

PHYSICIAN-FOCUSED PAYMENT MODEL
TECHNICAL ADVISORY COMMITTEE

PUBLIC MEETING

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

Monday, April 10, 2017
1:01 p.m.

COMMITTEE MEMBERS PRESENT:

JEFFREY BAILET, MD, Chair
ELIZABETH MITCHELL, Vice Chair

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

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P R O C E E D I N G S

[1:01 p.m.]

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3 CHAIR BAILET: Welcome. We are going to go ahead
4 and get started. I have some opening remarks, and I'll
5 turn it over to my Vice Chair, Elizabeth, and then we'll
6 open up to the Committee members to make some opening
7 remarks. And then I'll take you through our process for
8 today, and then we'll get into the meat of our meeting.

9 I'm Jeff Bailet, Dr. Jeff Bailet. I'm the Chair
10 of the PTAC. I want to welcome everyone for joining us
11 today, and there are a number of folks on the phone as
12 well.

13 This is our April meeting for the Physician-
14 Focused Payment Model Technical Advisory Committee, or
15 PTAC. We're delighted to have you all here.

16 As you know, this is our first meeting that will
17 include deliberations and voting on Medicare physician-
18 focused payment models submitted by members of the public.
19 We would like to thank you all for your interest in today's
20 meeting. In particular, thank you to the stakeholders that
21 have submitted models, especially those that are here
22 today. Your hard work and dedication to payment reform is
23 truly appreciated.

24 We have spent the past year establishing our

1 processes and procedures for receiving and reviewing
2 physician-focused payment models. We want to stress that
3 our process is shaped by the input from stakeholders.
4 Although we will begin deliberating and voting on proposals
5 today, we are committed to listening to your feedback and
6 evaluating our processes accordingly. We value your
7 comments at every level, especially as they relate to our
8 receipt and review of proposals.

9 We also want to remind you that the PTAC is a
10 Committee of 11 members, not a Committee of one. To the
11 extent that questions may arise in the process as we
12 consider your proposal, please reach out to staff through
13 the PTAC.gov mailbox. The staff will work with me as Chair
14 and with Elizabeth as Vice Chair to answer your questions.
15 In the interest of consistency, in responding to submitters
16 and members of the public, please reach out to us through
17 this process that we have in place.

18 Today we will be deliberating on one proposal,
19 and tomorrow we will deliberate on two proposals.
20 Discussion of each proposal will begin with presentations
21 from our preliminary review teams, or PRTs. The PRT
22 reports are reports from three PTAC members to the full
23 PTAC and do not represent the consensus or position of the
24 PTAC. PTAC reports are not binding. PTAC may reach

1 different conclusions and a different recommendation from
2 that contained in the PRT report.

3 And, finally, the PRT report is not a report to
4 the Secretary of Health and Human Services. PTAC will
5 write a new report that reflects deliberations and
6 decisions of the full PTAC, which will then be sent to the
7 Secretary.

8 Following the PRT presentation and some initial
9 questions from PTAC members, the Committee looks forward to
10 hearing comments from both the proposal submitter and the
11 public. The Committee will then deliberate and vote on
12 recommendations to the Secretary of Health and Human
13 Services.

14 Our job is to provide the best possible
15 recommendations to the Secretary, and we are excited to
16 begin this process.

17 So I want to turn it over to Elizabeth for
18 additional comments.

19 VICE CHAIR MITCHELL: Thank you, Jeff. I will be
20 brief.

21 I also wanted to thank everyone for being here.
22 Thank you for your interest and for the proposals that we
23 have received and just the commitment, I think, that we all
24 share to the promise of payment reform, which is better

1 care at lower cost. So that's why we're all here.

2 And I want to reiterate our commitment to a
3 transparent and inclusive process. We hope to get to yes.
4 We would like to include as many models as is appropriate
5 in the CMS portfolio, and we are looking for ideas from the
6 field. That is why we are here, to find those good ideas
7 and to help create opportunities to participate.

8 So we have a committed group, and as Jeff said,
9 we have spent about a year coming up with a process that we
10 hope is fair and open, and we invite your feedback on the
11 process and on the content.

12 So thank you again for being here, and we'll turn
13 it to the Committee.

14 CHAIR BAILET: Any of our Committee members have
15 any opening remarks they'd like to make before we get
16 started?

17 [No response.]

18 CHAIR BAILET: All right. So we have an eight-
19 step process in deliberating and voting today. We will
20 start with a summary of the deliberating and voting process
21 for the public. We will disclose the potential conflicts
22 of interest and threats to impartiality among our Committee
23 members. Then we will have a presentation by the proposal
24 review team, and that will go obviously to the full PTAC.

1 Then statements of the submitters, we have the
2 submitters present, also public comments. We have some
3 people who are signed up to make public comments. And then
4 the Committee will start deliberating and voting on each
5 criterion, and the Committee will ultimately end voting on
6 the recommendation, the final recommendation to the
7 Secretary. And then we will work with staff today to try
8 and lay out the framework to capture the deliberation and
9 the recommendation.

10 So unless there are other questions from the
11 Committee, we're going to go ahead and start our process by
12 introducing ourselves and including in that introduction
13 any areas of conflict or new potential areas of
14 impartiality. We as each individual Committee member will
15 do that now and then proceed.

16 So I will start with myself: Jeff Bailet. I'm
17 an otolaryngologist. When I was appointed to the PTAC, I
18 was the president of Aurora Health Care Medical Group in
19 Wisconsin. Since January, I have taken the position as
20 executive vice president of health care quality and
21 affordability with Blue Shield of California, so that is a
22 new disclosure. The Committee is aware, the Secretary is
23 aware, but I feel the need to disclose that today.

24 I'll turn it over to Elizabeth.

1 VICE CHAIR MITCHELL: Thank you. Elizabeth
2 Mitchell. I'm the president and CEO of the Network for
3 Regional Health Care Improvement, and I have nothing to
4 disclose.

5 DR. FERRIS: Tim Ferris. I'm a primary care
6 physician, internist, and pediatrician at Mass. General
7 Hospital in Boston and Partners Health Care in Boston, and
8 I have nothing to disclose with regard to this proposal.

9 DR. PATEL: Hi. Kavita Patel. I'm an internist
10 at Hopkins, Johns Hopkins, and also a fellow at the
11 Brookings Institution. And I disclosed on our disclosure
12 form and just verbally that I have heard the proposal
13 that's being discussed presented at meetings in the past.

14 DR. BERENSON: I'm Bob Berenson. I'm a fellow at
15 the Urban Institute, a former practicing general internist,
16 and I have nothing to disclose regarding the proposal.

17 DR. CASALE: Paul Casale, a cardiologist. I lead
18 the ACO at New York Presbyterian-Columbia-Weill Cornell,
19 and I have no disclosures.

20 MR. MILLER: I'm Harold Miller. I'm the
21 president and CEO of the Center for Health Care Quality and
22 Payment Reform. With respect to the proposal that we're
23 hearing from today, I know Dr. Kosinski, who is the
24 developer of the proposal, professionally not personally.

1 I know him because several years ago someone told me that
2 there was a physician out in Illinois who actually had an
3 alternative payment model with a private health plan, and
4 that was such an unusual thing to hear about at that point
5 that I went looking to find out who that was and came
6 across Dr. Kosinski. And I have invited him to come and
7 speak at some conferences about what he is doing, but I
8 have had no involvement in the proposal that he is
9 presenting today in any fashion, nor will I benefit from it
10 in any way.

11 I have also been involved with helping a number
12 of other medical specialty societies develop alternative
13 payment models, but there is no conflict that I can see
14 between any of that work and the proposal that is here
15 today. So I've told my colleagues that I don't believe
16 that I have any conflict of interest or lack of
17 impartiality with respect to this.

18 DR. NICHOLS: My name is Len Nichols. I'm a
19 health economist from George Mason University, and I have
20 no conflicts with respect to the proposal today.

21 DR. TERRELL: My name is Grace Terrell. I'm a
22 practicing general internist at Cornerstone Health Care, a
23 multispecialty medical practice. I'm on the board of
24 CHESS, which is a population health management company, and

1 I have just transitioned to the role of chief executive
2 officer of Envision Genomics, which is a biotechnology
3 company. I have no conflicts to disclose today.

4 MR. STEINWALD: I'm Bruce Steinwald. I'm an
5 independent consultant in Medicare and health care
6 financing issues here in Washington, DC. I have nothing to
7 disclose on this proposal.

8 CHAIR BAILET: Thank you.

9 We are going to go ahead and start with Dr. Paul
10 Casale, who will present the PRT report on Project Sonar.

11 DR. CASALE: Great. Thank you, Jeff.

12 Before I start with the actual presentation, just
13 to provide some overview. So the PRTs, as has already been
14 outlined, are composed of three members of the Committee
15 and a lead is identified within the team. The proposal
16 overview and summary of the PRT review are the next steps
17 in our presentation, followed by key issues identified by
18 the PRT, and then the initial evaluation from the PRT is
19 done using the Secretary's criteria.

20 So as I mentioned, the PTAC Chair and Vice Chair
21 assign two to three PTAC members, including at least one
22 physician, to each complete proposal to serve as the PRT.
23 And, again, one PRT member is selected to serve as the
24 lead.

1 The PRT identifies additional information needed
2 from the submitter and determines to what extent any
3 additional resources and/or analyses are needed for the
4 review. ASPE staff and contractors support the PRT in
5 obtaining these additional materials.

6 After reviewing the proposal, the additional
7 materials gathered, and public comments received, the PRT
8 prepares a report of its findings to the full PTAC. The
9 report is posted to the PTAC website at least two weeks
10 prior to public deliberation by the full Committee.

11 As already identified and mentioned by Jeff, the
12 PRT report is not binding on PTAC. PTAC may reach
13 different conclusions and a different recommendation from
14 that contained in the PRT report.

15 So with that background, I'm going to go through
16 our PRT review, so just a brief overview on the proposal.

17 The Project Sonar proposal describes their model
18 as a specialty-based intensive medical home intended to
19 address "high-beta chronic diseases," those associated with
20 high cost, high risk, and high variability in outcome and
21 cost. In this model they presented information
22 particularly around Crohn's disease.

23 And again, just a brief summary of the
24 intervention. The model uses evidence-based guidelines,

1 including clinical decision support tools embedded in the
2 electronic medical record to direct care. Risk assessment
3 uses the American Gastroenterology Association Crohn's
4 disease care pathway. An enrollment visit with a nurse
5 care manager initiates the model and subsequent
6 communication with the care manager through a Web- and
7 mobile-based platform or by phone calls.

8 Patients are "pinged" at least once. This can be
9 done via smartphone or other device of their choice to
10 submit self-assessment data based on the Crohn's Disease
11 Activity Index. And then the nurse care manager contacts
12 nonresponders by phone to administer the questionnaire,
13 again, for those who don't respond in other manners.

14 The patients receive follow-up from the care
15 manager if their data falls outside the standards. If
16 indicated, the nurse care manager communicates with the
17 specialist and arranges an office visit or phone call, and
18 use of the SonarMD platform, a cloud-based care management
19 platform, which utilizes proprietary chronic care
20 management algorithms, the clinical decision support tools,
21 and predictive analytics.

22 In regards to payment, CMS would provide the
23 alternative payment model entity additional payments for
24 remote patient monitoring services for each beneficiary

1 enrolled. So there's a payment for the enrollment visit
2 and then a per-beneficiary per-month payment. The APM
3 entity would also be eligible for shared savings and losses
4 based on retrospective reconciliation against a risk-
5 adjusted target price. There are stop loss provisions and
6 outlier protections also included. The APM entity would
7 distribute shared savings to individual physicians based on
8 the number of patients followed, ping response rate, and
9 risk-adjusted cost of care.

10 So the initial review by PRT, the results are
11 here, and I'm going to walk through each one of these next.

12 And, then just to highlight some of the key
13 issues identified by the PRT, the proposal indicates that
14 the model could apply broadly to diseases with high cost,
15 high risk, and high variability in outcome and cost. But
16 the evidence in the proposal only relates to inflammatory
17 bowel disease, and in particular, Crohn's disease. The
18 model makes innovative use of technology to monitor
19 inflammatory bowel disease patients to prevent unnecessary
20 emergency room visits and hospitalizations. But the
21 platform chronic care management algorithms and clinical
22 decision support tools and predictive analytics are
23 proprietary.

24 A care management fee rather than a new payment

1 model may be sufficient to achieve the care delivery
2 changes described in this model. The experience of the
3 model in general is in a younger commercial population, and
4 it may not necessarily translate to the elderly Medicare
5 population. And then, finally, the proposal lacks
6 comprehensive quality measures tied to payment.

7 So, with that as an overview, I'll go into each
8 of the criterion in our assessment.

9 Criterion 1, which is the scope of the proposed
10 payment model, which is a High-Priority criterion, the
11 proposal indicates that the model could apply broadly to
12 high-beta chronic diseases, but, again, details are limited
13 to the submitter's experience with IBD, specifically
14 Crohn's disease. And so within the scope, in 2015 the data
15 that we reviewed, approximately 0.48 percent of the
16 Medicare fee-for-service population had inflammatory bowel
17 disease, and this accounted for 1.25 percent of fee-for-
18 service spending. And while 20 large GI practices have
19 implemented the SonarMD platform, practice feasibility,
20 level of interest, and potential impact based on practice
21 size and specialty are not included. And, thus, it's hard
22 to conclude how the model would offer opportunities for
23 others to participate in the alternative payment model.
24 Because of the lack of information on additional disease

1 areas, it's not clear how this model, again, would offer
2 opportunities for others to participate.

3 Under quality and cost, quality reporting would
4 be based upon MIPS and Project Sonar-derived measures, but
5 the examples for IBD seem fairly limited. The proposed
6 quality reporting measures are primarily based upon
7 laboratory values and patient response rates, more metrics
8 tied to overall improvement in care, and patient
9 satisfaction as well as patient-reported measures are
10 needed.

11 We also discussed in our review that the
12 submitters were in the process of piloting the use of
13 hospital anxiety and depression score and the CDC Healthy
14 Day core measures, although this was in the pilot stage.

15 Medicare beneficiaries with IBD, as I already
16 mentioned, account for a small percentage of Medicare fee-
17 for-service spending. Younger patients with IBD often have
18 more active disease than -- or may have more active disease
19 than older patients, so impact on emergency room and
20 hospital utilization rates seen in the commercial
21 population may not necessarily translate to the Medicare
22 beneficiaries. And in our discussions, we also noted that
23 some of the cost-saving measures that were suggested by the
24 submitter included improved medication adherence and moving

1 infusion services from hospital outpatient to non-facility
2 office settings. But there was no data provided in support
3 of these statements.

4 Under Criterion 3 the payment methodology, again,
5 another high-priority area, the proposal does not address
6 how to manage payment when there are multiple chronic
7 conditions and providers. A care management fee rather
8 than a new payment model maybe sufficient to achieve the
9 care delivery changes described in this model.

10 In the Medicare population, IBD patients may have
11 fewer exacerbations of the disease compared to a commercial
12 population. Thus, there may be limited variation in
13 utilization; those opportunities for shared savings or
14 losses may be small. And individual providers do not
15 receive shared savings based on patient satisfaction or
16 care outcome measures.

17 Criterion 4, Value over Volume. It was not
18 obvious if office staff and arrangements might need to
19 change in order to accommodate Project Sonar, particularly
20 in different practice settings. The proposal does not
21 sufficiently describe the mechanisms that would drive
22 physicians to change behavior, so it's unclear whether the
23 presence of a care management fee is critical to any
24 behavior change or if it's more important for the patient

1 pings to drive behavior change.

2 The role, if any, of nonfinancial incentives is
3 unclear, and while opportunities for shared savings and
4 losses could be seen as one way to promote value over
5 volume, the specific financial incentives in this model do
6 not seem sufficiently structured to do so.

7 And I apologize. I should have started each
8 criteria by saying how the PRT voted. So, I know it's up
9 there, but I should say that the initial review on the
10 first four criteria was "Does Not Meet Criterion."

11 On Criterion 5, the PRT felt the model did Meet
12 criterion. The model allows patients to communicate with
13 the care management via a web- and mobile-based platform as
14 well as through phone calls.

15 The proposal indicates that small practices that
16 may not have the volume to support a care management could
17 engage in a shared service model. However, the proprietary
18 nature of the SonarMD platform, again, as it relates to
19 chronic care management algorithms, CDS tools, and
20 predictive analytics, may be an obstacle for others to
21 participate in the model.

22 On Criterion 6, again, the PRT concluded that it
23 Meets criterion. Metrics such as cost of care, including
24 ER utilization and hospitalization rates can be tracked

1 through the claims data as well as the ping response rates,
2 which can be tracked through the SonarMD platform.

3 The proposal provided results from the ongoing
4 pilot of the model with commercial payers. The quality
5 measures proposed can be evaluated but are felt not to be
6 comprehensive.

7 In terms of integration and care coordination,
8 the PRT felt that the proposal Does Not Meet the criterion.
9 The SonarMD platform enables the care manager to monitor a
10 practice's patients and initiate physician involvement when
11 necessary, but the involvement appears to be largely
12 limited to the specialist. The model seems to have little
13 integration with other clinicians, particularly primary
14 care providers. Primary care providers could potentially
15 access patient information from the SonarMD platform, but
16 it seems that they are more likely to receive notes via
17 fax.

18 And with the exception of the care manager, it is
19 unclear how the front-line office and nursing staff would
20 change in order to support this model.

21 Criterion 8 on Patient Choice, the PRT concluded
22 that it Does Not Meet criterion. Patients make the
23 decision to enroll and can interact with the care
24 management via web- and mobile-based platform. However,

1 the experience of Project Sonar in the Medicare population
2 is limited. It's a patient group and previously,
3 traditionally has been less inclined to use mobile apps as
4 a primary source of contact, and the potential technology
5 gap would be addressed by providing traditional phone call
6 care management, but it's unclear whether phone calls are
7 for the same benefits as the web- or mobile-based
8 communication.

9 In terms of patient safety, the PRT concluded
10 that it meets criteria. The model activities that would
11 likely improve patient safety include the remote monitoring
12 of patients to identify clinical deterioration and initiate
13 intervention early, reducing the need for ER visits and
14 hospitalizations, and the risk assessment to help determine
15 the appropriate frequency with which patients should be
16 pinged.

17 And then, finally, Criterion 10, Health
18 Information Technology, the PRT felt it Did Not Meet the
19 criterion, recognizing that the model makes innovative use
20 of technology to monitor inflammatory bowel disease
21 patients to prevent unnecessary ER visits and
22 hospitalizations, but the concern is that the platform and
23 clinical algorithms are proprietary.

24 There has been a positive patient experience with

1 the use of this technology in the commercial population but
2 again unclear how this would translate to the older
3 Medicare patients.

4 And the model still seems to face significant
5 interoperability challenges. In order to access notes from
6 the specialists, primary care physicians would need to
7 access a separate system or receive faxes.

8 And that's the end of the report.

9 CHAIR BAILET: Thank you, Paul.

10 I would like to open it up to the Committee to
11 ask any clarifying questions of Paul or the PRT teammates.

12 Grace.

13 DR. TERRELL: I have several questions. One is
14 you talked about the potential for the age to not be as
15 relevant in an older population, but Crohn's disease has a
16 bimodal distribution with a second peak between the ages of
17 50 and 80. Was there any evaluation on the part of the PRT
18 to understand the prevalence of disease in the older
19 population as it relates to that?

20 DR. CASALE: Yeah, go ahead. I'll let you --

21 DR. PATEL: I'll start. We actually knew that as
22 well, and so we asked our data team, our contractors who
23 are able to rapidly pull from the Medicare claims files,
24 data on that to then quantify patients, total number of

1 Medicare beneficiaries, looking back over the last four
2 years, just to see if there was anything different year to
3 year -- but there was not -- and look at beneficiaries with
4 inflammatory bowel disease, of which there were
5 approximately 136,000 on average each year, beneficiaries
6 with Crohn's disease, of which there were about 70,000, and
7 beneficiaries with ulcerative colitis, of which there were
8 about 65- to 70,000, but again, over four years, from kind
9 of year to year, thereby looking at that bimodal
10 distribution. And that's where we came up with kind of
11 understanding what the prevalence would be in the Medicare
12 population, so we did tease that out and asked our data
13 partners to look at that.

14 DR. Terrell: A couple more questions, clarifying
15 questions. So the idea of proprietary information has come
16 up in more than just this proposal, and in one of the other
17 PRTs, we were told that Medicare does sometimes permit
18 technology that is proprietary to have a bill, a code, or
19 whatever would be used. Was there an exploration with CMS
20 or any of the folks that were advising us with respect to
21 this particular point?

22 DR. CASALE: We did not explore with CMS. We
23 just asked the submitters again to understand the
24 proprietary nature of Sonar, is it the expectation that it

1 will remain proprietary, and an answer to that was that the
2 expectation is that it will continue to be proprietary.
3 But we did not explore it with CMS in terms of their
4 willingness to accept that as part of the model.

5 DR. TERRELL: Final question -- oh, go ahead.

6 DR. PATEL: I'll just add, we knew, again, that
7 the technology -- and we will hear form the submitters --
8 we knew the technology had these clinical algorithms, kind
9 of the pings, the response rates, and that platform, as
10 well as the analytics. The submitters did comment that the
11 clinical algorithms that underlie the proprietary
12 technology are public, or at least that is evidence-based
13 kind of disease recommendations. But, again, looking at
14 the total technology and really the analytics in that, kind
15 of proprietary pings and some of those things, that was
16 really what was felt to be part of what was offering this
17 larger care management that the nurse care manager would
18 draw from. And so we did not engage with CMS because that
19 was something that was very unique to just this aspect.

20 DR. TERRELL: All right. Final question. There
21 was a comment made about the lack of integration with the
22 primary care providers. That presupposes that there ought
23 to be, and although many of us have believed that and that
24 has been the party line, there is also a lot of work that

1 has been done around the concept for certain individuals
2 with complex chronic disease that the medical home concept
3 would be better served by a specialist. So how much work
4 did you all do in understanding the issues around those
5 tensions right now in the concept of chronic disease
6 management?

7 DR. CASALE: So I'll start, and then you can add
8 on.

9 Certainly, as a specialist, I certainly
10 understand that dynamic, but again, as was pointed out, one
11 of the concerns is that the model has been primarily in a
12 younger population, in which this might be their principal
13 diagnosis as compares to Medicare when we looked at the
14 data, when we looked at the tables that go up to 10 chronic
15 care conditions. There were quite a few of the Medicare
16 inflammatory bowel disease patients who had multiple
17 chronic conditions, and so that it was going to be
18 inherent. Even if the gastroenterologists were going to be
19 taking primary care of the inflammatory bowel disease
20 portion, that there would be a seamless information
21 exchange. In the model that was presented, it did not --
22 we had a lot of concerns around that information flow back
23 and forth, even if the gastroenterologists were taking
24 primary responsibility for the inflammatory bowel disease.

1 DR. PATEL: And we, just to also kind of -- I
2 think you were also asking, Grace, kind of what steps we
3 took to understand what was unique about the kind of
4 conditions suggested in the role of a specialist in terms
5 of a medical home or just even a specialist's care.

6 So we had our literature review, and then the
7 three of us tried to understand, even kind of at a deeper
8 level with that initial literature review, what really
9 would be kind of the state of evidence.

10 And we also drew the same conclusion that, in
11 fact, this is a condition that largely is managed by the
12 specialists, but even information being transmitted around
13 medication changes or things that might have an impact
14 because of other comorbidities, that was where there was a
15 functional limitation because those communications were
16 generally going to be done by fax or by the more
17 conventional communication that exists today. So that was
18 really more of a comment about not necessarily the primary
19 care physician has to drive it, but there's still a
20 coordination function. And that is obviously being done by
21 the current specialist, but it's still kind of outside that
22 really unique care management platform that was really
23 being offered as the core of the proposal.

24 DR. CASALE: And just to add on one other thing -

1 - and, again, if you look at the data, I believe about a
2 third of the patients had coronary artery disease. At
3 least half have hypertension, you know, the usual things.
4 And so those obviously need to be managed as well, so that
5 coordination is going to be important for this patient
6 population.

7 DR. BERENSON: Yeah. I'll be asking for any
8 proposal related to a condition, the following kind of a
9 question. Does the model itself -- well, given the fact
10 that Crohn's disease is often misdiagnosed and irritable
11 bowel, sometimes called Crohn's disease, colitis when it's
12 limited to the large bowel can be mistaken for ulcerative
13 colitis, Celiac disease, et cetera, et cetera, is there any
14 -- and when we're giving extra money and especially shared
15 savings, shared risk approaches-- is there anything in the
16 proposal that assures us that the patient actually has
17 Crohn's disease, or are we depending on a claim to
18 designate Crohn's disease?

19 I am looking at this thing called the AGA's
20 Crohn's Disease Care Pathway, and I'm wondering whether
21 that in some way provides some assurance that patients who
22 we are identifying as having Crohn's disease actually have
23 Crohn's disease. Does the PRT -- is this something you
24 looked into at all?

1 DR. CASALE: You know, I have to say I think --
2 and we could ask the submitters about this. My assumption
3 was that this was an endoscopically, pathological
4 diagnosis, and it went from there, but --

5 DR. PATEL: We did not -- as a part of -- as a
6 PRT, we did not ask specifically about confirmation of
7 diagnosis.

8 And I looked at the AGA pathway that you're
9 referencing, and I believe that is based on some sort of
10 endoscopic evidence of disease. But we did not question,
11 and nor did the proposal state, that there was a definitive
12 diagnosis up front.

13 CHAIR BAILET: Len.

14 DR. NICHOLS: So a couple questions for
15 clarification, which is where we are now. Right?

16 So I, too, was intrigued with the possibility of
17 the chronic care management fee being a simple substitute
18 because, as an economist, I'm always looking for simple.
19 But I guess I want to make sure that's actually applicable
20 in this particular case because it seemed like -- doesn't
21 the CCM require two chronic conditions to be present, and
22 did you all think about the relationship between what I
23 think the fee level is in the statute and what they're
24 implementing and the calculation that was done by the

1 applicants on what was required for this particular ongoing
2 PMPM?

3 DR. PATEL: I will take a first stab.

4 So we requested when we did that initial data
5 request around kind of incidence of these diseases. We
6 also looked at the comorbidities. So we felt very
7 comfortable that given the numbers of patients, numbers of
8 Medicare beneficiaries with inflammatory bowel, Crohn's, or
9 ulcerative colitis, and then looking at comorbidities, that
10 that would definitely trigger the CCM.

11 You're absolutely right that one diagnosis alone
12 would not obviously allow for them to get the CCM, but when
13 we looked at the data breakdown of presence of other
14 chronic conditions -- for example, 69.1 percent have
15 hypertension. So that would be a good example of kind of
16 meeting the criteria for a CCM, that that was what gave us
17 a little bit more kind of validity that yes, in fact --
18 now, a question to ask is would a gastroenterologist take
19 care of those two conditions, and certainly we can discuss
20 that. But there were certainly enough other comorbidities
21 to trigger a CCM.

22 In terms of the dollars, the commercial setting
23 in which they are doing it approximates about \$600 a year.
24 I am going back into my notes -- does that sound right,

1 Paul? I was just highlighting.

2 DR. NICHOLS: So that's 50 bucks a month.

3 DR. PATEL: Correct, about \$600, which does
4 approximately a CCM fee. So remember there is a split with
5 the beneficiary paying some of that --

6 DR. NICHOLS: Right.

7 DR. PATEL: -- and Medicare paying some of that,
8 but we felt like that was, again, a very nice potential,
9 which is why we posed that in our PRT report.

10 DR. NICHOLS: Okay. All I was getting to is it
11 may be that you and I both would tweak the parameters of
12 the CCM to fit this, and the current one might not.

13 DR. PATEL: It's just --

14 DR. NICHOLS: If they did have, I think, 70 bucks
15 a month, but anyway --

16 DR. PATEL: Which is why we were kind of -- what
17 we wanted to understand was, are there currently -- is this
18 really something that a care management fee like a CCM
19 could offer a pathway for specialists?

20 DR. NICHOLS: Okay. And to jump on Grace's point
21 about proprietary, because it is going to cut across a lot
22 of these, I think, and so I'm really -- this is more kind
23 of understanding how we should think about this or maybe
24 how you all thought about it at this point.

1 But if I understood your answer to Grace's
2 question, Kavita, you talked about how sort of the really
3 proprietary part was the analytics, was the model that
4 actually predicted which patient needs to be pinged
5 immediately.

6 DR. PATEL: Right. And I indicated that.

7 DR. NICHOLS: And I guess the question is -- and
8 this is not so much about this proposal, but again, how we
9 should think about these things, I wonder if we might
10 consider something where if something -- if applicants want
11 something to remain proprietary, we sort of talk about a
12 level of revelation to CMS and then figure out what you
13 could share.

14 For example, if it is data analytics and they let
15 us know which variables go into the model, then it would
16 not be all that secret, would it, to figure out how to use
17 that? But if it's hiding the variables that are in the
18 model, then clearly, that's a level of non-
19 recommendability.

20 So I just raise the question: How should we
21 think about what needs to be revealed to the larger
22 population, so it could be implemented program-wide without
23 having to pay? And I don't have an answer. That, to me,
24 is what's triggered by this question.

1 DR. PATEL: And just one other comment on the
2 proprietary aspect that intersects with -- we were looking
3 at Health Information Technology. We were also thinking
4 about just if that potentially could add infrastructure
5 burdens, which crossed-mapped to other criteria. So it was
6 also kind of an understanding of will there be a burden to
7 acquire such proprietary technology that almost creates an
8 inflexibility.

9 DR. CASALE: Yeah, I think -- I'm sorry. I think
10 that was the concern around infrastructure cost or burden,
11 if this were to be defused more broadly.

12 CHAIR BAILET: Bruce.

13 MR. STEINWALD: My question is, I think, similar
14 to Len's first question relating to payment methodology.

15 You said a number of times, Paul, during your
16 presentation and in your report that the PRT wasn't
17 convinced that a new payment model is necessary to achieve
18 the goals of this model, and although we have seen sort of
19 in the field, it's not uncommon to see an initiation fee
20 and then a per-member, per-month fee in order to create
21 financial incentives to change care.

22 So I'm wondering, what is it about this one that
23 makes you believe that the goals could be accomplished more
24 simply as compared to others that you've seen in the field?

1 DR. CASALE: Well, I think part of it was a
2 particular outcome was focused on decreased
3 hospitalization, decreased ER use as the primary outcomes,
4 and that would directly be impacted by care management. So
5 it seemed that there was sort of a closer line between a
6 care management fee and the outcomes they were looking for,
7 and it didn't necessarily sort of need an entire sort of
8 new model around it.

9 DR. PATEL: I'll just add, you all have access to
10 the full proposal. You know there is, as Paul mentioned,
11 kind of an emphasis on hospital admissions, ER visits, and
12 then there's this kind of lovely graph that talks about,
13 you know, how you deal with the payment model, dealing with
14 controlling hospitalizations and cost variation through
15 care management and patient engagement, which actually
16 strikes back -- we are not trying to -- I am not trying to
17 say that the CCM is a substitute, but as an example, in the
18 current fee-for-service schedule, there are those potential
19 payment models which are not alternative payment models.
20 They are part of the fee schedule that allow for people to
21 look at patient engagement outside the face-to-face office
22 visit and to also do the kinds of things that can lead to
23 controlling hospitalization costs and ER visits.

24 So, again, it's not as much just looking at like

1 a landscape of payment models. It's actually thinking
2 critically about, in the current fee-for-service schedule,
3 or even with maybe tweaks to the current fee-for-service
4 schedule, could you accomplish the same goals as set out by
5 the proposer of what's in the payment model, and that's
6 what the PRT came to a decision around.

7 You're looking at me quizzically, like --

8 MR. STEINWALD: I always look at you that way.

9 [Laughter.]

10 DR. PATEL: Generally everybody looks at me that
11 way, but, you know, I don't take it personally. But I
12 might add, I'm hoping I'm just trying -- what we went
13 through was trying to understand what was in this model
14 that could not be done potentially in the current fee-for-
15 service schedule.

16 MR. STEINWALD: No, thank you. I wasn't getting
17 that as completely as you just explained.

18 CHAIR BAILET: Yeah. Thanks. So my question
19 sort of follows on Len and Bruce's, relative to the payment
20 methodology. I'm curious, as you've interacted with the
21 proposer about the link between the payment methodology,
22 which is not only a PMPM but also their shared savings, and
23 the question around how does that impact behavior, because
24 that is one of the transformative elements of these models

1 that we're trying to evaluate.

2 I think there's some pieces of the bottle that
3 are extremely elegant, recognizing the behavioral overtone
4 of the disease and their assessment of the patient, and
5 then they are deploying certain resources based on the
6 behavioral issues, not just with this disease but clearly
7 that's a big issue with comorbidities, and particularly in
8 the Medicare population.

9 So I'm curious, were you able to discern the
10 level of behavior change that this model distributed across
11 these different practices that they saw, besides the
12 patient outcomes -- ER utilization, hospitalizations -- but
13 what about the actual clinical delivery? How was that
14 changed based on the payment model, shared savings? Did
15 that get people's attention to modify their practice
16 styles, I guess is what I'm trying to say?

17 DR. CASALE: You know, I think part of the
18 struggle is, again, the experience has been primarily in
19 the commercial population and translating that to the
20 Medicare or imagining how that might work, and although
21 there were some in there I don't think there were a huge
22 number. And so managing patients who might potentially
23 have quite a few comorbidities, again, trying to think
24 through the model in that patient group was a little

1 challenging, given that most of the experience was in the
2 commercial population.

3 I think that in terms of behavioral, you know,
4 again, I think physicians want to take better care of
5 patients, and so it does decrease -- I think the effective
6 part is having a care manager there and being proactive
7 with this commercial patient population, younger
8 population, does work. I mean, it does keep them out of
9 the ER and keep them out of the hospital. So I think even
10 if you don't get to the financial part, you get to have --
11 does this take better care of patients in the younger
12 inflammatory bowel disease group? I think their pilots
13 have been effective for those who are interactive, the
14 pingers, the ones who respond. But, you know, the data
15 also shows those who -- that don't respond, you know, the
16 results haven't been as good, and so how do we translate
17 that or understand how that might work in a Medicare
18 population where we don't have as much -- where the model
19 doesn't have as much experience?

20 So I think, does it change behavior? I think,
21 again, you can see better care in that younger population
22 in terms of managing them, being proactive. I think that's
23 all good. And then there is the potential on the shared
24 savings, although how exactly that's all distributed I

1 think wasn't as clear, in terms of who was going to get
2 exactly what in terms of the money.

3 DR. PATEL: And just to add, and we have this in
4 our report but there's so many moving parts, Paul mentioned
5 the interest. Twenty large GI practices that have
6 implemented the platform, very limited in the numbers.
7 Again, it's a commercial population of which there was a
8 very small handful of people over the age of 65 that were
9 part of it, so kind of limited in understanding what the
10 scale could be for the Medicare population.

11 But we do know, from their commercial experience
12 that there was an average -- that there would be a savings
13 of approximately \$1,000 per patient per year, of which that
14 would get shared, potentially, and the question is, again,
15 if it's a smaller population, when thinking about the
16 Medicare population that have this incidence and
17 prevalence, and the savings of approximately \$1,000, which,
18 no matter how you do the shared savings, you could almost -
19 - you could ask the question, is that going to have enough
20 financial impact to get to what you're asking around
21 behavior change.

22 In the proposal itself, there is not enough of a
23 runway of experience to say -- there was not a mention of
24 here is the definitive practice changes we have seen. We

1 did receive 28 letters of support -- Dr. Kosinski probably
2 knows this. We read through many letters of support that
3 talk about the excitement around this, and what we were
4 trying to do is understand what would that -- going back to
5 our criteria, how does that translate to scale and scope,
6 and would that \$1,000 of savings per year be enough to
7 change practice behavior as well, which is why we
8 ultimately decided that it did not meet that criteria on
9 that value over volume comment and secretary criterion.

10 CHAIR BAILET: Thank you. Tim.

11 DR. FERRIS: Thanks to the PRT for all the work
12 on this, helping us understand this.

13 I hoped you might elaborate on one point that was
14 made, which was that the PRT was concerned that the
15 individual providers do not receive shared savings, based
16 on patient satisfaction and care outcomes measures. And I
17 just wondered, since that was a little cryptic, if you
18 could explain a little bit more about what you were
19 thinking.

20 DR. PATEL: So right now the shared savings, the
21 kind of -- in the proposal there was no comment about
22 linking of the kind of potential in shared savings, or even
23 the monthly payments. None of that was linked in any way
24 to the proposed quality metrics or to any outcomes

1 measures. So the question and the concern there was would
2 there be any financial ties to any of the metrics such that
3 those finances were held at risk if certain thresholds of
4 metrics were not met, and in the current proposal there was
5 no linkage of those finances with those outcomes.

6 DR. FERRIS: So just to clarify, the concern that
7 was raised was not about a concern about a specific
8 proposed linkage. It was a concern that there was no
9 linkage.

10 DR. PATEL: No linkage. Correct.

11 DR. FERRIS: Okay. Thank you.

12 CHAIR BAILET: Elizabeth.

13 VICE CHAIR MITCHELL: Thank you. One of our key
14 criteria is scalability and I think that includes adoption
15 by multi-payer, CMS and other commercial payers. And I'm
16 wondering -- I'm curious about not only the
17 interoperability of the technology, which you shared
18 concerns about, but the interoperability of the model, as
19 it were.

20 So if this -- could this be integrated with other
21 care management models across populations, if it were to be
22 expanded, or did you explore that?

23 DR. CASALE: I don't think we explored that. I
24 mean, I think it potentially would have the ability to have

1 some interoperability across. Again, I think a lot of our
2 -- well, not a lot but a certain amount of our discussion
3 was particularly around the Medicare population, which is
4 what this was being -- which we were focused on, and as I
5 said before, I think their experience in the commercial has
6 been positive and very favorable.

7 So in terms of multi-payer, I actually feel more
8 comfortable in how this might work in the commercial
9 population -- where I feel like the PRT had our most
10 concerns was the lack of sort of data around how this works
11 in the Medicare population and if it can work in that
12 population.

13 VICE CHAIR MITCHELL: I'll just add for
14 reference, on page 9 of their original proposal, the
15 submitters did a nice job of laying out kind of what a
16 commercial payer would supply, and kind of what the
17 practice has to do. So to that end, we did talk about how,
18 because of their commercial experience, they thought
19 through very clearly kind of what structural components
20 need to occur to have another payer, multi-payer kind of
21 approaches.

22 But to your question about what, from a care --
23 how could this interdigitate potentially with other care
24 management programs, we did not discuss that.

1 CHAIR BAILET: Okay. Bob.

2 DR. BERENSON: Yeah. I just want to make sure I
3 understand the shared savings, shared risk model. Is it a
4 total cost of care approach for patients with Crohn's
5 disease, that there's a -- sort of a norm for spending, and
6 if they come in, regardless of what the spending is
7 attributed to, whether it's the Crohn's disease or any
8 number of other conditions, they would get savings if it
9 came in under that norm, et cetera, and it's not a targeted
10 savings to Crohn's disease; it's total cost of care? Do I
11 read that correctly?

12 DR. CASALE: Yeah. We asked the submitters
13 specifically that because in our initial read we were -- it
14 was not clear to us, and the submitters said that it's for
15 total cost of care, and not just for the costs around
16 inflammatory bowel disease.

17 CHAIR BAILET: Tim.

18 DR. FERRIS: So with regard to Criterion 8,
19 Patient Choice, the PRT noted that there wasn't a lot of
20 evidence around the effectiveness of the choices that would
21 be made available, and I wondered if you had a discussion
22 on the PRT about where we, as evaluators, should set the
23 bar on that particular issue. Because one could make the
24 argument, I think, that you can make choices available to

1 the patients, whether or not they avail themselves of those
2 choices is -- in any population -- is going to be variable.
3 But isn't it the job of the people making the proposal and
4 implementing just to make the choices available? Do they
5 have to go the extra step and say that patients actually
6 have to make use of those choices, which gets back to my --
7 you know, is that a -- that's a pretty high bar for -- as a
8 requirement.

9 DR. CASALE: I think that's a good question, Tim,
10 and I think we talked about it. You know, when you look at
11 the more expanded description of choice, you know, it talks
12 about, you know, potentially how demographics of the
13 patient population and social determinants of care are
14 addressed, and that's a pretty high bar, right, as opposed
15 to, you know -- because they obviously give you a menu in
16 here of options on how to interact, and if -- so I think we
17 struggled with, you know, where to set that bar and I --
18 you know, again, we sort of set it at we felt that --
19 recognized that they are providing some choice but that we
20 would have liked to have seen data, particularly around the
21 Medicare population, as to what they were choosing and, you
22 know, how that -- and just not sure that it's there, only
23 because of the small number of patients.

24 So it would have been helpful to have some

1 experience to make some judgment about that. But to your
2 sort of broader question, I think we will struggle with
3 that as we, you know, look at these PRTs.

4 CHAIR BAILET: So next steps. We're going to
5 invite the submitter to the table. Please.

6 As you get situated, if you could please
7 introduce yourselves, that would be helpful. Thank you.

8 DR. KOSINSKI: I'll begin. I'm Larry Kosinski.
9 I'm a gastroenterologist in Chicago, one of the managing
10 partners of Illinois Gastroenterology Group, which is one
11 of the co-presenters. And I also started SonarMD as an
12 offshoot of this project, and I sit on the governing board
13 of the American Gastroenterological Association and I
14 chaired both the Crohn's and ulcerative colitis care
15 pathway task forces that were published in *Gastroenterology*
16 in 2014. So anything you need to know about those
17 pathways, I will be happy to share. And I also sit on the
18 governing board of one of the advocate hospitals in
19 Chicago.

20 Bridget?

21 MS. GIBBONS: Good afternoon, everyone. My name
22 is Bridget Gibbons and I serve as the Chief Operating
23 Officer for SonarMD.

24 CHAIR BAILET: Thank you for being here. Please.

1 DR. KOSINSKI: Okay. Good afternoon, members of
2 the PTAC. And first of all I'd like to thank you all for
3 the opportunity for allowing us to address the comments and
4 conclusions of the PRT. It's obvious from the report that
5 the team did spend quite a bit of time reviewing our
6 proposal -- we do appreciate that -- but seem to have been
7 in need of further information that we either didn't
8 provide or could have provided more clearly. As a result,
9 they were not able to give us a favorable determination.

10 We welcome this opportunity to provide some
11 further information on Project Sonar, which will hopefully
12 allow the full committee to appreciate the value of our
13 proposition. It is our hope that the full PTAC will
14 approve Project Sonar for at least a limited scale testing
15 of the proposed payment model. A full response to all the
16 concerns of the PRT was sent to the PTAC members last week.
17 I will only hit some of the key points here in my short 10-
18 minute discussion.

19 Project Sonar has been a passion of mine for five
20 years, and I always open my presentations on Sonar with a
21 picture of the ocean, with myself standing in front,
22 looking out at the ocean. My chronic disease patients are
23 submarines. They're submerged. They're out there.
24 They're running silent and running deep. They only come up

1 if they're in trouble, which means two things have to
2 happen. First, they have to recognize they're in trouble,
3 and secondly, they have to realize that they can't fix it
4 themselves.

5 Unfortunately, they make mistakes in both of
6 those. Ultimately, we have to bring them into port. We
7 have to put them in the hospital, but it's not just a
8 hospitalization. It's a bowel obstruction. It's an
9 ileostomy. It's a fistula. It's an abscess. It's
10 something bad happening to a patient. If you just ask them
11 how they're doing, they'll tell you they feel fine. They
12 always feel fine, but it's only with the return of
13 structured data on a regular basis where we can actually
14 impact some change.

15 In the research that led to our project, Blue
16 Cross Blue Shield Illinois provided us data on 21,000
17 commercial patients with Crohn's, and the most startling
18 feature of that entire review was that less than a third of
19 the patients who went into a hospital for one of these
20 horrible complications had any contact with their provider
21 in the 30 days before their hospital admission. We
22 interviewed those patients, and what we heard back from
23 them was overwhelmingly that they were going over the cliff
24 without realizing it.

1 On the basis of this, we decided that we needed a
2 patient hovering system, a sonar system, a way that we
3 could ping the patients in between their face-to-face
4 visits so that we could bring back structured data to the
5 health care team, to the professional team, not just an app
6 that a patient can record their symptoms on but something
7 that interacts with the caregivers. This led to Project
8 Sonar, which, in 2014, became the first intensive medical
9 home that Blue Cross Blue Shield Illinois had ever entered
10 into with a specialty group, and even though they have
11 discontinued their primary care intensive medical home
12 project, they've continued the specialty one.

13 We have been in operation for two years, and the
14 50 doctors in the Illinois Gastroenterology Group have had
15 a very significant impact on the patients. Most recently,
16 the pingers are showing a \$6,000 per year decrease in costs
17 as compared to non-pingers, in a disease process that costs
18 \$24,000 a year. So on the basis of the success we had in
19 IGG, Blue Cross Blue Shield of Illinois has engaged us to
20 implement Project Sonar across the gastroenterology
21 practices in Illinois, and we've begun this process.
22 Bridget has implemented five so far this year.

23 Our success has also resulted in other non-
24 Illinois Blues plans coming into participation, both in

1 Minnesota and in New Jersey. But in states where no
2 intensive medical home program exists, there are an
3 additional 20 GI practices that involve over 600 physicians
4 that are using the Sonar platform. These practices are
5 participating even though they are not yet receiving any
6 IMH funds. There is a hunger amongst the physicians out
7 there to be part of the value-based transition.

8 As far as the specific issues that the PRT raised
9 with us, to me they fall into three main categories:
10 number one, limited scope of our project, we heard that
11 clearly; number two, lack of adequate quality measures that
12 drive changes in reimbursement, and I think we can clarify
13 that; and a lack of need of change in payment methodology.

14 As far as limited scope is concerned, we agree
15 with the PRT that Crohn's disease only represents a small
16 fraction of the current Medicare fee-for-service
17 population. But these are high-cost, high-risk, high-
18 variability patients, and their costs are two and a half
19 times their percentage of the population.

20 Ulcerative colitis, very similar to Crohn's
21 disease in its cost, its morbidity and mortality, and this
22 is a growing population. Even in the data that accompanied
23 the PRT review, there was an 8 percent increase in
24 incidence from 2012 to 2015, and most studies today show

1 that by 2025 there will be 2.2 million Americans with
2 Crohn's or ulcerative colitis in the United States. And
3 that should correlate to about 2 percent of Medicare's fee-
4 for-service budget.

5 So although our original study group only was
6 limited to IBD, we are confident, though, that the patient
7 characteristics that have been the driving force behind our
8 new care model are not specific to IBD, but are typical of
9 most patients who deal with chronic disease on a regular
10 basis.

11 Accordingly, we have moved beyond IBD and now are
12 engaged in multiple non-IBD projects, the first of which is
13 cirrhosis complicated by hepatic encephalopathy. Thirty-
14 seven percent of the patients discharged with a diagnosis
15 of cirrhosis have a readmission within 30 days, and 46,000
16 patients in the four categories of the CMS core measures
17 have a comorbidity of cirrhosis. So we have initiated a
18 study using the Sonar platform for patients with cirrhosis,
19 focusing on the immediate 30-day post-hospitalization
20 period where the patients will be pinged on a daily basis,
21 either they or their designated surrogate, because they may
22 be encephalopathic.

23 Although our practices to date have been GI
24 based, there is no reason why this same platform cannot be

1 implemented in any practice type, specialist or primary
2 care. Under the request of BlueCross/BlueShield Illinois,
3 we have initiated investigation of a project in Type 2
4 diabetes, focusing on periods of high hemoglobin A1C
5 levels, which are associated with high intensity of
6 services. This project will be deployed in primary care
7 groups in our service area.

8 The PRT is correct that the experience of Project
9 Sonar has been in a specialty-based intensive medical home.
10 We did not mean to exclude primary care doctors, but
11 conditions like IBD are predominantly managed by
12 specialists. We welcome the use of Project Sonar in
13 primary care practices and equally welcome the integration
14 of the platform across the primary-specialist interface.
15 SonarMD platform is a Web-based platform that can be used
16 concurrently by multiple providers at the same time. We
17 believe that the deployment of the Sonar platform across
18 all practices will allow more of the care to be pushed to
19 the highest level -- I mean the lowest level licensed
20 provider capable of providing that service and build
21 efficiencies into the system. We therefore believe that
22 the scope is not limited and actually can be applied in
23 multiple disease processes and across most practice
24 settings.

1 Number two is lack of adequate quality measures
2 that drive reimbursement. Most metrics available today are
3 process measures that are not directly associated with
4 clinical outcomes. Since BlueCross BlueShield provides us
5 with quarterly, now monthly claims data on our patients,
6 we've used this data to scientifically identify
7 quantifiable metrics that are clearly associated with
8 favorable outcomes. The albumin example that we included
9 in our PTAC proposal was just one example of this endeavor.
10 Early in our development, we performed linear regressions
11 on 26 risk metrics that were contained in the Crohn's
12 disease care pathway, so we linearly regressed the cost of
13 care against each of those metrics.

14 Serum albumin was the most powerful variable in
15 the variation of cost. As a result, we monitor albumin
16 quarterly. It's a simple lab test, but it has a
17 significant difference. And we're proud to say that in our
18 control population, the albumin slope is downward; whereas,
19 in our Sonar population, it's rising.

20 So today, though, our most powerful metric is our
21 average Sonar score. Even though we force our physicians
22 to complete complex clinical decision support tools and
23 maintain these metrics, the single most powerful driver is
24 can you get that symptom score down, which means you've

1 engaged the patients, you've applied the right therapy, and
2 that is a single metric we've plotted, and we included this
3 graph as a supplement in our proposal showing that over a
4 two-year period, they linearly parallel each other.

5 Other metrics that we have included, in addition
6 to hospitalization rate and emergency room visits:
7 appropriate use of biologic medications. Those fields
8 don't exist in EMRs. We had to create these in the
9 clinical decision support tool. Are they on time with
10 their immunizations? Are they appropriately using
11 steroids? The serum albumin I mentioned, the ping response
12 rate, patient satisfaction surveys by outside entities,
13 risk-adjusted average Sonar scores, and now we have
14 implemented quarterly HADs and CDC Healthy Day scores
15 because there is a 13 percent difference in cost in
16 patients who are depressed at enrollment into the program,
17 and that doesn't change so far. We have to figure out how
18 to do that.

19 The IMH payment received from the payer is not
20 distributed to the physicians but is maintained in a pool.
21 The costs of the program are first paid for from the pool,
22 which basically is the nurse care manager fees and the
23 Sonar platform. And then the remainder is distributed to
24 the physicians based upon the number of patients they're

1 following, the average Sonar score of their patients
2 compared to everybody else, and their patient satisfaction.
3 No physician is eligible for a distribution of Project
4 Sonar funds unless the CDS tool fields have been complete.

5 The final area was lack of change in payment
6 methodology. We are in agreement with the PRT's assessment
7 here. Unfortunately, the current language of the complex
8 care management codes do not allow us to participate.
9 Number one, it is based upon minutes per month. This
10 process does not clearly correlate with patient outcome and
11 just imposes an unwieldy verification process on the
12 practice. It doesn't reward practices for efficiencies
13 that minimize staff time requirements. It requires two or
14 more conditions, and I'm sorry, I'm not managing that
15 patient's hypertension. That's the primary care doctor's
16 responsibility. I would take it, but it's not usually one
17 that we bear. And, finally, only one practitioner can bill
18 for a CCM code per month per diagnosis. There's no ability
19 for us to share CCM fees across providers, which would be
20 indicated. The Sonar platform's agnostic to the provider
21 and can, therefore, be deployed in multi-condition, multi-
22 provider settings.

23 So, in conclusion, Sonar has been a passionate
24 pursuit of mine for five years, but it could not have

1 succeeded by my efforts alone. My 50 partners in IGG have
2 embraced the initiative and gone the full mile in its
3 implementation. They implemented Sonar long before they
4 received any care management reimbursement from
5 BlueCross/BlueShield. And thank God we found a payer who
6 actually thought in a forward fashion to partner with us.
7 Like in a "Field of Dreams," though, we felt if we built
8 it, they would come.

9 Even now, most of the care management fee goes to
10 cover the infrastructure necessary for Project Sonar. Very
11 little passes to the physicians. They persist based upon a
12 true hunger amongst physicians to be part of the solution
13 and not to be considered part of the problem.

14 Sonar has moved beyond IGG and has been deployed
15 on hundreds of patients across the country, which has led
16 to a decrease in morbidity and cost, not just
17 hospitalizations -- decreased morbidity. I was humbled by
18 my patients' testimonials that were submitted and posted on
19 the PTAC's public comment site. Sonar has changed
20 patients' lives. With an approval from the PTAC and HHS,
21 we can expand our success to other chronic diseases and
22 across other care settings.

23 Thank you.

24 CHAIR BAILET: Thank you both. We appreciate

1 your comments. Thank you.

2 We have questions now from members of the
3 Committee. Harold?

4 MR. MILLER: You beat me to it.

5 CHAIR BAILET: I beat you to it, Harold.

6 MR. MILLER: I have four questions.

7 The first question is: With respect to the care
8 management process, there has been a lot of focus on the
9 pinging. But when I read the proposal, I think there's a
10 statement in there, at least one place, that basically says
11 that the nurse care manager is critical to this. And at
12 least as I sort of read what you have in here, basically
13 you have a nurse care manager who is assessing and
14 contacting the patients and helping the physician decide
15 what to do with them. And the pinging technology, sort of
16 the smartphone technology, is a way of helping that be done
17 more efficiently than it could be done otherwise with just
18 home visits or telephone calls.

19 Is that an accurate interpretation of what you're
20 doing? And in a sense, if you had to choose one, you would
21 keep the nurse, if you had to give up the smartphone app,
22 as opposed to saying we have a smartphone app and no nurse?

23 DR. KOSINSKI: Harold, you've depicted it pretty
24 well. But when we first initiated Project Sonar, we were

1 using our patient portal because we did not have a
2 platform, and we could never get more than a 27 percent
3 response rate from the patients, and so the nurses did a
4 lot of calls. And once we embraced the platform, for some
5 reasons the patients -- and 20 percent of our patients are
6 Medicare patients. Once we deployed the platform, we have
7 over an 80 percent sustained patient response rate.

8 And so what the platform does -- how does it
9 change care? This was just the beginning of the month. I
10 get my Sonar pings on all my patients coming in through an
11 HL7 interface into our EMR, and we can push it into any
12 EMR. And so every month at the beginning of the month,
13 every one of my patients' pings comes in front of my eyes.
14 The nurse is managing it at the same time, but I see them.

15 And so any of you who are physicians know as well
16 as I do, when you're done with the patient, your total
17 focus goes on to the next patient you're taking care of.
18 But through this kind of a platform -- and there's nothing
19 really special about the platform. This could be
20 replicated very easily by other companies, and probably
21 will, but it brings the patient back in front.

22 And so I think you've depicted it well, but I
23 think we're learning something --

24 MR. MILLER: So you've found that it has made it

1 feasible for you to do it in a way that wasn't feasible
2 with just using a nurse and traditional technologies.

3 DR. KOSINSKI: Right.

4 MR. MILLER: But the nurse and the contact with
5 the patient -- there is personal contact with the patient -
6 - is critical.

7 DR. KOSINSKI: Right.

8 MR. MILLER: The second question is, if you have
9 an IBD patient who has COPD or asthma or heart failure or
10 hypertension or whatever, what do you do? Does that come
11 up in the assessment that the nurse does of the patient,
12 whenever you're talking to the patient? And then do you
13 actually then do any coordination or outreach to whichever
14 physician -- it may not be a primary care physician -- who
15 is managing that other condition?

16 DR. KOSINSKI: If it's something where the other
17 comorbidity directly interacts with the condition I'm
18 taking care of. For instance, in our liver patients, if
19 their fluid balance requires changes in their heart failure
20 management, we have to coordinate with the primary care
21 doctor all the time. That's a must.

22 In inflammatory bowel disease, infections --
23 we're immunosuppressing these patients. So I don't mean
24 any offense, but I don't want my patients calling their

1 primary care doctor when they spike a fever. I need to
2 know. If I have them on a biologic, I need to know if they
3 have a fever. But the primary care doctor also needs to
4 know. And we can push the Sonar scores to the primary care
5 physician, and now the patients have the ability to add
6 notes to it for the provider, which could be passed at the
7 same time to us and at the same to the primary care.

8 MR. MILLER: Okay. The third question was
9 there's references in the methodology to setting a target
10 price, but there really isn't a very detailed description
11 of how the target price gets set. Is your expectation that
12 that is based on past average spending for the patients,
13 then discounted by an amount that's necessary to pay for
14 the care management so that you're -- the fee that you're
15 getting, so that it starts at a budget-neutral level for
16 Medicare, whoever the payer is, and then you're at risk --
17 when you talk about being at risk for up to 5 percent, is
18 it 5 percent above what would be necessary, the savings
19 necessary to pay for the care management fee? Or would it
20 be up to 5 percent above simply historical spending? How
21 exactly would you calculate the target price?

22 DR. KOSINSKI: This has been a moving target for
23 us in this process, and at the time we submitted our
24 initial PTAC proposal, we had never received control group

1 data from BlueCross, from HCSC. In January, we received
2 that, and I did send that along with one of the responses
3 to questions.

4 So, scientifically, where we're going with this
5 is this way: We know what the cost of care is for a
6 patient who is participating in our process in the diseases
7 we are taking care of based upon historical information.
8 We also know how our risk assessments can be used to better
9 hone what that base price is and then an add-on based upon
10 the risk assessments that are included.

11 The major variable, though, is we know what the
12 platform can do to that cost of care. I mentioned that
13 \$6,000 difference. So where I envision us going with this
14 would be that section of money there that's developed and
15 the difference between pingers and non-pingers, it could be
16 an at-risk spend, and it would be up to the practice to be
17 able to take risk in there and know that they could provide
18 that care for the acceptable amount.

19 Blue Cross to date has not wanted -- I don't
20 think they want us to fail, and so it has been
21 predominantly a one-direction risk model, but we don't get
22 a pot of shared savings. What they do is they read just
23 our PMPM based upon our performance. We perform poorly,
24 that PMPM is going to go down or go away. And if we do

1 well, they've increased it on us a couple of times.

2 So I think we need to use science in how we
3 calculate where this risk pool takes us.

4 MR. MILLER: Fourth and final question. It
5 sounds to me like you are tracking a lot of things about
6 these patients, and where are you tracking those things?
7 Is that in an electronic health record?

8 DR. KOSINSKI: It's in the Sonar platform. All
9 of the risk assessments, all the costs, the CDS tool
10 measures are fed into the Sonar platform. We live in an
11 era today where EMR vendors are proprietary, and asking
12 them to change something is very, very difficult. There
13 are a lot of companies that can catch the data and give it
14 to CMS or give it off. But who's pitching it? We don't
15 have enough pitchers out there. And you can't tell the
16 major entities, "I need a field that tells me why you
17 changed a biologic on this patient." So we've built that
18 into the Sonar platform.

19 MR. MILLER: But you said, for example, serum
20 albumin is one of the things that you found is critical.
21 Can you ordinarily track that in the EHR?

22 DR. KOSINSKI: Yes.

23 MR. MILLER: Okay. So --

24 DR. KOSINSKI: If it's electronically sent.

1 MR. MILLER: Sure. But I'm just saying if that's
2 a critical thing to track on the patient, you do it in an
3 EHR and it could be done in an EHR.

4 DR. KOSINSKI: Right, yes.

5 MR. MILLER: Okay. Thank you.

6 CHAIR BAILET: Grace.

7 DR. TERRELL: Thank you, Doctor. Harold asked
8 one of the questions, so I've just got two more.

9 There's a lot of information about the difference
10 between your pingers and non-pingers. One of the questions
11 I have for you is how much you've actually dug into those
12 two, not just as a control group and a group that's using
13 the tool, but as something where folks either will bounce
14 back and forth or somebody will not be an adherent in the
15 pinger group, whether there's social determinants of
16 health, because it seems to me there might actually be a
17 spectrum of behaviors. And as you're having to present
18 data and get paid based upon a sort of, you know, yes-no,
19 what are you doing about the fact that actual patients tend
20 to sort of be yes-no-maybe, sometimes sort of possibly on
21 Thursdays? You know.

22 DR. KOSINSKI: This has been the toughest
23 question I've been faced with today so far, and it's the
24 one we wrestle with the most. The 13 percent difference in

1 cost -- we started doing depression analysis early with a
2 PHQ tool, a very simple -- and I'm not going to claim
3 anything for that. BlueCross asked us to do that.

4 DR. TERRELL: Yes, PHQ.

5 DR. KOSINSKI: But at the end of the first year,
6 we then filtered back and looked at how the patients did
7 financially if they answered positively on their depression
8 screen, and there was 13 percent delta that remained 13
9 percent even after our first year. So after our first
10 year, we said we need to address this, we need to build.
11 So that's where the HADs and CDC Healthy Days has come in,
12 and we're currently working with social workers to see can
13 we impact this better.

14 It's interesting. We send out five questions
15 every month, and the middle one is a health-reported
16 quality-of-life question, basically, a "How are you doing?"
17 question, and they have to answer in four different
18 categories. The patients who are depressed at enrollment
19 always answer that one negatively, "I feel terrible," even
20 if their symptoms are fine. I'm not as much worried about
21 them because they're calling us and seeking care. The bulk
22 of the patients, even when their symptoms are
23 deteriorating, their health-reported quality of life
24 remains favorable. They're going over the cliff.

1 So you've touched on where I think we need to
2 continue our focus, because somewhere along the line we
3 have to figure out how to get everybody participating.

4 DR. TERRELL: Yep. I would worry about a payment
5 system, maybe -- I mean, this would be something we would
6 have to solve -- where it rewards doctors for having the
7 good patients.

8 DR. KOSINSKI: Yeah.

9 DR. TERRELL: And, you know, you wouldn't want a
10 situation where somebody's not participating and there's
11 less reimbursement or whatever that it could have
12 consequences if we're not figuring out some of the patient
13 reasons that might be the case.

14 My second question is you made the comment that
15 there were folks doing this that aren't getting paid right
16 now, and you all did this without getting paid right now.
17 And I agree with you that there is a hunger in the medical
18 community to find solutions above and beyond the sort of
19 traditional fee-for-service system so that we can practice
20 the medicine that we want to practice.

21 I would be curious to understand a little bit
22 about those doctors out there now that are using this
23 platform without any reimbursement for it. You know, not
24 everybody is an altruist and not everybody can afford to do

1 that, so what percentage are doing it? And what does that
2 imply about the sort of costs of care that aren't being
3 paid for in the current system? And, you know, why are
4 people actually doing this?

5 DR. KOSINSKI: Well, I think that's why so many
6 of these practices are large. They have infrastructures.
7 They have nurses. There are so many practices out there
8 that don't even employ a nurse. They employ MAs, and I
9 don't mean any disrespect, but I have a slide I show that
10 says "MA does not equal RN."

11 And so that's why the larger practices have been
12 the ones that have migrated to us. They have the
13 infrastructure. They have the extra internal funds, and
14 they have more forward-thinking leadership.

15 In Sonar, we did it for over a year without any
16 reimbursement. I've got a practice -- I have got one
17 practice out in Washington State. The doctor has got over
18 100 Crohn's patients on. They've never received one penny,
19 but they want to change it.

20 DR. TERRELL: So it's been all large practices
21 that have been able to absorb the cost there?

22 DR. KOSINSKI: Well, we do have -- we have our
23 first solo practitioner that has now wanted to be on the
24 system. So we have both ends of the spectrum now, but it

1 is much more skewed to the large practices, yes.

2 CHAIR BAILET: Len.

3 DR. NICHOLS: So thanks for coming. Your passion
4 is obvious, and it's contagious. That's a good thing. It
5 makes me remember why I agreed to be on this damn
6 committee.

7 But, anyway, let me just say two questions. In
8 the appendix, which believe it or not I did read, it's hard
9 to -- so there's a discussion of the Project Sonar math and
10 talked about how you don't have statistical significance,
11 and you need a bigger sample.

12 If you could -- and I apologize if I missed this
13 part -- how many Medicare patients does your network have
14 now, and how many Medicare patients would you need to get
15 that sample where you want it to be? We're talking about
16 small-scale practices.

17 DR. KOSINSKI: Yeah. We're small here. We're
18 small here. We're probably only in the -- we probably only
19 have about 150 Medicare patients currently amongst the
20 practices.

21 DR. NICHOLS: Okay.

22 DR. KOSINSKI: We have had significant interest
23 from pharma to assist us in building our patient base. We
24 have a goal of 5,000 patients.

1 DR. NICHOLS: Yeah. Okay.

2 DR. KOSINSKI: And the problem comes up when
3 you're doing multiple regressions out of all these little
4 numbers. You need more numbers. The selfish side of me
5 says, "I want a bigger end so that we can prove more
6 things."

7 DR. NICHOLS: Yeah. Okay. Appreciate that.

8 And so the second question has to do with this
9 proprietary question.

10 DR. KOSINSKI: Oh. I'm glad you --

11 DR. NICHOLS: So you heard our exchanges before.

12 Let me state what I think is the fear, and then, I mean,
13 I'll just speak for myself. And I won't speak for CMS
14 because I can't. Right? But I'll just speak for myself.

15 I think the fear is that if the -- I'll just say
16 the analytic details are not revealed, and this thing
17 works, and it takes off, and CMS decides to require it.
18 Then, you sort of have a monopoly on what people have to
19 buy.

20 DR. KOSINSKI: Mm-hmm.

21 DR. NICHOLS: Okay. So, really, the question is,
22 how much information can you share and still maintain your
23 patent and all that? And second, how would you respond?
24 Because in an economist's mind, there's always a price at

1 which we can make this reasonable. Where does your price
2 sit now in all of this?

3 DR. KOSINSKI: Okay. Well, I'm very happy you
4 brought that up.

5 I've had a very altruistic approach at this, much
6 to the chagrin of my business partners.

7 [Laughter.]

8 DR. KOSINSKI: And I have a big mouth and have
9 told everybody everything.

10 But I'm also passionate that -- you know, I'm
11 ending my term at the AGA governing board, and I've wanted
12 to leave something. And if we look at the process whereby
13 guidelines, measures, e-metrics are integrated into medical
14 practice, they're thrown out there. We published these
15 care pathways; we throw them out there. We don't know
16 whether they actually made a difference.

17 So where my big vision of Sonar -- and it's
18 totally not proprietary -- would be that Sonar assists in
19 bringing the data back from these initiatives and feeds it
20 back to organizations where the people who write the
21 guidelines can rewrite them and recraft them, someone can
22 replicate our platform pretty easily.

23 DR. NICHOLS: That's what I thought.

24 DR. KOSINSKI: And I think we can't by ourselves

1 create new guidelines. We can assist and become part of
2 it.

3 So I'm not belittling the proprietary nature, but
4 I do have a benevolent side of this where I see it solving
5 a bigger purpose.

6 I don't know if I answered your question.

7 DR. FERRIS: I'm not -- unexpectedly, Len just
8 asked my question, so I'm going to pass, and go to the next
9 one.

10 CHAIR BAILET: Oh, okay. Bob.

11 DR. BERENSON: So I'm going to ask three
12 questions. Well, the first two, I asked before, and you
13 can sort of educate me a little bit. So how do we know
14 these patients have Crohn's disease or inflammatory bowel
15 disease?

16 DR. KOSINSKI: Again, another tough question.

17 We have a series of metrics, and in IBD, you have
18 clinical, endoscopic, pathological, serological,
19 combinations of data that provide someone a diagnosis of
20 Crohn's or ulcerative colitis.

21 If you have tissue, no question, you can make
22 your diagnosis, but there are not so much -- I'm going to
23 twist your question just one little bit. It's not so much
24 whether the diagnosis was correct, but is the risk level

1 assessed appropriately and should that patient be on a
2 biologic that you're making money in your office or your
3 HOPD for. And so I think we need to use science everywhere
4 we possibly can, and although medicine is an art and a
5 science, we need to push it as much to science as we can.

6 DR. BERENSON: So, but basically the trigger is a
7 clinical -- I mean is an ICD code.

8 DR. KOSINSKI: Yes. In fact, our patients that
9 were attributed to us by Blue Cross were our patients that
10 had seen us for at least a year and had a diagnosis based
11 upon ICD. It was 9 at first and now ICD-10 codes, and
12 that's how Blue Cross attributed. And they eliminated
13 anybody who was in another shared savings program of any
14 kind, and so the only ones that have been attributed to us
15 are our own patients that we have been consistent with that
16 have been part of Blue Cross and that have those ICDs.

17 DR. BERENSON: Okay. The second one does go to
18 what sounds like a total cost-of-care calculation. So I
19 just looked at the table that staff prepared that's on the
20 website, and patients with Crohn's disease, 16 percent have
21 chronic heart failure; 28 percent have chronic renal
22 disease; 19 percent have COPD; 26 percent, diabetes; 30
23 percent, ischemic heart disease. They claim that 40
24 percent have rheumatoid disease. I assume that's

1 arthritis.

2 DR. KOSINSKI: Arthritis from the IBD.

3 DR. BERENSON: Yeah. Well, okay.

4 But my question then would be, isn't the spending
5 for Crohn's disease relatively trivial for in the Medicare
6 population with those kinds of comorbidities, and isn't it
7 sort of random whether you save money or don't save money?

8 DR. KOSINSKI: You know, you have me at a little
9 disadvantage here because I only have access to the
10 commercial data that I've been provided through my payer.

11 I can tell you in our commercial group, in our
12 age -- our average age is in like 45, so we do have older
13 patients with comorbidities. We initially were trying to
14 only track our Crohn's-related costs, so I went through
15 this elaborate assessment of any ICD that could possibly be
16 related to inflammatory bowel disease, even to the point of
17 uveitis and certain skin diseases. And we tracked about
18 two-thirds of the costs were Crohn's-related, and this has
19 persisted to a point where it's remained fairly stable. So
20 now we don't go through that exercise. We take the total
21 cost of care, and that's what we've been measuring. But in
22 our population, it's about two-thirds of the cost.

23 DR. BERENSON: In your total population?

24 DR. KOSINSKI: Total population.

1 DR. BERENSON: And so then this is -- the last
2 question goes to sort of my experience, which is somewhat
3 dated right now, would be that Crohn's has a tendency to
4 burn out in older age. Is this largely a disease of, I
5 mean, the kinds of acute problems that lead to surgery and
6 develop fistulas and all of those complications? Does it
7 happen in 80-year-olds?

8 DR. KOSINSKI: I have used the same words with my
9 patients to make them feel better that it burns out as they
10 get older, but what actually happens in inflammatory bowel
11 disease, the inflammatory years are the younger years. The
12 fibrotic years are the older years, and the disease doesn't
13 go away or actually burn out. It converts into a chronic
14 fibrotic state. So you get obstructions, ischemia. You
15 get ischemic issues. You get different things in the older
16 population than you do in the younger.

17 But you are totally correct. The aggressive
18 inflammatory phase is younger.

19 DR. BERENSON: So I guess the follow-up to that
20 is, can you actually then head off those fibrotic changes
21 through pinging and that kind of thing? In other words,
22 are those more inevitable rather than in early intervention
23 to prevent?

24 DR. KOSINSKI: The goal in IBD is very similar to

1 rheumatoid arthritis in that as controlling the
2 inflammatory state, you will avoid the long-term fibrotic
3 state, and the answer is yes. If we can treat these
4 patients earlier --

5 DR. BERENSON: No, but that's my point, then. If
6 that's the younger population, what can you do with a 75-
7 year-old who has already been through the inflammatory
8 stage? What does the intervention accomplish? is my
9 question.

10 DR. KOSINSKI: We're in the nascent phase of
11 anti-fibrotic medications these days, but it's tougher.
12 You're correct.

13 CHAIR BAILET: Elizabeth.

14 VICE CHAIR MITCHELL: Thank you.

15 I'm curious about the payment model. You said
16 that this is being done on fee-for-service or not at all,
17 that people are just doing it. What would the optimal
18 payment model be from your view, and are the barriers
19 operational, or could you do something different or better,
20 in your view, if it were perspective or some other payment
21 methodology?

22 DR. KOSINSKI: A couple things. My first goal in
23 the payment methodology is to move physicians away from one
24 patient at a time making widgets to a focus on taking care

1 of an entire population of patients and being rewarded for
2 an outcome. Right now, we're not.

3 So to move physicians to that state takes some
4 money. It takes some investment. It takes some
5 leadership, practice redesign, and so there has to be an
6 investment, and that to me, the investment is the PMPM
7 payment.

8 We can call it a CCM payment, fixed to CCM
9 payments, and they're the same as our S codes that we're
10 using with Blue Cross now.

11 But there can't be an open end on this. You
12 can't say, "Well, you're going to get X number of dollars,
13 PMPM." No, there has to be a measurement. What was the
14 ROI for that?

15 I know with Blue Cross right now, they're touting
16 a very high ROI when they look at the \$600 that they spend
17 extra per year and the \$6,000 savings they're getting on
18 that population. So, to me, the appropriate thing is an
19 investment in a payment model followed by a risk-based
20 adjustment going forward in that payment, so that it
21 perpetuates itself and perpetuates the physicians to do
22 what we want them to do.

23 CHAIR BAILET: Kavita.

24 DR. PATEL: Thank you.

1 I just wanted to comment how great it was to
2 receive the proposal and understand your passion behind it,
3 but I had a question, because your comment about the
4 albumin, the serum albumin, just raised something.

5 Since it's such a significant kind of metric for
6 you, as you mentioned, is there any conversation or has it
7 been part of maybe potential conversations with your
8 commercial payers about having that downside financial
9 adjustment, if that albumin is not reflected? So I'm
10 asking, if they do not see that improvement, is there any
11 penalty, so to speak?

12 DR. KOSINSKI: Well, we've done this internally.
13 The payer, as I said earlier -- I don't think Blue Cross
14 Illinois wants us to fail, and our numbers are just not
15 high enough for them to be hitting us with too much
16 downside risk yet, but we're doing it internally.

17 DR. PATEL: In general, there is no downside risk
18 at all right now based on --

19 DR. KOSINSKI: Well, your payment, your monthly
20 payment would go down.

21 DR. PATEL: Would adjust, but it's based on that
22 total cost biologic use.

23 DR. KOSINSKI: Right.

24 DR. PATEL: Just again, nothing else is factored

1 into that.

2 DR. KOSINSKI: Blue Cross' major concern is
3 financial.

4 DR. PATEL: Okay.

5 CHAIR BAILET: Grace.

6 DR. TERRELL: We've been talking commercial, and
7 we've been talking Medicare, but there's a lot of younger
8 people who don't have commercial insurance. They have
9 something called Medicaid. I hear there's a lot of that in
10 Illinois.

11 DR. KOSINSKI: Mm-hmm.

12 DR. TERRELL: Do you have any data on the non-
13 Blue Cross population? Surely, you're serving that
14 population as well, or have you been able to provide that
15 service, even if it wasn't provided with payment back, or
16 is there any data that would allow us to think about it a
17 little more comprehensively than just Medicare versus
18 commercial?

19 DR. KOSINSKI: I'm glad we talked about this. I
20 had the word "Medicaid" in my presentation. I took it out.

21 Two out of every three babies born in Illinois
22 are born into public aid. It's a reality, and in our
23 practice, it doesn't matter what payer you're on as to
24 whether you get Sonar.

1 I don't have data. I don't have total cost data
2 on the Medicaid population. It's not been provided to us.
3 I would love to have that, my hands on that data.

4 CHAIR BAILET: Tim.

5 DR. FERRIS: So I want to also echo the comments
6 made about the work necessary to do all this work and to go
7 for the next step in Medicare.

8 I think I'll just characterize the fact that
9 you've had a fantastic demonstration in the commercial
10 population. I think the questions here today and your
11 answers in addition to the proposal and all the work that
12 has been done suggest that there is some legitimate
13 uncertainty in the Medicare population, and I wanted to ask
14 if some sort of assistance were available to you for trying
15 to answer some of these questions in the Medicare
16 population, would you be open to that kind of assistance?

17 DR. KOSINSKI: I always say yes to people giving
18 me things.

19 [Laughter.]

20 DR. KOSINSKI: I wrote an editorial in one of the
21 GI journals a few months ago with a colleague about "high
22 beta" illnesses. I would love to know in the Medicare
23 database what are the "high beta" illnesses, and by high
24 beta, I mean if you take a table and you look at

1 gastroenterology services and you have GERD, IBS, IBD,
2 colorectal cancer in the rows, and in the columns, we have
3 number of encounters, total cost, cost per encounter, but
4 the coefficient of variation of cost per encounter, if you
5 look at it in IBD, colorectal cancer screening has a 0.6
6 rating. IBD has a 3.6 rating. I would love to know the
7 other 3.6 illnesses out there where we can deploy this kind
8 of a platform. I would love to be able to get data that
9 would allow us to put some gasoline on this.

10 CHAIR BAILET: Paul.

11 DR. CASALE: So I don't really have a question.
12 I just wanted to make a comment, adding on that I thank you
13 for bringing this forward. Your passion is evident, and I
14 think all physicians practicing whatever specialty of
15 primary care would like to see movement in the same way.

16 And I just thank you, in particular, given my
17 role as the lead on the PRT and having been intimately
18 involved. So I just wanted to make that comment.

19 DR. KOSINSKI: Thank you. Thank you.

20 CHAIR BAILET: Harold.

21 MR. MILLER: Last week, I did the thing that
22 doctors fear that their patients will do, which is I went
23 digging on the Internet, and I did a bit of a search, and I
24 found a number of articles about, amazingly enough,

1 inflammatory bowel disease in the elderly.

2 *Journal of Crohn's and Colitis*, 2015.

3 "Inflammatory bowel disease amongst the elderly is common,
4 with growing incidence and prevalent rates. Approximately
5 10 to 15 percent of IBD in the USA is diagnosed after the
6 age of 60. This incident rate is conservative."

7 *American Journal of Gastroenterology*. "Elderly
8 IBD patients are prone to similar medical and surgical
9 interventions as younger patients, generally can be
10 expected that one surviving an initial severe attack, a
11 less severe disease course, with fewer relapses and
12 hospitalizations, occurs in elderly patients with
13 ulcerative colitis but not Crohn's disease."

14 *The Crohn's and Colitis Journal, Inflammatory*
15 *Bowel Diseases*, did a study that's titled "Inflammatory
16 Bowel Disease in the Elderly is associated with worse
17 outcomes." "Patients older than 65 years accounted for 25
18 percent of all IBD-related hospitalizations in 2004. Older
19 patients with IBD-related hospitalizations had substantial
20 morbidity and higher mortality than younger patients."

21 Is any of that inconsistent with your experience?

22 DR. KOSINSKI: No.

23 MR. MILLER: Okay. Thank you.

24 CHAIR BAILET: Thank you.

1 Seeing no other questions from Committee members,
2 we are going to thank you, Dr. Kosinkski --

3 DR. KOSINSKI: All right. Thank you.

4 CHAIR BAILET: -- for all of your work.

5 DR. KOSINSKI: Thank you.

6 CHAIR BAILET: Appreciate your coming. Thank
7 you.

8 Now I'd like to open up the public segment for
9 public comment. If the operator could open up the phone
10 lines, we have three individuals who have raised their hand
11 to provide a comment.

12 Oh, actually, okay. So do we want to do the
13 phone first?

14 MS. STAHLMAN: Two people are here. Why don't we
15 wait on the phone.

16 CHAIR BAILET: Well, why don't we go with the
17 folks -- yeah. Why don't we go with the folks here.

18 Sandy Marks from the AMA.

19 MS. MARKS: Thank you. So last week the AMA sent
20 a letter to the PTAC noting our disappointment that the
21 PRTs concluded that none of the four proposals should be
22 recommended to the Secretary for implementation, and I just
23 wanted to amplify that letter with a few examples where it
24 seems to us that the reviewers did not correctly evaluate

1 the proposals against the criteria that were published in
2 the regulations.

3 So under the definition of physician-focused
4 payment models, Medicare must be a payer. No criteria say
5 how much Medicare must be spending on the services that are
6 included in the payment model. The reviewers criticized
7 the SonarMD proposal by saying that Crohn's accounts for
8 just 1.25 percent of Medicare spending, but no one has
9 defined a threshold amount of Medicare spending that needs
10 to be involved for a model to be considered. Medicare must
11 just be a payer.

12 The reviewers also criticized the Sonar proposal
13 because the proposal said that a similar approach could
14 apply to other difficult-to-control conditions but limited
15 the detailed proposal to management of IBD. The fact that
16 a proposal has the potential to be used for other
17 conditions should be seen as a strength. It is
18 unreasonable to suggest that specialists who manage one
19 condition should design an APM for other conditions in
20 order for the PTAC to acknowledge that strength.

21 Moreover, it seems unlikely to us that the
22 specialists who manage the other conditions would accept an
23 APM developed by gastroenterologists for them, if it had
24 not first been implemented for the gastroenterology

1 conditions.

2 We are also concerned about the reviewers'
3 comments regarding the payment model, which they
4 characterize as fee-for-service supplemented by a care
5 management payment, and there has been a lot of discussion
6 of that today, but I just think it's important to point out
7 that the Sonar proposal involves the linkage of payment to
8 quality, involves financial risk, and requires use of HIT,
9 which are the criteria for MACRA payment models. The
10 Medicare fee schedule does not adjust payments for services
11 provided to patients with IBD, based on the quality of
12 their care, which a new payment model would do, and it does
13 not provide a share of savings to physicians who are able
14 to lower the rate of emergency visits and hospitalizations
15 for their patients.

16 The reviewers also were concerned that the model
17 did not provide shared savings payments to individual
18 providers based on their patient reported outcomes, but the
19 criteria say that the payment methodology must address how
20 APM entities are paid, not how the individual physicians
21 are paid.

22 So we are concerned that the negative preliminary
23 reviews will discourage the organizations who have been
24 working hard to develop APM proposals, and we hope the full

1 committee will look at all of the proposals with fresh
2 eyes.

3 Thank you.

4 CHAIR BAILET: Thank you, Sandy.

5 James Gajewski from the American Society of Blood
6 and Marrow Transplantation.

7 DR. GAJEWSKI: You did pretty good with my name.

8 CHAIR BAILET: Did I do okay, because I was
9 nervous.

10 DR. GAJEWSKI: It's Gayeski [phonetic].

11 CHAIR BAILET: Gayeski [phonetic].

12 DR. GAJEWSKI: It's Polish phonetics.

13 Thank you for allowing me to speak here, and I
14 actually do want to also applaud this society for
15 presenting this model.

16 As a blood and marrow transplant physician who
17 also does hematology and some oncology, I have to deal with
18 a patient population where I, as a subspecialist, am the
19 primary care physician for six months to a year. You could
20 describe our practice either as an inpatient or an
21 outpatient hospitalist practice. But I applaud that.

22 My concern for all of our alternative payment
23 models is access to care and that we preserve access to
24 care without cherry picking of patients, and this is going

1 to be a problem as we do it, because the human body is not
2 usually just one disease. We are multiple organ systems
3 that interact with one another. So how we do the acuity
4 adjustment, how we do these risk assessments are very
5 important, and much of our coding data lacks even primary
6 disease acuity, let alone truly this interactive effect,
7 and how do we deal with comorbidities where we have high
8 doses of steroids, like diabetes, and we have to look at
9 outcomes with diabetes as well as outcomes with
10 inflammatory bowel disease? These things are going to be a
11 problem.

12 Even probably more problematic are all the things
13 that we have never coded in the claims data: mental health
14 conditions; family dynamics; impending divorce; poor
15 financial assets such as difficult to get medications,
16 difficult to get the doctors; families with small children,
17 where you are stuck between taking care of your own health
18 or a small child. We don't have that adequately coded, yet
19 all these things are going to impact outcome. And the
20 thing -- if we can't both document and get credit for that
21 and do acuity adjustment, there will always be cherry
22 picking of patients, and somehow we have got to avoid that,
23 because that will do the greatest disservice to both the
24 population in this country as well as to any individual

1 patients. We need to pay attention to the outlier clauses
2 that we are going to need, because they are going to be
3 absolutely vitally important for these things.

4 I also worry about the assessments of patient's
5 personal feedback, because there are a lot of diseases with
6 psychosocial overlays where there has to be tough love. I,
7 as a cancer provider and hematologist, have to prescribe a
8 lot of narcotics for chronic pain in my patients. My
9 patients also become addicted. I have to set limits.
10 Well, those patients I set limits for, they don't give
11 really good patient satisfaction surveys. Those patients
12 who I am up-front with about bad cancer outcomes also don't
13 give good satisfaction surveys.

14 I think the issue of interrelationships of
15 proprietary software is a problem. As many of you know, I
16 do some work with the CPT Editorial Panel and the RUC
17 Committee. When transitional care codes first passed and
18 was approved by CMS, we were to bill 30 days after the
19 discharge. One of the major vendors of an EHR, which was
20 used at my institution, said, "This violates our billing
21 software. Go change CMS. We are not changing our
22 software." These are issues we are going to deal with.

23 I also think issues of tracking these labs -- I
24 was impressed with the albumin and I wanted to actually ask

1 an internist about pre-albumin being a better measure.

2 [Laughs.]

3 DR. GAJEWSKI: But the issue, though, we have is
4 a lot of commercial payers and Med Advantage plans have
5 outsourced labs to companies that do not interface well or
6 allow good tracking with the EHR that the cognitive
7 longitudinal care providers are doing. These are problems
8 that we have to look at and address.

9 Anyway, I thank you all for the comment and I
10 thought it was a very good presentation.

11 CHAIR BAILET: Thank you.

12 We have Leslie Narramore on the phone, from the American
13 Gastroenterological Association. Operator, is she present?

14 OPERATOR: If you could like to ask a question,
15 please press star and then the number 1 on your telephone
16 keypad.

17 Ms. Narramore's line is open.

18 MS. NARRAMORE: Hi. Can you hear me?

19 CHAIR BAILET: Yes. Yes, we can.

20 MS. NARRAMORE: Oh, excellent. Thank you so
21 much.

22 So good afternoon. My name is Leslie Narramore
23 and I am the Director of Reimbursement at the American
24 Gastroenterological Association. I am speaking today on

1 behalf of the AGA to provide comments on the Project Sonar
2 proposal submitted to the PTAC by the Illinois
3 Gastroenterology Group and SonarMD, LLC.

4 So first I want to say that we agree
5 wholeheartedly with Sandy's comments, on behalf of the AMA,
6 and just to kind of reiterate some of the comments that
7 you've already received from us, the AGA has long been a
8 leader in the development of episodes of care and value-
9 based care models, even before the passage of the MACRA
10 legislation, and we appreciate the opportunity to provide
11 feedback on physician-focused payment model proposals that
12 offer new ways for CMS to pay physicians for the care they
13 provide to Medicare beneficiaries.

14 Project Sonar is a model program for chronic
15 disease management for inflammatory bowel disease patients,
16 piloted with BlueCross BlueShield of Illinois, that has
17 proven effective at both managing costs and enhancing
18 quality. The model is based on the AGA's IBD clinical
19 service line, which contains evidence-based care guidelines
20 and other clinical decision support tools for IBD, to help
21 engage both providers and patients to change behavior and
22 improve outcomes.

23 We support the Project Sonar proposal as an
24 option, and we welcome the development and acceptance of

1 other models for gastroenterologists. Thanks.

2 CHAIR BAILET: Thank you. We have no one else on
3 the phone but I would like to open it up for anyone else
4 who is here, that might want to comment, or anyone else on
5 the phone who might want to comment. We'll start with the
6 folks in the room.

7 [No response.]

8 CHAIR BAILET: Seeing none, are there any folks
9 on the phone that may want to make an additional comment?

10 OPERATOR: Please press star and then the number
11 1 if you would like to ask a question.

12 [No response.]

13 OPERATOR: And there are no responses on this
14 end.

15 CHAIR BAILET: Thank you. So we are now going to
16 start our deliberations as a committee. Do any members
17 have any comments before we start, or are we ready to begin
18 our deliberations?

19 Len.

20 DR. NICHOLS: Remind me what deliberations mean.
21 Are we about to vote, or are we going to talk?

22 CHAIR BAILET: Yeah, we're going to -- well,
23 we're going to go through -- we're going to go through each
24 of the criteria --

1 DR. NICHOLS: Okay.

2 CHAIR BAILET: -- and formulate our own positions
3 on that, and you guys, we -- you know, this is a dialog.
4 We can talk about a particular perspective on each of these
5 criteria, and then as we go through each one we will vote,
6 using our electronic keypad here, and the tabulations will
7 be displayed on the screen behind me.

8 DR. CASALE: Jeff, sorry. Jeff, would it be
9 helpful, as we talk about each criteria --

10 CHAIR BAILET: To have it up there --

11 DR. CASALE: -- to put the slide up.

12 CHAIR BAILET: Yeah. They're going to put it up.
13 Yep. I think that's great.

14 MS. STAHLMAN: Give us a moment to get that
15 going.

16 CHAIR BAILET: So here we are with Criteria 1,
17 which we designated as high priority, and this is the scope
18 of the proposed physician-focused payment model. This
19 proposal aims to broaden and expand CMS's APM portfolio by
20 either addressing an issue in payment policy or in a new
21 way, including APM entities whose opportunity is to
22 participate in APMS.

23 MS. STAHLMAN: He's going to put something on the
24 screen.

1 CHAIR BAILET: What's he going to put?

2 MS. STAHLMAN: He's going to put up the voting.

3 CHAIR BAILET: Very good.

4 MS. STAHLMAN: Hold on just a minute. We're
5 going to get a new screen.

6 CHAIR BAILET: Okay. But as that screen is
7 coming up, I think we have the opportunity to discuss what
8 we heard today, relative to this criteria, and exchange any
9 points of view amongst ourselves that we feel compelled,
10 based on the information that has been provided for the
11 proposer but also from folks who have commented.

12 So this is --

13 MS. STAHLMAN: Here we go.

14 CHAIR BAILET: -- this is the grid relative to
15 the vote tabulation: 1 or 2, Does Not Meet; 3 or 4, Meets;
16 and 5 or 6, Meets and Deserves Priority Consideration.

17 MS. STAHLMAN: So you can ask them if they want
18 to deliberate --

19 CHAIR BAILET: Yeah.

20 MS. STAHLMAN: -- or if they would like to talk
21 about it.

22 CHAIR BAILET: Right. Do we want to talk about
23 this or are we going to go ahead and vote? I see Harold's
24 card up. Harold?

1 MR. MILLER: My reading of the criteria, which is
2 in the regulations, is that what we are determining is
3 whether this proposal either addresses an issue in payment
4 policy in a new way or includes APM entities whose
5 opportunities to participate in APMs have been limited.

6 My clear sense from this is that this gives
7 gastroenterology practices an opportunity to participate in
8 an alternative payment model for the patients that they
9 manage. There are no current gastroenterology models that
10 are implemented by Medicare, which, to me, means that the
11 proposal Meets the criterion.

12 CHAIR BAILET: Thank you. Bob?

13 DR. BERENSON: Yeah. I tend to agree with that,
14 and, in addition, would say that the fact that it doesn't,
15 in and of itself, represent a huge amount of Medicare
16 spending, I think is off the point. I think there will be
17 a great interest in developing models that change how
18 specialists interact with patients. I refrain from using
19 the term "medical home," because the American Academy of
20 Family Physicians submitted a letter on a different
21 proposal in which they feel very strongly that a medical
22 home has a very particular meaning, that specialists can't
23 achieve, so come up with a new term. Call it a lodge or a
24 shelter --

1 [Laughter.]

2 CHAIR BAILET: Tepee.

3 DR. BERENSON: It is -- I think we want to know,
4 you know, what has been called the specialty medical home,
5 which I would say we want to reserve medical home for
6 primary care, that's taking management across a whole range
7 of conditions, but that there would be a model for having
8 that kind of interaction with a patient. I'm somewhat
9 persuaded that the chronic care management code doesn't do
10 it today. So I do think it would meet this criterion.
11 I'll have some concerns about some of the other criteria,
12 but I don't think -- I think we probably want to be trying
13 to find models that are a specialty lodge.

14 CHAIR BAILET: Thank you, Bob. Grace and then
15 Paul.

16 DR. TERRELL: As a primary care physician, I
17 disagree with the concept that, by the way, that family
18 medicine has about that. It's who basically is taking
19 primary responsibility for the patient and that's not
20 always internal medicine, pediatrics, or family medicine,
21 as we all know.

22 But irrespective of that, I think that one of the
23 issues that all of our questions and all of the comments
24 was getting at, and it will continue to be an issue, I

1 think, that the PTAC is going to have to wrestle with, and
2 that is the difference between broad and specific. You
3 know, I believe that there are those who come to us with
4 the idea that something that is just in their practice or
5 that is just for their particular circumstances meets the
6 criterion and are coming before us, and then there are
7 others who are looking at things that are quite broad and
8 want to have something that might impact each and every
9 specialty in case.

10 And as we are doing our deliberations, this is a
11 big deal. This is may actually be the issue that we're
12 going to have the most difficulty with as a committee. My
13 general belief is, with respect to this one and Criteria 1,
14 that it's just right, and by that I mean it's specific,
15 it's for a particular specialty, it involves more than one
16 particular practice, and it could be exploited across more
17 than one setting or scenario.

18 But we're going to get folks who are going to
19 bring us things, I believe that are going to be more
20 specific than this, and we're going to get folks who are
21 bringing things that are quite broad, as we know, and we'll
22 probably deliberate on them more extensively. If we don't
23 get an understanding among ourselves about this, it's going
24 to be very difficult for all the proposers to understand

1 how to actually figure out what we're thinking and address
2 it appropriately. There are a lot of good ideas out there,
3 and some of them are at the practice level and some of them
4 are at the -- sort of already at the national scope level.

5 So with respect to this particular one, the
6 answer is it could be broadened. It could be expanded, and
7 it already is above and beyond just a single practice.

8 CHAIR BAILET: Paul.

9 DR. CASALE: Just responding to Harold's comment
10 about -- and I struggle with it. You know, APM entities
11 whose opportunities to participate in APMs have been
12 limited, I guess is part of what Grace is -- you know, how
13 do you define that?

14 So, for a cardiologist, you know, there's BPCI.
15 You know, you could have done acute MI. So when Harold
16 says there is no GI, you know, I'm trying to -- or one of
17 the struggles I have is the opportunities, because there
18 are some opportunities out there currently, for specialist
19 within BPCI, as an example, to participate.

20 But I think my broader comment is more related to
21 Grace's. It's the same struggle around limited and broad,
22 and again, we may just continue to struggle with this, but
23 that was part of my thinking around how to square this.

24 CHAIR BAILET: Len.

1 DR. NICHOLS: So I guess I'm now confused, Paul,
2 because I thought there's no BPCI for GI.

3 DR. CASALE: Well, again, GI bleed. I mean, you
4 could argue --

5 DR. NICHOLS: Oh, okay.

6 DR. CASALE: -- well, you know, so is that a GI?

7 DR. NICHOLS: Okay. So what I was going to say
8 is, I think you go back to Harold's point. There are two
9 elements of this, right, and by my lights there's not much
10 for GI docs out there, and that should be sufficient. But,
11 to me, the bigger reason to embrace this as a possibility
12 is Grace's point about how this could be expanded.

13 What I love -- just so you're wondering -- is the
14 Web-based analytics that could be applied in a number of
15 different directions, because you've all heard my stories
16 about EHRs. I think anything we can do to get out of the
17 vendor's hands is a good thing, and Web-based analytics has
18 all these potential ramifications.

19 But second, the potential can only be realized if
20 we get to the data he couldn't see, and that's where we've
21 got to figure out a way to square that circle.

22 CHAIR BAILET: Kavita.

23 DR. PATEL: It's very clear that we're having to
24 deal with what's kind of the Secretary's criterion, kind of

1 this very -- it's very limited language, so it gets exactly
2 to what Grace said.

3 I mean, we chose as a PRT to think about the
4 words "broaden" and "expand," not looking at any certain
5 threshold, but literally thinking what does that mean to be
6 broad and expansive and also thinking, addressing an issue
7 and a payment policy in a new way, and clearly, I think we
8 talked about why we did not think that that was necessarily
9 new, or including APM entities whose opportunities have
10 been limited.

11 And I actually -- we talked about GI and the fact
12 that even with BPCI -- and arguably, there are some
13 gastroenterologists in ACOs, that you're correct that there
14 aren't this proliferation of models out there for
15 gastroenterologists. All you have to do is look at the
16 literature scan that was provided to know that.

17 The question had been with the limited number of
18 practices that have implemented as well as some of the
19 opportunities, and it is a correct clarification. It is
20 the APM entities. That it was not clear if this would
21 broaden or expand the way it was currently submitted.

22 So I think just one thing I would like to impress
23 upon all of you, because, look, you had the three of us --
24 Rhonda is not here to speak for it, but we had many PRT

1 conversations where we were really trying to -- we wanted
2 to, at the outset of this, do as much as possible to be
3 flexible to allow for physician-focused payment models to
4 proliferate.

5 So let me just say that we were trying to go into
6 this with eyes wide open and be as broad as possible, but
7 despite kind of having that mindset, we were still
8 struggling with not filling in the white space and
9 interpreting what would be possible, but by kind of looking
10 at what was just in front of us.

11 So I would offer to all of you that not just the
12 specific criterion designated in the final rule, but then
13 also those information requirements that we attached to
14 that criterion kind of helped inform why we came to this
15 decision.

16 So, anyway, I feel like we're at this point where
17 we are going to kind of be flailing like an animal, so I
18 don't want to --

19 [Laughter.]

20 DR. PATEL: But I do want to -- I feel like it
21 would be remiss if it wasn't the fact that Paul, myself,
22 and Rhonda were desperately balancing what was in front of
23 us and what I would say is the "possibility" and we chose
24 not to try to interpret what that possibility could be. We

1 really had to rely on what was written to determine that,
2 and we did not feel like that was addressed in a broad or
3 expansive way.

4 CHAIR BAILET: Thanks, Kavita.

5 And to avoid the flog, I do want to acknowledge a
6 couple of things, and then I have a comment to make. As a
7 Committee, we appreciate the fact that you guys are the
8 astronauts, that this is new for everyone, everyone in this
9 room. So there is some degree of interpretation.

10 We are all on the same team. We talk often as a
11 Committee. We want this process to work. We want to be
12 able to foster models that are durable and scalable and
13 bring people into the tent.

14 At a hearing with a Subcommittee on Health with
15 the Energy and Commerce Committee at the one-year
16 anniversary of MACRA, they made it very clear that one of
17 the reasons they stood this Committee up was to get
18 specialists on the playing field with alternative payment
19 models.

20 I believe that this model allows that to happen
21 based on so far what I've seen, relative to this criterion.

22 I think it also -- I have had some experience
23 using this ping-pong, if you will, in the heart failure,
24 using predictive analytics, looking at cohorts of patients

1 who have a greater than 80 to 90 percent chance of being
2 hospitalized in the next six months using predictive
3 analytics, and retooling the practice outreach, ping-
4 ponging them, if you will, care management, having the physician
5 and clinicians wrapped around the social issues and the
6 beta-relative issues, it does make a difference. And our
7 particular experience reduced inpatient heart failure-
8 related admissions, not readmissions, but admissions by 60
9 percent.

10 So this kind of model, this clinical approach has
11 merit based on what I have seen and clearly what has been
12 demonstrated, albeit it, it's a small scale.

13 So I just wanted to make that point to my
14 colleagues on the Committee.

15 Elizabeth.

16 VICE CHAIR MITCHELL: Thank you, Jeff, and again,
17 acknowledging that this is our first time out, I actually
18 think that this process is serving its purpose.

19 I think the PRT's analysis of what was in front
20 of us was, I think, exactly right, and I have, I think,
21 been persuaded by what we have heard today, that this is,
22 in fact, expandable and could be broadened. The barriers
23 of the proprietary nature of the platform are not
24 restrictive, and that there is an interest to grow it to

1 additional conditions and specialties.

2 I guess the other comment I would make would be I
3 think we are not wanting to hold these early adopters
4 hostage to the environment in which they find themselves.

5 I read in you proposal that you asked, I think,
6 every commercial payer, and one said yes. So there are
7 external limits on how far it could be tested.

8 So while I think it was really important to
9 acknowledge the limited scope projected, I think hearing,
10 as you've said, Grace and Len, this could be expanded, I
11 think I am now persuaded that it could meet this criteria.

12 CHAIR BAILET: Harold.

13 MR. MILLER: Two points. One is I think we need
14 to revisit all this after we have completed all of our
15 reviews, but we asked a lot of questions and for a lot of
16 information on each of the criteria, and that was partly
17 because we really weren't sure what information we would
18 need to be able to evaluate the criteria.

19 But I think that the fact that we were asking for
20 the information, we tried to make that clear, and the
21 proposal did not mean that those questions were all
22 criteria. And I do not think in any circumstance ever
23 should we say that we are not supporting a model simply
24 because the number of Medicare beneficiaries that it would

1 support, that it would help is small. I think even if
2 there are a very small number of Medicare beneficiaries
3 with inflammatory bowel disease and if there is a way to
4 help them and there is a payment model to do that, then we
5 should be looking to support that.

6 The fact that this model -- I would agree with
7 Jeff. I have my own experience. I set up and ran a
8 program to help keep COPD patients out of the hospital a
9 number of years ago. The key intervention in that was a
10 nurse care manager. The major limitation on the nurse care
11 manager's ability to manage a number of patients was simply
12 the constraint of being able to contact the patients
13 frequently enough to be able to find out what was going on
14 with them. So I think there is potential to expand this,
15 and to me, we haven't really agreed on what a criterion
16 determination is for a recommendation with priority, but to
17 me a model that, in fact, has had some demonstrated success
18 does, in fact, enable a specialty that has not been able to
19 participate in the past and has the potential to expand to
20 other specialties, which have already seemed to express
21 some interest, to me, would make it a recommendation with
22 priority.

23 CHAIR BAILET: Thank you, Harold.

24 Seeing no other comments, are we ready to vote on

1 this criteria? Seeing the heads nod.

2 Just for the folks in the audience, there is that
3 circle with the zero out of 11. That tabulates the votes.
4 There's 10 of us voting, and the 11th person is the Wizard
5 of Oz, if you will, behind the curtain, who is controlling
6 all of this. So I didn't want you to think that there is
7 someone on the outside voting and calling in.

8 Without any further delay, we're going to go
9 ahead and vote, and it's a simple majority. So we're going
10 to go ahead and vote.

11 I can't --

12 MS. STAHLMAN: When we get the 10th one in -- has
13 everybody voted? Oh, there somebody just voted.

14 CHAIR BAILET: There we go.

15 MS. STAHLMAN: There you go.

16

17 And Ann is going to read the results for the
18 people on the phone, Mr. Chairman.

19 CHAIR BAILET: Please.

20 The voting is done.

21 MS. PAGE: Okay. So the voting is that we have
22 one member who voted Does Not Meet. We have three members
23 who gave it a score of 3, which means Meets the Priority
24 criterion. Four members gave it a score of 4, meaning

1 Meets the criterion. And we have two members who gave it a
2 score of 6, which means Meets and Deserves Priority
3 Consideration. And since seven members gave it a score of
4 Meets, that's a majority, and so the decision of the
5 Committee would be that this proposal Meets Criterion 1.

6 CHAIR BAILET: Thank you, Ann.

7 We are going to go ahead and move forward unless
8 members of the Committee want to discuss this particular --
9 based on the voting, any additional comments, or can we
10 move on?

11 [No response.]

12 CHAIR BAILET: We will move on.

13 Criterion 2, Quality and Cost. The proposal is
14 anticipated to, one, improve health care quality at no
15 additional cost, maintain the quality while decreasing
16 cost, or both, improve health care quality and decrease
17 cost. We also designated this as high priority, and I see
18 Harold -- I recognize Harold.

19 MR. MILLER: You recognize me. Oh, thanks.

20 CHAIR BAILET: I do. I do recognize, yes.

21 MR. MILLER: I would point out that I was not one
22 of those kinds that wanted to be an astronaut, but I'm
23 happy to do that.

24 Again, when we look at these, I think we need to

1 focus on what the criterion says. The criterion says the
2 proposal is anticipated to improve health care quality at
3 no additional cost, maintain health care quality while
4 decreasing cost, or both improve health care quality and
5 decrease cost.

6 This -- and I don't think we should ever penalize
7 an applicant for actually having put it in place with any
8 population, but unlike other things that are just ideas,
9 this actually has demonstrated that it has decreased cost
10 and has kept patients out of the hospital.

11 It is somewhat remarkable to me that we actually
12 have patient statements that we got saying that this helped
13 them, which is -- I think we will -- that may be the rare
14 thing that we get in terms of proposals that we get.

15 And I recognize while the concerns were raised
16 about whether this impacts the Medicare population, it
17 seems to me that there is published literature saying that,
18 in fact, this is a significant issue for the Medicare
19 population, newly diagnosed and severe, and so, therefore,
20 there is a reasonable anticipation that this would do the
21 same thing for the Medicare population.

22 CHAIR BAILET: Thank you, Harold.

23 I have Paul and then Grace -- or I'm sorry.
24 Grace first, then Paul. Got it.

1 DR. TERRELL: This is just a general comment for
2 us to think about as we're going through this process for
3 the first time, and we need to make sure that we don't put
4 people in a Catch 22. And by that, I mean we limit them to
5 20 pages in their proposal. We read that and evaluate it.
6 There's only so much if you've got 10 criteria that people
7 can actually put in 20 pages.

8 And then our process, I think we've -- at least
9 my experience, having read your report and been on the
10 other two, it's that then we ask a real deep series of
11 questions to try to get at all these things in more detail,
12 as you clearly have as well as we do.

13 But that process in and of itself is because we
14 don't want thousand-page proposals. This isn't a grants
15 type of proposal. This isn't the NIH. This is a proposal
16 to us for us to make a recommendation for then the
17 Secretary to decide and determine what to do with it
18 afterwards.

19 Within the context of that, within the context of
20 only having 20 pages, the real issue is these questions and
21 answers back and forth afterwards and making sure that our
22 proposers as well as those of us that are evaluating and
23 the PRTs having to write this up are having a process that
24 actually is going to kind of get to the meat of all these

1 things that we're talking about here today.

2 I think we're going to get better after we've
3 been through this a round or two, but I certainly would
4 welcome from everybody, particularly those who are going
5 through it this first time around, to give us some very
6 specific feedback with how -- if you didn't feel like your
7 points were being understood or if you did, what that
8 experience was like, because I think it will help us
9 without having to expand beyond that 20 pages, which I'm
10 loathe to do. And I'm sure everybody else would be too.

11 CHAIR BAILET: Thank you, Grace.

12 Paul.

13 DR. CASALE: Yeah. I just think in my assessment
14 on this quality and cost -- you know, I think as Kavita has
15 already said, we looked at what was in front of us, and
16 what was in front of us was very limited information about
17 what happens to Medicare patients.

18 And I would respectfully disagree with Harold
19 that a literature review is going to tell me how this model
20 is going to impact that population.

21 So for me, I just didn't see how this was going
22 to anticipate to lower cost in that population, and I think
23 we've already gone through on the quality measures. And I
24 am glad that they are piloting more of the patient report

1 outcomes and assessments, but I think at this point, I felt
2 that they were limited.

3 CHAIR BAILET: Kavita.

4 DR. PATEL: I think we're absolutely going to
5 have to talk about whether even any of these information
6 requirements are relevant. They are not part of the
7 Secretary's criteria. We knew that, but just taking the
8 words "improve health care quality at no additional cost,
9 maintain health care quality while decreasing cost, both
10 improve health care quality and decrease cost," we know
11 that clearly from the commercial pilot that we've seen
12 evidence of decreased cost. And we have an impression of
13 improving health care quality with a limited set of
14 measures. Did we have a predefined threshold of what that
15 needed to be? No, not at all. Did we think that it had to
16 be a certain percentage? Absolutely not. But we were
17 really trying to struggle with the age-old conundrum of
18 what really is value and doing that in reflection of the
19 impact on a Medicare population, not with a certain
20 threshold.

21 We didn't actually say, "Oh, it's only 1.25
22 percent? That's not enough," because if it's a disease
23 which has obvious quality implications, which all diseases
24 do, we know that as clinicians, but we were trying to

1 understand how could -- what was in front of us, improve
2 that health care quality, and did not feel like we had
3 enough, to the point of going back and forth.

4 We actually did go back and forth with the
5 submitters, and I brought this up even in our public
6 discussion. We really did try to understand where the
7 comment about serum albumin came into play, but then had a
8 hard time, struggled with the fact that one of the most
9 important clinical quality outcome indicators was actually
10 not in any way tied to the proposed physician-focused
11 payment model.

12 So I think all of us are probably thinking how
13 can we interpret and be kind of reflective of the process
14 but also take advantage of going back and forth, without
15 doing what we were also worried about doing, which is to
16 say, "Well, why don't you just rewrite this section this
17 way, and then you would actually meet these criteria." And
18 so we really tried as desperately as possible to stop short
19 of that. So I'm going to underscore something that Tim
20 just kind of briefly mentioned, that this kind of
21 reiterates that --

22 DR. FERRIS: Yeah.

23 DR. PATEL: -- there's almost like a value in
24 helping to give feedback, but we don't actually have that

1 as part of the regulation, part of the statute, or part of
2 the process.

3 CHAIR BAILET: Yeah. Bob.

4 DR. BERENSON: So I have adopted the Harold
5 precedent of going quickly to literature, and to some
6 extent, supporting what Harold found and to some extent
7 maybe not, here is a meta-analysis of inflammatory bowel
8 disease in the elderly. I can't vouch for the authors, but
9 it's cited by lots of folks.

10 And yes, in fact, it's not uncommon. This says
11 10 to 15 percent. "The clinical features of IBD and older
12 are similar to those in younger. There's more colonic-only
13 involvement, and this is important, and mostly in
14 uncomplicated course."

15 And then one other sentence, and then I'll stop
16 with this, "Management of late onset IBD is complex because
17 of the problems with misdiagnosis, treatment of comorbid
18 diseases, multiple drug interactions, impaired mobility and
19 cognition, and difficult social and financial issues."

20 So it is a real problem in the elderly, and it
21 can't simply say we're going to take our model from 30-
22 year-olds and lay it onto the Medicare population. I think
23 it needs the work to sort of figure out what the
24 interactions are with other physicians. It's more

1 complicated than treating IBD in the younger population, so
2 that's my concern about whether it meets the quality
3 criterion. It's probably better than doing nothing, but it
4 doesn't hit the potential of what we would want to do,
5 which is specific to the Medicare population.

6 CHAIR BAILET: So my sort of thinking about
7 alternative payment models and this transformation to
8 value, as I looked at this proposal, I thought about the
9 downstream ramifications that transcend the specific
10 disease, and I saw a couple of things that I think touch on
11 this particular criteria about quality and cost.

12 There are certain tracks that are laid down by
13 this particular model relative to the patient engagement.
14 It's a struggle that we've had for a long time in our
15 industry, trying to get the patients more engaged in their
16 care. I think that this model lays those tracks, and as
17 we've said, people who have this disease, they don't just
18 have this disease. They have other comorbidities, and so
19 this approach to patient engagement, I think there can be a
20 sentinel effect relative to other diseases and how they get
21 engaged and work with the clinical staff to improve their
22 care.

23 The other piece along that relative to quality,
24 another track is the behavioral overlay or that behavioral

1 component that I spoke to earlier. If they're depressed,
2 they're not -- it's not depression in the box of Crohn's
3 disease. It's depression overall, and I think that this
4 particular model illuminating this level of depression also
5 can help us as clinicians address that depression as it
6 relates to other disease states. So I just thought I'd
7 make that point.

8 And I think one additional point that I want to
9 make to my PRT colleagues and Rhonda, who is not here but I
10 know spent a tremendous amount of time on all of these
11 criteria and the analysis, we appreciate all of the work
12 that you guys have done to set this up to allow this kind
13 of discussion to occur, and I don't want to give anyone
14 listening in on the outside that our particular positions
15 based on the information and the discussion here in any way
16 mitigates or diminishes the work that the PRT has done
17 because, frankly, in my opinion, if they didn't do that
18 work and they didn't work with the proposal submitter and
19 set the table for us, we wouldn't have the rich dialogue
20 today to effectively and hopefully efficiently evaluate
21 these criteria.

22 So I just want to say, looking at my two
23 colleagues here, I don't want them walking away feeling
24 like we're at cross-purposes because we're absolutely not.

1 Harold.

2 MR. MILLER: First of all, I'd like to agree with
3 what Jeff just said and thank the PRTs in all cases,
4 present company excluded for tomorrow, I guess, but I think
5 we've all entered -- this is the first time around for
6 everybody, and we have not probably -- maybe to the
7 surprise of the public is that we have not collectively
8 discussed any of these proposals or had the opportunity to
9 do that, so everybody has been kind of just figuring it out
10 independently, and that can result in different things.

11 I put my card up, though, because I am a little
12 mystified at this issue about quality measures because it
13 seems to me that one of the ultimate quality measures is
14 that you enabled a patient to stay out of the hospital,
15 which is, in fact, what I understand the goal of this
16 project to be. And, in fact, there is discussion
17 nationally about trying to get away from all of the micro
18 quality measures and to try to have something like
19 percentage of days spent at home. So to me, staying out or
20 reducing hospitalizations is a quality measure. It is a
21 better measure than simply a total cost of care measure
22 that has no quality at all attached to it, but says how
23 we're saving money is, in fact, by doing that.

24 I think Bob was reading from the exact same

1 article of the pile that I have here, and they do talk
2 about the complexity in the elderly, which is why it seems
3 to me that it is a desirable thing to have a payment model
4 where there is not just a chronic care management fee that
5 is being paid without any accountability for outcomes, but
6 having physicians saying, in fact, we will take the money
7 and we will be accountable for achieving the results.

8 So if gastroenterologists want to take on a
9 population that is complex and try to make it work, and we
10 have some evidence that that could work, that seems to me
11 to be a good thing.

12 CHAIR BAILET: Thank you.

13 Any other comments? Are we ready to go to the
14 keypad? I feel like a game show here. Okay. We're going
15 to go ahead and vote. So we have --

16 MS. STAHLMAN: So, Ann will read the results.

17 CHAIR BAILET: Ann?

18 MS. PAGE: Yes, we have one member giving it a
19 score of 1, Does Not Meet; two members giving it a score of
20 2, Does Not Meet; three members giving it a score of 3,
21 Meets; two members giving it a score of 4, Meets; one
22 member giving it a score of 5, Meets and Deserves Priority
23 Consideration; and one member giving it a score of 6, Meets
24 and Deserves Priority Consideration.

1 So the majority give it a score of Meets when you
2 aggregate these up, so the criterion will meet the
3 Criterion 2, Quality and Cost.

4 CHAIR BAILET: Thank you, Ann. We have a fairly
5 diverse opinion on this particular metric.

6 DR. BERENSON: Got a high beta.

7 CHAIR BAILET: Pardon me?

8 DR. BERENSON: It's got a high beta.

9 [Laughter.]

10 CHAIR BAILET: So is there any additional
11 discussion that needs to be had at this point with the
12 Committee members on this criteria? Then we'll move --
13 seeing none, we'll move to Criterion 3, Payment
14 Methodology. Again, this is the third high-priority
15 criteria. Pay APM entities with the payment methodology
16 designed to achieve the goals of the PFPM criteria;
17 addresses in detail through this methodology how Medicare
18 and other payers, if applicable, pay APM entities; how the
19 payment methodology differs from current payment
20 methodologies; and why the PFPM cannot be tested under
21 current payment methodologies.

22 So I'm opening it up for discussion. Len, Bruce,
23 and Tim.

24 DR. NICHOLS: So I took -- and I very much

1 appreciate your legwork. Let me be clear about that,
2 because you helped me focus. But I took the thrust of the
3 critique of the model to be, well, you know, you could use
4 a chronic care management fee. And I think we've
5 established that's actually not technically feasible in
6 this case. You could adjust it, and Lord knows we all wish
7 that would happen, and it may. But then, you know, I sort
8 of feel like, look, you got a model here that's got the
9 structure that you want an alternative payment model to
10 have as a recognition of the fact that you're going to have
11 to do a pretty intense evaluation at the beginning, a PMPM
12 to cover all the cool stuff we don't pay for in fee-for-
13 service, and a willingness to bear downside risk and
14 putting yourself on the line for what that would be. And I
15 would point to -- and I'll just say I and I think
16 Elizabeth, too, and maybe others, there's a private sector
17 payer paying for some version of this now, which is in some
18 -- and citing a 10:1 ROI. They'll probably cite that for
19 20 years, whether it ends up being true. But, anyway, they
20 think it's working. And I would hesitate for us to say
21 this structural model is not a good one when, in a sense,
22 the private sector has validated it.

23 So I totally get that the Medicare population is
24 completely different, and we're going to come back to that

1 later. But as a technical matter on the payment
2 methodology, to me this meets the criteria.

3 CHAIR BAILET: Thank you, Len. Bruce.

4 MR. STEINWALD: Since when is my name two
5 syllables.

6 [Laughter.]

7 CHAIR BAILET: It's getting late in the day.

8 MR. STEINWALD: It's getting late in the day.

9 DR. TERRELL: You're moving to South Carolina
10 soon.

11 MR. STEINWALD: That's true. All right.

12 I guess for me the crux of this issue -- and this
13 one stands in greater contrast than any of the other ones
14 for me that we've discussed -- is do you need a model to
15 achieve the objectives or not. And if the chronic care
16 payment needs to be tweaked, wouldn't it be simpler to do
17 that than to actually launch a complete model?

18 And so, you know, I generally agree with Len that
19 it has a nice structure to it, but this sort of overall
20 question of do we need a model, does the system currently
21 allow for achieving the objectives with minor changes as
22 opposed to a payment model, I'm on the fence about that.
23 So I'd like to hear what other people have to say.

24 CHAIR BAILET: Tim.

1 DR. FERRIS: So let me just say that of the
2 different criteria, this one I had the hardest time with
3 for this model. And that's because of a series of things
4 that came up in conversation and in the review. And the
5 first one is the opportunity for cherry picking, and this
6 goes not to the issue of it has been tested in the
7 commercial population but to the issue of it has been
8 tested with a group who is incredibly forward-thinking and
9 generous to the people that they are taking care of. And I
10 believe our job is to recommend a model to the Secretary
11 that will work for whoever is a Medicare provider who is
12 implementing it. And I wish, but I'm quite sure that it's
13 true, that not everyone providing services to Medicare
14 beneficiaries is as high-minded and fantastically oriented
15 toward their patients as this particular group.

16 And so I worry that this particular payment model
17 has some opportunities for cherry picking. It has some
18 opportunities for risk selection, cherry picking, however
19 you want to state it. I'm also concerned about the total
20 cost of care model in the Medicare population, which, as
21 we've heard, is really very different than a commercial
22 population. That affects the payment model. And I'm
23 concerned about the lack of tie on the shared savings to
24 quality.

1 I think all three of these things are really
2 important to a Medicare payment model that differentiate
3 them from how one might do it in a commercial model. And
4 so I guess what I would say with none of these -- I would
5 back up first and say I think this kind of model can work
6 in a Medicare population. I am for this kind of model. I
7 think it's a really great idea. But I would say the model
8 as proposed from a technical perspective needs work. Like
9 it's not quite there yet. I don't think it needs a lot of
10 work, but I think it needs some work, because there are
11 some mitigation factors. I can't just say personally to
12 the Secretary, like, "Make this available to anyone
13 providing services to Medicare because it's going to make
14 the world a better place."

15 Something close to it might actually, and I think
16 actually have a pretty good chance of that, but not what's
17 in this proposal, because too many of these details have
18 not been specified. And so I just wanted to say that it is
19 specifically the payment model from my perspective that is
20 not sufficiently well specified for the Medicare population
21 and the Medicare payment system that gives me pause about
22 this model.

23 CHAIR BAILET: Bob.

24 DR. BERENSON: Well, Tim said it better than what

1 I would have said. I agree with his comments completely.
2 I would simply emphasize there needs to be some targeting
3 of the subpopulation of Crohn's patients or IBD patients
4 who don't have uncomplicated courses, because the majority
5 do in the elderly. And, number two, I just think total
6 cost of care is inappropriate for this. I would be much
7 happier to use what Harold suggested in the last one, is
8 hospitalization rates, quality metrics. The costs
9 associated with IBD will be trivial compared to the costs
10 associated with all these other conditions that these
11 patients have. And even if CMMI likes total cost of care
12 and the BPCI model, I don't.

13 So I just think, with Tim, that there's real
14 potential for this model, but we need to work on the
15 payment.

16 CHAIR BAILET: Thank you, Bob. Elizabeth.

17 VICE CHAIR MITCHELL: Thank you. I'm aligning
18 with Tim and Bob here. I think this is the toughest
19 criteria for me, and part of it just feels like a
20 confession because it says why the PFFM cannot be tested
21 under current payment methodologies, and I think we've
22 demonstrated that it can. I think we're doing fee-for-
23 service plus an enhanced payment for care management. So I
24 think it's a bit circular. But I just don't see this as a

1 big departure from current payment methodologies, and I
2 have the same concerns about potential unintended
3 consequences.

4 CHAIR BAILET: Len, your card is still up. Did
5 you --

6 DR. NICHOLS: Yeah [off microphone].

7 CHAIR BAILET: You were just testing me. Then
8 we're moving on to Harold. Grace is next. Sorry.

9 MR. MILLER: First of all, to Bruce's question, I
10 don't believe the criteria says that if it's possible
11 somehow for you to do this under current payment systems
12 that you fail the criterion. The issue is: Does it pay
13 with a methodology designed to achieve the goals? Which it
14 seems to me that it does.

15 That being said, I have the same concerns about
16 the methodology that Tim raised and that Bob raised. And,
17 I suspect, though, that we are going to get a lot of those
18 same questions on anything that comes.

19 I struggled with what is the level of specificity
20 that we and -- you know, sort of detail on all the things
21 being addressed in a proposal to us at this stage from
22 applicants, which is a pretty heavy burden to put on than
23 whenever they don't even have the vaguest idea whether it's
24 going to be approved at all, right? We have to think about

1 that. And the second question is kind of whether the
2 perfect should be the enemy of the good, and so what does
3 that mean? It seemed to me that one way to do that would
4 be to look at what are the other models that are out there.

5 So, for example, cherry picking I think is an
6 issue, but it's an issue in every other single Medicare
7 model that they have. You know, the oncology care model
8 does not prevent an oncologist from excluding patients that
9 are going to blow their cost budget under the model. There
10 is absolutely no protection against that there, and I'm not
11 sure that anybody has quite figured out exactly how to deal
12 with that.

13 I do think that there's a problem with the total
14 cost of care methodology for this, but I think a challenge
15 is that we said in our RFP that we wanted to see total cost
16 of care methodologies as the preference. And I think it's
17 a problem to say to an applicant, "We put out an RFP.
18 We're looking for total cost of care methodologies," and
19 then say, "Guess what? We don't like your total cost of
20 care methodology."

21 So I think what I'm struggling with is I don't
22 want them to have a total cost of care methodology either,
23 but I think it's a problematic thing to say, "Hey, guess
24 what? You went through this whole process. You've brought

1 in a model that sounded like what we were looking for, and
2 then we decided that we didn't like it." And at this
3 point, we don't have a good option for saying, "Recommend
4 with some fixes." But that may be what we need to do, is
5 to say it's actually pretty darn close in terms of overall
6 structure, and it needs to be fixed in the following ways.
7 Because when I look at it, I say it does need to be fixed
8 in the following ways, but I don't see them as fatal flaws
9 in the sense that you couldn't fix them. And every
10 Medicare model so far -- I think Tim has experienced this
11 personally -- comes out with benchmarking methodologies
12 that don't really work all that hot initially and need to
13 be adjusted. And to say to an applicant you have to come
14 in with a perfect benchmarking methodology and everything
15 all worked out in advance seems to me to be a pretty high
16 hurdle to put on it.

17 So I think -- I'm not exactly sure what the right
18 way to determine all that is, but it does seem to me we've
19 got to compare it to what we've said, we've got to compare
20 it to what other models have done, and we've got to compare
21 it to what is reasonable to have somebody have worked out
22 in advance, particularly whenever they cannot get access to
23 the damn data that they would need to be able to actually
24 model this and bring us a reasonable proposal.

1 CHAIR BAILET: Thank you, Harold. Grace?

2 DR. TERRELL: So one of the things I think we're
3 struggling with here, and I think we'll continue to
4 struggle with until we get our heads around it, is there's
5 a difference between care models and payment models. And
6 we are the Physician-Focused Technical Advisory Committee,
7 but it's about payment, and so we get all excited when
8 people bring us care models with a payment attached to it.
9 And then we start criticizing the payment model because we
10 get warm and fuzzy about the care model.

11 That's going to keep happening to us, and it's
12 because we're asking the physician community to bring us
13 things. And what they're doing is they're saying, "If I
14 could just have a different payment model, I could provide
15 this care." But they always start -- and if you'll pay
16 attention to every one of these proposals, by and large,
17 they start with a care model because that's what doctors
18 do. They think about patients first.

19 So the issue for me comes to is there a way that
20 we can be thinking about care models, and then Criterion 3
21 comes along, which is the payment model associated with
22 that, that will, to Harold's point, be good enough, because
23 I think it's going to be real crucial if we're going to get
24 a lot of innovation out of the physician community, because

1 they're always going to start with care.

2 So I have a lot of experience with my
3 organization, Cornerstone, developing care models, in
4 pulmonary and nephrology and diabetes, an extensivist
5 model, a Medicare/Medicaid model, congestive heart failure
6 model, one for polychronic clinic patients that were
7 stable, and we always came up with ways to save money for
8 the system and provide higher-quality care, the first two
9 models. But every single one of the current criteria
10 that's out there, including the chronic care fees, don't
11 work. And a lot of Cornerstone's experience has been
12 trying very hard within, you know, what's out there right
13 now in terms of accountable care and otherwise of having
14 ways of providing care that's better with payment models
15 that don't work necessarily, or at least without a lot of
16 roundabouts for it. And you heard about some of the
17 roundabouts today as they were giving some information.
18 They're giving some of it for free, the folks, and others.
19 It works in big groups and not small groups. So this is
20 our purpose as a Committee, is to figure out how to do
21 this, and it's not going to be easy, but it's going to be
22 absolutely crucial.

23 My belief is that the -- I think Bob could be
24 wrong about the cost of care being driven by a chronic

1 disease and, you know, I guess the data would tell you.
2 You always find mixed data. But biologicals are a big deal
3 in these particular diseases, and sometimes those costs can
4 dwarf the management costs for many of the others,
5 including diabetes. So that's just a point that we don't
6 know necessarily unless you've already found the data out
7 there.

8 I think that Sandy Marks was absolutely right
9 when she said there isn't a model right now in the current
10 chronic care management fees that also hold people
11 accountable for cost and risk and payments up and down on
12 that. And so the broad principles are in this. It may not
13 be perfect, and it's not going to be perfect, but we're
14 going to keep having this problem. We're going to keep
15 getting care models that we're going to have to figure out
16 some payment models for, and if our criteria are that
17 nothing on the market now works, they're bringing us
18 something that we think might work, it's going to lead to a
19 lot of the discussions that are going to happen at the CMS,
20 CMMI level of small-scale testing or technical help to get
21 it to the next level. But I don't think that we should be
22 throwing the baby out with the bath water because the baby
23 in this is better care, and it's the care models.

24 CHAIR BAILET: Thank you, Grace. Kavita.

1 DR. PATEL: So I'll clarify. Paul, and actually
2 in -- well, I'll hit a number of points.

3 One, we did not expect the methodology to be
4 perfect. Nowhere in criterion is the word "perfect," so we
5 did not apply some threshold of, does the methodology need
6 to be perfect. In fact, I think if you applied that to
7 CMS, nobody would say that current CMS payment methodology
8 is perfect. So, absolutely, was there no intention of
9 perfection to be a goal.

10 However, what we did try to do is understand how
11 the payment methodology differs from current payment
12 methodologies. I still don't think any of our payment
13 methodologies are perfect, but what we were struggling with
14 was, is there a difference in what's available now, both in
15 the alternative payment model portfolio or in even current
16 fee-for-service. So perhaps it was erroneous to
17 overemphasize what was meant to be just an example, that
18 is, that CCM is truly just an example. We probably could
19 have put in a lot of examples, including the oncology care
20 model, which, by the way, doesn't allow for the cherry
21 picking because it's a trigger that's done by
22 administration of chemotherapy, so I actually don't think
23 that is has as much of the cherry-picking notion.

24 However, you could almost argue that if you took

1 the oncology care model, given the use of biologics in this
2 inflammatory disease population, that that model, which is
3 basically a specialty payment model with a PBPM, as well as
4 potential shared savings, from a methodological standpoint,
5 is kind of a parallel to what is proposed here.

6 So it was a complete struggle. I feel like
7 whatever I'm going to say will do the opposite, so maybe I
8 should start with the opposite. But what we really did try
9 to do, in all seriousness, was understand how we could
10 almost think through, is there something different about
11 the payment elements from what is currently out there.

12 I think one thing that Sandy brought up in her
13 AMA's comments, that we were incorrect in discussing, is
14 that we do not need to deal with how payments are applied
15 to the individual, because she was absolutely correct, this
16 is about APM entities. So that was a good reminder that we
17 need to just keep going back and thinking through APM
18 entities, and not worrying so much about payments tied to
19 individual providers. But even if we removed that, I would
20 tell you that from a payment standpoint the methodology of
21 a PMPM or a care management fee, even with some shared
22 savings or shared losses, is very similar to existing
23 payment models.

24 And then we did want to point out, in Dr.

1 Kosinski's -- in Sonar's responses, they did mention, and
2 we do have inclusion around kind of what they call Crohn's-
3 specific target pricing and Crohn's kind of adjusted
4 utilization cost metrics. So in case that was not part of
5 it. It's not just -- they suggested total cost of care --
6 just as a clarification -- but there was also the inclusion
7 of kind of a Crohn's-specific. Again, it was to a
8 commercial population. So we're all kind of talking about
9 applicability to a Medicare population which speaks to the
10 need for more of that data and kind of assistance to
11 understand what that data actually looks like.

12 CHAIR BAILET: Thank you, Kavita. Bob.

13 DR. BERENSON: Yeah, no. To the point about
14 where the spending is, we do have a Table 3 online, which
15 finds that of \$4 billion spent in Medicare in Part A, B,
16 and D, only \$145 million is on biologics. It's largely a
17 Part A issue, so we don't have it sorted out in more useful
18 ways than that.

19 But my point, I guess, would be is if biologics
20 were a high-cost item, do we want a payment model that
21 would determine whether you get a bonus or a penalty based
22 on whether you're prescribing biologics? I mean, I'm not
23 sure that's the right incentive system that we would want
24 to create.

1 You're shaking your head.

2 CHAIR BAILET: Grace, can you put your microphone
3 on?

4 DR. BERENSON: That's a side point.

5 DR. TERRELL: I'm just confused. I don't -- I
6 mean, biologics should be used in the right situation,
7 sometimes more, sometimes less, depending --

8 [Overlapping speakers.]

9 DR. BERENSON: Well, that is right, and if you
10 have a strong financial incentive, based on shared savings
11 and shared risk, you might not -- that might affect not
12 reducing unnecessary hospitalizations but reducing the use
13 --

14 DR. TERRELL: Well, we've got that now with fee-
15 for-service as well --

16 [Overlapping speakers.]

17 DR. BERENSON: Absolutely. So if we're going to
18 fix that we don't want to just replicate it somewhere else.
19 But that's a whole different discussion. I think that --
20 I'll go back to the language, Harold. I don't think we
21 told people they have to use total cost of care. I think
22 we said that that was one, but I seem to remember that we
23 emphasized that there are alternatives, because I, for one,
24 was pushing that we didn't want to just limit opportunities

1 to total cost of care.

2 So if we said that was our preference, I think we
3 need to reconsider that. Clearly, that's what CMMI is
4 largely leading with. We can't disown it. It is
5 absolutely appropriate for some payment models, like any
6 population-based payment model, you want to look at total
7 cost of care. A disease-specific payment model, I don't
8 think, in most situations, it is appropriate and we should
9 just clean up our language a little bit.

10 CHAIR BAILET: Harold.

11 MR. MILLER: So it seems to me there's two sort
12 of categories of issues here. The first one is whether
13 this payment model concept is necessary and/or different
14 than what exists today. It seems to me that the answer to
15 that is yes, it's different, and maybe necessary in the
16 following way. It is not the chronic care management fee,
17 in ways that Dr. Kosinski raised. It is a flexible,
18 monthly payment that is not tied to minutes, and, more
19 importantly, it is tied to outcomes.

20 There are many, many examples around the country
21 of people who have gotten paid to hire a nurse care manager
22 with some amount of money and have achieved absolutely
23 nothing with it, because they hired the care manager and
24 they did something or other, but they didn't actually have

1 any accountability for the outcome. So tying that payment
2 very specifically to a set of outcomes of keeping patients
3 out of the hospital is a very important thing.

4 In the project I ran years ago, we hired nurses
5 and we said to the nurses, "Your job is to keep patients
6 out of the hospital, and you have a goal of how many
7 patients you have to keep out of the hospital," which, in
8 fact, was a very liberating thing for the nurses because it
9 enabled them to use their clinical judgment to be able to
10 do that, and I think this model is different than one that
11 says you've got to count up your minutes every month to be
12 able to make something happen.

13 So that's one category of issues. So from my
14 perspective, it passes on that.

15 The second category of issues that people have
16 raised, though, is are there aspects of the definition of
17 the model that are problematic and need to be fixed, and I
18 agree that there are. To Bob's point, I think we struggled
19 -- I am in Bob's court on this, that total cost of care is
20 much more problematic than people think it is, but you do
21 have to think about how you're not leaving out the key
22 things from a lesser thing, and everybody knows that CMS'
23 default is that they want total cost of care for
24 everything. So, again, I don't think that we should

1 penalize an applicant for coming in to do what it is that
2 they probably rightly believe that is desirable.

3 So it seems to me the other things we have to
4 decide, whether they are fatal flaws or not. Cherry
5 picking, to me, is an issue that needs to be addressed but
6 it is not a fatal flaw. Sorry to disagree with you,
7 Kavita, but the oncology care model is triggered by
8 chemotherapy and any smart oncologist is going to have to
9 think about whether or not they want to give chemotherapy
10 to a patient who is going to blow their budget. So it does
11 not protect against cherry picking.

12 That doesn't mean -- but I think the fact that
13 physicians who come into this and want to make it work are
14 not going to cherry-pick, but we should still try to build
15 in protections to that. That does not seem to me to be a
16 fatal flaw, because it's a problem with every model that
17 exists today.

18 I do think the other things -- my particular
19 conclusion is that those other issues are addressable, and
20 the question is should they be addressed before we approve
21 it or after? I'm leaning towards the fact that I think
22 that they are addressable after we would recommend it.

23 CHAIR BAILET: Thank you, Harold. Any other
24 comments from the Committee?

1 [No response.]

2 CHAIR BAILET: Are we sufficiently spent to vote
3 on this one? Very good. So without further ado, we are
4 good. Ann?

5 MS. PAGE: Yes. We have three members voted 1,
6 Does Not Meet; three members voted 2, Does Not Meet; three
7 members voted 3, Meets; zero members voted 4; one member
8 voted 5, Meets and Deserves Priority Consideration. So the
9 majority, six votes, voted for Does Not Meet, and that is a
10 majority, so that is the criteria -- that is the rating
11 given to that criteria.

12 CHAIR BAILET: Thank you, Ann. We're going to
13 move on, Criterion 4, Value over Volume. The proposal is
14 anticipated to provide incentives to practitioners to
15 deliver high-quality care.

16 Any comments from the Committee, or are we ready
17 to vote?

18 [No response.]

19 CHAIR BAILET: Not seeing any, we are going to go
20 ahead and vote on this criteria, please.

21 Ann?

22 MS. PAGE: One member voted 1, Does Not Meet;
23 three members voted 2, Does Not Meet; four members voted 3,
24 Meets; one member votes 4, Meets; one member votes 5, Meets

1 and Deserves Priority Consideration. So we have six
2 members -- I can do math -- six members voting that Meets,
3 or Meets and Deserves Priority Consideration, so it rolls
4 down and the vote will be recorded as six members voting
5 Meets criterion -- Meets the criterion, and that will be
6 the decision of the Committee.

7 CHAIR BAILET: Thank you, Ann. Criterion 5,
8 Flexibility. Provide the flexibility needed for
9 practitioners to deliver high-quality health care.

10 I just have a small comment to make.

11 DR. FERRIS: We already voted.

12 CHAIR BAILET: What's that? Wait. You guys are
13 already voting on me?

14 [Laughter.]

15 CHAIR BAILET: Holy cow. Teamwork and respect,
16 everyone.

17 So having supported --

18 [Laughter.]

19 MS. STAHLMAN: He's going to close it out and do
20 the vote again.

21 CHAIR BAILET: Jeepers, Wally. You guys are
22 killing me here.

23 DR. NICHOLS: We are guessing what you are
24 saying.

1 CHAIR BAILET: All right. Very good. Yeah,
2 right, the mind meld.

3 So I have found -- I don't remember whether we
4 had 45 or 50 gastroenterologists in my former practice in
5 Wisconsin, but one of the challenges that the physician
6 constituency raised around the GI physicians was getting
7 them to pay attention to diseases where they didn't
8 necessarily require a scope, that there was a lot of
9 medical management required.

10 This particular model allows the headroom for
11 that cohort of physicians to address this very labor-
12 intensive, complicated, complex, E&M sort of weighted, if
13 you will, disease state.

14 So I do think that this is -- while it's not the
15 panacea, it does, again, using my phraseology, lay a track
16 for getting the GI physicians to recognize that it's not
17 just all about getting to the lab, but there are some other
18 elements, that the practitioners want for their patients,
19 and I think that this particular model speaks to that. So
20 I thought I'd -- pardon me? Now you can vote. Like that's
21 really going to sway you guys.

22 All right. Let's go. Let's give this a vote
23 here. You guys are killing me.

24 MR. MILLER: You convinced me.

1 CHAIR BAILET: Yeah, thanks, Harold. You guys
2 are buying the first round tonight.

3 DR. PATEL: Is it closed?

4 CHAIR BAILET: Well, we can't tell if it's closed
5 but I can do the math, and it looks like we have 10 there.

6 MS. PAGE: Okay so zero committee members voted 1
7 or 2, which would mean Does Not Meet; four members voted 3,
8 Meets; three members voted 4, Meets; two members voted 5,
9 Meets and Deserves Priority Consideration; and one member
10 voted 6, Meets and Deserves Priority Consideration. So the
11 majority has voted that the proposal Meets this Criterion
12 5.

13 CHAIR BAILET: Very good. We're going to go to
14 number 6, Ability to Be Evaluated. Have evaluable goals
15 for quality of care, cost, and any other goals of the PFPM.

16 Seeing no comments from the Committee I'm feeling
17 that we need to go ahead and vote.

18 Ann?

19 MS. PAGE: Zero committee members have voted 1 or
20 2, which would mean Does Not Meet; four members voted 3,
21 Meets; five members voted 4, Meets; one member voted Meets
22 and Deserves Priority Consideration. The majority has
23 voted that this proposal Meets the Criterion 6.

24 CHAIR BAILET: Very good. Thank you, Ann.

1 Criterion 7, Integration and Care Coordination.
2 Encourages greater integration and care coordination among
3 practitioners and across settings where multiple
4 practitioners of settings are relevant to delivering care
5 to the population treated under the PFPM.

6 Harold?

7 MR. MILLER: I was troubled by this issue, and I
8 just wanted to clarify. Although the references in the PRT
9 report are really to primary care providers, it seems to me
10 that there is a bigger issue, to the point that Bob was
11 making earlier, is that if people have other significant
12 comorbidities that are, in fact, potentially driving
13 hospitalizations, et cetera, and that interact, then it
14 seems me that it is pretty important to try to figure out
15 how one is coordinating with them, if you are going to
16 manage total cost of care, and even if you're not, because,
17 as Dr. Kosinski said, it's hard to separate out exactly why
18 anybody ended up in the hospital.

19 So it does seem to me that one weakness that I
20 saw in the proposal description was a clear sense that
21 somebody -- the nurse care manager or someone was making
22 sure that everybody was informed, that if there was MedRec
23 to be done or a resolution of potential conflicts that that
24 was being done, et cetera, et cetera, et cetera.

1 CHAIR BAILET: So I -- Grace, go ahead. You go
2 first.

3 DR. TERRELL: One way that this might be able to
4 be addressed -- I would agree, Harold and Bob and others,
5 but one way that this might be able to be addressed broadly
6 in the future is actually through the care pathways and
7 care guidelines that are part of the actual disease
8 management itself. If we think about it as the need to
9 coordinate across specialties, when there is more
10 comorbidities as actual part of clinical guidelines, then
11 this can be addressed not only in this particular approach
12 but others.

13 So I would just use this as an opportunity, not
14 only for the gastroenterologists but for all the medical
15 specialties to be thinking about their care guidelines as
16 having this as a crucial component of it. It may not
17 completely solve the payment model per se, but since the
18 guidelines are going to be embedded in the quality
19 parameters it would be a way of potentially thinking about
20 it broadly, across the specialties for chronic disease.

21 CHAIR BAILET: And I guess I am conflicted, but I
22 would say that one of the challenges we have is driving
23 care coordination. I mean, it's the siloed behavior that
24 is impacting cost, and while this -- you know, there

1 clearly -- this is a specialty-specific model and I think
2 there's an opportunity to flesh this out. There's clearly
3 care coordination going on within the practice, but it's
4 really that sort of broadening the footprint of this
5 particular model. I think there's an opportunity there.

6 Paul?

7 DR. CASALE: Yeah. I would -- just to add on, I
8 mean, I think, as Grace said, that we are going to be
9 facing this a lot, because it's, you know -- part, as Dr.
10 Kosinski pointed out, it's technological. You have these
11 EMRs that are quite rigid. You try to work outside it.
12 But any practicing physician knows they don't want to log
13 into more than one system in their day-to-day work, so when
14 you end up doing things like faxing and -- you know, it
15 just sort of disappears into the EMR. So, you know, it's
16 something we're going to need to -- we'll be seeing a lot
17 of this and it's a difficult issue.

18 CHAIR BAILET: Thank you, Paul. Any other
19 comments?

20 We're going to go ahead then -- we're going to go
21 ahead and vote.

22 Ann?

23 MS. PAGE: Three committee members gave it a 1,
24 meaning Does Not Meet; six committee members voted 2, Does

1 Not Meet; one committee member voted 3, Meets; and zero
2 committee members gave it a 4 or a 5 or a 6. So the
3 majority finds that this proposal Does Not Meet Criterion
4 7.

5 CHAIR BAILET: Thank you, Ann.

6 Criterion 8, Patient Choice, encourage greater
7 attention to the health of the population served while also
8 supporting the unique needs and preferences of individual
9 patients.

10 Comments from the Committee? Harold.

11 MR. MILLER: This is one where I honestly did not
12 understand why the PRT rated it this way because it seems
13 to me, again, the model is that there are alternative ways
14 of contacting the patient, if that's the issue. I think
15 the criterion is about -- it says "encourage greater
16 attention to the health of the population while also
17 supporting the unique needs and preferences of individual
18 patients," which by, in fact, contacting the patient to
19 determine how they're doing and administering depression
20 screens, et cetera, it seems to me that it does, in fact,
21 support that.

22 So it seemed to me that there was a little bit
23 too much weight put on the notion that the dominant mode of
24 communication was mobile, particularly when there were

1 indications from the submitter in the material that many
2 Medicare beneficiaries -- and they had, admittedly, a small
3 sample -- are responding to that.

4 CHAIR BAILET: Thank you, Harold. Bob.

5 DR. BERENSON: Yes, this is a time when I think
6 the focus of attention should be on the population at risk
7 and in need rather than the broader population of Medicare
8 beneficiaries where targeted interventions like this do
9 make sense. So I guess in this case I would not sort of
10 endorse the principle that we're asking for and would not
11 hold it against the proposer. In fact, if anything, I want
12 more targeting, not less targeting, of resources to those
13 who actually are at risk of hospitalization and strictures
14 and all of the bad stuff. So I would give it a higher
15 rating.

16 CHAIR BAILET: Paul.

17 DR. CASALE: Yeah, I think when I mentioned
18 during our other conversation, I think part, at least for
19 me, in the thinking wasn't so much of the choice of
20 technology but around, as in the example, you know, the
21 demographics of the patient population. So the potential -
22 - I guess as Bob -- the at-risk population, but do they
23 have social determinants of health that would impact their
24 ability to have a choice around how they would be

1 contacted, if they can be contacted, et cetera. And so
2 that was part of at least my thinking around this criteria.

3 CHAIR BAILET: Thank you, Paul. Harold, you had
4 your card -- okay. I think we're ready to vote.

5 Ann?

6 MS. PAGE: One Committee member voted 1, Does Not
7 Meet; another Committee member -- one Committee member
8 voted 1 -- I mean 2, Does Not Meet; three Committee members
9 voted 3, Meets the criterion; five Committee members voted
10 4, Meets the criterion; and zero Committee members voted
11 either 5 or 6, Meets and Deserves Priority Consideration.

12 The majority of the Committee members voted that
13 this proposal Meets Criterion 8, Patient Choice, and that
14 would be the decision.

15 CHAIR BAILET: Thank you, Ann.

16 Criterion 9, Patient Safety. How well does the
17 proposal aim to maintain or improve standards of patient
18 safety? Comments from the Committee?

19 [No response.]

20 CHAIR BAILET: Seeing none, let's go ahead and
21 vote. Ann?

22 MS. PAGE: Zero Committee members voted 1 or 2,
23 which would mean Does Not Meet; five Committee members
24 voted 3, Meets; two Committee members voted 4, Meets; two

1 Committee members voted 5, Meets and Deserves Priority
2 Consideration; one Committee member voted 6, Meets and
3 Deserves Priority Consideration.

4 The majority of Committee members voted Meets for
5 Criterion 9, Patient Safety.

6 CHAIR BAILET: Thank you, Ann.

7 We're here at the home stretch here. Criterion
8 number 10, Health Information Technology, encourage use of
9 HIT to inform care. So, Committee, I think there's some
10 robust discussion. Harold, then Elizabeth.

11 MR. MILLER: Here I think that the PRT rating was
12 too focused on the pinging technology and not on the fact
13 that this model inherently is, in fact, encouraging
14 tracking of information about patients and using that
15 information about patients in EHRs because the
16 accountability is going to require understanding what
17 factors really do drive patients to be hospitalized, to
18 respond, et cetera.

19 So, anyway, I think that if one says is this, in
20 fact, as the criterion says, going to encourage use of
21 health information technology to inform care, it seems to
22 me that the answer is clearly yes, it does.

23 CHAIR BAILET: Thank you, Harold. Elizabeth.

24 VICE CHAIR MITCHELL: This may just be a general

1 statement, but I think I will be putting extra weight on
2 information sharing for all of these models, and whether it
3 gets there through an alternative way to cross EMR
4 platforms and vendors or however it's done, I just think
5 this is really important. And I am encouraged by how I now
6 understand that this information might be shared more
7 broadly. So I'm supportive.

8 CHAIR BAILET: Thank you, Elizabeth. Len.

9 DR. NICHOLS: So I was going to ask Paul, because
10 I learned something I didn't get from the written stuff,
11 and that was the ability to push the web-based analytics
12 back to an EHR. It's input into EHR. You don't have to
13 sign on the system. You could make it inserted. Did you
14 learn something that would change your view, this fax
15 business?

16 DR. CASALE: Well, in their proposal, when we had
17 questions back and forth, it mentioned particularly with
18 the primary care that faxing or that the primary care can
19 sign into their system, were potentially the more prevalent
20 options currently.

21 CHAIR BAILET: Bob.

22 DR. BERENSON: Yeah, I just wanted to ask the PRT
23 if their major concern for Does Not Meet had to do with the
24 proprietary nature of the software. Was that the basic

1 reason?

2 DR. CASALE: Yeah, I have to say for me I still
3 struggled with that particular piece, you know, and -- yes,
4 for me that is one of the major reasons why I voted the way
5 I did.

6 CHAIR BAILET: Kavita.

7 DR. PATEL: So I'll also respond that -- and this
8 goes back to kind of a larger question we'll have to have
9 about how maybe CMS would deal with something that's
10 proprietary. So that was one piece.

11 But, Bob, another piece was also the kind of
12 desire to avoid unintended consequences of technology that
13 is not interoperable, and so there were a couple of new
14 pieces of data from what Dr. Kosinski said here, which was,
15 one, that there was probably a willingness to open this up
16 to not be kind of a proprietary cost basis; and then, two,
17 that pushing back -- kind of that HL7 standard, then being
18 able to kind of push that into other EMRs. I will say from
19 a practical clinical perspective, my lovely employer and
20 institution has a vendor arrangement with a certain EMR
21 that, even when someone else wants to give us something,
22 that particular EMR charges us to receive said information.
23 So we know that in practicality, some of these things are
24 not as easy.

1 But even having said that, that piece of
2 information was new for us, but I do think that we probably
3 have to have a discussion about how -- if Dr. Kosinski
4 hadn't said that this was possibly able to be done kind of
5 without that cost burden, you know, does that still mean
6 something? Because it means other professionals would
7 still have to log into something separate, even if it was
8 free, and what that means for better coordination.

9 We do know that from limited literature of when
10 physicians have to log into multiple interfaces, they tend
11 not to do it. So we should have that discussion.

12 And it wasn't just something that like -- just to
13 make a point in the sand, we talk a lot about coordination,
14 and we use the refrain of specialists coordinating with
15 primary care. We actually discussed at the PRT level that
16 it was really more important, since this was such a
17 specialty-focused model, and to Bob's point that better
18 targeting is better, that it was even with the super
19 specialists, that this was actually more about
20 coordination, not just with good old primary care doctors,
21 which I am part of, but more important with a lot of the
22 super specialists that surround these patients because of
23 the complex interactions with the specialty care.

24 So we were worried that the proprietary nature

1 and the fact that it was so targeted just for GI might
2 limit the kind of Secretary's criteria of health
3 information technology to inform care. So that was the
4 concern.

5 CHAIR BAILET: Thank you, Kavita. Tim.

6 DR. FERRIS: So I guess I'm thinking about the
7 health information technology a little bit differently, and
8 maybe just to give some context, I think it's really
9 unlikely that my organization would ever participate in
10 anything like the platform because just think about the
11 implications of that for taking care of every specialty
12 diagnosis that we take care of. I mean, that's just not
13 going to happen.

14 We have functionality in our EHR and our extended
15 platforms that do everything that I read about and
16 translating the guidelines, which we do all the time, into
17 our EHR is an exercise, but it's just an exercise.

18 And so when I looked at this, I did not read this
19 as a requirement, nor did I think CMS would -- their
20 payment would be in any way like that platform. It would
21 be the ability to reproduce that functionality in any
22 platform.

23 CHAIR BAILET: Right.

24 DR. FERRIS: Because I'm just saying, since it

1 does fall under my span of control in my organization,
2 there's no chance we could do sort of disease-by-disease
3 platforms. No one would use it, and it's just simply not
4 an extensible model. And so I view this as the ability to
5 provide that kind of functionality independent of the
6 platform.

7 CHAIR BAILET: Yeah.

8 DR. FERRIS: So I'm just saying that's the way I
9 read this, and that's the way I would vote on it.

10 CHAIR BAILET: Okay. Well, I think your wish is
11 about to come true because seeing no -- oh, Paul, did you
12 have a comment?

13 DR. CASALE: Well, you know, part of the
14 struggle, though, is you're trying to analyze what's in
15 front of you, and you could imagine how it might integrate
16 into your EMR. But that's not what we were evaluating, so
17 there is this sort of tension around as we vote in terms of
18 we're voting on this or we're voting on, well, you know,
19 the guidelines can be put in every EMR and gone forward,
20 and it wouldn't be proprietary. So I have to say I'm still
21 struggling with that.

22 DR. PATEL: And I actually now see, Tim, kind of
23 what you're saying, because we had a lot of discussion
24 about like the ping response rate as an index -- I mean,

1 Dr. Kosinski even mentioned kind of the Sonar score as one
2 of the kind of metrics, and we really did read that for
3 what it was, tied to that kind of IP-protected technology.
4 But, actually, in hearing what Dr. Kosinski said today and
5 then just even that discussion, I can see where it's really
6 much more of the functionalities, and we would have to
7 think about how to kind of -- well, we wouldn't. Somebody
8 at HHS would have to think about how to cross-map kind of
9 what's underlying and unpacking all of this to, you know,
10 everybody else that is in the vendor space. But we kind of
11 went much more literally with like what was there. But I
12 agree, it does change my frame of thinking just hearing,
13 like, it's really much more about the functionality, and
14 that's something that we probably have to discuss as a
15 Committee.

16 CHAIR BAILET: Thank you, Kavita. Harold.

17 MR. MILLER: It seems to me that this gets at an
18 issue Grace was raising earlier about care models and
19 payment models. And at least as I understand the payment
20 model here, the idea is that the practice gets paid X
21 dollars PMPM and then takes accountability for whatever it
22 is they take accountability for, total cost or
23 hospitalizations or whatever.

24 The payment model is not you're being paid to use

1 the Project Sonar platform. If it were, I would not be
2 very happy with the model, because it doesn't -- as Tim
3 point -- you know, it somehow constrains you to a
4 particular technology, which may or may not work in your
5 particular setting. I think the issue, what is useful is
6 to know that somebody has a concept for how they will, in
7 fact, spend the money. That gives you some sense that that
8 amount of money is, in fact, something that sort of would
9 reasonably be able to achieve something that's like to
10 accomplish the results. But then the payment model says up
11 to you to decide how you do it, which is, in fact,
12 equivalent to the way most other payment models do it. We
13 pay physicians an E&M payment, but we don't tell them
14 exactly what they must do in the course -- well, maybe
15 people might disagree with that, but, anyway, it doesn't
16 tell them how many MAs they have to have --

17 CHAIR BAILET: Okay, you can come and get him
18 now.

19 MR. MILLER: Yeah, right. So...

20 CHAIR BAILET: I think Harold's done. All right.

21 DR. CASALE: Sorry.

22 CHAIR BAILET: Paul, go ahead. You keep flipping
23 your card up. You're confusing --

24 DR. CASALE: Well, I have to tell you the

1 struggles. But part of this is that --

2 MR. MILLER: We know you struggled, Paul. We
3 know.

4 DR. CASALE: I know. Part of the model, though,
5 is the dependence on this ping. You know, this is a
6 technology, you know, the ping response. So, again, as we
7 think through it, you were sort of going to make some
8 assumption that this can be done in other ways and other
9 platforms, et cetera. But we really don't know that. I
10 mean, we can imagine it could happen that way. But some of
11 the technology that leads to these results is not generic.

12 CHAIR BAILET: All right. I'm going to let Tim
13 go first.

14 DR. FERRIS: Just on that specific point. So we
15 don't call it the same thing, but for every -- we do this
16 across about 14 diseases right now, and we actually measure
17 our response rate in every single one of them. So it's not
18 like this is original, I'm sorry to say.

19 DR. CASALE: It's not original -- sorry, okay. I
20 was just trying to think more broadly around every practice
21 setting, you know, how would they use this?

22 CHAIR BAILET: Harold.

23 MR. MILLER: So the way I see this is a
24 gastroenterology practice brought us a payment model to

1 support an approach that they are using, which is written
2 in a way that enables other people to do something
3 different, or similar, if they wish to. I'm sorry, but
4 there is a lot of evidence that care management for
5 patients who have serious illnesses reduces
6 hospitalizations and ED visits. I have personal experience
7 doing that, and many other people do.

8 But there is no Medicare model today that enables
9 any specialist, not even, frankly, for primary care
10 physicians, to be able to take a per-member per-month care
11 management payment and take accountability for an outcome
12 associated with it. So that to me is what it is that we
13 are voting on today. And maybe we need some clarification
14 of that. I don't think we are voting to pay for a ping-pong
15 system that happens to be the one that was brought to us.

16 DR. CASALE: No, we're just talking -- we're
17 voting on the HIT technology, right? That's where we are.

18 CHAIR BAILET: We're on 10. We haven't voted
19 yet.

20 MR. MILLER: Yeah, but it has been raised by
21 other people, and to me, the issue is, the criterion is,
22 does it encourage use of health information technology? To
23 me it does encourage use of health information technology
24 more broadly, not just that particular ping-pong system,

1 because one is going to have to track things about patients
2 in whatever implementation one does.

3 CHAIR BAILET: Very good. I think it's time.
4 We're going to vote. Yeah, we're good. Okay, very good.
5 We don't mess around here.

6 All right, Ann. Fire it up.

7 MS. PAGE: Okay. Zero members voted 1, Does Not
8 Meet; one member voted 2, Does Not Meet; five members voted
9 3, Meets; four members voted 4, Meets; and zero members
10 voted 5 and 6, Meets and Deserves Priority Consideration.

11 So the majority decision of the Committee is that
12 this proposal Meets Criterion 10.

13 CHAIR BAILET: Thank you, Ann.

14 So the next step in the process, where the rubber
15 meets the road, is Matt, the person behind the curtain. He
16 will put up a summary of all of our deliberative votes.
17 And while we're waiting for him to do that, I guess I would
18 ask the Committee if we have further deliberation or
19 comments that we'd like to make before we actually vote
20 relative to making a recommendation to the Secretary. And
21 while that's happening -- well, Len.

22 DR. NICHOLS: So this was great. I'm glad we did
23 this. I feel better about my country. I feel better about
24 my Committee. It's just, you know, this is how it's

1 supposed to work. And I'll just sum it up very briefly
2 from my point of view.

3 We've got a pretty good proposal from creative,
4 dedicated people that needs some work. Our problem from my
5 point of view are the, I'll just say, straitjackets of the
6 categories we set up for ourselves, and part of that has to
7 do with our discussions with our friends at HHS that have
8 to receive these things. But I would observe that if there
9 is a proposal that cries out for technical assistance, this
10 is at least one of them. Just a prediction. There might
11 be one or two tomorrow. But the point is we need to think
12 about how to convey that, and I'm open to all alternatives.
13 But to me, this is an obvious place for where not that much
14 technical assistance could address a vast majority of the
15 concerns that have been legitimately discussed today. And
16 I just would like that to be recorded somehow in one of the
17 categories we're going to be able to go for.

18 So, you know, if you say no, you say yes, but it
19 seems to me this notion of somebody -- not necessarily us,
20 but somebody providing some technical assistance to beef up
21 the parts of this that need work. I just think we need to
22 do that.

23 CHAIR BAILET: Yeah. And I think that
24 opportunity -- and we'll speak to it in a little more

1 detail after we vote. I think we have the opportunity in
2 the comments that bolt onto the recommendation. I think we
3 have the ability to share that perspective in the comments
4 section when we send our recommendation to the Secretary.

5 Elizabeth, you had a question?

6 VICE CHAIR MITCHELL: This may or may not be
7 orthodox, but I actually had a question for the submitter.
8 I have no experience with this, but it seems to me this
9 could be like putting your child in a beauty pageant. I am
10 just wondering. Were there changes that you have for the
11 process, or are there assistance needs or things that might
12 make this different in terms of what you would bring to the
13 Committee?

14 That could be a long answer. I'm looking
15 probably right now for a shorter version, but are there
16 thoughts?

17 DR. KOSINSKI: Can I answer after you vote?

18 [Laughter.]

19 VICE CHAIR MITCHELL: Good question.

20 CHAIR BAILET: No. You can go to the microphone
21 at the front. Well, either one.

22 DR. KOSINSKI: Like I said, can I answer after
23 you place your vote?

24 I've learned a lot today in listening to

1 everybody, and it was clear to me. We were trying to fit
2 into 20 pages with 10 criteria, and we just couldn't say
3 everything we wanted to say, about 10 things in 20 pages.

4 And then when we get to supplemental questions, I
5 was trying to be brief. I was trying to focus specifically
6 on the question that was asked of me and not elaborate and
7 built a whole bunch of other stuff for you to read.

8 So I would love to debrief at length with you --

9 CHAIR BAILET: Thank you.

10 DR. KOSINSKI: -- if you vote for the project.

11 [Laughter.]

12 CHAIR BAILET: Yeah. Thank you.

13 So the summary, is it ready to be displayed?

14 Oh. And, Harold, please make a comment.

15 MR. MILLER: We have this category called
16 Recommend for Limited-Scale Testing, which was, at least in
17 my mind, intended to be a way of saying some models that
18 come to us will have issues that need to be resolved in
19 terms of refining the payment model that will be very
20 difficult to resolve without actually putting it in place.

21 So I am trying to think about that from this
22 particular perspective because I think we all agreed with
23 varying degrees of severity that there need to be some
24 improvements in the payment methodology.

1 One of the things that was driving that was lack
2 of understanding about how this actually works in the
3 Medicare population. Hard for me to imagine right now
4 exactly how one figures that out unless one actually does
5 something with the Medicare population, which means that
6 it's hard to do that if you don't actually have a payment
7 model to be able to support that. And I'm hoping that a
8 bunch of gastroenterology practices will all just go do it
9 voluntarily with a complex population that we've all said
10 is a complex population. It seems to me kind of a bit of
11 imposition on volunteerism.

12 Some of the other things could potentially be
13 designed theoretically in the absence of that but would be
14 hard to know how they actually play out. We have these
15 sort of odd statistics now that say X percent of people
16 have some other comorbidity, but we don't really have a
17 clear sense of exactly what that means in practice. So
18 there's lots of people, and there are lots of things, but
19 is it severe? Is it not severe? We don't know those
20 things.

21 So it does seem to me, as I think about it, that
22 it would be -- there are technical assistances necessary,
23 to Len's point, but it's hard for me to imagine exactly how
24 one wouldn't be able to satisfy all of the questions

1 without actually putting it in place on a limited scale.

2 CHAIR BAILET: Thank you, Harold.

3 We have the summary up, and everybody can see it,
4 but there are folks on the phone who can't.

5 So, Ann, do you want to just share the summary?

6 MS. PAGE: Sure. The chart the Committee is
7 looking at right now lists all 10 of the Secretary's
8 criteria, and it shows that the Committee voted that in two
9 of those criteria, the payment methodology, which is a
10 high-priority criterion, and Criterion 7, Integration and
11 Care Coordination, that the Committee voted that for both
12 of those two criteria, the proposal Does Not Meet the
13 criterion.

14 For the remainder of the Secretary's criteria,
15 the Committee voted that the proposal does Meet those
16 criteria.

17 CHAIR BAILET: All right. Thank you, Ann.

18 So we are going to now do the -- we have a sort
19 of two-pronged approach to voting. We are going to vote
20 electronically, and then we are going to vote by voice.
21 The Committee members felt it was important for folks to
22 know where each individual Committee member stood relative
23 to the recommendation to the Secretary.

24 I would just like to review what the numbers

1 mean, and this is a two-thirds majority threshold. So a
2 vote of 1 means we do not recommend the payment proposal to
3 the Secretary. A vote of 2 means we recommend the proposed
4 payment model to the Secretary for limited-scale testing.
5 Three means we recommend the proposed payment model to the
6 Secretary for implementation. And I want to be clear that
7 that's testing and implementation; that is, once we make a
8 recommendation, then CMS takes it from there, and we don't
9 want to overprescribe how they process our recommendation.
10 But it is up to the Secretary. And then a vote of 4 means
11 that we not only recommend the payment model to the
12 Secretary, but we also recommend that it be implemented as
13 a high-priority item.

14 So I believe we will electronically vote, and
15 then we will go around by the Committee and give a voice
16 vote.

17 MS. PAGE: Are we ready?

18 CHAIR BAILET: Are we ready to -- we may not be
19 ready.

20 DR. CASALE: Can I --

21 CHAIR BAILET: Yes, Paul.

22 DR. CASALE: Just a clarifying question, because
23 I know there was a discussion around technical assistance,
24 and so I'm not sure where that falls in here, or was that

1 just not related to which category we --

2 CHAIR BAILET: Len.

3 DR. NICHOLS: In my opinion, you can put
4 technical assistance where you want. What I would suggest
5 -- what I'm going to do is vote the way I think it ought to
6 go. So if you go limited testing, that means let's do the
7 technical assistance before you do limited testing. If you
8 vote no, then you're saying let's work out the details and
9 try again.

10 CHAIR BAILET: Any other questions, comments by
11 the Committee?

12 [No response.]

13 CHAIR BAILET: We're going to go ahead and vote,
14 then, please.

15 [Discussion off microphone.]

16 CHAIR BAILET: I think we are going to have to
17 pre-medicate Dr. Kosinski here.

18 DR. KOSINSKI: It's like the Academy Awards.

19 CHAIR BAILET: No. We promise you, it will not
20 be like that.

21 [Laughter.]

22 CHAIR BAILET: Okay. Let the record -- we're on
23 TV. That is not going to be like that.

24 Help the Doctor, Matt.

1 One more time with feeling.

2 All right, Matt. I know you want to slide it
3 over. Well, I think we should let it play through, and
4 then we can do the voice vote.

5 MS. STAHLMAN: Give him --

6 CHAIR BAILET: He's got it. I know it's right
7 there. I can see it.

8 [Pause.]

9 CHAIR BAILET: It's that high-anxiety moment.
10 Okay. No pressure, Matt.

11 [Laughter.]

12 CHAIR BAILET: This really is a fun Committee, by
13 the way. I'm just letting you folks know.

14 There we go. Come on, Matt. We'll give him --
15 and then we'll just go around. There we go. Come on.

16 Do we need to vote again?

17 MR. ELLENBURG: We need to vote again.

18 CHAIR BAILET: We will vote again. One more time
19 with feeling.

20 MR. ELLENBURG: No. I'm sorry.

21 CHAIR BAILET: All right.

22 MS. STAHLMAN: Or we could do a voice vote.

23 CHAIR BAILET: I think we could do a voice vote.

24 Yeah, let's do a voice vote because that's where we're

1 going to end up, anyway, is we are dispensing with the
2 technology, starting with Harold, and then we'll just go
3 around the room.

4 MR. MILLER: I vote 2 for limited-scale testing
5 because I think that based on all of the recommendations,
6 the key issue is to refine the model, and I don't believe
7 that the model can be refined with any technical assistance
8 to the level that would be satisfactory without actually
9 putting it in place. And I think that overrides the high-
10 priority criterion that we had on the payment methodology.

11 DR. TERRELL: He said 2.

12 DR. NICHOLS: I vote 2 because I look at it like
13 would we be better off with this being fixed or not, and I
14 think yes.

15 DR. TERRELL: 2.

16 MR. STEINWALD: I voted 1. I thought, at least
17 initially, we should adhere to what we had said among
18 ourselves that if they failed to meet a high-priority
19 criterion, we couldn't vote to implement. And I'm not
20 convinced that we couldn't improve it without limited
21 testing. In other words, I'm saying I think the payment
22 methodology could be improved without limited testing.

23 CHAIR BAILET: Well, I voted 3 to make the
24 recommendation. I didn't necessarily feel that limited

1 testing was required, although I know that it could help
2 refine and sharpen the proposal.

3 VICE CHAIR MITCHELL: I voted 2.

4 MS. PAGE: I'm sorry. I didn't hear that.

5 VICE CHAIR MITCHELL: 2.

6 DR. FERRIS: 2.

7 DR. PATEL: 1.

8 DR. BERENSON: 2.

9 DR. CASALE: 1.

10 CHAIR BAILET: So we have our mathematicians
11 here.

12 MS. PAGE: So, in this vote, the standard is that
13 we needed two-thirds majority, whereas when the Committee
14 was voting for a criterion, it was a simple majority. So
15 for the voters now, a two-thirds majority would mean that
16 we need seven votes to reach that standard, and so what we
17 have right now is three Committee members voted do not
18 recommend, six Committee members voted recommend for
19 limited-scale testing, and one Committee member voted to
20 recommend Implementation.

21 And according to our decision rules, you roll
22 down to that which gives you a vote of seven. So the
23 recommendation of the Committee would be to recommend for
24 limited-scale testing.

1 CHAIR BAILET: Thank you, Ann. Thank the
2 Committee members. I thought the process worked as we
3 designed.

4 We're not adjourning now. It is the next final
5 phase of the process is to talk about the recommendation to
6 the Secretary and comments. Right? And this is just to
7 get the framework detailed, and then we have an iterative
8 process within the Committee members to work the comments
9 to the point where they're ready for submission.

10 MS. STAHLMAN: So, in addition to any comments
11 you made today that we will get from the transcriptionist,
12 any other additional comments you'd like to make and report
13 to the Secretary or comments that you'd like to highlight
14 and make sure the staff is capturing when they take the
15 first draft of that?

16 CHAIR BAILET: Len.

17 DR. NICHOLS: Well, I'm not sure it's in addition
18 to what we've said since everybody said everything, but I'm
19 not sure everybody said it.

20 [Laughter.]

21 DR. NICHOLS: But I think I just would highlight
22 that at least I think this proposal would benefit greatly
23 from having access to real Medicare data, and I don't know
24 a better way to get it than what we just voted.

1 So to me, it is working with the team, with the
2 Medicare data people, some of whom we know, but some of
3 whom we don't, to really refine those parameters, and I
4 would submit it also applies to applying to the quality
5 metric link, what kind of quality links you really want
6 here. I think we're talking about not just that one
7 dimension, but all dimensions of the model.

8 CHAIR BAILET: Thank you, Len.

9 Elizabeth.

10 VICE CHAIR MITCHELL: Again, this may be already
11 captured in the notes or the comments, but I want to be
12 sure we talk about the interoperability, that should this
13 move forward with CMS, we are talking about the
14 functionality of the information sharing rather than this
15 particular proprietary technology. I assume that goes
16 without saying, but I'd like to say it.

17 MS. STAHLMAN: If the members would indulge the
18 staff -- oh, sorry.

19 CHAIR BAILET: Bob has his card up.

20 MS. STAHLMAN: Sorry, Bob. I didn't see you.

21 DR. BERENSON: That's okay.

22 I voted 2 rather than a 1 because I think we just
23 have to try to figure out how to change the incentives for
24 procedural specialists in particular, and this seems like a

1 dedicated group and a reasonable condition. And I think we
2 could learn a lot of sort of operational things by doing
3 this. So, to me, that's a reason for really trying to get
4 into the details but on a limited scale, because I'm quite
5 skeptical of our ability to actually do this right on a
6 large scale. So I think we would learn a lot.

7 CHAIR BAILET: Thank you, Bob.

8 Any other comments?

9 You have a question specifically for staff?

10 MS. STAHLMAN: I do have a question for staff.

11 Could members talk a little bit more about Criterion 4 and
12 your rationale for the way you voted on Criterion 4?
13 Because it did differ from the PRT report, and we want to
14 make sure the first draft captures what you'd like to say
15 there.

16 CHAIR BAILET: Four is value over volume?

17 MS. STAHLMAN: Four is value over volume. If
18 anybody has any remarks to make? Otherwise, we will go
19 back to the transcript, but a little bit -- a few more
20 words would be very helpful to us on that one.

21 CHAIR BAILET: Harold.

22 MR. MILLER: Well, I would say, first of all, I
23 think from my perspective -- again, this is just my
24 perspective -- that I think the wording of the secretarial

1 criterion is too narrow when referring to incentives. It's
2 used too commonly. It's the notion that somehow it's not
3 trying to overcome a particular barrier, and so what I view
4 as the issue here is the proposal will, in fact, overcome
5 barriers that practitioners face in terms of being able to
6 deliver high-quality health care, meaning they get
7 resources in the flexible fashion that they need to be able
8 to do that.

9 Anyway, I think driving the change in behavior is
10 the accountable for the cost, but I think that the notion
11 that this is -- it is not just about an incentive and that
12 somehow the model is not going -- in and of itself doesn't
13 create an incentive without fixing the barrier. So,
14 anyway, that to me is a key distinction in this is that it
15 does actually provide resources rather than just trying to
16 hold somebody accountable for spending and hoping for the
17 best.

18 CHAIR BAILET: Grace.

19 DR. TERRELL: So the comments that were made
20 earlier -- I don't remember who made them -- with respect
21 to the fact that this particular specialty has tended to be
22 rewarded for doing lots of colonoscopies and procedures
23 financially within the current care model sometimes means
24 that some of those individuals have been unable to provide

1 the type of care for chronic complex patients with
2 gastroenterology problems would be a good place to start
3 with this, because in any of the specialties where there is
4 a need to provide better care for complex folks for which
5 the current health care system, it's a thankless task.
6 It's what volume -- what value over volume is about, if
7 it's a way of actually getting at those thankless tasks
8 that are about better care.

9 CHAIR BAILET: Thank you, Grace.

10 Tim and then Bruce.

11 DR. FERRIS: Just that I think this -- of the
12 criterion, this one may have quite a bit of redundancy with
13 the prior two because it folds them in, and so when I think
14 about our response to 4, I actually think it's sort of a
15 blend of responses to 2 and 3 because 1 is about value and
16 payment and one is about equality.

17 This one may be -- the lack of discussion may
18 reflect the fact that we were sort of spent on the prior
19 two criteria, and it didn't really add much to this one.

20 CHAIR BAILET: Thank you, Tim.

21 DR. FERRIS: So it's just a thought.

22 CHAIR BAILET: Bruce.

23 MR. STEINWALD: Well, I am going to pogo-stick
24 off of that back to Criterion 3, since we voted the way we

1 did, and then we voted to recommend for limited-scale
2 testing.

3 I think it behooves us to be as specific as we
4 can about what deficiencies we think need to be corrected
5 in the payment methodology, and that could include some
6 that are correctable just with using volume data and
7 Medicare data, but it also could include some more
8 reflections on the kinds of problems that we identified and
9 the PRT identified that need to be addressed, either
10 through obtaining "how to" data in limited-scale testing or
11 by refinements to the model that could be accomplished a
12 priori, because I think the PRT did have some important
13 things to say about that.

14 And remember with implementation, it doesn't mean
15 that Dr. Kosinski is going to be looking over every
16 gastroenterologist's shoulder. It has to be implemented on
17 a wide scale, the point that Tim made earlier, among
18 general practice -- I'm sorry. Not general practice, but
19 around practicing doctors who are not as mission-oriented,
20 perhaps, as Dr. Kosinski and his colleagues are.

21 CHAIR BAILET: Harold.

22 MR. MILLER: Bruce, just foreshadowed the comment
23 I was going to make, which is I do think the staff may have
24 this, but I think we should have a list specifically of the

1 things that we think need to be kind of addressed or
2 improved during limited testing in the payment methodology,
3 one of which I think is -- and again, if others disagree,
4 they can, but I think is a method of verifying the
5 diagnosis, because when we suddenly have a model that is
6 triggered by a diagnosis, which doesn't exist today --

7 DR. TERRELL: It created an epidemic.

8 MR. MILLER: -- we could create an epidemic.
9 Yes, everyone will have IBD now. But I do think that
10 making sure that we can measure that, and I think one of
11 the advantages of doing limited-scale testing and working
12 with people who are doing that would be to, in fact, try to
13 refine a way of doing that. So that is one specific thing
14 that we've built into it.

15 I think the issue of cherry picking is an
16 important one to address. I think it's a tough one to
17 address, but it's something that would be worth thinking
18 about how to address. One of the common things you see in
19 some of the CMMI models is we will monitor this closely to
20 make sure nothing like that happens. Well, that's an
21 interesting question, but exactly what is it that you're
22 monitoring? And I think that would be worth thinking about
23 for this because I think particularly when you extend it to
24 other areas, so how do you determine that?

1 And I think the issue of trying to define an
2 accountability measure that is focused on the things that
3 the physicians can control -- and, for example, on the
4 drugs, can appropriately deal with kind of the utilization
5 of drugs without being at risk for price, but I think those
6 to me are a couple of the key things that need to be fixed
7 here. And it may be that there's some others that others
8 want to add to that list, but I think it would be useful to
9 be clear about what those specific things are that need to
10 be refined either before or during testing.

11 CHAIR BAILET: Thank you, Harold.

12 Any other comments by the Committee? Because I
13 have two announcements to wrap it up.

14 [No response.]

15 CHAIR BAILET: So I'll go ahead.

16 So, number one, I'm pleased to announce that the
17 PTAC will be visited tomorrow by the Secretary, Dr. Price,
18 Secretary of HHS. He will be providing remarks at our
19 public session tomorrow morning, April 11th. The
20 Secretary's remarks will begin at 11:00 a.m., Eastern Time,
21 here.

22 MS. STAHLMAN: At 8:00 a.m.?

23 CHAIR BAILET: Like I said, 8:00 a.m.

24 MS. STAHLMAN: You're counting California time.

1 CHAIR BAILET: You guys, you have to realize I am
2 from California. I can't believe -- a.m. I live in
3 California. Yeah, it's okay. Eleven, anyway. Thank you.

4 So, again, I don't mean to confuse folks, really.
5 It's eight o'clock tomorrow morning here, Secretary Price
6 will be addressing the public.

7 Following his remarks, we will deliberate on two
8 models, so we're excited about that and appreciate your
9 patience and participation today.

10 The second quick announcement is that this
11 Committee will reconvene upstairs for a few minutes to
12 debrief today and really set the table for tomorrow.

13 So any other comments before we adjourn?

14 [No response.]

15 CHAIR BAILET: We are adjourned. Thank you.

16 [Whereupon, at 4:51 p.m., the Committee
17 adjourned, to reconvene at 8:00 a.m., Tuesday, April 11,
18 2017.]

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20