Preliminary Comments Development Team (PCDT) Presentation:

An Overview of Care Coordination Components in Proposals Submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and Other Highlights from the Care Coordination Environmental Scan

Terry L. Mills Jr., MD, MMM (Lead)
Lauran Hardin, MSN, FAAN
Angelo Sinopoli, MD

June 10, 2021

Introduction

- From 2016 to 2020, PTAC received 35 stakeholder-submitted proposed Physician-Focused Payment Models (PFPMs), and voted and deliberated on the extent to which 28 of these proposed models meet the Secretary's 10 regulatory criteria.
- Criterion 7 (Integration and Care Coordination) is defined as:
  - *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.*
- PTAC found that:
  - One proposed model "Meets and Deserves Priority Consideration" for Criterion 7
  - 15 proposed models "Meets" Criterion 7
  - 10 proposed models "Does Not Meet" Criterion 7
  - 2 proposed models were "Not Applicable" for Criterion

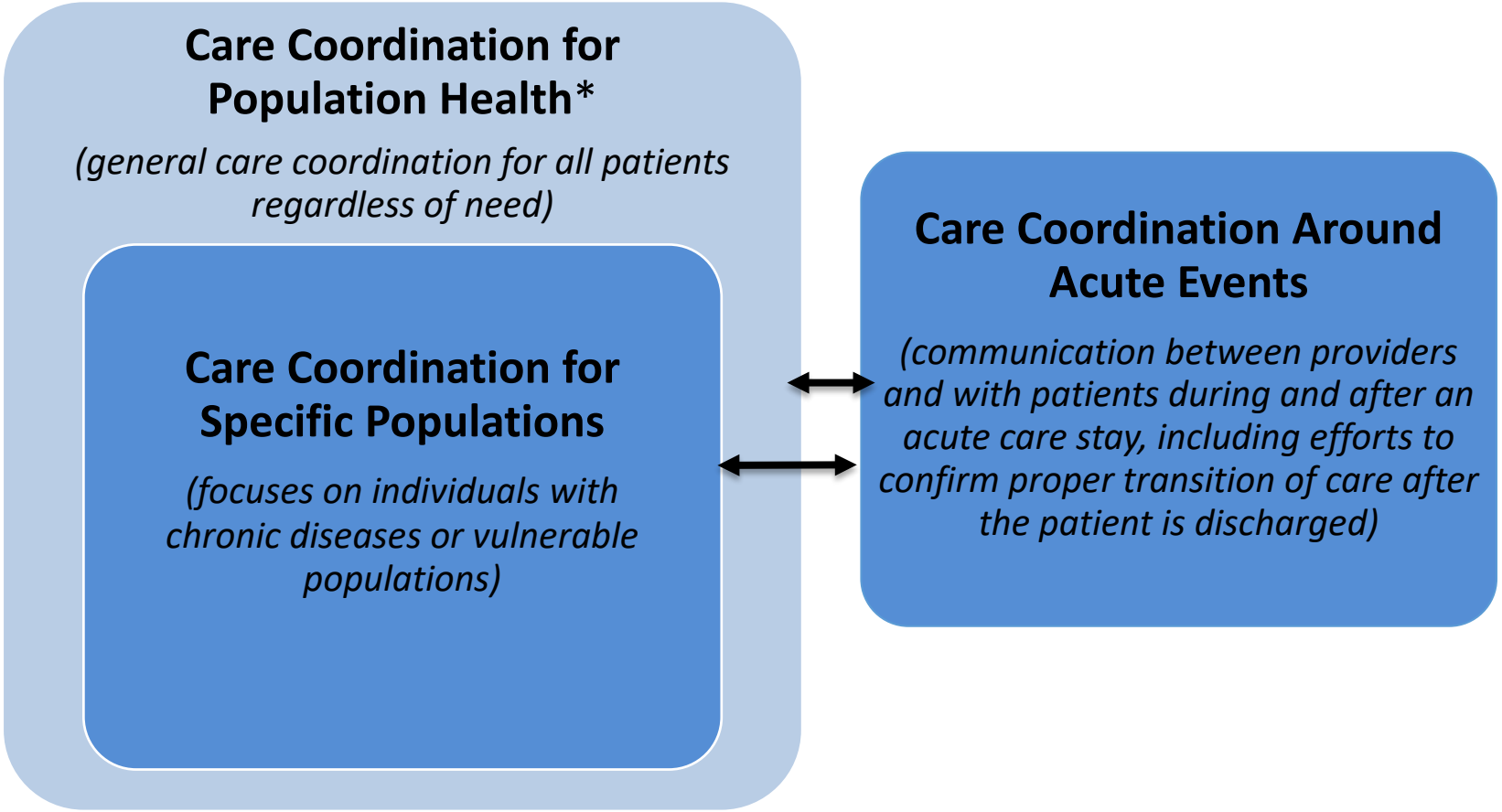
Background: Defining Care Coordination

- There is no consensus on the definition of care coordination.
- PTAC is using the following working definition from the Agency for Healthcare Research and Quality (AHRQ) as a starting point:

> *"Care coordination involves **deliberately organizing patient care activities and sharing information** among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the **patient's needs and preferences are known ahead of time and communicated at the right time to the right people**, and that this information is used **to provide safe, appropriate, and effective care to the patient**."*

Source: Agency for Healthcare Research and Quality. Care Coordination. Accessed May 2020. https://www.ahrq.gov/ncepcr/care/coordination.html

Contexts in Which Care Coordination Can Occur



*Can also include coordination across sectors to address health-related social needs/social determinants of health

Source: Agency for Healthcare Research and Quality. Care Coordination. Accessed May 2020. https://www.ahrq.gov/ncepcr/care/coordination.html

Functional Domains Associated with Care Coordination

- Care coordination can involve a wide range of functions and related activities depending on the needs of individual patients. The following are some key functional domains that have been identified by AHRQ:
  - Establish Accountability or Negotiate Responsibility
  - Communicate
  - Facilitate Transitions
  - Assess Needs and Goals
  - Create a Proactive Plan of Care
  - Monitor, Follow Up, and Respond to Change
  - Support Self-Management Goals
  - Link to Community Resources
  - Align Resources with Patient and Population Needs

Source: Agency for Healthcare Research and Quality. Care Coordination Measures Atlas Update. Published June 2014. http://www.ahrq.gov/ncepcr/care/coordination/atlas/chapter1.html

Key Activities for Optimizing Care Coordination in APMs

- The PCDT identified the following activities as being particularly important for optimizing patient-centered care coordination in the context of Alternative Payment Models (APMs):
  - Use of care coordinators
  - Coordination of treatment and care activities across settings, provider types, and sectors
  - Behavioral health management
  - Timely sharing of necessary information across care providers
  - Documentation of patient needs and preferences
  - Use of shared decision-making, as well as evidence regarding the effectiveness of care, to create a proactive plan of care that structures care to address patient needs and preferences

- While strategies could also involve structural changes (such as financial management and planning across operational units), PTAC is particularly focused on strategies for improving clinical aspects of care coordination in the context of APMs and value-based transformation.

Care Coordination Components in Proposals Submitted to PTAC

Characteristics of PTAC Proposals that were Found to "Meet" Criterion 7 (Integration and Care Coordination)

- Proposals that were found to "Meet" Criterion 7* varied by clinical focus, setting of care, and care coordination context.

Condition / Focus

HEALTH CONDITIONS

Cancer (ASCO, IOBS, HMH/Cota)
ESRD (RPA)
Hepatitis C Virus (NYC DOHMH)
Neurological (UNMHSC)

SERIOUS ILLNESS

C-TAC, AAHPM

OTHER

Cross-Clinical Across Specialties
Freq Hospitalized Pts. (UChicago)
Primary Care / Spec. Coord. (ACP-NCQA)

Clinical Setting

PRIMARY CARE

AAFP

PATIENT HOME

Mount Sinai, PRC

Skilled Nursing Facilities (SNFs)

Avera Health

CARE TRANSITIONS

ACEP, UChicago

RURAL PROVIDERS

UNMHSC

Care Coordination Context

POPULATION-WIDE HEALTH MANAGEMENT

AAFP, ACP-NCQA

SPECIFIC POPULATIONS

AAHPM, ACS, ASCO, Avera, C-TAC, HMH/Cota, IOBS, NYC DOHMH, RPA

RELATED TO AN ACUTE EVENT

ACEP, Mount Sinai, PRC, UChicago

* Includes one proposal (Mt. Sinai) that was found to "Meet and Deserve Priority Consideration" for Criterion 7. The Appendix contains a more detailed analysis.

Common Care Coordination Functions and Activities that were Included in PTAC Proposed Models to Support Care Delivery Objectives

- Most proposals submitted to PTAC addressed at least one care coordination function.
- Common care coordination functions that were emphasized in PTAC proposed models:
  - Establish accountability or negotiate responsibility (for example, through the use of designated interdisciplinary care teams or care coordinators).
  - Facilitate transitions and coordinate care across settings.
  - Communication (for example, supporting communication through electronic health record (EHR) integration; or through specific mechanisms such as notifying providers when patients are admitted to a hospital).
  - Assessing patient needs and goals (for example, documenting patient needs and goals through patient surveys and use of patient-centered care protocols).
- Less commonly, some proposals emphasized:
  - Developing a care plan.
  - Aligning resources with patients' and population needs (for example, through risk stratification).
  - Supporting self-management goals (including shared decision-making; and patient or caregiver education.

Summary of Strengths and Gaps that PTAC Identified in Proposed Models for Criterion 7 (Integration and Care Coordination)

- Common strengths for proposals found to "Meet" Criterion 7:*
  - Clear processes for care coordination
  - Explicit data-sharing mechanisms
  - Patient engagement
  - Performance quality metrics specific to care coordination
  - Effective payment mechanisms for addressing care delivery objectives
  - Engagement standards for primary care providers and specialists
  - Multidisciplinary teams
  - Continuity of care
  - Bundled episode payment model

- Common gaps for proposals found to "Not Meet" Criterion 7:
  - Unclear specifications or requirements for care coordination
  - Lack of clear accountability
  - Lack of interoperability of EHRs
  - Lack of guidance or mechanisms for data- or information-sharing
  - Inaccessibility of proprietary software
  - Lack of specific care coordination quality metrics
  - Concerns regarding the scalability of proposed models

The strengths and gaps are not presented in any particular order. * Includes one proposal that was found to "Meet and Deserve Priority Consideration" for Criterion 7.

Other Highlights From the Environmental Scan

Key Findings on Recent Initiatives in Care Coordination Payment

- Medicare has introduced billing codes that reimburse providers for care coordination services for fee-for-service (FFS) beneficiaries, including Transitional Care Management (TCM) codes in 2013 and several Chronic Care Management (CCM) codes since 2015.
- APMs can reimburse providers for care coordination.
  - In 2019, all but four state Medicaid programs had transitioned toward capitated payments through comprehensive risk-based managed care organizations (MCOs) and/or primary care case management (PCCM).
  - Some states have focused on care coordination for dual-eligibles.
- CMMI has designed/launched numerous APMs in Medicare FFS that include mechanisms to support care coordination.
  - Various models include population-based and performance-based payments, one-time or upfront funding, capitation, and FFS-based payments to promote care coordination in both primary and specialty care.
- Health plans across public and private payers have adopted other programs to support care coordination, such as Patient-Centered Medical Homes (PCMH).

Source: Care Coordination Environmental Scan.

Performance Metrics for Measuring the Effectiveness of Care Coordination

- Evaluators have encountered a number of challenges in isolating and measuring the effects of care coordination.
- Reported barriers include variation in whether and how care coordination is documented in claims and EHRs, and challenges in measuring care coordination using electronic data.
- Many of the available measures focus on outcomes to avoid (such as hospitalizations and readmissions) rather than outcomes to be achieved with effective care coordination.
  - Some CMMI models measure beneficiary and family caregiver satisfaction or practice-level process measures.
  - Some of the proposed models submitted to PTAC included direct process measures related to care coordination (e.g., completed care plans); while other proposed models used measures of cost, utilization, and quality to assess the impact of their care coordination initiatives.

Source: Care Coordination Environmental Scan.

Relationship Between Selected Assumptions About Care Coordination and Available Evidence in the Literature

- **Assumptions About Patients Who are Likely to Benefit From Care Coordination, with an Impact on Health Care Costs or Utilization Trends:**
  - Patients with modifiable risk factors, or risk factors that the individual can control.
  - Users of health care services, including those with chronic conditions.

- **Available Evidence Regarding the Effects of Care Coordination:**
  - Evidence is mixed about the impact of care coordination interventions on use, quality, and cost of care.
  - Some studies show certain care coordination functions have positive utilization outcomes, including targeting high-risk patients, facilitating care transitions, and primary care coordination.
  - Potential opportunity to improve care while reducing costs by coordinating care for high-cost patients.
  - Some promising findings exist related to reduced spending in post-acute care.
  - APMs have shown promise in improving specific performance metrics when they create incentives for care coordination.

Source: Care Coordination Environmental Scan.

The Impact of the COVID-19 Public Health Emergency (PHE) on Care Coordination

- Care coordination helped to mitigate the challenges associated with the PHE, enabling providers to proactively reach out to patients, removing barriers to access (e.g., transportation), and facilitating communication between providers and patients.
  - The temporary changes to Medicare billing requirements under the Section 1135 waiver authority have been beneficial.
- However, the increased reliance on telehealth posed challenges for some providers, including long-term care facilities or smaller practices, that do not have the necessary infrastructure to transition to virtual care coordination activities.
- The PHE may have made disparities in access to coordinated care more evident.
  - It became harder for some patients to engage in health care during the PHE due to competing priorities, especially in low-income and rural communities and among those with social isolation.

Source: Care Coordination Environmental Scan, based on discussions with previous submitters and subject matter experts.

Care Coordination and Behavioral Health

- A shortage of behavioral health providers presents a challenge for coordinating physical and mental health care.
- CMMI models that incorporate behavioral services include Comprehensive Primary Care Plus (CPC+) and Pioneer Accountable Care Organization (ACO).
  - One PTAC proposed model emphasized behavioral health (AAFP).
- The Financial Alignment Initiative integrates primary care, acute care, behavioral health care, and long-term services and supports (LTSS) for Medicare-Medicaid dually eligible enrollees.
  - Medicaid also has several other initiatives that focus on incorporating behavioral health into care coordination models.
- The American Rescue Plan Act of 2021 (ARPA) includes funding for addressing behavioral health needs and encourages grantees to coordinate care among local entities.

Source: Care Coordination Environmental Scan.

Areas Where Additional Information Is Needed

- What activities can help to optimize care coordination in APMs and PFPMs to improve quality and reduce or control costs?
- What types of payment models are likely to incentivize care coordination, including specific care coordination functions?
- How do care coordination functions vary by context, population, practice characteristics, and geographic region?
- How has care coordination evolved over the last year due to the PHE and increased attention to the priority of achieving health equity, including addressing social determinants of health (SDOH)?
- What are the best ways to measure the quality and effectiveness of care coordination, and what is the best time frame for assessing the benefits and costs of care coordination?
- What types of information or descriptions of care coordination are needed to facilitate PTAC evaluation of proposals?

Appendix:
Care Coordination Components in Proposed PFPMs Submitted to PTAC

16 PTAC Proposals That Were Found to "Meet" for Criterion 7, by Care Coordination Context

Care Coordination for Population-Wide health management:

- American Academy of Family Physicians (AAFP)
- American College of Physicians-National Committee for Quality Assurance (ACP-NCQA)

Care Coordination Related to an Acute Event:

- Icahn School of Medicine at Mt. Sinai (Mount Sinai)*
- American College of Emergency Physicians (ACEP)
- Personalized Recovery Care (PRC)
- University of Chicago Medicine (UChicago)
- University of New Mexico Health Sciences Center (UNMHSC)

Care Coordination for Specific Populations:

- American Academy of Hospice and Palliative Medicine (AAHPM)
- American College of Surgeons (ACS)
- American Society of Clinical Oncology (ASCO)
- Avera Health (Avera)
- Coalition to Transform Advanced Care (C-TAC)
- Hackensack Meridian Health and Cota Inc. (HMH/Cota)
- Innovative Oncology Business Solutions, Inc. (IOBS)
- New York City Department of Health and Mental Hygiene (NYC DOHMH)
- Renal Physicians Association (RPA)

* This proposal was found to *"Meet and Deserve Priority Consideration" for Criterion 7 ("Integration and Care Coordination").*

Key Characteristics of 16 PTAC Proposals That Were Found to "Meet" Criterion 7 (Integration and Care Coordination)*

	Pop Health Mgmt	Specific Pop	Acute Event	Clinical Focus	Payment Mechanism	Setting
1. AAFP	■			Primary care	Per Beneficiary Per Month (PBPM)	Primary care practices
2. ACP-NCQA	■			Primary care providers and specialists	PBPM	Primary care practices
3. AAHPM		■		Palliative care	PBPM	Inpatient, outpatient
4. ACS		■		Cross-clinical	Episode-Based	Inpatient, outpatient, ambulatory
5. ASCO		■		Cancer care	Episode-Based	Inpatient, outpatient
6. Avera		■		Primary care in Skilled Nursing Facilities	PBPM	SNFs, NFs
7. C-TAC		■		Palliative care	PBPM	Patient home
8. HMH/Cota		■		Cancer care	Bundled Episode-Based/Monthly	Inpatient, outpatient
9. IOBS		■		Cancer care	Episode-Based	Outpatient
10. NYC DOHMH		■		Hepatitis C virus	Bundled Episode-Based/Monthly	Primary care and specialty
11. RPA		■		End-stage renal disease	Episode-Based	Dialysis Centers
12. ACEP			■	Emergency Department (ED) services	Episode-Based	ED
13. PRC			■	Home health	Bundled Episode-Based/Monthly	Patient home
14. UChicago			■	Frequently hospitalized patients	PBPM	Patient home
15. UNMHSC			■	Cerebral emergent care	One-time/Visit-based	Inpatient, outpatient, ED
16. Mount Sinai *			■	Home health	Bundled Episode-Based/Monthly	Patient home

* Includes one proposal (Mount Sinai) that was found to "Meet and Deserve Priority Consideration" for Criterion 7.

PTAC Proposals that were Found "Meet" Criterion 7 by Care Coordination Context and Clinical Condition

- The proposed models that emphasized care coordination for specific populations were more likely to focus on specific health conditions.

Clinical Condition / Focus*	Proposals Found To "Meet" Criterion 7**	Care Coordination Context*		
		For Population Health	*For Specific Populations*	*Around an Acute Event*
Health Conditions	38%	0%	56%	20%
Serious Illness	13%	0%	22%	0%
Other	50%	100%	22%	80%
Total Number of Proposals	***16***	***2***	***9***	***5***

*Categorizations are based on areas emphasized or highlighted within the proposal and may not represent an exhaustive review of all model components. ** Includes one proposal that was found to "Meet and Deserve Priority Consideration" for Criterion 7.

PTAC Proposed Models that were Found to "Meet" Criterion 7 by Care Coordination Context and Payment Mechanism

- Half of the proposed models included an episode-based shared risk payment mechanism.

Payment Mechanism	Proposals Found To "Meet" Criterion 7*	Care Coordination Context**		
		For Population Health	*For Specific Populations*	*Around an Acute Event*
Additional Payments to the MPFS *(without PBPMs or an episode-based bundle)*	6%	0%	0%	20%
Per Beneficiary Per Month (PBPM) Payments and Shared Risk *(may include an additional payment)*	38%	100%	33%	20%
Episode-based Shared Risk *(target price for an episode, shared risk for performance based on spending and/or quality)*	56%	0%	67%	60%
Total Number of Proposals	***16***	***2***	***9***	***5***

* Includes one proposal that was found to "Meet and Deserve Priority Consideration" for Criterion 7. **Categorizations are based on areas emphasized or highlighted within the proposal and may not represent an exhaustive review of all model components.

Care Coordination Contexts That Were Addressed by PTAC Proposed Models

- **More than half of the proposed models that were voted on by PTAC addressed care coordination issues in population-specific contexts.***
  - Proposed models that were found to "Meet" Criterion 7 (Integration and Care Coordination) were more likely to address care coordination in the context of acute events than proposals that were found to "Not Meet" this criterion.**

Context	Proposals Voted on by PTAC*	Proposals Found to "Not Meet" Criterion 7	Proposals Found To "Meet" Criterion 7***
Care Coordination for Population Health	15%	20%	13%
Care Coordination for Specific Populations	62%	70%	56%
Care Coordination Around an Acute Event	23%	10%	31%
Total Number of Proposals	***28***	***10***	***16***

* Includes information for two proposals that were found to be Not Applicable for Criterion 7. **Categorizations are based on areas emphasized or highlighted within the proposal and may not represent an exhaustive review of all proposed model components. *** Includes one proposal that was found to "Meet and Deserve Priority Consideration" for Criterion 7.

Types of Care Coordination Objectives That Were Highlighted in PTAC Proposed Models

- **Two-thirds of proposed models PTAC voted on addressed health care system-related objectives.***
  - Proposed models that were found to "Meet" Criterion 7 (Integration and Care Coordination) were more likely to address continuity of care across different phases of care, settings, and treatments.**

Objective	Proposals Voted on by PTAC*	Proposals Found to "Not Meet" Criterion 7	Proposals Found To "Meet " Criterion 7***
Patient / Family-Focused Objectives	**31%**	**30%**	**31%**
Individual Provider-Focused Objectives	**15%**	**20%**	**13%**
Support and empower interdisciplinary care teams, team communication	12%	20%	6%
Health Care System-Related Objectives	**69%**	**60%**	**75%**
Reducing costs, readmissions, care escalation, complications	38%	50%	31%
Deliver evidence-based care	23%	40%	13%
Continuity of care across different phases of care, settings, treatments	19%	0%	31%
Facilitating appropriate discharge	4%	0%	6%
Specialty care in underserved areas / across specialties	12%	0%	19%
Total Number of Proposals	***26***	***10***	***16***

* Excludes information for two proposals that were found to be Not Applicable for Criterion 7. **Categorizations are based on objectives emphasized or highlighted within the proposal and may not represent an exhaustive review of all proposed model components. *** Includes one proposal that was found to "Meet and Deserve Priority Consideration" for Criterion 7.

Care Coordination Functions that were Highlighted in PTAC Proposed Models and Selected CMMI Models with Care Coordination Components

- Many proposed PFPMs emphasized functions associated with care coordination.*

Care Coordination Function	PTAC Proposed Models	CMMI Models
	Proposals Found To "Meet " Criterion 7**	Selected CMMI Models With Care Coordination Components
Establish Accountability or Negotiate Responsibility	63%	58%
Facilitate Transitions and Coordinate Care Across Settings	63%	79%
Assessing Patient Needs and Goals	19%	21%
Link to Community Resources	0%	21%
Aligning Resources with Patient and Population Needs	13%	68%
Communication	19%	32%
Developing a Care Plan	19%	16%
Monitoring and Follow-Up	25%	11%
Supporting Self-Management Goals	6%	21%
Total Number of Proposals or Selected Models	***16***	***19***

*Categorizations are based on functions emphasized or highlighted within the proposal or model documents and may not represent an exhaustive review of all proposed model components. **Includes one proposal that was found to "Meet and Deserve Priority Consideration" for Criterion 7.