Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home

A Proposal to the Physician-Focused Payment Model Technical Advisory Committee

From Personalized Recovery Care, LLC

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Physician-Focused Payment Model Technical Advisory Committee
C/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201
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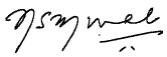
Cover Letter– Personalized Recovery Care, LLC, Home Hospitalization: An Alternative Model for Delivering Acute Care in the Home

Dear Committee Members,

On behalf of Personalized Recovery Care, LLC ("PRC"), a joint venture between Marshfield Clinic and Contessa Health, I respectfully submit this proposal for a Physician-Focused Payment Model entitled "Home Hospitalization: An Alternative Model for Delivering Acute Care in the Home" for PTAC review. PRC proposes to launch this model for Medicare Fee-For-Service patients at Marshfield Clinic, with the goal of expanding it to physicians and settings across the country.

PRC welcomes the opportunity to engage with PTAC Advisory Committee to test this model where physicians could provide hospital level care delivery to Medicare fee-for-service beneficiaries in their homes for a meaningful number of medical and surgical conditions. PRC is committed to and has demonstrated high quality of care focused on superior outcomes, excellence in patient experience and lower health care costs. The PTAC Advisory Committee offers a unique opportunity for PRC to join with HHS in these shared goals, and we look forward to your consideration of partnership.

Sincerely,



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Abstract

Descriptions of patient centered care and achieving the Triple Aim are often referenced, yet few programs create increased value and quality outcomes while also truly focusing on the preferences and experience of the patient. We believe that the following proposal for home hospitalization can achieve each of these goals and allow a broad cross section of physicians to participate in providing this type of care. Through testing of this proposed payment model of home hospitalization, Medicare fee-for-service patients would have the opportunity to receive patient-centered, acute care in their homes, whereas currently, the only option is an inpatient hospital stay with fragmented care following the discharge and recovery.

Submitted by Personalized Recovery Care, LLC ("PRC"), a joint venture between Marshfield Clinic and Contessa Health, the proposal closely tracks a program currently operational in Marshfield, Wisconsin. In this program, commercial and Medicare Advantage patients experiencing certain medical conditions normally requiring admission to an inpatient hospital instead consent to receive acute care treatment in their homes or a skilled nursing facility. Driven by Marshfield Clinic's experience in innovation and clinical excellence, this program allows superior clinical care in a patient's home or an alternative setting from an inpatient hospital, achieved through physician telehealth, health care service delivery, and focused, high-touch care coordination. The physicians responsible for the care take financial risk on the episode period, such that Medicare would be guaranteed savings from its historical spending on these conditions, while physicians would be rewarded for improved outcomes.

The PRC operators believe that this model has the potential to become a standard of care for treatment, enabling many different types of physicians to participate in the program. In general, any Medicare patient who is medically eligible for inpatient hospitalization admission for treatment of pre-selected conditions could be treated at home through the program, except if the patient needs a higher level of care such as ICU or telemetry, or if such patient has an unsafe home environment.

The PRC operators' goals are to: 1) improve health care quality by providing hospital level care in the comfort of the patient's home, while 2) changing the reimbursement for participating physicians by making them accountable for the quality and spend throughout a 30-day episode of care. Clinical data from previous operators of this type of care model demonstrate the superiority with respect to quality, including 33% reduction in mean length of stay, 24% reduction in readmissions, and 20% reduction in mortality. While results from the PRC program are in early stages and not statistically significant, the program is seeing similar outcomes and high patient satisfaction. Building on its previous track record with innovation, Marshfield Clinic committed to and has demonstrated high quality of care focused on superior outcomes, excellence in patient experience, and lower health care costs through its partnership with Contessa Health. Through this proposal, Medicare fee-for-service patients would have the opportunity to receive patient-centered, acute care in their homes, whereas currently, the only option is an inpatient stay with fragmented care following the discharge and recovery.

Background and Model Overview

Marshfield Clinic, Inc. ("Marshfield Clinic" or "MC") and Contessa Health, Inc. ("Contessa" or Contessa Health"), (collectively, the "PRC Operators") are proposing an Alternative Payment Model ("APM") for a home hospitalization care model in an episodic payment arrangement. The PRC Operators refer to home hospitalization throughout the proposal as the Personalized Recovery Care ("PRC") program or model. Home hospitalization is a clinical model that enables providers to deliver institutional-level care in a patient's home. The home hospitalization program is similar to the Hospital at Home ("H@H" or "HaH") models deployed by other health systems throughout the United States, as well as select countries across the globe.

The clinical aspect of the PRC program includes a pathway by which a patient could be treated. In this pathway, a patient that requires hospital-level care, yet meets select clinical and home-appropriateness eligibility, would be eligible for a direct-to-home pathway. The patient would then be transferred from the point of initial treatment directly home, where the patient would receive hospital-level care. The PRC model provides an alternative venue for the traditional institutional setting used for acute care and has demonstrated the ability to improve patient safety, enhance quality and reduce costs in several randomized trials.

The APM aspect of the PRC program involves the PRC Operators receiving an episodic payment for hospital-level care and related transitional services that would not be tied to an index admission to an acute care facility. From this payment, the PRC Operators would be responsible for all related care delivered to the patients over a 30-day episode. This includes any subsequent hospitalizations related to the initial anchoring event. The PRC Operators would be required to meet select clinical quality metrics to be eligible to receive savings generated from the program. The episodic rate would equate to a 3% discount to the historical benchmark for comparable episodes.

The home hospitalization model is not currently reimbursable in the Medicare Fee-for-Service ("FFS") system. Creating a mechanism that would allow not only the PRC Operators, but also other providers across the country, to be reimbursed for this model would fundamentally change the way in which hospital-level care is delivered throughout the United States. As a result of implementing this model, Medicare would create an opportunity to potentially realize $1BN in savings annually.

I. Scope of Proposed PFPM

A. Physician Practice Applicability

The PRC program is capable of substantially expanding the APM portfolio due to its broad applicability to both professionals and beneficiaries. The PRC model is currently being operated within MC for commercial and Medicare Advantage beneficiaries of Security Health Plan ("SHP") for medical conditions, and is in the process of being deployed for surgical conditions. Given the conditions that are currently being treated under the existing model, the model applies to many physicians and eligible clinical professionals.

The PRC program was initially launched in Marshfield, WI for general medical conditions within various sub-specialties of Marshfield Clinic's multi-specialty practice. The initial rollout of the PRC program covered the following practices: a) Internal Medicine, b) Cardiology, c) Pulmonology, d) Nephrology / Urology, e) Rheumatology, and f) Orthopedics (for DVT complications). In addition to the types of physicians referenced above, several other provider types are included in the model, including: home health, social workers, physical therapists and

infusion providers. The PRC program is currently contracted with a national home health operator, a national durable medical equipment ("DME") vendor and a national infusion provider.

B. Physician Practice Interest

As mentioned before, the PRC is similar to the Hospital at Home clinical model. Some of the organizations that have operated that model to date include[1]: Mount Sinai Health System (New York), Johns Hopkins Schools of Medicine (Baltimore), Advocate Health Care (Chicago), Presbyterian Healthcare Services (Albuquerque) and the Department of Veterans Affairs.

In addition to the aforementioned names, the PRC program partner, Contessa Health, is currently working with five organizations (both independent practices and health systems) to deploy the model.

Beyond physician practices, numerous national ancillary service providers have expressed interest in participating in the model. This includes two publicly-traded home health operators.

C. *Market Applicability at Scale*

Marshfield Clinic and Contessa Health believe that this model has the ability to become a standard of care, thus enabling all physicians and beneficiaries to participate in the program. Other countries have demonstrated the ability to effectively achieve scale. The health authority in Victoria, Australia elected to pay for home hospitalization admissions in the mid-1990s. As of 2009, nearly 33,000 annual admissions accounted for 5% of all acute bed days[1].

The limitations on physicians would largely be confined to the availability of ancillary resources in any particular market. For example, constrained resources from a home health, DME, transport, or infusion services perspective could hinder a physician practice's ability to operate the model for all patients, as there would be limited ability to deliver all necessary services in the home.

D. Payment Model for Employed Physicians

The proposed payment model is dependent upon delivering care at the agreed upon episode rate, while also meeting quality clinical outcomes. With the funds from the agreed upon episode rate, the PRC model includes two payment components: 1) FFS payments to participating providers for services rendered, and 2) participation in savings achieved for delivering quality care beneath the episode rate.

As it relates to the first payment component, no changes are necessary in compensation structure as both independent providers and employed providers currently work under this payment arrangement with CMS.

In order to appropriately distribute shared savings to providers that meet quality metrics in an independent practice structure, no compensation changes are needed. It is possible that compensation changes would be needed for individual physicians to participate in the savings in an employed provider structure.

The Marshfield Clinic operates under an employed provider structure. The PRC model distributes 49% of savings generated to the practice entity.

E. Commercial Payer Implementations

As stated above, the model was implemented for both the Commercial and Medicare Advantage product lines of Security Health Plan in Marshfield, WI starting in September 2016. The experience to date has been very well-received by SHP patients and participating providers. While the program is still in its early stages, it is meeting the goals of satisfying the Triple Aim. The cost of care has been reduced, patients are enjoying the experience, as evidenced by patient satisfaction surveys, and physicians are delivering better outcomes. Through setting the pricing for the health plan at a reduction from the average historical cost of the treatment period, the health plan is guaranteed savings with minimal changes to its administrative procedures. To underscore the early successes, the partners are already expanding the program to other payers / clinical diagnoses and assessing the viability of expanding to other payer classes (Managed Medicaid).

Contessa Health is working with several other payers to implement the program. This includes national and regional payers for both the medical and surgical models in various markets. An example of another system that launched a program in 2008, extending coverage to 470,000 Medicare Advantage, Medicaid and commercially insured members throughout the state of New Mexico, is Presbyterian Healthcare Services[2].

F. Small Practice Feasibility

With any pay for performance model ("PFPM"), there will be the potential exposure to additional cost and/or financial risk. Even with this implication, Marshfield Clinic and Contessa strongly believe that this model is feasible for small practices. This PFPM requires three primary areas of investment in order to be successful: clinical, administrative, and while not necessary but helpful in order to scale, technology.

The clinical investments necessary are centered upon developing protocols and pathways, and hiring personnel to manage the patient throughout the program. The personnel costs are not substantial, and could potentially be handled by existing resources within a small practice. To illustrate an order of magnitude, the PRC program in Marshfield hired three care coordinators (in Marshfield, these nurses are called Recovery Care Coordinators or "RCCs") to manage patients throughout the episode and those individuals are capable of managing ~350 admissions per year, per care coordinator. The remaining clinical costs are largely related to time needed to develop clinical protocols.

The administrative costs are principally related to time requirements to identify and train applicable clinical partners outside the existing practice. However, there can be costs related to taking full risk. One item is related to consultants that provide actuarial services; this can be secured for approximately $25,000. Another cost relates to the re-insurance needed to protect the practice in the event of adverse events (i.e. readmissions). This cost is dependent upon practice size, the actuarial soundness of the risk pool and typically costs between $50,000 - $100,000 for an annual premium. Surety bonds, another option for financial protection, are significantly cheaper than reinsurance policies.

The technology costs are determined by the level of technological integration the practice wishes to implement. Many of the processes can be handled manually; however, technology enables significant efficiencies in operating a program at scale. The Marshfield – Contessa PRC model incorporates telehealth tablets to better manage patients across the entire episode and this cost is less than $20,000 annually.

G. Addressable Market

Given the breadth of medical and surgical conditions that the PRC is capable of addressing, a substantial number of the hospital admissions, and thus corresponding spend, is able to be treated under this model. Contessa Health has analyzed claims data to identify the market potential. The charts in Appendix A illustrate the addressable market for the program in two potential initial stages (1) Medical Only and 2) Medical and Surgical) as well as at scale as described in the list of DRGs outlined in Appendix F reflecting 40 addressable conditions.

As depicted in Appendix A, the program has the ability to address 8% of hospitalizations in a medical-only model, 24% of hospitalizations in a Medical and Surgical model, and nearly 30%-50% in a model at-scale.

In addition to the commercial and Medicare Advantage populations of the select health plans referenced in the charts in Appendix A, a considerable addressable market exists within the Medicare population. For hospitalizations with COPD acute exacerbation as the principal diagnosis, Medicare accounted for 71.6% of the payer mix**,** with aggregate costs for hospital stays totaling $6.1 billion[3]. Furthermore, CHF accounts for approximately 1 million hospitalizations a year among adults over 65 and results in 24% of patients being readmitted to a hospital within 30 days [4]. The other major condition covered by the medical model, pneumonia, represented $10.2 billion in aggregate inflation adjusted hospital costs in 2010[5]. With hospital expenditures reaching $1.03 trillion in 2015 (5.6% growth from 2014)[6], and a projected average growth rate of 5.5% per year for 2016 – 2025[7] due to increases in growth in use and intensity of hospital services by Medicare beneficiaries, applying the market share percentage depicted in the graphs above for medical conditions to these hospital spend estimates underscores the potential addressable market for home hospitalization.

H. Patient Benefits

This model provides an opportunity to meaningfully improve the benefits patients receive as part of a care experience. Clinical data from previous operators of this model demonstrates the superiority with respect to quality, including 19% reduction in total cost of care, 33% reduction in mean LOS, 24% reduction in readmissions, and 20% reduction in mortality[8].

There have also been research studies quantifying the acceptability to older patients to receive hospital-level care in the home. The results of one study supports the tremendous benefits that can accrue to patients as a result of this clinical model. The majority of patients interviewed agreed that treatment in a home hospital model would be more comfortable compared to treatment in a traditional hospital admission (78.5%) and 72.3% would choose home hospital if it were available[9]. The familiarity of home reduces falls, delirium and exposure to hospital acquired infections, as well as provides a lower stress environment where a patient can receive instructions and education about his or her condition without being overwhelmed. Note that as part of the admissions process, the PRC program includes an informed consent process such that a patient chooses whether to receive care at home or in a hospital so any patient who is uncomfortable with being treated at home would still have the option of in-facility care.

As it relates to patient protections, the PRC model ties quality outcomes to payment. This largely mitigates any action that would result in a poor patient experience. Since the program is at-risk, denial of care would likely result in bad outcomes, and thus increased financial exposure, as well as the patient selecting other providers for future care needs. Alternatively, overutilization

would also result in excessive spend, and again, financial penalties. In order to avoid producing suboptimal patient outcomes, the PRC incorporates a health assessment and patient-centered care plan to achieve the patient's goals.

I. Impact on Medical Spend

For a medical only model, the PRC model has the ability to address approx. $40BN in Medicare spend. This assumes that of the $597BN in Medicare spending, approximately 24% is for inpatient care and the PRC Operators can address 30% of hospitalizations through its clinical protocols, and 50% would be clinically eligible for the program. If this program were available to all Medicare FFS patients, CMS could generate more than $600 million in savings annually, assuming the 3% discount proposed in Section II.

II. Quality and Cost

A. Improvement in Care Delivery and Quality

The results to date of the PRC program in Marshfield have demonstrated meaningful improvement in both reduction in cost of care and increased quality outcomes. The payment model with SHP involves the risk entity taking full risk related to the admitting condition for a period of 30 days, including readmissions. The episodic rate was set by setting a benchmark of the average historical spend for each condition (across the 30-day episode) using historical claims data, then discounting the benchmark for each condition.

With respect to quality, the PRC uses the metrics below to track clinical quality, patient engagement and program personalization on an episode basis.

Clinical Quality Measures	Link to Payment	Satisfaction Results in % of Savings
% of Episodes with Follow-Up PCP Appointment Scheduled Within 7 Days	Target > 90%	20%
% of Episodes with Medication Reconciliation	Target > 90%	20%
Patient Safety - % of Episodes with Adverse Events (DVT, Pressure Ulcer, Fall with Injury)	Target < 3%	20%
Patient Experience - % of Questions Answered with Top Box Response	Target > 90%	20%
Functional Status Assessments (Using PROMIS) - % of Episodes with Functional Status Assessments Completed for Each Patient	Target > 90%	20%

Prior studies have demonstrated the ability to not only maintain, but also improve quality beyond the initial baseline. Studies have been published comparing the differences in the functional outcomes experienced by patients cared for under this model and traditional acute care hospital care. One study illustrated that patients treated in a home hospitalization model experienced improvement in performance scores, as compared to patients treated in the acute care hospital whose performance scores declined (ADL, 0.39 vs -0.60, P=.10, range -12.0 to 7.0; IADL 0.74 vs -0.70, P=0.07, range -5.0 to 10.0)[10]. It also showed results of a greater proportion of HaH

patients improved in function and smaller proportions declined or had no change in ADLs (44% vs 25%, P=.10) or IADLs (46% vs 17%, P=.04) [10].

B. Barriers & Risks

The largest barrier to success for this clinical model has been the lack of payer willingness to contract with providers for this model. Prior attempts at this clinical model have achieved excellent outcomes with respect to clinical metrics and patient experience. The inability to scale has largely been due to a lack of reimbursement sources. Most programs to this point have relied upon grants to fund the treatment of patients.

An additional barrier to the success of the PRC program has been tied to the inability to adequately fund the resources needed to launch a program, given the limited payer sources, and thus limited potential patient volume. Prior attempts at the home hospitalization model have largely relied on a dedicated staffing model. Given the limited volume that would be reimbursed for the program, it has been difficult to reach a volume that produces profitability. The PRC program utilizes a network approach to defray the staffing of dedicated clinical professionals to the program. The network approach involves the PRC operators contracting with existing ancillary providers in the local market, and relying on those partners to deliver certain aspects of care, significantly reducing fixed overhead costs. Furthermore, the PRC contracts with the hospitalists and physicians of the multi-specialty clinic at Marshfield to provide the necessary follow-up visits for patients treated under the program. Utilizing this approach significantly increases the viability of a program, specifically for smaller practices, and further mitigates the need to unnecessarily admit patients that do not qualify in order to meet a volume threshold.

Furthermore, up until recently, physicians have not been rewarded for producing superior outcomes. Therefore, when one has the option to admit a patient to a typical acute care facility or a home hospitalization program, there has been no incentive to admit patients to the latter. With the advent of APMs, clinicians can now be rewarded for delivering higher quality care at a discounted price, thus increasing the likelihood of admitting to this program.

The risk related to lack of payer engagement would be significantly mitigated should Medicare FFS beneficiaries be eligible to be treated under this clinical model. Commercial and Medicare Advantage payers consistently follow the lead of CMS. The PRC operators believe that, should CMS reimburse providers for this model, there would be a domino effect with other payers. With that, additional payers would follow suit and the challenges associated with defraying infrastructure costs would also be mitigated as there would be ample volume to cover the costs of operating a program.

The PRC operators are confident their approach is attractive to the commercial payer market. The PRC operators have plans to bring the model to additional payers in the very near future.

C. Metrics

The PRC model incorporates the use of metrics for patient-reported outcomes, see Appendix B, as well as patient experience. The table below illustrates the patient satisfaction survey that the PRC Operators conduct at the conclusion of a patient's episode.

Patient Satisfaction Survey Questions	
1	During your time in the Personalized Recovery Care program, how often did the physicians treat you with empathy and respect?
2	During your time in the Personalized Recovery Care program, how often did the physicians explain things in a way you could understand?
3	During your time in the Personalized Recovery Care program, how often was your pain well controlled?
4	During your time in the Personalized Recovery Care program, how often did the nurses treat you with empathy and respect?
5	During your time in the Personalized Recovery Care program, how often did the nurses explain things in a way that you could understand?
6	During your time in the Personalized Recovery Care program, how often did the care team provider for your safety by wearing gloves and washing hands?
7	During your 30 days in the Personalized Recovery Care program, how often did you feel you had the help and support you needed from your Recovery Care Coordinator while recovering at home?
8	During your 30 days in the Personalized Recovery Care program, how often did you feel the Recovery Care Coordinator was responsive to your needs?
9	Using any number from 0 to 10, where 0 is the worst treatment and care possible and 10 is the best treatment and care possible, what number would you rate your experience with the Personalized Recovery Care program?
10	Would you recommend the Personalized Recovery Care program to your friends and family?

D. Incorporation of Data

The PRC program will incorporate data from multiple sources to appropriately manage this proposed risk arrangement. First, the program will utilize claims data (and currently does so in the program with SHP) to appropriately monitor total cost of care, utilization of resources, and adverse events (specifically ED visits and / or readmissions). Secondly, the regional care coordinators have electronic medical record ("EMR") access to appropriately complete clinical eligibility screening. The program also utilizes a telehealth platform to capture biometric data, clinical quality data and caregiver notes. That information is transferred from the providers that deliver care associated with the home stay, to the EMR of the PCP. Finally, a patient satisfaction survey is completed and the file is retained in the records of the PRC Operators.

E. Electronic Reporting

The PRC Operators have established robust reporting and monitoring capabilities in conjunction with the program launched in Marshfield. The monitoring information related to measurement calculations includes, but is not limited to: insurance type, number of calls received, number of calls placed to patients, number of patients screened, time to admit, number of readmits, ALOS, etc. The PRC Operators measure the turnaround time for RCCs to upload the Continuity

of Care Document (CCD) into the EMR at the end of the acute phase and post-acute phase. The RCCs also reach out to any out-of-network providers for the patient's medical records to be sent over to upload to the patient's profile in the EMR. PRC Operators scan daily for this information from the EMR and update the data for quality metric data. This data is disseminated in a timely manner through a Clinical Quality Council that meets at least Quarterly, but often monthly. This multi-disciplinary team includes physicians, nurses, administrative personnel and others to discuss the progress of the program related to outcomes, utilization, cost and other pertinent metrics.

F. Monitoring & Auditing

The PRC Operators collect data on a weekly basis for core operational metrics and claims data. Patient satisfaction metrics are collected at the end of the 30-day episode. Operational metrics and claims data are aggregated and cataloged in a proprietary platform. Patient satisfaction surveys are conducted telephonically with the outcomes stored in the proprietary platform, noted in section 2C.

G. Statistical Analyses

Prior statistical analyses have been completed for other home hospitalization programs, demonstrating the favorable impact on quality and spending. A study was conducted in the U.S. with 3 Medicare-managed care plans at Johns Hopkins and a Veterans Administration medical center. Measurements centered upon clinical processes, standards of care, clinical complications, satisfaction with care, functional status and costs of care. The mean costs was lower in the program than that for acute care ($5,081 vs. $7,480)[8]. Another study illustrated favorable impact on quality due to a lower level of readmissions at 90 days (24% vs. 42%) and fewer complications associated with delirium, urinary issues, intubation and transfers to the ICU[11].

III. Payment Methodology

A. Payment Methodology

The PRC Operators propose that a modified episodic (bundled) payment be created to reimburse providers for this model. The program would utilize a retrospective bundled payment model, similar to BPCI model 2, with the major change being that an episode of care would not be tied to an anchor admission at an inpatient acute care facility, thus enabling an episode of care to be triggered off a non-facility claim. The bundled payment would consist of two primary components: 1) risk payment for delivering high quality care as compared to the targeted cost of care (the "Target Bundled Rate"), and 2) a per episode payment made for the care being provided in lieu of an acute care hospitalization ("Home Hospitalization Payment").

Risk Payment Compared to the Target Bundled Rate:

The PRC Operators will provide a list of DRGs that will be covered by the program (See Appendix F) to establish Target Bundled Rates on DRG basis. The Target Bundled Rate will use the BPCI exclusion lists to create a definition for the episode of care to derive the historical 30-day episodic cost of related care (the "Benchmark Rate"). A 3% discount will then be applied to the Benchmark Rate to create the Targeted Bundled Rate.

In the event one of the DRGs in Appendix F is not one of the 48 BPCI episodes of care, the PRC Operators have mapped those DRGs to the most clinically-relevant BPCI DRG (See Appendix G.

Due to clinical eligibility criteria potentially preventing patients from being admitted to the program, an adjustment should be made to the historical Targeted Bundled Rate, prior to applying the 3% discount. The PRC Operators propose excluding beneficiaries that have the following clinical characteristics: end-stage renal disease, hospice enrollment, or initial admissions to the intensive care unit.

After applying the aforementioned logic, the Benchmark Rate will be set and the final Target Bundled Rate will be established for each of the episodes of care. All providers, other than the PRC Operators nursing care referenced below, will submit claims to CMS in the same FFS manner. During the designated reconciliation, all costs for the member related to the episode of care (per the definition and including the Home Hospitalization Payment referenced below) during a 30-day period will be compared to the Targeted Bundled Rate. If the total related costs are less than the Targeted Bundled Rate, the PRC Operators will retain 100% of the difference, up to 10% of the Benchmark Rate. If the total related costs are more than the Targeted Bundled Rate, the PRC operators will be liable for 100% of the difference, up to 10% of the Benchmark Rate. The amount of savings / liabilities will be modified depending upon the achievement of quality metrics as described in Section 2A. Each metric satisfied will result in the PRC Operators receiving 20% of the savings. If all five metrics are satisfied, the PRC Operators would receive 100% of the savings, whereas meeting none of the metrics would result in zero savings payments received by the PRC Operators in the reporting timeframe.

Home Hospitalization Payment

The Home Hospitalization Payment would compensate the PRC Operators for nursing and social work services rendered in place of the hospital admission and would be calculated as 70% of the DRG payment that would have applied to the acute care admission. The Home Hospitalization Payment will be included in the total cost of care calculation used to determine shared savings. For clarity, this does not include payment for infusion, DME, labs, and other ancillary services as those services will be billed directly to CMS and accounted for in the reconciliation. This percentage is in line with what our cost for nursing services when compared to historical DRG payments.

For example, if the Benchmark Rate is $10,000, the Targeted Bundled Rate would be $9,700. If the total related cost of care for that episode was $7,000, CMS would retain the first $300 (the guaranteed 3% savings), the PRC Operators would retain the next $1,000 (10% of Benchmark Rate cap) and the reaming $1,700 in savings would be retained by CMS. Given the model's deep physician involvement and care coordination, there could be savings well in excess of the targeted 10% cap. A detailed example of the proposed payment methodology is illustrated in Appendix H.

This model has been adopted by other payers, although there are slight modifications to the payment methodology. Other payers have implemented this model with the primary difference being that the payment is a prospective bundled payment. The methodology to set the Benchmark Rate is also the same. The PRC Operators determined that the level of infrastructure requirements / implementation resources necessitated by the fiscal intermediaries of CMS to adjudicate a prospective bundled payment may prevent a timely launch of the PRC model under a PTAC proposal. Therefore, the PRC Operators opted for a retrospective bundled payment model.

As care continues to migrate to outpatient / ambulatory settings, an alternative for inpatient care must be created to allow for appropriate cost reductions in our health care system. The proliferation of ambulatory surgical centers in the mid 1980's created an alternative to the hospital for surgical procedures. The PRC model and other hospital at home operators are following the same path as the ASC industry leaders by creating an alternative setting for inpatient acute care facilities for general Med / Surg treatment. This innovation is necessary to address the largest portion of spend in the health care environment, the acute care spend.

The potential to participate in the savings realized from delivering care under the Targeted Bundle Rate will not be allowed unless the PRC Operators meet the designated quality metrics designated in Section 2A. In the event the PRC Operators meet the target quality metrics but fail to deliver care under the Targeted Bundled Rate, the PRC Operators will still be liable for the incremental cost of care.

The mapping of the HCPCS codes point to a DRG, which accounts for the acuity, and therefore the medical expense risk, of the patient through the designation of Complications or Comorbidities classifications.

B. Proposed Payment Methodology's Difference from Current CMMI models

The primary difference between the proposed payment methodology and current CMMI models is that the existing bundled payment models require an index admission to an inpatient acute care facility. This requirement inherently makes bundled payment models facility-driven. The PRC model is truly physician-driven as the provider has the ability to decide whether or not a patient can receive acute care in an alternate setting than the inpatient acute care facility. Furthermore, the second difference is that if the providers generate savings above the anticipated target, while meeting clinical requirements, there is an ability for CMS to participate in those incremental savings.

C. Degree of Financial Risk for the Entity

As stated above, the degree of financial risk for the entity is limited to 10% of the Benchmark Rate. In the event a provider entity is more or less risk adverse, the discount to the Benchmark Rate can be adjusted to meet the provider entity's risk tolerance.

D. Establishing accuracy and consistency of identifying conditions, clinical appropriateness, and assignment of claims to episodes of care

A major focus for the PRC Operators is to avoid increasing admissions to the home hospitalization program when hospitalization to an inpatient acute care facility is not required. The PRC Operators suggest confirming the medical necessity of each admission, as dictated by either the Milliman Care Guidelines or the InterQual Level of Care Criteria for Acute Care.

Since this model avoids the anchoring hospitalization that occurs in a traditional hospital-based (i.e., BPCI model 2) episode, an episode DRG needs to be determined for comparison of actual episode costs to the Benchmark Rate and the Target Bundled Rate. For the episode's DRG determination process, the PRC Operators would use the last home hospitalization acute-phase physician rounding activity in the rounding physician's electronic medical record ("EMR") as the basis for determining the DRG for the PRC Operator's professional fee claim.This maintains the same level of accuracy and consistency of identifying / coding diagnoses and conditions as the existing hospital medical records abstracting process.

CMS would need to designate a set of unused HCPCS codes for this proposal, and each unused HCPCS code would map to a specific historical DRG (the 162 DRGs in Appendix F). The PRC Operators would use this map to convert the abstracted episode DRG to a specific HCPCS code, and that HCPCS code would be placed on the PRC Operator's submitted claim. Furthermore, the PRC Operators would like to make the mapping available to any other APM entity that would be interested in participating in a home hospitalization program.

During periodic (quarterly) reconciliation, each episode would be anchored using the PRC Operator's claim, with the HCPCS code on this claim representing the specific DRG to use for each episode, thus allowing easy assignment of claims to an episode of care.

Finally, this reimbursement methodology would make it possible to have independent physician practices participate in this, or a similar, program. Physician practices do not have experience in submitting DRG payments, as only facility based claims use DRGs. Our proposed approach, with the HCPCS mapping, allows physician practices to submit claims based on a DRG but in accordance with their current processes and infrastructure requirements.

E. Barriers to Establishing This Payment Methodology

The requirement to document inpatient eligibility through using Milliman or Interqual tools could be a barrier to small physician practices, as they may not have the experience nor technology resources to perform that evaluation. However, the price limitations on these resources are primarily tied to technology solutions; small practices could purchase reference copy and run the evaluation through charting rather than the more expensive software.

For patients who present at a physician's office or emergency room and may receive intravenous treatment prior to being sent home or otherwise be too ill to safely drive, ambulance transport may be the most medically appropriate form of transportation back to the home. However, under Medicare FFS rules, non-emergency medical transport to the home is not included as a benefit. In addition, the OIG did not include providing ambulance transportation from the anti-kickback statute safe harbor protection. Therefore, a physician provider or PRC Operator arranging for discounted or free ambulance transportation could be subject to regulatory risks even though the transportation itself is necessary for safe implementation of the program.

Physician organizations that participate in this payment model should be required to have or contract for nursing and social work resources that could be deployed to patients' homes. The PRC Operators believe that regardless of how the physician organization arranges for these services, they must be well coordinated and under the direction of the physician organizations beyond signing orders for such services. For example, physicians may opt to use telehealth technology to visit patients. If such technology is deployed, the PRC Operators recommend that nurses be in the home at the time of the physician telehealth visits. The nursing services being deployed are comparable to acute care hospital nursing services and not home health services, which tend to be rendered under longer episodes of care for lower acuity patients. Allowing physician organizations to contract for nursing and social work services is especially important in states that require a home health license to allow nurses or social workers to provide care in patients' homes. Furthermore, this contracting method is necessary in states where either the state is not issuing new home health licenses or the burden to obtaining and maintaining a home health license creates a barrier to physician organizations being able to participate.

For the proposed payment model, we would request a waiver of the Skilled Nursing Facility 3-Day Rule.

IV. Value over Volume

A. Financial Incentives for Providers

The APM entity will reward physicians for achieving the quality metrics noted in Section 2A. This is in direct contrast to the traditional methodology of linking financial payments to productivity-based metrics. By having a portion of one's compensation tied to quality metrics and outcomes, physicians will now have a vested interest to place the patient in the most appropriate site for care delivery. Engaging in the PRC program gives providers the best opportunity to produce a high-quality outcome at a lower cost than traditional acute care services.

Beyond the admitting physicians, the ancillary providers will also have an incentive to provide the best possible care without over-utilizing resources. The PRC operators have prior experience in value-based arrangements and have successfully established non-exclusive relationships with ancillary providers (such as home health), resulting in better care throughout the delivery system. While ancillary providers will not participate in any shared savings, experienced operators of these businesses know that poor performance will result in the APM entity seeking to align with other higher-quality providers.

B. Non-Financial Incentives

Physicians, like hospitals, are increasingly evaluated with regard to quality of care and patient care experience. In that process, there will be more objective measurement of care delivery at the individual care practitioner level. This program provides opportunities for the practitioner to place the patient's interests front-and-center by giving them the choice as to where they would like to receive care. By placing the responsibility to deliver high-value care with the admitting physicians, an incentive will now exist in that providers will be able to provide care in an environment preferred by the patient, likely resulting in higher evaluations. In addition to the ownership of patient care and having an alternative treatment methodology, other non-financial incentives are available to participating providers. In the time since the PRC program launched with SHP, the PRC operators have received anecdotal commentary that physician satisfaction has increased due to a reduction in ER wait times, and that it is easier to admit patients to the PRC program than a traditional acute care facility. Also, the mid-level clinical support provided by the program reduces administrative burdens.

V. Flexibility

A. Model Adaptability to Differences in Clinical Settings and Patient Subgroups

Given the extensive history of the home hospitalization model, numerous participants have proven the model's flexibility and potential to be adopted by different practice settings, thus benefitting numerous patient populations. The model has been proven to apply to various subgroups of 1) patients, 2) practices, and 3) physicians in different settings.

Entities that have previously adopted the model demonstrate the breadth of practice settings. While most operators to date have been large integrated systems in urban settings, Marshfield Clinic's recent adoption of the model underscores the ability for the model to be successful in a rural market. As previously mentioned, the program has achieved success from integrated operators in urban markets, including: Mount Sinai Health System (New York), Johns

Hopkins Schools of Medicine (Baltimore), Advocate Health Care (Chicago), and Presbyterian Healthcare Services (Albuquerque). Despite the concentration in urban markets, the PRC operators' success has generated interest from a number of operators that have engaged in discussions to launch programs in rural markets.

The model has also demonstrated an ability to apply to various subgroups of patients. Given that the clinical model largely focuses on exacerbations associated with clinical conditions, the program is most relevant in Medicare populations; however, the PRC has experienced success applying the model to the Commercial patient cohort. Numerous operators of the model have also achieved success treating Medicaid patients.

B. Adaptability for Changing Technologies

As with any value-based care initiative, significant attention must be given to evolving technologies. As stated above, a Clinical Quality Council was established to review the various components of the care model to ensure the PRC program has accounted for the relevant standards of care. This council is multi-disciplinary in nature and involves representatives from all participating parties.

The PRC also includes the use of a telehealth platform that incorporates video communication and biometric data tracking. The system is tablet-based and includes Bluetooth-enabled peripheral devices, such as a blood-pressure cuff, pulse oximeter, and scale. Recently, a Bluetooth-enabled stethoscope was added, further demonstrating the model's ability to adjust practices for changes in technology.

With the regularly-scheduled meetings of the Clinical Quality Council, adaptations in practices (both clinical and technical) can be quickly identified and vetted as to whether inclusion in the PRC program is merited.

C. Operational Burdens and Reporting Requirements

The PRC Operators believe that operational burdens and reporting requirements can be significantly mitigated with dedicated preparation prior to the launch of a program. As with any new care model and/or APM, operational changes and established reporting practices will be required. However, practices of varying degrees of size should be able to handle the operational changes necessary to launch a home hospitalization program given only four main requirements: 1) clinical protocols, 2) care coordinators, 3) home-visit capabilities, and 4) back-office reconciliation.

The first requirement involves developing clinical protocols that must be established to appropriately deliver hospital-level care in a patient's home. These general medical protocols require minimal capital investment, but do include ample time to create uniform processes and procedures. An additional operational requirement relates to hiring or re-allocating resources to serve as the care coordinator for the patient throughout the 30-day episode. In addition to the care coordinator, operational burdens could arise depending upon the methodology selected for home-visits. To create an operationally-efficient model, providers can use telehealth platforms to virtually treat patients admitted to the program. Alternatively, to avoid cost, practitioners could deploy the home-visit model, which requires they make house calls. The trade-off is the potential for an operationally inefficient model. Finally, processes must be established to reconcile the potential savings generated as a result of delivering care under the episodic payment. Despite four

new operational / reporting requirements, minimal burdens are created and steps can be taken to mitigate the inefficiencies associated with these new processes.

D. Model Preparation and Infrastructure Requirements

Numerous practices and systems, referenced in section 5A, have established infrastructure requirements necessary to successfully launch a program by using internally-developed resources. Various consulting firms have expressed an interest in supporting their healthcare provider clients to establish the necessary resources to launch home hospitalization programs. There are also privately held, venture-backed companies that have experience with the program and can help providers establish the necessary infrastructure to launch a home hospitalization initiative. Therefore, optionality exists to adequately prepare to launch the model and establish the necessary infrastructure, regardless of a model participant's size.

VI. Ability to be Evaluated

A. Evaluation Capabilities

In the existing program, the PRC Operators have successfully evaluated metrics related to core operations, clinical quality, cost and patient satisfaction. Those same metrics are proposed to be included and are denoted in Section 2A. The PRC Operators collect data on a weekly basis for core operational metrics and claims data. Patient satisfaction metrics are collected at the end of the 30-day episode. Operational metrics and claims data are aggregated and cataloged in a proprietary platform. Patient satisfaction surveys are conducted telephonically with the outcomes stored in the proprietary platform, noted in section 2C.

B. Evaluable Goals

The proposed metrics denoted in Section 2A are evaluable at numerous levels, including, but not limited to: patient, disease-state, payer / population classification and physician. Once the infrastructure and reporting requirements have been established, the outcomes associated with patients treated under this model can easily be evaluated. This is no different than evaluating the outcomes of a patient treated in a traditional acute care facility.

It should be noted that this model does not face the challenges of patient attribution, like other APMs. Upon admission, the patient is clearly identified, thus making assessment of the desired goals easy to conduct.

C. Evaluations Under Development

Evaluations of home hospitalization have been conducted and have been referenced in Section 2G. In addition to the aforementioned models, the PRC Operators are tracking the outcomes for all defined metrics that are part of this proposal, however not all measures are yet statistically significant.

D. Additional Evaluation Possibilities

At this time, the PRC Operators feel that the initial core metrics are an adequate set of criteria upon which the model can be evaluated. The proposed core metrics meet the various elements of the components of the Triple Aim: cost, quality and patient experience. Additional questions that may be more qualitative in nature could be difficult to track, thus possibly impeding the ability to attract more provider participants to the model.

VII. Integration and Care Coordination

A. Professionals Included in Model Implementation

This proposed model will utilize a multi-disciplinary care team including, but not limited to, primary care physicians, specialists, mid-level practitioners, pharmacists, nurses, social workers, therapists, home health resources and other allied health professionals.

B. Contribution to Greater Integration and Care Coordination

Greater care team integration is achieved in this model through the assignment of a primary care coordinator to each participating patient. The care coordinator is responsible for assisting the multi-disciplinary team with determining eligibility, coordination of acute care services, scheduling and logistics of post-acute care, ongoing monitoring and patient education, and transitional care at the end of the episode. Continuous feedback with the PCP is a cornerstone of the program, including a discharge summary with 48 hours of the conclusion of the home hospital period, an appointment with the PCP within 5 – 7 days and an overview of outcomes at the conclusion of the episode. Additionally, the care coordinator has access to medical social workers to connect patients with the appropriate community-based resources to address any psycho-social needs. Being that care during both the acute and post-acute phases is managed by the same care coordinator, there is a much greater ability to inform providers of patient-specific needs, thus reducing the likelihood of complications and readmissions.

The PRC Operators leverage partnerships and proprietary technology to create a seamless experience for patients throughout the episode of care. Appendix C highlights how the different members of the care team are engaged by the care coordinator throughout the episode to ensure patient safety. Appendix C also highlights the number of encounters that the care coordinators deliver throughout the various phases of the episode.

C. Potential Changes in Workforce Requirements

By leveraging existing resources, the PRC Operators have had minimal changes in the workforce required to operate this model. As stated in Section 1F, three care coordinators can manage approximately 1,050 admissions annually. For other practices, potential changes will be in the form of hiring or reassigning the duties of existing care coordinators, administrative staff and medical social workers to assist the patient with clinical and logistical needs throughout the episode.

D. Coordination with Parties that Lack Financial Incentives

The fragmentation of clinical providers across a care team is a challenge that providers encounter in existing APMs. The PRC Operators have experience successfully engaging ancillary providers in prior arrangements without those care team members being financially accountable. While Medicare members will have freedom of choice with respect to which providers they can choose in the PRC program, the PRC Operators will use the common practice of establishing preferred provider partners. The New England Journal of Medicine published a case study on how best to succeed in the bundled payment APM and cited the need to establish post-acute care partnerships as a key factor in redesigning care[12].

The PRC model will make beneficiaries aware of provider partners that are preferred due to their ability to deliver high quality care while maintaining excellent patient satisfaction ratings. While these care team members will not share in the savings or losses of the APM, they benefit

from the PRC Operator serving as a referral source, not only for the PRC model, but also for other lines of business due to their ability to meet the PRC Operators service standards. In the event they fail to meet expectations, the ancillary care team members stand to lose the PRC Operators as a referral source.

VIII. Patient Choice

A. Patient Choice Preservation

Patients are offered to participate in the PRC program based upon their ability to meet clinical criteria and pass a home evaluation that ensures the home is suitable for care delivery. Upon passing both screening evaluations, the patient gives informed consent before being admitted to the program. While the care coordinator is available to answer questions about the program, the informed consent is discussed with and secured by the patient's admitting physician. This is the ultimate form of patient choice. In the current Medicare environment, if a patient needs hospital-level care, there is no choice other than to be admitted to an acute care facility.

The patient characteristics and conditions that would prevent a patient from having the ability to participate in this program largely relate to the impact of safety, both for the patient and the caregiver, in the home. The social characteristics that would preclude a patient from participating include: lack of appropriate utilities (electricity, running water, space for equipment) or elements of a dangerous environment (visible firearms or illicit drugs). In addition, for some conditions and co-morbidities, cellular service is necessary for the ability to perform telehealth visits and maintain biometric data tracking through the tablet-based system. As it relates to conditions, there are very few restrictions that would preclude a patient from having the choice to participate in this program. The primary restrictions relate to those patients needing ICU-level care, telemetry, or those that have ESRD and are on hemodialysis. Studies completed to date demonstrate that patient choice is preserved by being able to accommodate individuals with differences in patient characteristics and conditions, as the baseline comparisons of illness-specific comparisons were highly comparable[8, 11].

B. Model Impact on Disparities in Beneficiaries

The PRC Operators do not envision the model having a disproportionate impact on any given sub-group of Medicare beneficiaries, as defined by race, ethnicity, gender, disability or geography. As previously stated, the model is hospital-level care and is thus applicable to a wide variety of disabilities. The model has been previously operated in both urban and rural markets, thus eliminating significant geographical constraints. Patients do need to live within 60 miles of a tertiary or quaternary acute-care facility in the event of a complication. The factors of race, gender or ethnicity should have no impact on the payment model.

C. Model Impact on Diversity of APM Participants

CMS has an expansive reach with respect to the various APMs that have been launched by CMMI. Despite the depth and breadth of existing initiatives, the PRC model has the ability to expand the clinical diversity of existing CMS models. More importantly, existing initiatives require an index admission to an acute care facility to trigger an episodic payment arrangement. The PRC model removes the clinical requirement of having an episode be triggered off a DRG payment. By being able to deliver hospital-level care outside of an acute care facility, the PRC

model would not require a hospital admission to initiate an episode. This approach adds a significant component of diversity to existing APMs.

IX. Patient Safety

The PRC model provides substantial mid-level clinical support to practices through the high touch care coordinators, thus strengthening the transitions between both providers that are part of the care team, as well as sites of care delivery. The largest gaps in care transitions typically occur upon being discharged from an acute care facility. By offering the ability to receive hospital-level care in the home, the PRC model mitigates this potential risk to patients. The level of engagement of the care coordinator, as described in Section 7B, underscores the level of attention that will be dedicated to the patients to ensure patient safety is the highest priority throughout the care experience. In addition, the ability to receive care in the home avoids patient risk of hospital acquired infections and other conditions such as delirium. Finally, we provide a Compliance Hotline number on the Notice of Privacy Practice form that each patient receives, providing a formal process to report issues related to patient safety.

A. Sanctity of Patient Safety

As described in Section 1D, the PRC operators are not only eligible to participate in savings produced, but are also liable for excessive costs of care up until the self-insured retention level of the reinsurance policy is reached. By accepting risk for readmissions / total cost of care, the PRC operators are incented to maximize quality and safety to reduce the chances of a patient adverse event or readmission.

B. Provision of Necessary Care

Savings will not be generated by rationing or limiting care. The model participants will have the opportunity to share savings by achieving a high-quality outcome, while avoiding complications associated with readmissions and adverse events. In order to ensure the necessary care is delivered, the model participants have key performance indicators related to patient engagement that are tracked, as listed in section 2A. Furthermore, the level of clinical engagement with the patient, as described in Section 7B, demonstrates the level of attention given to ensure the care model provides the care necessitated by each patient.

C. Assurance of Model Integrity

Preserving patient safety, while assuring the home hospitalization APM's integrity, centers upon two primary components: 1) appropriately managing care transitions, and 2) avoiding withholding of care throughout the episode. Section 7B demonstrates the level of detail that the PRC Operators place on the care model design. The frequency of engagement by the care coordinators underscores the monitoring that will be dedicated to improve patient safety. A potential unintended behavior that could be created to achieve a financial incentive would likely be withholding care until the conclusion of the 30-day episode. One form of monitoring that could be incorporated would be to measure outcomes for a period of time beyond the 30-day episode, and compare to historical benchmarks. A similar approach is utilized in the BPCI program.

X. Health Information Technology

The incorporation of information technology platforms is essential to successfully scale any Alternative Payment Model, including a home hospitalization program. Despite the PRC Operators' desire to incorporate technology for various aspects of the program, it is not required to successfully operate a home hospitalization program. The PRC Operators have integrated technology to support three primary aspects of the model: 1) claims / utilization analytics, 2) patient management / care coordination, and 3) documentation.

Given the unique nature of the home hospitalization care model, few platforms adequately meet the needs of managing a patient's care needs throughout the entire episode of care. Furthermore, existing EHR platforms are challenged to adequately document encounters across disparate members of a care team. A primary focus by the PRC Operators has been centered upon implementing a workflow tool that will improve the ability to communicate care plans and appropriately document services rendered throughout the continuum of care. Appendix E illustrates the patient management system's portal for managing a panel of patients.

Care coordination is also empowered through the use of a telehealth platform, allowing providers to virtually round on patients and track vital signs from Bluetooth devices. Using telehealth drastically improves both the experience, as patients are able to receive care in the comfort of their homes, and outcomes as care coordinators are tracking vital signs that are leading indicators for adverse events that could result in hospitalizations. Previous studies in telemonitoring have seen 50% reduction in readmissions and 37% fewer ED visits[13].

A. Patient Privacy

With this proposed model, patient privacy would continue to be protected in the same way as the patients' experience in the current Medicare program. The introduction of a care coordinator to a patient would take place through the physician practice, and that care coordinator would not differ in obligations regarding PHI from any other nurse in the practice. Similarly, where infusion or other ancillary services might be provided in the home, the vendors of these services would be Medicare certified. In our current operations, written agreements with any ancillaries include contractual provisions governing the vendors' use of PHI, as well as strict compliance obligations with federal and state laws including patient privacy laws. Where a telehealth tablet is used, a security review of the telehealth vendor is performed, and limitations are put in place to protect the security of patient information.

B. Cost & Quality Transparency

The PRC Operators utilize a proprietary analytics platform, (ContradoReports®), to encourage transparency related to cost and quality as delivered by providers involved in the model. This analytics platform has the ability to identify spend patterns by admitting condition, facility, practice, physician and patient. The platform is able to identify the timing related to when costs are incurred throughout the episode (Pre-admission, acute phase, post-acute phase). By having access to cost information, the Clinical Quality Council can inform participating physicians how best to change practice patterns to eliminate unnecessary variability in care without jeopardizing clinical quality. This platform also improves data sharing amongst the participating providers, providing access to data that is largely difficult to analyze. Appendix D provides screenshots for the various reporting capabilities for the participating providers.

Upon reaching statistical significance, the PRC Operators will share data pertaining to quality of care received and clinical outcomes.

C. EHR Interoperability

While beneficial, interoperability of EHRs is not required to guide better decision making. The PRC Operators have established capabilities of providing documentation through a PDF file referred to as the Continuity of Care Document (the CCD) to the resident EHRs of participating providers during the acute and post-acute phase. The care coordinators are provided read-only access to the provider's EMR, and all orders written by the providers are dispersed to ancillary providers delivering care to the patient in the program. In the event full EHR interoperability was not available, this model supports the electronic sharing of the CCD across the care team to inform clinical decision support and achieve optimal clinical quality outcomes.

D. IT Innovations

As stated above in this section, a combination of proprietary platforms and partner vendors are used to support superior outcomes, an improved consumer experience and efficiency of care delivery.

E. IT Requirement Flexibility

The start of section 10 denotes that, while the model participants have incorporated various IT components into the proposed model, there is no IT required to successfully operate the program. IT simply assists with the successful scaling of a program. It has been documented throughout this proposal that prior attempts at home hospitalization have achieved meaningful clinical success and those programs had limited to no IT elements in their care models. While the PRC Operators have developed many aspects of their IT internally, many options exist for future model participants to select the solution that best fits their respective needs. Options exist for the following: 1) Workflow tools to efficiently manage patients, 2) telehealth and patient engagement tools, and 3) analytics platforms for data sharing, clinical performance and practice patterns in risk arrangements.

XI. Supplemental Information

A. Governance Structure

The PRC Operators' governance is a Board of Directors with representatives from both Marshfield Clinic and Contessa Health. Contessa Health serves as the manager of the entity to manage the day-to-day operations of the home hospitalization program, similar to a physician practice or surgery center management company.

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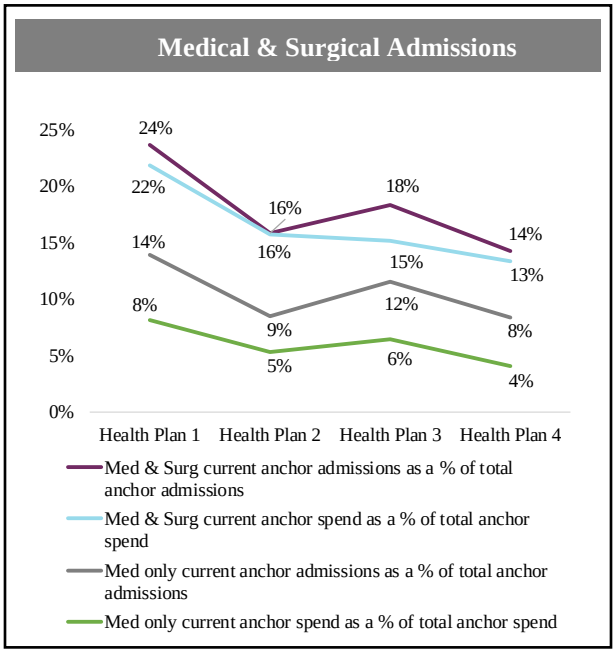
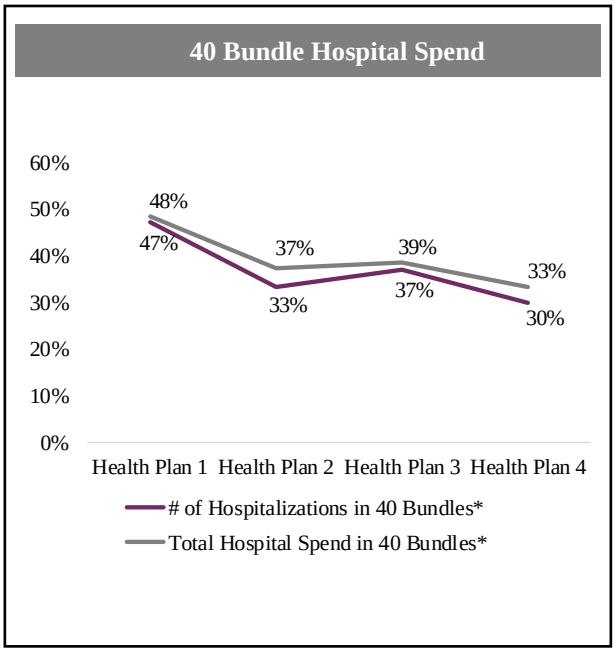
List of Appendices

Appendix A: Addressable Medical Spend

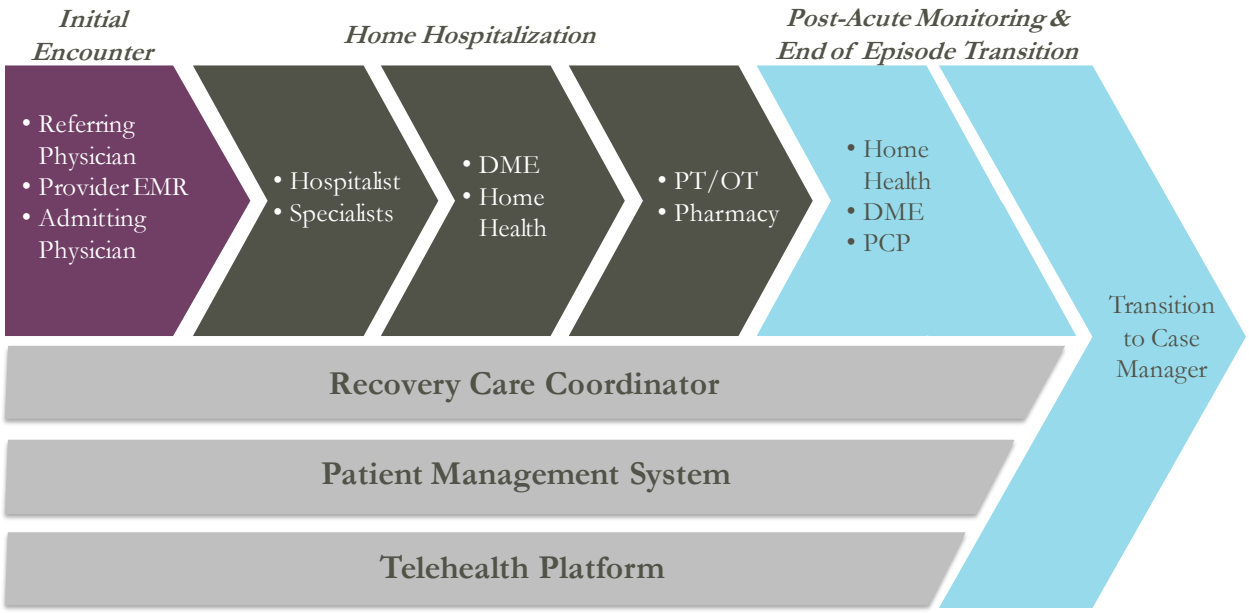




Appendix B: Patient Reported Outcome Metrics[14]

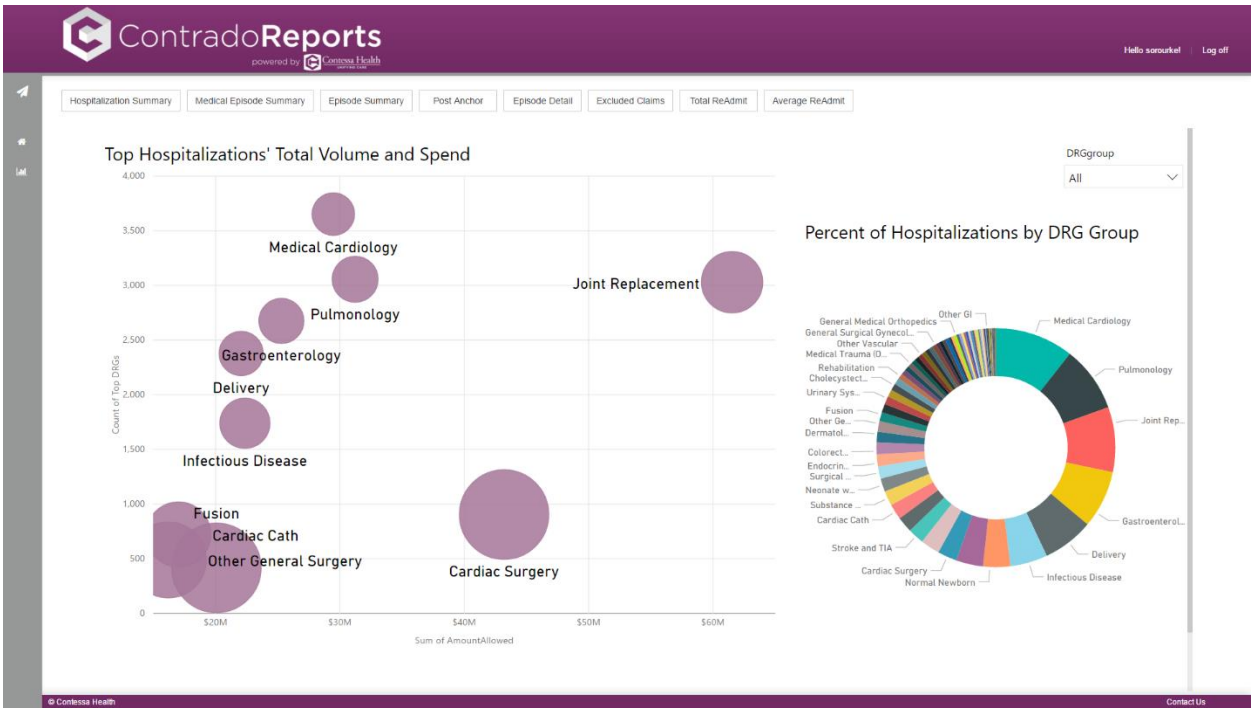
	Please respond to each item by marking <u>one box per row</u>	Excellent	Very good	Good	Fair	Poor
Global 01	In general, would you say your health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 02	In general, would you say your quality of life is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 03	In general, how would you rate your physical health?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 04	In general, how would you rate your mental health, including your mood and your ability to think?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 05	In general, how would you rate your satisfaction with your social activities and relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 09	In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		Completely	**Mostly**	**Moderately**	**A Little**	**Not At All**
Global 06	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
	In the past 7 days	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
Global 10	How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		None	**Mild**	**Moderate**	**Severe**	**Very Severe**
Global 08	How would you rate your fatigue on average?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 07	How would you rate your pain on average?	☐ 0 No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Worst Imaginable Pain				

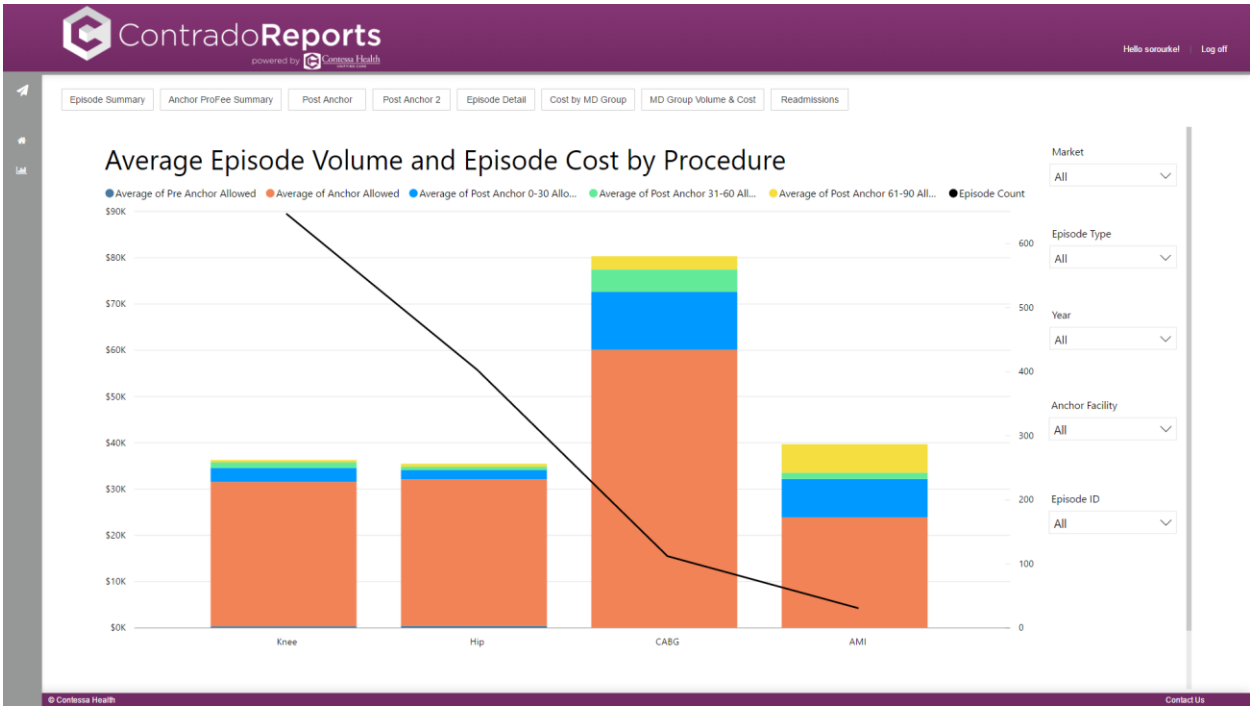
Appendix C: Care Coordinator Patient Involvement

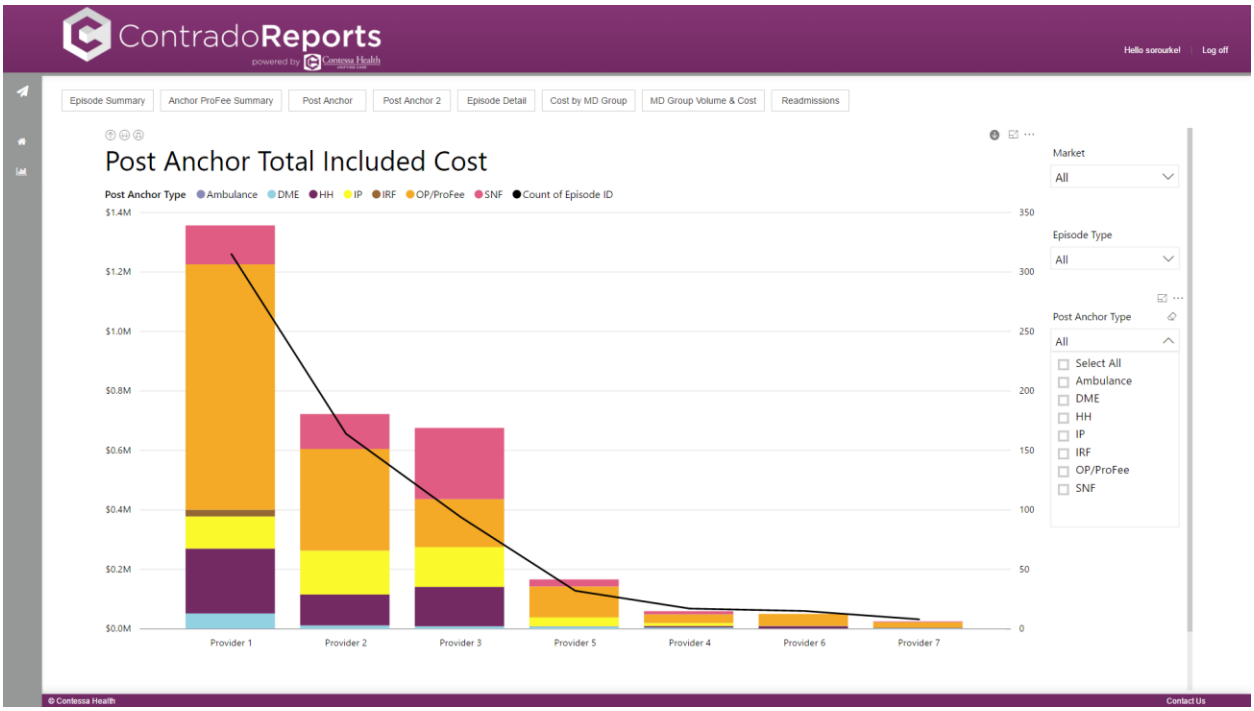


	Time Frame	Key Responsibilities	Average Patient Touch Points
Initial Encounter	1 Day	• Chart Review • Patient Education & Consent • Episode Care Planning • Verify DME & Home Health	1 Encounter *In-person*
Home Hospitalization	1-3 Days	• Patient Education • Round on Patient with Physician • Remote Patient Monitoring • Schedule Follow-Up Appointments	~4-6 Encounters *Telephonic & Remote Patient Monitoring*
Discharge *Acute Recovery*	14 Days 12 Days	• Daily Virtual Patient Rounding For 14 Days • Telehealth Monitoring for Remainder of Episode	~14 Encounters ~7 Encounters *Telephonic & Remote Patient Monitoring*
	30 Days		28+ Total

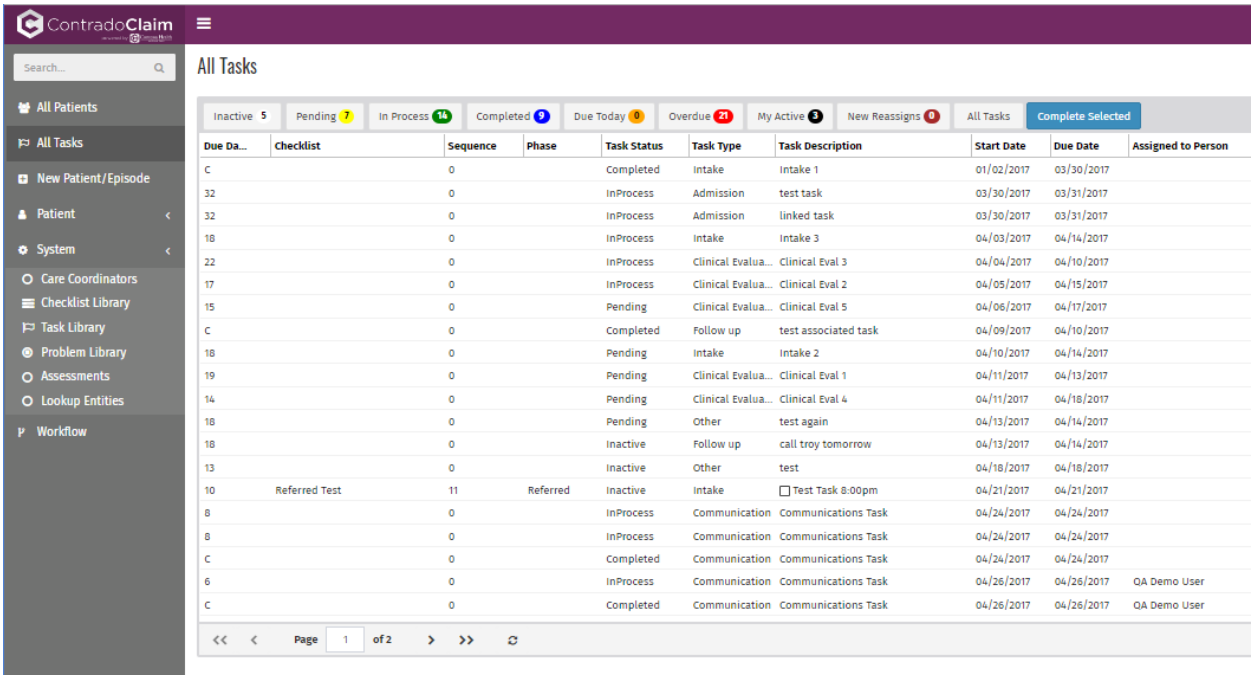
Appendix D: ContradoReports® Screen Shots







Appendix E: Patient Management System Screen Shots



Appendix F: Diagnoses Related Groups

General Medical

CH Bundle	MS-DRG	MS-DRG Description
Aftercare Musculoskeltal	559	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC
Aftercare Musculoskeltal	560	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC
Aftercare Musculoskeltal	561	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC
Allergic Reaction	915	ALLERGIC REACTIONS W MCC
Allergic Reaction	916	ALLERGIC REACTIONS W/O MCC
Asthma	202	BRONCHITIS & ASTHMA W CC/MCC
Asthma	203	BRONCHITIS & ASTHMA W/O CC/MCC
CELLULITIS	602	CELLULITIS W MCC
CELLULITIS	603	CELLULITIS W/O MCC
CHF	291	HEART FAILURE & SHOCK W MCC
CHF	292	HEART FAILURE & SHOCK W CC
CHF	293	HEART FAILURE & SHOCK W/O CC/MCC
Cirrhosis, Alcoholic Hepatits, Hepatitis	432	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC
Cirrhosis, Alcoholic Hepatits, Hepatitis	433	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC
Cirrhosis, Alcoholic Hepatits, Hepatitis	434	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC
Cirrhosis, Alcoholic Hepatits, Hepatitis	441	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC
Cirrhosis, Alcoholic Hepatits, Hepatitis	442	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC
Cirrhosis, Alcoholic Hepatits, Hepatitis	443	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC
Connective Tissue	545	CONNECTIVE TISSUE DISORDERS W MCC
Connective Tissue	546	CONNECTIVE TISSUE DISORDERS W CC
Connective Tissue	547	CONNECTIVE TISSUE DISORDERS W/O CC/MCC
COPD	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC
COPD	191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC
COPD	192	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC
Dehydration	640	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W MCC
Dehydration	641	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC

CH Bundle	MS-DRG	MS-DRG Description
Diabetes	637	DIABETES W MCC
Diabetes	638	DIABETES W CC
Diabetes	639	DIABETES W/O CC/MCC
Disorder of Biliary Tract	444	DISORDERS OF THE BILIARY TRACT W MCC
Disorder of Biliary Tract	445	DISORDERS OF THE BILIARY TRACT W CC
Disorder of Biliary Tract	446	DISORDERS OF THE BILIARY TRACT W/O CC/MCC
Disorders of Pancreas	438	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC
Disorders of Pancreas	439	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC
Disorders of Pancreas	440	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC
DVT/PE	175	PULMONARY EMBOLISM W MCC
DVT/PE	176	PULMONARY EMBOLISM W/O MCC
DVT/PE	294	DEEP VEIN THROMBOPHLEBITIS W CC/MCC
DVT/PE	295	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC
DVT/PE	299	PERIPHERAL VASCULAR DISORDERS W MCC
DVT/PE	300	PERIPHERAL VASCULAR DISORDERS W CC
DVT/PE	301	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC
Endocrinology	642	INBORN AND OTHER DISORDERS OF METABOLISM
Endocrinology	643	ENDOCRINE DISORDERS W MCC
Endocrinology	644	ENDOCRINE DISORDERS W CC
Endocrinology	645	ENDOCRINE DISORDERS W/O CC/MCC
ENT	149	DYSEQUILIBRIUM
ENT	150	EPISTAXIS W MCC
ENT	151	EPISTAXIS W/O MCC
ENT	154	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC
ENT	155	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC
ENT	156	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC
Eye Disorders	121	ACUTE MAJOR EYE INFECTIONS W CC/MCC
Eye Disorders	122	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC
Eye Disorders	123	NEUROLOGICAL EYE DISORDERS
Eye Disorders	124	OTHER DISORDERS OF THE EYE W MCC
Eye Disorders	125	OTHER DISORDERS OF THE EYE W/O MCC
Gastro	368	MAJOR ESOPHAGEAL DISORDERS W MCC
Gastro	369	MAJOR ESOPHAGEAL DISORDERS W CC
Gastro	370	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC

CH Bundle	MS-DRG	MS-DRG Description
Gastro	371	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC
Gastro	372	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC
Gastro	373	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC
Gastro	391	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC
Gastro	392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC
Gastro	393	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC
Gastro	394	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC
Gastro	395	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC
GenMedOrtho	564	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC
GenMedOrtho	565	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC
GenMedOrtho	566	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC
Headache	102	HEADACHES W MCC
Headache	103	HEADACHES W/O MCC
HTN	304	HYPERTENSION W MCC
HTN	305	HYPERTENSION W/O MCC
IBD	385	INFLAMMATORY BOWEL DISEASE W MCC
IBD	386	INFLAMMATORY BOWEL DISEASE W CC
IBD	387	INFLAMMATORY BOWEL DISEASE W/O CC/MCC
infection	864	FEVER
infection	867	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC
infection	868	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC
infection	869	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC
Injuries Hip, Pelvis and Thigh	535	FRACTURES OF HIP & PELVIS W MCC
Injuries Hip, Pelvis and Thigh	536	FRACTURES OF HIP & PELVIS W/O MCC
Injuries Hip, Pelvis and Thigh	537	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC
Injuries Hip, Pelvis and Thigh	538	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC
Med Spine	551	MEDICAL BACK PROBLEMS W MCC
Med Spine	552	MEDICAL BACK PROBLEMS W/O MCC
MedCard	314	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC

CH Bundle	MS-DRG	MS-DRG Description
MedCard	315	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC
Musculoskeletal	553	BONE DISEASES & ARTHROPATHIES W MCC
Musculoskeletal	554	BONE DISEASES & ARTHROPATHIES W/O MCC
Musculoskeletal	555	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC
Musculoskeletal	556	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC
Nerve Disorders	73	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC
Nerve Disorders	74	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC
Nervous System	56	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC
Nervous System	57	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC
Osteomyelitis	539	OSTEOMYELITIS W MCC
Osteomyelitis	540	OSTEOMYELITIS W CC
Osteomyelitis	541	OSTEOMYELITIS W/O CC/MCC
Other FX, SPRN Strains	562	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC
Other FX, SPRN Strains	563	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC
Other GenMed	600	NON-MALIGNANT BREAST DISORDERS W CC/MCC
Other GenMed	601	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC
Other GenMed	919	COMPLICATIONS OF TREATMENT W MCC
Other GenMed	920	COMPLICATIONS OF TREATMENT W CC
Other GenMed	921	COMPLICATIONS OF TREATMENT W/O CC/MCC
Other GenMed	947	SIGNS & SYMPTOMS W MCC
Other GenMed	948	SIGNS & SYMPTOMS W/O MCC
Other GenMed	949	AFTERCARE W CC/MCC
Other GenMed	950	AFTERCARE W/O CC/MCC
Other Neuro	91	OTHER DISORDERS OF NERVOUS SYSTEM W MCC
Other Neuro	92	OTHER DISORDERS OF NERVOUS SYSTEM W CC
Other Neuro	93	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC
Peptic Ucler	380	COMPLICATED PEPTIC ULCER W MCC
Peptic Ucler	381	COMPLICATED PEPTIC ULCER W CC
Peptic Ucler	382	COMPLICATED PEPTIC ULCER W/O CC/MCC
Peptic Ucler	383	UNCOMPLICATED PEPTIC ULCER W MCC
Peptic Ucler	384	UNCOMPLICATED PEPTIC ULCER W/O MCC
Pleural Effusion	186	PLEURAL EFFUSION W MCC
Pleural Effusion	187	PLEURAL EFFUSION W CC
Pleural Effusion	188	PLEURAL EFFUSION W/O CC/MCC

CH Bundle	MS-DRG	MS-DRG Description
Pleural Effusion	189	PULMONARY EDEMA & RESPIRATORY FAILURE
Pneumonia	177	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC
Pneumonia	178	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC
Pneumonia	179	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC
Pneumonia	193	SIMPLE PNEUMONIA & PLEURISY W MCC
Pneumonia	194	SIMPLE PNEUMONIA & PLEURISY W CC
Pneumonia	195	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC
Renal Failure	682	RENAL FAILURE W MCC
Renal Failure	683	RENAL FAILURE W CC
Renal Failure	684	RENAL FAILURE W/O CC/MCC
Respiratory	196	INTERSTITIAL LUNG DISEASE W MCC
Respiratory	197	INTERSTITIAL LUNG DISEASE W CC
Respiratory	198	INTERSTITIAL LUNG DISEASE W/O CC/MCC
Respiratory	204	RESPIRATORY SIGNS & SYMPTOMS
Respiratory	205	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC
Respiratory	206	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC
Skin Ulcer	592	SKIN ULCERS W MCC
Skin Ulcer	593	SKIN ULCERS W CC
Skin Ulcer	594	SKIN ULCERS W/O CC/MCC
Stroke w/o infarction	67	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC
Stroke w/o infarction	68	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC
Stroke w/o infarction	69	TRANSIENT ISCHEMIA
Syncope	312	SYNCOPE & COLLAPSE
Syncope	316	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC
Tendonitis, myosistis &Bursitis	557	TENDONITIS, MYOSITIS & BURSITIS W MCC
Tendonitis, myosistis &Bursitis	558	TENDONITIS, MYOSITIS & BURSITIS W/O MCC
URI	152	OTITIS MEDIA & URI W MCC
URI	153	OTITIS MEDIA & URI W/O MCC
Urinary Stones	691	URINARY STONES W ESW LITHOTRIPSY W CC/MCC
Urinary Stones	692	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC
Urinary Stones	693	URINARY STONES W/O ESW LITHOTRIPSY W MCC
Urinary Stones	694	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC
UTI	689	KIDNEY & URINARY TRACT INFECTIONS W MCC
UTI	690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC

CH Bundle	MS-DRG	MS-DRG Description
UTI	695	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC
UTI	696	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC
UTI	698	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC
UTI	699	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC
UTI	700	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC
Viral Ilness	865	VIRAL ILLNESS W MCC
Viral Ilness	866	VIRAL ILLNESS W/O MCC

Appendix G: Diagnosis Related Groups Mapped to BPCI DRGs

CH Bundle	MS-DRG	MS-DRG Description	BPCI Bundle	Closest BPCI Bundle
Aftercare Musculoskeltal	559	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	Aftercare MSK	
Aftercare Musculoskeltal	560	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	Aftercare MSK	
Aftercare Musculoskeltal	561	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	Aftercare MSK	
Allergic Reaction	915	ALLERGIC REACTIONS W MCC		Cellulitis
Allergic Reaction	916	ALLERGIC REACTIONS W/O MCC		Cellulitis
Asthma	202	BRONCHITIS & ASTHMA W CC/MCC	Asthma	
Asthma	203	BRONCHITIS & ASTHMA W/O CC/MCC	Asthma	
CELLULITIS	602	CELLULITIS W MCC	Cellulitis	
CELLULITIS	603	CELLULITIS W/O MCC	Cellulitis	
CHF	291	HEART FAILURE & SHOCK W MCC	CHF	
CHF	292	HEART FAILURE & SHOCK W CC	CHF	
CHF	293	HEART FAILURE & SHOCK W/O CC/MCC	CHF	
Cirrhosis, Alcoholic Hepatits, Hepatitis	432	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC		Nutrition
Cirrhosis, Alcoholic Hepatits, Hepatitis	433	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC		Nutrition
Cirrhosis, Alcoholic Hepatits, Hepatitis	434	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC		Nutrition
Cirrhosis, Alcoholic Hepatits, Hepatitis	441	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC		Nutrition
Cirrhosis, Alcoholic Hepatits, Hepatitis	442	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC		Nutrition
Cirrhosis, Alcoholic Hepatits, Hepatitis	443	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC		Nutrition
Connective Tissue	545	CONNECTIVE TISSUE DISORDERS W MCC		Signs & Symp MSK

CH Bundle	MS-DRG	MS-DRG Description	BPCI Bundle	Closest BPCI Bundle
Connective Tissue	546	CONNECTIVE TISSUE DISORDERS W CC		Signs & Symp MSK
Connective Tissue	547	CONNECTIVE TISSUE DISORDERS W/O CC/MCC		Signs & Symp MSK
COPD	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	COPD	
COPD	191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	COPD	
COPD	192	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	COPD	
Dehydration	640	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W MCC	Nutrition	
Dehydration	641	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	Nutrition	
Diabetes	637	DIABETES W MCC	Diabetes	
Diabetes	638	DIABETES W CC	Diabetes	
Diabetes	639	DIABETES W/O CC/MCC	Diabetes	
Disorder of Biliary Tract	444	DISORDERS OF THE BILIARY TRACT W MCC		Esoph, Gastro, & Misc Digest
Disorder of Biliary Tract	445	DISORDERS OF THE BILIARY TRACT W CC		Esoph, Gastro, & Misc Digest
Disorder of Biliary Tract	446	DISORDERS OF THE BILIARY TRACT W/O CC/MCC		Esoph, Gastro, & Misc Digest
Disorders of Pancreas	438	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC		Esoph, Gastro, & Misc Digest
Disorders of Pancreas	439	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC		Esoph, Gastro, & Misc Digest
Disorders of Pancreas	440	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC		Esoph, Gastro, & Misc Digest
DVT/PE	175	PULMONARY EMBOLISM W MCC		DVTPE
DVT/PE	176	PULMONARY EMBOLISM W/O MCC		DVTPE
DVT/PE	294	DEEP VEIN THROMBOPHLEBITIS W CC/MCC		DVTPE
DVT/PE	295	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC		DVTPE
DVT/PE	299	PERIPHERAL VASCULAR DISORDERS W MCC	DVTPE	
DVT/PE	300	PERIPHERAL VASCULAR DISORDERS W CC	DVTPE	
DVT/PE	301	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	DVTPE	
Endocrinology	642	INBORN AND OTHER DISORDERS OF METABOLISM		Diabetes
Endocrinology	643	ENDOCRINE DISORDERS W MCC		Diabetes
Endocrinology	644	ENDOCRINE DISORDERS W CC		Diabetes
Endocrinology	645	ENDOCRINE DISORDERS W/O CC/MCC		Diabetes
ENT	149	DYSEQUILIBRIUM		Other Respir

CH Bundle	MS-DRG	MS-DRG Description	BPCI Bundle	Closest BPCI Bundle
ENT	150	EPISTAXIS W MCC		Other Respir
ENT	151	EPISTAXIS W/O MCC		Other Respir
ENT	154	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC		Other Respir
ENT	155	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC		Other Respir
ENT	156	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC		Other Respir
Eye Disorders	121	ACUTE MAJOR EYE INFECTIONS W CC/MCC		Other Respir
Eye Disorders	122	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC		Other Respir
Eye Disorders	123	NEUROLOGICAL EYE DISORDERS		Other Respir
Eye Disorders	124	OTHER DISORDERS OF THE EYE W MCC		Other Respir
Eye Disorders	125	OTHER DISORDERS OF THE EYE W/O MCC		Other Respir
Gastro	368	MAJOR ESOPHAGEAL DISORDERS W MCC		Esoph, Gastro, & Misc Digest
Gastro	369	MAJOR ESOPHAGEAL DISORDERS W CC		Esoph, Gastro, & Misc Digest
Gastro	370	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC		Esoph, Gastro, & Misc Digest
Gastro	371	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC		Esoph, Gastro, & Misc Digest
Gastro	372	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC		Esoph, Gastro, & Misc Digest
Gastro	373	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC		Esoph, Gastro, & Misc Digest
Gastro	391	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	Esoph, Gastro, & Misc Digest	
Gastro	392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	Esoph, Gastro, & Misc Digest	
Gastro	393	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC		Esoph, Gastro, & Misc Digest
Gastro	394	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC		Esoph, Gastro, &

CH Bundle	MS-DRG	MS-DRG Description	BPCI Bundle	Closest BPCI Bundle
Gastro	395	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC		Misc Digest
GenMedOrtho	564	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC		Esoph, Gastro, & Misc Digest
GenMedOrtho	565	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC		Signs & Symp MSK
GenMedOrtho	566	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC		Signs & Symp MSK
Headache	102	HEADACHES W MCC		Signs & Symp MSK
Headache	103	HEADACHES W/O MCC		Syncope & Collapse
HTN	304	HYPERTENSION W MCC		Syncope & Collapse
HTN	305	HYPERTENSION W/O MCC		CHF
IBD	385	INFLAMMATORY BOWEL DISEASE W MCC		CHF
IBD	386	INFLAMMATORY BOWEL DISEASE W CC		Esoph, Gastro, & Misc Digest
IBD	387	INFLAMMATORY BOWEL DISEASE W/O CC/MCC		Esoph, Gastro, & Misc Digest
infection	864	FEVER		Esoph, Gastro, & Misc Digest
infection	867	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC		Cellulitis
infection	868	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC		UTI
infection	869	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC		UTI
Injuries Hip, Pelvis and Thigh	535	FRACTURES OF HIP & PELVIS W MCC	Fractures of hip/pelvis	UTI
Injuries Hip, Pelvis and Thigh	536	FRACTURES OF HIP & PELVIS W/O MCC	Fractures of hip/pelvis	
Injuries Hip, Pelvis and Thigh	537	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	Sprains	
Injuries Hip, Pelvis and Thigh	538	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	Sprains	
Med Spine	551	MEDICAL BACK PROBLEMS W MCC	Medical Back	
Med Spine	552	MEDICAL BACK PROBLEMS W/O MCC	Medical Back	
Musculoskeletal	553	BONE DISEASES & ARTHROPATHIES W MCC	Bone Disease	
Musculoskeletal	554	BONE DISEASES & ARTHROPATHIES W/O MCC	Bone Disease	

CH Bundle	MS-DRG	MS-DRG Description	BPCI Bundle	Closest BPCI Bundle
Musculoskeletal	555	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC	Signs & Symp MSK	
Musculoskeletal	556	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	Signs & Symp MSK	
Nerve Disorders	73	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC		Transient ischemia
Nerve Disorders	74	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC		Transient ischemia
Nervous System	56	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC		Transient ischemia
Nervous System	57	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC		Transient ischemia
Osteomyelitis	539	OSTEOMYELITIS W MCC		Cellulitis
Osteomyelitis	540	OSTEOMYELITIS W CC		Cellulitis
Osteomyelitis	541	OSTEOMYELITIS W/O CC/MCC		Cellulitis
Other FX, SPRN Strains	562	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	Fractures	
Other FX, SPRN Strains	563	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	Fractures	
Signs & Symptoms	947	SIGNS & SYMPTOMS W MCC		Syncope & Collapse
Signs & Symptoms	948	SIGNS & SYMPTOMS W/O MCC		Syncope & Collapse
Other Neuro	91	OTHER DISORDERS OF NERVOUS SYSTEM W MCC		Transient ischemia
Other Neuro	92	OTHER DISORDERS OF NERVOUS SYSTEM W CC		Transient ischemia
Other Neuro	93	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC		Transient ischemia
Peptic Ucler	380	COMPLICATED PEPTIC ULCER W MCC		Esoph, Gastro, & Misc Digest
Peptic Ucler	381	COMPLICATED PEPTIC ULCER W CC		Esoph, Gastro, & Misc Digest
Peptic Ucler	382	COMPLICATED PEPTIC ULCER W/O CC/MCC		Esoph, Gastro, & Misc Digest
Peptic Ucler	383	UNCOMPLICATED PEPTIC ULCER W MCC		Esoph, Gastro, & Misc Digest
Peptic Ucler	384	UNCOMPLICATED PEPTIC ULCER W/O MCC		Esoph, Gastro, & Misc Digest
Pleural Effusion	186	PLEURAL EFFUSION W MCC	Plural Effusion	
Pleural Effusion	187	PLEURAL EFFUSION W CC	Plural Effusion	
Pleural Effusion	188	PLEURAL EFFUSION W/O CC/MCC	Plural Effusion	

CH Bundle	MS-DRG	MS-DRG Description	BPCI Bundle	Closest BPCI Bundle
Pleural Effusion	189	PULMONARY EDEMA & RESPIRATORY FAILURE		Pleural Effusion
Pneumonia	177	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	Pneumonia	
Pneumonia	178	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	Pneumonia	
Pneumonia	179	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	Pneumonia	
Pneumonia	193	SIMPLE PNEUMONIA & PLEURISY W MCC	Pneumonia	
Pneumonia	194	SIMPLE PNEUMONIA & PLEURISY W CC	Pneumonia	
Pneumonia	195	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	Pneumonia	
Renal Failure	682	RENAL FAILURE W MCC	Renal Failure	
Renal Failure	683	RENAL FAILURE W CC	Renal Failure	
Renal Failure	684	RENAL FAILURE W/O CC/MCC	Renal Failure	
Respiratory	196	INTERSTITIAL LUNG DISEASE W MCC		Pleural Effusion
Respiratory	197	INTERSTITIAL LUNG DISEASE W CC		Pleural Effusion
Respiratory	198	INTERSTITIAL LUNG DISEASE W/O CC/MCC		Pleural Effusion
Respiratory	204	RESPIRATORY SIGNS & SYMPTOMS	Respiratory signs	
Respiratory	205	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	Other Respir	
Respiratory	206	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	Other Respir	
Skin Ulcer	592	SKIN ULCERS W MCC		Cellulitis
Skin Ulcer	593	SKIN ULCERS W CC		Cellulitis
Skin Ulcer	594	SKIN ULCERS W/O CC/MCC		Cellulitis
Stroke w/o infarction	67	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC		TIA
Stroke w/o infarction	68	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC		TIA
Stroke w/o infarction	69	TRANSIENT ISCHEMIA	TIA	
Syncope	312	SYNCOPE & COLLAPSE	Syncope & Collapse	
Tendonitis, myosistis &Bursitis	557	TENDONITIS, MYOSITIS & BURSITIS W MCC	Tendonitis	
Tendonitis, myosistis &Bursitis	558	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	Tendonitis	
URI	152	OTITIS MEDIA & URI W MCC		Other Respir
URI	153	OTITIS MEDIA & URI W/O MCC		Other Respir
Urinary Stones	691	URINARY STONES W ESW LITHOTRIPSY W CC/MCC		UTI
Urinary Stones	692	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC		UTI
Urinary Stones	693	URINARY STONES W/O ESW LITHOTRIPSY W MCC		UTI
Urinary Stones	694	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC		UTI
UTI	689	KIDNEY & URINARY TRACT INFECTIONS W MCC	UTI	
UTI	690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	UTI	

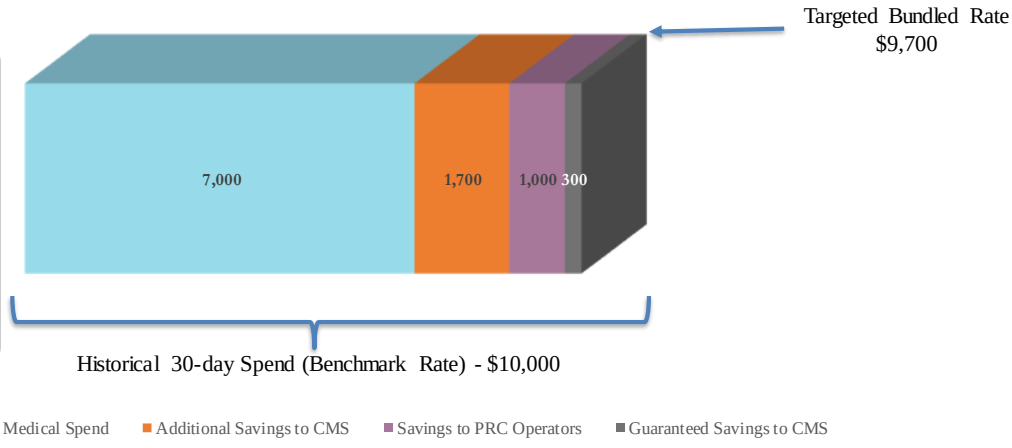
CH Bundle	MS-DRG	MS-DRG Description	BPCI Bundle	Closest BPCI Bundle
UTI	695	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC		UTI
UTI	696	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC		UTI
UTI	698	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC		UTI
UTI	699	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC		UTI
UTI	700	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC		UTI
Viral Ilness	865	VIRAL ILLNESS W MCC		Other Respir
Viral Ilness	866	VIRAL ILLNESS W/O MCC		Other Respir

Appendix H: Payment Methodology Illustration

Assumptions

- Benchmark Rate: $10,000 (30 Day total-included medical spend)
- Targeted Bundled Rate: $9,700 (3% discount to Benchmark Rate)
- Historical DRG Payment: $5,000
- Home Hospital Payment: $3,500 (70% of Historical DRG)

Example
Total Included Medical Spend of $7,000 (incl. Home Hospital Payment)



Appendix I: Letters of Support

Icahn School of Medicine at Mount Sinai

Brookdale Department of Geriatrics and Palliative Medicine

The Mount Sinai Hospital
One Gustave L. Levy Place, Box 1070
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October 13, 2017

Dr. Narayana S. Murali
President/Chief Executive Officer, Marshfield Clinic
Marshfield, Wisconsin

RE: Letter of support for "Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home" proposal as a physician-focused payment model

Dear Dr. Murali:

On behalf of the Icahn School of Medicine at Mount Sinai, I submit this letter in support of Personalized Recovery Care, LLC's request to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to recommend its proposal entitled "Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home" (PRC). PRC is a variant of the Hospital at Home model that we and others have tested and shown to be effective in improving outcomes and reducing costs. As such, we believe that PRC complements our Hospital at Home-Plus (HaH-Plus) proposal that the PTAC reviewed in September 2017.

As you are aware, we received PTAC's recommendation of implementation for our Hospital at Home Plus (HaH-Plus) model. In your PRC proposal, we see significant similarities and small differences in both the clinical and payment models. Both clinical models include integration of multiple care providers including PCPs, high touch care coordination and a focus on patient safety and continuity of care, all designed to improve patient experience and clinical outcomes. The two clinical models differ primarily in how physicians are engaged in the model because the PRC model is organized to deliver such care by smaller physician practices that would have difficulty supporting the team and service arrangements provided in HaH-Plus. PRC thereby complements HaH-Plus and could potentially extend Hospital at Home services to an even larger population.

Reimbursement for acute at home care historically represented the biggest hurdle in scaling the clinical model. Our proposals are similar in contemplating a 30 day payment bundle that includes shared savings based on quality metrics and cost reduction to Medicare. The HaH-Plus program sets payment as 95% of the sum of the expected professional services and DRG payment incurred if the patient was admitted as an inpatient, with that payment covering all HaH-Plus services required during the 30 days. However, the PRC program sets the payment as 70% of the DRG payment only; with this payment covering the nursing, social work and care management of the patient. Under the PRC, all other medical services required by a patient (physician services, infusion, DME, labs, etc.) would be billed directly to Medicare under traditional fee for service, making the PRC proposal potentially more accessible for small independent practices that might not desire having to manage additional staff or ancillary services.

Thus, the two proposals differ in the amount of initial payment but also in what is covered by those payments. After these other medical services are included, the initial payment cost to Medicare is more similar than different in the two proposals. All claims incurred during the 30 days plus the 70% payment would be reconciled against a historical benchmark in a similar manner to our proposal, with a guaranteed 3% savings off the historical baseline.

Improving quality of care and patient experience by providing hospital level care in the comfort of the patient's home while implementing reimbursement that reduces costs epitomizes the type of innovation the PTAC has requested. We remain committed to our HaH-plus program and hope to see it move into the next phase of implementation. The proposed PRC clinical and payment model is sufficiently different, yet complementary to the HaH-Plus model. HaH plus was proposed with the flexibility to accommodate varying organizational arrangements. Indeed, depending on the final rules and structure, the proposed PRC payment model is sufficiently similar to the HaH-Plus payment model that it could be implemented as a variation on the original HaH-Plus payment model if the APM entity contracted nonphysician services to an outside entity as described in the PRC clinical model. We advocate that the process for consideration of the HaH Plus model be separated from the process for consideration of the PRC proposal because they are proposed to serve different types of providers. We support the PRC proposal in that it will complement that HaH-Plus proposal and extend Hospital at Home services to an expanded group of beneficiaries.

Respectfully submitted,

Albert L. Siu, M.D., M.S.P.H.
Professor and Chairman Emeritus
Director, Center for Home-based Innovations in Healthcare

Linda V. DeCherrie, MD
Clinical Director, Mobile Acute Care Team (MACT)
Director, Mount Sinai Visiting Doctors & Chelsea-Village House Call Programs

amedisys

October 11, 2017

Physician-Focused Payment Model Technical Advisory Committee
C/O U.S. DHHS Asst. Sec. of Planning and Evaluation Office on Health Policy
200 Independence Ave S.W
Washington, DC 20201
PTAC@hhs.gov

Letter of Support to PTAC for Physician-Focused Payment Model (PFPM) for Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home

Dear Committee Members,

We are pleased to be writing on behalf of Amedisys Inc. (Amedisys), one of the nation's leading Home Health, Hospice and Personal Care providers, to strongly express our support for the Home Hospitalization model. Amedisys, and our nearly 17,000 associates across the nation, is dedicated to providing our patients with clinically distinct care, wherever they call home.

As a company that has a long history in Home Health and Hospice, and a familiarity with models similar to Home Hospitalization, we have a unique understanding of just how impactful this model can be. The true benefit of this model can be fully realized if this type of care is extended and offered to all eligible Medicare beneficiaries. The model has proven to be extremely cost-effective and most importantly focuses on the patient, driving positive outcomes, all while caring for patients in where they want to be: their homes. Other aspects of the model we are fully supportive of include:

- The patient centered construct of the Home Hospitalization model – providing hospital level care, in their homes, with impressive outcomes and an improvement in patient safety
- Aligns and coordinates interdisciplinary, integrated, mobile care providers
- Deploys an innovate approach to bundled payments – DRG based bundles
- Reduces total costs to the system
- Keeps patients safely at home

We the leadership team of Amedisys are happy to answer any questions the Committee may have and greatly appreciate the opportunity to express our support for this truly innovative model.

Kind Regards,

Paul Kusserow
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