Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

June 12, 2023
9:30 a.m. – 5:02 p.m. EDT
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attendance

Physician-Focused Payment Model Technical Advisory Committee (PTAC) Members

Lauran Hardin, MSN, FAAN, PTAC Co-Chair (Chief Integration Officer, HC^2 Strategies)
Angelo Sinopoli, MD, PTAC Co-Chair (Chief Network Officer, UpStream)
Lindsay K. Botsford, MD, MBA (Market Medical Director, One Medical)
Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)
Lawrence R. Kosinski, MD, MBA (Founder and Chief Medical Officer, SonarMD, Inc.)
Joshua M. Liao, MD, MSc (Associate Professor, Medicine and Director, Value and Systems Science Lab, University of Washington School of Medicine)
Walter Lin, MD, MBA (Chief Executive Officer, Generation Clinical Partners)
Terry L. Mills Jr., MD, MMM (Senior Vice President and Chief Medical Officer, CommunityCare)
Soujanya Pulluru, MD (Vice President, Clinical Operations, Walmart Health Omnichannel Care, Walmart, Inc.)
James Walton, DO, MBA (President, JWalton, LLC)
Jennifer L. Wiler, MD, MBA (Chief Quality Officer Denver Metro, UCHealth and Professor of Emergency Medicine, University of Colorado School of Medicine)

Department of Health and Human Services (HHS) Guest Speaker

Elizabeth (Liz) Fowler, JD, PhD (Deputy Administrator, Centers for Medicare & Medicaid Services [CMS] and Director, Center for Medicare and Medicaid Innovation [CMMI])*

Office of the Assistant Secretary for Planning and Evaluation (ASPE) Staff

Lisa Shats, PTAC Designated Federal Officer
Steven Sheingold, PhD

Via Webex Webinar

List of Speakers and Handouts

1. **Presentation: Improving Management of Care Transitions in Population-Based Models**
   Walter Lin, MD, MBA, Preliminary Comments Development Team (PCDT) Lead

Handouts

- Public Meeting Agenda
- PCDT Presentation Slides
- PCDT Presentation Reference Slides
- Environmental Scan on Improving Management of Care Transitions in Population-Based Models

2. Panel Discussion 1: Improving Management of Care Transitions from Facilities to the Community

Karen S. Johnson, PhD, Vice President, Practice Advancement, American Academy of Family Physicians (AAFP) (*Advanced Primary Care: A Foundational Alternative Payment Model [APC-APM] for Delivering Patient-Centered, Longitudinal, and Coordinated Care* proposal)*

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*

Handouts

- Panel Discussion 1 Day 1 Panelists' Biographies
- Panel Discussion 1 Day 1 Introduction Slides
- Panel Discussion Day 1 Discussion Guides

3. Listening Session 1: Relationship between Payment Features and Care Transition Innovations

Cheri A. Lattimer, RN, BSN, Executive Director, National Transitions of Care Coalition*

Diane Sanders-Cepeda, DO, CMD, Senior Medical Director, UnitedHealthcare Retiree Solutions*

Diane E. Meier, MD, FACP, Founder, Director Emerita and Strategic Medical Advisor, Center to Advance Palliative Care (CAPC)*

Handouts

- Listening Session 1 Day 1 Presenters' Biographies
- Listening Session 1 Day 1 Presentation Slides
- Listening Session 1 Day 1 Facilitation Questions

4. Panel Discussion 2: Provider Perspectives on Payment Models for Incentivizing Improved Management of Care Transitions

Charles Crecelius, MD, PhD, Medical Director, 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)*

Handouts

- Panel Discussion 2 Day 1 Panelists' Biographies
- Panel Discussion 2 Day 1 Introduction Slides
- Panel Discussion Day 1 Discussion Guides

Via Webex Webinar

[NOTE: A transcript of all statements made by PTAC members and public commenters at this meeting is available on the ASPE PTAC website located at: https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee].

The ASPE PTAC website also includes copies of the presentation slides and other handouts and a video recording of the June 12 PTAC public meeting.

Welcome and Co-Chair Update

Angelo Sinopoli, PTAC Co-Chair, welcomed the Committee and members of the public to the June 12-13 public meeting. He explained that the Committee has been exploring themes that have emerged from proposals that the public has submitted to PTAC and releasing public reports to the Secretary of Health and Human Services (HHS) with its findings on each theme. Co-Chair Sinopoli noted that in March 2023, PTAC released its Report to the Secretary on Optimizing Population-Based Total Cost of Care (PB-TCOC) Models in the Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs). He explained that to support the focus of the Center for Medicare and Medicaid Innovation (CMMI; the Innovation Center) on accountable care, PTAC is exploring key issues related to PB-TCOC models. Co-Chair Sinopoli indicated that the June 2023 public meeting would focus on improving care transition management, specifically in the population-based context.

Co-Chair Sinopoli introduced Elizabeth (Liz) Fowler, Deputy Administrator of the Centers for Medicare & Medicaid Services (CMS) and the Director of CMMI. Dr. Fowler noted that the Innovation Center's specialty integration team has been working on a specialty care strategy to integrate primary and specialty care to better serve individuals with chronic or serious conditions through CMMI models. Dr. Fowler thanked PTAC for providing useful insights about current challenges related to specialty integration, defining high-value specialty care, and appropriate performance measures for assessing specialty integration. She indicated that PTAC's current discussions about improving care transition management within PB-TCOC models will inform CMMI's approaches for improving management of care transitions across settings; determining financial incentives for improving transition management; addressing care transitions in model design; and measuring care transition quality.

Dr. Fowler provided an update on the Innovation Center's new primary care model, the Making Care Primary (MCP) Model. The MCP Model is built on the foundation of previous CMMI primary care models with the goal of making advanced primary care available and more sustainable for smaller independent practices serving a diverse set of patients, to improve quality, health equity, and overall patient care. She highlighted unique features of MCP, including an on-ramp for PCPs and practices that are new to value-based care; a focus on smaller independent practices and safety net organizations; up-front infrastructure payments to eligible providers; partnerships with state Medicaid agencies to achieve multi-payer alignment; a longer model test period to allow time for the model to demonstrate results; integration of primary care and specialty care; and a pathway for participants to adopt prospective population-based payments and gradually assume greater accountability for patient populations.

Dr. Fowler outlined the three model tracks: Track 1, for participants with no value-based care experience, who will begin to develop the foundation to implement advanced primary care services; Track 2 participants will implement advanced primary care and partner with social service providers and specialists to implement care management services and systematically screen for behavioral health needs; and Track 3 participants will use quality improvement frameworks to optimize workflows, improve care integration, develop social services and specialty care partnerships, and build connections with community resources.

She directed interested listeners to a CMMI blog post that outlines the Innovation Center's primary care strategy and the goals to strengthen primary care infrastructure through improved financing for advanced primary care, equitable access to high-quality primary care, and sustainable transformation across practices.

Co-Chair Sinopoli reviewed the meeting agenda, including exploring effective care delivery models and strategies that improve the management of care transitions, and how to structure financial incentives and performance measures to incentivize the adoption of these innovative approaches. He referred audience members to the background materials on these topics. Co-Chair Sinopoli indicated that the discussions, materials, and public comments from the June public meetings will inform a report to the Secretary of HHS on how to improve management of care transitions in population-based models.

Co-Chair Sinopoli reminded stakeholders that PTAC accepts proposals for PFPMs from the public on a rolling basis. He noted that PTAC offers two proposal submission tracks, allowing flexibility depending on the level of detail that is available regarding payment methodology. Co-Chair Sinopoli referred stakeholders to information on how to submit a proposal.

Co-Chair Sinopoli invited Committee members to introduce themselves and their experience with managing care transitions. Following Committee member introductions, Co-Chair Sinopoli shared that five PTAC members served on the Preliminary Comments Development Team (PCDT): Walter Lin (Lead), Lindsay Botsford, Lauran Hardin, James Walton, and Jennifer Wiler. He introduced Dr. Lin, who presented the PCDT's findings from the background materials.

Presentation: Improving Management of Care Transitions in Population-Based Models

Dr. Lin delivered the PCDT presentation. For additional details, please see the presentation slides, the PCDT presentation slides , transcript, and meeting recording (18:18-51:14).

Dr. Lin noted that the purpose of the public meeting was to better understand how financial incentives can be structured to incentivize improvement in care transition management throughout the Medicare program. He explained that PTAC has deliberated on the extent to which 28 proposed PFPMs met the Secretary's 10 regulatory criteria, including the Integration and Care Coordination criterion; many of the 28 proposals raised issues and challenges regarding managing care transitions between settings. Dr. Lin offered working definitions of care transitions and of care transition management. He suggested objectives of care transitions and components of effective care transition management models.

Dr. Lin emphasized the importance of complete and timely health information transfer between care settings, particularly as patients transfer between multiple settings, as transfers increase the likelihood of adverse events or medical errors.

Dr. Lin presented an idealized example of care transitions for a patient following a stroke in which there are no medical errors, health information is transferred effectively, there are no medical complications, and the patient proceeds linearly through progressively lower levels of care. Dr. Lin then presented an illustration of the many care settings to which a stroke patient may be discharged. He emphasized that each transfer requires active care transition management with effective and timely transfer of health information in order to optimize the patient's health outcomes. Dr. Lin explained that patients are often treated in multi-payer settings by multiple providers, which may not be accounted for in existing

attribution approaches; existing approaches focus on the provider furnishing the plurality of care or the provider caring for the patient during an anchor event or procedure.

Dr. Lin highlighted background information on transitional care management (TCM) codes, as well as findings from two recent studies conducted on behalf of PTAC. He provided an overview of Medicare enrollment, explaining that in 2021, over half of Medicare beneficiaries were enrolled in traditional Medicare fee-for-service (FFS), as opposed to Medicare Advantage (MA). Of those in traditional Medicare, 57 percent were not part of a value-based arrangement.

Dr. Lin cited evidence that care transition interventions are associated with substantial cost savings without any evidence of reductions in access or quality. He explained that in 2013, Medicare introduced two TCM codes to reimburse providers for assisting patients when the patients moved from inpatient to the community. Dr. Lin noted that evidence shows that uptake of the codes has been slow, potentially due to the relative cost compared to the financial incentives to provide TCM services, the lack of interoperability between electronic health records (EHRs), or eligibility and coinsurance requirements. Dr. Lin cited a descriptive analysis conducted on behalf of PTAC that found fewer than one in five potentially eligible Medicare beneficiaries received TCM services in 2019. He noted that the analysis also found that practices affiliated with an ACO were more likely to bill for TCM services and billed for higher proportions of their beneficiaries who were potentially eligible for TCM. He highlighted that this study suggests that TCM services were likely not provided to many FFS beneficiaries who could have benefited from them.

Dr. Lin introduced a new analysis on the impact of Medicare TCM services on hospital readmissions, TCOC, and healthy days at home. He explained that the analysis found that the use of TCM services within 30 days of hospital discharge in 2018 and 2019 was associated with significant improvements in outcomes during the 31-60-day period following discharge for hospital readmissions, TCOC, and healthy days at home.

Dr. Lin highlighted examples of effective care delivery models for transitional care; however, these types of models have not been widely implemented. He shared selected facilitators of TCM related to collaborating within and across organizations, tailoring services to patients and caregivers, and encouraging staff buy-in. He also presented care delivery challenges related to improving transitions between settings.

Dr. Lin described enablers of effective care transitions, based on policy goals and payment policies that serve as the catalyst through which care transition delivery can be transformed, resulting in improved quality and health outcomes.

Dr. Lin shared a slide illustrating examples of payment models supporting care transitions, from lower risk (for example, Medicare TCM services) to higher risk (for example, MA), noting that quality and financial outcomes vary between models and between organizations in the same payment model.

Dr. Lin gave an overview of payment model challenges related to improving TCM, including limited and/or conflicting financial incentives, the assigning of accountability for care transitions, establishing an optimal degree of flexibility, and implementing meaningful performance measures. He provided examples of potential care transition performance measures and technical issues affecting the implementation of meaningful performance measures.

Dr. Lin reviewed options to address certain payment model challenges, including sharing benchmarked financial and performance data in a timely manner, designing payment features that shift risk to providers

in the FFS environment, creating care models that support TCM innovation, and defining and disseminating best practices.

Dr. Lin highlighted areas PTAC would focus on during the public meeting, including improving care transitions under both Medicare FFS and value-based care models, and exploring why providers in value-based care organizations show better care transition services.

Co-Chair Sinopoli invited Committee members to ask questions about the PCDT presentation. Committee members discussed the following topics. For more details on the discussion, see the transcript and meeting recording (51:14-1:00:53).

- Interdisciplinary care teams (ICTs) play a key role in successful care management programs; however, under Medicare FFS, there are not many funding mechanisms for non-physician roles. One of the reasons why ACOs and other value-based care programs perform better care transitions is because of their ability to fund non-physician roles.
- There are many hospital readmissions that occur without any claim-based encounters between discharge and readmission.
- Given the evidence that providers in ACOs and value-based care arrangements are better at transition management, one way to improve care transitions is to encourage more providers to participate in value-based care; however, in the meantime, many Medicare FFS beneficiaries are not receiving the benefit of TCM services.
- Policy makers should consider increasing TCM payments so that providers are motivated to manage care transitions. Value-based care organizations can provide the support providers need to optimize transitions.
- Insufficient health information technology (HIT) and data analytics are a crucial barrier to effective care transitions.
- It may not be necessary to implement complex payment models when the results of the two studies reviewed by Dr. Lin show how providing TCM services can have a substantial positive impact on patient outcomes.

Panel Discussion 1: Improving Management of Care Transitions from Facilities to the Community

SMEs

- 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

Previous Submitter

- Karen S. Johnson, PhD, Vice President, Practice Advancement, American Academy of Family Physicians (AAFP) (*Advanced Primary Care: A Foundational Alternative Payment Model [APC-APM] for Delivering Patient-Centered, Longitudinal, and Coordinated Care* proposal)

Co-Chair Sinopoli moderated the panel discussion with three subject matter experts (SMEs) offering their perspectives on improving care transition management from facilities to the community. For additional details, please see the transcript and meeting recording (1:00:55-2:23:42).

Panelists introduced themselves and provided background on their respective organizations. Full biographies and panelist introduction slides are available.

- Karen Johnson introduced herself as the Vice President of Practice Advancement at the AAFP, where she works on payment, practice, and career-related policies and education. Dr. Johnson shared that successful care transitions require awareness that a care transition is taking place and that there are adequate resources to support patients. She noted that several barriers persist, such as PCPs not receiving timely and actionable information about their patient population. Dr. Johnson explained that payers can play an important role in care transitions, given their visibility into the overall patient journey, but their requirements can either help or hinder practices. Moving toward population-based payments for primary care will provide PCPs with sufficient funding and flexibility to invest in care teams and other resources to better address patient needs. For additional details on Dr. Johnson's background and organization, see the panelist introduction slides (slides 3-9).
- Scott Berkowitz shared his background as a general cardiologist and as Chief Population Health Officer and Vice President of Population Health at Johns Hopkins Medicine, where he helped launch the Office of Population Health with the goal to coordinate and deploy population health activities to enhance value and reduce disparities. He also noted his involvement in standing up an Accountable Care Organization and a CMMI demonstration to develop the Johns Hopkins Community Health Partnership. Dr. Berkowitz explained that increased patient complexity and reduced system capacity complicate care transitions, noting that Hopkins has coordinated across the organization to develop bundled hospital discharge strategies, to employ cross-functional care teams, and to develop a post-acute care collaborative to facilitate discharges to skilled nursing facilities (SNFs). For additional details on Dr. Berkowitz's background and organization, see the panelist introduction slides (slides 11-17).
- Robert Zorowitz explained that, as the Regional Vice President for Human Services for the Northeast Region of Humana, he oversees utilization management and clinical activities for Humana in the region. Dr. Zorowitz shared that, prior to his current position, he served as the American Geriatric Society advisor to the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel and helped to draft the TCM CPT codes. He provided some background on the development of TCM codes, noting that the codes were created based on the evidence of effectiveness from research by Dr. Eric Coleman and Dr. Mary Naylor and were developed as 30-day global codes because they were modeled partially after the 30-day end-stage renal disease (ESRD) and rehospitalization codes. He noted that TCM codes have had a slow uptake but that they offer options for different types of models. For additional details on Dr. Zorowitz's background and organization, see the panelist introduction slides (slides 19-26).

Panelists discussed which providers should be responsible for managing care transitions across the continuum of care.

- PCPs play a central role in the ongoing care of patients and should be engaged early in the transition process and receive as much information as possible. Provider-to-provider communication (rather than automatic alerts, for example) about transitions can help facilitate accountability among the care team.
- Transitional care management is a team effort and should be overseen by a physician or non-physician practitioner (e.g., nurse practitioner or physician assistant); however, a physician's clinical skills would be required to synthesize clinically complex information and develop a coherent and consistent transitional plan.

- Ideally, PCPs lead a care team that includes strong care management team members working at the top of their licenses to coordinate across the continuum of care. As patients move between facilities, there are different needs, constraints, and challenges associated with different settings.

Panelists discussed how to manage billing for transitional care management when patients are seen by multiple providers, including both PCPs and multiple specialists, during hospital admissions.

- TCM can be submitted only by a single provider, but that does not have to be a PCP; TCM services typically involve coordination and contact with multiple specialists. Transitional care requires a wide variety of services, including discharge planning, functional assessments, behavioral health consultations, social determinants of health (SDOH) evaluations, medication reconciliation, and specialist consultations; therefore, the physician working closest with clinical staff to coordinate transitional care needs should be the one to bill using the TCM code. It is difficult to establish the organizational structure, culture, training, and commitment needed to provide transitional care services effectively.
- Strong communication across the care team is critically important. While primary care is well-suited to coordinate care, depending on patient complexity and circumstance, specialists can play an increasingly important role in care management.
- Value-based arrangements will provide new opportunities to incorporate specialists into care teams in future models. By comparison, TCM codes were conceived as part of the CPT physician fee schedule, which is a rather narrow structure.
- Many TCM components are being delivered outside the framework of the TCM code, reflecting the importance of moving away from FFS structures toward population-based payment. Additionally, how transitional care is managed can vary based on geography, practice setting, patient needs, and community resources, further highlighting the importance of the flexibility of population-based payments outside of the FFS-based requirements, documentation, and coding.

Panelists discussed how population-based payments interact with transitions of care, including potential incentives for improved care and perverse incentives.

- In the Maryland All-Payer Model, the state has an increased focus on developing a TCOC framework for both Medicare and Medicaid. The framework has allowed for the growth of Hopkins' Office of Population Health—for example, the Maryland Primary Care Program that is analogous to Comprehensive Primary Care Plus (CPC+)—and for increased investment in care coordination teams. Population-based payments increase flexibility, but it can be challenging when reductions in hospitalizations and utilization result in increased costs. The model's complexity can make it difficult to fully engage clinicians, yet improvements in quality and overall patient health are key goals.

Panelists discussed the impact of community partnerships and shifts in payment to address health-related social needs (HRSNs) and health equity in the delivery of effective care transitions, and what roles and disciplines are emerging as key partners in delivery of effective care transitions.

- PCPs can have the most insight into HRSNs, given their longitudinal and trusted relationships with patients, and they need safe and secure ways to share information with other physicians and members of the care team at different points in the care journey. At the same time, physicians should not be held accountable to address social needs without adequate community resources. It is essential to develop community-based organizations and networks to address HRSNs.
- Many MA payers are seeking to make connections with organizations that address SDOH. Value-based arrangements offer additional flexibility to provide resources to address SDOH. Efforts can

begin during hospital discharge planning with screening and referrals for SDOH needs, with communication in the discharge materials that is comprehensive.

- HRSNs need to be considered holistically as part of a patient's broader set of needs, as they can affect a patient's ability to address the clinical aspects of their health, as patients move through care delivery toward other care settings. Some value-based initiatives provide additional funding to support SDOH needs (for example, transportation, food insecurity), but they are not sufficient. Collaboration between health care providers, government, and organizations is needed to address broader needs.
- Shared investment and multi-stakeholder engagement among practices, payers, and community-based organizations are crucial to address patient SDOH needs. Dr. Johnson gave the example of one initiative in which the AAFP is involved, the Partnership to Align Social Care, to expand the capacity of community-based organizations to receive referrals.

Panelists discussed how to improve care transitions from the hospital to home, as well as current funding innovations for care at home.

- Communication is key for discharges from the hospital to the home and needs to begin at the outset of the hospitalization. Multi-stakeholder teams need to closely coordinate to appropriately assess and plan for patients' post-discharge needs. Providers can do this is through a bundle of discharge strategies, including risk screening, assessing activity for post-acute care, embedding flags for high risk and high needs in the EHR, conducting daily interdisciplinary rounds to educate care teams, patient/family/caregiver education, and medication management to manage complexities with medications and ensure that medications are available to patients at discharge. It is also important to understand and provide supports for behavioral health needs and substance use challenges as patients transition out of the hospital.
- The major domains of a safe and timely discharge include mobility, mind, medications, patient priorities (for example, SDOH needs), and managing multiple comorbidities. When discharging patients, it may be necessary to refer them to additional services, such as home health, which can be challenging for independent PCPs to offer. Discharge plans for effective transitional care need to be broader than TCM codes.
- Discharge planning starts when admission begins, and PCPs need to be notified at the point of admission, so that they can begin to interact with care teams and to inform patient care based on their experiences. Transition to home requires access to essential medication and equipment, and adequate staffing by homecare workers and aides.

Panelists discussed how to incentivize collaboration among payers and other stakeholders, to improve care transition outcomes without duplicating efforts.

- Payment models need to clearly define accountability and flexibility for care teams while offering adequate resources for PCPs to provide multiple types of interventions for patient populations. Strong relationships between patients and their PCPs in the community are paramount to providing coordinated patient care. Payers need to support solutions for PCPs, such as proactively advising PCPs when they have engaged with a vendor solution, for example, with a special population or a specific need of members. Such solutions may not address the problem of patient confusion about the roles of different providers in their care, but more explicit discussion of clinical and care team roles under a given payment approach is important.
- Payers will have a vested interest in supporting care transitions that improve care and reduce costs. Value-based payment models, incentives, and metrics should be aligned to support transitional care activities and the development of infrastructure for transitional care at the practice level,

rather than at the payer level, as practices have the most access to important clinical information (e.g., through claims) and infrastructure to support care transition management activities.
- Payer flexibility and adaptability in scaling transitional care activities based on practice capabilities will be an important component. Strong lines of communication between physician practices and payers will help improve implementation and outcomes.
- The move toward value-based payment arrangements provides an opportunity to harmonize covered services among payers and providers, which may present opportunities for partnerships and to help patients better access care.

Panelists discussed the necessary components of payment methodology needed to incentivize small to medium-sized physician groups to develop infrastructure for transitional care services.

- TCM codes were designed to build a capitation structure into the FFS system and incentivize practices to develop the infrastructure to furnish transitional care services. It is difficult for small and medium-sized practices to develop the infrastructure needed to manage population health among a large panel of patients. Options include joining independent practice organizations or associating with managed service organizations, but it is difficult to understand how small independent practices will be able to address population health without larger economies of scale.
- Primary care has been undervalued and underpaid for years, and a course correction for small and independent practices is needed. One option could involve prospective value-based payments for primary care with additional up-front incentives to encourage initial investments in transitional care management infrastructure. Practices should consider what infrastructure to invest in themselves versus when they should join a shared investment model.
- Participation in the Maryland Primary Care Program is very high across primary care practices, including small and independent practices, perhaps because there is financing available through the model. The model has allowed for practices of all sizes to access the investments they need to support practice needs.

Panelists discussed the reasoning behind the slow uptake of TCM codes and how to increase uptake of TCM codes and use of TCM services.

- The explanation is multifactorial. Many physicians are not familiar with CPT codes. Additionally, the fragmented health care system challenges providers' and practices' ability to communicate across practices. Practices need education and skills training on CPT codes and care planning. Hospitals can facilitate discharge planning and incorporate PCPs to develop transitional care plans.
- Physicians are unlikely to drive the adoption of TCM codes because most do not own their own practices and therefore cannot determine how their EHR is structured or how to bill for certain codes. Additional challenges include the fact that care organizations acquiring primary care practices may not be focused on implementing TCM coding and that there is inconsistency in private payer adoption of TCM codes. Practices also struggle to afford the staff required to bill for the code.
- Staffing and workforce challenges emerging from the COVID-19 pandemic complicate the ability to address growing patient complexity, the growing role of SDOH and behavioral health needs, and level of care appropriately. In urban hospitals, there is often insufficient capacity in post-acute facilities, leading to longer patient stays in the hospital. Cross-continuum models of care need to support the workforce pipeline to best address patient needs.

Listening Session 1: Relationship between Payment Features and Care Transition Innovations

- Cheri A. Lattimer, RN, BSN, Executive Director, National Transitions of Care Coalition

- Diane Sanders-Cepeda, DO, CMD, Senior Medical Director, UnitedHealthcare Retiree Solutions
- Diane E. Meier, MD, FACP, Founder, Director Emerita and Strategic Medical Advisor, Center to Advance Palliative Care (CAPC)

Co-Chair Lauran Hardin moderated the listening session with three SMEs on the relationship between payment features and care transition innovations. Full biographies and presentations are available.

Cheri Lattimer presented on strategies and considerations to improve transitions of care for patients and caregivers across the care continuum.

- Many barriers that existed 20 years ago are still present today, including incompatible information systems, delayed information sharing, unusable data formats, and incomplete data.
- She quoted Dr. Eric Coleman's description of transitions of care as a team sport, noting the teams at each level of care and the importance of communication across the teams.
- There are system-level, clinical-level, and patient-level barriers to care transitions.
    - System-level barriers lead to poor communication, including challenges with information sharing.
    - Clinical barriers include a lack of communication between providers at each level of care (for example, when PCPs are not notified about their patient's hospital admission), resulting in delayed transfer of information and duplicated medication orders.
    - Patient-level barriers include poor health literacy.
- The patient and caregiver are at the core and move along a sizable continuum of care, where information is shared across multiple providers and at multiple levels of care. There may be more care transitions across providers as the patient's diagnosis becomes more complex.
- The National Transitions of Care Coalition (NTOCC) has highlighted several essential intervention categories for designing transition strategies. While some strategies have been accomplished, others still need work, particularly those related to medication management and transition planning, with pharmacy involvement related to counseling and education, as well as coordination.
- NTOCC has highlighted three key areas where there are gaps regarding patient assessment: physical health, SDOH and HRSNs, and mental health and substance use disorder (SUD). Assessing one of these components without assessing the others can lead to a gap in transitions of care.
- Ms. Lattimer discussed 12 reimbursement gaps identified by providers, patients, caregivers, and payers, including a delay in notifying providers of patient discharge and transition, as well as administrative and billing challenges associated with using TCM codes (e.g., only one provider can bill using a given code, and that codes don't cover administrative, documentation, and billing costs). She explained that there is improved experience with timely notification in ACOs but significant delays in Medicare and Medicaid FFS.
- Ms. Lattimer discussed several methods to improve transitions of care, including enhancing TCM codes to support more than one provider (for example, adding a secondary provider beyond the hub provider), easing the requirements for billing for TCM and Chronic Condition Management (CCM) services, and developing payment models that support collaborative practice and care coordination across the continuum of care. She also mentioned expansion of providers of care in rural areas from pharmacists (often the first contact for primary care) to registered nurses, especially those with certification in case management, and advanced practice nurses.

For additional details on Ms. Lattimer's presentation, see the presentation slides (pages 2-10), transcript, and meeting recording (0:00-13:52).

Diane Sanders-Cepeda presented on challenges related to infrastructure across the post-acute and long-time care continuum, as well as innovations for care delivery.

- The landscape of the post-acute long-term care continuum focuses on patients as they move out of the hospital and into different post-acute settings, including acute inpatient rehabilitation, long-term acute care hospitals, home health, and SNFs.
- The focus should be on how patients move across the continuum, what services are available to patients, and what challenges patients encounter. In post-acute long-term care, patients often require more services relative to patients in other settings.
- Nursing facilities face challenges related to where they are located, the competitive landscape, and the ways in which the facilities are paid. Nursing facilities receive funding from Medicaid payments for the long-term care component of a patient's care, which varies by state and county. There are pre-authorization delays with MA as well.
- SNFs face multiple barriers that affect care transitions. SNFs lack resources (for example, bed availability) and often experience staffing shortages, which can vary by geographic location. SNFs also face challenges related to leveraging technology to support care, such as not having compatible EHRs or the inability to share data with acute care hospitals. There is variability in how SNFs operate and interact with clinicians.
- There is variability in the use of TCM codes. Compared with providers affiliated with ACOs and value-based care models, independent clinicians do not understand these codes or have time to use them.
- There are several innovations that could improve care transitions to SNFs.
    - Models should incentivize partnerships between providers and SNFs. Incentivizing quality can improve transitions, such as tracking whether there is a coordinated discharge or how frequently patients visit their doctor after discharge.
    - A nurse or social worker can provide care coordination.
    - In-home care and services support should be provided to patients who need support during the transition back to home after a hospital discharge.
    - Social risk intervention should be conducted, such as post-discharge meal delivery. These efforts can help address social needs and prevent hospital readmission.

For additional details on Dr. Sanders-Cepeda's presentation, see the presentation slides (pages 11-19), transcript, and meeting recording (14:04-27:11).

Diane Meier presented on the integration of palliative care across levels of care, as well as considerations to incentivize high-value care.

- The delivery of palliative care to the subset of high-cost, high-need Medicare beneficiaries who have serious illness is based on patient need, defined in terms of a high risk of mortality rather than by prognosis. Palliative care is an added layer of support delivered at the same time as disease-directed treatment.
- Most high-cost, high-need patients are not near the end of life. If policies impose a prognostic criterion on palliative care, patients with persistently high costs, as well as some patients near the end of life, are not provided care that could improve their quality of life.
- Untreated symptom distress (such as pain), increases emergency department (ED) visits and hospitalizations.
- The goal should be early integration of palliative care in treatment planning and managing symptoms, instead of transitioning patients from curative care to palliative care. Most serious illness is chronic, and patients from historically underserved groups that have experienced bias may perceive such a transition as racist exclusion.

- Alternative Payment Models (APMs) incentivize palliative care implicitly but not explicitly. ACOs have used many strategies to manage their high-need, high-cost population. Although many ACOs implement routine identification of seriously ill patients, only a small percentage implement strategies such as hospital- or community-based palliative care. Moving forward, APMs should have explicit requirements for access to, screening for, and utilization of palliative care, as well as quality incentives for access to and screening for palliative care. Additionally, APMs should eliminate prognosis as an eligibility criterion for concurrent hospice.
- Screening for palliative care helps to identify the high-need, high-cost population, in terms of functional impairment, cognitive impairment, symptom distress, caregiver burden, frailty, SDOH, psychiatric comorbidity, and recurrent hospitalization/ED visits. Individuals who screen as appropriate for palliative care should be required to have a palliative care consultation and/or co-management. Quality measures and incentives should reflect the proportion of patients screened and referred to palliative care.
- One barrier to high-quality care transitions and palliative care is the conflation of palliative care with comfort measures and end-of-life care.
- Recommendations to incentivize high-quality care transitions include:
    - Use the new National Quality Forum (NQF)-endorsed Patient Reported Outcome Measures.
    - Establish explicit requirements and payment incentives for screening and referral to palliative care from an ED or hospital stay (similar to the CMS requirement for a palliative care specialist on the team for left ventricular assist devices).
    - Require access to palliative care specialists and screening for needs in all settings.

For additional details on Dr. Meier's presentation, see the presentation slides (pages 20-38), transcript, and meeting recording (27:19-41:09).

Following the presentations, Committee members asked questions of the presenters. For more details on this discussion, see the transcript and meeting recording (41:12-1:26:44).

Presenters discussed recommendations on how to integrate health equity and HRSNs throughout care transitions and across settings.

- The most valuable member of the palliative care team is the social worker, but Medicare FFS does not support social workers. If providers cannot find safe housing, organize transportation for the patient, or arrange payment for medications, the patient will likely end up in the ED because it is the only place that can provide care. Failure to recognize the role of social work in addressing HRSNs is one of the key faults in the traditional Medicare program.
- Certified case managers, including social workers and nurses, understand the need for coordination and resources. These individuals are considered a cost center rather than a revenue center even though in the long run, they improve quality of care and serve as an advocate for the patient and caregiver.
- Providers should focus on meeting patients' needs in their communities. Oftentimes, issues that do not seem medical in nature are still critical to keeping the patient healthy, safe, and in their home. There need to be more licensed social workers in SNFs and for visiting patients at home, to address HRSNs.

Ms. Lattimer discussed the use of primary care management (PCM) codes as a potential solution for integrating the specialist to help coordinate their component of care in the post-hospitalization period.

- Providers often misunderstand when to apply PCM codes. Clarification is needed on how the TCM, CCM, and PCM codes might work together. Although the application of the PCM code could be

expanded when patients have multiple specialists and a PCP, it is unclear which provider is considered the care team leader or hub.
- Providers should use pharmacists to help coordinate polypharmacy as part of medication management, since they provide a range of services and could be better integrated as a provider of care. However, the shortage of providers across primary care and in pharmacy case management must be considered.
- The health care workforce should better reflect the cultural and racial backgrounds of patients and their caregivers.

Presenters discussed how they partner with and integrate with PCPs.
- The Center to Advance Palliative Care health system's EHR has a chat function that can be used to update and communicate with the specialists caring for the patient, the palliative care team, and PCP. This function has revolutionized communication because it does not have to be synchronous. However, electronic health communication breaks down when patients receive care from providers outside the system, presenting a major barrier to improving quality and controlling costs.
- UnitedHealthcare's MA organization provides care to a diverse population and has a diverse group of providers. The infrastructure is set up to proactively connect patients through virtual or in-person visits within seven days of an ED visit. It includes an incentive program that gives a bonus to providers that meet quality metrics, which has worked well; however, barriers exist when patients are not attributed to a PCP, especially when they go to the ED.
- ACOs, integrated delivery networks (IDNs), and MA plans provide better coordination than Medicare FFS. Independent PCPs operating under Medicare FFS struggle with coordination and communication. One way to address this barrier is to incentivize the impact of value when coordination is provided. However, doing so will be more difficult in rural areas.
- As an independent practitioner, it is challenging to obtain information from multiple hospital systems and settings. Providers typically do not know when patients are hospitalized. Medicare FFS should consider how to better deliver this information to providers.

Presenters discussed how to incentivize high-value care for a team comprised of providers, nurse case managers, social workers, and a pharmacist, as well as the types of settings in which such payment could occur. Additionally, presenters discussed workforce challenges in innovative care models.
- The health care system does not incentivize palliative care, resulting in a workforce problem. Some bundled payment models embed palliative care consultation into the model and attribute their success to that embedded palliative care consultant and/or team. The government needs to support these efforts, for example, through an accreditation requirement.
- Cost-benefit ratios and utilization analyses show that active engagement and delivery of palliative care reduce costs. Palliative care has been shown to manage complicated patients, and should begin at diagnosis.
- Policy makers should consider a care delivery model approach that identifies and mandates a basic care team needed for the service. Billing codes can be used to pay for the care team to work together rather than used by one provider on the team billing the code, while other team members provide the service.

Presenters discussed whether the cost of a global model of palliative care model would be covered by savings.
- Most MA plans contract with private, for-profit palliative care vendors that receive a per member per month (PMPM) payment from the MA plans. However, success depends on the type of payment. Traditional Medicare FFS has not incentivized access to palliative care; there is a large

administrative burden, and the payment does not meaningfully match that burden. Policy makers should consider what the standard should be to implement a global model of palliative care and ensure that it is achievable.
- UnitedHealthcare is doing a cost-benefit analysis of a home-based medical care model that provides palliative care evaluation and treatment in the home, and exploring how to make this model work in an FFS setting.
- Palliative care should not be a transition, but it should be integrated into the care coordination model.

Presenters discussed methods to compensate a provider group for care coordination in the absence of a value-based arrangement.

- UnitedHealthcare has a program in which a quality field manager works with practice managers to examine what the practice is doing to provide value, close care gaps, and make recommendations to align with its Medicare star ratings gaps. Providers are paid to participate in this program and the model is being piloted in Georgia using Z codes. It ensures that PCPs understand that the codes provide valuable information about patients' social risk scores, and providers are also incentivized to screen for SDOH. The program allows providers to utilize the program's care coordination services.

Presenters discussed how palliative care should be reimbursed under traditional Medicare FFS.

- Currently, Medicare FFS does not incentivize palliative care except for reimbursing hospitals through the diagnosis-related group (DRG). Palliative care is extremely helpful to hospitals in preventing long hospital stays that block beds and cost money. Most hospitals nationally have a palliative care team because of those financial incentives, not because of an accrediting requirement or mandate that palliative care be available in hospitals. In outpatient settings, it includes Medicare Part B evaluation of management codes (e.g., care coordination, TCM). Many providers are leaving the Medicare FFS system to work for MA plans or MA vendors where they can earn a higher salary.
- The evaluation and management (E&M) code available in Medicare FFS does not address how to incentivize a provider to provide palliative care. Policy makers should apply lessons learned from MA plans and those programs discussed throughout today's meeting.

Presenters discussed barriers associated with patient Part B copays under CCM billing.

- Providers report that copays commonly prevent care at the outset because they are a disincentive, particularly for many seniors with a fixed income. There is not a copay for CCM services under MA plans, ACOs, or IDNs, and as a result, providers are encouraged to use these codes. Medicare FFS should consider ways to bill for services provided by a care team. The administrative burden of using these billing codes deters providers from using them.

Panel Discussion 2: Provider Perspectives on Payment Models for Incentivizing Improved Management of Care Transitions

- Charles Crecelius, MD, PhD, Medical Director, 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)

Co-Chair Sinopoli moderated the panel discussion with four SMEs offering their perspectives as providers on payment models to incentivize improved management of care transitions. For additional details, please see the transcript and meeting recording (0:00-1:31:18).

Panelists introduced themselves and provided background on their respective organizations. Full biographies and panelist introduction slides are available.

- Charles Crecelius shared that he recently retired from being the Post-Acute Medical Director at BJC Medical Group and is returning to clinical academic work. He discussed how communication barriers in care transitions can be a significant issue, due to different EHR systems across provider types. For example, SNFs did not receive the same financial support as hospitals to invest in EHRs and are less adept at communicating with other providers and health systems (e.g., through discharge summaries that may not be translated by other EHR systems). One way to reduce hospitalizations and complications from care transitions is to provide treatment in place, which has been shown to reduce hospitalizations. Advanced planning and developing goals of care have helped reduce intensive care unit (ICU) length of stay and improve patient status. Dr. Crecelius emphasized that care transitions involve coordination, timing, and communication. For additional details on Dr. Crecelius's background and organization, see the panelist introduction slides (slides 29-30).
- David Herman introduced himself at the Chief Executive Officer of Essentia Health, a rural health care provider focused on value-based care and an early adopter of dual side risk models with the Medicare Shared Savings Program (MSSP) and Minnesota Medicaid's Integrated Health Partnerships. Dr. Herman shared that to deliver value-based care in rural areas, Essentia Health became a vertically-integrated health care system, including hospitals, outpatient services and clinics, emergency medical services (EMS), long-term care facilities, and assisted living and independent care facilities. Given transportation and other challenges, he describes how Essentia has aimed to determine what services patients need and leverage the home location in terms of information, rather than move the in-office experience home. He noted that a strong HIT infrastructure has been critical in the transition to value-based care and has enabled a better understanding of the patient population, screening for SDOH and HRSNs, and provision of services. Essential Health focuses on stratifying its patients by their clinical and social needs, rather than by payer, making care more equitable. For additional details on Dr. Herman's background and organization, see the panelist introduction slides (slides 32-45).
- Jenny Reed explained that she leads the Baylor Scott & White Health Quality Alliance, which focuses on providing value-based care services for approximately one million individuals in Texas. Ms. Reed shared that, through participation in the MSSP, Baylor Scott & White has been able to reinvest shared savings in comprehensive care management and longitudinal case management infrastructure that has resulted in significant savings for members, particularly those with chronic conditions. She explained how her organization has invested in data analytics and solutions, such as digital care coaches, to help manage transitions to home and to triage patient concerns. The innovations have reduced post-acute care utilization, length of stay in SNFs, and readmission rates, and ultimately resulted in significant PMPM savings. For additional details on Ms. Reed's background and organization, see the panelist introduction slides (slides 47-48).
- Robert Wachter discussed his role as the chair of the Department of Medicine at the University of California, San Francisco, and provided context on the role of hospitalists in care transitions and the importance of interoperability for digitized information. He highlighted the potential of the Hospital at Home model, in contrast to the dominance of the hospitalist model, noting that regulatory and payment challenges have stagnated its potential growth. He shared that many patients under the care of hospitalists can be discharged to the next level of care, but are not due

to lack of capacity, workforce, or adequate payment for SNFs and long-term care facilities. He highlighted the importance of bundled care models to provide the appropriate incentives to work with post-acute care facilities and the necessity of federal investment to modernize EHR systems across the continuum of care and in particular, for the post-acute environment. For additional details on Dr. Wachter's background and organization, see the panelist introduction slides (slides 50-52).

Panelists discussed payment and regulatory barriers to value-based care and methods to overcome these barriers and expand value-based care.

- Moving to value-based care requires a commitment from organizational leadership and willingness to take on more risk. Because smaller patient panels are more volatile, it can be difficult for smaller practices to take on risk. Investments in the community and population health, as well as improving the regulatory environment to expand the provision of digital care, are necessary next steps.
- New models and regulations need to provide patients with the tools to make an informed choice about which providers will lead them to the best outcomes. Simplifying payment models such as an APM bonus and incentives will encourage more risk-averse providers to participate. Payment models should connect providers across the continuum of care to encourage communication among hospital, outpatient, and ambulatory providers, rather than segmenting only hospital-based providers or isolating PCPs.
- Long-term care nursing home patients should be able to go directly to SNFs and bypass hospitals, which, in conjunction with investments in SNF clinical capabilities, could reduce costs. Interoperable EHRs make information transfers easier, faster, and more accurate, saving time for providers. Incentivizing detailed discharge summaries would be helpful in both FFS and value-based contexts.
- Currently, the shortage of PCPs makes it difficult to build systems relying on a primary care infrastructure. Updated regulations related to telehealth would encourage the provision of effective telemedicine, particularly across state lines.

Panelists considered the feasibility and challenges associated with implementing and paying for the Hospital at Home model.

- Hospital at Home will require significant investments, particularly in the supply chain for at-home medical supplies. It will require a complex set of logistical, financial, and regulatory changes to make it just as simple to send patients home rather than to the hospital. Currently, the demand for Hospital at Home services is not enough for widespread adoption. The question of payment parity should be tested, but hospitals will likely require Hospital at Home to provide either parity or a reasonable margin to justify the investment, perhaps beginning with parity during the initial investment period. Telemedicine is not the correct analogy because the infrastructure, fixed costs, political challenges, and operational and workforce challenges are much more significant for a Hospital at Home program.
- Funding infrastructure investments for Hospital at Home is necessary, but care models also need to be redesigned to be less workforce-dependent, as the workforce is currently unable to keep up with demand.
- Current labor shortages make the politics of technological transformation more feasible, as technology will not be taking jobs from willing workers, but filling jobs that have gone unfulfilled.
- Baylor Scott & White tried implementing a Hospital at Home model but was unsuccessful because it lacked workforce capacity; however, the model does have promise.

- Staffing is an issue across nursing home and home care settings. Future models must address how to make progress, given staffing shortages.
- Home care is easier to provide in urban areas than rural areas due to travel distance. Advancing digital technologies used in home care could lead to increased success in rural contexts.

Panelists discussed the financial incentives needed to manage labor challenges while incentivizing care improvement and the use of new digital tools.

- In order to solve labor shortages, it is important to have all levels of providers practicing to the top of their licensure. There will be a need to look for lower skilled people to do more work, to solve the economic problems that will be faced.
- Model design needs to focus on improving patient health, rather than trying to adapt current models to function with fewer providers. Small communities do not have the scale needed to implement large models, and new models need to be open to working with smaller workforces.
- Government does not move quickly enough to choose winners or losers in technology or to make targeted investments; rather, provider organizations can be trusted to choose technology and make needed investments, with the exception of infrastructure technology such as EHRs. With the adoption of EHRs, health systems will be able to take advantage of new artificial intelligence (AI) tools. Investments to digitize health records should be extended to post-acute care. Digitizing the entire health system would likely require federal investment but can create the conditions for better continuity of care and more seamless transitions.
- It is important to incentivize EHR capabilities without choosing a particular EHR brand. EHR expansion can better connect incentives with provider behavior and clarify the cause-and-effect relationships of payment models. Current models that focus on primary care or hospital episodes are not integrated enough to motivate change; hospitals need to be engaged to incentivize collaboration in transitions of care.

Panelists shared their experiences with education and training methods to encourage longitudinal care management across health systems, as well as how to incorporate cross-sector integration of SDOH and information-sharing without violating the Health Insurance Portability and Accountability Act (HIPAA).

- For Essentia Health, tying provider compensation to quality measures and coordination measures was divisive and led to dissatisfied providers; building infrastructure to encourage care coordination and improve quality was much more successful than financial incentives at encouraging care management. Payment models should be aligned with desired care delivery models but will not drive care transformation alone. Addressing health-related social factors through partnerships with public health nursing, law enforcement, and public safety has been successful in reducing post-acute admissions for behavioral health. Using a trusted third-party intermediary helped integrate SDOH and HRSN data across providers and sectors. Stakeholders should look beyond hospitals when considering how to drive coordination within communities.
- Patient-centered medical home (PCMH) certification created awareness of patient needs within Baylor Scott & White, which were then shared across the provider network to obtain broader buy-in for care teams. Many care team services have now been automated, decreasing the cost of care delivery. Available funding and the assistance of EHRs offered providers the resources they needed to improve.
- Examining providers' individual quality measure outcomes and how they compare to others in the organization can help them improve and achieve better overall results. The feedback can be distributed throughout all levels of the medical office to achieve the most performance improvement.

Panelists discussed potential guardrails to prevent misuse of the three-night SNF rule by FFS providers when moving patients to nursing homes and post-acute skilled nursing stays.

- Policy makers should assess the net impact of the current rules. One option may be to offer patients care where they are without transitioning, recognizing that some unethical providers will not be caught, but that the system will be less expensive. In the future, as EHRs expand, they can be analyzed to understand the appropriate and most cost-effective care settings. Currently, the health care system encourages less effective care in order to receive compensation.
- It is not hard to implement guardrails, such as criteria for admission to the hospital and SNF (for example, fever, blood pressure, symptoms). As long as a physician certifies the criteria, the nursing home can receive the patient, and both the physician and the nursing home can be compensated with an extra payment, while still reducing overall cost.
- It is preferable for patients to receive the care they need in their current location, instead of transferring to a different setting. While the health care system provides a lot of data, gaining more insightful information should be considered.
- The two-week limit to telemedicine in nursing homes is an additional regulatory barrier.

Panelists discussed how to handle intermediate telehealth entities providing longitudinal specialty care for patients virtually.

- There is a potential for companies to innovate within a constrained group of conditions, but the solution could be too fragmented and inefficient. Payment models should push for integration; the decision about whether that integration occurs within a single system or through a set of individual entities will be determined by the market. These changes need to be monitored carefully to ensure that patients are being safely treated as they receive care from multiple providers. New digital tools may help facilitate integration across providers and settings.
- Dis-integrating care can have negative consequences, leaving hospitals with limited funding to care for the most complicated patients. Self-insured employers are leading health care innovation and need to be provided with integrated health care by embracing digital solutions to improve interoperability and communication across providers.
- Larger health care systems need to address asymmetries in gathering funding so that smaller start-ups do not take over the entire market.

Committee Discussion

Co-Chair Hardin opened the floor to Committee members to reflect on the day's presentations and discussions. The Committee members discussed the following topics. For additional details, please see the transcript and meeting recording (1:31:19-1:59:37).

- Policies should focus on care teams and their complexity as the unit of measurement, instead of individual physicians.
- The need for investment in data infrastructure for full interoperability has been a theme across multiple PTAC public meetings.
- The importance of team-based care is not reflected in payment policies, which focus on physician reimbursement. Policy makers should consider allowing non-physicians to bill for certain services and/or reimbursing care teams instead of individual physicians.
- There should be data integration standards for both inpatient and outpatient care.
- Models should incentivize investment in technologies to improve communication across physicians and care settings.
- TCM codes have been shown to improve patient outcomes and may be a helpful tool in the transition to value-based care.

- The term “transition” should replace the term “discharge,” which implies that the discharging physician has completed their responsibilities to the patient.
- Pre- and post-acute transitions and technologies should be integrated to provide continuity of care for patients.
- Payment policies should encourage acute care facilities to engage in transition management and to distinguish the unique challenges of discharge to home from discharge to a facility.
- TCM codes do not currently incentivize co-ownership of patients, which is important in cases where a patient’s primary care manager shifts between their PCP and specialist across settings. Payment models should incentivize successful handoffs and communication between physicians.
- Payment models should explicitly reimburse palliative care services.
- Policies that encourage effective transition management can prevent or reduce waste before and after acute care is delivered.
- Payment models should consider both employed and independent physician groups. Each has different resource needs, incentive structures, and workforce challenges, but both can accelerate innovation.
- Maintaining consumer choice is a strong driver for innovation. Performance metrics should be patient-centric.
- While new technologies can improve health care, they may create new challenges, such as physician burnout.
- More targeted payment mechanisms, such as TCM codes, in addition to population-based models, can help incentivize specific health care functions that global payment models are slow to encourage.
- A preexisting relationship with a PCP is crucial to a patient’s care transition. Without a PCP, there should be some entity that is responsible for quickly finding a substitute; however, it is unlikely that a hospital will be able to facilitate this.
- Care models should make it easy to implement the simple care delivery practices that have proven effective, such as connecting patients with PCPs, decreasing coinsurance and other barriers to care, and adequately funding primary care.
- Panelists and the environmental scan discussed the importance of ICTs, but there was no consensus on how to fund them.
- CMS could consider tying TCM billing codes to outcomes, making them a value-based payment.
- Payers should communicate more with providers about their performance data.
- The focus on health equity and HRSNs is driving the integration of community-based organizations across sectors.
- Individual providers or organizations cannot be expected to achieve desired outcomes without a deliberately built model.
- There is a need for more thoughtful regulatory adjustment.
- Stakeholders should commit to a delivery model.
- Models should incentivize people working together, rather than focus on individual providers.

Closing Remarks

Co-Chair Hardin adjourned the meeting.

The public meeting adjourned at 5:02 p.m. EDT.

Approved and certified by:

//Lisa Shats//
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Lisa Shats, Designated Federal Officer
Physician-Focused Payment Model Technical Advisory Committee

9/1/2023
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