Johns Hopkins School of Nursing and
Stanford Clinical Excellence Research Center
PTAC PROPOSAL: CAPABLE PROVIDER-FOCUSED PAYMENT MODEL
RESPONSE TO QUESTIONS

January 15, 2019

Dear PTAC Preliminary Review Team,

Thank you for reviewing our proposal and for your thoughtful questions. Please let us know if you have any additional questions or concerns.

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Response to Questions from PTAC Preliminary Review Team (PRT)
1/15/2018

The PRT questions are organized into three areas (Scope, Payment, and Patient Safety, Quality & Outcome Measurement). Some questions may overlap different areas.

Scope

1. **The PRT would appreciate a more clear indication of the target population for your model. The abstract indicates that the intended population is Medicare FFS beneficiaries with at least two chronic conditions and difficulty with at least one ADL. The scope section mentions additional inclusion and exclusion criteria used in prior CAPABLE studies.**

    a) **Please clarify the additional inclusion/exclusion criteria, if any.**

    We propose the following eligibility criteria:

    - Self-reported or positive screen for difficulty with at least one Activity of Daily Living[1] (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 healthcare provider using a standardized screening tool (e.g. Mini-cog[2]; SLUMS[3]; Short Portable Mental Health Questionnaire[4]).
    - Other high-risk features that may be considered include: recent hospitalization or emergency department 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) as this is a preventive model.

[1] Mlinac ME, Feng MC. Assessment of Activities of Daily Living, Self-Care, and Independence. *Archives of clinical neuropsychology : the official journal of the National Academy of Neuropsychologists.* 2016;31(6):506-516.
[2] Fage BA, Chan CC, Gill SS, et al. Mini-Cog for the diagnosis of Alzheimer's disease dementia and other dementias within a community setting. *The Cochrane database of systematic reviews.* 2015(2):Cd010860.
[3] https://www.slu.edu/medicine/internal-medicine/geriatric-medicine/aging-successfully/assessment-tools/mental-status-exam.php
[4] http://www.npcrc.org/files/news/short_portable_mental_health_questionnaire.pdf

b) **Does CAPABLE recommend a cognitive status assessment tool and specific cut-offs/thresholds for inclusion in the program?**

We do not recommend a specific cognitive assessment tool and have included multiple potential standardized screening tools for assessing cognitive status. We feel that individuals most appropriate to participating in motivational interviewing and goal-directed therapies would likely have either no or only mild cognitive deficits.

c) **The proposal indicates "we believe CAPABLE could be of benefit to those with higher incomes as well." Do you envision CAPABLE being available to all FFS beneficiaries regardless of income?**

We believe that all aging older adults would benefit from attempts to help them remain functional in their homes and communities, regardless of their income level in the same way that wellness visits, cholesterol checks, and other chronic management are equally available to all Medicare enrollees. That said, we understand that individuals with a lower income may have a more limited financial ability to contribute to paying for their home or medical care.

d) **If not, which income cut-off (e.g., 135% or 200% of FPL) or dual status (full or partial) are you proposing?**

If not available to everyone, we believe it should be available to individuals up to 200% of Federal Poverty Limit (FPL).

2. **The proposal identifies the participating providers as the OT and RN, with a contract to the handyworker. Page 7 indicates that primary care providers (PCP) could make referrals to the program, but otherwise the proposal does not describe explicit involvement by the PCP and or connection to other services.**

a) **Can you please elaborate on the ways that physicians would or would not be involved in CAPABLE? In particular, what involvement is required after initial referral for the service?**

One of the ways the CAPABLE program helps participants improve safety and functional capability is to advocate for participants by facilitating communication with healthcare providers, such as: primary care physicians, nurse practitioners, physician's assistants, specialists, social workers, psychologists, pharmacists, etc. Specific domains addressed by the team include pain, mood, strength/balance/fall prevention, medications, incontinence, communication with healthcare providers, smoking cessation, and sexual health. One goal of the CAPABLE team is to help participants identify the problems that bother them most and coach clients on how to communicate these concerns to their providers. The team can also initiate communication with and provide recommendations to the primary care providers directly, should the participant request assistance. We believe this facilitates physicians to be more efficient and effective in their regular practice

of medicine rather than try to require physicians to learn or do additional tasks in their already limited time.

b) Does the model include other components of care coordination between the CAPABLE team and other providers?

1. Communicating and care coordination with other providers is facilitated in several ways through the CAPABLE program. This includes both coaching clients in how to talk with their providers and acting as direct advocates if requested. The program utilizes a "Health Passport" to help the patient develop questions in the "Provider Questions" section. The nurse then coaches participants on how to use the tool during their visit with a healthcare provider. The CAPABLE team can act as direct advocates if an individual is unable to advocate for themself or requests assistance through the use of a phone call, e-mail, letter, or through direct messaging via the electronic medical record.
2. There is an EPIC module built out for CAPABLE so that any health system utilizing EPIC as an Electronic Health Record can adopt this module and use it to see the both the RN and OT notes during other visits (such as PCP visits).
3. The CAPABLE intervention is time-limited (approx. 5 months) and therefore aims at addressing the person-environment fit and educating patients on how to do this for themselves as their health changes.

Payment

3. The overall intent of the proposal appears to be to construct a payment model for a bundle of services that is not currently reimbursed for by Medicare. We also appreciate the submitter's indication that the best payment model is not currently known and consideration of a few different approaches.

a) Could the CAPABLE OT and RN services be provided to FFS beneficiaries using CPT codes in lieu of a PFPM?

We are currently unaware of CPT codes that would allow for CAPABLE to be provided to current FFS Medicare beneficiaries in its full form. While CPT codes 97165-97167 allow for a single occupational therapy evaluation, many of the interactions such as motivational interviewing, assessing individual goals, and evaluating person-environment fit are often not thought of as "skilled needs" under a Medicare FFS definition. Similarly, RN evaluation can be accomplished through a variety of CPT codes; however, many aspects of the CAPABLE intervention are not viewed as "skilled needs" under Medicare FFS definition.

b) The cover letter notes that Medicare payment for handyworker services and renovation costs would require a statutory change (though a waiver for a demonstration might also be possible). If payment for handyworker renovations could be resolved, would current FFS models such as

Accountable Care Organizations be an efficient mechanism for ordering the CAPABLE bundle?

We believe that if the problem of payment for handyworker renovations could be resolved, value-incentivized organizations would be an excellent method for delivering the CAPABLE model. The savings to Medicare through decreased hospitalizations and acute care visits or to Medicaid through decreased long-term care utilization could be passed back to the ACOs through their risk arrangements after calculating the savings.

c) **If a new provider-focused payment model is preferable to FFS billing (possibly through an integrated health care system or ACO), then given your experience with the program, could you please describe what you think would be the most effective PFPM or alternative payment model (APM)? In your description, please identify the following components of the payment model to the extent possible:**

Thank you for asking for more information on this. As we noted in our initial proposal and the question notes as well, there are several possibilities. We appreciate your thoughtful questions below. Having carefully considered the pros and cons of multiple payment models, we conclude that starting with a full or partial bundled payment with upside and downside risk based on an organization's cost-sharing model with Medicare (and Medicaid) would facilitate the adoption and spread of the model to the highest number of older adults, while providing higher financial incentives to groups willing to take full risk of their populations. Answers to your specific questions are below.

1. **The APM entity that would receive the payment for the CAPABLE bundle of services.**

   An accountable care organization or equivalent. We propose that the CAPABLE bundle would work similarly to surgery bundles or other bundled payment across services.

2. **Whether payment for the bundle would be a flat amount, or whether any risk adjustment would be involved.**

   Payment for bundle could be a flat amount because CAPABLE does not cost more to provide to those with more chronic conditions or more functional limitations.

3. **Would additional per beneficiary per month payments beyond the 5 month program would be involved? If so, what would be the time frame following initiation of CAPABLE, the cost components covered, and any risk adjustment?**

   While the savings from the intervention was shown to extend beyond the 5-month intervention (see page 9 of proposal), we envision the initial payment as a "lump sum" or "bundled payment" allowing for the ability to implement the model while further incentivizing organizations to take full or

partial risk for their population. Additional savings would occur to groups in risk-sharing arrangements due to Medicare savings through a decrease in hospitalizations and acute care visits or to Medicaid through a decrease in long-term care utilization.

4. **Whether the model would involve upside risk sharing.**

   As noted above, transitioning from upside to full downside risk sharing seems prudent, but we defer to the PTAC commission and staff to decide this.

5. **Whether the model would involve downside risk sharing.**

   See answer to number 4 above.

4. **Please help us understand the best estimate of the net costs of CAPABLE. The HCIA evaluation (Ahn et al., 2017) showed a non-significant effect on regression-adjusted quarterly Medicare total cost of care (n=172: $93 [95% CI: -$1,076; $1,262]) [QUARTERLY]. Ruiz et al. (2017) reported a propensity-score adjusted reduction in quarterly Medicare expenditures (n=171: -$2,765 [95% CI: -$4,963, -$567]). Szanton et al. (2018) used a Markov model with Monte Carlo simulation to estimate a non-significant difference in monthly Medicaid expenditures for CAPABLE versus a matched comparison group (n=281: -$867 [90% CI: -$2,352, $385]). Szanton et al. 2018 indicated that costs for CAPABLE were tracked after completion of the intervention. None of the three studies indicates that the cost estimates were offset by the CAPABLE program costs.**

   Ruiz et al (2017) and the Szanton et al (2018) show that the CAPABLE program costs were covered by the cost savings to Medicare and Medicaid. See below for additional information about Ahn et al (2017).

   a) **What is the best estimate of the impact of CAPABLE on monthly Medicare expenditures, and for what time period (e.g., two years following the end of the 5 month intervention)?**

      1. The peer-reviewed published Ruiz et al (2017) estimate comparing CAPABLE participants to matched controls is likely the most accurate. The Ahn et al (2017) estimate of aggregate savings ($547,174 [-$1,495,888 to $948,714] is perhaps a better measure of savings than the quarterly shown above in the question.

      2. Based on the Stanford CERC team's cost modeling[5] (submitted for publication), if CAPABLE was applied only Medicare beneficiaries with

[5] Altman M, Cannon K, Rinaldo F. Estimating the impact of patient-centered care on healthcare costs in late life. Submitted for publication 2018.

multiple chronic conditions and functional limitations (total 18.2 million from 2006 MEPS data) and assuming only 30% of the population was appropriate/reached and 25% efficacy compared to the original intervention, the team estimates an annual net savings of $4.5 billion (in $2015) to Medicare for at least 2 years (total length of time the initial intervention was monitored) following the intervention or $237 PMPM. This corresponds to a 0.74% net savings from total direct Medicare spending and 0.17% net savings from total direct U.S. healthcare spending annually.

3. If CAPABLE is targeted only to beneficiaries with multiple chronic conditions and functional limitations who are also in the top 5% of cost (4.7 million), and assuming 50% reach and 50% effect due to higher risk population, the net Medicare savings is estimated as $6.8 billion annually for at least 2 years following the intervention or $402 PMPM. This corresponds to a 1.12% net savings from total direct Medicare spending and 0.26% net savings from total direct U.S. healthcare spending annually.

b) What is the best estimate of the impact of CAPABLE on monthly Medicaid expenditures, and for what time period (e.g., two years following the end of the 5 month intervention)?

We estimated an additional $217 PMPM for 2 years to Medicaid if applied to all dual eligible with multiple chronic conditions and functional limitations (30% reach, 25% effect) and $437 PMPM to Medicaid if applied to top 5% of spenders with multiple chronic conditions and functional limitations (30% reach, 50% effect).

c) What is the estimated cost of the CAPABLE intervention services when implemented as intended over the 5-month period?

The exact cost per participant is $2,882 for the years 2012-2015 when tracked for research purposes. Since then, other implementing programs have provided CAPABLE for similar costs.

d) Do you have any information about implications of CAPABLE for Medicare beneficiary out-of-pocket costs?

There is no reason to believe they increase. We have not tracked it.

Patient Safety, Quality & Outcome Measurement

5. **The model does not currently provide specific recommendations for several quality metrics that are important for the model. We would appreciate it if the submitter could provider more information about how the model would measure and track the following components:**

   a) **Patient-centeredness of visits**

   While we do not advocate requiring providers of CAPABLE to measure participants' sense of the patient-centeredness of visits due to the burden of measurement, the entire CAPABLE model is based on participant's desires about how to age safely at home doing what they feel is most meaningful (take their own bath, walk to the mailbox, prepare their own food). In this way, the whole intervention is patient centered. At the final visit, providers ask participants the extent to which they attained their goals (fully, partially or not at all) and the occupational therapist asks the ability to perform ADLs as way to measure achievement of "aging in place." We also suggest asking the evidence-based question from the National Quality Forum: "Do you feel you were well taken care of?"

   b) **Ability to live safely at home**

   While there are multiple standardized home safety evaluation tools, we believe that this is most easily tracked by asking participants about their pre- and post-intervention comfort level with living at home, if living situation has changed, and by assessing their ability to perform activities of daily living (ADLs). Due to the individualized nature of this intervention, it is not presumed that one clinician's measure of "safety" is necessarily aligned with the participant's goals.

   c) **Monitoring the patient** (utilization, clinical progress (pcp part))

   The implementing organization will track based on their outcome needs. Since CAPABLE is a short-term program, tracking whether people meet their goals is tracking the clinical progress. An organization may track utilization to track own expenses with the bundle.

6. **Does the model involve provisions for care coordination?**

   a) Because the term "care coordination" can be interpreted in several ways[6], we feel it important to clarify that there is a flat hierarchy to the program and any individual role can act as the "point person" in coordinating the program. The handyworker primarily works directly with the occupational therapist rather than with the entire team due to the narrow focus of their work. The nurse and occupational therapist are expected to understand each other's roles and communicate about relevant findings at visits.

[6] McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination). Rockville (MD): Agency for Healthcare Research and Quality (US); 2007 Jun. (Technical Reviews, No. 9.7.) 3, Definitions of Care Coordination and Related Terms.

b) Because CAPABLE is now available in EPIC as a module, the ease of access between the CAPABLE team and the rest of a patient's clinical team is more easily facilitated for programs utilizing that EMR platform.

7. **Page 10 of the proposal mentions use of claims data for evaluation. Aside from evaluation, do you envision tracking any utilization measures for monitoring individual patients, either during or following the five month intervention?**

   This proposal does not include any recommendation for monitoring utilization on an individual patient level.

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ADDITIONAL RESPONSES TO QUESTIONS

April 5th, 2019

Dear PTAC Preliminary Review Team,

Thank you for reviewing our proposal and for your thoughtful questions. Here we provide additional information in response to specific issues that were raised in the report. Please let us know if you have any further questions or concerns.

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Additional Responses to Report from PTAC Preliminary Review Team (PRT)
1/15/2018

1. Payment Model and Risk Adjustment (Criterion 3)

We thank the PRT for their thoughtful comments related to the need for an APM, and also their feedback on risk adjustment.

The PTAC PRT raised the issue that ACOs may want risk adjustment to offer CAPABLE.

Current: The CAPABLE program has been tested in approximately 1000 clients ranging from 1 ADL or 2 IADL needs and limited medical complexity to clients with multiple ADL and IADL needs and more complex medical conditions. Each participant has been offered the same number of RN and OT visits and handyman services. In studies to date, improvement of disability associated with CAPABLE has not varied based on baseline function or health status.

Proposed: In response to the PTAC PRT's thoughtful report, we propose risk-adjusting for 3 levels of beneficiary complexity; a CAPABLE level 1, 2 or 3 with a higher dose of CAPABLE for clients with greater health and functional needs. If the PTAC recommends category c, then data from the sites testing under this category would be analyzed to determine whether 3 level risk adjustment results in enhanced health outcomes and/or greater cost savings when compared with the original, single level model. (See Figure 1: proposed risk adjustment and application of CAPABLE intervention at different points in time to bend the cost curve).

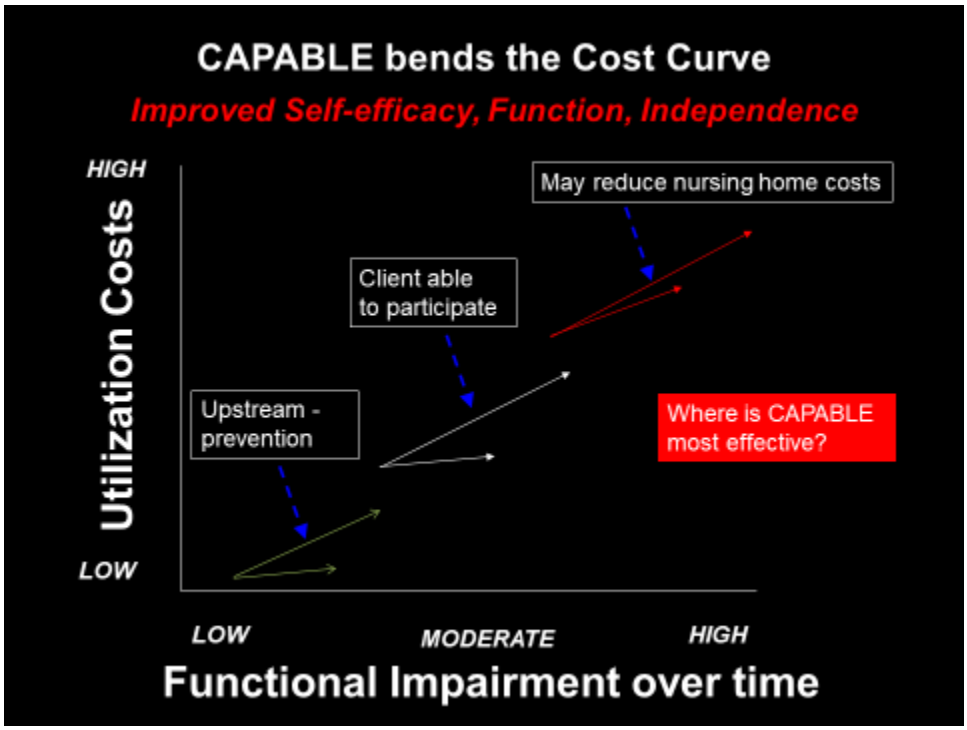

Figure 1. Proposed risk adjustment with CAPABLE: potential ways to bend the cost curve.

While initially we modeled CAPABLE with upside risk, we are confident that the cost savings will support CAPABLE in systems with both upside and downside risk. We believe we will clearly demonstrate this in the next phase of model testing (recommendation c) and anticipate both upside and downside risk within a year if CAPABLE is implemented widely as an APM.

Below is an example of how funds would flow from Medicare through CMMI in an APM CAPABLE model for a beneficiary:

1. Older adult qualifies for CAPABLE program based on set criteria including functional status – triggers referral (Please refer to clinical case study on page 7).

2. Physician bills on 1500 billing form:
    a. Physician uses J code or CAPABLE modifier on form each month for 4 months, similar to existing modifiers for chronic care management or advanced care planning. For example, modifier 112=low risk; 113=moderate risk; 114=high risk based on CMMI risk adjustment analysis. 112=$2500/participant; 113=$3000/per participant; 114=$3500/per participant. Divide each by 4 and bill each month for 4 months. Participants in moderate risk group receive 1 additional RN visit; participants in high risk group receive 2 additional RN visits. Physician initiates billing, then office billing staff does for the remaining 3 months.
    b. Billing stops automatically (client is disenrolled) after 4 months, unless PCP writes to continue for additional months. CAPABLE staff must notify office immediately if client dies, is hospitalized or drops out so that billing does not

continue. CAPABLE staff notifies billing department on the first of each month that client is still enrolled and participating in CAPABLE program. These systems will prevent potential fraud and abuse.

3. Detailed arrangements for flow of funds, including adjustment based on quality measures (e.g., NQF approved measures for falls, depression, care coordination) and acute care utilization will be determined by CMMI in a small scale CAPABLE expansion (recommendation c).
    a. Upside risk payments would be made annually based on NQF evidence-based quality measure scores for the practice for the prior year. Calculations will use a weighted average of practice improvement over time as well as practice performance relative to state and national averages.
    b. Risk adjustment for acute care utilization will use a formula including self-identified targets based on state and national averages for a similar population. A withhold will be set aside each year pending data analysis for that practice. Shared savings (upside risk) will be paid annually from the withhold to the practice based on a CMMI formula; in the case of low performance (failing to meet either quality or utilization targets) the practice will not receive a percentage of the withhold.

Operational fund flow with a CAPABLE APM may require attention to similar issues as experienced with ACOs, in which multiple partner organizations are engaged in the care of a member. This includes how funds are distributed, including any additional payments or withholds for upside or downside risk. We believe that payment operations can be addressed at each implementation site, so that any operational issues with billing, coding, multiple payers, MMIS or other systems, as well as specific risk arrangements, can be worked out early or even ahead of pilot implementation.

APM Model

Figure 2. Operational fund flow with APM CAPABLE model.

Could there be a new CPT code for CAPABLE?

The PRT suggested that it might be feasible to develop CPT codes to cover CAPABLE. Because CAPABLE is a model of care that differs from traditional home health and other models, RNs and OTs have not learned or practiced CAPABLE skills in traditional educational programs; therefore, CAPABLE requires specific training in its unique approach to person-

directed care. CPT codes would be challenging because each clinician must be trained first, similar to a surgery code not being used unless the procedure has been mastered and competency demonstrated. Since CAPABLE is a bundle of services (RN, OT, handy worker), individual CPT codes for each component could be confused with codes for traditional home health services, leading to inappropriate billing and coding. Thus we do not believe that new CPT codes for CAPABLE would be the best approach.

2. **CAPABLE and Primary Care Providers (Criterion 7, Integration and Care Coordination)**

We appreciate the PRT's request that we further explain how CAPABLE clinicians communicate at certain touchpoints with participants' primary care teams. **Encouraging participant communication and engagement with their primary care providers is a core element of the CAPABLE program.**

CAPABLE is a time-limited (5 month) program focused on promoting independence and optimizing functional mobility through motivational interviewing, goal setting and enhanced self-efficacy. Basic client-focused interventions may include fall prevention, medication review, assessment for person-environment fit, mood, pain and continence; home modification and provision of adaptive equipment. **These services do not replace comprehensive, primary care –** but provide in-home assessment and services to support the PCP's and the client's plan of care for ongoing health or medical conditions.

CAPABLE focuses on the client's own goals for well-being, mobility, aging with independence. There is strong support for the program from the many physicians, nurse practitioners, physician's assistants and other clinicians at primary care sites that have implemented the CAPABLE program. CAPABLE provides **distinct, enhanced services that align with the principles of high-quality primary care**, promotes advocacy and contributes important client information through home visitation that might otherwise not come to the attention of the primary care team.

How does the PCP know that a patient is enrolled in CAPABLE?

When clients are enrolled into the CAPABLE program, an overview email explaining CAPABLE is sent to the primary care practice/clinic. This email offers that a CAPABLE clinician can speak with a member of the primary care team to provide additional information, if the client agrees.

When does the CAPABLE RN update the PCP?

It is most useful for the CAPABLE clinician to contact the PCP: 1) after the first two visits; and/or 2) if a concern is raised (e.g., during medication reconciliation); and 3) at program completion. The optimal communication is by the client themselves but the CAPABLE clinician will reach out at the client's request.

Will CAPABLE interfere with existing case management?

In many settings, there is already a case manager. The CAPABLE RN is not the 'quarterback' when there are multiple case managers – rather, CAPABLE provides information to the existing case management team and coaches the client through effective communication strategies throughout the five month process. This leaves the client with stronger communication and self-advocacy skills through capacity building, so that the client is more able to solve problems and communicate with the primary care team going forward. This may save significant time during future office or hospital visits, reduce redundant communication with office staff, and may prevent unnecessary utilization and adverse events in CAPABLE program completers (see Table 1).

Primary care physicians talk about how CAPABLE enhances their practice:

"GD, a woman with visual impairment, spent most of her day on the second floor of her Baltimore row home where the bathroom is located. With the help of CAPABLE, which she described as 'just beautiful,' she had less knee pain, more confidence navigating obstacles and improved mood. I noticed that she was more engaged in care and was open to asking me questions regarding her health. The CAPABLE program is a wonderful example of person self-directed goal setting, evidence-based interventions aimed at low resourced older adults. CAPABLE staff become our eyes and ears in the home and can intervene on findings—it is a wonderful complement to the limits of traditional office-based medical care."

--Colleen Leavitt, MD, MPH
Medical Director for Internal Medicine
Johns Hopkins Community Physicians

"CAPABLE has been an invaluable resource to me caring for some of the most vulnerable patients in Baltimore. A patient with severe diabetes and blindness has had home visits with a nurse who has helped her with accommodations for her blindness and was able to help the doctor stay aware of her blood sugar. I also have an impoverished patient who suffers from food insecurity who had a refrigerator provided by CAPABLE to help her prepare food at home. I feel much more comfortable taking care of complicated, sick patients when I know that CAPABLE is able to visit them in the home and provide services outside of regular clinic-based care."

--William Garneau, MD
Baltimore, MD

Case Example – how CAPABLE supports primary care providers in care of older adults

Mrs. Whitaker is an 81 year old woman who lives alone in a small, one bedroom house in a rural area outside of Bath, Maine. Her son lives two hours away in Massachusetts, but he isn't able to visit often, although he frequently calls the PCP office with questions about his mother's health.

Mrs. Whitaker's diagnoses include hypertension, atrial fibrillation, osteoarthritis, low back pain, s/p right knee replacement, anxiety, macular degeneration, history of falls. Her medications include lorazepam for anxiety, oxycodone/acetaminophen as needed for moderate to severe pain, ibuprofen for mild to moderate pain, lisinopril for hypertension. She was previously on warfarin for atrial fibrillation, but she consistently refused INR testing, so it was discontinued.

Mrs. Whitaker is on Medicaid and arranging and paying for transportation to the primary care office is challenging for her. You have been her primary care provider for about 3 years, and lately she has been missing more and more appointments, and states that she just can't come in to be seen unless it's 'a real emergency'. However, she calls the office about once a week, asking the staff to go over her medications with her, and asking for help getting to the pharmacy to pick them up. Due to her anxiety and chronic pain, she often asks to speak with the physician, but refuses to come in for a visit. In the past year, she was hospitalized once for a fall with dizziness and was seen in the emergency department twice for low back pain and anxiety.

The outpatient care manager mentions that she's heard about a program called CAPABLE, in which an RN and OT visit an older adult in their home a number of times over 4-5 months, working to improve self-efficacy, function, independence and safety within the person's home environment – focused on the person's own goals for their health and well-being, and providing minor home repairs/modifications.

The outpatient care manager (CM) reviews the team's notes, and states that given Mrs. Whitaker's ADL and IADL impairments, she would be appropriate for the CAPABLE program, if Mrs. Whitaker is interested. This triggers a referral to the local CAPABLE program.

The CM make a referral and receive a letter from the CAPABLE program with a description of the program, contact information for the RN, and the client's consent to participate. After two months, you receive an email from the CAPABLE RN, stating that Mrs. Whitaker has been on a regimen of prn acetaminophen, has been using a heating pad (provided by the program) and has been doing the CAPABLE exercises regularly. Her osteoarthritis and low back pain have improved, and she is more confident about her medication regimen.

One of Mrs. Whitaker's goals was to reduce her pain so that she could 'get out more.' Working with the OT, Mrs. Whitaker has been moving around more in the house, and has even started walking to the mailbox to get the mail, weather permitting. This increased physical activity has lightened her mood. She told the nurse that she no longer feels like she needs her prescription pain and anxiety medications as often, and stated, 'I've just slowly weaned myself off of them.' She has more energy and has even started making meals for herself again, since she can now stand for longer periods with less back and knee pain. The CAPABLE RN has worked with Mrs. Whitaker on another one of her goals – connecting with a neighbor who is willing to give Mrs. Whitaker a ride to the pharmacy to pick up her medications.

Mrs. Whitaker met her CAPABLE program goals and also developed problem-solving skills that she can apply in the future. She no longer calls you or your office staff weekly, and her son has stopped calling the office as frequently as well. Mrs. Whitaker ends her participation in

the CAPABLE program after five months with improved function and mood, a safer home environment and fewer medications. She now agrees to come in to the office for routine visits 2-3x/year. The CAPABLE nurse sends a summary to your office and provides her phone number, in case you have any questions. CAPABLE has reduced Mrs. Whitaker's risk for falls, medication interactions, loneliness/isolation and nursing home placement. Improved communication with the office staff and primary care provider enabled the team to focus on Mrs. Whitaker's medical conditions, and optimized care coordination.

Mrs. Whitaker continued to receive all of her Medicare benefits. The practice manager used the CAPABLE billing code with the 012 modifier (for moderate risk) and submitted this each of the four CAPABLE-enrolled months via CMMI billing procedures. The practice was paid, covering the cost of the RN and OT visits, the home modifications and adaptive equipment. In addition, when compared to similar patients in the practice, Mrs. Whitaker had lower acute care costs, lower nursing home costs, fewer unnecessary office visits and calls to the office requiring staff time (see Table 1 below).

IMPACT OF CAPABLE

	Before CAPABLE	**After CAPABLE**	**Impact[1]**
Phone calls to primary care provider (PCP)	**Frequently.** Mrs. Whitaker calls her PCP's office once a week. Her son calls so often that the receptionists know him by name.	**Rarely**. She attends routine appointments and gets most of her questions answered there.	**Reduced outpatient costs.** Fewer phone calls means less uncompensated staff time and tied-up phone lines at her PCP.
Healthcare conditions	**Many.** Mrs. Whitaker lives with atrial fibrillation, anxiety, hypertension, low back pain, macular degeneration, osteoarthritis, and a history of falls.	**Showing progress**. She reports decreased anxiety and less low back pain – and has had six months with zero falls.	**Improved quality of life.** She is more mobile, better able to move around her home safely, and experiences less pain.
High-risk medications	**Multiple**. Mrs. Whitaker is taking lorezepam, oxycodone/acetaminophen, and ibuprofen.	**None**.	**Reduced risk of adverse drug events, interactions, and ED visits.**
Willingness and ability to come to PCP visits	**Only if she must.** Mrs. Whitaker has told her PCP she only comes to the doctor if it's "a real emergency."	**On recommended schedule.** She comes to routine and preventive appointments.	**Better outpatient management.** Her PCP team has more opportunities to prevent falls, cardiac events, and/or stroke.

	Before CAPABLE	After CAPABLE	Impact[1]
Hospitalizations	**Frequent**. Mrs. Whitaker has visited the ED three times due to a fall, back pain, and anxiety, including one inpatient admission.	**None**. Mrs. Whitaker hasn't been hospitalized since she completed CAPABLE.	**Reduced acute care costs.** CAPABLE saved $15,000+ in acute care costs in the first year.[2]
Transportation	**Limited**. Mrs. Whitaker sometimes misses PCP appointments if her son's schedule changes.	**Greater self-efficacy.** She is willing to ask her neighbor for a ride when she needs it.	**Increased mobility.** She picks up medicine refills on time, has the groceries she needs, and makes it to her PCP appointments.
Social isolation	**Lonely and isolated**. Mrs. Whitaker had stopped going to social events, religious services, and medical appointments because she doesn't feel safe outside her house.	**Makes it to what matters most to her**. She surprised her granddaughter at her birthday party last month.	**More active social life.** She finds meaning in social activities she used to enjoy.
Problem solving skills	**Feels discouraged.** Mrs. Whitaker finds it hard to problem-solve around health-related challenges.	**Likes to brainstorm.** She thinks and talks through possible solutions with healthcare providers or her son.	**Enhanced problem-solving.** She is better-equipped to handle what comes her way.
Family caregiver experience	**Overwhelming balancing act.** Mrs. Whitaker's son feels anxious about his caregiving role and doesn't trust the healthcare system.	**Less burdened.** Caregiving is still a tough job, but he feels like he, his mother, and the PCP are acting as a team.	**Improved quality of life.** Her son is more productive with work and has more time to spend with his family.

[1] Cost and quality of life differences pre-to-post (in the 12 months following CAPABLE program completion)
[2] Saved one inpatient admission@ $14,000 (average); plus 2 emergency department visits @ $1000 (average)

Table 1. Cost and Quality of Life Differences Before and After CAPABLE Program Completion.

This case illustrates many of the benefits of the CAPABLE program, not only to the participant but also to the primary care provider and office practice. Mrs. Whitaker has been coached in how to communicate effectively with her PCP and office team, and how to appropriately access healthcare resources. Her health and well-being are improved, without requiring additional time or adding burden to the outpatient office staff or PCP. The billing procedures are straightforward, and the practice is able to more than cover the cost of CAPABLE. In addition, since this practice is part of an ACO, by demonstrating cost savings through reduced acute care utilization the practice will benefit from shared savings (upside risk; based in part on quality measure scores), and/or reduced penalties or shared losses (downside risk). Mrs. Whitaker had no hospitalizations and no emergency department visits during the CAPABLE

intervention and for six months after the program.

Implement an optional peer-to-peer network of multi-payer practices

To further communication and continue to improve the program and the model for implementing it we propose an ongoing peer-to-peer learning network of multi-payer practices and health systems engaged in CAPABLE as an APM. Building on existing infrastructure at Johns Hopkins University and emerging work with the Institute for Healthcare Improvement (IHI), we plan to grow this network in two ways:

1) via an existing asynchronous web-based platform (Yammer site) on which providers can share best practices and communicate with other practices;

2) via regularly scheduled (optional), interactive open webinars with leading national experts and participating Medicare Advantage Plans, Special Needs Plans, PACE programs, ACOs, MCOs, physician practices and health systems. These forums will provide an opportunity for health professionals and office staff (billing and coding and other professionals) to share ideas, innovation, best practices and problem-solve issues together.

3. Electronic Health Records (EHR)- Criterion 10

The PRT requested additional information about how CAPABLE data exchange may be facilitated via EHRs and whether using HIT should be required. As mentioned in our proposal, we have tested the ability to modify existing EHR platforms through work with one of the largest U.S. EHR vendors, EPIC, and have developed an EPIC module specific to the CAPABLE program. At present, at least one implementation site is using EPIC for data exchange with primary care providers, and one other site using Cerner has plans to integrate CAPABLE metrics in their EHR in the future.

While we anticipate that additional EHR platforms will make a CAPABLE module available in the near future, primary care sites may have other preferred methods for data sharing. Therefore, we have developed the following data sharing plan, based on work by the Office of the National Coordinator (ONC) that is applicable across platforms and systems and conforms to CMS data interoperability standards. We propose that continued work on this data sharing plan would be part of testing CAPABLE to inform payment model development.

Data Sharing Plan

1. Define and describe the specific data elements needed by primary care providers from the CAPABLE program (e.g., standardized functional status, cognitive status, eCQMs or electronic clinical quality measures).
2. Standardize CAPABLE data elements using the CMS Data Element Library (DEL) and SNOMED CT or LOINC codes to ensure semantic interoperability at the data element level.
3. Explore preferred data sharing methods with shared care partners, recognizing that there is a wide spectrum of HIT capability and many providers may still prefer to use fax or secure email to exchange document files while others may prefer to exchange C-CDA (consolidated clinical document architecture) documents via DIRECT or through

an HIE. In the near future we anticipate there will be FHIR (Fast Healthcare Interoperability Resources) based APIs (application programing interfaces) that will enable interoperable data sharing with less HIT infrastructure and cost.

4. Develop a data transport process for each practice site. Refine as needed based on feedback from primary care providers and CAPABLE clinicians. Take advantage of opportunities to increase interoperable data sharing, such as app-based systems for CAPABLE data sharing that would meet FHIR standards.

Summary

Multiple sites implementing the CAPABLE program have reported improved function and quality of life in participants, a high degree of satisfaction among primary care providers, and significant cost savings. Specifically, as a result of a two-year pilot in the Trinity Health system in Muskegon Michigan, the national Trinity Board of Directors voted to expand CAPABLE to two additional Trinity sites. Through work with the SNP Alliance, after an 18-month study of CAPABLE, the SCAN health plan, a 5-star Duals Special Needs plan has decided to move forward with CAPABLE based on cost savings and quality outcomes. These major health systems/payers have experience with many alternative health care delivery and payment models. This vote of confidence in CAPABLE indicates that they believe in the value that CAPABLE brings to supporting older adults' ability to age in their homes and communities.