Physician-Focused Payment Model Technical Advisory Committee

September 6, 2019

Alex M. Azar II, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar:

On behalf of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), I am pleased to submit PTAC's comments and recommendation to you on a physician-focused payment model (PFPM), *Community Aging in Place – Advancing Better Living for Elders (CAPABLE) Provider-Focused Payment Model,* submitted by Johns Hopkins School of Nursing and Stanford Clinical Excellence Research Center. These comments and recommendation are required by section 1868(c) of the Social Security Act, which directs PTAC to: 1) review PFPM models submitted to PTAC by individuals and stakeholder entities, 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS), and 3) submit these comments and recommendations to the Secretary.

With the assistance of HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE), PTAC's members carefully reviewed the *CAPABLE* proposal (submitted to PTAC on October 31, 2018). PTAC also reviewed supplemental information on the model provided by the submitter and considered related issues in payment and care delivery, as well as relevant research findings. At a PTAC public meeting held on June 17, 2019, the Committee deliberated on the extent to which this proposal meets the criteria established by the Secretary in regulations at 42 CFR § 414.1465 and whether it should be recommended.

PTAC unanimously recommends the *CAPABLE* proposal to the Secretary for testing to inform payment model development as specified in PTAC's comments (which are reflected in this report). The Committee finds that the proposal meets seven of the Secretary's 10 criteria for PFPMs and deserves priority consideration based on the scope, patient choice, and patient safety criteria. PTAC believes that the proposal, which is aimed at improving beneficiary health

and well-being by enabling beneficiaries to live safely and independently at home, addresses an important gap in Medicare fee-for-service (FFS). The proposed model would include payment for medical and non-medical services organized around the patient's individual needs, including their physical environment, which the Committee recognizes as an important risk factor in health care costs and outcomes. While the CAPABLE care model has the potential to improve beneficiaries' functional outcomes and quality of life, the proposed *CAPABLE* services are not reimbursed by Medicare FFS and the impact on costs is unclear.

The Committee had several questions and concerns regarding the proposal. PTAC found that the payment model was not adequately specified and that additional work is necessary to determine whether *CAPABLE* should be a stand-alone alternative payment model or whether Medicare FFS payments should be modified to support the services used in *CAPABLE*. In addition, if *CAPABLE* were to be an alternative payment model, it is unclear whether and how it should become part of an existing model or program. PTAC also identified several *CAPABLE* model features that could benefit from further testing, such as adjusting the number of sessions and payment based on patient acuity, specifying the trigger event and requirements for program entry, and more closely coordinating with primary care providers, including identifying electronic means of collecting and exchanging beneficiary health record data.

The members of PTAC appreciate your support of our shared goal of improving the Medicare program for both beneficiaries and the providers who care for them. The Committee looks forward to your detailed response.

Sincerely,

//Grace Terrell//

Grace Terrell, MD, MMM

Vice Chair

Attachments

Physician-Focused Payment Model Technical Advisory Committee

REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

Comments and Recommendation on
Community Aging in Place – Advancing Better Living for Elders (CAPABLE) Provider-Focused Payment Model

September 6, 2019

About This Report

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to: 1) review physician-focused payment models (PFPMs) submitted by individuals and stakeholder entities, 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS), and 3) submit these comments and recommendations to the Secretary. PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR § 414.1465.

This report contains PTAC's comments and recommendation on the PFPM proposal *Community Aging in Place – Advancing Better Living for Elders (CAPABLE) Provider-Focused Payment Model.* This report also includes: 1) a summary of PTAC's review of the proposal, 2) a summary of the proposed model, 3) PTAC's comments on the proposed model and its recommendation to the Secretary, and 4) PTAC's evaluation of the proposed PFPM against each of the Secretary's criteria for PFPMs. The appendices to this report include a record of the voting by PTAC on this proposal, the proposal submitted by Johns Hopkins School of Nursing and Stanford Clinical Excellence Research Center, and additional information on the proposal submitted subsequent to the initial proposal submission.

SUMMARY STATEMENT

PTAC unanimously recommends the *CAPABLE* proposal to the Secretary for testing to inform payment model development as specified in PTAC's comments (which are reflected in this report). The Committee finds that the proposal meets seven of the Secretary's 10 criteria for PFPMs and deserves priority consideration based on the scope, patient choice, and patient safety criteria. PTAC believes that the proposal, which is aimed at improving beneficiary health and well-being by enabling beneficiaries to live safely and independently at home, addresses an important gap in Medicare fee-for-service (FFS). The proposed model would include payment for medical and non-medical services organized around the patient's individual needs, including their physical environment, which the Committee recognizes as an important risk factor in health care costs and outcomes. While the *CAPABLE* care model has the potential to improve beneficiaries' functional outcomes and quality of life, the proposed *CAPABLE* services are not reimbursed by Medicare fee-for-service (FFS) and the impact on costs is unclear.

The Committee had several questions and concerns regarding the proposal. PTAC found that the payment model was not adequately specified and that additional work is necessary to determine whether *CAPABLE* should be a stand-alone alternative payment model or whether Medicare FFS payments should be modified to support the services used in *CAPABLE*. In addition, if *CAPABLE* were to be an alternative payment model, it is unclear whether and how it should become part of an existing model or program. PTAC also identified several *CAPABLE* model features that could benefit from further testing, such as adjusting the number of sessions and payment based on patient acuity, specifying the trigger event and requirements for program entry, and more closely coordinating with primary care providers, including identifying electronic means of collecting and exchanging beneficiary health record data.

PTAC REVIEW OF THE PROPOSAL

The *CAPABLE* proposal was submitted to PTAC on October 31, 2018. The proposal was first reviewed by a Preliminary Review Team (PRT) composed of three PTAC members (Len M. Nichols, PhD; Paul N. Casale, MD, MPH; and Jennifer Wiler, MD, MBA). The PRT conducted its review of the revised proposal between December 10, 2018, and February 4, 2019. The proposal was also posted for public comment. The PRT's findings are documented in the PRT Report to the PTAC on the *CAPABLE* proposal, dated February 4, 2019. The submitter provided a written response to the PRT report on April 4, 2019, indicating their willingness to address some of the concerns about the model identified during PTAC's review of the proposal. At a public meeting held on June 17, 2019, PTAC deliberated on the extent to which the proposal meets the criteria established by the Secretary in regulations at 42 CFR § 414.1465 and whether

it should be recommended to the Secretary for implementation.[1] The submitter and members of the public were given an opportunity to make statements to the Committee at the public meeting. Remaining sections of this report provide a summary of the proposal, PTAC's comments and recommendation to the Secretary on the proposal, and the results of PTAC's evaluation of the proposal using the Secretary's criteria for PFPMs.

PROPOSAL SUMMARY

The proposal is based on a Health Care Innovation Award (HCIA) Round One pilot in which the submitter was involved and which is being evaluated as an NIH-funded randomized clinical trial. The *CAPABLE* model is designed to improve the functional ability of older adults with chronic conditions and functional limitations. Specifically, *CAPABLE* focuses on identifying and addressing issues facing older adults living in their homes that, if not addressed, could result in further functional decline and otherwise avoidable use of high-cost services (e.g., emergency department [ED] and hospitalizations). *CAPABLE* uses patient-centered approaches to improve safety for older adults living in their home and enable aging in place.

The care model is a time-limited intervention that includes 10 home sessions over a four- to five-month period. Six of the sessions are with an occupational therapist (OT) and four with a registered nurse (RN), each for 60 to 90 minutes. Both the OT and RN work separately with the patient, each identifying three goals on which to work during their *CAPABLE* visits. The OT also directs a "handy worker" to perform limited home repairs, adaptive modifications, or installation of assistive devices (up to $1,300 in 2013 USD) intended to help patients achieve their stated goals and allow the patient to continue living in their home safely.

In defining the *CAPABLE* approach to delivering services, the proposal identifies eight core principles, with a focus on patient-centeredness, and highlights the differences between the traditional roles of the two key providers (OT and RN) and their roles in a *CAPABLE* program. A committee member highlighted the submitter's point that pilot testing in several environments shows that the *CAPABLE* model is flexible and can be implemented with different types of providers and adapted for different care settings. For example, during the public meeting the submitters discussed adaptations made by Trinity Health in Michigan to incorporate community health workers into the team. In addition, one public commenter from the Colorado Visiting Nurse Association discussed implementation in a Home Health agency.

The *CAPABLE* pilot program was implemented at Johns Hopkins and is currently being implemented at 19 sites in the U.S. Most of these sites are grant-funded, but three

[1]PTAC members Tim Ferris, MD, MPH, and Rhonda M Medows, MD, were not in attendance. PTAC members Jeffrey W Bailet, MD, and Kavita Patel, MD, MSHS, recused themselves from deliberation and voting on this proposal.

organizations are implementing the program in an accountable care organization (ACO) model and one is implementing through a Medicaid waiver. In addition to these sites, at least one Medicare Advantage plan and several dual-eligible special needs plans (D-SNPs) have added CAPABLE to their services Current *CAPABLE* programs serve low-income individuals, and services are paid for through a variety of sources (e.g., Medicaid waivers, foundation funding). Although the submitters indicated that all older adults would benefit from attempts to help them remain functional in their homes regardless of income level, the submitters suggested that it was particularly important for *CAPABLE* to be available to individuals below 200 percent of the Federal Poverty Limit (FPL). They noted that "individuals with lower income may have a more limited financial ability to contribute to paying for their home or medical care." In proposing that the package of *CAPABLE* services be covered by Medicare, the submitters indicate the following criteria for program eligibility:

- Self-reported or positive screening for difficulty with at least one activity of daily living (ADL)—eating, bathing, dressing, moving around, transferring, toileting
- Community-dwelling (living in a home or an apartment)
- Absent or minimal cognitive impairment as assessed by a health care provider using a standardized screening tool (e.g., Mini-cog; Saint Louis University Mental Status, or SLUMS; Short Portable Mental Health Questionnaire)
- Other high-risk features that may include: recent hospitalization or ED visit related to falls or in-home accidents, debilitating chronic pain, polypharmacy (10+ medications), limited caregiver support, or depressive symptoms
- Not terminally ill (defined as not predicted to die in the next year)

Although FFS Medicare does cover home visits by OTs and RNs for patients meeting certain criteria, the proposed *CAPABLE* services, including home modifications, are not routinely reimbursed. Medicare's Home Health (HH) Benefit is available to beneficiaries enrolled in Medicare Part A and/or Part B and covers services such as intermittent skilled nursing care and occupational therapy, if a physician certifies that the beneficiary is confined to the home and needs skilled therapy services. During the public meeting, the submitters clarified how the providers' *CAPABLE* roles differ from those typically reimbursed under Medicare FFS. For example, many *CAPABLE* interactions—such as motivational interviewing, assessing individual goals, and evaluating person-environment fit—do not meet the definition of "skilled needs" under Medicare FFS.

The submitters estimated the cost of the *CAPABLE* services to be $2,882 per participant (based on their experience in providing *CAPABLE* services from 2012 through 2015). They suggested paying for services using a flat fee that is not risk adjusted based on the characteristics of the

patient, because in the current design of *CAPABLE,* services are not expected to vary by a participant's functional status or number of chronic conditions. They believe payment as a lump sum or bundled payment would allow services to be delivered to any FFS patient but would also allow accountable care organizations (ACOs) or similar entities that take full or partial risk to use the services. In written responses to questions, the submitters clarified the payment approach, suggesting that the alternative payment model (APM) entity could be an ACO or similar entity. The submitters believe that expenditure reductions occur for up to two years following receipt of *CAPABLE* services, but they did not address other aspects of the payment model. They agree there are potential benefits to including upside and/or downside risk as part of a payment model, but they said they do not have the expertise necessary to design such a model.

RECOMMENDATION AND COMMENTS TO THE SECRETARY

PTAC recommends the *CAPABLE* proposal to the Secretary for testing to inform payment model development, as specified in the comments below. PTAC believes that the proposal, which is aimed at improving beneficiary health and well-being by enabling beneficiaries to live safely and independently at home, addresses an important gap in Medicare FFS payments. The proposed model would include payment for medical and non-medical services organized around the patient's individual therapy needs and their physical environment, which the Committee recognizes as an important risk factor. While the *CAPABLE* care model has the potential to improve beneficiaries' functional outcomes and quality of life, the proposed *CAPABLE* services are not paid for by FFS Medicare and the impact on costs is not known. Committee members believe that it is worthwhile to invest in testing innovative models that, like *CAPABLE*, address social determinants of health and to create incentives for the uptake of models that bridge social and health care services, particularly for Medicare FFS beneficiaries.

While PTAC feels the *CAPABLE* care model has clear benefits for patients, it finds that additional work is necessary to identify the optimal payment model. Committee members were uncertain as to whether the model should be implemented as a standalone alternative payment model (APM) and discussed whether incorporating the model into existing payment and delivery models might be preferable. Many Committee members felt *CAPABLE* may fit best as part of an existing model or other existing Medicare payments. The Committee also acknowledged that if CAPABLE were to be developed as an addition to existing models, organizations using those models may choose not to include the *CAPABLE* component and that as a result, *CAPABLE* could become less available to beneficiaries than if it were a standalone payment model.

The Committee discussed the potential for integration into other alternative payment models. PTAC felt there was a lack of clarity about whether and how *CAPABLE* could be integrated into existing models or payment structures. During PTAC's public deliberation on the proposal, the

Committee discussed several model options that could accommodate *CAPABLE*. Examples include: CMMI's Independence at Home (IAH) demonstration, which delivers comprehensive primary care services at home; the CPC+ model, in which participating providers receive a care management payment to provide population health management and care coordination services; and ACOs or other shared savings arrangements with full risk-sharing. Some Committee members questioned whether ACOs would be willing to participate in *CAPABLE* if it were not risk-adjusted.

The Committee also discussed potential integration with the Medicare Home Health prospective payment system (HH PPS). The differences in approach to providing care were discussed as a potential barrier. Specifically, HH PPS pays for care to meet a specific skilled care need, which is fundamentally different from *CAPABLE's* person-centered and preventive approach. This consideration suggests that incorporating *CAPABLE* into HH PPS would likely require separate teams (for example, similar to the way an HH may offer hospice services in addition to HH PPS) or a significant shift in the paradigm for Home Health services.

Committee members would like to see greater clarity on the entity responsible for receiving payments and determining patient eligibility for and participation in *CAPABLE*. Specifically, PTAC sought information on what kind of APM entity (e.g., ACO or other health care provider) would receive payments and initiate *CAPABLE* services. The Committee discussed the possibility of focusing on primary care providers while also allowing testing of other approaches (for example, organizing *CAPABLE* and related payments around the activities of case managers or home health agencies).

The Committee finds that the CAPABLE model is designed to support value over volume, using a bundle of services to provide patient-centered care. PTAC suggests that CMS explore testing an adaptation to the *CAPABLE* model that incorporates risk adjustment. Specifically, PTAC asked whether patients with different levels of acuity could be identified and placed into different dose/length regimens according to their need. Some Committee members felt that allowing payment to vary according to patient acuity level could lead to greater cost savings, promote uptake of the model, and enable scaling to a larger patient population.

In addition, PTAC advises further testing of *CAPABLE* to assess how best to integrate the model with primary care and with digital means to share data and communicate (e.g., health information technology, or HIT). The submitters emphasized that CAPABLE has been implemented as an adjunct to primary care, with flexible coordination and communication arrangements with primary care teams. However, PTAC feels the model will require more formal coordination and communication, and PTAC suggested multiple touch points between *CAPABLE* and primary care teams to ensure integration with primary care. Committee members observed that HIT could be a vehicle for improving coordination with primary care teams. However, the proposed *CAPABLE* model does not require HIT.

Further, PTAC also called attention to the need to consider how nontraditional roles, like the handy worker, are integrated into the health care system. The Committee noted that scaling the model would likely require the establishment of specific, minimum competencies for handy workers and building quality assurance and oversight mechanisms.

PTAC believes that the care model would improve patients' functional status and would likely lead to improved long-term outcomes. Committee members noted studies finding that improvements in functional status, similar to the changes observed in the HCIA-funded *CAPABLE* pilot and National Institutes of Health (NIH)-funded randomized controlled trial (RCT), are linked to lower acute care use. As such, Committee members observed that improved quality of care would be reasonable to expect with *CAPABLE* but that a more robust evaluation of health service use should be conducted.

More broadly, Committee members expressed concerns regarding possible impacts on costs, noting a lack of clear evidence of impact on total cost of care and research to date that does not show statistically significant reductions in cost. The PRT reviewed findings from an independent evaluation of expenditures for the Health Care Innovation Awards (HCIA) *CAPABLE* pilot, which was inconclusive. The analysis estimated an average quarterly Medicare expenditures increase of $93 (90 percent CI: -$1,076; $1,262). However, these estimates are based on a small sample size (172 Medicare beneficiaries). The submitters provided unpublished cost modeling to the Committee. This modeling estimates an annual net savings of $4.5 billion (in 2015 USD) to Medicare for at least two years following the intervention, or $237 per member per month (PMPM). The submitters say this corresponds to a 0.74 percent net savings from total direct Medicare spending and 0.17 percent net savings from total direct U.S. health care spending annually. The estimates assume that *CAPABLE* services are delivered to 30 percent of 18.2 million Medicare beneficiaries with multiple chronic conditions and functional limitations (who were appropriate to participate based on other specified criteria) and that the intervention had 25 percent efficacy compared to the original intervention. PTAC members noted, however, that broad implementation of CAPABLE services could result in use by populations where cost reductions are not achieved even if such reductions are found for current programs.

Overall, PTAC feels the care model proposed by *CAPABLE* is innovative and valuable, and that it helps to fill a gap in meeting important non-medical needs that have health implications for Medicare beneficiaries. Given this conclusion and the need for further testing and refinement of the model, PTAC recommends work to encourage development of an appropriate payment model.

EVALUATION OF PROPOSAL USING SECRETARY'S CRITERIA

PTAC Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary (at 42 CFR § 414.1465)	Rating
1. Scope (High Priority)	Meets and Deserves Priority Consideration
2. Quality and Cost (High Priority)	Meets
3. Payment Methodology (High Priority)	Does Not Meet
4. Value over Volume	Meets
5. Flexibility	Meets
6. Ability to Be Evaluated	Meets
7. Integration and Care Coordination	Does Not Meet
8. Patient Choice	Meets and Deserves Priority Consideration
9. Patient Safety	Meets and Deserves Priority Consideration
10. Health Information Technology	Does Not Meet

Criterion 1. Scope (High-Priority Criterion)

Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.

Rating: Meets and Deserves Priority Consideration

PTAC concludes that the proposed model meets this criterion and deserves priority consideration. This proposal identifies a package of services that could improve health for a large and vulnerable group of Medicare beneficiaries living at home. The model incorporates providers not currently directly involved in APMs (OT and RN), and the services covered by the model can help address unmet needs with a patient-centered approach.

The Committee felt the proposed model's focus on social determinants of health and the provision of non-medical services to improve functional ability was a strength. Members noted that the current health care system does not adequately address this issue, despite growing recognition of the importance of social determinants of health. The Committee felt that *CAPABLE* can improve patient functional outcomes and quality of life by providing screening and prevention before problems occur. Furthermore, the proposed model has the potential to reduce burden on stakeholders, including caregivers, social service providers, and first

responders, as described by the submitter and public commenters during PTAC's public deliberation on the *CAPABLE* proposal.

Criterion 2. Quality and Cost (High-Priority Criterion)

Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

Rating: Meets

PTAC concludes that the proposed model meets this criterion. The evidence indicates that the *CAPABLE* services are likely to improve health care quality. The Committee felt that there was evidence suggesting that the *CAPABLE* model would improve health care quality and that cost decreases may be possible, especially for some groups, but that the evidence on cost savings is not robust. One Committee member pointed out that the comparison in the NIH-funded RCT was a randomized control group that received social engagement home visits (rather than simply not receiving *CAPBABLE* services). Therefore, the beneficial impact of *CAPABLE* on functional status might be stronger when compared to individuals receiving no intervention. Another Committee member noted that, in the absence of definitive evidence on utilization and cost outcomes about the *CAPABLE* program, it is possible to infer, using other evidence, a theoretical link between the impact of *CAPABLE* on functional outcomes and reduced acute care utilization. PTAC believes that additional research is needed to understand the impact of *CAPABLE* on health care utilization and costs.

The Committee discussed opportunities for larger health care system cost savings resulting from greater investment in social services. Members noted that the *CAPABLE* model could be one avenue for upstream investment in preventive care and social determinants of health that could improve quality of life among its participants. During PTAC's public deliberation, both the submitter and public commenters shared stories of improvement in quality of life and patient engagement among *CAPABLE* participants.

Criterion 3. Payment Methodology (High-Priority Criterion)

Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.

Rating: Does Not Meet

PTAC concludes that the proposed model does not meet this criterion. Although the submitter proposes starting with a full or partial bundled payment with upside and downside risk, the proposal lacks any formal description of how risk sharing or other aspects of a payment model

would work. PTAC expects additional work is necessary (either by the submitters or CMS) to specify the details of the payment model and to determine whether *CAPABLE* should be a stand-alone alternative payment model or if FFS Medicare could be modified to accommodate *CAPABLE* as a set of standalone services. In addition, if *CAPABLE* were to be an alternative payment model, it is unclear whether and how it should become part of an existing alternative model or program such as the CPC+ model, the IAH demonstration, or ACOs, or an existing Medicare payment system such as the physician fee schedule or the HH PPS.

In discussion about options for integrating *CAPABLE* into existing programs, at least one Committee member suggested that *CAPABLE* could be added as an option in other models that have a focus on keeping people in their homes and that have accountability features in their payment structure. Along similar lines and with a broader focus beyond helping patients age in place, ACOs are accountable for quality, cost, and experience of care and can share in savings they achieve for Medicare. Thus, ACOs may present another option for how to incorporate *CAPABLE* into existing programs. However, PTAC was uncertain as to whether ACOs would be interested in participating in *CAPABLE* if the payments were not risk adjusted. One Committee member questioned whether simply making payments for *CAPABLE* services available to participants in a shared savings model would be sufficient to incentivize providers to offer it.

Committee members also raised concerns over duplication should a beneficiary receive both *CAPABLE* and Home Health services and suggested that home health agencies could receive a modified prospective payment to enable them to deliver *CAPABLE* services. However, both the submitter and a public commenter from the Colorado Visiting Nurse Association noted fundamental differences between the *CAPABLE* model and Home Health that may pose barriers to integration. Notably, *CAPABLE* is patient-centered, goal oriented, and includes features such as motivational interviewing that are not part of traditional Home Health services.

The Committee also has concerns with the payment model related to risk adjustment. The submitter initially proposed a flat rate because all beneficiaries receive the same services. However, Committee members raised the question of whether some beneficiaries could benefit from a smaller or larger number of services (i.e., more or fewer RN and/or OT home visits). Committee members also noted that scaling the model to a larger population could warrant risk adjustment based on patient acuity level to account for both healthier and sicker populations. PTAC recommends further testing to explore varying the service level for beneficiaries based on acuity level.

Further, PTAC has questions about payment for the *CAPABLE* model under an APM. One member noted that an APM should have a global focus that includes the total cost of care and not simply the costs of providing *CAPABLE* services. In addition, it is unclear what kind of entity (primary care provider, Home Health agency, ACO or other) would receive payments from Medicare under the model. During PTAC's public deliberation on the *CAPABLE* proposal, the

submitter stated that an important goal of testing the model would be to determine the best approach to payment.

Criterion 4. Value over Volume

Provide incentives to practitioners to deliver high-quality health care.

Rating: Meets

PTAC concludes that the proposed model meets this criterion. The *CAPABLE* services are designed to provide value over volume. The model uses a bundle of services to provide patient-centered care that can help beneficiaries remain in their homes with improved function and safety. The proposal's underlying intent is to provide a patient-centered service that would improve quality of care, and it does not appear to increase costs (and may decrease costs) based on available evidence. PTAC assumes that risk-sharing provisions could be designed to help achieve desirable outcomes, such as fewer falls and reduction in high-cost hospital use.

Criterion 5. Flexibility

Provide the flexibility needed for practitioners to deliver high-quality health care.

Rating: Meets

PTAC concludes that the proposed model meets this criterion. *CAPABLE* focuses on patient-centered care. The model works to identify patient preferences, including the patients' belief regarding what they need most to remain in their home. The model also seeks to enhance communication between patients and their providers. However, *CAPABLE* would benefit from mechanisms for provider integration that are better defined. This is described in greater detail below under Criterion 7, Integration and Care Coordination.

Criterion 6. Ability to Be Evaluated

Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

Rating: Meets

PTAC concludes that the proposed model meets this criterion. The submitter notes a number of relevant measures, including activities of daily living (ADLs), instrumental activities of daily living, depression screening, and a falls risk assessment. The *CAPABLE* program embeds these measures to track changes in function over the course of the 10-session program. The Committee notes that a strong mechanism for tracking program measures and outcomes, including a post-program assessment, is necessary to strengthen the evidence of the program's value. Because the *CAPABLE* model focuses on screening and prevention, it is important to track outcomes over time and beyond the four- to five-month intervention period, in order to generate evidence of long-term impact on costs.

Criterion 7. Integration and Care Coordination

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.

Rating: Does Not Meet

PTAC concludes that the proposed model does not meet this criterion. The proposal does not include specific approaches for coordinating care with other health care providers. For example, the model does not specify a reporting system with required touch points with a patient's primary care provider. The Committee recognizes that CAPABLE coaches patients on improving their communication with their physicians. However, PTAC feels the model would benefit from defined mechanisms for the exchange of information between CAPABLE staff and primary care providers. Committee members feel this coordination would ideally occur through a standardized mechanism incorporated into electronic records.

The submitter acknowledges that there is not a formal mechanism for primary care provider involvement in the program. They described *CAPABLE* as an adjunct to primary care. They noted that the services, while delivered outside of the office setting, could potentially affect in positive ways patients' demeanor, sense of well-being, or in other ways be detectable in a clinical setting. The Committee sought clarity around how *CAPABLE* would be triggered, including who would order the services. PTAC recommends that further testing should inform how best to initiate the *CAPABLE* intervention. The submitter suggested that the primary care provider initiate *CAPABLE* participation but acknowledged that current *CAPABLE* sites vary in the method of program initiation.

PTAC discussed how the proposed model seeks to integrate nontraditional roles (i.e., the handy worker) into the health care ecosystem. Accordingly, they noted the importance of building oversight and quality assurance for this "non-health care" work into the model.

Criterion 8. Patient Choice

Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

Rating: Meets and Deserves Priority Consideration

PTAC concludes that the proposed model meets this criterion and deserves priority consideration. *CAPABLE* focuses on understanding the client's goals and preferences. Participants choose three goals to work on with the OT and three goals with the RN. *CAPABLE* also focuses on enhancing the client's skills in communicating their needs and preferences to providers beyond the *CAPABLE* team, for example, by encouraging use of a health passport that patients share to communicate questions or concerns to their physician. The Committee feels

that *CAPABLE* embodies a patient-centered approach that facilitates patient choice and independence in decision-making. PTAC identifies this approach as a key strength of the proposed model. Furthermore, *CAPABLE* aims to enable frail older adults to live safely at home, therefore preserving patients' autonomy and ability to choose to age in place, if desired.

Criterion 9. Patient Safety

Aim to maintain or improve standards of patient safety.

Rating: Meets and Deserves Priority Consideration

PTAC concludes that the proposed model meets this criterion and deserves priority consideration. *CAPABLE* services are intended to improve the safety of the home environment and to increase the length of time that individuals with chronic conditions and functional impairments may safely live at home. The services provided, including home modifications, are designed to reduce fall risk and improve patient mobility while other aspects promote safe use of medications through medication review. While PTAC finds that the model clearly met the patient safety criterion, members note that it would be desirable to formalize channels of interactions with other providers beyond the CAPABLE team, as discussed in Criterion 7, Integration and Care Coordination, to ensure patient safety can be maintained beyond the four- to five-month period of *CAPABLE* services.

Criterion 10. Health Information Technology

Encourage use of health information technology to inform care.

Rating: Does Not Meet

PTAC concludes that the proposed model does not meet this criterion. The use of HIT and health information exchange could enable touch points between the *CAPABLE* team and other health care providers. However, the proposed model does not currently require their use. An Epic module specific to *CAPABLE* exists such that any health system using Epic as an electronic health record (EHR) can adopt this module to enable access by other providers to the OT and RN notes recorded in the system. However, the submitters have not yet considered the feasibility of engaging a broader group of vendors to support *CAPABLE*. During PTAC's public deliberation on the *CAPABLE* proposal, the submitters noted that other vendors could follow Epic's lead and create modules for their EHRs that enable coordination of care between services offered by *CAPABLE* and primary care. Further, in their written response to the PRT report, the submitters also outlined an electronic data-sharing plan applicable across platforms and systems and suggested work on the data sharing plan be part of additional *CAPABLE* testing. PTAC considers improving the capacity for information-sharing and integration through use of HIT to be an important priority in further development and testing of the model.

APPENDIX 1. COMMITTEE MEMBERS AND TERMS

Jeffrey Bailet, MD, *Chair*

Grace Terrell, MD, *Vice Chair*

Term Expires October 2019

Paul N Casale, MD, MPH
NewYork Quality Care
New York-Presbyterian, Columbia University College of Physicians and Surgeons, Weill Cornell Medicine
New York, NY

Bruce Steinwald, MBA
Independent Consultant
Washington, DC

Tim Ferris, MD, MPH
Massachusetts General Physicians Organization
Boston, MA

Term Expires October 2020

Rhonda M Medows, MD
Providence St. Joseph Health
Seattle, WA

Len M Nichols, PhD
Center for Health Policy Research and Ethics
George Mason University
Fairfax, VA

Harold D. Miller
Center for Healthcare Quality and Payment Reform
Pittsburgh, PA

Grace Terrell, MD, MMM
Envision Genomics
Huntsville, AL

Term Expires October 2021

Jeffrey Bailet, MD
Blue Shield of California
San Francisco, CA

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APPENDIX 2. PFPM CRITERIA ESTABLISHED BY THE SECRETARY

PFPM CRITERIA ESTABLISHED BY THE SECRETARY

1. **Scope.** Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.
2. **Quality and Cost.** Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.
3. **Payment Methodology.** Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the Physician-Focused Payment Model cannot be tested under current payment methodologies.
4. **Value over Volume.** Provide incentives to practitioners to deliver high-quality health care.
5. **Flexibility.** Provide the flexibility needed for practitioners to deliver high-quality health care.
6. **Ability to Be Evaluated.** Have evaluable goals for quality of care, cost, and any other goals of the PFPM.
7. **Integration and Care Coordination.** 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.
8. **Patient Choice.** Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.
9. **Patient Safety.** Aim to maintain or improve standards of patient safety.
10. **Health Information Technology.** Encourage use of health information technology to inform care.

APPENDIX 3. DISTRIBUTION OF MEMBER VOTES ON EXTENT TO WHICH PROPOSAL MEETS CRITERIA[1]

Criteria Specified by the Secretary (at 42 CFR §414.1465)	Not Applicable *	Does Not Meet Criterion 1	Does Not Meet Criterion 2	Meets Criterion 3	Meets Criterion 4	Priority Consideration 5	Priority Consideration 6	Rating
1. Scope (High Priority)[2]	0	0	0	1	1	3	2	Priority Consideration
2. Quality and Cost (High Priority)	0	0	0	2	3	2	0	Meets Criterion
3. Payment Methodology (High Priority)	0	0	6	1	0	0	0	Does Not Meet Criterion
4. Value over Volume	0	0	0	3	4	0	0	Meets Criterion
5. Flexibility	0	0	0	1	4	2	0	Meets Criterion
6. Ability to Be Evaluated	0	0	0	2	3	2	0	Meets Criterion
7. Integration and Care Coordination	0	0	5	2	0	0	0	Does Not Meet Criterion
8. Patient Choice	0	0	0	0	2	2	3	Priority Consideration
9. Patient Safety	0	0	0	0	1	3	3	Priority Consideration
10. Health Information Technology	0	1	4	2	0	0	0	Does Not Meet Criterion

[1]PTAC members Tim Ferris, MD, MPH, and Rhonda M Medows, MD, were not in attendance. PTAC members Jeffrey W Bailet, MD, and Kavita Patel, MD, MSHS, were in partial attendance and each recused themselves from deliberation and voting on this proposal.
[2]Criteria designated as "high priority" are those PTAC believes are of greatest importance in the overall review of the payment model proposal.

APPENDIX 4. DISTRIBUTION OF MEMBER VOTES ON OVERALL RECOMMENDATION[1]

Overall Recommendation Vote: Part 1 of 2[2]

Not Recommended for Implementation as a PFPM	Recommended	Referred for Other Attention by HHS	Result
0	7	0	Recommended

Overall Recommendation Vote: Part 2 of 2 (if applicable)

Proposal substantially meets Secretary's criteria for PFPMs. PTAC recommends implementing proposal as a payment model.	PTAC recommends further developing and implementing the proposal as a payment model as specified in PTAC comments.	PTAC recommends testing the proposal as specified in PTAC comments to inform payment model development.	PTAC recommends implementing the proposal as part of an existing or planned CMMI model.	Result
0	0	7	0	PTAC recommends testing the proposal as specified in PTAC comments to inform payment model development.

Final recommendation to Secretary: PTAC recommends testing the proposal as specified in PTAC comments to inform payment model development.

[1]PTAC members Tim Ferris, MD, MPH, and Rhonda M Medows, MD, were not in attendance. PTAC members Jeffrey W Bailet, MD, and Kavita Patel, MD, MSHS, were in partial attendance and each recused themselves from deliberation and voting on this proposal.

[2] In 2018, PTAC adopted new voting categories, used first at their December 2018 public meeting. First, PTAC votes on the three categories listed above as Part 1 of 2. PTAC must achieve a two-thirds majority for one of these categories. If a two-thirds majority votes to not recommend the proposal for implementation as a PFPM or to refer the proposal for other attention by HHS, that category is the Committee's final recommendation to the Secretary. If the two-thirds majority votes to recommend the proposal, the Committee proceeds to Part 2 of 2 to determine the final, overall recommendation for the Secretary. The second vote uses the four subcategories listed above. A two-thirds majority must be achieved for one of these four categories.