Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on the

Community Aging in Place—Advancing Better Living for Elders (CAPABLE) Provider-Focused Payment Model

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In accordance with the Physician-Focused Payment Model Technical Advisory Committee's (PTAC's) Proposal Review Process described in *Physician-Focused Payment Models: PTAC Proposal Submission Instructions* (available on the ASPE PTAC website), physician-focused payment models (PFPMs) that contain the information requested by PTAC's Proposal Submission Instructions will be assigned to a Preliminary Review Team (PRT). The PRT will draft a report containing findings regarding the proposal for discussion by the full PTAC. This PRT report is preparatory work for the full PTAC and is not binding on PTAC. This report is provided by the PRT to the full committee for the proposal identified below.

A. Proposal Information

1. **Proposal Name:** Community Aging in Place—Advancing Better Living for Elders (CAPABLE) Provider-Focused Payment Model
2. **Submitting Organization or Individual:** Johns Hopkins School of Nursing and Stanford Clinical Excellence Research Center (Hopkins Stanford)
3. **Submitter's Abstract:**

   "Community Aging in Place—Advancing Better Living for Elders (CAPABLE), is a program designed to improve the functional ability of older adults with chronic conditions and functional limitations. CAPABLE is a time-limited intervention performed by an interdisciplinary team of an occupational therapist (OT), registered nurse (RN), and 'handyman' (henceforth handyworker). Intended patients include Medicare beneficiaries with at least two chronic conditions and difficulty with at least one activity of daily living (ADL). This population utilizes a larger proportion of healthcare resources compared to beneficiaries without chronic conditions and functional limitations. These costs are driven largely by hospitalizations and long-term care such as nursing homes.

Ideally, any patient identified as high-risk could be enrolled by a health plan, or a healthcare provider could write a "prescription" for CAPABLE services. The intervention includes 10 home sessions (6 OT and 4 RN), each 60-90 minutes over the course of 4-5 months. The participant, together with the clinicians, identifies specific functional goals for which the occupational therapist provides assessment, education, and interactive problem solving. The OT also directs the handyworker to perform limited home repairs, adaptive modifications, or installation of assistive devices (up to $1300 in 2013 USD). The nurse specifically addresses pain, depression, polypharmacy, common geriatric concerns and primary care communication.

While we outline several potential payment models in this proposal, after examining the pros and cons of each, we believe that, starting with a partial bundled payment with partial upside and moving towards a fully capitated model would facilitate the adoption and spread of the model, while providing higher financial incentives to those groups willing to take full risk of their populations. Given that there is not a model without drawbacks, we would also encourage continued discussion and evolution of the payment model to promote quality of outcomes.

Central to the premise of CAPABLE is prioritizing the needs of clients and working towards patient-centered outcomes. The CAPABLE bundle incorporates principles of motivational interviewing and interdisciplinary teamwork to identify and create individualized, client-directed plans of care. This program systematically targets both modifiable intrinsic (person-based) and extrinsic (environmental-based) risk factors to create a bio-behavioral-environmental program to increase functionality. Key components of the CAPABLE model are patient involvement in all goals, improving function, and addressing quality of life. In order to assure the quality and fidelity of the intervention, key quality metrics include measurement of ADL and IADLs, depression, and home hazard or fall risk. In practice, the ADL, IADL, and PHQ-85 scores as well as a fall risk assessment are obtained before the intervention and again afterwards for comparison.

This program leverages evidence-based services that allow functionally limited older adults to remain independent in their communities. Creating a payment mechanism for this evidence based, high-value solution would promote scalability whereby the CAPABLE intervention could impact the greatest number of lives."

B. Summary of the PRT Review

The Hopkins Stanford proposal, "Community Aging in Place—Advancing Better Living for Elders (CAPABLE) Provider-Focused Payment Model," was received by PTAC on October 31, 2018. The PRT met and corresponded between December 10, 2018 and February 4, 2019 to discuss the proposal submission. A summary of the PRT's findings is provided in the table below.

PRT Rating of Proposal by Secretarial Criteria

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

C. PRT Process

The PRT met two times, December 10, 2018 and January 17, 2019, to review the CAPABLE PFPM proposal as well as additional information. During this period, the submitter provided written responses to questions from the PRT. The proposal as well as the submitter questions and responses are available on the ASPE PTAC website.

1. Proposal Summary

As noted in the abstract, CAPABLE is designed to improve the functional ability of older adults with chronic conditions and functional limitations. More specifically, CAPABLE focuses on identifying and addressing issues facing older adults living in their homes that, if not addressed, could result in further functional decline and avoidable use of high-cost services (e.g., emergency department [ED] and hospitalizations). CAPABLE uses patient-centered approaches to improve safety for elders living in their home and enable aging in place.

As described in the abstract, the time-limited intervention includes 10 home sessions (6 with an Occupational Therapist [OT] and 4 with a registered nurse [RN]), each 60 to 90 minutes over the course of 4 to 5 months. The OT also directs the handyworker to perform limited home repairs, adaptive modifications, or installation of assistive devices (up to $1,300 in 2013 USD). The submitter estimated the cost of the CAPABLE services to be $2,882 (based on their experience in providing CAPABLE services from 2012 through 2015) and suggested reimbursement as a flat fee that is not risk adjusted.

Traditional Medicare (fee-for-service, or FFS) does not cover home modifications. Although traditional Medicare covers home visits by OTs and RNs for patients meeting certain criteria, some of the CAPABLE OT and RN services are not routinely reimbursed by Medicare because of coverage limitations. The proposal identifies eight core

CAPABLE principles, many of which emphasize the patient-centeredness of the model. Each principle is accompanied by a more detailed description and the process for implementing the principle. Tables in the proposal identify the roles of the two key providers (OT and RN) and provide a detailed description of the differences between the "traditional" role and the "CAPABLE" role for these providers.

The submitters note that 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 Medicare FFS definitions. 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 definitions.

In proposing that the package of CAPABLE services be covered by Medicare, the submitters indicate the following criteria for program eligibility:

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

Current CAPABLE programs serve low-income individuals, and services are paid for through a variety of sources (e.g., Medicaid waivers, foundation funding). Although the submitters indicate that all aging older adults would benefit from attempts to help them remain functional in their homes regardless of income level, the submitters suggest that CAPABLE should be available to individuals up to 200 percent of the Federal Poverty Limit (FPL).

Because the payment model is not well defined in the proposal, the submitters clarified the following points about the payment model in written responses to questions:

- The alternative payment model (APM) entity would be an accountable care organization (ACO) or similar entity.

- The CAPABLE bundle would work similarly to surgery bundles or other bundled payment across services. Payment for the bundle could be a flat amount because CAPABLE does not cost more to provide to those with more chronic conditions or more functional limitations.

- They 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.

- The submitters believe that expenditure reductions occur for up to two years following receipt of CAPABLE services, but they did not address other aspects of payment beyond the initial bundle. They agree with the benefits of having both upside and downside risk but would defer development of specific aspects of risk-sharing to other groups more knowledgeable about such arrangements.

Using unpublished cost modeling, the submitters estimate an annual net savings of $4.5 billion (in 2015 USD) to Medicare for at least two years following the intervention, or $237 per member per month (PMPM); the submitters say this corresponds to a 0.74 percent net savings from total direct Medicare spending and 0.17 percent net savings from total direct U.S. health care spending annually. The estimates assume that CAPABLE was applied to 30 percent of 18.2 million Medicare beneficiaries with multiple chronic conditions and functional limitations who were appropriate based on other criteria and that the intervention had 25 percent efficacy compared to the original intervention. Under similar assumptions, the submitters estimate a reduction in Medicaid expenditures of $217 PMPM for two years following receipt of CAPABLE services.

The CAPABLE model has already generated substantial support and endorsement from other organizations. The proposal identified 18 programs in the United States (and one in Australia) that are replicating or scaling up CAPABLE services; the proposal identified the implementing organization and payment mechanism for each program. The proposal also had letters of support from four organizations: AARP, Trinity Health, Institute for Healthcare Improvement, and SNP Alliance; the letters emphasize support for a payment model for CAPABLE services for Medicare FFS beneficiaries. The proposal identified "supporting research" in two peer-reviewed publications (*Health Affairs* 2017 and *Journal of the American Geriatric Society* 2018).

2. Additional Information Reviewed by the PRT

a. Literature Review and Environmental Scan

The Office of the Assistant Secretary for Planning and Evaluation (ASPE), through its contractor, conducted an abbreviated environmental scan that included a review of peer-reviewed literature as well as a search for relevant grey literature, such as research reports, white papers, conference proceedings, and government documents. The search and the identified documents were not

intended to be comprehensive and were limited to documents that meet predetermined research parameters, including a five-year look-back period, a primary focus on United States-based literature and documents, and relevance to the letter of intent. The scan was initially completed on December 4, 2018, and then updated on February 1, 2019, with a new publication in *JAMA Internal Medicine* (January 7, 2019). These materials are available on the ASPE PTAC website.

b. Data Analyses

To explore the potential size of the Medicare population that might be eligible for CAPABLE services, ASPE requested statistics through its contractors from the 2016 Medicare Current Beneficiary Survey on the number and percent of Medicare FFS beneficiaries who: 1) had multiple chronic conditions and functional limitations and were living at home; 2) did not have cognitive impairment, frequent recent hospitalizations, cancer, or limited life expectancy; and 3) were dual-eligibles or had income at or below 200 percent of the FPL. The analyses estimated that 3.1 million Medicare FFS beneficiaries could be eligible, based on the inclusion and exclusion criteria. These analyses are available on the ASPE PTAC website.

c. Public Comments

The CAPABLE PFPM proposal received three letters of public comment, all of which supported the proposal. The Center to Advance Palliative Care noted that CAPABLE targets many beneficiaries in need of a palliative approach. The Green and Healthy Homes Initiative described their own experience in serving households that were receiving CAPABLE services and expressed concern that Medicare cannot directly pay for certain types of home-based care. The American Occupational Therapy Association Inc. noted that "services defined in the CAPABLE Model are not routinely reimbursed by Medicare because of coverage limitations and failure to understand and use the full range of occupational therapy competencies." The three letters are available on the ASPE PTAC website.

d. Other Information

ASPE, through its contractor, developed a document summarizing public information pertaining to coverage of home modifications by federal programs. The document also includes an appendix identifying eligibility criteria and relevant services by state for Medicaid and non-Medicaid programs covering home modifications. This document is available on the ASPE PTAC website.

D. Evaluation of Proposal Against Criteria

Criterion 1. Scope (High-Priority Criterion). The proposal aims to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.

(Rating) PRT Qualitative Rating: Meets Criterion

Strengths:

- The submitter has identified a bundle of services that is not currently covered by Medicare in other APMs (though some of the services can be offered by Medicare Advantage plans).
- The model targets providers (OTs and RNs) whose services are not typically covered by APMs and focuses on patient-centered care.
- The model targets FFS beneficiaries who currently have the capacity to reside in their own homes and are not terminally ill but are at high risk of health decline (possibly resulting in hospitalization or nursing home placement) due to chronic disease and functional impairment. The model also targets beneficiaries at or below 200 percent of the FPL. An analysis of the Medicare Current Beneficiary Survey shows that the eligible population could be as high as 3 million beneficiaries.
- The submitters have made a substantial commitment to replicating the model in other settings, including 18 ongoing programs in the United States (listed in an appendix to the proposal), which often incorporate support or funding from local programs. Programs in Maine, Maryland, and Michigan are being implemented through ACOs.

Weaknesses:

- The providers involved in service provision (OTs, RNs, and handyworkers) are not likely in a position to operate an APM and would need to partner with a larger organization to offer the services through an APM. Although the submitter endorsed the idea of embedding CAPABLE services in an existing APM such as an ACO, the proposal does not provide any description of how to create and structure such a contract, though we do observe ACOs are participating with CAPABLE in three states.

Summary of Rating:

The PRT unanimously agreed the proposed PFPM meets the criterion. This proposal identifies a package of services that could improve health for a large and vulnerable group of Medicare beneficiaries living at home. The model incorporates providers not currently directly involved in APMs, and the services covered by the model can help address unmet needs with a patient-centered approach.

Criterion 2. Quality and Cost (High-Priority Criterion). The proposal is anticipated to 1) improve health care quality at no additional cost, 2) maintain health care quality while decreasing cost, or 3) both improve health care quality and decrease cost.

(Rating) PRT Qualitative Rating: Meets Criterion

Strengths:

- The CAPABLE pilot was supported through a Health Care Innovation Award (HCIA) and an NIH-funded randomized controlled trial.
- Focus group and survey evidence for improvements in quality of care and safety for high-risk beneficiaries living in their homes is high. Participants reported improvements in their health, physical functioning, and ability to conduct daily activities independently.
- Published analyses show a 30 percent reduction (p=0.013) in ADL disabilities at the completion of the intervention at five months for CAPABLE participants, relative to a randomized control group receiving attention visits only. However, assessment at 12 months after baseline showed no significant differences in ADL or instrumental ADL (IADL) difficulties for CAPABLE participants versus attention group controls.
- In response to questions, the submitters provided unpublished cost estimates based on modelling and an assumption of 25 percent efficacy compared to the original evaluation. PMPM estimates for the two years following completion of CAPABLE services (estimated to cost $2,882 per person) were:
  - Reductions in Medicare expenditures of $237 PMPM
  - Reductions in Medicaid expenditures of $217 PMPM

Weaknesses:

- The estimated effects on cost for the HCIA evaluation came from small samples in a highly controlled demonstration setting (e.g., 172 participants). Implications include:
  - Estimates for key health service outcomes (ED visits, hospitalizations, and readmissions) and Medicare expenditures were very imprecise and lack statistical significance. For example, average quarterly Medicare expenditures were estimated to increase by $93 [90 percent CI: -$1,076; $1,262] and average quarterly Medicaid expenditures were estimated to increase by $403 [90 percent CI: -$443; $1,249].
  - Effects could differ in a broader program with less rigorous targeting of services. The problem is not one of "cherry-picking" per se, as the services are intended for beneficiaries who are currently living at home but at risk of further functional and health decline. The HCIA evaluation noted ongoing challenges in recruiting participants.
- While quality in the CAPABLE pilot appears very high, protocols for interactions with the beneficiary's primary care physician and other providers are not clearly established.

Summary of Rating:

The PRT unanimously agreed the proposed PFPM meets the criterion of quality and cost. The evidence indicates that the CAPABLE services are likely to improve health care quality at least at no additional cost. PTAC should be open to recommending models that improve quality at no additional cost. The PRT felt that the evidence that the PFPM would both improve health care quality and decrease cost ranged from weak to good, though attaining this goal could be contingent on continued careful targeting of people most likely to benefit from the services.

Criterion 3. Payment Methodology (High-Priority Criterion). **Pay APM Entities with a payment methodology to achieve the goals of the PFPM Criteria. Addresses in detail through this methodology how Medicare, and other payers if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.**

(Rating) PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- The submitters understand the importance to CMS of developing APMs that encourage risk-sharing and accountability.
- The submitters agree that offering CAPABLE services through a value-incentivized structure such as an ACO could be an excellent approach to a payment model for CAPABLE services.

Weaknesses:

- The submitters propose a payment that is flat (i.e., is not risk adjusted). While it may make sense to pay on a FFS basis for the set of CAPABLE services (6 OT visits, 4 RN visits, and handyworker modifications), it is not clear that a broader set of providers such as an ACO would be willing to participate in a payment model that does not involve risk adjustment. It is likely that the total cost of care would vary substantially among CAPABLE-eligible beneficiaries.
- Although current Medicare CPT codes do not cover many of the CAPABLE OT and RN activities (e.g., motivational interviewing, assessing individual goals, and evaluating person-environment fit), it might be inherently more efficient to develop codes to pay for these services rather than develop a separate APM focused on CAPABLE services. The PRT acknowledges that Medicare FFS does not currently cover home modifications, so the handyworker services could not be handled with a CPT code without a change in statute or regulation. The question of which “non-medical” services Medicare should allow health providers to provide in search of outcomes improvement or cost reduction is one that needs more attention and clarification, far beyond the specifics of this CAPABLE proposal.

- Many aspects of the payment model, including the need for risk adjustment but extending to many components of bundling services and accounting for total cost of care, are not specified.

Summary of Rating:

The PRT unanimously found that the proposed PFPM does not meet the payment methodology criterion. The PRT feels that the submitters have not sufficiently specified how the model would work, and much further development by CMS would likely be needed to make a CAPABLE PFPM operational.

Criterion 4. Value over Volume. The proposal is anticipated to provide incentives to practitioners to deliver high-quality health care.

(Rating) PRT Qualitative Rating: Meets Criterion

Strengths:

- The CAPABLE services are inherently intended to provide value over volume by using a bundle of services to provide patient-centered care that can help beneficiaries remain in their homes with improved function and safety.

Weaknesses:

- Despite the underlying intent of the CAPABLE services to enable the provision of high-quality health care, the lack of detail on a number of important issues means it is difficult to assess how value over volume would be achieved. In particular, aside from proposing a flat rate for the bundle of CAPABLE services, the proposal does not identify which costs would be the responsibility of the APM or which costs would not be included in the calculation of upside or downside risk-sharing.

Summary of Rating:

The PRT unanimously feels that the proposed PFPM meets the criterion because of the proposal's underlying intent to provide a patient-centered service that would improve quality of care and does not appear to increase costs (and may decrease costs) based on available evidence. The PRT assumes that risk-sharing provisions could be developed to help ensure the desirable goals of reductions in events such as falls and high-cost hospital use.

Criterion 5. Flexibility. Provide the flexibility needed for practitioners to deliver high-quality health care.

(Rating) PRT Qualitative Rating: Meets Criterion

Strengths:

- Although some components of the CAPABLE services are not strictly health care services, the PRT believes they are consistent with the broader definition of non-medical services that are "primarily health-related" being used by Medicare Advantage for supplemental benefits. These supplemental benefits can cover items and services related to daily maintenance that diminish the likelihood and impact of injuries or detrimental health conditions. Furthermore, it is the PRT's understanding that the Bipartisan Budget Act of 2018 is changing this requirement for 2020 such that supplemental benefits are not required to be primarily health related.
- As described, CAPABLE focuses on patient-centered care, tries to identify patient preferences including what they believe they need most to remain in their homes, and seeks to enhance communication between patients and their physician providers.

Weaknesses:

- CAPABLE is a provider-focused payment model that does not clearly describe or define appropriate involvement by a beneficiary's primary care physician or other physicians.

Summary of Rating:

The PRT unanimously agreed the proposed PFPM meets the criterion of flexibility given the patient-centered focus of care. However, while the care provided under the CAPABLE pilot was shown to be high quality and flexible, expansion of the model may require more specific processes for involving primary care physicians to ensure flexibility to deliver high-quality health care.

Criterion 6. Ability to Be Evaluated. Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

(Rating) PRT Qualitative Rating: Meets Criterion

Strengths:

- The proposal notes measurement of a number of relevant measures. In particular, ADL, IADL, and PHQ-9 scores as well as a fall risk assessment are obtained before the intervention and again afterwards for comparison.
- Although the sample size for the randomized controlled trial was so small that precise estimates of service use and costs were not possible, it would be possible to identify a comparison group and use statistical methods (e.g., propensity score matching) to conduct an observational study.

Weaknesses:

- Obtaining a larger sample in a randomized controlled study could be challenging.

Summary of Rating:

The PRT unanimously agreed the proposed PFPM meets the criterion of ability to be evaluated. In addition to using an observational study to get more precise estimates of impacts on service use and costs, the CAPABLE program embodies measurement to track changes in function over the course of the intervention.

Criterion 7. Integration and Care Coordination. Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

(Rating) PRT Qualitative Rating: Does Not Meet Criterion (Majority)

Strengths:

- The CAPABLE proposal makes innovative use of OTs and RNs, who are very well positioned to understand patient needs and preferences as well as enhance communication of the needs and preferences to other providers, including physicians.
- The CAPABLE team can help address needs that office-based physicians may not have time or capacity to resolve even if they are aware of the needs.

Weaknesses:

- While the CAPABLE services seem inherently valuable, PRT members were concerned about the lack of physician involvement or oversight as described in the proposal.
- In particular, while the proposal emphasized coordination between the OT, RN, and handyworker services, scant attention was paid to integration of this information beyond the immediate CAPABLE staff.
- If expenditure reductions are to come from reductions in high-cost health services such as ED visits and hospitalizations, greater interactions with clinicians will be needed.

Summary of Rating:

A majority of the PRT felt the proposed PFPM does not meet the criterion of integration and care coordination. The proposal does not include specifics of approaches such as a reporting system with various required touchpoints with a patient's primary care physician. The PRT recognizes the value of CAPABLE's coaching of clients to enhance their communication with their physicians. However, the PRT would be more comfortable with some provisions for direct exchange of information between CAPABLE staff and physicians.

Criterion 8. Patient Choice. Encourage greater attention to the health of the population served while also supporting the unique needs and preference of individual patients.

(Rating) PRT Qualitative Rating: Meets Criterion

Strengths:

- CAPABLE focuses on understanding the client's goals and preferences. CAPABLE also focuses on enhancing the client's skills in communicating their needs and preferences to providers beyond the CAPABLE team.

Weaknesses:

- No weaknesses identified.

Summary of Rating:

The PRT unanimously agreed the proposed PFPM meets the criterion of patient choice. The PRT feels that CAPABLE embodies a patient-centered approach that facilitates patient function and independence in decision-making.

Criterion 9. Patient Safety. How well does the proposal aim to maintain or improve standards of patient safety?

(Rating) PRT Qualitative Rating: Meets Criterion

Strengths:

- CAPABLE services are inherently intended to improve the safety of the home environment and to increase the length of time that individuals with chronic conditions and functional impairments may safely live at home.

Weaknesses:

- It would be desirable to ensure interactions with other providers beyond the CAPABLE team to ensure that patient safety can be maintained beyond the four- to five-month period of CAPABLE services.

Summary of Rating:

The PRT unanimously agreed the proposed PFPM meets the criterion of patient safety. The services are intended to improve safety, and the concerns about enhanced interactions with other providers could be addressed.

Criterion 10. Health Information Technology. Encourage use of health information technology to inform care.

(Rating) PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- The CAPABLE submitters note that an EPIC module exists such that any health system using EPIC as an electronic health record can adopt this model to enable access by other providers to the OT and RN notes recorded in the system.

Weaknesses:

- EPIC is not the only electronic health record system vendor.

Summary of Rating:

The PRT unanimously agreed the proposed PFPM does not meet the criterion pertaining to use of health information technology (HIT). HIT could be a good way to enable touchpoints between the CAPABLE team and other health care providers, but the proposal does not currently require its use or consider the feasibility for a broader set of vendors or providers not linked to the CAPABLE team through an electronic health record system.

E. PRT Comments

The PRT views CAPABLE as an innovative approach to an important problem that is not addressed in current payment models. Medicare beneficiaries living at home with multiple chronic conditions and functional limitations are at high risk of further functional decline and high-cost health care use that could be avoided (e.g., prevention of falls). The CAPABLE model has shown success and garnered much support and attention, and the PRT finds that it meets many of the Secretary's criteria. The CAPABLE model meets the scope criterion because of the involvement of providers not currently participating in APMs and the size of the target population. The patient-centered services improve quality and function for program recipients. While reductions in total cost of care have not been definitively demonstrated, the program may improve quality without increasing cost. The CAPABLE services are well-defined and time-limited, likely resulting in value over volume. The services also enhance flexibility, patient choice, and patient safety.

The PRT is concerned, however, about several aspects of the proposal. The first and potentially most problematic issue pertains to whether an APM is needed for CAPABLE services and, if so, how that model would be structured. The PRT recognizes that CPT codes do not exist for some of the OT and RN services and that traditional Medicare does not cover home modifications. However, the proposal to pay a flat bundle rate without risk adjustment and the lack of many specifics about upside and downside risk-sharing make it difficult to envision how a CAPABLE PFPM would operate, and creation of an operational version could take considerable CMS resources. CAPABLE services are often currently paid for through Medicaid waivers or other programs (e.g., the Older Americans Act), and the PRT recognizes that coverage of the services through Medicare for qualified low-income beneficiaries would facilitate a uniform national approach. However, while the PRT can

endorse the benefits of CAPABLE services, PTAC has no authority over coverage decisions or CPT code creation, and the PRT is not convinced that an APM is the best way to provide the very specific set of services that CAPABLE provides.

Aside from payment considerations, PRT members were concerned about the lack of specificity of physician interactions with CAPABLE team members and, more broadly, care coordination and integration. The proposal describes the patient's primary care physician as playing an "integral role in identifying appropriate individuals for the intervention, ordering the intervention, and integrating the recommendations of the CAPABLE team into the patient's medical care plan." The proposal, however, did not describe specific mechanisms for attaining this involvement and these goals. Such involvement may have occurred easily in a demonstration being carefully administered by high-quality staff. Without established processes or requirements for information exchange, it is possible that quality could decline under a broadly implemented program.

In theory, electronic health records could provide a solution to the need for communication and interaction with a broader set of providers beyond the CAPABLE team. The proposal notes that an EPIC module exists that can facilitate access by physicians and other providers to notes recorded by the CAPABLE OTs and RNs. The proposed model, however, lacked requirements for such information exchange and did not address mechanisms for all types of providers, many of whom may not be using EPIC.