PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

PUBLIC MEETING

The Great Hall
The Hubert H. Humphrey Federal Building
200 Independence Avenue, SW
Washington, D.C. 20201

Thursday, September 7, 2017
9:00 a.m.

PTAC COMMITTEE MEMBERS PRESENT:

JEFFREY BAILET, MD, Chair
ROBERT BERENSON, MD
PAUL N. CASALE, MD, MPH
TIM FERRIS, MD, MPH
RHONDA M. MEDOWS, MD
HAROLD D. MILLER
ELIZABETH MITCHELL, Vice Chair
LEN M. NICHOLS, PhD
KAVITA PATEL, MD, MSHS
BRUCE STEINWALD, MBA

STAFF PRESENT:

ANN PAGE, Designated Federal Officer, Office of Assistant Secretary for Planning and Evaluation (ASPE)
KATHERINE SAPRA, PhD, MPH, ASPE
MARY ELLEN STAHLMAN, ASPE

AGENDA PAGE

AGENDA PAGE

P R O C E E D I N G S

[9:07 a.m.]

* DR. O'BRIEN: Good morning. I'm John O'Brien, Deputy Assistant Secretary for Health Policy in the Office of the Assistant Secretary for Planning and Evaluation, and on behalf of Secretary Price, I'd like to welcome all of you to this meeting of the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

As a physician himself, Dr. Price knows that providers have a unique perspective to share on how health care can be transformed to lower costs while increasing quality. As you heard at the last meeting, he's encouraged by the number and breadth of innovative ideas coming to PTAC for consideration.

And the Secretary is very appreciative of the thoughtful work that PTAC has done thus far to evaluate the ideas that have come forward, and he values the PTAC as one way for bringing physicians and their best ideas for health care delivery and payment forward for consideration.

HHS is looking forward to reviewing PTAC's recommendations for the three proposals now before the Committee, and I know it's going to be a busy couple days and you have a lot on your plate, so I'll let you get to work with the thanks of Secretary Price and myself.

Now I'd like to turn the meeting over to Dr. Jeff Bailet, PTAC Chair, and Elizabeth Mitchell, the Vice Chair.

* CHAIR BAILET: Thank you, John.

Good morning, everyone, and welcome to this meeting of the Physician-Focused Payment Model Technical Advisory Committee, or PTAC. We're delighted to have you all here. In addition to the members of the public here in person, we have participants watching the livestream and listening on the phone. As you know, this is PTAC's second meeting that will include deliberations in voting on proposals for Medicare physician-focused payment models submitted by members of the public.

We would like to thank all of you for your interest in today's meeting. In particular, thank you to the stakeholders who have submitted models, especially those here today. Your hard work and dedication to the payment reform process is truly appreciated.

PTAC has been active since our last public meeting in April. Since that meeting, we have submitted recommendations and comments on three physician-focused payment model proposals to the Secretary of Health and Human Services that were voted on at the April meeting.

We have written a letter to the Secretary outlining key lessons learned from our work to date, that

Dr. Price is aware of our progress and our thoughts on physician-focused payment models. You can find that letter on the ASPE (Office of the Assistant Secretary for Planning and Evaluation) PTAC website.

We have updated the proposal submission instructions to make the process for submitting a proposal even clearer and to accommodate changes to how the proposal review teams and PTAC conduct their work. The updated proposal submission instructions can also be found on the ASPE PTAC website.

PTAC has updated its bylaws to reflect an even stronger commitment to transparency and disclosures of potential conflicts of interest, and, of course, we have been very busy reviewing and evaluating physician-focused payment model proposals from the public.

I am pleased to report that interest in submitting physician-focused payment model proposals to PTAC continues. To date, we have received 15 full proposals and an additional 16 letters of intent to submit a proposal. The proposals are from a wide variety of specialties and practice sizes, and they propose a variety of payment model types.

For example, a dozen different specialties and subspecialties are represented in the letters of intent we

have received. There is interest in physician-focused payment models by both small and large group practices. Small physician groups have submitted six letters of intent and three proposals. And large group practices have submitted four letters of intent, and one full proposal has been received.

Bundled payments and care management models comprised the majority of the proposals to date, but we have also received proposals or letters of intent that relate to capitated payment and other payment models. We are pleased that we have so much interest from clinical stakeholders in proposing physician-focused payment models, and we're fully engaged to ensure proposals are reviewed expeditiously and comprehensively.

We are already looking ahead to our next public meeting, which will be held here in the Great Hall of the Humphrey Building on December 18th and 19th. One simple reminder, to the extent that questions may arise as we consider your proposal, please reach out to staff through the PTAC.gov mailbox. The staff will work with me as Chair and Elizabeth Mitchell, the Vice Chair, to answer your questions.

We have established this process in the interest of consistency in responding to submitters and members of

the public and appreciate everyone's cooperation in using it.

Today we will be deliberating on two proposals, and tomorrow we will deliberate on one. To remind the public, the order of activities for each proposal is as follows. First, PTAC members will make disclosures of potential conflict of interest and announcements of any Committee members not voting on a particular proposal. Second, discussion of each proposal will begin with presentations from our Preliminary Review Teams, or PRTs.

Following the PRT's presentation and some initial questions from PTAC Committee members, the Committee looks forward to hearing comments from the proposal submitter and then the public. The Committee will then deliberate on the proposal. As deliberations conclude, I will ask the Committee whether they are ready to vote on the proposal.

If the Committee is ready to vote, each Committee member will vote electronically on whether the proposal meets each of the Secretary's 10 criteria. The last vote will be an overall recommendation to the Secretary of Health and Human Services.

And, finally, I will ask PTAC members to provide any specific guidance to ASPE staff on key comments they would like to include in the report to the Secretary.

A few reminders as we begin discussion of the first proposal. PRT reports are from three PTAC members to the full PTAC and do not represent the consensus or position of PTAC. PRT reports are not binding. The full PTAC may reach different conclusions from that contained in the PRT report, and, finally, the PRT report is not a report to the Secretary of Health and Human Services.

PTAC will write a new report that reflects the deliberations and decisions of the full PTAC, which will then be sent to the Secretary.

It is our job to provide the best possible recommendations to the Secretary, and I have every expectation that our discussions over the next few days will accomplish this goal.

Let us all introduce ourselves. I'd like to introduce Elizabeth Mitchell. She's the PTAC's Vice Chair. I'll let Elizabeth start.

VICE CHAIR MITCHELL: Elizabeth Mitchell, president and CEO (Chief Executive Officer) of Network for Regional Healthcare Improvement.

DR. NICHOLS: Len Nichols, I direct the Center of Health Policy Research and Ethics at George Mason University.

DR. PATEL: Hi. Kavita Patel. I'm at Johns

Hopkins as an internal medicine physician and at the Brookings Institution.

DR. BERENSON: I'm Bob Berenson. I'm an Institute Fellow at the Urban Institute.

DR. MEDOWS: I'm Rhonda Medows. I'm a family physician. I'm the executive vice president for Population Health at Providence St. Joseph Health.

DR. FERRIS: Tim Ferris, primary care internal medicine and CEO of the Mass General Physicians Organization at Partners Healthcare.

DR. SAPRA: Katherine Sapra. I'm a Presidential Management Fellow in the Office of the Assistant Secretary for Planning and Evaluation working on PTAC.

MR. MILLER: I'm Harold Miller. I'm the President and CEO of the Center for Healthcare Quality and Payment Reform.

DR. CASALE: Paul Casale, a cardiologist and lead the ACO at Weill Cornell, Columbia, New York Presbyterian.

MR. STEINWALD: I'm Bruce Steinwald, a health economist with a small consulting practice in Northwest Washington and lots of government service in the past, including in this building.

MS. PAGE: I'm Ann Page. I'm staff in ASPE to this PTAC Committee and also the Designated Federal Officer

for the PTAC, which is an advisory committee under the Federal Advisory Committee Act.

MS. STAHLMAN: And I'm Mary Ellen Stahlman, ASPE staff and the staff lead for the PTAC support team.

CHAIR BAILET: And I'm Jeff Bailet, Executive Vice President of Health Care Quality and Affordability with Blue Shield of California, and I'm also the Chair of this Committee.

I'd like to thank my colleagues for all of the good work and the countless hours and the careful and thoughtful expert review of these proposals as they've come through the Committee. Again, I want to personally thank everyone for their work, and we're going to go ahead and get started.

The first proposal this morning we will discuss is the Icahn School of Medicine at Mount Sinai, and it is entitled Hospital at Home Plus Provider-Focused Payment Model.

* So PTAC members, let's start the process by having each of us disclose any potential conflicts of interest on this proposal. So I'm going to start, and we'll go around the room.

So with respect to the Mount Sinai Hospital at Home proposal, I have no conflicts.

VICE CHAIR MITCHELL: Nothing to disclose.

DR. NICHOLS: Nothing to disclose.

DR. PATEL: Nothing to disclose.

DR. BERENSON: I have something to disclose. I am a graduate of Mount Sinai School of Medicine and occasionally have made charitable contributions, very occasionally. I have no other relationship to Mount Sinai.

DR. MEDOWS: I have nothing to disclose.

DR. FERRIS: I have something to disclose. I know some of the submitters through presentations at national and international meetings that we have both attended. As a result of hearing Al Siu, Dr. Al Siu, speak at an international meeting, I organized for him to visit my institution and present the Hospital at Home concept at my institution.

MR. MILLER: I have no conflicts to disclose.

DR. CASALE: Nothing to disclose.

MR. STEINWALD: Nothing to disclose.

CHAIR BAILET: All right. We've previously reviewed the disclosures, and we've concluded that nothing in the disclosures should preclude any PTAC member from full participation and deliberations and voting on this proposal. We have 10 members voting on the proposal today.

And now I'd like to turn the microphone over to

the Preliminary Review Team for this proposal. Harold Miller is going to present the PRT's findings to the full PTAC as the PRT lead.

Harold?

* MR. MILLER: Thank you, Jeff.

So I am presenting on behalf of my colleagues on the PRT, Rhonda Medows and Len Nichols. Also, we had excellent staff support from Katherine Sapra, who is sitting to my right and will make sure I don't screw up anything during the process of this.

So the presentation that I'll go through basically will cover our composition and role, an overview of the proposal at least as we understand it, the summary that the PRT -- the summary of the PRT's review, the key issues that we identified, and then the evaluation that we did of the proposal based on each of the Secretary's criteria.

So just as a review for everyone of the process, we, the three members of the PRT, were assigned by the Chair and the Vice Chair. At least one of us, namely Rhonda, is a physician, and one of us, namely me, is assigned to serve as the team lead.

We go through a process of reviewing the proposal, of identifying additional information that we

need from the submitter and requesting that information. I want to commend the submitter for, first of all, giving us a very well-thought-out and prepared proposal and also giving us very detailed, clear, concise, and thoughtful answers to all of our many questions. We asked a lot of questions and also had an in-person discussion with them on the phone, which was very helpful.

After doing all that and some additional analysis that we did looking at the literature, et cetera, we prepared our report to the PTAC, which has been posted, and just also to comment on top of what Jeff said earlier, the only people on the PTAC who have discussed the proposal at all before today are the three of us. There has been no discussion by the full PTAC, so this will be the first time for everybody else on the PTAC. And our report is, obviously, as Jeff said, not binding.

So let me describe the proposal at least as we understand it, and then the submitter can clarify if there's anything that I state that's wrong. This proposal is essentially -- is a payment model designed to enable the delivery of hospital-level services at home for patients who would otherwise be hospitalized, and the goal is to try to reduce cost by delivering services in the home rather than the hospital, but also to improve quality by reducing

complications that patients can often experience when they are in the hospital, as well as to improve the whole transition process after hospitalization because the patient actually is not in the hospital -- they are at home during the acute phase as well as the post-acute phase.

So this model is targeted specifically to patients who could be hospitalized and would be eligible for hospitalization, but could be taken care of at home, which is obviously not everyone who would potentially come to the hospital.

The way the model was structured was that it identifies a series of diagnoses, which are expected to be patients who could be potentially taken care of at home, but then there are additional clinical characteristics of the patients beyond their diagnosis, which would suggest whether or not they are appropriate for home care and also whether they have the appropriate home environment to enable home care to be delivered.

The services that the patients receive are divided into two phases that the payment model supports. One is an acute phase, which is technically equivalent to what the patient would have been hospitalized for, and then a post-acute phase.

The proposal refers to the post-acute phase as

transition services. We found that slightly confusing, only because the term "transition" is often used by many people today to simply reflect a short period of time that occurs after discharge of the hospital, but what their proposal is actually proposing to support is 30 days of care for the patient after the conclusion of their acute phase. So we have tended to refer to it as more of a post-acute period rather than simply a transition period.

And all of that is basically home-based care for the patient, although if the patient needs an actual inpatient hospital admission, they can be what is referred to by the submitter as "escalated to an inpatient admission."

The payment model for this has two -- two components. One is essentially what you could call a bundled payment, a fixed amount of money that would come to the entity that delivers these services to support all of the services that they deliver during the acute and post-acute phase of this care.

The payment amount would be based on a calculation that would be based on the DRG, the diagnosis-related group, that would have been calculated for that patient under the Medicare DRG grouper, but also an estimate of the physician services that would have been

delivered in the hospital based on the average for that DRG, because under the current Medicare payment system, the hospital and the physicians are paid separately. And the physicians are paid on a per-visit or per-procedure basis. So the idea would be to create, essentially, a super DRG payment that would be the combination of what the hospital would have been paid and what the physicians would have been paid and then discounting that amount by five percent. That would essentially pay for the services that were being delivered in the acute and the post-acute phase.

Then there is a performance-based payment that looks at the total amount of spending that occurred during that period, during the acute and the post-acute phase, because not everything that the patient received would necessarily be covered by the payment that the entity participating in this would get. So if the patient, for example, went to see a specialist, the specialist would be billing separately for that. If they needed some other kind of billable service, they would be able -- the provider for that would bill for that.

So the second part of this payment essentially adds up all of the services that the patient did receive and that were billed to Medicare and compares that to a benchmark amount as to what would have been expected would

have been spent on the patient with these particular characteristics with a three percent discount on that. And then there is a shared saving, shared risk model attached to that. So if that spending is below what would have been expected, then some of that savings comes back to the entity. If that spending was higher than would have been expected, the entity has to pay that increase back to Medicare. So that's what's referred to as the target price and how that will be calculated.

And those savings and payment -- return payments are capped at 10 percent of the target price, and there would be an adjustment to that shared savings, shared loss payment based on the quality of care that would be delivered based on a series of quality measures as part of the payment model, which will become relevant to some of our later discussion.

So in our review of this, we went through each of the 10 criteria that are specified in regulation by the Secretary for our review, and I will review each of those individually in a few minutes. But, as a summary, we, as a PRT, unanimously agreed on all of the ratings that you see on the screen. We felt that the proposed physician-focused payment model met the criteria in all but one case. The only criterion that we felt did not -- the only aspect of

the proposal we felt that did not meet one of the criteria was with respect to patient safety, and so we unanimously agreed that the proposal as written did not meet that criterion.

So, as a summary of the key issues that we identified, this is sort of an overview, and then I'll talk about this with respect to each of the criteria.

We felt that this filled an important gap in the portfolio of Medicare payments because there really is very little that supports home care for patients and essentially nothing that is designed to support hospital-level care in the home for patients who would otherwise be hospitalized.

It is specifically designed to improve quality and to reduce costs. It is focused on avoiding essentially the undesirable things that can potentially happen to patients when they are hospitalized and to avoid the transition process that occurs when a patient has to be hospitalized and then sent back home because they are essentially at home through that entire period of time.

It is a bundled payment for both the acute and the post-acute phase. So at least during that period of time, there is no concern about shifting cost between one period and another, and there is a measure of the total spending that occurs. So there is no concern about

shifting cost between what the entity is paid for versus what is paid for separately by Medicare.

And we felt that this could potentially work well for other payers, certainly for the Medicare population, for Medicare Advantage plans, but also potentially for commercial payers because many patients who are younger than 65 are hospitalized and could potentially be cared for at home with the appropriate kind of support.

The weaknesses we saw at the broadest level were that this service --that the payment model would support requires a certain minimum capacity in terms of physicians, nurses, et cetera, to be able to deliver the services, yet the payment model is a per-patient payment. So if you don't have enough per-patient payments to be able to cover the cost of that minimum fixed cost of the service, then you could not sustain the service.

So the concern was that potentially leads to some incentives, if you will, to try to boost the number of patients who are included in the model in order to get enough patients to be able to cover the cost.

And that could go in two directions. One is that it could mean that some patients who really weren't appropriate to be cared for at home could be cared for at home in order to increase the volume. It could also be the

case that some patients who were not -- would not really have been hospitalized in the first place could be put into this program, who could certainly be cared for at home but wouldn't have been hospitalized.

A second concern is that the payments, because they are based on hospital-level payments and current spending on post-acute care may not really match the actual costs of delivering the care -- I described one reason why the cost might be higher than the payments. The other potential is that other examples of this kind of a program being implemented around the world have shown that potentially very significant savings can be achieved because patients could be cared for in many cases at much lower costs. So the question is whether or not the payments really match the appropriate costs.

We felt that there was a weak link between quality and payment. Although there are quality measures specified in the application, they are tied to the shared savings, shared loss payments. That is very similar to what is done in the Medicare Shared Savings Program for ACOs, but it is done there because essentially there is no payment for an ACO other than the shared savings, shared loss payment. Here, there is a payment to the -- to the entity delivering the services, so there is a different

payment that could be modified based on quality. And we felt that that should be considered.

We felt that while there are quality measures included, that they were not sufficiently comprehensive to really address the concern that patients who need hospital-level care are being cared at home, and there is no medical professional there at all times.

One of the concerns that was raised is that adverse events with a population like this occur, but they occur at fairly small rates. And so the concern about having a small rate measure affecting payment was a concern. So we noted that we thought that those things should be at least monitored, if not affecting payment, and so we felt additional mechanisms were needed, both for adjusting payment based on quality and also for monitoring safety.

So I'm going to go through quickly each of the individual criteria and just explain why we rated it as we rated it. So the first criterion relates to the scope of the proposed PFPM (physician-focused payment model), and the regulatory statement is that this proposal needs to either directly address an issue in payment policy that broadens and expands the CMS (Centers for Medicare and Medicaid Services) APM portfolio, Alternative Payment Model

portfolio, or to include APM Entities, entities that would be receiving the payments, whose opportunities to participate in Alternative Payment Models had been limited.

And, as I stated, we felt, as the PRT, the three members of the PRT felt that it met that criterion, and we felt that was true unanimously because we felt that this really did fill a gap by covering home-based acute services, which no other CMS model really does.

There are other models that do sort of pieces of that for certain kinds of patients, but they are mostly oriented at avoiding hospitalizations, not for caring -- avoiding people from having to go to the hospital and needing a hospitalization in the first place, rather than taking people who need a hospitalization, but delivering that in the home.

As I said, a concern is that there's a minimum number of patients who are needed to make the program viable. We did some analysis of -- based on what the applicant estimated was a minimum number of patients to participate. The applicant estimated at least 200 patients would need to participate in order to be able to make the model viable, and we looked at some estimates of how many patients were likely to meet those characteristics and concluded that probably in the vast majority of rural

areas, there would not be enough patients to meet that minimum. That there would be in urban areas, but even in many urban areas, there would not be.

That did not to us mean that this was an undesirable model. It just meant that the ability to be able to deliver it cost-effectively under this approach would be challenging in smaller areas, but who knows what innovation entrepreneurship might be able to deal with?

So we felt that at least, initially, this was likely to be something that larger organizations would do. It doesn't mean that down the road, smaller organizations wouldn't, but more likely applicable to larger communities and larger organizations, so -- but we did feel that overall, this was filling a gap.

Second criterion related to quality and cost. There are a variety of studies -- the United States is a bit behind on this -- there are other countries that have done this in a major way. The State of Victoria in Australia has a major Hospital at Home program, and someone there wrote an article a number of years ago describing the 500-bed hospital that was never built because of the number of patients who are participating in this program. So it does have some experience and evaluation showing that it improves quality and reduces costs.

And, as I mentioned earlier, there are some features of the model that really ensure that costs are not being shifted and that there are savings, but we do think that there are some safety risks, that there are some concerns about the minimum volume of patients.

We were somewhat concerned about the cost to whom the -- it would be designed to basically pay less than Medicare would pay or spend today, but that doesn't necessarily mean that it would not have some cost implications for a hospital. If you are taking some patients out of the hospital and putting them into the community and the hospital has no longer paid for those patients, then the hospital has fewer revenues to cover its costs.

And it is possible -- not clear at the moment, but some studies have shown this -- that you're essentially taking out of the hospital, patients who would otherwise have lower-than-average cost in the hospital, leaving the hospital with a higher-than-average-cost patient population, but with the same DRG payment remaining. So there would be some concerns about the potential implications that this would have for hospitals and potentially leading to, if this was implemented broadly, an increase in DRG rates to be able to cover that.

We thought that there are some concerns about the way the savings calculation was done, because you cannot necessarily assume that these patients would have had the same post-acute care costs as the average patient being discharged from the hospital. But we felt that those issues, those specific issues here in terms of benchmarking and price, et cetera, could be dealt with simply by adjusting the parameters of the model, and that, in fact, it's no different in that regard than many other payment models that get introduced and that you have to adjust over time.

The Medicare inpatient prospective payment system, for example, when it first created DRGs, ended up with DRGs that were priced higher than what hospitals ended up having to actually spend on care after they changed the level of care. So the DRG rates were adjusted, and the same thing could happen in a model like this. It would simply be there would need to be recognition that that kind of adjustment would need to be made.

Third criterion. With respect to the payment methodology, we thought that the applicant did an excellent job of describing the methodology in detail and trying to address a lot of the potential issues associated with cost shifting, how the calculations would be made, et cetera.

As I mentioned, there would need to be some further adjustments to all of that, and that there needed to be some adjustments for quality.

The applicant indicated that they were willing to consider adjustments to the basic payment based on quality, but I think preferred to have it adjusted based on the shared savings, shared losses. We felt fairly strongly that the basic payment needed to be adjusted because, in fact, if there are no shared savings or shared losses, then there is no adjustment for quality. And we felt that there should be some way of holding an entity accountable for quality, regardless of whether there were savings and costs.

But we felt that the methodology, as specified, was sufficient to merit meeting the criterion and that the adjustments that could be made were fairly easy to do. I would note that the applicant in the proposal really proposed three different things. They proposed something called Hospital at Home, Observation at Home, and Palliative Care at Home.

We, I think, probably succumbed to complexity a bit and concluded that trying to deal with three different -- three different payment models at the same time was a bit much because there were nuances associated with each of

them that would be different, and that in some sense, each of the models would really need to be fully specified rather than saying it would be kind of like Hospital at Home, but we'd have the following changes.

And so we really felt that in the absence of having a clearly specified model for each of those that we simply did not feel that we could review the payment methodology, so we essentially put those two pieces aside.

We did not feel -- and the applicant confirmed -- that having those two components was essential to implementing either the Hospital at Home program or implementing the Hospital at Home payment methodology. So we basically treated that, the Hospital at Home component, as what we felt this proposal was, and our recommendations relate specifically to that.

The fourth criterion was value over volume. We felt that, interestingly enough, this model is different than many current models in that patients don't get attributed to anything. They have to sign up. They have to agree that they want to receive their care in the home from this team, and, in fact, one of the difficulties that Mount Sinai has had in terms of implementing the model in their own environment is making patients feel comfortable with that in some cases and making physicians who would

need to refer to that.

So we felt that there is essentially a requirement for quality in this in that if you aren't delivering good quality care, people aren't going to want to sign up for it, as opposed to this being a more passive enrollment where you're concerned that something might happen to the patient that they're not aware of.

However, we were also concerned that because of the pressure to get enough patients enrolled that there might be some tendencies to convince patients that this was safer than it was. We didn't think that that was a compelling concern, but I would say for everyone's benefit, we looked at this as a payment model that would be available broadly in Medicare.

We were not evaluating Mount Sinai or Mount Sinai's implementation of the Hospital at Home program. We did not have concerns at all about what Mount Sinai was doing. What we were concerned about, though, was if a payment model was available broadly, what potentially unknown entities who sign up for this might do or not do and making sure that the payment model included enough protections in there for that. And the folks from Mount Sinai were very helpful in terms of helping to articulate how some of those things could be addressed, and as I

mentioned before, we felt that there needed to be some method of addressing quality directly in terms of the payment amount.

So we felt that on this particular criterion, providing incentives to practitioners to deliver high-quality care, that it met the criterion, and we felt that it did -- we felt unanimously that it did so.

Fifth criterion was flexibility. We felt that this was strong in terms of flexibility because, as essentially a bundled payment -- as a bundled payment, it gave the provider who received it the flexibility to do whatever it was that the patient needed rather than being restricted to particular kinds of services, essentially the same kind of flexibility that a hospital has in being paid a case rate.

The one concern would be that if, in fact, the volume of patients was not sufficient to generate the full revenues needed to cover all the costs, that that could potentially lead to some restrictions in terms of the services that might otherwise be desirable for patients.

We also were somewhat concerned that because there was responsibility for the full post-acute care period, but some patients might need much more extensive services, such as a skilled nursing facility, that there

really was not the ability to control the patient's choice of that. And so that might limit, to some degree, flexibility. But we felt that overall that this did provide significant flexibility, and so we felt that it met that criterion.

Sixth criterion is ability to be evaluated. As stated, it's to have evaluable goals for quality-of-care cost and any other goals of the PFPM. We felt that this met the criterion.

We felt that it could be evaluated. We felt that one could determine whether quality of care was being delivered, and we could [unintelligible] it could be compared to what it would have cost to have patients in the hospital.

The ease of evaluation and the precision of the evaluation is a different question, simply because trying to identify comparison patient populations when you're picking patients based on clinical criteria, which are not in claims, would be challenging, and that with the small number of patients that might be participating, that reaching statistical significance might be challenging.

But we didn't feel that that was any reason not to move forward with a model like this. The issue would simply be trying to do the best evaluation that one could,

given the kinds of size, scale, and significance that one could achieve. And this is something that I believe is being struggled with right now because -- by Mathematica because they are evaluating the Mount Sinai program -- not the payment model, but the program -- as part of the Health Care Innovation Awards.

Seventh criterion is integration and care coordination, whether this encourages greater integration and care coordination among practitioners and across settings, where multiple practitioners or settings are relevant to delivering care of the population treated under the PFPM.

We felt this met the criterion. We felt that unanimously because, essentially, if all goes well, this is actually reducing the need for coordination because the patient isn't going to one place for their hospitalization and going someplace else for their post-acute care. They're in the same place being managed and treated by the same provider entity. So, in a sense, it's better care coordination.

The one concern that we raised was that it could potentially introduce, in cases where it doesn't go well, more transitions, because if the patient needs to be escalated to the hospital and then sent back home, that

would create some new transition challenges. But overall, we felt that this was actually improving care coordination, and because the patient was staying in their home in the community, that coordination with their existing physician's primary care physician, et cetera, would actually be easier than it would be had they been in the hospital.

Eighth criterion, patient choice. Again, this is actually stronger in many ways than many other payment models in that it is the patient's choice as to whether to enroll. It is not a passive enrollment part -- a passive enrollment on their part, but we did say that it would be important to make sure that the patient was adequately informed about exactly what the services were and what the tradeoffs were in terms of the potential risks of being cared for at home, so that only appropriate patients were actually admitted.

And we felt and recommended, which the applicant agreed with, that there needed to be some external monitoring of not only adverse events, but also just making sure that the patients who were being admitted were, in fact, appropriate for that kind of care.

The ninth criterion was the only criterion that we felt the proposal did not meet, and we agreed on that

unanimously. The concern is that a patient who needs hospital-level care is being treated at home, and there is not a health care professional down the hall 24 hours a day when they are at home. And so that while it may protect the patient from some safety risks that they would have in the hospital, being in an unfamiliar environment, being subject to infection risks, et cetera, it would also subject them to different kinds of safety risks.

So we felt that there was a lot of things built into the proposal to address that in terms of minimum number of visits, a common set of providers, et cetera, but we did feel, again, based on the inability to know exactly who would be participating in a payment model like this if it was implemented broadly, that there would need to be some kind of external monitoring process. And so the applicant, again, agreed with that, but we felt that this was a sufficiently big change in terms of the proposal as it was submitted, that we needed to say the proposal as submitted really didn't meet the criterion.

We felt that could be addressed, this could be addressed, but we -- but it was not addressed adequately in the proposal that we received.

And the final criterion is health information technology. This criterion requires some careful -- sorry

-- careful reading to determine exactly what the criterion says in order to determine whether one thinks that the proposal meets it or not. The criterion says encourage use of health information technology to inform care.

We felt that a program like this and a payment model like this would certainly encourage people to have better HIT (health information technology) in order to be able to deliver a coordinated care and to coordinate all the things that were happening to them in the home.

We were concerned, which the applicant essentially confirmed in their own circumstances, that the current state of HIT was not exactly up to this, and so the ability to find some off-the-shelf EHR (electronic health record), HIE (health information exchange), HIT solution for this was limited. But the -- one counter to that was it's a small patient population, and so it's not like as if you're managing tens of thousands of patients.

It could be tracked manually in the short run, and we felt that this kind of thing was going to be needed to be done more and more often in the future, and that programs like this would, in fact, hopefully, encourage HIT vendors to be able to do more of this, although, again, that would depend on the ultimate scale of implementation. So our members of the PRT felt that this met the criterion,

and we agreed on that unanimously.

So that summarizes my long-winded but hopefully helpful summary.

Let me ask Len and Rhonda and Kate if I missed anything or if they would like to clarify anything that I said to make it clearer or fill in gaps.

Rhonda?

DR. MEDOWS: So I don't think it was possible for you to have missed anything in that presentation. Thank you very much. That was fantastic.

I do want to say a couple things in -- positive about this proposal. One, the concept of actually offering a patient and the providers taking care of them the option of treating them at home when they are low on the acuity scale, and that it's safe and effective, I think is a wonderful thing.

We all recognize and we discussed that it would be a low volume of patients, and whether or not the provider group with their hospital partner would find it sufficient for covering the cost of this, that would be another question that had to be asked. But the model itself is something that we actually supported.

The questions and concerns about the patient safety piece, we discussed with the applicant and amongst

ourselves on the PRT that these were things that could be rectified. They could be effectively addressed, everything from adverse event reporting, for outcome reporting -- and not just reporting, but actually including in the formal process, the performance improvement, the effort to avoid, and to reduce those risks.

[Unintelligible] I thought it was very well done, and I think that the patient safety piece can be addressed. It just simply wasn't in the original proposal. The subsequent responses were very helpful.

I also want to commend them on the part about making sure that the patient choice piece was fully emphasized.

The part about making sure that the patient only had a choice and then had home support, again, highly important to the effectiveness of the program.

MR. MILLER: I'll just add one other thing that I skipped over, which I think is important. We felt, based on -- certainly based on the experience of this applicant with their own program, which was a grant-funded program, and the experience that has been reported from other places where something like this has been done, is that it takes time to get it up and running. So you don't just suddenly like flip the switch and, bam, you've got 300 patients

being cared for at home.

And there is inherently some idiosyncrasy to the implementation in different communities based on the kinds of resources that are available in the communities and locations and transportation systems and things like that.

So we did feel that having essentially a flat risk standard that would be -- sort of start from scratch and not change -- didn't seem to make sense because there would be start-up costs, there would be a learning curve, et cetera, and that particularly given the desire to get more of this in place, that we wouldn't want to deter people from starting because their risks out of the gate were too large.

So we also suggested -- and, again, the applicant did not object to the notion -- that the risk might be transitioned over time. We didn't try to specify exactly what that time period would be, but not view it as simply being the end state begins at the beginning.

CHAIR BAILET: Harold, that was a wonderful summary, and I want to compliment the discipline in the approach that the PRT used for this analysis. I know there was extensive dialogue with the submitters, which we're going to hear from in just a moment.

* I would like to open the discussion up to the

Committee members, not to deliberate, but if there are clarifying questions that individual Committee members have. I see Bob has one. We'll start that conversation now, then Kavita and Elizabeth and Bruce.

DR. BERENSON: A very good presentation.

Let me do one more of my bio things. In 1999 and 2000, I worked at what was then called HCFA (Health Care Financing Administration), and one of the demos that was under my responsibility was Hospital at Home, the Johns Hopkins proposal. I met Bruce Leff at that time.

I recent -- I mean, in studying for this, I found commentary by Bruce in which he referred back to that demo, which happened in Medicare as well as the VA (Veterans Administration), and then said, "Development of a payment mechanism for Hospital at Home in the fee-for-service arena using a Medicare demonstration mechanism waiver is pending approval." That was 2009.

We have an Innovation Award that's being evaluated. I guess the question is, this has been around for 20 -- almost 20 years, and now it's coming to us. Is there a story that we need to know about as to why this either has not succeeded at CMS or that there may be some disabling problems, which we'll get to a little bit later in the payment model? What do we know about the reason

that this is still sitting as a proposal and not having been adopted by CMS already? Does the PRT have any insight or knowledge about that? I guess is my question.

MR. MILLER: I have no particular insight into that, other than to say, I guess, that -- and I think we should hear from the applicant about that in a few minutes, but as I said just a few moments ago, it is challenging to get something like this up and running. And it is essentially creating a kind of a new system, a new kind of a provider entity, and with a potentially small patient population in some communities and with the potential threat to the notion that -- you know, that the hospital is not the most ideal place in the world.

I do think that what -- to me, what is different today is that there is growing recognition that a hospital is not the best place to be for everyone, and so what might have been before sort of an interesting idea becomes more, more potentially compelling now. But I cannot answer that. I don't know if Rhonda, Len, or anybody else on the Committee may have a better answer than that.

DR. MEDOWS: I don't have the answer from CMS. I think they would have to provide that themselves, but I can -- I know that in our discussions, the concern was the cost of having a diverse multispecialty-type service available

at home. Putting that in place, having people on call, having people on hold waiting, depending on what the patient needs, would be a little bit of a challenge if you weren't well resourced and financed to start it up in the first place. That's what I would imagine would be the --

MR. MILLER: I guess the answer is Bob should have stayed at HCFA long enough to have gotten it into place.

[Laughter.]

CHAIR BAILET: You heard it here first this morning.

Kavita?

DR. PATEL: I just have some clarifying questions. On page 7 of your PRT report for your summary of your rating, you state that multiple studies have demonstrated that the Hospital at Home care model improves quality and reduces cost. Can you just comment compared to what? Because as -- you've alluded to some of the [unintelligible] -- and I'm not trying to point to you, Harold. The PRT alluded in reference -- and I've read some of the international studies -- there's the Cochrane Review -- a lot of this is somewhat dated, in that they found a decrease in mortality, but some savings here and there.

You already talked about the post-acute savings.

Was that reducing cost, is that just kind of a wrap-up comment summarizing, or do you have a sense based on some of the data tables -- which I couldn't appreciate -- that there could be a reduction in cost, despite the limitations, compared to something else?

And then I had a second question [unintelligible].

MR. MILLER: Well, I'll start, and, again, then Rhonda and Len can fill in.

First of all, I think it's important to distinguish what do we mean by cost.

DR. PATEL: Yeah.

MR. MILLER: Right?

DR. PATEL: Right.

MR. MILLER: So spending is really the relevant measure here, and so when we're saying cost, we're talking about spending. And so the notion that has been demonstrated in the studies that's being referred to is that you can take care of these patients at home for a smaller payment --

DR. PATEL: Right.

MR. MILLER: -- than you could for paying for them in the hospital.

Now, whether or not it is lower cost is a

completely separate and more complicated question --

DR. PATEL: Right.

MR. MILLER: -- which is what we were raising is -- so if these patients didn't have to have a nurse visiting them in the hospital, [unintelligible] coming to their bedside very often in the hospital, essentially they might have been viewed as low-cost patients, you know, and fully allocated. But, it's lower payment for them.

And in terms of quality, there are studies showing a number of comparative measures -- readmissions, decubitus, other things -- in which the rates of those for similar patients were lower, and interestingly, one study that was done a few years ago, I think by Bruce Leff, looked at a population of patients in the hospital, classified them as to whether or not they were appropriate for Hospital at Home services, but did not actually put them into Hospital at Home services, and then followed by an intervention period in which patients were classified as being eligible and put into Hospital at Home services.

So at least in that particular case, which is somewhat challenging to do, but was done in that particular case, there was a control group of patients who were classified in essentially what was viewed as the same way and then compared them. And so the comparisons that I'm

talking about in terms of quality were, in that sense, apples to apples. Other things have been more difficult to compare in terms of apples to apples, but there's at least that one study that I'm familiar with that did that.

And I don't know if Len or Rhonda recall other things -- or Tim?

DR. FERRIS: Just from our organization, we have a manuscript under review showing significant cost savings. It's a relatively small sample in our group, but the cost savings are for exactly the reasons that Harold stated were very clear, even in the small sample that we have.

DR. PATEL: And then just a second question, you reference in the flexibility criterion, I believe, or at least the limitations around small practices. From what you have in the transcripts and kind of the back-and-forth, it really does seem like it's not feasible for -- I just want to clarify. It really does not seem feasible for a non-hospital-affiliated group to actually do this, given the resources, intensity, and what's just been acknowledged about what will likely be a small sample size yet -- I don't want to say tremendous, but significant infrastructure and time spent to do it.

So I just want to clarify. It does not seem realistic, not even a small practice -- it doesn't seem

realistic for a non-hospital-owned or -affiliated practice to do this.

MR. MILLER: Well, let me start, and then Rhonda may want to add to this.

I wouldn't agree with that. I think that what I don't think it works for is you wouldn't say to your average primary care practice, "How about taking on a few of these patients?" because -- and sort of "And here's a payment for you to do it." That wouldn't work.

But if you look at the staffing associated with this, it's a physician, an NP (nurse practitioner), and some nurses, and I believe that at least at one point, the Presbyterian Health Care Model that was going on in New Mexico was essentially using that -- but it would be a dedicated practice.

Whether or not it had to be part of a hospital or not, I think depends on the level of collaboration that they could get from the hospital, because you have to have a hospital partner, whether they -- because you have to have the ability to find the patients and be able to admit them if they need to be admitted, but whether they would have to be part of the hospital is a different question.

And then I think the other issue is in terms of this risk question, is that if one, right out of the bat,

said you're at risk for paying up to 10 percent back to Medicare, that would be a big challenge if you didn't have capital. But if you phased it in and if somebody actually built up a reserve, it might well be possible to be able to do that with appropriate risk limits.

But I'll see what -- if Len or Rhonda want to add to that.

DR. MEDOWS: No.

Kavita, I was going to say in my humble opinion, it would take multiple small practices with a partnership, with a hospital for it to be successful. I just -- I think that, though, that may be one way for them to become a more integrated group and formally without hiring each other.

There is some additional information about the cost change on page 4 of the responses.

CHAIR BAILET: Elizabeth?

VICE CHAIR MITCHELL: Thank you. I have two questions.

This may well be beyond the scope of your review, but you talked about sort of setting the rates or prices per DRG. Did you consider at all some of the infrastructure cost that would remain at the hospital and any pricing effect that might then be shifted to other payers and what the impact could be on total cost of care?

You also referenced that this may lend itself to a multi-payer model. Did that -- was that part of your consideration when thinking about the multi-payer involvement?

MR. MILLER: On the first part, yes, we did think about that explicitly.

As I mentioned, if you sort of play out the economics of this overall, you would say, "Well, if I'm taking the lowest-cost patients to the hospital out of the hospital" -- we don't know that in all cases, but if one -- let's just assume that if, in fact, that were the case, then the hospital's average cost per its remaining patients would go up. And if Medicare payment didn't adjust for that, then the hospital would have to make up for that somewhere else.

Now, over time, if everybody was doing this, you would say, well, then the DRGs ought to be changed because, in fact, the cost [unintelligible] because the DRG is supposed to, in some fashion, reflect the cost to the patient care, and if you actually end up with a higher acuity group of patients in a DRG, then the DRG payment would go up. And, again, then you'd say, well, you shouldn't be giving them a five percent discount on the new DRG, et cetera. So there's kind of -- there's that.

That's that.

Now, your point is, well, if Medicare didn't do anything about that, then the hospital might be encouraged to raise prices for somebody else, and you're absolutely right.

On the other hand, this isn't just a Medicare need, and this could, in fact, be potentially very attractive to -- I think to commercial insurers, who, again, I'm just -- I'm just saying this without evidence or data, but you'd say that a, you know, younger -- younger, healthier, you know, less comorbid person who simply needs to have home infusions, it could be a really good deal to send them home. And, in fact, a lot of people are looking at that, but right now there is not a clear payment model for that. So it could, in fact, be very attractive for some commercially insured populations to have the ability to be able to be cared for at home.

And if, in fact, you get more and more patients participating in it, then the cost of this goes down, and, you know, so pretty soon, as in the complexity where everything is related to everything else, you get to the conclusion where it's really hard to know how that's all going to play out.

So it's there, and it would need to be monitored,

but I wouldn't necessarily say given the volume of patients involved here that you would suddenly see any legitimate reason -- legitimate reason for a hospital to suddenly go out and jack up its prices on -- for everybody else. It doesn't mean that they wouldn't, but no legitimate reason based on a program like this.

VICE CHAIR MITCHELL: Thank you.

And one different question, have -- are you confident that any sort of regulatory barriers, if there are any, could be addressed either at the federal or state level? Were those considered?

MR. MILLER: I personally am never convinced that regulatory barriers can be solved until one actually tries to do something and figures out what all the regulatory barriers are, because they always appear, you know, whenever something is actually ready to happen.

I think that the -- in this particular case, we have at least one and multiple examples of where this is being done. So it's not like a -- here's an idea that we have that we think would be good, and we can't do it because it's not being paid for it, and so if you pay for it, we'll do it. This is a case where people are doing it and can't get the money to sustain it. So I think in that sense, one would hope that the regulatory barriers would be

minimal, but whether this starts to -- once you create a payment model, whether this starts to implicate fraud and abuse rules and, you know, all the stuff that would have to be done on that, I think we'd only know that whenever this really started to move down the track for payment.

DR. MEDOWS: So can I add the only thing I can think about is, depending on which state is actually going to be doing it, scope of practice, it may be something that has to be just built into it, depending on the state, right?

CHAIR BAILET: Thank you.

Bruce.

MR. STEINWALD: Sorry to do this, but back on the issue of cost, you know, there's a lot of variability within DRGs and the amount of resources that it takes to care for patients. The introduction of MS-DRGs (Medicare Severity-DRGs) help ameliorate the problem, but didn’t eliminate it.

So, as you said earlier, the patients who are cared for at home that would have been cared for in the hospital are likely to be the less resource-intense patients.

And I've been thinking, well, what could you do to determine how much less resource-intensive? And it's

very hard to -- in the DRG framework to actually measure the resources that a hospital requires to take care of patients because it's not required for payment anymore.

However, you could measure, let's say, length of stay. You could -- you could identify to what extent the removal of a certain group of patients has increased length of stay. I wondered if the proposer proposed that or anything like it to be more precise about the extent to which the patients removed has increased the resource intensity of those that remain in the hospital.

MR. MILLER: They did not that I recall. Again, we can ask them when they come up.

I think the challenge, again, is that it depends on the circumstances. So if the hospital is bulging at the seams and its choice is between freeing up some beds or building a new unit and this would help them do that, that would be very different than if, in fact, the hospital is struggling to survive and this is taking more revenues away from them.

I think that the one study that I did review showed that these patients were less intensive on average than the overall patient population and it's -- that's one of the reasons why we suggested that, in fact, simply a five percent off the DRG might not be the appropriate

payment, and there could potentially be some way of saying that there would be -- if this is a hospital partnership in this, that the hospital gets essentially some of that back to cover its higher average cost through a process like this. But that was not included in the proposal that I recall, anything on that.

DR. NICHOLS: Bruce, if I could just interject. I think it's really important to think about what this proposal's about, and it's about trying to get people out of the hospital, and really it's the cost of delivering this level of comprehensive coordinated care outside the hospital relative to the payment that's the most relevant. What happens to the hospital's average cost is second order, and it's important, but it's not the focus of the proposal before us. And, therefore, I think in some ways it's something to be monitored and certainly something to be adjusted for. But you shouldn't hold this proposal accountable for not adjusting for potential changes in hospital costs. It's the non-hospital costs that really matter.

MR. MILLER: And I would just add, I mean, that's been the case in many other Medicare payments, is that one change got made somewhere that has led to a large number of people being treated in different locations, in some cases

more expensive, you know, so I think one then has to address it after it happens. So I do think that's -- it's kind of -- we're trying to deal with some of the first-order and second-order effects. It's hard when you get to the third-order effects to try to figure out what that is.

CHAIR BAILET: So my question follows on along the lines of the fee, the payment, 95 percent of the payment that would have been applied if they were admitted to the hospital. And I guess what I would like to know in the discussions that you had amongst yourselves and potentially with the submitter, do you have a line of sight on 95 percent, how rational is that? You talked earlier about the up-front cost to get this stood up. Did it -- was it 95 percent to help mitigate some of that lift that would be required to get this off the ground? I'm just curious if there were -- if there are other insights that you garnered from this discussion around that?

MR. MILLER: Well, my sense -- and, again, Len and Rhonda can add into this. My sense is that five percent was there because there needed to be a discount, and five percent was sort of in the order of what discounts were at other places.

We raised the question about whether or not given that many studies had shown that the actual cost of in-home

services for these folks was maybe as much as 50 percent below what it is in the hospital. But their point was we're not just paying for what the patient would have gotten in the hospital, we're also paying for 30 days of post-acute care, we're preventing readmissions, et cetera. And they did provide some data showing that -- what the costs were overall for the patients.

But, again, I think our question was we don't know that five percent is the right amount. It may be a different amount. It ought to be based on some analysis, and it will probably evolve over time. But that's not a fundamental issue in the payment model, right? It just basically says if we're going to go ahead and do this, let's look at the numbers and see what the right amount should be. And, you know, God bless the applicant that they're actually doing some of this work so we have some data that we could actually work with on that to be able to look at.

CHAIR BAILET: Thank you, Harold.

Bob?

DR. BERENSON: Yeah, I want to try to get a little better idea of sort of the clinical conditions that we're talking about and what happens now with them. So, as I'm thinking about the kinds of conditions that I would

think might have been and might be amenable to Hospital at Home, DVTs, deep vein thrombosis, non-life-threatening pulmonary emboli, actually [unintelligible] about 15 years ago, because of low-molecular-weight heparin and different routes of administration, the standard of care as written up in articles is to just treat these people on -- not on a Hospital at Home basis but on an outpatient basis. Cellulitis, other things -- I guess the concern I have or the questions I want to pursue, and also with the Mount Sinai people is the extent to which current Medicare, traditional Medicare patients are not getting treatment at home because of payment barriers that you can't get the right personnel. I mean, do you -- can you explain to me currently if a patient has a deep vein thrombosis in Medicare, are they hospitalized because there's no payment mechanism for the needed supervision on an outpatient basis? Or are they getting outpatient treatment for their DVT? So that's, I guess, my simple question.

MR. MILLER: Well, I'll try that, but I do think that one should be directed to Mount Sinai. My sense is some of those people are being treated at home if they have the appropriate supports. Some of them are not because they don't and they are having to be hospitalized. So in a sense, this program is trying to find kind of a third, a

middle group there that wouldn't have gone home today but doesn't need to be in the hospital, and that there is no option for them.

And, again, I think you're describing -- when I looked at the work in Australia, there seemed to be a lot more -- a majority of their patients were cellulitis and DVT patients. There seemed to be a lot more chronic disease exacerbations in the Mount Sinai population. But the concern that we had overall was that there would be potentially a risk in terms of trying to get enough patients that somebody who might have gone home today would suddenly be put into the Hospital at Home program, as many -- many other programs, when you suddenly say there's a new service available, right? And I didn't want to go to the hospital, but, you know, oh, well, why can't I have that service because that's better than the alternative?

So I think we should ask them that. I don't know that we have good, clear data on that, and the difficulty is it's very hard without detailed clinical information on the patient and information on their home environment to know exactly what the nature of those populations are that are being hospitalized or not. And Rhonda may [unintelligible].

DR. MEDOWS: I was going to say the list of DRGs

that they propose for the patients to be treated at home is in the book on page 7, right? And it's kind of what you would expect. You know, if people are just sick enough for consideration for hospitalization but not high acuity, as in medically unstable, that they would be eligible. I think we need to distinguish between are they getting some type of treatment at home or are they getting what this model proposes, which is a more integrated comprehensive treatment? I think that's part of the beauty of this proposal.

As a physician, I can see a Medicare patient. They can have cellulitis, and I can order IV antibiotics or whatever to be delivered, infusion therapy to be done. But then I'd have to also do the other things that they also need to be done, because the patient is not one condition. Typically my Medicare patients had multiple conditions that also needed to be addressed. So I might need other services. And I think part of this model is it's more comprehensive, it's multiple specialty, multiple services to take care of them. So that's a little bit different.

It's true that an individual physician for that individual patient could prescribe all of these things, but I think what they're talking about is something that is more integrated and that it's a package deal.

MR. MILLER: And I think that this is addressing something that's coming up in a number of different settings, in payment models, is that it depends on the level of home support that the patient has and -- which is not a comorbidity, but it significantly affects the cost and approach to care for patients. And so if this enables some patients who have weaker supports at home to be cared for at home, then the traditional -- we'll have a home health nurse show up, you know, and exactly who is it that they're training to be able to do -- you know, to change the infusion pump?

CHAIR BAILET: Thank you.

Paul?

DR. CASALE: Thanks. Just to add on before I ask my question, I think at least the list I saw of their conditions that they actually [unintelligible] were things like pneumonia, urinary tract infection, COPD (chronic obstructive pulmonary disease), heart failure. And, Bob, not to date you and I, but I don't think anyone's admitted for a DVT anymore. You know, I remember the days when people were admitted for cardiac cath for three days. I mean, I just don't think that really happens. But I think it's more of these more acute infectious illnesses, heart failure, COPD.

Anyway, that wasn't my question. My question was just clarifying on the discussion with PRT, so I have a better understanding -- on some of the criteria, like 2, it seems like the list of weaknesses is longer than the list of strengths, and I just want make sure I [unintelligible] but yet it met criteria unanimously. I just want to understand in the discussion -- was the feeling that you recognize all these weaknesses but felt that they were fixable and nothing was sort of a fatal flaw and that's why you ended up where you did? Just to get a sense of the discussion amongst the --

MR. MILLER: Well, I'll start, and then I'll let the others comment since it was -- we all voted on that. But, yes, we didn't view -- I guess you would say that one doesn't necessarily weight all the bullets equally. And so we, in fact, felt that it was important for a payment model that seemed to be desirable to try to identify where we thought there were weaknesses so that they could be corrected. But our general conclusion was that all of these things were either correctable or that the significance or severity of it was outweighed by the strengths and positive aspects of the model. That's at least the way I would view it, and I'll let my colleagues say how they felt about it.

DR. MEDOWS: I thought that the quality proposal, the metrics that they propose, was a good start. I just simply wanted more, and so you see some of that. But I also think that part of what they proposed here is relevant also to the patient safety one where we, you know, as we agreed that it did not meet, so there was some cross.

DR. NICHOLS: I mean, the strengths were stronger. I mean, that's the bottom line. What we liked about the structure of the model outweighs the second-order amendments that we would suggest that you make before you implement --

MR. MILLER: And I would just add that was a carefully considered conclusion. We started in several cases with a more negative draft to sort of kick the tires on it and concluded that, in fact, that didn't seem to be the right judgment given the balance of these things.

CHAIR BAILET: All right. I thought that was a great clarifying discussion, and I want to remind folks that that's the purpose of this particular part of the proposal review, working with the PRTs. We're not deliberating, and we may have brushed up against the fence line, but the DFO (Designated Federal Officer) didn't speak up, so --

We're going to now get to the sweet spot of the

presentation, which is having the submitters come forward. We welcome you guys to come up, and rather than have me introduce you, I'd like you guys to introduce yourselves, and just a gentle reminder that it's a 10-minute opportunity for you guys -- for your presentation. So, I'm going to turn it over to the team.

* DR. SIU: Thank you. I'm not going to try to address all of the PTAC's questions in 10 minutes, you know, but let me try to hit some high points.

First of all, this is not a physician-focused payment model for Mount Sinai. There is a great deal of interest and success in Hospital at Home around this country. At the VA there's seven sites, including one very robust program in Cincinnati. There's been experience at Presbyterian Health Systems in Albuquerque going back several years. You know, Dr. Ferris mentions the program at the Brigham that's been recently started. And, of course, you know, Bruce Leff over here, you know, had tremendous experience with this, you know, at Johns Hopkins a number of years ago.

So, Mount Sinai's not alone in its interest in Hospital at Home. Indeed, since submission, we've been asked many times by others whether they ought to submit their own APM proposal for their own Hospital at Home

program, to which we've responded, you know, no. You know, we've tried to incorporate the flexibility in our, you know, proposal to accommodate, you know, a number of other programs. We've purposely have -- included flexibility so this can be done in other places other than Manhattan. There's been success doing this in Albuquerque and Cincinnati and in other places.

To Dr. Patel's question, you know, this may or may not be the sweet spot for very small practices in very rural communities. But there's a lot of experience around this country in terms of being able to do Hospital at Home.

We've tried to accommodate this for organizations that may have slightly different structures -- that may not have a history, as we have, in terms of home-based primary care -- that may not have a home care agency of their own. We do not.

We've tried to engage, you know, and construct this in a way that could engage physicians of various different specialties in various different roles, you know, working either part-time or full-time in Hospital at Home. And we've tried, you know, to make use of different available resources. We recognize that different organizations will have -- will come to the table with different resources available to put up a program. So,

Mount Sinai's pleased, you know, to put forward this proposal, but this is not a Mount Sinai proposal.

Apart from flexibility, we've tried to incorporate a variety of safeguards into this proposal to create what we hope at least, you know, approaches somewhat of a Goldilocks condition almost. We want to target patients who are sick enough to be hospitalized yet not so sick that they would be unsafe to be cared for at home.

We've tried to create a framework and incentives for financial accountability, but we also have tried to include quality metrics to make sure, you know, that we don't result in skimping as well as bundling so that we don't have cost shifting.

We've tried, you know, to put in safeguards so that we are neither acceding to the transfer of patients that turn out to be more work than somebody anticipated and just transferring them to the hospital, while also not putting up undue barriers to transferring to the hospital -- we call it "escalation" -- when it's clinically indicated and someone has turned -- and the situation has turned bad.

So these safeguards are detailed in the various documents, you know, and I'm not going to, you know, go through them, you know, with you. Mr. Miller has done a great job in terms of summarizing our proposal.

CHAIR BAILET: Excuse me, Dr. Siu. Just for people on the phone who aren't in the room, if you could just -- I want to make sure that they know who's speaking, so, please, could you introduce yourself?

DR. SIU: Sure.

CHAIR BAILET: I'm sorry.

DR. SIU: I'm Al Siu. I'm an internist geriatrician. I'm the Chair of Geriatrics and Palliative Medicine at Mount Sinai. My colleague on my left.

DR. DeCHERRIE: I'm Linda DeCherrie. I'm also a geriatrician, and I'm the clinical director of the program.

DR. LEFF: I'm Bruce Leff. I'm a geriatrician and health services researcher at Johns Hopkins.

MS. PELIZZARI: I'm Pamela Pelizzari. I'm a health care consultant with Milliman, and we provided actuarial and financial modeling support for this proposal.

CHAIR BAILET: Great. Thank you.

DR. SIU: Thanks for the reminder.

CHAIR BAILET: Please continue.

DR. SIU: To Dr. Berenson's point, in terms of why it's taken 20 years, in our experience, Dr. Berenson, Hospital at Home sits in a place where -- which does not exist in our system. This is not hospital, this is not physician services, and this is not home care. So that

regulatory agencies and payers don't know how to deal with this, we've -- and this is something, you know, that we have encountered and dealt with over the last three years in trying to find a place, you know, for this program.

And to Doctor -- the point has come up, you know, whether five percent is the right discount. I just want to point out a couple of things. We've included a number of things, as Mr. Miller pointed out, you know, within this initial bundle. So it's not just the initial hospital episode, but it's the physician Part B component of the services that would otherwise have been, you know, separately billed that are part of this bundle. So it's not just the five percent discount.

We also have included the costs of all of the transition services -- I still call it "transition services" -- that we provide, so that that includes, you know, physician and nursing visits during the 30-day period if indicated. They're not separately billed. We have, you know, sent out community paramedicine partners during that 30-day period. We can't bill that.

If a patient needs a second Hospital at Home episode during that 30-day period, we just restart a second episode as opposed to readmitting them to the hospital, and that has happened in three percent of cases. So it's not

just -- there's a lot of other stuff that goes into the initial payment.

Now, the proposal in the related documents really provides a lot of clinical, financial, and programmatic detail, you know, on this proposal. So as a complement, let me close this by telling you about one of our actual patients.

So, Stanley is a 96-year-old man with advanced kidney disease but not on dialysis, and he was brought to one of our Mount Sinai doctors with decreased alertness and coughing. And in the office, his exam and X-ray were consistent with a left-lobar pneumonia. He also had a blood pressure of 80/40, a sodium of 154, and a creatinine of 6, all consistent with severe dehydration.

His goals of care were not fully specified. The Hospital at Home team actually declined to take him home because of unstable vital signs and high risk of decompensation. But Stanley and his family, you know, they wanted to treat reversible problems, including with IV antibiotics, but they did not want to come into the hospital. His primary care physician did not want to admit him to the hospital. She was concerned about him being at high risk for hospital-acquired complications or delirium, immobility, falls, decubiti, et cetera. And the Hospital

at Home team did not want to see him hospitalized.

But in our community and in many communities across this country, the hospital was really the only option for somebody with severe pneumonia, with hypotension, and with a narrow margin of safety for hydrating him because of his kidney disease.

So what we did actually was we opted to treat him in the observation unit with IV (intravenous) antibiotics and hydration, and saw him the next morning, by which point his blood pressure and his mental status had improved enough that we felt comfortable taking him home, where we provided further IV antibiotics, you know, and IV hydration over the next several days. He got better, and he was discharged from the program.

His goals of care were discussed with him and his family, but they were not ready to process this. He was acutely ill. You know, there was too much going on, not all family members were there.

So we followed him in the post-acute portion of our program and continued goals-of-care discussions.

We were called several days later because he had taken a turn, and when we arrived, he was in respiratory distress, probably re-aspirated.

The family considered the various options at that

point and decided on hospice, and we followed along with hospice for the next several days.

He passed away a few days later in the presence of family.

Now, in the final two weeks, Stanley spent 14 days at home, zero days in the hospital, zero days in the ICU (intensive care unit), and zero days in post-acute SNF (skilled nursing facility).

At home, Stanley passed away in an environment where he and his families and his caregivers were the hosts and not the guests of the care team. They had their goals-of-care discussions at their pace and when they were ready, not on our schedule.

Stanley received care that was, you know, concordant with his wishes throughout, and he received zero unwanted interventions.

His was actually the case that spurred our development of palliative care at home, and we thank the family for permission to share his story.

Before turning it over to the PTAC, I want to thank the PRT for prodding us and really for helping us strengthen our APM. We've been flattered by your engagement, and we actually have been pleased to answer your 159 questions over the course of this summer.

[Laughter.]

DR. SIU: And my colleagues and I look forward to answering more of your questions.

CHAIR BAILET: Thank you very much, Dr. Siu. That was very compelling. And let the record show it was 159 questions, not 160, so –

MR. MILLER: We did show some restraint.

[Laughter.]

CHAIR BAILET: So we're going to go ahead and open it up to Committee members, and I see Tim. Go ahead, Tim.

DR. FERRIS: Well, I want to add my thanks to the PRT and the Chair's thanks for all the work you put into this proposal.

And, as you know, I have the good fortune of supervising a couple programs in this area, and -- but I want to ask a question in the context of the volume-value issue and the -- what the PRT, I think, appropriately highlighted as a significant concern.

And the context will be so that we have a program, and we have a program that is not paid for. So we invest in the program in order to stand it up because we believe we get a return on investment because we're an ACO. Right? So we have risk for total cost of care for a

population, and we've done the math and have determined that we can avoid a certain percentage of hospitalizations that actually provide better care, as you have so beautifully illustrated with Stanley, a care that's more patient-centered in situations where there is extremely low risk of decompensation and the patient would have been hospitalized in order to receive a service that is normally only delivered or paid for in the hospital.

So, in that context, I think there is a legitimate concern that the cost structure in a -- outside of the umbrella of an organization that is concerned about total costs. What is the mitigation strategy? So I guess two questions. What is the mitigation strategy outside of a total cost umbrella, where you really aren't concerned, "We would like to get paid for the infrastructure cost, and we believe if we got paid, we would still -- that would still be a good deal for our ACO? We wouldn't exceed our TME (total medical expense) targets," so it would be a good thing? But why -- I guess the question is, “Why didn't you propose this simply as a payment structure inside of a total population TME approach?”

There are numerous examples of opportunities within ACOs to waive the traditional rules and get this kind of infrastructure funding, but your -- and that would

have completely mitigated from my perspective -- I'll just put my cards on the table -- the volume over value concern with this proposal. Why -- did you think about proposing it that way under a TME umbrella, and as restricted to being under a TME umbrella, why did you propose it in a traditional fee-for-service setting?

DR. SIU: I guess it depends on where you want to end up here. Okay. And where we wanted to end up was a robust program that probably, you know, would serve the needs of multiple payers in our environment and not just, you know, our Medicare ACO, which we have as well, et cetera.

My guess is that, you know, to be able to do this robustly, you probably want to be able to have about 200 patients, from what I can tell from other programs. And, that the only way that we could see others doing this would be to start with Medicare, but also to engage multiple payers.

You know, our issue has been that for every case of Hospital at Home that we admit and take on, we know that we're probably missing three or four, either because it's the wrong time of day -- it's hard for us to take somebody and begin a case at 3:00 a.m., okay -- or because it's the wrong payer.

And we have -- you know, not part of this proposal, but as part of our program -- have a number of strategies in place for getting to the issue of multiple payers, and I think we have to get there.

CHAIR BAILET: Kavita.

DR. PATEL: Just real briefly.

Thank you. This was, as Harold mentioned, a very well-written proposal, so everything that kind of corresponded to the criterion was there, and it was evident. And I hear you that it's not a Mount -- I did not read it as a Mount Sinai proposal, just to -- I don't want to speak for anyone else.

But I had two questions. One was related to something that was in the transcript of the robust discussion between the PRT and yourselves. Dr. Siu, I think you actually kind of talked at length about kind of how -- or it might have been Dr. Leff, but two strategies to try to mitigate either any sort of selection bias, on one end, kind of cherry-picking or too much and, on the other end, probably, you know, not getting patients in.

And you mentioned kind of an independent [unintelligible] you had at Sinai, I believe, and at other institutions kind of auditing and coders internally who offered that kind of independent process. In thinking

through a parallel with what would be proposed, would that be kind of the function that CMS would play in terms of an auditing function? And that's just one clarifying question.

And then the second question -- or let me just let you do that so I don't confuse things. Sorry. Go ahead.

DR. SIU: I think you're referring to the issue of an APM Entity perhaps admitting patients who don't need to be hospitalized --

DR. PATEL: Right.

DR. SIU: -- to begin with.

DR. PATEL: Correct.

DR. SIU: You know, Dr. Berenson's DVTs, you know, et cetera.

And at least in our case, okay, we have had all of our cases reviewed against, you know, various admission guidelines. We happen to use, you know, MCG (Milliman Care Guidelines), but, I mean, there are a number of other guidelines out there that could be used.

I think that that -- this could be a function of the APM Entity or, you know, subcontract it out to somebody else to do it for them.

DR. PATEL: Okay. But, again, the responsibility

of the entity. That's --

DR. SIU: Right.

DR. PATEL: I just want to make that clear. Okay.

And then the second question is also just a clarifying question about the commercial contracts. You touched on it in responding to Tim, but you mentioned in here -- actually, I think it was someone -- Mr. Gandhi or Dr. Gandhi -- who talked about how there was -- if you thought about it, it was actually much easier, especially in the commercial setting. It was attractive to do prospective bundles.

So I just want to kind of take a step back. Is it fair to say that -- and it builds off of Tim's point -- that really, ideally, this could be a prospective bundle rather than this retrospective -- I think you refer to it as a true-up, but a retrospective reconciliation. And I just wanted to hear any of your thoughts on that.

DR. SIU: I'm going to ask Dr. DeCherrie to jump in because she's been leading the effort on this, but, actually, Linda, take it over.

DR. DeCHERRIE: I think things can be done in both ways. I think it would be more challenging to set up the prospective bundles with Medicare to start off with. I

think that would take a longer time to get this kind of program started. So, at this point, that's why we proposed the retrospective true-up.

DR. PATEL: Just to clarify, it really was about time or at least the feasibility for an agency like Medicare to do it?

DR. DeCHERRIE: Correct.

DR. PATEL: It's not -- but it does sound like commercial payers potentially thought that that was a much more attractive option?

DR. DeCHERRIE: Correct.

DR. PATEL: Is that fair?

DR. DeCHERRIE: Yes, yes. When in discussions with commercial payers.

DR. PATEL: And are you -- and you're doing -- are you actually doing a prospective bundle with a commercial payer right now?

DR. DeCHERRIE: We are doing a prospective bundle with a commercial payer right now.

DR. PATEL: Okay.

CHAIR BAILET: Bob?

DR. BERENSON: Thanks.

First, let me -- since Bruce is right there, let me ask why are we 18 years later, and, you know, in

particular, I mean, I get Al's point about falling through the cracks, but I thought CMS was trying to figure out a payment model to support this. Why aren't we there yet?

DR. LEFF: Thanks for that question, Bob, and appreciate the opportunity to vent after working on this for 23 years.

[Laughter.]

DR. LEFF: I think it's a few things. So, first, at a meta scale, I think -- and Al touched on this a bit. You know, Hospital at Home doesn't fit. It is [unintelligible] in the health care culture, it is counter-culture. Right? Hospitals are very good at dealing with things that they are very comfortable with -- facility-based care. They are much less comfortable with things that happen in the community. They're [unintelligible] my view, they're uncomfortable with skilled home health care, but they're really uncomfortable with providing acute hospital care in the home.

So, you know, the system is geared towards serving the facility, everything from leadership and the C-suite and all of the management structure -- it all leads back to the facility. So I think that's at a very high level.

I think in terms of Hospital at Home and CMS, I

think it's just taken time. So we had submitted a proposal under -- what was it -- the Section 646 waiver that came out of the Medicare Modernization Act? Hopkins submitted that proposal. We basically asked for a similar kind of approach here, although we did not have that post-acute component built in quite as robustly. And so that was about 2006, 2007 or so, and at that time, CMS came back to Johns Hopkins and said, "Johns Hopkins, you're good actors. We like this model, but we would like Johns Hopkins to take full risk on a six-month episode of care for total costs, no matter what."

And, you know, the conversation was, "Okay. So on day 179, the patient gets hit by a bus crossing Broadway in front of the School of Medicine. We're responsible for that cost?" and CMS said, "Yes, you are responsible for that cost." So that was something of a nonstarter. I think appropriately a nonstarter for Johns Hopkins.

So I think -- you know, I think CMS has evolved in their thinking around bundles and risk and risk sharing, and I think in the wake of the Affordable Care Act, I think the whole ecosystem has changed, and health systems have also taken a broader view.

So I think a lot of it is culture. I think we're in a much better place now to try things like this, and I

would say just based on anecdotal evidence of the number of inbound inquiries that I get, that I know Al gets, and others who do this model, I mean, we've spoken to hundreds of systems and practices and entities. And I think there is some pent-up demand, and I think an appropriate and carefully designed payment will help move that, move that down the field.

DR. BERENSON: So my follow-up has to do with the shared risk part of this. I'm not always a big fan of shared risk, myself -- that's not the prevailing view, and I'm just wondering whether this model, a good payment model for Hospital at Home -- I think 95 percent may be a little generous, but without the shared risk part of it would also be attractive.

I mean, what I'm observing now is that lots of proposals are coming in because of the MACRA (Medicare Access and CHIP Reauthorization Act of 2015) rule about the five percent bonus you get if you take risk and exemption from MIPS (Merit-Based Incentive Payment System). I can't imagine you wouldn't make the 10 percent bonus with this much [unintelligible]. I assume it has to be a healthier population of people. You would be in Hospital at Home rather than in hospital, and that it would be hard not to make that 10 percent. And it sort of complicates things.

So tell me why the shared risk, and it is my presumption that you actually are -- have a very favorable selection here -- is that true?

DR. LEFF: Well, let me address the selection risk, and then I will let Al address the payment risk.

So the selection risk, it's actually not uncomplicated. One factor that I don't think I've heard discussed today is the notion of the fact that Hospital at Home improves outcomes, and then selection looks -- you know, it looks like it's a -- you are selecting more favorably towards Hospital at Home, but it's actually the effect of Hospital at Home.

So if you look at the studies of Hospital at Home, you have reductions in outcomes like incident delirium reductions of 75 percent. Incident delirium increases the length of stay of hospitalizations. It increases the cost. It increases mortality. So at six months later when people look healthier, you might retrospectively look back and say, "Well, they were just healthier to start with," but in fact, it's the effects of the model that enhance the appearance of selection, where it might not have been quite as drastic on the front end.

And so remember -- and this goes back to Dr. Patel's question. Dr. Patel, you were asking about

compared to what on cost, but also it would be reasonable as compared to what on outcomes? And, you know, the data from the international literature, those were meta-analyses of, you know, depending on the meta, you know, somewhere between 10 and 60 randomized controlled trials, randomized controlled trials comparing hospital care to Hospital at Home care, and noting substantial reductions in mortality at six months. So that's dead or alive at six months.

I think most people would choose alive, but it just gets back to the issue of selection.

And I'll let Al --

DR. SIU: Right.

So, Dr. Berenson, in some ways, a prospective model actually would be easier to administer, you know -- or the payers that we've talked to, you know, don't want to deal with the true-up and everything else, you know.

But the problem, you know, is setting the right number. We don't -- we just don't have the data by which to set the right number, and, indeed, our experience with the payers is that there's a certain back-and-forth and a number being pulled out of the hat saying that we'll revisit this next year. And I'm not sure, you know, that that's so feasible, you know, to do with the Medicare program.

Now, having said that, I actually have become somewhat of a fan of bundling this for 30 days -- in that I think that we actually do a lot of good during that 30-day period. First of all, you know, someone is at home, so the discharge day is kind of arbitrary. We don't have to transport the patient home. So the discharge process is actually somewhat more phased. You don't have to go from -- you know, from $1,000 a day to zero.

And the bundle allows us to provide a lot of services in that 30-day period, you know, that there simply is no other way of paying for.

DR. BERENSON: Just to clarify, I'm not concerned. I mean, I actually like the bundle concept. It's the shared savings thresholds and the possibility that it's a no-brainer that you guys would just get the 10 percent and Medicare would wind up -- I mean, under -- as I understand it, a five percent discount, you have to achieve savings of three percent, and then you can collect, keep up to 10 percent. By my calculation, Medicare loses money because you'll make the 10 percent, unless you get -- unless you really know how to do risk adjustment for this population. So why not give you the bundle, give you a payment model, but not necessarily do the share savings and shared risk is what I'm suggesting.

DR. NICHOLS: So, Bob, I don't -- we can probably quibble about the math, but it depends upon the relative base of the two payments, right? You're talking about guaranteeing Medicare 8, and we're talking about 10 percent on the second piece. So it really does depend upon the relative base.

It's an empirical question.

CHAIR BAILET: Thank you.

Paul.

DR. CASALE: Thank you, and thanks again for your comments.

I just had three specific questions. One is to add on -- I just wanted a clarification on Kavita's question around the cherry-picking, and the coders and billers sort of providing oversight. And I guess, you know, I'm thinking -- and, again, as you said, this is a model beyond Mount Sinai, so I'm thinking more globally. And so when I think of the ongoing confusion that continues around observation status versus admission and all the criteria and the RACs (recovery audit contractors) and everything else that's currently in place -- I'm trying to understand, would we expect that, again, there would be sort of a RAC-type entity, the big insurer that people aren't being enrolled in this program inappropriately? I

just wondered if you had any thoughts around that oversight piece, as opposed to just the internal control.

DR. SIU: Well, my proposal would be, you know, that the APM Entity do this, subject to outside audit if necessary as opposed to having the RAC do every single case.

DR. CASALE: Okay. The other question was around -- I know we talked about small practices being involved. Is there anywhere that is currently initiating any of this that is not an integrated system, that's doing hospital at home that's not an integrated delivery system?

DR. LEFF: So, the only one I know of is a physician group outside of Boston, which is in collaboration with an entrepreneurial group that is engaging in a Hospital at Home type of approach. They're not a full [unintelligible] they don't own hospitals. They don't own other things. It's just a big physician group.

DR. CASALE: Okay. And the last question, and this is sort of specific -- I know the visits can -- they're sort of physician/nurse practitioner. Is the initial visit always a physician and then beyond that is it either a physician or NP? I just want to understand the clinical evaluations.

DR. DeCHERRIE: In many cases, we use the

physician and NP interchangeably. So some days the NP is admitting patients in the emergency room, and the physician's doing the home visits. There's always an attending of record, a physician of record for all the cases, but -- and even sometimes when the NP's doing a visit or the RN's doing a visit, they'll do a video visit back to the physician in the office if they're not the one doing it. But, yes, some days it's the NP as the only provider doing the home visit. But there's team meetings every day about every case.

DR. CASALE: Okay. That's great. And, again, just trying to think as this broadens, since nurse practitioner training can vary depending on -- so do you provide additional training specific around the hospital for home for these NPs that are in the program?

DR. DeCHERRIE: We did find that for every practitioner there was additional training. There's not much training for physicians or nurse practitioners of how to do home visits in general. Nurse is a little bit more. Many of them have been exposed to home care. But even in those nurses who were exposed to home care, this is a higher level of care that they would have otherwise been maybe uncomfortable with in the home. So, yes, we did do a fair amount of training with all our team members on the

program and have, again, that ability of the video visit to communicate at any time.

DR. CASALE: So would you recommend that as part of this there be sort of a -- and I'm not picking on NPs, but a lot of them sort of trained in family practice, not necessarily in acute care. They're going into the home, and they're evaluating an acute situation. So would part of this be that additional training should be part of that, or would you leave it up to the entity to decide that?

DR. DeCHERRIE: It really depends on the experience of the NP, and I think that just like every institution has a way to determine if that physician is appropriate to be working in that setting, the same thing would be, I think, on the institution for determining if that NP is appropriate for the setting.

DR. CASALE: Okay. Thank you.

CHAIR BAILET: Harold and then Tim.

MR. MILLER: Just two things. One, I would just pick up on Linda's comment. I think having had some experience in setting some things like -- not quite like this, but myself, I think this is one more reason why time will be needed to have anybody who starts these things up. If you've got the perfect home health nurses sitting around ready to go, you're in much better shape than if you have

to go and find them. I've been disappointed to see how difficult it is anymore to find the kind of entrepreneurial home health nurses that I think used to more exist in the past. There's more people now who kind of want to go and do the fixed thing rather than being able to walk into a situation. But when you find them, they're wonderful, and they can make a huge impact.

I wanted to comment back on the issue that Bob raised, because we did ask the question whether this was the ideal payment model or whether this was the payment model that was sort of structured for practicality. And I think the simple paraphrase was “it's not the ideal model, but it's the model that sort of looks a lot like things that CMS is already doing and, therefore, may have -- may be a faster path to acceptance.” And I think that we will -- my personal feeling is that we will see that a lot with applicants coming in, is that we're seeing people proposing things that look like other CMS models, which doesn't mean that the other CMS model was the ideal way to do things, but it's kind of the thing that exists right now.

The thing that I did like about how they responded to us was that they were thinking about what a better model might be and would like to transition to that and were viewing this as a transitional step. I think one

of the challenges we're seeing around the country is that even those shared savings models they said were supposed to be transitioned to something, nobody's ever said what the hell the transition is to. And so people are sort of still in that model without clearly a sense of where to go.

So I think in this particular case, their interest in having some kind of more of a prospective episode payment and seeing the advantages of that is helpful to know that that's where they want to go. But we didn't try to say we don't like your model, we'd like some ideal thing. We said what you've proposed with appropriate modifications seemed to meet the criteria, and that's why we concluded what we concluded.

CHAIR BAILET: Tim.

DR. FERRIS: Sorry to keep beating on this horse, but as my thinking evolves, to hear the discussion, I wanted to clarify whether or not you think I'm correct in the following assertion: that the proposed approach to the coding issue -- the "retrospective review of appropriateness" is the way I'll characterize it; maybe that's an incorrect way to characterize it, but that's how I understand it -- is really in lieu of the fact that it's not in a total risk population; that, in fact, the whole -- if you were in a population risk situation, you wouldn't

need to do that step. You wouldn't need to include it because the organization would have every incentive not to overuse, [unintelligible] utilize home hospitalization. And so it's because you're proposing it in a fee-for-service mechanism as the payment, that you are using this mechanism to document the fact that you're not overutilizing to address the volume-value. Right? Is that -- would you agree with that statement?

DR. SIU: Yes. Indeed, we actually have taken care of some patients, you know -- Linda, you can tell them about our hospital-adverse experience -- which we did not put into this model because we couldn't figure out a way of doing that.

DR. LEFF: I think the only thing I would add is, Tim, I think your premise assumes that at-risk organizations are 100 percent efficient at not admitting -- at that exercise, which my clinical experience would suggest is not accurate.

DR. FERRIS: So, then since they at least have an aspiration, one would expect that if you were an at-risk organization, you would put in place that model to check yourself potentially. Right? I mean, it's an option. But at the end of the day, if they're overutilizing, they're actually paying for that overutilization.

DR. LEFF: Indeed, yes.

CHAIR BAILET: Elizabeth.

VICE CHAIR MITCHELL: Thank you. I don't actually have a question, but your patient story inspired me to make a statement that is admittedly more personal than professional. But a year ago this weekend, my father passed away in a hospital in intensive care two weeks after being admitted for a very routine procedure, after having suffered multiple unnecessary procedures, complications, and medical errors. So I just wanted to underscore what you said about options not being available, where he could have had an experience like Stanley, and he would have been better off. And I can't even quantify the savings, which are almost irrelevant. But the experience of having that alternative setting I think would have been incredibly important, at least in our situation.

CHAIR BAILET: Thank you. So, seeing my colleagues have exhausted themselves relative to questions, I really want to compliment the proposals -- the proposers and the proposal for the discipline and the insights that you have provided here in person and also all the work that was done between the PRT and your group. So, thank you for that.

It is now time during this transition, we're

going to transition to the public comments part of the discussion, in that we have six, potentially seven -- we have six folks, one here and several on the phone. We're going to go ahead, and you guys are welcome to return to your seats, and we'll go ahead and start the Public Comment section, and that's three minutes for the comments, starting with Patricia Barrett from the National Committee for Quality Assurance. Hi, Patricia. Yep, she's right here.

* MS. BARRETT: Good morning. Is this working? Great. Okay. Good morning. My name is Trisha Barrett. I'm the vice president of product design and support at the National Committee for Quality Assurance.

Over the past several months, Peggy O'Kane, the president of our organization, and I have been working closely with Dr. Siu and his colleagues to develop auditing protocols and accreditation standards for the Hospital at Home Plus PFPM, and I'm confident that the system we've outlined will help keep patients who stand to benefit from this program safe.

The accreditation tool we adapted from our patient-centered practice recognition criteria to align with this care model. We received some great input along the way from the Hospital at Home Plus providers, quality

experts at NCQA, and the Preliminary Review Team. The feedback and commentary that you provided and the dialogue that you had with the team really did help to further shape those criteria. Once approved, hopefully, we would be able to move forward pretty quickly to establish final criteria on which we could qualify organizations to be part of the program.

We've had a long history in measure development and implementation. We seek to unite diverse stakeholders to create consensus on what is important to measure and to improve. And then we follow that science. We translate the medical evidence into expectations and standards of what good care is. And we look to measure that performance against those expectations and continually evolve any criteria for the program to make sure that it takes into account any new findings.

The mechanism for Hospital at Home Plus APM would be no less rigorous and thorough. Based on feedback throughout this proposal process, we've added to our initial mechanisms several features to address specific review team concerns. This included requirements to report all patients who die during a full Hospital at Home Plus episode, except those patients in palliative care; experience a serious fall contributing to an ED (emergency

department) visit or hospitalization during the acute period; or experience an escalation that includes any ICU stay; requirements that these cases are reviewed internally by the team as well as by a mutually agreed-upon reviewer by perhaps CMS or other review committee external to the care team, with a final report submitted within 60 days of occurrence of the event, including conclusions, recommendations and actions taken if warranted -- essentially an improvement process built in to help reteach everyone participating in the program; requirements that each Hospital at Home Plus entity collect and report compliance with the minimum specified provider visits that are outlined in the model; requirements that the entity explain or act to improve on performance wherever they deviate from expectations; requirements to demonstrate a process for informing patients and caregivers of their rights, the right to report adverse events, and have their concerns addressed in a timely manner. They need to then show that they execute effectively on that process.

We believe these additions will make practices more transparent and patient safeguards more robust. In this way, the PTAC process in itself has been a patient safety mechanism. We applaud your commitment to safety and now believe the program is sufficiently protected from

risky care delivery. We hope today you will feel assured that the patient protections are sufficient to move forward with this promising care model.

Thank you.

CHAIR BAILET: Great. Thank you, Patricia.

Marc Westle is on the phone. We need to open the phone lines. He's from Mission Health System.

DR. WESTLE: Thank you. Can you hear me?

CHAIR BAILET: Yes, we can.

DR. WESTLE: Thank you. Marc Westle. I'm the senior vice president for innovation at Mission Health in Asheville, North Carolina. I'm an internist and practicing hospitalist.

On behalf of Mission Health, I'm pleased to present comments on Hospital at Home Plus Provider-Focused Payment Model, submitted by the Icahn School of Medicine at Mount Sinai.

Mission Health is North Carolina's sixth largest health system. We operate six hospitals, numerous outpatient and surgical centers, post-acute care, long-term care, and the region's only dedicated Level 2 trauma center.

For five of the past six years, Mission Health has been named one of the nation's top 15 health systems by

Truven Health Analytics, and we are the only health system in North Carolina to achieve this recognition.

Mission Health serves as the safety net provider for the residents of the 18 western North Carolina counties, a predominantly rural and economically depressed area. Since our inception in 1885, Mission Health has been dedicated to serving western North Carolina by providing high-quality care regardless of a patient's ability to pay.

All of our 18 counties are designated as health professional shortage areas, and it's estimated that we have about 140 physician primary care deficit alone. In addition, the region is challenged with high unemployment and poverty; 16 of the 18 counties in western North Carolina are designated as Tier 1 or Tier 2 economically distressed counties as defined by North Carolina's Office of Economic Development. Additionally, Mission's 8,500 square mile service area has mountainous terrain with challenging access issues. Travel from the western edge of our service area to the eastern edge is about 175 miles, with an average three-hour travel time.

These factors illustrate the need for innovative care delivery models in an area with profound access challenges, and as a rural provider, we are committed to addressing the needs of our community. Mission Health has

been actively developing alternative care site designs and prototyping options [unintelligible] for acute-care hospitalizations even though there are limited options for reimbursement. Our initial approach was to stand up a model for at-risk populations because of the clear outcomes and cost benefits. Mission Health is interested in moving forward with Hospital at Home Plus model, as it would aid us in serving the complex health care needs of our vulnerable populations, a population that is older, sicker, and poorer.

We have previously submitted statements and comments in support of Hospital at Home Plus. Several trials have shown that this approach improves patient safety, reduces mortality, enhances quality of care, and reduces the cost of providing care for various acute illnesses.

We urge PTAC to fully consider and recommend CMS implement Hospital at Home Plus model, which would cut Medicare costs and have a positive impact on the lives of Medicare's most vulnerable beneficiaries.

Thanks for the opportunity to provide additional comments on this provider-focused payment model that, if implemented, would greatly benefit Mission Health's patient population among other vulnerable beneficiaries. Thank

you.

CHAIR BAILET: Thank you, Dr. Westle.

Next we have Karrie Decker from the Presbyterian Health Services. She's on the phone as well.

MS. DECKER: Good morning. My name is Karrie Decker, and I'm the administrator of home and transition services at Presbyterian Healthcare Services. Thank you for the opportunity to offer my public support of the Hospital at Home Plus APM.

Since 2008, we have operated a Hospital at Home program in the greater Albuquerque region, modeled off of the Johns Hopkins program led by Dr. Bruce Leff. Our program is available to our health plan patients who are clinically appropriate for acute in-home care and live within a 25-mile radius of one of our PHS (Presbyterian Healthcare Services) emergency departments. It's approximately 2,000 square miles.

Amongst our findings since implementing the program, our patients have had comparable or better clinical outcomes and report higher satisfaction with their care while saving 19 percent over costs for similar inpatient services. In this care model, we advance the triple aim of clinical quality, affordability, and exceptional patient experience. We've had significant

savings in the post-acute care arena, too.

I wanted to insert a comment here from my normal script in regards to the population being healthier. We have not experienced that this group is the healthier group. In fact, we've experienced that the population we serve has a tendency to be those that are in the last couple years of life, that are struggling with advanced illness, that have experienced a significant number of hospitalizations in the course of their care, and choose vehemently to avoid hospitalizations and to stay at home. And we find this population is also a population that is most commonly admitted when they present, even though a person younger and healthier presenting with the same condition might not be hospitalized, the frail elderly with significant secondary complications are often admitted.

The Hospital at Home Plus results are just as promising as the results that we've experienced, and we respectfully disagree with the Physician Review Team's findings related to patient safety. Not only do our outcomes show a decrease in adverse events, such as falls and hospital-acquired infections, we also have found that our patient population maintains a significant amount of independence that is often lost when they are hospitalized.

The Hospital at Home Plus has implemented a

program that performs similarly well to existing proven practices and speaks not only to the efforts of the entire team but also to the merits of the proposal on which it is built. We further applaud the proposal's efforts to implement safeguards that would be generalized to any participating APM Entity, as well as to elaborate a thoughtful auditing mechanism on par with or exceeding the audit inpatient providers undergo today.

We are excited to see the Hospital at Home Plus team advancing a payment model to match this proven clinical model. Gaps in the MS-DRG schedule leave many services critical to delivering safe, high-quality care in home unpaid for. We at Presbyterian are fortunate to work in a capitated model, but Hospital at Home deserves the opportunity to thrive in the multi-payer market. PTAC, Medicare, and HHS have an opportunity to lead this expansion in this consequential APM.

We published earlier outcomes from our Hospital at Home program in June 2012. In laying out the results, which replicated the work of previous studies, we noted that, "Despite such evidence, the dissemination of Hospital at Home in the United States has been limited by attitudes, payment, and policy. Additional issues arise from the assumption that hospital care is safer and that providing

acute care in the home setting is inherently inferior. Traditional payment models create barriers to new care delivery methods because of standard and sometimes restricted coverage policies. Fee-for-service Medicare Part A and B have no payment mechanisms for a Hospital at Home admission."

Five years later, it is time to close the gap between proven care models and lacking payment models. The Hospital at Home Plus proposal is just such a framework to begin this task.

Thank you.

CHAIR BAILET: Thank you, Karrie.

The next speaker is also on the phone, Andrew Molosky from UnityPoint at Home.

MR. MOLOSKY: Good morning. I want to thank everybody for the opportunity to address you this morning. As indicated, my name is Andrew Molosky. I'm the president and chief operations officer of UnityPoint at Home.

And I want to take a moment to express my support for the Hospital at Home physician-focused payment model. I believe it offers an immense opportunity for providing high-quality patient-centered care in the home setting.

UnityPoint at Home conducts roughly 600,000 home visits on an annual basis treating nearly 70,000 unique

patients in their homes across Iowa, Illinois, and Wisconsin. In-home treatments range from acute to subacute to chronic conditions, including but not limited to the following services. We have about 3,000 home care patients average daily census in the moment, roughly 13,000 prior care visits, nearly 300,000 hours of pediatric home care we delivered, 15,000 patients being monitored virtually for WOCN (Wound, Ostomy, and Continence Nurses) services, et cetera, and a large, robust specialty pharmacy.

Many of these services could be adapted to deliver acute care, should physician-focused payment model of Hospital at Home be recommended for approval by the PTAC. We're very encouraged by the positive outcomes that Hospital at Home Plus pilot has demonstrated and are enthusiastic about their, you know, palliative care and observation home programs as well.

We've actually piloted our own Hospital at Home program in the Des Moines metro area, which to give you a perspective, it's geographically very distinct from the Mount Sinai experience. The Des Moines population over in the metro region is around 600,000 people, and in respective footprints, it makes for population densities of about 211 and 2,911 people per square mile, respectively. So, despite being roughly one-tenth the density of a New

York City environment, our pilot program was still very viable to serve our patients effectively in their home.

That said, the current fee-for-service schedule is really insufficient to promote the broad adoption of a Hospital at Home for suburban and rural geographies. You know, the Physician Review Team report is correct in noting that this particular PFPM covered services that are not currently by Medicare or other APMs; however, it's our experience as well as those of other successful pilots in geographically diverse areas, you know, as a counterpoint to the PRT's suggestion, that this payment model would likely be limited to urban areas.

UnityPoint Health's motto is, "Best outcome for every patient every time," and often the best outcomes result from in-home care, rather than in hospitals where patients are more likely to experience delirium, all [unintelligible] infections, et cetera. You know, this is especially true for the Medicare population and for the patients we care for at UnityPoint at Home. You know, really, ultimately, we offer our support because we think this model holds significant promise for patient care and really, you know, adheres to and delivered on the triple aim.

So, again, many thanks for your time and

consideration this morning.

CHAIR BAILET: Great. Thank you, Andrew.

Stephanie Glover from the National Partnership for Women and Families. She's also on the phone.

MS. GLOVER: Thank you. Good morning.

Good morning. My name is Stephanie Glover, and I'm commenting on behalf of Debra Ness, the president of the National Partnership for Women and Families.

The National Partnership represents women across the country who are the health care decision-makers for themselves and their families and who want to ensure that health care services are both affordable and of the highest quality.

We're deeply invested in improving the quality and value of health care and committed to ensuring that all models of care delivery and payment provide women and families with access to comprehensive, high-quality, well-coordinated care.

We believe that the Hospital at Home Plus APM is an innovative approach to improve health outcomes and experience of care, as well as lower cost, and hope that the PTAC will recommend this proposal to Secretary Price.

The National Partnership strongly supports innovative models that endeavor to meet the needs of the

patients they serve and to improve how care is delivered. We believe this model is consistent with those goals and values.

For example, the inclusion of transition services in the model also encourages interdisciplinary teams of physicians, nurses, and social workers to link patients to community-based partners, to provide services, and address ongoing needs.

We are also encouraged by the potential integration of palliative care services into this model. Palliative care is a valuable addition to any acute medical event, especially for Medicare -- for the Medicare population, who often have contraindications for entering a hospital. The patient should not have to choose between avoiding complications from a hospital stay and receiving palliative care. This will not only merely allow but rather embraces the role that palliative care can play in the home setting.

Moreover, consistent with the over 90 percent of older Americans who want to be able to age at home and in their communities as long as possible, this model provides the kind of care we know patients want and need; that is, whole person care in the setting of their choice.

Ultimately, the success of any model rests on its

ability to meet the needs of patients through sustained implementation of patient and family-centered care. The Hospital at Home Plus APM has demonstrated that it is, indeed, an innovative model to approach -- an innovative model approach to try to achieve this goal.

Thank you.

CHAIR BAILET: Thank you, Stephanie.

Dr. Arnold Milstein, the Clinical Excellence Research Center at Stanford University, is also on the phone.

DR. MILSTEIN: Good morning. Thank you for the opportunity to comment on the Hospital at Home Plus Physician-Focused Payment Model proposal and PRT recommendations.

I am a previous MedPAC commissioner, currently medical director of the Pacific Business Group on Health, professor of medicine, and the director of Clinical Excellence Research Center at Stanford University.

The research center I run is specifically focused on designing and demonstrating scalable care delivery innovations in diverse regions of the U.S. that provide more with less.

The Hospital at Home Plus model exemplifies such a value innovation. Its development, refinement, and

multiple proofs of beneficiary benefit has been physician-led from its inception.

I have previously served on the National Advisory Board as an unpaid member for the Mobile Acute Care Team, the pilot on which this proposal is based, and have seen it be refined and evolve over years into the robust program, ready for scaling, that is before the Committee today.

Drs. Siu, Leff, and DeCherrie have provided strong evidence of the success of the care model in improving the clinical, as well as cost-of-care outcomes and beneficiary experience of care in diverse U.S. locations over the past 20 years.

I had a chance to review the very well-done PRT preliminary report. I would like to briefly address why I believe the proposed payment model, in combination with annual accreditation by NCQA (National Committee for Quality Assurance) and other forces, is likely to assure that Hospital at Home scales safely as a physician-focused payment model.

First, this program's 20-year history of meticulously measured proofs of success and the use of this history to set clinical cut points for quality adjustment of the proposed payment formula, I believe, constitutes a -- in and of itself a robust approach to quality protection.

Secondly, continuous tracking of early trends of these measures, both by the clinicians leading these innovations and claims-based signals, such as unplanned hospital admissions by CMS, will enable -- will enable and support clinical process improvement as well as signal unsuccessful improvement effort.

Third, an APM stands to lose substantial funding if they apply this care innovation to inappropriate patients with a high risk for escalation to require hospital admission. This will mitigate the risk of unsafe admissions to a Hospital at Home program. Other adverse events will also lead to higher costs.

Fourth, all adverse events expose the APM Entity to the risk of an audit, quality sanctions, loss of NCQA program accreditation, and reputational risk. I believe that these four attributes comprise a strong set of forces that will focus APM Entities on the important job of protecting quality of beneficiary care.

The PRT has suggested a supplementary quality adjustment of each individual DRG-like payment beyond the proposed application of quality adjustment to the proposed provider repayments to CMS and shared savings payments as well as annual NCQA program accreditation.

I would encourage reconsideration of the

supplemental quality protection recommendation, since a single adverse outcome does not reliably signal whether the program is underperforming, what would have occurred if a patient had been hospitalized instead of cared for in their home.

For Hospital at Home Plus, evidence of unsatisfactory performance on quality and safety is best determined by assessing the frequency of adverse events relative to proposed benchmarks. Using a statistically significant unfavorable frequency over a prior period, be it annually or semiannually, or relative to the proposed quality adjustment payment thresholds, which are grounded in results from prior successful Hospital at Home clinical trials, would be a better approach to assuring quality risk -- for managing quality risk from uptake more broadly of this very successful care innovation.

I strongly agree with all other PRT findings and encourage you to move forward with a care innovation carrying, I believe, uniquely strong proof, that in diverse U.S. locations, substantial improvement will occur in patient-centeredness and all other domains of quality and value.

Thank you for the opportunity to share my comments.

CHAIR BAILET: Thank you, Dr. Milstein.

I have one other person that's registered. They're in the room, and I'm not sure that this is the proposal they want to speak to. So I'm just going to mention the name: Allison Brennan. If this is not the proposal, we can -- we'll just keep your name, and hopefully, you can clarify at the break which proposal you want to comment on.

MS. BRENNAN: I'm good.

CHAIR BAILET: You're good? Okay, very good. Awesome.

So in the interest of my colleagues, what I'd like to do is take a 10-minute break before we start deliberations. So we're going to reconvene at a quarter to, so thank you. Appreciate it.

[Recess.]

CHAIR BAILET: All righty. So we're now going to move -- I guess I would ask Committee members if there are any other additional comments that people want to make on the proposal. If not, I'm asking the Committee, are we ready to start deliberating and voting at this point in time?

DR. MEDOWS: I have one comment, Mr. Chairman.

CHAIR BAILET: Absolutely.

DR. MEDOWS: One comment. I just want to share that I see this proposal as part of the evolution of medicine. I believe this is part of our work to actually transition from hospital settings. We already did some of this work when we did elective surgeries in ASCs (ambulatory surgery centers), when we actually moved chronic care to home care and community-based care. Now we're talking about a lower acuity acute care that can be done at the home.

I think that some of the comments we've heard from the public and from the submitter about the possibilities of strengthening the patient safety aspect to formalize training, accreditation, et cetera, is helpful and will only make the proposal stronger.

I also appreciate the comments and the recommendations from some of the folks on the phone also about not only doing the internal work of ensuring that the appropriate patient is a candidate for the in-home care, but also the possibility of a CMS external audit to be determined.

End of comments.

CHAIR BAILET: Thank you, Dr. Medows.

I guess I'm going to take the liberty to make an additional comment. As I think about the Secretary's

criteria and the backbone of why we're here today, the guiding principles were these proposals need to enhance quality and also, if possible, when possible, lower cost; and there are clearly connections here. But I want to make a comment relative to quality. You know, there are quality metrics we track and monitor, but there's also some quality metrics relative to compassion and allowing people who otherwise would be in hospital settings to have the opportunity to be at home with their families. And I think that's very important. I see that as, as important relative to a quality metric, if you will, than some of the other clinical quality metrics that we all track and monitor.

So, I just want to personally call out the fact that when I look at the backbone of why we're here today, that this covers a lot of the waterfront relative to quality, and, again, this model isn't for all patients. It's for a select number of patients who can tolerate and have the systems and processes to support them at home.

* So we're going to go ahead and start to deliberate and vote, and let me walk people through the process. First, I need the Committee to acknowledge that we are ready to move forward to actually start voting.

MR. MILLER: Ready.

MR. STEINWALD: So moved.

CHAIR BAILET: Okay. Second. All in favor?

[A chorus of ayes.]

So we're going to go ahead. It is a simple majority of those present for the motions to carry. So we have 10 people here today that will be voting, and as I understand it, there'll be -- is there one extra for -- or has that been --

MS. PAGE: That will show on the slide. This slide that everyone will see will show 11 members. That's just the person recording the vote. So we have 10 members voting, and six members is the majority.

CHAIR BAILET: Right. So Ann, as our DFO, will be going back and forth to confirm the numbers of votes, and then we will move through the 10 criteria. We're voting using an electronic tool. The graphs and tracking of this will be displayed on the screen behind me, but also Ann will call out the vote for folks who are participating via teleconference.

So we're going to go ahead and start with the first --

MS. STAHLMAN: Just a moment, please.

[Pause.]

CHAIR BAILET: I think we're ready to go, so

we're going to continue to move forward, and we're going to go ahead and start with the first criteria, and this is scope of the proposed PFPM. It's a high-priority item by the Committee's perspective. The proposal aims to broaden or expand CMS' alternative payment model portfolio by either, one, addressing an issue in payment policy in a new way or, two, including alternative payment model entities whose opportunities to participate in alternative payment models had been limited.

So the numbers here are numbers 1 and 2, do not meet; 3 and 4, meet; and 5 and 6, meets and deserves priority consideration.

MS. STAHLMAN: You can go ahead and open the vote.

CHAIR BAILET: So we're going to go ahead and open the vote, and everybody please vote.

[Vote in process.]

CHAIR BAILET: So, are these working?

MS. STAHLMAN: Yep. They should be working just fine. We've tested them, so go ahead and press it again. Okay. So it's okay to press it a second time. You'll just override your first vote.

CHAIR BAILET: When it registers, it's supposed to turn -- I got it. Okay.

MR. MILLER: It's sunspots today. There are sunspots.

CHAIR BAILET: So, one more time with feeling. All right?

MS. STAHLMAN: If we wait just one moment, I think we're going to swap your voter.

CHAIR BAILET: Mine is -- mine might be -- mine might have the Harold affliction. I don't know. I'm getting a big goose egg here on mine. Take a peek at it.

MS. STAHLMAN: It's not open right now, so you will get a big goose egg. We have to wait until it comes back up.

CHAIR BAILET: All right. I think we're going to -- I think we're done, right? Are we good? We have the man behind the curtain. Stay with me. Stay with the doctor.

Harold? So we're going to vote -- are we going to need to vote again?

MS. STAHLMAN: Just a moment. Hold on.

[Pause.]

MS. STAHLMAN: Voting is open.

CHAIR BAILET: Now we're good.

MS. STAHLMAN: So look at your clicker while you press to make sure your vote is registered.

CHAIR BAILET: Come on.

MS. PAGE: And you can vote multiple times. It will only record your most recent vote. So, if you're not sure, enter it again.

CHAIR BAILET: Mine worked.

DR. NICHOLS: [off microphone].

CHAIR BAILET: When it works, Len, it will record your number on that screen. So, if you're not getting the recording, it's not working. So, it looks like we have everybody's vote.

MS. PAGE: Nope, we don't. That's only eight.

CHAIR BAILET: Eight?

MS. PAGE: We need 10.

MS. STAHLMAN: Matt, there's an error message. Is anybody else getting an error message on their keypad?

MS. PAGE: We're down two. We're not tracking two votes.

MS. STAHLMAN: And, Matt, can you tell who the two are that are not --

MR. MILLER: And who in this room has not had technology challenges at a meeting that you've run, hmm?

[Pause.]

CHAIR BAILET: We will motor forward here in just a minute, once we get this resolved. One at a time. So,

what we're going to do is he's going to clear it, and then we're going to start with Rhonda, one at a time, and as you push it, we can watch it record to find the ones that aren't responding. So, I will -- he's going to give us the gun here.

MS. STAHLMAN: Only Matt will be able to see it.

CHAIR BAILET: Like I said, only Matt will be able to see it. So, let us know, Matt, when we should start. We'll start with Rhonda. Go ahead. All right. Go ahead, Rhonda.

MS. STAHLMAN: Rhonda's good.

CHAIR BAILET: Kavita?

MS. STAHLMAN: Bob’s is good. Press it again.

CHAIR BAILET: I think we’re good. Yeah, we

SPEAKER UNKNOWN: [unintelligible]

MS. STAHLMAN: Let’s see who else. We might need to swap yours out, Kavita.

CHAIR BAILET: Yea. Hold on. Hold on. Len? Yep.

MS. STAHLMAN: Kavita's finally went.

CHAIR BAILET: Okay. Len? Did you vote, Elizabeth? Go ahead. Yep, okay.

MS. STAHLMAN: Elizabeth, did you get it? Did you record it?

MR. ELLENBURG: Yes, I did.

MS. STAHLMAN: Is Len’s still good? 1, 2, 3, 4 --

CHAIR BAILET: Okay, well, here we go.

MS. STAHLMAN: [unintelligible, Jeff?]

CHAIR BAILET: Yes.

MS. STAHLMAN: Yours is good? Yep. Paul? Paul’s good? Paul’s bad.

CHAIR BAILET: Harold? Firm, but gentle, Harold.

[Laughter.]

That’s funny. Yeah, we may have to come up with plan B here.

MS. STAHLMAN: Well, we have a plan B here but it’s not as fast and efficient.

UNKNOWN SPEAKER: Hold them up.

CHAIR BAILET: Yep. Okay. All right. Maybe that’s the problem. Tim, try it. So, did you get 11?

CHAIR BAILET: Okay. Awesome. Yeah, well hold it up. Maybe hold it up a little higher, you know. But yours did go through. You never got the right message? But he recorded yours.

He did say it worked at one point. We'll try it again. So we have the number here, Matt? All right. So let's go ahead. Let's go ahead and share the results, please.

So, Matt, let us know when we can go ahead, and

we'll just revote on this one last time. We can't until -- we've got to wait 'til -- there we go. It's coming up. Hang on. Hang on. Hang on.

All right. We can go ahead and vote.

[Vote in process.]

CHAIR BAILET: Yep. All right. It worked. Great. Poetry. Ann?

* MS. PAGE: Okay. So, we have one member voting 6, meets and deserves priority consideration; seven members voting 5, meets and deserves priority consideration; two members voting 4 meets; and zero members voting 3, 2, or 1. So the majority of the Committee has voted that this proposal meets and deserves priority consideration for Criterion 1.

CHAIR BAILET: Thank you, Ann.

Let's go on to Criterion 2, please, which is the quality and cost. The proposal's anticipated to, one, improve health care quality at no additional cost; two, maintain health care quality while decreasing cost; or, three, both improve health care quality and decrease cost. This also is a high-priority item. We're waiting for the circle here, and now we can go ahead and vote, please.

[Vote in process.]

* MS. PAGE: Zero Committee members have voted 6,

meets and deserves priority consideration; four Committee members have voted 5, meets and deserves priority consideration; four Committee members voted 4, meets; two Committee members voted 3, meets; and zero Committee members voted 2 and zero Committee members voted 1. So, the proposal is found to meet this Criterion Number 2 on quality and cost.

CHAIR BAILET: Thank you, Ann.

Let's go with Criterion 3, please. Payment methodology, so pay the alternative payment model entity with a payment methodology designed to achieve the goals of the PFPM criteria, addresses in detail through this methodology how Medicare and other payers, if applicable, pay alternative payment model entities, how the payment methodology differs from the current payment methodologies, and why the PFPM cannot be tested under current payment methodologies. This is a high-priority item. Go ahead and vote, please.

[Vote in process.]

CHAIR BAILET: All right. Ann?

* MS. PAGE: One Committee member voted 6, meets and deserves priority consideration; one Committee member voted 5, meets and deserves priority consideration; four members voted 4, meets; three members voted 3, meets; and

one member voted 2, does not meet; and zero members voted 1, does not meet. The majority has found that the proposal meets this payment criterion.

CHAIR BAILET: Thank you, Ann.

Let's go with Criterion 4, please, value over volume. The proposal is anticipated to provide incentives to practitioners to deliver high-quality health care. Wait for it. All right. Go ahead and vote, please.

[Vote in process.]

CHAIR BAILET: Ann.

* MS. PAGE: Zero Committee members voted 6, meets and deserves priority consideration; one member voted 5, meets and deserves priority consideration; eight members voted 4, meets; one member voted 3, meets; and zero members voted 1 or 2, does not meet. The majority have found that the Committee -- that this proposal meets Criterion 4.

CHAIR BAILET: Thank you.

Criterion 5, please, flexibility. Provide the flexibility needed for practitioners to deliver high-quality health care. Go ahead and vote, please.

[Vote in process.]

CHAIR BAILET: Ann.

* MS. PAGE: Zero Committee members voted 6, meets and deserves priority consideration; five members voted 5,

meets and deserves priority consideration; three members voted 4, meets; two members voted 3, meets; and zero members voted 1 or 2. The majority has found that this proposal meets the criterion.

CHAIR BAILET: Criterion 6, ability to be evaluated, have evaluable goals for quality of care, cost, and other goals of the PFPM. Go ahead and vote. One more time Bob.

[Vote in process.]

MS. STAHLMAN: There you go.

* MS. PAGE: Zero Committee members voted 5 or 6, meets and deserves priority consideration; seven members voted 4, meets; three members voted 3, meets; and zero members voted 2 or 1, does not meet. The majority finds that this proposal meets Criterion 6, ability to be evaluated.

CHAIR BAILET: Thank you, Ann.

Criterion 7, integration and care coordination. Encourage greater integration and care coordination among practitioners and across settings with multiple practitioners or settings -- where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM. Wait. Vote.

[Vote in process.]

* MS. PAGE: One Committee member voted 6, meets and deserves priority consideration; five members voted 5, meets and deserves priority consideration; three members voted 4, meets; one member voted 3, meets; and zero members voted 1 or 2, does not meet. The majority has found that this proposal meets and deserves priority consideration under Criterion 7.

CHAIR BAILET: Thank you, Ann.

Criterion 8, patient choice. Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients. Go ahead and vote, please.

[Vote in process.]

* MS. PAGE: Two Committee members have voted 6, meets and deserves priority consideration; seven members voted 5, meets and deserves priority consideration; and one Committee member voted 4, meets; zero Committee members voted 3 or 2 or 1. So, the majority finds that this proposal meets and deserves priority consideration under Criterion 8.

CHAIR BAILET: Thank you, Ann.

Criterion 9, patient safety. How well does the proposal aim to maintain or improve standards of patient safety? Please vote.

[Vote in process.]

* CHAIR BAILET: We are hung up on one. There we go.

MS. PAGE: Zero Committee members voted 5 or 6, meets and deserves priority consideration; two Committee members voted 4, meets; eight Committee members voted 3, meets; and zero Committee members voted 1 or 2, does not meet. The majority finds that this proposal meets Criterion 9 on patient safety.

CHAIR BAILET: Thank you, Ann.

And the last criterion, number 10, health information technology. Encourage use of health information technology to inform care. Please vote.

[Vote in process.]

* MS. PAGE: Zero Committee members voted 5 or 6, meets and deserves priority consideration; four Committee members voted 4, meets; six Committee members voted 3, meets; and zero Committee members voted 1 or 2, does not meet. The majority of Committee members find that this meets Criterion 10 for health information technology.

CHAIR BAILET: Thank you, Ann.

So, now is the moment when we have the opportunity to ask additional clarifying questions that we may have thought about before we are actually going to

vote, and this is a vote that we do individually. We're going to go around the room relative to the recommendation, the overall recommendation of the model to the Secretary. And we have, Ann --

MS. PAGE: I'll just give a recap.

CHAIR BAILET: A recap. Please, go ahead.

MS. PAGE: So, of the 10 criterion -- criteria, the Committee found that on 7 of those criteria, the proposal met the criterion. On 3 of the 10 criteria, the Committee decided that it met and deserved priority consideration, and those criterion were on integration and care coordination, patient choice, and the scope of the proposed model.

CHAIR BAILET: Thank you, Ann.

So, we are now going to actually vote on the recommendation to the Secretary, and there are several options. I'm going to read them.

First, is do not recommend the proposed proposal payment model to the Secretary.

We have three options under recommend the proposal to the Secretary. One is limited-scale testing of the proposal. Second is implementation of the proposal payment model, or three, implementation of the proposed payment model as a high priority.

So, we're going to –-

UNKNOWN SPEAKER: [unintelligible]

CHAIR BAILET: Okay, so we're going to vote electronically first and then individually publicly, one at a time. So the first is -- would be a vote. One -- like I said, one is do not recommend. Two is recommend for limited-scale testing. Three is recommend for implementation, and four is recommend for implementation as a high priority.

So, can we go ahead and vote? Yep. So, go ahead and vote, please.

[Vote in process.]

CHAIR BAILET: Ann?

* MS. PAGE: Six Committee members have voted that the -- to recommend the proposed payment model to the Secretary for implementation as a high priority. Four Committee members voted to recommend the proposed payment model to the Secretary for implementation. The majority finds that this -- to recommend the proposed model to the Secretary for implementation as a high priority.

CHAIR BAILET: Thank you, Ann.

So, Rhonda, you're on the end. So I'm going to start with you.

DR. MEDOWS: [Shows placard.]

CHAIR BAILET: Oh, so we have our placards.

MS. PAGE: Okay. And if you can say it verbally so it will be captured in the transcript.

DR. MEDOWS: Number 3, recommend proposed payment model to the Secretary for implementation.

MS. STAHLMAN: You don't have to hold them up if you don't want to. It was our backup in case something happened with the technology. We are prepared.

CHAIR BAILET: I would like to get a shot of Rhonda holding up her placard. Thank you.

[Laughter.]

CHAIR BAILET: Very good.

Bob?

DR. BERENSON: So I recommended 3. After 20 years, it's time we found out whether this thing works or not, and the logic of it is pretty, pretty strong. I thought the PRT did a very good job of identifying concerns, and I was with Paul, as you had a lot more weaknesses than you had strengths in a couple of those areas, so why did you come out positive?

I now understand why they came out positive, but I don't think the payment model is a lay-up by any means. And what we didn't really discuss in much detail at all -- and I raised it -- was whether the shared savings model

around total cost of care really is what we should be rewarding or is it performance on quality metrics that we have some concerns about, which could even include metrics around appropriateness.

So I would -- I think this has to go forward. It needs to be tested, but I do think the Secretary should use some discretion and try to get the payment model right, in fact, maybe even try a couple of different versions of the payment model to see what works best.

CHAIR BAILET: So, Bob, I'm just wondering in the interest of expediency -- and, Rhonda, we may have to go back to you. If there are -- as you provide your insights, if you have a specific comment that you want to make sure is in the record, I want to make sure you weave that into your discussion, to your points, as we go around, just for efficiency.

So I don't know, Rhonda, if you had anything specific you wanted on the record.

DR. MEDOWS: The two things that I mentioned previously was the -- make sure that we have a formalized process included in the proposal, the plan to go forward. That includes how to do the internal assessment as well as a plan to have CMS do, as appropriate, external audit.

CHAIR BAILET: Okay.

DR. MEDOWS: The second piece was the part about formalizing the training and having the accompanying certification program for patient safety.

CHAIR BAILET: Great. Thank you.

Bob?

DR. BERENSON: I pretty much --

CHAIR BAILET: Okay.

DR. BERENSON: Assuming that a lot of the good bullet points can be captured -- they're all -- they're on paper -- I just added the one, which is the concern about shared -- the shared savings model --

CHAIR BAILET: Savings, yes.

DR. BERENSON: -- and whether that's appropriate. So I would just endorse a number of those bullets in the category 2, which was how it could go wrong and would want to work through that.

I agree -- it's doable, but I think it will take some work.

CHAIR BAILET: Yes. Thank you.

Kavita?

DR. PATEL: I voted number 3, to recommend this to the Secretary for implementation, and the only [unintelligible] I think it's a -- it's a very important model. I think, like Bob said, it's 20 years in the

making.

The only comments for the record would be, one, to really just be clarifying about how appropriate this could be, given the infrastructure and the time it takes to set this up, kind of the appropriateness for kind of smaller settings or -- I'll just say this, organizations with limited capital reserves.

And then the second would be some mechanism that is not solely the responsibility of the APM Entity for what I'll call safeguards.

CHAIR BAILET: Dr. Nichols?

DR. NICHOLS: So, I gave it a 4 because I liked it a lot. I think it's extremely important for our nation to move this model forward and in Bob's lifetime. That'd be good.

[Laughter.]

DR. NICHOLS: But I did have concerns, which Harold expressed quite well, about I don't think the parameters, as specified, should be what you go to on day one. And I would say working in either a range of models or a pathway to bearing more risk over time and/or ending up in a full bundle as [unintelligible] give a practitioner, an applicant a chance to get to a full bundle if they want to go there after a couple years. That's what

I'd recommend, flexibility on the parameters.

CHAIR BAILET: Thank you, Len.

Elizabeth.

VICE CHAIR MITCHELL: Thank you.

I actually gave it a 4, and I would just add to the concerns or suggestions to have an external patient safety function.

My bigger concern was actually around Criterion 10, rather, on information sharing, because I actually think -- we've talked a bit about HIT, but I don't think that the structures are in place to share information across communities the way that would fully enable this, so I think that deserves attention.

CHAIR BAILET: Thank you.

And I gave it a 3, and I guess the one comment I would make is I could see where this would be very attractive to lots of practitioners across the country, and I would caution that there can be unintended consequences if patient selection and patient monitoring and, frankly, the expertise of the team -- and that also includes the physician's advanced practice folks and the nurses and others -- are not where it needs to be. So there needs to be a robust, very clearly spelled-out milestones in training and some wet lab work, if you will, to make sure

that the patients -- I mean, we're talking about patients who typically otherwise would be in the hospital. So if we're going to move them out of the hospital, I think we need to double down and make sure that the infrastructure is in place to support them safely.

That's my comment. Thank you.

MR. STEINWALD: I gave it a 4. I think if we really believe the time has come, then I think we ought to state that -- with some priority that the time really has come.

Also, I think personal experience matters. Elizabeth shared hers with us. I faced a similar situation a year ago. If you will recall, I had to meet -- miss part of the public meeting because my mother-in-law, who had lived with us for 18 years, was in the process of passing away, and we were able to keep her at home, although we had to kind of create our own in-home service by pulling resources. We had to hire a navigator to do that because we didn't -- even though we're all in the health care field, we didn't have the right expertise.

And so I truly do believe the time has come and with some priority.

I would also add, I think it would be a good idea in the evaluation to make sure that it includes some

examination of the DRGs and what happens to them if this model is scaled up so that it really does influence what kinds of cases remain in the DRGs that are donating patients for care at Hospital at Home.

CHAIR BAILET: Thank you, Bruce.

Paul?

DR. CASALE: I also recommended implementation as a high priority, number 4, and in terms of the comments, I think most of them have already been made, just to emphasize Rhonda's point about this is where we want to go. We want to move the care out of the hospital appropriately.

I also wanted to emphasize the need for the external auditing. I don't think internal auditing is going to be sufficient to be sure that a patient selection -- well, to be sure of appropriate patient selection.

And then, finally, to your point around, you know, these are patients who are in the hospital. They're now being treated at home, and although we've heard from NCQA and this whole idea of certification, that clearly needs to be well vetted, because we didn't really receive that as part of this, to be well vetted to understand the safety part.

CHAIR BAILET: Thank you, Paul.

Harold.

MR. MILLER: I vote to recommend it as a high priority.

I think that -- I'll build on something that Rhonda said earlier, which is that I think this is a step in what we need to do to transform the overall health care system, and I think one thing that we didn't talk about here, but we did talk about as a PRT, was that while we've been treating this as sort of a very specific service and a payment to support it, that the people who do this could also then do other kinds of things to keep people at home, and that some of that infrastructure is complementary. So, if you're doing an Independence at Home program and a Hospital at Home program and other things, that many of those capabilities of having home visits and other kinds of things would be helpful for all of those things.

So, I think we should be thinking about these as building blocks, and I think this is a good building block towards that overall system.

I believe that it should have -- to the extent that there are adjustments for quality measures, which I think there should be, they should be applied to the payment, not to the shared savings or shared loss or primarily there because I think the goal is to move it to a prospective payment, and that that's where the quality

should be attached.

I actually think that we should be underemphasizing the shared savings part of this and focusing much more on getting the payment right to be able to do the service that needs to be done and not have so much emphasis on shared savings.

And I do think that more of the complexity of the model is associated with assigning benchmarks, et cetera, for shared savings. So if we minimize that part of it, then I think we will be better off.

I think that there needs to be the external review process to assure safety and appropriateness, which will enable it to be done broader than just in total cost models.

I do not believe that this model should be contingent on accreditation by NCQA or anyone else. I think that there should be reasonable standards put in place by CMS or whatever other payer is doing it to say what an entity doing this needs to have, and that they should demonstrate that. But I don't think that they should have to pay anybody to do that, and I don't think that -- I think that it risks what I think has been happening far too often, is that accreditation standards start to metastasize, and that everything gets floated into

them.

And I think that we should be trying to encourage this to be done as creatively and flexibly as possible while making sure that it's the outcomes that matter, and as long as there is a good method of protecting for outcomes and measuring quality, then the accreditation should be -- the rule should be minimized.

And, finally, I would endorse Bruce's point. I think in general for all of these models that we are talking about as physician-focused payment models, most of them that are going to achieve any kind of significant savings are going to achieve that savings through reductions in hospitalizations and hospital-based procedures, and that we need to be thinking very seriously as a country about better ways of paying hospitals, and that we shouldn't be just saying -- and I know how people sometimes feel about hospitals, but we should be saying that, yes, we want to take patients out of the hospital, but there are still always going to be patients who need to be hospitalized. And hospitals need to be paid appropriately for those hospitals, and we need to find better ways of being able to support the critical core infrastructure of hospitals without having everything they do be paid on a per-episode, per-patient, per-procedure

basis. And so we need to be moving to that, and so the more we get models that are trying to keep people out of the hospital, the more important, I think, that becomes.

That's not kind of in our purview at the moment, but I do think that it needs to be part of all of this, so thank you.

CHAIR BAILET: Thank you, Harold.

Tim?

DR. FERRIS: So I voted number 4, recommend as a priority, as a high priority.

I don't want to repeat all the comments of my colleagues because I think I agree with absolutely everything that everyone said, with two small caveats.

One is, I think, given what I heard from my colleagues, I'm a little less concerned about the safety issues. I think I would like to associate myself with Dr. Milstein's comments. I thought he did an excellent job of cataloging all the influences and pressures on anyone doing this kind of program that is going to in and of itself inherently create incredible caution among the people implementing these programs. And so I'm -- I think, given the comments, I'm a little less concerned about that.

I also think -- to Dr. Berenson's comments and some of the other comments, I, too, am not convinced that

the model is exactly right, especially on the shared savings issues and some of the DRG issues that were mentioned. But, honestly, I think those, I would consider those things tweaks and not reasons to not be wholly enthusiastic, given especially the compassion issues associated with this proposal.

And, finally, I do see an opportunity in terms of the speed of implementation of this, and I alluded to this in several comments already. But if this program were, quote/unquote, "tested" as payments to existing advanced APMs, a lot of the actuarial concerns in the fee-for-service system immediately go away, and I see that as an opportunity for the Secretary to implement it fairly rapidly within the context of advanced APMs, and then give them time to work out some of the more accreditation-type issues and oversight issues that would be inherent and necessary in a fee-for-service context.

I would like to see this available to the benefit of the U.S. population as quickly as possible.

Thank you.

CHAIR BAILET: Thank you, Tim.

I'm now going to have Ann Page, the DFO, summarize where we are at this point.

* MS. PAGE: So the verbal votes are the same as

the electronic votes. I do need to clarify that the vote to the Secretary is determined by a two-thirds majority rather than a simple majority, and when 10 people are voting, a two-thirds majority requires 7 votes, so this rolls down to recommendation number 3, recommend proposed payment model to the Secretary for implementation. And that will be the Committee's recommendation, as opposed to implementation as a high priority.

CHAIR BAILET: Thank you, Ann.

I just want to take a moment again to thank the submitters for the disciplined process and approach that you've provided in the care that is going to emanate from your work, and now we will make a recommendation to the Secretary, as Ann described, and then it will be up to the Secretary to respond and next steps.

Katherine.

DR. SAPRA: Thank you, Mr. Chair.

For staff, it will be useful as we're crafting the report to the Secretary to hear a little bit more on the Committee's thoughts on Criterion 9, which the PRT has rated as does not meets, but the full PTAC has rated as meets. So I've heard it through your comments, but it would just be really helpful if they could be clarified in a couple of concrete points for the report to the

Secretary.

Thank you.

CHAIR BAILET: Harold.

MR. MILLER: I'll start. I think that basically what Mount Sinai proposed is -- would be the core to me of a solution, which is to have an external monitoring process. The details of exactly who that is and how that is need to be worked out, but I think that was the concern, that there needed to be some monitoring of admission and of adverse events. But I think they did lay out in one of the final documents they sent us a fairly detailed process, but I'll defer to Rhonda to identify what she thinks may have been missing from that.

DR. MEDOWS: So the external review was one, but I actually do think that the training part needs to be formalized, and I actually do think having the accreditation is a plus. Does it have to be a requirement? We can debate, but I think it is a plus. My concern is that I want to make sure that the patient safety is standardized, that the approach and commitment is there.

I don't have the benefit of being in the middle of a program and having that confidence. I'm just a hopeless conservative and who believes that we trust and verify.

CHAIR BAILET: Thank you, Dr. Medows.

Dr. Berenson.

DR. BERENSON: Just two quick comments. I think Tim had it right by citing Arnie Milstein. I think there's a lot of inherent cautions about applying this inappropriately. My concern is just the opposite of calling a hospitalization something that could be safely done as an outpatient.

On the accreditation side, I mean, I understand Harold's point about we create barriers. The observation I would make is that we've talked about NCQA, and yet hospitals are primarily accredited by JCAHO (Joint Commission on Accreditation of Healthcare Organizations). And whether -- it's actually a question for people who are doing this: Does JCAHO actually look at these programs, regardless of what we have to say about it? So that's just a question, and I don't think it has to be reflected in our comments, but I think it is something that needs to be worked through.

CHAIR BAILET: Harold.

MR. MILLER: Just in the spirit of transition, I would say I think that to me, one should rely more on accreditation-type things early and more on outcome kinds of things later.

So, I think the problem I see today is that it becomes permanent, and it grows. And I think so -- I did not mean to suggest that anybody in America should suddenly start doing this without having to meet minimum standards, but I don't think that that should [unintelligible] once someone is in place, has appropriate training, et cetera, and is demonstrating the appropriate kind of quality care, then they should not have to go through that kind of an exercise in the long run. So that's what I meant by it shouldn't be built into the payment model as a permanent element.

CHAIR BAILET: Thank you, Harold.

Dr. Berenson?

DR. BERENSON: I'm done.

CHAIR BAILET: Oh, you're done. You're good.

All righty. So, I want to thank the audience for their patience while we work through our deliberations. I appreciate the engagement of my Committee colleagues, and also, again, I want to compliment the submitters for their good work.

What we are going to do now is we're going to take a recess until 1:30, and we'll be back at 1:30. Thank you.

[Whereupon, at 12:32 p.m., the meeting recessed

for lunch, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION

[1:36 p.m.]

* MR. GRAHAM: "Honor the physician with the honor due him, according to your need of him. The skill of the physician lifts up his head, and in the presence of great men, he is admired." The Book of Sirach or Ecclesiasticus, depending on your denomination.

I'm sorry I missed you at lunch. I don't usually say grace after lunch, but I thought this passage was appropriate.

My name is John R. Graham, the Acting Assistant Secretary for Planning and Evaluation, in the U.S. Department of Health and Human Services. I regret I was not able to join you this morning, and I'm grateful my colleague Dr. John O'Brien, the Deputy Assistant Secretary for Health Policy, conveyed the Secretary's welcome and his thanks, and I'd like to add my own now, before you continue on with your deliberations this afternoon.

As you may recall from Dr. Price's confirmation hearing earlier this year in the Senate, he was inspired to enter public service as a result of his experience as an

orthopedic surgeon. As well as the patient and the doctor and the others in the operating room, there was someone whom he had not previously expected to be there -- the government.

Today, we turn the tables, and the physicians are literally in the government, in this building, in our Great Hall, literally turning that dynamic around.

The Secretary's particularly interested in improving the quality of health care with the help of ideas submitted by practicing physicians from across the country. We're very pleased that the number of physicians sending their ideas to PTAC is growing. This demonstrates a strong interest in improving the quality of health care and testing payment models.

I'm grateful to my colleagues at ASPE for providing the staff and other technical and operational support to the PTAC, and we're very committed to supporting your work, to making sure that this Committee is successful in rigorously reviewing the models which you receive. Whether it's a small group of physicians who want to share a care improvement that has improved quality and reduced costs in their own practices, or larger physician groups who want to bundle services to improve care, or specialists who want to improve care for a wide array of conditions, we

are sending -- all are sending forward ideas from which we can learn as we develop models to test and improve quality and reduce costs for Medicare beneficiaries. HHS looks forward to working with physicians to test the most promising models.

I know you all have busy day jobs, to say the least, and your work on PTAC goes above and beyond what you might have expected when you first asked to serve on this Committee. And I know you have a full schedule today, so I won't delay you from your review of the models at hand today. I understand you've already had a very productive discussion of one and voted on how to proceed on that.

On behalf of Secretary Dr. Price, I'd like to close by thanking you all again for your efforts in this process. Your rigorous review of each model and your thoughtful and detailed comments and recommendations will help us to select the most promising models for testing by the CMS Innovation Center.

Thank you very much.

[Applause.]

* CHAIR BAILET: Thank you for those comments, John.

We're going to go ahead with the review of a second proposal, the Coalition to Transform Advanced Care, Service Delivery and Advanced Alternative Payment Model.

The first part of our meeting will involve conflicts of interest, and we are going to, I guess, go around the room. First of all, I want to welcome everybody. I see a lot of new faces that weren't here this morning. My name is Jeff Bailet. I am the Chair of the Committee. Elizabeth Mitchell is my Vice Chair. And we're going to go around the room very quickly and address conflicts of interest, starting with Dr. Ferris.

DR. FERRIS: No conflicts.

MR. MILLER: I'm Harold Miller. I -- up to the beginning part of this year and from last year provided some assistance to the American Academy of Hospice and Palliative Medicine in developing a palliative care model, which will address patients and care needs that are similar but not identical to the C-TAC (Coalition to Transform Advanced Care) proposal. So I'm going to recuse myself from the model.

I also guess I have one other slight conflict, which is, if you will, which is I discovered last night that one of the people assisting on the C-TAC proposal was my mother's primary care physician who cared for her in the 12 months before she died and provided absolutely superb care, and I would recommend her to anybody who wants a primary care physician in their final 12 months of life. I

don't think that would bias me against the proposal, but just because of any potential concerns about conflicts, I'm going to recuse myself from the vote.

DR. CASALE: Nothing to disclose.

MR. STEINWALD: Nothing to disclose.

CHAIR BAILET: So in the spirit of making sure that we not only address conflicts but we also talk about impartiality and transparency, in reviewing the model -- I am the executive vice president for Blue Shield Health Care Quality and Affordability. And, Blue Shield -- I went back to my team to understand all of the interconnectedness between Blue Shield of California and C-TAC, and so I have a very detailed description, which I think I need to review again for impartiality and for my colleagues to hear so that they can advise on my participation and at what level.

So four years, for the past four years, Blue Shield has been a member of C-TAC. We are no longer a member, but recently our membership termed out. We did not renew. We have been asked and will be speaking at the C-TAC meeting, the C-TAC summit in November. And we're partnering with C-TAC on multiple Blues workshops on palliative care. We have a home-based palliative care model that was deployed in January, which the C-TAC has actually publicly commented on.

There was a survey that was referenced in the proposal that C-TAC sent to the members, including Blue Shield at the time, and at that point there was an endorsement from Blue Shield about the concept of an advanced payment model for palliative care. So there is interconnectedness. I personally have not been involved in any of these discussions with C-TAC. I've been at Blue Shield since January, and had I not probed deeper to my team, I would be completely unaware of this interconnectedness, but I think it needs to -- in the spirit of transparency, I'd like to disclose that.

And I guess before we move on, since the Committee has not had a chance to digest the information I just shared, I would look to my colleagues for guidance on -- just like we did in previous settings, whether I can participate. I don't feel like I'm conflicted, but I'd like to hear from my colleagues. Tim?

DR. FERRIS: I agree that those -- I applaud your candor and transparency. I don't think what you cited in any way presents a conflict or substantial impartiality to this Committee.

DR. PATEL: Second.

CHAIR BAILET: I'm taking that as a motion.

[Laughter.]

CHAIR BAILET: All in favor?

[A chorus of ayes.]

CHAIR BAILET: Any opposed?

[No response.]

CHAIR BAILET: All righty, then. Elizabeth?

VICE CHAIR MITCHELL: Nothing to disclose.

DR. NICHOLS: Nothing to disclose.

DR. PATEL: Nothing to disclose.

DR. BERENSON: Nothing to disclose.

DR. MEDOWS: Nothing to disclose.

CHAIR BAILET: All right. Thank you, colleagues. So the PTAC has previously reviewed the disclosure, and had I not had this new information, we would have gotten through this a little faster.

Harold has recused himself on voting of the proposal, but the Committee feels supportive that Harold's allowed and we would actually welcome Harold's participation in the conversation up to the voting process. So we will have nine members to follow the process. We'll have nine members instead of 10 voting on this proposal today.

So I'd like to turn it over to Bruce Steinwald, who is the PRT lead for this proposal. Bruce.

* MR. STEINWALD: Thank you, Jeff. The other

members of the PRT are Paul Casale and Elizabeth Mitchell, who is also the Vice Chair. And we are staffed by Ann Page, and I am going to ask you to continue your duties by advancing the slides for me.

So we received this proposal -- I can't remember exactly when. We've had a number of PRT meetings by telephone. We've had one round of questions and answers for C-TAC and its members. Not 159 questions, Harold, but they were fairly substantial. And then we had one conference call with C-TAC in June, where we asked some additional questions and clarifications.

In addition to that, we've had the literature review by Social & Scientific Systems, focusing on, among other things, the prognostication of mortality within a given time period. We had a consultation with a palliative care physician available to us through our subcontract with Penn, I believe. We had consultation with CMS (Centers for Medicaid and Medicaid Services) on the hospice benefit and potential overlaps between hospice benefit and what C-TAC is proposing. We had consultation with CMMI (Center for Medicare & Medicaid Innovation) to make sure we understood the Medicare Care Choices Model program and how it might overlap also with what C-TAC is proposing. And we had consultation also with the CMS actuaries on, among other

things, calculating shared savings and shared losses.

In addition to all of the above, we posted our preliminary report of the PRT on our website and received a letter in response from C-TAC within five working days of this meeting, as requested, and that five working days includes Labor Day as a holiday. You may not be aware that PTAC members consider weekends and holidays as working days. Nevertheless, we still appreciate your responsiveness.

There's a lot of substance in the letter that you sent, and rather than -- let me say two things about that. One is I'm going to present the PRT report as it was posted on our website. However, I will verbally note areas where you have proposed some elaborations or modifications to your proposal, but I will not be qualitative about them, in large part because the PRT and PTAC in general has not really had a full opportunity to evaluate them. However, I think it's worthwhile to note where you have, in response to our report, suggested some changes and elaborations. And in every case, I hope that Paul and Elizabeth will join in with what I have to say and correct me if I'm wrong and then fill in some gaps.

The Preliminary Review Team and its role, I think we've gone over this enough, haven't we?

CHAIR BAILET: One second, Bruce. What I realize is there are a lot of new faces in the room, and I think it's important to review just to level set so people know what it is and what it isn't.

MR. STEINWALD: You're right. I know it's a new group. So our Chair and Vice Chair have appointed two to three -- in this case, three members. No conflicts of interest. At least one of the members must be a physician. In this case it's Paul Casale.

I've already mentioned the additional information and resources that we have drawn on to make our evaluation and -- oh, and you know the process -- after this meeting, if we decide to deliberate and vote, a report will go to the Secretary, and then there are the rules about posting it on the website. And it's important also to know that the PRT is only three members of an 11-member Committee, and the report that we made is not binding. Other members of PRT -- of the PTAC may come to different conclusions than the PRT came to on the Secretary's criteria.

The overview of the model -- and this is just an overview without much detail. The target population is Medicare beneficiaries who are in their last 12 months of life. And in order to identify that population, the potential participants must meet two of these four criteria

on acute care utilization, functional decline, nutritional decline, and performance scales. Plus the responsible physician must give a negative response to the question: Would you be surprised if the patient died within the next 12 months? And we refer to this as the "surprise question." It turns out in the literature it has a substantial amount of validity.

The model does not require beneficiaries be told prior to enrollment that the program is for people in the last 12 months of life. This information is discussed at an appropriate time. This is one of the modifications that C-TAC made in its August 30th letter. They propose to explicitly inform patients within 90 days of enrollment of the 12-month prognosis, and that depends largely on the relationship between the clinician and the patient and family as to when exactly that would occur.

The payments are made to the ACM (Advanced Care Model) Entities who cover both palliative and curative treatment. The ACM Entities can be a broad range of organizations: ACOs (accountable care organizations), hospitals, medical groups, home health agencies, and hospices, among others. They would include interdisciplinary teams delivering both palliative care and care management and include a network of treatment and

curative care physicians choosing to participate in the model. So, a unique feature of the model is that it includes both palliative and curative care with a lot of interaction with patient and family.

The payment model includes a $400 wage-adjusted per member per month payment for patients who are in the model and living, and it's a shared risk -- that's phased into after the first year on total cost of care in the last 12 months of life.

The monthly payment replaces fee-for-service payments to palliative care providers, although other providers may continue to receive their fee-for-service payments. And it's made up to 12 months and earlier if death occurs or enrollment in hospice occurs or in other unlikely conditions that might cause the patient to be discharged from the program.

The original proposal has the $400 per month payment lasting only 12 months; in part in response to our proposal, we assume that they have proposed now that they would continue that payment for the entire length of life of the patient. However, the additional payments for those who survive more than 12 months would count against the shared savings that would be calculated, and then if there were shared savings, shared with the ACM Entity.

It's two-sided risk in these statistics, these percentages; basically there is a four percent corridor. There has to be at least four percent savings or four percent loss for there to be any shared savings or losses. That's, I guess, to be interpreted that to take care of any statistical aberration or savings. And then, there's a 30 percent living limit on the savings, and the amount of -- percentage amount of savings depend in large part on the performance on quality metrics. The same with losses. The losses are limited to 10 percent, and then the savings rate on losses again depend on their performance on quality metrics. And then if there are entities that do not achieve savings, there's a correction phase, in which case eventually the entity would be required to drop out if it can't perform in a two-sided risk environment.

An overview of the care delivery model. Interdisciplinary teams provide comprehensive care management, advanced care planning, and 24/7 access to a physician. And this team will manage both the palliative care and act, I guess, as kind of a traffic cop with the continuation of curative care.

Comprehensive care management includes care coordination and management of the total patient's health care across all services and providers -- primary,

specialty, hospital, post-acute, and social services. The interdisciplinary teams have at least a minimum of one provider with palliative or hospice expertise, RNs, social workers, delivering care in face-to-face and telephone encounters. Treatment and curative care is through the patient's primary and specialty providers who may or may not be a part of the model and would continue to be compensated on fee-for-service basis. And the ACMs may continue to provide care after 12 months of the PMPM (per member per month). If the modification that they proposed was implemented, presumably that could continue for a number of months.

Okay. Here is a summary of the PRT's review of the patient's -- sorry, not the patient's but the Secretary's criteria. As you can see, there's some variety there, a little bit more than you saw this morning, and now I'll continue to go over the individual criteria and the PRT's thinking with regard to each one of them.

The criterion 1, which is a high priority on the scope of the PFPM, the PRT's conclusion that this was -- meets the criterion with priority consideration largely because the PRT felt that this is a large and growing population within the Medicare beneficiary population, whose need for coordinated care is substantial, and that

the combination of providing both curative and palliative care, we think is something that deserves consideration in contrast to the hospice benefit that's limited to palliative care in the last six months of life.

These are all Medicare beneficiaries with advanced progressive illness and not eligible for hospice, and we discussed at length the 12-month criterion. We discussed this with our palliative care physician expert. It's somewhat arbitrary, but it seemed to us at the end of our deliberations, or our consideration of it, that it's a reasonable amount of time to consider a population in need of coordinated care. If you take it out much more than 12 months, it certainly becomes more difficult to predict what the patient's life expectancy would be.

Criterion 2 on the quality and cost, we concluded that the proposal does not meet the Secretary's criterion here. We acknowledge that the coordinated care has the potential to reduce hospitalizations in the ER, these emergency room visits, and improve the patient and family experience of care, but we were concerned that the majority of the proposed quality measures were utilization measures. We were concerned also about the subset of patients who would survive after 12 months and would no longer have a per-member, per-month payment supporting their care. And

we were concerned that the interdisciplinary team leader could either be a provider with hospice or palliative care certification or one who has experience of three years or more in hospice or palliative care.

This is an area where the proposer has proposed some modifications. They, I think, first of all, didn't agree with our characterization that most of the quality measures were utilization, but that aside, they proposed extending them to include more patient-oriented measures, and they wanted to install some NCQA (National Committee for Quality Assurance) standards as well.

They also proposed that the lead clinician should have formal palliative care certification -- remember this is in their letter of August 30th -- rather than just experience in palliative care and hospice care.

Criterion 3, payment methodology another high priority. The PRT concluded that the proposal did not meet this criterion.

It is the payment elements are there for the 12-month period -- per-member, per-month payment; shared savings, shared losses. We thought that this would encourage both provider and patient participation.

We were somewhat concerned that the model might not be suitable for every patient with advanced illness,

and our literature generally supported the view, the conclusion that cancer patients are generally more predictable than patients with other illnesses.

Again, we were concerned about the 12-month period and the cessation of the per member, per month after 12 months. Again, they are proposing to fill in that gap.

And we were also concerned that there were difficulties in calculating the shared savings baseline amounts and the adjusted -- and the accurate risk adjustment for calculating shared savings and losses.

In addition to extending the per member, per month for the entire patient's life, in the August 30th letter, they provided a fairly detailed appendix, I guess, working with actuarial consultants on how to calculate the baseline and the shared savings amounts. This is something that I read once or twice -- twice -- and it's something that’s very hard to evaluate. I mean, we can at least say that they certainly made an effort in response to our suggestion that we weren't so sure about the ability to do this accurately. Whether or not their specific proposals in their August 30th letter fill in that gap is really hard to tell.

In criterion 4, value over volume, we concluded that the proposal meets the criterion. We thought the

incentives to substitute less costly palliative care for more costly curative services when appropriate was there.

And, also, you know, I didn't mention this earlier, and I could have -- the Medicare Care Choices Model is designed to provide both curative and palliative care services but only for patients who qualify for the hospice benefit and only for providers that are hospices, and so we thought that this proposal created a much broader reach to achieve the value over volume than the hospice benefit by itself or by the Medicare Care Choices Model.

Once again, we were a bit concerned about the - from our view - lack of more patient-oriented quality measures and a little bit concerned also about the financial incentives, especially considering that one of the ways that the patient exits the model is admission to the hospice program, and we were wondering if that could create a bit of a conflict of interest, especially if the program is being run by a hospice organization.

On flexibility, we concluded that the proposal meets the criterion. The availability of both curative and palliative services in a coordinated care environment provides a lot of flexibility of both patients and providers and patients' families and their ability to choose the path that they want to follow and whether it is

more curative-oriented or palliatively oriented.

Once again, our concerns in this instance, again, about hospices having a conflict of interest, but also whether smaller organizations would be able to really participate in the model. The proposal states that a lot of different provider types would be able to participate. However, one of our public comments and one of our comments from our experts suggested that it might be a program that requires some volume of resources that you would find in a health system or maybe a large home health agency.

The ability to be evaluated, we concluded that the proposal meets the criterion. Once again, when we noted that the proposal recommended episode-based actuarial model linked to develop an evaluation strategy, but left the specifics to CMS, here again, they've -- in their August 30th letter, they have provided some expanded information on the methodology.

Once again, we were somewhat concerned that there should be more patient-oriented measures for evaluation, and then, once again, the actuary's concern, that the effects on cost of care requires you to measure actual costs against predicted costs, and it's a common problem that a number of these models face, but it's also shared by the C-TAC model.

Criterion 7, integration and care coordination. We concluded that the proposal meets the criterion with priority consideration. It's really what the whole model is about, is care coordination. It's the principal focus. It's the focus on a population with an evident need for care coordination, and it includes both curative and palliative care services. And since this is a principal focus of the model, we concluded that it was priority consideration.

Patient choice, we concluded that the proposal meets the criterion. The model is designed to encourage shared decision-making between patients and families and the providers. The PRT generally agreed that the model would promote patient choice in a fragmented system, and we noted also that we wanted to make sure that patients on enrollment into the model were fully informed about the -- both the goals and the specifics of the model. That, for example, that they'd be in a program where providers would be paid additional payments in return for coordinating their care, and that they would share in cost savings to the Medicare program, if there were any.

And, once again, the issue of being recruited and one of the criteria being that the patient is expected to have no longer than 12 months to live is an issue that we

discussed at length among the PRT members about whether that should be up front or it should be left to the patient and provider sort of in the trenches having that conversation, and once again, the proposer has proposed that that information should be shared within 90 days.

Criterion 9, patient safety, meets the criterion. Generally agree that home-based care coordination and the elements in the model should promote safety. Especially as we talked about early this morning, in the home there are certainly risks in a provider environment, in the hospital in particular, but again, I'm not going to repeat this because I already have, about the concern for the patients who would survive over 12 months if there was a cessation of the monthly payment.

Also, just as a note, the model also seeks waivers of conditions of participation for hospice and home health parties that seek to provide these services. I guess there's some sense that the conditions of participation that they currently operate under would need to be waived.

Criterion 10, heath information technology, the proposal meets the criterion, would require participating entities to utilize health care information technology, and it proposes that they would use expanded claims data

collection to enhance provider's ability to access eligibility and care process activities.

In a large part, shared with other models that we've seen, this is a situation where you want to have extensive sharing of information among the different providers of care in an environment where patients could be receiving both palliative and curative care, and there might be as many as 10 or more different physicians participating in the care of the patient.

There's not a lot of information given on how the exchange of information among those providers would be optimized in a way to enhance care coordination and integration across the curative and palliative care boundary.

And that concludes our assessment of the 10 criteria. In a general way, I think our most positive feelings towards the model relate to the target population and its need for the kind of care that is proposed by C-TAC and the fact that it includes both curative and palliative, and that providers working with families can decide the course that works best for them.

We think that the shared savings and risk are congruent with the general objectives of coordinated care, but we noted a number of concerns. And I think I've

probably covered just about all of them. So rather than repeat them and repeat what the proposer has suggested in its August 30th letter, I think I will leave it at that and open up -- oh, and sorry. First, ask Elizabeth and Paul to correct my mistakes, fill in some gaps, and give your own perspectives on the things that you think should be emphasized as we discuss.

DR. CASALE: Yeah. No, Bruce, that was a terrific job. I think you've summarized our PRT discussions well, and as you said, we had multiple discussions with not just the submitter -- the submitter's discussion, but with our palliative care expert at Penn, the Office of the Actuary, and CMMI, which were all very informative.

I do have some comments related to the August 30th -- and which you've highlighted. Do you want me to make those comments now, Jeff, or do you want others to clarify before I --

CHAIR BAILET: Yeah. Go ahead.

DR. CASALE: Okay. I just want to be sure.

So, in my view, I have significant concerns about receiving these, the letter on August 30th, and having a limited amount of time to evaluate what I see are substantive changes to the model, and I think you've

outlined them well from the removal of the cap on the PMPM, additional quality measures, and then the shared savings calculation, among others.

So my recommendation is that this come back to the PRT, because to me this is substantive change to the original proposal, before moving on to further deliberation and voting and the PRT have a chance potentially to reengage with our experts, with the actuary, with others, and then come back as well as give an opportunity for public comment, on what I see as a substantially different model than the one that we initially reviewed.

CHAIR BAILET: Elizabeth.

VICE CHAIR MITCHELL: Thank you.

I also want to compliment Bruce for the report. I think it very well captured what we discussed.

A couple of issues that I just wanted to underscore as sort of my personal concerns were partly with the payment model itself, which is primarily enhanced fee-for-service, with very limited risk, but the patient engagement and patient notification was a key concern for me to both at enrollment and discharge, if it were post 12 months.

So I appreciated the input we got in the August letter. I think it did go to several of the concerns

raised by the PRT, but I don't believe that there has been adequate time, particularly for public review and public comment. So I would share Paul's hesitation about moving forward with deliberation until we can fairly and adequately incorporate some of that input.

CHAIR BAILET: So thank you, Elizabeth. Bruce, thank you for your leadership on the PRT and, Paul, your comments.

I think it would be helpful to level-set for the participants in the audience what is our process and what are we doing here today.

So you've already heard the conflict of interest disclosures. You've heard the PRT analysis, and this is the time where the Committee asks clarifying questions, having heard the information that was shared by the PRT. This is a global description of our process, irrespective of the model under consideration.

Following the Committee's clarifying questions, the next step is to have the submitters, who were invited in here today, to provide their presentation, and then equally important to have the public -- and we have a number of people who are signed up to speak -- to provide their comments.

And at that point, the Committee moves into the

next phase, which you've heard Dr. Casale reference, which is the deliberation and ultimately the voting.

What I'm reflecting back, based on what I'm hearing, is that the letter was extremely detailed and had material suggestions relative to the feedback that you've been getting from the proposal review team, and we have put in place a very transparent process to sharpen our thinking and to sharpen our deliberation. And there is, as Elizabeth said, there's the public input. We want to be thoughtful and critically evaluate these models, and we want to be able to consider all of the information that is put before the Committee.

So I respect the process, which we have built collaboratively as a Committee, and you are here as the submitters. And what I would like to ask is, hearing the concerns of the proposal review team, to move the process forward to the point where we allow and engage and invite you to provide your perspective, hearing what you've heard today, and also the dialogue you've had with the proposal review team up to this point.

We then welcome the public to provide their feedback and their comments. And then I will turn to my colleagues on the Committee, and we will ask the next question to move into deliberations and voting.

* So I just want to be respectful. We really pride ourselves on being transparent and candid, and we actually now -- unless there are additional comments or questions from the Committee members? Rhonda and Len, go ahead.

DR. MEDOWS: So of the 10 criteria, there were modifications or changes that impact how many of them? Do you know?

MR. STEINWALD: I'm laughing only because I was prepared to answer the question how many modifications were there -- not, how many criteria there were affected by the modifications.

DR. MEDOWS: It's okay.

MR. STEINWALD: Several.

Certainly, I think all of the first three, which are our high-priority ones --

DR. MEDOWS: Okay.

MR. STEINWALD: -- and I don't have a count of the number out of 10.

DR. MEDOWS: That's fine. I think you -- the first three are the ones that we prioritized.

MR. STEINWALD: Mm-hmm.

DR. MEDOWS: Okay. Got it.

CHAIR BAILET: Len?

DR. NICHOLS: So, Bruce, thank you for that

outline, and, Paul, I really appreciate you raising your concerns, which I must say I share.

As I was reading the PRT report, when I got to the part where the actuaries raised the concern that the shared savings amount will be difficult to calculate, as I understand the proposal, it basically suggested why HCCs (hierarchical condition categories) alone weren't enough, and it essentially asked for CMS help to do this.

But the actuary said here -- where did I see it? – figuring out the baseline against which to compare actual costs will present challenges that will be difficult to overcome, and it's almost like the actuary couldn't figure out how to do it.

Then we get this letter on the 30th of August, which had a fair bit of detail about how to calculate these savings. I guess I'd like to know the actuary's opinion of that before I personally check the math, but, you know, that's what I mean.

MR. STEINWALD: I can almost guarantee you that their opinion would be more valuable than mine, and -- but, yeah, it's a fairly detailed thing that they laid out for sure.

But it is -- as they described it, it's based on our actuarial analysis as opposed to the typical kind of

risk adjustment that CMS does.

CHAIR BAILET: One last call for other Committee members to comment before we invite our guests to provide their presentation.

VICE CHAIR MITCHELL: I'd like to add one. I just wanted to add one thing. Rhonda, to your question about how many criteria, I think it's also notable that two of the criteria that were addressed were where the PRT had noted that it does not meet. So I think that it could have really impacted our initial review to have that additional information.

I know that it was responsive to our concerns, which we applaud, but it could have certainly led to different recommendations. So I think there is -- it's important to fully consider the input.

CHAIR BAILET: So I've been advised that there are five? Is that right, five of you that are coming up? So I'd ask all of you to come up, and we probably need an extra chair. If someone could help us with that, that would be great.

And it would be great if you guys, when you come up, if you just introduce yourselves, because there's a lot of people on the phone, and it would be helpful if they could hear who you are. Thank you.

So this is a 10-minute presentation.

* MR. KOUTSOUMPAS: We're fast talkers.

CHAIR BAILET: Okay. Very good. We're good listeners.

MR. KOUTSOUMPAS: Should we just do introductions first and then go into --

CHAIR BAILET: Yes, please. Absolutely.

MR. KOUTSOUMPAS: Okay. My name is Tom Koutsoumpas. I'm the co-founder and co-chair of C-TAC.

DR. NGUYEN: Good afternoon. My name is Khue Nguyen, and I am a project lead on this project.

DR. SMITH: Good afternoon. Dr. Kristofer Smith. I'm the senior vice president for Population Health at Northwell Health.

MR. SMITH: My name is Brad Smith. I'm the CEO of Aspire Health. We're a home-based palliative care company.

MR. BACHER: Hi. Gary Bacher. I'm a senior advisor to C-TAC.

CHAIR BAILET: Welcome. The floor is yours.

MR. KOUTSOUMPAS: May we begin? Thank you. Thank you so much.

Well, again, my name is Tom Koutsoumpas. I'm the co-founder and co-chair of C-TAC, the Coalition to

Transform Advanced Care.

I want to thank the members of the Physician-Focused Payment Technical Advisory Committee for their consideration of our alternative payment model proposal today. It's really an honor to have this opportunity, which represents the culmination of the work of hundreds of experts across the country, united by a shared vision that people with advanced illness deserve comprehensive, high-quality care.

The advanced care model is designed to test a care delivery model for supporting the over 1 million Medicare beneficiaries living with advanced illness by bridging medical and social services, ensuring that patients receive high-quality and person-centered care, and bringing together health plans, health systems, hospice providers, clinicians, faith and community leaders, all united in an effort to provide better care to this fragile population.

I began my work in health care in 1982, where I had the honor of being part of a small team that developed the Medicare hospice benefit, the first patient and family-centered interdisciplinary capitated model to care for the terminally ill. The hospice model remains a gold standard for care for the terminally ill, but it's clear, based on

the fact that approximately 25 percent of all Medicare spending still occurs in the last year of life. We need to reach people earlier in the care continuum.

My personal experience has driven my passion to address this issue. My mother was a proud woman, lived here in Washington, worked on Capitol Hill for over 30 years, lived independently for years with multiple chronic conditions. As she aged and her conditions progressed, she needed high-quality coordinated care and support, but frankly, it wasn't there.

Late at night, when the doctor's office was closed, simple answers to simple questions did not come quickly. They were often provided only after ER (emergency room) visits and unnecessary hospital stays. This became the norm. It was exhausting and debilitating for my frail mother and for all of us, her family.

Personal experience is also what's driven so many of my colleagues here today. My co-founder, Bill Novelli, had his own personal experience; and those others here today share the same personal experiences, which drive our passion to change this issue. C-TAC is a unique coalition of 140 health care stakeholders and has been a leading voice for people living with advanced illness.

My mother ultimately passed away with the

extraordinary hospice care provided here in Washington by Capital Caring, but the days before hospice were so challenging and so difficult, my sister, her caregiver, who also had worked on Capitol Hill, developed autoimmune disease, which we believe was triggered by her stress. It really doesn't have to be this way.

So we all got together - all of my colleagues here - to talk about what we could do and how we could address this issue. I want to thank everyone on the C-TAC team, who has worked tirelessly, driven by the passion of their own personal stories, to create this innovative model from the broad evidence base of successful programs from around the nation. Many of them are here today, determined to make a difference for this vulnerable population.

We currently, under this model and in partnership with CMMI, Medicare Advantage, and philanthropy, have served over 100,000 patients across the nation. We are so pleased to be here today to talk about this model and our work and appreciate the opportunity to be with you.

Gary?

MR. BACHER: Good afternoon.

Following up on Tom's comments and as a prelude to highlighting some specific features of the advanced care model, I wanted to highlight three core principles

underlying the design of the ACM. Khue Nguyen will highlight further the clarifications and adjustments that were just referenced.

In combination, the core principles that I wanted to speak about were to close the gaps in care that patients with advanced illness often encounter in our current health care system. These gaps reflect the spaces and care that can leave some without a model, like the ACM, returning to the hospital unnecessarily, and struggling with their family, as Tom described, to help keep family members safe in the home, particularly before they qualify for hospice.

The principles. First, improving quality of care, this is the bedrock principle around which all other elements of the ACM are built. By improving quality, we mean care that breaks down and cuts across existing silos related to curative versus palliative care and that fosters interdisciplinary practice and the building of better bridges across traditional medical and social services.

Second, flexibility. By flexibility, we mean creating a model that can operate in a stand-alone fashion or be integrated with other alternative payment models and that is consistent with and reinforcing of the MACRA quality payment program. It also means a model that supports primary care and specialty provider participation,

whether practicing on a small- or large-scale basis, and it's consistent with models that are growing in Medicare Advantage and in ACOs. We think taking these factors into account and incorporating an appreciation for broader trends in the health system is critical to making ACM services available to the greatest number of Medicare beneficiaries in need of them.

And, third, ensuring fiscal responsibility through aligning incentives. Improving quality of care, particularly for patients with advanced illness, also requires a payment model that ensures care can be sustainably provided. The ACM brings this principle to bear by aligning incentives across care sites and providers; and - consistent with population-based payment principles - is flexible in allocating resources to best meet care needs while establishing high levels of accountability for total cost of care and quality.

DR. NGUYEN: Good afternoon, PTAC. Thank you so much for this opportunity. Again, my name is Khue Nguyen, and I came to this work from having designed and implemented the Sutter AIM (Advanced Illness Management) program.

We designed the ACM in collaboration with a group of diverse health care leaders who have provided palliative

care and advanced illness care to diverse populations across this country. As Tom mentioned, many of them are here today.

We are especially grateful to the PRT for your very thoughtful feedback, and as you see and as Bruce has already mentioned, we incorporated -- we listened and we incorporated your thoughtful feedback into our proposal. Your review has allowed us to be more clear and robust in certain areas.

I'd like to go through the -- I'd like to provide some additional details behind the three key principles of the care model.

First, quality of care. We designed a very robust quality program here to track the program success, to measure the program success, and delivering person-centered high-quality care to patients that are aligned with their goals. Specifically, we propose 18 quality measures that would be tied to payment. Many of them would be collected through patient and family survey.

Thirdly, and most importantly, we believe that it would be important that the ACM Entity provide assurance that the care plan developed for every patient would meet his or her preferences. We'd like to be able to go into the Q&A and walk through some of those quality metrics with

the PTAC, as needed.

On flexibility, we created flexibility in several key areas. First, it was important to design a vigorous quality and accountable program that would allow as many providers who can meet the standards to be able to participate.

Secondly, we provide a proposal on how small practices can aggregate to operate the ACM.

Thirdly, we propose ways that the ACM can further enhance other APMs.

Lastly, on payment, as discussed, we propose a payment model that would align incentive that would reflect a shared risk model. The methodology, the shared savings methodology that we proposed in our original proposal and provided with further detail is modeled after the CMMI independent evaluation of the Sutter AIM program. We would like to have the opportunity to walk you through the details of that proposal.

MR. KOUTSOUMPAS: So in closing of our formal remarks, I would just like to conclude by saying, from our perspective, it's so clear that we have to better support people living with advanced illness, and we're deeply committed to this mission.

I think back about when we were creating the

Medicare hospice benefit. People often said it would never become part of Medicare, it would never fit within the structure of Medicare.

Similarly, when we started C-TAC, people said this problem was too big to solve, yet here we are today, because of the hard work and determination of our team, to address this issue, to take it head-on, and to come up with results that we believe can achieve our goals and mission.

We're humbled and honored and excited to be here to have the opportunity to talk with you today and thank you for your consideration. We'd love to answer any questions that you might have and look forward to that dialogue. Thank you.

CHAIR BAILET: Great. Thank you, Tom, Khue, Brad, Kristofer.

So I'm going to turn it over to my Committee colleagues that may have questions, top of mind. Tim.

DR. FERRIS: Well, first, let me add my thanks and appreciation to all the work you've done on this. I've been familiar with your work for years and have deep respect for it.

I want to start off by also adding that as a primary care doctor, I experience the gap that your proposal is proposing to fill every single day that I

practice. It is very clear to anyone who practices medicine that deals with the elderly that the hospice benefit, as good as it is, leaves a huge hole, so no question about it.

It's also very clear to me and to anyone who practices that the clinical services, the clinical aspect of the model you propose is much, much better care for the huge number of Medicare beneficiaries, of which I will be one someday, so out of self-interest. It's not a conflict, I don't think.

[Laughter.]

DR. FERRIS: But I would like to have access to this, so that my kids don't have to do for me what I have to do with my parents right now.

MR. KOUTSOUMPAS: Right.

DR. FERRIS: Having said all that, I want to ask a question related to the apparent necessity, the tie of this program and the financial model to end of life. And I want to just ask the question. Well, let me pose it this way. There is an alternative way of looking at this, which is end of life is something that occurs to someone with advanced illness, independent of the need for services. And if one were to look around the country at what ACOs and capitated systems in the Medicare program are doing, they

are universally -- and I think there's some literature to back this up -- providing care coordination services of which a subset are palliative services.

You've sort of -- your model turns that on its head -- right?

MR. KOUTSOUMPAS: Right, it does.

DR. FERRIS: -- and ties it to the end of life, which I will say from my perspective focuses brilliantly on where the most need is, but at the same time creates a real -- what I will call a head-scratcher of a problem, which is when you tie the financial model -- and here, I'm talking about the financial model, not the clinical model. When you tie the financial model to end of life, you are tying the financial model to no matter how good -- we use the surprise question, very predictive, but not so predictive that it doesn't create all kinds of variability in what you end up with in terms of the financial -- the variance that would come at the end of life in whatever way you do this, right?

So, again, I love it! But, could you address, “is there really a need to tie this to the end of life?” Because once you free the financial model from end of life you're now dealing with actually financial models where we have lot of experience, and doesn't seem quite so new and

potentially so scary. So sorry for the long question.

DR. SMITH: So they turn to the physician to answer the financial question.

[Laughter.]

DR. SMITH: So let me just start by saying thank you, Tim, for your comments. Clinically, I'm an internist as well. The clinical care that I've done since I finished my training has actually only ever been in that gap. I'm a house calls physician. I take care of the frailest of the frail, elderly patients who struggle to get to ambulatory care, which is why this type of program is so meaningful to me professionally, as well as we can all share stories about loved ones who need something like this.

In terms of your question, I just want to make sure, since it was a complicated question. Your question is instead of using risk adjustment models kind of prospectively, we're tying it to what happens in the last 12 months of life and why is it that we've chosen to do it that way.

I think -- and, Khue, you'll be able to jump in on this.

DR. NGUYEN: Yes.

DR. SMITH: I think we've chosen to do it this way because we do believe that there is, obviously, an

acceleration of spending in the last 12 months of life. We do believe that the PMPM payment of $400 is substantial, and so we needed to get into a frame for these patients, where this investment or this up-front payment in a high-intensity clinical model would be layered into a population of patients where there was a high likelihood that you could achieve savings, enough to overcome that up-front payment.

And so some of the challenges we've seen with other models -- I run one of the Independence at Home demonstration sites, and one of the challenges you see with these up-front payments is if you move back too far, there's not as much -- there's not as much spend in your -- in month, say, 12 to 36, so there's not as much opportunity to recoup that $400.

So we're trying to strike a balance here, where we are getting to a population where there is this tremendous acceleration in cost, such that high-quality coordinated care will reduce that cost that will overcome that up-front payment, so that we don't leave all these programs, taking this money in up front, and wind up having on the back end to pay back money because we didn't target this last 12 months of life.

I don't know if that helps to answer the

question.

DR. NGUYEN: Yeah. And maybe if I could just add to that, Kris, where I was sort of stepping back, because in some way, this was an obvious question because our design is purely focused on designing a care model and an accountable payment model specifically focused on the last 12 months of life. Why did we do that? We could look at other alternative payment models right now that touch this patient population; for example, ACO that already has financial incentive, the OCM (oncology care model) that focuses on cancer patients, Independence at Home, yet none of these models are able to give the focus around the kind of care that you need to deliver to make a difference in this last year of life.

That concurrent curative treatment and palliative care, that intensive care coordination, that advanced care planning, that advanced care planning that paces with the patient and the family over care setting across -- over care setting over time, these are specific interventions that requires specific focus, and it requires a specific payment that supports that.

This is where the need is, and so for us, it was important to define the focus, and that was why we needed to build care and payment tied to where the need is.

MR. SMITH: And just to add one thing to that, so as background, our organization partners with Medicare Advantage plans across the country, so we partner with all five of the largest payers to serve their Medicare Advantage population as well as about 15 additional payers, mostly BlueCross BlueShield plans, and this is similar to the model that we've implemented. And the reason that we've implemented it is just a practical reason from a measurement standpoint, which is when you run regressions of all kinds to try to predict cost for this patient population, the biggest predictive variable in every single model you run is how many months back from death you are.

So if you're going to serve this population, you have to be able to calibrate for that in order to, at least based on our experience, actuarially figure out what the cost is likely to be, because that's such a variable, and you can see in all the published articles around how the cost increased so dramatically. So it's really been a practical consideration for accurately being able to predict the cost.

MR. KOUTSOUMPAS: If I could just make one more comment, I can't resist, Tim, to comment on your comment, because I think you'll find it a little funny. Two things, one, in my own personal experience with my mother, it was

really during that last year, the progression of her chronic illnesses became intensified, and the set of services needed before hospice were clear but not available. And that is something I think about every day as I think about the model that we have and the work that we're doing.

But the other thing I wanted to mention to you, because as you said we need to get this right because of your own family and your future, as you know, the Medicare hospice benefit was bipartisanly supported. President Reagan signed it into law, and Senator Bob Dole was one of the key advocates and helped with the construction.

And I saw Senator Dole not long ago, and he said -- during the time we were developing the benefit, he said, "Tom, you know, we've really got to get this right because we're going to need it for ourselves one day, so we have to think selfishly about this." And I saw him recently, and he said, "You know, I think I'm nearer using the hospice benefit than you are. I hope we did get it right. I think we did."

And I think it's an interesting comment because these things are real to real people, to our families, and to our friends and loved ones, and getting this right is critically important. And that's what we're really focused

on and determined to do.

DR. NGUYEN: We also believe that from a practical perspective of how CMS would operationalize this model, we know that in risk adjustment, it has actually been pretty difficult to predict, to use a current risk adjustment method to predict patients with rising high cost, especially those associated with mortality.

And so while the need is a primary focus, by focusing on defining the episode as the last 12 months of life, we have clarity over what that prior episode experience is, which will allow us to compare the performance of the program against, and so there was a practical consideration around that as well.

CHAIR BAILET: Great. Thank you.

I'm going to go ahead with Bob and then Len and Elizabeth.

DR. BERENSON: I wanted to also talk about this topic but come from a slightly different perspective. I guess I am the curmudgeon on this Committee, and partly, that's based on having worked at CMS and seeing what comes in. In this case, I'm also going to reflect on my experience on MedPAC (Medicare Payment Advisory Commission) in looking at the hospice benefit.

And I agree -- well, actually, my view is that

the hospice benefit is both the best and the worst benefit in Medicare. When it's done well, it is remarkably good, and at the same time, we have a largely not -- a largely for-profit hospice industry that causes horrendous abuse that we have had trouble protecting against.

So one of the more dramatic statistics I remember from my experience on MedPAC -- and I think I have this right; I may be off by a percentage point or two -- that in the State of Mississippi, 55 percent of hospice benefits are discharged alive, okay? Somebody said they were going to die within six months. What's presumably happening here is that there's a per capita cap for every hospice benefit. They actually get paid per diem, not capitation. They're paid per diem, and when they hit the cap, "Oh. Well, you don't need to be here anymore." That's how you game a per diem system. In capitation, you can game it a different way.

So my concern is stinting on care in a model that has big gains and big penalties based on financial performance as opposed to -- I mean, every other industrialized country basically provides a palliative care benefit, but they don't necessarily tie it to rewards, financial rewards, and I'm much more comfortable with that concept.

My specific question is -- you've emphasized the quality metrics -- are the quality metrics good enough to prevent those who want to misuse what could be a very good program and stint on care and basically say, "Oh, no, you don't need to go into the hospital anymore. You won't benefit from it"?

You know, everybody has told the experiences of over-care. I had a relative who in his 80s, two times, was put on a ventilator, in both cases for a long period of time in an ICU (intensive care unit) and went back to his business, had another few years of life. I could imagine with the right incentives that he would have not been offered the opportunity to go into that ICU and have a few more productive years.

So that is my question, is how are you going to protect against stinting and both in the design of the financial model and in the use of quality metrics? What confidence do you have that the bad guys won't misuse what we're talking about here?

DR. SMITH: So if you have the answer to how to eliminate bad guys in health care, I'm all ears.

But I do agree that anytime you introduce new payment dynamics that there is a possibility that it will be used for ill, and hospice certainly has its challenges.

I think there's a couple of things that we have to acknowledge about the design. So one of the quality measures that we think is incredibly important and part of whether or not you qualify for getting a shared savings, is the documentation of a care plan, where you have elucidated the desires of that patient and their family. And so, yes, certainly anyone can falsify documents, but I think the most important quality measure in this demonstration is the conversation, the documented conversation with the patient and their family about what their goals are for the time they have remaining. In most cases, we're looking for 12 months. So that's number one.

Number two, I think it's really important to recognize that if you want to realize shared savings in this population, yes, you could try and lock people in their homes and not let them call 911, but the far more successful way to do it is actually to provide really good care. And what we've seen over the demonstrations and in the literature is that when you provide really good care, starting with the conversation about what is it that you want, you get this reduction in total cost of care.

And so while I agree we're going to have to have regular audits, I agree that we're going to have to be able to look at whether there's apparent patterns of utilization

in some of these entities, I do also think that making the primary quality measure about documenting what patients and families want and then, number two, what we've learned about providing high-quality care in this population can reduce total cost of care, I think, is our buffer against some --

DR. BERENSON: Yeah. Well, I guess that plays into my argument, -- is if, in fact, you're doing the right thing by having a conversation --

DR. SMITH: Mm-hmm.

DR. BERENSON: -- which you update periodically, having a plan --

DR. SMITH: Mm-hmm.

DR. BERENSON: -- why do you need the financial incentives? If that's a requirement of a palliative care benefit, that that's what you have to do, why do you need to, on top of that, add financial rewards?

MR. SMITH: So one of the challenges we've seen in the Medicare Advantage space is that you guys are exactly right that you can't exactly identify when a patient is going to pass away, and so we believe the way that we structured the financial model helps incentivize palliative care programs to make sure they're seeing the right patients.

And so the reason we originally had the 12-month PMPM was the idea, since you were only getting compensated for 12 months, you would really target patients who were -- you believed were highly likely to be in their last 12 months. We recognize and respect the feedback from the PRT that there's some risk around that, and so what we proposed back in our letter -- and we apologize it got in August 30th, but of August 30th, around that, is to address that it's allowing for that payment to continue for a longer time to ensure that there's care, but rolling all of that payment, if it's for 16 months, into the last 12-month-of-life-cost calculation. So that you're still incentivizing to see the right set of patients, the patients who are really in this gap, and so that was why we designed it that way.

DR. NGUYEN: There are a lot of room for improvement, the amount of fragmentation that currently occurs, and so the quality that we're striving here for the majority of patients is about better coordinated care and support that would allow a patient to remain safely in the home.

We recognize that not every patient will want that, and so this is a population health approach. But the overall direction here and the numbers of patients that Tom

has quoted, we see this consistently, that at a population level, more patients are able to stay at home, less ICU days, especially terminal ICU days, preventable hospitalization, as a result, a better coordinated care.

And so for us, it was important to tie a shared risk payment to this model to ensure -- to incentivize achieving high quality.

MR. KOUTSOUMPAS: Bob, I think I can't pass without at least commenting on your comment, and at least from my perspective in assuring you, there's nothing more important than abuse of the Medicare hospice benefit. And I think it's clear in our minds and clear in the minds of all of us who find abuses in hospitals or other house -- home care settings and other health care delivery models, but from my perspective, even worse in the hospice arena.

I work with a group called the National Partnership for Hospice Innovation, community-based not-for-profit organizations, and we're working very hard with CMS to further develop initiatives that can safeguard and work to prevent those kind of abuses from occurring. So I want you to -- I wanted to recognize that and know that we are really working hard on that, and we consider that in this work as well. Yes.

CHAIR BAILET: Thank you, Tom.

Kavita, I'm going to call on you. You were next. Thank you.

DR. PATEL: Thanks. Sorry. I actually had to step out because I'm normally in clinic today, and because I'm not in clinic, I had a 106-year-old patient for whom this would have been the perfect thing to actually have. So I echo Tim's comments and apologize.

I had three discrete questions. One, I did try to search for the CMMI Sutter Innovation Award evaluation. This is all the awards -- of the fact that we have not deliberated in any form or fashion, so I was trying to kind of google and search for stuff based on the August 30th letter, and I could not find the CMMI evaluation somewhere. So is that -- am I missing something, or is that available --

DR. NGUYEN: Yes.

DR. PATEL: -- publicly?

DR. NGUYEN: Yes, it is --

DR. PATEL: It is. Okay.

DR. NGUYEN: -- off of the CMMI website, and there is also a Health Affairs article that summarized the outcomes.

DR. PATEL: Would other people indulge me to just ask if I could just ask you to give us some of the

highlights that informed what you had referenced in the August 30th letter?

DR. NGUYEN: Yes, yes. So what we've referenced there in terms of the shared saving analysis -- so the Sutter AIM program very much mirrored the principles of the ACM. It has -- it employs a team-based care approach following patients in the last year of life. One would say that it is a perfect example of the ACM.

Under the HCIA (Health Care Innovation Awards) program, the AIM programs serve over 10,000 beneficiaries over a three-year time frame. The evaluation of that program was published in the final third-year report, and so in there, we've referenced the patient-matching methodology that CMMI utilized to determine -- so there were two analyses. One is, “What is the impact on quality?” And second is, “What is the impact on utilization and overall cost of care?”

And so there was a match-control method that was utilized, and we propose a similar approach to -- in terms of developing the control group for this payment analysis, so that's one aspect.

And then, secondly, in that analysis, it was found that the Sutter AIM program was probably one of the most successful HCIA programs in terms of impact on

reducing hospitalization, preventable hospitalization, and it -- that generated a savings of roughly $6,000 in the last 30 days of life.

For the AIM program, not only was hospitalization reduced, but hospice length of stay was increased, and so the issue that we currently face in hospice is many patients have very short length-of-stay. Actually, the national data out of Health Affairs in July show that 35 percent of hospice enrollment occur in the last week of life.

On the other side, there are 10 percent of patients who are enrolled too long, and the consensus around the policy on this is one way to really improve that is to build this kind of program, where you're able to care for patients upstream. Not only will you be able to help those who want and be ready to enroll in hospice sooner, but also the ability to also reduce the long length of stay associated with.

DR. PATEL: Okay. And so I have a little bit of a follow-up. If you were here this morning, it's a little bit of a refrain from if the evidence is so compelling -- and, obviously, we've had, I think, throughout the years, MedPAC, a number of policymakers have kind of opined on the importance of this -- why hasn't this been done, or why

hasn't -- if the HCIA award was so compelling, why hasn't this been carried forward or carried anywhere by CMS to some extent?

DR. NGUYEN: Yes. In our conversation with CMMI, they encouraged that we go through this channel with you to really bring this innovation forward.

Your question about why hasn't this happened, it happened, but it happened in places where we have payment and support, and the scaling --

DR. PATEL: Well, yeah, like MA (Medicare Advantage), et cetera. I mean --

DR. NGUYEN: -- has been the ability to scale is truly limited without a Medicare fee-for-service payment.

DR. PATEL: Okay. So I have one more question and then a comment.

I just want to be clear. Let's say -- I think you have in somewhere here an estimate on the potential number of beneficiaries who could benefit from this. I feel like I want to quote four percent, but maybe I'm --

DR. NGUYEN: Yes.

DR. PATEL: I could maybe understand how to staff this. That the comment -- and this is for anybody, not just for you. The comment was that it should ideally be led by a palliative care -- I'm assuming board-certified or

someone trained in palliative care medicine. As I sometimes feel -- as a primary care doc, I sometimes feel like that's saying they grow on trees, and we can just pluck them off and put them into these models.

I know locally, just I'll tell you right now, I can't find anybody to do that.

DR. NGUYEN: Yeah, yeah.

DR. PATEL: So talk a little bit about potential workforce shortages, mismatching and staffing, and then I have a comment after that. And then I'm done, I swear.

DR. NGUYEN: Yeah. This is why it's important to really tackle this through a team-based approach.

A lot of what patient -- you definitely need that physician expertise to provide guidance and oversight, but a lot of the support can be further extended by other members of the team, such as your social worker or your nurses. And so by utilizing a team-based approach, not all of the resource need will be concentrated in the provider level.

DR. PATEL: I'm not even talking about resource need.

DR. NGUYEN: Yes.

DR. PATEL: I'm just offering why wouldn't a non-palliative care physician who might have appropriate skills

training be able to lead one of these teams?

DR. SMITH: Yes. So I think the most important thing is that these teams have both, right? So that they have -- particularly considering the model that we're proposing, right? Because if you have a group of patients who have, you know, 12 months or less to live –

DR. PATEL: Right.

DR. SMITH: -- they have enormous palliative needs, but they still have curative and primary care needs, and so I do think that that team must have a palliative care clinician to help with the symptom burden that is the cause for so much suffering in this patient population.

But I think you will also need skilled clinicians that still have well-oiled machinery in terms of primary care, which has always been the question of simply extending the hospice benefit further out, because then you're only using clinicians who are hospice-trained.

In terms of your question about workforce, though, I mean, workforce is -- we spend a lot of time wondering why we don't have primary care doctors, why we don't have hospice and palliative care doctors. I mean, the answer is quite simple. The payment methods don't support that workforce.

Part of what is important about this is -- you

know, to Bob's question of why are we paying up front, why are we providing these financial incentives -- is because we have to create a more fertile ground for these types of programs, and part of it is we have to be able to track the clinical talent to go into this field.

This model, scaled widely with up-front payments, will provide more stability so that organizations can business plan, because one of the big problems -- I run a lot of different population health programs. Tim does as well. One of the big problems with many of these shared savings models, which maybe you might earn some money 24 months from now, it's really hard to staff based on a model, you know, a payment model like that.

And so if you have some stability that you know if you have a hundred patients, it will be 400 PMPM, then you can start to really build business models and recruit clinicians, and it will take years for that pipeline to open up, but it will open up if there are stable payment methods.

DR. PATEL: Okay. And then my -- the final is not a question. It's really more of a comment, that I feel like there's so much that was offered in this August 30th note -- and I think this was alluded to by the PRT -- that I just feel like I have not had a satisfactory ability to

digest it. And it feels a little like I'm reading almost -- I don't want to say two different proposals, but it does feel significantly different than what I have read prior, so I'll just stop there. And I don't -- I feel like I'm shortchanging --

MR. KOUTSOUMPAS: Sure.

DR. PATEL: -- high-quality work because of that.

MR. KOUTSOUMPAS: Well, and if I could just comment on that -- in fact, thank you for mentioning that -- our goal was to meet the issues and objectives that we received back from the feedback, so that's why we did that.

DR. PATEL: It's very good quality.

MR. KOUTSOUMPAS: Thank you.

DR. PATEL: It's just it was a lot of work that went into it.

MR. KOUTSOUMPAS: Yes.

DR. PATEL: It feels like we couldn't -- or let me speak for myself.

MR. KOUTSOUMPAS: Sure, absolutely.

DR. PATEL: It's hard to take that into consideration.

CHAIR BAILET: To do it justice.

MR. KOUTSOUMPAS: To do it justice. Thank you.

CHAIR BAILET: Right.

So Len and then Elizabeth.

DR. NICHOLS: So thanks.

Tom, you may not remember, but I remember when this C-TAC was a gleam in --

MR. KOUTSOUMPAS: I do.

DR. NICHOLS: -- Bill Novelli's eye.

MR. KOUTSOUMPAS: Yes.

DR. NICHOLS: And I would say, you know, Bill wears glasses, but he's got pretty good vision. So I'm very glad you did this.

MR. KOUTSOUMPAS: Thank you. He does, indeed, and he would be here today if he could.

DR. NICHOLS: The room is a testament to your success in making this all happen.

MR. KOUTSOUMPAS: Thank you so much, Len.

DR. NICHOLS: So we all want this to work, and like you said, we all want to get this right.

MR. KOUTSOUMPAS: Right.

DR. NICHOLS: And, you know, I haven't risen to the level of curmudgeon yet, like my colleague, Bob.

[Laughter.]

DR. NICHOLS: But I am the economist. I am the economist, so I'm working on this.

So I have two questions on the shared savings

calculation, and they've come in sort of two parts. One is why, and one is how long?

On the why, I was really struck at how you got all these little cute adjustments and this and that, and there's one called the "entity adjustment factor," which seems to be trying to adjust for the fact that depending on which entity's in charge, you expect there to be different costs.

And I would just say as a principle matter in the modern world, most of us are trying to move away from site-specific pricing. So tell me why you have an entity adjustment factor.

DR. NGUYEN: Yeah. And this is -- I think this is the kind of decision where we could have changed if we were given the ability to do a regression analysis with CMS.

What we wanted to make sure -- we agree with you there, and I think the regression -- so for the PRT here, what we propose here is to look at -- in order to construct the episode, and we recognize that there are diversity in this population, different diagnosis. Most of them will have one of the 11 diagnosis category that we listed.

But one way to really construct an episode cost is to do a national regression analysis looking at your

national sample and looking at factors that we know impact that price, including what other comorbidities -- age, sex, HCC. And so these were the factors that had been tested through CMMI in terms of matching up to a control population.

And so that allows to take a look at a national average episode score, and we believe that the regional adjustment is all that is needed.

We added on that entity adjustment because we have not had a chance to see. What we wanted to do is to make sure that you do run an entity adjustment. We anticipate that when you look at the entity and the regional, that there would be very little differences.

DR. NICHOLS: Well, let's hope. Yes. Okay.

DR. NGUYEN: And really what we were -- what we were leaning toward is to make sure that we capture any entity-specific nuances around how they practice in this population, that that would be factored in, but we would -- we are definitely leaning toward -- and we would support -- a regional adjustment.

DR. NICHOLS: Yeah. Well, okay. That's helpful.

And, obviously, you get the concern that you don't want to bake in inefficiencies because of a particular entity being used in a particular region.

DR. NGUYEN: Yes.

DR. NICHOLS: So I think we're on the same page here.

MR. KOUTSOUMPAS: Yeah.

DR. NICHOLS: So on the "how long" -- and this may get to the point you made, Brad, about working with other plans and so forth out there and Medicare Advantage space, but when I look at the regression adjustments that you're talking about making in your shared savings calculation and then ultimately the risk adjustor that will have to come out of that, I think this is not a two-week process. This is going to take a while.

So if somebody were to say, okay, try to make this happen, how long do you think this analysis is going to take before you're ready to go live, and how much can the experience you have with Medicare Advantage plans speed this up?

MR. SMITH: We have done this for lots of Medicare Advantage plans across the country. We're probably serving 8 of the 18 million Medicare Advantage plans across this country. Sutter has obviously implemented this model at scale with CMMI, and I think we're highly confident based on our ability to, one, respond to the PRT comments in two weeks and get additional

detail, but we believe that we could do it fairly quickly. Whether that's two or three months or a longer period, I think it's hard to say in the moment, but I would think that we -- the work that we've done, the lessons that we've learned from Medicare Advantage, from CMMI grants, from where foundations have backed some of this research before would be very helpful in speeding that up.

DR. NICHOLS: Well, let me just make sure I understand. Sutter has implemented it, but in an HCIA kind of framework. So there's not really a risk payment involved.

Medicare Advantage, they get capitated at this level, but not necessarily at the provider level. So have you been doing risk adjustment for providers underneath this Medicare Advantage umbrella?

MR. SMITH: Yes. We've done a number of different ways.

DR. NICHOLS: Okay.

MR. SMITH: So with each health plan, we had to work out how they would like to do it, but we've never done everything from [unintelligible]to exact matching to propensity matching to disease-specific baselines for the last 12 months of life. So there's a lot -- we have experience in a lot of different ways of doing it.

DR. NICHOLS: Okay.

MR. SMITH: We understand the pros and cons of different ways that you could think about it, and this was our best attempt, working with an actuarial firm, to get something that we thought was best-in-class based on the lessons that we've learned today.

DR. NICHOLS: Thank you.

DR. SMITH: But I think the last point is, though, while we can get this set up and we could get going, we would anticipate that year over year, there would be modifications and improvements to the target pricing and to the risk adjustment.

So what we think we can do is we can get to a good enough place to start, so that we have some stability in the target pricing and that it's close to the truth. But there will be modifications over time. We don't anticipate that this is perfect right now.

CHAIR BAILET: Elizabeth.

VICE CHAIR MITCHELL: Thank you.

I'm going to confess that one of the prerogatives of being Vice Chair is that we get to assign the PRTs, and I signed up for this one because I think this is so important and so needed, so really want to congratulate you on bringing this forward.

One of my major concerns, though, through the PRT process has been sort of patient engagement, patient education, and knowledge of the model. And you actually have included in your August 30 letter that you would begin -- you would inform the patient within 90 days. That's, I think, a really important change to the initial proposal that I'd like to know more about.

And you also indicated that you think setting the patient goals is one of the clearest predictors of quality, and so it's clear that it's important. But what level of knowledge and sort of proactive choice do the beneficiaries need to opt into the model? Or then if they are discharged from the model, do they need to know this, and do you believe they need to understand some of the related financial incentives to their participation? And so could you just address how patients are informed and engaged throughout this?

DR. NGUYEN: Yes.

DR. SMITH: Sure. So, you know, I've had the good fortune of having to do this, and so for Independence at Home, I'm a provider in the Independence at Home demonstration. As you probably know, you have to inform the patient that they are a part of this program. You have to inform them why they're a part of this program, and you

have to inform them a little bit about the implications participating in the program.

And for us, that has always included a brief conversation about the fact that if it looks like us doing a better job taking care of you, it reduces the cost of care that we might share in those, those savings.

And so what I will tell you is that it can be done. It can be done thoughtfully, honestly, but it can be also done in a way that doesn't cause a conflict or make it difficult to establish a relationship with patients and families.

I think one of the reasons, though, that we chose to give a little bit of a window, as opposed to it has to be in the first visit, is because it clinically -- for folks who spend time in the hospice and palliative care space, you know, sometimes it's too soon to say, "Hi. I'm here to help. Oh, by the way, I'm here to help because you're going to die in 12 months." And you do need sometimes to assess whether patients and families are ready for that conversation.

And in my clinical experience, what I have found is that by the second or third conversation, almost everyone has enough trust in a high-quality clinical team to be ready for that conversation, but sometimes the first

time is not the right time.

So by giving us a window period, we were sort of acknowledging the fact that not everybody is ready, but also putting an endpoint on it to address your concerns that people do need to understand the clinical implications of the program as well as the financial implications of the program. And it can be done.

CHAIR BAILET: Rhonda and then Harold. Rhonda?

DR. MEDOWS: I just want to make sure that I understand. When does the program -- when does the payment methodology kick in? After the patient is informed and agrees, or do you --

DR. SMITH: They have to say yes to the program, yes.

DR. MEDOWS: They have to -- they have to agree. Okay.

DR. SMITH: Right.

DR. MEDOWS: Thanks.

CHAIR BAILET: Harold?

MR. MILLER: I had two questions. The first question is, does your financial projections for the model -- does it count on getting shared savings? In other words, if you got no shared savings, but you got the $400 PMPM, is that enough?

MR. SMITH: Based on our experience across the country, yes.

MR. MILLER: So you wouldn't have to have a shared savings component to this. You could be accountable for cost, but not necessarily have to get a share of savings, if there are savings?

MR. SMITH: [Nods yes.]

MR. MILLER: Okay. Second question.

CHAIR BAILET: That's a "yes" for the folks on the phone.

MR. MILLER: Well, that was a -- we're not quite prepared to say that yet, but second question is -- no, go ahead.

MR. SMITH: Let me actually clarify that a little bit. So there's a wide variety of programs that offer a different cost. We are the largest scale provider in this space across the country, and so we probably -- I don't know for sure, but based on our internal discussions, I believe we have the ability to offer it at the lowest cost of care.

MR. MILLER: Mm-hmm.

MR. SMITH: I would say in the vast majority of our Medicare Advantage contracts, there is the ability to be -- to receive more than that, and that's necessary for,

in our case, being able to make the infrastructure investments that we need. So while in our case at a marginal level you can, I could understand why there would be lots of others who would have that.

MR. MILLER: So how much more is it that you think you need beyond $400?

[No response.]

MR. MILLER: Well, think about that.

So I guess the question is to what extent, if there is a cost to simply get paid for the cost and then be accountable for the fact that it doesn't increase overall cost, rather than introducing the idea of the shared savings.

The second question is when I was reading through the back-and-forth between the PRT and you, that I think the PRT was concerned, as I read it, by the way the model is described as -- or the impression it leaves is that you get $400 a month, and you do something in a month that's worth $400. And then when the $400 stops, you stop doing something because you're not getting the $400 anymore.

But then the response was "But we're still accountable for them for the 12 months before they're dead, so we will still have to do something for them because of that."

And I guess as I thought about your response, it seemed to me that what you were, in effect, saying is that we are going to be accountable for somebody's last 12 months of life, and we're going to take a $4,800 fee for that, which we will prorate if they die sooner, but basically, we're getting $4,800, which we may spend in very different ways, depending on what the patient needs.

I'm presuming that you don't give identical $400-per-month services to every patient. Hospice doesn't do that. It's one of the problems in the hospice program, is that the spending at the beginning, at the end are dramatically different than in the middle, but they get a flat amount of money. So, in a sense, they're getting a pool of money, and they're allocating it based on the patient's need.

So it seemed to me that you were really saying we're accountable for the last 12 months of life in the spending there, and we're getting a $4,800 fee. So I'm curious as to whether why you wouldn't characterize the program as saying to the patients, "We will take care of you until you die for $4,800, and we will ensure that it doesn't cost any more to Medicare than it costs otherwise," and make your own judgments about which patients to admit, because it is not clear to predict. And I think, to Tim's

point, is simply having a criterion that says something about 12 months implies that you have to make that judgment, and then you have to tell the patient about it as opposed to you deciding yourselves who to take into the program on that basis.

So I'm curious. Did you think about that? Does that make any sense to say to the patient, which seems to me a much more patient-centered thing, "We will take care of you till you die, and we will" -- and the payment model is "We'll be accountable for the last 12 months of spending," but that's sort of irrelevant to the patient in some ways. What you're saying to them is "We will take care of you till you die, and if it takes you 24 months to die, then we will take care of you for 24 months, because that's what our commitment to you has been," but you're going to make the judgment about when they need to enter the program because of when they really need that service. And if you thought that maybe starting someone sooner than you thought was necessary might actually be helpful to them, that that would be a good thing, because you want palliative care to phase in early rather than waiting until too late at the end.

But anything that requires you to somehow say to them, "We think you're going to die in 12 months," is going

to be a deterrent for some people and for you to participate. So I'm just wondering how you would react to that.

DR. NGUYEN: Yes. So I think there are several points here, Harold, so we'll -- and the team will back me here.

So the first point is, you know, why wouldn't you be accountable for patients for the duration of the program, and we are. We're simply structuring so that there is an opportunity for patients to access the hospice benefit. But the accountability of the payment essentially said that we're -- you know, the ACM Entity is once you enroll, once you meet the eligibility, we're going to be accountable to you. So it achieves that, and I think we built in where the PMPM stop, when the hospice benefit begins, because we -- it's important that patients have access to the hospice benefit, so that -- but it achieves the same goal here in terms of taking full accountability.

Your prior point about why not -- why have shared risk -- and so the alternative here would be to have a PMPM payment and then to have essentially a pay-for-performance that would be attached to arbitrary -- that would be attached to reduction in hospitalization, more [unintelligible] -- and a set of improvement in quality.

But that translates to -- that translates to cost, and so I think it is just simply another -- it's the same calculation, and I think by looking at shared risk, it gives us an opportunity to really understand how far can we improve, rather than setting arbitrary X percent reduction in hospitalization, X percent in X, Y, and Z. We set -- here are the set of quality metrics.

MR. MILLER: Just to be clear, I was not suggesting what you're just saying. I was simply saying why don't you take accountability for the last 12 months of spending, but say to the patient, "We're going to take care of you until you die."

DR. NGUYEN: Yes. And we are essentially by building the accountability for the 12 months, and the only operational change there is that we support patients being able to access the hospice benefit.

MR. SMITH: And the thing I'd add, too, is you're going to have a distribution of patients, and I think you could potentially do that. You're going to have a distribution of patients, right? You're going to have some that are three or four months. You're going to have some that are 12. You're going to have some that are 16. And I think the important thing, if you did something like you're proposing, would be to do that for all of the patients,

including the three-month group, because you needed to offset the cost of the 16-month group. And so the balance for that is why we proposed the per member, per month versus sort of a one-time payment.

You know, if the average length of stay was 12 months, the math would be exactly the same as sort of what you proposed.

MR. MILLER: Well, just to be clear now -- and then I'll be finished -- what I was saying was the concern was the implication was that somehow when you get the PMPM, you're delivering a service, and I was simply saying what you're really describing that you're doing, essentially, is getting a $4,800 fee, which you'll prorate down if the patient dies sooner or whatever.

But to dissociate the notion that somehow they'd get something in the month that's worth $400 is the -- I mean, paying it that way, sure, because you want it, but the implication that it was drawing for people was that you got something worth -- it was a fee for a service in a month, and I was just trying to clarify. I don't think you're thinking about the notion that somebody is getting $400 worth of services in a month or not.

DR. NGUYEN: Yeah.

MR. MILLER: They're really getting a set of

services which may vary from month to month, and in a sense, as a practical matter, if someone lives 12 months, you're going to get $4,800. And you're going to figure out how to spend that $4,800.

DR. NGUYEN: Right, right. Yes.

MR. SMITH: That's right.

My only comment back was around the prorating on the short end, because you know you're going to have people on the long end. So you could do it, and it would balance across the population. But given that you know you're going to have some people longer than 12 months, you have to balance it across.

MR. MILLER: But if you -- but if you reduce spending in the final 12 months of life and they didn't live as long and you got $4,800 for it or whatever you got, then you'd figure out how to balance that out.

DR. NGUYEN: Yes.

MR. SMITH: That's right.

DR. NGUYEN: Conceptually, we're in full alignment here.

DR. SMITH: Right. But, Harold, I think one thing that we also just have to acknowledge is part of the reason that we built both a PMPM up front as well as a shared savings is to address some of the concerns that

Robert brought up.

If you simply say to someone, "We're going to give you $4,800," you're going to have what we see in home care all the time, which is, "I really hope, then, I don't take care of complex patients," right? And so we have to figure out a balance here, and we think that the shared savings piece is the balance to push people to actually try and find the sicker patients, because it's clear from various studies -- you know, one of the more recent studies that came out of New York by Dana Lustbader, you know, that the spending that happens in those last few months of life are where you can sort of generate some savings. So we have to figure out how to push people to go after the sickest patients, where the sickest is really the ones who are suffering the most.

CHAIR BAILET: Thank you. Thank you, Harold.

I'm going to go with Paul and then Kavita.

DR. CASALE: Thanks.

I just want to clarify to Rhonda's question about when the payment starts and when the notification occurs, because when I read the letter from August 30th, it says you propose that the patient would be informed within the first 90 days of program enrollment. So I read that to mean you're enrolled in the program, the $400 per member,

per month begins. So you're [unintelligible] -- but so the notification to the patient could occur on the third month, but the payment would occur --

DR. NGUYEN: Yeah.

DR. CASALE: -- on the first month.

DR. NGUYEN: Yes. So we can clarify this, Paul.

So I think what we said in our proposal, once patients are identified, they will be informed of the program, and then we were really focusing in on at what point do you tell patients that this program target those with a 12-month prognosis.

And so specifically to that point of communication about the 12-month prognosis, we recommend that that occur within 90 days, and that was going back to what Kris said here, where we were really trying to balance here to make sure that that communication occurs in a patient-centered way, once relationship has been established.

So we were responding mainly to that patients would be -- would be notified about the 12-month prognosis within the 90-day, but at the moment of enrollment, they would be informed of the program. And we would follow any CMS recommendation of what are the required communications that you must communicate about the payment model. We

would comply with that.

We are asking for the communication around the 12-month prognosis that there be a built-in time for that, but we would --

DR. SMITH: Right.

So, Paul, just one other thing. If you look at the literature on having conversations with patients and families about advanced illness and advanced care planning, it's pretty clear that it's in the best interest of both high-quality care as well as total cost of care to have that conversation as early as possible.

So I think what we're trying to do is provide some flexibility for some patients and families who aren't ready to have that conversation, but the incentives are all aligned for you to have that conversation as early as possible, preferably at the first visit, because it's very clear when you look at studies where advanced -- high-quality advanced care planning conversations are introduced into a patient's care plan, you immediately start to see an improvement in quality and a reduction in total cost of care.

DR. CASALE: No. I don't just -- I'm just trying to understand when the payment starts --

DR. SMITH: Right.

DR. CASALE: -- because you used the word "enrollment." To me, that means payment starts --

DR. NGUYEN: Yes.

DR. CASALE: -- at enrollment.

DR. NGUYEN: Yes.

DR. CASALE: But you don't have to inform the patient until 90 days.

MR. SMITH: Just for clarity, so you would inform -- so let's say you start in March, is the first time you see a patient, so you start getting paid in March. You would inform that patient about everything about the program in March, with one exception, which would be the fact that they're likely to pass away in the next 12 months. You would have 90 days to do that one specific piece, but everything else would occur in March.

MR. KOUTSOUMPAS: And that conversation could come well before the 90 days. I think the point again is to allow the flexibility for patients and families who might want a little time to develop a trust, to develop a relationship.

DR. CASALE: I do understand that. I just still the --

MR. KOUTSOUMPAS: Yes.

DR. CASALE: If you're getting paid for something

where a patient -- if Medicare is paying for this -- and we talked about it, I think, amongst the PRT -- shouldn't the patient be -- understand the entirety of their program? I understand the need for time, but the timing of the payment and that – [unintelligible], you say it's the only piece, I think it's an important piece of this.

MR. KOUTSOUMPAS: Sure.

DR. MEDOWS: So what if the patient once informed of the 12-month prognosis and wants to opt out?

DR. NGUYEN: Yes.

DR. MEDOWS: Does he -- do the first two or three months, get refunded back?

MR. SMITH: I think that would be the kind of thing that we could definitely look at and work on with CMS.

DR. MEDOWS: I just -- I think it's really important that if we build a program for a very sensitive population --

MR. SMITH: Yes.

DR. NGUYEN: Yeah.

DR. MEDOWS: Right?

DR. NGUYEN: Yeah.

DR. MEDOWS: The patient, the family, the caregivers -- I understand the need to build trust, but I

also understand that if you're giving people all these services, you're not giving it to them just because you just want to be nice. You're giving it to them for a purpose.

MR. KOUTSOUMPAS: Sure.

DR. MEDOWS: I think that they should know some of that purpose. I think if they opt -- if they choose not to be in --

MR. KOUTSOUMPAS: Sure.

DR. MEDOWS: -- then I don't know that Medicare should be billed for a service if they don't -- I'm a little bit concerned about what comes first. I just –

DR. SMITH: Yeah. Rhonda, I think it's an -- I think it's an excellent point that we have to make sure --

DR. NGUYEN: Yes.

DR. SMITH: -- that we are having honest conversations with patients, right? And I think where we're tripping over is you would never have a conversation about this model without having a conversation about the fact that you're very sick, and whether we get to actually saying what that means is you have 12 months on average to live is very different than a conversation of "We're here today because you have a lot of complex illness. You've been in and out of the hospital, and we're here to help,

right? And because of your illness, you're going to continue to need these special support services." That conversation will happen every single time. Whether we actually give a prognostication of 12 months will most likely happen at the initial visit but may happen a little bit later.

To your point, though, about what if they decide once they hear the news that they want to withdraw from the program, I would offer up to this group that will happen so rarely that I would easily just say, "Fine. We will pay back the money," because it will happen so rarely. And if it brings Medicare comfort that we would have a mechanism for paying back for this one- or two- or three-month period, that would be fine because it so rarely happens clinically when you actually get down to that final conversation.

MR. SMITH: And I think just as a broader comment, what hopefully you're hearing from us and I think what you saw in our PRT response is that we care deeply about making sure that this is done right, and we know that as more people engage in the process, whether that's PTAC or at some point CMMI, that there will continue to be refinements for it. And I hope sort of what you guys take away from both our PRT response as well as the way we're

answering some of the questions is that our goal is to get it right and to work with all the folks that are involved in that process, to get closer and closer to the best answer possible. I just think we start in a great spot, bringing our experience to the table, but hopefully, we're showing that we want to listen and get it right.

MR. KOUTSOUMPAS: Yeah. And I would just add to that, Rhonda. I think sort of adding on to what Kris and Brad have both said, clearly if that was an issue that we needed to address, to pay back, we would absolutely do that.

And the other issue around the information about the 12 months is another one of those things that we think this is our best judgment based on the care that's been delivered by the organizations that are part of it, but certainly, if we wanted to work with you or to tweak it or work with CMS to tweak that, to change the dynamic, we'd certainly be open to that.

Our goal, as Brad and Kris have said -- and Khue and Gary -- is to get it right, and so we're really open to the important suggestions that you all will make and others at CMS to make sure that we get it right for this population. There's nothing more important than that.

DR. MEDOWS: And, Tom, we want you to have it

right --

MR. KOUTSOUMPAS: Yeah.

DR. MEDOWS: -- because of the population.

MR. KOUTSOUMPAS: Yes.

DR. MEDOWS: We really absolutely do.

MR. KOUTSOUMPAS: Yes.

DR. MEDOWS: So I appreciate you letting me have my little say --

MR. KOUTSOUMPAS: I love your say.

DR. MEDOWS: -- and you have my question. Thank you.

MR. KOUTSOUMPAS: Thank you.

CHAIR BAILET: Elizabeth, you had something that --

VICE CHAIR MITCHELL: Yeah. Thank you.

And I just want to underscore this was an issue of great concern to the PRT. What is the proper notification? How do patients make this informed decision? It was just very high stakes for all of us.

And while I really appreciate your response and your commitment to this, to me it's just still not quite clear, and it reflects sort of important changes that we haven't had the opportunity to fully process. So I just wanted to note that.

CHAIR BAILET: Yeah. And so, Kavita, your time and then Bob.

DR. PATEL: So who's having in this concept of the beneficiary conversation -- and I assume it's a G Code that'll get billed for this PMPM, but who is the triggering clinicians having this original conversation, of not even about the prognosis, but that initial conversation that I'm assuming is a G Code bill? One, is that correct that this would be like a G Code of some kind to kind of --

DR. NGUYEN: We propose for that, yes.

DR. PATEL: And who is having that conversation? Is it the palliative care physician, since that's who we said the PMPM is for? I'm just asking.

DR. NGUYEN: Yes. So there are --

DR. PATEL: And I find that problematic because we're now going -- I mean, I'm taking care of somebody who could probably be in this model, and then -- and is going to swoop a palliative care physician that is not well known to a team that's part of an ACM Entity --

DR. NGUYEN: Right.

DR. PATEL: -- who is going to start this conversation. Do I have that correct?

DR. NGUYEN: Yes. So the structure -- so in order to be an ACM Entity, you need to have a group of

physicians who agree to participate in the model and agree to the concept of the model.

The patients would come from that network, that defined network of physicians, and so the communication about the program could start at the physician office, who is identifying that patient and referring that patient into the program, or it could be --

DR. PATEL: But then they can't bill for that triggering PMPM. I'm just getting -- I'm trying not to be pedantic, but it makes a difference --

DR. NGUYEN: Yes.

DR. PATEL: -- with who's getting -- I mean, $400 is not a small -- by the way, that's the largest PMPM to date, I believe, for any payment model. So you're saying a primary care physician who may be part of this would need to be part of this ACM Entity and would be -- but might not be the actual continuity care, primary care physician would be initiating this. Is that correct? I just want to make sure I'm understanding.

DR. NGUYEN: Yes. So we would have a --

DR. PATEL: Because that's a little problematic.

DR. NGUYEN: Right. So we would have a defined physician network and along with -- so the ACM Entity would have a defined physician network and these additional

services, including a palliative care physician and the interdisciplinary care team.

The $400 -- it is up to the ACM Entity in terms of how it shares that payment.

DR. PATEL: I'm not talking about sharing. I'm trying to be -- because I administer this for our clinic.

DR. NGUYEN: Yeah.

DR. PATEL: I mean, I'm trying to be incredibly, like, pedantic about in my fee-for-service billing form with my NPI (National Provider Identifier) of record to get this $400. Who does that have to be that's having the conversation? What's the trigger? Who is the triggering NPI, so to speak? Is it a palliative care physician or the ACM Entity? Is it an NPI of any tax ID number who then refers into an -- I'm just confused.

DR. NGUYEN: Right. So the ACM --

DR. PATEL: So maybe the PRT understood this better.

DR. NGUYEN: -- entity consists --

DR. PATEL: Let me make sure my question is making sense.

DR. NGUYEN: Yeah. Yeah.

DR. PATEL: Who is actually billing for this – I don’t even care -- you know, for this $400 PMPM, for that

initial conversation, and who in your mind is having that conversation?

DR. NGUYEN: Yeah, yeah.

DR. SMITH: So, Khue, I think, you know, so -- I just want to unpack your question a little bit.

DR. PATEL: Yes. Sure.

DR. SMITH: So I just want to make sure that I understand. So it sounds to me like there's a couple of concerns here. One is sort of how do we -- how do we administer the program?

DR. PATEL: Correct.

DR. SMITH: So is it that these ACMs are going to have their own TIN (tax identification number), and they're going to be a billing entity?

DR. PATEL: Right, or whatever. Who is the doctor having this first conversation?

DR. SMITH: Right. So the administrative back-end, I think we can figure out, and there's lots of ways to create billing entities that can -- that can bill for this, and we're going to have -- the model, the ACM model, is an interdisciplinary care team model that is not simply, you know, a primary care doctor taking on added responsibility and then billing for the $400.

But I think, if I -- underlying your question is

how do we honor the long-term relationship that many of these patients have with a primary care physician, while trying to introduce a new set of services and a new team into that milieu.

DR. PATEL: Right.

DR. SMITH: Is that part of what --

DR. PATEL: That, and the third question, then, is really so you're really thinking about that PMPM not as a face-to-face visit with a G Code, so to speak, or it might be a G Code, but it's really to be almost like the -- you referenced the oncology care model. It's a little bit like a MEOS (monthly enhanced oncology services) payment, in some regard.

DR. SMITH: Little like a what?

DR. PATEL: Monthly enhanced -- help me out, Harold. Monthly enhanced -- I keep forgetting what the O is for.

DR. SMITH: Yes, so --

DR. PATEL: Oncology services. So it's more of a general payment --

DR. SMITH: Right. So we're not --

DR. PATEL: -- not generally for a face-to-face visit.

DR. SMITH: We're not -- so the initial encounter

has to be face-to-face. We are not proscriptive in the model about --

DR. PATEL: To do it.

DR. SMITH: -- whether or not, you know, at week two there has to be a face-to-face encounter, week three there has to be a telephonic encounter, week five --. What we've set -- if you -- as you saw in the proposal, what we've set is a basic set of services that have to be available, 24/7 availability, interdisciplinary care team, advanced care planning, patient-centered care plans that are revisited, so --

But when the programs that have responsibility for total cost of care and quality will modulate the intensity of the program as the patient and family need changes, and so it may be that one month a telephone conversation is all that's needed, and it may be that the next month, you know, four visits in a week are needed. That's part of why you have the PMPM up front to help make that possible.

In terms of how this program relates to the existing primary care providers, that's something that is happening across the country right now. As I'm sure you are aware, there are lots of entities that are coming in and doing this work, and you know my experience in doing

this in the home-based primary care space, where most of my patients have had a prior relationship with a primary care doctor, is if you provide a high-quality program, the primary care community is really excited to partner with you. And if you provide some feedback and some care coordination and information back, you do include that primary care provider within the larger care team, but it is the ACM that's getting paid for the work.

DR. PATEL: Okay. And then what I really raised this for was that, Brad, you said something about being able to take on, when you and Harold were talking about maybe you could -- it sounds like you could kind of amortize at least the risk of taking only certain payments and not shared risk, whatever. But that just made me think your organization would kind of fall into -- you would not be making an assumption that every ACM Entity would have to, for example, partner with somebody like you who has this volume, but then that sets up to me the counter-factual that there could easily be other ACM Entities who do not have the ability to have -- I think you said you service like 48,000 patients or 100,000 lives.

So there could in a new -- in a kind of alternative payment methodology, we could have ACM Entities who have very little experience and would not have the

benefit of having run thousands of patients' claims, et cetera.

So I just wanted to ask kind of if the thinking was -- or I know that that's asking you to think hypothetically, but how would people who have not had that type of claims analysis experience, et cetera, do you see this as something they would just kind of have to outsource and try to find people for, or how would you help talk to interested physicians who might want to do this, but certainly don't have this set of bench strength and the lives that you have had experience on running risk adjustment models on?

MR. SMITH: Yes. So I have a couple different answers to that.

So there are actually a wide array of folks across the country who have tried to run these programs. So there's folks who are at scale like us. There's a lot of local non-profit hospices who have tried to do this with philanthropy for a period of time but not been able to sustain it, and I think you have a number of different folks around the country with all different levels of resources who would try to participate in something like this.

I think what would be really important, if a

demonstration project happened, is to have centralized resources, whether they're by CMS or folks like C-TAC or AAHPM (American Academy of Hospice and Palliative Medicine) or others, who are then coordinating and sharing best practices, and I think all of us who are participating here today would offer up everything that we know and everything that we've learned to assist with that across the country.

DR. NGUYEN: We've also built in here what are the most high-value, effective interventions. So in terms of how do you do this, it's through -- you know, we've outlined here what are those core interventions, what are those core processes that an entity needs to deliver. If you deliver these -- if you deliver these interventions, if you attend to these metrics, you will achieve high quality. So in terms of the analytic support, a formal CMS program would provide that in the sense of each of these entities would have access to what is their prior baseline and would have access to that data, would have access to the ongoing reporting. So it's through a formal program that organizations will have better access and better tools.

DR. SMITH: I think, one last thing, we spent a lot of time trying to figure out how do we balance creating a program that would be appealing to a broad array and not just large health systems or for-profit organizations, and

some of the ways in which we tried to make it easier for a broader swath of providers to participate is, one, the up-front payment, because right now many of these programs, you have to -- you take on the cost and hope that there are shared savings later.

The other thing that we did is that there is upside only in Year One, which is now sort of a somewhat standard way of enticing people in a lower-risk environment to learn. If that one year needed to be two years, I mean, that's certainly something that we could consider as we go forward.

And then I think limiting the downside loss to 10 percent is another important aspect, because for many of these programs, if we want to attract new entrants in the beginning, they are going to be small numbers, and those small numbers can vary quickly, have outliers that can really cause a lot of disruption in terms of the shared savings and downside risk.

CHAIR BAILET: Tim.

DR. FERRIS: So you guys are doing a great job. Hang in there.

I hope you interpret all the sort of raking over the coals that's going on here as our intense interest in getting this right, even as you've expressed your intense

interest in getting this right, and I'm -- because I'm sure that's what it is.

The multiple conversations that have occurred have brought me back to the question that I started with, and I want to come back to it, not to be redundant, but to be potentially a little bit more clearer, because, again, I'm -- the complexity that I alluded to that is inherent in the tying to the end of life, much of that complexity goes away if one considers, as you have so aptly pointed out, a market-based solution, if indeed you're correct, which I know the data supports, that the best period to get return on investment for investment and care coordination is the time right before death. Why not let the market decide, meaning the clinicians who are engaging in this, who want to collect this payment and provide these services, decide when they do it and just make it, to build on Harold's point, a fee-at-risk situation?

And I know that introduces different complexities, but I'm struggling with why that wouldn't achieve the same goals because the people implementing this get the up-front payment. They get all the same services, but by removing the tie to death, you actually -- you sort of push -- you allow the market to just choose when they're going to enroll a patient, right? And if that's the best

time to enroll the patient, that's the best time to enroll the patient.

I would argue, actually, there's a lot of patients upstream from the last year of life that would benefit substantially from this.

So help me understand in the context of this conversation why that wouldn't be either a viable or alternative or a potentially a simpler model to achieve your ends.

DR. NGUYEN: I think we talked about the -- we're not debating on the importance of focusing on this population. You're really asking us about the payment.

And we know that, for example, that the costs of care for month 12, month 8, month 7, month 6, month 5 vary drastically. They vary drastically for a patient of a given profile. They vary drastically across episodes, and so we felt that it would be very challenging for practices and for programs to not have a sense of where their patients are in terms of -- in terms of what is that baseline utilization. And so that was one of the considerations in terms of making sure that there is clarity for the entity and understanding the utilization associated with each month prior to death for that last 12 months.

MR. SMITH: I don't want to speak out of turn, but I think it's a really interesting idea. You know, I think the thing you have to protect within these payment models is having too many folks in for too long who aren't that sick, right? And the solution that you've -- we've tried to do that by having this 12-month cap, which we then sort of said, okay, it can be longer than that, and we're going to protect it by having 12 months. But you have to figure out some way to do that.

And I think the way that you and Harold have proposed is quite elegant, honestly, and I think if you all said to us, "Hey, we think this is a really important problem you're going after. We think on this point and several other points that you all have raised, there's something there," and said, "Here's our feedback to you all. Will you consider it?" I think we would love the opportunity to do that, to provide you another letter with more than five days' notice that takes that into account right, to learn as we go through this process, because our goal, just as you started, is to get it right. And I think you all have great feedback, and I wish you had been part of our team preparing it. We would have had a stronger recommendation, but yeah.

MR. KOUTSOUMPAS: Well, I would actually concur

and commit to that. I mean, I think it's an absolutely eloquent discussion, idea, and one that we would take very seriously.

When we started C-TAC and I started talking about my mom, she was really multiple years out of going through a difficult period. The intensity that occurred during the last 12 months was significantly different, but a lot of my colleagues said, "I think you're stretching a little too far." But I certainly -- we certainly would welcome that discussion in more detail and see if we could come up with an approach that would be feasible.

DR. FERRIS: And just to be clear and to argue from your perspective on your proposal, one of the main differences between what you're proposing is -- to go to Kavita's point, is actually the size of the payment.

MR. KOUTSOUMPAS: Sure.

DR. FERRIS: So care coordination payments tend to be in the $100 PMPM range because they involve a care coordinator --

MR. KOUTSOUMPAS: Right.

DR. FERRIS: -- and not all the intensive, more intensive services.

And so in an ideal world, it would be nice to be able to match payment with the intensity of services on a

continuum, right? But, of course, we don't live in a world where that's possible.

MR. KOUTSOUMPAS: Right.

DR. FERRIS: That introduces far too much complexity. So we have to draw arbitrary lines at some point.

MR. KOUTSOUMPAS: Exactly.

DR. FERRIS: You've chosen a large payment and a time of life where that large payment is necessary to provide the services, and all I'm suggesting is you might be able to achieve that end with a smaller payment, right, but with the ability to flex to those --

MR. KOUTSOUMPAS: Further out.

DR. FERRIS: -- to those full services, depending on the total number of patients that are in your -- I mean, that is the way it works in our ACO right now. We do provide the full wrap services to a small number of patients. That's because we're providing care coordination underneath a much broader --

MR. KOUTSOUMPAS: Sure.

DR. FERRIS: -- set of patients at a much lower PMPM. So --

DR. NGUYEN: Yeah.

MR. KOUTSOUMPAS: Yeah.

DR. FERRIS: And I don't pretend to have the solution.

MR. KOUTSOUMPAS: No, no. It's good, though. Thank you.

MR. BACHER: I think a couple of the other -- thanks. That's a great point, and as Tom and Brad were saying something to really think through, I think some of the other considerations that have come up is the type of population we receive. So in a general population model, such as an ACO, there's a lot more averaging that occurs, and depending on the kind of population that the ACM is selecting, the question would be how much, how much variation is there? And there may be less variation, but the problem is if you haven't come up with a model, then, that recognized that the cost structure and the risk adjustment for that population is very different than what you would find in a more average population, you could run into a challenge.

And so those are some of the things that we've kind of run into, which is organizations that, because of their model, really do select -- and particularly along the spectrum of extremely sick population, and then the question is what do you do, for instance, for them, and how might that differ if you're thinking about this across a

broader population, but really appreciate the points that you're making.

DR. NGUYEN: Tim, on --

CHAIR BAILET: Go ahead.

DR. NGUYEN: Tim, on also your idea of starting with a smaller PMPM and having the potential to then increase that PMPM based on need -- so for us, it's important to make sure that there is clarity around accountability and how far will you be accountable, and so that was back to Harold that this is about taking accountability for the patient's care experience over a defined episode.

Then on that, I think we're less strict around the PMPM. It's more so that there is up-front payment that allows you to really deploy that as needed.

From our own experience, much of the work, there is a heavy lift initially, actually. There's a heavy lift initially to really settle the patient, to really understand where they are, to really establish the relationship with their physicians, to really spend that time building that foundation, and so, actually, there is the intensive work initially. And then what we believe the right strategy here in clinical care is you build that foundation, and then you tailor your services based on the

needs. And it's going to vary, and some of that is not something that we can see in claims data.

A dementia patient without a strong support system may have been doing well but will reach a point where they may need a lot more support, and the team has to be able to flex up and deliver that service.

CHAIR BAILET: So I just have a -- I'm trying to be respectful of the -- we have a fairly significant number of folks who want to make public comments, but I think what we've seen play out really harkens back to Bruce's original observation that when I look at -- and these are the question-and-answer exchanges, and I had to go back, because I don't trust my own memory here, but, quote, "The alternative payment replaces the fee-for-service payment for palliative care providers only," and that everyone else on the team that contributes to the care of these patients gets paid fee-for-service, right? So if they do work, they get a fee-for-service payment.

DR. NGUYEN: Yes.

CHAIR BAILET: What we're seeing is that as we've had this dialogue and exchange, the model, I mean, it is an alternative payment model at the end of the day, and it's changing and being modified and tweaked as we speak. And so my observation -- and this is my observation, and I

think it's shared by others, but I won't speak for them -- that this is going under stages of refinement, and when we make a recommendation to the Secretary, I think we need to be very concrete and very specific and very focused on what it is that we're recommending.

And as I sit here, I have seen this model sort of play through based on the input and the exchange. It has changed. It's changed by the August 30th letter. It's changing now as we give you feedback, and that's fine. That is, frankly, a testament to the process.

But I want to caution. I'm speaking now for myself. I want to make sure that when we deliberate and give this the due that it deserves that we're not -- it's not squishy, it's not gray, that we're clear about what it is that we're actually deliberating on.

And I'm personally speaking again for myself. I don't feel comfortable that you have arrived at your best efforts, which allows us to apply our best efforts to be laser-focused and make a recommendation that is firm to the Secretary.

So I'm throwing that out there to the Committee. I also want to be respectful. We have 15, potentially more people who are lined up to provide public comment, and if we hold fast to the three minutes a piece, we're good,

potentially, at least close to another hour into this before I even turn to my colleagues and say, "Okay, team. Are we ready to then go to the next phase of the discussion, which is deliberation?"

But I think it's appropriate to highlight what has played through here, and I guess I would stop and turn to my other colleagues on the Committee. Is my visual acuity on this accurate, or have I misread what I'm looking at?

Elizabeth?

VICE CHAIR MITCHELL: Well, I will weigh in. I think your acuity is accurate. I think it has been an important and healthy process, but not only has the proposal changed since our PRT report, but I think it may have changed today. It may have improved, which is great, but in terms of us really knowing what we're evaluating, it's not as clear to me as I'd like it to be.

CHAIR BAILET: Paul?

DR. CASALE: Yeah. And just to echo the comments I made earlier, again, in my view, you know, the letter was very thoughtful, and it addressed a lot of concerns, but I think it substantially changed the model in a way that I feel that we need an opportunity to bring it back.

And I guess my feeling -- I don't know when to

make this recommendation -- is to ask C-TAC and the submitters to revise and incorporate what they would like to see as their model, bring it back, and then allow the PRT an opportunity to review it, and then expedite that review. And we may want to, as I said, go back to the Office of the Actuary to get some more input on that or back to our palliative care expert, et cetera, but do it in an expedited way so that we can then come back in December to do the deliberation and vote.

CHAIR BAILET: Bob and then Len.

DR. BERENSON: Yeah. I think that makes perfect sense.

I would just want to make sure that there was an opportunity for public comment on a revision, so revise and resubmit in an expedited way is what I would suggest.

CHAIR BAILET: Thank you, Bob.

Len?

DR. NICHOLS: I agree with all that.

I think the obligation that I feel compelled to articulate is that I think we owe these people some suggestions about exactly how we think it would be improved, and then you all can decide to cast them aside or not. But I think we've had a far-ranging discussion. We've raised many, many different issues, some of which are

elegant, some of which are not, but all of which may confuse you unless we give you priority.

So I would suggest we can do that in some kind of communication from the Chair to the applicants, and then we sort of have Round 2 later as we go forward.

CHAIR BAILET: Yeah. To be true to the process, it is your proposal, not ours. So what I -- let me reframe what my esteemed colleague, Dr. Nichols, just said. We are -- we are, I believe, where we're going to land, but I want to give the public the opportunity to provide feedback, and then I think we will revisit this issue.

You have the ability to recast, based on where we are today and what you're going to hear from the public, your best efforts and your best guess on where you want this to land. What we're committing to is with that proposal resubmission, we will then use our best efforts in an expedited fashion to go through our own internal processes, actuarial analysis, et cetera, hear from the public on whatever you put forth, and do it in an expedited way, so that we can keep the momentum moving.

But, again, I go back to what is the end state? The end state is we are obligated to make a recommendation to the Secretary, and I want to make sure that it's not shifting sand. That when we actually make that

recommendation, it's crisp and firm and it's concrete. Does that --

MR. KOUTSOUMPAS: If I may comment from our perspective?

CHAIR BAILET: Please. Go ahead. Yeah.

MR. KOUTSOUMPAS: Certainly, given the esteemed nature of the PTAC Committee, we welcome your comments, and we welcome the important information that you've given us today.

We will take that feedback with great interest and obligation to incorporate that into our model, into our thinking, and come back to you, as you've suggested.

I think it's a wonderful dialogue today and a wonderful opportunity, as we've all agreed to make this the best that it can be, and so we would welcome that and appreciate that opportunity.

CHAIR BAILET: Great.

Rhonda, did you want to make a comment?

DR. MEDOWS: I just wanted to say thank you for putting up with all of us, for listening to us, but also being willing to go back.

I think you will be better served --

MR. KOUTSOUMPAS: Yes.

DR. MEDOWS: -- coming back with something even

more fantastic.

MR. KOUTSOUMPAS: Yes.

DR. MEDOWS: But I think most important, if you could take away from our conversation today, we believe this population is very important.

MR. KOUTSOUMPAS: Yes.

DR. MEDOWS: We believe this work is critical to our being able to address the needs of a very important part of our families.

MR. KOUTSOUMPAS: Yes.

DR. MEDOWS: So please don't take this as something that you shouldn't do.

MR. KOUTSOUMPAS: No.

DR. MEDOWS: Our idea is to make sure that it's the best and that it's something that we can come more favorable on. How about that?

MR. KOUTSOUMPAS: I love it, and I think as I said in my opening comments, the opportunity to work with you to make this the best is what we want, so thank you for all of these wonderful comments. And we will work together to get it right.

CHAIR BAILET: Great.

So here's where we are. It is, what, four o'clock? Four o'clock. As a surgeon, I don't need a bio

break, but I bet there's a few people here that do. So here's what I'm going to do. Because we have a lot of public comments and --

MR. KOUTSOUMPAS: Cut out the water.

[Laughter.]

CHAIR BAILET: Yeah.

All right. Look, I am going to leave you with this for 10 minutes.

MR. KOUTSOUMPAS: Okay.

CHAIR BAILET: The public comments, what has played through here may alter some of the folks who are lined up to speak. So we're going to go through the process, but if, in fact, that's changed your thinking and you potentially might change your comment or decide to waive off your comment right now based on the process and where we are right now, that's perfectly acceptable. But I have to honor the list. Right now I'm starting at, at least 15, 16 names.

MR. KOUTSOUMPAS: Yeah. Sure.

CHAIR BAILET: So let's take a solid 10-minute break. I will pound the gavel. We will come back and then motor through the public comments. All righty?

MR. KOUTSOUMPAS: Perfect.

CHAIR BAILET: All right. Thank you.

MR. KOUTSOUMPAS: Thank you.

[Recess.]

CHAIR BAILET: Okay. We're going to go ahead and get started. If I could harness my brain trust of a Committee here, bring everybody back, that would be great.

[Pause.]

CHAIR BAILET: No, no, no. We're good. We're good.

So as everybody is making their way back to the table, we've had a good number of the folks prefer to hold their comments until the next phase of the proposal process occurs.

So I have a much shorter list, but I am going to start with -- I believe it's Randy Krakauer. Is that right? Yep? Please go ahead.

Yeah, sure. You can -- that's fine. If you want to sit in front, that's fine.

* DR. KRAKAUER: Good afternoon.

CHAIR BAILET: You have to push the button there.

DR. KRAKAUER: Thank you.

CHAIR BAILET: We're good. Go ahead.

DR. KRAKAUER: Hi. Good afternoon. I'm Randy Krakauer. I'm formerly chief medical officer for Medicare for Aetna. I'm now retired.

In 2003, when we first looked to address this issue, we had just built a care management capability, and we were looking at what we now call advanced illness, and at the time, we knew that the quality metrics, for example, the [unintelligible] and other studies indicated that there was a tremendous amount of quality gaps between what is possible and what was extant at the time. And we thought we could use our care management [unintelligible] capability to have an impact.

At that time, the evidence that we could have such an impact was equivocal, and the evidence that we could save money by doing so was even more equivocal.

Nonetheless, we went ahead, and we trained case managers in this area, and we developed a means of identifying a population. And the impact was quite dramatic. Although initially undertaken without any publicity, we subsequently reported and published results, which is now part of the body of evidence, which shows a rather very impressive impact on satisfaction, quality, and cost, most particularly in a Medicare population.

The reasons are partly because, of course, we had a good program, but also because we're providing a support and service that was very much needed, sometimes almost desperately needed and too often simply not provided or

available until late or too late or not at all.

Over the years, we continued to offer this program, developed it, enhanced it, used embedded case managers, worked with provider collaboration groups, which eventually evolved into ACOs, and I became convinced that this is perhaps the greatest opportunity, particularly in Medicare, for impact at the intersection of quality and cost.

I retired about two years ago, but I can't give -- I can't let go of this. I am now on the board of directors of C-TAC, and I'm a strategic advisor to C-TAC.

I'm not going to say that anecdotes constitute evidence, but I have had enough experience with individual cases, and I was prepared to read one right now, but it will probably take a little bit too long, but to tell you that the impact is not only dramatic, but the depth of it and the need for it is sometimes almost desperate.

So I'm here to support this application in saying that my goal right now in my current work with C-TAC in retirement is to see what we've accomplished and what others have accomplished and which is now your body of evidence of the value of this becomes standard of care.

This proposal you see here today is something that will put us on the On Ramp to the highway to standard

of care for this, and I strongly encourage it.

Thank you.

CHAIR BAILET: Thank you, Randy.

Greg -- is it Gadbois? Yep? Did I get it right?

DR. GADBOIS: That's the first time anyone has ever gotten it right.

CHAIR BAILET: I have one in my closet. All right.

DR. GADBOIS: Thank you.

Again, my name is Greg Gadbois. I'm a family physician by trade. I currently work at Priority Health, which is a regional health plan in Michigan, and I also have a personal experience with my mother who passed away two years ago from pulmonary fibrosis, who actually had the luxury of an outpatient home-based palliative care service. And I can tell you it made a huge difference. So I have a very interesting perspective of everything.

I'm going to speak kind of from my Priority Health standpoint because that's where I am right now. Full transparency, I've been on the group at C-TAC working on this for the last two years.

We at Priority Health are currently supporting programs like this across the state. Luckily, we have the flexibility as an MA (Medicare Advantage) plan to be able

to do that. Some of them are a little different. They all have their idiosyncrasies, but for the most part very similar to what's being proposed today. And I can tell you we have good data showing significant improvement.

We talk about the triple aim and all three pillars. I've never seen another program hit all three pillars as significantly as an in-home, team-based palliative care program for those with advanced illness. I'm amazed at the work that we do. We actually get thank-you letters from family members thanking Priority Health, an insurance company, for delivering this service to them. We don't get that very often, just so you know.

And I can also tell you just from our experience that there are some specific things that I think we need to take into account, and I think this model does that. One of those is we really do need to focus on targeting the right population for this. We didn't have that right off the bat, and things didn't go as well. We started to incorporate our own targeting process for the different programs, and finding those right patients, because they are different, it's not just about saying someone is two months from the end of life versus 12 months or 15 or 22 months. They are different, and they have different needs.

We have a very strong care management program,

and even my care managers, who are coordinating care with all of our complex patients, will tell you they really appreciate these programs because they have a challenge taking care of the needs that they have in this end-of-life stage.

So I do want you to know we appreciate all the information, and we will be going back to the skunkworks to work on this. But I can't stress enough the importance of making this happen, because there's a significant number of patients out there in need that don't have access to these programs right now, and I do believe we owe it to them to get it to them. We should treat them like we'd want our parents or our grandparents or our loved ones to be treated.

So thank you for your time.

CHAIR BAILET: Great. Thank you, Greg.

I'm just going to call Allison Brennan again.

MS. BRENNAN: Oh, thank you. So my name is Allison Brennan. I'm with the National Association of ACOs.

And I think pretty much everybody in this room would probably agree that treating this patient population is certainly a laudable goal.

One thing that sort of confused me, as you were

talking through their proposal, was how these new care teams would mesh with the existing primary care teams, and I think that's something that's really important to consider. We don't want to have a situation where the new care team kind of swoops in and maybe has a situation like we see in Medicare with the annual wellness visits, where it's a great fit if the right people are providing it, but if a new set comes in or somebody else, sometimes it's not really living up to the intent. So that was just something I was a little bit confused about and maybe you'd want to consider further.

Also, in the presentation, there was an acknowledgement that the introduction of this model and its patient recruitment might affect the evaluation of other models, including ACOs, and this is something that goes to the challenges we see with the overlap of different models as they're introduced and implemented. And I'd just encourage the Committee to keep that in mind, and I think that's going to be one of the biggest challenges that we face in terms of seeing new models, because the overlap is very confusing right now and can also be problematic as we look at the effects on existing programs.

And also, I noticed in the proposal that they said that if fully implemented, the ACM would provide

accountability for 25 percent of Medicare expenditures, and the scope of that just sort of stuck out to me as I was thinking about the overlap issue.

So just a couple things to consider, and thank you very much.

CHAIR BAILET: Thank you, Allison.

Next up, we have Maria Gatto from C-TAC.

MS. GATTO: Hello, everybody. I'm short but mighty.

First of all, I want to thank everybody today. I'm very overwhelmed and humbled to be in this room because I'm recognizing that this is a moment where there's visionaries and pioneers.

And I was listening to everybody ask questions and be very passionate and be very vested and share their stories. Elizabeth, tears were in my eyes listening to your family story and everybody else here because we've all experienced it.

And I just want to say that when I heard a lot of the questions you were asking the team, I felt very validated because that showed how much, like you said, you want this to work and that you're so passionate about this.

And when people are introduced this type of model and approach with palliative care and serious illness, this

is how everybody reacts: "Tell me more. I have more questions. Let me be really clear. I really want this to work." So, to me, I got really excited because the questions meant, oh, my gosh, they understand the potential, the change, right, the work that could be coming forward and affecting the future.

So I'm the system director for Palliative Care for Trinity Health. I'm a palliative care board-certified nurse practitioner, and my one and only role for Trinity Health, which is the second largest Catholic health system across the country that serves 22 states, is to implement palliative care models and serious illness models across the system.

Our CEO and president, Rick Gilfillan, came to me and said, "What are we doing about palliative care?" and I said, "Rick" -- I said, "We have taken huge variation and standardized it across our system for all of our models and our hospitals." He says, "That's really great. What have you shown?" I said, "We have saved over $10 million according to our only $3 million projection. We have increased patient satisfaction. Patients recommend us highly, highly satisfied. We have people out of the ICU. We have people where their symptoms are controlled, and we have goals-of-care conversation, 70 percent of the time, on

consultation." He says, "That's great, but what about the community?" and I said, "Okay. I'm it. I'm the only person, Rick. I need help." And he said, "That's where we need investment, because serious illness and palliative care in the community is the future," and he goes, "You know" -- he goes, "I invested in something called the Sutter model. Have you heard about it? Have you heard about C-TAC?" And I said, "No, Rick." He says, "Well, I want you to connect with them."

So we did, and we have a partnership with C-TAC. We've been working on a two-year project of something that you're questioning right now today, and we have had a lot of great outcomes regarding this type of model that we're talking about.

And when we gave Rick Gilfillan the results of -- the preliminary results about this new model, Khue said, "Rick, we're going to be going to present this in Washington," and he says, "What? They're not doing this already? We need to support this." He says, "I would like you to go there and tell them that Trinity Health is behind this because this is our future. This is the future of our patients," and this is what I'm here to support today.

CHAIR BAILET: Thank you, Maria.

Suzanne Johnson from C-TAC.

MS. JOHNSON: Hi. I'm Suzanne Johnson, and I am here on behalf of Sharp HealthCare and also C-TAC. I've been a member of C-TAC since nearly the beginning of time.

A little bit about Sharp HealthCare, 70 percent of our population is in a Medicare Advantage or full-risk health plan arrangement, so I'm very familiar with managing our own resources.

My colleague, Dr. Dan Hoefer, and I started a program, Community-Based Palliative Care Program, in 2007. With my background in hospice and his background in family practice, we were just stunned at the number of patients who came to hospice so late and after having had several emergency room visits and/or hospitalizations. And we were saying to ourselves, there's a better way, there's a better way, there's a better way. We know how to do this. We know how to take care of people who have chronic advancing illness.

So we started a community-based palliative care program through a grant that I got through our foundation. We did use the Sutter model as the platform for our model and then expanded it to work for our culture.

Essentially, we focused on a disease-specific model that used prognostication criteria to help physicians know when to refer, and we began to teach our physicians,

"Let's go for the never event. How about never in the hospital, never in the emergency room?" Because for heart failure patients, we know what's coming next, and we can teach primary care and specialty care how to anticipate what's coming next by the simple question, "Would you be surprised if the next time you talked to your patient, they're in the hospital?" And that's how we started our program.

Last year, we had an article published in JAGS, the *Journal of American Geriatric Society*, called the "Effects of Community-Based Palliative Care on Utilization and Costs." The results are stunning. They're stunning. What we showed is that we can keep patients out of the hospital altogether, and when we keep patients out of the hospital altogether through a community-based co-management program -- in other words, we keep -- [unintelligible] primary care and specialty care keeps their patients, and we overlay. We're the support team out in the home setting -- nurses, social workers, and on the back side, a palliative physician who is used in a consultative role.

What we've been able to show is that we can improve quality. We can reduce cost, and we can change utilization patterns. Ninety percent of our patients come on to hospice, which is remarkable, and we've increased the

average length of stay for our hospice patients and the median length of stay. And the way we've done that is that we use what's called "anticipatory guidance." We help prepare our patients and families for what's coming next in collaboration with primary and specialty care.

We can do -- and we must do -- a better job in our country of taking care of people who are at the most at risk and the most vulnerable for serious illness and the consequences that come with a hospitalization that is not necessary. We can do this together, and I applaud this group today. Thank you for your challenging us to think out of the box and to be better and to create a model and propose a model for you that will help our citizens, our people, and our beneficiaries. We can do it.

So I encourage you to read our article, the "Effects of Community-Based Palliative Care on Utilization and Costs." I think you'll see what we can do together, so thank you.

CHAIR BAILET: Thank you, Suzanne.

Brad Stuart.

DR. STUART: Hi. Thank you for your patience and hanging in with everyone.

I am an internist, like many of you, with 40 years of experience, not retired yet, much to my wife's

distress, but I wanted to -- as the founder of the program at Sutter Health that we've heard a lot about, I just want to make a point that I think may need a little emphasis here today, especially, Tim, in response to your opening and closing comment.

Let me tell you why I felt -- and I'm not boasting about starting the program. So many people have had -- and you're only seeing a handful of the people here today who made this program what it is and got the results we saw with CMMI, but the reason I felt in the late '90s that something like this was needed was because leaving it to the market or leaving it to us to do one particular task was not ever going to work, and that task is actively managing the transition between disease-modifying care, as aggressive as it can get, and the end of life. We don't do that well. We need people who are trained, who are deliberately recruited, who are motivated to do it, and are trained well to do it, because system left to itself, it doesn't happen.

So the night that woke me up was early in my practice. I was in the ICU seeing a woman who had just come in with sepsis, a bloodborne infection. Her blood pressure had dropped to zero. She was very elderly, no advanced care plan. In order to get her blood pressure

back up, I had to put an arterial line in. That's a painful procedure where you have to thread a catheter into an artery somewhere. I chose the wrist. And it's very hard to put enough local anesthetic in to get that area numb. This woman was so demented, she didn't recognize people. She had no real awareness at all, I thought, until I stuck her in the wrong place, and she opened her eyes and stared at me with a look that for the rest of my life I won't forget, because it was a mixture of shock, horror, hatred. Sum up everything that you never want to see somebody looking at you with, and that was it. And it made me really stop and think, you know, why was I doing this?

I succeeded in getting the line in. I got her blood pressure up, stabilized her. Two hours later, she died. After many other cases like that, I realized we need a way to -- a specialized way to help people make this transition.

So it's very gratifying to hear that folks on the Committee are in support of this, and having more detail provided about the payment, critical to have. But the why of why it's necessary to do and why we need $400 per month and not something less, that's a small amount to fund a new infrastructure that's needed to do the task that, unfortunately, for whatever reason, we don't seem to be

able to do ourselves.

So I'll stop there. Thank you very much for the time and especially for your consideration.

CHAIR BAILET: Thank you, Brad.

Beth Mahler, also from Sutter Health.

MS. MAHLER: I'll defer.

CHAIR BAILET: Monique Reese.

[No response.]

CHAIR BAILET: Very good. That completes the -- unless there's somebody on the phone?

MS. MAHLER: There's another speaker. Lori Bishop.

CHAIR BAILET: Like I said, Lori Bishop.

[Laughter.]

CHAIR BAILET: I got to keep the Committee, you know, on their toes, you know. Okay? Come on.

MS. BISHOP: You've got to keep us all on our toes.

CHAIR BAILET: All right.

MS. BISHOP: It's that time of day.

CHAIR BAILET: I feel like the Amazing Kreskin. Lori Bishop. Okay. Here we go.

MS. BISHOP: And the answer is.

CHAIR BAILET: Yeah.

MS. BISHOP: First of all, I just want to acknowledge, Bob, that I am married to a curmudgeon, so I resonated with your comments there. And I also want to say thank you for the time that you've taken with us today and all of your thoughtful questions, and I think we will come out of this stronger with a better model.

I am a nurse by background. I spent 30-plus years focused on -- first, I did my care in the hospital with patients there. I was told by many colleagues, you should get into the community, and I said, "Oh, gosh, no. Going to patients' homes, no way." And once I did, I was totally hooked, and when I started in the model of hospice care, I said, "Why isn't all of health care like this model?" and partly because it's holistic.

So we've talked a lot about medical issues today, and, of course, that's appropriate. But our patients are people, and when they're terminally ill people or people in serious illness, they're very frightened. They're very scared, and so are their families. And we do need a safety net for this population that does not exist today.

I inherited the opportunity to be the chief executive of the Advanced Illness Management Program for Sutter Health. Thank you, Brad. And I will tell you to operate that program post grant is always a challenge.

There's a lot of priorities in the health system.

We have an average daily census of 2,500 patients that we serve across a wide geography in Northern California of both urban and rural. There is a cost associated with this care, and I really respect my colleagues, but many of us cannot do it for less than $400. And I would tell you that that's bare minimum if we want to invest in alternatives and innovation.

I understand the staffing shortage. That's a very real concern for us, and so we're looking at things like virtual visits and virtual connection to some members of our team. We're looking at community health workers and how do we help train them to be part of our team. So those are some of the innovations that we're investing in as we continue to evolve our model.

I heard a lot of concern about patient engagement, and I will just let you know that in our model, we have our patients do a self-rating of their health on admission. And most of our patients are rating their health, fair or poor. So many of our patients are already acknowledging where they're at in their disease process when we enroll them in our program.

Ninety-eight percent of our patients have advanced care planning documented in their electronic

health record within the 30 days of enrollment, and I would say over 90 percent of those come to us with some documentation in their electronic health record already. So to the concerns about informed consent, I agree with you and would just acknowledge that in our program, we are addressing that concern on enrollment.

I also would like to say that in our patient population with that advanced care planning, 55 percent of them change their wishes over the course of the care with us, and I think that's a significant thing to track and monitor, because it isn't a one-and-done, as we all know, and it evolves, depending on what's happening with you.

We also feel it's very important to connect patients to hospice care. I feel like that's the Cadillac of services. I cannot provide hospice care, the full gamut of that, for $400 a month, and I want patients to get connected to that if they want those services and are appropriate for them.

And so we do track and monitor our -- about 44 percent of our patients move to hospice care, and we have increased the median length of hospice care for our patients by two to three days, which doesn't sound like a lot, but again, it makes a huge difference. And that's the median, not the average. The average length of stay in our

program is about 190 days.

I know that there were questions about the article. NORC -- N-O-R-C –- (National Opinion Research Center) just published their final report, and you can see that on CMS, CMMI Innovation -- it's published. It just got published yesterday, so you should be able to see that report, if that helps you with the original CMMI grant for the Sutter Health program.

We continue to track all of the great quality measures that were required of the CMMI grant in our program, and I can tell you that we continue to have high quality, both in patient satisfaction and in utilization. And we do believe that a patient's experience relates to their utilization. Most patients do not get up and say, "Gee, I wish I'd go to the emergency room today." Some do, but most don't.

I would also say that from our diagnoses, it's primarily heart failure and COPD, and yes, cancer, but otherwise it's not primarily oncology.

Lastly, I just want to go back to the presenters from earlier today and Stanley. If you recall, Stanley had quite an experience where he started in observation and went home with Hospital at Home, and I would tell you if Stanley were in Advanced Illness Management Program, he

wouldn't have had to have that experience at all. We would have moved him into home care, and we would have done the infusions through home care. And he wouldn't have had to go through that.

Thank you.

CHAIR BAILET: Thank you.

No one else on the phone; is that right? No? Okay, very good. Thank you.

So that concludes the public comment section.

* I'd like to now turn to my Committee members, and I think there's one point of clarification that is worth revisiting, and that is that the Committee will not be providing additional feedback to you, to the C-TAC team. I think it might have been alluded to, but we'll dialogue, but we're not going to provide a written -- you know, everything that we've said is on the record, and there are ways for you guys to access that. But if you're waiting for a formal document from us, that's not forthcoming.

So I think where we are next is that we are requesting that the proposers, the submitters, provide a revised and resubmit of the proposal, and we will commit -- and we are committed -- to putting it on what we call an expedited track, if you will, to keep this process moving forward.

I'd turn to my Committee members. I guess I'd like to have a motion and then move from there.

MR. STEINWALD: So moved.

DR. MEDOWS: Second.

CHAIR BAILET: Second of Rhonda.

All in favor?

[Chorus of ayes.]

CHAIR BAILET: What? Yeah. Like I said, discussion. Of course, Len.

DR. NICHOLS: Well, I take the point that no one wants to write this memo, but I would observe that the transcript is going to be a bit meandering. And so what I would suggest, Mr. Chairman, is that we just take two minutes each and say these are the things we think are the most important to address as opposed to here's the transcript, do with it what you will, because I just don't think that's fair.

CHAIR BAILET: Brilliant. Brilliant, Len. So why don't you start.

DR. NICHOLS: So, basically, I would ask to clarify a couple of things. First, I take the point that the Innovation Award grant has been evaluated, and somebody did a great job of pairing, so we've got a control group. But that's not the same thing as risk adjusting, right?

And it's not the same thing as what should the target price be.

So I think you could help us a lot by telling us your experience with these private plans that exist out there, the different models that are going on. In essence, comb through way more experience than you were able to reflect in your application so far and tell us what the options are for doing this. Okay. That's really what I would like to see: How are you going to risk adjust for people actually delivering care?

CHAIR BAILET: Thank you, Len.

Anyone else want to add?

Tim.

DR. FERRIS: I guess, in order to clarify the points of uncertainty for me, as you heard, no question about the need.

Also, as I think you heard, but I just want to clarify, no question about the effectiveness of the intervention against triple aim.

What I'm still uncertain about, though, is -- and here, this is an important point. A lot of the evidence on effectiveness was actually created under a different financial model than the financial model you're proposing. In fact, as I understand it, all, 100 percent of the

evidence that has been presented about the effectiveness of the clinical model, which is not under dispute, at least not by me, has been produced in a different financial model than the model that's in this proposal.

And I can't over-emphasize the importance of that link, because in a capitated system, in a Medicare Advantage plan, the financial incentives are quite different than the model that's being proposed here. And I will say, to my way of thinking, provides much more flexibility. You basically get to do what you think is the right thing to do because you're capped, right, under a total cost-of-care model.

The model that's in the proposal is not the same thing. It tries to get there, and the more you can link the model that you're proposing to the clinical model that we all understand as being effective, the more it will help, I think, this Committee deliberate on the likelihood that the financial model that is being proposed is going to produce the clinical results that we all share a desire and willingness --

So I hope that statement is clarifying.

CHAIR BAILET: Thank you, Tim.

Len?

DR. NICHOLS: A friendly amendment to my

colleague, and it's okay if the payment model is proposed to evolve. It's okay to have it different in Year One than you might think it would be in Year Three and, by the way, completely different in a different setting with different assets on the ground. That's, in fact, desirable.

CHAIR BAILET: Bruce.

MR. STEINWALD: In your revised proposal, I think you can incorporate some of what you had in your August 30th letter without too much difficulty. The most complex part of your August 30th letter has to do with the national ACM episode price and the methodology for calculating the baseline and the shared savings, which is good.

You might consider we're likely to want to go over this with the CMS actuaries, and you made one sort of passing reference to the support letter from the American College of Surgeons and the potential use of the episode grouper for Medicare methodology that they have developed.

My suggestion is I think you're going to either need to explain that, or if you're -- if it's not important to your revised proposal, maybe not have it, but as it stands right now, it's sort of kind of dropped in and without being fully explained what you mean by it.

So one or the other, I think would be fine.

CHAIR BAILET: Thank you, Bruce.

Bob, and then, Len, were you going to make a comment too?

DR. NICHOLS: No.

CHAIR BAILET: No? Okay.

DR. BERENSON: Very quickly to, I guess, mostly repeat, the model you've proposed assumes well-intentioned, dedicated people. I would want you to think a little bit about not well-intentioned people who want to take advantage and what are the protections.

MR. STEINWALD: People like Bob, yeah.

CHAIR BAILET: Strike that from the record.

DR. NICHOLS: People that Bob knows.

CHAIR BAILET: Yeah. People that Bob knows. Okay. Very good.

[Laughter.]

* CHAIR BAILET: All righty, then. So we have a motion. We've had dialogue, and we have a second from Dr. Medows. I think it's time to call the question. All in favor?

[Chorus of ayes.]

CHAIR BAILET: Any opposed?

[No response.]

CHAIR BAILET: All right. Well, with that --

MR. MILLER: And I'm abstaining.

CHAIR BAILET: And, Harold, we understand you're abstaining.

So, with that, I just want to thank everybody, the Committee, and everyone here today and everyone who was on the phone listening and following along.

The level of engagement is palpable. I'm very proud of the Committee and the work that we're doing, and I hope that you're getting a bird's-eye view of the commitment that we all have to get it right. We know that the decisions we make are recommendations, but nonetheless, we are influencing the care delivery in the United States, and we're very proud and grateful for the opportunity to do that.

So, again, thank you for all your patience. It's been a long but productive day. I wish everybody safe travels, and, again, from my esteemed colleagues from California, travel safe.

And we're going to be back at it tomorrow. So thank you very much.

[Applause.]

* [Whereupon, at 4:50 p.m., the Committee recessed, to reconvene on Friday, September 8, 2017.]