PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE

PUBLIC MEETING

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

Monday, March 13, 2017
1:02 p.m.

COMMITTEE MEMBERS PRESENT:

JEFFREY BAILET, MD, Chair
ELIZABETH MITCHELL, Vice Chair (via telephone)

ROBERT BERENSON, MD
PAUL CASALE, MD, MPH
TIM FERRIS, MD
RHONDA M. MEDOWS, MD
HAROLD D. MILLER
LEN NICHOLS, PhD
KAVITA PATEL, MD
BRUCE STEINWALD, MBA
GRACE TERRELL, MD, MMM

AGENDA

PAGE

P R O C E E D I N G S

[1:02 p.m.]

CHAIR BAILET: Okay. We are going to go ahead and start the meeting. Welcome. Thank you everybody. This is our March 13th PTAC public meeting. We're very happy to be here. I'll introduce myself, and then I'll ask the committee members to introduce themselves as well.

My name is Dr. Jeff Bailet. I am the Chair of the PTAC committee, and my position recently changed. I was the President of the Aurora Health Care Medical Group in Wisconsin. I recently took a position as the Executive Vice President of Health Care Quality and Affordability with Blue Shield of California, so I've relocated to San Francisco as of January 1st. So, I know some people -- I just think I heard, "Sorry to hear that," but I can just tell you there's plenty of people who said I went to the dark side, but there's plenty of light at Blue Shield.

On that note, we have the PTAC Vice Chair, Elizabeth Mitchell, who I believe is on the phone, so I'm going to ask her, before we go around the room with the committee members here, if she could introduce herself.

VICE CHAIR MITCHELL: Thank you, Jeff, and I'm sorry not to be there. Elizabeth Mitchell, President and CEO of the Network for Regional Healthcare Improvement.

CHAIR BAILET: Thank you.

Do you want to start, Bruce?

MR. STEINWALD: I'm Bruce Steinwald. I'm retired from government service. I have a little consulting practice right here in Northwest Washington.

DR. PATEL: Hi. Kavita Patel, Brookings Institution and Johns Hopkins, where I'm an internist.

DR. MEDOWS: Dr. Rhonda Medows, Providence, St. Joseph Health.

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

DR. CASALE: Paul Casale, New York Presbyterian.

DR. KAHVECIOGLU: Daver Kahvecioglu, Centers for Medicare & Medicaid Innovation.

MS. MENTNECH: Renee Mentnech, Centers for Medicare & Medicaid Services, CMMI.

MS. RITTER: Chris Ritter, same place.

[Laughter.]

DR. FERRIS: Tim Ferris, internal medicine and pediatrics at Mass. General in Boston.

DR. NICHOLS: Len Nichols, health economist from George Mason University.

DR. TERRELL: Grace Terrell, internist at Cornerstone Health Care, currently founder and strategist

for CHESS, which is a population health management company, and in two more weeks CEO of Envision Genomics.

CHAIR BAILET: Ann?

MS. PAGE: Ann Page, Designated Federal Officer for the PTAC. I'm with ASPE.

MS. STAHLMAN: Mary Ellen Stahlman with ASPE and Staff Director for PTAC.

MR. MILLER: And I'm Harold Miller from the Center for Healthcare Quality and Payment Reform.

CHAIR BAILET: Great. Thank you. So I'm going to start by providing a brief update, and then we'll walk through the agenda and proceed from there.

So, the PTAC just to level set was created by MACRA in April of 2015 to make comments and recommendations to the Secretary on proposals for physician-focused payment models submitted by individuals and stakeholder entities. PTAC is dedicated to transparent operations that encourage and incorporate feedback from the public. PTAC began receiving letters of intent on October 1st, 2016, and full proposals on December 1st of 2016.

Update as it relates to -- we're going to first talk about update on proposals and letters of intent that we've received, and we actually got a letter of intent -- another one – today, which I will summarize. We're going

to talk about upcoming PTAC meetings and events, publicly available documents related to the proposals, and then we're going to finally end up on today's agenda.

So we have 21 letters of intent, and we have received five formal complete proposals, which the committee is actively reviewing. They're listed here:

"The COPD and Asthma Monitoring Project," submitted by Pulmonary Medicine, Infectious Disease, and Critical Care Consultants Medical Group Inc. of Sacramento California;

"The Comprehensive Colonoscopy Advanced Alternative Payment Model for Colorectal Cancer Screening, Diagnosis, and Surveillance," submitted by the Digestive Health Network;

"Project Sonar," submitted by the Illinois Gastroenterology Group and SonarMD, LLC;

"The American College of Surgeons-Brandeis Advanced APM," submitted by the American College of Surgeons;

And, finally, "The Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model," submitted by the Coalition to Transform Advanced Care.

So all of these proposals and letters are posted on the PTAC's website, and the PTAC website is appearing on

the screen behind me.

The letters of intent that we have received, I'm not going to review them all, but they are here and part of the record for your review. But I do think it's worthy of note that there's a broad spectrum of specialty activity here, which is exactly what Congress was hoping when they stood up our committee, was to really illuminate and elicit a broad range of specialty and primary care proposals. And I believe based on the letters of intent that that preference is being met. This is the second bolus of proposals.

Now, again, letters of intent are not binding, but they need to be submitted 30 days prior to the submission of the full proposal, and the reason behind that is we as a committee need to know directionally how to allocate our resources, and having that heads up on the numbers of LOIs has helped guide our work.

This is the PTAC calendar. There is a public meeting April 10th through the 11th, and at that point the four proposals listed here -- COPD, the American College of Surgeons Advanced APM, Project Sonar, and the Comprehensive Colonoscopy AAPM for Colorectal Cancer Screening, Diagnosis, and Surveillance -- these four will be deliberated, discussed, and voted on in April.

There is another public meeting in June. Deliberations and voting on proposals at that time will be ready based on when the Proposal Review Teams have completed their work and the committee is ready to do a full deliberation.

There will be ongoing quarterly public meetings thereafter -- September, December, and March of 2018 -- and, again, the committee always reserves the right to add meetings if they feel, based on the numbers of proposals that are submitted, that we need to meet more often for deliberation.

As we said earlier, transparency is very important to the committee, and getting feedback and input from stakeholders is critical. So we are making publicly available documents related to these proposals 2 weeks prior to the public meeting. We will have the Preliminary Review Teams report. We will have questions to the submitter and the submitter responses available for public review. And then any additional analyses used in the Proposal Review Team's decision-making, that will all be public and shared for comment. Again, the spirit of that is to help us guide our thinking and ultimately our deliberations when it comes time to vote.

Letters of intent and full proposals are also

posted on the website at the time that they are received. Public comments on the proposals will be posted one week following the conclusion of the comment period and updated weekly to include comments received after the deadline.

Submitters are invited to make a statement at the public meetings, so for the four that will be reviewed in April, those stakeholders have been invited to participate in the meeting. And we also welcome additional public comments and questions at all of our public meetings.

So today's agenda, quickly, CMMI presentation. They will overview the Bundled Payments for Care Improvement, or BPCI, Initiative and Evaluation Results, and then BPCI Initiative Participants' Perspective: Success and Challenges. CMS Updates on Health Care Innovation Award Initiative, so the HCIA Initiative, and then time will be set aside for public comments and questions from 3:15 to 3:45 p.m.

I'm going to now turn it over to my colleague Harold Miller, who is going to introduce our guests.

MR. MILLER: Thanks, Jeff.

So just a bit of background on why we put this next item on the agenda. If you've read the PTAC RFP -- and I'm sure everyone has studied the PTAC RFP and has memorized it – but it has in it 10 criteria that we are

evaluating proposals against, and the 10 criteria are really derived from the regulations that were established by the Secretary of Health and Human Services under the MACRA statute.

And the first of those criteria is related to the scope of the model, and there are two elements to that: one is that the model needs to in some fashion expand the portfolio of payment models that CMS has today by addressing an issue, a payment issue, in some new way; or it is supposed to in some fashion be able to provide an opportunity for physicians/providers who have not had adequate opportunity in the past to participate.

So one of the things that we have to do whenever we review proposals is to determine whether a proposal, in fact, meets that criterion, and that we have defined as a high-priority criterion because the goal is to try to provide additional opportunities rather than to simply replicate what has already been done.

The Bundled Payment for Care Improvement Initiative from CMMI is really, I would say, the broadest and most diverse of the whole set of programs that CMMI has implemented. I don't think people actually recognize how broad it is. There are, at least as it was initially implemented, four different payment models within it that

could be applied to 48 different diagnosis or procedure groups and was open to participation by a wide range of provider groups, whether it be physician practices or hospitals or home health agencies or skilled nursing facilities.

So there is really a lot of things going on, and there are a lot of people participating in it. So we really wanted to understand, first of all, more clearly ourselves as well as those who may be listening exactly what it is doing and what it isn't doing, what the structure is, who has been participating and who has not been participating so that we can more clearly identify what models would fill gaps both for participants and payment model, and what's working and what's not working so that both we and potential applicants can learn from that as they prepare their own proposals.

So that was why we put that on the agenda today, and we broke the agenda into two pieces. One is first we'll be hearing from CMMI that is managing the program and also evaluating it to find out both what they intended and what they are learning from it; and then we wanted to hear from participants in the program.

Now, there are a lot of different participants in the program, and it would be difficult to hear from all of

them. So what we did today is ask two of the conveners that have been helping a wide variety of participants in the program to come and share their perspectives on that.

We recognized that that may not reflect the full range of thoughts about the program, and so during the public comment period, if anyone here wants to provide additional comments, they have an opportunity to do so, as well as to send us comments about the program and what we should learn from it after the meeting. So that's basically the structure that we're going to follow today.

So we're going to first start off with CMMI, and we have with us today Renee Mentnech and Chris Ritter -- Chris Ritter from the same place as Renee is -- but both of them are veterans of CMS for a long time, have a wide range of experience, as well as playing senior roles at CMMI. They will probably do a better job of explaining who they are than I can, so I will let them move on.

Now, one other word of advice both to our presenters and to the audience. We have a fairly limited amount of time today, and these are big programs with lots of issues associated with them. So it's going to be, as a practical matter, very difficult to cover everything that we might like. So we've asked the presenters to give us as concise as possible a presentation, and we want to leave

enough time for questions from the PTAC members. So I just say that in advance so that if I end up having to shorten someone because it's running long, that no one will be offended, because we do want to allow enough time for discussions. And thanks to Mother Nature, we have a little bit less time today than we had originally expected.

So with that, I'm going to turn it over to Chris and Renee to give us the CMMI side of how the program is working and what you've been seeing so far.

MS. RITTER: Thank you so much for having us. We're really excited to be here. We work with the BPCI program every day, so it's kind of fun to come in and talk about it.

The Bundled Payments for Care Initiative -- let me make sure I know how to do this -- is the Granddaddy of bundled models. It’s been in place -- was the first real bundled model that came out of the Innovation Center, and certainly has been a tremendous learning experience for us, and I hope, as you hear from the participants in the program, a great learning experience for them as well. And there's plenty of stuff that we've learned that we might not do the same again, but overall a very good model for getting our feet wet in terms of what bundles do and don't do and how to operationalize them.

We have here at the beginning of the slides just an overview of the authority that's afforded to the Innovation Center, and folks are probably familiar with that.

The bundled payments here, obviously the case for bundled payments, we may not need to go into that here in a committee dedicated to talking about models, but obviously the goal is to have the eagle's-eye view of the entire episode of care and look for places to both improve the quality and reduce the costs, which is not something that would traditionally be done under the fee-for-service system kind of systematically. Clearly, each individual practitioner or facility brings their own overview, but the requirement there, that's also embedded in a payment incentive.

So here's BPCI. It's a single payment for the episode of care, and it's designed to take into account, as we say here, accountability for both cost and quality. I would say the initial Bundled Payments for Care Initiative, it does not uniformly include quality metrics the way we're talking about them now. At the time that it was begun, the requirement is for each hospital -- or at the time, it was hospitals. It's since been expanded, as Harold talked about, to many different entities. They do put together

their own internal improvement plan, but the link between pay for performance that we will talk about under advanced alternative payment models, that's not part of the Bundled Payments for Care Initiative. So it is looking at streamlining the care and is requiring folks to look at the entire episode under a self-designed improvement plan, but there's no formal quality metrics that are tied back to the payment.

We know from many of our participants they take those performance plans very seriously, and I think you'll hear from some of our folks that are going to present today that they've spent quite a bit of time looking at how to incorporate quality into the delivery of care.

It does have four models. Model 1 has ended this past December, and it was solely based in the inpatient setting. We have 2, 3, and 4. Our biggest models are 2 and 3. They are both retrospective models that look at the entire episode of care for the hospitalization and the 90-day post-discharge period, and they include -- they are done for either the admission to the hospital or begin in Model 3 with the admission to the post-acute-care facility.

I found this design very confusing when I first started at CMMI because I couldn't quite figure out who was doing what. And I think that has to do with the number of

individual categories of providers and practitioners that have been added as the program has evolved. I would say the key piece here that we have, maybe starting at the bottom, is the episode initiators. These are the entities that are actually furnishing the care, the hospital or the practitioner, the skilled nursing facility.

Some of these are also risk-bearing entities, but others, many of our physician group practices work through an awardee convener, and the awardee convener is the risk-bearing entity. And so mostly it comes down to the difference between who's bearing the risk and ultimately who's initiating the episode and providing the care. And as we'll talk about in a minute, there are provisions made for how the dollars can flow down through the different participants at each level of the arrangement.

So here's another quick overview on Models 1, 2, 3, and 4 -- 2 and 3 being our biggest -- and as you can see just from the participants and something Dr. Miller alluded to when we got underway, the number of participants, many more skilled nursing facilities and home health in the post-acute space under Model 3, but more dollars concentrated under Model 2.

And here is a breakdown for you of our most recent data on who is participating.

It might be worth backing up and noting a big part of the Bundled Payments for Care Initiative has to do with what we call the "precedence rules," which is, since there are so many overlapping participants, providers, skilled nursing facilities, home health agencies, and we have some IRF as well as the short-stay acute-care hospital, we have created rules that have developed over the course of the model, which just began with hospitals and has expanded as it has been implemented as to which type of entity garners an episode if there's overlap between the facility, the physician group practice, or the skilled nursing facility and the hospital. And they are complicated. They have somewhat to do with which entity began the program and also with the preference towards the physician group practices.

I'll just make a note because it is and it remains a contentious issue among the different participants, obviously, as to who would garner from the investments that are being put in to participate in the bundled care.

Here are the 48 episodes that are currently covered under the Bundled Payments for Care Initiative. They are many, both medical and surgical, and constitute somewhere in the vicinity -- Daver would know -- 70

percent, roughly, of the inpatient spend.

So the baseline prices are a target price that was derived from the historical data between '09 and '12, and it's updated quarterly using an annual trend factor. So we calculate -- basically we trend up each year to its current year and then apply a trend factor to bring that base episode price forward. Lately, I will note, we are trending the entire episode, which includes all of the post-acute care, which has been declining with all of the focus on readmissions, and so our trend factor in the program has been declining. I think that was not expected. It was expected that it might increase. It's not inflation adjustment. It is a growth factor that's designed to maintain the episode cost to be consistent with the other care provided in the Medicare program. And then here we have that the final target price is the baseline price with an adjustment for 2 to 3 percent, depending on the risk in the model.

So the net payment reconciliation amount is the amount that goes to each convener, each entity that's bearing risk. We do not pay the episode initiators directly if they are not also bearing risk. And here, obviously, if it's greater than zero, we issue a payment; and if it's less than zero, we send a demand letter. And

we have gainsharing savings. Folks are familiar with these. These are the waivers for fraud and abuse that have to be put in place so that arrangements can be made between the various entities competing in the marketplace. Gainsharing is used by 50 percent, roughly, of our awardees, and they are specifically allowed to share positive NPRA dollars and any funds they can demonstrate were created from internal cost savings. That's particularly true for the hospitals where changes to care pathways may result in internal cost savings for the episode.

And the other waivers, the CMMI under the Affordable Care Act is allowed to waive certain regulatory requirements, the ones that are in place here for the Bundled Payments for Care Initiative, and ones we use generally across our models a lot of times are the waiver for the three-day hospital stay, which is, I have to say, not used a lot at all -- I think folks are nervous about using it, among other things; our telehealth, the originating site; and then there's a payment for a post-discharge home visit where the supervision rules are waived, the nurse can attend on their own.

We also have other waivers for fraud and abuse, such as patient engagement incentives where transportation

and other types of incentives can be furnished. And I think Daver is going to walk you through -- or maybe Renee is going to talk a little bit. I can do them here, which is at a very high level, and then Renee should chime in. Certainly the most prominent finding from the Bundled Payments for Care Initiative certainly in the early years and one of the bases for the joint replacement model is the success in the lower extremity joint replacement episodes, which have demonstrated good evidence -- maybe not "good"; I'll let Renee comment on the evidence -- evidence of savings -- that's her job -- throughout the first part of the analysis. The current evaluation reports that are public are not as timely as we would like. I think that we've also provided some self-reported experiences from different participants where they talk about their experiences of the program, and you'll hear about some of those here.

But we also have some evidence of -- nothing statistically significant in the cardiovascular arena, that's what I would say. And generally speaking, we see concentration in several -- maybe seven or eight episodes that are very high volume, others not so much, and we feel like the participants tend to move around to find the best place where they can really dig in and focus.

Maybe I should stop there and let Renee go ahead and talk, and here's the results, the very early results, the Model 3 evaluation results.

MS. MENTNECH: This is Renee Mentnech. I also want to thank you for the chance to come here to speak. I have along with me -- to my right is Daver Kahvecioglu. He is actually the lead on our staff overseeing the evaluation of the bundled payment initiative Models 2 through 4.

Chris gave you a very brief overview of the results from the evaluation that are currently public. I think what we're finding is that the models where there is an opportunity to make decisions about post-acute care placement seem to be the ones where we're experiencing the best results, and mostly, it seems to be associated with a shift away from institutional post-acute care services towards home health.

The evaluation report that is currently available was very early on in the evaluation. So the results are fairly limited. We are in the process right now of drafting the next report, and while I can't speak to the results that will be in that report, I am going to give you a very quick overview of what you can expect to see in the report in terms of the topics that it covers. And we expect that report to be available towards the summertime,

hopefully no later than the fall. It will be much more extensive than the report that we've issued so far.

It will include an analysis of all the episodes that we had from the first 2 years from Models 2, 3, and 4. We will be covering a comprehensive description of the characteristics of the initiative and the participants as well as a section on the impacts of all these bundled payment initiatives on cost and quality, also looking at unintended consequences. There will be in the report, 20 fuller clinical issue briefs that I think we did not have in the last report.

Regarding the characteristics of the initiative and the participants, the report will summarize the participants' readiness and entry decisions as well as the episode lengths and the selections that they made in terms of which episodes to focus on.

We plan to explore considerations for participation as a convener of the various partnerships that the conveners have established. So this will be the qualitative analysis that we present.

We'll be comparing characteristics of the markets with BPCI participants to those without bundled payment participants.

We'll be exploring in depth the various waivers

that were available, including, as Chris mentioned, the 3-day hospital stay waiver for SNF care, the beneficiary incentive waivers, the gainsharing agreement waivers, the telehealth waivers, and any home health service waivers.

We'll be looking at summarizing the care redesign efforts that the participants put in place and the challenges that they experienced and a little bit about the participants who exited the model and why they exited.

In terms of the quantitative impact analyses, this report will have a lot more than the past reports. We anticipate 140,000 episodes, covering 39 different, unique combinations of model episode initiator type and clinical episodes, and I think Harold mentioned that there are 48 of them. So this will be a very long and comprehensive report.

MR. MILLER: Harold will also mention that we should wrap up so we can ask some questions.

MS. MENTNECH: Very quickly, then, we will be looking at the quality of care, looking at claims-based measures, assessment-based measures, patient experience measures, looking at impacts on cost and expenditures, changes in patient mix, shifts in patient mix, market volume, and factors contributing to the variation in the monetary gains that various participants were able to

garner.

MR. MILLER: So thank you both.

We're going to open up for questions from the PTAC members.

Let me just ask you one question to get it started. Can you say something briefly about who in terms of physician groups you see participating and not participating? What kinds of physicians groups aren't participating, and what's the nature of their involvement on the ones where the hospital is the initiator?

MS. RITTER: So we have among our physician groups -- many hospitalist groups are participating in the model, and they work very closely with the hospitals with whom they are working, and/or in the reverse, if the hospital is the initiator, frequently hospitalists are with whom they are working.

We also have several participating orthopedic groups. That is our largest model, participation generally, and as discussed, one of the ones where people feel very comfortable.

We also have some other multispecialty groups participating, but predominantly, if you ask me, I would say hospitalists and orthopedic groups.

MR. MILLER: Other questions? Bob?

DR. BERENSON: I'm going to start with --

MR. MILLER: We'll see how good they are first.

DR. BERENSON: Yeah. Okay. Fair enough. I'll put that down.

One of the concerns that some people have raised, including myself about paying for bundles, is it is a form of fee for bundle. It is still volume-related. If you have more bundles, you get more payment.

Is there anything in the design of the models that addresses appropriateness of the episode? And in the evaluation, my understanding is that you're looking at what's happened to per-case spending, but is there any look at per-beneficiary spending associated with those services? In other words, a volume might increase in the community. It's much more complicated to do that, but the general question is, What do we know about the volume of services?

MS. RITTER: So I would say, generally, as pointed out -- and we definitely heard this about the model -- that there is no appropriateness assessment that's been built into the bundled payments for care initiative. It does initiate with the discharge or with the admission. It includes the hospital stay plus the discharge in Model 2.

I think that we have heard that. We know many of our participants of their own volition spend time looking,

but I think that's different. So I would say as a modeled sign, it does not formally consider appropriateness any more than any other ordering of reasonable and necessary services might consider under the fee-for-service program.

MS. MENTNECH: The only thing I would add is the initial analysis that we did in -- I think it's in the JAMA paper that Chris referred to -- at least for the lower joint, we did not see evidence of changes in volume at that point.

The analysis that we did, though, was fairly limited. So, in this next report, we are planning to look at volume in a couple different ways. One is increases or changes in volume at the institutions themselves and then also looking at the market that these BPCI participants are operating in.

DR. BERENSON: So you did that for the ACE's demo, that’s going to be part of the BPCI evaluation also, is the volume in the community? Because one could argue from first principles that if you've got now an efficient place doing, let's say, hip replacements, there might be a redistribution of cases into that institution, or you could argue that there might be an increase as the competing hospitals sort of want to increase their volume or the index hospital finds that this is a lucrative business. So

you're going to be looking carefully at that.

MS. MENTNECH: Yes. We're not just looking at the BPCI participants themselves but also looking at the market that these BPCI participants are offering --

DR. BERENSON: Good.

So what I'm confused about then is that Elliott Fisher has a commentary on the JAMA article suggesting that volume was up. Was that wrong, volume at the hospitals that were part of the demo?

MS. MENTNECH: Well, since it was Daver's paper, I should probably let him comment, but I think it's fair to say that the -- I don't think Daver would disagree with this, but the volume analysis that we were able to do at that point was fairly limited. I think there have been other analyses suggesting that volume at least at the institutions themselves hasn't changed.

MR. KAHVECIOGLU: I don't know that I can say that Elliott's paper was wrong at this point. I think the next report will -- I think it was pretty early on in the model to be able to draw any conclusions at that point.

MR. MILLER: Okay. Questions from other members?

Paul.

DR. CASALE: Thanks for that presentation, and I know we are going to hear from some others who are

implementing these, but I'm just wondering if you can give us a sense of some of the feedback you've maybe gotten over the years from some of the people who have participated, particularly around unintended consequences, things that they sort of identified that were sort of deficient in the model or suggestions to change. Do you see some general themes around that?

MS. MENTNECH: Yeah. I think Chris actually had some plans to talk a little bit about what we had been hearing from participants.

MS. RITTER: Well, I think you have participants coming, so maybe we should let them do that.

I think, in general, folks find as they get into the model that it is much bigger effort for them to get under way to figure out exactly -- that's part of the things, I would say. It is a much bigger undertaking than they realize to just find out who is where and what's what, and they feel that coordinating the discharging, reaching out to the hospital, all of these things become very -- are much more challenging than I think they thought when they started. They put a lot in.

I think they also find loopholes in their own -- what we hear. I had no idea had the SNF -- all of that is sort of part and parcel of getting under way, and it's a

much bigger lift. And for some of the institutions, it's too big a lift, and they feel like they can't get there. And we do see them drop out, and for others that really dig in and make an investment, we see them go forward.

MS. MENTNECH: I think the other thing I would add is we've recently -- I haven't been directly involved, but I have heard from the staff -- had opportunities to reach out to some of the participants to go over with them the data on their own feedback reports to help them understand what they're experiencing, and when we point out to them various patterns of care that we're seeing in their data, they're often surprised that we're seeing what we're seeing in the data, that they didn't sort of have a full handle on what was happening to patients once they sort of walked out the door and were discharged. However, that's where the opportunities exist for trying to do a better job of streamlining care and find efficiencies.

MS. RITTER: Yeah. That's a really interesting point.

I would note something that came up in a recent call they had, and then I know my lead for the project officers is on, if she wants to throw anything else out.

There was a hospital that has an incredibly efficient and coordinated internal system that had no idea

that their downstream wasn't working quite as well, but the amount of metrics that they could produce internally was amazing and knew almost nothing about what happened when they left, even though they were working very hard to participate in the program.

Amy, do you want to add anything else, since you're on the phone?

MS. BASSANO: No. I think in terms of one of the things that we heard as a point of feedback is just how we can revise some of the waivers to make them more advantageous for the awardees, more specifically, a skilled nursing facility waiver.

MR. MILLER: Okay. Let me keep going. I've got comment -- questions from Kavita, then Tim, then Grace, then Bob.

DR. PATEL: I will just make mine brief. Thank you.

So how -- and I know we'll hear from conveners and facilitators, but how have you thought about this dynamic interaction between APMs? Because one of the things that we'll have to struggle with is people bringing forward models, and certainly, we've seen a lot on both sides of the coin about the ACO-BPCI interaction. So maybe you want to start there, but then thinking broadly about

APM interaction, lessons learned, or ideas for the future, and then briefly kind of the MACRA issue, so kind of the lack of like a cross-walking to MACRA has also posed problems in my observation.

MS. RITTER: Well, there's no question we've been struggling for the kind of eureka paradigm that would allow us to reconcile all of the ACOs and the different bundles and the potentially new alternative payment models coming on, and I think that's true from a couple perspectives.

One is both operationally and how it relates to like the day-to-day of the participants in the model, the beneficiary and where they are and what they understand them to be in, and I think the evaluation in particular poses challenges that aren't the same as how, for example, the payment or quality might get reconciled.

You'll see in our recent rulemaking under the EPM, the episode payment models, that last rule, we took an approach that identified full-risk ACOs as being first for identification. So if you were taking full population risk prospective payment, then that was first, followed by the bundles, which is a shorter, more intensive period of focus from the participant and less so than like a kind of broader population focus retrospective, and then followed back into the ACOs.

I don't know that that's a good answer. That followed sort of a paradigm of who was doing the most, paying the closest attention, whether or not that is the way to reconcile some of these, in a kind of how to get there in terms of tiering, is difficult. I think each model that we look at, we have to think about differently in terms of what it's doing, who should -- how the population spreads, for example, where the concentration would be. And that's just operations.

Then I think Renee has another huge set of issues that have to be undertaken -- I should let her address them -- about needing sample size and being able to make some conclusions legitimately.

MS. MENTNECH: So the overlap issue from an evaluation perspective is very tricky and is an issue that we deal with in every single one of our evaluations, and it's getting trickier figuring out sort of what the right -- and the sample size issue alone is a big deal. That part of the reason why we can't look at every single episode is there's 48 different episodes, and when you look at that in relationship to the various different episode initiators, sometimes the sample sizes are just too small to be able to say anything. And then if you couple that with overlap, it becomes even more challenging. So figuring out what is the

right comparison group is a good part of the reason why it takes us so long to actually issue results, because if you don't get the comparison group right, you get the answer wrong. And so we spend a lot of time thinking about building a comparison group that is as well matched as possible, and we take into consideration all these overlap issues when thinking of how to construct the comparison group.

Up till this point, it hasn't been as big of a problem, but it's going to be a bigger problem as we go forward -- or I shouldn't say problem.

MR. MILLER: Okay.

MS. RITTER: Challenge.

MS. MENTNECH: Challenge.

MS. RITTER: Challenge.

DR. FERRIS: Thanks so much --great presentation and for your thoughtful answers.

You may be challenged by this question because it asks about the extent to which the design in the model itself, the payment model itself, provides an equal playing field for everyone in the country. We have a really big country, and the country is really diverse in terms of not -- and I am not talking about practice operations here. I'm talking about the design and how the design itself may

be unequal in terms of what people have to do to be successful in the model. And I just wondered if you have thoughts about that.

MS. RITTER: Do you have something in mind that could help? Is this in terms of where the sophistication of different practices in terms of being able to --

DR. FERRIS: No.

MS. RITTER: No, okay.

DR. FERRIS: No, this is about the model, the design of the model, and the benchmarks associated. So not in BPCI, but in other models, there's tension between the extent to which, for example, regional spend, like where do you start and how where you start affects your performance --

MS. RITTER: Yes.

DR. FERRIS: -- and so if someone has been doing this really well and has been all over this, are they relatively disadvantaged compared to someone who is starting here?

MS. RITTER: Yes.

DR. FERRIS: So it's in the design related to the heterogeneity of what --

MS. RITTER: Right.

DR. FERRIS: -- a practice in our country.

MS. RITTER: So absolutely. I think you've seen in the last two rounds of work that we've done both in next generation and the shared savings programs, an attempt to recognize the regional pricing, and so that you recognize where different organizations or groups of practitioners have been versus where they are going in an attempt to recognize kind of how far along each different -- both region and practice and/or hospital is in its design.

I think it is very challenging to find the right mix to do that. That will give you a pricing incentive that encourages without discouraging and still gets you all of the places you need to get. I think you're right, and we are struggling with it. And those are the two things that we've done to date, is mix in the regional pricing. But there's much more that could be done. I think we're thinking about that, and we'll have to see how it goes, but yes.

MR. MILLER: Grace.

DR. TERRELL: Last week, I went to a hospital bundled payment summit to learn more about this industry and what's going on in the world that's out there, and as I am listening to you this morning, I'm thinking about what I learned there as well as elsewhere, and I've kind of got several things I wanted to ask you about with relation to

my experience last week.

One is that a lot of the really innovative things that are being done that various participants were telling us about is redesigning things that is impacting the relationship with vendors in the pharma to a certain extent and in many ways probably should have been done already. Well, what that's done for the vendor side is they're wanting to come up with ways of actually partnering with the participants in new ways.

So one of my questions -- and I've got just four -- is, Are you all looking at the regulatory environment with respect to how this will change the relationship between vendors and participants in ways that might be conducive to what our goals are in this program, or is that something that's come up for you yet?

I'll just kind of go through my things here, and then maybe you can pick and choose how you want to answer these.

The second one is one of the things I was hearing loud and clear from many of the participants last week, was their frustration that so much of this is just about the acute hospital stay and therefore is DRG fixed in terms of the way it's being measured and evaluated, and they believe that there could be improvement if there was a way of when

appropriate to do site-of-service changes but is not particularly possible in a lot of this type of model. And there was a hint that perhaps some of that was being thought about in terms of some changes in this program. So, if that's true, I'd be interested to hear about it.

The third thing that was obvious last week is how early the industry is in terms of being ready for this. There was a complaint about a dearth of information. Obviously, this is still relatively early in your experience, and the complaints that we were hearing last week, a lot of it had to do with the time it took to get information back from the program, so there were a lot of workarounds going around. As you are trying to figure out how to do this in ways that are as effective as possible, what are you doing to engineer your own ability to get information back to people timely?

That's it.

MS. MENTNECH: A lot of these, I think apply to Chris, but I'm going to just take that last one about the dearth of information.

MR. MILLER: She was hoping they applied to you.

MS. MENTNECH: So I think you could think about information back to the participants in two different ways. One is around their reconciliation reports, and I'll let

Chris address that one. The second is around the feedback reports that get produced for the purpose of monitoring.

It's true it takes a while to have enough sample size that accrues to be able to report on an individual episode level, and what they really want is information at the episode level. And because these episodes are a certain length, you have to wait, one, for there to be enough accumulation of enough sample size. Then you have to let the episode end, and then you have to let the claims run out occur. So by the time that all sort of happens, it takes about four quarters after the end of a reporting period where you have enough sample size to report back on in the beginning. And then we start rolling out. We have been rolling out reports on a quarterly basis, but that first report takes a while.

We have been using the evaluation for the purpose of producing those reports, which has an added wrinkle because of the degree of rigor that we put into those reports. We believe -- we've been talking about ourselves -- that there's something sort of more timely but maybe a little bit less rigorous that we could speed up the production of those reports in the future, not in this current environment, but in future bundled payment initiatives where it would give them the information they

need for feedback purposes in a more timely way, maybe a little bit less rigorous in terms of comparators. But it does take a while for there to be enough episodes to report on.

But in terms of reconciliation reports, I'll let Chris talk to that.

MS. RITTER: So I guess we'll start -- let's start there and go backwards. Right now, reconciliation is occurring on a quarterly basis, and I think you'll hear from some of our participants that's a favored time frame.

We hear from our participants that that's even too short -- I mean, sorry -- that's way too long for the time that they have. They said, "If you're working with doctors, last week is so last week ago. That's like not close enough." For us, the Medicare program, we don't even see the claims for 9 months, sometimes. I don't know that we're ever going to meet in the middle right there. I think what we've tried to with the VPC -- with the reconciliation reports, is go quarterly right now. This is a very, very detailed and intensive process, because we have to vet gainsharing lists. They have to be looked at for fraud and abuse issues. We have to update everybody's episodes, plans. They have to get put in the system. They have to get run through the claims. So the, kind of,

operations involved in maintaining the quarterly structure, I don't know that we've been on time with that quarterly structure, and we have a really good team -- government, though we may be, it's actually pretty efficient -- going on a quarterly basis. And that's been probably the most frequent we, at our level, can handle. That's not to say that there aren't mechanisms that we've thought -- that's from a payment. Okay. Those are the payments flowing. That's not to say we haven't tried to think through, as Renee said, ways where we can improve the timeliness of data or other pieces of information that can go back to participants. And I'll just note that the quarterly process, we are -- we have really struggled under the onus of that, to keep it moving even with many, many, many folks helping us out.

So that's what I would say, generally, about the payment feed. But payment information to help you manage your program, I think those are two things that we look at to see if there's any way we can make it simple, more streamlined.

Another thing we hear, I'll point out to people, is that the data files that we provide, and one of the big benefits of participating in these programs is you get your own data from us that tells you everybody who is downstream

from you. Those -- we, right now, put them out in a file that's manipulatable by everybody, but we've certainly heard from participants in different programs that it's very difficult for them to manipulate them. They don't love dealing with claims the way Renee and I do.

So one thing we've certainly been thinking about, we've made it available in a form that everybody can use, but we've been trying to figure out if there's ways we can improve on that, so that you have something that's a little more digestible for people. So those are all things we continue to work on, to try and make that flow of information as available as possible. That's not to say we'll meet everyone's expectations, but that would be certainly a goal, as you guys think about what could go into programs.

For the frustration about being very DRG fixed, it's true. Certainly one of the things we've said we're thinking about, as we think about the next version of bundled payments, is whether we could, for example, incorporate some outpatient components to it. So I think that's there. I'm not in a position to say what that will look like right now, but certainly we've heard those are areas that we need to start thinking about. Whether that would be true site-of-service, as in the pricing same, I

think those are all issues we've been struggling with, so that the incentives that are made are appropriate. But, yes, I think, you know, we definitely hear that.

And another one we hear quite a bit about, which Dr. Berenson already raised, is the appropriateness component of feeding into the program versus having it occur at admission.

And then I think another thing, to go back to your first question, which is relationship with vendors, so some of that has to do with how the gainsharing waivers are created. In order, for example, I think what you're alluding to, and we've heard from AdvaMed and others about creating gainsharing between various vendors, so that they, too, could benefit from the value relationship. If I give you something and you benefit, then you could share back for me, for example, in the lower joint arena. Right now we're not able to do that with the structure of the fraud and abuse waivers. We hear that loudly. We think there's some very good thinking in this area, very creative. For the record, the Office of the Inspector General is the one who issues the fraud and abuse waivers and they are their own entity. I can't speak for them. But we are aware that that's an area of interest, and it makes sense.

MR. MILLER: Okay. One final question from Bob

Berenson and one final quick answer to Bob Berenson's question.

DR. BERENSON: Total cost of care and the length of the episode. I assume that the farther you go from a hospital discharge towards 90 days, more and more of the costs of a beneficiary are not related to the, let's say, joint replacement under Model 2, but to a whole series of other medical conditions they might have.

So the question is, I'm assuming -- but correct me if I'm wrong -- you're using a total cost of care analysis on spending. I'm aware of where I am and I don't want to denigrate orthopedists, necessarily, but are orthopedists the right people to be accountable for total cost of care for patients with a myriad of conditions, and do we know, qualitatively, how they actually attempt to address total cost of care, unrelated to the joint replacement?

MS. MENTNECH: So I think it's entirely true that the further you get away from the indexed stay, the less likely something is related. In this model, the way it's designed, there are choices that the participants made in terms of the length of an episode. So we do, actually, in the evaluation, take an approach where we standardize and say we're going to look at everybody on the same playing

field, so we look 90 days out.

Within that episode of time we are looking at total cost of care. We're not looking at total cost of care on an annualized basis but we're looking at total cost of care within a time period of 90 days. We're looking at things like is there a shift in the kinds of services for which these expenditure are going towards within that 90-day period? We are also looking to see if costs are sort of shifting outside of the window of the bundle.

So there's a lot of different ways that we're looking at cost, but I don't – we're not going to be able to answer the question about appropriateness in terms of should the orthopedic surgeon, for example, have been attributed this cost. The evaluation isn't looking at it in that way, but we are looking at total cost of care.

DR. BERENSON: Do you have a ballpark for, at day 89, what percentage of a beneficiary's spending, who has had a joint replacement, is associated with the joint replacement? Do you have a ballpark for that?

MS. MENTNECH: Is associated with the --

DR. BERENSON: With the --

MS. MENTNECH: -- from a clinical perspective is related?

DR. BERENSON: -- joint replacement from a

clinical -- yeah.

MR. MILLER: During the episode.

DR. BERENSON: Using an episode group or something to just get a sense of how much of that spending --

MS. MENTNECH: We have not applied --

DR. BERENSON: -- at that point -- what's that?

MS. MENTNECH: We have not applied an episode grouper that's clinically based, to try to tease out what proportion of the costs associated with the bundle, or the time period of 90 days, is attributable back to the episode, but it's actually an interesting idea.

MR. MILLER: Okay. We're going to need to transition to our next segment. Thank you to the three of you from CMMI for coming and for providing --

DR. BERENSON: Thank you.

MR. MILLER: -- very helpful information.

So our next speakers, come on up. We're going to have everybody come up. Danielle Lloyd is here from Premier, Inc. We have both Steve Wiggins and Carolyn Magill. Steve is the Founder and Chairman of Remedy Partners and Carolyn is the CEO of Remedy Partners. They are both groups are conveners of the -- of various participants in the BPCI program. I'll let them say what

more they want to say about their involvement, but I would note that they have somewhat different relationships with their participants. Premier has been involved in the ACO program heavily, as well as in the BPCI program, but does not share risk with its participants. Remedy does share risk with their participants, so they're somewhat different in that regard, and also has somewhat different types of participants.

So we're going to -- Danielle won the coin toss so Danielle is going to start. Each of the teams is going to take 10 minutes each. We'll do both sets of presentations and then we'll do questions for everybody afterwards.

So Danielle, you're on.

MS. LLOYD: Okay. The question is how do we get to our slides?

MR. MILLER: That is beyond my pay grade.

[Laughter.]

MR. MILLER: Click. Just click. Click, she says. They should all be in order.

MS. LLOYD: We just need the next deck.

Okay. So I'll go ahead and start anyway, without the slides.

MR. MILLER: We actually have slides in our books

so we can look at those while you start --

MS. LLOYD: Okay. Great.

MR. MILLER: -- and we'll try to catch up for the audience.

MS. LLOYD: So 2 seconds on Premier. So, first of all, thank you for having us to share our experiences and learning from this program. Premier is a unique organization. We are an alliance of 3,700 hospitals nationwide, as well as 120,000 alternate sites, so that's physician groups, skilled nursing facilities, et cetera. We are -- as Harold said, we are a facilitator convener within BPCI, but we do also have, as part of our bundling collaborative, organizations that are part of the CJR, Comprehensive Care for Joint Replacement; EPM, the Episode Payment Models; as well as OCM, the Oncology Care Model. So we've got about 130 providers who are within those different bundling systems on the ACO side. We've got about 400 hospitals that are part of ACOs and 45 that are part of the Medicare Shared Savings Program.

So we certainly believe that the value-based purchasing program, the ACO program, bundles, et cetera, that with these types of new systems we can really improve the sustainability of health care as well as -- now she took the clicker, though, so we can't move them forward.

MR. MILLER: You can't have both slides and a clicker, Danielle.

MS. LLOYD: I know. MR. MILLER: You've got to pick.

[Laughter.]

MS. LLOYD: I'm asking for too much. I'm sorry.

So that with these different types of programs we can improve health care sustainability as well as quality of care.

So we're starting with the eye test here, so I've got it printed out myself, too. A lot of folks have asked us -- thank you -- for -- you know, what conditions are working, are not working? You know, how is it that you choose bundles? Why are -- you know, which ones do you think you're going to be successful at, et cetera. Now, noting that these are health systems and a small slice of the full pie, so it is a biased sample here. We didn't put anything in here that has only one participant, lest you figure out who they are. So this is just an example, some examples.

But as you can see here, some of the things that we look at, and we have found as a first for the health systems, the procedural-based ones are easier. Not surprising. The other things that we look for is the

amount of post-acute care spend in the episode, so anything that has greater than 50 percent of the episode cost associated with post-acute care would be something we would look into, two things that we are obviously trying not to pick, based on our higher variation of costs within the episode or the likelihood of outliers, essentially, and certainly low volume can lead to variability. That's treated differently in all the different bundling programs but that's of concern as well.

So what you can see here in the green are the conditions for which we have -- our bundlers have saved money, the yellow are the ones where they have saved but not been able to achieve the discount, and then the reds are the ones where they've actually overspent the target. So, again, the procedures tend to be ones that the organizations do better, but also you can see some of the extreme negatives here, for instance, is diabetes, right, a medical condition. And you can see on the top end we're topping out at around 7 percent. So you guys can look at that later, but I'm not going to use all my time there.

So let's go ahead and talk about sort of the kind of the good, bad, and the ugly from our perspective, as conveners, and noting, again, that we have participants in all of the different bundling programs. Our perspective is

that we've been very pleased with CMMI in terms of its ability to now dynamically test and take things that we learn and build them into the new programs. So we really see it as an evolution from BPCI to CJR and then the EPM rules, which, as you know, are on hold, that despite the fact that some of those are hospital-based models, there are aspects of the methodologies that we think should be applied to even the physician-focused models.

In terms of the data, which is interesting given Grace's question, we think that the data feeds have actually been quite good. This is an unprecedented amount of data that we're getting through these different programs. We're getting very large claims files. Particularly we're pleased with the baseline data in advance, so that you can really determine whether or not you should be in the program altogether, let alone which bundles, and do your care planning.

The monthly data feeds have been very valuable. It went to quarterly for CJR and EPM. We were not particularly pleased with that. We're hopeful that monthly will be par for the course going forward.

As you might imagine from provider groups, we are very much supportive of the voluntary nature of BPCI, as well as your ability to choose which bundles to enter. A

lot of the -- you know, the organizations can't boil the ocean. They look at things where they have a particular physician champion, et cetera, to decide where to go first.

In terms of the gainsharing caps, that's something that has evolved a bit as well. So this is where the physicians -- I think Chris may have mentioned this -- but in terms of gainsharing, the physicians can't receive more than 50 percent of what they otherwise would have been paid. Initially, in the beginning of the program, there were organizations, physician groups, who basically asserted that if you have a dollar come in through BPCI to a physician group and it is distributed in the same way that they distribute, essentially, all of the payments that come into the group, that it's not a gainsharing dollar, and thus the 50 percent cap would not apply. Once you get to the EPM rule, it's made clear that those caps should basically apply in all of the situations for physicians. And we think that that's valuable because you don't want to get to the point where, basically, a dollar saved is a dollar earned, because it creates too much of a perverse incentive for the physicians.

So moving on to some of the barriers, not surprisingly, I have two slides for barriers and one for good things.

[Laughter.]

MS. LLOYD: We think in terms of the target pricing there are some concerns there. Again, this works a little bit differently across each of the bundling programs, but the baseline for BPCI is held fixed for a three-year period and then during the performance period it is trended forward quarterly, and so that causes sort of this race to the bottom to go very quickly. And partially this is also because the underlying trend is often decreasing. So if you look at joints, for instance, the general national trend is for the cost for an episode to go down. So what started as a 2 to 3 percent discount is really effectively, by 2016, a 10 percent discount. So that has been problematic.

In terms of the implementation protocol, that basically is the application. So you think about the organizations have to apply to be part of these programs, and they're very extensive, and we think probably could use some streamlining.

In terms of precedence rules, which I know was mentioned by CMS so I won't go through what that is, it does create some confusion, both within the program and among programs. I have a sort of crazy chart that goes through what goes first -- Who gets the beneficiary first?

Right? You get independence at home first, then you have NextGen, then you have MSSP Track 3, then you have ESCO First Touch. It's a crazy document. We're not entirely sure it's accurate either --

[Laughter.]

MS. LLOYD: -- because it hasn't been truly put out transparently. We just sort of ask FAQ by FAQ to the e-mail boxes.

So with these precedence rules, you find yourself in a couple of situations. First, within BPCI, a hospital may have -- basically, physicians always get precedence over the hospitals. So even if the hospital has the surgeon, if the physician group has the attending, the physician group gets it, with the exception of the very first cohort within that program.

So the second thing is when you look at these across and you think of CJR, for instance. If you have a hip replacement patient coming into a CJR hospital, the hospital thinks it's theirs. Well, if the surgeon or the attending is a BPCI physician, well, that's not our bundle anymore. If the patient is discharged to a Model 3 post-acute care site, that's not our bundle anymore. And so at some point, you know, how are you going to know who should be starting the care protocols and who should be calling

the beneficiary, for that matter, because they're going to get confused as we all start to implement these protocols. And certainly our concern with a number of these is that the health system-associated physicians are at a disadvantage to the independent physicians.

In terms of discounts, there is a uniform discount across all of the different conditions, so we find that that causes some organizations to simply not pick certain episodes. The other things is risk adjustment. We're not entirely sure that the risk adjustment system is adequate as of yet, particularly for the medical conditions where there are more comorbidities, et cetera.

And then also on the quality metrics, there are no quality metrics applied to payment in BPCI. There are metrics but not applied to payment, and there are no CEHRT requirements, which is a concern for becoming an advanced APM. When you look at something like CJR and EPM, where there are quality metrics, they're also not ideal. So within both of those programs, HCAHPS, for instance, the patient experience instrument, is used, but it's used for the entire hospital, not for the joints or for the cardiac, so it's not exactly telling. Or for something like shifts, the fractures, there are no measures that are specific to fractures. They use the non-fracture quality measures.

So two quick other things. Legal waivers, as were mentioned, these are very important tools. There have been some -- We've actually discouraged our participants from using the skilled nursing facility waiver because of issues with the process there. You can have episodes that are cancelled for various reasons, which means you lose the waiver, and theoretically, the beneficiary is on the hook. We've had difficulty getting it approved for us to eat the cost for those beneficiaries, so we don't want to be in the situation of, you know, of basically lumping that fee onto the beneficiaries.

And transparency, I think, it was -- and I'm sure Steve will comment on this -- I think it was a bit of a rough go at the beginning, but I think we've improved quite a bit. There was a part at the beginning where we had to meet as conveners and sort of say, "Did you see this in the data? Did you see this? You know, what's going on here?" It's a lot better now, but nobody has the national data to replicate anything, which is troublesome.

So if I hadn't gone fast enough, I'm going to zip through this list very quickly, a few things that we think are key to moving forward with new bundle programs. We agree that they should be voluntary, that the transparent methodologies are important, that there should be more than

one opportunity for you to enter the program, like the current NextGen and CPC, et cetera. We --

MR. MILLER: Let me just suggest, focus on the things that are most relevant to us approving a model, rather than how CMS should implement the model.

MS. LLOYD: Okay. Well, I think these apply to you in reviewing PTAC as well. So, for instance, as Model 2, that you should be looking at models that are more broader, that are more inclusive and longer episodes, so 90 days, et cetera.

Certainly you want to make sure anything is an advanced APM. Patient assessment instruments I think are very important because it does help with some of Bob's questions on how do you start getting a sense of whether or not the patient is actually appropriate for this bundle. It's something that was not built into the workflow with BPCI and thus was essentially removed. Risk adjustment, obviously more research is needed there.

So I would say in terms of the pricing pieces, we do believe that regional pricing is appropriate, that the NextGen way is actually quite elegant, where you're both looking at your relative costliness within the region, as well as to the nation, and that also the variability and the target pricing has been very difficult. So setting the

target in advance, or prospectively setting the target -- not prospectively paying us but setting the target, so that we know what it's going to be, is important. And when you're trending the target, you should take the bundlers out of the national trend, because we are helping drive that down, which is difficult in terms of looking at us versus, basically, everyone else.

The last thing I would just say here is the overlap piece is a really important one from our perspective. We think that, again, within the program and across the program, that we really need to figure out a way to better account for this, and, in particular, we think one thing that should be tested, which hopefully we'll be back here to present on, is a layered model, where you're intentionally testing partial capitation, inpatient and outpatient bundling, within an ACO cap, all in one model, where the providers are choosing to come together to test this model, where they, themselves, are working out the overlap within a single, essentially legal organization.

MR. MILLER: Thank you, Danielle. I'm going to turn it over to Steve.

MR. WIGGINS: Thank you. Okay.

So -- well, first of all, thanks for allowing us to be here and talk with you and give you our feedback. We

appreciate greatly, and we have a lot of things to share, so I'll jump right into it.

But to start, since some people don't know what an awardee convener is, I just want to cover what an awardee convener is so that everybody understands. And I got into this because I volunteered to go to work at CMS. They didn't take me up on it, and Rick Gilfillan said, "I need you out there. Providers are going to need help going into these models, and you've had experience doing that." And so that's why here I am. I've been doing this part-time. It's not been my day job. I'm the Chairman. Carolyn is actually the CEO of Remedy, just to be clear, but she's new and I don't want to throw her to the wolves quite yet.

[Laughter.]

MR. MILLER: Oh, we're not wolves.

[Laughter.]

MR. WIGGINS: So the objective of an awardee convener is essentially to enable both CMS and the providers to succeed. This is complicated. For someone like myself who got into bundles in the early 1990s, we built the largest commercial bundle program in the business. I built Oxford Health Plans in New York. We grew it to be a very large commercial bundled payment

program. One thing we learned is that this is the toughest contracting challenge that there is. You need a lot of people to help providers succeed. They need a lot of tools and technologies surrounding them, so that they can be successful.

If you go to the second slide in my deck, what exactly an awardee convener does, think of an awardee convener like an ACO. That's a special purpose entity, or an IPA, or a physician hospital organization. It's the entity that enters into the contract with the payer. In our case, we have a contract with CMS. We're now bringing commercial insurers into bundled payments, and we're in active dialogs right now with all of the major commercial insurers, and you might be interested to hear what they're doing because it is instructive. They have very strong views about how their programs should evolve.

But as Alan Muney, who is the Medical Director of Cigna said, he gave a speech recently and asked for a show of hands of everybody that's willing to take downside financial risk in bundled payments, and two out of a room full of providers raised their hands, which provided evidence to him that you need somebody that sits alongside for a while. One of the organizations in Premier's program now is an organization with us for three years. One of our

most successful organizations, they can go from working with us to not working with us, and they are free to do that. It's voluntary.

But essentially what we do is we help CMS and Medicare bulk up the program because it's hard to recruit participants. You have to, in some respects, persuade people, because there's a lot of reasons not to do it. It's very risky. Risk in bundles is the square root of program size, so when you go into one bundle in one site, you're really increasing your relative risk of being in these programs. As someone that has taken actuarial risk all my life, all my professional life, I can assure you these are particularly difficult actuarial challenges at small scale.

And so if you're not going to have systemic adoption of these payment models, you're adding to your relative risk as an organization. And so what we do is we help organizations have the nerve to do 10 or 12, not one or two, because if you're not making systemic change, then it's really hard to really make change in a lot of these organizations. They have a difficult time with that.

We also have about 150 people managing software. We build and deploy software that helps these organizations. It integrates with their EMRs. We have

over 980 integrations where we're pulling the EMR data. We're sorting through it to figure out which one is their bundled payment patient.

MR. MILLER: Just in the interest of making sure you get through all your comments, I think we've got a good advertisement for Remedy now. Let's go on and talk about the BPCI program.

MR. WIGGINS: Actually, that wasn't my point because what I'm doing, Harold, is the same thing that any awardee would do. I'm just trying to outline what an awardee does. So I won't go into it if you've read the loop there that we have. Right now awardee conveners have about 62 percent of the BPCI participants, so the program would be much smaller. You're much less likely to drop out of the program if you have help; 35 percent of the single awardee participants dropped out of the program, which, of course, for all the reasons that Chris just described, this is very complicated.

If you go to the next slide here, just in terms of scale so that you understand with my comments what I'm talking about, we are actively managing alongside our partners programs inside of acute-care settings. We have partnerships with physician groups and hospitals, so we work with either. We're agnostic. We don't have a

viewpoint, maybe as Danielle might have, of which is better or -- we'd like to make them all successful. I think Medicare needs them all to be successful.

Right now, the perspective that I offer is based on about 300,000 episodes annually. We are saving at Remedy Medicare $120 million dollars annualized at present off of the baseline.

If you go to page 7, it shows you data that we got approval from CMS to release, which is our aggregate savings rates across all that spending on the previous page. So a very different story than maybe you've heard. But across this $5.7 billion dollars of spending, it doesn't start out necessarily successful right away. I think the Lumen report, as was mentioned, was reflective of a time when very few people were in the program yet. It hadn't really matured. Organizations need a lot of time to get their change processes in place. But as you can see, once you do that, it can be rewarding both for Medicare and for the participants.

If you look on the next slide, which is patient outcomes, you can see that on patient outcomes, as Chris mentioned and as CMS in the presentation said, SNF admissions are going down. Readmissions, however, are not going up; they're going down. So there's a meaningful

reduction in readmissions despite more careful use by our partners in the skilled nursing facility. Part of that is they're using decision support tools during discharge rounds that are helping them to have a better idea of what the patient needs, where they could successfully recover. And, of course, the goal is a successful recovery.

On the next slide, I'd like to address something that was touched on, which is we believe that bundles and population health go together. The reason years ago I got into bundled payments is I had a big -- I had 2.5 million people in various forms of population health at Oxford, and I really needed something to manage the care. During that very intense period of time when the specialists were dominating the care and the connection to the patient, in a typical episode of care we will see anywhere from 4 to 14 physician groups. We'll see a large number of physicians touching the patient. Many times in an episode we will -- we can't find a primary care claim, and so we don't want to lose that patient during that period of time to the coordination, and so it's best if these are together. I've encouraged my ACO brethren -- and we overlap with a lot of ACOs -- to actually become participants in the next phase of this.

My observations as I think about the program,

first of all, I think CMS is doing a fantastic job. This is hard stuff. They made the right tradeoffs as they designed these bundles. They've been incredibly collaborative, and I'm not just trying to suck up to the CMS people. But I will say I've known everybody that's run CMS for my career, and I think that they've done as good a job as I've ever seen CMS do rolling out a program. I was involved way back in Medicare+Choice and some of those initiatives. It's having a big impact in the C-Suites of health care organizations. We've observed that any type of organization can be successful. Physician groups we find modify their practices quicker and can be the most successful early. But all types of organizations succeed, to the point that maybe bundles are only appropriate for procedure episodes. Seventy percent of the medical episodes in our -- I'm sorry, 70 percent of the total episodes in our program accrete through the ER, which is why we went out and encouraged hospitalists to participate so aggressively, because we wanted to be connected to those organizations that were most meaningfully involved in some of the key decisions.

On the next slide, on the financial slide, it costs a lot. It generally costs someone that is going into the program and buying point solutions anywhere between 4

and 6 percent. That's published in literature that I'm sure you can find on the Internet from people that have published about their experience. When you share it over large programs, you can get that down to 2 percent, but it's still expensive. We spent $100 million. We have partners that have spent $30 and $40 million, individually, organizations. One large physician organization has spent very meaningfully on this program.

In terms of my principles for what I think is the right way to go, first of all, I think you need fair and transparent pricing policies. The baseline prices need to be stable for three to five years. The biggest reason providers will say, "I don't want to participate," is they're afraid of being ratcheted down by their own performance, and so they're very afraid of that.

CMS has done a very nice job of providing transparency on a lot of things. They give us monthly claims files, so if you know how to use those, you can provide response to Grace's concerns of much more meaningful and immediate feedback.

The second point I'd make here is you want to have a program that meets the needs of Medicare. Medicare needs to get a lot of spending into these programs that have the really meaningful savings, and this is proving to

have a higher level of savings, at least in our program, than any of the payment models that we've seen at this scale.

To do that, you need to encourage all types of organizations to participate. With all due respect to Premier, I don't think that it should be a hospital centric. I think any type of organization that's willing to take the risk should be allowed to do that, much like a private insurer would view it. Facilitators, awardees -- you're going to need them all. You need to really harness the power of the free market to succeed here to make a dent in what some of the Medicare goals are.

I think that there should be an incentive for organizations that take more than 10 episodes or 12 episodes. There should be an increased discount, because if they're taking that much risk, they're trying to make that systemic change, it shouldn't be a flat discount across the board. That's one of the things I've advocated.

I would be careful --

MR. MILLER: You mean a smaller discount for people who take on --

MR. WIGGINS: Correct. So instead of a 2 percent discount on Model 2, you might have a 1.5 or a 1.75, or something that is an incentive for organizations to make

the systemic change that this represents.

I would avoid some of the things I saw in the Brandeis piece, which was a very prescriptive approach to gainsharing. I think you allow that to be more organic. I don't think it's the role of rulemaking to figure out --

MR. MILLER: I'd rather not get comments on other people's proposals.

MR. WIGGINS: Fine.

MR. MILLER: This is about the BPCI.

MR. WIGGINS: Fair. I wasn't sure based on your guidance, Harold, to stay on the things that you would do in a set of recommendations, and so one of the things I would avoid is prescriptions on gainsharing programs. That's being handled quite nicely in the market, and to Danielle's point, even between payment models, I think the marketplace can do a pretty good job of that.

As to precedence rules, the last point I'd make here, I think if you're an insurance company or if you're Medicare, any payer needs to retain their flexibility to innovate on payment reform at the most granular level and reconcile from there. Just as Medicare has things like competitive bidding on DME, just like there's home health resource groups for home health agencies, there's DRGs for hospitals, bundles are another level up in that lower level

granularity. And in all reconciliations, they should reconcile from granular up. That's generally consistent with the patient's experience. And a patient-centric view going up I think is going to lead to the preservation for Medicare of the greatest degree of flexibility long term in how they manage these programs. So thank you for that.

MR. MILLER: Great. Thank you both.

Okay. We're open for questions from PTAC members. Len?

DR. NICHOLS: Yes, I have one for each. Danielle, I was struck at your slide on risk adjustment, because one of the issues I'll just say generically we have observed is that creative people coming up with new ideas cannot possibly have the data to do risk adjustment ahead of time. So talk to me about what you knew when your colleagues entered the BPCI. How clear were the data about how the risk adjustment was going to work? Were the parameters all specified ahead of time? Did CMS give that to you all, or did you all work it out in some kind of what you might call trial period?

MS. LLOYD: Yeah, well, the risk adjustment -- and CMS can get up here and correct me, but the risk adjustment takes a lot of different forms. There is case mix adjustment. There is the winterization, the outliers,

there's empirical base for low volume. I'm missing something else. But it's all sort of the exclusions, and the exclusions are something that is evolving over time of what exactly needs to be out of the episode.

But I think we had a pretty good sense at the beginning. I think we all sort of struggled a little bit on the application of the empirical base and such can be quite complicated. But I think that it's only after a time that we're starting to realize which episodes that is becoming more difficult within and which ones we're finding that comorbidities and complications we think anecdotally -- - this is where the evaluation will come in, and Renee will be able to tell us with the next pass -- that it is more cumbersome.

But we don't know -- this is not like a magic bullet thing. It's not like we can just say, oh, go pick up HCC. We know on the ACO side they use that, but they also cap it so that you can't -- the continuously assigned can't grow; they can only -- you can only lose payment, you cannot gain payment.

DR. NICHOLS: Right.

MS. LLOYD: Because they're so afraid of code creep. So there are some other ways to do it like the Model A episode grouper and such. I don't think that we

can say what's the best way to go. We can just say that we think that this is probably more complicated than it needs to be, and it's not quite achieving the result we would like to see.

DR. NICHOLS: So that segues into my question for Steve, and I wonder if there is a role for reinsurance for providers thinking about entering into these kinds of arrangements before, that as you put it, they don't feel ready. They may be ready. What can you tell us about that?

MR. WIGGINS: Well, first of all, on the subject of risk adjustment, you're talking to the wrong guy because I don't think we should be risk-adjusting Medicare Advantage either, because at some scale you have enough risk under -- you've taken enough risk that you've smoothed those outliers. And Medicare has done a nice job in their pricing. The risk adjustment is only the DRG. The truncation points that were mentioned are the reinsurance. That's a different point. And they've also offered very fair free reinsurance. You can't buy free reinsurance in the market. Medicare's offering free reinsurance. There's no friction costs. Normally to buy reinsurance, I pay a dollar, I get 50 cents back. In Medicare, they provide truncation of the episode. If you think of a bell curve of

the financial outcomes, they truncate it at the 99th, the 95th, and the 75th, and you can choose by bundle, by episode initiator, how much risk you want to take. I think that's a very fair way to do it. We've suggested that to all the major payers. We think Medicare's model is one that should be rolled out as a way to go forward.

But risk adjustment shouldn't be confused with episode definitions. You can adjust the provider's risk by how you define the episode. Right now, Medicare has done a good job of getting a lot of dollars in with an acute onset episode definition, so when the patient hits the hospital, the episode begins. Most of our commercial insurance dialogues, we're launching the episode at diagnosis, so we pick up a variety of other savings opportunities, quality opportunities.

There is a way -- you know, again, this is the nuance -- where you can adjust episode definition based on patient pathway, the big things that change for a patient that were uncontrollable by the provider. You can adjust payment and have multiple endpoints on your pricing.

To CMS' credit -- and I don't mean this critically -- they started with kind of the training wheels version of bundles. It's a good way to move the markets towards bundled payments, to inform people as to how it

works. You are taking a lot of risk, and you're taking period risk. But it's a good way for Medicare to meet their goals. If you're thoughtful as a participant, you want to take more episodes in that model, not less. You don't want to just lower major joint.

And so, again, your question touched on risk adjustment, but Danielle took us into truncate --

MS. LLOYD: Yeah.

MR. WIGGINS: -- took us into reinsurance, and a lot of that can be -- in bundles, you can move down to just performance risk by just how you define the bundle. But this is a wonderful start. The payers will start to come out with more nuanced versions of this where the episode's going to launch at diagnosis. You won't see cardiac -- or you won't see orthopedic bundles launch at acute admission in the commercial space.

MR. MILLER: So, Danielle, I sense you want to make a quick enhancement to this point?

MS. LLOYD: Yes. I think you have to remember with the corridors, right, you still have to lose money up to the corridor, and you still have I think it's a 20 percent share after that, right? So you still can lose your shirt, right? And that's ultimately my definition of risk.

I think also the thing is it depends on the context of the program. If it's a mandatory program and you have to take low volume, that's a very different situation than having a massive program where you can smooth the edges. So you have to put it within the context.

MR. MILLER: Paul and then Grace.

DR. CASALE: Thank you. Thanks for those presentations.

On the topic of gainsharing -- and we anticipate as we get models to us there will be a variety of proposals around, you know, how to share the savings, particularly with the gainsharing on the physician side. So on your slide, you said you supported the 50 percent gainsharing cap on Part B spend. And then, Steve, you started to talk about gainsharing before Harold --

MR. WIGGINS: Put me in my place.

[Laughter.]

DR. CASALE: Cut you a little short. But I'm interested to hear a little bit -- because when you talk to physicians, they'll often say, well, you know, we're sort of doing the work, we're leading the change, a lot of the cost is on the hospital side, why shouldn't we, you know, share in that? And I suspect we're going to see some

models that have that.

So I just wanted to get some further comments or your thinking around gainsharing since I suspect we're going to see a variety of models.

MS. LLOYD: Yes, so we have extensive gainsharing models that we do with our members where they get to choose how much does the hospital get? How much do the physician groups get? Within the physicians, how much do you give the primary care or to the specialist? It's very specific to the organization and their market, and we think that part of it in some respects is a good thing. They get to choose within that gainsharing.

But that's not to say that we don't think there need to be backstops as a beneficiary protection, and in that case that's what we believe CMS is trying to do with the 50 percent gainsharing cap.

That's not to say, I don't think, that we couldn't have it set up where the organization who is administering this can't also get some of the share to hire the case managers, et cetera, but that the individual amount given back to the physician is capped at the 50 percent.

Does that answer your question?

DR. CASALE: Yeah. As I said, it was a matter of

trying to share some of the costs on the Part A side in some way with the physicians or others as opposed to what -- specifically around the CMMI models.

MS. LLOYD: So there are two aspects of it, right? It can be the dollar you get from CMS or it can be internal cost savings, right? So if we're working with somebody on physician preference items and reducing the costs associated with that in the inpatient stay, the DRG is the DRG is the DRG. But we might be making a higher margin at the hospital, and then we can share that with the physicians, and that is also tracked and allowed to be within bundles to share with the physicians, and most of our organizations have that somewhere in their process to share back.

It's something, I will say, is not on the ACO side. They do not have that waiver, and we think that was a very important addition on the bundling and should be retained in models.

MR. MILLER: Okay. Steve, did you want to add to that?

MR. WIGGINS: I'd just like to make a point of clarification. I believe your suggestion was that physician groups should be capped also. Is that correct?

MS. LLOYD: I think what I said specifically is I

said the individual physician should be --

MR. WIGGINS: Okay.

MS. LLOYD: You know, I think there is room to allow the physician groups to keep, you know, administration types of funds that are beyond the 50 percent that go to the individual docs.

MR. WIGGINS: Yeah, I just want to emphasize that so much of the innovation is happening with physician groups, and so you want to retain the ability of particularly some of the large national groups like Sound Physicians and Team Health and some of these organizations that came in and made big financial commitments to the program, you want to let them make commitments and be the episode initiator, as long as they can work that out with their hospital that they're working with, and then still have the 50 percent gainsharing caps down at the individual physician level. Most of them don't actually move the incentive down like that, anyway. They simply have overall incentives to follow certain protocols. And so it's not related to profits. It's just did you follow the new set of protocols and care redesign initiatives that they're seeking to undertake. And they in particular are doing -- Sound is doing quite an extensive job. We wouldn't want to keep organizations like that out of these programs.

MR. MILLER: Okay. Grace and then Kavita.

VICE CHAIR MITCHELL: Harold, I have a question as well.

MR. MILLER: Okay.

DR. TERRELL: I want to follow up a little bit on your comments, Steve, about risk adjustment, because if you think back to the Medicare Advantage program and how it started, before there was risk adjustment, the behavior that people were having is having the insurer on the third floor with the elevator broken, so only the healthy people went up the steps, so Medicare put in risk adjustment to basically have an incentive in place for people to actually provide appropriate care for beneficiaries who were sicker. So in every particular situation, there's a potential cheat. You know, the concern with, you know, the creep of coding right now is the other side of that that may be happening if you're over adjusting so you're getting more of that premium and making people look sicker than they are.

So your comment was that you didn't think that risk adjustment needed to occur per se in the way that it's happening right now in the Medicare program. And then you mentioned you can work around the way that you package the bundles to sort of deal with that.

But I guess my question is a little more basic than that, because there's already reports out there of people sort of behaving like the original Medicare Advantage program again and not -- if they're in a bundled area, not taking care of some of the sickest patients if it looks like it's going to be too -- you know, they've got too many complications even if they need the procedure.

So what do you think is a solution for that other than compliance? Which ought to be the solution at one level. Either side has a potential moral hazard, if you will.

MR. WIGGINS: Well, that's a philosophical question, so my philosophical answer is I think our best regulatory body is the SEC. If you've ever run a public company, it's amazing that if you have to disclose everything material and if there's a schedule of things you have to disclose, and you have to behave in a certain way and if you don't you go to jail, it engenders enormously cooperative behavior among those of us that have been in those seats where you have to sign something every quarter and you're really having to pay close attention.

When I said that about risk adjustment, having owned a bunch of Medicare Advantage plans and having founded, you know, some of the first Medicare+Choice

programs, I heard all those stories about the second-story walk-up that you'd set. I don't know anyone that ever did that, but there is a concern. The problem is now we've gone the other way, and risk adjustment focuses people on coding. When you focus people on coding, they're focused on revenue. When you focus on revenue, you're really taking your eye off true patient care. And I want to get back to models that focus people on patient care, and I think through regulation and rulemaking, I think you can make sure to set up guardrails around what you called the "cheats" to make sure that their marketing practices have to adhere to a certain standard. Now, that's in Medicare Advantage.

As it relates to risk adjustment in bundles, it's a very hard thing to do. You could get this really wrong. I'm sure CMS is dealing with it every day. We've modeled up lots of ways to do it. It's not easy. I think you're going to orient people towards coding again, particularly at that moment when there's so much rich opportunity for coding. You've got all these people involved. I wouldn't want a model that does that. That would make me nervous.

MR. MILLER: I sense that Chris wants to say something on this point.

MS. RITTER: I just wanted to point out, in the

bundles model, in BPCI in particular, it is hospital-specific data. So we find typically your case mix has been changing and your historic data relative. That's different. That's not to say there is not a role for risk adjustment. There is, potentially. But it's a different situation than when you're dealing with the models we have where you're basing it on regional pricing or other things are coming into effect.

So for what it's worth, I think there's a difference between what you might consider appropriate risk here versus what you might put into a different model.

MR. MILLER: Well, I guess I heard Grace's question being how do you protect patients from -- high-risk patients from being excluded. You've sort of jumped into whether it's risk adjustment or not. I'm wondering what either of you has done in the programs to make sure that that's not happening.

Danielle, did you have any comments on that?

MS. LLOYD: Well, I mean I think it is a little bit different from the health system perspective because they show up on our doorstep and we take them, right? So I think that --

MR. MILLER: Not for elective knee surgery.

MS. LLOYD: Yeah. Well, generally speaking,

though, I mean, it's the physician who has credentials who says, "This is where I'm going to do the surgery." So I don't think this is as much of an issue with the health systems.

MR. MILLER: Okay. Let me keep moving. Kavita and then Elizabeth.

DR. PATEL: Mine is pretty straightforward.

A lot of what we're asking for proposals is to kind of talk to us about data. You both mentioned that the monthly process -- can you walk through -- so when -- for kind of a performance period or whatever you want to call it, what is the flow and kind of a lag time between when an episode initiator kind of has their hands on the data? It sounds like BPCI is probably one of the fastest turnaround models that I've seen. So could you just walk through like what the actual release, for what performance period that covers, and then when that actually hits conveners? And then I imagine there's a little bit of a lag between convener to initiator.

MR. WIGGINS: Well, the lag -- the first time that you actually see the first report card on how a quarter went is essentially nine months later because, if you think about it, if an episode ends -- if somebody is hospitalized December 31st, they're in the hospital for

five days, and they might be in a 90-day episode, that the claims are landing all the way through the first quarter, maybe into the first week of April. And then you have to wait for all those claims to get paid, and so you're not going to see the results of that prior quarter. That fourth quarter of one year, you're not going to see that until much later, the October reconciliation generally.

However, the data feeds that you can still get are the monthly claims are valuable. There is a lag on those. There will be a couple months' lag, and so they're not great, but they're pretty good. In our case, we give away software to everybody in the program, so they're tracking in real time. We're also connected to their EMRs.

So we're pretty good. We're predicting about -- we're capturing about 95 percent of the people. Our software predicts about 75 percent of the people accurately of who is going to eventually be in BPCI because you don't know until they drop the DRG on the invoice that goes out. So you just don't know if they're in or out, so you overserve. You end up serving more patients than you originally anticipated.

So that's the second source of data that you have, and then the third is the reconciliation. So you have those three feeds, and they're not -- the claim feeds

are admittedly not very timely, but they're right now only slightly less timely than the commercial insurers deliver to their risk-contracted pop health or bundled payment programs.

DR. PATEL: And how much time between your delivery, you receiving the claims, to the initiated --

MS. LLOYD: We have a direct access to that portal in which the providers would download it. So we immediately get the data as a convener the same time as the providers do.

DR. PATEL: But I imagine they're not -- if you're doing their data for them, they're not probably downloading so that --

MS. LLOYD: Some of them look at it themselves as well, but by and large --

DR. PATEL: And so what's generally the lag between --

MS. LLOYD: -- it is not for the faint of heart to try to download a CMS claims file.

DR. PATEL: But in general, what's the lag between convener to initiator? How much time usually?

MS. LLOYD: From the convener to --

MR. WIGGINS: Two weeks.

MS. LLOYD: You mean to give them a report?

DR. PATEL: Right.

MS. LLOYD: Yeah, about two weeks.

MR. WIGGINS: Two weeks.

MS. LLOYD: Same for us.

MR. MILLER: Okay. Elizabeth Mitchell.

VICE CHAIR MITCHELL: Hi. Thank you.

My question is sort of around multi-payer engagement. I have a couple questions. One, are you seeing any impact on commercial cost either shifting to commercial, or alternatively, are these typically more efficient across payers, the participants in the program?

And then are you finding distinct benefits of multi-payer alignment in terms of accelerating more?

MR. WIGGINS: A really good question.

First, we're seeing payers desire a rollout of bundled payments that starts with the Medicare 48 episodes, first for their MA and then for as many commercial customers as those can help with. The 48 Medicare bundles capture quite a bit of Medicare Advantage spending, not so much of commercial spending. Different episodes dominate spending in a commercial program.

And so the sequence with which we're seeing discussions around adoption go first, the Medicare bundled payments and then a second wave of bundles that are bundles

that consumers have a lot of influence over cost outcomes and quality outcomes, and then finally adding additional bundles beyond that. And so we're seeing with the commercial programs, a significant interest in adoption.

As regards to your second question, if I understood it, benefit design is where they all want to go with this. They all want to use bundles as a way to drive consumer patient engagement to select the most appropriate side of care and to understand what that cost looks like.

We're also seeing in the commercial programs, they want to use bundled payments as a decision support vehicle for their primary care doctors in population health programs. They want to give the primary care doctors a menu of bundle providers that a primary can refer to with known financial and proven patient outcomes, and so we'll start to see that in 2018, not 2017. We're talking about organizations that want to incorporate into their bids for some of their exchange and other individual enrollment programs, bundles that drive people to these -- or benefit plans -- excuse me -- that drive people towards bundles so they would have higher benefits for people that use a bundled payment contractor.

MS. LLOYD: Yeah. I would agree with what Steve said. I would also note that we have quite a few providers

that are also in -- I believe it's Tennessee, Ohio, and Arkansas, the Medicaid bundles, and are doing those at the same time. I use the word "bundles" loosely. It's obviously a very different structure within that.

And then also, our ACOs, as Steve pointed out, from a population health perspective, some of them are looking to do what we call "faux bundles," which is it's not administered by CMS or another payer, but they basically track bundles within their ACOs so that they have a more concrete target for their specialist to orient around to try to drive their ACO savings.

MR. MILLER: Let me ask one more question, and then we have to wrap up. This is a retrospective program built on the current fee-for-service structure and the existing Medicare payment structures. Give me one or two examples of anything that is being paid for that is not paid for today under Medicare under your bundles as opposed to simply giving higher payments to physicians. In other words, are you doing a different kind of post-acute care, or are you doing a different service?

And then part two is, would it be better if, in fact, those things were paid for directly rather than in a retrospective reconciliation?

But first, I'd like to hear, are there any

examples of things being paid for through this?

MS. LLOYD: So I can't say specifically for the bundles, but I can say more broadly for population health that there is a move towards paying -- trying to pay for within the extent of the legal waivers, more telehealth types of services, in-home services, as well as things like food pantry deliveries and housing, et cetera, but all of it is very difficult within the current legal waiver structure. So I think that would really be enhanced if we had more legal waivers.

MR. MILLER: So just to be clear, you're saying that the things that the waivers are waiving and allowing to be billed for would be good, except that the waiver structure is making it difficult to do it?

MS. LLOYD: Yeah. So like telehealth, for instance, right now, there is a very narrow waiver for certain G-codes in home health services for a non-home-bound population. So to the extent that that was opened up, that's one of the ways people want to go.

MR. MILLER: Okay. Steve?

MR. WIGGINS: Well, Harold, things like in-home IV therapy where you want to -- you want to avoid a high-cost facility setting when it's really not necessary, where the patient's condition is such that they could be just

fine at home. They've got wonderful support. They could have family that is involved, or maybe they just don't need any help, other than somebody to come in and do the administration.

We have had partners that have said, "We want to pay for that," but you've got to walk. First you crawl, then you walk, then you run in these payment models.

Saint Luke's, for instance, was very anxious early on, on this particular point, to pay themselves. They asked us if we'd split it. We said, "Okay. We'll split it with you," and we were coming out of pocket, a year before we were getting any money from Medicare, paying for some of these things. And it turned out to save money because you avoided -- that's the sort of thing that we probably need regulatory relief on to be able to pay for some of these things.

It's too bad that you can't follow the commercial payer model, which is once you're at risk, let us decide how to spend the money. You probably won't get to that until there's prospective, not retrospective, but if you're taking full downside risk, which these programs are taking, we have every incentive to get the patient healthy. We're held responsible for 30 days after the episode ends for anything that's viewed to maybe have been pushed off until

after the episode.

So let these organizations that we work with, if they're willing to come out of their own pocket and we are willing as their partner -- some of them take 80 percent of the risk. Some take 50. Let us make those decisions.

MR. MILLER: Okay. Great. Thank you all for coming. We appreciate the excellent input and responses to the questions.

We are going to transition now to our next segment and invite Renee back up to talk about the Health Care Innovation Award. She looks like she wants some other people to come and support her.

We put this on the agenda because the Health Care Innovation Awards was a broad two rounds of CMMI grants to a variety of projects, and one of the things that was supposed to happen as part of those projects was that they were to -- if they were successful, to have a payment model, develop a payment model proposal to continue the project. So that may well be leading to applications to the PTAC at some point in the near future, and we wanted to get a status report on that program and hear about what might be happening in terms of the payment model piece.

So, Renee, thank you for staying with us.

MS. MENTNECH: My pleasure. Glad to be here

again.

I want to introduce Tim Day, here to my right. Tim, was the lead of the evaluation under me for bundled payment. Tim is one of -- he's our sort of team lead. We have many staff working on these evaluations, but he's been our team lead, is one of the leads on a specific evaluation and also the lead on the meta-analysis.

So there are many awardees that are part of this grants program. The first round was 107 separate awardees, and the second round was, I believe, 39. I might not have that number exactly right. So there are many. They are all doing very different things.

At this point, the second round of awardees, there is one annual report that was very early. We're working on the second annual report. Hopefully, that will get released later this summer. It will not have impact analyses at this point for a variety of reasons, including sample size issues, the time it takes to get the identifiers from the awardees, and difficulty constructing comparison groups and the like. So we hope to -- in the beginning of the first round, we also had this same experience, and we're now at a better place, a couple years in, on the first round than we were. So I expect that the second round awardees, we will also be in a better place in

the future, but that means that we won't have impact analyses on those second round awardees for some time. I believe there are a couple of them that have actually submitted LOIs already to the PTAC.

So today's discussion really is focused more on the Round 1 awardees, which was the 107 I mentioned. They are all completed at this point. I think you will notice -- I believe you may have been sent some links to some reports that were just released at the end -- or the beginning of last week, so about a week ago. The third annual reports for all of the first round awardees were just issued last Monday. They are up on our website. They do have impact analyses, where we were able to produce them.

And we also released four manuscripts in Health Affairs last week that has specific findings for a few of the awardees.

As I mentioned, the period of performance for all these awards are now complete, but I am going to focus a little bit on a few of them. They were diverse. They focused on a lot of different things, including care coordination, care management, patient navigation, shared decision-making, patient-centered medical homes, patient engagement and support, workflow redesign, telemedicine,

and medication therapy management, among the topics.

In order to manage this, we grouped these awardees. So if you have an opportunity to go on our website and look at the individual reports, we tried to group these into categories of similar topics. It is the case that it's a bit of a nuance. Some of the awardees could have been in more than one global topic, but I do encourage you to look at the actual reports.

With respect to the Health Affairs manuscripts, there were four covering home visiting models, the oncology care models, the Y-USA diabetes model program, and then a meta-analysis of ambulatory care models.

The first manuscript covered five awardees that used home-based care delivered by teams, led by registered nurses or lay health workers, along with a mix of different components to strengthen connections to primary care among fee-for-service Medicare beneficiaries with multiple chronic conditions.

Two of these models achieved significant reductions in Medicare expenditures, and three models reduced utilization in the form of emergency department visits, hospitalizations, or both the beneficiaries relative to their comparators.

The second manuscript examined three awardees

that aimed to reduce cost in use of health services and improve the quality of care for Medicare beneficiaries with cancer. Each emphasized a different principle: the oncology medical home, patient navigation, or palliative care. So they all tried slightly different things, but all of them focused on caring for cancer patients, some with more of a focus on end-of-life care than others.

The patient navigation model was associated with fewer emergency department visits in the last 30 days of life and increased hospice enrollment in that last 2 weeks of life. The oncology medical home and patient navigation models were both associated with decreased cost in the last 90 days of life and fewer hospitalizations.

The third model, which analyzed the Y-USA award, provided a diabetes prevention program, certified by the CDC but run by the Y-USA in 17 different Y-USA locations. This manuscript, we reported a reduction in total cost of care for the pre-diabetic patients that participated in the model.

And then, finally, the fourth manuscript analyzed the results of 43 different awardees at implemented ambulatory care programs. Using the meta-regression approach, the authors found that innovations that used health information technology or employed community health

workers achieved the greatest cost savings, and importantly, savings were also larger in programs targeting a clinically fragile population.

With respect to the third annual report, beyond sort of the Health Affairs manuscript, it is difficult to go into the specifics because there's 107 different awardees to comment on, but just to sort of a few --

MR. MILLER: And they are very long reports.

MS. MENTNECH: They are long reports.

I do want to offer that if at any time you have specific questions on any given awardee, we'd be happy to follow up and provide specific information on any one of the awardees you might be interested in.

I did mention earlier when I was talking about the second round that at this point, we don't have the impact estimates, and that was the same situation at this point when we were evaluating the first round. I am happy to say that we have in these reports, impact estimates for 80 out of the hundred and -- it's different. Some people say we have 107 awardees; some say 108. So I'm going to stick with 107.

There are a number of awardees that we still could not generate impact estimates for some of the same reasons that I alluded to for the second round, either

insufficient sample size or we just had unreliable identifiers from the awardees or we couldn't develop a comparison group, a reliable comparison group. So there's a number of reasons why there are still some awardees for whom we don't have impact estimates.

There is an additional report that we will be creating for the first round that we hope -- oh, I think another issue is lack of timely data. There's a lag on the Medicaid side.

We're hoping that some of these issues will get resolved in the next report that we issue, but I am fully expecting that some of the remaining awardees that we couldn't generate impact estimates for, we probably won't be able to again. But they were all evaluated in some way. For the ones that we couldn't generate impact estimates, we did do a qualitative analysis.

I also want to point out that among the ones that we were able to generate impact estimates, I'm actually happy to say 27 of the awardees -- I mean, part of innovation is not everything is going to work. You test a lot of things, and the expectation is some things are just going to fail. That's just part of innovation.

I'm pleasantly surprised. I didn't actually expect this. Twenty-seven of the awardees actually

demonstrated promising results. By promising, I don't mean that all of them were statistically significant. It does mean that they showed savings in the right direction. So they were some of them approaching significance, some not quite so significant, but still showing promise in the right direction. Of those 27, 19 of them did show statistically significant savings.

A large portion of the 107 are planning to sustain their models going forward in one way or another, some in their entirety, some through additional funding that they have got -- received elsewhere, which was part of the goal was to see these things sustained.

There is an important distinction between Round 1 and Round 2. In Round 1, the awardees were not asked to think about what it would look like if it was changed to a payment model. These are grants. So they're not getting paid. There's nothing changing about the way that Medicare or Medicaid pay for services under any of these awards, and in the first round, that wasn't a focus. They weren't asked to sort of think about the development of a payment model.

The second round awardees were asked to think about and propose as part of their testing what a payment model could look like.

These findings from the first round have led to a number of important changes in the innovation center. For example, I'm sure folks have heard that we have, through certification, expanded the -- and through rulemaking, the diabetes prevention program. The results from the Y-USA evaluation were the trigger for that certification exercise.

It is important to note, though, that unlike most of the other awardees, for the Y-USA, there was quite a bit of existing evidence out there from well-done rigorous randomized control trials that supported the same finding. So while the evaluation of the Y-USA model helped -- or was the impetus behind why we were able to engage in a certification exercise, it wasn't the only evidence that the actuaries had at their disposal to actually do that certification. And that's important to keep in mind for these kinds of programs that are grants programs.

It's difficult to think about expanding or turning into a program, a grant that didn't test anything related to payment and where the model test is limited to one or two sites, which is one of the disadvantages of the Health Care Innovation Awards, is that they were typically small tests or confined to just a few participants. So from an evaluation perspective, it presents a challenge

when you have -- I tend to call these one-off kinds of innovations. When you think about what that means from expansion from an evaluation perspective, we can't reliably say in the evaluation, what it would look like beyond the model test. It's not very generalizable when you just have these very small tests.

The Y-USA, as I said, had been widely tested through other non-CMMI activities, and that's the reason -- or one of the reasons why we felt comfortable with the generalizable question, but for many of these others, we don't have that sort of evidence.

I also want to point out that one of the oncology care models, the results from that and the experience and the things that they were testing were used to inform some of the decisions in the development of the oncology care model, and then two awardees, Welvie and MedExpert, which were testing shared decision-making, the lessons that we learned from that were also used to inform the design of the beneficiary engagement model. So even though these models weren't designed to test a specific change in payment policy, we are using the lessons that we're learning from these models as to inform other innovations as we go forward.

I think -- oh, and one other one is the

University of Chicago. Their activity was also instrumental in helping us think about how to structure the accountable healthy community model, which we hope to launch very soon.

So in terms of next steps, we will be releasing these -- well, these reports are released. We will be producing an addendum to each of these reports where we hope to have even more impact analyses and to hopefully be able to include impact analyses from the ones that we haven't been able to do so thus far.

And then stay tuned for the results coming for the HCIA Round 2.

MR. MILLER: So we have a few minutes for questions. Let me ask you first, it sounds like what you're saying is that you got some number of projects that had positive results, but they were being done with a grant, not with a payment model. If you're going to sustain them you presumably are not going to sustain them with grants forever. You would need to have some kind of a payment structure.

And it sounds like they were too small to declare, sort of moving to full scale. Does that argue that there should be some intermediate step that says that those projects should be done on a bigger but still small

scale, with a payment model to try to work out the details of a payment model before, then, trying to do them on a larger scale?

MS. MENTNECH: Well, I can only answer from my evaluation lens. I don't think I can sort of opine on the policy part of it. But from an evaluation perspective, I think I'm uncomfortable with the idea that you can generalize from a grant what behavior would have happened when it's a payment. I think that, you know, just from a behavioral economics perspective, if you have a blank check you may behave one way, versus the incentives that are tied to something that changes about payment policy. So that makes me a little uncomfortable. And then the fact that it's just, you know, these -- the participants in most of these cases, and some of these the cell size, or the sample sizes are really, really small. Some of them not so small, but many of them are. It does make me a little concerned that, you know, that it might be a microcosm and I can't say, from a replication perspective, if you were to take this beyond, you know, the one or two participants in that model, what it would look like.

So I personally believe in sort of testing things a little bit bigger than a one-off, but that, I think, is speaking to my evaluation hat and not necessarily --

MR. MILLER: Okay.

MS. MENTNECH: -- a policy lens.

MR. MILLER: Okay. That's good. Bruce and then Len.

MR. STEINWALD: Thanks. Harold, you asked half of my question, so the other half is, do you have the capability, especially in the cases where the -- they're small size, a couple of sites -- do you have the capability of just scaling it up in order to get more reliable -- even though it's still in a grant mode and not a payment policy mode, can you just add scale if you want to?

MS. MENTNECH: The way the award structure worked is no, not directly. You know, these awards were time-limited and, you know, as in anything in government, when you're talking about that kind of a funding stream, it's a competitive process. And there's also language in the statute that sort of dictates the process that we follow for expansion.

So just to take that awardee and scale it up isn't -- is not an option that we have available to us, as far as I know.

MR. MILLER: Okay. Len.

DR. NICHOLS: So thanks, Renee. For a lot of us, the Health Care Innovation Awards are among the more

exciting parts of the first part of the Affordable Care Act. And so, if I remember correctly, there were 5,000 letters of intent and 2,000 actual applications, out of which you picked 107. So I'm impressed you actually still survived after reading all those proposals.

But what I want to ask about is you mentioned how some in the first round were able to sustain themselves somehow, I mean, through maybe a deal with the payer or whatever, and then in the second round explicitly you asked for what would a payment model look like. Is there a matrix, or can you point us to a place where we can learn more about both the survival of those that did in the first round --

MS. MENTNECH: I actually think -- that's a good question.

DR. NICHOLS: -- and this --

MS. MENTNECH: I think that the third annual reports do -- do they contain a section, Tim, on sustainability?

MR. DAY: As well as the second.

MS. MENTNECH: Yeah. So I think the actual reports talk a little bit about --

DR. NICHOLS: Okay.

MS. MENTNECH: -- the sustainability plans of the

awardees.

DR. NICHOLS: Okay.

MS. MENTNECH: In many cases, they didn't necessarily sustain their whole, and not all of them sustained.

DR. NICHOLS: Right.

MS. MENTNECH: They may have sustained certain aspects, and it may have been that the institution that they were collaborating with or operating --

DR. NICHOLS: Just decided to do it?

MS. MENTNECH: -- may have decided this is something that we want to continue to do on our own.

DR. NICHOLS: Yeah.

MS. MENTNECH: So I think that the reports --

DR. NICHOLS: Okay.

MS. MENTNECH: -- do talk a little bit. I think, in the second round report, because we don't have any impact analyses yet, I think there may be more discussion about this, particularly around sort of what their plans are for the future.

DR. NICHOLS: Okay. Thank you.

MR. MILLER: So is it correct then that the only Round 1 projects that CMS sustained in any fashion, directly, or the diabetes prevention project and

potentially the oncology care model for some of the oncology projects -- was there anything else that has been done to actually -- or anything in the works, to try to sustain any of those projects?

MS. MENTNECH: Well, I think the one is definitely the diabetes prevention, because through rulemaking we've expanded that, or will be expanding it. I wouldn't say that the oncology care model is a sustaining. I would describe it instead as the design of the oncology care model was informed by --

MR. MILLER: Well, what I meant by that was I know that some of the projects that were in the Round 1 awards in oncology applied for the oncology care model in order to sustain what they were doing.

MS. MENTNECH: I see.

MR. MILLER: That's kind of what I was asking, is are there any things that exist to sustain any of the others that are either done or in the works?

MS. MENTNECH: Well, I think the beneficiary engagement model, which is around shared decision-making, is one that the awardees testing shared decision-making could apply to. I think we're in the application stage at this point, so I can't say if they did or didn't, but that is something they could have applied to.

Similarly, the accountable health community model, there were a number of awardees that were testing that same kind of concept. There's the activity going on in -- with Jeff Brenner in New Jersey. There was the Chicago site. So again, I can't comment to who is actually going to -- who applied and who would get selected, but those were opportunities that they could have applied to, because it would have been something similar to what they were doing.

MR. MILLER: Okay. A question from Bob and then we'll wrap up on this.

DR. BERENSON: Very quick, I'll go look at the list, but except for -- other than oncology, were there very many specialty-specific things -- grants that could be turned into a specialty-specific payment model? I mean, was there much interest?

MS. MENTNECH: Tim, what are your thoughts on that --

MR. DAY: You might --

MS. MENTNECH: -- on specialty specific --

MR. DAY: -- look at the hospital setting report. There were a number of interventions that focused on hospital setting. One, in particular, focused on intensivists, so ICU care, and Emory University, that was

one in particular that sticks out that we saw some favorable results, where they're using tele-ICU to sort of enhance --

MS. MENTNECH: I think that a lot of the telemedicine kind of interventions had more of a specialty kind of focus to it, not exclusively, but I think that's another area where you could look to.

MR. MILLER: Great. Thank you, Renee and Tim, for coming. Appreciate the information.

MS. MENTNECH: Thank you for having us.

MR. MILLER: So we're going to now transition to the final part of the agenda, which is the public comment period. We have a few people who are registered to provide public comments, and we will go to them first, but then anybody who is here -- that means all of back there, if you would like to make a comment, we will have some time to be able to do that.

We also would welcome any questions that you may have. So if there are not things you want to comment on but things that you're puzzled by, or want clarification on, you're welcome to ask those questions. There is no such thing as a dumb question, so if you would like to ask a question, my guess is that there's probably a bunch of other people in the room that will say, "Wow, I'm glad they

asked that question because that was very useful."

So we're going to go to our scheduled commenters first. So first we have Sandy Marks from the American Medical Association.

MS. MARKS: [Off microphone.]

MR. MILLER: Microphone -- hang on. Hang on. Yeah, go ahead. Push the button. It works just as well.

MS. MARKS: Okay. Thanks for the -- wow, that's loud.

[Laughter.]

MS. MARKS: So regarding the Bundled Payments for Care Initiative, we think it was a really good start, but it's important for future payment models to also take advantage of opportunities to improve care for patients before they go to the hospital. BPCI rewards physicians for reducing complications, readmissions, and post-acute care costs for patients following a hospital admission, but it really doesn't help physicians provide care that could have prevented the admission from occurring in the first place.

We've met with the Premier and Remedy. We know that they're taking a number of steps to bring down costs and improve quality. They share information with the participants. They provide feedback reports. They help

coordinate patients' care. They help patients choose lower-cost, higher-quality providers for services like rehabilitation, and those same kind of steps could be applied to improve care for conditions and prevent patients from developing health problems or complications that lead to hospitalizations in the first place.

And we've seen this with early implementation, with private payer support of some of the models that have been submitted as proposals to you, and also with some of the models that were supported by Health Care Innovation Awards. I don't think anyone who received a HCIA award thought of it as a blank check, but they were certainly limited and also limited in time, and I think that was kind of a problem, because it's what happens afterwards. It just ends.

There are number of specialty societies that are working on models that would help patients better manage chronic diseases and prevent exacerbations. Others are focused on improving the speed and accuracy of diagnosis for symptoms or conditions and improving the process of selecting an initial treatment plan. The PTAC could support these efforts and availability of data would be a huge help to further developing those models. Physicians need to understand what's driving total spending for their

patients, where the opportunities are to identify savings, and also the potential financial risks that they face due to costs over which they have no control. And I think it's clear from that BPCI discussion that it's hard for everyone to get a good grasp on that kind of data.

So we really commend PTAC. I think we mentioned this in previous comments as well, but we commend PTAC again for the data tables that you produced late last year, and would encourage more of that, more condition-specific data that could be made available to those that are developing proposals, and really for each of the major conditions that people are managing, so that they could think about where the opportunities are for them.

Thank you.

MR. MILLER: One of the things that you could do, I think, to help us, perhaps, and everybody in the room, is we asked for comments on those data tables that are on the website and we haven't gotten any. And so if there are people who would like data relative to whatever it is they may be thinking about or working on, it would be helpful to know that, and more importantly, to know what detailed kind of breakdowns you would like to see on the data, because the fact that we haven't gotten any comments doesn't seem to reinforce the idea that people are really desperate to

be able to get that data. So it would be nice to hear that people are actually interested in that.

Any questions anybody has for Sandy?

[No audible response.]

MR. MILLER: Sandy, a quick question for you. Do you -- what's your impression of the feasibility of the BPCI methodology for small physician practices that may want to propose alternative payment models? Basically no change in the current payment system but simply if you save money you would be able to get a payment somewhere down the road, whether it's quarterly or annually or whatever -- is that a feasible methodology for the kinds of specialties that you were talking about that are interested in changing the way they deliver care?

MS. MARKS: Well, there was some discussion earlier today about -- I think you brought it up -- that, you know, being able to save in the savings from Part A, or from the costs that are incurred for things other than physician services, and I think that's where most people see the biggest opportunities. So, as I said, preventing admission. I noticed sepsis is one of the episodes in the 48. So if you could identify that infection as potentially leading to sepsis, prevent it from happening, prevent the ED visit and the hospitalization, that's a huge amount of

savings. So, yes.

MR. MILLER: Okay. Great. Thank you very much. Next on the list is Nick Bluhm from Remedy Partners. Are you here? I've heard of Remedy Partners before, somewhere today. And Nick is apparently delegating it to Carolyn, who didn't speak because Steve was speaking before, so we'll hear from Carolyn on behalf of Nick on behalf of whomever.

Go ahead, Carolyn.

MS. MAGILL: We are a team.

[Laughter.]

MR. MILLER: Yes.

MS. MAGILL: The one that -- actually, to build on what Sandy just spoke about, with respect to the scope of bundles and the question that we had from Grace around what commercial providers are thinking, also with respect to bundles. So we hear frequently that the applicability should be beyond the existing scope. So as you may be aware, most of the bundles we focus on right now are acute to post-acute transitions. There's an opportunity, as Sandy said, to trigger, prior to an admission, to avoid an unnecessarily hospitalization.

Another one is that we are truly seeking to avoid fragmentation of care, and one way to do that would be to

incorporate drugs. So right now only Part B, as in boy, is included, not Part D. Another one -- and my background is in Medicaid so this is something near and dear to my heart -- relates to behavioral health. So opportunities to think about patients more holistically, in addition to some of the chronic care areas that are spoken about.

MR. MILLER: So you're saying even in, like, BPCI, Part D is not there and should be, in your mind?

MS. MAGILL: Yeah. Absolutely. There's an opportunity to expand that scope, and not only -- you know, and then beyond the 48 bundles as well.

MR. MILLER: Okay. Questions from anybody for Carolyn?

[No audible response.]

MR. MILLER: So I'm going to go slightly off the program here and ask Chris, could you say, quickly, a word -- yes, Chris -- could you say a word about why Part D is not in the -- and is that something that we should be looking for when we get models in? Is that operationally feasible, to be able to do that?

MS. RITTER: We include D in some of our models. We haven't included it in BPCI, because we're looking at the payments made within the fee-for-service program. But OCM does look at D. I don't remember exactly how. I think

it's --

MR. MILLER: Parts of D. It looks at the catastrophic --

MS. RITTER: Yeah, it looks at that piece. I don't know the whole -- I think we'd have to go back and think about it. It's very -- it's definitely difficult to include D. There is the who you're paying, what costs they have --

MR. MILLER: Because D runs through plans rather than directly, right?

MS. RITTER: D runs through plans. We don't do that, just like Medicare Advantage. But that being said -- so I don't -- but I don't think we'd ever want to say no- no. I think that the merit of the statement is there, in terms of what kinds of costs we'd be looking at. I think operationally, you -- I'll be employed, if you guys go down that path. So we'd have to think about it.

MR. MILLER: Okay. No, I do think it is challenging and it is something that -- it sounds desirable but it is challenging to do.

MS. RITTER: Very challenging.

MR. MILLER: So it's something that we need to look at carefully to figure out how to be able to do that.

Okay, great. Thank you.

We have Allison Brennan. Is Allison here? Is Allison on the phone? Okay, Allison Brennan from National Association of ACOs has registered to make a public comment. And we've got a question from Blair Atkinson, Moffitt Cancer Center.

Do I need to ask the operator to pen the phones?

OPERATOR: Thank you, ladies and gentlemen. If you would like to register a question, please press the 1 followed by the 3 -- the 1 followed by the 4, on your telephone. You will hear a three-tone prompt to acknowledge your requests. If your question has been answered and you would like to withdraw your registration, please press the 1 followed by the 3. And if you are using a speakerphone, please lift your handset before entering your request.

Once again, ladies and gentlemen, to register for a question please press 1-4 on your telephone.

One moment, please, for the first question.

MR. MILLER: So if either Allison or Blair are on the phone, please press whatever the appropriate buttons were.

[Laughter.]

OPERATOR: Our first questions comes from the line of Blair Atkinson --

MR. MILLER: There's Blair. Okay, great. Blair. Ask your question.

OPERATOR: -- Moffitt Cancer Center. Please go ahead.

MS. ATKINSON: Can you all hear me?

MR. MILLER: Yes.

MS. ATKINSON: Great. Thank you for taking my question.

So when we were looking at submitting proposals to CMMI and then also to PTAC, one of the questions that was coming to our mind, and we were just wanting to try and get some more clarification on, was the scope and the scalability of the model. I know that PTAC is looking for the position focus. We've talked a lot here today about large, you know, acute care type of projects. But I was just kind of wondering if PTAC would entertain, you know, projects that might be on a smaller scale with that position focus, or if we should still try to submit, you know, proposals with, you know, a larger CMMI emphasis, if that makes sense.

MR. MILLER: Let me try to answer, and I'll see if my colleagues have different answers, because I'm not entirely sure I understand the question.

We are looking for things that will fill gaps in

what CMMI currently does, or CMS currently does, and we are looking for -- in terms of payment models -- and we are looking for projects that will bring in different physicians, small physician groups than may be able to participate today. It isn't necessary for someone who is making a proposal to necessarily bring along with them all of the people who might be able to implement it, but we are looking for models, payment models that could be implemented by a broader array of people. Now that may be only small practices. It may be only single specialty practices. It may be whatever is appropriate. But that's -- we are looking for things that will fill gaps in the current portfolio.

Now, having said that, let me ask you. Did that answer your question or is there a different dimension of that that you're interested in?

MS. ATKINSON: It does. I think our question is kind of in -- around the, you know, the scalability. If we're looking to fill gaps, does that necessarily mean that it has to be -- you know, that it has a large-scale impact in terms of those types of gaps, or -- obviously it wouldn't be something that's, you know, just focused on a single center or a single region. You're looking for things that can be implemented nationally. But just trying

to get, I guess, a better idea or sense of that scalability.

MR. MILLER: Well, I think it should be something that could be scaled beyond one site, but if there are a limited number of -- for example, if it's focused on a particular condition and there are only a limited number of patients who have that condition, but it could have a significant benefit for them, that would be something of potential interest to us.

Ultimately, it's going to be up to CMS to decide what is feasible for it to implement, and they'll have to make those decisions, not us. But that doesn't really weigh into our decision-making.

Bob wants to add to that.

DR. BERENSON: Yeah. I would just add that in the final MACRA rule, the secretary exempted almost 400,000 physicians and small practices, many of whom, because their revenues didn't hit a threshold of $30,000. One can scale to lots of practices in small practices -- small, independent practices. So I think very much the same answer, is we are very interested in getting payment model suggestions for primary care and specialty, small, independent practices. You can scale a lot of patients -- I mean, a lot of beneficiaries in those practices.

MR. MILLER: Okay. Thank you, Blair, for the question.

Is Allison Brennan on the phone?

[No audible response.]

MR. MILLER: Is there anyone else on the --

OPERATOR: You may press 1-4 to register for a question.

MR. MILLER: Is there anyone else on the phone who has either a comment for us or a question?

[No audible response.]

MR. MILLER: Is there anyone in the audience who has for us a comment or a question? Yes, sir. Come on over to the microphone over here and identify yourself, and press the button there and it will light up, and tell us who you are and --

MR. INTROCASO: Thank you. So I'm David Introcaso with the American Medical Group Association, AMGA.

So just maybe, first, with two questions. In December, PTAC took comments on the evaluation, how PTAC will evaluate proposals. I'm wondering if that went final. Does anybody know?

MR. MILLER: Yes. The document is final.

MR. INTROCASO: So your criteria has gone final.

MR. MILLER: Yes.

MR. INTROCASO: Okay.

MR. MILLER: Although I would say "final" is, you know, a relative term. I mean, we have said that we will, in fact, continuously reevaluate what we were doing. We won't necessarily change it every day, obviously, but we do have a current set of final criteria on the website.

MR. INTROCASO: Great. Thank you. And the second is, in that document it was noted that once a proposal is posted on the website it's three weeks for public comment. Is that still the --

MR. MILLER: Yes, that's correct, except when we happen to do it over Christmas and New Year's, and then we decided that we maybe should be a little bit more flexible than that. But yes.

MR. INTROCASO: Then I would just make two comments relative to the discussion today. So there was discussion about this issue of counting for overlap, and if you remember, when CJR dropped in August of '15, the text in the proposed rule was, let's just say, challenging to understand, so I'd encourage the Committee to spend particular attention as it relates to rolling out these models and how it accounts for overlap with ACOs and the various others.

The second comment I would make is, there was discussion as well today about the gainsharing issue, and my understanding is that the gainsharing rules differ between the ACO MSSP program, because of the foreign abuse waivers -- ACOs are permitted -- and how gainsharing is conducted under BPCI. So relative, at minimum, if this organization, or PTAC would look towards having some standard relative to how -- what's allowed relative to gainsharing and what's not allowed, I think would be helpful.

So those would be my two comments.

MR. MILLER: Well, I would just say we don't necessarily have standards. We have a set of criteria and we're actually looking for people to come to us and propose things. If you have suggestions as to how you think what we think we should be thinking of when we look at them, that would certainly be welcome comments. But we -- and we provided some comments in our RFP, in terms of the kinds of things we described it as, that we would be potentially more likely to get a recommendation. But we're not trying, at this point, to preclude proposals from coming in that may have innovative approaches to things.

I don't know if any of my colleagues have any comments on that. Anybody have any questions for David?

[No audible response.]

MR. MILLER: Thank you, David.

Any other comments or questions from anyone in the audience?

[No audible response.]

MR. MILLER: Any questions are welcome. Yes, I know it's a big room and it's hard to get up, but if you have a question, this is your opportunity to ask us, or make a comment.

If not, I think we have drawn to the end of our agenda. Anything else that we should be doing? Anything else from the other members of the PTAC?

[No audible response.]

MR. MILLER: Rhonda is saying -- signing off. So thank you all for attending, and we are now officially adjourned.

[Whereupon, at 3:37 p.m., the meeting was adjourned.]