

**Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes**

**June 10, 2021
10:00 a.m. – 3:55 p.m. EDT
Virtual Meeting**

Attendance*

Physician-Focused Payment Model Technical Advisory Committee (PTAC) Members

Jeffrey Baillet, MD, PTAC Chair (President and Chief Executive Officer, Altais)
Paul N. Casale, MD, MPH, PTAC Vice Chair (Vice President, Population Health, NewYork-Presbyterian, Weill Cornell Medicine and Columbia University)
Carrie H. Colla, PhD (Professor, The Dartmouth Institute for Health Policy and Clinical Practice in the Geisel School of Medicine at Dartmouth College)
Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)
Lauran Hardin, MSN, FAAN (Senior Advisor, Partnership and Technical Assistance, National Center for Complex Health and Social Needs, Camden Coalition of Healthcare Providers)
Joshua M. Liao, MD, MSc (Associate Professor, Medicine and Director, Value and Systems Science Lab, University of Washington School of Medicine)
Terry L. Mills Jr., MD, MMM (Senior Vice President and Chief Medical Officer, CommunityCare)
Kavita K. Patel, MD, MSHS (Nonresident Fellow, The Brookings Institution)
Bruce Steinwald, MBA (President, Bruce Steinwald Consulting)
Jennifer L. Wiler, MD, MBA (Chief Quality Officer Denver Metro, UHealth, and Professor of Emergency Medicine, University of Colorado School of Medicine)

PTAC Members Not in Attendance

Angelo Sinopoli, MD (Executive Vice President and Chief Clinical Officer, Prisma Health)

Centers for Medicare & Medicaid Services (CMS) Guest Speaker

Elizabeth (Liz) Fowler, JD, PhD (Deputy CMS Administrator, and Center for Medicare and Medicaid Innovation [CMMI] Director)

Office of the Assistant Secretary for Planning and Evaluation (ASPE) Staff

Lisa Shats, PTAC Designated Federal Officer
Audrey McDowell
Steve Sheingold, PhD

***Via Webex Webinar unless otherwise noted**

List of Speakers, Public Commenters, and Handouts

- 1. Presentation: Care Coordination Components in Proposals Submitted to PTAC and Other Highlights from the Environmental Scan**

Terry L. Mills Jr., MD, MMM, Preliminary Comments Development Team (PCDT) Lead

Handouts

- Agenda
- PCDT Presentation
- Care Coordination Environmental Scan
- RFI (Request for Input)

2. Panel Discussion on Care Coordination with Subject Matter Experts (SMEs)

Sara Barry, MPH, OneCare Vermont (Cross-Sector Perspective)

Linda Elam, PhD, MPH, Manatt Health (Payer Perspective – Commercial and/or Public)

William E. Golden, MD, MACP, University of Arkansas for Medical Sciences (Payer Perspective – Commercial and/or Public)

Laura Gottlieb, MD, MPH, University of California, San Francisco (Social Determinants of Health Perspective)

Sachin H. Jain, MD, MBA, SCAN Group and Health Plan (Payer Perspective – Commercial and/or Public)

Robin P. Newhouse, PhD, RN, NEA-BC, FAAN, Indiana University School of Nursing (Academic Research Perspective)

Catherine Olexa-Meadors, Aledade, Inc. (Provider Perspective)

Sandra Wilkniss, PhD, Families USA (Patient Advocacy Perspective)

Handouts

- Care Coordination SME Biographies & Discussion Guides

3. Panel Discussion on Care Coordination and Physician-Focused Payment Models (PFPMs) with Several Previous PTAC Proposal Submitters

Christina Borden, The National Committee for Quality Assurance (NCQA) – (*The "Medical Neighborhood" Advanced Alternative Payment Model [AAPM] ACP-NCQA proposal*)

Shari M. Erickson, MPH, American College of Physicians (ACP), The National Committee for Quality Assurance (NCQA) – (*The "Medical Neighborhood" Advanced Alternative Payment Model [AAPM] ACP-NCQA proposal*)

Kate Freeman, MPH, American Academy of Family Physicians (AAFP) – (*Advanced Primary Care: A Foundation Alternative Payment Model [APC-APM] for Delivering Patient-Centered, Longitudinal, and Coordinated Care proposal*)

Kendall Hagood, RDN, Contessa Health, MD, Dip. NB, FACP, CPE, Marshfield Clinic Health System (Personalized Recovery Care, LLC) – (*Home Hospitalization: An Alternative Model for Delivering Acute Care in the Home [HH-APM] proposal*)

Narayana S. Murali, MD, Dip. NB, FACP, CPE, Marshfield Clinic Health System (Personalized Recovery Care, LLC) – (*Home Hospitalization: An Alternative Model for Delivering Acute Care in the Home [HH-APM] proposal*)

Susan Nedza, MD, MBA, SMN Health Policy Insights – (*American College of Emergency Physicians [ACEP] Acute Unscheduled Care Model [AUCM]: Enhancing Appropriate Admissions proposal*)

Joe Rotella, MD, MBA, HMDC, FAAHPM, American Academy of Hospice and Palliative Medicine (AAHPM) (*Patient and Caregiver Support for Serious Illness [PACSSI] proposal*)

Handouts

- Care Coordination Previous Submitter Biographies & Discussion Guides

[NOTE: A transcript of all statements made by PTAC members and public commenters at this meeting is available on the ASPE PTAC website located at: <https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>].

The ASPE PTAC website also includes copies of the presentation slides and a video recording of the June 10 PTAC public meeting.

Welcome and Care Coordination Session Overview

Jeffrey Baillet, PTAC Chair, welcomed members of the public to the June 10 virtual public meeting, and indicated that it would focus on optimizing care coordination in the context of Alternative Payment Models (APMs) and PFPs. He also announced that the Committee's next theme-based discussion would examine how efforts to address social determinants of health (SDOH) and equity can be optimized in the context of APMs and PFPs. Next, Chair Baillet introduced Elizabeth (Liz) Fowler, Centers for Medicare & Medicaid Services (CMS) Deputy Administrator and Center for Medicare and Medicaid Innovation (CMMI) Director.

Dr. Fowler thanked Chair Baillet and the Committee members for their ongoing work throughout the public health emergency (PHE). Dr. Fowler discussed the importance of CMS' role in setting a direction for value-based care, and noted that CMMI has been conducting a strategic review based on the past 10 years of lessons learned in order to develop a shared vision for moving forward. She indicated that this review has helped to identify several priorities, including the importance of developing a patient-centered health care system, which involves delivering care in the least restrictive and most accessible settings possible, including home, community, and virtual settings.

Dr. Fowler also discussed the importance of delivering high-quality care that is seamlessly coordinated across settings and providers. She described a vision in which every Medicare and Medicaid beneficiary would be in a care relationship that includes meaningful accountability for quality and total cost of care, and alignment with patients' goals and values. She also discussed the importance of holistically addressing patient needs, including behavioral health and SDOH.

Additionally, Dr. Fowler discussed the importance of bringing high-quality value-based care to every community; advancing a continuum of total cost of care models; addressing issues related to prescription drug pricing; achieving alignment across payers and stakeholder groups; and developing targeted initiatives to address underserved populations. She emphasized the importance of ensuring that payment models are focused on improving health and equitable outcomes, and noted that advancing health equity is one of the Department's priorities. Dr. Fowler also indicated that making progress in advancing health equity will require stakeholders working together, including policymakers such as federal, state, and local government; tribal organizations; health care providers; families; individuals; and other stakeholders.

Dr. Fowler highlighted PTAC's value in identifying strategies and solutions for achieving value-based care, including the Committee's thoughtful and rigorous review of PFP proposals and the Committee's recent roundtable discussions related to telehealth. Dr. Fowler concluded her remarks by indicating that she welcomes PTAC's input on issues related to addressing health equity as the Department continues to develop payment and service delivery models. In particular, she highlighted challenges related to adopting common definitions; the lack of uniformity in data collection, measurement, and analysis as an added barrier to data-sharing; and the role of payment design.

Chair Bailet thanked Dr. Fowler for her remarks. He also thanked support staff, family members, caregivers, and PTAC stakeholders for their work supporting patients during the COVID-19 pandemic.

Chair Bailet noted that common themes have emerged across multiple proposals submitted to PTAC from a variety of stakeholders. During the previous two public meetings, the Committee explored the theme of telehealth in the context of APMs, resulting in a [report to the Secretary](#). During this public meeting, the Committee plans to examine the role that care coordination can play in optimizing health care delivery and value-based transformation in the context of APMs and PFPMs.

Chair Bailet also provided additional updates on the Committee's work since the December 2020 public meeting. In April, the Committee released updated [Proposal Submission Instructions](#) with the goal of making it easier for stakeholders to submit proposals. The Committee developed a two-track proposal review process to provide additional flexibility for stakeholders who have important care delivery, payment, or policy issues to raise but may have varying degrees of resources available to develop their proposed models.

The Committee released the [Common Alternative Payment Model \(APM\) Approaches: Reference Guide](#) as a resource for stakeholders who would like to explore potential payment methodologies that may be appropriate for their care delivery model. Chair Bailet noted that PTAC accepts proposals on a rolling basis, and indicated that while the Committee does not currently have any proposals to review, the Committee remains ready to accept proposals and engage with stakeholders.

Chair Bailet gave an overview of the day's agenda, including a presentation by the care coordination Preliminary Comments Development Team (PCDT), a panel discussion with subject matter experts (SMEs) on care coordination, a panel discussion of previous PTAC proposal submitters (whose proposed models included care coordination components), a public comment period, and Committee discussion to inform comments that will be included in the report to the Secretary. Chair Bailet emphasized that the previous submitter panel is not a re-deliberation of the submitters' proposals, but an opportunity to learn from the previous submitters about the relationship between care coordination and APMs.

Chair Bailet invited Committee members to introduce themselves and their experience related to care coordination. After introductions, Chair Bailet introduced Terry (Lee) Mills, the care coordination PCDT lead who presented the PCDT's findings from an [environmental scan on care coordination and APMs](#).

Presentation: Care Coordination Components in Proposals Submitted to PTAC and Other Highlights from the Environmental Scan

Dr. Mills indicated that the other two members of the PCDT were Lauran Hardin and Angelo Sinopoli. Referencing a slide presentation, Dr. Mills provided an overview of care coordination components included in proposals submitted to PTAC. Between 2016 and 2020, PTAC reviewed 35 proposed PFPMs and deliberated on the extent to which 28 of those proposed models met the Secretary's 10 regulatory Criteria. Criterion 7, "Integration and Care Coordination," assesses the extent to which the proposed model encourages care coordination among practitioners and across settings. Of the 28 proposed models deliberated on by PTAC, the Committee found that 16 proposals "Met" Criterion 7 (including one proposal that PTAC found "Meets and Deserves Priority Consideration" for Criterion 7, and 15 proposals that PTAC found "Meet" Criterion 7); 10 proposed models "Did Not Meet" Criterion 7; and two proposed models were found to be "Not Applicable" for Criterion 7.

Dr. Mills noted that while there is no consensus definition of care coordination, the PCDT used the Agency for Healthcare Research and Quality's (AHRQ's) definition as a starting point. He discussed the contexts in which care coordination can occur, including care coordination for population health, for specific populations, and around acute events. Dr. Mills noted that AHRQ has identified key functional domains of activities related to care coordination. The PCDT identified several activities that are particularly important for optimizing care coordination in the context of APMs. Dr. Mills noted that PTAC is particularly focused on payment model-based strategies for improving clinical aspects of care coordination.

Dr. Mills provided an overview of the care coordination components of proposals that have been submitted to PTAC. The 16 proposals that were found to have "Met" Criterion 7 varied by clinical focus, setting of care, and care coordination context. He summarized several key findings from the environmental scan regarding the analysis of the PTAC proposals:

- Most of the proposals addressed at least one care coordination function.
- Common care coordination functions across the proposed models included establishing accountability and responsibility; facilitating transitions and coordinating across care settings; communication; and assessing patient needs and goals.
- Common strengths that PTAC identified in its review of proposed models included clear processes for care coordination, explicit data-sharing mechanisms, and patient engagement, among others.
- Common gaps in care coordination that PTAC identified included unclear requirements, lack of accountability, lack of interoperability of electronic health records (EHRs), and lack of guidance or mechanisms for data- or information-sharing, among others.

Dr. Mills also discussed several additional findings from the care coordination environmental scan:

- There have been a number of recent initiatives focused on payments for care coordination in Medicare, Medicaid, and private health plans.
- Measuring the effectiveness of care coordination is challenging due to variation in how care coordination is documented and difficulties isolating the impacts of care coordination. Many measures aimed at capturing the effectiveness of care coordination focus on outcomes to avoid (i.e. hospitalizations and readmissions) rather than outcomes to be achieved.
- There is a difference between assumptions in the current payment models about patients who are likely to benefit from care coordination and the available evidence on the effects of care coordination on costs and utilization.
- Care coordination helped to mitigate some of the challenges associated with the COVID-19 PHE by facilitating communication between providers and patients and removing barriers to access (e.g., transportation). However, the PHE has also exposed disparities in access to coordinated care for patients for whom engaging in health care was made more difficult by competing priorities, especially in low income and rural communities.
- A shortage of behavioral health providers presents a challenge for coordinating physical and mental health care. Some payment models, including the Comprehensive Primary Care Plus (CPC+), Pioneer Accountable Care Organizations (ACOs), and the Financial Alignment Initiative, support incorporating behavioral health services. Additionally, PTAC received a proposed model from the American Association of Family Physicians (AAFP) that highly emphasized behavioral health services and integration.
- There are a number of areas for further research on the role of care coordination in APMs and PFPMs.

Dr. Mills indicated that additional information is available in the appendix of the PCDT presentation. Committee members discussed their takeaways from the PCDT presentation, as follows:

- Ms. Hardin noted that there is an opportunity to take lessons learned from the PHE about cross-sector collaboration and to apply them to future payment and care delivery models.
- In response to a question from Jay Feldstein about the role of technology in care coordination, Dr. Mills noted that timely communication among care team members is a necessary, but not sufficient, first step toward coordinated care.
- Ms. Hardin noted that a benefit of the recent proliferation of telehealth is that there have been fewer missed behavioral health visits because of easier access. She commented that there has been growth in technology companies that facilitate care coordination by connecting communities with resources to address SDOH.
- In response to a question from Bruce Steinwald about the role of care navigators, Ms. Hardin noted that care navigators provide crucial longitudinal and cross-sector care management, but evidence-based research on care navigators is limited. She emphasized that care navigators should be able to provide services regardless of payer source, hospital system, or community-based organization. Ms. Hardin noted that palliative care and hospice care providers navigate care regardless of setting, but many patients with multiple chronic conditions could benefit from a longitudinal holistic approach to care coordination.
- Dr. Mills commented on the importance of establishing accountability and clear communication procedures, which care navigators can help manage throughout a patient's relationship with their care team. He noted that the need for care navigators may not be necessary as the system moves toward emphasizing longitudinal, patient-centered relationships.
- In response to a question from Joshua Liao on the most and least positive evidence around care coordination, Dr. Mills commented that most evidence of effective care coordination is in the context of high-cost disease-based initiatives. He noted that there is less evidence of effectiveness for primary care-based care coordination. Ms. Hardin added that there is insufficient evidence about what patients and families define as valuable.
- Paul Casale, PTAC Vice Chair, noted that stakeholders often focus on the monetary return on investment of care coordination activities, but that measuring value to patients is equally, if not more, important. Dr. Casale emphasized that care coordination does not occur organically and requires investment.
- Ms. Hardin emphasized the importance of considering not only cost and utilization metrics when calculating value, but also patient, family, and provider satisfaction, as well as measures of equity.

Panel Discussion on Care Coordination with Subject Matter Experts

Chair Bailet moderated the panel discussion of SMEs representing the following perspectives on care coordination: cross-sector; payer; SDOH; academic research; provider; and patient advocacy. He invited each of the participating panelists to introduce themselves, noting that full biographies of each panelist can be found on the [ASPE PTAC website](#):

- Sara Barry, MPH, Chief Operation Officer, OneCare Vermont (Cross-Sector Perspective)
- Linda Elam, PhD, MPH, Manatt Health (Payer Perspective – Commercial and/or Public)
- William E. Golden, MD, MACP, University of Arkansas for Medical Sciences (Payer Perspective – Commercial and/or Public)
- Laura Gottlieb, MD, MPH, University of California, San Francisco (Social Determinants of Health Perspective)

- Sachin H. Jain, MD, MBA, SCAN Group and Health Plan (Payer Perspective – Commercial and/or Public)
- Robin P. Newhouse, PhD, RN, NEA-BC, FAAN, Indiana University School of Nursing (Academic Research Perspective)
- Catherine Olexa-Meadors, Aledade, Inc. (Provider Perspective)
- Sandra Wilkniss, PhD, Families USA (Patient Advocacy Perspective)

The panelists were asked to share their perspectives on the role and objectives of care coordination in the context of value-based payments; unique challenges and lessons learned regarding how care coordination affected access to services during the PHE; opportunities and best practices for implementing and evaluating care coordination activities; and challenges, as well as technical, clinical practice, or financial limitations or barriers. The following are highlights of some of the key themes that were discussed by each panelist.

- Sachin Jain emphasized the importance of proactively identifying patients who may need care coordination in advance and developing strong relationships with these patients in anticipation of patients’ future acute care needs.

Dr. Jain noted that during the recent COVID-19 PHE, there was increased utilization of programs developed to address the increase in loneliness and social isolation, including outreach by staff advocates to patients who were identified as being high-risk for social isolation; a new Togetherness Program which is a peer-to-peer health care system navigation program; and a program to assist patients using technology to access health care.

Dr. Jain posited a question around who is the right care coordination workforce and observed that the least experienced staff members are often working with the most complex patients in an effort to lower costs of providing care coordination. He observed that as a result, the workforce can be underqualified for the care coordination work assigned to them.

- Robin Newhouse discussed the role of care coordination in understanding the needs and goals of patients to improve outcomes that are patient-centered and important to the patient and to avoid the misallocation of resources.

Dr. Newhouse then emphasized the importance of implementation and how to help systems implement evidence-based care. She recommended providing toolkits for intervention that highlight essential parts that can be adapted to practice settings; ensuring essential components for care coordination are adaptable to different systems; implementing different strategies for patient engagement; and incorporating expert recommendations (e.g., Patient-Centered Outcomes Research Institute [PCORI]).

Finally, Dr. Newhouse recommended leveraging the nurse workforce to connect patients back to their care team, noting that advanced practice nurses are able to provide care, but the baccalaureate nurses are not often utilized for this purpose. She noted that baccalaureate nurses are ready, they know the community, and they could have their own care coordination models.

- Linda Elam added that care coordination should begin with the patient and what they desire. Dr. Elam emphasized looking through the “whole person lens” to ensure the patient has access to supports such as housing, food, and other elements to help them achieve optimal health. While

health information technology (HIT) and calculating the appropriate reimbursement for care coordination activities are important, Dr. Elam noted that neither is sufficient to drive successful care coordination by itself. She noted that care coordination connections need to be intentionally created and maintained, and that there needs to be a personal touch for effective care.

While discussing the importance of telehealth during the PHE, Dr. Elam highlighted that it has the potential to further exacerbate disparities in the system. For example, disparities in providers' ability to engage in telehealth activities can have a downstream impact on the populations served.

- Catherine Olexa-Meadors discussed the need for a common framework around how care coordination should work, and indicated that primary care providers (PCPs) can provide an anchor where care coordination activities can be focused. Ms. Olexa-Meadors also indicated that it is important to understand which care coordination functions primary care practices can provide on their own, and how to ensure they have the necessary resources to effectively coordinate care. Ms. Olexa-Meadors also indicated that it is important to understand what additional services PCPs need to facilitate in order to support patients, such as the more complex care management that the standard primary care practice isn't positioned to deliver. She also posited the following questions: who owns the care coordinator or care navigator role and relationship, which patients need that support, and for how long will each patient need care coordination?

Ms. Olexa-Meadors noted that access to better data, can help providers understand who needs care coordination and for how long. Without data, providers may apply broad care coordination interventions that are less effective. She added that it is important to consider how to set up PCPs for successful care coordination, including payments for care coordination and associated services, and incentives to make changes.

While discussing the PHE, Ms. Olexa-Meadors noted the fragility of the financial situation of primary care practices. Her organization, Aledade, assisted PCPs that were struggling financially and had no means of identifying which patients needed help in their community by giving them access to a telehealth platform and using data to conduct outreach to high-risk individuals. For example, Aledade launched a Stay Well at Home initiative, which enabled PCPs to screen their patients for unmet social needs via the telephone during the PHE. Ms. Olexa-Meadors also emphasized the importance of transitioning PCPs from being dependent on fee-for-service (FFS) payments to APMs.

For care coordination to assist with provider burnout, rather than further exacerbating the issue, Ms. Olexa-Meadors stated that providers need resources (i.e., funding) in place and not too many requirements. She added that practices need to be in financial alignment in order to make sure care coordination takes tasks off of a provider's plate and is part of a support system for the provider.

Ms. Olexa-Meadors noted that her organization works with systems to focus on the funding streams and then determines how the system can work backward from that in order to implement care changes. She recommended that practices take on financial risk in partnerships to help manage downside risk and focus on implementing care coordination and the associated

outcomes. Finally, Ms. Olexa-Meadors suggested aiming toward a higher reimbursement structure for care coordination services to enable providers to address patient needs with care coordinators who have the right level of licensure. By comparison, she indicated that the current Chronic Care Management [CCM] code and Transitional Care Management [TCM] codes have relatively low reimbursement per event.

- William Golden discussed the role that changing the way that providers are reimbursed can have on encouraging a shift toward a more patient-centered approach in which providers focus more broadly on managing panels or the patient's journey, as opposed to focusing on individual visits or care events. He noted that when Arkansas Medicaid launched its episodes of care model in 2012 and its patient-centered medical home model, care moved away from being office visit-oriented, care coordination increased, and changes in the culture of primary care practices made room for a discussion on the types of services needed to manage a panel.

Dr. Golden highlighted how per beneficiary per month (PBPM) payments have helped Medicaid practices keep their doors open during the pandemic and have helped practices be less reliant on patient visits. In response to a question about provider burnout, Dr. Golden noted that Arkansas Medicaid has invested money in data feeds to practices and has worked with health information exchanges (HIEs) to facilitate peer-to-peer learning between providers.

Dr. Golden highlighted an example of redesigned rural practice care teams in Arkansas (PBPMs, 24/7 live voice access, removal of answering machines, standards for patient care notes) and the resulting transformation from a focus on office-based visits and the improved ability to recruit staff for practices. He also discussed the need to update some performance measurement tools (such as the Consumer Assessment of Healthcare Providers and Systems [CAHPS] survey) to include metrics related to care coordination and SDOH.

Dr. Golden stressed the challenge of EHR interoperability, and how the incorporation of EHR into useful data flows should be a top priority. Finally, Dr. Golden expressed concern over an overreliance on financial risk in primary care models, particularly for small practices, due to concerns about the ability to control for biologic variations of small populations. He suggested that rewarding better activities and approaches to care delivery could be more effective in improving care delivery, which may not require putting small practices at financial risk.

Sandra Wilkniss recommended meeting the needs of the patient as holistically as possible and prioritizing each patient's goals through shared decision-making. Dr. Wilkniss noted that the majority of health outcomes hinge on cross-sector care, and SDOH should be considered for care coordination. She added that if the aim of care coordination is to improve a patient's quality of life, then there is a strong case to move from FFS to APMs to allow for more flexibility across different provider types.

Dr. Wilkniss noted that along with social isolation, there has been a major increase in substance use among young people and that this should be a major focus of care coordination. She added that COVID-19 testing and vaccine distribution have highlighted ongoing disparities, and while data are still being collected, there are some needs that are readily apparent and could be addressed now. Finally, Dr. Wilkniss discussed challenges related to care coordination, including that the focus of care coordination may shift depending upon lifespan or levels of acuity, and

that there are often multiple care coordinators (e.g., housing, clinical) for each patient who need to work together.

- Laura Gottlieb explained that the National Academy of Medicine helped frame interventions for care coordination by categorizing care coordination activities. She noted that providers need to know their patients' needs by gaining consensus around screenings, and they can use social risk data to improve the care that is provided (e.g., ensuring that patients have access to broadband for telehealth services).

Dr. Gottlieb explained that care coordination is a tool to bridge health, medical, and social services, but that there is a lot of work that still needs to be done to bridge these three fields. She discussed the need for shared data governance, technology, and ethical guardrails to effectively accomplish this objective.

Dr. Gottlieb highlighted the enormous innovation that has occurred in response to the PHE, including health systems and social service systems working together; changes in prevalence of screening and an increase in what providers are screening for (e.g., broadband access and SDOH); changes in what providers were willing to assist with (e.g., meals and temporary housing); wider adoption of telehealth; and the creation of smart phone loaner programs or other programs to increase broadband access for patients.

Dr. Gottlieb also highlighted the need to strengthen new programs to make them sustainable. She noted potential ethical concerns associated with these new changes. For example, she discussed the need for ethical guardrails for sharing data, including whether or not data are shared, whether data can be changed, and whether a patient can say no to sharing data. In response to a question about increases in provider burnout during the PHE, Dr. Gottlieb discussed the correlation between the capacity of an organization to identify and address a patient's social needs and provider burnout. She noted that it is important to give providers the ability to provide person-centered care, while also ensuring that SDOH interventions do not fall to the providers but are instead done by staff who are more familiar with the community's resources.

Dr. Gottlieb noted that it is important to determine which social, medical, and behavioral interventions are most effective for each patient population. Measure development is important, and Dr. Gottlieb explained that model developers need to talk clinicians through structural measures (e.g., workforce and technology), process measures (e.g., how much do you use this system), and then impact and outcome measures.

- Sara Barry discussed care coordination from a systems perspective, noting that ACOs (like OneCare Vermont) support health care providers at the systems level to align expectations across provider types through the lens of population health management. She described how through this work, her organization learned that different provider types use different vocabulary, so they created a shared care planning tool that is person-centered and is accessible to all provider types.

Ms. Barry noted the importance of ensuring that the broader care team has funding and resources to help support care coordination. She discussed the challenge of balancing short-term and upstream investments in health and wellness and noted that an issue with upstream

investments is that they do not show dollars saved but that they are critical to changing health care.

Ms. Barry noted that during the PHE, OneCare Vermont was able to take advantage of health IT and innovation to use algorithms to identify patient panels for health and safety check-ins. She described common issues during the PHE as including social isolation, issues with pharmacy refills, housing, transportation, and broadband issues. In order to address social isolation, she recommended investments in broadband, transportation, and housing to increase the satisfaction of patients and health care providers. Ms. Barry noted how her organization leveraged flexibility for audio-only calls and telehealth; developed virtual community care team models to check in on patients; bought tablets and created a lending library; offered telehealth training for patients; and is now focusing on sustaining these changes in the long term.

Panel Discussion on Care Coordination and PFPMs with Several Previous PTAC Proposal Submitters

Vice Chair Casale moderated the panel discussion with previous proposal submitters. He noted that care coordination emerged as a theme in PTAC's review of proposals that were submitted to PTAC, with most proposals including at least one care coordination component, in part because "Integration and Care Coordination" is one of the Secretary's 10 regulatory Criteria for reviewing PFPMs. He invited the previous submitters to share their insights about care coordination and noted that this discussion does not represent a re-deliberation of their proposals. Vice Chair Casale indicated that the information gleaned from NORC's review and this discussion is expected to inform PTAC's review of future proposals and its recommendations and comments to the Secretary on PFPMs, particularly related to care coordination and APMs. He then introduced the participating panelists, noting that full biographies of each panelist can be found on the [ASPE PTAC website](#):

- Shari M. Erickson, MPH, American College of Physicians (ACP) and Christina Borden, The National Committee for Quality Assurance (NCQA) – (*The "Medical Neighborhood" Advanced Alternative Payment Model [AAPM] ACP-NCQA proposal*)
- Kate Freeman, MPH, American Academy of Family Physicians (AAFP) – (*Advanced Primary Care: A Foundation Alternative Payment Model [APC-APM] for Delivering Patient-Centered, Longitudinal, and Coordinated Care proposal*)
- Kendall Hagood, RDN, Contessa Health and Narayana S. Murali, MD, Dip. NB, FACP, CPE, Marshfield Clinic Health System (Personalized Recovery Care, LLC) – (*Home Hospitalization: An Alternative Model for Delivering Acute Care in the Home [HH-APM] proposal*)
- Susan Nedza, MD, MBA, SMN Health Policy Insights – (*American College of Emergency Physicians [ACEP] Acute Unscheduled Care Model [AUCM]: Enhancing Appropriate Admissions proposal*)
- Joe Rotella, MD, MBA, HMDC, FAAHPM, American Academy of Hospice and Palliative Medicine (AAHPM) (*Patient and Caregiver Support for Serious Illness [PACSSI] proposal*)

The panelists were asked to describe how care coordination was incorporated into their respective proposed PFPMs; the role and aims of care coordination in the context of value-based care and APMs and PFPMs; how to optimize care delivery through care coordination in APMs and PFPMs; emerging lessons from their recent experience delivering health care under the PHE; any challenges or unanswered questions that need to be addressed to better incorporate care coordination in APMs and PFPMs; and any additional critical insights they would like to share with regard to care coordination and APMs and PFPMs. The following are highlights of some of the key themes discussed by each panelist.

- Joe Rotella explained that the *Patient and Caregiver Support for Serious Illness (PACSSI)* proposal includes a comprehensive assessment of patients' needs, goals, and preferences that help to inform the care plan. The proposal includes an interdisciplinary palliative care team with physicians, nurses, social workers, nurse practitioners, counselors, and other team members. He noted that care coordination is a foundational element of palliative care, and patient care plans are updated whenever there is a change in patients' circumstances. This proposed model offers care coordination that goes beyond patients' medical needs by offering a holistic, person-centered approach that also addresses their psychological, social, spiritual, cultural, financial and practical needs/concerns.

Dr. Rotella emphasized the need for the seriously ill patient and their family to be partners in a patient's care plan to ensure that the treatments they receive are meeting their goals. He emphasized that comprehensive assessments support equitable care, and equity cannot be achieved without prioritizing patients' goals and developing a care plan based on an individual's goals and needs.

Dr. Rotella noted that the pandemic increased levels of grief and depression and added limitations to family visits, but new telehealth flexibilities during the pandemic made a difference for patients who had previously experienced difficulty accessing care but can now receive regular care via telehealth. Dr. Rotella emphasized the importance of ensuring equal access to telehealth to address urgent issues for those who struggle with or lack transportation.

Dr. Rotella expressed a belief that there is a gap in quality measures, especially for seriously ill patients, noting that most current quality measures are process measures that can lead to a "checked box" approach. He recommended moving toward outcome and utilization measures, or measures of patient experience of care. As an example, Dr. Rotella explained that key outcomes could include preventable hospitalizations, and timely and appropriate use of hospice care. He observed that care coordination requires upfront investments.

Dr. Rotella described the challenge of comparing an APM to a traditional FFS model that is more limited in the services it provides, noting that palliative care is not adequately paid for under FFS. He explained that such under-payment sets a high bar for the APM to both show value and achieve cost neutrality or savings. He added that CMMI should be testing two or three palliative care models simultaneously.

- Shari M. Erickson noted that the proposed *The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM)* model emphasizes the collaborative relationship between primary care and specialty care practices to ensure effective care coordination.. The proposed model includes specialty referrals where appropriate; pre-screening for referral requirements and required documentation to ensure appropriate steps for the patient; care planning with patients and the referring primary care practice; and a formal agreement between the specialty and PCPs.

Ms. Erickson noted that FFS can lead to problems for practices and exacerbate disparities. She explained that by offering payments for providers to deliver care to all patients and standards for specialty practices, the proposed model will help improve access. She added that a critical component of the proposed model is the care coordination use agreement which lays the groundwork for how information is shared over time.

Ms. Erickson noted that telehealth was critical during the PHE, especially audio-only telehealth that helped provide care to the Medicare population who faced challenges accessing video conferencing. She noted that telehealth can increase availability so that those most in need can get access to in-person visits that are needed. She emphasized the importance of all-payer models, noting that more models need to incorporate both Medicare and Medicaid to address the needs of the broader population. Ms. Erickson stressed the need to evolve better risk adjustments (e.g., building in hierarchical condition category [HCC] coding or layering onto it) to assess the risk of patient populations and account for social drivers of health.

Ms. Erickson emphasized the importance of using robust quality and utilization measures, adding that certain measures are more applicable for some patient populations than others. She added that there should be more on-ramps for practices to move from FFS to APMs. She noted that the structure of a model can be more aligned with value pathways to get providers to a place where they can take on the risk of APMs. She also noted that patients delayed care during the PHE, so it is important to ensure care coordination in the short term to have care available to them.

Ms. Erickson stressed the importance of deliberately organizing patient care by incorporating patient needs and preferences upfront and throughout care coordination. She explained that to accomplish this, there need to be more opportunities for practices to invest in care coordination; more investments in APMs and performance measures; more on- and off-ramps and stability for models; and more research into how models can be better enabled to reduce health inequity.

- Christina Borden discussed how relevant standards (e.g., expanding access and same-day appointments; electronic access to patient information; standardized process for closed-loop referral, tracking, and coordinating care across settings; team-based approaches; identifying and coordinating patient populations; and planning and managing care that includes medication management) developed in the proposed *The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM)* model help to facilitate the coordination of primary and specialty care. She noted that both large and small practices have achieved success in this proposed model.

Ms. Borden noted that care coordination can address social risks, but that there need to be improvements in collecting and analyzing patient data to better capture social needs and connect patients to community resources. Ms. Borden added that access to data is important (including data liquidity [i.e., can the data securely flow through the health care system?]) and data-sharing across all settings) and emphasized giving data access to patients, families, and caregivers. She recommended reviewing utilization measures, ensuring that outcomes are the main focus, and that care is adapted to the patient and their needs (including cultural, language, and diversity).

- Kate Freeman described the evolution of the proposed Advanced Primary Care: A Foundation Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal and Coordinated Care model. She noted that the proposed model allows practices to deliver innovative care to the right patient at the right time; decreases the administrative and reporting burden (in comparison to CPC+); provides technical assistance in addition to payments to ensure practices understand how to best use these payments to support their patient populations; and provides a foundation to move from FFS to deliver quality care and reduce costs.

Ms. Freeman noted that one of the biggest barriers to effective care coordination is that there are not widely available cost and care data for providers to effectively manage care in risk-based models. She added that a critical piece of care coordination is how to help PCPs make the best decisions for their patients' care.

Ms. Freeman noted that primary care suffered at the beginning of the PHE, adding that providers with prospective payments fared better during the PHE and were better able to adapt to telehealth. However, she added that telehealth exacerbated disparities in care. Ms. Freeman noted that continuing to test payment and delivery system models in the same regions limits innovation in new places and creates inequities. She proposed risk adjustment based on social needs to provide resources to practices serving vulnerable populations.

Ms. Freeman explained that care coordination needs to be foundational in primary care. She discussed the need to evaluate and consider the level of risk that practices can take on in risk-based APMs, so that small practices are not overly burdened with risk. One challenge to the evaluation of models, she noted, is that it is challenging to effectively evaluate when there is model overlap. Ms. Freeman concluded that if such evaluation challenges remain unaddressed, we cannot create an equitable system overall.

Ms. Freeman indicated that FFS payments chronically undervalue primary care and agreed with Dr. Rotella's thoughts that value-based payments are required to compete against a benchmark that is too low in terms of cost savings. She emphasized that payment reform needs to precede care delivery reform, moving toward payments that better reflect and meet the needs of patient populations and provide upfront investments.

- Narayana Murali described the proposed *Home Hospitalization: An Alternative Model for Delivering Acute Care in the Home (HH-APM)* model, which includes a multidisciplinary team; a care coordinator who is involved in engaging patients when they enter the hospital; and screening criteria to determine whether patients meet skilled nursing facility (SNF) or hospital care criteria. Dr. Murali described how as part of the screening, the care team determines whether patients have home support available; if a patient qualifies, care coordinators manage the medical equipment, telehealth, home care, and other logistics of care. He explained that once a patient is discharged, the care team manages care for a 30-day period. The proposed model ensures continuous feedback to the patients' primary care physicians. Dr. Murali noted that telehealth is key to the proposed model. Additionally, nurses visit the patients' homes, monitor SDOH needs, and can put in any referrals for SDOH needs.

Dr. Murali noted that multidisciplinary care teams use the supports of their network to ensure patient satisfaction and improved safety outcomes. He added that important elements of the proposed model include interoperability in resident health centers, training and logistics of care coordination, and risk-based models that tie incentives to measures. Dr. Murali suggested that roughly two-thirds of payments should be given upfront and the remaining one-third of payments should be tied to outcomes.

Dr. Murali noted that their proposed model was able to rapidly pivot during the PHE and emphasized the need to reimburse audio-only phone calls, given that some of the people served in the model lived in rural areas and did not have broadband access or younger family

members/caregivers that could help them access care. He also emphasized considering equity in terms of race, income, access, and other factors.

Dr. Murali stressed the importance of training care coordinators for meeting both the clinical and social elements of their patients' needs, as well as the logistical pieces of care coordination; risk-based global payments to ensure that all people on the care team are invested in achieving outcomes;; metrics; care planning; clear documentation; and focusing on gaps in care and primary care follow-up.

Finally, Dr. Murali emphasized the value of the Hospitals Without Walls program that CMS implemented in March 2020 in response to the PHE and recommended continuing this program after the pandemic is over. Dr. Murali also noted that if CMS continues to support this program, it will put pressure on other health plans to adopt similar programs, which may ultimately lower costs and decrease utilization by increasing the number of patients able to receive care at home.

- Kendall Hagood added that the proposed *Home Hospitalization: An Alternative Model for Delivering Acute Care in the Home (HH-APM)* model includes a multidisciplinary team that is empowered through telehealth to manage a patient's SDOH needs at the patient home and engages with their PCP to keep the entire care team updated on the patient's health.

Ms. Hagood noted that the proposed model helped facilitate and coordinate appropriate care in health systems during the PHE by offering safe hospital-level care at home for patients when appropriate. This helped to reduce the burden on health systems and decreased the number of people delaying care. She also added that care coordinators need proper training, and metrics should be implemented to hold them accountable for care coordination activities (e.g., advanced care planning, communicating with clinicians based on vital signs, or setting up primary care appointments within seven days of discharge, or 30-day episode post-discharge). Without these measures, Ms. Hagood noted that it is hard to measure and track the effectiveness of care coordination.

- Susan Nedza explained the importance of care coordination in the proposal *American College of Emergency Physicians (ACEP) Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions*, noting that emergency department (ED) physicians must be aware of patients' housing status in order to discuss opportunities to send patients home or to admit them to the hospital. Additionally, Dr. Nedza noted that the proposed model includes incentives and measures for emergency room (ER) doctors who already know how to coordinate care to ensure that patients have adequate care once discharged.

Dr. Nedza added that the most important focus for care coordination in the proposed model is the discharge, stressing that there is often a chasm between an ED discharge and the next provider who is seeing the patient. The proposed model is designed to coordinate the handoff so that the ED becomes an integrated part in the care delivery team and is part of the solution for patients who require unscheduled acute care services. She noted that care coordination allows flexibility in a model that is dependent on the facility and discharge, which she added is often dependent on any social determinants of health that are present in the patient's life. She stressed that there needs to be better information transfer between the ED and primary care offices.

Dr. Nedza noted that emergency care was at the epicenter of the PHE, adding that ED providers would have benefited from connections to other referral areas to fill the gap for patients who needed help. She noted that they did learn that some patients they would not have discharged prior to the PHE were able to receive successful and effective care at home, and this will inform their discharge practices moving forward.

Dr. Nedza emphasized timely access to emergency care, and including emergency care providers as part of the solution and not a problem, noting that most APMs have measures related to avoiding the ED. She believes that current payment models should be expanded to include emergency care providers.

Dr. Nedza discussed the benefits of submitting a proposal to PTAC. She highlighted that because of recommendations from PTAC during the proposal review process, her team worked to incorporate and improve the review of data for patients once they left the emergency room. She suggested that CMS should integrate the lessons learned from these proposals in its adoption of APMs.

Public Comment Period

No public comments were provided.

Committee Discussion

Chair Bailet introduced the Committee discussion portion of the public meeting by noting that Committee members would be discussing what they had learned from the panelists, as well as the background materials presented by the PCDT. He also indicated that the Committee's comments and findings would be synthesized in a report to the Secretary (RTS) on the role that care coordination can play in optimizing value-based transformation in APMs and PFPs. Chair Bailet used a framework of topics to assist Committee members in structuring their conversation.

The Committee discussed promising approaches for optimizing the use of care coordination in value-based care to improve quality and reduce or control costs.

- Vice Chair Casale noted that both SMEs and previous submitters emphasized the role of the care coordinator and the importance of their relationship with the patient.
- Mr. Steinwald recalled Dr. Jain's statement on how care coordination is a function most needed by patients with complex illnesses, but coordinators are often "strangers" who are not well-trained or well-compensated. He noted that the previous submitter panel discussed training care coordinators, but did not address the care coordinator's personal relationship with the patient. He indicated that the Committee members may want to include in the RTS that the function of the primary care doctor is to have a relationship with the patient.
- Ms. Hardin emphasized the importance of relationships to build trust and understanding between patients and their providers. Ms. Hardin emphasized that longitudinal relationships are crucial for effective care coordination. She noted a common theme throughout the day's discussions was that brief periods of care coordination are not very effective.
- Dr. Feldstein noted that selecting a care coordinator is challenging because many patients have multiple complex needs. He reiterated that the level of training and the compensation for care coordinators may need to be increased, as discussed by panelists. Dr. Feldstein raised the issue

of how to provide the resources necessary to get the right person to provide care coordination in the correct setting.

- Jennifer Wiler emphasized that while there are care models that effectively implement care coordination, research on best practices for implementing care coordination is limited.
- Dr. Mills recalled Dr. Jain's comment about how surgeons have transitioned from managing the patient's procedure to managing the patient's journey. He emphasized the importance of managing the patient's entire care journey, including SDOH needs, rather than focusing only on patient visits. Dr. Mills added that the FFS delivery system emphasizes patient visits, which do not further the goals of value-based care.
- Chair Bailet discussed the challenge of tying the care coordinator community to the care team in a way that suits the patient's needs. In some cases, care coordinators may be most effective if they are located in the practice, instead of from the community or connected to the patient's insurance plan. Chair Bailet also discussed the importance of reliable resources for providers to fund care coordination activities. He noted that practices may not devote resources to care coordination programs if future funding is uncertain. He emphasized that in order to fully support care coordination efforts, the services have to be funded long-term.
- Ms. Hardin highlighted some of the care coordination components implemented by SME panel participants, including ensuring cross-continuum, cross-sector care teams; identifying an individual with the strongest relationship to the patient to be the patient's main contact; developing shared plans of care and longitudinal care coordination; and creating a community of care coordinators to share best practices.
- Dr. Liao noted that a potential challenge of coordinating a patient's care journey (rather than a specific episode) is identifying which care team member would be in the best position to coordinate care in a way that affects quality and costs.
- Dr. Mills noted that there are many models of care coordination (i.e., primary care-based, transitioning from acute to post-acute care, condition-specific) that can be applied to patients at the appropriate time and setting.

The Committee discussed challenges related to optimizing the use of care coordination and opportunities for addressing them.

- Chair Bailet discussed the challenges that families face in navigating care coordination services, such as paying for services out of pocket.
- Dr. Wiler noted that data access and interoperability continues to pose a challenge to patient and provider communication. Additionally, Dr. Wiler discussed the role of payment models in incentivizing patients to participate in care coordination activities. She noted that incentives for patient engagement in care coordination could be an opportunity for further exploration.
- Ms. Hardin highlighted the importance of addressing costs incurred by patients and caregivers. She noted that incentives to reduce post-acute care spending often result in those costs being transferred to the patient and their family. Ms. Hardin indicated that there is an opportunity to enhance the role of patients' families in the care coordination of behavioral health and substance use disorder (SUD).
- Dr. Patel noted that care coordination can be particularly challenging in behavioral health when PCPs do not have a strong relationship with their behavioral health care provider counterparts. She discussed how at-risk multispecialty providers are motivated to coordinate care among providers. Dr. Patel suggested that a toolkit for care coordination best practices would be a useful resource.

- Chair Bilet noted that while many PCPs are incorporating behavioral health into their practices, supply and infrastructure limitations are a challenge. He agreed with Dr. Patel that a toolkit or playbook for smaller practices on how to implement care coordination best practices in various contexts would be helpful. Chair Bilet emphasized that behavioral health is a critical component of care coordination.
- Dr. Liao agreed with Dr. Patel and Chair Bilet that a playbook would be a useful resource and added that multiple playbooks may be needed. He discussed how care coordination practices that work for large, multispecialty, integrated health systems may not be appropriate for smaller practices without the same resources and infrastructure.
- Chair Bilet emphasized the importance of highlighting the communities, delivery systems, and practices that have implemented effective care coordination solutions. He noted that technical assistance is not in PTAC's purview, but that the Committee could encourage the development of a care coordination playbook that incorporates best practices from various stakeholder communities.
- Dr. Wiler indicated that the health care community waits for peer-reviewed literature before making changes to its systems. She agreed with Chair Bilet that there are successful care models around the country that are not highlighted because they are outside of traditional research. She discussed the opportunity to connect health services researchers with care model developers to highlight the work being done in the field.
- Ms. Hardin agreed with Dr. Wiler and noted that providers serving underserved populations in many communities are often under-resourced, which can lead them to develop innovative solutions for coordinating care and addressing equity and SDOH. She indicated that the lessons learned in those communities could translate into broader system-wide changes.
- Vice Chair Casale noted that it is challenging to prove the impact of care coordination on costs and outcomes, but that more of a focus on real-world experiences could help supplement the information not captured by peer-reviewed literature.
- Dr. Liao discussed how research is often drawn to where costs and outcomes are easily quantified, often to its own detriment. He agreed with other Committee members that it is important to connect researchers to communities with successful care coordination programs and highlight those best practices.
- Chair Bilet discussed the importance of shared decision-making and patient engagement, which have been shown to be effective in lowering costs, and improving health outcomes and patient experience. He noted that while the care coordinator is instrumental in facilitating shared decision-making, all clinicians play a role in ensuring that patients are informed at various points with potential insights that help the patient to navigate their care.
- Dr. Liao discussed how various stakeholders have different motivations for pursuing care coordination, such as cost savings or a desire to implement evidence-based guidelines.
- Chair Bilet discussed disruption and innovation in the health care delivery market and the importance of considering how payment models can support emerging health care companies. He noted that many of these new companies focus on connecting directly with patients and coordinating care.
- Dr. Feldstein agreed with Chair Bilet that it will be important to understand how emerging companies are approaching care coordination within the commercial context, and their potential effects on Medicare and Medicaid.
- Chair Bilet added that market disruption can drive innovation, but can also have potentially harmful downstream consequences. He gave the example of certain patients potentially being

sorted into certain models in a way that leaves hospital systems at an economic disadvantage and caring for a disproportionate number of challenging patients.

- Ms. Hardin noted that some valuable ideas have emerged from these companies, such as including screening for and addressing SDOH as part of a holistic assessment of patient needs. She also noted that these companies tend to view high utilization as a system failure, and stated that health systems that have already started to change their care delivery approach will be less vulnerable to disruption.

The Committee discussed the role of APMs and PFPMs in care coordination and what types of models might be most effective for incentivizing care coordination.

- Vice Chair Casale stated that shifting focus from patient encounters to patient journeys will incentivize care coordination. Dr. Mills agreed and added that all APMs should include care coordination components.
- Ms. Hardin discussed the promising potential of integrated care coordination across payers.
- Chair Bailet mentioned that Dr. Fowler discussed CMS' and CMMI's multi-payer strategy in model development. He noted that commercial payers are often better positioned to test models in smaller communities. Chair Bailet emphasized the importance of coordinating with commercial payers in future CMS and CMMI models.
- Vice Chair Casale indicated that the majority of proposed models that PTAC found "Met" the "Integration and Care Coordination" Criterion focused on specific populations. He noted that care coordination tends to focus on a clinical condition or specific episode.
- Dr. Liao noted that while many care delivery models focus on the connection between hospital and post-acute care, fewer models focus on the connection between primary and specialty care. He added that improved care coordination between primary and specialty care could have positive impacts on utilization.

The Committee discussed the best practices for measuring the quality and effectiveness of care coordination.

- Vice Chair Casale discussed the importance of including patient-reported outcome measures when measuring the impact of care coordination.
- Carrie Colla noted that it would be helpful to have more studies on patient-reported outcomes and care coordination.
- Chair Bailet reiterated the importance of moving away from measures that focus on outcomes to avoid and toward measures that focus on outcomes to achieve.
- Mr. Steinwald noted that, from his own personal experience, it is challenging to measure the impact of outcomes that are difficult to count, such as avoided ED visits or money saved.
- Ms. Hardin emphasized the importance of including measures of equity.
- Dr. Wiler discussed the importance of process measures, sub-process measures, and patient-reported outcome measures.
- Dr. Mills discussed how measures that are very methodologically precise can be difficult to implement. He suggested that a combination of semi-outcome and process measures may be more effective at capturing the impacts of care coordination.
- Dr. Liao noted that precise measurements are difficult to connect back to a clinician, which makes them less useful in evaluating the impact of care coordination.

The Committee discussed potential areas for additional research around care coordination.

- Dr. Colla discussed the opportunity for research about care coordination across settings, such as comparing the effectiveness of primary care-based care coordinators and hospital-based care transition managers in managing patients being discharged from the hospital.

The Committee discussed potential insights for the Committee’s review of care coordination components in future PFPM proposals.

- Dr. Liao reiterated the need for precision around the transition from primary care to other ambulatory care.
- Dr. Colla added that for specialty models, there should be a plan in place for communicating and coordinating with PCPs.
- Dr. Feldstein discussed the importance of including coordination with behavioral health, regardless of what specialty the proposal is focused on.
- Dr. Mills emphasized the need for care coordination activities that focus on the patient’s needs.
- Dr. Wiler noted that there is an opportunity for proposed models to pursue interspecialty collaboration.

The Committee discussed potential insights for stakeholders as they consider developing proposed models.

- Mr. Steinwald suggested that PTAC could consider revisiting the emphasis placed on the “Integration and Care Coordination” Criterion. Committee members agreed that it may be a good time to revisit the descriptions of how PTAC prioritizes the Secretary’s 10 Criteria and incorporates them into the Committee’s proposal review process.

Closing Remarks

Chair Bailet thanked the Committee members, panelists, ASPE staff, and the public for their contributions to the public meeting. He announced that a RFI on care coordination would be posted on the ASPE PTAC website. Chair Bailet noted that the next public meeting in September would focus on SDOH and equity in the context of APMs.

The public meeting adjourned at 3:55 p.m. EDT.

Approved and certified by:

//Lisa Shats//

8/10/2021

 Lisa Shats, Designated Federal Officer
 Physician-Focused Payment Model Technical
 Advisory Committee

 Date

//Jeffrey Bailet//

8/6/2021

 Jeffrey Bailet, MD, Chair
 Physician-Focused Payment Model Technical
 Advisory Committee

 Date