - Prevention of Disease Escalation – Identification of and tailored interventions for patients with rising or high risk

# Examples of Components of Effective Care Transitions, Continued

- Improve quality
  - Safety – Medication reconciliation, targeted checklists
  - Efficacy – Case management across settings, tailored discharge planning
  - Patient-Centeredness – Advance care planning, discussion of care goals, education, empowerment
  - Timeliness – Availability and access to follow-up care
  - Efficiency – Pre-visit planning and pre-appointment laboratory testing; appropriateness of discharge settings and transition decision-making
  - Equity – Population-specific interventions and measures for racial and ethnic minorities, older adults, individuals who are dually eligible for Medicare and Medicaid, individuals with limited English proficiency (LEP)

# Examples of Components of Effective Care Transitions, Continued

- Improve spending
  - Reduce Avoidable Utilization – Avoidable readmissions and ED visits
  - Payment Model Innovation – Changes in fee-for-service billing (chronic care management, advance care planning codes), financial supports (capitated payments, PBPM payments, episode-based payments)



Appendix C  
Selected Federal Programs Supporting Care  
Transitions

# Selected Federal Programs Supporting Care Transitions

- Money Follows the Person (MFP; *enacted 2006*)
  - Initiative to assist states in their efforts to reduce reliance on institutional care while developing community-based long-term care opportunities
- Community-based Care Transitions Program (CCTP; *effective April 2011*)
  - Created by Section 3026 of the Affordable Care Act
  - Tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries

# Selected Federal Programs Supporting Care Transitions, Continued

- Hospital Readmissions Reduction Program (HRRP; *effective October 2012*)
  - Medicare value-based purchasing program
  - Encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions
  - Section 1886(q) of the Social Security Act sets forth the statutory requirements for HRRP.
- Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP; *effective October 2018*)
  - Awards incentive payments to SNFs to encourage quality of care improvements
  - Established in Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA)
  - Under the SNF VBP Program, SNFs:
    - Are evaluated by their performance on a hospital readmission measure;
    - Are assessed on both improvement and achievement, and scored on the higher of the two;
    - Receive quarterly confidential feedback reports containing information about their performance; and
    - Earn incentive payments based on their performance.

Appendix D  
Care Transition Management Activities in  
Center for Medicare and Medicaid Innovation  
(CMMI) Models

# Key Characteristics of Selected CMMI Models with Care Transition Management Activities

Model	Care Transition Management Activities
Comprehensive Primary Care Plus (CPC+)	Participating practices have access to a robust learning system and feedback to guide future decision-making, improve care coordination, and enhance care management for beneficiaries identified as high-risk.
Accountable Care Organization Realizing Equity, Access, and Community Health (GPDC/ACO REACH)	Participants within the ACO must have a robust plan for meeting the needs of their patients with Medicare FFS in underserved communities and make measurable changes to address health disparities.
Next Generation Accountable Care Organization (NGACO)	Certain benefit enhancements (BEs) available to participants are relevant to care transitions, such as a post-discharge home visit BE or a care management home visit BE.
Primary Care First Model Options (PCF)	Episodic care management services, such as practices following up after ED visits and hospitalizations; improving care transitions and adherence to post-discharge care plans, resulting in fewer readmissions, ED visits, or both; providing transportation cost assistance
Accountable Health Communities Model (AHC)	Coordinated referrals from clinical delivery sites (e.g., physician practices, behavioral health providers, clinics, hospitals) to community services organizations that can help address unmet health-related social needs (HRSNs), including housing, food, violence intervention programs, utilities, or transportation
Bundled Payments for Care Improvement Advanced (BPCI Advanced)	Designates participant as leading engagement and coordination efforts
Comprehensive End-Stage Renal Disease (ESRD) Care (CEC)	Encourages and supports patient-centered care that addresses health needs both in and outside the dialysis clinic; designates ESRD Seamless Care Organizations (ESCOs) as facilitators for care coordination
Comprehensive Care for Joint Replacement (CJR)	Providers develop a tailored recovery plan for each patient, including details such as treatment preferences; the CMMI provides tools for analyzing spending and utilization data and encourages sharing of best practices through a learning and diffusion program; certain Medicare requirements are waived to encourage flexibility.

# Key Characteristics of Selected CMMI Models with Care Transition Management Activities, Continued

Model	Care Transition Management Activities
Enhancing Oncology Model (EOM)	Supports personalized services; considers patients' preferences and goals for treatment, HRSNs, and psychosocial health needs; engages patients regularly and proactively; requires redesign activities, such as 24/7 access to care, patient navigation, care planning, use of evidence-based guidelines, use of electronic Patient Reported Outcomes (ePROs), screening for HRSNs, use of data for quality improvement, and certified electronic health record (EHR) technology
ESRD Treatment Choices (ETC)	Offers patients education to support treatment options
Expanded Home Health Value-Based Purchasing (Expanded HHVBP)	Provides incentives for better quality care with greater efficiency, studies new potential quality and efficiency measures for appropriateness in the home health setting, and enhances the current public reporting process
Frontier Community Health Integration Project Demonstration (Frontier Community)	Enhanced payments for certain services designed to improve access to care for patients and increase the integration and coordination of care among providers within the community; goal to reduce avoidable hospitalizations, admissions, and transfers
Home Health Value-Based Purchasing (HHVBP)	Leverages the successes and lessons learned from previous value-based purchasing programs and demonstrations to shift from volume-based payments to a value-based model designed to promote the delivery of higher-quality care to Medicare beneficiaries
Independence at Home Demonstration (IAH)	Medical practices led by physicians or nurse practitioners will provide primary care home visits tailored to the needs of beneficiaries with multiple chronic conditions and functional limitations; practices adopted formal risk-stratification processes to identify patients at high risk for hospitalization or ED utilization for intervention (additional care management services, such as frequent check-in calls); documenting medication reconciliation.
Integrated Care for Kids (InCK)	A child-centered local service delivery and state payment model that aims to reduce expenditures and improve the quality of care for children under 21 years of age with Medicaid coverage through prevention, early identification, and treatment of behavioral and physical health needs
Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents: Phase 2	Nursing facilities partnered with Enhanced Care and Coordination Provider (ECCP) organizations to provide on-site training for staff on providing preventive services and improving the assessment and management of medical conditions to reduce avoidable hospitalizations. For example, ECCPs provided medication management and end-of-life support.

# Key Characteristics of Selected CMMI Models with Care Transition Management Activities, Continued

Model	Care Transition Management Activities
Maternal Opioid Misuse (MOM)	Supports the delivery of coordinated and integrated physical health care, behavioral health care, and critical wrap-around services
Oncology Care Model (OCM)	Facilitates transitions and coordinate care across settings, including monitoring follow-up
Value in Opioid Use Disorder Treatment	Financial incentives available, including care management fees, to provide tailored services

Appendix E  
Care Transition Management Activities in  
Proposals Submitted to PTAC



# Selected PTAC Proposals that Included Care Transition Management Activities

Nearly all of the proposals that have been submitted to PTAC addressed the potential impact on costs and care coordination, to some degree – including at least 20 proposals that addressed issues related to facilitating transitions and coordinating care across settings in PFPMs.

## Broad or holistic focus

- American Academy of Family Physicians (AAFP)\*
- American Academy of Hospice and Palliative Medicine (AAHPM)\*
- American College of Physicians – National Committee for Quality Assurance (ACP-NCQA)\*
- American Academy of Neurology (AAN)\*\*
- The American College of Surgeons (ACS)\*
- Coalition to Transform Advanced Care (C-TAC)\*
- Dr. Sobel (Sobel)\*\*
- University of Chicago Medicine (UChicago)\*

## Acute events or transitions involving hospitals

- American College of Emergency Physicians (ACEP)\*
- American Society of Clinical Oncology (ASCO)\*
- Avera Health (Avera)\*
- Icahn School of Medicine at Mount Sinai (Mount Sinai)\*
- Personalized Recovery Care (PRC)\*

## Transitions for specialty care populations

- Community Oncology Alliance (COA)\*\*
- Innovative Oncology Business Solutions (IOBS)\*
- Hackensack Meridian Health and Cota, Inc. (HMH/Cota)\*
- Minnesota Birth Center (MBC)\*\*
- New York City Department of Health and Mental Hygiene (NYC DOHMH)\*
- Renal Physicians Association (RPA)\*
- University of New Mexico Health Sciences Center (UNMHSC)\*

\* Sixteen proposals received a PTAC rating of “Meets” or “Meets and Deserves Priority Consideration” for Criterion 7, Integration and Care Coordination.

\*\* Four proposals did not meet Criterion 7, but included components related to facilitating transitions and coordinating care across settings.

# Selected PTAC Proposals – Broad or Holistic Focus

Submitter Name	Clinical Focus	Patient Population	Care Transition Management Focus and Activities
<b>1. AAFP</b>	Primary care	Primary care providers' (PCPs') patient panels	Broad focus; primary care medical homes work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange.
<b>2. AAHPM</b>	Serious illness and palliative care	Patients with serious illness	Broad focus; primary care teams (PCTs) 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.
<b>3. AAN</b>	Neurology	Patients with headaches	Broad focus; the model is based on a strong internal and/or referral network of providers that involves multiple types of physicians, non-physicians, and other eligible professionals.
<b>4.ACP-NCQA</b>	Coordination between specialists and PCPs	Patients with multiple chronic conditions	Hospitals and other facilities; participants facilitate transitions and coordinate care across settings, and align resources with patient and population needs.
<b>5.ACS</b>	Cross-clinical focus	Broad (includes 100+ conditions or procedures)	Broad focus; model increases integration across specialties by grouping general and specialty surgeons who participate in a single episode of care, a selected set of procedural or condition episodes, or cumulative patient-level aggregations of all outcomes.
<b>6. C-TAC</b>	Serious illness and palliative care	Patients with serious illness	Broad focus; participants ensure that evidence-based treatments align with patient preferences and provide symptom management, 24/7 access to clinical support, comprehensive care planning, support for transitional and PAC, reliable handoff processes, and advance care planning.
<b>7. Sobel</b>	Broad/not specified	Broad/not specified	Broad focus; Regional Referral Centers (RRCs) can provide specialist expertise at any setting, reducing unnecessary transitions by leveraging telehealth to consult with specialists.
<b>8. UChicago</b>	Frequently hospitalized patients	Frail/complex patients with hospitalizations	Inpatient and ambulatory care; a single provider is responsible for seeing their patients in both inpatient and outpatient settings, including the patient home or rehabilitation settings.

# Selected PTAC Proposals – Acute Events or Hospitals

Submitter Name	Clinical Focus	Patient Population	Care Transition Management Focus and Activities
<b>1. ACEP</b>	ED services	Patients with qualifying ED visits	Hospitalizations and observations stays; participants facilitate appropriate discharge, inform patients of treatment options, manage unscheduled care episodes, and arrange post-discharge home visits.
<b>2. ASCO</b>	Cancer care	Patients with cancer	Reduce utilization for conditions that could be averted, total ED visits and observation stays; emphasis on monitoring and follow-up
<b>3. Avera</b>	Primary care (skilled nursing facilities [SNFs])	SNF residents	Reduce avoidable ED visits and hospitalizations; the care team is responsible for a wide range of activities associated with care transition management, including monitoring and follow-up, aligning resources with patient and population needs, developing care plans, assessing patient needs and goals, and facilitating transitions.
<b>4. Mount Sinai</b>	Inpatient services in home setting	Eligible patients with acute conditions	Acute care events, reducing complications and readmissions; to provide transition services over a period of 30 days, beginning upon discharge from the acute episode, to complete recovery from the acute episode
<b>5. PRC</b>	Inpatient services in home setting	Eligible patients with acute conditions	Acute care, including multidisciplinary care and management around an acute care event/episode; participants provide hospital-level care to patients at home, mitigating risk to patients that typically occurs upon discharge from acute care facility.

# Selected PTAC Proposals – Specialty Care Populations

Submitter Name	Clinical Focus	Patient Population	Care Transition Management Focus and Activities
<b>1. COA</b>	Oncology/cancer care	Patients with cancer	During episode of care for cancer; participant activities 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.
<b>2. HMM/Cota</b>	Oncology	Patients with cancer	Broad focus; activities include EHR integration to enable sharing of key information across the spectrum of professionals that touch the patient, investment in analytics to standardize and integrate feedback processes on performance on as real-time of a basis as possible, and seamless physician communication to optimize care.
<b>3. IOBS</b>	Cancer care	Patients with cancer	Reduce avoidable ED visits and hospitalizations; participants facilitate transitions and coordinate care settings by delivering evidence-based care and providing early intervention.
<b>4. MBC</b>	Maternity/newborn care	Women during prenatal care, labor and birth, and postpartum care	Maternity care and coordinated effort across prenatal care, labor and birth, and postpartum care; participants facilitate transitions and coordinate care across settings, leveraging use of a birth center, a lower-cost facility.
<b>5. NYC DOHMH</b>	Hepatitis C Virus	Patients with chronic condition (HCV)	Multidisciplinary; participants facilitate transitions and coordinate care across settings through a wide range of care coordinator services.
<b>6. RPA</b>	End-stage renal disease (ESRD)	Patients with chronic condition (incident ESRD)	Coordinated initiation of dialysis directly in the outpatient setting, bypassing the need for hospital admission to begin dialysis therapy; 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.
<b>7. UNMHSC</b>	Cerebral emergent care	Patients with neurological emergencies	Reducing need for patient to travel for a neurological consultation in the case of a neurological emergency; telemedicine consults with neurological specialists provide a diagnosis with which a rural hospital can then continue care and treatment at their own facility.