

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

June 6, 2023

This environmental scan was prepared at the request of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) as background information to assist the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in preparing for a theme-based discussion on key issues related to improving the management of care transitions in population-based models. Topics that are addressed in this environmental scan include barriers to effective and appropriate care transition management; opportunities to improve care transition management through care delivery innovation; using financial incentives to improve care transition management; care transition management in the Center for Medicare and Medicaid Innovation (CMMI) Models; care transition management in PTAC proposals; performance measurement of care transition management; and considerations for equity in care transition management.ⁱ The environmental scan is based on information that was publicly available relating to this topic in the literature as of the time that the analysis was completed.

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List of Acronyms

ACA	Affordable Care Act
ACO	Accountable Care Organization
ACO REACH	Accountable Care Organization Realizing Equity, Access, and Community Health
ACP	Advance care plan
ACSC	Ambulatory care-sensitive condition
AHC	Accountable Health Communities
AHRQ	Agency for Healthcare Research and Quality
AIM	Accountable Care Organization Investment Model
APM	Alternative Payment Model
APN	Advanced practice nurse
ASPE	Office of the Assistant Secretary for Planning and Evaluation
BCBSM	Blue Cross Blue Shield Michigan
BE	Benefit enhancement
BOOST	Better Outcomes for Older Adults through Safe Transitions
BPCI	Bundled Payments for Care Improvement
CAH	Critical access hospital
CCTP	Community-based Care Transitions Program
CEHRT	Certified electronic health record technology
CHIP	Children’s Health Insurance Program
CJR	Comprehensive Care for Joint Replacement
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CPC+	Comprehensive Primary Care Plus
CTI	Care transition intervention
ECCP	Enhanced care and coordination provider
ED	Emergency department
EHR	Electronic health record
EOM	Enhanced Oncology Model
ePROs	Electronic Patient Reported Outcomes
ESCO	End-stage Renal Disease Seamless Care Organizations
ESRD	End-stage renal disease
ETC	End-stage Renal Disease Treatment Choices
FFS	Fee-for-service
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GCT	Geriatrician Care Team
GPDC	Global and Professional Direct Contracting
HaH	Hospital at Home
HCBS	Home- and community-based services
HHA	Home Health Agency
HRRP	Hospital Readmissions Reduction Program
HHS	Department of Health and Human Services
HHVBP	Home Health Value-based Purchasing
HIT	Health information technology

HRSN	Health-related social need
IAH	Independence at Home
ICU	Intensive care unit
InCK	Integrated Care for Kids
IRF	Inpatient rehabilitation facility
KCC	Kidney Care Choices
KCE	Kidney Contracting Entity
LEP	Limited English proficiency
LTC	Long-term care
LTCH	Long-term care hospital
LTSS	Long-term services and supports
MACRA	Medicare Access and CHIP Reauthorization Act
MedPAC	Medicare Payment Advisory Committee
MFP	Money Follows the Person
MOM	Maternal Opioid Misuse
MSSP	Medicare Shared Savings Program
NASEM	National Academies of Sciences, Engineering, and Medicine
NF	Nursing facility
NGACO	Next Generation Accountable Care Organization
NTOCC	National Transitions of Care Coalition
OCM	Oncology Care Model
OT	Occupational therapy
PAC	Post-acute care
PBPM	Per Beneficiary Per Month
PCDT	Preliminary Comments Development Team
PCF	Primary Care First
PCP	Primary care provider
PFPM	Physician-focused payment model
PHE	Public Health Emergency
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PRT	Preliminary Review Team
PT	Physical therapy
PTAC	Physician-Focused Payment Model Technical Advisory Committee
PY	Performance Year
SDOH	Social determinants of health
SLP	Speech-language pathology
SNF	Skilled nursing facility
SUD	Substance use disorder
TC	Transitional care
TCM	Transitional Care Management

I. Introduction and Purpose

Under the bipartisan Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act (MACRA) of 2015, Congress significantly changed Medicare fee-for-service (FFS) physician payment methods. The law also specifically encouraged the development of Alternative Payment Models (APMs) known as physician-focused payment models (PFPMs) and created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review stakeholder-submitted PFPM proposals and make comments and recommendations on them to the Secretary of Health and Human Services (HHS; “the Secretary”).

Since its inception, PTAC has received 35 proposals for PFPMs from a diverse set of physician payment stakeholders, including professional associations, health systems, academic groups, public health agencies, and individual providers.ⁱⁱ PTAC evaluates the PFPM proposals based on the extent to which they meet the Secretary’s 10 regulatory criteria for PFPMs (specified in federal regulations at 42 CFR § 414.1465). Several of the 10 criteria for proposed PFPMs that PTAC uses to evaluate stakeholder-submitted proposals are especially pertinent to improving care transition management.

Given the increased emphasis on developing larger, population-based APMs that encourage accountable care relationships, PTAC has conducted several theme-based discussions between 2021 and early 2023 that have examined key care delivery and payment issues related to improving care coordination.

A key theme that has emerged during these theme-based discussions relates to improving management of care transitions in population-based models and, especially, issues and opportunities for structuring financial incentives to encourage improved care transition management in population-based models. Relevant topics identified for investigation include:

- Barriers to effective care transition management in population-based models, particularly relating to transitions between settings of care;
- Opportunities to improve care transition management in population-based models;
- Using financial incentives to improve care transition management;
- Care transition management strategies and incentives in Center for Medicare and Medicaid Innovation (CMMI) Models and PTAC proposals;
- Performance measurement of care transition management in population-based models; and
- Considerations related to improving equity in care transition management in population-based models.

Several previous submitters have addressed care transitions in their proposals, including management of care transitions between settings, in the context of care delivery innovations, payment methodologies, and performance measures that are part of their proposed models. PTAC has assessed the submitters’ ideas for care transition management and has provided comments and recommendations on the strengths and weaknesses of their proposals in the Committee’s Reports to the Secretary.

ⁱⁱ The 35 proposals submitted to PTAC represent an unduplicated count (i.e., proposals with multiple submissions are counted only once) of the number of proposals that have been voted and deliberated on by the Committee (28) and the number of proposals that have been withdrawn by stakeholders (7, including one proposal that was withdrawn prior to any review by the Committee).

The purpose of this environmental scan is to provide PTAC members with background information and context reflecting expert perspectives on issues related to care transitions and opportunities for improving care transition management in PFPMs. The information in this environmental scan is expected to help PTAC members review care transition management components in proposals previously submitted to the Committee. In addition, the environmental scan can inform the Committee's review of future proposals, and future comments and recommendations that Committee members may submit to the Secretary relating to care transition management in population-based models.

This environmental scan summarizes relevant information from PTAC's review of proposals from previous submitters and findings from relevant literature, selected CMMI Models, and other Centers for Medicare & Medicaid Services (CMS) and state models, demonstrations, and programs.

Section II provides key highlights of the findings from the environmental scan. Section III describes the research questions and methods used in the environmental scan. Subsequent sections explore the background on care transitions, contexts, and related activities (Section IV); trends in utilization, spending, and reimbursement related to care transitions (Section V); barriers to effective and appropriate care transition management in population-based models (Section VI); opportunities to improve care transition management in population-based models through care delivery innovation (Section VII); using financial incentives to improve care transition management (Section VIII); care transition management in CMMI Models (Section IX); care transition management in PTAC proposals (Section X); performance measurement of care transition management in population-based models (Section XI); and considerations for equity in care transition management in population-based models (Section XII). Additionally, a list of exhibits and list of abbreviations can be found at the beginning of the environmental scan, following the table of contents.

II. Key Highlights

The following section provides important definitions and highlights key findings from this environmental scan on managing care transitions in population-based models and APMs.

II.A. Definitions

The following are key definitions related to care transitions and care transition management in the context of population-based total cost of care (TCOC) models.

Care coordination:ⁱⁱⁱ As discussed in PTAC's [*Environmental Scan on Care Coordination in the Context of Alternative Payment Models \(APMs\) and Physician-Focused Payment Models \(PFPMs\)*](#), "there is no consensus on the definition of care coordination."¹ The Agency for Healthcare Research and Quality's (AHRQ's) definition provides a starting point: "Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient."²

ⁱⁱⁱ For additional discussion on defining care coordination, refer to Section II in *Environmental Scan on Care Coordination in the Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs)*, available at <https://aspe.hhs.gov/sites/default/files/private/pdf/261946/Jun-2021-CC-Escan.pdf>.

Care transitions: Care transitions may be defined as the movement patients make between health care providers, settings, and levels of care as their condition and care needs change during the course of a chronic or acute illness, or throughout a patient's lifespan.³ Transitions are often necessary to provide the patient, particularly those with chronic conditions, with care from health care professionals practicing different specialties, with different levels of training, and/or in different settings to treat certain aspects of their condition(s). Without adequate management, care transitions may increase the risk of patient safety events, such as medication errors. Patient safety events may be due in part to miscommunication during handoffs, as responsibility shifts to new practitioners or the extent to which a given provider is responsible for overall care management changes.^{4,5} However, many transitions are avoidable through better care planning, sharing information with the patient and their family/caregiver on how to manage their condition and medications, and improved communication among care providers.^{6,7}

Care transition management: Care transition management encompasses "the ongoing support of patients and their families over time as they navigate care and relationships among more than one provider and/or more than one health care setting and/or more than one health care service. The need for transition management is not determined by age, time, place, or health care condition, but rather by patients' and/or families' needs for support for ongoing, longitudinal individualized plans of care and follow-up plans of care within the context of health care delivery."⁸ Depending on the involved care settings and the patient's condition, 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.^{9,10} Health care professionals who may provide care transition management services include, but are not limited to, physicians, clinical nurse specialists, nurse practitioners, physician assistants, and certified nurse midwives.¹¹ Non-clinical professionals, such as social workers and community health workers, can also support care transitions.¹²

II.B. Key Findings

Below are the key findings from the different sections covered in this environmental scan.

Trends in utilization, spending, and reimbursement

Medicare FFS spending for post-acute care (PAC) has remained relatively stable over the past decade; however, trends emerge when broken down by setting.¹³ Numerous researchers and policy analysts have voiced concerns that the current FFS payment structure results in overspending.¹⁴ As a result, CMS has developed bundled payment models and Accountable Care Organization (ACO) models to help improve care coordination and reduce excess or avoidable utilization and spending. Initial evaluations have shown promising results, prompting the recommendation to identify additional conditions and procedures with standard treatment pathways to include in future models.^{15,16} These same conditions and procedures can often benefit from enhanced care transitions. This is particularly important for patients who receive acute and post-acute care, and these care transitions are typically evaluated via patient satisfaction, information sharing, and hospital readmission rates.^{17,18} Research has found that while CMS has recently emphasized improving care transitions, inefficiencies remain and may contribute to excess utilization and spending (e.g., due to avoidable hospital readmissions).^{19,20}

Barriers to effective and appropriate care transition management in population-based models

Barriers to effective and appropriate care transition management exist at the patient, provider, and system level, and may also vary based on the specific care setting, condition, and patient population. General barriers include a lack of electronic health record (EHR) interoperability, ambiguous staff roles during discharge, difficulty retaining care management staff, and insufficient performance measures for assessing care transitions.^{21,22,23} At the patient level, patients are not always aware of care coordination staff and, similar to other areas of health care, there are also patient-level challenges specific to certain sociodemographic groups.^{24,25} Certain conditions—both somatic- and behavioral health-related—introduce their own unique challenges; for example, follow-up for stroke and substance use disorder (SUD) patients is critical for avoiding readmission due to hypertension or relapse, respectively.^{26,27} At the provider level, the type of practice or health system plays an influential role in care management processes; for example, more integrated systems seem to be better positioned to manage care transitions,^{28,29,30,31} whereas teaching hospitals face the challenge of integrating a labor force of residents with high rates of turnover.³² At the system level, there continue to be challenges tied to low uptake of Medicare transitional care management (TCM) and advance care planning (ACP) codes, as well as an FFS-based approach that does not incentivize prospective investment in care management and coordination resources.^{33,34}

Opportunities to improve care transition management in population-based models through care delivery innovation

Several approaches exist to improve care transition management between care settings, which work to minimize incomplete transference of patients' diagnostic information, and/or the occurrence of patients not receiving and/or understanding full follow-up care information.

Providers and health care settings can take the following steps to improve transitions:

- Medication management and reconciliation;
- Transition planning and facilitation;
- Patient and family/caregiver engagement;
- Health care provider engagement and shared accountability across health care settings; and
- Physical health, behavioral health, and social determinants of health (SDOH) triune.³⁵

Research has found that educating patients to promote self-management of their condition is the most common approach to improving transitions' effectiveness. Telehealth allows for earlier detection of clinical deterioration and can also provide patients with increased access to specialty care, both of which reduce the need for transitions.^{36,37}

Impact of Transitional Care Management (TCM) codes in the Medicare Physician Fee Schedule

In 2013, Medicare introduced two codes for transitional care management (TCM) in the Physician Fee Schedule to reimburse providers for assisting patients during the transition from a hospital, skilled nursing facility (SNF), or community mental health hospital stay to a community setting. These new codes: 1) require a provider to communicate with the patient or caregiver within two business days of discharge; 2) make a medical decision of at least moderate or high complexity; and 3) have a face-to-face or telehealth visit within seven days (high complexity) or 14 days (moderate complexity) after discharge. Prior studies have showed low uptake of these codes. In March 2022, an *Analysis of 2019*

Medicare Fee-for-Service Claims for Chronic Care Management (CCM) and Transitional Care Management (TCM) Services was published as a follow-up to PTAC's June 2021 theme-based discussion on care coordination in the context of APMs³⁸. This report described the overall use of TCM and Chronic Care Management (CCM) services in 2019 by patient characteristics, and practice-level use of TCM and CCM codes to provide a baseline assessment of use of these codes prior to the COVID-19 public health emergency (PHE). The report concluded that in 2019, Medicare CCM and TCM services for FFS beneficiaries were likely not used for many beneficiaries who might have benefited from them. Moreover, practices affiliated with a MSSP ACO were more likely to bill for providing TCM services to at least one attributed beneficiary who was potentially eligible for TCM services. Potential barriers contributing to slow uptake of TCM codes could include insufficient payment levels to cover the additional resources needed to deliver TCM services, lack of interoperability of electronic health records across practices and systems, restrictive patient eligibility rules, coinsurance requirements, and documentation requirements that may place excess burden on providers.

In June 2023 an analysis of the *Impact of Transitional Care Management Services on Utilization, Health Outcomes, and Spending Among Medicare Beneficiaries, 2018-2019*³⁹ was published in preparation for PTAC's theme-based discussion on improving the management of care transitions. This report describing the impact of TCM services on utilization, spending, and health outcomes among Medicare FFS beneficiaries in 2018 and 2019. Compared to beneficiaries who did not receive TCM services, beneficiaries who received TCM services had fewer rehospitalizations, lower total Medicare Parts A and B spending, and almost one-third of an additional healthy day at home. Overall, results from the report suggest that TCM services not only have a positive impact on health outcomes but result in lower total cost of care among Medicare FFS beneficiaries.

Using financial incentives to improve care transition management

CMMI Models, as well as previously submitted PTAC proposed PFPs, frequently offer performance-based financial incentives linked to care transition management. More often than not, however, financial incentives related to care transition management are tied to performance measures that may be affected by several other model activities. For example, financial incentives linked to readmission rates or patient satisfaction are likely to be a function of model activities that go beyond those associated with care transition management.^{40,41,42} Nevertheless, financial incentives were commonly associated with activities such as additional funds for investing in technology (e.g., to support enhanced data sharing capabilities, tools to identify high-risk patients, and platforms to offer e-consults) or capitated or per beneficiary per month (PBPM) payments to support care coordination and management activities that may not be linked to a specific procedure.⁴³ Other models that rely on FFS payments offered incentives linked to prior spending benchmarks and in relation to peer performance.^{44,45}

Care transition management in Center for Medicare and Medicaid Innovation (CMMI) Models

Several CMMI Models incorporate mandatory or voluntary care transition management activities. Common model requirements have included practicing person-centered care that aligns with patient and population needs, designating a single individual or organization to assume full responsibility for facilitating care coordination, enhancing primary care (including home health) and long-term care (LTC) facilities, and increasing access to educational services related to prevention, early identification, and treatment of chronic diseases.^{46,47,48,49} Voluntary care transition management activities have included

establishing interdisciplinary care teams and providing proactive treatment/services. Some models also focused on making technological investments to support transition management through better health information technology (HIT) infrastructure.^{50,51,52,53} Evaluations of models that include these strategies to improve care transition management have had mixed results. Models that focus narrowly on specific acute or specialty care needs, as well as those targeting specific patient populations (e.g., terminal illness or lower extremity joint replacements), have tended to be most successful in achieving desired outcomes. However, model evaluations often prioritized evaluation impact on utilization and spending over the relationship between model implementation and patient satisfaction.⁵⁴

Care transition management in PTAC proposals

Nearly all of the 35 proposals that were submitted to PTAC between 2016 and 2020 addressed the proposed model's potential impact on quality, cost, and care coordination, to some degree. Of these, at least 20 previous submitters have addressed issues related to improving care transition management as part of their proposal submissions, in the payment methodology and performance measures for their proposed models. The proposals that have been submitted to PTAC included several activities intended to support care transition management. Some PTAC proposed models sought to provide greater clarity regarding the responsibilities for different providers involved in a patient's care. To address ambiguity about provider roles, some proposals suggested that providers designate a specific member of the care team to function as a care coordinator or manager responsible for leading these activities. Additionally, nearly all (85 percent) of the 20 proposals related to care transitions included enhanced processes for making referrals and scheduling follow-up appointments. Proposals included linking initiation of scheduling follow-up visits to specific triggering events (e.g., contacting patients to schedule a follow-up visit within 48 hours of their being hospitalized). More than half of the relevant proposals sought to encourage use of telemedicine to avoid transitions between settings when an e-consult can achieve the same clinical objective. A number of proposals also identified outcomes, including utilization and quality performance measures, specific to care transition activities.

Performance measurement of care transition management in population-based models

Poor management of care coordination, including care transitions and the effects of those transitions, was estimated to cost the U.S. health care system between \$25 and \$45 billion in 2011.⁵⁵ Several existing process and outcome measures are relevant for use in evaluating care transition management, including the timely transfer of patient data,⁵⁶ the rate of unplanned readmissions within 30 or 60 days of hospital discharge, percentage of patients who have been re-hospitalized after a nursing home admission, and number of emergency department (ED) visits post-discharge.⁵⁷ Moreover, each PAC setting has a Quality Reporting Program (QRP) that establishes public reporting requirements. One measure included in the PAC QRPs is Discharge to Community-Post Acute Care (DTC-PAC), which assesses a patient's success with discharge to the community from a PAC setting (i.e., SNF, inpatient rehabilitation facility [IRF], or long-term care hospital [LTCH]). In addition, the PAC QRP includes measures on the transfer of health information at discharge (e.g., medication information) from the PAC provider to either the patient's next provider or the patient/caregiver. Inadequate care transitions can lead to higher rates of hospital readmissions, which are costly and may be preventable, as well as increased length of hospitalization, which may put patients at risk of other complications, such as hospital-acquired infections.^{58,59} Existing approaches to attribution may not sufficiently account for the contribution of multiple providers to care transitions.^{60,61}

Considerations for equity in care transition management in population-based models

Some populations face significant barriers to care transition management, such as being discharged to lower-quality skilled nursing facilities (SNFs), not receiving a phone number to contact with questions following discharge, or not having the technology or other resources needed to complete follow-up visits.^{62,63,64}

These barriers can lead to poor outcomes, including fewer completed post-discharge follow-up visits and higher risk for hospital readmission. Several successful strategies and models have been developed and implemented to address these barriers. For example, assisting patients with housing support during their transition from LTC facilities to home can help patients stay in the community, while the use of automated rideshare-based software that does not require patients to have a smartphone can help patients complete their in-person follow-up visits despite barriers with transportation.^{65,66}

III. Research Approach

This section provides a brief review of the research questions and methods that were used in developing this environmental scan.

III.A. Research Questions

Working closely with ASPE staff and with input from a subset of Committee members known as a Preliminary Comments Development Team (PCDT)^{iv}, the following research questions were developed to inform this environmental scan:

- How are care transitions defined?
 - What are the major types of care transitions?
 - What activities are involved in care transition management?
- How can patients and caregivers be empowered to support care transitions?
 - At what stages during care transitions is patient and caregiver involvement most critical?
- What are the greatest barriers to improving care transition management between settings of care (e.g., emergency departments [EDs], acute care hospitals, post-acute care [PAC] facilities, home health care, ambulatory care)?
 - To what extent do barriers to improving care transition management vary by condition/procedure?
- For which kinds of care transitions between settings (e.g., between hospital and PAC) are there opportunities to reduce avoidable spending?
 - For what conditions with standard treatment pathways or episodes of care is there substantial variation in acute care and post-acute care spending?
 - How common are care transitions in the Medicare beneficiary population? How often are care transitions avoidable?
 - How does reimbursement for care transition management vary across payers, including FFS Medicare, Medicaid, Medicare Advantage (MA), and commercial plans?

^{iv} A Preliminary Comments Development Team (PCDT) comprised of five PTAC members: Lindsay Botsford, MD, MBA, CMQ, FAAFP; Luran Hardin, MSN, RN-BC, CNL, FNAP; Walter Lin, MD, MBA; James Walton, DO, MBA; and Jennifer Wiler, MD, MBA, also provided feedback relating to the research approach used in this environmental scan.

- What proactive care delivery innovations should providers implement to improve care transition management for different types of settings and patient populations?
- What provider/entity activities (e.g., communication, medication management and reconciliation, transition/discharge planning, shared decision-making, patient/family education, proactive follow-up) are associated with improved care transition management between care settings?
- What financial incentives are/should be used to improve care transition management between care settings?
 - What existing APMs use financial incentives to encourage improvements in care transition management? What existing APMs integrate care transition management in their model design?
 - In addition to financial incentives, how else can APMs influence care transition management through their model design (e.g., attribution, benchmarking)?
- How can providers/entities most effectively use HIT and data analytics to improve care transition management (e.g., identifying care patterns or trajectories for certain conditions/procedures)?
- How is quality of care transition management measured?
- How can APMs address disparities related to care transition management?

A summary of research questions by the environmental scan section is provided in Appendix A.

III.B. Research Methods

The environmental scan presents background information from a targeted review of the literature, PTAC documents, and resources related to CMMI and other models. The aim of the targeted internet search was to identify and to synthesize information from existing peer-reviewed publications and gray literature from organizations focused on health care delivery transformation. The following terms were used to conduct this targeted internet search: “care transitions,” “population-based cost of care,” “care management,” “financial incentives,” and “performance measurement.” These terms were used with more specific search terms for each section. The inclusion criteria focused the search on publications from health care agencies and research organizations between 2012 and the present, in the English language, and based in the United States. The detailed search strategy is provided in Appendix B.

The analysis of PTAC proposals included a thorough review of past proposals, PTAC Reports to the Secretary, and content available in other PTAC process documents (e.g., public meeting minutes, Preliminary Review Team [PRT] reports). The analysis of CMMI APMs was based on a review of publicly available resources, including the description of and technical documents related to each selected model on the CMMI website and recent CMMI Model evaluation reports for the model, when an evaluation report was available. Where CMMI Model evaluation reports were not available on the CMMI website, an internet search was conducted to locate other relevant evaluations, including those that may have been initiated by the participants themselves. For CMMI Models that involved a state Medicaid agency, the agency’s website was reviewed to identify any additional information on the model.

IV. Background: Care Transitions, Contexts, and Related Activities

Care transitions can occur between settings (e.g., from a hospital to a skilled nursing facility) and/or levels of care (e.g., from an intensive care unit to a general ward in an acute care hospital); care transitions between settings of care and between levels of care may occur at the same time. Care

transition management involves activities and engagement between the patient and the provider/care team pre-transition, during the transition, and post-transition. This section provides relevant definitions, contexts in which care transitions can occur, characteristics of care transitions that can be targeted for improvement, and common functions and activities related to care transitions.

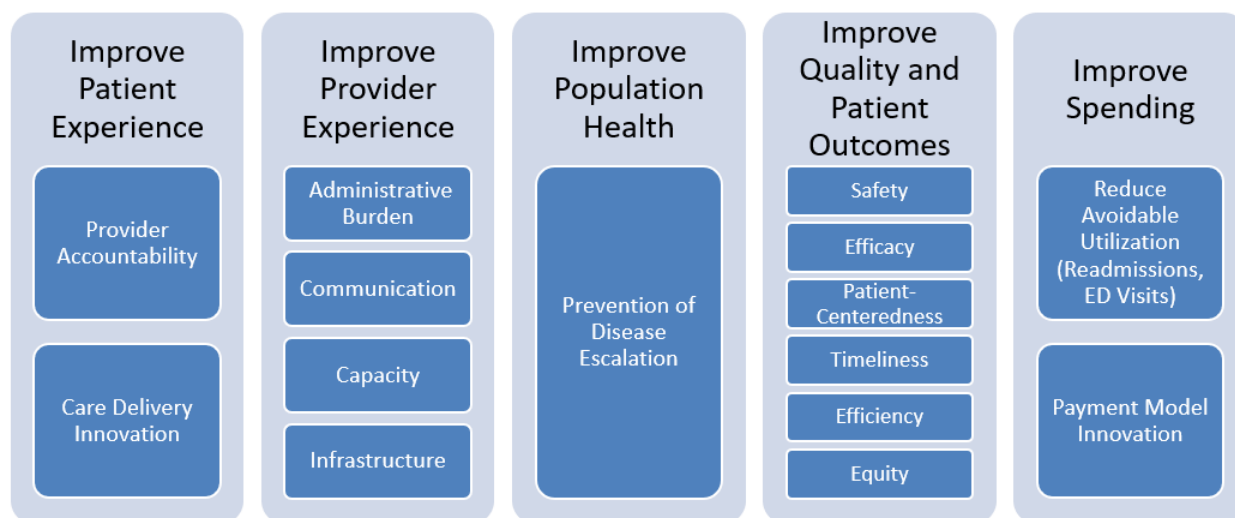
IV.A. Defining Care Transitions

Care transitions may be defined as the “movement patients make between health care providers, settings, and levels of care as their condition and care needs change during the course of a chronic or acute illness, or throughout a patient’s lifespan.”⁶⁷ Transitions are often necessary to provide the patient, particularly those with chronic conditions, with care from health care professionals practicing different specialties, with different levels of training, and/or in different settings to treat certain aspects of their condition(s). Without adequate management, care transitions may increase the risk of patient safety events, such as medication errors. Patient safety events may be due in part to miscommunication during handoffs, as responsibility shifts to new practitioners or the extent to which a given provider is responsible for overall care management changes.^{68,69} However, many transitions are avoidable through better care planning, sharing information with the patient and their family/caregiver on how to manage their condition and medications, and improved communication among care providers.^{70,71}

IV.B. Defining Care Transition Management

Care transition management encompasses “the ongoing support of patients and their families over time as they navigate care and relationships among more than one provider and/or more than one health care setting and/or more than one health care service. The need for transition management is not determined by age, time, place, or health care condition, but rather by patients’ and/or families’ needs for support for ongoing, longitudinal individualized plans of care and follow-up plans of care within the context of health care delivery.”⁷² Depending on the involved care settings and the patient’s condition, 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.^{73,74} Exhibit 1 provides an overview of the objectives of care transitions.

Exhibit 1. Objectives of Effective Care Transitions

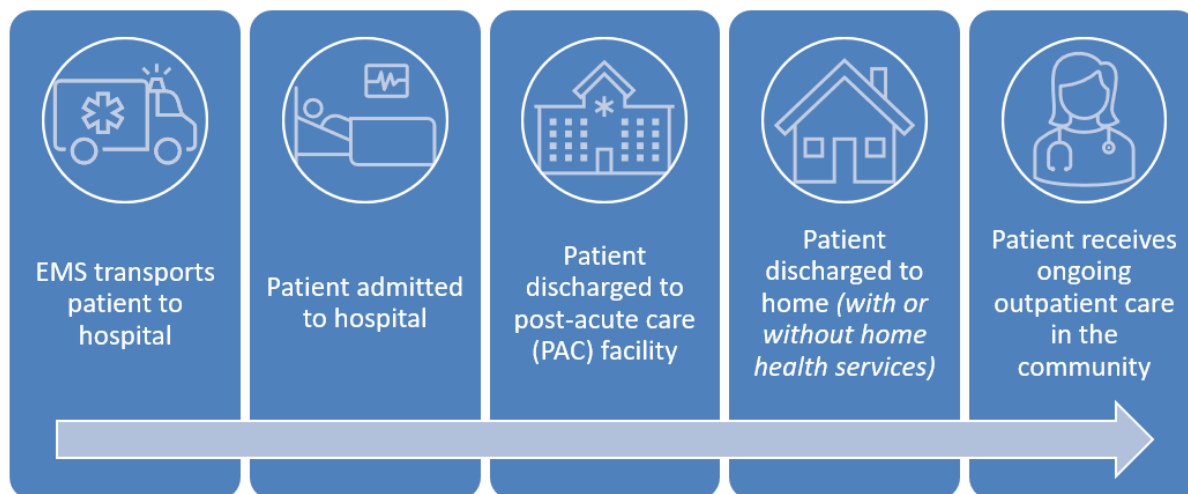


Health care professionals who may provide care transition management services include, but are not limited to, physicians, clinical nurse specialists, nurse practitioners, physician assistants, and certified nurse midwives.⁷⁵ Non-clinical professionals, such as social workers and community health workers, can also play a role in care transitions across settings since these professionals are trained to link patients with home- and community-based resources, reduce fragmentation across health and social services, and address both medical and psychosocial needs of patients.⁷⁶

IV.C. Contexts in Which Care Transitions Can Occur

Care transition activities and the contexts in which they occur vary based on the patient's condition and organizations involved. This environmental scan will focus on care transitions between settings of care.^y Throughout their care journey, patients may transition between different settings of care, including, but not limited to, acute care hospitals, EDs, outpatient hospital clinics, ambulatory surgical centers, PAC settings (e.g., SNFs, LTCHs, IRFs, and home health agencies [HHAs]), outpatient settings (such as physician offices or office-based rehabilitation therapy, including physical therapy [PT], occupational therapy [OT], and speech-language pathology [SLP]), behavioral health settings, and long-term services and supports (LTSS), which may include care provided in residential facilities (e.g., nursing facilities [NFs]) or home- and community-based services (HCBS). Care can also be provided to the patient in their residence (e.g., through telehealth visits or Hospital at Home [HaH] programs).⁷⁷ Exhibit 2 illustrates a potential care trajectory for a patient recovering from a stroke.

Exhibit 2. Potential Care Transitions for a Patient with Stroke^{vi}



^y Patients may also experience transitions between levels of care, such as care transitions between different health care professionals within the same facility (e.g., between an 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.

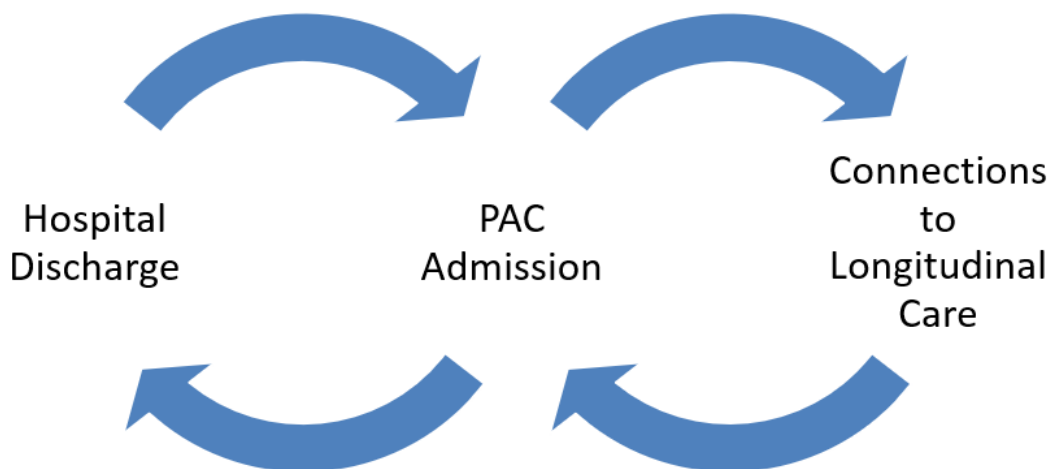
^{vi} Although patients may be readmitted to the same facility, they may not be treated by the same provider. Some patients who are discharged to the community may receive follow-up outpatient services (e.g., physician services; occupational therapy, physical therapy, speech-language pathology; labs/tests).

Care transitions between settings can be particularly vulnerable points in the patient’s health care journey,⁷⁸ as failure to make adequate discharge arrangements can lead to excess utilization (e.g., avoidable hospital readmissions) and spending, and other adverse effects.^{79,80,81}

IV.D. Characteristics of Ineffective Care Transitions that Can Be Targeted for Improvement

Transitions between settings and providers can result in suboptimal care delivery and even patient harm. When patients transition, there is a potential for an incomplete transfer of information about the patient’s care plan. This information gap can lead to duplicative or conflicting services for the patient, such as polypharmacy. There is also a potential that the patient does not receive necessary follow-up care, which could stem from unclear discharge instructions or a lack of patient and family engagement in post-discharge planning. Administrative hurdles, access barriers, or health-related social needs (HRSNs) can also play a role in suboptimal outcomes associated with transitions. The patient and caregivers may not recognize the worsening of symptoms or have timely access to providers, which could result in another transition back to an acute care setting (e.g., a readmission) or revisiting an ED.⁸² These characteristics mark inappropriate care transitions and highlight areas for potential improvement. The potential relationship between discharging and admitting providers with longitudinal care providers is illustrated in Exhibit 3.

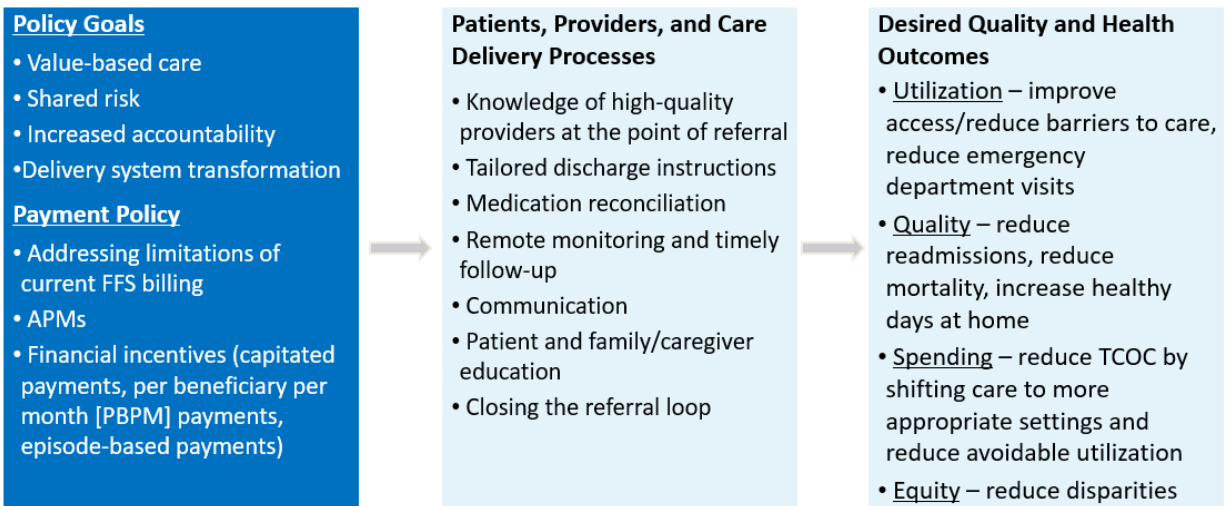
Exhibit 3. Patient Handoffs During Care Transitions



IV.E. Common Functions and Activities Related to Care Transitions

Care transition management can include an array of activities pre-transition, during the transition, and post-transition.⁸³ These activities involve preparing the patient for the transition, providing the patient with ongoing information regarding their condition, and preparing them for their discharge from the hospital, either into their home/community or another care setting.⁸⁴ As an example, the diagram below identifies several high-level activities that may contribute to effective care transition management.

Exhibit 4. Enablers of Effective Care Transitions



The following list summarizes best practices in care transition management activities pre-transition, during the transition, and post-transition.

Pre-transition activities may involve preparing the patient for the care transition and, ultimately, discharge:

- The patient and family/caregivers are educated on the patient’s condition, and the patient is provided with knowledge and skills training to empower them to self-manage their condition.
- The provider informs the patient and family about rehabilitation options, as applicable, and recommends a rehabilitation approach.
- The provider and care team determine the appropriate discharge destination for the patient, taking into account the patient’s preferences and health goals.
- The provider currently managing the patient’s care shares any diagnostic test results and other clinical information with the providers who will be involved in the patient’s care during the transition.
- If the patient will be transitioned to another setting, their insurance status may be used to help determine their eligibility for different care settings or services post-discharge.
- The patient is screened for health-related social needs (HRSNs) that should be addressed post-discharge to improve their recovery.⁸⁵

During transition, activities may be centered around preparing patients for discharge:

- The patient is provided with tailored discharge instructions.
 - Providing patients with comprehensive discharge instructions and ensuring that they fully understand these instructions is imperative to the patient having a successful recovery.⁸⁶ Patients who received full discharge instructions have been found to have significantly lower readmission rates than those who received none.⁸⁷
- The provider managing the patient’s care during the transition discusses the patient’s treatment plan with other providers who will be involved in their care.
- The provider and patient/caregiver discuss their expectations for the recovery process.

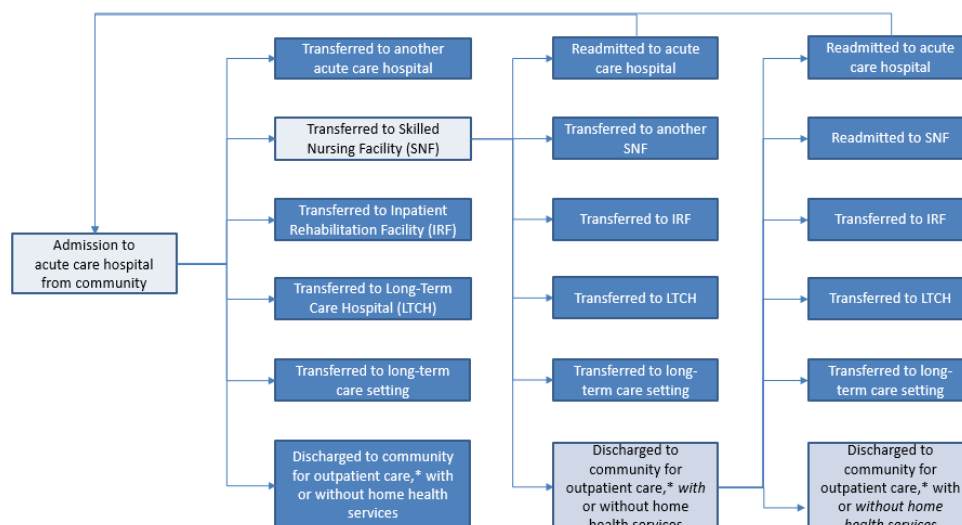
- As needed, transportation arrangements are made for the patient’s discharge.
- If the patient will be discharged to their home or to the community:
 - They are provided with referrals for follow-up care, and outpatient or home visits are arranged; and
 - The provider/care team connects the patient with community resources and social service organizations to address any HRSNs.
- If the patient will be discharged to another care setting, availability of beds/units and required services in the subsequent facility is confirmed for their stay.⁸⁸

Post-transition activities may be focused on facilitating the patient’s recovery:

- In consultation with the patient/caregiver, the provider reviews and manages the patient’s medications, considering the patient’s symptoms and care goals.
- The patient is provided with tailored education on prevention and management approaches for their condition or procedure.
- If the patient has been discharged to another care setting:
 - The patient’s functional ability and goals for rehabilitation are evaluated and reevaluated to determine appropriate services and care needs; and
 - The patient’s care trajectory and options for institutional or community-based long-term services and supports, as applicable, are discussed with them.
- If the patient has been discharged to their home/community (with or without Medicare home health services):
 - They are provided with resources for procuring durable medical equipment, if needed;
 - Their in-home needs are assessed and any necessary modifications are implemented;
 - The patient’s care is monitored remotely, and the provider/care team follows up with the patient on the status of their referrals for outpatient or home visits; and
 - The provider/care team confirms that the patient is receiving support for any HRSNs.⁸⁹

Exhibit 5 illustrates some examples of potential care transitions for a patient recovering from a stroke.

Exhibit 5. Care Setting Transitions Represent Risk of Patient Harm: Potential Care Transitions for a Patient with Stroke



V. Trends in Utilization, Spending, and Reimbursement Related to Care Transitions

Effective care transition management may support improvements in outcomes and reductions in avoidable utilization and spending. However, reimbursement for care transition management and associated activities is limited under the existing FFS system. This section describes relevant trends in Medicare utilization and spending, the potential impact of improved care transition management, and trends in reimbursement related to care transitions by payer type.

V.A. Trends in Medicare Utilization and Spending Related to Care Transitions

Medicare utilization and spending related to care transitions, including acute care and PAC utilization and spending, are described below.

Share of acute care and PAC spending. The proportions of Medicare national health expenditures on acute care and PAC have decreased in each year from 2014 to 2021. As of 2021, acute care and PAC, including facility-based and home health care, comprised roughly 39 percent and 11 percent of Medicare national health expenditures, respectively.⁹⁰ From 2010 to 2020, SNFs accounted for the greatest portion of PAC expenditures, followed by HHAs, IRFs, and LTCHs, accounting for \$29, \$17.2, \$8.5, and \$3.2 billion in 2020, respectively.⁹¹ When broken down by PAC setting, FFS spending on SNFs and IRFs shows small increases, while LTCH and HHA spending decreased during the same period.⁹² Additionally, an estimated \$17 billion, or nearly 20 percent of Medicare payments, are attributed to unplanned rehospitalizations following acute care.⁹³

Variation in acute care and PAC spending. One challenge with Medicare's FFS structure is that patients with similar conditions and acuity can be treated in different PAC settings and accrue different costs, due to Medicare's separate prospective payment systems (PPSs).^{94,95} An Institute of Medicine report suggested that the use of PAC and acute care services are substantial drivers of variation in Medicare spending.⁹⁶ To address the discrepancy in costs between different PAC settings, researchers have previously recommended that Medicare standardize the unit of service, functional assessment (used to establish patient care plans and risk-adjusted payments and to measure quality), and PAC requirements (e.g., determine and adhere to a set of competencies to treat the average patient).⁹⁷ Episode-based and bundled payments, such as the Bundled Payments for Care Improvements (BPCI) initiative and Comprehensive Care for Joint Replacement (CJR) mandatory bundling program, may be most successful for conditions and procedures with standard treatment pathways; when conditions/procedures have more variation in treatment options, episode-based payments may not be as appropriate. Additionally, because clinical judgement is typically required to select the appropriate PAC setting based on the patient's needs, establishing more formalized educational programs on transitional care and PAC options within medical schools or residency programs could help to improve care and decrease readmissions.⁹⁸

A study conducted by the University of Michigan compared utilization and cost of PAC in individuals in their 60s covered by traditional Medicare or a Blue Cross Blue Shield Michigan (BCBSM) preferred provider organization (PPO) for several conditions, including heart attack, heart failure, cardiac bypass surgery, stroke, hip replacement, and colon surgery. In this study, researchers found that, except for stroke, all other conditions regardless of PAC setting resulted in higher costs to Medicare than to BCBSM.^{99,100} Specifically, Medicare PAC spending for patients who had hip replacement surgery and

cardiac bypass surgery was 230 percent and 68 percent greater, respectively, than that of BCBSM.¹⁰¹ Despite the differences in spending, the percentage of patients seeking PAC services and readmission rates were similar between Medicare beneficiaries and BCBSM members.¹⁰² Researchers noted that these findings suggest a potential opportunity to standardize care and consolidate payments to cut Medicare costs.¹⁰³

Quantifying care transitions between settings. The effectiveness of care transitions, or lack thereof, is often evaluated by the number of poor clinical outcomes, patient safety events, and rates of excess utilization, such as avoidable ED visits or hospital admissions/readmissions.^{104,105}

Improvements in PAC related to care transitions have been observed in recent years. Trends from the July 2022 Medicare Payment Advisory Commission (MedPAC) Report show that the percentage of patients successfully discharged to the community from for-profit and nonprofit SNFs increased from 2015 to 2019, and the percentages of unplanned hospitalizations, readmissions, and outpatient stays that occurred during SNF visits decreased during the same period.¹⁰⁶ Similarly, by 2019, the percentage of patients successfully discharged from HHAs and IRFs to the community rose to 72.2 percent and 65.5 percent, respectively.¹⁰⁷

Qualitative evaluations concerning patient or caregiver satisfaction with recovery processes have also shed light on the quality of transitions. These evaluations suggest that the quality and quantity of information provided to patients and caregivers during care transitions can be improved. Focus groups and interviews have identified the need for additional support, particularly during the transition from acute to post-acute care. In a qualitative evaluation of patients' and caregivers' PAC decisions, researchers found that patients and caregivers were asked about their preferences when choosing a PAC facility, and that providers emphasized patient choice. Patients/caregivers expected guidance on what services PAC facilities could provide but reported not receiving any information and, usually, did not conduct any research themselves. Patients and caregivers had little means of knowing which facilities would best fit their needs and, subsequently, patients were often placed in PAC facilities based on bed availability, proximity to the patient's home, or financial relationships between the referring hospital and PAC providers.¹⁰⁸

The lack of information and support identified in this qualitative evaluation often leaves patients and caregivers frustrated, confused, and overwhelmed. To better support patients and caregivers during transitions from acute care to PAC, the authors suggested that care coordinators should provide lists of PAC facilities and locations, recommendations for PAC facilities based on patient/caregiver preferences, and comprehensive, simplified explanations of what to expect during their PAC stay.¹⁰⁹

CMS revised the discharge planning Condition of Participation to ensure hospitals have effective discharge planning processes in place that take into account patients' goals and treatment preferences and reduce factors that could lead to preventable readmissions. At an early stage of hospitalization, hospitals' discharge planning processes must identify and evaluate patients at higher risk of experiencing adverse health consequences at discharge. In addition, hospitals must also include a list of available HHAs, SNFs, IRFs, or LTCHs in the discharge plan. At the time of discharge, hospitals must transfer patients' medical information, goals of care, and preferences for treatment to the PAC service provider or facility. These requirements apply to discharges to home or HHA services, SNFs, IRFs, or LTCHs.

V.B. Potential Impact of Improved Care Transition Management

Effects of improved care transition management may vary by the settings involved. This section summarizes potential impacts of improving care transition management between acute care and the community and between acute care and PAC.

Acute care to the community. A study analyzing readmission rates for Medicare patients after hospitalizations for acute myocardial infarction, heart failure, and pneumonia found readmission rates were lower in hospitals with palliative care services and in communities with a greater local supply of primary care physicians.¹¹⁰ In addition, compared to inpatient care, HaH care combined with 30-day post-acute transition care can result in lower costs of care.¹¹¹ These findings suggest that hospitals may benefit from improving outpatient provider networks to foster continuity of care after a hospital discharge. The authors suggested that, without alternatives to hospitals, individuals residing in communities with limited access to post-discharge care, such as low-income or rural communities, may have to be readmitted if post-discharge complications arise.

An evaluation by Stanford University found that the “three-day rule,” which requires Medicare coverage of certain SNF costs for patients following a hospital stay of three or more consecutive days, hinders the transition from acute care to the community.^{vii} Researchers noted that the three-day rule was associated with an increase in discharges to SNFs and a decrease in discharges to home. Patients discharged to SNFs had longer hospital stays (three days instead of one or two days), potentially putting patients at risk of adverse events (e.g., hospital-acquired infections). Patients discharged to SNFs also had higher readmission rates than patients of similar acuity discharged to home. Therefore, researchers concluded that the three-rule may contribute to excess utilization and spending (from longer hospital stays, as well as potentially avoidable SNF stays and hospital readmissions) that may have been avoided had patients been discharged to their homes.¹¹²

Acute care to PAC. Additional attention is needed to improve care transitions from hospitals to PAC settings. An evaluation conducted by the Commonwealth Fund identified three strategies to improve care transitions to various PAC settings that have shown promising results. The first strategy involves identifying patients who lack social support or motivation, as they may be more vulnerable to readmission. Clinicians have also found it helpful to monitor patients’ functional status, vital signs, and risks daily, along with regularly predicting length of stay in different care settings. In addition, providing written summaries and conducting “virtual handoffs” via videoconferencing can help introduce patients to their next set of clinicians/care settings, and prepare care teams, patients, and caregivers for the next stage of recovery. Each of these activities was associated with decreases in hospital readmission rates, avoidable medical services, and PAC facility lengths of stay.¹¹³

In addition to the acute care to PAC transition strategies described above, researchers have found that certain activities show promising results in specific PAC settings. A study examining the relationship between PAC after major abdominal and chest surgeries and readmission rates highlighted the importance of care transition management on patient outcomes and hospital costs. The authors found that hospitals’ SNF ownership was associated with lower hospital readmission rates among patients

^{vii} The three-day rule establishes that Medicare patients who stay in the hospital for at least three consecutive days will receive full coverage (with no copays) for SNF care for 20 days, and partial coverage for days 21-100. After 100 days, the patient is responsible for all costs. The three-day rule for Part A SNF benefit eligibility is a statutory requirement.

discharged to SNF, due in part to improved communication about discharge planning for patients discharged to hospital-owned SNFs.¹¹⁴ Although SNF ownership may not be a viable solution, hospitals can learn from the communication benefits that being part of the same health care system affords, and bring these strategies to affiliated or in-network PAC settings.

In a study of home health settings, researchers found that patients discharged from hospitals to HHAs accounted for one out of four hospital readmissions related to infections. Based on these findings, researchers recommended standardizing inpatient care, improving care protocols and trainings, and establishing care team communication about care transitions. These strategies may reduce some complications and avoidable utilization.¹¹⁵ The Home Health Value-Based Purchasing (HHVBP) and Expanded HHVBP Models may help to address these issues on a broader scale. These models were designed to incentivize higher-quality care and care coordination in HHAs and associated health care settings.^{116,117}

V.C. Trends in Payment Mechanisms for Care Transition Management

Available payment mechanisms for care transition management activities vary by payer. This section provides a discussion of relevant payment mechanisms under Medicare, Medicaid, and commercial insurers.

Medicare. In 2013, Medicare introduced two CPT codes (99495 and 99496) for transitional care management (TCM) in the Physician Fee Schedule to reimburse providers for assisting patients during the transition from an approved inpatient setting, such as an inpatient acute care hospital, skilled nursing facility (SNF), or community mental health hospital to a community setting. These new codes require a provider to 1) communicate with the patient or caregiver within two business days of discharge; 2) make a medical decision of at least moderate or high complexity; and 3) have a face-to-face or telehealth visit within seven days (high complexity; CPT 99496) or 14 days (moderate complexity; CPT 99495) following discharge. Relative to other care management interventions (e.g., Augmented Standard Care, Resource Nurse Care), TCM services are associated with lower total cost of care 30 days following discharge.¹¹⁸ A March 2022 report that was published as a follow-up to PTAC's June 2021 theme-based discussion on care coordination in the context of APMs¹¹⁹ described overall use of TCM and Chronic Care Management (CCM) services in 2019 as well as beneficiary-level and practice-level use of the codes to understand the use of these codes prior to the COVID-19 public health emergency (PHE). The report concluded that, in 2019, Medicare TCM services for FFS beneficiaries were likely not used for many beneficiaries who might have benefited from them. The report also highlighted the need for additional evidence on outcomes from the use of TCM services.

The Hospital Readmissions Reduction Program (HRRP; Section 3025) and the Community-Based Care Transitions Program (CCTP; Section 3026) were established under the Affordable Care Act (ACA). The HRRP encourages improvements in care transition management, such as discharge planning, by penalizing hospitals for excess readmissions for congestive heart failure, pneumonia, and acute myocardial infarction occurring after October 1, 2012, and hip/knee arthroplasty and chronic obstructive pulmonary disease (COPD) beginning in 2015.¹²⁰ Hospitals with excess readmissions beyond a risk-adjusted average accrue penalties equal to one percent of their base payments in fiscal year (FY) 2013 and three percent beginning in FY 2014.¹²¹ Beginning in FY 2019, a methodological adjustment was introduced to address health equity concerns: the HRRP program began stratifying hospitals into five peer groups by social risk (i.e., proportion of patients dually enrolled in Medicare and Medicaid) due to

evidence that disproportionate share hospitals (DSHs) and safety net hospitals were unfairly penalized.¹²² The HRRP is still in effect.

The CCTP, which ran from 2012-2017, aimed to reduce avoidable readmissions and address care continuum deficiencies by encouraging community-based organizations to take a larger role in providing care transition services.¹²³ During 2011-2015, up to \$300 million in funding was available. Community-based organizations (CBOs) were paid an all-inclusive rate per eligible beneficiary discharge. Payment rate was based on the cost of both care transition services provided and implementation of hospital-level changes (e.g., adding outpatient clinics, implementing pre-discharge medication reconciliation, simplifying discharge instructions, and arranging physician follow-up appointments prior to discharge).

Another health reform policy that has implications for PAC utilization and spending is the “three-day rule,” described above. Current and past ACO models – including the Medicare Shared Savings Program (MSSP), Pioneer ACO Model, Next Generation ACO (NGACO) Model, and the Global and Professional Direct Contracting (GPDC)/ACO Realizing Equity, Access, and Community Health (REACH) Model – have included waivers to this rule as benefit enhancements. The three-day rule waiver allows ACOs flexibility to drive value-based care, admit patients directly to SNFs if their health status does not warrant a hospital level of care, and decrease costs.¹²⁴ During the COVID-19 Public Health Emergency (PHE), the three-day rule was waived, providing temporary Medicare coverage of SNF services for beneficiaries without a prior three-day hospital stay.¹²⁵

Through CMMI, ACO models and bundled payment initiatives have also been used in part to encourage improvements in care transitions and, as a potential result, reduce excess utilization and spending. Although ACO models are not evaluated on care transitions alone, ACO model evaluations have shown significant reductions in gross Medicare spending for the Pioneer ACO Model, the ACO Investment Model (AIM), and the NGACO Model. Significant reductions in care transition-related utilization were observed for the Pioneer ACO Model (ED visits) and the AIM (ED visits and inpatient readmissions).¹²⁶

Bundled payments encourage care coordination, including care transition management, because providers are accountable for all spending that exceeds pre-determined target prices. Evaluations of BPCI Advanced, a bundled payment program, found that cost savings were attributable to reduced utilization of PAC services and shorter SNF stays, but did not assess whether these findings were related to care transition improvements.¹²⁷

Medicaid. The original Money Follows the Person (MFP) demonstration, conducted from 2007 to 2020 (including extension and expansion under the ACA), aimed to: 1) increase the use of HCBS and decrease use of facility-based services; 2) eliminate barriers to LTSS; 3) improve care transitions from institutions to the home; and 4) set quality assurance procedures to improve care.¹²⁸ Under MFP, grantee states received funding to provide qualified home and community-based LTSS, demonstration services, and supplemental services, rebalancing LTSS from institutional care to HCBS. Through the MFP demonstration, states transitioned over 100,000 people from institutional care to HCBS.^{129,130}

Commercial plans. Some researchers suggest that private insurers have had an advantage in terms of managing PAC spending.¹³¹ SNF utilization and spending patterns for patients with private health care coverage may be different to those for patients with Medicare coverage because:

1. Patients with private health care coverage may have coinsurance or higher copayments than those under FFS Medicare. This may curb excess utilization, but could also reduce appropriate utilization.
2. SNFs covered by commercial plans tend to be higher-quality, since plans determine which providers are in- versus out-of-network and can use their negotiating power to contract with higher-quality facilities. Patients with private health care coverage who receive PAC in SNFs may, on average, have better post-discharge health outcomes than patients with other sources of health care coverage.^{132,133}
3. There are no pre-qualification rules for SNF care based on hospital length of stay, meaning that patients are not exposed to potential adverse events during avoidable acute care stays.¹³⁴

VI. Barriers to Effective and Appropriate Care Transition Management in Population-Based Models

Achieving improvements in appropriate and effective care transition management requires an understanding of the barriers that impede current efforts to improve care transition management. Population-based models and APMs offer the potential for integrated, team-based care in which care team members communicate across the care continuum to deliver patient-centered care.^{135,136}

Coordinating care across an extensive care team, especially as patients move between settings, however, introduces challenges when attempting to manage these transitions.¹³⁷ These barriers to successful care transition management may be specific to a particular care setting, provider type, or patient population.^{138,139} This section summarizes barriers to care transition management between settings/providers and factors that influence these barriers.

VI.A. Barriers between Settings/Providers

Research about care transition management efforts has highlighted three common barriers with respect to the care transition process: ambiguous staff roles, HIT challenges, and lack of funding.

Care transition management challenges may arise due to ambiguous staff roles. Both clinical and non-clinical, administrative staff have cited ambiguity related to staff roles as a barrier to effective care transition management.¹⁴⁰ For example, practitioners have noted that it can be difficult to determine the outpatient primary care doctor where there is more than one physician responsible for providing care post-discharge.¹⁴¹ Even when APMs incorporate care coordination staff as a model feature, including those responsible for facilitating care transitions, studies have observed challenges integrating non-clinical care coordination and management staff into the broader care team.¹⁴² For example, the evaluation of the CCTP Model showed that non-clinical staff struggled to develop relationships with providers, and often lacked access to EHR systems and other data relevant to care management activities.¹⁴³

Other studies have reported HIT challenges, particularly those stemming from the lack of EHR system interoperability.¹⁴⁴ These challenges have presented additional barriers, such as the inability to link chronic disease management programs to primary care data, thus complicating patients' transitions between care settings.¹⁴⁵ Research has also highlighted care transition management barriers resulting from care management software programs that cannot run targeted reports stratified by a specific condition, which are valuable for monitoring and assessing care transition processes.¹⁴⁶ It can be

particularly difficult to overcome these challenges when there is a lack of buy-in from hospital leadership and clinical staff.¹⁴⁷

There are also barriers linked to the allocation of funds for supporting care management activities and associated complications with staff retention. Reimbursement for care management activities is low (relative to many of the other services that practitioners provide), rarely tied to quality, and infrequently measured in evaluations.^{148,149} As a result, staff responsible for care transition management are often overworked (e.g., asked to manage care for many patients), which can contribute to staff burnout and decreased retention.¹⁵⁰ It is then difficult for hospitals and other providers to hire and train new staff if they are not receiving prospective payments to support these activities.¹⁵¹

Setting-specific barriers. Patients are particularly vulnerable as they transition from inpatient to outpatient settings.¹⁵² Transitions between inpatient and outpatient settings introduce coordination-related challenges to effective care transition management that often stem from different clinical priorities and provider cultures between these settings. Lack of coordination may, for example, stem from inconsistent or incomplete medication and treatment plans, the absence of standardized discharge documentation, and/or cultural differences, such as in communication styles (e.g., face-to-face versus electronic).¹⁵³ Communication between inpatient or acute care settings and outpatient or primary care settings is further complicated by the fact that those providing inpatient care often lack a holistic understanding of the settings to which they discharge a patient.^{154,155} Communication across inpatient and outpatient settings is further complicated by the time pressures under which physicians often work, especially acute care and inpatient providers, which may result in providers giving lower priority to communication at discharge.¹⁵⁶

VI.B. Factors That Influence Barriers to Improving Care Transition Management

Barriers to effective care transition management outlined in the above section (VI.A.) may be further influenced by factors at the patient, provider, and system level, as well as for specific conditions. Addressing these factors may help health systems and providers to overcome some of the aforementioned barriers to effective care transition management.

Patient-level factors. Existing research has highlighted factors at the patient level that inhibit effective care transition management, including lack of awareness of care coordination staff and disparities based on sociodemographic characteristics. Population-based models and other APMs often rely on care coordination staff, such as care managers, to help facilitate care transition management. However, existing research suggests that patients are not always aware of care coordination resources, which can make patients less likely to engage with these staff; subsequently, it is more challenging for care coordinators to effectively manage care transitions.¹⁵⁷ A lack of patient awareness of staff focused on care coordination has been linked to lower levels of patient activation—i.e., the degree to which a patient understands and agrees to take part in care decisions and processes.¹⁵⁸

Similar to other areas of health care, challenges associated with care transition management are intensified for certain sociodemographic groups. For example, prior research has noted linguistic barriers and a shortage of bilingual staff available to manage care for non-English speaking patients.¹⁵⁹ Past studies have also observed that certain sociodemographic groups were less likely to report that their primary care provider (PCP) had their medical records and other information about their care, that they received help managing their care, and that their PCP had up-to-date information from specialists

on treatment and care plans. All three of these factors add complications and impede smooth care transitions, which in turn intensifies existing disparities in care delivery and patient outcomes.¹⁶⁰ Community Health Workers (CHWs), for example, could help mitigate these challenges by serving as a liaison between health services and the community. CHWs typically have a strong understanding of the community in which the patient resides, and this understanding can improve the patient's access to services while ensuring cultural competence of service delivery. In the proposed CY 2023 Medicare Physician Fee Schedule Rule, CMS included a Request for Information on Medicare Part B payments for services that include CHWs.^{viii}

Condition-specific barriers. Effective and appropriate care transition management may vary by medical condition and, as a result, so too may the barriers associated with care transition management for these conditions. For example, patients with cognitive impairments, such as dementia or delirium, may have a particularly difficult time navigating the health system and may benefit most from managed care.¹⁶¹ Likewise, care transition management for stroke patients is essential for avoiding complications of risk factors, such as hypertension, that can occur post-discharge.¹⁶² Past studies have identified a range of barriers to post-discharge care for stroke patients, such as suboptimal follow-up and broken communication between inpatient specialists and outpatient primary care providers.¹⁶³ Although these approaches may not be unique to stroke patients, they may be especially relevant to stroke patients due to the constellation of patient factors – including symptoms, complications, and comorbidities – relevant to the stroke care continuum. Despite the need for further research on condition-specific barriers to care transitions, there is a lack of condition-specific care transition measures, which introduces challenges for those evaluating the efficacy of different condition- or procedure-specific care transition management approaches.¹⁶⁴

Provider-level factors. Prior research has indicated that health system integration and hospital type—i.e., whether a hospital is a teaching hospital—can influence barriers to care transition management. The CCTP Model evaluation showed that the sites that were integrated with their hospital partners tended to have greater success with program implementation.¹⁶⁵ Other research has also suggested that integrated systems may be better able to avoid communication breakdowns during discharge, such as through the use of a common EHR system.¹⁶⁶ Although an efficient and effective method for standardizing patient transfer documentation, care transition management that relies on the electronic transfer of information can lead to less face-to-face and direct telephonic communication between members of the care team.¹⁶⁷ Face-to-face interactions and direct telephonic communication are believed to best support relationships between staff, reduce ambiguity surrounding staff roles, and make it easier for staff to ask one another questions during patient handoffs.¹⁶⁸ Integrated health systems can also benefit from access to readily available services, such as on-site behavioral health resources that can support patients during transitions.¹⁶⁹

Although teaching hospitals are often larger and part of an integrated system, they present challenges to care transition management due to resident staffing turnover. Prior research has suggested that residents lack accountability for patient care and longitudinal knowledge of their patients.¹⁷⁰ Additionally, several residents may deliver care to a single patient, but in a piecemeal approach whereby

viii <https://www.govinfo.gov/content/pkg/FR-2022-07-29/pdf/2022-14562.pdf>

one resident admits the patient, a second resident cares for the patient during their hospitalization, and then a third resident is made responsible for discharge.¹⁷¹

System-level factors. The current FFS-based system presents challenges for effective care transition management, such as low uptake of TCM and ACP codes, as well as the tendency for health systems and providers to use retrospective, as opposed to prospective, payment approaches.

In 2013, Medicare introduced TCM billing codes to better support care transition processes.¹⁷² Existing research indicates that the use of TCM codes has increased in the years following their implementation and suggests that the use of these codes is associated with improvements in care transition indicators, such as reductions in readmissions.¹⁷³ On balance, however, the use of TCM codes is limited, which may be due to lower reimbursement levels for these activities, compared to other services that physicians provide, especially relative to the cost associated with implementing and maintaining these services.¹⁷⁴

Similarly, in 2016, Medicare implemented ACP codes to compensate practitioners for time allocated to these services, including planning related to care transitions.¹⁷⁵ However, ACP code uptake has been slow, which research suggests may be due to several factors, including burdensome time requirements, a lack of institutional support and training, unexpected charges for patients, and the exclusion of ACP codes from certain health care systems and facilities, such as Federally Qualified Health Centers (FQHCs), among others.¹⁷⁶

Finally, the current FFS-based system is less conducive for prospective payment approaches and, therefore, makes it more difficult for providers to invest in resources and retain staff essential to care transition management.¹⁷⁷

Considerations for Behavioral Health Care

Care transition is a critical period for patients with behavioral health care needs, such as behavioral health conditions or SUD. Quality of care, cost, safety, and patient experience each pose important considerations in managing care transitions for patients receiving behavioral health services.¹⁷⁸

Increased patient complexity and the presence of comorbidities can negatively affect care transitions for patients with behavioral health needs. Specific factors that can influence the success of transitions in behavioral health care include age, as older adults with behavioral health care needs are at higher risk of hospital readmission, and patient knowledge and attitudes, as stigma around behavioral health care can affect patient support.¹⁷⁹ These factors create a unique set of consequences and considerations for behavioral health patients that make supporting successful care transitions particularly challenging.

In a study of the top 10 conditions contributing to adult hospital readmissions by payer, the AHRQ found that, among Medicaid enrollees, patients originally admitted for treatment of mood disorders and schizophrenia and other psychotic disorders had the highest number of all-cause 30-day readmissions. Other conditions in the top 10 included alcohol and substance use disorders.^{180,181} The high proportion of readmissions for these conditions may be due in part to lack of care transition support for health-related social needs (HRSNs) and other issues that may be associated with poorly managed behavioral health conditions. Existing disparities in care, discussed in **Section XII**, may be exacerbated in patients with behavioral health care needs. For example, patients with behavioral health care needs who are unhoused or incarcerated may require additional support during care transitions.¹⁸² Housing instability and incarceration often create a cycle in which the patient may struggle to maintain contact with health care providers, leading to poor condition management and higher rates of relapse.¹⁸³ Support for

patients with behavioral health care needs who have or may experience housing instability and/or incarceration is critical to the success of care transitions for these patients from inpatient to outpatient settings.

To address the challenges associated with behavioral health care transitions, integrating primary care and behavioral health care through collaborative care models has been identified as a key strategy. Assigning a behaviorally trained care manager to each patient, using a registry to track patient engagement, and having a consulting psychiatric provider work with the primary care-based team are three main integration features that may lead to more successful care transitions.¹⁸⁴ This collaboration helps ensure a patient's safety and provides tools for patients to use outside of hospital care.

Considerations for Rural Patient Populations and Providers

There are specific factors unique to rural settings that are important to consider when assessing the state of care transition management for rural patient populations and providers. For example, non-medical, social factors, such as insufficient transportation infrastructure in rural areas, may leave recently discharged patients without personal vehicles unable to access necessary outpatient services, thus increasing the risk of readmission.¹⁸⁵ Distance can also influence receipt of follow-up care. When patients have to travel longer distances to physician offices or outpatient clinics, they may be more likely to discontinue follow-up care.¹⁸⁶

Workforce availability and willingness to travel can hinder care transitions for patients in rural areas. Lack of available post-discharge care, including institutional and community-based care, may contribute to patients in rural areas not receiving follow-up care and being at higher risk of poor, post-discharge health outcomes.¹⁸⁷ For example, under the CCTP, some beneficiaries discharged to their homes in rural locations struggled to receive follow-up home visits.¹⁸⁸

VII. Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation

This section provides an overview of opportunities to improve care transition management in population-based models through care delivery innovation. Using a framework for successful care transitions, this section describes specific activities that can improve care transition management between care settings and provides examples of several existing models for care transition management. This section also specifically addresses the role of telehealth in care transition management and special considerations for care transitions for people with behavioral health conditions.

VII.A. Provider/Entity Activities that Improve Care Transition Management Between Care Settings

A 2020 AHRQ report¹⁸⁹ focused on care transitions as an aspect of improving health care safety, using a framework from the National Transitions of Care Coalition (NTOCC) as a guide. The NTOCC framework identified seven essential elements:¹⁹⁰

1. **Medication management services and coordination:** Ensuring the safe use of medications by patients and their identified family caregiver with a focus on the patients' plans of care. This can include assessing medications and social determinants of health (SDOH), providing education and counseling about medications, and developing a plan for medication management.

2. **Transition planning:** Creating a plan/process that facilitates the safe transition of patients from one setting or level of care to another, including home, or from one practitioner to another. This includes the clear identification of a practitioner or team to facilitate and coordinate the transition plan, management of patients' transition needs, the use of formal transition planning tools, the completion of a transition summary, and the development of a plan for medical devices and remote monitoring if necessary.
3. **Patient/family engagement and education:** Educating and counseling patients and families to enhance their active participation in their own care, including shared decision-making. Ideally, patients and caregivers are knowledgeable about their condition and care plan. Providers communicate transition information in a patient-centered format and develop patients' self-management skills. Technology and virtual visits can enhance patient and caregiver engagement.
4. **Communicating and transferring information:** Sharing of important care information among patient, family, caregiver, and health care providers in a timely and effective manner. This includes the implementation of clearly defined communication models, use of formal communication tools, and identification of a practitioner to facilitate the timely transfer of essential information.
5. **Follow-up care:** Facilitating the safe transition of patients from one setting/level of care or provider to another through effective follow-up care activities. This includes ensuring patients and caregivers have timely access to key providers and communicating with patients and other health care providers post-transition.
6. **Health care provider engagement and shared accountability across the health care spectrum:** Demonstrating ownership, responsibility, and accountability for the care of the patient and family/caregiver at all times. This includes convening the care team to establish processes that improve transitions and coordination, establishing appropriate communication and networks with all levels of care and community-based resources, and assuming responsibility for the outcomes of the care transition process by providers both sending and receiving the patient.
7. **Physical health, behavioral health, and SDOH triune:** Ensuring complete assessment of physical health; behavioral health, including SUD; and SDOH to avoid missing crucial factors that may significantly affect the others; they are not separate but integrated.

Hospitals and other providers implementing transitional care (TC) quality improvement efforts can adopt these elements and tailor them to their individual context. A 2021 article reviewed hospital-based TC strategies using claims data and machine learning to predict the impact of the TC strategy on 30-day readmissions.¹⁹¹ The study identified five types of strategies similar but not identical to the NTOCC elements that were commonly adopted by hospitals and that showed promise in improving patient outcomes: 1) Patient Communication and Care Management; 2) Hospital-Based Trust, Plain Language, and Coordination; 3) Home-Based Trust, Plain Language, and Coordination; 4) Patient/Family Caregiver Assessment and Information Exchange Among Providers; and 5) Assessment and Teach Back.

The 2020 AHRQ report¹⁹² mentioned above reviewed literature published between 2004 and 2017 for three models focused on care transitions and patient safety: Better Outcomes for Older Adults through Safe Transitions (BOOST), the Care Transitions Intervention (CTI), and the Transitional Care Model. The evidence review found that all three models reduced hospital readmissions and reduced health care costs. A summary of each model is provided below.

- The Society for Hospital Medicine created BOOST in 2008 to improve care for patients transitioning from the hospital to home.¹⁹³ 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. All clinicians involved in the discharge process – including physicians, nurses, social workers, case managers, and others – are encouraged to deploy the toolkit. Once hospitals adopt BOOST, they become part of a collaborative network, and have access to a BOOST data center that allows users to store data and benchmark against control practices.
- CTI, developed in 2002, is another model focused on the transition from hospital to home that seeks to improve outcomes by providing patients with the tools and support to navigate the health care system and manage their health conditions.^{194,195} 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.
- The Transitional Care Model is an older, nurse-led model originally developed in 1981 that also focuses on the transition from hospital to home. 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.^{196,197} 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. In the Transitional Care Model, advanced practice nurses (APNs) meet with patients either in the hospital or soon after discharge. The APN provides home and telephone visits to educate patients, conduct medication reconciliation, monitor symptoms, and coordinate follow-up care.

Variation in Effectiveness by the Direction of the Transition

Published literature has not compared the effectiveness of care transition management interventions across settings and by direction of the transition, such as comparing whether a certain intervention is more or less effective when applied to transitions from a hospital to the community versus the community to a hospital. Existing literature has focused on the effectiveness of interventions when patients are discharged home from the hospital. For example, a 2021 systematic review examined the effectiveness of patient- and family-centered care transition interventions and found that, among the 28 interventions included in the review, educating patients to promote self-management was the most commonly included component and was described in all 28 interventions.¹⁹⁸ Further research could examine the degree to which interventions focused on patient and family engagement are more effective when patients are discharged to or admitted from the community or their usual source of care, and whether interventions focused on transferring information and follow-up care are more effective when the patient transitions to a clinical setting from the community/their usual source of care.

Rise of Telehealth and the Role of Telehealth in a Post-PHE “New Normal”

Telehealth has the potential to facilitate successful care transitions, with novel approaches and innovations emerging as its use becomes more widespread. The COVID-19 PHE ushered in a rapid increase in telehealth utilization, particularly for primary care and behavioral health care providers. While use has decreased from its peak in late 2020 during the pandemic lockdowns, utilization remains above pre-pandemic levels.¹⁹⁹ Use has increased both by patients at home and for patients in institutional settings, such as nursing homes.

Telehealth can enable the detection of clinical deterioration early, allowing patients to be treated in place and avoiding a setting transition. A 2021 integrative review of evidence of the impact of telehealth in nursing homes concluded that telehealth affected both process improvements, such as timely access to specialists, and downstream outcomes, such as reduced hospital and emergency admissions, reduced physical restraints, improved vital signs, and cost savings.²⁰⁰ In a 2022 study, researchers assessed the effectiveness of a telehealth videoconference consultation implemented at two academic hospitals in improving the post-discharge transition between the hospital and an SNF.²⁰¹ The authors found that the telehealth conference uncovered 327 potential patient safety errors among the 263 patients, primarily relating to medication and communication. However, the intervention did not have a statistically significant impact on the odds of readmission.

In addition to focusing on the patient, telehealth interventions can target a patient’s family or caregivers, which can improve engagement during a health care transition. In an ongoing randomized controlled trial study, researchers are assessing the impact of a telehealth intervention to support caregivers of adults with dementia who transition to a residential long-term care facility, hypothesizing that the intervention will reduce caregiver stress and improve self-efficacy.²⁰²

Regulatory flexibilities during the PHE have supported telehealth expansion. Once the PHE ends on May 11, 2023,²⁰³ and related flexibilities have concluded, Medicare and other payers will contend with the challenge of identifying a long-term payment approach for telehealth. The inclusion of telehealth in APMs may overcome some of the limitations of FFS payment for telehealth.²⁰⁴

Leveraging Telehealth Capacity to Provide Care for Rural Populations

Telehealth has the potential to improve care for rural populations by facilitating timely access to providers and overcoming transportation hurdles, which reduces the likelihood of a care transition. Telehealth can connect rural patients with providers, and it can also more easily connect rural providers with a larger network of providers around the country.²⁰⁵ Telehealth can also improve patient monitoring and communication with the health care system, one element of a successful care transition.²⁰⁶ In 2012, prior to the COVID-19 pandemic and rapid expansion of telehealth, the National Academies of Sciences, Engineering, and Medicine (NASEM) convened a workshop focused on the role of telehealth in an evolving health care environment.²⁰⁷ The NASEM report highlighted a few additional ways in which telehealth could potentially improve care for rural populations, including telepharmacy, such as providing critical access hospitals (CAHs) with access to pharmacists. Tele-emergent care and tele-ICU (intensive care unit) care could potentially enable patients to stay closer to home and receive necessary care in rural settings. Telehealth can promote connectivity between providers and reduce the isolation sometimes experienced by rural health care providers.

Despite the potential of telehealth to improve care transitions for rural populations, one challenge that remains is broadband access and cellular coverage in rural areas.²⁰⁸ Credentialing and licensure of providers who treat patients across state lines also remains a challenge.

VII.B. Special Considerations for Behavioral Health Care

While continuity of care is important for all patients, interruptions in care can be particularly harmful for people with behavioral health conditions.²⁰⁹ Over the past few decades, behavioral health care has shifted from a predominantly institutional setting to a greater use of community-based and outpatient care. This shift aligns with patient preferences, but it also presents the potential for greater fragmentation between settings. Continuous engagement of treatment and recovery services is an important element of addressing acute behavioral health episodes. Implementing interventions to improve continuity of care for patients with behavioral health conditions can lead to reduced inpatient utilization and recidivism.²¹⁰

The American Association of Community Psychiatrists (AACP) developed guidelines for managing transitions in behavioral health services.²¹¹ Many of these guidelines echo the NTOCC's essential elements of successful transitions, including engagement of patients and caregivers, early and explicit planning, designation of responsible providers and accountability for outcomes, and continuity and integration across service providers and resources. The guidelines also include considerations that are especially important for behavioral health care. For patients with behavioral health needs, a gradual transition that reflects an individual's ability to adapt to changing roles and expectations is preferable. Transition plans must recognize the needs of special populations, including persons with addictions, children and adolescents, older adults, women, and criminal offenders. Incorporating resources to address the needs of these populations is an essential element of successful transition planning.

The AACP guidelines also emphasize respect for patient choices in care transitions, noting that transition plans for patients with behavioral health conditions should reflect reality and address the patient's needs in the most practical way possible, recognizing the patient's phase of recovery or illness. Patients may choose to leave treatment early or have marginal investment in their care. Regardless of the circumstances of their departure or the likelihood of their continuing in treatment, the AACP guidelines recommend that a comprehensive plan be developed that is as inclusive of the client's wishes as possible. Also, for patients with behavioral health conditions, AACP notes that "plans for making a transition from highly structured settings to loosely structured settings should include comprehensive relapse prevention plans that recognize early warning signs." AACP further suggest that "strategies should be identified that help the consumer avoid reinitiating old, dysfunctional patterns of behavior." Finally, the AACP guidelines recommend that care transition plans for patients with behavioral health conditions should be culturally sensitive.²¹²

VIII. Using Financial Incentives to Improve Care Transition Management

To encourage participation, several CMMI Models and PTAC proposals offer financial incentives to providers who meet quality and cost benchmarks. Impactful financial incentives on care transitions can include but are not limited to reimbursement mechanism, reward, and penalty.²¹³ In select cases, financial incentives may be linked to performance measures that capture care transition management activities; examples of these performance measures include hospital readmission rates, ED utilization, and ambulatory care-sensitive condition (ACSC) hospitalizations. This section describes the financial

incentives used to encourage improvements in care transition management in CMMI Models and PTAC proposals. A summary of CMMI Models with performance-based financial incentives related to care transitions is organized according to incentive structure and evaluation criteria in Exhibit 6. For additional information on care transition management in CMMI Models and in the MSSP, refer to Appendix C and Appendix E, respectively.

Exhibit 6. Evaluation Criteria of Selected CMMI Models that Address Care Transition Management

	Model	Care Transition Focus	Evaluation Criteria				
			Patient Satisfaction	Communication	Clinical Quality	Utilization	Spending
Episode-based	Bundled Payments for Care Improvement Advanced	Broad			■	■	
	Comprehensive Care for Joint Replacement Model	Transitions among acute care hospitals, institutional PAC settings, and HHAs		■	■		■
	Enhancing Oncology Model	Broad, with a special focus on improved communication with primary care providers; participating oncology providers and suppliers can reduce risk of hospitalization through benefit enhancements, including telehealth visits, post-discharge home visits, and care management visits.	■	■	■		■
	Oncology Care Model	Ensure each patient's needs and preferences are met and bridge gaps between different systems of care	■	■	■		■

	Model	Care Transition Focus	Evaluation Criteria				
			Patient Satisfaction	Communication	Clinical Quality	Utilization	Spending
PBPM	Comprehensive Primary Care Plus	Reducing transitions by expanding breadth and depth of services provided in the office setting	■		■	■	
	Independence at Home Demonstration	Ambulatory services (primary and specialty care visits; in-person, telehealth, and telephone visits); whether providing comprehensive primary care services at home improves care for Medicare beneficiaries with multiple chronic conditions		■	■		■
Capitation	Kidney Care Choices Model	To delay the onset of dialysis and to incentivize kidney transplantation				■	■
FFS	Home Health Value-Based Purchasing	Support greater quality and efficiency of care among Medicare-certified HHAs while reducing health care expenditures; provide home health care appropriately and as a substitute for higher-intensity intensity care settings			■		
	Expanded Home Health Value-Based Purchasing	Improve quality and efficiency of home health care of Medicare beneficiaries to reduce avoidable ED visits			■		

Note: Selected models identified financial incentives as a key model feature.

VIII.A. Care Transition Management Activities that Have Been Improved through Bundled Payments

Performance-based financial incentives have been used to enhance care transition management in numerous episodic and bundle-based models, including the BPCI Advanced Model, CJR Model, Enhancing Oncology Model (EOM), and the Oncology Care Model (OCM). These four models were selected as each identified financial incentives as a key component of their model design.

The BPCI Advanced Model is a bundled payment model that 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.²¹⁴ 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.²¹⁵ One measure included in the Composite Quality Score (on which gains and losses are based) considers whether an ACP has been developed by the full care team.²¹⁶ An ACP is a particularly useful tool for managing chronic diseases and care across multiple settings; it ensures that a physician explains treatment options and encourages the patient, family members, and/or other physicians to collectively develop a treatment plan that meets the patient's personal preferences and conditions, thereby supporting effective care transition management.

The CJR Model aims to provide coordinated care from all physicians, physical therapists, and at-home rehabilitation specialists throughout the recovery process for common hip, knee, and ankle replacements.²¹⁷ Model components that can support care transition management include sharing relevant spending and utilization data, waiving certain Medicare requirements to encourage flexibility in care delivery, and facilitating the sharing of best practices and resources across hospitals, physicians, and PAC providers participating in the CJR Model.²¹⁸ Additionally, an analysis comparing model outcomes indicated favorable care transitions (i.e., discharged at the right time and received the right amount of PAC); however, CJR patients were slightly less satisfied with care than their peers in the control group.²¹⁹

Lastly, the EOM and OCM address historically fragmented care by providing financial incentives for participating providers to improve quality through redesign activities.²²⁰ These incentives may encourage value-based care transformation related to care transitions. EOM providers can receive payments for successfully implementing new patient navigation and care planning, which may improve care transitions.²²¹ The OCM provides participating practices with performance-based financial incentives for favorable results on measures related to communication and coordination, patient and caregiver experience, and health outcomes, which may positively influence care transitions. In particular, participating practices can also receive financial incentives for performance on measures of transitions to palliative care or end-of-life care, if needed.^{222,223}

Proposed Care Transition Management Activities in PTAC Proposed PFPs with Episode-Based Payments

Several episode-based PTAC proposals have also included bundled payments to help facilitate care transition management activities. The American College of Emergency Physicians (ACEP) proposed model offers payments to emergency department physicians to cover acute care transition services, telehealth, and post-discharge home visits. Similarly, the Hackensack Meridian Health and Cota, Inc. (HMH/Cota), Innovative Oncology Business Solutions (IOBS), Minnesota Birth Center, Renal Physicians Association (RPA), and New York City Department of Health and Mental Hygiene (NYC DOHMH) proposed models offer prospective, bundled episode-based payments, which are intended, in part, to support care coordination. The Icahn School of Medicine at Mount Sinai (Mt. Sinai) proposed model proposes a prospective, episode-based payment to support non-covered services for specific acute conditions, including care management.

VIII.B. Care Transition Management Activities that Have Been Improved through Per Beneficiary Per Month (PBPM) Payments

Financial incentives were also provided to Comprehensive Primary Care Plus (CPC+) and Independence at Home (IAH) Demonstration participants for quality improvements. The CPC+ Model sought to improve quality, access, and efficiency of primary care by changing care delivery pathways according to access and continuity, care management, comprehensiveness and coordination, patient and caregiver engagement, and planned care and population health.²²⁴ One strategy to improve care coordination under the CPC+ Model was to assign specific care transition activities to different staff. For example, the CPC+ care manager was responsible for follow-up calls for patients with complex needs, while other clinical staff, such as a certified nurse or medical assistant, contacted all other patients.²²⁵ Scripted talking points were developed and used in both scenarios to ensure standardized and quality care.²²⁶ A comprehensive review of the fourth program year (2020) found that the CPC+ Model improved comprehensiveness and coordination of services by increasing the use of on-site behavioral health providers, and nearly all practices implemented a strategy to address behavioral health needs as an approach to targeting barriers in access.²²⁷

The IAH Demonstration rewards participants who provide home-based primary care to their chronically ill patients, contingent on their meeting at least three out of six quality and savings standards, with the potential for extra compensation if additional measure thresholds are met.²²⁸ Although care transitions are not specifically evaluated, care coordination is encouraged by incentivizing the use of consolidated care in home settings, thus simultaneously reducing the need for outside consultation and care received in alternative locations. Quality measures relevant to care transitions included follow-up procedures for all visits, medication reconciliation, and documentation of patient preferences.²²⁹ As a result, the quality of the care transition may be reflected via reductions in utilization (e.g., hospital admissions, ED visits, and readmissions) and increased patient satisfaction. An evaluation of the first five years of the IAH Demonstration showed that more practices were able to achieve utilization and clinical improvements, as compared to care coordination improvements.²³⁰

Proposed Care Transition Management Activities in PTAC Proposed PFPMs with PBPM Payments

Some PTAC proposed PFPMs have also proposed PBPM payments to support care transition management activities. For example, the models proposed by the American Academy of Family Physicians (AAFP), the American Academy of Hospice and Palliative Medicine (AAHPM), the American Academy of Neurology (AAN), the Community Oncology Alliance (COA), and Personalized Recovery Care (PRC) offer monthly payments to allow providers to facilitate care management and coordination. Some of these models, such as the PRC proposed model, also include performance-based incentives, which hold providers accountable for care transition management-related activities, including medication reconciliation and the arrangement of follow-up appointments with PCPs. Similarly, the Avera Health proposal includes PBPMs; however, to encourage model participation, payments carry less risk during the initial performance years while participants adjust to model implementation. Other proposals, such as the Coalition to Transform Advanced Care (C-TAC) proposed model, offer performance-based PBPM payments contingent on performance measures linked to care transition management, which include, for example, quality of transitions from acute care setting to hospice care and medication reconciliation. Likewise, the model proposed by the University of Chicago Medicine (UChicago) offers a PBPM payment

that includes a care continuity fee for participating physicians who meet benchmarks for providing both inpatient and outpatient care to their patients.

VIII.C. Care Transition Management Activities that Have Been Improved through Capitated Payments

The Kidney Care Choices (KCC) Model and the GPDC/ACO REACH Model provide performance-based incentives via capitated payments. In the KCC Model, participating nephrologists and other kidney care providers offer integrated care for dialysis, transplant, and end-of-life care, if needed.²³¹ The expectation is that care coordination, including care transition management, will improve by incentivizing providers to center treatment options according to beneficiary choice and promote continuity of care across all stages of the disease.²³²

The GPDC/ACO REACH Model encourages health care providers (primary and specialty care doctors, hospitals, and other health care professionals) to work together to deliver high-quality coordinated care, improve health outcomes, and manage costs within ACOs.²³³ ACOs can successfully improve care coordination, including care transitions management, by implementing a range of system-wide initiatives and targeted interventions to support individuals with chronic conditions, as well as acute care needs.²³⁴ Since several of the GPDC/ACO REACH Model's goals target health equity concerns, participating ACOs may address SDOH through care transition management. For example, ACOs may use social risk assessment tools within EHRs, allowing providers to screen beneficiaries at the time of care.²³⁵ This information can be helpful when developing an individualized care plan and can ensure care coordinators refer the beneficiary to appropriate community partners, key factors in appropriate care transition management.²³⁶ Both the KCC and GPDC/ACO REACH Models are relatively early in their tenure; therefore, evaluation reports are not yet available.

Proposed Care Transition Management Activities in PTAC Proposed PFPs with Capitated Payments

Some PTAC proposed PFPs proposed capitated payments to help support care management and coordination. Examples of these proposed models include the proposals submitted by C-TAC, AAFP, and AAHPM. Some of these models proposed evaluating domains specific to care transition management; for example, the C-TAC proposal included a performance domain for the quality of care transitions from curative to palliative care settings.

VIII.D. Care Transition Management Activities that Have Been Improved through Other Financial Incentives

The Home Health Value-Based Purchasing (HHVBP) and Expanded HHVBP Models offer adjustments to Medicare FFS payments based on higher-quality HHA care. An evaluation of the HHVBP Model after its third year found that HHAs responded to performance-based financial incentives as agencies achieved better clinical outcomes, including decreases in unplanned hospitalizations, ED visits, and SNF use, which may be related to improvements in care transition management; however, patient experience measures had mixed results.²³⁷ In comparison, the Expanded HHVBP Model used clinical outcomes along with patient experience measures relevant to improving care transition management, including communication between providers and patients and use of team discussions on specific care issues.²³⁸ Patient-provider communication and care team collaboration can facilitate care transitions to other settings, when appropriate. Evaluation results are not yet available for the Expanded HHVBP Model.²³⁹

Proposed Care Transition Management Activities in PTAC Proposed PFPMs with Other Financial Incentives

The PTAC proposal submitted by the University of New Mexico Health Sciences Center (UNMHSC) offers a consultation fee intended to support e-consults between ED physicians in rural settings and neurologists and neurosurgeons. By providing this consultation fee, the goal is to reduce avoidable transfers for patients seen in rural hospital-based EDs.

VIII.E. Considerations for Certain Conditions/Procedures

For a detailed discussion on considerations for specific conditions or procedures, refer to Section VI.

VIII.F. Considerations for Behavioral Health Care

Additional discussion related to considerations for behavioral health care is provided in Section VI and Section VII.

VIII.G. Considerations for Rural Patient Populations and Providers

For a detailed discussion on considerations for rural patients and providers, refer to Section VI and Section VII.

IX. Care Transition Management in CMMI Models

Several CMMI Models include components that seek to address inefficient or fragmented care transitions between care settings. Management activities introduced through these models can be either required or voluntary. As described above, some CMMI Models may also offer financial incentives tied to the successful integration of care coordination and care transition management activities. This section highlights CMMI Models that focus on care coordination, paying particular attention to model features and activities related to care transition management. When specific care transition activities were not available, broader care coordination initiatives relevant to care transitions were described. A list of the CMMI Models included in this section by their focus is provided in Exhibit 7.

Exhibit 7. Selected CMMI Models that Address Care Transition Management Activities by Care Focus

Category	Models	Care Transition Management Activities
Primary Care and Population Management	<ul style="list-style-type: none"> 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.
	<ul style="list-style-type: none"> 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 FFS Medicare in underserved communities and make measurable changes to address health disparities.
	<ul style="list-style-type: none"> 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.

Category	Models	Care Transition Management Activities
	<ul style="list-style-type: none"> • Primary Care First Model Options (PCF) 	<p>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</p>
Acute or Specialty Care and Targeted Population	<ul style="list-style-type: none"> • Accountable Health Communities Model (AHC) 	<p>Coordinated referrals from clinical delivery sites (e.g., physician practices, behavioral health providers, clinics hospitals) to community services organizations that can help address unmet HRSNs, including housing, food, violence intervention programs, utilities, or transportation</p>
	<ul style="list-style-type: none"> • Bundled Payments for Care Improvement Advanced (BPCI Advanced) 	<p>Designate participant as leading engagement and coordination efforts</p>
	<ul style="list-style-type: none"> • Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) 	<p>Encourage and support patient-centered care that addresses health needs both in and outside the dialysis clinic; designate ESRD Seamless Care Organizations (ESCOs) as facilitator for care coordination</p>
	<ul style="list-style-type: none"> • Comprehensive Care for Joint Replacement (CJR) 	<p>Providers develop a tailored recovery plan for each patient, including details such as treatment preferences; 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.</p>
	<ul style="list-style-type: none"> • Enhancing Oncology Model (EOM) 	<p>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 EHR technology</p>
	<ul style="list-style-type: none"> • ESRD Treatment Choices (ETC) 	<p>Offer patients education to support treatment options</p>
	<ul style="list-style-type: none"> • Expanded Home Health Value-Based Purchasing (Expanded HHVBP) 	<p>Provide incentives for better quality care with greater efficiency, study new potential quality and efficiency measures for appropriateness in the home health setting, and enhance the current public reporting process</p>

Category	Models	Care Transition Management Activities
	<ul style="list-style-type: none"> • Frontier Community Health Integration Project Demonstration (Frontier Community) 	<p>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</p>
	<ul style="list-style-type: none"> • Home Health Value-Based Purchasing (HHVBP) 	<p>Leverage 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</p>
	<ul style="list-style-type: none"> • Independence at Home Demonstration (IAH) 	<p>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.</p>
	<ul style="list-style-type: none"> • Integrated Care for Kids (InCK) 	<p>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</p>
	<ul style="list-style-type: none"> • Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents: Phase 2 	<p>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.</p>
	<ul style="list-style-type: none"> • Kidney Care Choices (KCC) 	<p>Patients with chronic kidney disease may experience fragmented care and high-cost treatments, and receive limited to no education about their disease and treatment options. Kidney Contracting Entities (KCEs) offer coordinated and seamless care (including dialysis, transplant, and if appropriate, end-of-life care) and provide patient education.</p>

Category	Models	Care Transition Management Activities
	<ul style="list-style-type: none"> • Maternal Opioid Misuse (MOM) 	Support the delivery of coordinated and integrated physical health care, behavioral health care, and critical wrap-around services
	<ul style="list-style-type: none"> • Oncology Care Model (OCM) 	Facilitate transitions and coordinate care across settings, including monitoring follow-up
	<ul style="list-style-type: none"> • Value in Opioid Use Disorder Treatment 	Financial incentives available, including care management fees, to provide tailored services

IX.A. Required Care Transition Management Activities

Regardless of the model’s overall focus (primary care and population management, or acute and specialty care and targeted population), the CMMI Models noted in Exhibit 7 required at least one of the following care transition management activities to ensure beneficiaries receive high-quality coordinated care:

- 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 services at primary care, home health, and long-term care (LTC) facilities;
- Designing and providing resources aligned with patient/population needs; and
- Providing increased access to educational programs and services targeting prevention, early identification, and treatment of chronic diseases.

The most cited care transition management activities among these CMMI Models include focusing on patient-centered care, tasking a single entity with the role of facilitating care coordination, and offering resources to enhance services offered in primary care settings. For example, the EOM and OCM require care teams to develop patient-specific care plans specifying engagement and care preferences, prognosis, treatment options, and symptom management.²⁴⁰ Likewise, the Integrated Care for Kids (InCK) Model requires model participants to develop person/family-centered care plans for each of their beneficiaries, as well as to offer patient education to support patient activation.²⁴¹ In addition, the HHVBP, Maternal Opioid Misuse (MOM), and CJR Models fund activities to identify and address care gaps experienced by high-risk patients and those with unmet HRSNs.^{242,243,244}

In addition to emphasizing patient-centered care, many of the CMMI Models seek to improve care transition management by assigning a single individual or organization to facilitate care across all settings—i.e., serve as the care coordination “quarterback”—for a specified number of patients. Although this role of care coordination often falls to primary care providers, the locus of control may shift depending on the care setting or condition type. For example, rather than assigning an individual to facilitate care coordination activities, under the InCK Model, a local entity or “lead organization” is responsible for coordinating care between physical and behavioral health providers, early care and education programs, Title V Agencies, and child welfare,²⁴⁵ along with housing, food, and crisis response services.²⁴⁶

Some models have focused specifically on strategies to reduce the number of care transitions. For example, the Primary Care First (PCF) Model allows patients to receive select behavioral health services at their primary care practice.²⁴⁷ Similarly, the IAH Demonstration expands home health services, and

the Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents: Phase 2 provides extra resources to treat patients on site in nursing homes rather than in ED settings.^{248, 249}

IX.B. Voluntary Care Transition Management Activities

Several CMMI Models encourage participants to adopt supplemental activities intended to support and improve care coordination. Common voluntary care transition activities include:

- Establishing an interdisciplinary team;
- Providing preventive and early identification/treatment services; and
- Investing in technological advancements and enhanced data infrastructure.

Some models facilitate care management by limiting the number of transitions through the development of interdisciplinary teams and early detection/prevention of diseases.^{250,251,252} For example, the InCK Model unites physicians, community partners, and home health workers to address early signs of disease and take preventive measures.²⁵³ The diversity of the health care team and the emphasis on early disease management allows the team to provide care in home and community-based settings rather than EDs. In turn, these strategies reduce the need for numerous care teams, across a variety of settings.²⁵⁴

Model evaluations have also noted the need for improved data sharing systems to better support interdisciplinary teams and develop larger, integrated health care networks. Some more recently implemented models have been able to incorporate more dynamic and integrated data sharing technologies. For example, the GPDC/ACO REACH Model relies on advanced data sharing tools, such as EHRs, to reduce administrative burden and encourage transparency and data sharing.²⁵⁵ Improved EHR data systems can help ensure a timely and comprehensive transition of relevant medical records, thus enhancing care transitions between settings. Models such as the CPC+ Model rely on EHRs to support clinical and non-clinical information sharing that can affect health and treatment success, including care transitions, while the AHC Model uses clinical-community collaboration to identify unmet HRSNs, make relevant referrals, and advertise resources, all of which may support appropriate care transitions.^{256,257} Additionally, under the CJR Model, it is recommended that discharge planning and patient follow-up are coordinated across the full health care team, with representation from physicians, home health agencies, SNFs, and other providers, which may help improve care transition management for aligned beneficiaries.²⁵⁸

IX.C. CMMI Model Performance Related to Care Transitions

Some CMMI Models with a care transition component have had mixed results. Models that focus on acute or specialty care, as well as those targeting specific patient populations (e.g., terminal illness or lower extremity joint replacements), have tended to be most successful in achieving model outcomes.²⁵⁹ A meta-analysis of all models implemented between 2012 and 2020 found that 14 of the models resulted in gross savings (primarily driven by reductions in inpatient admissions and/or post-acute care), six models achieved net savings, and four models effectively reduced mortality rates; however, only two models documented improvements in self-reported patient satisfaction.²⁶⁰ While this meta-analysis included measures of utilization and quality related to care transitions (e.g., ED visits, hospital readmissions), success was defined more broadly according to clinical outcomes, cost efficiency/savings, and utilization.²⁶¹ Additionally, this analysis found that, while financial incentives were often helpful in encouraging participation, they posed challenges to achieving net savings.²⁶²

All selected CMMI Models included strategies to address care transitions or care coordination more broadly, but only a few used them as a key indicator of model performance. A comprehensive review of the CPC+ Model in its fourth program year (2020) found that the model improved comprehensiveness and coordination of services by increasing the use of on-site behavioral health care providers,²⁶³ reducing the need for care transitions between settings by integrating behavioral health care in primary care settings.

Similarly, an evaluation of the InCK Model suggested that participants were coordinating care, educating providers and communities, integrating data systems, and improving service delivery navigation,²⁶⁴ which can support care transitions between settings and from pediatric to adult care. Interviews with CJR providers also identified specific strategies to coordinate care throughout the episode; however, some participants cited limitations to a hospital's control over coordination activities due to lack of resources and market conditions, limiting ability to influence care transition management.²⁶⁵ In some selected CMMI Models, care transitions tended to be addressed in quality measurement, for example, by including measures such as hospital readmission rates and self-reported patient satisfaction. However, evaluation of most CMMI Models was typically centered around clinical quality, utilization, and total cost of care.

X. Care Transition Management Activities in PTAC Proposals

Several proposals previously submitted to PTAC have included features related to care transition management. For example, PTAC proposals include approaches to clearly delineate provider responsibilities for all providers involved in care transition activities, proactive referrals and scheduling of follow-ups, the use of e-consults, care transition management performance measures, and financial incentives to support care transition management activities, as outlined in Section VIII. This section highlights key care transition management features found in an analysis of 20 PTAC proposals. One proposal received a rating of "Meets and Deserves Priority Consideration" and 15 proposals received a rating of "Meets" on Criterion 7, Integration and Care Coordination. The four remaining proposals did not meet Criterion 7, but included components related to facilitating transitions and coordinating care across settings. The full analysis can be found in Appendix D.

Delineation of provider responsibilities in care transition management. Fifteen of the 20 proposals outlined provider responsibilities with respect to care transition management. For example, in the Avera Health proposed model, Geriatrician Care Teams (GCTs) are responsible for facilitating transitions and coordinating care across settings. Some of these proposals have also assigned a specific staff member—clinical or non-clinical—to lead care transition management activities. For example, under the American Society of Clinical Oncology (ASCO) proposed model, a medical oncologist directs the care team and care coordination efforts. Similarly, the UChicago proposed model calls for a member of the clinical team to serve as a care coordinator.

Proactive referrals and scheduling of follow-ups. Seventeen of the 20 proposals mention activities to provide proactive referrals and schedule follow-up visits. Some proposals call for the use of physicians, specialists, and care coordination teams to help patients and their caregivers navigate referrals and follow-up appointments. In addition to proactive referrals, some proposals, such as the UNMHSC proposed model, allow for follow-up visits via telehealth. Under the ASCO proposed model, certain events or care processes trigger referrals to be made; for example, patients are contacted within 48 hours of being hospitalized to schedule a follow-up visit and, when appropriate, an on-site psychosocial

screening is performed and then used to inform referrals for behavioral health care. Similarly, the AAN proposed model notes that specialists assist with proactive referrals and follow-ups based on patient needs and headache severity.

E-consults. Eleven of the 20 proposals included references to the use of e-consults. For some proposals, the use of an e-consult is integral to the model being proposed, whereas for other proposals, e-consults are included as an option for an additional specialist visit. Additionally, for some proposals, e-consults are a component to consider when preparing for HIT implementation. For example, the UNMHSC, the Avera Health, and the Dr. Sobel proposed models require e-consults to pull in the specialists for emergency medical situations or to mitigate the necessity for a patient to be moved to a new care setting.

While the e-consult was not an integral part of the NYC DOHMH or Mt. Sinai proposed models, they directly referenced using e-consults with specialists to reduce additional in-person visits. The models proposed by PRC and the American College of Physicians-National Committee for Quality Assurance (ACP-NCQA) included the consideration of e-consults as an ancillary tool to improve the quality of care throughout the health care episode. Additionally, the models proposed by UChicago, C-TAC, HMH/COTA, and ACEP all addressed e-consults as a tool to incorporate as needed as HIT technology becomes more widely used, and often included a consideration of how those visits would be billed.

Care transition management performance measures. Eighteen of the 20 proposals included care transition management performance measures. Reducing hospital readmissions and medication reconciliation were the most common focus of these measures, with at least one of these measures present in 12 of the 20 proposals. The Advanced Care Model Service Delivery and Advanced Alternative Payment Model proposed by C-TAC included measures for the quality of care transitions from curative to palliative care settings, via a proposed survey slated to be field tested by CMS and quantified through a composite score. Additionally, another common measure included patient education or care plans as a part of discharge, present in the Patient-Centered Oncology Payment Model proposed by ASCO, the Oncology Care Model 2.0 proposed by COA, and the Home Hospitalization Model proposed by PRC. The following section provides a discussion of performance measurement of care transition management in the broader context of population-based models.

XI. Performance Measurement of Care Transition Management in Population-Based Models

Poor management of care coordination, including care transitions and the effects of those transitions, were estimated to cost the U.S. health care system between \$25 and \$45 billion in 2011.²⁶⁶ Validated performance measures are important tools for measuring the effectiveness of care transition management in relation to utilization, spending, and quality of care, including patient-reported outcomes. The following section highlights performance measures associated with care transition management.

XI.A. Existing Process and Outcome Measures Used to Assess Care Transition Management

Process measures, which measure how providers maintain or improve a patient's health and are generally guided by standards of clinical practice, are important tools to assess care transitions.²⁶⁷ A key process measure related to care transitions is the timely transfer of patient data from one clinical entity to another (e.g., from the discharging provider to the admitting provider). This transfer of patient information between providers or care settings is essential to clearly communicate diagnostic information, including results of any tests; course of treatment, including medications; and

recommended care plans and follow-up, which may include outpatient therapy (e.g., PT, OT, SLP) or other rehabilitative care. In addition to sharing patient information, process measures related to patients receiving their prescribed medications, reducing patient exposure to duplicative tests, and understanding a patient's functional status are all useful process measures in evaluating care transition management.²⁶⁸

Outcome measures, which measure the impact of an intervention or quality of care provided, are another way for policy makers to measure the effectiveness of care transitions.²⁶⁹ Outcome measures – such as rate of unplanned readmissions within 30 or 60 days of hospital discharge, percentage of patients who have been re-hospitalized after a nursing home admission, and number of ED visits post-discharge – are all useful measures to evaluate the care transition management process.²⁷⁰ Although these outcome measures are not exclusive to care transition management activities, they can be used to gather actionable data to support care transition management and broader care coordination enhancements.

Many of the PTAC proposals included in this environmental scan incorporated performance measures related to care transitions in their model design. Several proposals included measures that reflect effective communication and coordination within or across care settings, including care planning and shared decision-making (ACP-NCQA, Mt. Sinai), medication reconciliation (Mt. Sinai, PRC), shared decision-making (ACP-NCQA), recovery care coordinator support (PRC), use of Certified Electronic Health Record Technology (CEHRT; ACP-NCQA), excess or duplicative treatments and services (AAHPM), and care transitions with errors (Mt. Sinai). Some proposals included measures of post-discharge utilization, including emergency transportation (AAHPM), ED visits (AAHPM), and hospital admissions or readmissions (AAHPM, ACP-NCQA, Mt. Sinai). Several proposals included measures related to referrals and appropriate follow-up care, including access to timely, patient-focused care (ACP-NCQA) and percentage of episodes with follow-up PCP appointment scheduled within seven days (PRC).

XI.B. Relationship Between Care Transition Management Activities and Health Care Quality Outcomes

As described above, improvements to care transition management may reduce overall health care spending and improve quality of care. Since care transition management activities take place during vulnerable periods of time for patients, there is a chance for adverse events.²⁷¹ In addition to increased cost of care related to inefficiencies or excess utilization, inadequate care transitions can lead to higher rates of hospital readmissions, which are costly and may be preventable, as well as increased length of hospitalization, which may put patients at risk of other complications, such as hospital-acquired infections.^{272,273}

XI.C. Strategies to Attribute Patients Experiencing Care Transitions to Providers

In value-based models, attribution is a tool to create accountability for financial and quality outcomes. Providers may make decisions about patient care that affect total cost of care, utilization, and quality using data on their attributed patient panel.²⁷⁴ Providers may also use these data on their attributed population at the organizational level to make decisions on allocation of resources, such as care managers; investment in data infrastructure; and building community partnerships.²⁷⁵

Patient attribution, or the identification of the patient-provider health care relationship, is an important element of care transition management because care transitions are points in care when there may be a

lack of clarity as to who is coordinating different facets of a patient's health care.²⁷⁶ Existing attribution approaches typically use voluntary alignment, which occurs when a patient selects or confirms his or her primary clinician, and/or claims-based alignment.²⁷⁷

Under claims-based alignment, patients may be attributed to providers prospectively or retrospectively. Prospective alignment can be determined by "first touch" or using a previous period's (e.g., a calendar year's) health care claims to determine attribution in the following period. Retrospective alignment looks back over a period's health care claims to determine attribution for the same period. Prospective attribution enables providers to take a more proactive approach to care coordination, including care transition management, as they know who is in their attributed patient panel at the start of the performance period.²⁷⁸ However, prospective attribution is not as common, and many organizations still depend on retrospective attribution methods.²⁷⁹ Several recently concluded or ongoing CMMI Models, including the Comprehensive ESRD Care (CEC), CPC+, PCF, NGACO, and GPDC/ACO REACH Models, have included prospective attribution approaches.

Claims-based alignment procedures often attribute patients based on where they receive their first or the plurality of their primary or specialty health care services. These approaches may not sufficiently capture all providers who contributed to a patient needing an avoidable care transition, or who facilitated a successful, appropriate care transition. For example, for a community-based patient who receives a joint replacement surgery, an attribution approach based on plurality of services may align a patient to their PCP, but not the hospital or PAC setting involved in their surgery and rehabilitative care. Similarly, a "first touch" approach may attribute a patient to their admitting provider, but not their discharging provider, who can also influence the patient's quality of care.^{280,281} Under ACO models, participants can address accountability for care transitions by sharing quality performance data or distributing shared savings or losses among participating providers, but are not required to do so.

Additional Considerations for Patients with Multifaceted Needs

While most patients can be attributed through one of the attribution processes outlined above, there are some patients who remain unattributable. In one study of the MSSP that used 2012 data, researchers found that 12 percent of FFS Medicare beneficiaries could not be attributable to any provider group. The unattributable beneficiaries were more likely to be male, younger, from a minority group, enrolled in Medicare due to a disability, and more likely to live in a high-poverty area.²⁸² For some of these unattributable beneficiaries, extending the attribution period helped identify the responsible provider group. In some instances of serious illness for unattributable beneficiaries, attribution to a palliative care or hospice care provider could be considered.²⁸³ Unattributed beneficiaries may experience worse care coordination and management, including care transition management, as compared to their attributed counterparts.

XII. Considerations for Equity in Care Transition Management in Population-Based Models

In addition to disparities based on sociodemographic differences, described in Section VI.B, this section summarizes some of the barriers that different populations face during care transitions, as well as several successful strategies and models that have been implemented to address those barriers.

XII.A. Disparities in Care Transitions

Disparities exist in care transition management among racial and ethnic groups, older adults, individuals who are dually eligible for Medicare and Medicaid, and individuals with limited English proficiency (LEP).

Patients who identify as African American or Hispanic are more likely to be discharged to lower-quality SNFs for post-acute care²⁸⁴ and are more likely to be readmitted to the hospital directly from SNFs, relative to white patients.²⁸⁵ In addition, compared to white patients and patients of other racial and ethnic groups, Black patients tend to have fewer scheduled and completed follow-up visits with their physician.²⁸⁶

There are also disparities in end-of-life care transition management for racial and ethnic groups. African American Medicare FFS beneficiaries have more end-of-life care transitions and later hospice enrollment compared to white FFS beneficiaries.²⁸⁷ In addition, relative to white beneficiaries, non-white beneficiaries are more likely to have repeated hospitalizations during end-of-life and are more likely to die in the hospital.²⁸⁸

Care transitions from hospital to home can be particularly challenging for older adults, especially older adults with comorbid conditions, functional deficits, and cognitive impairment.²⁸⁹ Individuals with Alzheimer's disease or related dementia (ADRD) are more likely to be discharged from the hospital to lower-quality SNFs.²⁹⁰ There may also be racial and ethnic differences in post-acute care transition management for individuals with ADRD, as unadjusted 30-day readmission rates are higher among Black patients with ADRD compared to white patients with ADRD.²⁹¹

Dually eligible Medicare and Medicaid beneficiaries are particularly vulnerable to adverse health outcomes during transitions between providers and health care settings.²⁹² Dually enrolled beneficiaries are more likely to be discharged from the hospital to lower-quality SNFs for post-acute care²⁸⁴ and have a higher rate of 30-day mortality, compared to non-dually eligible patients.²⁹³

Vulnerable populations face a number of barriers in care transition management. Compared to white patients and patients of other racial and ethnic groups, Black patients are less likely to receive a phone number to contact with post-discharge questions and are less likely to receive prescribed home medical equipment.²⁹⁴ Many older individuals do not receive the support needed during a care transition, such as assistance from SNFs with scheduling follow-up appointments with primary care providers or receiving adequate medication education.²⁹⁵

Limited access to technology and other resources can also contribute to poor care transitions. Hispanic and Latino patients face limited access to the technology needed to complete telehealth visits following discharge and are less likely to access patient portals, compared to white non-Hispanic patients.²⁹⁶ People with LEP oftentimes lack access to medical interpreters and translated resources at discharge from the hospital. Compared to non-LEP patients, patients with LEP are also less likely to have access to technology (e.g., smartphones, computers) and are less likely to access their online patient portal.²⁹⁶ In addition, patients of lower socioeconomic status, who are at higher risk for hospital readmission, experience barriers related to medication access, use, and adherence following discharge from the hospital.²⁹⁷ Fewer post-discharge follow-up visits and more hospital readmissions occur when patients' psychosocial needs and other social determinants of health, such as housing stability and access to transportation,^{298,299} are left unaddressed.

XII.B. Successful Strategies to Reduce Disparities in Care Transitions

Several successful strategies have been implemented to improve care transition management for populations that face barriers in care transitions. These strategies include:

- Early discharge planning.³⁰⁰
- Improved communication between patients, caregivers, and providers,³⁰¹ as a lack of communication between providers within and across health care settings can lead to poor care transitions.³⁰²
- Improved post-discharge phone contacts with patients.³⁰³
- Strengthened collaboration with community organizations (e.g., regular meetings between acute care organizations and community partners to build trust and facilitate transitional care planning).³⁰⁴
- Providing education on care needs and resources before, during, and after the care transition.³⁰⁵
- Development of condition-specific educational tools and instructions.³⁰⁶
- Assistance with relearning community living skills for people who have lived in SNFs for long periods of time.³⁰⁷
- Assisting patients with housing support and intensive case management during the transition from long-term care facilities to home. For example, under the Health Plan of San Mateo's Community Care Setting Program, eligible participants are provided support with finding housing that fits their needs and assistance with care management to ensure that participants have the greatest opportunity to return to and/or stay in the community, reduce utilization of long-term care, and reduce health care expenditures.³⁰⁸
- Development of an automated rideshare-based software that does not require a smartphone or mobile app for patients who experience barriers with transportation.³⁰⁹

Although many of the strategies listed above could improve overall care transition management, these strategies are intended to address some of the specific challenges different populations face during care transitions. For example, the development of condition-specific educational tools and instructions could address barriers related to health literacy, and providing housing support for patients who do not have stable housing could help them to remain in the community following discharge.

In addition to the strategies listed above, specific models have been developed to improve care transition management for populations that face barriers in care transitions. Models aim to not only improve care transitions but also reduce health care costs. Two models are described in the following paragraphs. An additional model, the Transitional Care Model, is described in Section VII.A.

Independent Care's (*iCare's*) Follow to Home Program aims to improve care transitions and reduce readmissions for dually eligible beneficiaries transitioning from the hospital to home. The model identifies patients who are at high risk for hospital readmission and offers post-discharge nursing case management in the patient's home for 90 days. The first home visit occurs within 72 hours from discharge from the hospital. During the initial visit, the nurse does an environmental home assessment and a medication reconciliation with the patient, ensures that the patient knows how to use the durable medical equipment in the home, and confirms that the patient's follow-up appointments are scheduled. The contracted Home Health Agency is then required to contact the *iCare* team each week following the visit to provide a detailed account of each patient. *iCare* uses an APM with case rate payments at 30-, 60-, and 90-days post-discharge.^{310,311}

CareSource’s Care Management Model to Improve Care Transitions not only identifies dually eligible beneficiaries living in nursing facilities who can transition to community settings, but also aids in post-discharge to home and community-based services to help beneficiaries remain at home. The model includes assessment of members’ needs, a designated care manager to support discharge planning, and assistance with use of community resources and programs.³¹²

XIII. Relevant Features in Selected PTAC Proposals

This section summarizes findings from an analysis of components and themes related to care transition management in previously submitted PTAC proposals. The analysis begins with a discussion of the criteria that were used to identify PTAC proposals with components related to improving care transition management, followed by a review of care transition-related information in proposals that were submitted to PTAC and a summary of comments and recommendations related to care transitions that were identified by PTAC during the Committee’s deliberations on these proposals.

XIII.A. Criteria for Identifying Relevant PTAC Proposals with Components Related to Improving Care Transition Management

Since its inception, PTAC has received 35 proposals for PFPMs from a diverse set of physician payment stakeholders, including professional associations, health systems, academic groups, public health agencies, and individual providers. PTAC evaluates the PFPM proposals based on the extent to which they meet the Secretary’s 10 regulatory criteria for PFPMs (specified in federal regulations at 42 CFR § 414.1465).

Two of the 10 criteria for proposed PFPMs that PTAC uses to evaluate stakeholder-submitted proposals are especially pertinent to care transition management activities and using financial incentives to improve care transition management within population-based models. For example, the Secretary of HHS has established “Payment Methodology” and “Integration and Care Coordination” as two of the 10 criteria for proposed PFPMs that PTAC uses to evaluate stakeholder-submitted proposals. The goal of the Payment Methodology criterion is to ensure that each proposed model will “pay APM Entities under a payment methodology that furthers the PFPM Criteria” (Criterion 3). The goal of the Integration and Care Coordination criterion is to “encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM” (Criterion 7).

Given the increased emphasis on developing larger population-based APMs that encourage accountable care relationships, PTAC conducted a series of theme-based discussions from 2021 through early 2023 that examined key care delivery and payment issues related to care coordination, development and implementation of population-based models, and improving integration of specialty care in population-based models. A key theme that emerged during the 2021-2023 meeting series was improving care transition management in population-based models and, especially, opportunities to structure financial incentives to encourage care transition management activities in population-based models. Within this context, PTAC has assessed previous submitters’ use of proposed model design components related to care transition management activities and using financial incentives to improve care transition management in population-based and episode-based models.

Nearly all of the 35 proposals that were submitted to PTAC between 2016 and 2020 addressed the proposed model’s potential impact on quality, cost, and care coordination, to some degree. Of these, at

least 20 previous submitters have addressed issues related to improving care transition management in advanced primary care models and episode-based or condition-specific models as part of their proposal submissions, in the payment methodology and performance measures for their proposed models. Exhibit 8 includes a list of these proposals, and Appendix D includes additional information about these proposals.

Exhibit 8. List of Proposals Submitted to PTAC for Review That Included Components Related to Care Transition Management

Submitter Name, and Submitter Type	Proposal Name	Abbreviated Submitter Name	Care Transition Focus
American Academy of Family Physicians <i>(Provider association and specialty society)</i>	Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care	AAFP	Broad
American Academy of Hospice and Palliative Medicine <i>(Provider association and specialty society)</i>	Patient and Caregiver Support for Serious Illness (PACSSI)	AAHPM	Broad
American Academy of Neurology <i>(Provider association and specialty society)</i>	The Patient-Centered Headache Care Payment (PCHCP)	AAN	Broad
American College of Emergency Physicians <i>(Provider association and specialty society)</i>	Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions	ACEP	Hospitalizations and observations stays; multidisciplinary care around an acute care event
American College of Physicians-National Committee for Quality Assurance <i>(Provider association and specialty society/other)</i>	The “Medical Neighborhood” Advanced Alternative Payment Model (AAPM) (Revised Version)	ACP-NCQA	Between hospitals and other facilities to close gaps and eliminate fragmentation across settings
American College of Surgeons <i>(Provider association and specialty society)</i>	ACS-Brandeis Advanced Alternative Payment Model	ACS	Broad
American Society of Clinical Oncology <i>(Provider association and specialty society)</i>	Patient-Centered Oncology Payment Model (PCOP)	ASCO	To reduce utilization for conditions that could be averted and reduce total ED visits and observation stays

Submitter Name, and Submitter Type	Proposal Name	Abbreviated Submitter Name	Care Transition Focus
Avera Health <i>(Regional/local multispecialty practice or health system)</i>	Intensive Care Management in Skilled Nursing Facility Alternative Payment Model (ICM SNF APM)	Avera	To reduce avoidable ED visits and hospitalizations
Coalition to Transform Advanced Care <i>(Coalition)</i>	Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model	C-TAC	Broad
Community Oncology Alliance <i>(Nonprofit organization)</i>	Oncology Care Model 2.0	COA	Multidisciplinary during episode of care for cancer; transitions during treatment (such as from chemotherapy to radiation therapy); transitions to hospice care at clinically useful point in patient’s disease trajectory
Dr. Sobel <i>(Individual)</i>	Remote specialists and experts on demand improving care and saving costs	Sobel	Broad
Hackensack Meridian Health and Cota Inc. <i>(Regional/local multispecialty practice or health system; Device/technology company)</i>	Oncology Bundled Payment Program Using CAN-Guided Care	HMH/Cota	Broad
Icahn School of Medicine at Mount Sinai <i>(Academic institution)</i>	HaH Plus (Hospital at Home Plus) Provider-Focused Payment Model	Mt. Sinai*	Multidisciplinary around an acute care event; goal of reducing complications and readmissions
Innovative Oncology Business Solutions, Inc. <i>(For-profit corporation)</i>	Making Accountable Sustainable Oncology Networks (MASON)	IOBS	To avoid excess ED visits and hospitalizations
Minnesota Birth Center <i>(Regional/local single specialty practice)</i>	A Single Bundled Payment for Comprehensive Low-Risk Maternity and Newborn Care Provided by Independent Midwife Led Birth Center Practices that Are Clinically Integrated with Physician and Hospital Services	Minnesota Birth Center	Maternity care and coordinated effort across prenatal care, labor and birth, and postpartum care; leveraging use of a birth center, a lower-cost facility

Submitter Name, and Submitter Type	Proposal Name	Abbreviated Submitter Name	Care Transition Focus
New York City Department of Health and Mental Hygiene <i>(Public health department)</i>	Multi-provider, bundled episode of care payment model for treatment of chronic hepatitis C virus (HCV) using care coordination by employed physicians in hospital outpatient clinics	NYC DOHMH	Multidisciplinary; hospital-based clinics (with PCPs able to refer to other diagnostic and treatment services within same facility). Goal is to reduce patient handoffs through telementoring and assist patient navigation through the health care system.
Personalized Recovery Care <i>(Regional/local single specialty practice)</i>	Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home	PRC	Acute care; multidisciplinary care and management around an acute care event/episode
Renal Physicians Association <i>(Provider association and specialty society)</i>	Incident ESRD Clinical Episode Payment Model	RPA	Coordinated initiation of dialysis directly in the outpatient setting, bypassing the need for hospital admission to begin dialysis therapy
University of Chicago Medicine <i>(Academic institution)</i>	The Comprehensive Care Physician Payment Model (CCP-PM)	UChicago	Broad
University of New Mexico Health Sciences Center <i>(Academic institution)</i>	ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Cerebral Emergencies	UNMHSC	Reducing need for patient to travel for a neurological consultation in the case of a neurological emergency

* PTAC determined that Mt. Sinai “Meets and Deserves Priority Consideration” for Criterion 7. PTAC determined that all other proposals reviewed in the table above should be assigned the rating of “Meets” for Criterion 7, except for AAN, COA, Dr. Sobel, and MBC. These four proposals were withdrawn.

XIII.B. Summary of Information in Selected PTAC Proposals Related to Care Transitions between Care Settings

Twenty previously submitted PTAC proposals addressed several themes related to care transitions, including:

- Focus of care transition management;
- Overview of care transition management activities;
- Delineation of provider responsibilities in care transition management;
- Provision of e-consults;
- Proactive referrals and scheduling of follow-up visits; and
- Dedicated care management/care navigator staff.

Focus of care transition management. Of the 20 previously submitted proposals that included components related to care transition management, eight proposals had a broad or holistic focus on

care transition management. Five proposals focused on transitions around acute events, including reducing inpatient hospitalizations, readmissions, ED visits, and observation stays. Seven proposals focused on transitions related to a care specialty (cancer [COA, HMH/Cota, IOBS], renal care [RPA], neurology [UNMHSC], hepatitis C virus [NYC DOHMH], and maternity care [MBC]).

Overview of care transition management activities. The 20 selected proposals engaged in different activities to support care coordination and care transition management. The list below categorizes proposals by seven high-level activities.^{ix}

- Using a patient-centered medical home or neighborhood model to support care transition management (three proposals).
- Developing and implementing a care plan (three proposals).
- Emphasizing provider-provider and/or provider-patient communication, including patient education (four proposals).
- Implementing patient care teams or integrating additional physicians via consult, either on site or remotely (seven proposals).
- Prioritizing a constellation of discharge care services, including discharge planning, as well as remote monitoring and follow-up (five proposals).
- Reducing avoidable care transitions by providing care at an alternative site, allowing the patient to receive different types of care in the same setting/location or from the same provider (four proposals).
- Focusing on shared decision-making (one proposal).

Delineation of provider responsibilities in care transition management. Of the 20 selected proposals, 15 specified provider or care team responsibility for care coordination and care transition management. Six of these 15 proposals assigned accountability to PCPs or providers in primary care specialties. For example, the Avera proposal noted that geriatricians led the development of individualized care plans. Eight of these 15 proposals assigned responsibility to the care team, which included shared management with specialists, such as neurologists (AAN) and oncologists (COA). Two of these 15 proposals assigned accountability to a physician other than a PCP, including specialists (medical oncologists; ASCO) and admitting physicians (PRC). Five of the 20 selected proposals did not specifically delineate provider responsibilities in care transition management.

Provision of e-consults. Adoption and use of e-consults were mixed in the 20 selected proposals. Nine of the 20 proposals did not specify any e-consult use. E-consult use varied in the 11 proposals that did include e-consults. For example, the ACP-NCQA proposal used e-consults to improve efficiency, providing virtual visits to gather information prior to in-person follow-up appointments. E-consults were integral to some proposals, such as Mt. Sinai, PRC, and UNMHSC.

- Mt. Sinai – the HaH-Plus team was available 24/7 to engage in a telehealth-supervised visit from a community paramedic team that is part of the care team.
- PRC – the proposal’s telehealth platform incorporates video communication and biometric data tracking for remote monitoring.

^{ix} The number of proposals does not sum to 20 because proposals could have included one or more care transition management activities.

- UNMHSC – e-consults were used for specialist consults and were instrumental to model design.

Proactive referrals and scheduling of follow-up visits. Sixteen of the 20 selected proposals included proactive referrals and scheduling of follow-up visits in their care transition management activities. Six of these 16 proposals included referrals in their design, two of these 16 proposals addressed scheduling of follow-up visits, and eight of these 16 proposals included both referrals and scheduling of follow-up visits.

Both primary care- and specialty care-focused proposals included referrals and follow-up visits in their design. For example, in the ACEP proposal, care coordinators are responsible for scheduling follow-up visits with PCPs or specialists. Some proposals included proactive referrals and scheduling of follow-up visits that were most relevant to their patient populations. For example, the COA proposal noted that participating practices would provide certain services—including rehabilitation, nutritional support/counseling, surgical and radiation oncology, diagnostic imaging, laboratory studies, psychosocial evaluation and support, genetic counseling, palliative care/symptom management, and home care—on site or by referral. Similarly, the ASCO proposal performed on-site psychosocial distress screening and referred patients for provision of psychosocial care as needed, and the NYC DOHMH proposal provided referrals for support services, psychosocial issues, and other comorbid conditions. Four proposals did not specify whether proactive referrals and/or scheduling of follow-up visits were provided.

Dedicated care management/care navigator staff. Only four of the 20 selected proposals had identified dedicated care management or care navigator staff as a key care delivery feature. For example, NYC DOHMH noted that care coordinators will help patients find and use resources to improve their health: checking patient eligibility for benefits and programs, assisting patients in acquiring medical insurance or health care resources, and helping patients find other supportive services. In this proposal, care coordinators were also expected to assist patients throughout their hepatitis C virus (HCV) treatment, including documenting milestones in their treatment for HCV, accompanying patients to appointments, or supporting care coordination plan development. Seven proposals noted that a member/members of the practice, medical home, or care team would be responsible for care coordination, but did not specify which team member(s) would be best suited to this role or for which activities they would be responsible. One proposal noted that one of the clinical team members would be responsible for care management/care navigation. Nine of the 20 selected proposals did not specify whether their proposed model included dedicated care management or care navigator staff.

XIII.C. PTAC Comments and Recommendations Related to Care Transitions

This section draws on an analysis of PTAC voting patterns and comments on proposed PFPMs to highlight PTAC’s findings related to care transitions in the Committee’s Reports to the Secretary, with a particular focus on Integration and Care Coordination in the context of PFPM development (Criterion 7).^x

PTAC Findings Regarding Care Transitions. The following are key findings from a synthesis of PTAC comments and recommendations regarding the care transition management in proposed PFPMs based

^x For additional PTAC comments on approaches to improve care coordination in PTAC proposals, refer to Appendix F in Environmental Scan on Care Coordination in the Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs), available at <https://aspe.hhs.gov/sites/default/files/private/pdf/261946/Jun-2021-CC-Escan.pdf>.

on a review of PTAC voting patterns and recommendations for proposals that were deliberated and voted on by the Committee:

- Care management and interdisciplinary palliative care teams encourage integration and care coordination among practitioners. PTAC identified two proposals (AAHPM, C-TAC) that specifically included care management and interdisciplinary palliative care teams. Both of these proposals adopted a broad focus to care transition management to address patient needs, support transitions across care settings, and reduce avoidable utilization.
- Four proposals included a focus on coordination between providers. PTAC commented that the Mt. Sinai proposal included mechanisms for coordination with usual providers, and noted that the ACEP proposal incentivized greater communication and coordination between ED and ambulatory physicians who may plan follow-up, and devoted resources to coordination during a 30-day episode. PTAC also commented that the UChicago and UNMHSC proposals both addressed coordination during transitions between care settings, with the UChicago proposal focusing on coordination during an immediate period surrounding a transition between settings, and the UNMHSC proposal attempting to improve coordination between different care settings, namely rural hospitals and tertiary care facilities.
- Care coordinators are key to assisting patient navigation of the health care system. PTAC noted that the NYC DOHMH had a particular emphasis on care coordinator roles in patient navigation.
- Reducing care transitions was a specific goal of two proposals. PTAC commented that fewer transitions improve continuity (Mt. Sinai) and noted that empowering PCPs would translate to fewer patient handoffs, with PCPs being more likely to have a comprehensive picture of patient health (NYC DOHMH).

XIV. Areas Where Additional Information is Needed

This section includes a summary of some areas for consideration to guide future research on care transition management in the context of population-based models and APMs. Appendix F further describes additional areas for future exploration and research.

Condition-Specific Barriers

Despite the need for further research on condition-specific barriers to care transitions, there is a lack of condition-specific care transition measures, which introduces challenges for those evaluating the efficacy of different condition- or procedure-specific care transition management approaches.³¹³

Variation in Effectiveness by the Direction of the Transition

Further research could examine the degree to which interventions focused on patient and family engagement are more effective when patients are discharged home, and whether interventions focused on transferring information and follow-up care are more effective when the patient transitions to another clinical setting.

Appendix A. Research Questions by Environmental Scan Section

Section	Research Questions
Section V. Trends in Utilization, Spending, and Reimbursement Related to Care Transitions	<ul style="list-style-type: none"> • For which kinds of care transitions between settings (e.g., between hospital and PAC) are there opportunities to reduce avoidable spending? • For what conditions with standard treatment pathways or episodes of care is there substantial variation in acute care and post-acute care spending? • How common are care transitions in the Medicare beneficiary population? How often are care transitions avoidable? • How does reimbursement for care transition management vary across payers, including fee-for-service (FFS) Medicare, Medicaid, Medicare Advantage, and commercial plans?
Section VI. Barriers to Effective and Appropriate Care Transition Management in Population-Based Models	<ul style="list-style-type: none"> • What are the greatest barriers to improving care transition management between settings of care (e.g., EDs, acute care hospitals, PAC facilities, home health care, ambulatory care)? • What specific barriers do these settings face in managing care transitions (e.g., physician buy-in, unplanned discharges, communication breakdown, resource availability)? • What patient-, provider-, and system-level factors influence barriers to improving care transition management? • What barriers have the most negative effects on care transition management? • To what extent do barriers to improving care transition management vary by condition/procedure? • What are the specific barriers to improving care transition management in acute care settings? • What are the specific barriers to improving care transition management in PAC settings? • What are the specific barriers to improving care transition management in behavioral health care settings? How do these barriers vary by the type of behavioral health issue(s)?
Section VII. Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation	<ul style="list-style-type: none"> • What proactive care delivery innovations should providers implement to improve care transition management for patients for different kinds of settings and different kinds of patients? • What are examples of organizations that have implemented effective approaches for improving care transition management in different kinds of settings? • What proactive care delivery innovations should providers implement to improve care transition management for patients with multiple chronic conditions? • What proactive care delivery innovations should providers implement to improve care transition management for patients with issues related to frailty/functional ability? • What proactive care delivery innovations should providers implement to improve care transition management for patients with health-related social needs (HRSNs)? • What proactive care delivery innovations should providers implement to improve care transition management for patients with behavioral health care needs? • What resources are needed to improve management of care transitions for patients with behavioral health care needs?

Section	Research Questions
	<ul style="list-style-type: none"> • What provider/entity activities (e.g., communication, medication management and reconciliation, transition/discharge planning, shared decision-making, patient/family education, proactive follow-up) are associated with improved care transition management between care settings? • What is the role of physicians in improving management of care transitions between settings (e.g., primary care, specialist, hospitalist)? • What is the role of other care delivery team members in improving management of care transitions between settings (e.g., nurses, care coordinators)? • Does effectiveness of provider/entity activities vary by the types of care settings involved or the direction of the transition (e.g., from acute care hospital to SNF vs. from SNF to acute care hospital)? • What proactive care delivery innovations should financial incentives encourage (e.g., promoting appropriate use of telehealth, discharge planning, employing care managers) to improve quality of and patient experience with care transition management? • What characteristics of inappropriate care transition management should financial incentives target to improve quality of and patient experience with care transition management and reduce TCOC?
<p>Section VIII. Using Financial Incentives to Improve Care Transition Management</p>	<ul style="list-style-type: none"> • What financial incentives are/should be used to improve care transition management between care settings? • How can these incentives be leveraged to encourage value-based care as it relates to care transition management? • What incentives are most applicable to specific barriers to improving care transition management between settings? • How are financial incentives structured to improve care transition management? • Do financial incentives to encourage improvements in care transition management vary between population-based and episode-based APMs? If so, how? • What payment mechanisms (e.g., capitation, per beneficiary per month [PBPM] payments, bundled payments) are used to incentivize improvements in care transition management? Which payment mechanisms are most effective in incentivizing improvements in care transition management? • What participating entities have improved management of care transitions between settings? What strategies did participating entities implement (e.g., dedicated transition care staff, pre-discharge referrals for ambulatory care, follow-up home visits)? What financial incentives did these entities implement?
<p>Section IX. Care Transition Management in CMMI Models</p>	<ul style="list-style-type: none"> • What existing APMs use financial incentives to encourage improvements in care transition management? What existing APMs integrate care transition management in their model design? • What care settings are included in these APMs? • Do financial incentives to encourage improvements in care transition management vary between population-based and episode-based APMs? If so, how? • What care management activities did these APMs require?

Section	Research Questions
Section X. Care Transition Management Activities in PTAC Proposals	<ul style="list-style-type: none"> • What previous PTAC proposals have addressed barriers to improving care transition management in their model design? • What care settings were included in these proposals? • What innovative care transition management activities did these proposals include? • What payment mechanisms (e.g., capitation, PBPM payments, bundled payments) were used to incentivize care transition management improvements?
Section XI. Performance Measurement of Care Transition Management in Population-Based Models	<ul style="list-style-type: none"> • What proactive care delivery innovations should financial incentives encourage (e.g., promoting appropriate use of telehealth, discharge planning, employing care managers) to improve quality of and patient experience with care transition management? • What characteristics of inappropriate care transition management should financial incentives target to improve quality of and patient experience with care transition management and reduce TCOC? • What proactive care delivery innovations should financial incentives encourage (e.g., promoting appropriate use of telehealth, discharge planning, employing care managers) to improve quality of and patient experience with care transition management? • What characteristics of inappropriate care transition management should financial incentives target to improve quality of and patient experience with care transition management and reduce TCOC? • To which provider/entity should patient outcomes related to care transition management be attributed? • Are there additional considerations that should be made with respect to measuring quality of care transition management for patients with multifaceted needs, including patients with behavioral health care needs or health-related social needs (HRSNs)?
Section XII. Considerations for Equity in Care Transition Management in Population-Based Models	<ul style="list-style-type: none"> • How can APMs address disparities related to care transition management? • For what population characteristics are there disparities in the effectiveness of care transition management (e.g., rurality, literacy, numeracy, primary language, age, insurance status, behavioral health)? • What barriers to appropriate care transition management do these populations face? • What organizations have improved care transition management for these populations? What strategies did they implement?

Appendix B. Search Strategy

Research Questions	Search Terms
Section V. Trends in Utilization, Spending, and Reimbursement Related to Care Transitions	
<ul style="list-style-type: none"> • For which kinds of care transitions between settings (e.g., between hospital and PAC) are there opportunities to reduce avoidable spending? • For what conditions with standard treatment pathways or episodes of care is there substantial variation in acute care and post-acute care spending? • How common are care transitions in the Medicare beneficiary population? How often are care transitions avoidable? • How does reimbursement for care transition management vary across payers, including fee-for-service (FFS) Medicare, Medicaid, Medicare Advantage, and commercial plans? 	Care transition OR transitions (AND): <ul style="list-style-type: none"> • Management • Payer • Medicare • Medicaid • Commercial • Acute care • Post-acute care • Discharge • Community
Section VI. Barriers to Effective and Appropriate Care Transition Management in Population-Based Models	
<ul style="list-style-type: none"> • What are the greatest barriers to improving care transition management between settings of care (e.g., EDs, acute care hospitals, PAC facilities, home health care, ambulatory care)? • What specific barriers do these settings face in managing care transitions (e.g., physician buy-in, unplanned discharges, communication breakdown, resource availability)? • What patient-, provider-, and system-level factors influence barriers to improving care transition management? • What barriers have the most negative effects on care transition management? • To what extent do barriers to improving care transition management vary by condition/procedure? • What are the specific barriers to improving care transition management in acute care settings? • What are the specific barriers to improving care transition management in PAC settings? • What are the specific barriers to improving care transition management in behavioral health care settings? How do these barriers vary by the type of behavioral health issue(s)? 	Care transition OR transitions (AND): <ul style="list-style-type: none"> • Management • Patient • Provider • System • Practice • Characteristic • Factor • Sociodemographic • Socioeconomic • Acute care • Post-acute care • Discharge • Community • Behavioral health • Mental health
Section VII. Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation	
<ul style="list-style-type: none"> • What proactive care delivery innovations should providers implement to improve care transition management for patients for different kinds of settings and different kinds of patients? • What are examples of organizations that have implemented effective approaches for improving care transition management in different kinds of settings? 	Care transition OR transitions (AND): <ul style="list-style-type: none"> • Management • Patient • Provider • System • Practice • Characteristic • Factor

Research Questions	Search Terms
<ul style="list-style-type: none"> • What proactive care delivery innovations should providers implement to improve care transition management for patients with multiple chronic conditions? • What proactive care delivery innovations should providers implement to improve care transition management for patients with issues related to frailty/functional ability? • What proactive care delivery innovations should providers implement to improve care transition management for patients with health-related social needs (HRSNs)? • What proactive care delivery innovations should providers implement to improve care transition management for patients with behavioral health care needs? • What resources are needed to improve management of care transitions for patients with behavioral health care needs? • What provider/entity activities (e.g., communication, medication management and reconciliation, transition/discharge planning, shared decision-making, patient/family education, proactive follow-up) are associated with improved care transition management between care settings? • What is the role of physicians in improving management of care transitions between settings (e.g., primary care, specialist, hospitalist)? • What is the role of other care delivery team members in improving management of care transitions between settings (e.g., nurses, care coordinators)? • Does effectiveness of provider/entity activities vary by the types of care settings involved or the direction of the transition (e.g., from acute care hospital to SNF vs. from SNF to acute care hospital)? • What proactive care delivery innovations should financial incentives encourage (e.g., promoting appropriate use of telehealth, discharge planning, employing care managers) to improve quality of and patient experience with care transition management? • What characteristics of inappropriate care transition management should financial incentives target to improve quality of and patient experience with care transition management and reduce TCOC? 	<ul style="list-style-type: none"> • Sociodemographic • Socioeconomic • Acute care • Post-acute care • Care setting • Care delivery • Discharge • Community • Care team • Direction • Activities • Initiatives • Improvement
Section VIII. Using Financial Incentives to Improve Care Transition Management	
<ul style="list-style-type: none"> • What financial incentives are/should be used to improve care transition management between care settings? • How can these incentives be leveraged to encourage value-based care as it relates to care transition management? • What incentives are most applicable to specific barriers to improving care transition management between settings? 	<p>Care transition OR transitions (AND):</p> <ul style="list-style-type: none"> • Management • Payment • Financial • Mechanism

Research Questions	Search Terms
<ul style="list-style-type: none"> • How are financial incentives structured to improve care transition management? • Do financial incentives to encourage improvements in care transition management vary between population-based and episode-based APMs? If so, how? • What payment mechanisms (e.g., capitation, per beneficiary per month [PBPM] payments, bundled payments) are used to incentivize improvements in care transition management? Which payment mechanisms are most effective in incentivizing improvements in care transition management? • What participating entities have improved management of care transitions between settings? What strategies did participating entities implement (e.g., dedicated transition care staff, pre-discharge referrals for ambulatory care, follow-up home visits)? What financial incentives did these entities implement? 	<ul style="list-style-type: none"> • Methodology • Shared savings • Shared losses • Capitation • Per beneficiary per month • Per patient per month • Bundled payment • Episode-based payment • Spending • Utilization • Quality • Patient experience • Discharge • Community
Section IX. Care Transition Management in CMMI Models	
<ul style="list-style-type: none"> • What existing APMs use financial incentives to encourage improvements in care transition management? What existing APMs integrate care transition management in their model design? • What care settings are included in these APMs? • Do financial incentives to encourage improvements in care transition management vary between population-based and episode-based APMs? If so, how? • What care management activities did these APMs require? 	<p>CMS Program Statistics, and CMS and Innovation Center websites and associated evaluation and model overview documents</p>
Section X. Care Transition Management Activities in PTAC Proposals	
<ul style="list-style-type: none"> • What previous PTAC proposals have addressed barriers to improving care transition management in their model design? • What care settings were included in these proposals? • What innovative care transition management activities did these proposals include? • What payment mechanisms (e.g., capitation, PBPM payments, bundled payments) were used to incentivize care transition management improvements? 	<p>PTAC proposal documents</p>
Section XI. Performance Measurement of Care Transition Management in Population-Based Models	
<ul style="list-style-type: none"> • What proactive care delivery innovations should financial incentives encourage (e.g., promoting appropriate use of telehealth, discharge planning, employing care managers) to improve quality of and patient experience with care transition management? • What characteristics of inappropriate care transition management should financial incentives target to improve quality of and patient experience with care transition management and reduce TCOC? 	<p>Care transition OR transitions (AND):</p> <ul style="list-style-type: none"> • Management • Payment • Financial • Incentive • Methodology • Performance AND measure OR metric

Research Questions	Search Terms
<ul style="list-style-type: none"> • What proactive care delivery innovations should financial incentives encourage (e.g., promoting appropriate use of telehealth, discharge planning, employing care managers) to improve quality of and patient experience with care transition management? • What characteristics of inappropriate care transition management should financial incentives target to improve quality of and patient experience with care transition management and reduce TCOC? • To which provider/entity should patient outcomes related to care transition management be attributed? • Are there additional considerations that should be made with respect to measuring quality of care transition management for patients with multifaceted needs, including patients with behavioral health care needs or health-related social needs (HRSNs)? 	<ul style="list-style-type: none"> • Benchmark AND outcome • Patient-reported measure • Patient experience • Voluntary attribution • Claims-based attribution • Retrospective attribution • Prospective attribution
Section XII. Considerations for Equity in Care Transition Management in Population-Based Models	
<ul style="list-style-type: none"> • How can APMs address disparities related to care transition management? • For what population characteristics are there disparities in the effectiveness of care transition management (e.g., rurality, literacy, numeracy, primary language, age, insurance status, behavioral health)? • What barriers to appropriate care transition management do these populations face? • What organizations have improved care transition management for these populations? What strategies did they implement? 	<p>Care transition OR transitions (AND):</p> <ul style="list-style-type: none"> • Disparity • Underserved • Vulnerable • Race/ethnicity • Age • Language • Limited English proficiency • Equity • Social determinant of health • Health-related social need

Appendix C. Summary of Model Features and Characteristics of Care Transition Management between Settings for 21 Selected CMMI Models with Components Related to Care Transition Management

The following tables provide specific details on CMMI Model characteristics (i.e., clinical focus, providers, setting, and patient population); components related to care transition management (i.e., focus of care transition management, overview of care transition management activities, delineation of provider responsibilities in care transition management, provision of e-consults, proactive referrals and scheduling of follow-up visits, and dedicated care management/care navigator staff); payment design features (i.e., financial incentives and whether financial incentives are used to support care transition activities); performance measurement features (i.e., types of performance measures, including care process measures and patient-reported outcomes; performance measures related to care transitions; whether performance is tied to payment; and benchmarking); and the approach to beneficiary alignment (if applicable) for selected CMMI Models that included care transition components.^{xi} The selected CMMI Models are presented in alphabetical order by CMMI Model name in three categories denoting the focus of care transition management: broad or holistic; transitions related to acute events, including inpatient hospitalizations, readmissions, ED visits, and observation stays; and transitions related to a care specialty.

Overview of Methodology Used to Review the Selected CMMI Models

The available information on each of the 21 selected CMMI Models' summary pages on the Innovation Center website was reviewed. This included an overview of the model, financial operating and performance measurement methodologies, informational webinars, evaluation reports and findings (as applicable), summaries, fact sheets, and press releases. Information found in these materials was used to summarize the models' main themes related to care transition management and other administrative, payment, and performance measurement characteristics. The categorizations were based on the key information highlighted in these documents and are not exhaustive. Models included in the tables are those that addressed care transitions in their model design; are ongoing, under development, or completed within the last five years; and operate in more than one state market. The selected models may have elements that fall into additional categories of context, objective, functions, and payment models.

^{xi} For additional details on approaches to improve care coordination in CMMI Models, refer to Appendix E in *Environmental Scan on Care Coordination in the Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs)*, available at <https://aspe.hhs.gov/sites/default/files/private/pdf/261946/Jun-2021-CC-Escan.pdf>.

Exhibit 9. Characteristics of CMMI Models with Components Related to Care Transition Management – Broad or Holistic Focus

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>Accountable Health Communities (AHC) Model <i>No longer active</i> Years active: 2017-2022</p>	<p>Clinical Focus: Primary care Providers: Community bridge organizations Setting: Multiple (e.g., hospitals— inpatient and outpatient, clinical delivery sites, community service provider sites) Patient Population: High-risk Medicare and Medicaid beneficiaries</p>	<p>Focus of Care Transition Management: Broad; health care services organizations to community services organizations Overview of Care Transition Management Activities: 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, including housing, food, violence intervention programs, utilities, or transportation Delineation of Provider Responsibilities in Care Transition Management: Transition from clinical provider to navigators, who assisted beneficiaries in</p>	<p>Financial Incentives: Funds for this model support the infrastructure and staffing needs of bridge organizations, and do not pay directly or indirectly for any community Services. <u>Assistance track:</u> Funding for screening Medicare and Medicaid beneficiaries for five HRSNs <u>Alignment track:</u> Same as Assistance track plus additional funding to support establishing a governing body of community partners/organizations and conducting a gap analysis to determine available resources and additional resources needed</p>	<p>Types of Performance Measures: Utilization, quality <u>Care Process Measures:</u> Not specified <u>Patient-Reported Outcomes:</u> Beneficiary satisfaction Performance Measures Related to Care Transitions: Number of beneficiaries who scheduled and completed clinical visits, rates of missing data from navigators, the timeliness of navigation, and Web traffic to online portals; number of ED visits, hospitalizations, and readmissions avoided Performance Tied to Payment: No Benchmarking: N/A</p>	<p>N/A^{xii}</p>

^{xii} Beneficiaries identified as having unmet HRSNs can decline services.

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>connecting with community services</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Yes, to available community resources</p> <p>Dedicated Care Management/Care Navigator Staff: Yes, with staff typically managed centrally by bridge organizations. Enrollee use of navigator services was optional.</p>	<p>Financial Incentives to Support Care Transition Activities: No; model funds cannot be used to pay directly or indirectly for any community services.</p>		
<p>Bundled Payments for Care Improvement Advanced (BPCI-A) Model</p> <p><i>Accepting applications</i></p> <p>Years active: 2018-present</p>	<p>Clinical Focus: Cross-clinical focus</p> <p>Providers: Acute Care Hospitals, Physician Group Practices, Medicare-enrolled providers</p> <p>Setting: Inpatient and outpatient services</p>	<p>Focus of Care Transition Management: Broad, depending on the Anchor Stay or Anchor Procedure and the index setting</p> <p>Overview of Care Transition Management Activities: Designate participant as leading engagement and coordination efforts</p>	<p>Financial Incentives: One risk track; 90-day clinical episodes with retrospective, bundled payments</p> <p>Financial Incentives to Support Care Transition Activities: No; funds primarily support quality improvements.</p>	<p>Types of Performance Measures: Quality</p> <p><u>Care Process Measures:</u> Yes, specific to clinical episode service line groups</p> <p><u>Patient-Reported Outcomes:</u> Patient experience</p>	N/A ^{xiii}

^{xiii} All BPCI-A Clinical Episodes are aligned to participants. Clinical episodes begin 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).

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
	<p>Patient Population: Medicare beneficiaries with certain clinical episodes (29 inpatient, 3 outpatient)</p>	<p>Delineation of Provider Responsibilities in Care Transition Management: The BPCI-A participant is responsible for ensuring that the entire health care team (from all health settings) communicates and collaborates on quality and total cost of care.</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Not specified</p> <p>Dedicated Care Management/Care Navigator Staff: Convener Participants may provide optional care management services to downstream Episode Initiators.</p>		<p>Performance Measures Related to Care Transitions: Percentage of excess days in acute care after hospitalization for acute myocardial infarction; three-item care transition measure</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Prospective; based on historical expenditures, patient characteristics, and characteristics and trends of the hospital's peer group for the episode; rebased annually and updated to reflect changes in Medicare FFS payment rates</p>	
<p>Comprehensive Primary Care Plus (CPC+) <i>No longer active</i> Years active: 2017-2021</p>	<p>Clinical Focus: Primary care</p> <p>Providers: Primary care providers (PCPs)</p>	<p>Focus of Care Transition Management: Reducing transitions by expanding breadth and depth of services provided in the office setting</p> <p>Overview of Care Transition Management Activities:</p>	<p>Financial Incentives: Care management fee; performance-based incentive payments; Medicare Physician Fee Schedule (MPFS)</p> <p>Financial Incentives to Support Care Transition</p>	<p>Types of Performance Measures: Utilization, spending, quality</p> <p><u>Care Process Measures:</u> Not specified</p>	<p>Prospective, claims-based alignment using a two-year "look back" period; the Centers for Medicare & Medicaid Services (CMS) attributes beneficiaries to</p>

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
	<p>Setting: Primary care practices</p> <p>Patient Population: All Medicare and Medicaid beneficiaries in participating regions</p>	<p>Participating practices have access to a robust learning system and feedback to guide future decision-making and improve care coordination and enhance care management for beneficiaries identified as high-risk.</p> <p>Delineation of Provider Responsibilities in Care Transition Management: Practices make changes in the way they deliver care based on the model's key functions: access and continuity, care management, comprehensiveness and coordination, patient and caregiver engagement, and planned care and population health.</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Participating providers were required to ensure 1) that all patients received timely follow-up contact from the practice</p>	<p>Activities: Yes; three payments each used to encourage improvements in quality, access, and efficiency.</p>	<p>Patient-Reported Outcomes: Patient experience</p> <p>Performance Measures Related to Care Transitions: Patient-reported quality/experience from the electronic clinical quality measures (eCQM) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) metrics</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, using risk-adjusted Patient Experience of Care (PEC) survey scores</p>	<p>practices every quarter</p>

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>after emergency department (ED) visits and hospitalizations, as clinically indicated; and 2) coordinated referral management, including addressing behavioral health care and health-related social needs (HRSNs).</p> <p>Dedicated Care Management/Care Navigator Staff: Participating practices were responsible for care management, and used care management fees to continuously employ care managers.</p>			
<p>Global and Professional Direct Contracting (GPDC)/Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH)^{xiv}</p>	<p>Clinical Focus: Primary and specialty care</p> <p>Providers: Direct Contracting Entities (DCEs) under GPDC, ACOs under ACO REACH; Participating and Preferred Providers</p>	<p>Focus of Care Transition Management: Broad; to encourage primary and specialty health care providers to form ACOs to deliver coordinated care to patients and manage costs</p> <p>Overview of Care Transition Management Activities: Participants within the ACO</p>	<p>Financial Incentives:</p> <p><u>Professional:</u> Risk-adjusted, monthly Primary Care Capitation payment; 50% shared risk</p> <p><u>Global:</u> Risk-adjusted, monthly Primary Care Capitation payment or Total Care Capitation</p>	<p>Types of Performance Measures: Utilization, spending, quality</p> <p><u>Care Process Measures:</u> Not specified</p> <p><u>Patient-Reported Outcomes:</u> Patient</p>	<p><u>Prospective, voluntary:</u> Beneficiaries confirm care relationships with participating providers (annual).</p> <p><u>Prospective Plus, voluntary:</u> Beneficiaries</p>

^{xiv} The Centers for Medicare & Medicaid Services (CMS) redesigned the GPDC Model, renaming it the ACO REACH Model. Participation in the ACO REACH Model began January 1, 2023.

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p><i>Participants Announced</i></p> <p>Years active: 2022-present</p>	<p>Setting: Broad applicability</p> <p>Patient Population: Medicare FFS beneficiaries; patients with complex chronic diseases and serious illnesses</p>	<p>must have a robust plan for meeting the needs of their patients with FFS Medicare in underserved communities and make measurable changes to address health disparities.</p> <p>Delineation of Provider Responsibilities in Care Transition Management: DCE/ACOs coordinate beneficiaries' health care services across clinicians and care settings^{xv}.</p> <p>Provision of E-Consults: Yes</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Not specified</p> <p>Dedicated Care Management/Care Navigator Staff: Not specified</p>	<p>payment (for all covered services, including specialty care); 100% shared risk</p> <p>Financial Incentives to Support Care Transition Activities: Shared risk and capitation</p>	<p>experience measures from CAHPS surveys</p> <p>Performance Measures Related to Care Transitions: Risk-standardized all-condition readmission measure; all-cause unplanned admissions for patients with multiple chronic conditions (UAMCC); days at home for patients with complex, chronic conditions; timely follow-up after acute exacerbations of chronic conditions</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, based on historical baseline expenditures and/or DC/KCC Rate Book OR a blend of historical and regional expenditures OR regional</p>	<p>confirm care relationships with participating providers (quarterly).</p> <p><u>Prospective, claims-based, primary care providers:</u></p> <p>Based on Primary Care Qualified E&M (PQEM) services furnished by primary care providers^{xvi} if 10% or more of the allowable charges incurred on PQEM services are billed by primary care providers (annual)</p> <p><u>Prospective, claims-based, non-primary care providers:</u></p> <p>Based on PQEM services furnished by non-primary</p>

^{xv} At least 75% control of each ACO's governing body generally must be held by participating providers or their designated representatives, compared to 25% during the first two Performance Years of the GPDC Model.

^{xvi} Primary care providers include physicians in general practice, family medicine, internal medicine, pediatric medicine, and geriatric medicine, as well as nurse practitioners, clinical nurse specialists, and physician assistants.

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
				expenditures, depending on DCE/ACO type and alignment	care providers ^{xvii} if less than 10% of the allowable charges incurred on PQEM services are billed by primary care providers (annual)
Home Health Value-Based Purchasing (HHVBP) Model <i>No Longer Active</i> Years active: 2016-2021	Clinical Focus: Home health care Providers: Medicare-certified Home Health Agencies (HHA) Setting: Home health setting Patient Population: Medicare beneficiaries requiring home health services	Focus of Care Transition Management: Support greater quality and efficiency of care among Medicare-certified Home Health Agencies (HHA) while reducing health care expenditures; provide home health care appropriately and as a substitute for higher-intensity care settings Overview of Care Transition Management Activities: Leveraged the successes and lessons learned from previous value-based purchasing programs and	Financial Incentives: Performance-based payment adjustment; shared risk Financial Incentives to Support Care Transition Activities: Episode-based bundled payments tied to quality; budget-neutral quality-based bonus payments; management payments	Types of Performance Measures: Utilization, spending, quality <u>Care Process Measures:</u> Drug education on medications provided to patient/caregiver during episodes of care; influenza immunization received for current flu season; pneumococcal polysaccharide vaccine ever received; herpes zoster (shingles) vaccination for patient; advance care plan	N/A ^{xviii}

^{xvii} Eligible non-primary care providers include physicians in cardiology, gastroenterology, osteopathic manipulative medicine, neurology, obstetrics/gynecology, hospice and palliative care, sports medicine, physical medicine and rehabilitation, psychiatry, geriatric psychiatry, pulmonology, nephrology, infectious disease, endocrinology, rheumatology, multispecialty clinic or group practice, addiction medicine, hematology, hematology/oncology, preventative medicine, medical oncology, gynecological/oncology, and neuropsychiatry.

^{xviii} All Medicare-certified HHAs from participating states are included in the HHVBP Model.

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>demonstrations to shift from volume-based payments to a value-based model designed to promote the delivery of higher-quality care to Medicare beneficiaries</p> <p>Delineation of Provider Responsibilities in Care Transition Management: Not specified</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Not specified</p> <p>Dedicated Care Management/Care Navigator Staff: Not specified</p>		<p><u>Patient-Reported Outcomes:</u> Patient experience measures from CAHPS surveys</p> <p>Performance Measures Related to Care Transitions: ED visits without hospitalization, unplanned acute care hospitalizations, improvement in management of oral medications, improvement in ambulation-locomotion, improvement in bathing</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes</p> <p><u>Achievement threshold:</u> Based on the median measure value for all HHAs in the state during the baseline period</p> <p><u>Benchmark:</u> Based on the mean measure value for the best performing decile of all HHAs in the state during the baseline period</p>	

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>Independence at Home (IAH) Demonstration</p> <p><i>Ongoing</i></p> <p>Years active: 2011-present</p>	<p>Clinical Focus: Primary care, chronically ill</p> <p>Providers: Primary care providers^{xix}</p> <p>Setting: Home-based</p> <p>Patient Population: Medicare beneficiaries with multiple chronic conditions</p>	<p>Focus of Care Transition Management: Ambulatory services (primary and specialty care visits; in-person, telehealth, and telephone visits); whether providing comprehensive primary care services at home improves care for Medicare beneficiaries with multiple chronic conditions.</p> <p>Overview of Care Transition Management Activities: 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);</p>	<p>Financial Incentives: Quality and financial performance-based incentive payments to provide home-based primary care to chronically ill beneficiaries; practices can earn incentive payments if their patients' Medicare expenditures are below the practice's target expenditures and the practice meets required standards for a set of quality measures.</p> <p>Financial Incentives to Support Care Transition Activities: Billing codes for chronic care management (CCM) services</p>	<p>Types of Performance Measures: Spending, quality</p> <p><u>Care Process Measures:</u> Not specified</p> <p><u>Patient-Reported Outcomes:</u> Not specified</p> <p>Performance Measures Related to Care Transitions: Unplanned readmissions; outpatient ED use; potentially avoidable outpatient ED use</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes</p> <p><u>Quality measure target performance:</u> Achieve measure-specific achievement thresholds on three or more of six measures</p> <p><u>Practice-specific PBPM target expenditures:</u> Based on historical</p>	<p>N/A^{xx}</p>

^{xix} Participating medical practices included independent practices, members of Visiting Physicians Associations, and academic medical centers.

^{xx} Participating medical practices screen beneficiaries, who can voluntarily enroll.

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>documenting medication reconciliation.</p> <p>Delineation of Provider Responsibilities in Care Transition Management:</p> <p>Participating practices were required to provide home-based primary care to high-cost chronically ill beneficiaries; participating practices were responsible for coordinating care.</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: IAH sites provided follow-up contacts for patients within 48 hours of a hospital discharge or ED visit.</p> <p>Dedicated Care Management/Care Navigator Staff: Some multidisciplinary teams included nurse case managers.</p>		<p>Medicare FFS per capita expenditures for non-participating beneficiaries in the same counties, adjusted for risk, frailty, and a utilization factor; trended to the PY by the increase in total per capita Medicare FFS expenditures</p>	

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>Integrated Care for Kids (InCK) Model</p> <p><i>Participants announced</i></p> <p>Years active: 2019-present</p>	<p>Clinical Focus: Primary care</p> <p>Providers: State Medicaid agencies, Lead Organizations (e.g., health care providers, managed care organizations, and public health departments), and Partnership Councils</p> <p>Setting: Managed care organizations</p> <p>Patient Population: Children under the age of 21 covered by Medicaid; Children’s Health Insurance Program (CHIP) beneficiaries; pregnant women over 21 with Medicaid</p>	<p>Focus of Care Transition Management: Broad; the goals of the InCK Model are to improve child health, reduce avoidable inpatient stays and out-of-home placement, and create sustainable Alternative Payment Models (APMs). The InCK Model supports states and local providers in early identification and treatment of children with health-related needs across settings.</p> <p>Overview of Care Transition Management Activities: 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 covered by Medicaid through prevention, early identification, and treatment of behavioral and physical health needs.</p>	<p>Financial Incentives: State-specific pediatric APMs that incorporate provider accountability and integrated care coordination, and focus on meaningful improvements in care quality and health outcomes</p> <p>Financial Incentives to Support Care Transition Activities: Varied by state APM; some state APMs transitioned individuals with complex physical and/or behavioral health needs to tailored managed care plans.</p>	<p>Types of Performance Measures: Utilization, quality</p> <p><u>Care Process Measures:</u> Screening for clinical depression and follow-up plan; initiation and engagement of alcohol and other drug abuse or dependence treatment</p> <p><u>Patient-Reported Outcomes:</u> Family experiences with coordination of care</p> <p>Performance Measures Related to Care Transitions: Family experiences with coordination of care</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, using baseline data submitted by Award Recipients (ARs) during the model pre-implementation period; varies by state</p>	<p>N/A^{xxi}</p>

^{xxi} Beneficiaries are voluntarily enrolled in the InCK Model through population-based screening.

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>Delineation of Provider Responsibilities in Care Transition Management:</p> <p>Participants are required to integrate care coordination and case management across physical and behavioral health and other local service providers to provide child- and family-centered care.</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Participants used data sharing to support service integration and care coordination, including community-based closed-loop referral platforms.</p> <p>Dedicated Care Management/Care Navigator Staff: Service integration coordinators serve as, or facilitate, the main point of contact for a beneficiary's integrated care coordination and/or case management of all health and Core Child Services;</p>			

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>service integration consultants partner closely with existing coordinators to provide families with a single point of contact and make sure they are receiving needed services.</p>			
<p>Maternal Opioid Misuse (MOM) Model <i>Ongoing</i> Years active: 2019-present</p>	<p>Clinical Focus: Pregnancy and postpartum care, opioid use disorder (OUD) Providers: Maternity care and behavioral health providers Setting: Maternity and behavioral health provider facilities Patient Population: Pregnant Medicaid and CHIP beneficiaries with OUD and their infants</p>	<p>Focus of Care Transition Management: Broad; to address fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with OUD Overview of Care Transition Management Activities: Support the delivery of coordinated and integrated physical health care, behavioral health care, and critical wrap-around services Delineation of Provider Responsibilities in Care Transition Management: Peer recovery staff will help coordinate OUD treatment and obstetric care; four states have care delivery partners manage care coordination.</p>	<p>Financial Incentives: <u>Transition funding:</u> For care delivery services not otherwise covered by Medicaid <u>Implementation funding:</u> To support implementation based on state-specific needs (e.g., coordinated and integrated care, improved capacity and infrastructure) <u>Milestone funding:</u> Encourage positive outcomes and continued care delivery transformation Financial Incentives to Support Care Transition Activities: Transition, Implementation, and</p>	<p>Types of Performance Measures: Spending, quality <u>Care Process Measures:</u> Screenings (e.g., HIV, mental health), any maternal postpartum check-up within three weeks/3-12 weeks after birth <u>Patient-Reported Outcomes:</u> Not specified Performance Measures Related to Care Transitions: Not specified Performance Tied to Payment: Yes Benchmarking: N/A</p>	<p>N/A^{xxii}</p>

^{xxii} Eligible beneficiaries with OUD can voluntarily participate in the MOM Model.

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>Provision of E-Consults: Yes, telephone center offering real-time consultations to providers on how to treat pregnant and postpartum women with OUD</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Yes, referrals to and follow-ups with community providers</p> <p>Dedicated Care Management/Care Navigator Staff: Yes, care coordinator staff, which include registered nurses, social workers, peer recovery coaches, and community health workers</p>	Milestone Funding can be used to support care transition activities.		
<p>Medicare Advantage Value-Based Insurance Design Model (MA VBID)</p> <p><i>Accepting Applications</i></p> <p>Years active: 2017-present</p>	<p>Clinical Focus: Chronic conditions</p> <p>Providers: Medicare Advantage Organizations (MAOs)</p> <p>Setting: Broad</p> <p>Patient Population: Medicare Advantage beneficiaries</p>	<p>Focus of Care Transition Management: Broad; to improve coordination and efficiency of health care service delivery</p> <p>Overview of Care Transition Management Activities: Remove obstacles to health and health care by tailoring benefits, lowering costs for prescription drugs; grocery assistance; transportation</p>	<p>Financial Incentives: Varied by PO; options included bonus payments and reduced cost sharing, and were tied to completing activities, such as preventive screening, medication review, care management, or disease management.</p>	<p>Types of Performance Measures: Spending, quality, utilization</p> <p><u>Care Process Measures:</u> Not specified</p> <p><u>Patient-Reported Outcomes:</u> Care experiences/satisfaction among targeted beneficiaries</p>	N/A

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>services; support managing chronic health conditions; the Hospice Benefit Component additionally helps patients needing end-of-life care experience a seamless transition to hospice care, if consistent with their and their caregivers' wishes, by enabling MA plans to be financially responsible for all services, including hospice.</p> <p>Delineation of Provider Responsibilities in Care Transition Management: Parent organizations (POs) establish hospice networks and process hospice claims.</p> <p>Provision of E-Consults: Varied by PO; some POs required beneficiaries to have a telephonic education consultation regarding their medication regimens.</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Approaches included a physician-referral-based system, as well as data-</p>	<p>Financial Incentives to Support Care Transition Activities: Supported flexibilities in benefit enhancements tailored to enrollee populations; for example, POs expanded on medical device use to help with remote monitoring or partnered with a provider group to offer primary care, social services, and care management services in one location.</p>	<p>Performance Measures Related to Care Transitions: Care utilization, Star Ratings</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Projected costs of offering the plan are compared to a geography-based benchmark amount, usually based on the cost of traditional FFS Medicare.</p>	

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>driven algorithms and varied by PO.</p> <p>Dedicated Care Management/Care Navigator Staff: Yes, varied by PO</p>			
<p>Next Generation Accountable Care Organization (NGACO)</p> <p><i>No Longer Active</i></p> <p>Years active: 2016-2021</p>	<p>Clinical Focus: Primary and specialty care</p> <p>Providers: Participating PCPs and specialists</p> <p>Setting: Primary and specialty care practices, hospitals, inpatient and outpatient settings</p> <p>Patient Population: Original Medicare FFS beneficiaries</p>	<p>Focus of Care Transition Management: Broad; facilitate care integration and coordination across care continuum by delivering care in lower-cost settings and avoiding duplicative services</p> <p>Overview of Care Transition Management Activities: Model participants are NGACOs that help improve care coordination; certain benefit enhancements (BEs) address care transitions, such as a post-discharge home visit BE or a care management home visit BE.</p> <p>Delineation of Provider Responsibilities in Care Transition Management: NGACOs are responsible for care coordination.</p>	<p>Financial Incentives: FFS payments with fixed per beneficiary per month (PBPM) infrastructure payments, population-based payments (PBPs), all-inclusive PBPs; shared risk</p> <p>Financial Incentives to Support Care Transition Activities: Model provides for shared savings/losses based on spending benchmarks and quality measures tied to care transition management activities (e.g., hospital and SNF readmissions).</p>	<p>Types of Performance Measures: Spending, quality</p> <p><u>Care Process Measures:</u> Not specified</p> <p><u>Patient-Reported Outcomes:</u> CAHPS (Getting Timely Care, Appointments, and Information; How Well Your Doctors Communicate; Health Promotion and Education; Shared Decision-Making; Stewardship of Patient Resources)</p> <p>Performance Measures Related to Care Transitions:</p> <p>Risk-standardized, all condition readmission; SNF 30-day readmission; documentation of</p>	<p><u>Voluntary:</u> Beneficiaries confirm care relationships with participating providers (annual).</p> <p><u>Prospective, claims-based:</u> Beneficiaries are aligned to the participating provider that provided the majority of that beneficiary's evaluation and management (E&M) visits (annual).</p>

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Not specified</p> <p>Dedicated Care Management/Care Navigator Staff: Not specified</p>		<p>current medications in the medical record</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, prospectively set, based on historical expenditures and national trends</p>	
<p>Primary Care First Model Options (PCF)</p> <p><i>Ongoing</i></p> <p>Years active: 2021-present</p>	<p>Clinical Focus: Primary care</p> <p>Providers: PCPs</p> <p>Setting: Primary care practices</p> <p>Patient Population: Medicare patients with serious illness/chronic conditions</p>	<p>Focus of Care Transition Management: Broad; care continuity, coordination, and management; patient and caregiver engagement</p> <p>Overview of Care Transition Management Activities: 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</p> <p>Delineation of Provider Responsibilities in Care</p>	<p>Financial Incentives: Total Primary Care Payment paid to deliver advanced primary care in/outside of office; Performance-Based Adjustment to reduce acute hospitalizations to reduce total cost of care, while meeting quality and experience of care performance thresholds; separate payment structure for practices that care for Seriously Ill Populations (SIP) beneficiaries, including one-time per beneficiary payment for patient outreach and engagement, as well as monthly per beneficiary</p>	<p>Types of Performance Measures: Utilization, spending, quality</p> <p><u>Care Process Measures:</u> Colorectal cancer screening, advance care planning</p> <p><u>Patient-Reported Outcomes:</u> Patient experience of care survey</p> <p>Performance Measures Related to Care Transitions: Potentially preventable hospitalizations, documentation of advance care plan</p> <p>Performance Tied to Payment: Yes</p>	<p>Prospective voluntary or claims-based alignment using a two-year “look back” period; CMS attributes beneficiaries to practices every quarter.</p>

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>Transition Management: Not specified</p> <p>Provision of E-Consults: Yes</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Requirements for timely callbacks and coordinated referral management</p> <p>Dedicated Care Management/Care Navigator Staff: Yes, varied by practice</p>	<p>payments with an upward or downward adjustment based on quality</p> <p>Financial Incentives to Support Care Transition Activities: Capitated payments support care coordination</p>	<p>Benchmarking: Yes, using national benchmarks and regional performance adjustments (based on reference group of practices)</p>	

Exhibit 10. Characteristics of CMMI Models with Components Related to Care Transition Management – Acute Event Focus

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>Comprehensive Care for Joint Replacement (CJR) Model</p> <p><i>Ongoing</i></p> <p>Years active: 2016-present</p>	<p>Clinical Focus: Lower extremity joint replacements (LEJR)</p> <p>Providers: Hospitals, physicians, and post-acute care providers</p> <p>Setting: Inpatient or outpatient</p> <p>Patient Population: Medicare patients undergoing hip, knee, and ankle replacements</p>	<p>Focus of Care Transition Management: Acute care hospitals, institutional post-acute care settings, and home health agencies</p> <p>Overview of Care Transition Management Activities: Providers develop a tailored recovery plan for each patient, including details such as treatment preferences; CMS 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.</p> <p>Delineation of Provider Responsibilities in Care Transition Management: Participating hospitals are financially accountable for the</p>	<p>Financial Incentives: Retrospective, bundled payment model with prospective, quality-adjusted target prices for each joint replacement episode</p> <p>Financial Incentives to Support Care Transition Activities: Yes; funds support increased coordination efforts by providing hospitals with data, waiving certain Medicare requirements, and facilitating the sharing of best practices.</p>	<p>Types of Performance Measures: Utilization, spending, quality</p> <p><u>Care Process Measures:</u> Pain management, anesthesia, wound care, and use of hospital-approved implants or prostheses</p> <p><u>Patient-Reported Outcomes:</u> Patient satisfaction with care, including discharge destination, care coordination, and treatment instructions</p> <p>Performance Measures Related to Care Transitions: Yes, Hospital CAHPS (HCAHPS) Survey measure reporting</p>	<p>Eligible beneficiaries are aligned to participating hospitals based on discharges with qualifying joint replacement Medicare Severity Diagnosis Related Groups (MS-DRGs).</p>

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>quality and cost of a CJR episode of care.</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Not specified</p> <p>Dedicated Care Management/Care Navigator Staff: Yes; some participants had dedicated care coordination staff.</p>		<p>patients' experience of hospital care</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Performance year (PY) target prices based on hospital-specific and regional episode expenditures, including a three percent discount</p>	
<p>Expanded Home Health Value-Based Purchasing (Expanded HHVBP) Model</p> <p><i>Ongoing</i></p> <p>Years active: 2022-present</p>	<p>Clinical Focus: Home health care</p> <p>Providers: Medicare-certified Home Health Agencies (HHAs)</p> <p>Setting: Home health setting</p>	<p>Focus of Care Transition Management: Improve quality and efficiency of home health care of Medicare beneficiaries to reduce avoidable ED visits</p> <p>Overview of Care Transition Management Activities: Provide incentives for better quality care with greater efficiency, study new</p>	<p>Financial Incentives: Quality performance^{xxiii}-adjusted Medicare FFS payments; HHAs receive adjustments to their Medicare FFS payments based on their performance against a set of quality measures, relative to their peers'</p>	<p>Types of Performance Measures: Spending, quality</p> <p><u>Care Process Measures:</u> Not specified</p> <p><u>Patient-Reported Outcomes:</u> Patient experience</p>	N/A ^{xxiv}

^{xxiii} Relative to peers

^{xxiv} All Medicare-certified HHAs from participating states are included in the Expanded HHVBP Model.

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
	<p>Patient Population: Medicare beneficiaries requiring home health services</p>	<p>potential quality and efficiency measures for appropriateness in the home health setting, and enhance the current public reporting process</p> <p>Delineation of Provider Responsibilities in Care Transition Management: Participants must report 1) acute care hospitalization during the first 60 days of Home Health Care Use; and 2) ED use without hospitalization during the first 60 days of home health use.</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Not specified</p> <p>Dedicated Care Management/Care Navigator Staff: Not specified</p>	<p>performance; performance in a specified year also impacts payment adjustments in a later year.</p> <p>Financial Incentives to Support Care Transition Activities: Implementing a value-based purchasing policy for home health care may increase quality of care and reduce burden on emergency medical services.</p>	<p>Performance Measures Related to Care Transitions: Home Health CAHPS (HHCAHPS) surveys assess care of patients, communications between providers and patients, specific care issues, overall rating of home health care, and willingness to recommend the agency.</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: For each quality measure, the benchmark is based on the mean of the top decile of all Medicare-certified HHAs' performance scores, calculated separately for larger- and smaller-volume cohorts.</p>	

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>Frontier Community Health Integration Project Demonstration (Frontier Community)</p> <p><i>Extension Authorized</i></p> <p>Years active: 2016-present</p>	<p>Clinical Focus: Essential services</p> <p>Providers: Participating Critical Access Hospitals (CAHs)</p> <p>Setting: Participating CAHs</p> <p>Patient Population: Medicare beneficiaries residing in sparsely-populated rural counties in AK, MT, NV, ND, and WY</p>	<p>Focus of Care Transition Management: Develop and test new models of integrated, coordinated health care in CAHs in the most sparsely populated rural counties using telehealth, Part B ambulance services, and SNF/NF care, with the goal of improving health outcomes and reducing Medicare expenditures</p> <p>Overview of Care Transition Management Activities: 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</p> <p>Delineation of Provider Responsibilities in Care</p>	<p>Financial Incentives: Medicare waivers offered to CAHs with low population density; enhanced Medicare payments for telehealth, Part B ambulance, and home health services</p> <p>Financial Incentives to Support Care Transition Activities: Providers reimbursed at 101% of reasonable costs of furnishing Part B ambulance services, instead of being paid at the Medicare ambulance fee schedule rate; reimbursed at 101% of reasonable costs for providing telehealth services when serving as the originating site</p>	<p>Types of Performance Measures: Utilization, spending, quality</p> <p><u>Care Process Measures:</u> Not specified</p> <p><u>Patient-Reported Outcomes:</u> Not specified</p> <p>Performance Measures Related to Care Transitions: Not specified</p> <p>Performance Tied to Payment: No</p> <p>Benchmarking: N/A</p>	<p>N/A^{xxv}</p>

^{xxv} Frontier Community Demonstration claims are furnished by CAHs.

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>Transition Management: The Health Resources and Services Administration (HRSA) provided technical assistance to help CAHs make operational changes and to market hospital services to the surrounding community.</p> <p>Provision of E-Consults: Yes</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Not specified</p> <p>Dedicated Care Management/Care Navigator Staff: Not specified</p>			
<p><u>Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents: Phase Two</u></p> <p><i>Ongoing</i></p> <p>Years active: 2016-present</p>	<p>Clinical Focus: Pneumonia, chronic obstructive pulmonary disease (COPD)/asthma, dehydration, congestive heart failure (CHF), skin</p>	<p>Focus of Care Transition Management: To reduce potentially avoidable inpatient hospitalizations by providing acute care on site to residents</p> <p>Overview of Care Transition Management Activities:</p>	<p>Financial Incentives: Facilities treating an eligible resident for one of six conditions could receive a short-term per diem payment from</p>	<p>Types of Performance Measures: Spending, quality, utilization</p> <p><u>Care Process Measures:</u> Not specified</p>	None ^{xxvi}

^{xxvi} Residents in participating facilities were eligible for the Initiative if they had one of six acute conditions that could be treated on site in NFs.

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
	<p>infections, urinary tract infection (UTI)</p> <p>Providers: Physicians, advanced practice registered nurses (APRNs), and physician assistants</p> <p>Setting: Nursing facilities (NFs)</p> <p>Patient Population: Long-stay LTC facility residents enrolled in Medicare or Medicaid</p>	<p>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 end-of-life support.</p> <p>Delineation of Provider Responsibilities in Care Transition Management: ECCPs provided education and support to facilities to improve clinical care processes and communication.</p> <p>Provision of E-Consults: During the COVID-19 PHE, nurses were permitted to provide clinical consultations telephonically.</p>	<p>Medicare if the condition met certain CMS-defined criteria; special Medicare billing codes for facilities and practitioners.</p> <p>Financial Incentives to Support Care Transition Activities:</p> <p>Participants can submit claims with special Medicare billing codes, which serve as a financial incentive to nursing facilities and practitioners to provide acute care to eligible Medicare FFS long-stay residents on-site, rather than transferring them to hospitals. Practitioners can submit a bill to receive a hospital-level visit payment when</p>	<p><u>Patient-Reported Outcomes:</u> Self-reported pain</p> <p>Performance Measures Related to Care Transitions: All-cause and potentially avoidable hospitalizations, ED visits, and acute care transitions; mortality</p> <p>Performance Tied to Payment: No</p> <p>Benchmarking: None</p>	

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>Proactive Referrals and Scheduling of Follow-Up Visits: Not specified</p> <p>Dedicated Care Management/Care Navigator Staff: Some state interventions included registered nurse care coordinators (RNCCs) who provided education and training to improve transitions between nursing facilities and hospitals.</p>	evaluating patients as part of providing on-site treatment.		
<p>Value in Opioid Use Disorder Treatment (Value in Treatment) Demonstration Program</p> <p><i>Participants announced</i></p> <p>Years active: 2021-present</p>	<p>Clinical Focus: Opioid use disorder (OUD)</p> <p>Providers: Physicians, hospitals, health centers, treatment</p>	<p>Focus of Care Transition Management: Reducing hospitalizations and ED visits</p> <p>Overview of Care Transition Management Activities: Financial incentives available, including care management fees, to provide tailored services</p> <p>Delineation of Provider Responsibilities in Care</p>	<p>Financial Incentives: Performance-based incentive</p> <p>Financial Incentives to Support Care Transition Activities: Per beneficiary per month (PBPM) care management fee to “deliver additional services to applicable beneficiaries,</p>	<p>Types of Performance Measures: Quality</p> <p><u>Care Process Measures:</u> Not specified; may include evidence-based medication-assisted treatment</p> <p><u>Patient-Reported Outcomes:</u> Not specified</p>	N/A ^{xxviii}

^{xxviii} Eligible beneficiaries can voluntarily enroll in the Value in Treatment Demonstration Program.

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
	<p>programs with OUD services^{xxvii}</p> <p>Setting: Outpatient OUD treatment facility</p> <p>Patient Population: Medicare A and B beneficiaries (not Medicare Advantage) with a current diagnosis for an opioid use disorder</p>	<p>Transition Management: Not specified</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Not specified</p> <p>Dedicated Care Management/Care Navigator Staff: Not specified</p>	<p>including services not otherwise eligible for payment under [Title XVIII]"</p>	<p>Performance Measures Related to Care Transitions: Not specified; may include patient engagement and retention in treatment</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Performance threshold relative to national benchmark</p>	

^{xxvii} OUD care teams must participate in Medicare and can comprise the following types of individuals/entities: physicians, physician group practices, hospital outpatient departments, Federally Qualified Health Centers (FQHCs), rural health clinics (RHCs), community mental health centers (CMHCs), clinics certified as community behavioral health clinics pursuant to Section 223 of the Protecting Access to Medicare Act of 2014, opioid treatment programs (entities specified by the Secretary), and critical access hospitals (CAHs; entities specified by the Secretary).

Exhibit 11. Characteristics of CMMI Models with Components Related to Care Transition Management – Specialty Care Focus

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>Comprehensive ESRD Care (CEC) Model <i>No longer active</i> Years active: 2015-2021</p>	<p>Clinical Focus: End-stage renal disease (ESRD)</p> <p>Providers: Nephrologists; ESRD Seamless Care Organizations (ESCOs)^{xxix}</p> <p>Setting: Nephrology clinics</p> <p>Patient Population: Medicare beneficiaries with ESRD</p>	<p>Focus of Care Transition Management: Acute care hospitals and outpatient dialysis clinics</p> <p>Overview of Care Transition Management Activities: Encourage and support patient-centered care that addresses health needs both in and outside the dialysis clinic; designate ESRD Seamless Care Organizations (ESCOs) as facilitator for care coordination</p> <p>Delineation of Provider Responsibilities in Care Transition Management: Participating ESCOs involving dialysis clinics, nephrologists and other providers, share responsibility for clinical</p>	<p>Financial Incentives: <u>Large dialysis organizations (LDOs)</u>^{xxx}: Two-sided risk and higher overall risk, compared to non-LDOs</p> <p><u>Non-LDOs</u>^{xxxi}: One- or two-sided risk, depending on resources</p> <p>Financial Incentives to Support Care Transition Activities: Yes; funds are used to enable innovative care delivery strategies.</p>	<p>Types of Performance Measures: Utilization, spending, quality</p> <p><u>Care Process Measures:</u> Not specified</p> <p><u>Patient-Reported Outcomes:</u> Quality of dialysis care</p> <p>Performance Measures Related to Care Transitions: In-Center Hemodialysis CAHPS (ICH CAHPS) score based on six sub-measures: nephrologists’ communication and care, quality of dialysis center care and operations, providing information to</p>	<p>Based on first dialysis utilization encounter with a participating facility; conducted quarterly</p>

^{xxix} ESCOs comprise nephrologists, dialysis facilities, and other providers.

^{xxx} LDOs have 200 or more dialysis facilities.

^{xxxi} Non-LDOs include fewer than 200 dialysis facilities, independent dialysis facilities, and hospital-based dialysis facilities.

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>quality and financial outcomes.</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Yes; ESCOs partnered with hospice and palliative care organizations to improve referral processes; several ESCOs had partnerships with behavioral health organizations.</p> <p>Dedicated Care Management/Care Navigator Staff: Yes; several ESCOs established centralized care navigation services.</p>		<p>patients, rating of kidney doctors, rating of dialysis center staff, and rating of dialysis center</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, based on historical Medicare Parts A and B expenditures for beneficiaries who would have been aligned to the ESCO in each of the three years prior to the start of the first PY, trended forward using national data</p>	
<p>ESRD Treatment Choices (ETC) Model</p> <p><i>Ongoing</i></p> <p>Years active: 2021-present</p>	<p>Clinical Focus: Home dialysis and kidney transplants for patient with ESRD</p>	<p>Focus of Care Transition Management: Reducing avoidable hospitalizations and incentivizing in-home dialysis care</p> <p>Overview of Care Transition Management Activities:</p>	<p>Financial Incentives: <u>Home Dialysis Payment Adjustment (HDPA):</u> Positive adjustment</p>	<p>Types of Performance Measures: Utilization, spending, quality</p> <p><u>Care Process Measures:</u> Not specified</p>	<p>Beneficiaries are attributed on a month-by-month basis. A beneficiary is attributed to the ESRD facility accounting for the</p>

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
	<p>Providers: Nephrologists</p> <p>Setting: ESRD facilities, transplant centers, large donor hospitals, patient home</p> <p>Patient Population: Patients with ESRD</p>	<p>Offer patients education to support treatment options</p> <p>Delineation of Provider Responsibilities in Care Transition Management: ETC participants are responsible for educational services and increasing treatment flexibility for their patients.</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Not specified</p> <p>Dedicated Care Management/Care Navigator Staff: Not specified; the End-Stage Renal Disease Treatment Choices Learning Collaborative engages ETC participants, transplant centers, Organ Procurement Organizations (OPOs), large donor hospitals, transplant recipients, and donor family members in education on</p>	<p>on home dialysis claims during the first three years of model</p> <p>Performance Payment Adjustment (PPA): Positive or negative adjustment based on rates of home dialysis and transplant in a measurement year; adjustment made to the adjusted ESRD Prospective Payment System PPS per treatment base rate under the ESRD PPS for selected ESRD facilities and to the Monthly Capitation Payment for selected Managing Clinicians</p> <p>Financial Incentives to Support Care Transition Activities: Additional incentives to treat underserved patients such as those who are dually eligible</p>	<p>Patient-Reported Outcomes: Not specified</p> <p>Performance Measures Related to Care Transitions: CMS will monitor inappropriate referrals and assess the impacts of the model on mortality and hospitalizations</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Achievement benchmarks are based on historical home dialysis rate and transplant rate of non-participating ESRD facilities and Managing Clinicians who provide care in Comparison Geographic Areas.</p>	<p>most dialysis claims during the month, and the Managing Clinician billing the first MCP for the month.</p>

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		best practices for kidney procurement, recovery, and utilization.	for Medicare and Medicaid, and Medicare beneficiaries who receive assistance with prescription drug costs		
<p>Enhancing Oncology Model (EOM)</p> <p><i>Applications Under Review, Ongoing</i></p> <p>Years active: 2022-present</p>	<p>Clinical Focus: Oncology</p> <p>Providers: Oncologists</p> <p>Setting: Oncology practices</p> <p>Patient Population: Medicare beneficiaries with cancer</p>	<p>Focus of Care Transition Management: Broad, with a special focus on improved communication with primary care providers; participating oncology providers and suppliers can reduce risk of hospitalization through benefit enhancements, including telehealth visits, post-discharge home visits, and care management visits.</p> <p>Overview of Care Transition Management Activities: Supports personalized services; considers patients' preferences and goals for treatment, health-related social needs, and psychosocial health needs; engages patients throughout regularly and proactively;</p>	<p>Financial Incentives: Monthly Enhanced Oncology Services (MEOS) payment; retrospective PBP or performance-based recoupment (PBR)</p> <p>Financial Incentives to Support Care Transition Activities: Program funds support efforts to redesign care and improve quality of care for beneficiaries receiving chemotherapy, including care coordination and patient navigation.</p>	<p>Types of Performance Measures: Spending, quality</p> <p><u>Care Process Measures:</u> Not specified</p> <p><u>Patient-Reported Outcomes:</u> Patient experience</p> <p>Performance Measures Related to Care Transitions: Patient-reported experience of care, avoidable acute care utilization, management of symptoms and toxicity, management of psychosocial health,</p>	<p>Based on first qualifying Evaluation & Management (E&M) service after chemotherapy initiation if that practice provides at least 25 percent of cancer-related E&M services during the episode OR the majority of E&M visits</p>

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>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 EHR technology</p> <p>Delineation of Provider Responsibilities in Care Transition Management: EOM participants assume accountability for health care quality and spending.</p> <p>Provision of E-Consults: Available through telehealth benefit enhancement</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Yes, to follow-up clinical services, as well as community services</p> <p>Dedicated Care Management/Care Navigator Staff: Yes,</p>		<p>and management of end-of-life care</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, based on predicted episode amounts from trended forward baseline expenditures</p>	

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		including 24/7 access to an appropriate clinician with real-time access to patient medical records, patient navigation services, and screening for HRSNs			
Kidney Care Choices (KCC) Model <i>Ongoing</i> Years active: 2020-present	Clinical Focus: ESRD Providers: Accountable care/dialysis facilities, nephrologists, and other health care providers form ESRD-focused ACOs (Kidney Contracting Entities ^{xxxii} [KCEs]) Setting: Dialysis facilities	Focus of Care Transition Management: To delay the onset of dialysis and to incentivize kidney transplantation Overview of Care Transition Management Activities: Patients with chronic kidney disease may experience fragmented care and high-cost treatments, and receive limited to no education about their disease and treatment options. KCEs offer coordinated and seamless care (including dialysis, transplant, and if appropriate, end-of-life care)	Financial Incentives: <u>Kidney Care First (KCF):</u> Quarterly and adjusted monthly capitation payments and a kidney transplant bonus (KTB) <u>Comprehensive Kidney Care Contracting (CKCC) Graduated Option:</u> Same as KCF plus one-sided risk <u>CKCC Professional Option:</u> Same as KCF plus 50% shared savings/losses for all Part A and B services	Types of Performance Measures: Spending, quality <u>Care Process Measures:</u> Not specified <u>Patient-Reported Outcomes:</u> Not specified Performance Measures Related to Care Transitions: Not specified Performance Tied to Payment: Yes	Alignment based on where beneficiary receives the majority of their kidney care; when aligned beneficiary receives kidney transplant, they remain aligned to provider for the following three years (if successful; otherwise, they could be re-aligned).

^{xxxii} Nephrology practices and their nephrologists and nephrology professionals who meet certain eligibility requirements can participate in the Kidney Care First (KCF) Option. KCEs can participate in any of the Comprehensive Kidney Care Contracting (CKCC) Options and are required to include nephrologists or nephrology practices and transplant providers; optional participants in KCEs include dialysis facilities and other suppliers and providers.

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
	<p>Patient Population: Patients with ESRD</p>	<p>and provide patient education.</p> <p>Delineation of Provider Responsibilities in Care Transition Management: KCEs (primarily through nephrologists) coordinate care for aligned beneficiaries.</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Not specified</p> <p>Dedicated Care Management/Care Navigator Staff: Not specified</p>	<p>for aligned beneficiaries</p> <p><u>CKCC Global Option:</u> Same as KCF plus 100% shared savings/losses for all Part A and B services for aligned beneficiaries</p> <p>Financial Incentives to Support Care Transition Activities: Shared risk and capitation</p>	<p>Benchmarking: Yes, based on historical baseline expenditures, prospectively trended forward each performance year (PY) using the projected U.S. per capita cost (USPCC)</p>	
<p>Oncology Care Model (OCM)</p> <p><i>No Longer Active</i></p> <p>Years active: 2016-2022</p>	<p>Clinical Focus: Cancer care</p> <p>Providers: Oncology providers</p> <p>Setting: Outpatient</p>	<p>Focus of Care Transition Management: Ensure each patient's needs and preferences are met and bridge gaps between different systems of care</p> <p>Overview of Care Transition Management Activities: Facilitate transitions and coordinate care across</p>	<p>Financial Incentives: Per beneficiary MEOS payment for the duration of the episode; PBP for chemotherapy care episodes</p> <p>Financial Incentives to Support Care Transition Activities:</p>	<p>Types of Performance Measures: Spending, quality</p> <p><u>Care Process Measures:</u> Not specified</p> <p><u>Patient-Reported Outcomes:</u> Patient-Reported Experience</p>	<p>Chemotherapy care episodes were aligned to the practice that provided the majority of that beneficiary's cancer-related E&M visits.</p>

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
	<p>Patient Population: Patients with cancer</p>	<p>settings, including monitoring follow-up</p> <p>Delineation of Provider Responsibilities in Care Transition Management: Responsibility for specific aspects of a patient’s care must be documented in the electronic health record (EHR).</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Yes; for example, in some practices, mental health screenings are used to flag patients for referral to a social worker or psychologist.</p> <p>Dedicated Care Management/Care Navigator Staff: Care coordinators and nurse navigators</p>	<p>Potential for performance-based incentive payments based on measures that relate to care transitions, such as the proportion of patients who died who were admitted to hospice for three days or more</p>	<p>of Care (Modified Cancer CAHPS)</p> <p>Performance Measures Related to Care Transitions: Proportion of patients who died who were admitted to hospice for three days or more; all-cause and chemotherapy-related acute care hospitalizations and ED visits; hospital-based care and chemotherapy at the end of life; hospice use and timing</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Based on risk-adjusted historical expenditures</p>	

Appendix D. Summary of Model Features and Characteristics of Care Transition Management between Settings of Proposals Reviewed by PTAC as of September 2020 with Components Related to Care Transition Management

The following tables provide specific details on PTAC proposal characteristics (i.e., clinical focus, providers, setting, and patient population); components related to care transition management (i.e., focus of care transition management, overview of care transition management activities, delineation of provider responsibilities in care transition management, provision of e-consults, proactive referrals and scheduling of follow-up visits, and dedicated care management/care navigator staff); payment design features (i.e., financial incentives and whether financial incentives are used to support care transition activities); performance measurement features (i.e., types of performance measures, including care process measures and patient-reported outcomes; performance measures related to care transitions; whether performance is tied to payment; and benchmarking); and the approach to beneficiary alignment (if applicable) for 20 selected PTAC proposals. Selected proposals were those that received a rating of “Meets and Deserves Priority Consideration” (one proposal) or “Meets” (15 proposals) on Criterion 7, Integration and Care Coordination.^{xxxiii} Also included in the tables are proposals that did not meet Criterion 7, but included components related to facilitating transitions and coordinating care across settings (four proposals). The selected PTAC proposals are presented in alphabetical order by the proposal submitter’s name in three categories denoting the focus of care transition management: broad or holistic; transitions related to acute events, including inpatient hospitalizations, readmissions, ED visits, and observation stays; and transitions related to a care specialty.

Overview of Methodology Used to Review the Proposals

The following information was reviewed for each submitter’s proposal, where available: proposal and related documents, Preliminary Review Team (PRT) Report, and Report to the Secretary (RTS). Information found in these materials was used to summarize the proposals’ main themes related to care transition management and other administrative, payment, and performance measurement characteristics. The categorizations were based on the key information highlighted in these documents and are not exhaustive. Proposals may have elements of their proposed models that fall into additional categories of context, objective, functions, and payment models.

^{xxxiii} For additional details on approaches to improve care coordination in PTAC proposals, refer to Appendix F in *Environmental Scan on Care Coordination in the Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs)*, available at <https://aspe.hhs.gov/sites/default/files/private/pdf/261946/Jun-2021-CC-Escan.pdf>.

Exhibit 12. Characteristics of PTAC Proposals with Components Related to Care Transition Management – Broad or Holistic Focus

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>American Academy of Family Physicians (AAFP) <i>(Provider association and specialty society)</i></p> <p>Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care</p> <p>Recommended for limited-scale testing, 12/19/2017</p>	<p>Clinical Focus: Primary Care</p> <p>Providers: All physicians with a primary specialty of family medicine, general practice, geriatric medicine, pediatric medicine, or internal medicine</p> <p>Setting: Primary care practices</p> <p>Patient Population: PCPs' patient panels</p>	<p>Focus of Care Transition Management: Broad; acknowledges that patients with complex or multiple chronic conditions may reap additional benefits from care transition management support</p> <p>Overview of Care Transition Management Activities: Primary care medical homes work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange.</p> <p>Delineation of Provider Responsibilities in Care Transition Management: Primary care provider has central responsibility/ oversight for care coordination and management.</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Referrals managed by primary care medical home; responsibility for scheduling of follow-up visits not specified</p>	<p>Financial Incentives: Capitated per beneficiary per month (PBPM) payment with shared risk</p> <p>options for accountability</p> <p>Financial Incentives to Support Care Transition Activities: Yes; monthly payments support provider flexibility to provide care coordination.</p>	<p>Types of Performance Measures: Utilization, spending, quality</p> <p><u>Care Process Measures:</u> Not specified</p> <p><u>Patient-Reported Outcomes:</u> Patient satisfaction</p> <p>Performance Measures Related to Care Transitions: Medication reconciliation post-discharge</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, based on historical performance and reassessed after two or more years</p>	<p>Prospective, hierarchical process based on patient choice, wellness visits, Evaluation & Management (E&M) visits, and primary care prescription and order events</p>

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>Dedicated Care Management/Care Navigator Staff: Medical homes provide care management for patient with complex medical needs.</p>			
<p>American Academy of Hospice and Palliative Medicine (AAHPM) <i>(Provider association and specialty society)</i> Patient and Caregiver Support for Serious Illness (PACSSI) Recommended for limited-scale testing, 3/26/2018</p>	<p>Clinical Focus: Serious illness and palliative care Providers: Palliative care teams (PCT) Setting: Inpatient; outpatient; other palliative care settings Population: Patients with serious illness</p>	<p>Focus of Care Transition Management: Broad; PCTs would be able to organize themselves and determine the appropriate level of representation across multiple disciplines, including physicians, nurses (including advanced practice nurses), social workers, spiritual care providers, physician assistants, pharmacists, counselors, and others, as necessary and appropriate to address the needs of the local patient community.</p> <p>Overview of Care Transition Management Activities: Develop a coordinated care plan with input from all of the patient’s physicians and providers, arrange for services from other providers, and maintain ongoing communication with other physicians and providers to ensure care is being delivered</p>	<p>Financial Incentives: Capitated PBPM with shared risk options for accountability</p> <p>Financial Incentives to Support Care Transition Activities: Yes; monthly payments support provider flexibility to provide tailored services, including care management.</p>	<p>Types of Performance Measures: Spending, quality</p> <p><u>Care Process Measures:</u> Completion of a comprehensive assessment (physical, psychological, social, spiritual, and functional); screening for pain, dyspnea, nausea, and constipation; documentation of a discussion regarding emotional needs, or screening for anxiety or depression; documentation of a discussion of spiritual concerns or screening with the “Do you have any unmet spiritual needs?” question; documentation of a discussion about advance care planning, including preferences for surrogate decision-</p>	<p>N/A^{xxxiv}</p>

^{xxxiv} Model entities identify eligible patients based on serious illness, functional limitation, and health care utilization; enrollment is voluntary.

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		<p>consistent with patient’s care plans. PCTs encouraged to incorporate clinical and/or non-clinical staff to address the needs of a specific patient community</p> <p>Delineation of Provider Responsibilities in Care Transition Management:</p> <p>PCTs lead care coordination activities and have the freedom to structure their team with a variety of clinical and non-clinical staff as necessary. Care plans are developed with input from the full patient care team; however, the proposal does not indicate if these care plans identify the specific roles that team members will play in care transition management activities.</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Not specified</p> <p>Dedicated Care Management/Care Navigator Staff: PCTs are designated as patients’ primary providers of care management services.</p>		<p>maker(s) and life-sustaining treatments; and completion of a structured assessment of caregiver needs and distress</p> <p><u>Patient-Reported Outcomes:</u> Patient/Proxy-based survey</p> <p>Performance Measures Related to Care Transitions:</p> <p>Reduction of ED visits, hospital admissions, emergency transportation, and excess or duplicative treatments and services</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, based on performance assessment of prior year</p> <p><u>Quality performance:</u> Based on historical trends</p> <p><u>Financial performance:</u> Based on risk-adjusted historical trends, adjusted at the regional level and weighted toward more recent episodes</p>	

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>American Academy of Neurology (AAN) <i>(Provider association and specialty society)</i> The Patient-Centered Headache Care Payment (PCHCP) N/A - Withdrawn</p>	<p>Clinical Focus: Neurology Providers: PCPs; neurologists; other physicians with expertise in headache care Setting: Inpatient or outpatient in primary care; patient home Patient Population: Patients with headaches</p>	<p>Focus of Care Transition Management: Broad; payments under the proposed model would enable neurologists or headache specialists to form a Headache Care Team and collaboratively treat patients with headache or to work with primary care physicians and additional health care team members such as a patient care coordinator, nutritionist, physical therapist, mental health provider, or pharmacist to co-manage the patient’s headache and other health problem.</p> <p>Overview of Care Transition Management Activities: The proposed model is predicated on a strong internal and/or referral network of providers that involves multiple types of physicians, non-physicians, and other eligible professionals; it allows for the creation of a Headache Care Team, when feasible, establishing accountability or negotiating responsibility to facilitate transitions and coordinate care across settings.</p>	<p>Financial Incentives: One-time payment, PBPM payments, or add-on payments (depending upon payment category) with shared risk</p> <p>Financial Incentives to Support Care Transition Activities:</p> <p>Clinicians are incentivized to contain their costs to below the fixed payments they receive, which in turn encourages timely and accurate diagnosis and care coordination, as well as the appropriate use of medications and other interventions to reduce headache incidence, as well as population health management. The proposed model adjusts payment based on performance on</p>	<p>Types of Performance Measures: Utilization, spending, quality of care</p> <p><u>Care Process Measures:</u> Screening and brief counseling for unhealthy alcohol use, screening for clinical depression, and follow-up plan</p> <p><u>Patient-Reported Outcomes:</u> Reductions in headache frequency, severity, and disability; medication side effects; percent of patients rating access to providers and experience of care as “excellent”</p> <p>Performance Measures Related to Care Transitions: Average per-patient rates of visits to EDs for management of headaches, average per-patient rates of admission and duration of stay to the hospital for management of headaches</p> <p>Performance Tied to Payment: Yes</p>	<p>N/A^{xxxv}</p>

^{xxxv} Patients must voluntarily opt-in to the model.

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		<p>Delineation of Provider Responsibilities in Care Transition Management:</p> <p>PCPs can and should be involved upon a patient’s admission to the PCHCP proposed model. Neurologists or headache specialists provide oversight for stable patients and manage direct treatment for the most complex patients. Patient care coordinators, nutritionists, physical therapists, social services, or mental health providers provide supplemental preventive care.</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Yes, based on patient need and headache severity</p> <p>Dedicated Care Management/Care Navigator Staff: Not specified</p>	<p>select quality metrics, comparable to those included in the Merit-based Incentive Payment System (MIPS), that are linked to utilization and spending, as well as patient experience and health outcomes.</p> <p>HCT members refer their patients within the HCT, incentivizing providers to participate in order to be within the preferred network.</p>	<p>Benchmarking: Not specified</p>	
<p>The American College of Surgeons (ACS)</p>	<p>Clinical Focus: Cross-clinical focus</p>	<p>Focus of Care Transition Management: Broad; the proposed episode model in the</p>	<p>Financial Incentives: Episode-based model with</p>	<p>Types of Performance Measures: Care process,</p>	<p>N/A^{xxxvi}</p>

^{xxxvi} Episodes of care that are either procedural or condition-based and both acute and chronic are aligned to the team of clinicians providing care, with responsibility for any savings or losses during the risk period attributed to each participating Qualified Participant based on the episodes they are involved in and their specific role in that care.

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<p><i>(Provider association and specialty society)</i></p> <p>The ACS-Brandeis Advanced Alternative Payment Model (APM)</p> <p>Recommended for limited-scale testing, 4/11/2017</p>	<p>Providers: Single/multispecialty practices; groups of small provider practices</p> <p>Setting: Inpatient, outpatient, ambulatory</p> <p>Patient Population: Broad (includes 100+ conditions or procedures)</p>	<p>ACS-Brandeis Advanced APM is based on shared accountability, integration, and care coordination as fundamental building blocks. The episode grouper automatically identifies most of the clinicians who are participating in the care for a patient during a defined episode of care.</p> <p>Overview of Care Transition Management Activities: Increase 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</p> <p>Delineation of Provider Responsibilities in Care Transition Management: The attribution framework assigns the responsibility for the care provided to all involved clinicians in each patient relationship category. The individual providers that constitute a clinical affinity group are encouraged through incentives to participate in the risks for the</p>	<p>continued FFS and shared risk</p> <p>Financial Incentives to Support Care Transition Activities:</p> <p>The proposed model addresses care coordination between participating and non-participating clinicians by creating financial incentives for improved quality and reduced cost in the form of shared savings and by providing detailed information to the APM entity and participants. Participating providers who work with or refer patients to other efficient providers who deliver high-quality care are more likely to share in savings and avoid penalties.</p>	<p>spending, patient experience, quality</p> <p><u>Care Process Measures:</u> Tobacco screening and cessation intervention</p> <p><u>Patient-Reported Outcomes:</u> CAHPS patient experience measures</p> <p>Performance Measures Related to Care Transitions: Measures quality and care coordination during five phases of surgical care (preoperative, perioperative, intraoperative, postoperative, and post-discharge)</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, based on risk-adjusted expected spending per episode</p>	

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>episodes through contracting with the APM entity.</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Not specified</p> <p>Dedicated Care Management/Care Navigator Staff: Not specified</p>			
<p>Coalition to Transform Advanced Care (C-TAC) (Coalition)</p> <p>Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model</p> <p>Recommended for limited-scale testing, 3/26/2018</p>	<p>Clinical Focus: Serious illness and palliative care</p> <p>Providers: ACM care team; other ancillary collaborator organizations</p> <p>Setting: Patient home</p> <p>Patient Population: Patients with serious illness</p>	<p>Focus of Care Transition Management: Broad; beneficiaries, caregivers, and their family members will have access to a dedicated interdisciplinary care team that will follow their care into the home and support transitions across care settings; goal to reduce unwanted/duplicate visits and interventions.</p> <p>Overview of Care Transition Management Activities: Evidence-based treatments that align with patient preferences, symptom management, 24/7 access to clinical support, comprehensive care plan, support for transitional and PAC,</p>	<p>Financial Incentives: Capitated PBPM with shared risk</p> <p>Financial Incentives to Support Care Transition Activities: PMPM reimbursement and pay-for-quality bonus for the ACM entity; the pay-for-quality bonus for higher-quality, person-centered care is a trade-off for forgone revenue associated with hospitalization and ICU care. Using</p>	<p>Types of Performance Measures: Spending, quality, care process, patient experience</p> <p><u>Care Process Measures:</u> Timeliness of advance care planning, medication reconciliation post-discharge</p> <p><u>Patient-Reported Outcomes:</u> ACM Beneficiary and Family Caregiver Survey (e.g., securing help for symptoms, patient satisfaction, care coordination, effective communication, patient</p>	<p>Based on the participating entities' full Medicare population or only those that are ACM-eligible (those with advanced illness^{xxxviii})</p>

^{xxxviii} Identification of advanced illness is based on *International Classification of Diseases, 10th Revision* (ICD-10) primary diagnosis codes in the diagnosis category that appeared on the majority of a patient's claims in their last 12 months of life.

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		<p>using established reliable handoff processes, and advance care planning</p> <p>Delineation of Provider Responsibilities in Care Transition Management:</p> <p>Interdisciplinary team is responsible for the implementation of the proposed model's care delivery services. For example, physicians may initiate advance care planning discussions with a patient during an office visit, then hand off to the ACM team to continue the discussion at home. The ACM provides needed care coordination services and palliative care expertise to primary care providers and specialists.</p> <p>Provision of E-Consults:</p> <p>ACM services would be provided on an ongoing basis through a mixture of face-to-face and telephonic encounters that would be proactively deployed based on beneficiaries' current and anticipated needs.</p> <p>The ACM supports collaboration with telehealth providers.</p>	<p>home-based teams enables existing providers to manage their sickest and most vulnerable patients at home, allowing the group to avoid the cost of augmenting clinical and office staff and disrupting practice workflow.</p>	<p>engagement composite); Family Evaluation of ACM (e.g., caregiver support composite, quality of care transitions from ACM to hospice composite)</p> <p>Performance Measures Related to Care Transitions:</p> <p>Quality of Transitions from ACM to Hospice Survey & Composite Score to be field tested by CMS; timeliness of advance care planning, medication reconciliation post-discharge, proportion of patients who died and who were admitted to the intensive care unit (ICU) in the last 30 days of life, proportion of patients who died who were admitted to hospice for three days or more</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, quality performance based on historical trends; financial performance based on risk-adjusted^{xxxvii} historical</p>	

^{xxxvii} Risk adjustment factors include clinical risk, prior utilization, and Medicare-Medicaid dual eligibility.

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>Proactive Referrals and Scheduling of Follow-Up Visits: The ACM team ensures the patient returns to the office, where shared decision-making can yield actionable physician orders.</p> <p>Dedicated Care Management/Care Navigator Staff: ACM team</p>		trends, adjusted at the regional level, and weighted toward more recent episodes	
<p>Dr. Sobel (Sobel) <i>(Individual)</i></p> <p>Remote specialists and experts on demand improving care and saving costs (Revised version)</p> <p>N/A – Withdrawn</p>	<p>Clinical Focus: Broad/not specified</p> <p>Providers: Regional Referral Centers (specialists)</p> <p>Setting: Not specified</p> <p>Patient Population: Broad/not specified</p>	<p>Focus of Care Transition Management: Broad; to mitigate or reduce the escalation of care for conditions where access to physician specialists could forestall or prevent hospital admissions or transfer from community to more care-intensive settings, such as ED, inpatient, and rehabilitation settings</p> <p>Overview of Care Transition Management Activities: Regional Referral Centers (RRCs) can provide specialist expertise at any setting, reducing avoidable transitions by leveraging telehealth to consult with specialists.</p> <p>Delineation of Provider Responsibilities in Care Transition Management:</p>	<p>Financial Incentives: Not specified; FFS payment mechanism</p> <p>Financial Incentives to Support Care Transition Activities: Additional fees for bypassing avoidable care and admission to hospital</p>	<p>Types of Performance Measures: Quality, utilization, patient satisfaction</p> <p><u>Care Process Measures:</u> Not specified</p> <p><u>Patient-Reported Outcomes:</u> Patient satisfaction</p> <p>Performance Measures Related to Care Transitions: Not specified</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: N/A</p>	N/A

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>Not specified</p> <p>Provision of E-Consults: Yes; RRCs would be available to service an entire geographic area.</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Occur as a result of telehealth consultation with specialist from RRC</p> <p>Dedicated Care Management/Care Navigator Staff:</p> <p>No; patient’s primary care doctor requests consult.</p>			
<p>University of Chicago Medicine (UChicago) <i>(Academic institution)</i></p> <p>The Comprehensive Care Physician Payment Model (CCP-PM)</p> <p>Recommended for limited-scale testing, 9/7/2018</p>	<p>Clinical Focus: Frequently hospitalized patients</p> <p>Providers: Inpatient and outpatient providers</p> <p>Setting: Home care and rehabilitation</p> <p>Patient Population: Frail/complex patients with hospitalizations</p>	<p>Focus of Care Transition Management: Broad; care transitions between inpatient and ambulatory care</p> <p>Overview of Care Transition Management Activities: A single provider is responsible for seeing their patients in both inpatient and outpatient settings, included the patient home or rehabilitation settings.</p> <p>Delineation of Provider Responsibilities in Care Transition Management: Not specified</p>	<p>Financial Incentives: Add-on PBPM with shared risk</p> <p>Financial Incentives to Support Care Transition Activities: Care continuity fee for participating physicians who meet benchmarks for providing their patients with both inpatient and outpatient care. If targets are not met, participating</p>	<p>Types of Performance Measures: Utilization; subject to spending and quality measures under their proposed umbrella payment model (e.g., Merit-based Incentive Payment System [MIPS] or Medicare Shared Savings Program [MSSP])</p> <p><u>Care Process Measures:</u> CCP-PM proposes to condition the care continuity fees based on reaching established benchmarks for the</p>	<p>Eligible physicians can enroll a panel of CCP-PM patients for which they intend to provide an increased proportion of inpatient and outpatient general medical care, and eligible patients join the program by</p>

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		<p>Provision of E-Consults: Given that the CCP-PM proposed practice model concentrates inpatient and outpatient care with one physician, the proposed model provides a network with lower barriers to uptake of novel health care technology, for example, virtual visits,</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Not specified</p> <p>Dedicated Care Management/Care Navigator Staff: One additional clinical team member should be focused on care coordination (e.g., clinic coordinator, social worker).</p>	<p>clinicians are subject to a fine.</p>	<p>percentage of inpatient and outpatient general medical care provided by the participating clinician.</p> <p><u>Patient-Reported Outcomes:</u> HCAHPS survey measures, self-rated mental health, patients' rating of provider</p> <p>Performance Measures Related to Care Transitions: Number of unplanned hospitalizations, number of ambulatory care-sensitive hospitalizations</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, based on percent provision of inpatient care and outpatient general medicine care for their enrolled patients</p>	<p>enrolling in the CCP-PM panel of a participating physician; alignment can continue for up to six years, with pathways based on whether the patient has had an additional hospitalization.</p>

Exhibit 13. Characteristics of PTAC Proposals with Components Related to Care Transition Management – Acute Event Focus

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>American College of Emergency Physicians (ACEP) <i>(Provider association and specialty society)</i></p> <p>Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions</p> <p>Recommended for implementation, 09/06/2018</p>	<p>Clinical Focus: Emergency department (ED) services</p> <p>Providers: ED physicians</p> <p>Setting: ED</p> <p>Patient Population: Patients with qualifying ED visits</p>	<p>Focus of Care Transition Management: Hospitalizations and observations stays; multidisciplinary care around an acute care event that will provide emergency physicians with the necessary flexibility and tools to better coordinate care for their patients</p> <p>Overview of Care Transition Management Activities: The proposal calls for facilitating appropriate discharge, informing patients of treatment options, managing unscheduled care episodes by protocol, and arranging post-discharge home visit.</p>	<p>Financial Incentives: Episode-based model with continued FFS, with shared risk options for accountability</p> <p>Financial Incentives to Support Care Transition Activities: Proposed payments for ED acute care transition services, telehealth services, and post-discharge home visits</p>	<p>Types of Performance Measures: Patient engagement, process of care coordination, post-discharge outcomes</p> <p><u>Care Process Measures:</u> Shared decision-making at discharge</p> <p><u>Patient-Reported Outcomes:</u> Safe Discharge Assessment</p> <p>Performance Measures Related to Care Transitions: Post-discharge outcome rates</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, based on participant’s</p>	<p>N/A^{xxxix}</p>

^{xxxix} Episodes are attributed to the ED physician.

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>Delineation of Provider Responsibilities in Care Transition Management: The ED clinician will be the preliminary clinician but communicates and designates hand-off to the PCP or specialist for follow-up treatment.</p> <p>Provision of E-Consults: Emergency physicians are allowed to provide telehealth services to a beneficiary in their home.</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Yes; care coordinators are responsible for scheduling follow-up visits with PCP or specialists.</p> <p>Dedicated Care Management/Care Navigator Staff: Not specified</p>		historical performance, risk-adjusted for factors that impact the admission decision	

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>American College of Physicians-National Committee for Quality Assurance (ACP-NCQA) <i>(Provider association and specialty society/other)</i></p> <p>The “Medical Neighborhood” Advanced Alternative Payment Model (AAPM) (Revised Version)</p> <p>Recommended for testing to inform payment model development, 09/15/2020</p>	<p>Clinical Focus: Coordination between specialists and PCPs</p> <p>Providers: Primary Care Practices in Comprehensive Primary Care Plus (CPC+) and Primary Care First (PCF), specialty practices meeting clinical transformation and care coordination criteria for Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA)-recognized Patient Centered Specialty Practices (PCSPs)</p> <p>Setting: Primary care and specialty practices</p>	<p>Focus of Care Transition Management: Between hospitals and other facilities to close gaps and eliminate fragmentation across settings</p> <p>Overview of Care Transition Management Activities: Proposed model establishes accountability or negotiates responsibility, facilitates transition, coordinates care across settings, and aligns resources with patient and population needs.</p> <p>Delineation of Provider Responsibilities in Care Transition Management: Specialists may be designated as the continuing principal co-manager or primary manager of care for the relevant condition through an ongoing care agreement.</p>	<p>Financial Incentives: Add-on PBPM with shared risk</p> <p>Financial Incentives to Support Care Transition Activities: The clinician/practice receives incentives for meeting performance expectations, but does not share losses if costs exceed targets.</p>	<p>Types of Performance Measures: Utilization, behavioral health, patient-reported outcomes, patient experience, and care coordination</p> <p><u>Care Process Measures:</u> Not specified</p> <p><u>Patient-Reported Outcomes:</u> CAHPS patient experience survey</p> <p>Performance Measures Related to Care Transitions: Patient-Centered Specialty Practice (PCSP) standards emphasize enhanced access to timely, patient-focused care, shared decision-making, continuous improvement, and use of Certified Electronic</p>	<p>Patients must be appropriately referred by CPC+ participating primary care clinicians and have an office visit billed through the participating Medical Neighborhood Model (MNM) specialist; attribution conducted on quarterly basis.</p>

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
	<p>Patient Population: Patients with multiple chronic conditions</p>	<p>Provision of E-Consults: Yes, when there is inadequate information in the patient record to effectively treat the patient without performing tests again or scheduling a visit to gather information and then another appointment</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Yes; when making a referral, the specialist informs the primary care clinician and the referring clinician about all secondary referrals.</p> <p>Dedicated Care Management/Care Navigator Staff: Practices may establish this role to fulfill community care coordination functions, or may delegate these responsibilities to existing care team members.</p>		<p>Health Record Technology (CEHRT); claims-based readmission measures.</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, based on practice's historical spending and trended forward based on regional growth rates</p>	

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>American Society of Clinical Oncology (ASCO) <i>(Provider association and specialty society)</i> Patient-Centered Oncology Payment Model (PCOP) Referred for other attention by the Department of Health and Human Services (HHS), 9/15/2020</p>	<p>Clinical Focus: Cancer care Providers: Providers delivering hematology/oncology services; partners Setting: Inpatient, outpatient Patient Population: Cancer patients</p>	<p>Focus of Care Transition Management: To reduce utilization for conditions that could be averted and reduce total ED visits and observation stays Overview of Care Transition Management Activities: To establish accountability or negotiate responsibility and monitoring and follow-up Delineation of Provider Responsibilities in Care Transition Management: A medical oncologist directs the patient’s care team within the practice, directs care coordination with other pertinent physicians and services, and manages or co-manages the inpatient team-based care.</p>	<p>Financial Incentives: Episode-based payment with two tracks; add-on payments worth two to three percent of total cost of care, including FFS payments; add-on performance payments Financial Incentives to Support Care Transition Activities: Incentives to improve care management and quality are provided through Care Management Payments and</p>	<p>Types of Performance Measures: Care processes, spending, quality, and patient satisfaction <u>Care Process Measures:</u> Dedicated advance care planning sessions; practice follows Quality Oncology Practice Initiative (QOPI) safety standards for the administration of chemotherapy. <u>Patient-Reported Outcomes:</u> Patient satisfaction Performance Measures Related to Care Transitions: Multiple measures in the domains of</p>	<p>N/A^{xi}</p>

^{xi} Episodes aligned to providers or practice groups based on billing provider for the Cancer Treatment Care Management Payment (CMP) or the billing of an antineoplastic, endocrine therapy, or select immunosuppressive agent.

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Yes; practice tracks patient ED visits, hospital admissions and readmissions; analyzes the data regularly for process improvement and patient education purposes; and contacts patients within 48 hours of hospitalization or ED visits for follow-up. Additionally, on-site psychosocial distress screening is performed, and referral for the provision of psychosocial care is provided, as needed.</p> <p>Dedicated Care Management/Care Navigator Staff: Not specified; medical oncologist and care team as coordinators for patients</p>	<p>Performance Incentive Payments. Accountability for providers is introduced through progressively greater adjustments to fee-for-service reimbursement, bundling a portion of traditional fees into monthly payments.</p>	<p>patient engagement (e.g., patient education), availability and access to care (e.g., ED visits, hospital admissions and readmissions), and comprehensive team-based care (e.g., advance care planning)</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, based on percentile of metric adherence</p>	

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		before, during, and after active cancer care treatment. All patients are provided navigation for support services and community resources specific to the practice patient population.			
<p>Avera Health (Avera) <i>(Regional/ local multispecialty practice or health system)</i> Intensive Care Management in Skilled Nursing Facility Alternative Payment Model (ICM SNF APM) Recommended for implementation, 3/27/2018</p>	<p>Clinical Focus: Primary care (geriatricians) in skilled nursing facilities (SNFs) Providers: Geriatrician Care Teams (GCTs) Setting: SNFs and NFs Patient Population: SNF residents</p>	<p>Focus of Care Transition Management: To reduce avoidable ED visits and hospitalizations Overview of Care Transition Management Activities: The GCT establishes accountability or negotiates responsibility, provides monitoring and follow-up, aligns resources with patient and population needs, develops a care plan, assesses patient needs and goals, facilitates</p>	<p>Financial Incentives: Add-on PBPM with shared risk options for accountability Financial Incentives to Support Care Transition Activities: Proposed model is structured with less risk to geriatricians during preliminary years of the program to</p>	<p>Types of Performance Measures: Utilization, spending, patient experience, quality^{xli} <u>Care Process Measures:</u> Rates of seasonal influenza and pneumococcal vaccination <u>Patient-Reported Outcomes:</u> Self-reported pain for short-stay and long-stay nursing home residents</p>	<p>Based on trigger event being the beneficiary’s admission to a participating SNF/NF; beneficiaries are aligned to the facility throughout their stay, and the alignment period ends 30 days following</p>

^{xli} Includes measures currently reported for nursing homes on Medicare Care Compare and as part of the Skilled Nursing Facility Value-Based Purchasing Program.

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>transitions, and coordinates care across settings.</p> <p>Delineation of Provider Responsibilities in Care Transition Management:</p> <p>The geriatrician leads the development of the individualized care plans for high-risk individuals, as well as provides direct specialty care in coordination with the PCP. Other suggested members of the GCT include pharmacists, social workers, nurses, and behavioral health practitioners.</p> <p>Provision of E-Consults: Yes</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Not specified</p>	<p>provide time to fully implement and hone their proposed care model.</p>	<p>Performance Measures Related to Care Transitions: ED visits; hospital readmissions</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, with measure-specific performance criteria for achievement and improvement</p>	<p>facility discharge.</p>

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		Dedicated Care Management/Care Navigator Staff: Yes			
<p>Icahn School of Medicine at Mount Sinai (Academic institution) HaH Plus (Hospital at Home Plus) Provider Focused Payment Model Recommended for implementation, 9/17/2017</p>	<p>Clinical Focus: Inpatient services in home setting Providers: Physicians; HaH Plus providers Setting: Patient home Patient Population: Eligible patients in one of 44 diagnosis-related groups (DRGs) for acute conditions</p>	<p>Focus of Care Transition Management: Multidisciplinary around an acute care event; goal of reducing complications and readmissions Overview of Care Transition Management Activities: Establish accountability and negotiate responsibility; facilitate transitions and coordinate care across settings; provide transition services over a period of 30 days, beginning upon discharge from the acute episode, to complete recovery from the acute episode</p>	<p>Financial Incentives: Prospective, episode-based^{xlii} payment replacing FFS and with flexibility to support non-covered services; shared risk through retrospective reconciliation Financial Incentives to Support Care Transition Activities: Providing physicians who order services with means and</p>	<p>Types of Performance Measures: Care processes, spending, patient experience, quality <u>Care Process Measures:</u> Measures of care planning, medication reconciliation post-discharge, documentation of current medications in the medical record <u>Patient-Reported Outcomes:</u> Patient experience and satisfaction (HCAHPS) Performance Measures Related to</p>	<p>N/A^{xliii}</p>

^{xlii} Episodes of care were based on an inpatient stay and 30-days post-discharge.

^{xliii} Claims with qualifying diagnosis-related groups (DRGs) are aligned to the furnishing provider.

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>Delineation of Provider Responsibilities in Care Transition Management: Physicians and nurse practitioners will deliver hospital, transition, and home care services, as well as manage and coordinate services delivered by other eligible professionals not participating in the proposed PFPM (including physical therapists, occupational therapists, qualified speech language pathologists, clinical social workers, and registered dieticians), as well as services provided by registered nurses and home health aides. Core HaH-Plus services consist of physician and nurse practitioner services in the home; registered nurse services in the home; physical, occupational, and speech therapy as needed</p>	<p>incentives to control costs and account for quality; physicians will be invested to engage in activities that could improve quality and patient experience, but were previously poorly reimbursed.</p>	<p>Care Transitions: Measures of care planning, medication reconciliation post-discharge, hospital-acquired infections, mortality, complications, care transitions with errors, readmissions, post-acute ED visits</p> <p>Performance Tied to Payment: No</p> <p>Benchmarking: Separate achievement thresholds for each of 10 quality metrics linked to payment</p>	

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>to preserve functional status; home health aide support for activities of daily living; and administrative support and program oversight.</p> <p>Provision of E-Consults: The HaH-Plus team is available 24/7 to engage in a telehealth-supervised visit from a community paramedic team that is part of the care team.</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: The HaH-Plus team is available 24/7 for an urgent visit.</p> <p>Dedicated Care Management/Care Navigator Staff: Not specified; recommended care teams have overlapping core competencies.</p>			

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>Personalized Recovery Care (PRC) <i>(Regional/local single specialty practice)</i></p> <p>Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home</p> <p>Recommended for implementation, 3/26/2018</p>	<p>Clinical Focus: Inpatient services in home setting</p> <p>Providers: Admitting physician at facility receiving PRC payments; On-Call Physician; Recovery Care Coordinator</p> <p>Setting: Patient home</p> <p>Patient Population: Commercial and Medicare Advantage patients with acute conditions, based on approximately 150 DRGs</p>	<p>Focus of Care Transition Management: Acute care; multidisciplinary care and management around an acute care event/episode</p> <p>Overview of Care Transition Management Activities: Hospital-level care being received at home mitigates risk to patients that typically occurs upon discharge from acute care facility.</p> <p>Delineation of Provider Responsibilities in Care Transition Management: PRC Operators are responsible for all related care delivered to patients during a 30-day episode.</p> <p>Provision of E-Consults:</p>	<p>Financial Incentives: Bundled episode-based payment^{xliv} replacing FFS, with shared risk</p> <p>Financial Incentives to Support Care Transition Activities: Episode-based payment supports care coordination, and engaging in the PRC program gives providers the best opportunity to produce a high-quality outcome at a lower cost than traditional acute care services.</p>	<p>Types of Performance Measures: Spending, quality</p> <p><u>Care Process Measures:</u></p> <p>Percentage of episodes with follow-up PCP appointment scheduled within seven days; percent of episodes with medication reconciliation</p> <p><u>Patient-Reported Outcomes:</u> Percent of survey questions answered with top box response; support of recovery care coordinator during episode</p>	<p>N/A^{xliv}</p>

^{xliv} DRGs for professional fee claims are based on the last home hospitalization acute-phase physician rounding activity in the rounding physician's electronic medical record (EMR).

^{xlv} Claims with qualifying DRGs are aligned to the furnishing provider.

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>Yes; telehealth platform incorporates video communication and biometric data tracking.</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: The proposed PRC model will make beneficiaries aware of provider partners that are preferred due to their ability to deliver high-quality care while maintaining excellent patient satisfaction ratings.</p> <p>Dedicated Care Management/Care Navigator Staff: Recovery care coordinators</p>		<p>Performance Measures Related to Care Transitions: Percentage of episodes with follow-up PCP appointment scheduled within seven days; percent of episodes with medication reconciliation; support of recovery care coordinator during episode</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, based on historical, episodic expenditures for each condition plus a three percent discount to derive target prices</p>	

Exhibit 14. Characteristics of PTAC Proposals with Components Related to Care Transition Management – Specialty Care Focus

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>Community Oncology Alliance (COA) <i>(Nonprofit organization)</i> Oncology Care Model 2.0 N/A – Withdrawn</p>	<p>Clinical Focus: Oncology/cancer care</p> <p>Providers: Individuals or groups of medical oncologists providing services to patients</p> <p>Setting: Oncology medical home</p> <p>Patient Population: Patients with cancer</p>	<p>Focus of Care Transition Management: Multidisciplinary during episode of care for cancer; transitions during treatment (such as from chemotherapy to radiation therapy); transitions to hospice care at clinically useful point in patient’s disease trajectory</p> <p>Overview of Care Transition Management Activities: Assess patient needs and goals; facilitate transitions and coordinate care across settings; and establish accountability or negotiate responsibility. Examples include: updating referring physicians and primary care providers; clear communication with</p>	<p>Financial Incentives: Episode-based payment with shared risk; trigger code (onset of episode) payment, monthly care management fee, “value-based” cost management for drugs and therapies</p> <p>Financial Incentives to Support Care Transition Activities: Episode-based payments allow flexibility to provide tailored care</p>	<p>Types of Performance Measures: Care process, quality</p> <p><u>Care Process Measures:</u> A comprehensive care plan is provided to the patient; adherence to recognized pathway and treatment guidelines; screening for clinical depression and follow-up plan; a survivorship care plan is given to the patient; pneumococcal vaccination is provided to older adults.</p> <p><u>Patient-Reported Outcomes:</u> Not specified</p> <p>Performance Measures Related to Care Transitions: 14 Oncology Medical Home (OMH) Standards; Accreditation Commission for Health Care (ACHC)</p>	<p>Patient enrollment would be triggered by the submission of a G-code, or similar code, which must be submitted within 30 days of providing the corresponding treatment plan. Patients identified through the G-code would be attributed to the participating team. In the rare instance in which different oncology teams are attributed to the same</p>

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>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.</p> <p>Delineation of Provider Responsibilities in Care Transition Management: Oncology team acts as the PCP during episode; medical oncology team is hub of care delivery paradigm, and provides care while communicating with network of PCPs, surgeons, and other specialists.</p>	<p>coordination services; incentives promote and support value-based clinical decision-making relating to high-value drug treatment choices, current coverage guidelines, relevant diagnostics, and national coverage guidelines.</p>	<p>improvement metrics; a comprehensive care plan is provided to the patient; adherence to recognized pathway and treatment guidelines; screening for clinical depression and follow-up plan; a survivorship care plan is given to the patient; proportion of patients with cancer receiving chemotherapy in the last 14 days of life; proportion of patients with cancer who died but without being admitted to hospice</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, to capture cost of care differences among peers</p>	<p>patient, the attribution would be made based on the number of E&M billing codes of 99212-99215 (established patients, levels 2 to 5) for the agreed upon time period.</p>

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Participating practices provide the following services on site or by referral: rehabilitation, nutritional support/counseling, surgical and radiation oncology, diagnostic imaging, laboratory studies, psychosocial evaluation and support, genetic counseling, palliative care/symptom management, home care</p> <p>Dedicated Care Management/Care Navigator Staff: Not specified</p>			
<p>Hackensack Meridian Health and Cota, Inc. (HMH/Cota)</p>	<p>Clinical Focus: Oncology</p> <p>Providers: Eligible professionals in HMH health system with</p>	<p>Focus of Care Transition Management: Broad; to increase adherence to treatment medications, provide prompt medical</p>	<p>Financial Incentives: Prospective, bundled episode-based</p>	<p>Types of Performance Measures: Spending, quality</p>	<p>N/A</p>

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p><i>(Regional/ local multispecialty practice or health system; Device/ technology company)</i></p> <p>Oncology Bundled Payment Program Using CNA-Guided Care</p> <p>Recommended for limited-scale testing, 9/8/2017</p>	<p>attributed Medicare cancer patients</p> <p>Setting: Inpatient and outpatient care</p> <p>Patient Population: Cancer (breast, colon, rectal, and lung)</p>	<p>attention by a member of their dedicated care team, and improve the ability to make better and more informed decisions about their care</p> <p>Overview of Care Transition Management Activities: The integration of the various EHRs across Hackensack Meridian Health enables the sharing of key clinical and treatment information across the spectrum of professionals that touch the patient. The investment in analytics aims to standardize and integrate feedback processes on performance on as real-time of a basis as possible. This also requires seamless</p>	<p>payments with retrospective reconciliation, replacing FFS; shared risk</p> <p>Financial Incentives to Support Care Transition Activities: Episode-based payments support care coordination</p>	<p><u>Care Process Measures:</u> Included measures vary by type of cancer, including:</p> <p><u>Breast cancer:</u> Needle biopsy completed within 10 days of screening mammogram, lymph node assessment, Tamoxifen recommendation or prescription</p> <p><u>Colorectal cancer:</u> Metastatic work-up CT scan completed within 30 days of surgical exam, MRI preoperatively for rectal cancer, pre-operative antibiotics administered within 60 minutes of incision, antibiotics discontinued within 24 hours post-operatively</p> <p><u>Lung cancer:</u> Length of stay after lobectomy is less than three days</p>	

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>physician communication to optimize care. There will also be a reorganization of staff from the inpatient to the outpatient divisions as HMH provides more services in the outpatient environment.</p> <p>Delineation of Provider Responsibilities in Care Transition Management: Not specified</p> <p>Provision of E-Consults: Yes</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Yes, based on certain factors</p> <p>Dedicated Care Management/Care Navigator Staff: Not specified</p>		<p><u>All disease groups:</u> Pain score documented, advance care plan documented</p> <p><u>Patient-Reported Outcomes:</u> Yes, through surveys</p> <p>Performance Measures Related to Care Transitions: Surgery, oncology, genetic quality measures, oncology/infection monitoring, COTA analytics, risk management, finance monitoring, patient experience/satisfaction, patient-reported outcomes</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, based on data-driven classification system for cancer patient risk and treatment pathways</p>	

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>Innovative Oncology Business Solutions (IOBS) <i>(For-profit corporation)</i></p> <p>Making Accountable Sustainable Oncology Networks (MASON)</p> <p>Referred for further development and implementation, 12/10/2018</p>	<p>Clinical Focus: Cancer care</p> <p>Providers: Oncology physicians</p> <p>Setting: Outpatient</p> <p>Patient Population: Patients with cancer</p>	<p>Focus of Care Transition Management: To avoid excess ED visits and hospitalizations</p> <p>Overview of Care Transition Management Activities: Facilitate transitions and coordinate care settings, delivering evidence-based care and providing early intervention</p> <p>Delineation of Provider Responsibilities in Care Transition Management: One team (medical home) manages the patient throughout the course of their disease.</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Same-day appointments scheduled as needed; the practice</p>	<p>Financial Incentives: Episode-based model with continued FFS payments; shared risk for cancer-related expenditures</p> <p>Financial Incentives to Support Care Transition Activities: Episode-based payments allow flexibility in providing care coordination services; recommended payment at time of new patient consult.</p>	<p>Types of Performance Measures: Spending, quality, utilization</p> <p><u>Care Process Measures:</u> Diversion from ED to office</p> <p><u>Patient-Reported Outcomes:</u> Patient satisfaction</p> <p>Performance Measures Related to Care Transitions: Hospitalization rates, diversion from ED to office, ED visits</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, based on distribution of expenditures, as opposed to a point estimate</p>	<p>N/A</p>

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>should schedule appointments and tests and arrange for the information to get back to the patient, rather than asking the patient or caregiver to navigate the confusing system of referrals.</p> <p>Dedicated Care Management/Care Navigator Staff: Practices should coordinate care, including support services, with every member of the extended care team having the information needed to provide care.</p>			
Minnesota Birth Center (MBC)	Clinical Focus: Maternity/newborn care	Focus of Care Transition Management: Maternity care and coordinated effort across prenatal	Financial Incentives: Additional one-	Types of Performance Measures: Patient satisfaction, quality	N/A ^{xlvi}

^{xlvi} Actual costs of providing care are assessed within the BirthBundle®, a comprehensive package of perinatal care services that is provided for a single price.

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p><i>(Regional/local single specialty practice)</i></p> <p>A Single Bundled Payment for Comprehensive Low-Risk Maternity and Newborn Care Provided by Independent Midwife Led Birth Center Practices that Are Clinically Integrated with Physician and Hospital Services</p> <p>N/A - Withdrawn</p>	<p>Providers: Rural clinic providers</p> <p>Setting: Outpatient</p> <p>Patient Population: Women during prenatal care, labor and birth, and postpartum care</p>	<p>care, labor and birth, and postpartum care; leveraging use of a birth center, a lower-cost facility</p> <p>Overview of Care Transition Management Activities: Establish accountability or negotiate responsibility, facilitate transitions, and coordinate care across settings</p> <p>Delineation of Provider Responsibilities in Care Transition Management: Certified Nurse Midwives (CNMs) are the primary providers, with integral physician involvement</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Care coordinated through CNMs</p>	<p>time bundled payment</p> <p>Financial Incentives to Support Care Transition Activities: Episode-based payment will also help to reduce complications and improve maternal and newborn outcomes as providers will be incentivized – via the use of outcome-level maternity quality measures – to provide “high-touch” evidence-based interventions,</p>	<p><u>Care Process Measures:</u> Not specified</p> <p><u>Patient-Reported Outcomes:</u> Expanded postpartum survey to capture maternal experience with care</p> <p>Performance Measures Related to Care Transitions: Not specified</p> <p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Not specified</p>	

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		Dedicated Care Management/Care Navigator Staff: Not specified	such as enhanced prenatal care, more meaningful care coordination, and doula services.		
New York City Department of Health and Mental Hygiene (NYC DOHMH) <i>(Public health department)</i> Multi-provider, bundled episode of care payment model for treatment of chronic hepatitis C virus (HCV) using care coordination by employed physicians	Clinical Focus: Hepatitis C virus (HCV) Providers: Primary care physicians (trained by hepatologists/gastroenterologists); specialists; nurse practitioners; physician assistants; and non-clinician staff Setting: Primary care and specialty	Focus of Care Transition Management: Multidisciplinary; hospital-based clinics (with PCPs able to refer to other diagnostic and treatment services within same facility). Goal is to reduce patient handoffs through telementoring and assist patient navigation through the health care system. Overview of Care Transition Management	Financial Incentives: Bundled episode-based payment replacing FFS, with shared risk Financial Incentives to Support Care Transition Activities: Episode-based payment supports flexibilities in	Types of Performance Measures: Spending, quality, care process <u>Care Process Measures:</u> Medication adherence <u>Patient-Reported Outcomes:</u> None Performance Measures Related to Care Transitions: Medication adherence Performance Tied to Payment: Yes	N/A ^{xlvii}

^{xlvii} Qualifying episodes are identified using *International Classification of Diseases, 10th Revision* (ICD-10) codes, Current Procedural Terminology (CPT) codes, and HCPCS codes.

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>in hospital outpatient clinics</p> <p>Not recommended, 12/18/2018</p>	<p>Patient Population: Patients with chronic condition (HCV)</p>	<p>Activities: Facilitate transitions and coordinate care across settings through a wide range of care coordinator services</p> <p>Delineation of Provider Responsibilities in Care Transition Management: Provider is responsible for furnishing whatever services are needed by the patient to achieve sustained virologic response (SVR).</p> <p>Provision of E-Consults: Yes; specialists provide telementoring.</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Referrals for support services, psychosocial issues, or other comorbid conditions</p> <p>Dedicated Care Management/Care</p>	<p>providing care coordination.</p>	<p>Benchmarking: Yes, based on risk-adjusted, facility-based sustained virologic response rate, compared against other proposed model participants (e.g., compared to the average among all participants)</p>	

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>Navigator Staff: Care coordinators will help patients find and use resources to improve their health. They will check patient eligibility for benefits and programs, help acquire medical insurance or health care resources, help find other supportive services, and assist patients throughout HCV treatment. Care coordinators may help to document milestones in treatment of HCV, accompany patients to appointments, or support development of a care coordination plan.</p>			
<p>Renal Physicians Association (RPA) <i>(Provider association and specialty society)</i></p>	<p>Clinical Focus: End-stage renal disease (ESRD) Providers: Nephrologists, PCPs</p>	<p>Focus of Care Transition Management: Coordinated initiation of dialysis directly in the outpatient setting,</p>	<p>Financial Incentives: Episode-based model with continued FFS</p>	<p>Types of Performance Measures: Spending, quality <u>Care Process Measures:</u> Evidence-based</p>	N/A

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>Incident ESRD Clinical Episode Payment Model</p> <p>Recommended for implementation, 12/18/2017</p>	<p>Setting: Dialysis centers</p> <p>Patient Population: Patients with chronic condition (incident ESRD)</p>	<p>bypassing the need for hospital admission to begin dialysis therapy</p> <p>Overview of Care Transition Management Activities: 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</p> <p>Delineation of Provider Responsibilities in Care Transition Management:</p> <p>Not specified</p> <p>Provision of E-Consults:</p>	<p>payments and an additional payment for transplant; one- and two-sided risk options</p> <p>Financial Incentives to Support Care Transition Activities:</p> <p>Episode-based payments support flexibility in managing care coordination</p>	<p>measures; process improvement for care coordination with other specialists and the patient's primary care physician, including enhanced evaluation after hospitalizations; advanced care planning</p> <p><u>Patient-Reported Outcomes:</u></p> <p>Patient-Reported Outcomes Measurement Information System (PROMIS) measures; regular evaluation of patient satisfaction, perception of care, and care goals</p> <p>Performance Measures Related to Care Transitions: Home dialysis, referral to transplant</p> <p>Performance Tied to Payment: Yes</p>	

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		Not specified ^{xlvi} Proactive Referrals and Scheduling of Follow-Up Visits: Yes; referral to transplant center Dedicated Care Management/Care Navigator Staff: Not specified		Benchmarking: Yes, based on risk-adjusted target expenditures	
University of New Mexico Health Sciences Center (UNMHSC) <i>(Academic institution)</i> ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural	Clinical Focus: Cerebral emergent care; telemedicine Providers: Neurologists and neurosurgeons; providers in rural and community systems Setting: Inpatient; outpatient; or emergency department Patient Population: Patients with	Focus of Care Transition Management: Reducing need for patient to travel for a neurological consultation in the case of a neurological emergency Overview of Care Transition Management Activities: Telemedicine consults with neurological specialists provide a diagnosis with	Financial Incentives: Additional one-time payment without shared risk Financial Incentives to Support Care Transition Activities: Consultation fee covers fair	Types of Performance Measures: Spending, quality <u>Care Process Measures:</u> Quality control measures: imaging results for acute stroke patients within 45 minutes, timeliness of emergency medicine care	N/A

^{xlvi} The submitter noted that they anticipate that health information innovations such as telehealth and remote monitoring could be used as part of the health care delivery and monitoring structure, and that participating groups would have the flexibility to choose the HIT infrastructure most appropriate for their geography and practice.

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>Cerebral Emergencies</p> <p>Recommended for further development and implementation, 9/16/2019</p>	<p>neurological emergencies</p>	<p>which a rural hospital can then continue care and treatment at their own facility.</p> <p>Delineation of Provider Responsibilities in Care Transition Management:</p> <p>Not specified</p> <p>Provision of E-Consults:</p> <p>Instrumental to the proposed model; used for specialist consults</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Patients who still require transfer to tertiary facility have the benefit of having an expert diagnosis made sooner so that the referral center can be better prepared for intervention when they arrive. Telehealth system allows ACCESS physicians to provide written report</p>	<p>market value of consulting physician, and if the patient travels to specialist for follow-up care, they are expanding the practice of consulting physician. Keeping patients at rural health care setting after consulting diagnosis reduces risks (e.g., patient safety) during transition.</p>	<p><u>Patient-Reported Outcomes:</u> Patient experience questionnaire (PEQ) and the Telemedicine Satisfaction Questionnaire (TSQ)</p> <p>Performance Measures Related to Care Transitions: Hospital-wide all-cause unplanned readmissions</p> <p>Performance Tied to Payment: Not specified</p> <p>Benchmarking: Not specified</p>	

Submitter, Submitter Type, Proposal Name, and PTAC Recommendation and Date	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>of recommendation to referring hospital. Patients may be referred to the consulting physician for follow-up care.</p> <p>Dedicated Care Management/Care Navigator Staff:</p> <p>Rural hospital staff (local physicians) coordinate care with consulting specialist.</p>			

Appendix E. Summary of Model Features and Characteristics of Care Transition Management in the Medicare Shared Savings Program (MSSP)

The following table provides specific details on the Medicare Shared Savings Program (MSSP), including characteristics (i.e., clinical focus, providers, setting, and patient population); components related to care transition management (i.e., focus of care transition management, overview of care transition management activities, delineation of provider responsibilities in care transition management, provision of e-consults, proactive referrals and scheduling of follow-up visits, and dedicated care management/care navigator staff); payment design features (i.e., financial incentives and whether financial incentives are used to support care transition activities); performance measurement features (i.e., types of performance measures, including care process measures and patient-reported outcomes; performance measures related to care transitions; whether performance is tied to payment; and benchmarking); and the approach to beneficiary alignment.^{xlix}

^{xlix} For additional details on characteristics of the Medicare Shared Savings Program, refer to Appendix D in *Environmental Scan on Issues Related to the Development of Population-Based Total Cost of Care (TCOC) Models in the Broader Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs)*, available at <https://aspe.hhs.gov/sites/default/files/documents/62d8a7a4d673e659b4c38086f43c7e49/PTAC-TCOC-Escan.pdf>.

Exhibit 15. Characteristics of the Medicare Shared Savings Program (MSSP) Related to Care Transition Management

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
<p>Medicare Shared Savings Program (MSSP)</p> <p><i>Ongoing</i></p> <p>Years Active: 2012-Present</p>	<p>Clinical Focus: Total care</p> <p>Providers: Providers and suppliers (e.g., physicians, hospitals, and others involved in patient care) that create an Accountable Care Organization (ACO)</p> <p>Setting: Broad</p> <p>Patient Population: Medicare FFS beneficiaries</p>	<p>Focus of Care Transition Management: Broad</p> <p>Overview of Care Transition Management Activities: Optional benefit enhancements included expanded access to telehealth services, post-discharge home visits, care management home visits, the chronic disease reward program, and waiver of the three-day hospital stay requirement for a Medicare Part A-covered SNF stay.</p> <p>Delineation of Provider Responsibilities in Care Transition Management: Not specified</p> <p>Provision of E-Consults: Not specified</p> <p>Proactive Referrals and Scheduling of Follow-Up Visits: Yes, with beneficiary choice to receive care outside of the ACO's provider network</p>	<p>Financial Incentives: Four risk options: Levels A-E and an "Enhanced" track. Levels A and B of the basic track offer upside risk up to 40 percent of savings/losses with a 10 percent cap. The remaining tracks call for two-sided risk of 50 to 70 percent of savings/losses with caps of 10 percent to 20 percent.</p> <p>Financial Incentives to Support Care Transition Activities: Not specified</p>	<p>Types of Performance Measures: Utilization, spending, quality</p> <p><u>Care Process Measures:</u> Not specified</p> <p><u>Patient-Reported Outcomes:</u> CAHPS measures</p> <p>Performance Measures Related to Care Transitions: Yes; unplanned hospital readmissions and CAHPS measures, such as receiving timely care, appointments, and information; provider communication; and care coordination. MSSP ACOs are also given a quality score based on their performance on three quality measures related to care coordination/patient safety, preventive health, and control of diabetes, depression, and hypertension.</p>	<p><u>Voluntary:</u> Beneficiaries confirm care relationships with a primary clinician who is an ACO professional participating in the ACO.</p> <p><u>Prospective and retrospective claims-based:</u> Based on receiving the plurality of primary care services from primary care physicians, nurse practitioners, physician assistants, clinical nurse specialists, or specialist physicians in the participating ACOs</p>

Model Name	Clinical Focus, Providers, Setting, and Patient Population	Components Related to Care Transition Management	Payment Design Features	Performance Measurement Features	Beneficiary Alignment
		<p>Dedicated Care Management/Care Navigator Staff: Yes; care management programs target high-risk populations</p>		<p>Performance Tied to Payment: Yes</p> <p>Benchmarking: Yes, based on spending for beneficiaries who would have been assigned to the ACO in the baseline years and the region. When establishing the historical benchmark, CMS uses the hierarchal condition category (HCC) scores to adjust for changes in severity of the population assigned to the ACO. CMS risk-adjusts the county-level expenditures used in calculating the regional component of the national-regional blend growth rate.</p>	

Appendix F. Areas for Future Exploration and Research

Please note the items listed below may be better addressed through the Request for Information (RFI), Subject Matter Expert (SME) discussions or listening sessions, roundtable panel discussions, or another research approach. They are captured here for further exploration.

- Best practices for effective care transition management between different kinds of settings
- Differences in key issues related to managing care transitions by care setting
- Patient and caregiver empowerment at critical stages during care transitions
- Barriers to improving care transition management between specific care settings
- Variation in barriers to improving care transition management by condition or procedure, or for certain patients with higher or rising risk (e.g., patients with multiple chronic conditions, patients with functional disability)
- Proactive care delivery innovations to improve care transition management, targeting patients with specific needs (e.g., HRSNs, behavioral health care needs)
- Variation in effectiveness of provider or entity activities to improve care transition management by the types of care settings involved or the direction of the transition
- Financial incentives that are most applicable to addressing specific barriers to improving care transition management between settings
- Structure of financial incentives (e.g., tying incentives to specific provider activities or performance, providers flexibility to use program incentives across a range of approved activities)
- Accounting for care transition management in attribution, benchmarking, and health care outcomes
- Best practices in assessing patient experience with care transitions

Appendix G. Annotated Bibliography

Accelerating and Aligning Population-Based Payment Models: Patient Attribution. HCP-LAN Work Group Report. 2016. Accelerating and Aligning Population-Based Payment Models: Patient Attribution <https://hcp-lan.org/workproducts/pa-whitepaper-final.pdf>

Subtopic(s): Performance Measurement of Care Transition Management in Population-Based Models

Type of Source: White paper

Objective: To provide guidance on payer and provider approaches to patient attribution, performance measurement, reporting, and payment in their population-based payment models.

Main Findings: There are 10 recommendations providers nationally can use to guide their patient attribution process.

Strengths/Limitations: N/A

Generalizability to Medicare Population: The authors discuss how Medicare programs attribute beneficiaries and suggest researching further how to align Medicare patients with commercial populations.

Methods: Model review and discussion of different approaches.

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

Subtopic(s): Barriers to Effective and Appropriate Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To explore practices' billing proportions for Transitional Care Management (TCM) and Chronic Care Management (CCM) services among eligible Medicare beneficiaries from when Medicare started allowing practices to bill for these service (2013 for TCM and 2015 for CCM) through 2016.

Main Findings: Practices' uptake of billing Medicare was low, with only a 3.7 percent increase for TCM and 1.2 percent increase for CCM from 2012 to 2016.

Strengths/Limitations: Claims data may have resulted in an overestimation of the population potentially eligible to receive TCM or CCM services, and taxpayer identification numbers do not always identify individual practices.

Generalizability to Medicare Population: Strong; the study focused exclusively on Medicare beneficiaries.

Methods: Analysis of Medicare claims data from 2012 – 2016.

Agency for Health Care Research and Quality. Transitions of Care.

<https://www.ahrq.gov/research/findings/nhqrd/chartbooks/carecoordination/measure1.html>

Subtopic(s): Background: Care Transitions, Contexts, and Related Activities

Type of Source: Chartbook

Objective: To provide guidance on how to successfully transition hospital patients into other care settings.

Main Findings: Providing patients with complete discharge instructions and engaging them in culturally competent discharge planning has been proven to result in higher successful discharge rates (i.e., no readmissions to the hospital). A hospital's readmission rate may indicate a lack of discharge planning or instruction provision to the patient and their caregiver/family.

Strengths/Limitations: The source only looked at hospitals' discharge patterns and considerations, other care settings might have factors that require attention for successful discharge.

Generalizability to Medicare Population: Strong; Medicare patients have higher rates of chronic conditions and hospitalizations compared to other patient populations.

Methods: Analyses of Centers for Medicare & Medicaid data sets.

American College of Physicians. The Patient-Centered Medical Home Neighbor. The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices. (2010).

https://www.acponline.org/sites/default/files/documents/advocacy/current_policy_papers/assets/pcm_h_neighbors.pdf

Subtopic(s): Key Highlights; Background: Care Transitions, Contexts, and Related Activities

Type of Source: Position paper

Objective: To provide guidance on how specialty and subspecialty practices can be integrated into Patient-Centered Medical Homes (PCMHs) as patient-centered medical home neighbors (PCMH-Ns) and best practices for this model.

Main Findings: PCMHs' collaboration with specialty practices is crucial to achieve improved care integration and coordination. Interactions between the PCMH and PCMH-N include a pre-consultation exchange, a formal consultation, co-management of the patient's condition and a possible transferring of the patient. Incentives must be aligned with PCMH-N's efforts to collaborate with PCMHs.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Moderate; Medicare patients receive care at PCMHs.

Methods: Formed through workgroup deliberations and feedback from the American College of Physicians' Council of Subspecialty Societies.

An All-Payer View of Hospital Discharge to Postacute Care, 2013 #205. Accessed April 17, 2023.

<https://hcup-us.ahrq.gov/reports/statbriefs/sb205-Hospital-Discharge-Postacute-Care.jsp>

Subtopic(s): Trends in Utilization, Spending, and Reimbursement Related to Care Transitions

Type of Source: Report

Objective: To present data on hospital discharges to post-acute care (PAC) settings among different payers.

Main Findings: In 2013, 22 percent of inpatient stays were discharged to a PAC setting; 73 percent of discharges to PAC settings were Medicare; 42 percent of Medicare inpatient stays were discharged to PAC; the average length of an acute hospital stay for patients discharged to PAC was nearly 2 times longer than stays with a routine charge (7.0 days vs. 3.6 days); 70 percent of discharges to PAC were among patients 65+, compared to 22 percent for routine discharges; 51 percent of discharges to PAC were from urban teaching hospitals; hospitals in the Northeast accounted for 17 percent of routine discharges but 24 percent of discharges to PAC; hospitals in the West accounted for 21 percent of routine discharges but only 16 percent of discharges to PAC; geographical representation of discharges was consistent across payers; hip/knee joint replacement was the most common condition/procedure with discharge to PAC.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Strong; report evaluated discharge rates by different payers, including Medicare.

Methods: Analysis of 2013's National Inpatient Sample.

Babitsch B, Gohl D, von Lengerke T. Re-visiting Andersen's Behavioral Model of Health Services Use: a systematic review of studies from 1998–2011. *GMS Psycho-Social-Medicine*. 2012;9

Subtopic(s): Barriers to Effective and Appropriate Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To assess the utilization of Andersen's Behavioral Model of Health Services Use in studies that used this model.

Main Findings: The model has been used in several health care systems for varying diseases. The studies reviewed included age, marital status, gender/sex, education, and ethnicity as predisposing factors and income/financial situation, health insurance, and having a usual source of care/family doctor as enabling factors. The need factor variables included health status and self-reported/perceived health. Findings between these variables and health care use was inconsistent across the studies reviewed.

Strengths/Limitations: There is a need for further research on the application of the Behavioral Model using statistical analysis.

Generalizability to Medicare Population: Weak; none to the United States Medicare population, but one of the studies evaluated Australian Medicare beneficiaries' use.

Methods: Systematic search of articles using the Andersen model between 1998 and March 2011.

Backman C, Chartrand J, Crick M, Devey Burry R, Dingwall O, Shea B. Effectiveness of person- and family-centered care transition interventions on patient- oriented outcomes: A systematic review. *Nursing Open*. 2021;8(2):721-754. doi:10.1002/nop2.677

Subtopic(s): Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation

Type of Source: Journal article

Objective: To evaluate the effectiveness of person and family-centered care transition interventions on patients' quality of care and experiences.

Main Findings: Interventions educating patients to promote self-management was included in all 28 interventions and discharge planning was included in 24 interventions. The studies found increases in patients' compliance with their physical exercise plan; improvement in patient self-care approaches, their health outcomes, their satisfaction, and their knowledge of their diagnoses and how to care for it.

Strengths/Limitations: Only randomized controlled trials were included and only some gray literature databases were searched, thus limiting the studies and subsequent findings included.

Generalizability to Medicare Population: Moderate; study did not focus on Medicare, but findings may be applicable to beneficiaries.

Methods: Systematic literature review.

Barber RD, Coulourides Kogan A, Riffenburgh A, Enguidanos S. A role for social workers in improving care setting transitions: a case study. *Soc Work Health Care*. 2015;54(3):177-192. doi:10.1080/00981389.2015.1005273

Subtopic(s): Key Highlights; Background: Care Transitions, Contexts, and Related Activities

Type of Source: Journal article

Objective: To present a case study of an older, dually eligible woman who received a social work-driven transition intervention, including in-home and telephone contacts.

Main Findings: The patient was not readmitted during the six-month study period, mitigated her pain levels, and engaged in social outings, suggesting the high value of a social worker in a transitional care role.

Strengths/Limitations: Findings limited to a single case study.

Generalizability to Medicare Population: Moderate; case study focused on dual-eligible beneficiary; however, generalizability to larger Medicare population may be limited.

Methods: Case study.

Barreto EA, Guzikowski S, Michael C, et al. The Role of Race, Ethnicity, and Language in Care Transitions. *American Journal of Managed Care*. 2021;27(7):e221-e225. <https://www.ajmc.com/view/the-role-of-race-ethnicity-and-language-in-care-transitions>

Subtopic(s): Key Highlights; Considerations for Equity in Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To understand how the transition from hospital to community settings can be improved.

Main Findings: Hispanic/Latinos and Black patients had lower rates of access to computers than white patients (26 percent, 57 percent and 72 percent respectively). More than half of patients with limited English proficiency reported lack of access to medical interpreters and translated materials at discharge. Patients with limited English proficiency were less likely to report access to a smartphone (56 percent), to a computer (25 percent), and to our patient portal (10 percent) compared with non-LEP patients (85 percent, 73 percent, and 58 percent, respectively)

Strengths/Limitations: The study is relatively small (224 participants) and only included patients from one hospital.

Generalizability to Medicare Population: Moderate; study did not focus on Medicare, but findings may be applicable to beneficiaries.

Methods: Survey.

Becker C, Zumbrunn S, Beck K, et al. Interventions to Improve Communication at Hospital Discharge and Rates of Readmission: A Systematic Review and Meta-analysis. *JAMA Network Open*. 2021;4(8):e2119346. doi:10.1001/jamanetworkopen.2021.19346

Subtopic(s): Background: Care Transitions, Contexts, and Related Activities

Type of Source: Journal article

Objective: To evaluate the impact of communication interventions at hospital discharge with readmission rates.

Main Findings: Communication interventions at discharge were significantly associated with lower readmission rates, higher adherence to treatment regimen, and higher patient satisfaction.

Strengths/Limitations: The authors only included studies focused on adult medical inpatients, did not evaluate multidisciplinary discharge processes, some of the studies may have publication bias for some of their findings, and they did not include studies that had ongoing interventions.

Generalizability to Medicare Population: Moderate; study did not focus on Medicare, but findings may be applicable to beneficiaries.

Methods: Systematic literature review.

Bellantoni J, Clark E, Wilson J, et al. Implementation of a telehealth videoconference to improve hospital-to-skilled nursing care transitions: Preliminary data. *Journal of the American Geriatrics Society*. 2022;70(6):1828-1837. doi:10.1111/jgs.17751

Subtopic(s): Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation

Type of Source: Journal article

Objective: To evaluate the impact of a multidisciplinary telehealth videoconference program on patients discharging to Skilled nursing facilities (SNFs).

Main Findings: 327 patient errors were found, with the most frequently cited relating to communication and medications. The difference in the probability of patients' hospital readmissions prior to the program and after the program's implementation was not statistically significant.

Strengths/Limitations: The program has limited generalizability, only a portion of eligible patients were discussed in the videoconferences, the analysis did not include SNF-level data, and a blinded adjudication of errors was not performed.

Generalizability to Medicare Population: Moderate; study did not focus on Medicare, but findings may be applicable to beneficiaries.

Methods: An intention-to-treat analysis using logistic regression to evaluate the probability of hospital readmission and descriptive statistics on conference process measures, patient and index hospitalization characteristics, and patient safety errors.

Berenson R, Shartz A. The Mismatch of Telehealth and Fee-for-Service Payment. *JAMA Health Forum*. 2020;1(10):e201183. doi:10.1001/jamahealthforum.2020.1183

Subtopic(s): Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation

Type of Source: Position paper

Objective: To highlight issues with setting rates, particularly in terms of fee-for-service, for telehealth visits.

Main Findings: Paying primary care practices lump sums for telehealth services when there is an established, ongoing patient relationship allows practices to determine how to optimally provide virtual care and will reduce billing costs.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Moderate; authors discuss how to implement this payment model into Medicare payments (the lump sum would be added to monthly capitated Medicare payments).

Methods: N/A

Bindman AB, Cox DF. Changes in Health Care Costs and Mortality Associated With Transitional Care Management Services After a Discharge Among Medicare Beneficiaries. *JAMA Internal Medicine*. 2018;178(9):1165-1171. doi:10.1001/jamainternmed.2018.2572

Subtopic(s): Performance Measurement of Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To investigate the impact of TCM services on health care costs and beneficiaries' mortality. **Main Findings:** TCM services were billed following eligible discharges in 3.1 percent of cases in 2013, 5.5 percent in 2014, and 7.0 percent in 2015. The adjusted total Medicare costs and mortality were higher for beneficiaries who did not receive TCM services compared to those who did in the 31 to 60 days after discharge.

Strengths/Limitations: Follow-up period was only one month after the potential provision of TCM services; results could differ with a longer observation period.

Generalizability to Medicare Population: Strong; study focused on Medicare beneficiaries.

Methods: Researchers conducted a retrospective cohort analysis of all Medicare fee-for-service (FFS) claims.

Boutwell A, Calderon V, Khan A. STAAR Issue Brief: Reducing Barriers to Care Across the Continuum - Engaging Physicians. 2010;(5).

Subtopic(s): Barriers to Effective and Appropriate Care Transition Management in Population-Based Models

Type of Source: Issue brief

Objective: To report on physician experiences in the State Action on Avoidable Rehospitalizations (STAAR) initiative.

Main Findings: Physicians noted that the following three categories were important for reducing rehospitalizations: using financial incentives to elicit delivery reform, improving funding and support for services that help coordinate care (e.g., case managers, commitment by organizational leadership, IT infrastructure), and using professional norms to improve physician engagement around strategies to reduce rehospitalization.

Strengths/Limitations: This brief includes results from focus groups with physicians who chose to participate in the STAAR initiative. Therefore, the results may not be generalizable to the physician population more broadly.

Generalizability to Medicare Population: Moderate; although the brief is not specific to the Medicare population, the initiative outlined may impact Medicare beneficiaries.

Methods: The researchers conducted focus groups.

Brystana G, Kaufman P, William K, Bleser P, Robert Saunders P, et al. Prospective or Retrospective ACO Attribution Matters for Seriously Ill Patients. 2020;26. Accessed April 17, 2023.

<https://www.ajmc.com/view/prospective-or-retrospective-aco-attribution-matters-for-seriously-ill-patients>

Subtopic(s): Performance Measurement of Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To analyze the relationship between a Medicare Shared Savings Program (MSSP) Accountable Care Organization's (ACO's) attribution method and the resulting incentives for care among the seriously ill Medicare population.

Main Findings: Death during the first 90 days of the performance year was correlated with a decrease in the odds of retrospective attribution, when compared to beneficiaries that survived 270 days or more. Additionally, hospice use appeared to be linked to reduced odds of retrospective attribution. Finally, for the ACOs that failed to achieve shared savings, the average per capita Medicare expenditures were \$2459 greater for prospective compared to retrospective ACO populations; for ACOs that achieved shared savings, the average per capita Medicare expenditures were \$834 higher for prospective compared to retrospective ACO populations.

Strengths/Limitations: The analyses relied on data from between 2014 and 2016 and therefore may no longer represent the current effect of attribution method on outcomes and spending.

Generalizability to Medicare Population: Strong; study focused on the Medicare population.

Methods: The retrospective, cross-sectional study employed generalized linear models with ACO and year fixed effects.

Burke RE, Whitfield EA, Hittle D, et al. Hospital readmission from post-acute care facilities: risk factors, timing, and outcomes. J Am Med Dir Assoc. 2016;17(3):249-255. doi: 10.1016/j.jamda.2015.11.005

Subtopic(s): Trends in Utilization, Spending, and Reimbursement Related to Care Transitions

Type of Source: Journal article

Objective: To understand the risk factors and timing associated with hospital readmissions from PAC facilities, and then to assess the effect of readmission on patient outcomes.

Main Findings: The most common factors associated with readmission included impaired functional status, markers for increased acuity, and for-profit PACs. Readmitted beneficiaries also had higher mortality rates at 30 and 100 days.

Strengths/Limitations: Some of the variables included in the models violated the proportional hazards assumption, even after undergoing transformations.

Generalizability to Medicare Population: Strong; the study focused on the Medicare population.

Methods: The study relied on the longitudinal Medicare Current Beneficiary Survey data linked to Medicare claims data. Univariable analyses were used to identify significant risk factors associated with readmission; these factors were then used to develop a multivariable Cox proportional hazards regression to model readmission. The study employed a multivariate logistic regression model to assess the relationship between hospital readmission on post-PAC outcomes.

Burton, Rachel "Improving Care Transitions, " Health Affairs Health Policy Brief, September 13, 2012. DOI: 10.1377/hpb20120913.327236

Subtopic(s): Barriers to Effective and Appropriate Care Transition Management in Population-Based Models

Type of Source: Policy brief

Objective: To consider the factors influencing poor care transitions, highlight aspects of effective approaches to care transitions, and explore policy issues tied to payment reforms aimed at addressing ineffective transitions.

Main Findings: The brief highlighted issues that impede effective care transitions, such as that primary care physicians often lack information on their patients' hospitalizations and the services provided to their patients while hospitalized. The brief mentioned current models aimed at improving care transitions like the Care Transitions Intervention developed by the University of Colorado, which consists of "transitions coaches," typically nurses and social workers, who meet with patients in the hospital and then provide follow-up through home visits and telecommunication. The paper also highlighted features of the Affordable Care Act related to care transitions, including funding for demonstrations that support care transitions. Finally, the brief proposed future policy options like tracking whether hospitals transfer patient records to primary care doctors.

Strengths/Limitations: The brief does not include a methods section; however, it incorporates both more academic research and policy-related work to offer an overview of challenges to care transition as well as potential avenues for future policy.

Generalizability to Medicare Population: Strong; although the article addressed the health care system more broadly, much of the focus was on Medicare.

Methods: Review of academic and gray literature as well as relevant policies and legislation.

CMS. Care Coordination Toolkit. Learning Systems for Accountable Care Organizations. Published March 2019. Accessed March 27, 2023. <https://innovation.cms.gov/files/x/aco-carecoordination-toolkit.pdf>

Subtopic(s): Key Highlights; Using Financial Incentives to Improve Care Transition Management

Type of Source: CMS Toolkit

Objective: To describe care coordination strategies that ACOs use to deliver efficient, high-quality care.

Main Findings: The toolkit highlighted some of the strategies that ACOs have used to facilitate effective care transitions, including: supporting the exchange of data between primary care providers (PCPs) and emergency departments (EDs); establishing networks of PAC partners; launching a home visit program; and, enhancing IT capabilities to streamline referrals to community-based organizations.

Strengths/Limitations: The study relied on data from three specific Medicare ACO models and therefore may lack external validity.

Generalizability to Medicare Population: Strong; the toolkit specifically addresses Medicare.

Methods: The toolkit was developed based on focus groups and interviews with representatives from 21 ACOs that have participated in the MSSP, Next Generation Accountable Care Organization (NGACO), and ESRD CED models.

CMS. Synthesis of Evaluation Results across 21 Medicare Models, 2012-2020. Accessed April 16, 2023.

<https://innovation.cms.gov/data-and-reports/2022/wp-eval-synthesis-21models>

Subtopic(s): Key Highlights; Trends in Utilization, Spending, and Reimbursement Related to Care Transitions; Care Transition Management in CMMI Models

Type of Source: Report

Objective: To synthesize the results of Center for Medicare and Medicaid Innovation Center (CMMI) models occurring between 2012 and 2020 with at least two years of impact estimates.

Main Findings: Over half of the models analyzed experienced gross savings to Medicare. Among the models that offered financial incentives, six had net savings, six incurred net losses, and six had no discernable effects on net spending. Beneficiary or caregiver self-reported experience of care remained relatively constant among the majority of models. Additionally, mortality rates were largely unchanged for in models with improvements in mortality in four models. Models that focused on reducing acute or specialty care or that targeted specific populations such as terminal illness and lower extremity joint replacements were more likely to have gross savings and greater favorable impacts on utilization compared to models focused on primary care and population management.

Strengths/Limitations: Although the model performance periods did not occur during the same time period, the relatively small window for analysis (eight years) decreases the likelihood that the cross-model analysis was biased due to time-variant effects. For some of the later models, it is possible that an insufficient amount of time passed to truly observe model effects.

Generalizability to Medicare Population: Strong; the report focuses on Medicare model evaluations.

Methods: The study identified measures common across studies (e.g., spending, utilization, and quality of care) and then summarized these results.

Coming Home and Staying There: Improving Care Transitions for Dually Eligible Beneficiaries. Center for Health Care Strategies. Accessed March 22, 2023. <https://www.chcs.org/resource/coming-home-and-staying-there-improving-care-transitions-for-dually-eligible-beneficiaries/>

Subtopic(s): Key Highlights

Type of Source: Presentation Considerations for Equity in Care Transition Management in Population-Based Models

Objective: To explore innovative approaches to integrated health within the context of care transitions for low-income beneficiaries.

Main Findings: Three health plans presented their respective care transition strategies, which included how the plans identify individuals requiring support, develop partnerships with delivery systems and community-based organizations, and assist beneficiaries with issues tied to housing insecurity. Some of the approaches included post-discharge nursing support, using Alternative Payment Models to incentivize desired care practices, screening beneficiaries for high risk of readmission, and assisting with housing searches as well as affordable housing applications.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Strong; much of the presentation focused on the dually eligible Medicare and Medicaid population.

Methods: N/A

Cook NL, Clauser SB, Shifreen A, Parry C. Reconceptualizing Care Transitions Research From the Patient Perspective. *Med Care*. 2021;59(8 Suppl 4):S398-S400. doi:10.1097/MLR.0000000000001594

Subtopic(s): Key Highlights; Performance Measurement of Care Transition Management in Population-Based Models

Type of Source: Position paper

Objective: To discuss progress by the Patient-Centered Outcomes Research Institute (PCORI) with respect care transition delivery and research.

Main Findings: As of April 2021, PCORI had funded more than \$132 million in care transition research, yielding 29 studies, which have sought to better understanding model fidelity in addition to model outcomes. PCORI efforts have also sought to enhance stakeholder engagement. Areas of future research include studying patient-centered outcomes (PCOs) through the lens of social determinants of health (SDOH), advancing the development of PCO clinical and utilization measures, and using expanded models and metrics to reconceptualize care transitions from the patient perspective.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Moderate; although the article does not focus on the Medicare population, the topics covered pertain to the Medicare population.

Methods: N/A

Cope R, Jonkman L, Quach K, Ahlborg J, Connor S. Transitions of Care: Medication-Related Barriers Identified by Low Socioeconomic Patients of a Federally Qualified Health Center Following Hospital Discharge. *Research in Social and Administrative Pharmacy*. 2018;14(1):26-30.

doi:10.1016/j.sapharm.2016.12.007

Subtopic(s): Key Highlights; Considerations for Equity in Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: Describe barriers to transitions of care as they relate to medication access, use, and adherence in an effort to improve the transitions of care processes for practices serving primarily low socioeconomic status populations.

Main Findings: Common themes found in the analysis included: assumptions on patient plans to access/appropriately use discharge medications negatively impacts adherence; there are unmet expectations for care coordination between PCP and hospital; a disconnect between patients and health care workers leads to disengagement; and lack of personal contact hinders access to services.

Strengths/Limitations: Some underserved populations were likely excluded (e.g., those without access to a telephone or non-English speakers).

Generalizability to Medicare Population: Strong; study population included Medicare beneficiaries.

Methods: Qualitative study using semi-structured interviews of recently discharged patients between January and June 2015.

Dickson KS, Sklar M, Chen SZ, Kim B. Characterization of multilevel influences of mental health care transitions: a comparative case study analysis. *BMC Health Serv Res.* 2022 Apr 2;22(1):437. doi: 10.1186/s12913-022-07748-2. PMID: 35366865; PMCID: PMC8976965.

Subtopic(s): Barriers to Effective and Appropriate Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To characterize the different types of mental health care transitions across three types of United States-based health system contexts: pediatric, Veterans Affairs (VA) adult, and non-VA adult.

Main Findings: The study identified key factors influencing mental health care transition practices including community capacity or availability, cross-system or agency collaboration, provider training and experience related to mental health care transitions, client care experience and expectations, and client clinical characteristics or complexity. Some of these factors were present across site type whereas others were unique to one or two of the site types.

Strengths/Limitations: The papers reviewed in this study were identified based on the substantive knowledge of the research team rather than through a systematic review of the literature. Another limitation of the study pertains to the fact that the analysis did not examine the outcomes associated with the different care transition approaches categorized as part of the study.

Generalizability to Medicare Population: Moderate; the study addressed several patient populations including the Medicare population.

Methods: The study employed a comparative multi-case study design to characterize care transition approaches highlighted in the literature.

DuGoff EH, Dy S, Giovannetti ER, Leff B, Boyd CM. Setting Standards at the Forefront of Delivery System Reform: Aligning Care Coordination Quality Measures for Multiple Chronic Conditions. *J Healthc Qual.* 2013;35(5):58-69. doi:10.1111/jhq.12029

Subtopic(s): Key Highlights; Barriers to Effective and Appropriate Care Transition Management in Population-Based Models; Performance Measurement of Care Transition Management in Population-Based Models; Areas Where Additional Information is Needed

Type of Source: Journal article

Objective: The objective is to assess how ACOs, Independence at Home (IAH), and Community-Based Care Transitions Program (CCTP) measure care coordination for people with multiple chronic conditions.

Main Findings: There is a lack of consistent measures across ACOs, IAH, and CCTP when it comes to measuring care coordination, which creates challenges for providers.

Strengths/Limitations: As ACOs, IAH, and CCTP lack consistent measures, it is difficult to compare the three and draw connections between how each are tracking something.

Generalizability to Medicare Population: Strong; the article references Medicare specifically and points to what is measured for Medicare patients.

Methods: The Care Coordination Measurement Framework and Mapping Table are used to assess what parts of care coordination should be captured by the three forementioned bodies. An analysis of how and if those factors are measured is then done.

Earl T, Katapodis N, Schneiderman S. Care Transitions. Agency for Healthcare Research and Quality (US); 2020. Accessed March 21, 2023. <https://www.ncbi.nlm.nih.gov/books/NBK555516/>

Subtopic(s): Background: Care Transitions, Contexts, and Related Activities

Type of Source: Journal article

Objective: The objective is to examine transitions of patients from Hospital to other care settings and make recommendations for safe and seamless discharges to lower the rate of readmission.

Main Findings: Lack of proper transition arrangements leads to readmissions, and ensuring a successful transition begins well before discharge.

Strengths/Limitations: The literature review goes up until 2017, so newer models may not be included.

Generalizability to Medicare Population: Strong; much of the report is focused on Medicare beneficiaries.

Methods: A literature review was conducted to inform best practices of care transitions and a patient-centric framework was created to inform researchers decisions throughout the process.

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>

Subtopic(s): Key Highlights; Barriers to Effective and Appropriate Care Transition Management in Population-Based Models

Type of Source: Report

Objective: To evaluate the CCTP based on the following four criteria: Was the CCTP associated with lower readmission rates and lower Medicare expenditures for the beneficiaries directly served by the CCTP? How were CCTP characteristics associated with lower readmission rates? Which CT components were associated with lower readmission rates? Did CCTP have an impact on readmission rates and Medicare expenditures?

Main Findings: Common implementation problems such as maintaining staffing were found across the CCTP sites. Participants from all sites exhibited lower readmission rates and Medicare part A and B expenditures comparatively. Sites that were integrated with hospital partners had more successful program implementation.

Strengths/Limitations: Definite estimates of the effect of CCTP were not possible to obtain in the analysis.

Generalizability to Medicare Population: Strong; the report is centered around Medicare patients readmitted to the hospital within 30 days of being discharged.

Methods: The evaluation used a variety of Medicare datasets to compare differences in outcomes between participants and comparable nonparticipants in the CCTP.

Evaluation of the Independence at Home Demonstration: An Examination of the First Five Years. *Mathematica*; 2020. <https://innovation.cms.gov/files/reports/iah-yr5evalrpt.pdf>

Subtopic(s): Using Financial Incentives to Improve Care Transition Management

Type of Source: Report

Objective: To report on the findings of the IAH demonstration.

Main Findings: The demonstration did not have a statistically significant effect on total Medicare expenditures. The demonstration was associated with fewer ED visits, but the estimated effect on hospital admissions, avoidable ED visits, or unplanned readmissions was not statistically significant. There was no evidence that the demonstration impacted the mortality rate or the probability of entry into institutional long-term care.

Strengths/Limitations: Due to small sample sizes, the evaluation lacked the statistical power to identify small effects of the demonstration across all demonstration sites.

Generalizability to Medicare Population: Strong; demonstration focused on Medicare beneficiaries.

Methods: Evaluation methods included analyses of claims data, provider interviews, and patient and caregiver surveys.

Finkel C, Worsowicz G. Changing Payment Models: Shifting Focus on Post Acute Care. *Mo Med*. 2017;114(1):57-60.

Subtopic(s): Trends in Medicare Utilization and Spending Related to Care Transitions

Type of Source: Journal article

Objective: To describe the importance of physician understanding of PAC services, costs, and outcomes in LTCHs, IRFs, SNFs, and home health, particularly as payment models reinforce value-based care.

Main Findings: As payment models evolve to penalize readmissions, reward care coordination and quality, and place risk on providers, health care systems and physicians should develop integrated PAC programs.

Strengths/Limitations: This article summarizes existing studies, but does not contribute new findings.

Generalizability to Medicare Population: Strong; article specifically describes the importance of PAC in the context of Medicare payment models.

Methods: Summary of evidence.

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).

Subtopic(s): Key Highlights; Barriers to Effective and Appropriate Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To describe experiences and perspectives of care coordinators across the US.

Main Findings: Coordinators identified barriers and facilitators in their work at the organization/system level, the interpersonal level, and the individual level. Some factors emerged as both barriers and facilitators: clinical IT, community resources, interactions with patients and clinicians, and self-care practices.

Strengths/Limitations: The online discussion forum may have contributed to sampling bias, and participants were not required to answer every question. Individuals with stronger opinions may have been more likely to volunteer. However, the data is real-time and provides insight to their day-to-day work.

Generalizability to Medicare Population: Moderate; study does not specifically talk about Medicare beneficiaries, but findings are likely applicable to the experiences of care coordinators caring for Medicare patients.

Methods: Researchers conducted a private online discussion forum to gather data from 25 care coordinators from a diverse set of PCMH practices.

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

Subtopic(s): Opportunities to Improve Care Transition Management

Type of Source: Journal article

Objective: To evaluate the cost avoidance associated with the implementation of the Care Transitions Intervention.

Main Findings: The intervention group had significantly lower utilization in the six months following discharge and lower average total health care costs (\$14,729 compared to \$18,779). The cost avoided per patient receiving the intervention was an estimated \$3,752, and there was no observed shifting of costs to other types of utilization.

Strengths/Limitations: Study design was quasi-experimental and not randomized. The convenience sample used may have introduced sampling bias.

Generalizability to Medicare Population: Strong; study focused on Medicare beneficiaries.

Methods: Quasi-experimental cohort study using consecutive convenience sampling.

Gaugler JE, Statz TL, Birkeland RW, et al. The Residential Care Transition Module: a single-blinded randomized controlled evaluation of a telehealth support intervention for family caregivers of persons with dementia living in residential long-term care. *BMC Geriatrics.* 2020;20(1):133. doi:10.1186/s12877-020-01542-7

Subtopic(s): Key Highlights; Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation

Type of Source: Journal article

Objective: To provide a controlled study evaluation of the Residential Care Transition Module.

Main Findings: Helping families and organizations navigate residential care transitions is a valuable approach to improving long-term clinical benefits.

Strengths/Limitations: More objective measures of stress are not considered. The data collection is survey and interview based, leading to more subjective measures.

Generalizability to Medicare Population: Weak; the Medicare population is not specifically examined in this study.

Methods: Mixed methods in which family members with a cognitively impaired relative admitted to a residential long-term care setting are randomly assigned to the care control condition.

Gavin K. Bigger Spend, Same End: Post-Hospital Care Study Suggests Medicare Could Save Money. Michigan Medicine: University of Michigan. Published September 3, 2019. Accessed March 29, 2023. <https://www.michiganmedicine.org/health-lab/bigger-spend-same-end-post-hospital-care-study-suggests-medicare-could-save-moneyGavin>

Subtopic(s): Trends in Utilization, Spending, and Reimbursement Related to Care Transitions

Type of Source: Journal article

Objective: The objective is to analyze the effect, or lack thereof, of Medicare spending on post-hospital care for people in their 60s.

Main Findings: Medicare spends more on post-hospital care for people in their 60s than private insurance, however this spending does not decrease readmissions.

Strengths/Limitations: The data only looks at Michigan, opposed to taking a national view.

Generalizability to Medicare Population: Strong; article is about Medicare spending.

Methods: Data from over 25,000 patients over four years in Michigan was compared and analyzed.

Griffith KN, Schwartzman DA, Pizer SD, et al. Local Supply Of Postdischarge Care Options Tied To Hospital Readmission Rates: Study examines supply of postdischarge care options' association with hospital readmission rates. *Health Affairs*. 2022;41(7):1036-1044. doi:10.1377/hlthaff.2021.01991

Subtopic(s): Key Highlights; Trends in Utilization, Spending, and Reimbursement Related to Care Transitions

Type of Source: Journal article

Objective: The objective is to research the influence local availability of post-discharge care options has on post hospitalization readmission rates.

Main Findings: Increased readmissions were found to be associated with hospitals that have greater home health agencies. Lower thirty-day readmission rates were observed at hospitals with palliative care services. Hospitals may benefit from improved local access care.

Strengths/Limitations: The study design is observational; therefore, results should be interpreted as associations and specific causal mechanisms underlying relationships cannot be identified.

Generalizability to Medicare Population: Strong; Medicare readmission rates are a main consideration of the study.

Methods: Readmission rate data was obtained from CMS. Annual county level data was obtained from HRSA's 2013–19 Area Health Resources Files. A weighted average of the Area Health Resources Files variables was calculated for each hospital according to the proportion of their Medicare inpatient discharges.

Groom LL, McCarthy MM, Stimpfel AW, Brody AA. Telemedicine and Telehealth in Nursing Homes: An Integrative Review. *Journal of the American Medical Directors Association*. 2021;22(9):1784-1801.e7. doi:10.1016/j.jamda.2021.02.037

Subtopic(s): Key Highlights; Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation

Type of Source: Journal article

Objective: The objective is to review telehealth and telemedicine's impact on patient's and outcomes in nursing homes.

Main Findings: A number of impacts were found such as reduced emergency and hospital admissions, financial savings, reduced physical restraints, and improved vital signs.

Strengths/Limitations: Studies in the sample did not use a theoretical framework to guide their approach. There was also a lack of rigorous experimental studies.

Generalizability to Medicare Population: Moderate; Medicare savings are examined but it is not a main focus of the report.

Methods: A literature review was conducted to explore the different types of telehealth and their impact on nursing home patients.

Haas S, Swan B. Developing the Value Proposition For the Role of the Registered Nurse In Care Coordination and Transition Management in Ambulatory Care Settings. *Nursing Economics*. 2014;32(2):70-79.

Subtopic(s): Key Highlights; Background: Care Transitions, Contexts, and Related Activities

Type of Source: Report

Objective: To examine care coordination and transition management in ambulatory care settings in regard to the role of registered nurses.

Main Findings: Development of the registered nurse in Care Coordination and Transition Management (CCTM) model and role for ambulatory care nurses offers opportunities for nurses to work at their full potential as an integral part of the interprofessional team.

Strengths/Limitations: This report is from 2014 and more knowledge may exist in the landscape of this subject since the report's publication.

Generalizability to Medicare Population: Weak; Medicare population is a small consideration in the report but not central to the research.

Methods: Online focus groups were used in the development of the CCTM model from RNs.

Hansen LO, Greenwald JL, Budnitz T, et al. Project BOOST: Effectiveness of a multihospital effort to reduce rehospitalization. *Journal of Hospital Medicine*. 2013;8(8):421-427. doi:10.1002/jhm.2054

Subtopic(s): Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation

Type of Source: Journal article

Objective: To determine the effect of Project BOOST (Better Outcomes for Older adults through Safe Transitions) on rehospitalizations and length of stay.

Main Findings: Project BOOST, an effort to implement best practices for hospital discharge care transitions and facilitated by external experts, resulted in both an absolute and relative reduction in rehospitalization rates. This was determined using rehospitalization rates for matched control units during preintervention and postintervention periods. Findings suggest participation in Project BOOST appears to be associated with decreased readmission rates, suggesting a potential strategy for addressing health care quality improvement and performance-based reimbursement.

Strengths/Limitations: While the article directly assesses an approach to improve care transitions, the initiative was conducted in academic and non-academic hospital settings.

Generalizability to Medicare Population: Strong; the paper acknowledges Medicare specifically, and the need to improve care transitions, particularly for this population.

Methods: Prospective cohort study of clinical acute care units within hospitals, signed rank test.

Higuera L, Carlin C. A Comparison of Retrospective Attribution Rules. 2017;23. Accessed April 18, 2023. <https://www.ajmc.com/view/a-comparison-of-retrospective-attribution-rules>

Subtopic(s): Performance Measurement of Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To compare different methods of retrospectively attributing patients to provider systems.

Main Findings: All 32 retrospective attribution rules assessed exhibit a tradeoff between stability of attribution and fraction of the population attributed. When multiple years of data are available, the lookback method performed the best, minimizing this tradeoff; PCP-based

rules could maximize stability as well. Broadly, hierarchical rules were more successful in maintaining stability than simple all-provider rules.

Strengths/Limitations: Specifically addresses issues relevant to Medicare and Medicaid populations but cites potential limitations with external validity.

Generalizability to Medicare Population: Moderate; paper focuses on Medicaid population, but suggests overlap with Medicare population, and specifically mentions the MSSP as an example.

Methods: Retrospective cross-sectional study.

Hines, Anika L., Barrett, Marguerite L, Jiang, Joanna, Steiner, Claudia. Conditions With the Largest Number of Adult Hospital Readmissions by Payer, 2011. *Statistical Brief #172, Agency for Healthcare Research and Quality*. April 2014

Subtopic(s): Barriers to Effective and Appropriate Care Transition Management in Population-Based Models

Type of Source: Report

Objective: To identify the top 10 conditions with the largest number of readmissions and their associated costs for each payer.

Main Findings: In 2011, readmission rates per 100 admissions ranged from 8.7 for privately insured to 17.2 for Medicare beneficiaries. Medicare had the largest share of total readmissions (56 percent), followed by Medicare (21 percent) and private insurance (19 percent). Medicare also had the highest associated costs for readmissions (58 percent), followed by private insurance (20 percent), and Medicare (18 percent). The top three conditions among Medicare patients included non-hypertensive congestive heart failure, septicemia, and pneumonia as the top three. The top three conditions among Medicaid patients aged 18 to 64 included mood disorders, schizophrenia and other psychotic disorders, and diabetes mellitus with complications. The top three conditions among privately insured included maintenance for chemotherapy and radiotherapy, mood disorders, and complications of surgical procedures or medical care.

Strengths/Limitations: Expansive exploration of readmission rates and top conditions by payer.

Generalizability to Medicare Population: Moderate; considers hospital readmissions by payer, including Medicare, Medicaid, and privately insured populations.

Methods: Claims analysis using 2011 Healthcare Cost and Utilization Project (HCUP) data

In Focus: Increasing Collaboration Among Physicians, Hospitals, and Postacute Providers to Reduce Variation and Spending. The Commonwealth Fund. Published March 29, 2018. Accessed March 29, 2023. <https://www.commonwealthfund.org/publications/2018/mar/focus-increasing-collaboration-among-physicians-hospitals-and-postacute>

Subtopic(s): Trends in Utilization, Spending, and Reimbursement Related to Care Transitions

Type of Source: Blog post

Objective: To describe PAC use and spending across time, as well as share promising approaches to improving patient care, while reducing health risk and cost.

Main Findings: Medicare's FFS PAC expenditures fell in 2011 and have remained relatively stable since. SNFs are the most common source of PAC (followed by home health agencies, inpatient rehab hospitals, and long-term care hospitals). SNF admissions increased but stays were shorter in 2015 compared with 2014. Promising practices to improve care transitions include use of care navigators, improving communication between acute care and PAC settings, creating standard care protocols, timely sharing of electronic health records (EHRs) and

performance data, monitoring medical and social risks, and involving PAC providers in shared savings programs.

Strengths/Limitations: Few details on analyses/methods involved and promising approaches section relies on initial findings.

Generalizability to Medicare Population: Strong; specifically mentions Medicare communities and initiatives.

Methods: Trend and utilization analyses.

Institute of Medicine: Variation in Health Care Spending: Target Decision Making, Not Geography. 2013. Accessed June 1, 2023. https://nap.nationalacademies.org/resource/18393/geovariation_rb.pdf

Subtopic(s): Trends in Medicare Utilization, Spending, and Reimbursement

Type of Source: Journal article

Objective: To report on the findings of the IOM committee to investigate geographic variation in health care spending and quality of care for Medicare beneficiaries, and to analyze Medicare payment policies that could encourage high-value care.

Main Findings: There are regional differences in Medicare and commercial health care spending and use. There is also variation within geographic areas, regardless of how broadly or narrowly they are defined. The committee recommends that Congress not adopt a geographically-based value index for Medicare payments because the majority of health care decisions are made at the provider or health care organization level, not by geographic units.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Strong; recommendations focused on Medicare payment policy.

Methods: IOM-convened committee.

Jabbarpour YM, Raney LE. Bridging Transitions of Care From Hospital to Community on the Foundation of Integrated and Collaborative Care. *Focus (Am Psychiatr Publ)*. 2017 Jul;15(3):306-315. doi: 10.1176/appi.focus.20170017. Epub 2017 Jul 12. PMID: 31975864; PMCID: PMC6519545

Subtopic(s): Barriers to Effective and Appropriate Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To describe the importance of improved care transitions from hospitals to the community for reducing early psychiatric readmissions and identify strategies to address existing challenges.

Main Findings: Care transitions from inpatient to community-based services are essential to patient safety, quality of care, health care cost, along with patient, family, and physician satisfaction. Strategies to improve care transitions involve patient and family engagement; patient education; standardized care plans and transitions including comprehensive discharge planning, risk assessment, staff training; timely planning and follow-ups regarding labs or study results or future medical appointments/lab work; crisis planning; and shared accountability. Post-discharge activities should include telephone follow-ups, efforts to ensure psychiatric follow-up, psychoeducation, home visits, family education and intervention, structured needs assessment, a post-discharge hotline, and peer support.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Moderate; some of the studies involved Medicare populations.

Methods: Systematic review of 15 studies focused on reducing readmissions of adults

Jacobsohn GC, Jones CMC, Green RK, et al. Effectiveness of a care transitions intervention for older adults discharged home from the emergency department: A randomized controlled trial. *Academic Emergency Medicine*. 2022;29(1):51-63. doi:10.1111/acem.14357

Subtopic(s): Background: Care Transitions, Contexts, and Related Activities

Type of Source: Journal article

Objective: To test the effectiveness of the Care Transitions Intervention (CTI) with community-dwelling older adult ED patients.

Main Findings: CTI aims to improve hospital-to-home transitions. While CTI implementation did not reduce 30-day ED revisits, it did significantly increase key care transition behaviors, including outpatient follow-up, and clinical signs/symptoms prompting patients to seek immediate medical attention (red flag knowledge). There were no significant differences in medication adherence.

Strengths/Limitations: Evaluated effectiveness of efforts to reduce readmissions and identified care transition activities, however generalizability may be limited generalizability since the study was conducted within two ACO health care systems, both in mid-sized urban environments.

Generalizability to Medicare Population: Moderate; Medicare populations were not specifically mentioned but results may be relevant as study considers older adults more broadly.

Methods: Randomized controlled trial, multivariate regressions for intention-to-treat and per-protocol analyses

Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med*. 2009;360(14):1418-1428. doi:10.1056/NEJMsa0803563

Subtopic(s): Key Highlights; Performance Measurement of Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To describe the patterns of Medicare rehospitalization and the influence of patient and hospital characteristics on rehospitalization rates.

Main Findings: Nearly one-fifth of Medicare beneficiaries who were discharged from a hospital were re-hospitalized within 30 days, and 34 percent were re-hospitalized within 90 days. Among patients re-hospitalized within 30 days after a surgical discharge, over 70 percent were re-hospitalized for a medical condition, though an estimated 10 percent of rehospitalizations were likely planned. The average stay of re-hospitalized patients was 0.6 days longer than that of comparable patients who did not require rehospitalization. An estimated \$17.4 billion was attributed to unplanned Medicare rehospitalizations in 2004.

Strengths/Limitations: Medicare billing data provides an incomplete picture and contains some unreliable data elements. Assessment of outpatient-follow-up was limited by the use of billing data, which do not capture most visits to non-physician providers.

Generalizability to Medicare Population: Strong; specifically focused on Medicare population.

Methods: Medicare claims analysis.

Jones B, James P, Vijayasiri G, et al. Patient Perspectives on Care Transitions from Hospital to Home. *JAMA Network Open*. 2022;5(5):e2210774-e2210774.

Subtopic(s): Considerations for Equity in Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To investigate patients' perspectives on their care transition experience from hospital or SNFs to home.

Main Findings: Patient discharge experiences from hospitals and SNFs identified inconsistencies in care transition processes, social determinants of health issues, and racial disparities between patients who attended follow-up appointments. Approximately one in five patients reported at least one social determinant of health issues, such as lack of transportation. Compared with other patient groups, Black patients were less likely to report completing a post-discharge follow-up visit or to receive prescribed medical equipment. Overall, patients reported receiving a follow-up telephone call to be a helpful care transition activity.

Strengths/Limitations: Study found racial disparities, but failed to provide explanations for these disparities, and may also suffer from selection bias.

Generalizability to Medicare Population: Moderate; analysis includes Medicare populations, along with Medicaid and other insurance types.

Methods: Chi-square analyses.

Kanak MF, Titler M, Shever L, Fei Q, Dochterman J, Picone DM. The effects of hospitalization on multiple units. *Applied Nursing Research*. 2008;21(1):15-22. doi:10.1016/j.apnr.2006.07.001

Subtopic(s): Background: Care Transitions, Contexts, and Related Activities

Type of Source: Journal article

Objective: To determine the effect of hospitalization on multiple units upon selected nursing treatments, resource use, and clinical outcomes.

Main Findings: After controlling for primary medical diagnosis, severity of illness, and comorbidities, the evaluation found a significant association between the number of units resided on during hospitalization and the use rate of selected nursing treatments, resource use, and a variety of clinical outcomes (e.g., circulatory). Care coordination generally fall to nurses, thus nurses are well positioned to develop and implement strategies to improve care transitions across units.

Strengths/Limitations: Study depended on secondary data from a single health care organization.

Generalizability to Medicare Population: Moderate; study sample consisted primarily of Medicare-aged populations.

Methods: General linear modeling and logistic regression analyses.

Kasdorf A, Dust G, Venedey V, et al. What are the risk factors for avoidable transitions in the last year of life? A qualitative exploration of professionals' perspectives for improving care in Germany. *BMC Health Serv Res*. 2021;21:147. doi:10.1186/s12913-021-06138-4

Subtopic(s): Key Highlights; Background: Care Transitions, Contexts, and Related Activities

Type of Source: Journal article

Objective: To describe patient experiences with care transitions between health care settings in their last year of life.

Main Findings: The study suggested strategies to address transitions between care settings in a patients' last year of life span the health care system, organization, health care professional, patient and relatives. Participants cited timely identification and communication, consideration of palliative care options, availability and accessibility of care services, and having a designated health care professional for care planning as being most helpful to them.

Strengths/Limitations: Study based in Cologne, Germany.

Generalizability to Medicare Population: Weak; no mentioning of Medicare-aged populations, and study based in another country.

Methods: Focus groups and individual interviews

Kosar CM, Mor V, Werner RM, Rahman M. Risk of Discharge to Lower-Quality Nursing Homes Among Hospitalized Older Adults With Alzheimer Disease and Related Dementias. *JAMA Network Open*. 2023;6(2):e2255134. doi:10.1001/jamanetworkopen.2022.55134

Subtopic(s): Considerations for Equity in Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To assess whether hospitalized older adults with Alzheimer's disease and related dementias (ADRD) are more likely to be discharged to lower-quality SNFs.

Main Findings: The analysis found that Medicare beneficiaries with ADRD hospitalized between 2017 and 2019 were more likely to be discharged to lower-quality SNFs after accounting for discharging hospital, residential neighborhood and other characteristics (e.g., PAC specialization). These findings remained after stratifying by race and ethnicity, payer, and primary diagnosis.

Strengths/Limitations: The logit model was created based on SNF characteristics observed in administrative data sources, and may not be applicable to Medicare Advantage beneficiaries.

Generalizability to Medicare Population: Strong; analysis specifically conducted on Medicare populations.

Methods: Conditional logit model, sensitivity analyses.

Ladin K, Bronzi OC, Gazarian PK, et al. Understanding The Use Of Medicare Procedure Codes For Advance Care Planning: A National Qualitative Study. *Health Aff (Millwood)*. 2022;41(1):112-119. doi:10.1377/hlthaff.2021.00848

Subtopic(s): Key Highlights; Barriers to Effective and Appropriate Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To identify barriers and facilitators to the use of Current Procedural Terminology (CPT) codes for Medicare FFS enrollees through qualitative research.

Main Findings: Increased reimbursement, strong institutional commitment and support, and streamlined workflow could improve the use of the new CPT codes to document receipt of and ensure access to Medicare advance care planning.

Strengths/Limitations: As a qualitative study, the study's findings may be subject to response bias and may not be generalizable to all systems; however, efforts were taken to choose diverse health systems and limit response bias. Additionally, the findings apply to Medicare FFS enrollees and may not be generalizable to Medicare Advantage.

Generalizability to Medicare Population: Strong; the study is focused on Medicare CPT codes and their usage with Medicare FFS enrollees.

Methods: Qualitative case study, including key informant interviews with clinicians, administrators, and leadership.

Lambert MT. Linking mental health and addiction services: a continuity-of-care team model. *J Behav Health Serv Res*. 2002 Nov;29(4):433-44. doi: 10.1007/BF02287349. PMID: 12404937.

<https://pubmed.ncbi.nlm.nih.gov/12404937/>

Subtopic(s): Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation

Type of Source: Journal article

Objective: To describe and assess the impacts of the continuity-of-care team model on clinical services provided to patients with psychiatric and addiction comorbidity.

Main Findings: After model implementation, overall inpatient utilization and recidivism decreased. The model improved access to care, continuity of caregivers, inpatient utilization, and patient satisfaction.

Strengths/Limitations: As a case study from an individual VA medical center, it is unclear if the results will be generalizable to other contexts.

Generalizability to Medicare Population: Moderate; the study was conducted at a large VA medical center; however, the model can be applied to the Medicare population.

Methods: Statistical analysis of patient outcomes and costs, patient satisfaction surveys, and focus groups.

Lee A. How Medicare Can Reduce Waste in Post-Acute Care: The Case of Skilled Nursing Facilities. Stanford Institute for Economic Policy Research; 2022. Accessed March 29, 2023.

<https://siepr.stanford.edu/publications/policy-brief/how-medicare-can-reduce-waste-post-acute-care-case-skilled-nursing>

Subtopic(s): Key Highlights; Trends in Utilization, Spending, and Reimbursement Related to Care Transitions

Type of Source: Policy brief

Objective: To provide an overview of the PAC sector and discuss the impacts of a Medicare reimbursement rule for SNFs.

Main Findings: The Medicare “three-day rule” impacts discharge destination, showing that, on the third day of care, Medicare patients are more likely to be discharged to a SNF than non-Medicare patients. SNF discharges are very costly and appear to significantly increase 30-day hospital readmission rates for patients who stay in a hospital for three days. Medicare reimbursement may increase overuse of SNFs and generate increased Medicare costs by as much as \$345 million per year.

Strengths/Limitations: The estimates are based on a specific analysis sample from New York and Florida and may not be representative of the entire country’s spending and tendencies.

Generalizability to Medicare Population: Strong; the brief specifically discussed Medicare payment policy.

Methods: Policy analysis and statistical analysis of Medicare spending.

Lee AJ, Liu X, Borza T, et al. Role of Post-Acute Care on Hospital Readmission After High-Risk Surgery. *Journal of Surgical Research*. 2019;234:116-122. doi:10.1016/j.jss.2018.08.053

Subtopic(s): Key Highlights; Trends in Utilization, Spending, and Reimbursement Related to Care Transitions

Type of Source: Journal article

Objective: To understand the relationship between PAC and hospital readmission rates among patients receiving major surgery.

Main Findings: Patients receiving PAC had higher readmission rates than those who were discharged to home. The risk-adjusted readmission length of stay was highest for patients receiving care from SNFs, followed by those receiving home care, and lowest for those who did not receive PAC.

Strengths/Limitations: The analysis was limited to four states and may not be generalizable to the entire country. Additionally, the study used 30-day readmission rates, which may not be as informative in calculating high-risk surgery outcomes as 90-day readmission rates. The retrospective, observational nature of the study does not allow for causal conclusions.

Generalizability to Medicare Population: Moderate; while the study did not focus exclusively on the Medicare population, the study includes Medicare beneficiaries, and the findings can be applied to the Medicare population.

Methods: Retrospective observational analysis with generalized estimating equations modeling.

Lemke M, Kappel R, McCarter R, D'Angelo L, Tuchman LK. Perceptions of Health Care Transition Care Coordination in Patients With Chronic Illness. *Pediatrics*. 2018;141(5):e20173168.
doi:10.1542/peds.2017-3168

Subtopic(s): Barriers to Effective and Appropriate Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To assess the effectiveness of care coordination during health care transitions (HCT) on quality of chronic illness care and for adolescents and young adults

Main Findings: Questionnaire findings show that intervention participants had 2.5 times increased odds of endorsing mostly or always receiving the services they thought they needed and had 2.4 times increased odds of having talked to their provider about future care.

Strengths/Limitations: The study used convenience sampling and may therefore not be generalizable to populations with different demographics.

Generalizability to Medicare Population: Weak; the study focused on care coordination for adolescents and young adults.

Methods: Adolescents and young adults with special health care needs were enrolled in a randomized HCT care coordination intervention, and perceptions of chronic illness care quality were assessed at 0, 6, and 12 months.

Levine C, Ramos-Callan K. The Illusion of Choice: Why Decisions about Post-Acute Care Are Difficult for Patients and Family Caregivers. United Hospital Fund; 2019. Accessed March 29, 2023.
https://uhfnyc.org/media/filer_public/ca/45/ca451839-bd0e-4203-a31b-9f63871da53b/pt-caregiver-diffdecisions2-190107.pdf

Subtopic(s): Trends in Utilization, Spending, and Reimbursement Related to Care Transitions

Type of Source: Report

Objective: To better understand the challenges facing patients and caregivers when making PAC decisions.

Main Findings: Patients and caregivers often struggled to find adequate information regarding SNF choice and available services. Location, access to transportation, and insurance coverage and financial concerns factored strongly into patient decision-making, but often availability was the deciding factor.

Strengths/Limitations: As a qualitative study, the study's findings may be subject to response bias and may be specific to the populations interviewed.

Generalizability to Medicare Population: Moderate; while not all of the individuals interviewed specifically relied on Medicare payment, PAC and transitions to SNFs are highly relevant to the Medicare population.

Methods: Literature review and discussion groups and interviews with individuals (patients or family caregivers) who has experienced discharge from a hospital to a nursing home.

Li J, Du G, Clouser JM, et al. Improving evidence-based grouping of transitional care strategies in hospital implementation using statistical tools and expert review. *BMC Health Serv Res.* 2021;21(1):35. doi:10.1186/s12913-020-06020-9

Subtopic(s): Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation

Type of Source: Journal article

Objective: To evaluate which groups of transitional care strategies or activities commonly implemented by hospitals correspond with improved patient outcomes

Main Findings: There were five transitional care strategies that were commonly delivered by hospitals: 1) patient communication and care management; 2) hospital-based trust, plain language, and coordination; 3) home-based trust, plain language, and coordination; 4) patient/family caregiver assessment and information exchange among providers; and 5) assessment and teach back. Transitional care strategies patients reported receiving were more important in predicting readmissions than transitional care strategies that hospitals reported delivering.

Strengths/Limitations: Self-report bias or incomplete implementation of strategies could have influenced survey results.

Generalizability to Medicare Population: Moderate; study did not differentiate by patient type, but results could be applicable to Medicare beneficiaries.

Methods: Literature review.

Li J, Young R, Williams MV. Optimizing transitions of care to reduce rehospitalizations. *CCJM.* 2014;81(5):312-320. doi:10.3949/ccjm.81a.13106

Subtopic(s): Background: Care Transitions, Contexts, and Related Activities

Type of Source: Journal article

Objective: To summarize factors contributing to poor care transitions, highlight programs that improve them, and discuss strategies for successful care transitions.

Main Findings: Unsuccessful transitions can be due to ineffective patient and caregiver education, incomplete or uncommunicated discharge summaries, lack of follow-up with PCPs, and poor patient social support. Some programs aimed at improving transitions have shown reductions in hospital readmission rates and ED visits. These successful programs use multiple interventions, including improved communication among providers, better patient and caregiver education, and coordination of health and social services.

Strengths/Limitations: Article did not include a methodology on how the authors analyzed these programs.

Generalizability to Medicare Population: Moderate; study did not differentiate by patient type, but results could be applicable to Medicare beneficiaries.

Methods: N/A

Mansukhani RP, Bridgeman MB, Candelario D, Eckert LJ. Exploring Transitional Care: Evidence-Based Strategies for Improving Provider Communication and Reducing Readmissions. *P T.* 2015;40(10):690-694.

Subtopic(s): Key Highlights; Trends in Utilization, Spending, and Reimbursement Related to Care Transitions; Performance Measurement of Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To discuss strategies for improving provider communication and reducing readmissions

Main Findings: Improved handoffs and provider communication can have a positive impact on readmissions, quality of care, and patient satisfaction, and ultimately reduce overall health care costs. Effective provider communication utilizes health information technology, provides medication reconciliation, ensures access to care after discharge, effectively communicates information to patients and families, and includes follow-up telephone calls and home visits.

Strengths/Limitations: Article did not include a methodology on how the authors analyzed these programs.

Generalizability to Medicare Population: Moderate; study did not differentiate by patient type, but results could be applicable to Medicare beneficiaries.

Methods: N/A

Marcotte LM, Reddy A, Zhou L, Miller SC, Hudelson C, Liao JM. Trends in Utilization of Transitional Care Management in the United States. *JAMA Network Open*. 2020;3(1):e1919571.

doi:10.1001/jamanetworkopen.2019.19571

Subtopic(s): Barriers to Effective and Appropriate Care Transition Management in Population-Based Models

Type of Source: Journal Article

Objective: To examine trends in TCM use.

Main Findings: Almost 300,000 TCM services (62.7 percent) were accepted and over \$56 million in payments were provided in 2015. This increased to almost 1.3 million TCM services (95.1 percent) accepted and over \$243 million payments provided in 2018.

Strengths/Limitations: Study limitations include descriptive design, lack of granular practice and patient-level data, and inability to evaluate the association of TCM use with patient outcomes.

Generalizability to Medicare Population: Strong; TCM is a Medicare-specific billing program.

Methods: Researchers calculated total service counts and payments for TCM, as well as counts and potential payments for denied services.

Mathematica. Independent Evaluation of Comprehensive Primary Care Plus (CPC+). Published May 2022. Accessed March 2, 2023. <https://innovation.cms.gov/data-and-reports/2022/cpc-plus-fourth-annual-eval-report>

Subtopic(s): Using Financial Incentives to Improve Care Transition Management; Care Transition Management in CMMI Models

Type of Source: Report

Objective: To report on meaningful changes to care delivery, implementation of CPC+ and its impacts on Medicare FFS beneficiaries in program year 4.

Main Findings: In the fourth year of implementation, CPC+ practices reduced acute care utilization and improved some claims-based quality of care measures. The report also highlighted improvements in providing care for beneficiaries with behavioral health needs. Year 4 of CPC+ took place in 2020 among the COVID-19 pandemic which forced many primary care practices participating to shift resources away from many CPC+ activities. However, the CPC+ enhanced payments, including care management fees provided the ability to retain care managers and other key staff needed.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Strong; the report is focused on the impacts of the program on Medicare FFS beneficiaries.

Methods: Evaluation methods included analyses of claims data, payer and provider surveys, program documentation, beneficiary and provider interviews and beneficiary surveys.

McCoy RG, Bunkers KS, Ramar P, et al. Patient Attribution: Why the Method Matters. Am J Manag Care. 2018;24(12):596-603

Subtopic(s): Performance Measurement of Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To understand how five different measurements of primary care attribution influence measures of clinical quality, care utilization, and total costs of care among primary care patients in an integrated health care delivery system.

Main Findings: The choice of method used to measure primary care attribution of patients created variation in care utilization and total costs of care measures but not quality measures. Whichever method is chosen will have implications for which patients are more likely to be accurately attributed. Overall, patients who had more primary care visits were more likely to be attributed to their primary care physician by all methods. The authors suggest that a gold standard attribution method be implemented in order to improve comparability between studies.

Strengths/Limitations: All the attribution methods were applied to institutional administrative data which may mean missing services and encounters occurring outside that institution. There may be a lack of generalizability given the study being limited to one system. However, the conclusion of this study showing the extent of variation dependent on attribution methods used warrants merit given its implications for future studies of integrated health care delivery systems.

Generalizability to Medicare Population: Moderate; one of the methods used to attribute patients is used by CMS for Medicare ACO attribution and the MSSP.

Methods: Five attribution methods were applied to administrative data across one integrated health care delivery system over the course of two years. Patients attributed across each method were compared by who they were attributed to as well as the three other performance metrics.

McElroy V, Ordon R, Bakerjian D. Post-Acute Transitional Services: Safety in Home-Based Care Programs. AHRQ: PSNet. Published April 27, 2022. Accessed April 13, 2023.

<https://psnet.ahrq.gov/primer/post-acute-transitional-services-safety-home-based-care-programs>

Subtopic(s): Trends in Utilization, Spending, and Reimbursement Related to Care Transitions

Type of Source: Primer

Objective: To describe the patient safety issues and the approaches to post-acute home-based transitional services as well as to review the best practices to optimize care and reduce adverse events.

Main Findings: Home-based care programs are preferred by patients following hospital discharge due to cost concerns and risk potential of adverse events. Home Health Agency Services, Home-Based Primary Care, IAH and Hospital at Home are reviewed for studies on quality and safety of patients.

Strengths/Limitations: This review provides a call to action to do more research on quality of care and safety issues in alternatives to PAC in hospital but does not reach any independent conclusions.

Generalizability to Medicare Population: Moderate; IAH, a CMMI demonstration project is reviewed in this primer.

Methods: Literature review.

Mechanic D, Aiken LH. Improving the Care of Patients with Chronic Mental Illness. *N Engl J Med*. 1987;317(26):1634-1638. doi:10.1056/NEJM198712243172605

Subject(s): Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation

Type of Source: Journal article

Objective: To provide an overview of efforts to improve care for chronic mental illness and the role of community-based care.

Main Findings: There have been several programs that have been shown to improve care for people with mental illness: community mental health centers, case management, and improving funding for local managed care through hospital funds, state and local governments, and private insurance. The challenge is in developing community care that integrates these many disparate programs into one program with appropriate authorities and control over finances and organization of care delivery systems.

Strengths/Limitations: This is a shorter article that gives an overview of the history and reform efforts to improve chronic mental illness care, but a more scoping, systematic review would provide more exhaustive evidence.

Generalizability to Medicare Population: Weak; no mention of Medicare populations, but focused on Medicaid and reform efforts that would improve mental health outcomes.

Methods: Review of literature regarding community care for people with chronic mental illness

Medicare Telehealth Trends Report Medicare FFS Part B Claims Data: January 1, 2020 to September 30, 2022, Received by February 10, 2023. Available online at <https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-service-type-reports/medicare-telehealth-trends>

Subject(s): Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation

Type of Source: Report

Objective: To provide information about people with Medicare who used telehealth services between January 1, 2020-September 30, 2022.

Main Findings: Between Quarter 1 of 2020 and Quarter 4 of 2022, Medicare users with a Telehealth Service has leveled off from a high of 45 percent (Q1 2020) to the current rate of 15 percent (Q3 2022). This pattern holds steady across race/ethnicity, Medicaid eligibility, Medicare entitlement (a wider range in Q3 2022), sex, age (also a wider range in Q3 2022), and rural/urban populations.

Strengths/Limitations: Due to using claims data, there is a lag between when a service occurs and when the claim is in the CMS database.

Generalizability to Medicare Population: Strong; the datasets focus on Medicare beneficiaries.

Methods: Data used are sourced from CMS's Chronic Conditions Warehouse using final action Medicare FFS Part B claims data and are used to create trend visualizations of Medicare telehealth users and eligible users.

MEDPAC. Chapter 9: Payment Issues in Post-Acute Care.; 2019. Accessed March 27, 2023.
https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch9_medpac_reporttocongress_sec.pdf

Subtopic(s): Key Highlights; Trends in Utilization, Spending, and Reimbursement Related to Care Transitions

Type of Source: Report

Objective: To evaluate three issues that have arisen from the Post-Acute Care Prospective Payment System (PAC PPS), and to offer an alternative as a recommendation.

Main Findings: The comparison between a PAC episode-based design and a stay-based design led to a recommendation to pursue stay-based design to help protect beneficiaries against undesirable provider behavior who in the past have responded to financial incentives by choosing to avoid patients who would require extended PAC and who based treatment decisions based on financial incentives instead of the best choice for the beneficiary. The second issue looked at PAC providers' recording of functional assessment data and ended with a discussion of potential strategies that could improve reporting of data and reduce the risk of providers from reporting this data in a way that raises payments and misreports important assessment and performance data. The last issue looked at the differences in current requirements by setting and recommended a two-tiered approach to adjust for patients who have specialized or high care needs versus patients whose care can be met with the common set of requirements for the setting.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Strong; focus of report is on Medicare.

Methods: Assessment of PAC admissions data.

Mishori R, Antono B. Telehealth, Rural America, and the Digital Divide. *The Journal of Ambulatory Care Management*. 2020;43(4):319. doi:10.1097/JAC.0000000000000348

Subtopic(s): Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation

Type of Source: Journal article

Objective: To propose solutions to improving telehealth, particularly in rural America.

Main Findings: In order to improve delivery of telehealth services, improvement must be made in four areas: technology and infrastructure, payment reimbursement regulations, an increase in outcome-based research on model telehealth interventions, and health equity from a regulatory perspective.

Strengths/Limitations: This is a shorter article that gives an overview of the telehealth debate in 2020, but a more scoping, systematic review would provide more exhaustive evidence.

Generalizability to Medicare Population: Moderate; the current reform effort for Centers for Medicare & Medicaid Services to ensure reimbursement for telehealth services is mentioned as evidence that regulations to improve delivery services are one possible solution.

Methods: Review of current literature surrounding telehealth and rural disparities in health care delivery.

National Academies of Sciences, Engineering, and Medicine. 2012. The role of telehealth in an evolving health care environment: workshop summary. <https://nap.nationalacademies.org/catalog/13466/the-role-of-telehealth-in-an-evolving-health-care-environment>

Subtopic(s): Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation

Type of Source: Workshop summary

Objective: To understand how telehealth technology can fit into the U.S. health care system.

Main Findings: Studies need to be fast-tracked to improve the current data and evidence to ensure that implementation of telehealth is done effectively. Telehealth is important for broadening the base of consumers and improving health care. Workforce scarcity needs to be addressed in order to ensure role out of telehealth has support for programs. Medicaid concerns include the ability of telehealth to improve timely access to services and increase in provider availability and choice for consumers.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Strong; there are several sections focused on Medicare, its existing infrastructure and how telehealth would improve access for Medicare beneficiaries.

Methods: N/A

Navigating Care Transitions From SNF To Home During A Pandemic—Lessons Learned. Health Affairs. Accessed March 22, 2023. <https://www.healthaffairs.org/doi/10.1377/forefront.20210504.781272/full/>

Subtopic(s): Considerations for Equity in Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To develop a learning collaborative between eight nonprofit SNFs and implement quality improvement approaches to improve the rate of successful transitions from SNF to home in older adults.

Main Findings: Of the patients surveyed, 90 percent indicated they were prepared to go home, but only 52 percent of patients indicated that they had received information about symptoms and problems they may experience. An equal number of caregivers and patients (42 percent) said they had received sufficient medication instruction while at the SNF. The study found that the most important concern for SNFs was to start with improving internal processes before improving their reach out into the community. Additionally, due to varying access to technology, the researchers encountered a digital divide between SNFs which slowed down the process of the study.

Strengths/Limitations: The study faced delays due to the onset of the COVID-19 pandemic, and a digital divide between SNFs.

Generalizability to Medicare Population: Strong; the learning collaborative focused on staff of SNFs in an effort to improve care for older adults, particularly those with Medicare Part A coverage.

Methods: Create a learning collaborative project between eight nonprofit SNFs and implement quality improvement approaches, coaching calls and a patient survey for those who were recently discharged from participating facilities as well as a survey for their caregivers.

Naylor MD. Transitional care for older adults: a cost-effective model. LDI Issue Brief. 2004;9(6):1-4.

Subtopic(s): Considerations for Equity in Care Transition Management in Population-Based Models

Type of Source: Issue brief

Objective: To summarize transitional care and its effects on the costs and quality of care for hospitalized elderly patients.

Main Findings: Having transitional care from hospital to home has significant clinical and economic benefits and should be directed by clinical nurse experts who understand the resources needed. A transitional care benefit should be considered for adoption under Medicare. Physicians and nurses need to be integrated into a longitudinal form of care to ensure positive health outcomes for elderly patients, especially high-risk elders.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Strong; the focus on these studies are older adults who are primarily Medicare beneficiaries.

Methods: Summary of research on one specific model of transitional care delivered by nurse experts.

Next Generation Accountable Care Organization (NGACO) Model Evaluation: Fifth Evaluation Report. NORC at the University of Chicago; 2022. <https://innovation.cms.gov/data-and-reports/2022/nextgenaco-fifthevalrpt>

Subtopic(s): Barriers to Effective and Appropriate Care Transition Management in Population-Based Models

Type of Source: Report

Objective: To report on program year 5 of the NGACO advanced Alternative Payment Model, changes made in response to COVID-19 as well as impacts on gross and net overall spending and its impacts on specific categories of Medicare spending and utilization.

Main Findings: NGACO was associated with a 1.5 percent reduction in spending and increased cumulative net Medicare spending. Participating organizations found that partnerships and resources developed during their time in the model allowed them to better respond to needs during the COVID-19 pandemic. These organizations reduced hospital spending and utilization, SNF stays and days and spending in institutional PAC settings.

Strengths/Limitations: COVID-19 severely impacted the model and resulted in significant changes to accommodate the needs during the pandemic. However, participating organizations found that the work done in previous program years allowed them to improve their ability to respond to the needs of their patients.

Generalizability to Medicare Population: Strong; this is an evaluation of a model that was developed through the Centers for Medicare and Medicaid Innovation fund.

Methods: Difference-in-difference framework was used to estimate differential changes in spending and utilization between the baseline year and each program year.

NORC at the University of Chicago and the Department of Health and Human Services' Office of Health Policy of the Office of the Assistant Secretary for Planning and Evaluation (ASPE). 2021. Environmental Scan on Care Coordination in the Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs). <https://aspe.hhs.gov/sites/default/files/private/pdf/261946/Jun-2021-CC-Escan.pdf>

Subtopic(s): Key Highlights; Relevant Features in Selected PTAC Proposals; Summary of Model Features and Characteristics of Care Transition Management between Settings for 21 Selected CMMI Models with Components Related to Care Transition Management; Summary of Model Features and Characteristics of Care Transition Management between Settings of Proposals Reviewed by PTAC as of September 2020 with Components Related to Care Transition Management

Type of Source: Report

Objective: To report on the current context of the role of care coordination in the optimization of health care delivery and value-based transformation, as well as review proposals received by PTAC for novel alternative payment schemes.

Main Findings: Care coordination has no agreed upon definition but its use in health care delivery can be described. Care coordination varies between states using Medicaid/Medicare funds. CMMI models embed care coordination into their plans but vary on reimbursement schemes. 16 PTAC models highlighted barriers and promising practices to optimize care coordination. The report also focused on performance and outcome metrics for evaluating care coordination as well as evidence of effectiveness. The report found that care coordination has a limited impact unless it is targeted for specific patients or to improve transitions in care.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Strong; there are several analyses that focus on the Medicare population.

Methods: Literature review, document review and content analysis of discussions with PTAC members and subject matter experts.

Ouayogodé MH, Meara ER, Chang CH, et al. Forgotten Patients: ACO Attribution Omits Low-Service Users and the Dying. *Am J Manag Care*. 2018;24(7):e207-e215.

Subtopic(s): Performance Measurement of Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To understand the profile of patients who are not attributable to any provider group from a clinical standpoint.

Main Findings: Beneficiaries who are unattributable to any provider group (12 percent) are more likely to be younger, male, from a minority group with a disability as the basis for enrollment and more likely to live in high-poverty areas. These beneficiaries are less likely to use health care services often except when they die within the attribution year. The study suggests that capturing the profiles of these users when they come in at end of life, may have significant implications for improving population health efforts and end-of-life care.

Strengths/Limitations: Only one attribution method was used in this study, and alternative methods may show slightly different distributions of beneficiaries across categories, a longitudinal study may show trends more clearly and finally, claims-based measures miss out on those people who do not seek out care.

Generalizability to Medicare Population: Strong; focus of study was on Medicare beneficiaries.

Methods: Use of MSSP attribution method to assign beneficiaries and then compared several demographic markers and used multivariate regression models to describe correlates of attribution status.

Pauly MV, Hirschman KB, Hanlon AL, et al. Cost impact of the transitional care model for hospitalized cognitively impaired older adults. *J Comp Eff Res.* 2018;7(9):913-922. doi:10.2217/cer-2018-0040

Subtopic(s): Trends in Utilization, Spending, and Reimbursement

Type of Source: Journal article

Objective: To compare post-acute care costs of three care management interventions.

Main Findings: The Transitional Care Model had significantly lower costs than the Augmented Standard Care Group at both 30 and 180 days post-discharge, and significantly lower costs than Resource Nurse Care at 30 days post-discharge.

Strengths/Limitations: Only sites, not patients could be randomly assigned to each model, and the methodology does not account for unobservable characteristics among patients or sites.

Generalizability to Medicare Population: Strong; study focused on Medicare beneficiaries.

Methods: Estimated costs at 30 and 180 days post-hospital discharge for 202 hospitalized older adults with cognitive impairment who received either Augmented Standard Care, Resource Nurse Care, or the Transitional Care Model.

Parry C, Coleman EA, Smith JD, Frank J, Kramer AM. The Care Transitions Intervention: A patient-centered approach to ensuring effective transfers between sites of geriatric care. *Home Health Care Serv Q.* 2003;22(3):1-17. doi:10.1300/J027v22n03_01

Subtopic(s): Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation

Type of Source: Journal article

Objective: To evaluate a patient-centered, interdisciplinary intervention aimed to improve efficiency and quality of care during care transitions for older adult patients with chronic conditions.

Main Findings: This article provided an overview of the CTI, including the goals of the intervention and the methods used to develop the intervention. The intervention is structured with four primary pillars: (1 medication self-management; (2 use of a patient-centered record; (3 primary care and specialty follow-up; (4 knowledge of red flags. The article also described the types of health care settings in which the intervention could improve care transitions for older patients, including traditional fee-for-service environments. Although results were not reported in the article, the intervention was examined at two nationally recognized health care systems.

Strengths/Limitations: The CTI has several strengths, including its patient-centered orientation and relatively low cost to implementation. However, organizational and structural barriers can hinder providers' adoption of the intervention.

Generalizability to Medicare Population: Moderate; among other health care settings and financing structures, the intervention was designed to be implemented in a traditional FFS Medicare health care setting.

Methods: This article did not include original research; it only introduced the intervention.

Peebles V, Dolle J. Money Follows the Person: Updated state transitions as of December 31, 2020. Published July 20, 2020. <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/mfp-2020-transitions-brief.pdf>.

Subtopic(s): Trends in Utilization, Spending, and Reimbursement Related to Care Transitions

Type of Source: Report

Objective: To describe Money Follows the Person grantee states' progress toward meeting their annual goals of transitioning eligible individuals to the community.

Main Findings: The number of Money Follows the Person transitions declined each year between 2017 and 2019 but increased 5.5 percent from 2019 to 2020. The number of cumulative transitions varied substantially across states. Older adults and adults with physical disabilities represented three-quarters of all cumulative transitions. One reported challenge with the Money Follows the Person (MFP) demonstration included uncertainties related to long-term funding.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Moderate; this report discussed the MFP demonstration which directly impacted Medicaid programs and beneficiaries.

Methods: The report described self-reported data provided through MFP grantee states' semiannual progress reports from 2017 to 2020.

Probst JC, Hung P, Benavidez GA, Crouch E, Eberth JM. Access to health services across rural and urban minoritized racial/ethnic group areas. *Rural & Minority Health Research Center Policy Brief*. 2023.

Subtopic(s): Barriers to Effective and Appropriate Care Transition Management in Population-Based Models

Type of Source: Report

Objective: To describe disparities in geographic access to health care services for individuals from racial and ethnic minority groups.

Main Findings: Compared to urban locations, rural locations were more likely exceed distance cutoffs across different types of health care services. Within urban locations, areas with a relatively high proportion of non-Hispanic black as well as Hispanic and non-Hispanic Asian residents were closer to providers compared to areas with a relatively high proportion of non-Hispanic white residents. Rural areas with a high proportion of American Indian/Alaska Native residents were more likely to exceed 15- and 30-mile distance thresholds from the nearest provider. Rural areas with a high proportion of Hispanic residents showed similar distances to the nearest provider as rural areas with a high proportion of American Indian/Alaska Native residents.

Strengths/Limitations: The use of straight-line distance between the center of ZIP Code Tabulation Areas and the nearest providers may not accurately reflect driving distance or driving time. Distance was not calculated for residents living in Alaska or Hawaii, two states that may have unique challenges with geographic access to health care services.

Generalizability to Medicare Population: Moderate; although the sample nor health care settings focused specifically on Medicare beneficiaries or programs, Medicare beneficiaries may benefit from this information.

Methods: Across several categories of health care services, straight-line distance to care was measured from the population center of rural and urban ZIP codes Tabulation Areas to the nearest provider.

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

Subtopic(s): Key Highlights; Barriers to Effective and Appropriate Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To describe factors that influenced communication practices among inpatient providers who support the longitudinal care management of patients with hypertension.

Main Findings: Factors that influenced communication between providers included complete medication and treatment plans, standardized discharge documentation, and use of multiple channels of communication outside of the EHR.

Strengths/Limitations: Findings may not generalize to other health care systems given the small sample size and the sample was drawn from a single setting. In addition, patient perspectives were not collected in the study, so the results are limited to the perspective of providers.

Generalizability to Medicare Population: Moderate; the study did not focus on the Medicare population specifically, but findings may be relevant to beneficiaries.

Methods: Twenty-one providers, including eight physicians, eight nurses, and five clinical pharmacists, completed semi-structured interviews. The research team conducted thematic analysis of the qualitative interview data to understand factors that influence provider communication.

Regenbogen SE, Cain-Nielsen AH, Syrjamaki JD, Chen LM, Norton EC. Spending on postacute care after hospitalization in commercial insurance and Medicare around age sixty-five. *Health Affairs*. 2019;38(9):1505-1513. doi:10.1377/hlthaff.2018.05445

Subtopic(s): Trends in Utilization, Spending, and Reimbursement Related to Care Transitions

Type of Source: Journal article

Objective: To determine whether PAC spending was greater for patients with Medicare versus commercial insurance.

Main Findings: Across medical and surgical conditions, PAC spending was 68-230 percent greater for Medicare FFS beneficiaries compared to patients with commercial insurance. Despite greater spending on PAC among Medicare beneficiaries, there were no significant differences in readmission rates between Medicare beneficiaries and patients with commercial insurance.

Strengths/Limitations: Results are limited to the geographic region studied because the private insurer was located in Michigan. For example, regional differences in commercial prices could influence the generalizability of the findings to other states. In addition, the authors operationalized PAC quality by hospital readmission rates, but there are other measures of quality beyond readmission rates (e.g., patient satisfaction, functional recovery).

Generalizability to Medicare Population: Strong; this article directly examined PAC spending among Medicare fee-for-service beneficiaries and determined there is opportunity for additional savings in Medicare without reducing PAC quality.

Methods: PAC use and spending among Medicare beneficiaries were compared to use and spending among patients with private insurance in Michigan. Analyses focused on a clinically similar sample of adults approximately aged 65.

Report to the President and Congress: The Money Follows the Person (MFP) Rebalancing Demonstration. Published June 2017. <https://www.medicaid.gov/sites/default/files/2019-12/mfp-rtc.pdf>.

Subtopic(s): Trends in Utilization, Spending, and Reimbursement Related to Care Transitions

Type of Source: Report

Objective: To describe findings from the MFP rebalancing demonstration in order to satisfy the legislation's requirement for a final report to the President and Congress.

Main Findings: Through 2015, grantee states transitioned 63,337 Medicaid beneficiaries to the community. Medicare and Medicaid experienced cost savings when MFP beneficiaries transitioned to community living. Evidence suggested that the transition to community-based services and supports improved and helped to sustain beneficiaries' quality of life.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Moderate; this report discussed the MFP rebalancing demonstration which directly impacted Medicare and Medicaid programs and beneficiaries.

Methods: Semiannual progress reports provided by each state grantee between 2008 and 2015 were analyzed. The report assessed and summarized the effectiveness of the Money Follows the Person rebalancing demonstration, such as whether state grantees met numerical benchmarks (e.g., number of eligible persons transitioned to qualified residences), the savings associated with the transition of persons to qualified residences within each state, and changes in beneficiaries' quality of life.

Rivera-Hernandez M, Rahman M, Mor V, Trivedi AN. Racial disparities in readmission rates among patients discharged to skilled nursing facilities. *Journal of the American Geriatrics Society*. 2019;67(8):1672-1679. doi:10.1111/jgs.15960

Subtopic(s): Considerations for Equity in Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To identify and describe racial and ethnic disparities in rates of rehospitalization directly from SNFs among Medicare fee-for-service and Medicare Advantage beneficiaries.

Main Findings: Black patients and Hispanic patients had higher readmission rates compared to white patients. There are within-SNF racial and ethnic disparities, such that Black patients in the same SNF are more likely than white patients to be readmitted to the hospital. Readmission rates were lower for Medicare Advantage beneficiaries compared to fee-for-service beneficiaries.

Strengths/Limitations: One strength is the inclusion of Medicare Advantage beneficiaries who are excluded by the CMS SNF readmission measure. Regarding limitations, the analyses did not consider caregiver or family support and the data did not allow stratification of medical versus surgical patients.

Generalizability to Medicare Population: Strong; the study focused specifically on racial and ethnic group differences in readmission rates among MA beneficiaries and fee-for-service beneficiaries.

Methods: The outcome variable was readmission directly from the SNF and the primary independent variables included race/ethnicity and enrollment in Medicare fee-for-service or Medicare Advantage. Several data sets were merged for the purposes of the study: Minimum Data Set (MDS); the Medicare Master Beneficiary Summary File (MBSF); the Long-Term Care: Facts on Care in the United States (LTCFocus); the Nursing Home Compare (NHC) Five-Star Ratings database; and the US Census.

Roper KL, Ballard J, Rankin W, Cardarelli R. Systematic review of ambulatory Transitional Care Management (TCM) visits on hospital 30-day readmission rates. *Am J Med Qual.* 2017;32(1):19-26. doi:10.1177/1062860615615426

Subtopic(s): Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation

Type of Source: Journal article

Objective: To review the existing literature and evaluate the effectiveness of TCM on 30-day readmission rates.

Main Findings: TCM reduced all-cause hospital readmissions within 30 days following discharge. The effect ranged from modest (1.8 percent reduction in readmission) to strong (approximately 20 percent reduction in readmission).

Strengths/Limitations: The systematic review highlighted the limited evidence on the topic, as only three articles met the inclusion criteria. In addition, none of the analyzed studies were randomized controlled trials.

Generalizability to Medicare Population: Moderate; this article examined an approach to transitional care for which some Medicare beneficiaries are eligible.

Methods: This systematic review screened peer-reviewed journal articles published between 2004 and 2015. Articles were included in the review if they reported hospital readmissions of adults in the United States health care system under the Medicare TCM bundle. Three studies met the inclusion criteria.

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

Subtopic(s): Trends in Utilization, Spending, and Reimbursement

Type of Source: Journal article

Objective: To determine if combined acute and 30-day post-acute care costs were lower for hospital at home (HaH) patients compared to inpatient comparison population.

Main Findings: HaH costs were \$5,116 lower than the comparison group, and \$5,977 lower when adjusted for age, sex, insurance, diagnosis, and ADL impairments.

Strengths/Limitations: Analysis was of a single HaH program it is early phase of implementation.

Generalizability to Medicare Population: Strong; study focused on impact of Medicare demonstration program.

Methods: Retrospective observational cohort study of patients admitted to either HaH or inpatient care.

Scott AM, Li J, Oyewole-Eletu S, et al. Understanding facilitators and barriers to care transitions: Insights from Project ACHIEVE site visits. *The Joint Commission Journal on Quality and Patient Safety.* 2017;43(9):433-447. doi:10.1016/j.jcjq.2017.02.012

Subtopic(s): Considerations for Equity in Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To describe stakeholder perspectives on facilitators and barriers to achieving effective implementation of transitional care services that have been adopted or adapted from evidence-based models.

Main Findings: The main facilitators of care transitions included internal and external collaboration within and across organizations, patient and caregiver education and involvement

in transitional care planning, and staff engagement. Barriers to care transitions included poor integration of transitional care services into the organization (e.g., lack of communication across providers, poor information management), unmet patient or caregiver needs, inadequate mediation education, underutilization of palliative care, and lack of buy-in from staff.

Strengths/Limitations: This study included a wide range of health care settings that varied in geographic region, organization type (e.g., community hospitals, academic medical centers, integrated health systems, broader community partnerships), population served, and transitional care program implementation.

Generalizability to Medicare Population: Moderate; although the study sample nor health care setting focused specifically on Medicare beneficiaries or programs, Medicare beneficiaries may benefit from this information.

Methods: This study was part of a larger project called Project ACHIEVE (Achieving Patient-Centered Care and Optimized Health In Care Transitions by Evaluating the Value of Evidence). One- to two-day site visits were conducted at 22 health care organizations across the United States. Site visits included direct observation of hospital work pace and flow, document review, and semi-structured interviews with a variety of stakeholder groups (i.e., management and leadership, care team members, community partners, and patients and their families or caregivers). Interview data were qualitatively coded and observational data and document review were synthesized to evaluate each site's implementation of transitional care strategies.

Shashikumar S, Waken RJ, Aggarwal R, Wadhera R, Joynt Maddox K. Three-year impact Of stratification in the Medicare Hospital Readmissions Reduction Program. *Health Affairs*. 2022;41(3). doi:10.1377/hlthaff.2021.01448

Subtopic(s): Trends in Utilization, Spending, and Reimbursement Related to Care Transitions

Type of Source: Journal article

Objective: To evaluate the impact of stratifying the Medicare Hospital Readmissions Reduction Program with penalties on hospitals caring for vulnerable populations.

Main Findings: Following the stratification mandate, the Hospital Readmissions Reduction Program assigned fewer penalties to hospitals serving a high proportion of patients experiencing poverty as well as patients from racial or ethnic minority groups. Privately owned hospitals and hospitals serving the fewest dually enrolled patients had the largest increase in penalties following the stratification mandate. Overall, stratification in the Hospital Readmissions Reduction Program led to equity.

Strengths/Limitations: Although the study reports penalty percentages, the study does not report actual changes in dollar amount. In addition, hospitals vary across states due to the non-uniformity in expansion of Medicaid under the Affordable Care Act.

Generalizability to Medicare Population: Strong; the study evaluated data from the Centers for Medicare & Medicaid to determine the impact of a Medicare program, the Medicare Hospital Readmissions Reduction Program.

Methods: The change in three-year-average annual penalty percentage from the pre-stratification period (fiscal years 2016-2018) to the post-stratification period (fiscal years 2019-2021) was examined among hospital serving vulnerable populations, including safety net hospitals, rural hospitals, and hospitals caring for a high percentage of black and Hispanic or Latino patients.

Solomon P, Hanrahan NP, Hurford M, DeCesaris M, Josey L. Lessons learned from implementing a pilot RCT of Transitional Care Model for individuals with serious mental illness. *Arch Psychiatr Nurs*. 2014;28(4):250-255. doi:10.1016/j.apnu.2014.03.005.

Subtopic(s): Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation

Type of Source: Journal article

Objective: To describe barriers and facilitators to implementing an adapted Transitional Care Model for individuals with serious mental illness.

Main Findings: Participants with immediate medical care needs most actively utilized the intervention. Although the nurse practitioner faced HIPAA regulations and other privacy issues while trying to contact patients in behavioral health facilities, the nurse practitioner did not face these challenges when trying to communicate with patients admitted to physical health facilities and was instead welcomed and valued by the physical health providers. The nurse practitioner served as a bridge between physical and mental health systems. Based on the lessons learned from the study, the authors recommended using a team-based approach when implementing Transitional Care Management for individuals with serious mental illness. The team should include a psychiatric advanced practice nurse, a social worker, a peer specialist, and a consulting psychiatrist.

Strengths/Limitations: One limitation of this study is the relatively small sample size from which case narratives were provided. In addition, the authors did not provide sufficient detail on the approach used to analyze the data.

Generalizability to Medicare Population: Moderate; although the study sample nor health care setting focused specifically on Medicare beneficiaries or programs, Medicare beneficiaries may benefit from this information.

Methods: Meeting minutes from monthly advisory group meetings and case narratives of participants provided by a psychiatric nurse practitioner were content analyzed to identify barriers and facilitators of implementing the intervention. Consensus regarding the emerging themes were discussed among three research team members and an advanced practice nurse.

Sowers WE, Rohland B. American Association of Community Psychiatrists' Principles for Managing Transitions in Behavioral Health Services. *PS*. 2004;55(11):1271-1275. doi:10.1176/appi.ps.55.11.1271

Subtopic(s): Opportunities to Improve Care Transition Management in Population-Based Models through Care Delivery Innovation

Type of Source: Journal article

Objective: To describe a set of guidelines for maintaining continuity of care as developed by the American Association of Community Psychiatrists.

Main Findings: Transition planning should involve a progressive conceptualization of an integrated service system, with overlapping and integrated services and resources, to better manage unique patient needs and reduce opportunity for relapse. Key aspects of care to be taken into account include: prioritization, comprehensiveness, coordination and integration, continuity, service user participation, support system involvement, respect for the service user's choices, cultural sensitivity, access to resources, gradual transitions, designation of responsibility, accountability, and recognition of special needs.

Strengths/Limitations: The guidelines are based on discussion and communication and are not yet able to be considered evidence-based practice. Existing literature is insufficient in evidence to support all the identified principles. Additional research is needed to examine the impacts of the guidelines.

Generalizability to Medicare Population: Moderate; the guidelines are not developed for the Medicare population; however, guidelines may be appropriate for Medicare beneficiaries transitioning between levels of psychiatric care.

Methods: Discussion between the quality management committee informed by clinical experience and committee consensus, review by providers and consumers, and revision based on feedback.

Temkin-Greener H, Yan D, Cai S. Post-Acute Care Transitions and Outcomes Among Medicare Beneficiaries with Dementia: Associations with Race/Ethnicity and Dual Status. *Health Services Research*. 2023;58(1):164-173. doi:10.1111/1475-6773.14059

Subtopic(s): Considerations for Equity in Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To evaluate how PAC transitions affect dual Medicare-Medicaid eligible and minority older adults with Alzheimer's disease or related dementia.

Main Findings: Differences in PAC transition outcomes and PAC hospital readmissions were more strongly impacted by dual-eligible status than by race or ethnicity.

Strengths/Limitations: Researchers were unable to measure actual transitions of care, and instead used PAC referrals as the study measure, which may or may not reflect actual receipt of care by the population. Additionally, the study was not able to take into account additional measures of disease severity, external caregiver support, and patient/family preferences, which may influence referrals and outcomes.

Generalizability to Medicare Population: Strong; study focused exclusively on Medicare beneficiaries.

Methods: Retrospective cohort study of Medicare beneficiaries with Alzheimer's disease or related dementia.

Urbanski D, Reichert A, Amelung V. 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 International Publishing; 2021:437-451. doi:10.1007/978-3-030-69262-9_26

Subtopic(s): Key Highlights; Background: Care Transitions, Contexts, and Related Activities; Barriers to Effective and Appropriate Care Transition Management in Population-Based Models

Type of Source: Book

Objective: To describe discharge management and its components, related challenges, necessity in health care systems, and potential organization.

Main Findings: Discharge management is necessary to provide integrated care in health systems, particularly considering the rising demographic challenges of increased average life expectancies, rising health care costs and financial pressure, declining length of hospital stays, variety of financing and reimbursement systems, and the complex needs that the discharge needs to address. Organizing and sustaining successful discharge management can be costly and should be enabled by an adequate reimbursement system, such as bundled payments, but has a high potential for increasing efficiency and ultimately reducing costs.

Strengths/Limitations: Article did not include methodology on how the authors assessed discharge management.

Generalizability to Medicare Population: Moderate; the article does not specifically address the Medicare population, but the concepts of integrated care and discharge and transition management can be applied to the Medicare population.

Methods: Literature review.

VanSuch M, Naessens JM, Stroebel RJ, Huddleston JM, Williams AR. Effect of discharge instructions on readmission of hospitalized patients with heart failure: do all of the Joint Commission on Accreditation of Healthcare Organizations heart failure core measures reflect better care? *Qual Saf Health Care*. 2006;15(6):414-417. doi:10.1136/qshc.2005.017640

Subtopic(s): Background: Care Transitions, Contexts, and Related Activities

Type of Source: Journal article

Objective: To determine whether documentation of compliance with any or all six required Joint Commission on Accreditation of Healthcare Organizations instructions is correlated with hospital readmissions or mortality.

Main Findings: Sixty-eight percent of patients received all six instructions, and 6 percent received no instructions. Patients who received all instructions were significantly less likely to be readmitted for any cause and for heart failure than those who did not receive at least one type of instruction. There was no association between documentation of discharge instructions and mortality.

Strengths/Limitations: Discharge instructions actually provided may differ from the documentation.

Generalizability to Medicare Population: Moderate; study did not differentiate by patient type, but results could be applicable to Medicare beneficiaries.

Methods: Retrospective study on randomly sampled patients hospitalized for heart failure.

Wang SY, Hsu SH, Aldridge MD, Cherlin E, Bradley E. Racial Differences in Health Care Transitions and Hospice Use at the End of Life. *Journal of Palliative Medicine*. 2019;22(6):619-627. doi:10.1089/jpm.2018.0436

Subtopic(s): Considerations for Equity in Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To examine racial and ethnic differences in transitions of care and hospice use.

Main Findings: The average number of care transitions within the last six months of life was 2.9 transitions for White beneficiaries, 3.4 transitions for Black beneficiaries, 2.8 transitions for Hispanic beneficiaries, and 2.4 transitions for Asian beneficiaries. Adjusting for age and sex, having at least four transitions was significantly more common for Black beneficiaries compared to White beneficiaries, and less common among Hispanic beneficiaries and Asian Americans. Among hospice users, White, Black, and Hispanic beneficiaries had similar length of hospice enrollment, which was significantly longer than that of Asian Americans.

Strengths/Limitations: Patient race/ethnicity in data is subject to reporting errors, particularly for Hispanic and Asian beneficiaries. Data was not available on patient preferences.

Generalizability to Medicare Population: Strong; study focused exclusively on Medicare beneficiaries.

Methods: Retrospective cohort study of Medicare beneficiaries.

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

Subtopic(s): Using Financial Incentives to Improve Care Transition Management

Type of Source: Journal article

Objective: To review evidence on financial aspects that may have an impact on long-term care transitions among older adults.

Main Findings: Three types of financial incentives play a role in care transition: reimbursement mechanism, reward, and penalty. The majority of the 19 studies discussed the role of rewards, specifically pay-for-performance programs and their impact on care coordination.

Strengths/Limitations: Terminology “transitional care” and “care transition” not widely or consistently used by researchers.

Generalizability to Medicare Population: Strong; study focused on Medicare-aged beneficiaries.

Methods: Systematic review of relevant literature.

Zuckerman RB, Wu S, Chen LM, Joynt Maddox KE, Sheingold SH, Epstein AM. The Five-Star Skilled Nursing Facility Rating System and Care of Disadvantaged Populations. *Journal of the American Geriatrics Society*. 2019;67(1):108-114. doi:10.1111/jgs.15629

Subtopic(s): Key Highlights; Considerations for Equity in Care Transition Management in Population-Based Models

Type of Source: Journal article

Objective: To examine characteristics and locations of high- and low-quality SNFs and whether certain vulnerable individuals were differentially discharged to low-quality facilities.

Main Findings: Low-quality facilities were more likely to be in the south, for-profit, and larger. Dual enrollment was the strongest predictor of admission to a one-star facility. Racial or ethnic minority status and geographic prevalence of facilities were also significant predictors.

Strengths/Limitations: Study did not include beneficiaries enrolled in MA and relied on Medicare enrollment files, which have limited demographic and socioeconomic status measures.

Generalizability to Medicare Population: Strong; study focused exclusively on Medicare beneficiaries.

Methods: Retrospective observational study.

Zurlo A, Zuliani G. Management of care transition and hospital discharge. *Aging Clin Exp Res*. 2018;30(3):263-270. doi:10.1007/s40520-017-0885-6

Subtopic(s): Key Highlights; Background: Care Transitions, Contexts, and Related Activities

Type of Source: Journal article

Objective: To describe strategies for successful hospital discharges of frail older patients.

Main Findings: It is essential for hospitals to consider 1) adequate attention to assess the clinical, social, and care conditions; 2) respect the expectations of patients and their families; 3) formalize institutional roles or teams designated to planning and coordinating discharge; 4) knowledge of TCM programs; and 5) strong communication.

Strengths/Limitations: Article did not include a methodology on how the authors analyzed discharge strategies.

Generalizability to Medicare Population: Strong; article focused on frail elderly patients.

Methods: N/A

Appendix H. References

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