Informing PTAC's Review of Care Coordination and PFPMs: We Want to Hear From You

The June 2021 public meeting of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) included PTAC's second theme-based discussion to inform the Committee on topics important to physician-focused payment models (PFPMs). This public meeting included a Care Coordination session that was designed to give Committee members information about current perspectives on the role care coordination can play in optimizing health care delivery and value-based transformation in the context of alternative payment models (APMs) and PFPMs specifically.

There has been an interest in care coordination as a potential tool to improve quality and reduce spending while helping to reduce fragmentation of care and duplication of services for Medicare beneficiaries (including dual eligibles). Care coordination also has the potential to improve the management of chronic conditions and episodes of care, and to address acute events and social determinants of health. Additionally, the Secretary of Health and Human Services (HHS) has established "Integration and Care Coordination" as one of the 10 criteria for proposed PFPMs that PTAC uses to evaluate submitted proposals. The goal of this 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).

Between 2016 and 2020, stakeholders submitted 16 PFPM proposals to PTAC that were determined by the Committee members to "Meet" Criterion 7, including one proposal that was determined to "Meet with Priority Consideration." Additionally, 11 PFPM proposals that PTAC has deliberated and voted on were determined to "Not Meet" the Integration and Care Coordination Criterion. Therefore, sharing the insights of stakeholders and building on those insights may help to optimize the use of care coordination in the context of APMs and PFPMs.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) provides an environmental scan for every proposal reviewed by PTAC so that Committee members have a good understanding of the clinical and economic circumstances within which a proposed model would be implemented, as well as related resource information that can inform their evaluation of each proposal. To help PTAC prepare for the care coordination theme-based discussion in June, a brief environmental scan was developed with background information on care coordination, the role of care coordination in the context of APMs and PFPMs, and issues and opportunities associated with care coordination in APMs and PFPMs. Additionally, the Care Coordination session that took place on June 10 included panel discussions with: (1) several stakeholders who had previously submitted PFPM proposals to PTAC that were determined to "Meet" the "Integration and Care Coordination" Criterion (five proposals; seven panelists), and (2) a diverse group of subject matter experts. Stakeholders also had an opportunity to make public comments.

PTAC used the Agency for Healthcare Research and Quality's (AHRQ's) working definition of the term care coordination as a guide for focusing the discussion during the June 2021 public meeting:

> *"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."*[1]

Within the broader context of care coordination, PTAC considers the following AHRQ functional domains to be particularly important for optimizing care coordination in the context of APMs and PFPMs:

- Establish accountability or negotiate responsibility
- Communicate
- Facilitate transitions
- Assess needs and goals
- Create a proactive plan of care
- Monitor, follow up, and respond to change
- Support self-management goals
- Link to community resources
- Align resources with patient and population needs [2,3]

While strategies for optimizing some functions could also involve structural changes (such as financial management and planning across operational units), PTAC is particularly focused on strategies for improving clinical coordination in the context of value-based transformation.

PTAC will continue to evaluate the extent to which stakeholder-submitted proposals that are received in the future meet Criterion 7, "Integration and Care Coordination." PTAC seeks to build upon the insights of stakeholders and use such insights and considerations to further inform the Committee's review of proposals and recommendations that the Committee may provide to the Secretary relating to this topic. The environmental scan and discussions during the June 2021 public meeting will serve to inform PTAC on this topic. PTAC is now seeking additional information on: definitions and objectives of care coordination; how care coordination is implemented, reimbursed, measured, and evaluated; best practices relating to care coordination; and the role of care coordination in the context of APMs and PFPMs. Therefore, PTAC is requesting stakeholder input on the questions listed below.

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[1] Agency for Healthcare Research and Quality. Care Coordination. Accessed February 11, 2021, from https://www.ahrq.gov/ncepcr/care/coordination.html

[2] Agency for Healthcare Research and Quality. Care Coordination Measures Atlas Update. Published June 2014. Accessed April 12, 2021. https://www.ahrq.gov/ncepcr/care/coordination/atlas/chapter3.html

[3] [Placeholder footnote for Care Coordination Environmental Scan Citation]

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Please submit written input regarding any or all of the following questions to PTAC@HHS.gov. Questions about this request may also be addressed to PTAC@HHS.gov.

Questions to the Public:

1. How do the definitions and objectives of care coordination differ by organization, specialty, clinical setting, and/or geographic area? What kinds of patients are most likely to benefit from care coordination?
2. To what extent does care coordination, and the activities associated with care coordination, vary by specialty, setting, provider type, and geographic area?
3. To what extent does care coordination, and the activities associated with care coordination, vary when the context is a single episode of care versus coordination of continuous care for a population over time?
4. What are some of the most effective approaches for improving care coordination within the context of value-based care? Are there experiences and lessons learned from providing care coordination in existing APMs and PFPMs that may be informative when developing or evaluating proposed PFPMs?
5. What are some innovative approaches to care coordination that have emerged recently, particularly in the context of the COVID-19 public health emergency?
6. What are the major barriers for health care providers and patients related to optimizing the use of care coordination for Medicare beneficiaries (including dual eligibles)? To what extent do these barriers vary for independent physician practices vs. integrated delivery systems, or for rural vs. urban vs. suburban areas?
7. In the APM and PFPM context, what are considerations relevant to supporting health equity within the context of effective care coordination? Can care coordination exacerbate disparities? What opportunities exist for using care coordination interventions to improve health equity or to address existing disparities in care (e.g., by race/ethnicity, disability status, language, health literacy, geographic area, access to the internet and other resources, etc.)?
8. In the APM and PFPM context, how can stakeholders leverage care coordination to optimize care for Medicare beneficiaries (including dual eligibles) within and across settings, during episodes of care, and in different contexts such as:
    - Supporting population-wide health management;
    - Supporting care for specific populations, such as those with chronic diseases or vulnerable populations; or
    - Supporting care related to an acute care event

9. Are there advantages in making improvements related to the use of technology, workflows, staffing, data sharing, quality standards, information, and supports needed by beneficiaries to optimize the use of care coordination?
10. What time and resource investments from practices, patients, and other stakeholders are required for implementing various types of care coordination interventions, and to what extent do these factors vary by setting?
11. What impacts have various care coordination activities had on reducing costs, improving quality and outcomes, or improving patient satisfaction? Which types of care coordination interventions have been most effective in various settings? Which types of care coordination interventions have been most effective for various types of patients?
12. In what areas is further evidence about care coordination needed?
13. What payment methodologies and value-based approaches are likely to be most effective in incentivizing improvements in care coordination? What are some important elements of these payment methodologies?
14. What are key issues in the evaluation of care coordination? In the context of APMs and PFPMs for Medicare beneficiaries (including dual eligibles), what are the most informative performance and outcome metrics for monitoring and evaluating the use and effectiveness of various care coordination approaches (including both short-term and long-term effects)?
15. In the context of APMs and PFPMs for Medicare beneficiaries (including dual eligibles), what federal and/or state policy issues exist that may need to be addressed to facilitate appropriate and effective use of care coordination?

Where to Submit Comments/Input: Please submit written input regarding any or all of the above questions to PTAC@HHS.gov. Questions about this request may also be addressed to PTAC@HHS.gov.

Note: Any comments that are not focused on the topic of APMs and PFPMs for care coordination services by physicians and related providers caring for Medicare fee-for-service (FFS) beneficiaries, or are deemed outside of PTAC's statutory authority, will not be reviewed and included in any document(s) summarizing the public comments that were received in response to this request.