

November 28, 2018

Center to
Advance
Palliative Care



Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Assistant Secretary of Planning and Evaluation Office of Health
Policy
200 Independence Ave S.W.
Washington, D.C. 20201
PTAC@hha.gov

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RE: Letter of Support – CAPABLE

Dear Committee Members,

I am writing on behalf of the Center to Advance Palliative Care (CAPC) to express our support for an advanced alternative payment model targeted to Medicare beneficiaries with functional impairments.

CAPC is a national organization dedicated to ensuring that all persons with serious illness have access to quality palliative services, regardless of diagnosis, prognosis, setting, or stage of illness. "Serious illness" is defined as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their caregivers. (modified from Kelley AS. Defining "serious illness." J Palliat Med. 2014;17(9):985).

The CAPABLE model, submitted by the Johns Hopkins School of Nursing and Stanford School of Medicine, targets many of beneficiaries in need of a palliative approach to their care, and uses trained clinicians to educate the patient and family, while clarifying goals of care and attending to symptoms, stressors, and safety in the home environment. As an advanced alternative payment model, CAPABLE will also close key reimbursement gaps to help Medicare beneficiaries with functional impairments maximize their quality of life and, in so doing, prevent avoidable hospital and emergency department utilization.

We encourage PTAC to approve CAPABLE for implementation, allowing many more beneficiaries in need to get this valuable and cost-effective innovation.

Sincerely,

A handwritten signature in blue ink, appearing to read "Allison Silvers", is written over a light blue horizontal line.

Allison Silvers, MBA
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December 11, 2018

Physician – Focused Payment Model Technical Advisory Committee
C/o Angela Tejada, ASPE
200 Independence Ave.
SW. Washington, DC 20201

Re: CAPABLE Provider Focused Payment Model

Dear Chairperson Bailet and Members of the Committee,

Founded thirty years ago as a community-based organization dedicated to promoting public health by improving the home environment in which we live, today the Green & Healthy Homes Initiative (GHHI) works with healthcare providers in over twenty cities around the country to help them secure healthcare reimbursement for their patient-centered services that are proven to deliver better health outcomes and at lower costs. Core to this healthy housing network is GHHI's Maryland program, which serves on the leadership team of "Housing Upgrades to Benefit Seniors" (HUBS), a HUD-funded collaborative that has leveraged \$25M to help seniors complete 2,543 applications and receive 1,300 housing services. As a HUBS housing provider, GHHI's team has directly served over 200 older adult households over the last two years with fall prevention and home rehab interventions, with many of these households also participating in CAPABLE.

Based on our own team's direct experience and in working with organizations across the country on the front lines of innovation and service delivery, we repeatedly encounter two government burdens preventing organizations like ourselves from scaling evidence-based interventions: 1) Medicare cannot directly pay for certain types of home-based care because it has an outdated definition of medical services and providers and 2) government health insurers (Medicare, Medicaid, MCOs) hesitate to let providers take the additional risk needed to implement advanced payment models.

The CAPABLE Provider Focused Payment Model provides a scalable pathway to address both.

On the first, the proposed bundled payment structures a) clearly define a target population based upon medical-need, b) incentivize physicians to provide care that will improve the health of patients more than would otherwise be allowed within Medicare Fee-For-Service, and c) advance an evaluation framework of greater rigor than patient care is currently measured by today. Among the providers we work with around the country, the benefits of the bundled payment efficiency over FFS coupled with providing them the ability to better serve their patients outweigh the additional evaluative burden, which as proposed would fit within the existing data management processes already required of many physicians.

On the second, the proposal can address two sources of risk, financial and operational, that would otherwise limit the model's reach. Financially, providers can mitigate the upside risk in the partial bundle by partnering with third-party impact investors to provide the initial gap funding while they wait to receive their retrospective outcomes payment. This 'pay for success' model has gained momentum as a way to scale philanthropy, but has not caught on in the healthcare space because of a lack of outcome-based payment models in Medicare and Medicaid. Operationally, CAPABLE's web-based training materials coupled with its network of 22 sites across the country ensure that physicians will be able to

easily develop the program as designed. For example, we are working with a Tennessee hospital that has been trained by an existing Denver-based CAPABLE program and is ready to begin piloting its services. Yet, like the other CAPABLE programs, it will be limited to the handful of families that grant funding can support. What about the 7 million seniors injured from falls each year?

Beyond the direct scalability of the payment mechanism among Medicare providers, we believe this payment model would provide a pathway for other HHS programs (e.g. Medicaid) and agencies (e.g. HUD) to follow in Medicare's footsteps in funding evidence-based home interventions that lower federal expenditures while improving health outcomes. In our work with both HUD and Medicaid Managed Care, all parties agree that we should shift expenditures from post-fall hospitalizations to addressing medical risk factors, as identified through programs like CAPABLE, before our grandparents ever fall in the first place. And yet, it seems as if each of these risk-averse government programs are waiting to see who will move first. CAPABLE, with its proven \$922 pmpm of savings over at least two years and improved health outcomes, provides a good place to start.

On behalf of the Green & Healthy Homes Initiative Aging in Place Team please accept these comments for consideration

Sincerely,

Ruth Ann Norton
President and CEO

Via online submission to PTAC@hhs.gov

December 12, 2018

Physician-Focused Payment Model Technical Advisory Committee
Assistant Secretary of Planning and Evaluation, room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Re: CAPABLE Provider Focused Payment Model: Community Aging in Place: Advancing Better Living for Elders

Dear PTAC Committee Members:

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 213,000 occupational therapists, occupational therapy assistants, 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 participation in daily occupations or activities. In so doing, growth, development and overall functional abilities are enhanced and the effects associated with illness, injuries, and disability are minimized.

We appreciate the opportunity to provide feedback on the “CAPABLE Provider Focused Payment Model, Community Aging in Place: Advancing Better Living for Elders” (hereinafter “the CAPABLE Model”) proposal for PTAC. AOTA supports the benefits associated with alternative payment models (APMs) that are intended to more efficiently and effectively address the challenges affecting the Medicare population’s ability to access high quality and effective interventions to promote health and well-being while aging in place. AOTA recognizes that as the Medicare population continues to live into advanced years, the critical necessity for APMs, like CAPABLE, that more creatively and effectively promote functional performance also continues to increase.

AOTA strongly supports the CAPABLE Model as an APM. The CAPABLE intervention makes important strides in reframing how we can meet the needs of our aging society and addresses critical factors that directly drive healthcare costs but are not readily addressed in current care models. Below, AOTA provides detailed comments and outlines important future considerations.

I. Role of Occupational Therapy in the CAPABLE Model

Occupational therapy is an essential component of the CAPABLE Model and the CAPABLE team (along with nursing and a handyworker) as funded by the Center for Medicare and Medicaid Innovation and the National Institutes of Health. The program, evolved and developed

through a series of studies, has clearly demonstrated the importance of addressing Medicare beneficiary problems related to everyday functioning and the home environment—specific domains of occupational therapy. CAPABLE has resulted in reduced disability, healthcare cost savings, and the promotion of aging in place. Further, the CAPABLE intervention is consistent with the perspective and role of occupational therapy, especially in community health and prevention. CAPABLE as a model promotes safe and effective aging in place to positively impact population health while at the same time meeting unmet individual Medicare beneficiary needs that directly drive healthcare costs but are not readily addressed in current care models.

CAPABLE is a person-directed program for older adults with functional deficits that addresses both modifiable individual limitations and changes to the environment.¹ This program aims to reduce the impact of disability among low-income older adults by addressing individual needs and capacities and promoting changes to the home environment.² In order to be eligible for participation in the program, participants needed to be sixty-five years of age or older, dually eligible for Medicare and Medicaid and have reported having at least some difficulty in performing activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs).³ Additionally, participants had to be living at home and could not be cognitively impaired, be receiving skilled home health care services, nor have been hospitalized four or more times in the previous year.⁴ This five-month interprofessional team based intervention is delivered by an occupational therapist, who makes six visits to each participant; a nurse, who makes four visits; and a handy-person, who contributes up to a full day's work by way of providing home repairs, installing assistive devices, and making home modifications that were prescribed by the occupational therapist.⁵

We find in large part that success with the CAPABLE program is found with its use of qualified professionals and the procedural and methodical approach which begins with attention to the patient's preferences, identification of functional barriers, followed by prioritizing patient goals and how the identified barriers interfered with achieving those goals. Specifically, the occupational therapist conducts an initial evaluation including a clinical interview based on existing principles for an occupational therapy evaluation. The participant's performance is observed and difficulties with tasks assessed. Realistic functional goals are established in partnership with the client based on the assessed performance deficits and the patient's desired goals. Following the performance assessment, the therapist assesses the home for safety issues including, but not limited to, unsafe flooring, poorly lit entrances, and loose banisters, and other issues that are safety hazards or limit safe performance of activities of daily living such as self-care. The OT then generated a work order to the handyworker that was prioritized with the participant's functional and safety goals in mind and within the 2013 \$1,300 budget set for the individual dwelling.⁶ Remaining visits with the occupational therapist focused on task analysis,

¹ Sarah L. Szanton, Bruce Leff, Jennifer L. Wolff, Laken Roberts and Laura N. Gitlin, Home-Based Care Program Reduces Disability And Promotes Aging In Place, *Health Affairs* 35 no. 9 (2016): 1558, doi:10.1377/hlthaff.2016.0140

² *Id.*

³ *Id.* at 1560

⁴ *Id.*

⁵ *Id.* at 1559

⁶ *Id.*; *id.* at 1560 noting that “the handyman made the financially feasible fixes that were most relevant to the goals and for the more expensive items, the therapist referred the participant to public benefits”; see also Sarah L. Szanton

gathering information from the participant on performance and creating strategies for achieving functional goals.⁷

The final outcomes of the project identified CAPABLE's participants' improved abilities to perform ADLs and IADLs, participants' decreased depressive symptoms, and the reduction of home hazards in multivariate models.⁸ It was concluded from the study that from a baseline level to the five-month follow-up that there was demonstrated improvement in more than half of the participants in each category⁹ with favorable results observed uniformly across demographic and chronic disease groups, i.e., none of the factors that often modify intervention success (age, race, sex, depression, and chronic illness) had an impact on these improvements.¹⁰ The report notes that due to the high costs associated with ADL difficulty, decreased difficulties in this area will result in cost-savings for the Medicare/Medicaid programs over time.¹¹

The profession of occupational therapy is built on delivering person-centered care, seeking to keep clients participating in life tasks at the highest functional level in the least restrictive setting and reducing caregiver burden and health care system resource utilization. With respect to potentially preventable readmissions, several recent studies indicate that returning to the community from a recent hospitalization with unmet activities of daily living need may be a considerable risk factor.

AOTA urges PTAC to recognize the value that this program encompasses with regard to full use of the competencies of occupational therapy to focus on participants' own functional goals rather than medically determined disease management goals or, in the alternative, imposing professionals' goals onto the participant.¹² Training for fidelity and understanding of the premises of the project are critical as are use of qualified professionals (i.e., an OT and an RN) for provision of the program. The dual eligible elderly population with functional limitations accounts for a high utilization of health care resources, and that amount of utilization is only expected to dramatically escalate. However, due to limits in federal program reimbursement, Medicare beneficiary needs for successfully aging in place have been inadequately addressed.

et al., Preliminary Data From Community Aging In Place, Advancing Better Living For Elders, A Patient-Directed, Team-Based Intervention To Improve Physical Function And Decrease Nursing Home Utilization: The First 100 Individuals To Complete A Centers For Medicare and Medicaid Services Innovation Project, *The Journal Of The American Geriatrics Society* 63 no. 2 (2015): 372, Table 1. noting that the "Top Ten Common Repairs or Modifications to Support Functional Goals of CAPABLE Participants" included: Install railings in stairwells, Install or tighten railings at home entrances, install grab bars in tub area, install nonskid safety treads for tub or shower floor or supply rubber bath mats, Improve lighting (repairs, motion sensor lights, bulbs), Repair holes, broken tiles, or tears in linoleum flooring, install raised toilet seats, add chain extensions to ceiling fans and lights, install flexible shower hoses, install doorbells.

⁷ *Supra*, n.1, at 1559

⁸ *Id.* at 1561, Exhibit 1; *see also* Alison Pighills et al., A Critical Review Of The Effectiveness Of Environmental Assessment And Modification In The Prevention Of Falls Amongst Community Dwelling Older People, *British Journal of Occupational Therapy* 73(3) (2016), 133 noting that one study observed 'accident/environment' factors to be the second most commonly perceived cause of falls by older people, specifically identifying wet and uneven surfaces, objects on floors...Consequently, environmental assessment and modification has featured heavily in multi-factorial intervention strategies designed to prevent falls."

⁹ *Supra*, n.1, at 1561, Exhibit 1

¹⁰ *Id.* at 1561

¹¹ *Id.* at 1562

¹² Sarah L. Szanton et al., at 374

The CAPABLE team-based approach reflects that considerations regarding function, home safety, and appropriate attention to ADL/IADL needs result in better quality and more cost-effective care for the target population.

II. Important Future Considerations

AOTA supports the CAPABLE Model. We would like to point out several issues for the PTAC's consideration that demonstrate the Model's innovative nature and differences from traditional coverage criteria to support the critical goal of community aging in place for the elderly:

- Occupational therapy is a skilled therapy service under Medicare Part A (institutional settings as well as the Medicare home health care benefit) and under Medicare Part B, which can be provided in the home as the site of service. However, the 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 CAPABLE Model sets forth proven results with the specified use of the qualified professionals (i.e., occupational therapist and nurse) with a handyworker as part of a coordinated, comprehensive effort to meet elderly patients' needs for safety, full function, improved mental health, and reduction in health care costs while at the same time honoring patient preference by supporting the patient's goal of aging in place.
- The Model expands the potential impact of occupational therapy beyond traditional interpretations of Medicare coverage criteria such as beneficiaries who have multiple chronic conditions and are experiencing gradually eroding performance.
- The CAPABLE Model follows the evidence-based studies by including training, collaboration and use of qualified professionals, not substitutes.
- The CAPABLE Model discusses the need for a quality metric to demonstrate patient outcomes. AOTA agrees with the need for appropriate quality measures and requests that any outcome performance measures put forward are appropriately risk adjusted.

* * *

Thank you for the opportunity to comment on the PTAC CAPABLE Model. AOTA looks forward to a continuing dialogue with PTAC, CMS and external health care entities on APMs that are intended to more efficiently and more effectively improve quality and cost outcomes for Medicare beneficiaries.

Sincerely,



Sharmila Sandhu, JD
Counsel and Director of Regulatory Affairs