

**Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes**

**June 13, 2023
9:03 a.m. – 2:02 p.m. EDT
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201**

Attendance

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

Lauran Hardin, MSN, FAAN, PTAC Co-Chair (Chief Integration Officer, HC² Strategies)
Angelo Sinopoli, MD, PTAC Co-Chair (Chief Network Officer, UpStream)
Lindsay K. Botsford, MD, MBA (Market Medical Director, One Medical)
Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)*
Lawrence R. Kosinski, MD, MBA (Founder and Chief Medical Officer, SonarMD, Inc.)
Joshua M. Liao, MD, MSc (Associate Professor, Medicine and Director, Value and Systems Science Lab,
University of Washington School of Medicine)
Walter Lin, MD, MBA (Chief Executive Officer, Generation Clinical Partners)
Terry L. Mills Jr., MD, MMM (Senior Vice President and Chief Medical Officer, CommunityCare)
Soujanya Pulluru, MD (Vice President, Clinical Operations, Walmart Health Omnichannel Care, Walmart,
Inc.)
James Walton, DO, MBA (President, JWalton, LLC)
Jennifer L. Wiler, MD, MBA (Chief Quality Officer Denver Metro, UCHHealth and Professor of Emergency
Medicine, University of Colorado School of Medicine)

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

Lisa Shats, PTAC Designated Federal Officer
Steven Sheingold, PhD

****Via Webex Webinar***

List of Speakers and Handouts

1. Listening Session 2: Financial Incentives for Improving Care Transition Management

Richard J. Gilfillan, MD, MBA, Former President, Trinity Health and Geisinger Health Plan, and
Director, Center for Medicare and Medicaid Innovation (Retired)*
Mary D. Naylor, PhD, RN, Marian S. Ware Professor, Gerontology, School of Nursing, and Director,
NewCourtland Center for Transitions and Health, Penn Nursing, University of Pennsylvania*

Grace Terrell, MD, MMM, Chief Product Officer, IKS Health*

Handouts

- Listening Session 2 Day 2 Presenters' Biographies
- Listening Session 2 Day 2 Presentation Slides
- Listening Session Day 2 Facilitation Questions

2. Listening Session 3: Addressing Care Transitions in Alternative Payment Model (APM) Design

John Birkmeyer, MD, President, Sound Physicians*

Marc Rothman, MD, CMD, Chief Medical Officer, Signify Health*

Lewis G. Sandy, MD, FACP, Co-Founder, SuLu Consulting LLC (former SVP, Clinical Advancement, UnitedHealth Group)*

Handouts

- Listening Session 3 Day 2 Presenters' Biographies
- Listening Session 3 Day 2 Presentation Slides
- Listening Session Day 2 Facilitation Questions

****Via Webex Webinar***

[NOTE: A transcript of all statements made by PTAC members and public commenters at this meeting is available on the ASPE PTAC website located at:

<https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>].

The [ASPE PTAC website](#) also includes copies of the presentation slides and other handouts and a video recording of the June 13 PTAC public meeting.

Welcome and Co-Chair Update

Angelo Sinopoli, PTAC Co-Chair, welcomed the Committee and members of the public to day two of the June 2023 public meeting. He noted that Elizabeth (Liz) Fowler, Centers for Medicare & Medicaid Services (CMS) Deputy Director and Director of the Center for Medicare and Medicaid Innovation (CMMI; the Innovation Center), spoke at day one of the public meeting about how PTAC's work is related to some of the Innovation Center's areas of focus. Co-Chair Sinopoli provided an overview of the second day of the public meeting, including two listening sessions, a public comment period, and a Committee discussion to shape PTAC's comments for a report to the Secretary of Health and Human Services (HHS) on improving the management of care transitions in population-based models.

Co-Chair Sinopoli invited Committee members to introduce themselves and their experience with managing care transitions.

Listening Session 2: Financial Incentives for Improving Care Transition Management

- Richard J. Gilfillan, MD, MBA, Former President, Trinity Health and Geisinger Health Plan, and Director, CMMI (Retired)*
- Mary D. Naylor, PhD, RN, Marian S. Ware Professor, Gerontology, School of Nursing, and Director, NewCourtland Center for Transitions and Health, Penn Nursing, University of Pennsylvania*
- Grace Terrell, MD, MMM, Chief Product Officer, IKS Health

Co-Chair Sinopoli moderated the listening session with three subject matter experts (SMEs) on financial incentives for improving care transition management. Full [biographies](#) and [presentations](#) are available.

Richard Gilfillan presented on Alternative Payment Model (APM) investment, implementation, and transformation.

- Since the passage of the Affordable Care Act (ACA), knowledge has advanced on how to improve outcomes while lowering costs, including through the evaluation of different payment models. Overarching lessons learned include:
 - Policy makers should consider the context in which payment models are implemented (sometimes half-heartedly) as part of their assessment of these models. Most payment models offer limited business opportunities to providers, resulting in limited provider investment and commitment.
 - Transforming knowledge about APMs into practice will require investment and commitment from providers and payers.
 - The COVID-19 pandemic stalled progress on implementation of APMs, because health care organizations are still recovering from pandemic-related financial challenges.
 - Moving forward, APMs must explicitly address inequities, which have persisted or worsened during previous efforts.
 - Care delivery changes take time. For example, mandatory diagnosis-related groups (DRGs) took five to 15 years to show results.
- Accountable Care Organizations (ACOs) evaluations have shown proof of concept: the best performing organizations demonstrate cost savings of over 10 percent. However, evaluation results are averaged across organizations with varying levels of investment, resulting in only modest quality improvement overall.
 - ACOs should be evaluated on proof of concept on the organization level rather than average impact across all ACO participants.
- Primary care-based models alone do not deliver lower costs and better quality. Models must be embedded in broader population health models to make a difference.
- The Bundled Payments for Care Improvement (BPCI) Model also showed proof of concept by decreasing costs among some participants. However, BPCI did not result in overall savings, partially because participation was voluntary rather than mandatory.
- Model participation should be mandatory. Most current models lack incentives necessary to convince providers and institutions to invest in care transformation.
- Views of APMs differ by participant type. For payers, value-based care translates to easy profits associated with Medicare Advantage (MA) risk coding. Integrated health systems have experienced poor financial results under APMs, resulting in limited commitment to APMs. Many physicians have experienced success with physician-based ACOs and remain committed to ACO models despite their challenges, while some primary care providers (PCPs) need targeted incentives to encourage engagement in APMs.
- Because it is generally easier to profit in MA compared with ACOs, CMS may need to level the playing field, for example, through the new regulations for risk coding. Voluntary APMs that promise potential future payments or penalties do not drive aggressive investment,

implementation, or transformation—particularly in an environment dominated by Medicare Advantage subsidies and relatively easier profits.

- Capitated models with up-front payments may be necessary for institutions to invest in health care delivery reform.
- New APM evaluations should consider health equity, how providers are incentivized to invest, how model effectiveness is defined, how the model can be scaled, and whether the evaluation is structured in a way that justifies scaling. For example, evaluation results of a voluntary APM may not apply to mandatory participation in the real world, and vice versa.

For additional details on Dr. Gilfillan’s presentation, see the [presentation slides](#) (pages 2-11), transcript, and [meeting recording](#) (7:58-20:22).

Mary Naylor presented on the Transitional Care Model for older adults.

- The Transitional Care Model provides older adults with hospital to home services from hospital admission through 60 days post-discharge.
 - An advanced practice registered nurse (APRN) coordinates care, collaborating with team members in hospital, ambulatory care, and community settings.
 - The model focuses on engaging and building trust with older adults and their caregivers, including seven days per week availability.
 - The long-term goal is to prevent unnecessary use of acute care services.
 - There is ample evidence-based research on the effectiveness of the Transitional Care Model, including randomized clinical trials, comparative effectiveness studies, and real-world implementation in diverse contexts.
- Dr. Naylor illustrated the Transitional Care Model with an example about a fictional Mrs. Jones, an 84-year-old widow with more than five chronic conditions. During Mrs. Jones’ four-day hospital stay, the APRN visits Mrs. Jones at least twice to establish a trusting relationship. The APRN visits Mrs. Jones in her home on day one post-discharge and joins Mrs. Jones on a follow-up visit to her PCP one week later. During weeks two to seven post-discharge, the APRN continues coordinating Mrs. Jones’ health and social services care. At week eight post-discharge, the APRN meets with Mrs. Jones and her health and social services teams to communicate the transitional plan detailing recommended next steps.
- Medicare fee-for-service (FFS) should implement an episodic 60-day case rate per member for transitional care services, as 30 days are not sufficient.
- CMMI should implement a voluntary demonstration of the Transitional Care Model, including a path from voluntary to mandatory participation. Demonstration participants must provide evidence of cross-site partnerships, agree to measure key outcomes and processes, and commit to absorbing acute care costs for three months following hospital discharge.
- To build infrastructure for effective transitional care, advanced investment payments should be made to accountable entities (for example, ACOs, hospital or post-acute providers).
- MA should strengthen the criteria for the Transitions of Care star rating measure.

For additional details on Dr. Naylor’s presentation, see the [presentation slides](#) (pages 12-24), transcript, and [meeting recording](#) (20:25-38:55).

Grace Terrell presented on redesigning patient care models and payment models for transitional care delivery.

- Substantial change requires a comprehensive redesign of the patient care, payment, and operational models. All three aspects must be redesigned in tandem and integrated into a comprehensive transformed delivery system.
- Payers and regulators are skeptical that payment will influence quality of care, but physicians and other stakeholders believe that health care services could be provided more effectively in an FFS model by paying for proposed services and not paying for unnecessary services that contribute to waste in the health care system, such as documentation requirements.
- The FFS payment model uses Transitional Care Management (TCM) codes to encourage effective care transitions.
 - The current primary care system is not designed to provide comprehensive transitional care management.
 - TCM codes create documentation burden and patient safety risks when there is poor communication during patient handoffs.
- One example of a patient care model approach was Wake Forest Health Network's transition care clinic for patients in Medicare Advantage and Medicare Shared Savings Program (MSSP) risk contracts with high risk of readmissions.
 - The transition care clinic included a large team of general internists, advanced practice providers (APPs), pharmacists, social workers, and other clinic staff who saw patients within 72 hours of hospital discharge.
 - The transition care clinic seemed effective anecdotally, but organization leadership was skeptical that the clinic's high expenses were justified because it was difficult to prove reductions in readmissions in real time.
- Payment models and care models must be considered together. Care models must first be rigorously evaluated using controlled trials. If a care model is effective, stakeholders should then determine how to pay for services using existing payment models, including FFS, pay-for-performance, partial capitation, and full-risk capitation models.
- Machine learning technology can measure care model effectiveness and payment model efficiency simultaneously, and this information should be integrated to improve transitional care delivery.
- Payment model changes cause delivery system operational changes, such as how the DRG payment system led to distinctions between specialists, PCPs, and hospitalists.
- Transitional care delivery should be considered an ongoing opportunity for innovation to understand how best practice care delivery models, when properly paid for, can improve patient outcomes.

For additional details on Dr. Terrell's presentation, see the [presentation slides](#) (pages 32-38), transcript, and [meeting recording](#) (39:17-54:33).

Following the presentations, Committee members asked questions of the presenters. For more details on this discussion, see the transcript and [meeting recording](#) (54:38-1:40:00).

Presenters discussed quality and financial outcome measures to include in evaluations of transitional care management models.

- Communicate to decision-makers that care transition management reduces readmissions, thereby making better use of increasingly finite Medicare resources. Quality measures should consider the patient's experience, including symptom status, functional status, and perceived quality of life. Simple cost measures should assess the return on investment.
- Initial evaluations should focus on effectiveness, rather than cost, because institutions are hesitant to make the initial investment needed to implement a new model. For example, funding could be provided to ACOs to implement and evaluate the effectiveness of a TCM model. The ACO could still track savings, but the focus should initially be on effectiveness in reducing utilization and improving care.

Presenters discussed application of care transition management in different contexts, such as in rural communities and smaller practices.

- It is important to consider how needs differ in different communities and environments. For example, a model that is effective in a large medical community may not be effective in a rural area. TCM codes should not be so rigid that models cannot be applied across various types of communities.
- It is essential to invest in technological infrastructure needed for efficient communication, particularly for communities without internet access. Investments in digital infrastructure are also needed for smaller physician practices to capitalize on transitional care services, such as having APRNs credentialed in hospitals so they can follow their hospitalized patients' journeys digitally. Larger, integrated health systems sometimes have the necessary technology, while smaller systems often need to invest in new technology.

Presenters discussed team members needed on transitional care teams.

- Because of the complexity of patients' needs, including clinical, social, and behavioral needs, APRNs are best suited to oversee patients' transitional care services. The APRN is the leader of the care transition team, and the APRN's collaboration with other team members is central to patient outcomes. Other team members include community health workers, social workers (particularly for patient populations where social determinants of health [SDOH] dominate patient needs), physicians, and pharmacists.
- Physicians are typically trained in disease management, but Medicare patients have broader needs, including social, financial, and nutritional needs. Moving forward, CMS should consider creating a payment model using a system's thinking approach.
- Instead of building new teams or adding new team members, systems should be created that allow existing team members to add value in different contexts. For example, hospital social workers can add value to the work of PCPs by quickly communicating patients' social needs.
- If existing team members are used to deliver transitional care services, the operating model changes, and team members' scope of work changes. It is important to consider whether and how different types of entities can operationalize the delivery of transitional care services, such as rural health systems with limited resources.

One presenter discussed strategies to achieve full beneficiary participation in TCM models.

- Models should be tested within the context of accountable entities. Additionally, CMS also should test the effectiveness of different care and payment models to encourage institutional leaders to

participate. It is important to consider whether models are tested in an ACO or FFS environment and how that context impacts evaluation implications. Furthermore, Congress should take steps to put MA and ACOs on equal footing, for example, by eliminating a percentage of premium contracts.

One presenter discussed the importance of conducting initial in-person visits in the Transitional Care Model.

- Face-to-face contact helps patients trust that health care team members work on their behalf. Facilitated video visits work as well when in-person visits are not possible, for example, in rural areas. Addressing home risks and medication issues early is important, through contact as soon as possible after hospital discharge.

Presenters discussed distinctions between clinical and operating models and implications for how to pay for transitional care services.

- It is important to remember the distinction between paying physicians and incentives toward specific outcomes. For example, a 60-day readmission rate is an incentive toward desired outcome, because 30 days is not long enough for transitional care services. This distinction should guide future considerations on proposed payment models.
- Most decision-makers are institutional leaders rather than physicians, so it is important to understand institutional drivers and incentives rather than focus solely on physician payments.
- It is important to pay for evidence-based interventions, as well as for an accountable entity committed to building the relationships needed to effectively deliver transitional care services. The Transitional Care Model should be tested as both a payment model and a clinical delivery model, to jump-start systems change to meet the needs of the growing older adult population.

Listening Session 3: Addressing Care Transitions in APM Design

- John Birkmeyer, MD, President, Sound Physicians
- Marc Rothman, MD, CMD, Chief Medical Officer, Signify Health
- Lewis G. Sandy, MD, FACP, Co-Founder, SuLu Consulting LLC (former SVP, Clinical Advancement, UnitedHealth Group)

Co-Chair Hardin moderated the listening session with three SMEs on addressing care transitions in APM design. Full [biographies](#) and [presentations](#) are available.

John Birkmeyer presented on payment models for improving acute and post-acute care and lessons learned from the Bundled Payments for Care Improvement Advanced (BPCIA) Model.

- Sound Physicians is a national medical group focused on value-based care as part of its clinical and business models. The focus is on managing quality and total cost of care (TCOC) related to acute care episodes, and the group has decreased institutional post-discharge spending four times faster than the national trend. The organization participated in the BPCI and BPCIA Models, exiting in 2022.
- Spending during acute care hospitalizations and the 90 days post-discharge accounts for about half of total Medicare Parts A and B spending for Medicare FFS. About one-third is the DRG payment, with the rest open to efforts to reduce spending.

- Sound Physicians has addressed key clinical drivers of quality and TCOC related to acute care episodes, through having an individual physician (rather than a case management team) be responsible to decide post-discharge setting; telemedicine to stem readmissions from understaffed skilled nursing facilities (SNFs) after hours and on the weekends; technology-enabled, diagnosis-specific guidelines to reduce variation in specialty care; and supporting physicians to engage patients and families in meaningful end-of-life conversations to guide intensity of care.
- Lessons learned from the model experience included: 1) the value of explicit partnering agreements between treating physicians and hospital case management; 2) investing in technology, point-of-care tools, and checklists, beyond relying on guidelines; and 3) investing in predictive analytics.
- Dr. Birkmeyer outlined three options for bundled payment models:
 - Sunset, forgoing the chance to improve quality and cost.
 - Emphasize episode cost metrics in the Merit-based Incentive Payment System (MIPS), which may be impractical and insufficient to motivate physicians to improve care.
 - Implement nesting bundled payment programs into ACO programs.
- Dr. Birkmeyer made four recommendations for implementing nested bundles:
 - Focus on hospitalists, who are responsible for over 70 percent of Medicare inpatient discharges. Most hospitalists are contracted or employed by hospitals, making contractual risk-sharing models more feasible, with a focus on the number of episodes rather than episode efficiency. CMMI should develop specialty-specific spending metrics at the population level rather than bundles.
 - Move from disease-specific bundles to an all-admissions framework. Focusing on all acute medical discharges as a single bundle would be a simpler and more empirically rigorous approach, providing a larger sample size and more stable risk adjustment.
 - Take a different approach to pricing and discounts. Models with 2 to 3 percent annual discounts in the face of rising prices were sustainable only when there was enough variation in pricing that participants could choose the most favorably priced bundles.
 - Move from stand-alone bundled payment to nesting bundles in ACOs and MSSPs.
- Dr. Birkmeyer offered three suggestions for leveraging bundled payments to accelerate ACO adoption:
 - Bundled payment models should be mandatory to accelerate value-based care adoption.
 - Both hospitals and physicians, including inpatient and outpatient physicians, should be included in bundled payment models.
 - Attribution and risk sharing mechanisms should differ by ACO type.

For additional details on Dr. Birkmeyer’s presentation, see the [presentation slides](#) (pages 41-53), transcript, and [meeting recording](#) (1:40:54-2:00:27).

Marc Rothman presented on the Transition to Home (TTH) program and strategies for reducing readmissions in APMs.

- Signify Health is a national organization that operates ACOs with over half a million beneficiaries.
- There are many examples of evidence-based approaches to care transition management; however, it is challenging to implement, scale, and sustain transitional care programs.
 - It is challenging to achieve sufficient panel size, particularly because care transition management involves a significant number of in-person interactions.

- There is an absence of clear funding and administrative support, especially in the FFS system.
- For care transition management programs to be cost-effective, there is a dependence on high-cost providers making fewer visits.
- The savings from preventing readmissions do not accrue to practitioners in real time, making it difficult to attribute these savings to practitioners.
- Because outcomes do not accrue to a single cost center, the benefits of the program are diffused.
- It is challenging to deliver in-person services to broad geographies, particularly rural communities.
- Key enablers of success in the TTH program include:
 - A “virtual first” approach, which has a lower cost per visit and is easier to scale nationally.
 - Addressing patient concerns, including issues related to SDOH, to ensure that they take the advice of their physicians after discharge.
 - A rapid-cycle improvement strategy that enabled the program to grow quickly.
- It is challenging, but important, to engage Medicare beneficiaries in value-based programs and to accurately identify which beneficiaries are attributed to the program.
- The TTH program reduced readmissions at both 30- and 90-days post-discharge, partially due to encouraging patients to engage with their PCP or specialist following discharge. TTH patients who were discharged with home health or to inpatient rehabilitation facilities (IRFs) had lower readmission rates than those discharged to SNFs, which may be because this population has more complex medical needs.
- It is important to ensure that patients follow up with PCPs and specialists, and to ensure medication adherence.
- Many organizations try to reduce operational costs, use less expensive providers, and implement technological solutions to improve return on investment (ROI); however, clinical care is crucial to the success of transitional care programs.

For additional details on Dr. Rothman’s presentation, see the [presentation slides](#) (pages 55-77), transcript, and [meeting recording](#) (2:00:38-2:21:48).

Lewis Sandy presented on relationships between care transitions and APMs.

- APMs can help, hinder, or be neutral regarding care transitions, depending on the payment model’s vision of the ideal care transition.
- APMs should feature specific, prospective technical pieces or components such as attribution and benchmarking, with a direct connection between the element and the incentive. Incentives should be aligned to facilitate quality care but will not alone drive quality.
- Continuing to adjust the FFS system will not improve quality, affordability, or patient experience.
- Many providers are not aware that they are participating in an APM and require training and technical assistance to be able to provide the services needed to succeed in an APM (for example, eliciting care preferences, medication reconciliation, care coordination) and to prioritize care transitions.
- Policy makers should iterate and refine APMs as payers and providers learn more about how to incentivize quality care. APMs should focus on the most essential elements of care transition, to connect quickly with the patient and family for follow-up and to recognize the differences in

transitions between stable patients and those for whom the transition represents a real change in health status, SDOH, and risk.

- Models should be kept as simple as possible, balancing technical refinements for risk adjustment and design choices related to attribution and benchmarking.

For additional details on Dr. Sandy's presentation, see the [presentation slides](#) (pages 79-86), transcript, and [meeting recording](#) (2:22:00-2:34:59).

Following the presentations, Committee members asked questions of the presenters. For more details on this discussion, see the transcript and [meeting recording](#) (2:35:07-3:07:57).

Presenters discussed how transition teams build relationships within existing health care systems, considering design toward a long-term impact on populations.

- PCPs are not well-positioned to affect patient care in acute care settings, but their longstanding relationships with their patients have the potential to influence a patient's post-discharge trajectory, complementing rather than competing with longitudinal care. Payment models can help PCPs better integrate into acute inpatient care.
- Signify Health does not compete with PCPs for patients or revenue or with post-acute care (PAC) providers. What it does is establish relationships with patients at the right time and frequency, as a trusted resource. It can be challenging to establish an organized suite of resources for a patient when the health care system is so fragmented.
- Patients fall through the cracks in fragmented care delivery systems. Payers and ACOs can be particularly important in helping patients navigate complex health systems.

Presenters discussed incorporating longitudinal services into nested bundled payment models to make inpatient services more appealing to specialists.

- Bundled payment models should be structured differently for elective surgeries versus acute medical illness, as these are two different populations. It is the exception to the rule that non-hospital specialists earn most of their income in the hospital.
- Most of his experience has been with inpatient-only bundles, with some effort to develop explicit partnerships with risk-bearing primary care groups. It is challenging to design bundles that encourage longitudinal patient care.
- Pricing and quality transparency encourage model participants to carefully consider which physicians they choose.
- Model complexity is a barrier to participation, particularly for specialists who are less familiar with APMs.
- Two options for bundled payments for outpatient care would be to bundle one year's worth of PAC utilization into a bundle or use a clinical pathway approach with an FFS structure.

Presenters discussed the value of requiring data infrastructure, in addition to other accountability requirements, to enable meaningful data interoperability and communication.

- Signify Health established an electronic health record (EHR) platform to help community-based organizations (CBOs) communicate about social care and SDOH, but because it had no billing capabilities for Current Procedural Terminology (CPT) codes and was not connected to hospitals,

patient assessments had to be recreated. Establishing common software among all providers, facilities, and CBOs could reduce duplication and add cost savings but may be too challenging and resource-intensive to be practical.

- Sound Physicians invested approximately \$200 per risk-based patient discharge in non-physician staff, health information technology (HIT), and data infrastructure, which is roughly how much the program generated in savings. The organization withdrew from the BPCIA program because it was not making a positive ROI.
- Organizations that are successfully nesting bundled payments are functionally subcontractors of ACOs or other contracted entities that take on population-level risk. The larger entities need to set the standards for how subcontractors are integrated into their systems.

Presenters discussed how to incentivize, rather than work around, PCP engagement during care transitions.

- PCPs should be informed as care is being provided, not afterwards. Other providers should establish relationships through accountability, transparency, and personal connection.
- Primary care-centered ACOs emphasize coordinating care to keep patients out of hospitals but have not focused on addressing care coordination when patients are discharged. If bundled payment models are nested within ACOs, that structure of shared accountability will encourage provider communication.
- It is important to establish trust between PCPs and other providers.

Public Comment Period

No public comments were provided.

Committee Discussion

Co-Chair Sinopoli opened the floor to Committee members to reflect on the day's presentations and discussions. The Committee members discussed the following topics. For additional details, please see the transcript and [meeting recording](#) (0:20-43:48).

- Best practices for optimizing care transitions include bundled payments, care pathways, transition guides, flags, and standard of care practices in reaching to other systems. This would involve using tools, workflows, and best practices to be proactive in addressing medical needs and to use the same framework to address SDOH.
- Health-related social needs (HRSNs) increase the complexity of care transitions. Payment and delivery system reforms should encourage integration of community health organizations.
- Mechanisms for improving transition management may include reimbursing non-physicians and using digital tools to extend the reach of interdisciplinary care teams (ICTs).
- The Transitional Care Model included specific metrics for measuring outcomes and should be considered as a bundled payment model to integrate into other APMs or ACOs.
- There is a need for integrated data systems, particularly for outpatient care and community organizations.
- The path from FFS toward accountable, value-based care must include a transition period. Hybrid solutions such as TCM codes can help bridge that transition.
- The term "discharge" should be replaced with the term "transition" to encourage providers to take responsibility for longitudinal care. An organized approach is needed to guide the development of digital therapies and their integration into care.

- Models nested into population-based TCOC models should include outpatient, as well as inpatient, care to encourage longitudinal care across providers and settings.
- There should be investment in ensuring that all EHRs and databases are interoperable across health systems.
- Effective care transition models may take different forms (for example, TCM codes, episode-based models), which are necessary considering that different organizations and situations may call for different models. However, there should be consistency in outcome measures.
- Policy makers should consider standardizing the definition of a transition and the appropriate period during which to measure transitional care outcomes. Greater clarity is needed on how to define a payment model versus a clinical model versus an operating model.
- Additional discussion is needed about how PCPs can be integrated into different systems and provide longitudinal care.
- Policy makers should consider how to equalize incentives across FFS, MA, and ACOs, or the market will move toward the path of least resistance.
- Model incentives should be more closely tied to the desired outcome.
- Interoperability of data infrastructure is crucial, particularly for PAC.
- Current payment mechanisms, including TCM payments and the BPCI program, do not adequately cover the resources needed to effectively manage care transitions.
- Policy makers should consider the transitions of care incentive in MA's star rating program.
- PCPs have invested time and resources to build networks that can compete in value-based agreements, but because patient attribution is often blinded to acute episodes, providers do not know about SDOH and as a result, cannot respond to SDOH variables that can have a major influence on population health.
- Technology can help providers identify and deliver appropriate services to each patient at each stage, for example, using machine learning and big data to predict the need for referrals to palliative care.
- PTAC members should take what they have learned throughout the public meeting and disseminate learnings to physicians, who are at risk of burnout from increasingly complex demands.
- Physicians are intrinsically motivated to provide quality care and do not necessarily need the same ROI that their organizations do to participate in value-based care models.
- There is opportunity to reduce waste in the health care system during the pre-acute and post-acute phases of care.
- It is crucial for physicians to have visibility into the care being provided to their patients by other care team members.
- There should be accountability for transitional care measures in both the FFS system and future value-based care models.
- Mandatory participation in APMs has been a consistent theme throughout several PTAC public meetings.
- Future policies should make Medicare FFS more "uncomfortable" for providers.
- There is not a lot of room for further decreasing the costs of hospitalization, but there is ample opportunity for providers to decrease costs post-discharge.
- Who leads an ICT should be determined by the needs of the patient—it does not necessarily have to be a physician.

- The incentives and risk of current payment models, particularly MIPS, are not sufficient to encourage effective transition management.
- There are many effective models of care transition management, which may necessitate a variety of payment mechanisms.
- Payment models influence care delivery models.
- Up-front payments and monitoring of implementation, as opposed to future reconciliation, may accelerate care transformation, particularly in systems such as ACOs where there are already incentives to reduce utilization.
- Patient experience should be considered as an important performance metric, in addition to reducing utilization and improving quality.
- To reduce barriers to transitional care services, patients should be encouraged to utilize providers providing effective transition management, and there should be decreased patient responsibility for these high-value activities.
- It is concerning that successful APM participants such as Sound Physicians and Signify Health have had to withdraw from models because of new regulations. To encourage successful and scalable operating models, APMs should ensure that future regulations will not impede participants' success.
- Payment for transitional care services is another form of FFS. Payment models should focus on paying for outcome rather than paying for services.

Closing Remarks

Co-Chair Sinopoli thanked presenters, panelists, Committee members, and the public for their contributions to the meeting. He announced that PTAC will continue to gather information on the themes discussed throughout the meeting through a Request for Input (RFI) that will be posted on the ASPE PTAC website and distributed to the PTAC listserv. Co-Chair Sinopoli noted that PTAC will prepare a report to the Secretary with the Committee's findings and recommendations from the meeting.

The public meeting adjourned at 2:02 p.m. EDT.

Approved and certified by:

//Lisa Shats//

9/1/2023

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

Date

//Lauran Hardin//

9/1/2023

Lauran Hardin, MSN, FAAN, Co-Chair
Physician-Focused Payment Model Technical
Advisory Committee

Date

// Angelo Sinopoli//

9/1/2023

Angelo Sinopoli, MD, Co-Chair
Physician-Focused Payment Model Technical
Advisory Committee

Date