

Physician-Focused Payment Model Technical Advisory Committee

Questions to Guide Panel Discussion #1 for the March 2023 Theme-Based Meeting:

Improving Management of Care Transitions in Population-Based Models

Topic: Improving Management of Care Transitions from Facilities to the Community

Monday, June 12, 10:40 a.m. – 12:10 p.m. EDT

Panel Discussion Subject Matter Experts (SMEs):

- **Karen S. Johnson, PhD**, Vice President, Practice Advancement, American Academy of Family Physicians (AAFP)
- **Scott A. Berkowitz, MD, MBA**, Chief Population Health Officer, and Vice President, Johns Hopkins Medicine; and Associate Professor of Medicine, Division of Cardiology, Johns Hopkins University School of Medicine
- **Robert A. Zorowitz, MD, MBA**, Regional Vice President, Health Services for the Northeast, Humana

Committee Discussion and Q&A Session

To assist in grounding the Committee's theme-based discussion, this portion of the theme-based discussion will examine the following areas.

- A. Barriers to improving care transition management
- B. Care delivery innovations to improve care transition management
- C. Ideal provider roles in care transition management
- D. Payer approaches for encouraging care transition management improvement

At the beginning of the panel discussion, the facilitator will briefly introduce each panelist, noting that full bios are available on the [ASPE PTAC website](#) (to be posted before the public meeting). The facilitator will give each panelist an opportunity to provide a brief five-minute framing of what they do and what they think about the topic that is being discussed.

The facilitator will then ask the italicized questions below and will invite the panelists to answer the questions. For most questions, the facilitator will begin by inviting SMEs to provide their expertise and perspectives for each topic. Panelists will also have an opportunity to respond to follow-up questions from Committee members.

NOTE: *In the interest of ensuring balance across different perspectives and questions, the facilitator will encourage all panelists to keep each response to a few minutes.*

A. Barriers to improving care transition management

Question 1: *What kinds of care transitions do you think are most important for improving health care quality and outcomes, especially for high-risk patients? What are the greatest barriers to improving how we manage transitions between settings of care?*

- a) What patient-, provider-, and system-level factors influence barriers to improving care transition management?
- b) To what extent do these barriers vary by condition or procedure or circumstance (e.g., unscheduled versus scheduled)? Are certain conditions, procedures, or circumstances associated with more challenging care transitions? Why?
- c) What are specific barriers to improving care transitions in an acute setting (e.g., acute care to community, acute care to post-acute care)? In a post-acute care setting (e.g., post-acute care to community, post-acute care to acute or post-acute care, etc.)? Between ambulatory care settings? From ambulatory care to an acute care setting?
- d) How do geographic factors affect care transitions from the facility to the community? What are the challenges associated with managing care transitions in rural areas?
- e) How do financial incentives inherent in fee-for-service inhibit effective care transition management? How should Alternative Payment Models address these incentives?

B. Care delivery innovations to improve care transition management

Question 2: *What activities are associated with better management of transitions between the facility and community?*

- a) What are effective acute care and post-acute care discharge planning tools and processes that can improve care transition outcomes, such as preventable hospital readmissions?
- b) What are examples of effective care delivery models for improving management of care transitions between different kinds of settings?
- c) Does the effectiveness of care transition management activities vary by condition or procedure?
- d) Does the effectiveness of care transition management activities differ based on the types of care settings involved or the direction of the transition?

C. Ideal provider roles in care transition management

Question 3: *One issue we wanted to get your perspective on is the ideal provider role when it comes to care transitions. When patients are moving between settings, who should be responsible for carrying out care transition management activities?*

- a) What is the role of physicians and other members of the care delivery team in improving management of care transitions between settings (e.g., hospitalists, primary care physicians,

specialists, etc.)? How should accountability for care transition outcomes be shared between physicians and facilities?

- b) What are the necessary criteria for determining the appropriate timeframe for transitioning from care transition management services to ongoing condition management and/or disease monitoring?
- c) How should care transition management activities inform primary care providers' ongoing condition monitoring?
- d) Do the care coordination roles of acute care, primary care providers, and specialists differ in care transitions for patients with health-related social needs? If so, how do they differ?
- e) Which provider, provider team or related organization should be accountable for managing patient care transitions?
- f) To which provider or related organizations should performance measures and outcomes related to care transitions be attributed?

D. Payer approaches for encouraging care transition management improvement

Question 4: *How have you seen payers improve the management of care transitions between settings? We're interested in how this works for patients with a home health plan of care, as well as for patients without one.*

Proposed Response Order: *Zorowitz, Johnson, Berkowitz*

- a) How does the use of Medicare Transitional Care Management (TCM) procedure codes and services align with or differ from other effective models for managing care transitions between settings?
- b) What has been the impact of the use of TCM procedure codes and services? What challenges have providers experienced in using TCM codes to bill for care transition management activities? What opportunities exist for expanding the provision of TCM services?
- c) What kinds of care transitions are most important for managing quality and cost of care?
- d) Are there specific procedures, episodes of care or settings where improvement in care transition management has greater opportunities for reducing avoidable spending?
- e) In your experience, have you witnessed differences in care transition outcomes between providers engaged in fee-for-service compared to providers engaged with an Accountable Care Organization or Medicare Advantage plan?
- f) What are some care management activities that payers can engage in to improve care transition management?

- g)** What kinds of resources can payers provide that would be most effective in supporting providers' care transition management activities?
- h)** What kinds of tools can payers make available for the receiving providers and across providers in the trajectory of a patient's illness or injury to encourage improvements in care transition management (e.g., tools at hospital discharge and across post-acute care (PAC) settings to help with placement decisions, care planning; quality metrics; payment levels)?
- i)** How does reimbursement for care transition management vary across payers, including Medicare fee-for-service (FFS), Medicaid, Medicare Advantage, and commercial plans?

Question 5: *Are there any additional insights you would like to share about improving management of care transitions, especially in population-based total cost of care models?*

Physician-Focused Payment Model Technical Advisory Committee

Questions to Guide Panel Discussion #2 for the June 2023 Theme-Based Meeting:

Improving Management of Care Transitions in Population-Based Models

Topic: Provider Perspectives on Payment Models for Incentivizing Improved Management of Care Transitions

Monday, June 12, 2:50 – 4:20 p.m. EDT

Panel Discussion Subject Matter Experts (SMEs):

- **Charles Crecelius, MD, PhD**, Medical Director for Post-Acute Care, BJC Medical Group
- **David C. Herman, MD**, Chief Executive Officer, Essentia Health
- **Jenny Reed, MSW**, Senior Vice President, Value-based Care, Baylor Scott & White Health
- **Robert M. Wachter, MD**, Professor and Chair, Department of Medicine, University of California, San Francisco (UCSF)

Committee Discussion and Q&A Session

This portion of the Committee's theme-based discussion will explore practicing providers' perspectives on the following areas.

- A. Innovations in care transition management innovations
- B. Payment models for improved care transition management
- C. Infrastructure for care transition management
- D. Addressing disparities in care transition management

At the beginning of the panel discussion, the facilitator will briefly introduce each panelist, noting that full bios are available on the [ASPE PTAC website](#) (to be posted before the public meeting). The facilitator will give each panelist an opportunity to provide a brief five-minute framing of what they do and what they think about the topic that is being discussed.

The facilitator will then ask the italicized questions below and will invite the panelists to answer the questions. For most questions, the facilitator will begin by inviting two SMEs to provide their particular expertise and perspectives for each topic. Other panelists will have an opportunity to provide their perspectives on a given topic, time permitting. Panelists will also have an opportunity to respond to follow-up questions from Committee members.

NOTE: In the interest of ensuring balance across different perspectives and questions, the facilitator will encourage all panelists to keep each response to a few minutes.

A. Challenges and best practices for improving care transition management

Question 1: *What kinds of challenges have you seen or experienced related to managing care transitions within your context? What are some best practices and innovations for improving care transitions across different settings?*

- a) What kinds of challenges related to managing care transitions have the biggest impact on different kinds of providers? What have been some effective approaches for addressing these challenges?
- b) For patients with multiple chronic conditions, what proactive care delivery innovations can be most effective for improving care transition management? What approaches can be most effective for patients with issues related to frailty and functional ability?
- c) What provider activities, such as medication management and reconciliation, discharge planning, communication, shared decision-making, patient education and proactive follow-up, are most associated with improved care transition management between settings?
- d) Does the effectiveness of provider activities vary by the types of care settings involved, the direction of the transition, or the size of the provider, etc.?
- e) What approaches can be used to assist providers who do not have experience with value-based care arrangements in improving management of care transitions between settings?
- f) What are the ideal care coordination roles for acute care, primary care providers, and specialists relating to care transition management? How can Alternative Payment Models encourage the adoption of these roles?

B. Payment models for improved care transition management

Question 2: *What financial incentives do you think would help providers adopt some of these care delivery innovations meant to improve care transition management?*

- a) What incentives are most applicable for addressing specific barriers related to improving care transition management between settings?
- b) How do existing financial incentives inherent in fee-for-service payment models prevent providers from engaging in care transition management best practices? How can Alternative Payment Models and associated financial incentives help address these barriers?
- c) Are there financial incentives that can be implemented within fee-for-service payment models to improve care transition management? What opportunities exist for increasing billing for the provision of Medicare FFS transitional care management (TCM) services?
- d) What incentives have the greatest potential to improve care transition management for certain specialties or conditions and procedures? Does effectiveness of certain types of incentives vary

by specialty or condition and procedure, or by other factors (e.g., scheduled vs. unscheduled)? If so, how?

- e) How should incentives be structured to yield the greatest improvements in care transition management? For example, should incentives be tied to specific provider activities, or should providers have flexibility to use program incentives across a range of approved activities?

C. Leveraging health information technology for care transition management

Question 3: *How can providers and other care management entities leverage health IT and data analytics to improve care transitions and communication across different settings?*

- a) What data sources, such as Admission, Discharge, Transfer Notifications (ADTs), claims, encounter data or patient assessment data, are available to providers to use to improve management of care transitions and identify care patterns or trajectories?
- b) What resources or supports do providers need to better access and analyze this data? How can Alternative Payment Models support providers in this effort?
- c) What other resources or health information technology and care management infrastructure do providers need to support activities related to improving care transition management? How do resource needs vary depending on the type of provider (e.g., independent practice, integrated delivery system, safety net, rural, etc.)?

D. Addressing disparities in care transition management

Question 4: *We have heard there can be disparities in who receives care transition management and the quality of that management, for a variety of reasons. Some of those reasons might be provider-related, and some may be access issues on the patient side. How can Alternative Payment Models address some of these disparities?*

- a) For what population characteristics, including race and ethnicity, literacy, primary language, and insurance status, are there disparities in the effectiveness of care transition management? What barriers to appropriate care transition management do these populations face?
- b) What proactive care delivery innovations should providers implement to improve care transition management for patients with health-related social needs (HRSNs)? How can Alternative Payment Models support these innovations?
- c) How do care transition management best practices differ for providers and patients in rural areas?

Question 5: *Are there any additional insights you would like to share about improving care transition management in population-based total cost of care models?*