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

On June 10, 2021, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) requested input from the public on information that could help inform their review of the use of care coordination to optimize health care delivery under physician-focused payment models (PFPMs) and alternative payment models (APMs). PTAC received seven responses from the following stakeholders that are listed below in the order in which their responses were received:

1. American Academy of Family Physicians
2. American Medical Association
3. SCAN Health Plan
4. American College of Emergency Physicians
5. Partnership to Empower Physician-Led Care
6. American Academy of Physical Medicine & Rehabilitation
7. American Occupational Therapy Association

For additional information about PTAC's request, see PTAC's solicitation of public input.

AMERICAN ACADEMY OF FAMILY PHYSICIANS

July 1, 2021

Jeffrey Bailet, MD
Committee Chair
Physician-focused Payment Model Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation (ASPE), Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Dr. Bailet,

On behalf of the American Academy of Family Physicians (AAFP), which represents 133,500 family physicians and medical students across the country, I write in response to the request for information that the Physician-Focused Payment Model Technical Advisory Committee (PTAC) solicited in June 2021 to inform the role care coordination can play in optimizing health care delivery and value-based transformation in the context of alternative payment models. The AAFP was an early participant in the PTAC review process with our proposal for an Advanced Primary Care Alternative Payment Model (APC-APM) and remains fully supportive of the PTAC's role in evaluating physician-focused payment models (PFPM). Most recently, the AAFP participated as a panelist in a June 10, 2021, PTAC public meeting during the care coordination session. We are pleased to respond to this current request for public input.

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?

Primary care is the first point of contact for many patients, and therefore is the center of patients' experiences with health care. As a result, primary care is best positioned to coordinate care across settings and among physicians in most cases. Primary care medical homes work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange. Additionally, care coordination activities incorporate the provision of non-face-to-face services and processes that help patients transition back into the community after hospital and nursing home stays. Family physicians are advocates for their patients' well-being by promoting the highest quality of health care in such facilities.

To identify patients most likely to benefit from care coordination, many primary care practices utilize risk-stratification to assign a health risk status to a patient and use the patient's risk status to direct and improve care. In a practice panel of 1,000 patients, there will likely be close to 200 patients who could benefit from an increased level of support. According to The Commonwealth Fund, this 20% of the population accounts for 80% of the total health care spending in the United States, with the highest medical costs concentrated in the top 1%. Typically, patients with complex chronic conditions fall into the top 20% and would benefit from enhanced care coordination and management services.

To what extent does care coordination, and the activities associated with care coordination, vary by specialty, setting, provider type, and geographic area?

Primary care is the provision of integrated, accessible health care services by physicians and their health care teams who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The care is person-centered, team-based, community-aligned, and designed to achieve better health, better care, and lower costs.

Care coordination in primary care considers the needs of the whole person, including their family, social, mental, financial needs, in the context of the community in which they live. It is much more encompassing than care coordination outside of primary care, which is often episodic in nature or limited to a single organ system or disease state. Primary care provides patient advocacy in the health care system to accomplish cost-effective and equitable care by coordination of health care services.

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?

Episodic care coordination often addresses one acute issue and does not necessarily incorporate the needs of the whole person when provided outside the context of the primary care physician-patient relationship. It may result in short-term savings and quality improvement, but the time-limited nature of episodic care does not provide the comprehensive care that can generate long-term savings and impact patient outcomes. However, when episodic care coordination is provided by the primary care team, this ensures the patient is being treated in a holistic approach.

Longitudinal care coordination in the primary care setting facilitates the family physician's role as a cost-effective coordinator of the patient's health services by making early recognition of problems possible, and it ensures continuity of care. Continuity is rooted in a long-term patient-physician partnership in which the physician knows the patient’s history from experience and can integrate new information and decisions from a whole-person perspective efficiently without extensive investigation or record review. Longitudinal care coordination in this context reduces fragmentation of care and thus improves patient safety and quality of care.

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?

The goal of care management and coordination is to individualize health care to meet each patient’s specific needs. Health care systems that are patient-centric, outcome driven, and include payment structures that support services which patients need will be better aligned to meet this goal. In the current fee-for-service (FFS) health landscape, this alignment is often difficult to accomplish, as outcomes are based on how care is incentivized. But the landscape is changing. With the shift away from FFS, primary care serves as the foundation of value-based

payment (VBP). Likewise, care management and coordination are integral to aligning and meeting the goals of VBP.

The Health Care Payment Learning & Action Network's (HCPLAN) alternative payment model (APM) framework outlines the payment reform landscape and provides a path to greater flexibility supported by alternative payment and partnership between patients and their care teams. The table below outlines progressive care coordination abilities when payment reform precedes and supports care delivery reform. Practices that utilize the flexibility that VBP provides, along with innovative care delivery, thrive in meeting the quadruple aim of health care—better patient outcomes, lower costs, improved patient experience, and improved clinician experience.

Health Care Payment Learning & Action Network APM Framework Category	**Care Management and Coordination Activities Supported by Payment System**
Category 1 Fee-for-service (FFS) with no link to quality and value	Practices tied to FFS may use the Annual Wellness Visit to identify care gaps, connect with patients who have not had a visit recently, and engage more frequently with patients with higher care costs. Use of chronic care management (CCM) and transitional care management (TCM) services facilitate coordination and management of patient care on a volume basis. However, CCM and TCM have specific billing requirements that limit the flexibility to implement innovative care management and coordination practices.
Category 2 FFS with link to quality and value	Additional—albeit often minimal—payment tied to quality may allow practices to transform care in VBP models. In addition to the volume-based, FFS care management and coordination codes, quality incentive payments may allow practices to nominally expand their care management and coordination services through focused efforts (e.g., using risk-stratification to identify patients most at risk for poor health outcomes to focus primary care practices' care management resources).
Category 3 Alternative payment models (APMs) built on FFS	Models, such as the Comprehensive Primary Care Plus Track 1, the Medicare Shared Savings Program, and Accountable Care Organizations, provide flexibility through additional payments for taking on accountability for utilization and/or cost. However, the extra payments may not fully replace FFS. Additional payments allow for increased flexibility in care delivery, including hiring additional staff to support care management and coordination (e.g., care managers and coordinators, integrated behavioral health providers, social workers, integrated pharmacists).
Category 4 Population-based payments	Partial- to full-capitation arrangements provide the highest level of flexibility for care delivery innovation. Management services are often expanded to address health disparities and social determinants and provide care to patients at the time, place, and level of intervention most appropriate to their needs.

Outside of aligning flexibilities supported by moving along the continuum of VBP, these models must also address the chronic underfunding of primary care. The recent National Academies of Science, Engineering, and Medicine report on primary care calls on Medicare to increase payment rates for evaluation and management services by fifty percent. As most alternative payment models are based on the FFS chassis, appropriate payment for primary care under FFS would ensure payment levels are commensurate with high quality primary care in VBP models.

What are some innovative approaches to care coordination that have emerged recently, particularly in the context of the COVID-19 public health emergency?

Over the last year, family physicians rapidly changed the way they practice to meet the needs of their patients amid a global pandemic. Arguably, the most dramatic shift was the unprecedented uptake of and increase in telehealth services. Last spring, out of necessity, physicians quickly pivoted from providing a majority of care in-person to caring for their patients virtually to promote social distancing and infection control. This would not have been possible without the swift legislative and regulatory action that expanded coverage, increased payment, and added flexibility for telehealth services.

Prior to COVID-19 — due in large part to Medicare restrictions and inadequate payment — fewer than15% of family physicians were providing virtual visits to their patients, and during the public health emergency (PHE), that number surged to more than 90%. Despite technical challenges on the part of patients and physicians, both quickly came to realize the value of virtual care. According to a recent survey of AAFP members, seven in ten family physicians want to continue offering more virtual visits in the future.

Telehealth, when implemented thoughtfully, can improve the quality, comprehensiveness, and coordination of patient care and expand access to care for under-resourced communities and vulnerable populations. As outlined in our Joint Principles for Telehealth Policy, in partnership with the American Academy of Pediatrics and the American College of Physicians, the AAFP strongly believes the permanent expansion of telehealth services should be done in a way that advances care continuity and the patient-physician relationship. **Expanding telehealth services in isolation, without regard for previous physician-patient relationship, medical history, or the eventual need for a follow-up, hands-on physical examination, can undermine the basic principles of the medical home, increase fragmentation of care, and lead to the patient receiving suboptimal care.** In fact, a recent nationwide survey found most patients prefer to see their usual physician through a telehealth visit, feel it is important to have an established relationship with the physician providing telehealth services, and believe it is important for the physician to have access to their full medical record.

Telehealth can enable timely, first-contact access to care and supports physicians in maintaining long-term, trusting relationships with their patients, both of which are central to continuity of care. It can also facilitate better coordination between primary care and sub-specialists, especially in areas where there may be health care shortages, further eliminating disparities in access to necessary services such as behavioral and mental health. Given these benefits, patients and physicians agree some current telehealth flexibilities should continue beyond the PHE (see Federal policy recommendations).

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?

Payment Barriers
The greatest barrier to optimizing care coordination in the primary care setting is the reliance on FFS. Most care coordination activities do not lend themselves to a traditional FFS approach, which is why payment reform for primary care must focus on creating prospective, capitated payment mechanisms for primary care. Payment reform must precede care delivery transformation, but with this transition comes an operational shift on the part of practices, their physicians, and other eligible clinicians ranging from revenue cycle management to practice transformation efforts. The AAFP encourages VBP models that include technical assistance, especially for those practices early in the transformation continuum, to ensure successful participation, improved quality, and reduced costs.

More broadly, the key functions of a medical home depend on enhanced, prospective payment. This is especially important for small, solo, and independent primary care practices as they typically lack the resources to hire additional staff to support care coordination activities, particularly in the current payment environment. Accordingly, the AAFP recommends a payment method for advanced primary care that will compensate them for care not captured through traditional FFS, with an increased investment in primary care, and empower them to commit temporal and supportive resources to their patients, particularly those of high complexity. The AAFP believes prospective, risk-adjusted payments allow primary care practices to invest in the infrastructure and resources necessary to provide and optimize their advanced primary care practice capabilities to the benefit of their patients.

The AAFP supports payment models that provide prospective payment, but also recognizes the need for a continuum of models to meet the needs of diverse practice settings. A continuum of models across payers is necessary, as well as creating on and off ramps to create model stability, particularly for models under testing by the Center for Medicare & Medicaid Innovation (CMMI). Regarding dual eligibles, low Medicaid payment rates may be another barrier to optimizing the use of care coordination. Ensuring Medicaid rates are on par with Medicare payment rates for primary care services would be helpful in this regard.

Barriers for Rural Physicians
Rural areas often suffer from health care shortages, making access to and coordination with sub-specialists difficult. Additionally, there are limited opportunities for physicians and care teams to train in rural health settings, which coupled with a lack of incentives to draw primary care physicians and clinicians to rural areas further exacerbate limited access and coordination opportunities for patients.

Once a primary care clinician is practicing in a rural area, they face additional barriers to optimizing their care delivery. Many rural practices do not have access to reliable broadband services that enable effective use of telehealth, which limits their ability to provide important care coordination services. The Medicare physician fee schedule (MPFS) also typically pays less for services provided in rural payment localities, meaning Medicare funds care coordination less in those areas than it does in urban and suburban localities. Accordingly, the AAFP

supports the elimination of all geographic adjustment factors from the MPFS except for those designed to achieve a specific public policy goal, such as encouraging physicians to practice in underserved areas.

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.)?

Physician-focused payment models need to be designed to support care coordination services for all patients. Existing FFS structures typically do not pay for or support robust care coordination activities, which can disadvantage patients who require more support and the physicians who care for them. The AAFP's policy on social determinants of health outlines how family physicians are uniquely qualified to identify social needs and connect patients with third-party services and public programs in their community to address those needs.

This can be achieved through models that include adjustment of payment rates to provide additional resources to account for the social needs of their patient population. One approach, outlined in a recent Health Affairs blog post and used by the AAFP in the Advanced Primary Care Alternative Payment Model (APC-APM), is to use geographic indices of social risk such as the Robert Graham Center's (RGC) social deprivation index (SDI). The RGC SDI is a composite measure of area level deprivation based on seven demographic characteristics collected in the American Community Survey and used to quantify the socio-economic variation in health outcomes. While there are mechanisms to adjust payments, the larger outstanding question of what it costs to manage populations with increased social risks remains.

One additional opportunity to expand care coordination and increase equitable access is to expand where models are tested. Current primary care models tested by CMMI have been geographically limited in scope and repeatedly tested in the same regions. Since most care coordination occurs through primary care settings, efforts should be made to expand where models are tested to increase equitable access and avoid further exacerbation of disparities.

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?

Interoperability is essential for facilitating care coordination. If important parts of patients' records are not easily shareable across a patient's care team, it creates a barrier for physicians trying to obtain relevant information for their care plan. The AAFP has supported regulations that advance interoperability by requiring electronic health record vendors to incorporate certain data sharing standards (at no added cost to physician practices).

The AAFP has also strongly advocated for improving patients' access to their own health care data. This allows them to be active participants in their own care plan and help to share relevant information with various members of the care team.

Given the current technical challenges to achieving interoperability in practice, we have concern with the complexity of the regulatory environment covering health information exchange. There are inconsistencies between HIPAA and Information blocking, such as required timelines and the data elements that must be exchanged. We have strong concerns about the administrative burdens, especially for smaller sized practices, to manage compliance with the complex regulations around health information sharing.

As a result of the interoperability requirements in the Meaningful Use regulations, we saw many health care organizations err on the side of transfer of large volumes of health data instead of focusing on clinically relevant data. Since EHRs were not (and currently still not) capable of semantic interoperability, the end-user, many times the physician, had to manually review all the incoming documents to ensure there were not key clinical data buried in the volumes of data transferred. We have concern that the pressure from the lack of clarity around the Information Blocking regulations could result in similar “data dumps” on primary care.

Regarding workflow and supporting the needs of patients, we do have concern that the fears of non-compliance caused by uncertainty and short timelines of the information blocking regulations will result in patient data being released to patients before clinicians have a chance to review. Many lab tests can be abnormal from the laboratory but clinically they are within a normal for a patient and diagnostic studies, like imaging, that have interpretations can contain potential “cannot rule out” discussions. For patients this can lead to unwarranted concern and anxiety until they are able to speak to their physician about these results.

Regarding quality standards, alignment and harmonization of quality measurement would help by reducing the burden on physician practices and freeing up physician and staff time that could be better spent in coordinating care. The lack of alignment is particularly onerous for family physicians, many of whom contract with 10 or more payers.

In what areas is further evidence about care coordination needed?

Care coordination often occurs in non-face-to-face settings, and with the rapid growth of telehealth since the beginning of the PHE, the use of telehealth for care coordination requires further investigation. Careful consideration is needed to determine which clinical circumstances should command in-person attention and which cases can be managed just as effectively—and perhaps more conveniently—with a telehealth visit, including care coordination activities. The ideal combination of telehealth and in-person visits that optimizes efficacy and cost efficiency is not yet known. Physicians will need to determine standards and protocols for which symptoms and conditions can be safely managed via telehealth, and protocols should be developed to address the evolving landscape while safeguarding the “Four Cs” of Primary Care: first contact; comprehensive care; continuous care; coordinated care.

Research is needed in emerging APMs to determine where telehealth may improve the ability to share risk and attain quality, cost, and patient satisfaction outcomes, in addition to the cost required to implement and sustain care coordination activities inclusive of multiple modalities of delivery. Additionally, clinical and administrative data will need to reflect service modality to evaluate the provision of telehealth services within APMs without adding undue physician burden. Currently, coding systems do not allow clear designation of telehealth use, and many telehealth applications lack integration with the electronic health record. Medical documentation

will need to be modified to automatically differentiate care delivered via telehealth versus in-person to allow comparisons in outcomes to be made and to avoid adding documentation burden. Data collection should be automated to the extent possible to reduce burden, and measures should be aligned.

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?

The AAFP believes payment for primary care should be prospective, include a comprehensive or global primary care payment, be risk-adjusted, and include evaluation of performance. This type of payment adequately supports and sustains a comprehensive care management and care coordination program. Additionally, these payments should be made within the context of a patient's medical home to avoid potential fragmentation, such as from third-party direct to consumer telehealth providers.

Not only is this payment infrastructure beneficial to practices, it's essential to ensuring access to high quality, continuous primary care for patients. When primary care practices can be nimble in the evolving environment and marketplace with a stable patient flow that is supported by a predictable, prospective revenue stream for the full range of care delivered, primary care practices thrive, and patients have better outcomes.

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)?

Measures of care coordination need further development, as no existing measures are adequate for primary care accountability purposes. At a high level, the Core Quality Measures Collaborative (CMQC) noted a gap around "integration across settings/specialties and populations," which is reflective of care coordination. The National Quality Forum (NQF) measure for medication management/reconciliation (NQF 0097) assesses a component of care coordination and is in the CQMC accountable care organization (ACO) Core Set. However, the measure is a "check-box" measure and doesn't adequately measure the effectiveness of medication reconciliation. The Person-Centered Primary Care Measure developed by the Larry A. Green Center touches on care coordination among other core elements of primary care, but the measure has not been adopted widely and systems to support implementation have limited availability. There is one HEDIS measure for transitions of care with accountability at the plan level, however this measures performance of sub-specialists, emergency department, hospital, and payers but does not assess the accountability of primary care.

There are also indirect measures of care coordination, but typically, these measure the performance of entities outside of primary care. Care coordination activities improve adequacy, timeliness, and accessibility of public health and community services to patients who need them, but evaluation of such coordination is complex. Coordination of care can also result in an avoidance or reduction of repeat care and duplicative services, however identifying what portion of primary care spend is reduced by these efforts is nearly impossible. Overall, there is much

work to be done in the measurement space to find ways to adequately assess the outcomes of care coordination delivered in the primary care setting with an integrated, team-based approach.

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?

The AAFP offers the following policy recommendations:

- **Adopt telehealth policies that enhance the physician-patient relationship rather than disrupt it, and incentivize coordinated, continuous care provided by the medical home.**
- Adopt payment models that support patients' and physicians' ability to choose the most appropriate modality of care and ensure appropriate payment, preferably prospectively, for care provided.
- Encourage evaluation of CMMI models to include not just cost savings as a measure of model success, but also goals such as quality improvement, increased quality of care, increased care coordination/continuity of care, and increased access to care, even if improvements aren't linked to lower costs.
- Ensure Medicaid rates are on par with Medicare payment rates for primary care services to reduce barriers to access and coordination of services for dual eligibles.
- **Permanently remove telehealth geographic and originating site restrictions to ensure all Medicare beneficiaries can access telehealth care at home.**
- Adjust the current Medicare Shared Savings Program benchmarking methodology to correct a flaw that systematically disadvantages accountable care organizations (ACO) in rural areas by including an ACO's own beneficiaries in the benchmarking calculation.
- Eliminate all geographic adjustment factors from the MPFS except for those designed to achieve a specific public policy goal.
- Encourage measure alignment and harmonization among federal payment programs and within Medicare (e.g. MIPS v. Medicare Advantage v. CMMI models).

We appreciate the opportunity to provide these comments. Please contact Kate Freeman, Care Delivery and Payment Strategist, at 913-906-6168 or katef@aafp.org with any questions or concerns.

Sincerely,

Gary L. LeRoy, MD, FAAFP

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July 1, 2021

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Chair
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Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
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Washington, DC 20201

RE: Request for Public Input on Care Coordination and Physician-Focused Payment Models

Dear Dr. Bailet:

On behalf of the physician and medical student members of the American Medical Association (AMA), thank you for the opportunity to provide our input on the role of care coordination in the context of Physician-Focused Payment Models (PFPMs) to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). When patients have multiple or complex health conditions and require services from multiple physicians and/or other health professionals, those services should be coordinated to avoid gaps, duplication, and conflicts in patient care. Effective coordination requires more than just a willingness by a physician to coordinate care; it requires that the physician assume the responsibility for making that coordination happen. This responsibility requires significant time and effort by the coordinating physician and the practice staff, as well as the other members of the care team.

Unfortunately, the current fee-for-service (FFS) system does not provide payment sufficient to support the time required to provide this type of care coordination. Moreover, even though one of the goals of creating Accountable Care Organizations (ACOs) is to improve care coordination, the Medicare Shared Savings Program does not provide enhanced payments to support care coordination. Rather than paying a physician to coordinate care, many ACOs and health plans have hired care coordinators and care managers to perform this function. As Dr. Sachin Jain observed during PTAC's June 10 meeting, these care coordinators are typically "strangers" that have no established relationship with the patient and are first introduced during what is already likely a highly stressful time for the patient. Additionally, these care coordinators may have no relationship with the physician and no ability to change the way the patient receives services. As a result, this approach can add another layer of services that may complicate care.

In addition, if one or more of the services a patient receives is not adequate or appropriate to meet their needs, coordination will not solve the problem. There are many situations in which there are inadequate payments in either standard FFS or alternative payment models (APMs) to support the services that a patient needs (such as home-based care, transportation to physician offices, palliative care, etc). In some cases, a patient is forced to receive multiple uncoordinated services because there is no payment for the single, coordinated service. The solution is to pay for the service the patient actually needs rather than trying to coordinate less-than-ideal services.

The PFPMs that physicians developed and submitted to PTAC are designed to address the specific barriers in the current payment system that prevent a patient from receiving the best care at the most

affordable cost. As PTAC's review demonstrated, most of these models include provisions for care coordination. By design, physicians proposed ways to provide coordination as an integral part of the patient's care, rather than as a separate program.

The AMA urges the PTAC to strongly advocate for implementation of the PFPMs it has already recommended without delay—doing so is one of the best ways to ensure the delivery of better, more coordinated care for Medicare beneficiaries. We thank the Committee for the opportunity to comment.

Sincerely,

James L. Madara, MD

From: Ryann Hill <RHill@scanhealthplan.com>
Sent: Thursday, July 1, 2021 3:13 PM
To: PTAC (OS/ASPE) <PTAC@hhs.gov>
Cc: Brenda Sulick <BSulick@scanhealthplan.com>; Eve Gelb <EGelb@scanhealthplan.com>; Romilla A. Batra <RBatra@scanhealthplan.com>; Sachin Jain <SJain@scanhealthplan.com>
Subject: Submission: Informing PTAC's Review of Care Coordination and PFPMs

Good Afternoon-

On behalf of SCAN Health Plan, I would like to thank you for the opportunity to inform PTAC's Review of Care Coordination and PFPMs. We would like to take this opportunity to follow up on the remarks given by SCAN Health Plan CEO Sachin Jain, MD, MBA at the June 2021 PTAC Public Meeting. Below, you will find answers to several questions outlined in the Care Coordination and PFPM RFI as well as a brief overview of SCAN Health Plan. We would be happy to provide additional insight and look forward to engaging with PTAC in the future.

SCAN Health Plan Background

SCAN (Senior Care Action Network), founded in 1977 by seniors, is a not-for-profit health plan that offers a variety of Medicare Advantage (MA) plans, including institutional (I-SNP), chronic care (C-SNP), and dual eligible special needs plans (D-SNPs). Since 1985, SCAN has specialized in providing comprehensive, high quality care to the most vulnerable Medicare beneficiaries, including those who live with multiple chronic conditions, are eligible for nursing home care, and have difficulty performing activities of daily living. SCAN is the second largest not-for-profit Medicare Advantage-Prescription Drug Plan (MA-PD) in California with over 220,000 members. SCAN earned a 4.5 Star Rating on a five-point scale from the Centers for Medicare & Medicaid Services (CMS) in each of the last four years and named one of the best insurance companies for MA in California by U.S. News and World Report for the third straight year.

Question #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?

Patients with complex health and/or social needs are most likely to benefit from care coordination. In the clinical setting, care coordination ensures that all members of the Interdisciplinary Care Team (IDT) can work as a team to care for the patient. Members of the IDT utilize care coordination to share test results, clinical notes, and other important information to care for the patient. For health plans, care coordination activities include benefit explanations, encouraging health plan members to interact with their provider portals, and other activities that facilitate engagement between plan members and their IDT.

Question #5

What are some innovative approaches to care coordination that have emerged recently, particularly in the context of the COVID-19 public health emergency?

In the context of the COVID-19 public health emergency, SCAN Health Plan is engaging in numerous activities to ensure that we continue to meet the needs of our members with a special focus on outreach and partnership with members, providers, and the broader community.

The following outlines SCAN's five key actions:

1. **Collecting and Analyzing Health Equity Data**
   SCAN is collecting and analyzing health equity data to promote equitable vaccine distribution. We identify vulnerable members based on the community needs and social vulnerability indexes, homebound indicators, difficulties with activities of daily living, race, and language. This information helps us to determine which of our members have received the vaccine, identify inequities in vaccine distribution, and provide outreach to specific populations to address inequities. We also share this data with providers to assist them in targeting older adults with high needs and coordinating vaccine appointments.

2. **Building Trust Through Targeted Outreach**
   SCAN is targeting culturally and linguistically aligned outreach activities to Spanish-speaking and Black members to help them determine if the vaccine is right for them and to navigate the distribution system. Outreach includes contacting Black and Hispanic older adults by phone, holding TeleTalks in Spanish, facilitating conversations in Black communities, and conducting research on Black and Hispanic caregivers.

3. **Helping SCAN Members Get Vaccinated**
   SCAN launched a COVID-19 Vaccine Hotline (800#) with staff dedicated to helping members navigate the process of registering and receiving vaccines. We also identify vaccine appointments for vulnerable members and helps them schedule appointments, with the help of transportation and home care workers.

   In April 2021, we launched a program to provide in-home COVID-19 vaccinations to homebound members in Los Angeles County with the goal of targeting an initial group of 1,000 homebound members. Recognizing that many homebound seniors live in multifamily or multigenerational homes, we also vaccinated caregivers and relatives in order to extend immunity to entire households.

4. **Supporting Health Providers**
   SCAN is working closely with providers to support equitable distribution of the COVID-19 vaccine. Our efforts include:
   a. Establishing a "Provider Integration Task Force" with the provider organizations that serve most of our membership. SCAN collaborates with provider groups, pharmacies, and community partners at large on vaccine distribution.
   b. Sharing specific provider group data to promote targeted vaccine distribution. This includes information on chronic conditions, member demographics on race, ethnicity, language, as well as low-income subsidy data and homebound indicators.
   c. Providing communications to members about each provider's approach to vaccine dissemination. SCAN creates tip sheets for medical groups on using telehealth (in

lieu of face-to-face appointments) and helps them develop their own health equity strategies.

5. **Serving the Greater Community**
   During COVID-19, SCAN is continuing to serve older adults in the community, in addition to our members, by supporting community agencies and events with resources, education, and funding. SCAN Independence at Home (IAH) program, a program providing no-cost support and resource referrals for older adults and caregivers regardless of plan membership, addresses older adults' social needs in the community. IAH is providing funding to safety net organizations closest to our members and their caregivers to help them keep their doors open during this challenging time. IAH contributed over $1.8 million to community-based organizations (CBOs) to respond to the increased demand for their services.

Question #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?
Advancing the interoperability of electronic systems would optimize the use of care coordination and therefore improve patient health outcomes. Interoperability allows for seamless and timely transfers of information, enabling patients, health plans, providers, and other members of a patient's care team to develop comprehensive care plans. Making improvements to encourage the use of interoperable electronic systems would remove data sharing barriers and increase the utilization and effectiveness of care coordination.

Question #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?
Investing in hiring and training staff who are culturally competent is crucial to implementing care coordination interventions for certain populations.

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

July 13, 2021

Jeffrey Bailet, MD
Chair
Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Room 415F
200 Independence Avenue SW
Washington, DC 20201

RE: Request for Public Input on PTAC's Review of Care Coordination and PFPMs

Dear Dr. Bailet:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on a request for information (RFI) released by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) related to role that care coordination plays in alternative payment models (APMs) and physician-focused payment models (PFPMs). We would like to provide input on a few of the questions that the PTAC includes in the RFI.

Question 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?

ACEP strongly believes that there is significant potential to improve care coordination in the emergency department (ED). ED care is by its very nature episodic and unscheduled. Safe, effective, and high-quality emergency care requires that the outcome of the evaluation, diagnosis, and treatment associated with these episodes be communicated to primary care professionals and specialists who will assume responsibility for continuing that care. Physician decision-making must be informed by the social determinants of health and personal context and wishes of patients and their caregivers.

The Acute Unscheduled Care Model (AUCM), a PFPM that we proposed to the PTAC and that the PTAC fully recommended to the Secretary of Health of Human Services (HHS) for implementation, was designed to ensure safe discharge from the ED. The thought process of how to incorporate care coordination features into the AUCM was informed by the literature, by reports highlighting best practices and gaps in post-ED care coordination, by prior Center for Medicare & Medicaid Innovation (CMMI) models, and finally by other Centers for Medicare & Medicaid Services (CMS) initiatives that encouraged care coordination to limit inpatient readmissions.

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These included:

- The GEDI WISE Initiative
- National Quality Forum Report: Emergency Department Transitions of Care: A Quality Measurement Framework
- The Patient Safety in the Emergency Department Task Force Report of the American College of Emergency Physicians (2001)
- The Hospital Readmission Reduction Program
- Comprehensive Care for Joint Replacement (CJR) Model
- ACEP's Geriatric Emergency Department Accreditation Program
- Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model

The goal was to build upon work the scientific evidence and consensus recommendations of organizations involved in developing, supporting, or measuring programs that had already been recommended to CMS or had been tested.

The AUCM specifically fosters care coordination by holding emergency physician groups accountable for the cost and quality of care Medicare beneficiaries receive over a 30-day period for specific episodes of acute unscheduled care. The model includes payment waivers for ED acute care transition services, telehealth services, and post discharge home visits. The waivers provide emergency physicians with the necessary tools to better coordinate care and promote improved patient outcomes. Concurrent to clinical care provided during the patients ED visit, an emergency medicine healthcare professional will administer a safe discharge assessment (SDA) to identify socio-economic factors and potential barriers to safe discharge, needs related to care coordination, and additional assistance that may be necessary. Information captured in the SDA informs unique patient care instructions provided at the time of discharge. The emergency physician participates in shared decision-making by coordinating with the primary care physician or specialist assuming care of the patient after ED discharge. Finally, the ED group arranges follow-up services by telephone, in-person visits, or telehealth outreach.

The ways in which the AUCM attempts to improve care coordination in the ED can be used as a model for how other APMs and PFPMs can address this important topic. ACEP hopes that the AUCM, or some elements of the model, is incorporated into APMs that CMMI has implemented or will develop going forward.

5. What are some innovative approaches to care coordination that have emerged recently, particularly in the context of the COVID-19 public health emergency?

One innovative approach that EDs used during the COVID-19 public health emergency to enhance care coordination has been to increase the use of follow-up telehealth services. Emergency physician groups have set up systems and protocols to follow-up with patients once they are discharged from the ED, ensuring that patients are taking their medications appropriately or are seeing their primary care physician or specialist if needed. These follow-up services have helped enhance care coordination efforts and avoid trips back to the ED or inpatient admissions. In addition, for patients under investigation for COVID-19, the treating ED group has been able to follow up with the patient to make sure their COVID symptoms are not progressing. Some groups have sent patients home with portable pulse oximeters and followed up to check their general status and oxygen levels.

Emergency physicians have learned an important lesson during the pandemic when discharging acutely ill patients in situations where there is a lack of hospital capacity. They have been able to improve the safety of that discharge and

follow-up care using three tools (all of which are available in the AUCM): transitional care management services, telehealth services, and post discharge home visits. Going forward, payment for these services should be included in any APM as a core component of disaster preparedness and response.

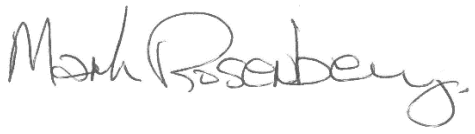
6. What are the major barriers for health care providers and patients related to optimizing the use of care coordination for Medicare beneficiaries (including dual eligibles)? To what extent do these barriers vary for independent physician practices vs. integrated delivery systems, or for rural vs. urban vs. suburban areas?

With respect to emergency care, some people are reticent to initiate care coordination programs given the misperception that the majority of the care is avoidable and that no value can come from an ED visit. However, only a small minority of ED visits are actually unnecessary or can be replaced by primary care interventions. In fact, the Center for Disease Control and Prevention's (CDC's) National Hospital Ambulatory Medical Care Survey from 2018 found that only around 3 percent of ED visits were classified as "non-urgent." When ED visits do occur, there is so much potential for emergency physicians to help connect or reconnect patients to community-based interventions, primary care physicians, and specialists, and to work collaboratively to help avoid hospital admissions. That is specifically why ACEP developed the AUCM. We believe that all emergency physicians, regardless of whether they are part of an independent physician practice or academic medical center or work in an urban or rural area, could participate in the model if implemented.

Another issue has historically been reimbursement models. Under the current fee-for-service model, there are no rewards for the hospital or the physicians to take the time to adopt a strong care coordination model. Even institutions participating in pilot projects designed to improve discharge outcomes could not sustain the models when the funding to pay for care coordination, adopt health information technology systems, and to build change management processes ended. **Therefore, funding for care coordination needs to be implemented and sustained.**

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory Affairs at jdavis@acep.org.

Sincerely,



Mark S. Rosenberg, DO, MBA, FACEP

ACEP President

PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

July 15, 2021

Submitted via email at PTAC@HHS.gov

Dr. Jeffrey Bailet
Physician-Focused Payment Model Technical Advisory Committee (PTAC)
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U.S. Department of Health and Human Services
200 Independence Avenue, SW
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Re: Request for Information (RFI) on Informing PTAC's Review of Care Coordination and PFPMs

Dear Chair Bailet:

Thank you for the opportunity to provide comment on the PTAC's Care Coordination and Physician-Focused Payment Models (PFPMs) Request for Information (RFI). We welcome the opportunity to share our view 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.

The Partnership to Empower Physician-Led Care (PEPC) is a membership organization dedicated to supporting value-based care to reduce costs, improve quality, empower patients and physicians, and increase access to care for millions of Americans through a competitive health care provider market. We believe that it is impossible to achieve truly value-based care without a robust independent practice community. Our members include Aledade, American Academy of Family Physicians, California Medical Association, Florida Medical Association, and Medical Group Management Association. We also have individual and small medical group supporters across the country, many of whom are independent physicians or practices and wish to remain so.

We are united in a common commitment to value-based care with care coordination as a means of achieving improved outcomes for patients. We believe physicians are best positioned to drive delivery system transformation. Physicians – especially independent physician practices – are the lynch pin of our nation's health care system. They have repeatedly demonstrated their superior ability to generate positive results in value-based care arrangements, both in improved health outcomes and reduced costs. They are the most powerful tool we have to foster an affordable, accessible system that puts patients first and play a critical role in optimizing care coordination and value-based transformation.

Given our specific area of focus, we are well-positioned to offer thoughts in response to Question 15 in the RFI *("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?").*

To facilitate effective and appropriate use of care coordination in APMs and PFPMs, federal and state policymakers must: 1) encourage physicians and practices to adopt value-based care models which inherently incorporate and rely on care coordination to drive improvements in quality and cost savings; 2) reduce barriers to care coordination by discouraging large, market-dominant provider groups from

using patient information for anti-competitive purposes; and 3) build care coordination into the metrics of success for APMs and PFPMs. Each of these issues is discussed in turn below.

Encouraging Independent Physicians and Practices to Adopt Value-Based Care Models

Historical data from the Medicare Shared Savings Program (MSSP) shows that physician-led accountable care organizations (ACOs) have consistently generated more savings than hospital-led ACOs, largely because financial incentives in physician-led ACOs are fully aligned with key components of value-based care. Implementing more physician-led models can encourage participation and achieve quality outcomes and savings, as well as improved care coordination.

To increase physician participation in value based care models, federal policymakers should consider the unique circumstances of physicians in independent practice, ensuring that there are models available for this cohort of the workforce and recognizing that models that are appropriate for large hospital-led groups and/or large physician practices may not be appropriate for all.

Additionally, federal policymakers should recognize the need for a glidepath for physicians and practices to take greater amounts of financial risk. This glidepath should include a path for physicians and practices to assume greater amounts of risk over time, but also a clear bridge to another model once the model they are participating in ends. Taking on full risk at the start can be difficult for independent practices, and full downside risk is not always needed to get results. Having an entry-level opportunity for shared savings and gradually moving into more aggressive risk profile has been helpful for physicians. Practices should clearly understand what the glidepath looks like so that they do not fall back into fee-for-service once their particular model ends.

Discouraging Providers From Using Patient Information for Anti-Competitive Purposes

Real population health management, including care coordination, cannot be achieved without timely access to patient health care information. Today's value-based care practices have to go hospital-by-hospital to find facilities willing to share information about their own patients. In the event that they are unable to find willing partners, they have to make do with the information they have or can get from their patients. This jeopardizes the success of our system-wide movement to value-based care and is counterproductive to care coordination.

Too many providers continue to see the data generated as proprietary rather than as an enabler of higher value care. In the case of admission/discharge/transfer or ADT feeds, the failure to communicate is not a technical problem, but rather a strategic decision not to share information to preserve its "competitive value." We were encouraged that CMS recently finalized a Condition of Participation (CoP) requiring hospitals participating in Medicare and Medicaid to share event notifications with a patient's care team. However, the advance notice of the survey guidance instructing hospitals how to implement the new CoP states only that the event notification requirement does "not limit the hospital's ability to notify additional entities based on hospital policy, such as ACO attribution lists." It does not encourage hospitals to accept or use rosters/attribution lists, which is problematic because value-based payment models – including those run by Medicare and Medicaid – almost universally utilizer rosters (i.e., attribution lists). We

strongly encourage federal policymaker to the new CoP is implemented in a manner that supports value-based care. This will have the greatest impact on the health and safety of Medicare and Medicaid patients.

We also strongly support efforts to discourage information blocking and streamline other regulatory requirements to make it easier for small, independent practices and providers to move to value-based care and to implement robust care coordination strategies. We encourage policymakers to explicitly state that providers who choose not to share information with other providers for competitive reasons are information blocking. We also urge policymakers to consider an information blocking exception for small practices that are acting in good faith, and to provide technical assistance to support small and mid-sized practices in understanding and navigating new requirements.

Build Care Coordination Into The Metrics of Success for a Model

Quality and access to care are important factors for model success. Goals such as quality improvement, increased quality of care, increased care coordination/continuity of care, and increased access to care should be considered a success, even if improvements aren't linked to lower costs. Often, these types of interventions lead to preventive care and downstream savings, which may or may not be considered during formal model evaluations. There are many ways to define the above concepts, and we believe that policymakers should take a holistic approach in measuring the full range of benefits realized by payment and delivery system reform models.

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Thank you for the opportunity to comment on the RFI. Please do not hesitate to reach out to me if the Partnership to Empower Physician-Led Care can be a resource to you. I can be reached at kristen@physiciansforvalue.org or 202-640-5942.

Sincerely,

Kristen McGovern
Executive Director

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August 13, 2021

PTAC Review of Care Coordination and Physician Focused Payment Models
Submitted via email: ptac@hhs.gov

Dear PTAC Members:

The American Academy of Physical Medicine & Rehabilitation (AAPM&R) thanks the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for the opportunity to offer comments on your discussion of care coordination and physician focused payment models. AAPM&R is the national medical specialty organization representing more than 9,000 physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, are medical experts in treating a wide variety of conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disabilities, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

During the June 10 public meeting, the PTAC briefly addressed the topic of care coordination in the post-acute care setting. Members of the Committee acknowledged that the priorities – as well as the potential challenges of post-acute care coordination – vary substantially from care coordination of chronic conditions, for example. We recommend the PTAC separately consider post-acute care coordination in its future work. Additionally, as key leaders in a range of post-acute care settings including inpatient rehabilitation facilities, skilled nursing facilities and long-term acute care hospitals, AAPM&R strongly recommends the PTAC engage physiatrists in these efforts.

We recognize that primary care practitioners are often considered the leaders in care coordination for many outpatient services, as asserted many times during the June 10 public meeting. However, in the inpatient rehabilitation setting, this important role is regularly filled by a physiatrist, who typically serves as the rehabilitation physician, directing the rehabilitation care for his or her admitted patients. As rehabilitation physicians, physiatrists are responsible for leading the interdisciplinary care team and coordinating the full range of services provided to each patient, which are tailored to their specific needs based on medical and functional status. As an example, care coordination for a patient who has suffered from a stroke is likely to include coordination of physical, occupational and speech language therapies; behavioral health; and ongoing medical care via the physiatrist and often one or more additional physician specialists. The physiatrist is also often crafting and coordinating a discharge plan, which includes home care and ongoing therapies and medical treatment to

ensure the patient reintegrates into the community and avoids unnecessary readmissions. Patients with limited assistance in the home, in particular, can benefit from the physiatrist's efforts in discharge planning. Physiatrists place an early and ongoing focus on regaining function during the IRF stay and also engage in comprehensive patient and family education to best prepare the patient for return to home and community.

In recent years, increasing numbers of patients with rehabilitation needs are also being cared for in the skilled nursing facility (SNF) setting. This includes brain injury and spinal cord injury patients who traditionally would have received care in inpatient rehabilitation facilities in addition to more traditional SNF patients such as those recovering from joint replacement surgery. While not all SNFs are able to have a physiatrist on staff, those that do can benefit significantly from the leadership in rehabilitation care coordination physiatrists provide. Similar to their role in IRFs, physiatrists in the SNF establish the rehabilitation plan of care for patients, tracking not only the patient's medical status but also documenting the patient's functional status to demonstrate progress and identify barriers to reaching functional goals. The physiatrist also serves as a key communication point between the rehabilitation team, nursing staff, and other staff physicians, as well as the patient and family. Having a physiatrist at the helm of rehabilitation coordination can help ensure patients in the SNF have a care plan that addresses the patient and family goals and expectations including eventual discharge back into the community if applicable.

Given the distinct care coordination needs of patients receiving post-acute care, AAPM&R encourages PTAC to include considerations for care coordination in post-acute care settings in your report to the Secretary. To connect with AAPM&R physician leaders on this topic, please contact Carolyn Millett, AAPM&R Senior Manager of Reimbursement and Regulatory Affairs at cmillett@aapmr.org or (847) 737-6024.

Sincerely,

Christopher Standaert, MD
Chair, AAPM&R Innovative Payment and Practice Models Committee

American Occupational Therapy Association

Sent electronically via PTAC@hhs.gov

September 16, 2021

Jeffrey Bailet, MD
Chair
Physician-Focused Payment Model Technical Advisory Committee
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RE: Request for Public Input on PTAC's Review of Care Coordination and PFPMs

Dear Dr. Bailet:

The American Occupational Therapy Association (AOTA) is the national professional organization representing the interests of more than 213,000 occupational therapists (OTs), occupational therapy assistants (OTAs), and students of occupational therapy. The science-driven evidence-based practice of occupational therapy enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. AOTA appreciates the opportunity to comment on PTAC's Review of Care Coordination and PFPMs.

I. Objectives of Care Coordination

Practitioners responsible for care coordination must have a proper understanding of the overall needs of specific patient populations in order to ensure referrals are made to the appropriate disciplines for the best possible outcomes. Practitioners also need skills associated with interprofessional collaboration and shared decision making, as well as knowledge of system-wide initiatives and targeted interventions to support patient needs, strategies for sharing data and information between practitioners and facilities, and how to leverage community resources.

Patients with chronic conditions benefit greatly from care coordination. According to the CDC, "90% of the nation's $3.8 trillion in annual health care expenditures are for people with chronic

and mental health conditions."[1] Conditions that fall into this category include heart disease, cancer, chronic lung disease, stroke, Alzheimer's disease, diabetes, and chronic kidney disease.[2] Patients with these conditions in addition to patients with low back and neck pain, other musculoskeletal disorders, other forms of dementia and patients experiencing imbalance or falls can most benefit from care coordination to address cross-cutting physiological, cognitive and psychological consequences associated with additional comorbidity and cost.

Proper referrals to occupational therapy can address:

- Pain – need for distribution, uptake of more effective nonpharmacological interventions (compared to pharma or surgery)
- ADLs, IADLs, fear of falling
- Cognitive changes – need for early detection, surveillance, and intervention
- Physical activity changes/sedentary behavior – need for range of solutions for assessing, monitoring, and intervening – particularly among people with disabilities for whom most strategies require adaptation, modification and/or new solutions
- Sleep disturbance, fatigue - need for early detection, surveillance, and intervention
- Psychosocial concerns- need for early detection, surveillance, intervention and uptake of more effective nonpharmacological interventions
- Environmental modifications

Additionally, having an occupational therapist on the care coordination team can provide the interprofessional collaboration needed to ensure that patients receive appropriate care that results in quality, cost-effective outcomes.

II. Care Coordination within Value Based Care

To implement a vision that is truly patient-centered and targeted toward long term outcomes, systems need to have a comprehensive view of capabilities of all members of the setting or systems team so that each team member is viewed as an active partner in case coordination, as well as a comprehensive view of the patient to consider the patient's desires and situation and a comprehensive view of illness/condition.

Efforts to develop new models of coordinated care for individuals with multiple chronic conditions should adopt a broad, team-based approach to service delivery. For example, they should not define primary care services as only physician or physician extender services nor should they view acute hospital primary care services as only a service that can be provided by the social worker. Coordinated care approaches should be constructed with a full range of comprehensive services encompassing rehabilitative and habilitative services (as required in the Affordable Care Act) like occupational therapy that, if provided as early and along a continuum, can increase

[1] Centers for Disease Control and Prevention. (2019c). Health and economic costs of 181 chronic diseases. https://www.cdc.gov/chronicdisease/about/costs/index.htm

[2] Centers for Disease Control and Prevention. (2019b). Chronic diseases in America. 179 https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm

patient engagement and involvement and limit the number of people whose conditions become complex. Occupational therapy practitioners are trained to provide interventions that can maximize independence and functioning, before the onset of disease or disability. These interventions have been shown to lead to health care savings and should be allowed along with other prevention-based interventions that have not traditionally been covered in the FFS model, including group interventions.

AOTA recommends allowing providers such as occupational therapists to provide other skilled primary health care services within the occupational therapy scope of practice, in coordination with the NPP or PCP. This development would broaden the reach and utility of the interdisciplinary team. Occupational therapists receive training in pathophysiology, neurology, task analysis, ergonomics, mental and behavioral health, and activity modification, all of which represent core functions to address issues that are prevalent in primary health care.[3]

III. Barriers to Care Coordination

Understanding what disciplines provide the most needed care services to ensure the patient can remain independent in the community and not return to the hospital is a major barrier in both independent practice and integrated delivery systems. Also, insurance reimbursement is not always available for services most needed to transition patients back into their homes. Reimbursement is a significant barrier that needs to be addressed by health insurers and systems in order for care coordination services and activities to experience the critical uptake needed to create effective care outcomes for patients.

For example, medication non-adherence in patients with chronic conditions results in higher hospitalization rates, poorer outcomes, and dramatically increased health care costs. With more than half of Medicare-age Americans taking at least three or four medications daily to treat chronic conditions, AOTA recommends increased attention be paid to medication compliance and the establishment of daily medication routines.

Studies in this area indicate that medication habits need to be individually developed to promote realistic integration into existing life routines. This finding is consistent with client-centered practice. Evidence also strongly suggests that patients need and would significantly benefit from skilled intervention, whether it is assisting in developing cues, arranging for equipment, assessing the environment, or arranging for monthly refills. These findings substantiate occupational therapy practitioners' role in developing specific, individualized, concrete plans for integrating medications into daily routines, thus increasing the patient's odds of adherence exponentially.

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[3] Dahl-Popolizio, S., Manson, L., Muir, S., & Rogers, O. (2016, July 21). Enhancing the Value of Integrated Primary Care: The Role of Occupational Therapy. *Families, Systems, & Health*. Advance online publication. http://dx.doi.org/10.1037/fsh0000208.

PFPMs should fully recognize this critical area for occupational therapy intervention that could easily be coordinated with the care plans and activities of the prescribing physician and nurse, at a minimum.

IV. Using Care Coordination to Optimize Care

Giving the patients the support they need to transition to community based care both lowers costs and increases quality. Any policy initiative aimed at delivering better care and outcomes for those with chronic conditions should emphasize, to a much greater degree, caregiver training services and community education campaigns. PFPMs must also follow suit in fully recognizing the importance of education and training for Medicare beneficiaries' caregivers.

Recommendations and interventions delivered by occupational therapy practitioners play an integral part in improving the lives of patients living with chronic conditions and helping caregivers maximize their effectiveness in the role. Occupational therapy practitioners understand the importance of supporting caregivers, and mitigating the stress and burnout associated with the role. Occupational therapy practitioners are skilled in identifying the caregiver's needs, values, barriers to participating, and, ultimately, helping to construct a more positive caregiving experience.

V. Care Coordination and Cost Reduction

Some examples of how occupational therapy can be an integral part of care coordination to reduce costs and improve quality include: screening for functional deficits upon entrance into an ACO or other APM entity; addressing function and safety during discharge planning from acute and post-acute care to prevent rehospitalization; managing care –especially for chronic conditions such as diabetes, neurological conditions, or mental illness – to promote self-management; screening and prevention in areas such as falls; and other wellness interventions that will help achieve quality outcomes at reduced cost.

Occupational therapy has also been proven to reduce hospital readmissions through the distinct practices related to focusing on ADLs, IADLs, fear of falling, functional cognition, social participation, and roles, habits, and routines.[4]

VI. Further Evidence Needed

[4] Roberts, P., Robinson, M., Furniss, J. & Metzler, C. (2020, April 23). Occupational Therapy's Value in Provision of Quality Care to Prevent Readmissions. *American Journal of Occupational Therapy.* 2020;74(3):7403090010. https://doi.org/10.5014/ajot.2020.743002

Further evidence for care coordination is needed in several areas including strategies to overcome organizational/system-level barriers to interprofessional participation in care coordination, strategies to empower patients to initiate coordinated care after discharge, strategies to support shared decision-making, comparing care-coordination to regular care for different patient groups (outcomes, cost, hospital re-admissions), and comparison of different methods of care coordination (e.g., in person, virtual).

In addition, mental health is often overlooked in care coordination. Many disciplines play a role in caring for patients with mental health challenges and without proper care coordination, patients may not receive the quality care needed to ensure the best possible outcomes. Occupational therapy practitioners can assist in this area by addressing psychological and social factors of mental health through occupational engagement and therapeutic use of self.[5]

VII. Policy Issues Surrounding Care Coordination

Occupational therapy practitioners have a key role to play in primary care and related teams, and it's critical that all new payment and care systems adopt the broader team-based approach to service delivery. Team based approaches ought not to define primary care services as only physician or physician extender services. Team-based approaches are much more effective in managing chronic conditions and in preventing the development of more complex conditions. Consideration should be given to incentives for preventative approaches to health and wellness that decrease the proportion of the covered population with chronic conditions that develop more "complex" conditions.

The establishment of Chronic Care Management (CCM) CPT® codes was an important step forward in coordinating care for this complex population. CMS continues, however, to limit the use of CCM codes to physicians, which limits the effectiveness of these codes. Incentivizing greater care management must be more inclusive of non-physician providers, like occupational therapists, physical therapists, and speech-language pathologists, who are also part of the overall care continuum for many patients in our health care system.

In occupational therapy, care coordination or management may actually involve an intervention that is coded using an intervention code. But some coordination and management may occur outside of intervention. **AOTA recommends that the role and impact of non-physician providers in chronic care management be valued, especially as part of CCM teams in ACOs and other new models. With that in mind, AOTA recommends broadening the use of the CCM codes to professionals, like occupational therapy practitioners, who play a key role in patient engagement and compliance. These services should be allowed under appropriate changes to coverage criteria and be able to be reimbursed properly. With**

[5] American Occupational Therapy Association. (2016). Occupational therapy services in the promotion of mental health and well-being. *American Journal of Occupational Therapy, 70,* 7012410070. http://dx.doi.org/10.5014/ajot.2016.706S05

these reimbursement expansions, professionals who are part of the care team that play a critical role in care coordination can be fairly compensated for valuable services that are currently unrecognized by the system, but which produce quality outcomes for patients every day.

Thank you for the opportunity to comment on PTAC's Review of Care Coordination and PFPMs. AOTA looks forward to a continuing dialogue with PTAC on advanced payment models that affect the ability of occupational therapy practitioners to provide quality, cost effective outpatient therapy to Medicare beneficiaries. If you would like additional information, please contact Monica Wright, AOTA's Manager, Coding and Payment Policy, at mwright@aota.org.

Sincerely,

Monica Wright, MHA, CPC, CPMA, CPCO
Manager, Coding and Payment Policy