PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE

PUBLIC MEETING

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

Monday, March 26, 2018
8:30 a.m.

COMMITTEE MEMBERS PRESENT:

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

STAFF PRESENT:
Ann Page, Designated Federal Officer (DFO), ASPE
Mary Ellen Stahlman, ASPE

AGENDA PAGE

Coalition to Transform Advanced Care (C-TAC): Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model

PRT: Bruce Steinwald, MBA (Lead)
Paul N. Casale, MD, MPH; Elizabeth Mitchell
Staff Lead: Ann Page

Personalized Recovery Care, LLC:
Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home

PRT: Harold Miller (Lead);
Rhonda Medows, MD; Len Nichols, PhD
Staff Lead: Ann Page for Timothy Dube

P R O C E E D I N G S

[8:40 a.m.]

* **Opening Remarks by Chair Bailet**

CHAIR BAILET: All right. We're going to go ahead and start. Good morning. Good morning and welcome to the Physician-Focused Payment Model Technical Advisory Committee, or PTAC. We are pleased to have you all here today. In addition to the members of the public here in person, we also have participants watching the live stream and listening in on the phone.

This is the PTAC's fourth meeting that will include deliberations and voting on proposed Medicare physician-focused payment models submitted by members of the public. We would like to thank all of you for your interest in today's meeting. In particular, we would like to thank the stakeholders who have submitted models, especially those who are here today. Your hard work and dedication to payment reform is truly appreciated.

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

These six reports are now available on the ASPE-PTAC website. And, of course, we have been very busy reviewing and evaluating physician-focused payment model proposals from the public, and I would like to take a moment to recognize Mary Ellen, Ann Page, and the staff for the incredible work that they are doing supporting this Committee because of the volume of activities and supporting all of us as members of the Committee. We're very grateful for that, so thank you.

In addition, the recently enacted Bipartisan Budget Act of 2018 grants PTAC new authority to provide initial feedback to submitters' proposed models. We have been considering how to operationalize this new authority, and we'll share our plan with the public soon.

PTAC is also looking forward to working with Secretary Azar. Secretary Azar has identified value-based transformation of the health care system as one of his top priorities and we believe that the proposals we are receiving and our comments and recommendations on them can support this effort.

I am pleased to report that interest in submitting physician-focused payment model proposals to PTAC continues. Since PTAC first began accepting proposal

models for review on December 1, 2016, PTAC has received 24 full proposals and an additional 13 letters of intent to submit a proposal.

The proposals represent a wide variety of specialties and practice sizes, and they propose a range of payment model types. We are pleased that we have so much interest from clinical stakeholders in proposing physician-focused payment models, and we are fully engaged to ensure proposals are reviewed carefully and with the needs of both clinicians and patients in mind. We are already looking ahead to the agenda for our next public meeting, which will be held here in the Great Hall of the Humphrey Building June 14th and 15th.

One simple reminder. To the extent that questions may arise as we consider your proposal, please reach out to staff through the PTAC at HHS.gov mailbox. The staff will work with me as Chair and with Elizabeth, the Vice Chair, to answer your questions. We have established this process in the interest of consistency in responding to submitters and members of the public and appreciate everyone's continued cooperation in using it.

Today we will be deliberating on three proposals, and we will deliberate on one proposal tomorrow. To remind

the audience, the order of activities for each proposal is as follows:

First, PTAC members will make disclosures of potential conflicts of interest and announcement of any Committee members not voting on a particular proposal.

Second, discussions of each proposal will begin with presentations from the Preliminary Review Team, or PRT. Following the PRT's presentation and some initial questions from PTAC members, the Committee looks forward to hearing comments from the proposed submitters and then the public.

The Committee will then deliberate on the proposal. As deliberations conclude, I will ask the Committee whether they are ready to vote on the proposal. If the Committee is ready to vote, each Committee member will vote electronically on whether the proposal meets each of the Secretary's ten criteria.

The last vote will be on an overall recommendation to the Secretary of Health and Human Services, and, finally, I will ask PTAC members to provide any specific guidance to ASPE staff on key comments they would like to include in the report to the Secretary.

A few reminders as we begin the discussions of

the first proposal. PRT reports from three PTAC members to the full PTAC, these reports do not represent the consensus or position of the PTAC. PTAC reports are not binding. The full PTAC may reach different conclusions from that contained in the PRT report. And, finally, the PRT report is not a final report to the Secretary of Health and Human Services. PTAC will write a new report that reflects deliberations and decisions of the full PTAC, which will then be sent to the Secretary.

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

I would like to take this opportunity to thank my PTAC colleagues, all of whom give countless hours to the careful and expert review of proposals before them. Thank you again for your work, and thank you to the public for participating in today's meeting in person, via live stream, and by teleconference.

So let's go ahead and get started. The first proposal we will discuss today was submitted by the American Academy of Hospice and Palliative Medicine, AAHPM, and is entitled "Patient and Caregiver Support for Serious

Illness."

American Academy of Hospice and Palliative Medicine (AAHPM): Patient and Caregiver Support for Serious Illness

* **Committee Member Disclosures**

CHAIR BAILET: So, PTAC members, let's start the process by introducing ourselves. At the same time, read your disclosure statements on this proposal. So why don't we start with Dr. Medows?

DR. MEDOWS: Dr. Rhonda Medows, Executive Vice President, Population Health, Providence St. Joseph Health. I have nothing to disclose, Mr. Chairman.

DR. BERENSON: I'm Bob Berenson from the Urban Institute, a fellow at the Urban Institute. I have nothing to disclose.

DR. PATEL: Kavita Patel, internist at Johns Hopkins and a fellow at the Brookings Institution, and nothing to disclose.

DR. NICHOLS: Len Nichols. I am a health economist from George Mason University, and I have nothing to disclose.

VICE CHAIR MITCHELL: Elizabeth Mitchell, Network for Regional Healthcare Improvement. Nothing to disclose.

CHAIR BAILET: Jeff Bailet, Executive Vice President of Health Care Quality and Affordability with Blue Shield of California. I have nothing to disclose.

MS. STAHLMAN: I'm Mary Ellen Stahlman. I'm the ASPE team lead for PTAC.

MS. PAGE: Ann Page. I'm Designated Federal Officer for the PTAC Committee, which is a Committee that has to comply with the Federal Advisory Committee Act.

MR. STEINWALD: Bruce Steinwald, health economist here in Washington, D.C. Nothing to disclose.

DR. CASALE: Paul Casale, cardiologist, and Executive Director of NewYork Quality Care, the ACO for New York-Presbyterian, Columbia, and Weill Cornell. I have nothing to disclose.

MR. MILLER: Good morning. I'm Harold Miller. I'm the President and CEO of the Center for Healthcare Quality and Payment Reform. I provided assistance to AAHPM in the early phases of its development of a payment model for palliative care. I was not involved in the preparation of this specific proposal, but I am going to recuse myself from voting on it.

DR. TERRELL: Good morning. I'm Grace Terrell. I'm a practicing general internist at Wake Forest Baptist

Health and the Chief Executive Officer of Envision Genomics. Nothing to disclose.

DR. FERRIS: Tim Ferris, CEO of Mass. General Physicians Organization. Nothing to disclose.

CHAIR BAILET: Thank you. I would now like to turn the microphone over to Dr. Paul Casale -- he is the Preliminary Review Team lead -- to present the PRT's finding to the full PTAC. Paul?

* **PRT Report to the full PTAC**

DR. CASALE: Great. Thanks, Jeff.

So as I go through these slides, there's quite a bit of information on each slide. I'll just be highlighting specific points and not reading through each of them.

So this is just a reminder and summary of composition and role of the PRT, and Jeff has already described that.

So this proposal overview is a five-year demonstration, and it's focused on palliative care services. Participating beneficiaries must meet detailed diagnostic and functional status and utilization criteria in two clinical complexity tiers. Payments, there are two tier-based monthly care management payments and two

different financial incentive tracks.

So some of the specifics around the proposal, Tier 1 -- and, again, a lot of information. I just wanted to highlight a couple things. In addition to the clinical health conditions listed at the top, you can also -- are eligible if you have three or more chronic conditions from the Dartmouth Atlas.

In terms of functional status, they're split up into non-cancer and cancer diagnosis in terms of the criteria.

And, finally, on health utilization, one significant utilization the past 12 months, either ED, Ob Stay, or inpatient hospitalization.

To get into Tier 2, which is a higher complexity, it excludes dementia as a primary illness. Again, the functional status is separated into non-cancer and cancer diagnosis, and, again, the functional status criteria are lower for Tier 2. And health care utilization is increased in that there is at least one inpatient hospitalization in the past 12 months and either a second hospitalization or an ED visit or an Ob Stay.

So continuing with the overview in terms of palliative care services, you can see they are listed

there. I just wanted to highlight on the services delivered by the palliative care team, it must include the team -- a physician, a nurse, social worker, and spiritual care provider. There are other members who may be part of the team. And just to highlight on the certification, one core interdisciplinary team member must be certified, but it's, to clarify, not required to be the physician or the nurse practitioner. Any of the team members can be certified.

In terms of payments, the palliative care team, or PCT, are the APM entities, and they receive the payment. They can be independent provider organizations or associated with, as you see listed there, hospices, home health organizations, et cetera. And there is payment differences based on the tiering and the track.

So, again, a lot of information here, just to highlight a couple of things. Tier 1, the base payment is $400 per beneficiary per month; Tier 2, $650. And, again, there are other adjustments as previously described in the slides. The per beneficiary per month payment replaces E&M payments. However, providers that are not part of the PCT continue to receive E&M and other payments, but cannot bill for CCM, chronic care management, or complex CCM codes.

As I mentioned, there are two tracks in terms of the financial incentives. Track 1 is positive and negative incentives of up to 4 percent based on the total per beneficiary per month payments received for the year. Track 2 is based on shared risk and shared savings based on the total cost of care. And then the risk-adjusted benchmark limited to the lesser of 3 percent of total cost of care or 8 percent of each PCT's total Medicare A&B revenues. Shared savings is capped at 20 percent of total cost of care benchmark. And all of this is dependent on performance on quality measures.

In terms of the quality standards, again, it lists their minimum participation standards, and just to highlight, they must have at least one face-to-face visit with each patient monthly, is the minimum participation standard. In terms of the quality measures, years 1 and 2, the PCTs are required to report only, payment not tied to performance, on the 15 measures, and in year 3 PCTs are accountable for the quality performance.

So I'm going to go through all of these individually, so I was not going to sort of go through them at this point, so I'll just go through each one.

So for Criterion 1, Scope, the PRT conclusion was

that the proposal meets the criterion and deserves priority consideration. And, again, there's a listing here of why we feel that having a -- expanding the scope as it relates to palliative care is important. Certainly we know there's a need, and the current Medicare hospice benefit and Medicare Care Choices demonstration have significant limitations as regards to the number of patients who may be eligible. And so the PRT agrees that palliative care should be a more widely available Medicare benefit. And so for these reasons, the PRT finds that this proposal model meets Criterion 1 and deserves priority consideration.

Criterion 1, Quality and Cost. PRT conclusion was that the proposal does not meet the criterion, and the PRT has significant concerns about how quality is measured and monitored. So one of our concerns was around the insufficient outcome measures. There were only two outcome measures described: adequacy of treatment for pain and symptoms, and help with pain and trouble breathing. PRT felt there was a need for more robust outcome measures.

PRT was also concerned about the timing of the measures. The measures described were limited to, quote-unquote, front and back end of service. So it's through an admission survey, completion of activities within 15 days

of enrollment, and then after death.

The PRT also had concerns about insufficient utilization measures. Of the three proposed measures, two address hospice utilization and one addresses ICU days. So the concerns included that there were no reliable benchmarks for these utilization measures and the potential risk of unintended consequences when attempting to reward cost reduction from decreased utilization.

The PRT was also concerned about the potential variation in PCTs and minimal standard for contact with beneficiaries. As I already stated, the minimum was once a month face-to-face. And the degree of clinical expertise in palliative care potentially could vary depending on which provider type has the certification.

Further concerns around payment methodology as it relates to cost. The PRT was concerned about potential susceptibility to bias in beneficiary enrollment decisions and potential to incentivize enrollment of patients expected to be lower cost. There was concerns about the interaction of this model in hospice care.

The PRT had concerns of the risk of potential upcoding patients to the higher Tier 2, which is the $650 per member per month versus $400, may potentially

incentivize assigning beneficiaries to the high complexity tier. And there were no specifics on how spending benchmarks and risk adjustment to be calculated and no minimum savings or loss rate before risk sharing starts. So the PRT was concerned that this may require a new risk adjustment and benchmarking methodology that needed to be developed specifically for the PACSSI model.

PRT had concerns about the lack of confidence intervals around savings or loss thresholds, and so the model would share a higher proportion of savings or loss in the first 5 percentage points than it does after savings or losses exceed 5 percent. And the PRT was concerned about proposed risk-sharing asymmetry which would favor loss over -- sorry, favor savings over losses.

On payment -- or, sorry, Criteria 3, the payment methodology, PRT conclusion: proposal does not meet the criterion, so many of the concerns for Criterion 2 are really a function of the payment methodology and why the PRT finds the model also does not meet Criterion 3. I've already highlighted some of the narrow dividing line between Tier 1 and 2, the issues with confidence intervals, the payment methodology inversion. So the PRT felt that there were similar issues around payment as there were with

cost.

Moving on to Criterion 4, Value over Volume, notwithstanding the concerns, the PRT concluded that PACSSI's provision of care management payments to interdisciplinary palliative care teams has the potential to deliver high-value care.

For Criterion 5, Flexibility, PRT conclusion: proposal meets the criterion for the reasons listed below, and, in particular, the current fee-for-service schedule does not provide reimbursement for this type of care.

In terms of Criterion 6, Ability to be Evaluated, the PRT conclusion was the proposal meets the criterion. Again, PRT noted that the model's goals are -- in terms of the performance measures -- are generally weak. However, as we discussed some of the issues around potential enrollment bias, lack of confidence intervals, which I've already discussed, we really grappled with how -- with how well it can be evaluated, but ultimately concluded that it met this criterion minimally.

For integration and care coordination, PRT conclusion was the proposal meets the criterion, and again, use of interdisciplinary palliative care teams will likely encourage greater integration and care coordination among

practitioners.

In terms of patient choice, the proposal emphasizes the process and provides limited evaluation of patient experience or patient-reported outcomes. That was certainly one of the concerns. However, in spite of the concerns as listed, the PRT concluded the proposed model would offer support of the unique needs and preferences of individual patients.

For Criterion 9, patient safety, PRT concluded proposal meets the criterion. The PRT has concerns about how the PCTs will work with the patient's procurement providers, but concluded the model's components that address care coordination aim to improve standards of patient safety.

And then, finally, for Criterion 10, health information technology, the PRT conclusion was that the proposal meets the criterion. This one was not unanimous. HIT will be used to facilitate service delivery, et cetera. One PRT member concluded that this is insufficient to meet this criterion because the proposed model fundamentally requires information be shared across multiple providers and practice settings, but the proposal does not discuss if or how HIT will be used to accomplish this.

In addition, there were some public comments, as listed below, concerns about how HIT could potentially be used and were not included in the proposal, such as allowing patients access to their clinical health information, enabling patients and caregivers to track and share information with providers, as described below.

So, in summary, the key issues identified by the PRT, some of them are described here. The PRT felt the model is overly complex, having multiple paths to eligibility, with two tiers of eligibility and two different payment tracks. The propose model's approach to quality assurance and measurement including minimal standard for contact with beneficiaries, insufficient attention to patient outcomes, weaknesses and the period of time to be captured in the measures, and insufficient utilization measures as described in Tier 1 and Tier 2.

With respect to payment methodology, PRT's concerns are described below. The narrow dividing line between Tier 1 and Tier 2, the absence of confidence intervals around benchmarks, absence of minimum savings or loss rate before risk sharing starts, some of the methodology concerns I've described previously, and the asymmetry of the proposed risk sharing.

With that, I'll turn it back to you.

CHAIR BAILET: Thank you, Paul.

Any other comments from other members of the PRT?

Yes.

VICE CHAIR MITCHELL: Thank you, Mr. Chair.

Paul did a great job sort of describing our report. I just wanted to underscore a couple of concerns that I had that were reflected, but I'd like to just sort of state them again.

First, this is a high-priority need area, and I think that the evidence shows the benefits of palliative care. So we do think this is a high priority area to address.

But I think the lack of patient engagement reflected here, the lack of meaningful shared decision-making, I think it's a really important omission.

And then also the lack of payment tied to outcomes, I personally think that the -- simply having a care plan or agreeing to monitor utilization without having any payment attached to performance does not qualify as sort of what we are hoping to achieve.

And then the asymmetry of the downside risk of 3 percent, upside of 20 percent just was also quite striking.

And then, finally, I was the hold-out on Criterion 10. I think the point of the HIT criteria is about enabling important information to be shared to enhance patient safety and outcomes, and I don't think we saw evidence of that.

CHAIR BAILET: Thank you, Elizabeth.

Any other comments from the PRT?

[No response.]

* **Clarifying Questions from PTAC to PRT**

CHAIR BAILET: Questions then from the Committee members?

Tim and then Bob, Kavita, and Len.

DR. FERRIS: So I wanted to thank the PRT for a very thorough and clear analysis.

I did have a question on Elizabeth's last point that she made about the asymmetry and the risk, upside and downside risk, and I wondered if you think of the infrastructure investment required to pull off any kind of care delivery as itself, in a sense, downside because it's your cost of operations. Did that figure into your thinking about the asymmetry?

And I would just point out that there is actually an existing CMS model that has no downside risk but gives

credit to the participants for the fact that they had to make a large up-front investment in infrastructure as their downside risk.

Does thinking about it that way change the way you think about the symmetry or asymmetry in a risk arrangement?

DR. CASALE: I'm not sure if that -- I can't remember if that point specifically came up. It's a good point.

I think the blending of the per member per month, which was pretty large numbers in addition to this potential on total cost of care, I think we focused -- well, in my thinking, that Track 1, where you are getting that up front, recognize the investment.

So I think it's a good point. I have to say I don't think we really had a discussion around that specifically.

MR. STEINWALD: Yeah. That's my recollection too. I don't think we discussed that specifically. I think we did certainly discuss the per member per month.

I think the sense of the PRT was that those per member per month payments were sufficient to cover the expenses, added expenses incurred without distinguishing

startup from ongoing expenses.

CHAIR BAILET: Bob?

DR. BERENSON: Yeah. I've got two kinds of questions. The first is simple. The second will take a bit of time.

The first is picking up on this. I had looked up at the Medicare Care Choices Model demo, and they were providing $400 and $200 of a PMPM, and this is significantly higher. So what confidence do you have that these numbers are the right numbers? They're 50 percent higher than what Medicare is paying for. It's not the same, but it's comparable.

VICE CHAIR MITCHELL: One of our observations was that there wasn't supporting information for those numbers. That was one of our questions.

DR. BERENSON: Okay.

So here's my more serious question. I got a real problem with a total cost of care, shared saving, shared risk on a patient population with a high risk of dying, creating perverse incentives relating to providing care.

So my question is did you look at -- for the definition of the eligible population, is there a ball park for the percentage of people who would be dead within 12

months, for example? Is that something that you looked into at all?

DR. CASALE: I think this gets back to our discussion -- and we'll probably have it again -- around the C-TAC. We had this discussion when we had C-TAC and their initial proposal around how do you predict who is going to die in 12 months, and I think we continue to struggle with that.

Again, a lot of the data is around cancer patients, this proposal, and I think when we talk about C-TAC later, it's much broader. And we had a lot of concerns around particularly the criteria for the Dartmouth Atlas three chronic conditions. We could think of many Medicare patients that would fit that, and I'm not sure how easily it would be to predict how many will die within 12 months.

So I think we've discussed a lot of similar concerns around predicting --

DR. BERENSON: Did you discuss the appropriateness of a shared savings on total spending model for a population for whom dying is a real possibility? I mean, I could see doing this with Track 1 using utilization metrics, inappropriate hospitalizations, all the questions, some of which are here, about patient and family, sense of

interaction and responsiveness and all of that stuff. But when it comes down to a calculation of "We saved a lot of money, and by the way, some people didn't get hospitalized who otherwise would have, and, oh, by the way, they died," that makes me nervous. And I'm wondering if the PRT had that discussion.

DR. CASALE: Yeah, I think we -- yes, I think. And I think it was reflected a little bit in the comments around the unintended consequences and then the interaction between the model and hospice in particular, so yes, we did discuss it.

DR. BERENSON: But that didn't -- except for some technical problems, you thought that the Tracks 1 and 2 approaches were reasonable approaches to take?

DR. CASALE: Well, as we said, we didn't think it met criterion. One of the concerns we had around that was unintended consequences broadly, and so I think what you're articulating is, again, one of the potential unintended consequences.

DR. BERENSON: Okay. Thank you.

VICE CHAIR MITCHELL: I would say that we did discuss that concern, and it actually underscores the importance of better metrics and better measurement, better

engagement to really understand from the patient family point of view is care being appropriately delivered. So it really made those even more important.

DR. BERENSON: Do you think you can measure -- I mean, I am very skeptical that you can measure that form of interaction with a patient that helped them form a judgment about how they want their care provided at the end of life. That's my basic problem. I don't think you measure that.

VICE CHAIR MITCHELL: Well, it was simply another reason that we were concerned about the measures, but it did not overcome our concern about the incentives.

CHAIR BAILET: Bob, are you saying you can't measure it, or it wasn't measured here?

DR. BERENSON: I'm saying I'd be very skeptical that you can measure it. As the palliative care team is interacting with the patient and their family and providing guidance around end-of-life decisions, I don't know how you measure whether the financial incentives are overwhelming their sort of neutral advice-giving. So I have a real reluctance to thinking that we want to have strong financial incentives for this particular population.

I'm all for total cost of care when somebody is taking care of general population. I have particular

concerns about that strong spending incentive when it comes to a population who are very vulnerable near the end of life, I guess, is what I'm saying.

And I don't think -- I think as I have written and talked about, I think we have magical thinking around measurement. Some things, you're not going to be able to easily measure.

So I think this model could work, without that spending incentive related to PMPM, utilization metrics strike me as the right way to proceed in this area, not sort of total cost-of-care spending. That's redundant.

CHAIR BAILET: Thank you, Bob.

Kavita?

DR. PATEL: I'll just reinforce because I think that we're seeing so many PTAC models that feel the need to use kind of the CMMI playbook previously of some inclusion of shared savings or gain-sharing or even this kind of notion of total cost of care, which we're seeing problematic with the oncology care model, just as an example.

So I would just say as a comment, it would be my desire to see some of those things and not say that this submitter did that on purpose, but it just seems like I

agree that this might not be the right way to incorporate what feels like it's almost now just a kind of take-it-for-granted submission. So that's not my question but a statement.

I did want to ask the PRT, I find that in taking care of these patients, it's extremely difficult to kind of engage in like a very -- you know, it's not the traditional metrics we have for engagement in a crude way in this system. I wanted to just ask, because it looks like in your teleconference, you got into how complicated prognostication was and some of these other issues.

Did you feel on the PRT that this potential for better engagement, whether it's the patient or the caregiver, was really possible considering the severity of the illnesses that we're talking about? Because I just find it difficult to do, so that's one question.

And then the second question is around a clarification. The PMPM would go into place kind of in six-month aliquots; is that correct? So they would only reassess? There's a monthly kind of face-to-face or whatever requirement for the PCT, but then the prognostic changes that might occur would only be assessed at six months? So that's a clarifying question.

DR. CASALE: Do you remember, Ann? I'm trying to remember. I don't remember the six-month.

Do you mean in terms of reassessment, if they go from Tier 1 to Tier 2 or that kind of thing over whatever they --

DR. PATEL: Correct, or whatever. Just because this is --

DR. CASALE: Yeah.

DR. PATEL: Again, just in my clinical practice --

DR. CASALE: Right.

DR. PATEL: -- six months is a long time for some of these conditions. So to kind of reassess their prognostication, if that's the way I'm reading it, but I could be reading it wrong.

DR. CASALE: I don't remember that, but I keep looking at Anna because she's --

MS. PAGE: I don't think the frequency with which people were reassessed to determine are you now a Tier 2 rather than a Tier 1 was specified.

DR. PATEL: It was not specified?

MS. PAGE: I don't believe so.

DR. CASALE: I'm sorry. Your first question? I

want to make sure I understand your first question.

DR. PATEL: Do you really think patients can engage? And I'm asking like is there -- was this kind of a general -- because it was one of your like real strong shortcomings, or at least that's how I heard it.

And what would patient engagement when -- I mean, I just had a patient die of cancer, and engagement in some of these settings is difficult, and I also don't know how to measure that in a way that I can reproduce. So I'm just curious.

DR. CASALE: Yeah. I mean, I think that's reflected in our concerns around how do you measure that. Can they be engaged? I mean, potentially, but how are we going to measure that? And I guess that gets to both your point and Bob's point around is that really measurable in a meaningful way in this kind of model.

DR. PATEL: Just my last, Jeff --

MR. STEINWALD: By the way, they are assessed every six months.

DR. PATEL: That's what I thought. Okay. So there is a reassessment --

MR. STEINWALD: Yeah.

DR. PATEL: -- but it's only every six months.

Okay.

And then just the last one, did attribution come up in terms of -- there is this attribution where if you're on the PCT team, you can't do like CCM or you kind of get carved out of other things, but I would see potentially, methodologically, that's not part of our criteria. But I was just curious because I could see attribution being a pretty kind of complex issue. So I just wondered if that came up on the PRT discussion.

DR. CASALE: I don't think we had a lot of discussion around attribution in terms of thinking that once the PCT is formed and, you know, that -- I don't remember having a lot of discussion around that.

MR. STEINWALD: I think attribution at this point is the team, the palliative care team, as opposed to any individual member of the team or other physician, is my recollection.

CHAIR BAILET: Len.

DR. NICHOLS: So a couple questions. Picking up on Bob's question, which was one of mine, how many people are likely to die that are in this circumstance, and apparently, you didn't know and can't find out.

And what I really want to know is how much money

is attached to them compared to the rest, and I assume SSS wasn't asked that either.

So what I'm just going to say as an economist is one needs to think about the right benchmark here, and certainly, I get the untoward nature of an incentive where people could die and save money. But if you compare spending on people who died in the program versus people who died outside the program, you can construct a benchmark that might be useful. So it's just as a matter of how you define what the right benchmark is. I'm not saying they defined it correctly. I'm just saying it's not impossible for me to imagine a world in which we get the right comparison group to do this.

Which gets to the larger point about what I'm hearing, and I'm just a simple country economist, so I don't know this doctor stuff. But I'll observe. What you all are saying is that it's impossible to measure quality for these people. I don't think that's true. I think the people who do this for a living know a lot about that, and what I want to ask is, when I look at their Table 3 and I see a lot of stuff, patients' perceptions, obviously family perceptions in some circumstances, timeliness response to urgent need, adequacies of treatment for pain and symptoms,

likelihood to recommend to PCT to friends and family, and in the first couple of years, it's pay for reporting, which I agree is soft.

But then it gets to pay for performance, and my question really comes down to, did you take into account the learning that's going to have to happen in this space when you decided these quality metrics weren't good enough and that's really what killed the payment model as well? So that's my question. Can we not learn while we play the game?

DR. CASALE: Yeah. I think our concern in terms of the quality measures that they were not sufficient to -- again, particularly around process versus outcomes in this very chronically ill population.

DR. NICHOLS: But the ones I am citing are patient-reported outcomes, which in the first couple of years is pay for reporting, and then years three to four would be pay for performance. So that would seem to me to be outcome-based, patient-centric, and actually incentivized in years three and four, not years one and two. But we all agree there's some fuzziness.

DR. CASALE: Yeah. I guess part of it was when those were going to be assessed and how often the

requirements around the assessment. It seemed that the minimal wasn't sufficient in terms of the number of times that would be assessed throughout their care as well.

CHAIR BAILET: I'm going to just -- I saw Bob. Did you want to respond to Len's --

DR. BERENSON: Very briefly. I just wanted to be clear. I actually think in this area, you can develop quality metrics, and you can develop utilization metrics, so you could have a payment model that does not require total cost of care and spending incentives, but rather there are ways to actually -- on top of a PMPM, you can actually measure performance and build in protections there that you can't build in when it's just the total cost-of-care analysis.

DR. CASALE: Yeah. I think the PRT agreed with that. It wasn't that -- so we felt it could be much stronger.

CHAIR BAILET: Grace?

DR. TERRELL: I wanted to respond a little bit to Bob's remark about his anxiety or concern about strong financial incentives in this population. I think the reason we exist is because there's already strong financial incentives in our current situation with mostly fee-for-

service that people are concerned about.

And so as opposed to this being greenfield, we were looking at it as everything is perfect and now we've got something that we've got to react to. We are not looking at greenfield. We're comparing it to something that's already out there, and there's been a lot of measures out there, a lot of studies, a lot of mythology, that, you know, X percent of the cost of Medicare is in the last year of life, and some of that has been deconstructed subsequently and shown that, well, maybe it's not the case or maybe it is the case.

One place perhaps this could be strengthened would be to understand what has been learned from studying this population in the fee-for-service system with respect to the perverse incentives that we're all concerned about with that.

So, with that thought process, when I look at this, it's a classic example of when you separate out the payment model from the care model. When you look at the care model, you're thinking, of course, everybody wants that.

I was experiencing in my own family this weekend, a call from a cousin of mine who is very anxious about a

situation that was three of those categories in criteria with someone in my own family, and they did not have the care model that is in this that would have solved a lot for him.

So my thought process is that as we are thinking about this type of model, many of the others that I think we are going to be looking at today that are similar in terms of taking care of vulnerable complex patients and trying to come up with a payment model that properly incentivizes, so that we don't do it wrong, we don't do it right. We need to think about the payment model, which there seems to be enthusiasm -- I mean the care model, which there seems to be universal enthusiasm for.

And then look at the payment model not just in terms of it in and of itself against greenfield, but what are the actual perverse incentives now. What date is out there that can allow us to think through it within the context of the complexity of real time?

DR. CASALE: So just to -- and I think those comments are well said, and, you know, I think when you get to the data part -- and I think we've talked about this before -- where the prognostication around -- there's data particularly around the Stage IV cancer patients, and now

we're trying to expand it to other, you know, various severe conditions, like heart failure, et cetera, where it's not as easily predictable. And then I think so the challenge around the payment becomes that -- not that they shouldn't -- I think we'd all agree that these -- there's a clinical need for sure, but how do you construct a payment model around sort of much broader conditions.

CHAIR BAILET: Thank you for that discussion.

I am now going to invite the submitters up to the table, if you could please come up and turn your placards right side up and then introduce yourself.

I want to remind the submitters we have 10 minutes for your remarks, and then the Committee will ask questions. Welcome.

*** Submitter's Statement, Questions and Answers, and Discussion with PTAC**

DR. KAMAL: Good morning. I'm Arif Kamal. I'm a medical oncologist and palliative care physician at Duke University, member of the Board of Directors of the American Academy of Hospice and Palliative Medicine, and Immediate Past Chair of the Quality of Care Council for the American Society of Clinical Oncology.

DR. ROTELLA: I'm Joe Rotella, Chief Medical

Officer for the Academy, and I bring to our team my early career experience as a rural primary care physician in New Hampshire and two decades as a palliative care specialist and hospice medical director. I'm a co-author of "Measuring What Matters" and a consultant to a CMS contractor working on the Hospice Quality Reporting Program.

DR. BULL: Good morning. My name is Janet Bull. I'm the Chief Medical Officer of Four Seasons Compassion for Life, a nonprofit hospice and palliative care organization in Hendersonville, North Carolina. I'm also the Immediate Past President of the American Academy of Hospice and Palliative Medicine, and I co-chair the Global Palliative Care Quality Alliance, one of two clinical data registries for palliative care.

DR. RODGERS: I'm Phil Rodgers, and I practice palliative medicine and family medicine at the University of Michigan where I direct our adult palliative medicine program. I have also been honored to serve as volunteer chair for AAHPM's Alternative Payment Model Task Force, which designed and drafted the proposal under consideration today.

CHAIR BAILET: Welcome.

MS. KOCINSKI: Hi. I'm Jackie Kocinski. I serve as the Director of Health Policy and Government Relations for AAHPM.

MS. MOON: Hi. I'm Cindy Moon. I'm Vice President of Health Care Payment and Delivery Reform at Heart Health Strategies, and we're a consultant to AAHPM.

CHAIR BAILET: Welcome.

DR. RODGERS: Good morning, and thank you for the opportunity to come before you today to discuss AAHPM's proposal for a physician-focused payment model, which we call "Patient and Caregiver Support for Serious Illness," or PACSSI.

AAHPM is the professional organization for physicians specializing in hospice and palliative medicine. Our more than 5,000 members also include nursing, social work, and spiritual care professionals who are deeply committed to improving the quality of care and the quality of life for patients living with serious illness and their caregivers.

Numerous research studies demonstrate that high-quality, interdisciplinary palliative care can improve -- can provide significant benefits for patients, caregivers, and payers. Despite these proven benefits, however, many

do not receive palliative care because current payment systems do not provide adequate support to deliver palliative care services where patients want the most, which is where they live. AAHPM developed PACSSI to overcome these barriers and create an accountable payment system to deliver community-based palliative care to high-need patients who are not yet eligible or ready to elect hospice care.

Members of our task force represent the diversity of palliative care providers serving Medicare beneficiaries today across communities of all types. We charged ourselves with developing a payment model that would support palliative care teams of different sizes, organizational structures, and geographies in the delivery of effective, high-value care to our sickest, most vulnerable patients and their caregivers. We look forward to discussing that proposal in detail with you today.

Before we move into that discussion, we think it would be valuable to share the guiding principles that we used to develop PACSSI. These include the following:

Payment model design should both increase access to and ensure sustainability of high-quality palliative care and hospice services.

Patient eligibility should be based on patient and caregiver need, not on prognosis.

Provider eligibility should encourage participation by palliative care teams of many sizes and types, working in many different geographies and markets, and at various levels of risk readiness.

Palliative care teams' structure and service requirements should align with the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care.

Quality measurement and accountability should align with a state-of-the-field framework known as "Measure What Matters" an expert consensus project convened by AAHPM and the Hospice and Palliative Nurses Association. This framework is in wide use among community-based palliative providers and has a maturing evidence base to support its validity and its impact on care quality.

Payment should be sufficient to cover the cost of delivering care in diverse settings, including rural and urban underserved communities, without increasing net costs to the Medicare program, and benchmarks should be accurately risk-adjusted to avoid exaggerated losses or gains.

And, finally, the APM development process should be transparent and inclusive and engage the breadth of stakeholders in the serious illness provider community to address cross-cutting, high-priority concerns. We remain as committed to these guiding principles today as we did when we began model development.

DR. BULL: We started our palliative care program in 2003 as a way to meet the needs of the seriously ill people who live in our community. Far too often we were seeing people referred late to hospice care, never having a discussion about what was important for them or how they wanted to live out the last days of their life. We saw a fragmented health care system where families and patients struggled to get support, where they had misunderstandings of the severity of their illness, and where their suffering was not being addressed. We knew that the only way to provide high-quality palliative care was through philanthropy and grant dollars.

In 2014, our organization received the CMS Innovation Grant to demonstrate the value of community-based palliative care. Over the course of the next three years, we scaled the model throughout western North Carolina and upstate South Carolina, working with

hospitals, health care systems, and community-based hospice and palliative care organizations to create a longitudinal delivery model, integrating interdisciplinary palliative care across inpatient and outpatient care settings. This program addresses the needs of people with serious illness through goal concordant care, advanced care planning, symptom management, prognostication, psychosocial and spiritual support, patient and family education, and caregiver support.

We enrolled 5,800 participants and were able to demonstrate improved symptom management, decreased hospitalization, increased hospice utilization and length of stay, and high patient, family, and provider satisfaction scores.

The grant allowed us the flexibility to meet the needs of the individual patient. For instance, in rural areas where workforce shortage and response times lag, we piloted a telehealth project where combined remote patient symptom monitoring and videoconferencing were used. As a result, more timely interventions occurred and problems could be managed preemptively, often avoiding emergency room visits or hospitalizations.

There are currently few palliative programs in

rural areas. Creating an APM where small organizations participate aligns with our guiding principle of being able to provide access to palliative care, regardless of where people live.

One of the charges of this grant was to come up with an alternative payment mechanism. Our team collaborated with the Academy's APM Task Force, and we were able to take what we learned in this project to help inform the PACSSI model.

Under fee-for-service reimbursement, community-based palliative care is not sustainable. Today these programs exist only through community donations, grant support, or being subsidized through a health care entity. A value-based payment system will help create a sustainable model, aligning with another one of our core principles.

It is my hope that all people living with serious illness will have access to high-quality palliative care where treatment is informed by a person's values and preferences, where the focus is on improving symptoms and enhancing quality of life, and where suffering is addressed in the physical, psychosocial, and spiritual domains. Participating organizations of an APM should be held accountable to quality, cost of care, and patient

experience of care.

Thank you.

DR. ROTELLA: As Dr. Rodgers mentioned, our guiding principles for quality are to ensure sustainability of high-quality palliative care and hospice services and align with the state of the field -- even more, to deliver outcomes and an experience of care that truly transforms the quality of life for people living with serious illness and those who care for them.

We acknowledge gaps in the development and implementation of quality measures for this population. PACSSI advances quality improvement and accountability while building on the best tools now in use in hospice and palliative medicine, including Measuring What Matters, the Hospice Item Set, and the Hospice CAHPS Survey. These are evidence-based, tested, and proven to be feasible, actionable, and meaningful.

Our process measures are based on the key elements of a comprehensive assessment as outlined by the National Consensus Project's Clinical Practice Guidelines for Quality Palliative Care. The patient and caregiver surveys are administered after admission and again after death, and domains include help with pain and symptoms;

multiple symptoms, including shortness of breath, constipation, sadness, and anxiety; timeliness of care; quality of communication; support for spiritual and religious beliefs; respect for the patient and family; overall satisfaction with care; and also a shared decisionmaking domain that gets at whether they were able to make a decision without feeling pressured by the health care team.

We were parsimonious in selecting utilization measures for accountability. We picked the ones that matter most and we have the most impact on, but others are included in program evaluation and would be reflected in the costs.

Palliative care is whole-person care delivered by an interdisciplinary team, not limited to symptom management and physical outcomes, and that means that the patient and caregiver experience items in the surveys reflect more than mere satisfaction and are actually key outcomes of palliative care. We're mindful of the burdens to vulnerable patients and stretched caregivers were we to survey them too frequently and also challenges that might discourage smaller practices from participating were we to mandate the use of quality instruments that don't reflect

current practice.

Where measures have not yet been developed, tested, and implemented for this population, we require pay for reporting in the first two years, before setting a benchmark for pay for performance in year 3 and beyond. We built accountability for quality into every aspect of our model.

We appreciate this opportunity to present this proposal on behalf of the sickest and most vulnerable patients in our health care system. We know that there are some aspects of the model that can only be refined once CMMI engages in development of a demonstration. In the seven months since we submitted PACSSI to you, more evidence has been published. New data sets are available for analysis. New quality instruments and measures have begun development, and the National Consensus Project Clinical Practice Guidelines are getting a major update. Knowledge and resources for quality and paying for value are rapidly evolving, and that's great.

We're committed to working with CMS and all stakeholders to find the best solutions for our seriously ill patients and those who care for them, and it's urgent that we start now. They're counting on us.

We thank you for your careful review. Your feedback is extremely valuable, and we urge you to recommend PACSSI to the Secretary for a national demonstration.

Thank you.

CHAIR BAILET: Thank you.

I now open it up to my Committee members. Bob?

DR. BERENSON: Well, to continue where I was earlier, I didn't hear, Dr. Rodgers, in your principles any mention of one of the principles should be to reduce total spending for this vulnerable population. If anything, you emphasized the need to pay for the costs of high-quality palliative care. So where does the -- I guess here's the question: Couldn't this work without the strong financial incentives around spending reductions? I agree with the development of measurement sets, pay for performance, paying adequately for the care in the first place. Why do you need to have these spending incentives? And to what extent was trying to become an advanced APM a contributing factor in what this looks like?

DR. RODGERS: Excellent questions all, and I appreciate your pointing them out. I will say that when I did articulate the key principle about adequately paying

for the service, I apologize if I was speaking too quickly, but baked into that principle is a balance that that should not add to the next cost to Medicare. We actually believe -- we agree with your concern that we should not rely on savings in this vulnerable population. We did include that in the design for two reasons.

The first is that there is abundant evidence that we have cited and included in the proposal that when we do palliative care right, it does save money. And it saves money primarily by aligning care plans with what matters most to patients when they're at their sickest, and that often means not engaging in low-value care.

So that is a reality. There's data about palliative care in hospital settings saving money. There's emerging data about palliative care in the community saving money.

I will say that in model design particularly in Track 2, we were intending to have Track 2 meet the criteria for an advanced APM as outlined in the statute. And as Dr. Patel pointed out, like many, we did look to the shared savings methodology from CMMI's playbook.

I would also echo Mr. Nichols' comment that we would very much like to work with CMMI to get to a place

where we could use spending benchmarks to be able to set the performance standards on spending to ensure that we hold them not only to our guiding principles of improving care quality without increasing cost, but also meet the statutory requirements in MACRA.

CHAIR BAILET: Grace.

DR. TERRELL: I was really interested in the North Carolina data that you had, being a North Carolinian and living in that area, with respect to the 5,500 individuals, and I've got a couple questions related to that.

Was the data with respect to the cost of care and what you were able to save with all the overall hospitalizations and all that directly tied back in any way to the numbers that you put in this proposal? Because it would seem to me that for 5,500 people, if you've got good data, if this is similar to the model that you have here, you certainly in a grants-based, you know, project have cost of implementation of that. Was that actually tied back to the numbers in this proposal?

DR. BULL: So actually the cost of delivering the care --

DR. TERRELL: Yes.

DR. BULL: -- was informed -- informed the two different tiers that you see in this model. And it was not only based on our data, but some of the other members of our stakeholder the Academy's task force.

In terms of the savings cost, we unfortunately did not get all of the claims data until about two months ago, so we are still going through that, our team at Duke. But we have shown a reduction in hospitalizations -- I don't have a final number yet, but that was clear -- and in ED visits.

DR. TERRELL: So you believe after you have those final numbers we will have some hard data from which we could actually look at this and other projects and make a determination with respect to what numbers you have in here?

DR. BULL: I think it will definitely help inform the project. There is also other data that's out there. Dana Lustbader, who's going to be commenting today, ran a model at ProHEALTH, and they published on their cost, overall cost of savings. So there have been some other publications out there around cost.

But the actual -- the way we based the cost on this was what it cost to deliver this care.

DR. TERRELL: Okay. So my next question is somewhat related, and that is, one of the other PTAC members expressed a concern about the potential perverse incentives of having a tiering of complexity. Obviously, this is now baked into any sort of tiering system based on how ill a person is. And that will, therefore, lead to other types of measures where you have to prove they're that sick and all of that.

So as you made the decision to do that, what I just heard you say is that you were using those type of criteria in a program that probably wasn't based on actual -- an incentive at the time to, if you will, upcode severity, right? I mean, it was to identify what their needs were.

DR. BULL: It was to identify what their needs -- but as people got sicker, we had a priority risk stratification system we developed, so as people got sicker and their functional scores declined, they required more help. They required more visits. So the cost of care in that population was higher.

DR. TERRELL: But so if every six months you're reevaluating, people tend to get sicker in this population. So is there a reverse incentive, if you will, to look at --

in other words, is there not -- what would be the difference between doing it this way where you've kind of broken down the cost into two different, you know, categories that may create a perverse incentive, versus having a blended rate that would take care of everybody? Tell me why you chose to do it this way. Any of you. I'm staring at you, but --

DR. RODGERS: So I would say, just to echo Janet's point, we started this based on the cost of what it takes to deliver care to patients, especially as they get sicker. I will say many of us in the palliative care and hospice world have a lot of experience with a PMPM or a capitated rate because that's how the hospice benefit is structured. So we've gotten 30 years of experience of delivering high-quality care to very seriously ill patients in the community.

If you think about the hospice per diem and convert that to a PMPM, that's about a $4,000 PMPM. So we realize that these numbers may look high coming at it from a traditional Part A/Part B perspective, but we're accounting for the fact that these -- many of the patients in the model are those who may be nearing hospice eligibility but may not be yet ready to enroll or are right

there. So that higher number accounts for the increased intensity of services to deliver on the quality accountability that we've built into the model.

To your point about a blended rate, we talked about that because we actually, you know, accept the PRT's observation that there is complexity in this model with the tiers and the tracks. Part of why we didn't feel like we could get to a blended rate with confidence is we don't yet have the data. Community-based palliative care is in its -- if not infancy, in its early childhood. As a family doc, I'll use that word. And really we need to inform this model with data. We are very open to working with CMS to understand from the data that they may have that we don't have access to what that might look like. But this was based on the experience we have on what we were able to put together in August of 2017 when we submitted.

As Joe mentioned, we're getting more information and data all the time. Janet's CMMI project is an excellent example of that. And we're in this for the long haul, and we're willing to work however we can to make it viable.

DR. BULL: And one point I just wanted to clarify, the recertification was put in there because there

are occasionally people who actually get better, and it wasn't meant that if somebody came into the model and in a month started to have significant decline, they could go into the second tier. There wasn't a weighting to be looked at every six months to determine what level that patient fell into.

CHAIR BAILET: Tim?

DR. FERRIS: Thanks for all your work on this.

So I have a question -- and maybe it's best to think of it in more abstract terms -- about when you were thinking about this model and the composition of the care team and the qualifications of the people on the care team, and I ask you to respond thinking about the fact that at least from my perspective, we almost certainly don't know what the best mix of people to take care of these patients. And I'll just say I'm right now, the ward attending at Mass General. I rounded yesterday. Half of the 30 patients on the floor that I'm attending on would qualify for this model today. And I would tell you, reading this and thinking about their care, they would all benefit enormously from what you're proposing. So I want you to answer knowing that I feel that way.

But I'm also pretty sure that the health care

delivery system needs to be open to the possibility that there are going to be entirely new job descriptions and rules, and that overly prescriptive requirements for participation for particular rule groups and particular qualifications, I would say potentially stifles innovation.

Could you reflect on your proposal and those general comments, which I think probably weren't too cryptic to understand?

DR. RODGERS: So we absolutely appreciate that, and we did conceive, again, one of our guiding principles is that this model be able to be engaged by providers of all types working in all communities.

And one of the reasons why we put in the certification requirements for one of the members of the team is we did not believe that we wanted to be overly prescriptive and say, for example, the physician on the team had to be board-certified in palliative medicine. Not only is that a problem because of the workforce issues that we have in our subspecialty field, but it's also not the right thing for patients and families.

If a patient is with family -- and I come to the table with the hat of a family doc as well, and my practice tends to skew towards a more complex older population, I

would see colleagues of mine who I know who are very skilled, have long relationships with their patients, want to engage this, and if we could provide their practices the opportunity to build out a team that would allow them to extend their reach into the home, I think that would be in the model that would be allowed under this. So I would see flexibility.

We did feel, though, just because one of our guidelines, especially at this critical time of development in the field, is that we strive for high-quality care that's aligned with the state of the field, not only with measurement matters, but with also the National Consensus Project, which sets the stage for what it means to get high-quality palliative care, that we needed to have some infrastructure there to ensure that.

And when we get to talk a little bit more about the quality metrics, that's where we're putting in the accountability for that care, and the results of the demonstration, our hope is, in the long run, informed better benefit development, and that may look quite different than this. We are very open to that idea, but really what we want to achieve is providing a vehicle to extend that support where it's needed most. And I think --

we think some degree of flexibility while also retaining some guardrails around quality.

CHAIR BAILET: Thank you.

Elizabeth.

VICE CHAIR MITCHELL: Thank you.

And, again, I wanted to just underscore the PRT's support for this and the need for this change. I had a question -- I think Grace asked it as well -- sort of the basis for the numbers, and I think you said it was the cost of delivering care. Is there anything you wanted to add to that? Because there were questions from the PRT about how we got to those rates.

DR. RODGERS: So I will say that we did provide in an appendix to our proposal, an analysis of Medicare fee-for-service data cross-walked with enhanced responses that are kind of a way to get at patient function. And the idea there was to start getting an estimate from the data that were available to us by one of our colleagues, Amy Kelley at Mount Sinai who does excellent work in this field, to try to get at what is the cost of care and to sort of begin to say could we look at a way to make sure that we align again with our guiding principle, cost neutrality, and the statutory requirement. And that did

inform part of how we came to those numbers.

We understand that our view of that data is incomplete because we have access to only so much in terms of claims data, but we wanted to show that as kind of an early proof of concept.

In that same appendix, we were also able to work with colleagues who are doing this kind of work in other venues. So you will notice Janet's data in that appendix from the CMMI group. We were also very pleased to have collaboration from the team at Aspire Health, who has gotten a lot of experience working with Medicare Advantage plans. As we're all aware, Medicare Advantage plans have much more nimble access to claims data than we do on the traditional side.

So we're trying to show that we're moving in the direction of setting those price points, not only where we can support the kind of quality care that we know beneficiaries deserve, but can also do it with a goal of at least cost neutrality, if not some modest cost savings.

VICE CHAIR MITCHELL: I actually wanted to underscore something publicly, maybe for the comments, that's also sort of the Catch-22 of this, where if we need benchmarks, but we can't establish benchmarks or we can't

establish some of the information needed without some form of testing. So I just wanted to underscore that for our comments.

Finally, could you speak at all to the initial 2 years of pay for reporting versus paying for outcomes and sort of address that issue?

DR. ROTELLA: This gets back at our principle of wanting to build on the current reality.

We know that there are great gaps right now in having a really robust measure set for people with serious illness. We're closing that gap as fast as we can, and in fact, the Academy is involved in a number of initiatives and measure development, bringing quality registries together where we can then really vault forward with patient-reported outcomes and that sort of thing.

The measures we're bringing to you come from hospice populations, inpatient palliative care populations. They have not actually, necessarily been validated, tested in the community-based palliative care population. If we're going to be scientific about that, we should actually test those and validate them before we set benchmarks.

So the reality is it's pay for reporting in year one and two because we actually have to learn as we go

along.

This is the same thing we saw with the hospice quality reporting program, where the first few years were pay for reporting, because until the reporting occurred, nobody could figure out exactly what was topped out, what's a decent minimum performance status, what's the right benchmark.

So we're just being honest with you. Current reality is if you want to wait for the quality to catch up, we're going to be delaying testing a model that's really needed right now.

CHAIR BAILET: Thank you.

I have a question about the interface between the program and the patient. As I understand it, there's a survey. The patients are surveyed at the time of admission into the program, and then there's another follow-up with the family members at the time of death. Do I have that right?

DR. ROTELLA: [Nodding affirmatively.]

CHAIR BAILET: Yes.

So this is a -- I think there have been comments about this is a learning process. I heard the word "demonstration." I heard the word we don't have all the

data we need to for us to sharpen this model, which I completely agree is incredibly important to the patients who need it the most, and I applaud your efforts and in particularly driving this into communities where there aren't organized systems of care, and those patients desperately need this kind of support and compassion.

My question is if we really want to learn and try and sharpen the program, asking folks, getting the members or the patient's perspective at the beginning, at the signing up -- and we understand that there is a deterioration obviously of their condition, how they interact. Their needs change in flight. I just want to understand why we wouldn't want to lean in and acquire additional input as the program plays out.

I understand the family's perspective at the end is very, very important, but it seems to me there's a lost opportunity, and I'd like to know your thinking about that.

Thank you.

DR. ROTELLA: Sure. Thank you for that.

So the balancing act in asking, say surveying patients and their caregivers more often, is that because we're trying to gather actually quite a few outcomes and experience items, it is -- there can be a burden to taking

the survey. So we are sensitive to the fact that we don't want to do it more frequently than necessary.

The current hospice quality reporting program, there's really only one point in time when the survey is done, and it's after death. We've added, in this case, something after admission, and we would be quite open to having more frequent surveys, for example, something like every six months while under service. But what we have to be careful we do is that we don't over-survey this vulnerable population on picking up on -- I think Dr. Patel was suggesting this is a vulnerable population that we have to consider the burdens.

When you think about the process measures that come from measuring what matters, which have been used some in the field, I think those could be gathered more often. What we have to think about there is that some of the smaller practices that are just ramping up to do the service, which we'd like to include in the model, we don't want to overburden them by doing it more often than is really necessary to build the database.

So I accept your concern that we might learn faster if we could gather more data points more often, and as long as we're balancing that against the potential

burden and discouragement of smaller practices from joining or overburdening our families and their stretched caregivers, I think that's worth considering.

CHAIR BAILET: Right.

And, again, just to punctuate my point, it seems like there should be one set of input from the actual patient, aside from when they sign up, on how the program is -- how we're doing, I guess, to allow the program to make adjustments and to learn. And it just seems like there's a lot opportunity, so thank you for that.

Rhonda?

DR. MEDOWS: I don't know if I -- oh, Paul, I think, was next.

No, I just simply wanted to say thank you for bringing to us a proposal that addresses a whole person and the whole person and their family.

I want to thank you for actually speaking to the overwhelming need to expand this to a larger portion of our population.

I think what you hear are questions more about process more than -- I don't think there's a concern about support or any difficulties with understanding the need to doing this in a better way.

When you guys were talking and I heard some of the questions, I initially thought that you were already part of an innovation grant, but you are not, correct?

DR. BULL: Yes.

DR. MEDOWS: You are?

DR. BULL: Just my organization.

DR. MEDOWS: Part of you is.

DR. BULL: Yes, part of us.

DR. MEDOWS: Okay. And so CMS has already had an opportunity to work with you. They obviously thought this was a worthy concept, at least the proposal that you put forth.

DR. BULL: Correct.

DR. MEDOWS: And they are evaluating a payment model but not necessarily this payment model.

So there is already work underway to review and hopefully to consider expansion; is that correct?

DR. BULL: So part of the charge in Round 2 of the Innovations was to come up with an alternative payment model. So we were working with our colleagues at Duke who were the co-principal investigators, and as we started model development in that particular arena, I was also involved as president of the American Academy and was on

that task force. And it made sense as we went forward to put those two together.

DR. MEDOWS: So is that what this is coming from?

DR. BULL: So this is really --

DR. MEDOWS: This is another one?

DR. BULL: No, no, no, no, no. No, no. No.

DR. MEDOWS: Okay.

DR. BULL: This is the PACSSI model. It helped inform the PACSSI model that kept --

DR. MEDOWS: Okay.

DR. BULL: Yeah. This model was from the Academy. It is informed by some of our work at CMMI.

DR. MEDOWS: I'd like to see something move, so I'm just asking how many paths are going.

DR. RODGERS: We're doing our very best to coordinate, work together, and I think what we're learning from Janet's model, even as we're just getting the claims data has been -- will be very helpful in understanding this. But even in the experience with understanding cost of care in an organization that's working in one of our priority communities, which is western North Carolina and update South Carolina, which is a rural area, it has specific challenges.

We, however, will want to make sure that we're broad to make sure the model is applicable across all communities, more intensely with the populated suburban/urban areas, because all the beneficiaries deserve this service, regardless of ZIP Code. So we're broadening out the kind of composition of this, and we are bringing one proposal to you together.

DR. MEDOWS: Thank you.

CHAIR BAILET: Paul. I apologize for getting out of sequence too.

DR. CASALE: That's okay. You would have left Rhonda's nice --

CHAIR BAILET: I know. Rhonda's speech, you know, it's like we listen.

DR. CASALE: Yeah. So sorry.

CHAIR BAILET: I couldn't help myself.

DR. CASALE: So, yeah, underscoring, clearly, I think you're hearing we all recognize the need, and I think that's reflected in the PRT's vote on the scope, that it meets criteria and deserves priority consideration. So I don't think there's really any question there.

Just two specific questions, and again, in talking to our palliative and hospice care expert and the

discussions we had there, these are two areas. One was the certification. So it could be physician, nurse practitioner, social worker, spiritual care provider, and again, this may be -- I have certainly a much better understanding around the physician, and the certification, I don't have so much around social workers or spiritual care.

And I understand the flexibility is important, but I guess it just raised the concern. Could you -- and I'm not picking on the spiritual care provider, but I just don't know their certification, if they're the certified one, and then you have others who may or may not have the background. So it was brought up by the expert, and I just wondered if you had that discussion.

And then the second has to do with this Tier 1, Tier 2 jump and the comment from the expert around, well, the palliative performance scale can fluctuate quite a bit, so going from 60 percent to 50 percent may occur not infrequently, and then the comment from the expert that the utilization criteria, particularly moving into Tier 2, was a little light.

So, again, you probably had discussions because, again, this dichotomy versus sort of a continuum, and so

how you got to those.

DR. RODGERS: I'll speak to those in order, if I can, and then maybe hand off the past part to my colleagues.

So speaking first to the certification, kind of echoing back to Dr. Ferris' comment, we want flexibility in the model.

I will say we've had a lot of discussion about kind of how to balance that against ensuring the fidelity of the intervention.

Specifically to spiritual care, there's no current specialty certification in spiritual care for palliative care. There are professional chaplains who go through a certification process.

So there is subspecialty certification for physicians, nurses, and social workers, so that's one piece, and that's meant, again, to allow this to be applied in a wide variety of settings, where we hope to be able to ensure the fidelity of our intervention is on the quality accountability side. So we ensure there's accountability for quality throughout the model, and that that's how we want to kind of get to that piece.

To the kind of tiering, again, I won't reiterate

our earlier comments. The tiers were meant for the clinical reality that patient intensity increases as they get sicker, and we absolutely understand that any clinical assessment, whether it's for function or prognosis, is subject to significant judgement.

We actually have some harder data and a stronger evidence base for function, so that that's why we chose that over a prognosis model. Also, tying back to what many of us deeply believe in one of our guiding principles is that patient eligibility and enrollment needs to rely on patient need, not how long we think they have to live because, frankly, we're not that good at it.

And even if we were, patients may have a short prognosis without significant need, and they may have a significant need without a prognosis we can determine.

So, really, when we get down to trying to meet unmet needs and reduce suffering of patients, families, and caregivers, that kind of patient-facing stature.

And I'm going to respectfully ask you to repeat the last question because I just forgot it. I apologize.

DR. CASALE: No, no, no. It was just around the utilization piece, again, Criteria 1, 2, and the expert sort of said, well, it seemed a little light.

DR. RODGERS: Yes.

DR. CASALE: No, no, no. It was just around the utilization piece, again, with criteria 1-2, and, you know, the experts sort of said, well, it seemed a little light.

DR. RODGERS: Yeah. Thank you. Again, from the modeling that we have, you'll see in Appendix 5 -- I apologize, the patient data, we use that utilization to try, with the data that was available to us, to identify patients who had enough opportunity with respect to reducing affordable spending, to keep the model cost neutral. Patients are expensive in the hospital. We know that. That's where we tend to spend money. Sick patients are very expensive in the hospital.

So we do have a more stringent utilization threshold for Tier 2 than Tier 1, which includes the hospitalization and at least one other unplanned contact with the system -- so ED visit, observation stay, second hospitalization. And what those tend to mark in our clinical experience, and I'm sure many of yours who face patients, is that when patients come to an ED or get admitted, it is a sign of an unmet need, either because their disease has progressed to a place where the family can no longer take care of them, caregiving is broken down,

all kinds of reasons. So that's why we did have a stricter criteria for Tier 2.

CHAIR BAILET: Seeing no other questions, I want to thank all of you for your hard work and coming here today, and comments. We are going to move with our process, so again, I thank you for your efforts.

*** Comments from the Public**

CHAIR BAILET: We are going to go ahead and open it up for public comment now. We have quite a few folks who want to make public comments, and in order to allow for everyone to get their time, I really do want to hold folks to three minutes. We have been fairly gracious in the past, but because of the number of people who want to make comments, we are going to try and stick to the three minutes. I would just like folks to be mindful of that.

We are going to go ahead and start with Sandy Marks from the American Medical Association. Hi, Sandy.

MS. MARKS: Hi. Thank you. We commend the PRT for its careful review of this proposal, also the other Committee members' comments and your efforts to identify the strengths and weaknesses.

I think for APMs to be successful they need to be designed well, and there's really nowhere that physician

practices or specialty societies can go today for technical assistance developing good payment models. That's why the AMA successfully urged Congress to clarify the MACRA law last month. The comments, suggestions, and feedback from the PTAC on proposals are very helpful to those who are developing APMs.

But just because there are areas where improvements are needed in a proposal does not mean the proposal fails to meet the criteria. The PTAC has reviewed other proposals that it recommended for testing, even though they needed some improvement.

In the AMA's comments on the CMS Innovation Center's new direction last fall, we said it is impossible for physicians to accurately determine the costs or outcomes of a new approach to care delivery without actually implementing it, that this requires having a payment model that will support the new approach and that CMS should assume that every APM will need refinement, and that goes for the PTAC as well.

In terms of the quality and cost criterion, this APM is designed to support services that are really not available to Medicare patients today. It doesn't seem reasonable to us to expect a proposal for something new

like this to already have experience with outcome measures and performance standards. In fact, when CMS created the Comprehensive Joint Replacement Model, it provided additional payments to participants that were willing to collect outcome measures for joint replacement.

The PRT also expressed concern that the proposed model might not improve health care at no additional cost, but couldn't that be said about every APM that is tested? If the PTAC requires proposals to guarantee savings or quality improvements before it will recommend that they be tested, it will be very hard to make progress. It should be possible to pilot-test models and then make changes as people get more experienced with them. That's why there are so many different ACO tracks, medical home models, and bundled payment initiatives right now.

Current Medicare spending is very high on patients with advanced disease and it is impossible for patients' caregivers to coordinate everything themselves and keep people from getting unnecessary tests, procedures, consultations, medications, and emergency visits, because today no one is really accountable and too often there is no real team. It is difficult to imagine that this APM would not both save money and improve the quality of life

for patients.

Thank you.

CHAIR BAILET: Thank you. Next is Diane Meier from the National Coalition for Hospice and Palliative Care.

DR. MEIER: Thank you very much for the opportunity to address you. My name is Diane Meier. I am a Professor of Geriatrics and Palliative Medicine at the Mount Sinai School of Medicine, and Director of the Center to Advance Palliative Care. However, today it is my pleasure to be here as the President of the National Coalition for Hospice and Palliative Care.

The coalition represents 10 leading professional national organizations dedicated to the provision of high-quality palliative and hospice care. Our organizations represent more than 5,000 doctors, 1,000 PAs, 11,000 nurses, 5,000 chaplains, 7,000 social workers, researchers, pharmacists, along with over 1,800 palliative care teams and 5,300 hospice programs. Together we care for millions of seriously ill patients and families every year.

Our coalition strongly supports the model outlined in PACSSI. Specifically, we want to comment on four key provisions.

The first is that the model should be based on the consensus-established palliative care guidelines that were earlier mentioned. These guidelines have been in place since 2004, are evidence-based, and reflect expert consensus on the key elements, and must, therefore, serve as the platform or the standard for the design of any payment and delivery model.

The second is that the team composition that the interdisciplinary team is indeed essential. The quality guidelines underscore this. Each team member addresses the distinct and diverse aspects of care needed by people living with a serious illness as well as those of their family and other caregivers. Research demonstrates that palliative care delivered by such a team improves quality of life, quality of care, and by averting preventable crises reduces costs.

Importantly, and this differs somewhat from what you heard before, the coalition recommends that at least one team member is a prescribing clinician with board certification. We are concerned that without this certification beneficiaries are at risk of poor-quality care, including, and very importantly, poor prescribing of opioid analgesics. Most clinicians have had no training in

how to do that safely.

Eligible entities is our third point. We encourage PTAC to recommend the widest possible range of qualified entities, be eligible to participate, thus serving the broadest possible group of beneficiaries and caregivers. This would include teams working as independent practices, associated with hospices, home health organizations, hospitals, health systems in urban, suburban, and rural communities. We would be concerned if the eligible entity requirements limited or prevented participation by these smaller practices, such as the one that you heard about just a minute ago, working with grossly underserved patients and their families.

And finally, our fourth point is who is in the eligible beneficiary population, and I want to underscore that it should be based on patient and caregiver need and not prognosis, not only because needs should be the reason for receiving services but also because it is almost impossible to predict prognosis until the last few days or weeks of life.

Need for palliative care services is marked by functional decline, poorly controlled symptoms, patient or family distress can occur at any time in the course of a

serious illness and it is quite common early after diagnosis of a serious illness, and should not be limited to the very small fraction of this high-need population who have a predictably short prognosis.

It is also essential that the enrollment criteria be based on data that are accessible to the front-line clinicians participating in this model, like diagnosis, functional impairment, and utilization that are readily available and do not require access to claims or large administrative databases that are not available to most palliative care teams.

We thank you for your thoughtful consideration of the PACSSI model and thank you for the opportunity to address you today.

CHAIR BAILET: Thank you. Next, Lori Bishop, National Hospice and Palliative Care Organization. Welcome.

MS. BISHOP: Thank you. Good morning. I am the Vice President of Palliative and Advanced Care for the National Hospice and Palliative Care Organization. I am also a clinician, a nurse by background, certified in hospice and palliative nursing. I've had the privilege of doing clinical care for seriously ill patients and I've

also been an administrator of programs, community-based palliative care in the Midwest, and most recently in northern California for Sutter Health's Advanced Illness Management Program.

NHPCO is here today as a founding member of the National Coalition of Hospice and Palliative Care, and we appreciate the opportunity to particularly provide feedback on the quality measures component of the PACSSI model.

NHPCO and the coalition strongly support the expectation that quality measures are an essential part of this model, and especially for quality assurance and performance improvement. There are three main points we want to make regarding quality measures.

The PACSSI survey used to obtain patient-reported outcomes and experience of care builds on the hospice CAHPS survey, which is a part of the Hospice Quality Reporting Program. These NQF-endorsed measures in both models, PACSSI and hospice, allow for seamless experience of care for seriously ill patients and their families.

Second, the process measures that PACSSI model recommends align with the NCP Clinical Practice Guidelines for Quality Care, which Diane just mentioned, and the PACSSI team has mentioned to you as well. These allow

access to an interdisciplinary team, including social workers and chaplains, which is very important for holistic care for these patients and their families.

The third point is the utilization measures include the percentage of patients that transition to hospice. We not want to see this model become a replacement for a service you are already well established. We feel that measures that track the utilization of hospice and the connection to hospice service are essential for a model. We also recognize that there is a recommendation of patients that are served seven days or more before death in a hospice, and we would say that this is likely an inadequate measure for patients, and would recommend that actually the hospice median length of stay is a more accurate measure for those patients and could be done to also ensure that patients aren't transitioned to hospice in too long a length of stay, which we sometimes see in dementia patients today.

The PACSSI model provides an alternate for these patients that allows for dementia patients and caregivers to get services further upstream, so we would again recommend the hospice median length of stay to track short lengths of stay and long lengths of stay.

In addition, we support the broad array of entities that the PACSSI models allows to participate. NHPCO's member organizations participate in 50 states, including Puerto Rico, and in rural, urban, and large communities. So we are ready to participate in this model.

Thank you so much for the opportunity to come before you today on behalf of NHPCO, the coalition, and, more importantly, the growing number of seriously ill patients and their families who need models like this upstream.

Thank you.

CHAIR BAILET: Yeah, thank you. Elizabeth, you had a question?

VICE CHAIR MITCHELL: Thank you. I was actually hoping to just ask for your thoughts on, do you believe that there are improvements possible in including patients and families more in the development of the care plan, so that it is done jointly, as opposed to on behalf of?

MS. BISHOP: Thank you for the opportunity. It's a great question. Yes, I believe the patient -- we believe the patient and the family are the drivers of the care plan, so we have to sit down and find out what their needs are, and that care plan should be based on their needs.

And we know sometimes their basic needs are not medical. They may be financial. They may be emotional or psychosocial. So, yes, absolutely, the patient and family need to be engaged and be the driver of the care plan. Thank you.

CHAIR BAILET: Thank you. We now have several folks on the phone. I'd like to ask the operator to open up the phone lines, and I will introduce the first speaker, and that's Betty Ferrell from Hospice and Palliative Nurses Association.

DR. FERRELL: Good morning. This is Betty. Can you hear me?

CHAIR BAILET: Yes, we can.

DR. FERRELL: Great. My name is Dr. Betty Ferrell and I'm the Director of Nursing Research and Education and a Professor at the City of Hope National Medical Center in California. I also serve as the Principal Investigator for the End-of-Life Nursing Education Consortium, the ELNEC project. Today I am pleased to represent the Hospice and Palliative Nursing Association, HPNA, the national professional organization that represents the specialty of palliative nursing. This includes more than 11,000 members and 52 chapters

nationwide. Our vision is to transform the care and culture of serious illness.

HPNA is a founding and current member of the National Coalition for Hospice and Palliative Care. We support the statements provided by Dr. Meier on behalf of the national coalition. HPNA supports the development of an alternative payment model that provides access to care for appropriate patients based on needs and not a specific prognosis or time frame, and with the interdisciplinary team of providers as described in the PACSSI model.

I serve as the co-chair and HPNA's representative to the National Consensus Project's Steering Committee that is currently developing the fourth edition of the guidelines. The NCP guidelines have served as the standard for quality palliative care since the first edition was published in 2004. The NCP guidelines describe the essential components and elements of quality palliative care.

During this most recent revision process, we heard from several insurance companies, the National Quality Forum, several accreditation organizations such as the Joint Commission, and the Community Health Accreditation Partners and quality measure developers that

these guidelines serve as the framework for their standards and processes of care, and these consensus-based guidelines were widely recognized as the guideline for the provision of serious illness care.

HPNA and the National Coalition for Hospice and Palliative Care commend the Academy and PACSSI proposal for recognizing the NCP guidelines, an outline of essential services and components needed in any serious illness model. The goal of the guidelines is to ultimately improve access to quality palliative care for all people with serious illness, regardless of setting, diagnosis, prognosis, or age. The guidelines formalize and delineate evidence-based processes and practices for the provision of safe and reliable high-quality palliative care for adults, children, and families with serious illness in all care settings.

The essential eight domains for which experts have reached consensus are necessary for quality palliative care. It is the interdisciplinary team of nurses, physicians, social workers, and chaplains who are trained to provide these essential services to patients and families. Any serious illness model must address structures and processes, physical aspects, psychological

and psychiatric, social, spiritual, religious, and existential, and cultural aspects of care, as well as care of the patient near the end of life and ethical and legal aspects of care.

Thank you very much for your time and attention this morning. On behalf of HPNA and all the nurses and related personnel we represent, thank you for your consideration of support for the PACSSI model.

CHAIR BAILET: Thank you. Next folks -- the next person on the phone is Dana Lustbader from ProHEALTH.

DR. LUSTBADER: Good morning. This is Dana Lustbader. I am the Chairman of the Department of Palliative Care at ProHEALTH, and prior to joining ProHEALTH I was a critical care physician in a large health system and also started an inpatient palliative care program.

I currently work at ProHEALTH as chair of the department, which is a large, multispecialty group of 1,000 physicians, and we serve the New York City metro area and all of Long Island, as well as the rural areas in the tip of Long Island and the most densely populated areas in Queens and the Bronx. Our ACO, our Medicare-shared savings program, ACO at ProHEALTH, serves about 32,000 Medicare

beneficiaries. We also have six other shared savings programs. We serve a larger population than that, about 1.2 million patients, and do not own hospices or home health agencies or hospitals.

So we are very clinic-centered, and several years ago, in our ACO, invested a substantial amount of money to begin a home palliative care program. This investment was made out of some of the successes of the MSSP-ACO, and we put in about $2 million to start an infrastructure for home palliative care. And in 2014, started with about 20 patients and have grown today so we serve about 1,600 or 1,700 patients in their homes, with about 16,000 visits per year, 11,000 phone calls, and over 500 telemedicine visits to seriously ill patients in all of New York City and Long Island areas.

We also serve two Medicare Advantage health plans for a PMPM rate.

I'm going to discuss two things today that I think are very important. One is I'm going to describe our home-based palliative care team and the second thing is I'm going to share some outcome data that we published on.

So the team is comprised of a Board-certified palliative care doc, and we've got several docs. We use

RNs, nurses, nurse practitioners, social workers, volunteers, and we partner with the patient's chaplains as well as partnering with all of their other doctors.

And one of the things that's most striking is that many of our patients do not have a captain of their ship. There isn't one doctor who knows them. They've been in and out of the hospital or ER so often, and it's difficult to find somebody who is really coordinating their care.

Nonetheless, we do communicate with many different doctors that are involved in patients' care, so that a patient might be followed at Mount Sinai, and they may have their gastroenterologist at NYU, and they may have somewhere else. So we actually regularly call the different doctors that are involved in the patient's care, and of course, these medical records are not electronically on the same system, either so the docs often don't know what's going on with the other docs either. So we really try to be the ducktape and spackle and really make sure that that care is coordinated across the different doctors that the patients are seeing. Most of our patients, though, are becoming more frail, and it's difficult for them to get out to see these other doctors, and so very

often the doc hasn't seen the patient in over a year.

We also support the family caregivers, and regarding patient engagement, much of that occurs because we provide 24/7 access to care. We answer the phone. It's always a warm answer, and we do either respond with a visit, with a virtual visit with telemedicine, or the right advice and guidance as to what to do. They don't get a voice-mail when they call our service, and we do really work very closely with the very burdened, overworked, and stressed-out family caregivers, and our social workers are especially helpful with providing family caregiver support.

The next thing I want to touch on is some of the outcomes that we did publish on our outcomes board, our Medicare shared savings program, ACO patients that were enrolled in home palliative care, and to make this a rigorous study, we looked at only patients that died. And we compared patients that died who were enrolled in our program to those that died that weren't enrolled in the program for 2015 and 2016, and we started now to look at that again for patients that did not die. But to be very rigorous in the methodology, we wanted to ensure that both groups had death as the outcome.

And what our data showed was that the location of

death for those in our program was 87 percent compared to about 25 percent with usual care.

Hospice referral increased by 35 percent, and in fact, the hospice median, like the stay, increased from a baseline of 10 days to 34 days. So when they're enrolled in a home palliative care program, they are enrolled in hospice more often, and their hospice length of stay is longer.

They also get to be at home in their final days or months of life, whether they're in hospice or not, because the interdisciplinary team is so good at advanced care planning and providing actual treatment and guidance as symptoms progress and escalate in the final weeks and months.

Hospital inpatient admissions dropped 34 percent for the final month of life for people who are enrolled in the home palliative care program, whether they were in the hospice or with the program and not in hospice.

The cost savings in the final 3 months of life was demonstrated to be $12,000. For people who died in our program, the cost was $12,000 less than in usual care.

We started to look at a larger sample size to see if, in fact, this is reproducible. This was a study that

we published in January of 2017 in the Journal of Palliative Medicine, and the one thing I'll say about the article, it was the second most popular downloaded article for the entire year, and I think it speaks to the interest in this space and that people really do want to figure out ways to provide care to seriously ill people and their caregivers at home.

But in a fee-for-service world, it's just not possible to do that without losing money, which is also why we have pivoted a bit to serve Medicare Advantage because we are able to provide this service to Medicare Advantage patients in our market. We have partnered with two MA plans. One, we've partnered with for three years. One has been for one year, and we're scaling up with both of them because of demonstrated positive outcomes in folks that died but also in the patients that don't die.

In our population, 70 percent of patients are not terminally ill or dying and in fact are just very, very sick with high disease burden, so they might be 87 years old with heart failure and COPD and some renal impairment and diabetes and live alone in Queens with a daughter who works two jobs in the Bronx and can't get his Lasix refilled, doesn't have a mechanism for that, and keeps

going to the ER. So it's patients like that that aren't hospice-eligible, not dying, but are high utilizers and suffering, and those are patients that we also focus on heavily in our program.

CHAIR BAILET: Dana, I don't mean to interrupt --

DR. LUSTBADER: So I just want to stress how --

CHAIR BAILET: We're just running out of time.

DR. LUSTBADER: Oh.

CHAIR BAILET: So if you could please wrap up your comments, we'd appreciate it. Thank you.

DR. LUSTBADER: Absolutely. Thank you so much. I just want to again thank you for considering this proposal, and it would be extremely important for seriously ill people.

Thank you.

CHAIR BAILET: Thank you.

Next is Martha Twaddle from Northwestern Medicine.

DR. TWADDLE: Good morning. I want to thank you so much for this really privileged opportunity to lend my voice to this space or perhaps, better said, be a container for the voices of many patients and families for whom I have provided care, and I am grateful and moved by really

the input of this entire group and see that you have -- you see this as relevant and timely.

I am a palliative medicine physician of nearly 30 years. I see patients in all settings of care. As mentioned, I'm the medical director of Palliative Medicine and Supportive Care for Northwestern North Region. I'm also a senior advisor to Aspire Health and have been since its inception.

I had the privilege of co-chairing the National Consensus Project with Berry Ferrell, and soon this will be more than consensus since we are undergoing a systematic review of the literature.

This vital publication lays out what are the essential elements of quality palliative care and really speaks to the absolute critical need for the interdisciplinary team in providing care to this population. It speaks to the requirements of this team and also pays attention to transitions of care for these very vulnerable patients and families as well as to the needs of their caregivers.

My personal experience over these past three decades continues to reinforce the necessity of the interdisciplinary team and how critical it is to really

support the quality of care for this group of patients.

The multivariate needs of this patient population transcend the medical model. Historically, we have been constrained to respond to patient family needs by sending resources that might be reimbursed. We have over-medicalized our response.

We otherwise depend on philanthropy or cobbling together initiatives that are typically not sustainable.

Likewise, I am daily confronted with our current quality metrics, do not well reflect the needs of this patient population and their caregivers. Better are the softer measures of satisfaction, sense of being cared for, the responsiveness of the team.

This demonstration project would give us the opportunity to really bring into the light, the invisible suffering of this population. I think we have so much to learn and so much that we do not know.

I call to mind a gentleman just this past week, 81 years old with pulmonary fibrosis. His primary caregiver is his wife who is 60 years, who suffers from cognitive impairment, and his cognitive impairment is further challenged by his illness.

Typically, their calls are after hours, and

unfortunately, the response of EMS to their need is a mismatch and whisks him off to the most wasteful place he could go, the ED, where further testing simply confirms his hypoxia and frailty and does not meet his need and further depletes his reserve and that of his wife.

So programs like we are building where we can be the first interface, the phone call is answered by a clinician. We can troubleshoot and reassure, can make a huge difference in just the utilization patterns and typically the waste in the system.

The PACSSI model gives vital support to provide truly essential quality care to this population. Again, I think we are on the brink of learning more as we explore the needs of this population.

Mr. P. throughout his time under our care, once we got him into palliative care, did not consider himself to be dying. So I caution us always to look through the lens of prognosis but rather to look through the lens of need. About 11 to 15 percent of people will get better in these programs and actually graduate back to ambulatory care and not need our services.

So let's build a model that can be responsive, and I trust that we will do so. Thank you.

CHAIR BAILET: Thank you.

I believe we've got one more person on the phone. Tahirih Jensen, are you on the phone from Empath Health, Suncoast Hospice?

[No response.]

CHAIR BAILET: So let me -- it was unclear whether they actually made it. They signed up.

So that ends our public comment session. I turn it back to my colleagues on the Committee for any clarifying questions amongst ourselves before we go ahead and start to vote.

[No response.]

CHAIR BAILET: Seeing none, we are going to go ahead, then, and start with our voting on the individual criteria.

Maybe we should take a five -- before we start the voting, five-minute break? Okay, very good. Thank you.

[Recess 10:40 a.m. to 10:51 a.m.]

* **Committee Deliberation**

CHAIR BAILET: All right. We're going to reconvene, and I'm going to ask my colleagues again if we want to make some comments, talk amongst ourselves before

we go ahead and start our voting on the criterion. Len, please.

DR. NICHOLS: Thank you, Mr. Chairman. I just thought before we jump in to vote, we should kind of have a little bit of a discussion, because I've never been through two hours and 20 minutes and heard Harold say nothing. So I just think something --

[Laughter.]

DR. NICHOLS: Something's clearly up. But I just wanted to frame it to see if other people might be in a place they want to associate themselves with this or not. But here is the way I see it, for what it's worth.

Obviously, the quality measures have to be developed. Obviously, the benchmarks and the risk adjustment has to be worked out. None of that can happen without a lot more work.

The question we have before us then is: Do we want to tell these people to go back and work it out on their own in the absence of real data? Or do we want to move them along in the process so we can get to what we all agree is a huge, huge need for this patient population and have them work with CMS in a way that can be more productive?

To me, I hate to say it, we've got a blunt instrument here. It is, yes, go home and do it yourself or let's help you. And I just think we should be thinking about that. I get where the PRT came from. Given the criteria, technically, you can judge them this way. I just don't think that's the wisest way for us to proceed as we go, and I just wanted to say that.

CHAIR BAILET: Thank you, Len. And was it Bob or Tim that was up first? Tim.

DR. FERRIS: So I'll associate myself with your comments, Len. I also want to -- and maybe this is related to what Bob said earlier. But in thinking about -- so the care model here, no dispute about the need and the critical importance of it. I see it every day when I'm practicing.

But the financial model is -- I do believe requires some additional thinking, and I would say to Bob's point earlier about the -- I don't have any trouble with having asymmetry in the financial model, but in the optics around having potentially large financial incentives on the upside associated with end-of-life care is just a really problematic structure. And so while I understand in the rationale that was given by them, because that's actually how prior models have been structured that were approved,

it seems to me in this specific context, a pay for performance with downside risk being the infrastructure costs is a really legitimate ongoing structure, not necessarily just a temporary structure. And I think some of the optical issues associated with large incentives associated with this particular population, large financial incentives, might be ameliorated in more of a cost-plus model than having potentially large downside and large upside. I just think that's sort of where I'm coming from. I'm very interested in hearing others.

CHAIR BAILET: Thank you, Tim. Bob?

DR. BERENSON: Well, yeah, I think it's more than optics. There is an optics problem, but there's a reality. I will reflect for a moment on my experience on MedPAC. The most stunning bit of data that I was exposed to in my term on MedPAC was the misuse of the hospice benefit. When in good hands, it is the greatest thing going. In the State of Mississippi, about -- this is now five-year-old data, but my guess is it hasn't changed a lot -- something like 56 percent of hospice patients were discharged alive. So what's that all about? There's a per capita cap in hospice. Medicare won't pay more than X. So the strong inference is that these people, many of whom probably

didn't -- shouldn't have been in hospice in the first place, they generated lots of fee-for-service revenue. They came up against their cap. Goodbye, good luck to you. That's what the for-profit hospice industry has created along many of the Southern tier states, Louisiana, Mississippi, Texas, et cetera.

So we have this tendency to think that this payment model is going to be used by good guys. The people in this room would probably do very well under a shared savings/shared risk approach. They would have protections in place, et cetera. This can't be restricted to just the people we would hand-select for it, and I think there's a real potential not just for optics but for real bad behavior when you give substantial financial incentives.

Palliative care works. Most developed countries cover palliative care. They pay for it. We should be doing that. We could add pay for performance. I just think the fundamental -- that this payment model -- oh, yeah, let me add one other point I was going to make. Not a single commenter said an important part of this proposal is the shared savings/shared risk component. It was all about the care. It was all about the benefits of doing this.

So I think it almost doesn't matter whether we ultimately give it a thumbs up or thumbs down. We're all saying this is a huge important area, and I think we've got a -- we should explicitly talk about our concerns about shared savings in this model.

And I'll just finish by emphasizing the point that Kavita made earlier. I think CMMI and then MACRA has done a real disservice by saying that substantial financial risk is part and parcel of an advanced payment model. It absolutely makes sense for a broad population in ACOs being accountable for total cost of care. At the last meeting I think we all agreed -- or at least most of us -- that for prostate cancer and for early dialysis, the idea that those specialists would be accountable for total costs of care doesn't make sense, and I would say here's another example where the concerns about misuse are such that that's not -- shouldn't be part of this payment model.

So I think we can figure out how to tell CMS you got to develop a payment model for palliative care. But we should also be expressing concern about this overreliance on financial incentives.

And the final final point is that Dr. Rodgers correctly said this saves money. It saves money without

those financial incentives. If it's done right, I have no doubt that palliative care will save money. We don't need to layer on financial incentives to what should be part of good practice and, as I said earlier, that every other country provides; we should be doing it, too.

CHAIR BAILET: Thank you, Bob. Grace and then Bruce.

DR. TERRELL: I think Tim's remarks about the importance of understanding the cost of infrastructure development for this are really important, and one additional point related to that is remember that in our current fee-for-service system, the RVUs has that built in it, albeit not necessarily appropriately in many cases, and there's a lot of controversy and politics around that. But that is ultimately built into the current fee-for-service system. So in any alternative payment model, maybe one of the things we need to be thinking about as a PTAC is making the assumption that the cost of infrastructure development ought to be built into whatever that is, because then some of the issues related to “risk” versus “not-risk” is that piece of it is just a given, and that should be something that maybe we need to put as a comment to CMS.

One of the things that was alluded to earlier was

the significant amount of data that's available through Medicare Advantage but not necessarily through traditional Medicare, and many of those patients have, you know, plans for which they're taken care of through the end of life. This is another example where we may need to make some comments to the Secretary about learning not just from the data from traditional Medicare but from Medicare Advantage products to see if there is some learnings from that that would inform how that relates to hospice and all the other end-of-life services.

And, finally, I think it's really important for us to think about hospice very differently than palliative care, and it's not the same thing, but often traditional health care providers go there immediately. And a lot of our conversations today, whether it's Bob's remarks about some of the absolutely inappropriate scandals that have been part of some but not all of the hospice programs, gets into the real problem. This particular model, because it's focused on palliation, may be a way to get around and above and beyond some of those current dilemmas that we have where hospice is traditionally based on end-of-life. It's got those six months cutoffs, it's got those ways of working around and then getting discharged and discharged

out. And as we're writing this up, if we really make a distinction that hospice and palliation are not the same things, they're interrelated and important and need -- as all of our speakers have said today, need to work together, but it is not the same thing. And having a palliative care model is very different than an end-of-life model per se.

CHAIR BAILET: Thank you, Grace. Bruce.

MR. STEINWALD: It's fun to associate yourself with other people's comments. First of all, it's a lot easier than thinking it up yourself.

[Laughter.]

MR. STEINWALD: And it gives you an opportunity to make other people feel good.

So Tim I think makes a good point. I hadn't thought of it myself. And the team -- regardless of whether you're talking about PACSSI or C-TAC, there is a risk associated with mounting them up with the infrastructure. And so even if you don't have a shared risk/shared savings program, any entity that seeks to set one of these things up is incurring some risk. That's a point well made.

Second, in addition to what Bob said about problems with shared savings, another problem is

measurement. I mean, in both of these proposals, we have pointed out that establishing what that baseline is in order to measure what actual costs are and what the savings and costs actually are is not trivial. And it's just the kind of thing that when you talk to the HCFA -- God help me -- the CMS actuaries --

[Laughter.]

DR. BERENSON: We won't hold it against you, Bruce.

MR. STEINWALD: It's one of the things that they get exercised about in these kinds of models, is how difficult it is to actually measure these things.

It should be part of the evaluation for sure, but that's a different structure than having it actually part of the payment system.

CHAIR BAILET: Thank you, Bruce. And I have been -- I don't normally associate with anyone, but I do want to associate my comment with Len because I am struck by the elegance and the absolute need for a model to address this population, period, dot. I would agree with all of my colleagues who I feel also feel as strongly about the fact that this is fundamental. We need to inject compassion back in the work of the business of medicine. I think at

some times we get far afield, and this population, there's no room for that. There's no room for the business. These folks need compassion; they need care. And I do fundamentally believe, if you provide the care that this model tees up, that the costs will improve because these patients will have a much greater say in what they need and a deeper understanding of the care that is potentially going to be provided before it's provided. And I think with that clarity, with the family involvement, that as these plans get developed, there'll be less care delivered, more compassion delivered, and the costs will obviously follow. So I do agree with the challenges of this -- of the economics of the model, but I'm also acutely aware of the importance of the economics that need to be embedded in these models.

And so for us as a Committee, we have a proposal in front of us, and for us to just say, you know, we got to go back to the well I think loses a tremendous opportunity to put on the field a model that patients tomorrow will and can benefit from and, more importantly -- and as important, I should say, is that the clinicians in the country can learn from having this model in front of them. And so I think we need -- as a Committee, we need to think about the

downstream ramifications as we make these determinations, particularly on this model and the model that will follow, because of the gap in caring for these patients and what's happening in the country is the population -- as the demographic ages, this population of folks is growing.

So, again, I don't have a specific answer, but, again, it's top of mind, Len, and I appreciate you raising the flag before we start going through the criteria, because I do think statutorily we are obligated to evaluate these models against the Secretary's criteria, which we will go ahead and do. But I also think we do -- in our write-up, we have degrees of freedom in what our comments are, and advice, and how we land at the ultimate recommendation to the Secretary.

So, Elizabeth?

VICE CHAIR MITCHELL: Thank you, and I completely agree. The only thing I would add, at the risk of confusion, is that the next model addresses the same priority population that -- and I think we've all agreed that that is a high priority, but may have some different approaches. So as I vote for this I'm keeping both in mind, but agreeing that we've got to do something for this population now.

CHAIR BAILET: Thank you.

Are we ready to go ahead and vote for the criteria? Seeing affirmative, we're going to go ahead and start, if we could set that up.

* **Voting**

CHAIR BAILET: So just to remind folks, we are going to go all through the individual criterias. We're going to do it electronically. You're going to see the results displayed with Ann, our designated officer, helping us. So we're going to go ahead and start with Criteria 1. There are ten members voting, and you'll see 11, though, I believe, because the 11th is actually the instrument, just so -- just for clarity. Harold has no clicker in his hand. He's clicker-less.

Okay. So here we go. So Criterion 1, Scope, high priority, aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM entities whose opportunities to participate in APMs have been limited. This is a high priority. We're going to go ahead and vote.

[Electronic voting.]

CHAIR BAILET: Ann?

* **Criterion 1**

MS. PAGE: Seven members voted 6, meets and deserves priority consideration; zero members voted 5, meets and deserves priority consideration; one member voted 4, meets; two members voted 3, meets; and zero members voted 1 or 2, does not meet; and zero members voted not applicable. So the finding -- the simple majority determines the Committee's recommendation, so the majority has determined that this priority meets and deserves priority consideration.

CHAIR BAILET: Thank you, Ann.

Criterion 2 is Quality and Cost, also high priority, anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both, improve health care quality and decrease cost.

Go ahead and vote, please.

[Electronic voting.]

CHAIR BAILET: Ann?

* **Criterion 2**

MS. PAGE: Zero members voted 6, meets and deserves priority consideration; two members voted 5, meets and deserves priority consideration; one member voted 4, meets; two members voted 3, meets; five members voted 2,

does not meet. This -- according to the Committee's rules, this would roll down to where we have a majority of six, so the Committee's decision on this would be that the proposal does not meet Criterion 2, Cost and Quality -- Quality and Cost.

MS. STAHLMAN: Five and five.

MS. PAGE: It's a majority --

MS. STAHLMAN: You need --

DR. NICHOLS: [off microphone]

MS. PAGE: It's the other way -- it's the other way. So we roll -- we start at the top, what would be the best or the highest recommendation. We roll down until we have a simple majority. Simple majority is six out of ten, so we meet six when we get into the Column 2, two plus one plus two plus one more.

CHAIR BAILET: So we can talk about and then revote, which probably there may be value in that. So why don't we just quickly discuss this and then we'll revote.

Does anybody have any comments about this? Let me put it a different way, should we revote?

SIMULTANEOUS SPEAKERS: No.

CHAIR BAILET: No?

DR. NICHOLS: Maybe we should go outside for 5

minutes and come back.

[Laughter.]

DR. NICHOLS: I mean, look, in my opinion the quality metrics as are ready today do not meet. That is not the question. The question is, can we develop quality metrics in time to make this model operational in years three or four? That, to me, is the question. I believe the answer to that question is yes. I just think some people are voting one way and some people are voting another way.

DR. CASALE: Yeah, I would agree with that, and I think this is a recurring question around are we voting on the proposal in front of us as opposed to, you know, what we see as the future, and we struggle with that. It doesn't necessarily reflect our ultimate -- whether we recommend the model, but when I look at this criterion, it's that same issue of, to me, anyway, you know, assessing it on where it currently is.

CHAIR BAILET: Well, and I think that that's what we're -- I think that's where we landed in the past, when we've looked at models. Tim?

DR. FERRIS: I believe the current measures, as stipulated, actually do a great job. I think they cover

all the bases. So I'm perfectly comfortable with the quality measures that they have. They are exactly the same that we use in our program that is designed very similar to this, and I'm -- so I'm not sure I understand and would like to hear more why the existing quality measures don't actually cover the territory that is required to provide assurance that the goals of improved quality could not be met using the measures that they've proposed.

CHAIR BAILET: Does anybody -- any other PRT members want to -- Paul?

DR. CASALE: I think the concerns around the -- at least in my mind have been around the frequency of the assessment, in particular. Maybe that's easily overcome, you know, if you were to change it. But in terms of what I see here, that's a particular concern.

And then the conversation we had, you know, can we have sort of some additional stronger outcome measures as well. So again, things that can be solved but, you know, I'm voting on, again, sort of where we are.

CHAIR BAILET: Yeah. Okay. So we're going to go ahead and just revote, just for completeness. So let's go ahead and -- can we reset it, and go ahead and do that again?

All right. Ann.

* **Criterion 2**

MS. PAGE: One member voted 6, needs and deserves priority consideration; two members voted 5, needs and deserves priority consideration; zero members voted 4, meets; one member voted 3, meets; and six members voted does not meet; zero members voted 1, does not meet. The majority, again, finds that the proposal does not meet Criterion 2.

CHAIR BAILET: Thank you, Ann. We're going to go to 3, Criterion 3, which is the payment methodology, high priority. To pay the alternative payment model entities with a payment methodology designed to achieve the goals of the PFPM criteria, addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM entities, how the payment methodology differs from current payment methodologies, and why the physician-focused payment model cannot be tested under current payment methodologies.

This is a high priority. Please vote.

[Electronic voting.]

* **Criterion 3**

MS. PAGE: Zero committee members voted 5 or 6,

meets and deserves priority consideration; two members voted 4, meets; one member voted 3, meets; six members voted 2, does not meet; one member voted 1, does not meet. The majority has found that the proposal does not meet Criterion 3.

CHAIR BAILET: Thank you, Ann. We'll move to Criterion 4, which is value over volume. Provide incentives to practitioners to deliver high-quality health care.

Please vote.

[Electronic voting.]

* **Criterion 4**

MS. PAGE: One committee member voted 6, meets and deserves priority consideration; one member voted 5, meets and deserves priority consideration; three members voted 4, meets; four members voted 3, meets; one member voted 2, does not meet; and zero members voted 1, does not meet. The majority finds that the proposal meets Criterion 4, value over volume.

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

Please vote.

[Electronic voting.]

* **Criterion 5**

MS. PAGE: Two members voted 6, meets and deserves priority consideration; one member voted 5, meets and deserves priority consideration; six members voted 4, meets; one member voted 3, meets; and zero members voted 1 or 2, does not meet. The majority finds that the proposal meets Criterion 5.

CHAIR BAILET: Thank you, Ann. We are going to go with ability to be evaluated. Have the evaluable goals for quality of care cost and other goals of the PFPM.

Please vote.

[Electronic voting.]

* **Criterion 6**

MS. PAGE: One member voted 6, meets and deserves priority consideration; one member voted 5, meets and deserves priority consideration; two members voted 4, meets; six members voted 3, meets; and zero members voted 1 or 2, does not meet. The majority finds that the proposal meets Criterion 6.

CHAIR BAILET: Thank you, Ann. Integration and care coordination. Encourage greater integration and care coordination among practitioners and across settings where

multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

Please vote.

[Electronic voting.]

* **Criterion 7**

MS. PAGE: One member voted 6, meets and deserves priority consideration; three members voted 5, meets and deserves priority consideration; four members 4, meets; two members 3, meets; and zero members voted 1 or 2, does not meet. The majority finds that the proposal meets Criterion 7.

CHAIR BAILET: Thank you, Ann. Criterion 8, patient choice. Encourage greater attention to the health of the population served by also supporting the unique needs and preferences of individual patients.

Please vote.

[Electronic voting.]

* **Criterion 8**

MS. PAGE: One member voted 6, meets and deserves priority consideration; five members voted 5, meets and deserves priority consideration; three members voted 4, meets; zero members voted 3, meets; one member voted 2, does not meet; and zero members voted 1, does not meet.

The majority finds that this proposal meets and deserves priority consideration for Criterion 8.

CHAIR BAILET: Thank you, Ann. Patient safety. Aim to maintain or improve standards of patient safety.

Please vote.

[Electronic voting.]

* **Criterion 9**

MS. PAGE: Zero members voted 6, meets and deserves priority consideration; one member voted 5, meets and deserves priority consideration; three members voted 4, meets; five members 3, meets; one member voted 2, does not meet; and zero members voted 1, does not meet. The majority finds that the proposal meets Criterion 9.

CHAIR BAILET: And the final criterion, health information technology. Encourage the use of health information technology to inform care.

Please vote.

[Electronic voting.]

* **Criterion 10**

MS. PAGE: Zero members voted 5 or 6, meets and deserve priority consideration; zero members voted 4, meets; eight members voted 3, meets; two members voted 2, does not meet; and zero members voted 1, does not meet.

The majority finds that the proposal meets Criterion 10.

CHAIR BAILET: So do we summarize, I think. Go ahead, Ann.

MS. PAGE: Sure. The Committee found that on two of the criteria, that being Scope and Patient Choice, the proposal meets and deserves priority consideration. The Committee also found that on two criteria the proposal did not meet the Secretary's criteria, and those were on Payment Methodology and Cost and Quality. On the remaining six criteria, 4, 5, 6, 7, 9, and 10, the Committee found that the proposal met the Secretary's criteria.

CHAIR BAILET: Thank you. Next is the actual recommendation to the Secretary, so as a Committee, seeing the results, do we have any other additional comments to make before we go ahead and make our recommendation to the Secretary? And the way that will work is we will vote electronically and then we go around the room and share our perspective, where we landed, and ultimately it's important to include in that discussion making sure that any comments that Committee members want to be sure to be in the record will actually be very specific as we go around the room, to make sure that the report, that the staff has the ability to capture those comments, to get them on the record.

So seeing no interest in further deliberation we are going to go ahead and vote for recommendation to the Secretary. You see the asterisk, which is where we feel the model is not applicable; 1, does not meet, where we do not recommend the proposal payment model; 2, recommend the model to the Secretary for limited scale testing; 3 is recommend the model to the Secretary for implementation; and 4 is recommend the model not only for implementation but as a high priority item.

So we are going to go ahead and vote as a committee.

[Electronic voting.]

* **Final Vote**

MS. PAGE: I will also clarify, for the public, that although the Committee's vote on the individual criteria are determined by a simple majority, the recommendation to the Secretary requires a two-thirds majority, and given that 10 Committee members are voting, the recommendation to the Secretary would be determined by 7 votes.

* **Instructions on Report to the Secretary**

MS. PAGE: On the recommendation to the Secretary, zero members have voted 4, recommended for

implementation as a high priority; one member voted 3, recommend to the Secretary for implementation; seven members voted 2, recommend to the Secretary for limited-scale testing; and two members voted 1, do not recommend the payment model to the Secretary. The two-thirds majority of the Committee has determined that the model be recommended to the Secretary for limited-scale testing.

CHAIR BAILET: Thank you, Ann. We're going to go ahead and start with Tim.

DR. FERRIS: Great. So I voted for limited-scale testing, and in this case I wish I had another option which was limited-scale testing with a high priority. I think it's imperative that CMS move in this space with all deliberate speed. The U.S. public should demand this, and we'll talk about it more with the next proposal as well. But this -- I mean, as I mentioned earlier, I rounded in the hospital yesterday. About half the patients that I saw would have been dramatically better served and probably not in the hospital if they had this kind of support that this kind of, and I will say, clinical model clearly outlines.

I think the controversy that I heard around here was around the payment model. I think we can work that out, and this needs to be -- the worry that I had about

voting for limited-scale testing was that that does not convey the need here, I think, or it runs the risk of not conveying the urgent need for this.

In thinking about -- and one other comment. Sorry to go on and on. But the -- one other issue is the reason to have powerful financial incentives is because you want rapid adoption. That's what produces -- rapid adoption is incented by strong financial incentives. And so I think what we are balancing here is the specific clinical situation and having strong financial incentives in that clinical situation. But we also want to encourage adoption of a critical clinical model, and how best to balance the incentives -- the financial incentives for widespread adoption with the specific clinical situation, I think requires more thought.

But, to me, those are the -- that's the balancing point here that CMS needs to consider in implementing this model.

CHAIR BAILET: Grace.

DR. TERRELL: So the way I dealt with not being able to have that fifth option was to wildly skew things towards 5 and 6 on my voting, but then vote for limited-scale testing when it came to the final one, because I

think that they're both true, true, and related.

With respect to some of the things that I hope will be in the final report that we go out, I made a note to myself earlier that the pay for performance -- excuse me, the pay for reporting of the first two years, with learning that they said has to occur before we then implement risk in years three, four, and five, there needs to some way, while that learning is occurring in real time, that the people participating are not punished for reporting, and getting the rules changed, even as we are learning from it. I think what we realize now, coming out of CMS, some of the people that have dropped out of pioneers or recently Next Gen is because they have felt that there has been a bait-and-switch, perhaps, in terms of what they signed up for, relative to what happened.

And this is pertinent to all the comments that Tim was making relative to the investment that you put in it. And so there's the infrastructure investment cost but there's also the cost to the early pioneers in participating in the learning process. So we, as we are thinking about a limited-scale testing as sort of a way that you're learning, there needs to be a way that we can encourage the limited-scale testing to be something that

allows very quick adoption afterwards, and that means that it has to be done in a way that participants are encouraged to go on with it relative to the cost of investment in there.

I'd like to also have something in the final report about learning from all sources of data. There was a lot of discussion here about the need for further data and learning. So I mentioned earlier Medicare Advantage. There is data that Bob mentioned with respect to previous data on hospice, and we need to emphasize to the Secretary that if they're doing limited-scale testing that this needs to be an opportunity to really dig into the data and do it with all deliberate speed.

And then, finally, I would hope that the language that we use is very cogent with respect to this is about palliation and the distinction made earlier between the difference between hospice and palliation, because I think it will allow, if we go ahead and say that correctly and articulately, a wider adoption earlier on in ways that will be helpful for patients.

CHAIR BAILET: Thank you, Grace. Paul.

DR. CASALE: So my recommendation was for implementation, so I was one of the outliers on the

positive side, and that was my way of addressing the two, meaning the high priority scope and then the -- what I see as some of the issues around quality and certainly the payment model.

So my concern about -- and again, I understand the limited -- in reality, maybe it will all be limited testing. So when I vote for implementation it's not to say that this model is ready to go tomorrow, and as others have said about the issues that need to be addressed. And I think part of my vote is, you know, we have voted limited testing on other models and we haven't gotten the feedback to know -- to understand, on those models, when we recommend to the Secretary what actually that means, you know, in terms of working with CMS and others.

So I voted for implementation because I want to say, as strongly as possible, that this needs to move forward, and my assumption is that the quality and the payment things will be worked out as we go -- as that moves to implementation.

CHAIR BAILET: Thank you, Paul. Bruce.

MR. STEINWALD: I'm right where Paul is except I said limited scale, not implementation. And despite the fact that I was a member of the PRT that, by consensus,

voted does not meet on two priority criteria. And the reason has to do with the need for a model of this nature to be tested, and as soon as possible.

I would also like AAHPM to be part of that conversation with CMS, and I think one of the ways of suggesting that is to say, yes, let's recommend this model with all of the qualification that we have already discussed. And that should include, I think, the point that Bob raised, that do we really need a shared savings, shared risk model to implement this kind of palliative care model, and it's not clear. I wouldn't be willing to say we don't need it, but I think our report should say that that should be a consideration.

I also think we should consider whether we need tiering or not, and I'm not so sure we do.

CHAIR BAILET: Thank you, Bruce. And I voted for limited-scale testing as well, but I want to emphasize that that does not mean limited speed to execution. But I respect the fact that we don't know what we don't know. There are potentially, as Bob has brought up, some unintended consequences of this model on the economic side, so we need to understand that. I do feel like there needs to be a higher level of connectedness to the actual patient

along the way, because of the nature of the population and their clinical deterioration.

I do want to emphasize the importance that CMS has to plant a flag in this space. I think that's clear. I think that this model, given the discipline that was put on the front end, getting the stakeholders to actually help provide input and insight into this model, means a lot, and that should not be lost, I think, on the Secretary as they consider what to do next, after we are done with our process.

So again, I want to thank the submitter for their efforts to put this together and coming here today. I found it very, very helpful. Thank you.

VICE CHAIR MITCHELL: Thank you. I'm guessing I'm associating myself with Team Bob, but I voted not to recommend. And I am separating my views on the urgency and importance of doing something in this space. I agree with everyone that it is a very high priority. I'm not convinced this is the model. And my concerns about, similar to Bob, the incentives, the measures, patient reported measures, the inclusion of family and patients in the design of the care plan.

And then the HIT, which we really didn't talk

about, but I think there are opportunities for more robust data-sharing opportunities with both the patients and with providers across the community.

So, again, I think it's an important step. I think we have got to do something in this space, but I had reservations about this particular model.

DR. NICHOLS: So I voted limited scale testing, but I could not be more interested in conveying in the recommendation to the Secretary that that means with highest priority possible and the greatest sense of urgency one can muster.

I take Bob's point about the -- I'll just call it straitjacket that applicants feel like they've got to go through in order to get advanced APM status, which was part of the motivation here. They feel like they've got to have this big pot of money swinging, and I totally agree. I could imagine a world in which we could properly incentivize this behavior without anything like that size of pot dangling there, and therefore, I think the benchmark and the risk adjustment issues are the ones that are the most problematic as it's written. They're ones for which they've asked for help.

I don't know who can give them that help, other

than CMS, and I believe the need of this population is so great, it merits doing it, and I trust the people who put this together to work with CMS to make that work.

I would also point out, given the erudition of my colleague that all deliberate speed came, of course, from the Supreme Court in 1954, and in 1969, the Supreme Court revisited the fact that approximately 1,000 school districts across the South were still delaying, and they used the phrase "All deliberate speed means now." We should remember that as we go forward.

CHAIR BAILET: Kavita.

DR. PATEL: I also voted for limited scale testing, and instead of echoing what others who did the same said, high priority, all of that, I'll just kind of make some comments.

We're two floors underneath where CMS staff are kind of working on things. I would just say, number one, this is -- the problems in the current CMMI models have to do with their payment methodology risk adjustment, so we shouldn't have to, unfortunately, hold a standard to submitters for things that our current models in the Innovation portfolio are extremely flawed and would not probably meet our criteria. So I'll just say that.

And then, number two, I mean, we've got Dr. Meier, Dr. Rodgers, we have some legends in this field, and I can't stress enough how this should not be confined to the notion that it would affect patients that are interacting with these palliative care teams. This is really potentially going to be transformative for care in any kind of advanced elder setting or internal medicine, kind of general medicine, family physician setting. So the effect on primary care is noteworthy, just because of things that Tim, Grace, myself, others have mentioned.

And then, third, just the fact that we are going to be dealing with another model, I just kind of want to respect that while we're voting on this individual submission, that it would be nice to also, in giving our recommendations to the Secretary, think about how to take the notion of palliative care and the spectrum at which we're facing, as you mentioned, Jeff, kind of older patients and how to really move this into the ambulatory setting, which I think is a theme of not only this submission but also the one that we'll see following.

CHAIR BAILET: Bob?

DR. BERENSON: So I voted against, although I'm not unhappy with limited scale testing with all the caveats

we're throwing around.

I would simply point out that we are not the Physician-focused Delivery Model Technical Advisory Committee. We are the Physician-focused Payment Model Technical Advisory Committee, and I'd emphasize the word "technical." We are supposed to be able to evaluate the readiness of a payment model at least to go to the starting gate to then have the demonstration go forward. I think this is a dangerous payment model, and that's why I voted against it.

CMMI is fully aware -- CMS, HHS -- of the need to develop a palliative care payment model, and I don't think whether we voted against this payment model or for limited scale testing that they need us to tell them that this is an important priority. We're supposed to be giving -- we're supposed to be deliberating on whether this is the payment model to go forward with and test, and I would say no.

And I would just want to say one thing to Tim. I actually think that you don't need powerful financial incentives to get adoption. We know that from the Medicare physician fee schedule. If CMS decides they're going to pay for a new code without lots of strings attached, you

often get major uptake.

For this one, I am quite confident that the early adopters -- I'm sorry -- the first movers and the early adopters, the people in this room, if we paid generously for their costs, would adopt, and we would gain experience. We add the measures. We add the pay for performance. We have a robust discussion about whether spending incentives make sense, would go forward, but I would have no concerns that if it was a narrower focused payment model, we wouldn't get significant uptake from the people we want initially to have that significant uptake from.

CHAIR BAILET: Rhonda?

DR. MEDOWS: I voted for limited scale testing for the following reasons.

I believe this is a -- and I am going to go right back to it, Bob -- a population that actually needs the choice, needs a safe choice, and needs a choice that is adequately compensated for in order to be able to expand beyond the traditional or the old-fashioned notion that people have to be in the last six months of life in order to receive this type of multidisciplinary type of care that provides for their every need as well as aides and families going through an end-of-life transition.

I believe that the reason that I am going to say that it goes to limited scale is because of the patient choice, the value that it brings to the patient and to the family.

I believe that the quality measures that are put forth do need to evolve, but they began with the patient experience. The caregiver experience needs to be built in. There's clinical quality, more patient safety. Those can come, but to me, I was impressed that it started with the patient experience and quality of life.

The payment model, I will have to tell you that I was really hoping that it would begin with something like a quality incentive tied to both clinical, patient safety, and patient experience itself, and then with the understanding that cost reductions achieved still have to be measured, so that they're reported on. But there should be a cost avoidance that comes from good multidisciplinary integrated care and not so much with what would certainly be an incentive to sign people up for something without them understanding what it is they're signing up for.

So that's my explanation.

CHAIR BAILET: Thank you, Rhonda.

Harold.

MR. MILLER: Since the Committee has decided, can I make two comments?

CHAIR BAILET: Please.

MR. MILLER: One is I guess I am a little perplexed by -- I read this proposal, and it had two tracks in it. And everyone seems to be talking about it as though there's only one track, which is a shared savings model, and it seems to me that when there ought to be something said about Track 1 and whether Track 1 is in fact a desirable approach or not because it seems to me that it takes away some of the concerns that were associated with the shared savings model.

I do think that my suggestion is that the report make it clear that people are feeling compelled to include -- I will not speak for these applicants in particular, but I think in general, we are seeing people who feel compelled to include that kind of an approach in there because they think it is the only thing that will get approved.

And the fact that there are two tracks in this model suggests that this group did not necessarily feel that that was the only and best way to do things.

The other comment I wanted to make was a number of people have made negative comments about the tiering,

and I think the challenge in any payment model is that if all patients were the same, you would not need to have any tiering. But all patients are not the same.

The hospice program has certainly seen the phenomenon that patients are more expensive at certain parts of their hospice trajectory than others, both the beginning and the end, and I think in this particular case, it seems clear to me -- and the applicants said this -- that patients who have more severe needs will need more time and effort.

It's clear that there is the potential for gaming on any kind of tiering. I think what no one seemed to have commented on was the fact that there is also the risk of cherry-picking whenever there is not tiering. So that, in fact, if it turns out that patients who have more severe needs in advanced illness come along and the payment is the same flat amount regardless of their need, then a practice who takes on the more severely needy patients will be penalized financially.

And I think that it is important to recognize the significance of that when we talk about small and rural practices. If you're a very large organization, you might be able to average that out, but if you're trying to do

this in a small community and it turns out that in fact the patients who come along to you happen to be high-need patients, which we would all, I think, agree would be a desirable thing if the highest-need patients were in fact getting served, but the payment amounts were all based on an average population, then that program would be put at risk.

And so I do think it's important. I would suggest that whatever comments get made about that do not get made in a way that implies that there isn't another side to that story.

CHAIR BAILET: Rhonda and then Bob.

DR. MEDOWS: I just want to put on record that I do not think reporting on quality measures is adequate. I think it has to be quality improvement that has to be achieved in order to receive this additional compensation. So we may not tie it to achieving a cost savings for sharing, but reporting alone is not adequate.

CHAIR BAILET: Bob?

DR. BERENSON: Yeah. I thought I was going to be able to say Track 1 is the one to support and not Track 2, but I think it's a total spending analysis, and the dollars at stake are less. But I think the same problem exists.

So I think Track 1 could be modified to be more of a pay for performance measure base, but it's not based on spending, as I understand it.

DR. NICHOLS: So I just wanted to get for the record that this proposal may be a very good example of one that could have benefitted from early feedback and what the heck ever the language really is, and I would just like to say that I think we're voting now on a proposal that came to us before that legislation was operational.

CHAIR BAILET: Correct.

DR. NICHOLS: And therefore, I think we should take that into account when we talk about our report to the Secretary. We could fix this.

CHAIR BAILET: Thank you, Len.

So that completes our review of the first proposal.

Again, I want to tip my hat to the submitters for their work and all of the folks who spoke to say and all of the folks in the field who are doing this incredibly valuable work, and the patients who are getting this compassionate care. So, again, thank you for that.

So we're going to go ahead and move on to the next proposal, and I don't -- are the submitters here?

Yep. I see them here. I see some hands. Okay, great.

So we're going to go ahead and do the next proposal, and I don't -- are the submitters here?

MS. STAHLMAN: Yep. They should be. It was supposed to start at 11:30. They're here.

CHAIR BAILET: Yep. I see them here. I see some hands. Okay. Great.

So we are going to --

MS. STAHLMAN: We'll start with disclosures.

Coalition to Transform Advanced Care (C-TAC): Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model

CHAIR BAILET: Yeah. So we're going to go ahead, as people reposition themselves, and start with the disclosures. This is the Coalition to Transform Advanced Care, or C-TAC, Advanced Care Model, Service Delivery, and Advanced Alternative Payment Model.

The PRT is Bruce Steinwald, Paul Casale, and Elizabeth Mitchell.

We are going to start with reading our conflicts of interest.

Tim, do you want to start on that? We'll just go around this way, or do you --

* **Committee Member Disclosures**

DR. FERRIS: Did I report any conflicts?

CHAIR BAILET: No. But we just have to -- you have to say no, and this is your time to shine, Tim.

DR. FERRIS: No, I knew I had said something.

So this is actually -- so I oversee palliative care programs at Partners HealthCare. I guess that was a conflict of the first one. I would just underscore that.

And I did once present at a conference, at a C-TAC conference as an invited presentation. It was an unpaid engagement.

CHAIR BAILET: Great.

Grace.

DR. TERRELL: Grace Terrell, internist at Wake Forest Baptist Health, CEO of Envision Genomics, and I have no disclosures.

CHAIR BAILET: Harold?

MR. MILLER: Harold Miller, Center for Healthcare Quality and Payment reform. As noted earlier, I assisted the American Academy of Hospice and Palliative Medicine in early work on developing an alternative payment model for palliative care, which had some similarities to this.

I recused myself from voting on the earlier

version of this proposal in the fall, which it never quite came to at that point, and so I am going to recuse myself again today from voting on this particular one also.

CHAIR BAILET: Paul?

DR. CASALE: Paul Casale, New York Quality Care. I have no disclosures.

MR. STEINWALD: Bruce Steinwald. Nothing to disclose.

CHAIR BAILET: Jeff Bailet, the Executive Vice President of Health Care Quality and Affordability with Blue Shield of California.

And I do have to disclose that Blue Shield has been a member of C-TAC for four years. We did not renew our membership this year, but Blue Shield of California still works closely with many of their committees. We will be speaking. I believe this now has passed because this was -- at the first, these were a disclosure at the first pass. We spoke at the November C-TAC summit as well, and we are partnering with C-TAC on multi-Blues workgroup on palliative care, supported by Blue Shield Blue Cross Association.

There was a survey of C-TAC members to provide input into the alternative payment model proposal over a

year ago with an endorsement of support on the concept of an alternative payment model for palliative care at that time. Leadership confirmed that the alternative payment model aligned with our current plan to roll out, and we have subsequently rolled out an alternative payment model and will support a Medicare APM.

There was no formal commitment made to C-TAC, nor did I participate in the survey to communicate with C-TAC staff in any capacity.

Elizabeth?

VICE CHAIR MITCHELL: Elizabeth Mitchell, Network for Regional Healthcare Improvement. Nothing to disclose.

DR. NICHOLS: Len Nichols. I'm a health economist. I direct the Center for Health Policy Research and Ethics at George Mason University, and I have nothing to disclose.

DR. PATEL: Kavita Patel, internist at Hopkins and a fellow at the Brookings Institution. Nothing to disclose.

DR. BERENSON: I'm Bob Berenson. I'm a fellow at the Urban Institute, and I have nothing to disclose.

DR. MEDOWS: Dr. Rhonda Medows, Executive Vice President, Population Health, Providence St. Joseph Health.

I have nothing to disclose.

CHAIR BAILET: Thank you.

I am going to go ahead and turn the mic over to Bruce.

*** PRT Report to the Full PTAC**

MR. STEINWALD: Thank you, Jeff.

This is -- the composition of the PRT is the same as the previous proposal, the only difference being that I am the lead reviewer on C-TAC, and Paul was the lead reviewer on PACSSI. And Elizabeth Mitchell was a member of both of those, and that wasn't an accident. We decided -- or the leadership of our P-TAC decided it would be a good idea to have substantial, if not total overlap, when PRTs are evaluating proposals that overlap considerably with each other, and these two obviously do.

I am going to be pretty succinct. I think I should be able to get through this pretty quickly and leave as much time as we possibly can for our own questions and discussion and also hearing from the proposer.

So the overview, you have seen this several times. We can go right by that. The preliminary review team's composition and role, you already know about that.

Now we get to the overview of the proposal. On

this exhibit are the criteria for identifying eligible patients. They're a combination of clinical and functional criteria, and it's probably worth emphasizing that they are accompanied by what we have called the "surprise question." And it's stated this way: Would you not be surprised if the patient died within the next 12 months? That must be answered in the affirmative in addition to meeting at least some of these other criteria.

Covered services are a combination of palliative and curative care, attempting to break down the silo between curative care and palliative care, especially as exists in the context of hospice.

A number of things that are similar between the two proposals -- shared decision-making, care planning, access to a clinician -- and services continue until the beneficiary dies, enrolls in hospice, dis-enrolls, and moves out of the service area.

The ACM team has to have at least one member with board-certified palliative care expertise, and the palliative care team takes over the palliation, but they also coordinate curative services for the patient and the patient's family.

Payments are made to the ACM entities, which

could be a broad range of entities, including hospices. It has to be a Medicare provider. I'm not going to go through all of these things. You can see -- read them.

The principal elements of the payment model are a wage-adjusted $400 per member per month. Wage-adjusted simply means there's an adjustment upward in areas of the country where costs of labor and other services are high, adjusted downward for areas where that's not the case.

One of the major changes from this and the previous proposal is that that per member per month payment continues indefinitely until the patient dies as opposed to only within 12 months as the original proposal had said.

There are bonus payments based on quality metrics.

The savings or losses have to be at least 4 percent before a payment is triggered or a loss is triggered. Losses don't occur until the third year. Isn't that right? The first two years is just an upside.

Quality bonus payments -- yeah, that's right. Shared loss begins in year three. Remediation period. And then the payments, the ACM entities' payments, the per member per month, would include all evaluation and management and chronic care management and these other

codes for the team itself, although it may not replace them for external physicians and others who are not members of that team.

There are a substantial number of quality metrics. This was one of the other changes from the previous proposal. They expanded the metrics based on our comments.

And I'm not even going to go into any more detail there.

Okay. So here is the evaluation by the PRT of the 10 criteria. I'll go over them one by one.

I'm not going to talk about scope because it's the same conversation as we've already had this morning with regard to the other proposal. Obviously, we think it's a huge unmet need, and something really of this nature needs to be done.

Quality and cost. We decided that it meets the criteria. This is one that we decided didn't meet in the last -- previous proposal. Although in this and in other criteria, there might be some psychology at work here. As an economist, of course, I'm not an expert on psychology. Len might be, actually. There's a lot of psychology in economics, especially these days.

DR. NICHOLS: More than there used to be.

MR. STEINWALD: Yeah.

Since we have concluded on each of the criteria that it meets or meets with priority consideration, we thought as a PRT, it was important to point out some of the areas where we thought they needed improvements.

And so our report kind of reads kind of negative, and I think it's partially for that reason, is that we didn't want anyone to get the impression that we thought that this proposal was perfect and didn't need some improvements. And so in each of these criteria, we've emphasized some of the areas where we think there needs to be greater attention, and that includes things on the quality and cost criterion.

Same with payment methodology. This was in the previous proposal. We had judged that this did not meet. The main thing that they did -- and I already mentioned that, that assuaged us to a large degree, is they continued the per member per month payments for the entire life of the patient, not just the 12 months.

As I mentioned earlier in regard to the other proposal, there is still a concern about establishing the baseline against which to compare savings and losses, and

it's a very difficult thing to do. And there -- well, I'll just leave it at that.

Some concern about the role of hospices since they are identified as one of the entities. Bob, I guess alluded to this issue. We're concerned a little bit. If the hospice is the entity and the hospice is being paid a per member per month amount and then the patient is admitted to hospice, per member per month goes away, but the hospice benefit clicks in. We're a little concerned about a potential conflict of interest there.

I'll keep going. In any case, we have concerns, but we did reach a judgment that the proposal met the Secretary's criterion on payment.

Value over volume, same thing. Flexibility. I'm just going to let these stay up for just a few seconds as opposed to reading the slide.

Ability to be evaluated. Obviously, an evaluation is important. Even if we decide that we don't need shared savings, we still need to have an evaluation of whether the model actually saves money and in what fashion it does that.

Integration, care coordination, we judged meets and deserves priority consideration. I mean, this is

really what a model like this is all about. It's all about care coordination. It's all about breaking down siloes between curative care and palliative care, and we thought that the model was sufficiently engaged in this issue, that it deserves priority consideration.

Patient choice. Of course, patients and families will continue to have choice between palliative and curative care, and there's still some issues about prognosis, but we decided that it met the criterion.

Patient safety, the same thing. Just leave it up there for a few seconds.

And finally, health information technology, there is some potential here for the model to result in more sharing of data in a way that would benefit the patients and families and help them make choices on what mode of care to prefer.

Our key issues, as before, our most positive observations on the proposal derive from the needs to have a model in this space, and we absolutely believe and agree with whatever what other people have said, that we need to have something in the field as soon as possible.

We thought the incentives were generally congruent with the model's coordinated care objectives, and

we have a number of places where we said that there were improvements needed, and I'll just leave those for you to review yourself.

So we have some reservations, and I think some of them overlap with the previous model as well. But our general conclusion was that this model was sufficient with some adjustments for PTAC to recommend its implementation.

*** Clarifying Questions from PTAC to PRT**

CHAIR BAILET: Paul and Elizabeth, would you like to add anything before turning it over to our colleagues?

DR. CASALE: Nothing from me. I'd probably wait for the questions, I think, before I had anything specific at this time.

CHAIR BAILET: All right. I saw Bob go to the placard quickly. Len. No, no. Bob? Bob, go ahead.

DR. BERENSON: So two questions. The first one is, what is the applicant's justification for getting paid for 12 months for a patient who dies in month one, and is there any precedent for that kind of an approach in Medicare payment?

MR. STEINWALD: In Medicare payment, I don't know of one. I think it's -- there are a couple things that would be good to ask the applicant when they have a chance

to step up, but yeah, that is a feature of the model. It's the last 12 months, regardless of when the patient passes away. So there's a period of time before the patient is in the model that still counts, and it's probably worth talking with the applicant about that.

DR. BERENSON: Was that part of the discussions back and forth with the PRT?

MR. STEINWALD: Yeah.

MS. PAGE: The Committee clarified with the submitter that we were reading their intent correctly.

DR. BERENSON: Correctly. Okay.

MS. PAGE: So we did reflect back to them what we thought they said, and they confirmed to us that that was indeed the intent that's --

DR. BERENSON: Okay. All right. So I'll ask them.

The second question is, is there a way to simply say -- you have a number of well-taken concerns that you've articulated on 2 and 3. You have those -- the PRT had those for the first proposal. Why did you come out in a different place? What was significant? What was the basis for the different judgment, if you could tell us?

MR. STEINWALD: So aside from the psychology that

I mentioned a moment ago -- well, another -- you know, you could as a preceding question, which I'll answer first, which is why did you evaluate this model more positively than we did the previous one. And I think the answer to that is they were indeed responsive to our concerns, and even though they didn't address every one of them, they did address the ones that were most serious for us. And that includes the per member per month payment continuing through the patient's lifetime, buttressing the quality measures and at least one other thing that I'm forgetting for the moment.

As far as comparing it to the other model and why we would rate meets on quality and cost and payment methodology on this one and not the previous one, if that's your principal question, I'm going to let Paul and Elizabeth -- in fact, I'm going to encourage you to help me out here.

But one has to do with the complexity of the AAHPM model with the tiering and the tracks and the concern that there was a potential for gaming. We thought the quality measures in the revised C-TAC proposal were more comprehensive than the PACSSI model, and we thought that they generally addressed -- well, as I said, they addressed

our concerns, but I don't want to do all the talking here, so --

VICE CHAIR MITCHELL: I agree with what Bruce said. Again, we liked both models. To me, this one was less administratively complex and had more robust measures and I think leveraged health IT in a way that we didn't see in the others, and I think that the 12-month payment, we had been concerned about some of the incentives. And we felt that it was addressed in some of the changes that they made.

DR. CASALE: Yeah. I'm not sure I have much to add to that, particularly around things like the specificity around HIT. I mean, they gave a whole list of things of how they're going to interact, rather than saying we will interact with primary care.

And on the payment side, again, had some concerns, but was hard not to think -- well, that the complexity, as Bruce mentioned, of the first one was of particular concern.

CHAIR BAILET: Any other -- oh, like I said, Len.

DR. NICHOLS: So Bob asked my question, but I'll try to drill a little deeper.

So I guess what I was trying to figure out was,

was the payment model of this one over the line and the other one not because this one has a cap on how much they can take home from the shared savings. Was that important?

MR. STEINWALD: That was a factor.

There are also -- it's a little wonky, but there's an invertedness of the PACSSI model of paying more for shared savings early on and less later. The CMS actuaries actually raised that as a particular concern of the PACSSI model.

But there is an issue here. If you are on a continuum and you get to a point on a continuum, the two points on either side of the continuum could be very close, and so that's a very wonky way of saying that -- were not so clear to us that C-TAC is vastly superior to PACSSI, but it was enough to make us come to the judgment that they had met the criterion.

CHAIR BAILET: Tim.

DR. FERRIS: I think this is consistent with what you were saying, Bruce, and also consistent with what you two were just driving at, Bob and Len. But I wanted to test that, and that is I think it is possible to provide additional services in the last year of life and actually not reduce cost. You simply provide additional services.

And so to me, the discussion in the prior model and this model around how strong the incentive is, which I think is what you were getting at, Len, the difference -- and it really comes down to me, whether you choose total cost of care or, for example, hospitalizations, which in this period of life is the big driver of cost, typically, is sort of an academic distinction to me -- maybe, maybe not, maybe or not -- because I think they result in the same thing.

But I think it's actually -- it is important to have some incentive. It's probably important that that incentive be quite small in the scope of the entire thing.

So that would be my take on the last set of comments. I don't know if you want to comment on that, and then I have another issue.

MR. STEINWALD: Okay. Go to the next one.

DR. FERRIS: Well, the second issue is very wonky and in the weeds, but this has the 4 percent corridors, which you said in the other model, they didn't have any corridors. And this -- did I understand that correctly? The 4 percent up or down before you get the -- and that's for -- I assume for statistical variability and performance.

MR. STEINWALD: Right. C-TAC, there has to be a 4 percent saving or loss before there's any shared savings or losses. But once you reach that threshold, the entire amount is shared.

DR. FERRIS: Yes.

MR. STEINWALD: Okay. In PACSSI, there was a difference.

DR. FERRIS: Yeah.

MR. STEINWALD: And, geez, it loads up on the savings that are close to zero --

DR. FERRIS: Right.

MR. STEINWALD: -- 4 percent, and then diminishes thereafter, which is what the CMS actuary said was an inverted model, not atypical from what they're used to seeing.

DR. FERRIS: Yeah. I just wanted to make a point, and this is a policy conundrum that CMS has to face all the time. I actually think they are reducing -- their current approach to this problem is reducing the sustainability of all APMs, and that is the one-size-fits-all approach to corridors on upside and downside.

The fact is, if you're a real practice and you've got 10 people in this model, then maybe the corridors

should be 20 percent, and if you are a very large, integrated delivery system, you are hurting the sustainability to go at 4 percent. Maybe their risk corridor should be 0.5 percent. Determining what the variance is, based on the size of the program, is easy math. It is not hard to do. And yet, probably because of administrative simplification -- sorry, I'm sort of grandstanding right now; I accept that -- it's easy math to do and yet, probably for administrative simplification reasons, we choose one number.

To Grace's point before about why some people might be leaving APMs, it's partially because they could be knocking it out of the park and not achieving those shared savings if they're big and are missing it because of arbitrarily set distinctions that don't take into account the size -- and I say it works in both ways.

I really think CMS needs to, and we need to convey to them that the size of the risk corridor should not be a one-size-fits-all. It should be based on the number of patients enrolled in the program.

MR. STEINWALD: Duly noted. I wanted to raise one more thing. In the previous proposal discussion, there were a number of references by both the team, the PACSSI

team and the commenters about prognosis. And I think it might be worth raising as an issue to the presenter, because they do use prognosis. They use this surprise question, and that is definitely prognostic. Now I know they do it in an effort to define the population as narrowly as they could, of a population that had 12 months to live, with very few exceptions. But we might want to ask them to say more about that, and why they did it that way, and what they think the benefits are.

CHAIR BAILET: All right. Seeing no further comments from the Committee I'd like to invite our submitters up to the table, turn your placards right-side up. This is the Coalition to Transform Advanced Care, or C-TAC. Welcome back.

*** Submitters Statement, Questions and Answers, and Discussion with PTAC**

CHAIR BAILET: If you could introduce yourselves and then you have 10 minutes to address the Committee.

MR. KOUTSOUMPAS: Well, good afternoon and thank you for this exciting opportunity. My name is Tom Koutsoumpas. I'm the Co-Founder and Co-Chair of the Coalition to Transform Advanced Care, C-TAC.

This is, indeed, for us, a very exciting day, we

believe for patients and families across the nation. I want to thank the members of PTAC for their consideration for our payment model proposal today. We are honored to have this opportunity to be with you here again today, which represents the culmination of work by hundreds of experts across the country, united by a shared vision that people with advanced illness deserve comprehensive, high-quality care.

Our previous meeting with PTAC -- at our previous meeting, we took seriously your thoughtful feedback and submitted an updated model, which we feel addressed your comments and incorporated your thoughts and comments as well. We believe that your advice and counsel has made our proposal stronger, and for that we are very grateful.

For example, we established a flat PMPM with a bonus for quality, rather than a shared savings approach. We thought that was very helpful and important.

The Advanced Care Model is designed to test a model for potentially supporting millions of Medicare beneficiaries living with advanced illness by bridging medical and social services, ensuring patients receive high-quality, person-centric care and linking clinicians, health systems, hospices, faith and community groups, and

many others that are united in this effort.

As we have all talked about today, with 10,000 baby boomers eligible for Medicare every day, many of whom will have or have advanced illness, we must find a way to provide quality care to this population or fragmented care and cost will continue to spiral out of control. We believe the ACM is one answer to this problem, and we are very pleased to be here to talk about that.

We believe that having a payment model approved by the PTAC, or models, is a critical step in the process, and our model will be a tool in addressing this much needed quality improvement initiative. We also would like to commend the Academy for the extraordinary work and leadership that they too have put into this issue for this population, and we are pleased to be able to work with them as well.

Our personal experience continues to drive the passion to address this issue. Few of us have escaped the chaos of our current system, myself included. As I mentioned at our first meeting, my personal passion is driven by my mother's experience, who, for almost five years, lived with multiple chronic conditions, visited the ER and the hospital on many, many occasions, and it became

almost impossible for her and for our family. Late at night, answers did not come quickly. It often required an ER visit or a stay.

As I mentioned before, as well, but I wanted to reiterate because of the importance of this, my sister, who was her caregiver, became very ill, which we believe, and she spent many years dealing with her illness as a result of the stress that took her over as a caregiver. It was extraordinarily difficult.

I want to thank everyone here who has worked tirelessly to create this innovative model, from the broad evidence base of successful program. In addition to our extraordinary panel, I want to just quickly acknowledge a number of folks that were working on this with us that I think you all should know were involved. Dr. Alena Baquet-Simpson, the Director of Health Services at AETNA; Dr. Gregory Gadbois, the Director of Priority Health; Dr. Randy Krakauer, the former National Medical Director at Aetna; Dr. Elizabeth Mahler, the VP of Clinical Transformation at Sutter Health; Dr. David Longnecker, the former CMO and Senior Vice President at the University of Pennsylvania Health System; Dr. Brad Stuart, formerly with Sutter and now the CMO of C-TAC; Mark Sterling, who is also with C-TAC

as a fellow at Harvard Petrie-Flom Center at Harvard University.

Again, we want to thank everyone for this opportunity. We applaud your thought leadership, and it's essential for us to have this leadership to effectively deal with those with advanced illness. It's clear we have to better support people living with advanced illness. When we started C-TAC, and I know that with the Academy as well, people thought that this problem was so big it would be almost impossible to deal with. Yet here we are today, ready to move forward in helping to solve this issue with models that will do just that.

We are humbled and honored and excited about the opportunity to be here today, and thank you for your consideration. Since we actually -- others on the Committee, on the panel, gave opening statements at our last meeting, we thought we would just have one simple opening statement and then move right to questions to address.

CHAIR BAILET: Great, Tom, and just for folks on the phone, if you at least could introduce yourselves --

MR. KOUTSOUMPAS: Yes.

CHAIR BAILET: -- for comments, that would be

helpful.

MR. KOUTSOUMPAS: Excellent. Let's start right here with Kris.

DR. SMITH: Hello everyone again. Thank you so much for having us back. We're excited to talk about our model. Dr. Kris Smith. I'm an internist and palliative care physician. I practice at Northwell Health, where I am the Senior Vice President for Population Health, and in addition I run an Independence at Home demonstration site.

DR. NGUYEN: Good morning. This is Khue Nguyen and I run C-TAC Innovation, which is focused on helping providers and payers design community-based advanced illness programs.

MR. BACHER: Hi. Good morning. I'm Gary Bacher. I'm a senior advisor to C-TAC. I'm also one of the founding members for a health consultancy called Healthsperian, and an adjust assistant professor at Georgetown University.

MR. SMITH: My name is Brad Smith. I'm the Co-Founder and CEO of Aspire Health. We are a home-based palliative care program operating in 25 states and 67 cities, primarily with Medicare Advantage plans, and over the past five years I have served over 45,000 home-based

palliative care patients.

MR. KOUTSOUMPAS: Thank you.

CHAIR BAILET: All right. I put it up to the Committee to ask questions of the submitters. Bob?

DR. BERENSON: I'll ask you the question that I asked to the PRT. What's the logic of paying -- giving you credit for 12 months of spending when the patient dies in month one, and is there a precedent for this kind of an approach, as far as you know, in either Medicare or commercial products?

MR. BACHER: Thank you very much for the question. I'll start off.

One thing I think we just wanted to clarify, and I'm not sure if it's in part of the question or not, is the way that we had proposed it, it was, in terms of the example where somebody is enrolled in the program for one month and then they disenroll, they wouldn't, after disenrollment, that the ACM, the APM entity, would not continue to receive the PMPM amount. And so we actually came at it at a slightly different way, although we noted in the comments from the PRT the concerns that could be there.

So we went the other way, which was we were

actually trying to encourage accountability, so the idea that if someone was to have been discharged from the program, that the ACM, the APM entity, would still remain accountable, and that was also to try to make sure that there is incentive for choosing the patients that the model was actually designed for.

Brad or Kris, anything you all want to add?

DR. BERENSON: Yeah, I mean, when you make your comments I'm more concerned about the patient who dies, not disenrolls, and why you're getting paid for 12 months for -- essentially getting paid because that's what the comparator is based on.

MR. SMITH: Yeah, so just for clarification, you're only eligible for the PMPM quality bonus payment for the months that you were actually actively enrolled. So, in other words, if you didn't get a PMPM payment, you can't get the bonus payment, so you couldn't enroll a patient for one month and then get 12 months of bonus payment. You could only get the bonus payment for the one month that you were actually enrolled.

You are correct. The calculation would be over a 12-month period, but the payment would actually only be for the months that you were enrolled.

DR. BERENSON: Go over that again. What would be available for the 12 months?

MR. SMITH: Yeah, so think of it as effectively what the model does is it gives you a range of a PMPM you could receive, based on, essentially, quality, that goes from 300 to 650. The way it works is you get $400 for the month that a patient is enrolled, and then at the end of the period, when a patient passes away, you go back and calculate the total cost savings for that last 12 months of a patient's life.

DR. BERENSON: So you're continuing the monthly payment once the patient dies --

MR. SMITH: That's correct.

DR. BERENSON: -- but only calculating this -- and that brings up my second question. Tom, in your remarks you said you took -- sort of went back after our last meeting and sort of substitute quality -- positive quality measures for spending. And yet I see the model still -- as Tim points out there's now sort of limits, but it's still bonuses based on spending and penalties based on spending. Is that right, but with 4 percent corridors either direction?

DR. SMITH: Yeah, so I think the way we've

recalibrated the model is that we put an emphasis on a quality program that can drive additional payments. Now that quality program, you're correct, is funded out of shared savings --

DR. BERENSON: I see.

DR. SMITH: -- but as we've all talked about, we believe that a model such as this, executed, will generate savings because we've seen it in other models, and this is the right way to take care of these patients in this last period of their lives, 12 to 24 months. So it is more a quality bonus payment, and I think what we tried to do is we tried to navigate the tension that we've been talking about, which is how is it that we incentivize providers to do a good job while not incentivizing them to stint on care, which is why, in the PRT comments, there was a comment about is $250 enough. We believe that it is enough to incentivize infrastructure be built to realize these quality payments.

At the same time, we do believe that there is an important element here in having some downside risk to these programs, but we wanted to limit the downside risks such that we could encourage broad participation in the model. And that's why you'll see that there is asymmetric

upside and downside. It was because we wanted to have there be skin in the game, but we wanted it to be the case that it was modest, so that we could draw many types of providers into this care model.

CHAIR BAILET: Grace.

DR. TERRELL: Good afternoon. I was not able to be here in September because of a family wedding so I'm getting to hear you all for the first time and have been looking forward to this and thank you for being here.

As I have -- therefore, my perspective is a little bit different because I'm seeing two things at the same time, as opposed to seeing them asynchronous, like others. So most of my questions, for better or for worse, may be understanding sort of some comparator things relative to the conversation this morning, which you may or may not be prepared to answer, and I apologize if you are not.

But one has to do with this concept of the 12 months as opposed to the point I was making, if you were there, in the earlier conversation, about just palliative care as a need, in general, without a sort of limitation or a time unit related to it.

So my question for you all, with results to that,

is that so much of hospice has always been around time units and prognosis related to that. Is that absolutely crucial to this model? There's a lot of people out there -- my experience has been developing extensivist model-associated work with frail elderlies and others who have high need, but we don't necessarily put time around it.

So how much does prognosis have to be related to units of time in your payment model, relative to what we were hearing this morning?

MR. BACHER: Sure. I'll start and then I'll turn it over to Kris. And just one question, clarification, just for answering in a precise way. Is the question you have around the so-called surprise question that was mentioned earlier, in terms of in relation to the prognosis?

DR. TERRELL: Yes.

MR. BACHER: That's the principal question? Great. Kris, do you want to address that one?

DR. SMITH: Sure. I'm going to ask for further clarification before I jump into this. I learned from my last session.

[Laughter.]

DR. SMITH: So I just want to make sure. Is the

question about do we need the surprise question, or are you asking a different set of questions?

DR. TERRELL: I'm actually -- well, I don't know that I like the surprise question, for a lot of reasons. I think doctors are odd people and sometimes will just say odd things. But I'm actually thinking about a real patient I have who has -- she is in her 30s, she has Wolf-Hirschhorn, you know, genetic syndrome. She was predicted to not live past her 15, 16 years old. She's got congenital heart disease with neuro developmental delay, and she's been in a hospice program now for five years, and should be.

And so there's people like that out there that are in need of something that is what I would call palliation. She doesn't need to be -- you know, she doesn't need heart surgery. She doesn't need stupid ER visits. She needs care. And I would always answer the -- I would never be surprised related to her passing away in the next 12 months.

So within the context of that patient is where my questions are coming from. How important is the payment model to be around a unit of time as opposed to the needs of the patients relative to the sort of, not so much

prognostic but sort of functional aspects of their health condition?

MR. SMITH: I'm happy to take the first shot at that. So I think there's two competing priorities here. One, you want to make sure you're focusing the amount of time enough and a time that has value for the patient in the overall health care system, but at the same time you don't want to constrain it so much that you can't serve a patient who needs services for longer than 12 months.

The way we tried to hit that balance in our model was by two complementing pieces of it. So one was the idea that you could get the PMPM now for longer than 12 months, so you could get it for 18 months or 24 months. But to correct for the sort of five-year issue was the idea that when you look at cost savings you're really looking at that last 12 months. So think of it as you have to take all of your costs from however long somebody is in and load it against those last 12 months. And we thought that was a good way to balance the appropriateness of being able to get it for longer, but also preventing a lot of patients who would get it for five years, as an example.

DR. TERRELL: And then one briefer question, and this may have been addressed in September, for which I

apologize, and that's related to the title of our Committee here, which is Physician-Focused Technical Advisory Committee. And I heard this morning, I'm hearing here, about a broad team.

I need to understand, relative to the need of services, relative to it being about different types of health care workers and community service, what the actual physician focus needs to be, or not needs to be, in these models, because I think we're going to have that come up over and over again as we're sort of transforming care outside of traditional ways of thinking about it.

DR. SMITH: Yeah. So I think there's a couple of ways in which we think about this. So I think there was a comment in one of the earlier sessions about the membership of the care team. We're not exactly sure for which patient, which member of the care team is going to be the most important for that patient. But what we do know is that, by and large, when you do have an interdisciplinary team layered into these settings of patients and families that are struggling with advanced illness, there tends to be positive outcomes. So we do believe that it is a must to have an interdisciplinary team.

Now in terms of the role of the physician in

these teams, I think there is are many models out there where you have the physician in the lead position on these teams, working with the rest of the care team to help. Once problems have been identified, to work together and lead that team to improve upon more of the medical issues. And so I think the physician tends to lead more on the medical side, where the participating social worker or chaplain can be a lead on some of the social determinants of health, et cetera.

So I think you do -- you would expect that everybody would bring their particular skill set to the table. The physician could lead the team or not but would definitely be responsible for finding the right type of medical care to meet the patient where they're at.

DR. TERRELL: I'm actually concerned about the absentee landlord issue that I've seen in my clinical experience through the years, where there's a shortage, for example, of primary care individuals willing to go to a nursing home or be part of palliative or hospice care. So there's somebody that's getting a medical director role, the funding is going through another -- you know, through an entity, if you will, that's responsible for services and they are desperate to get a clinician involved with the

care but they're not an integral part of it.

MR. KOUTSOUMPAS: Sure.

DR. TERRELL: So part of what I'm wanting to understand is how we can prevent absentee landlords.

DR. NGUYEN: I think, Grace, in our proposal we definitely have clarity here that there has to be a provider-level oversight of the care team. And I think here we're trying to balance again this idea of innovation where potentially in the future, as this care is more widely needed, we're going to need to think about fully leveraging the interdisciplinary care team. But we absolutely agree that there has to be palliative care-trained, provider-level oversight.

DR. SMITH: And, Grace, one last comment. I think as we thought about this, and Robert mentioned this last time we were here, there is an opportunity for a myriad ways in which there can be bad actors in this space. And that is also partially why we put in a more robust set of quality metrics that need to be followed, as well as why we believe there needs to be some downside to this, because in what you described where you basically have a non-functional interdisciplinary team, you probably won't generate the outcomes that the patients and families

deserve, and those outcomes won't also reveal themselves in the better management of total cost of care.

So we do believe that there is a lot about our proposal that is about checks and balances, and that is a potential concern. But part of the balance is if you don't do a good job in this model, you won't avail yourselves of the quality bonus potential.

DR. TERRELL: Thank you.

CHAIR BAILET: Tim.

DR. FERRIS: I think Grace touched on this, so I'm going to go a little bit more into this, the tension between innovation and assuring yourselves that you have the right team. And unlike the prior proposal, which actually didn't define by role and certification the members of the team, your proposal does, actually, in a quite detailed way. And I guess I just wondered, the board certification in palliative care, so the vast majority of palliative care delivered in the United States is by internists and family practitioners. There, even if we tripled -- I'm going to make up some numbers now -- the number of palliative care docs trained every year, there wouldn't even be close to enough. And so I'm -- there's sort of a workforce capacity issue, and I will say -- and I

don't mean this in any way in a derogatory way, but sort of you worry about guild protectionism, so like only a palliative care doc can do this. Is that true? Like -- and so I wonder if you might respond to that.

And in the context of like five years from now, when we learn so much because this is rapidly adopting, who will be the -- will they be certified palliative care docs, like requirement? Or is this -- or is this someone who does a lot of it as an internist or a family practitioner and did a two-week course and is great at it because they do it a lot? I'm just trying to understand the balance there.

MR. SMITH: So I'll take the first shot at this. I think one of our goals was to come up with something that had the right checks and balances that could be implemented now, and so we felt like one of the appropriate checks and balances to get a model launched quickly was requiring that they had to have a board-certified palliative care physician because we know that some of the quality metrics will still be getting worked out by CMS. As those metrics become more robust for measuring quality, I could imagine there could be other parts of the proposal where you could pull that back or allow for a larger amount. But our key

goal was to try to hit the balance and also have something that could be rolled out quickly.

DR. FERRIS: Okay. And just in follow-up, Jeff, along the same lines -- and this is the difference between how one would do it in real life and writing policy. And so the surprise question. So we use the surprise question in our community-based palliative care program. It's a very effective way. I never imagined it would be sort of required as part of policy. It's actually something that a good organization could decide to adopt or not adopt. And so I'm -- because of the issues that Grace raised, do you see that as a required part of the program? Like could you be successful by choosing some other way of doing it? It's sort of a -- this sort of gets to the point of micromanagement of what people are doing in the field. If it's useful, they'll do it. If something else is useful, they'll do something else. Could you comment on that?

DR. SMITH: So our thinking in bringing the surprise question as one of the entry criteria into the model was that through utilization measures, through functional status, we were basically creating a pool of potentially eligible patients that were likely to have need. But because we had some other checks and balances

upside and downside, we did want to continue to tighten those criteria so that we identified patients who were in the sort of last 12 to 24 months, though, to your point, not exclusively, and the model can take care of someone for three, four, and five years. But we did feel like it was important from the ability for this model to be cost neutral to get a little bit closer to patients who had a median survival of 12 months.

And now, you know, I thank the PRT for their thoughts and the citations on the surprise question, and I think if you really get into that summary from the Canadian Medical Association systematic review, you know, the surprise question works better in populations where there is a high expected mortality. By using the selection criteria of utilization as well as functional decline, we've basically created that. And so the surprise question will probably function better than that systematic review would, say, for what was basically kind of an all-comers population.

The other thing that that article was also really helpful was that it's pretty good at if you say I don't think the person's going to die in the next 12 months, it's pretty helpful in identifying people who aren't going to

die in the next 12 months. And so, therefore, again, it allows us to, we believe, hone in a little bit closer on patients who have a median survival of 12 months and, therefore, are about to enter that period of medical care that we all know has an enormous amount of suffering that's manifest in a lot of cost of care.

DR. NGUYEN: I would say that, Tim, what you recommended there and how you describe how the surprise question is being used in practice is how we envision it. It is really a clinical decisionmaking process that clinicians use, and as you said, it is one of the most effective tools we have out there. And so that was definitely the intent of all -- of how we construct the eligibility criteria.

DR. FERRIS: So you wouldn't be opposed to, say -- say someone developed an AI algorithm that did just as well, right?

DR. NGUYEN: Correct, yes.

DR. FERRIS: That would work, too.

DR. SMITH: Right. Yes. But we don't want to get into the place where we got last time where we're accepting suggestions for change in our model.

[Laughter.]

DR. SMITH: We are here to --

MR. KOUTSOUMPAS: We definitely don't want to go back to --

DR. SMITH: We are here to defend what we put, and we believe that there is value to the surprise question in this population.

CHAIR BAILET: So I personally want to thank you guys again for coming. We have some folks who are here in person and potentially a few folks on the phone, so I'd like to make sure we can get in the comments. And then as we get through the comments, then I think I'd like to just pose the question to my Committee members relative to momentum and the process, if we should motor or break after the public comments. And we don't -- we're not going to answer that right now. I just wanted you guys to think about that. But if we could ask you guys to take your seats, and then we will have the --

MR. KOUTSOUMPAS: Thank you so much.

CHAIR BAILET: You're very welcome. Thank you.

So as they transition out, we have three minutes for public comments. The first individual is Bradley Stuart from the Coalition to Transform Advanced Care, or C-TAC. Welcome.

* **Comments from the Public**

DR. STUART: Thank you. I'm a primary care internist. I was a hospitalist before it became a specialty, hospice medical director, palliative care physician. I was the architect of the AIM Model at Sutter that was funded by CMMI, and I'm very proud to be the CMO of C-TAC.

Bob Berenson has left, but I just wanted to comment that payment for -- especially payment incentives for care at the end of life are always going to be controversial, and they have for the last 20 years that we've been engaged in putting these programs together. But my belief is they're critical, it's critical to help incentivize the system to counter, as you mentioned, the incentives that are already in place for pretty radical treatment for people who often don't want it. So I would like to defend that concept.

And then in response to Tim and innovation, we do a lot of work with health systems around the country, and we have found, I think, that this model works very well not to impose a structure on systems that inhibit their innovation but, on the other hand or in contrast, to provide the system with a flexible means of innovating even

with its own staff, because staff can be retrained, reprogrammed, brought in, and taught to do this, and it works extremely well.

So we hope that this model promotes innovation throughout the system, and to echo my colleagues, we're very, very grateful to be here, particularly to be invited back for a second shot.

Thank you.

CHAIR BAILET: Thank you.

We have two other folks in the room, and I want to make sure -- is this Dr. -- is it Perry Fine? Is that right?

DR. FINE: I'm going to defer [off microphone].

CHAIR BAILET: And I -- yeah, we --

DR. FINE: What Brad said [off microphone].

CHAIR BAILET: Okay. Very good. Thank you, sir. And is it Marlene Davi? Did I get it right?

MS. DAVIS: Malene Davis, and I defer as well [off microphone].

CHAIR BAILET: Very good. All right. Thank you.

There are a couple of folks who signed up but so far have not presented, so I'm just going to call out the names, and if you're here, that would be fine. Gregg Pane?

[No response.]

CHAIR BAILET: Randall Krakauer?

PARTICIPANT: He's on the phone.

CHAIR BAILET: He's on the phone? He's not on the phone, okay. And then, lastly, Marlene McHugh.

[No response.]

CHAIR BAILET: So that completes the public comment section. I guess I look back to my colleagues. We do have a certain amount of momentum here, and I understand the hour, but I also think that there's a possibility of richness here. So that's the team that I know I have. All right. Very good.

So based on public comment and the submitter feedback, any other comments that we want to make before we get into the actual voting on the individual criteria? Len.

* **Committee Deliberation**

DR. NICHOLS: Very briefly. I just want to make the point that this presenter group, applicant, is sort of proof in the pudding of how feedback is a good idea, because they came to us, we didn't even vote, they heard us talk, we weren't allowed to write it down, and they went home and made it better. And I just think that's proof we

could interact in a positive way.

CHAIR BAILET: And, Len, you know, I just want to remind folks that we provided that feedback to Congress, Elizabeth and I, about the need to be able to provide feedback midstream for exactly how this played out. And I would argue had we been able to have that feedback opportunity with the previous submitter, we probably would have had a different -- segments of the model probably would look differently, as they have with C-TAC. So absolutely correct, and we are going to -- again, as I mentioned earlier in my opening remarks, we as a Committee are going to land on how we want to use that additional authority to provide that feedback. And when we land as a Committee, we'll be sure to share that with the community to make sure if there's additional feedback, that we can refine our process.

So seeing no other comments, we're going to go ahead and start with the ten criteria. Are you ready, Ann? Ann is ready. Okay, very good.

* **Voting**

CHAIR BAILET: So number one, find the clicker. Do you -- is it in your pocket, Bob?

[Comments off microphone.]

CHAIR BAILET: Hold on. There's a rogue clicker here somewhere. Harold, do you have a vote, a clicker that you could --

MR. MILLER: I have no clicker.

CHAIR BAILET: You're clicker-less. He did find it. Okay, we're ready to roll here. So that was a momentary lapse, but we're good. We're back in. Criteria 1, Scope, aim either to -- either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited. It's a high-priority item. Please vote.

[Electronic voting.]

CHAIR BAILET: Ann?

* **Criterion 1**

MS. PAGE: Five members voted 6, meets and deserves priority consideration; four members voted 5, meets and deserves priority consideration; one member voted 4, meets; zero members voted 3, meets; and zero members voted 1 or 2, does not meet. The majority finds that the proposal meets Criterion 1 with high priority -- and deserves priority consideration.

CHAIR BAILET: Thank you.

Criterion 2, Quality and Cost, high-priority item. Anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost or both improve health care quality and decrease cost. High priority. Please vote.

[Electronic voting.]

* **Criterion 2**

MS. PAGE: Zero members voted 2 -- zero members voted 6, meets and deserves priority consideration; two members voted 5; meets and deserves priority consideration; seven members voted 4, meets; one member voted 3, meets; and zero members voted 1 or 2, does not meet. The majority finds that proposal meets Criterion 2.

CHAIR BAILET: Thank you, Ann.

Criterion 3 is Payment Methodology. Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM. Criteria addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the physician-focused payment model cannot be tested under current payment methodologies. A high priority. Please vote.

[Electronic voting.]

* **Criterion 3**

MS. PAGE: Zero members voted 5 or 6, meets and deserves priority consideration; five members voted 4, meets; five members voted 3, meets; and zero members voted 1 or 2, does not meet. The majority finds proposal meets payment -- Criterion 3, Payment Methodology.

CHAIR BAILET: Thank you, Ann.

Criterion 4, Volume over Value. Provide incentives to practitioners to deliver high-quality care. Please vote.

[Electronic voting.]

* **Criterion 4**

MS. PAGE: Zero members voted 6, meets and deserves priority consideration; one member voted 5, meets and deserves priority consideration; nine members voted 4, meets; zero members voted 3, meets; and zero members voted 1 or 2, does not meet. The majority finds the proposal meets Criterion 4.

CHAIR BAILET: Thank you, Ann.

Criterion 5 is Flexibility. Provides the flexibility needed for practitioners to deliver high-quality health care.

[Electronic voting.]

* **Criterion 5**

MS. PAGE: Zero members voted 6, meets and deserves priority consideration; one member voted 5, meets and deserves priority consideration; nine members voted 4, meets; zero members voted 3, meets; and zero members voted 1 or 2, does not meet. The majority finds it meets Criterion 5, Flexibility.

CHAIR BAILET: Thank you, Ann.

Criterion 6, Ability to Be Evaluated. Have evaluable goals for quality of care, cost, and any other goals of the PFPM. Please vote.

[Electronic voting.]

* **Criterion 6**

MS. PAGE: Zero members voted 5 or 6, meets and deserves priority consideration; seven members voted 4, meets; three members voted 3, meets; and zero members voted 1 or 2, does not meet. The majority finds the proposal meets Criterion 6.

CHAIR BAILET: Criterion 7, Integration and Care Coordination. Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to

delivering care to populations -- population treated under the PFPM. Please vote.

[Electronic voting.]

* **Criterion 7**

MS. PAGE: Two members vote 6, meets and deserves priority consideration; three members voted 5, meets and deserves priority consideration; five members voted 4, meets; zero members voted 3, meets; and zero members voted 1 or 2, does not meet. The majority finds the proposal meets Criterion 7.

CHAIR BAILET: Criterion 8, Patient Choice. Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients. Please vote.

[Electronic voting.]

* **Criterion 8**

MS. PAGE: One member voted 6, meets and deserves priority consideration; two members voted 5, meets and deserves priority consideration; six members voted 4, meets; one member voted 3, meets; and zero members voted 1 or 2, does not meet. The majority finds that the proposal meets Criterion 8.

CHAIR BAILET: Criterion 9 is Patient Safety, aim

to maintain or improve standards of patient safety. Please vote.

[Electronic voting.]

* **Criterion 9**

MS. PAGE: Zero members voted 5 or 6, meets and deserves priority consideration; seven members voted 4, meets; three members voted 3, meets; and zero members voted 1 or 2, does not meet. The majority finds the proposal meets Criterion 9.

CHAIR BAILET: Criterion 10, Health Information Technology, encourage use of health information technology to inform care.

[Electronic voting.]

* **Criterion 10**

MS. PAGE: Zero members voted 6, meets and deserves priority consideration; one member voted 5, meets and deserves priority consideration; five members voted 4, meets; four members voted 3, meets; and zero members voted 1 or 2, does not meet. The majority finds the proposal meets Criterion 10.

CHAIR BAILET: Ann, do you want to summarize, please?

MS. PAGE: The Committee found that the proposal

meets 9 out of the 10 criteria and found that it meets and deserve priority consideration under Criterion 1, Scope.

CHAIR BAILET: Thank you, Ann.

Any comments before we move to actually make the recommendation?

[No response.]

CHAIR BAILET: All right. We'll go ahead and make the recommendation to the Secretary, and as before, we're going to do it electronically first. Then we'll go around the Committee members that can share their point of view, and included in that making sure to emphasize particular points that we want on the record, so that as we develop a letter to the Secretary, we can make sure that those comments and perspectives are shared.

So we have an asterisk, which is not applicable. Then 1 is we're not recommending the proposed payment model to the Secretary; 2 is recommend the model for limited scale testing; 3, recommend the model for implementation; 4 is recommend the model for implementation with high priority.

So we are ready to vote.

* **Final Vote**

MS. PAGE: Two members voted 4, recommend for

implementation as a high priority. Three members voted 3, recommend the payment model for the implementation. Five members voted 2, recommend the proposed payment model to the Secretary for limited scale testing, and zero members voted 1, do not recommend.

This recommendation to the Secretary is determined by a two-thirds majority member vote, which would be seven votes, and so that rolls to Item No. 2, recommend the proposed payment model to the Secretary for limited scale testing.

CHAIR BAILET: Ann, I had a fat finger on this one, and so I actually wanted to push 3, and I pushed 4 by accident. So I don't know. Just for the record --

MS. PAGE: We could revote.

CHAIR BAILET: Not that it changes anything. I mean, what?

MS. STAHLMAN: You're going from 4 to 3?

CHAIR BAILET: I am going --

MS. STAHLMAN: It doesn't affect the overall --

CHAIR BAILET: I know it doesn't, but I just --

MS. PAGE: Unless you wanted to --

CHAIR BAILET: I am a purist, and I just -- yeah, because I'm going to go around, and then people are going

to do the math and say, "Wait. Someone is not being truthful here." That's all I'm saying.

MS. PAGE: We do include it in the report to the Secretary.

CHAIR BAILET: Pardon me?

MS. PAGE: We do include the numerical results in the report to the Secretary.

CHAIR BAILET: Right. So that's all. So should we just vote again just -- all right. Let's do it one more time with feeling.

Right. Thanks, Paul. All right.

MS. PAGE: Did you look?

CHAIR BAILET: I did look.

MS. PAGE: Okay.

CHAIR BAILET: Look at that.

MS. PAGE: Zero members voted 4, recommend for high -- implementation of high priority.

MS. STAHLMAN: Did somebody else change their vote? Did somebody intend to change their vote?

DR. NICHOLS: So let's not ask too many questions.

MS. PAGE: Five members voted 3, recommend for implementation, and five members voted 2, recommend for

limited scale testing, and zero members vote 1, do not recommend. And so the two-thirds majority is recommended for limited scale testing.

* **Instructions on Report to the Secretary**

CHAIR BAILET: All righty, then.

So we're going to go ahead around the room, starting with Rhonda this time. Rhonda?

DR. MEDOWS: I recommended for a full-scale testing.

The screen just went blank. Is that okay?

MS. PAGE: Do you mean No. 2 or 3?

DR. MEDOWS: Full implementation, 3. No. 3. I thought it actually addressed the population, the patient choice. The quality of performance measures improved, and I thought the payment model was actually improved as well.

DR. BERENSON: So I recommended 3 as well, full testing. I'm not sure that limited testing means anything. So until we get some clarification on that, I think this has passed the test for real testing, given the priority we've given to it.

I still have concerns about risk, but at least it's carefully delimited in this model as opposed to the first one.

I had actually -- one reason I like full testing is I would love to see two arms, one with shared savings and one without, to see whether it makes any difference, and part of that analysis would be qualitative on the nature of the interaction, given financial incentives.

But they did a good job of refiguring out what our issues were when they were here before. They deserve credit for that, and this is a high priority, so why do limited testing when we can actually test the model.

Because one final point is I think we need to test it not just on early adapters and first -- first movers and early adapters. We should try to figure out a model where we're dealing with a broader segment of the provider population. So we see where the fault lines are on this kind of an approach. So, again, that would call for -- I mean, limited testing, I think of as sort of beta testing. I think we could get beyond that.

There's been a lot of beta testing already. In Medicare Advantage and elsewhere, I think we really want to test it.

CHAIR BAILET: Thank you, Bob.

Kavita?

DR. PATEL: I also voted No. 3, to move ahead. I

think it meets all the criterion, and I would just say that I think, to the Secretary's comments, to make a note of the public letter from the National Partnership on Women and Families around beneficiaries. Just one of the aspects to try to mitigate unintended consequences with respect to beneficiary and patient notification would be service.

And then I'll just comment that this may look, the way we voted, that we thought the previous model was not sufficient, but I would argue that the best would actually be kind of rigorous payment methodology and some of the metrics that were included, time period, et cetera, kind of married with the spirit of the previous submitter, which offered, I believe, more flexibility to introduce palliative care to a broader audience dealing with smaller settings, competitive markets, and other limitations.

CHAIR BAILET: Len.

DR. NICHOLS: So I voted 2, limited scale. I agree with Bob. I don't know what it means, but what I wanted to convey to the Secretary was we want both of these to go forward at the same pace, which means now. And I think it's important to recognize the fundamental difference in the models.

It seems to me C-TAC is ready to go for large

organizations, and both of them, frankly, need some work on the technical details of risk adjustment. So I want them to proceed at pace together, and the other one is better for smaller practices, and I think that's important to go at the same time.

CHAIR BAILET: Elizabeth.

VICE CHAIR MITCHELL: Thank you.

I actually voted 2. I was swayed by Tim, who -- oh, great. So talking about workforce concerns and sort of testing how this might be done with different sort of team compositions, I had actually said to Jeff that my ideal would be having both submitters get together and do a hybrid model. But I think -- yeah, so that may happen.

But I think to the extent we can expand the availability of this offering and care for a broader population, we need to, but because of the fragility of the population just wanting to test it on a limited basis.

CHAIR BAILET: I voted, as everyone knows -- I voted to implement for the reasons, actually, that Bob stated. So I don't necessarily want to repeat myself, but I do think that -- but I think to go on Elizabeth's comment -- I mean, it would be really, I think, beneficial, given the intellect that went into both models, if there could be

some cross-pollination, if you will, or coming together for both teams to potentially work with CMMI and CMS to think about maybe making a comprehensive model because they address different areas of population. They have strengths on both sides. I would really welcome that. If that can happen, I think that we will all benefit from maximizing the potential.

But, again, I voted 3 because I think this is more ready in part because we were able to provide input, and you were able to sort of re-cast it a bit. But I do think it's ready for a larger exposure to a larger group of clinicians and patients.

MR. STEINWALD: So, like others, I was conflicted by not having the choice that I wanted, which would be limited but large scale testing, but -- and what I mean by that is limited because there's some issues that need to be worked out.

When the PRT met over these two proposals, we sort of briefly addressed could we choose elements of Proposal A and elements of Proposal B and then combine them, and we decided it was just not that simple. That creating the model that we would really like to put in the field was a bit more complex than that, but we like the

idea of having both organizations involved in discussions with CMS about that.

So I think the sense of it should be we'd like to get something in the field right away, which could be limited, but then scale it as quickly as we possibly could, as we figure out how to fix the issues that we've raised.

CHAIR BAILET: Thank you, Bruce.

Paul.

DR. CASALE: Yeah. I also voted for recommended implementation, and I think they responded to our concerns from our initial evaluation. And I also want to be consistent with my voting since I voted for implementation on the PACSSI as well.

But part of that, I think is the signal, as Bob and Len said. I don't know what limited testing is because, again, we haven't gotten a lot of feedback on that, and I think it sends the signal that we think this needs to happen now, as Len has said.

I think there are some improvements that can still potentially be made. I think it's pretty ready to go, but there still could be some improvements. I think, again, the PACSSI needs-based is really helpful. I still have some issues with the surprise -- the prognosis. I

just think that it can be helpful as a filter, as Tim said. Operationally, I'm not sure it needs to be actually in the model, whereas PACSSI had that sort of more everything is around the needs.

So, anyway, I think there's certainly good things in both. This one, yes, is probably closer to being ready to go, but I think that's how I decided to vote. Thanks.

CHAIR BAILET: Thank you, Paul.

Grace.

DR. TERRELL: I voted for limited testing for many of the reasons that everybody else has already articulated, but I would want to emphasize that I think this happens to just be an incredible opportunity that we happen to have now, which are two very thoughtful proposals on the same problem. And so the idea, therefore, that one should be implemented and not the other to me is an irrational approach because we all say that there's good points to both and some concerns we have.

So from a logic process, I mean, it seems to me that the only thing you could do is say you've got to get them together. Its' going to be CMS's responsibility to take our language and what we write up and understand what we like or don't like about the individual ones or how we

think that they could be better strengthened or whatever.

This is also sort of an existential moment for us because, as we've gone around the table here, we're like, "I don't know what it means, what we just voted on," and that's probably a problem.

[Laughter.]

DR. NICHOLS: I know what it means in my head.

DR. TERRELL: Right.

DR. NICHOLS: I don't know what it means in CMMI's head.

DR. TERRELL: Well, that's my point and the reason I say it's an existential moment. If it looks like when we say limited testing, we're saying it's not a valuable as something -- I mean, I think it's going to be extremely rare maybe for us to say, "This is perfect, deserves high priority. These people got it exactly right, and go out there, CMS. Don't think about it. We're God. Just do it." Right? That's No. 4. If we ever do that very often, we're going to have to have some thoughts as to what that means about us.

The other one, it's the nuance and the subtlety between the two, which is sort of what Bob was getting at, which is, "Okay. This is pretty darn good. It's pretty

close. We know you got to actually work out the details. CMS, that's why you get paid every day. Do it" versus "We've got some stuff here that we think needs some serious thought."

I would have probably voted for both of them to just be implemented, had I seen them one at a time, but by seeing both at the time, we actually have a better opportunity. Limited testing is a better thing if you've got two good proposals with things that are actually beneficial in both.

So as a result of that, I think our existential moment is actually to make CMS understand that when we say limited testing and high priority or however we're going to like get that sort of thing across, it means that this is actually a better opportunity than if we just say yeah, yeah, yeah.

So this should be -- we should be nothing but grateful that we happen to have one PRT, two committees. One came back, and it's just been an incredible amount of work for which you're all to be applauded. And we need to make sure that CMS understands that.

CHAIR BAILET: Tim.

DR. FERRIS: Can I change my vote?

[Laughter.]

DR. FERRIS: So I voted for limited scale testing, but after hearing what Bob said in his argument, I think we all agreed. We made two different votes, but we pretty much agreed about what we were -- the signal we were trying to send with that.

CHAIR BAILET: I think you need to be -- the final determination needs to reflect where you are. So if you have -- through this deliberative process, if your position has changed, then I think that needs to be reflected to be accurate.

DR. FERRIS: Yeah. So my position is that this is too important, and we've gone too far down the road to be satisfied with limited scale testing. I think we should implement some.

I think we're close enough, say six months of work at CMS, to implement something that is some sort of combination of good ideas from these two models, and so I would like to change my vote from limited scale testing to implement.

DR. TERRELL: I want to change my vote on the other one.

DR. FERRIS: No, no. That's not --

CHAIR BAILET: Yeah. Okay. Well --

DR. FERRIS: If you don't want to accept that, that's fine. It doesn't matter, really, in terms of what we're recommending to the Secretary because what matters, I think, is what we're saying in the written words and not the distribution of the voting is my --

CHAIR BAILET: So Len and then Bob.

So my suggestion is that we write one letter. In the letter, explain all of this.

DR. FERRIS: I think that's what we do, right.

CHAIR BAILET: No, no, no. For both.

DR. NICHOLS: No, no. For both.

So we cannot -- we cannot unpack, and we get to say now, right? I just think that's the way to solve the problem.

DR. FERRIS: That's interesting. I don't know if that blows up our process.

CHAIR BAILET: Yeah. We may be crossing the fence line here. DFO, are we?

MS. PAGE: That was going to be one of my questions as staff. Did the Committee want to have one report that speaks to these two proposals that came in on the same topic for which the Committee has some strong,

positive findings on some issues that they think need attention? The statute does not require us to do a separate report on each. We have to do comments and a recommendation to the Secretary.

I think that we could craft our report to the Secretary that gives due attention to them individually but then raises up those issues that you think are cross-cutting, and certainly the importance of the topic and the timing being right and a lot of the advance work that has gone on with some of these cross-cutting issues.

CHAIR BAILET: Bob and then Elizabeth.

DR. BERENSON: Yeah. I wanted to sort of just comment on the limited testing and -- what's the word? -- implementation.

To bring up some ancient history, do you all remember Mai Pham with her 26 items of what has to happen to get something out of this?

They're not -- CMMI isn't going to take this model and say this is it. They're going to go through 26 steps presumably to get something that they can then do as a demo.

I thought our limited testing -- and, Harold, you're allowed to speak now -- was about new ideas, that we

lacked real basic information. We needed to get some data. We needed to know if it was operationally feasible. We needed to get some sort of alpha and beta testing.

This palliative care was a well-developed approach. It's been around for a long time. We're not in the same place. So my view is that does the payment model that we were presented sort of -- is it basically the right approach, which will need all sorts of massaging as it goes through the CMMI process, but is it -- does it pass that initial threshold? I didn't think the first one did. My concern had to do with the overreliance on shared savings and shared risk.

This one strikes me as, yeah, this is in the ball park, but I fully expect there will be changes. In our report, we're pointing out a number of the things that we would like CMMI to pay attention to.

So I think they really -- for different purposes, in that this one qualified for full testing, for implementation. Implementation.

CHAIR BAILET: Elizabeth?

VICE CHAIR MITCHELL: So I am motivated by whatever it may take to get CMMI to respond to our recommendations, and I like the idea of a single letter in

part because having been on the PRT, we did consider both proposals, and I think there are strengths to both and challenges. And I think that that analysis will help them in their ultimate model, and I think it may underscore the urgency with which I think we are commending this, for them to do something. So I support that.

CHAIR BAILET: Harold and then Grace.

MR. MILLER: Just to follow up on Bob's point, we actually developed a fairly detailed paper which we, I believe, sent to the Secretary and never heard back on, as to what we thought limited scale testing should be. The notion was that in order to implement any kind of a payment model, you have to know how much people are being paid, and you have to know what benchmarks are, et cetera, et cetera. And if no one has ever done the service before, then it's hard to know what those amounts are.

And I think those questions certainly came up in the AAHPM proposal. There were a few sites. I think they based their numbers on a few sites, including Janet's project, but the question of what is this going to actually cost in a variety of different settings in rural areas is not known until one actually tries it.

I would make the observation -- I think we ought

to talk about separately -- is that this is the AAHPM proposal, and maybe this one is the second one now where we've said limited scale testing with a priority, which is not a category that we have. And that rather than sort of picking the wrong category or picking the category in the middle to try to represent something other than what it is we really mean, it may mean that we need to create a category like that.

My personal opinion on the one letter is I think one letter would be a good idea because I think that otherwise it will be confusing to try to find out what it is that we thought was good and bad, et cetera, in going forward.

I think that in many cases from applicants' perspective, they have put a lot of work into their proposal work, and they would like to see their proposal approved, but I think in the interest of Medicare beneficiaries and the Medicare program, the idea should be to get the best model.

And I would further say that I don't think that there is one best model in any of these areas. I think that they are going to end up being different models that are needed, whether you're talking about palliative care or

home hospitalization or Crohn's disease or whatever in rural areas versus large urban areas, et cetera, just because of scale and resources, et cetera.

And so I think the notion that here's something that you could do if you have larger scale, here's something that you could do if you didn't have larger scale, and having those two things together is an important thing because I do personally believe that we have entirely too many models that only work in large systems and not nearly enough that work for small practices and small community.

CHAIR BAILET: Thank you, Harold.

Before we go to Grace and Tim, I have our actual language. We went through a process. We wrote a letter to the Secretary, and then we took that information out and put it into our process.

Now, we can refine it, but if you would indulge me, I can quickly read what limited scale testing is, at least as where we landed when we put this together, which is this category may be used when the PTAC determines a proposal meets all or most of the Secretary's criteria, but lacks sufficient data to (1) estimate potential cost savings or other impacts of the payment model, and (2)

specify key parameters in the payment model, such as risk adjustments or stratification, and the PTAC believes the only effective way to obtain those data would be through implementation of the payment model in a limited number of settings.

So that's where we landed, just to level-set on our discussion.

MR. MILLER: One thing. At least in my mind the idea was, and I think this is the nature of all of our discussions, doesn't clearly say that in the letter, was that limited-scale testing was a step towards broader-scale testing. It was not the idea that you could test it in a couple of places and decide whether it worked or not. The idea was to do it in a small number of places in order to get those parameters refined, et cetera, so that you could test it on a broader scale, to be able to determine true impact. And we may need to make that clear. As I said, that's at least in what's in my head.

But I think we have used the term differently in different settings. When we first talked about it, that was where it came up, was that the idea being that you needed to do, first, limited, in order to be able to get to something broader.

CHAIR BAILET: Okay. Thanks. Grace and then Tim.

DR. TERRELL: So often the question is, is the sum greater than the whole of the parts, and what I believe, if we're going to have a single report does, is it allows us to have another opportunity to basically say we recommend implementation. Here's the limitations that need to be understood or studied, or the, you know, within this model or that model.

Now Bob may well not agree with me because he may think that one is ready to implement under these criteria and another one is not, but the fact that there are certain things in one that actually could contribute and improve the other, which many of us have seen, and vice versa, may mean that one of the things we could do at the reporting level is actually say we recommend implementation of a palliative care model that has, you know, payment model aspects of these things.

Now it's going to require a little bit more work on our part, maybe even more thought process than we've got today, but it may well end up taking care of this particular problem. If we're going to basically go with this idea that we're going to have a single report, it

really gives us some new degrees of freedom.

CHAIR BAILET: Tim and then Bob.

DR. FERRIS: I'm not sure I got an answer to my question about my vote.

CHAIR BAILET: Would you like an answer?

DR. FERRIS: Yeah.

CHAIR BAILET: So I think if that's your point of view today, in the deliberation, then the vote should reflect that. So if that means we need to take a pause and revote --

DR. FERRIS: [Inaudible comment.]

CHAIR BAILET: Pardon me? On both?

DR. TERRELL: We would have to revote on both because if he's going to do that, I'm going to do that on the first one.

DR. FERRIS: Okay. Never mind.

DR. TERRELL: Okay. That's the point.

DR. FERRIS: All right. So, then, after such great deliberations on existential issues --

[Laughter.]

DR. FERRIS: -- this is going to seem ridiculous, but I would like to go on record related to this.

So this model is going to pose a really big

financial challenge to those hated integrated delivery systems who are ACOs, who depend on doing precisely this in order to meet their targets in shared savings and the next gen models, because this is the biggest source of savings to deliver better care to this population, and everyone who is doing an ACO in the Medicare population is already doing this as a subset. And if you then have groups around the country doing this separate, then you have to create a hierarchy of who gets credit and who is eligible and who is in.

So there's a really big issue associated with the multiple different payment models in the same geography issue here. I would suggest, from my point of view, the --

DR. TERRELL: It's no different than bundles.

DR. FERRIS: It is no different than bundles, except the amount of savings in bundles doesn't come close to the amount of savings available in this particular type of intervention.

So I think CMS has to think very carefully about the adjacency issue that comes up, with respect to these models, and my suggestion would be that the hierarchy prioritize those who are going after total populations, and we could debate it but I just wanted to go on record.

CHAIR BAILET: Thank you, Tim, and I think we should formally arrive at a single letter versus two, just for clarity. I think the Committee is leaning towards a single letter, but I'd like to actually have a motion for a single letter.

DR. TERRELL: So moved.

CHAIR BAILET: Second?

DR. NICHOLS: Second.

CHAIR BAILET: All in favor.

[Chorus of ayes.]

CHAIR BAILET: Any opposed?

[No response.]

CHAIR BAILET: So, Ann will -- again, that's going to require some more discipline, but we're -- Ann, yeah?

MS. PAGE: And just a staff question. So the conversation on the second model has been higher level, and I didn't know if the group wanted issues captured in the PRT report reflected in this report that will now go. So the three categories that come to mind are issues around the quality measures, issues around the payment methodology, issues around prognosis being the basis for eligibility. Do you want those captured in the report, or

no.

DR. NICHOLS: Yes. I mean, in my opinion this letter, or whatever we're going to call it, is going to have two chapters, and so you're going to talk about each one, because, in my opinion, what made my morning complicated was when I read both proposals. I always read the proposals. Then I read the PRT reports. I read both proposals, I weighed my little pros and cons, I read the PRT reports, and I'm like, whoa, what is this, because the complaints about the second one were things that were in the first one, but you came down in a different place.

And so my point was they're so close in conceptual goals. One is certainly more advanced because they had more time and they got to respond specifically. But both of them need parameters to be worked out, which is what I mean by limited scale. We don't even know how to offer it to anybody until we get the risk adjustment and the benchmarks determined completely. That's got to go in there. All that's got to go in there.

MS. PAGE: Okay. So just to follow up, so I'm -- I'd have to go back and look at my notes on the first proposal, but in general I wasn't hearing that this full Committee overturn the findings from the PRTs? So on this

one I've been listening for that. On the first one, I guess, I'd have to go back.

DR. NICHOLS: When you say "overturned," we voted to recommend --

MS. PAGE: Oh, I know the vote, but --

DR. NICHOLS: -- but we -- but --

MS. PAGE: -- I'm just talking about the discussion of the issues.

DR. FERRIS: So the issues were presented in written form --

MS. PAGE: Right.

DR. FERRIS: -- but we did not, on a number of them we didn't discuss --

MS. PAGE: -- discuss the issue.

DR. FERRIS: -- the issues. And I don't know, but from my perspective, I agreed with the issues as surfaced by the PRT, and maybe if we just say that then we don't need to actually verbally walk through each one of them.

MS. PAGE: No, that was --

CHAIR BAILET: Right.

MS. PAGE: -- what I wanted to be clear on.

CHAIR BAILET: Yeah.

Okay. We are done. Oh, wait. Bob.

DR. BERENSON: I think Tim brought up a very interesting point in whether we should, at the very least in our one-letter report, indicate this issue of overlapping responsibility for reducing -- well, for providing palliative care, let's say it that way, and whether we are prepared to discuss a -- whether we agree with Tim, I do, that the priorities should be on the ACO. But at the very least we should identify this as a design issue that needs a lot of attention. So I throw that out. I don't think we should just pass Tim's comment without deciding how we're going to deal with it.

CHAIR BAILET: Okay. So logistically we are going to take a 45-minute break. Again, I want to thank both submitters who stuck together, hung together, support each other. This is a tremendous amount of work, but it's also tremendously valuable work, and we are going to be better as a country for the work that you guys have done. So again, a whole heartfelt thank you for both folks.

And we're going to reconvene in 45 minutes, so that would be -- what time would that be?

MS. STAHLMAN: About 2:15.

CHAIR BAILET: About 2:15. Thank you.

[Whereupon, at 1:27 p.m., the Committee recessed for lunch, to reconvene at 2:15 p.m. this same day.]

AFTERNOON SESSION

[2:21 p.m.]

CHAIR BAILET: All right. If everyone could take their seats, please, we're going to go ahead and get started.

So welcome back. This is, again, the fourth public meeting of the Physician-Focused Payment Model Technical Advisory Committee, or PTAC. We are now going to deliberate and review and evaluate the Personalized Recovery Care Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home. And the PRT members are Harold Miller, Dr. Rhonda Medows, and Len Nichols, and Harold is the lead.

Personalized Recovery Care, LLC:

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

*** Committee Member Disclosures**

CHAIR BAILET: So if we could first introduce ourselves and go around the room for disclosures, conflict of interest and impartiality disclosures, and I'll start with myself, and then maybe we'll go from Rhonda back

around. Jeff Bailet, Executive Vice President of Health Care Quality and Affordability with Blue Shield of California. I was previously at Aurora Health Care in Wisconsin. I know Dr. Turney when I served with her on the Wisconsin Chamber of Commerce Board, and also as Dr. Turney is currently the CEO of the Marshfield Clinic, which was the submitter. I've also met Dr. Murali while visiting the Marshfield Clinic, and while I am familiar with the Marshfield Clinic while leading the Aurora Medical Group, I have not had any involvement in the development of the Personalized Recovery Care LLC Home Hospitalization: An Alternative Model for Delivering Acute Care in the Home.

Rhonda?

DR. MEDOWS: Dr. Rhonda Medows, family medicine, Executive Vice President of Population Health at Provident St. Joseph Health. I have no disclosures.

DR. BERENSON: I'm Bob Berenson. I'm an internist and I'm a fellow at the Urban Institute, and I have no disclosures.

DR. PATEL: Kavita Patel, Johns Hopkins and Brookings Institution. No disclosures.

DR. NICHOLS: Len Nichols, George Mason University. Nothing to disclose.

VICE CHAIR MITCHELL: Elizabeth Mitchell, Network for Regional Healthcare Improvement. Nothing to disclose.

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

MS. PAGE: Ann Page, the Designated Federal Officer for this Federal Advisory Committee Act, FACA, committee.

MR. STEINWALD: Bruce Steinwald, a health economist here in Washington, D.C. Nothing to disclose.

DR. CASALE: I'm Paul Casale, a cardiologist, Executive Director of NewYork Quality Care. Nothing to disclose.

MR. MILLER: I'm Harold Miller from the Center for Healthcare Quality and Payment Reform. I have no conflicts or disclosures.

DR. TERRELL: Grace Terrell. I'm a general internist at Wake Forest Baptist Health System in North Carolina and CEO of Envision Genomics. Nothing to disclose.

DR. FERRIS: Tim Ferris, primary care internist at Mass. General Hospital in Boston. I'm the CEO of the Mass. General Physicians Organization, and I have nothing to disclose.

CHAIR BAILET: Harold.

* **PRT Report to the Full PTAC**

MR. MILLER: Thank you, Jeff.

So as Jeff said, we're going to be reporting on the Home Hospitalization Alternative Payment Model that was submitted by an organization called "Personalized Recovery Care, LLC," which is a joint venture between Marshfield Clinic and Contessa Health.

The Preliminary Review team consists of three members. I was asked to be the lead on this. I was joined by Len Nichols and by Rhonda Medows. All the PRTs have one physician, and Rhonda Medows was our designated hitter on that score.

We as the PRT, our role was to try to elicit all the relevant information that we could and get questions answered about the proposal. I want to commend the submitters for responding. They responded to two sets of questions from us with somewhat over 40 questions and provided very detailed and thorough responses. Thank you. And we also had a one-hour call with the applicant to discuss some issues, which I think is always a very valuable thing to do.

So I'm going to be reporting today on the

conclusions that Len and Rhonda and I drew as the PRT. It is only this -- these comments are only from the three of us. Just, again, for those of us -- those out there who are not familiar with the process, the rest of the members of the PTAC have not discussed this before. This is the first time today that we will be discussing it as a group. So the PRT report is really just intended to inform the discussion by the rest of the PTAC members. So let me give a brief overview, as we understand it, of the proposal, and then questions obviously can be directed to the applicant.

This is designed to provide new payments that would allow Medicare beneficiaries who would otherwise be hospitalized to get care in their home. This service is being delivered on a limited scale now by the applicants with support from a health plan that is owned by the Marshfield Clinic, and I think there are efforts to get it in place in other areas by the partners.

Who is eligible for this? Patients who have a range of different either acute conditions or chronic conditions that essentially come to the hospital and would be eligible for a hospital admission but could potentially then be managed at home. And so the criteria for eligibility are that they would be eligible for a hospital

admission, but that they could safely for that condition receive care at home in the kind of home environment they have -- so it's not just an assessment of their diagnosis but it's also an assessment of their home environment -- and the patient agrees to accept the care in the home. So it's essentially those three or four criteria: their diagnosis, their eligibility for a hospital admission, their ability of their home environment, and their willingness to be cared for at home.

What they receive is 30 days of services which are conceptually divided into an acute-care phase and a post-acute-care phase. The acute-care phase essentially mimics what -- the kind of care that they would have theoretically gotten in the hospital but in the home.

The applicant has suggested some minimum standards, if you will, in terms of the kinds of services that patients should get. There's no limit in terms of how much they could get. I'll talk about the payment in a second. But their concept is that the patient would get a telehealth visit from an admitting physician at least daily. They would get an in-person registered nurse visit to the home at least twice daily. There would be what they referred to as a "recovery care coordinator" who's a

registered nurse who would be available 24/7 and really monitoring their care to make sure that all those other things are happening. There would be 24/7 access to -- on-call access to a physician. And if necessary, in probably a limited number of cases, if the patient really needed to be in an inpatient facility before they went home, they might start their care in a skilled nursing facility. And then in the post-acute-care phase, hopefully they are essentially discharged from acute care, and then they would get whatever they might get otherwise, having been discharged from the hospital, seeing their primary care physician, et cetera, and the recovery care coordinator continues with that.

The payments, if you will, are really -- there's two or three different components to the payments, depending on how you think about it. There is a payment that comes to the entity that is delivering these services in the home to support those services I just described. But those services are not all that the patient would need to get. They would also potentially need home infusion therapy. They might need specialist visits. They might need durable medical equipment, et cetera. Those they could get, but those would be billable separately to

Medicare.

So a key aspect of this proposal is that there is a bundled payment that comes to the applicant to deliver essentially the home nursing service, social work service, and these telehealth visits by the admitting physician, all of which are things that are not reimbursable from Medicare today, and then orders could be issued for other services to the patient in the home or for them to transport, for example, for imaging, et cetera, that would be billable separately to Medicare.

So the payment model essentially has these three conceptual components to it. One is there is a bundled payment to them to support the nursing and social work services. Second, Medicare continues to pay for additional services beyond that. And then there is a look at the overall spending during the 30-day episode, and there is both upside and downside risk, financial accountability for that. So if the spending during that 30-day episode is higher than it would have been theoretically for equivalent patients who had been hospitalized, then the applicant -- the participant in the model pays money back to Medicare. If the spending is lower than would have been expected, then they get a bonus.

But the bonus that they would get if spending is lower is reduced if quality measures are not met. There are five in the proposal. There are five quality measures, and any kind of a shared savings payment is reduced by 20 percent for each of those measures that's not met. So that's the model, and I guess I just skipped over that slide there.

So our PRT reviewed this, as I said, reviewed a variety of information and responses, and our conclusions -- and I'll talk about these individually -- were that it met all of the criteria except for one, which was the patient safety criterion. We were unanimous in that regard.

Now, this model happens to be, I guess, the first one that we have any kind of case law on given that we reviewed a very similar model back last fall in September, a hospital at home model that was submitted by Mount Sinai. They referred to theirs as "the Hospital at Home Plus." This is referred to as the "Home Hospitalization APM." And what you can see on the slide that's here is these models were very similar but different in a couple of key respects.

One is that this model proposed that a much

broader array of patients could be potentially eligible based on their diagnosis than were in the Mount Sinai model and that had been in many other home hospitalization models. Again, it still depends on your home environment. It depends on the patient's willingness, et cetera, and their ability to be managed in the home, but a broader range of diagnosis. A slightly different definition of the time period. Theirs is 30 days following the date of admission rather than 30 days plus the acute-care phase.

What is also different is because this bundled payment in this particular model is only paying for nursing, social work, and physician telehealth services, there is a smaller payment. It's still proportional to the payment that the hospital, the MS-DRG payment that the hospital would have received had the patient been in the hospital, but it's only 70 percent. In the Mount Sinai model, it was 95 percent, but the Mount Sinai model, the payment was essentially covering everything. It was covering the -- all nursing, all DME, all those kinds of services. The only exception was some drugs. So some of the payments under this model are being billed directly to Medicare rather than them all essentially being stopped in respect to this bundled payment.

Now, the case law that we have at the moment is our report to the Secretary. We have not received a response to our report to the Secretary, so we don't yet know how the Secretary would react to that. I personally tend to view that as a favorable thing in this particular case because since the ones that we submitted that we got responses back on were negative, and since we haven't gotten a response back to this one, I'm assuming that that must mean they like it and they just haven't gotten around to telling us that yet.

Now, the key issues that we identified were: This model is very, very similar to the model that we approved in the fall for Mount Sinai, and so we felt that many of the same strengths and weaknesses that we identified with respect to the Mount Sinai model would also apply to this one. But as I noted, there were some differences. Those differences in some ways actually align with things that we said in the report to the Secretary back in September. We actually said in that model that we thought that it would be desirable to potentially have a broader range of DRGs involved because, particularly for smaller practices, the need to have enough patients to make the numbers work was desirable. We also said that we

thought that it would be desirable to test some different versions of the payment methodology, and so this is, in fact, a somewhat different payment methodology.

That being said, one of the things that we had a concern about and our recommendation with the Mount Sinai model was that we recommended that it should proceed to implementation, but with some adjustments to deal with issues related to quality and safety, and we had some of the same kinds of concerns with respect to this particular proposal.

We felt, for example, that while the broader range of DRGs was helpful here and potentially enabling smaller practices to participate by having a broader range of patients, it also raised some concerns about safety. I don't know that we were necessarily, when we thought about a broader range of DRGs, thinking of going from 40 to 150. So we were concerned that that is a very broad range of DRGs, and that could potentially raise some questions about whether that broad range of diagnoses could be effectively managed.

So we thought that, in fact, it would be -- while it was desirable to expand the number of DRGs, it might make sense initially for anyone participating in this to

start with a smaller number of DRGs. And we also felt that it was desirable, as I'll talk about in a second, to have some enhancements to the quality and mechanisms to try to protect patient safety in the model.

But, overall, our conclusion as a PRT was, as we concluded with the Mount Sinai model, that this is a -- the ability to support home hospitalization is a big gap in the Medicare program, and that efforts need to proceed to be able to support that.

I'll just go through quickly in terms of the criteria to talk about them. Again, we identified for this model strengths and weaknesses. We specifically tried to identify both strengths and weaknesses, not to suggest that the model was bad because it had weaknesses, but to try to make sure that it was clear where areas -- there might be areas for improvement. I don't personally believe that there is any payment model that is perfect. All models have strengths and weaknesses. It's a matter of trying to trade off whether the strengths outweigh the weaknesses. So we were trying to be explicit about what we think those things are. And in this particular model, in almost all respects, we felt that these strengths outweighed the weaknesses.

So in terms of scope, we felt that this did fill a gap for Medicare beneficiaries. It filled a gap in the CMS portfolio because it has nothing like this, and that we thought that this particular model would also help to fill that gap.

The key distinction in many ways between this and the Mount Sinai model was there are aspects of this model which do make it potentially more feasible for smaller practices to do. As I mentioned, there's a broader range of DRGs, but the other key difference with this model is that because many of the home services would simply be delivered by existing providers and billed separately, it would not require a small practice to have to create an entire team to deliver home hospitalization services, that they could potentially partner with or contract with home health agencies in the community, DME providers, infusion companies, et cetera, to be able to deliver those services.

So, in that respect, it could theoretically make it more feasible for smaller practices to participate in, and that was one of the concerns that we found with respect to the Mount Sinai model, was simply a concern about whether or not it would be feasible in many rural areas to be able to do a model like this, given the need to put

together enough staff to be able to do that.

In terms of quality and cost, we felt on balance, unanimously felt that it met the criterion, but we felt that it should be strengthened in terms of the quality measures. The applicants themselves said to us that they were tracking a lot more quality measures than this, but they only included in the proposal five measures. And so we felt that there could be an opportunity to expand that. And in subsequent correspondence, which you have all seen, that we got about a week ago, they proposed some enhancements to the quality measures.

We honestly have not really had enough time to review that. They have suggested that as a modification to the proposal. I think our policy is that significant changes that we're getting a week before the meeting we are not going to consider as a modification to the proposal, but I would note that they have, in fact, identified ways in which the quality measures could be strengthened beyond what were in the proposal.

The payment methodology we felt also met the criterion because it was designed to basically enable patients to be cared for in the home, better for the patients at equal or lower cost than they would have

otherwise. We felt that with respect to the payment methodology here, again, as with the Mount Sinai project, that there should be some refinements made to the payment methodology because these patients in theory are going to be less intensive care needs and potentially less intensive post-acute-care needs, so simply comparing them to the standard population of people who would be hospitalized may not be an appropriate comparison. But we felt that that was something that could be addressed.

We felt that that could be addressed.

We felt that it met the value over volume criterion in the sense that this was in fact enabling people to be taken care of in home rather than in the hospital. We had some of the same concerns with this that we had with the Mount Sinai model, which is that the pressure to have enough patients in the model to make the finances work could potentially lead to identifying some patients for this program that might not have been admitted to the hospital otherwise, and so there would have to be some controls. But, again, we thought that the value that this would create outweighed those concerns.

We felt that it was a very flexible model in the sense that there was a payment for home hospitalization

services, which did not prescribe exactly what set of services needed to be delivered, so that whoever was delivering this model would have the flexibility to do what the patients really needed in the home and including to return them to the hospital or to a skilled nursing facility, if necessary, for their care.

Ability to be evaluated, we concluded that it met the criterion, although as with many of these models, we're seeing there will be challenges in that because any model that is basing the eligibility on some clinical information that is not commonly available in claims data will make it hard to identify a comparison group.

And so, in this particular case, they are determining patients to be eligible based on characteristics of their home environment. They will know for these patients what their home environment is, but no one will know what patients in another area's home environment would have been to know whether they were equivalent or not. But we felt that overall that could still be adjusted in the evaluation process.

And moreover, so many other home hospitalization programs have been evaluated elsewhere successfully, positively, that we thought that that could be combined.

We felt that this was -- met the criterion on integration and care coordination because, in fact, it actually solves one of the common problems, the transition between hospitalization and home because the patients are always home, and the same team is managing during that period of time. And they have explicit mechanisms included for trying to make sure that there is a connection maintained with the primary care physician during and afterwards.

In terms of patient choice, a fairly simply conclusion. This expands patient choice. Nothing forces the patient into this model. It is their choice, and it is a new choice that they don't have right now because home hospitalization is not supported by Medicare.

So the criterion that we had the most concern about was the patient safety criterion, and we unanimously felt that it did not meet this criterion.

I think we felt that it could be -- those problems could be rectified. We had some of the same concerns about the Mount Sinai proposal in that we felt that there needed to be careful mechanisms of making sure that the patient was actually getting the care in the home that they needed to be getting in the home because there

weren't people watching quite the same way that there might be in an inpatient setting.

We felt that there needed to be mechanisms for investigating safety problems, unexpected deaths, et cetera, that were not explicitly built into the model. Again, we saw some of the same issues with Mount Sinai.

And both groups have proposed ways of solving that, but we felt that that was sufficiently a concern and particularly because we didn't want to see the initial versions of home hospitalization get sullied by patient safety problems, that we felt that that really needed to be strengthened.

And then finally, health information technology, this is a criterion I think we all struggle with exactly how to evaluate because it does really encourage use of HIT. One of the challenges is there is not really good HIT right now for being able to connect multiple services being delivered in the home.

So the hope is, in fact, that if this kind of a model gets supported and implemented, it would encourage HIT vendors to do a better job of supporting this kind of service.

So that's really an overview of our findings.

I'm going to ask Len and Rhonda if they want to add anything to that and particularly any feedback in terms of the kinds of comments that we got back from the applicant on our model.

Rhonda, do you want to go first?

DR. MEDOWS: Okay. I'm going to start with the patient safety questions.

Initially, we were talking about, okay, now we've got a larger group of DRGs that can be taken care of in the home hospital model. We thought, okay, this is going to be kind of good, and then I started looking at the list of what was included in the expanded list of DRGs, about 150 of them, and it expanded not only in the number, but also in the diversity of the conditions that were going to be addressed. And, again, we were talking about people who were acutely ill requiring inpatient, and there's different levels of severity when you decide to admit somebody because they are acutely ill.

The diagnosis included everything from cellulitis to maybe a simple uncomplicated community pneumonia, maybe -- I'm going to say CHF, could be mild, moderate, and more severe, and there could be something like an acute pulmonary embolism.

So my question that the candidates did address in our conversation was how, one, would the clinicians who are evaluating the patient for enrollment in a program be prepared to make the decision about where they're going to come in. There needed to be protocols, and the more DRGs, the more diagnoses, the more conditions you have, the more you have to have prepared to be able to do that.

On the same hand, if somebody is enrolled in a home-based hospital care program, the team that actually comes in and sees them also has to be prepared to be able to treat a diversity of conditions and disease states.

And, initially, I was thinking only of the applicant, but then when I started thinking about that this could be applied multiple other places that may not have as much of a robust -- and I'd be concerned would they knowingly and willingly narrow it down to within a scope that they could manage and control as opposed to basically looking at all of Christmas laid out and maybe not doing the homework of being prepared.

The applicants did also speak to another question, because as soon as I saw acute pulmonary embolism, I had all kinds of things going on in my head, and they did speak to -- verbally about the idea that if

someone actually was evaluated and was thought to be so acutely ill or not -- let me put it this way. Maybe their stability would still be in doubt for the first 24 hours or so that they could be admitted inpatient first and the moved into a home hospital program.

Tell me if I get it wrong. Okay. Good.

Then we went back and forth a little bit and got additional questions answered about quality measures, patient experience measures, and what Harold talked to about the need to have the system to actually include not only the capture of patient and family adverse events, but actually then to do something about it and to have it matter and count to where the performance evaluation of the program itself.

At some point, I think is when it finally dawned on me, at least I thought I read and I thought I heard, that the physician visit was only telehealth. I'm not saying "only." Don't get upset, anybody. But the idea of only telehealth with CHF, acute PE, those things, it made me a little bit nervous because we're talking about a broader spectrum of conditions and diseases of varying severity. So that was one of the things that we included in our comments about that.

I have no concerns about the RN visits twice a day. I have no concerns about the social worker, the other people coming in, but I was concerned that if they were to limit it to telehealth only, there would be a higher likelihood that they would either, one, not see or be able to assess something for somebody with a more severe condition itself.

And then the applicant, I think responded to our PRT report and said that home visits could be done by a clinician, and it would be included in the bundle.

Okay. That was pretty much it.

DR. NICHOLS: So you both covered everything. I think I'll just say, as Harold said, we had to review it and judge it based upon what was in front of us, and the last response we got from them, which I guess was a response to the PRT report, in my opinion is worth reading for the Committee as a whole before you vote because I think they answered a lot of the questions that we had outstanding at that time.

CHAIR BAILET: Okay. Comments? Tim and then Grace.

*** Clarifying Questions from PTAC to PRT**

DR. FERRIS: First of all, thanks for doing all

the work, and thanks for the submission.

I had three questions for the PRT, and the first one is just to put a fine point on the last exchange you just had. So I read the responses to your questions, and it seemed like a lot of these concerns were addressed in the responses. Am I to understand that your assessment of does-not-meet criteria was based on before and not based on sort of including the answers? Because I was confused by that.

DR. NICHOLS: So we had two sets of questions that we asked them. They answered those before we made our PRT report, but there's another memo --

DR. FERRIS: Right. Yes.

DR. NICHOLS: -- that came after --

DR. FERRIS: Yes.

DR. NICHOLS: -- that was in response to the PRT report. That, we did not --

DR. FERRIS: Oh, I see. Okay. And that's not -- I see. Okay. Yeah.

MR. MILLER: So what they sent in a week ago basically said we want to amend our proposal to include the following things. So we agreed we're not sort of taking last minute revisions to the proposal.

DR. FERRIS: Right.

MR. MILLER: I would say -- and I'll turn to Rhonda to add to his -- my conclusion personally was that a lot of their answers were responsive to what we were looking for, but some of them were not. And I think that some more work needs to be done beyond what they submitted.

DR. FERRIS: Okay.

DR. MEDOWS: And that's true. There were common elements of the program that they could do across multiple DRGs, but they wanted more specifics.

They answered the question about the house visit with the clinician, and that actually saved them from me saying no.

DR. FERRIS: Right, right.

DR. MEDOWS: But that's -- it was really important.

I know we have all the priorities of the different criteria, but for me, I cannot see us going forward with something that is not something we are comfortable with patient safety-wise.

DR. FERRIS: Yes.

DR. MEDOWS: That's why it was a big deal to get more information, and honestly, I think when the candidates

come up and they can speak, it would be really helpful for me to make sure that I hear from them on these subjects and that we all understand what's real, what's not, right?

So if a physician can do a home visit, have they been doing home visits? Is there a training program for the home care providers that are coming into the house, and are there protocols developed? Those are questions for the candidate when they come up, but I think we need to know that before we can agree. It's not enough to have the statement is what I'm saying.

MR. MILLER: One clarification I want to make, because I wanted to make this during the report, is -- and we've seen this in a number of our applications -- when we raised these concerns about patient safety, we're raising them with respect to a model, which would be broadly applicable. We are not saying that we think the folks at Marshfield are delivering unsafe care. Nobody felt that the folks at Mount Sinai were. But the issue is going to be if this is broadly available, are the mechanisms adequate to deal with that.

The other thing I would say that I am struggling with on these things is there is a desire to make it broadly applicable to a wide range of practices in

communities, but we honestly don't know until it gets tried what's going to work there. So it's really hard to come up with patient safety mechanisms that will work.

Some places might have the right resources to be able to put that in place. A community agency, you could look to help with that. Some might not. We just don't know that yet. So that's the other thing I think is difficult to keep in mind is I'm not sure in all cases exactly how to specify it, but what was clear to me was that they didn't even have sort of a slot, an adequate slot in there to be filled in with options for how to do it.

DR. FERRIS: At least initially.

So my second question is actually sort of almost the opposite of this, which is -- and I think it's in here, but I was a little bit confused by it, which is why aren't -- what is the backstop against sending people home with home hospitalization when they wouldn't have been hospitalized in the first place? So that this is always that tricky issue of the trigger. What triggers the initiation, and did you feel confident that what triggers the initiation would be -- like you'd be sort of guaranteed? I know there's no guarantees, but like most of the time, that patient would have actually been admitted to

the hospital.

And just to say the way we deal with this in my hospital, where we have a home hospital program is you are not eligible for the home hospital program unless an ED physician has actually put you in for an admission, and then you become eligible.

And I just wonder if -- because we think about, oh, it would be really nice to expand this to the outpatient setting and let people direct-admit to home hospitalization, but then you worry about the cost implications of that, and are you actually saving money in that case?

DR. MEDOWS: So I think the candidates can speak when they come up, but it is an emergency room physician that is evaluating the patient.

My concern was I wanted it to be a consistent set of guidelines or protocols or whatever that actually helped people decide whether or not they qualified for inpatient, and given the broad range of DRGs, that would be an enormous undertaking.

But I think when the candidates speak, they're going to kind of clarify a little bit about how they did their process, but that's really important, as you pointed

out, because in every other place, it may not be that way without some kind of a guide or some kind of criteria.

DR. FERRIS: Yeah. So there's plenty of literature, and we'll ask them when they come up. But there's plenty of literature to show that the decision that's made by the ED physician --

DR. MEDOWS: Is critical.

DR. FERRIS: -- is dramatically different in hospitals that are full and hospitals that are not full, and that's a --

DR. NICHOLS: And I would call it economics.

[Laughter.]

MR. MILLER: The challenge is -- and both they and Mount Sinai proposed to use InterQual or Milliman guidelines, which, of course, are discretionary things.

We did raise that concern, and you will see in their response to us a week ago, they proposed a mechanism for dealing with it. I'm not convinced it's completely adequate, or it may be a little bit too generous. It was basically if you do a review and as long as they have less than 20 percent were potentially not -- would not have been admitted, that's okay. That seemed to be a bit generous.

I'm not sure that we know exactly how to protect

against that overall right now.

DR. FERRIS: The third question was -- I didn't understand. Could you explain a little bit better what you meant under Criterion 4, that the financial penalty, if a patient had to be escalated in the inpatient unit, because the payment to the hospital for the inpatient would be counted towards the episode spending?

I was confused by that because if they're getting paid 70 percent of the DRG that the hospital got, how do you get credit? By definition, the DRG spending would be higher than the payment.

MR. MILLER: So the point is if the patient goes home and they get a 70 percent of the DRG payment and then the patient gets admitted to the hospital, then the hospital would get a DRG payment. There would essentially be 170 percent of the DRG would be counted towards the episode payment.

DR. FERRIS: Okay. Got it.

MR. MILLER: Or if they went in for a day, they'd get a per diem equivalent.

So the financial penalty was if you admit the patient to the hospital, you're going to have to pay a bunch of money out of your budget, per se, to be able to --

DR. FERRIS: Yeah. That's very strong, actually. Thank you. That clarified it for me.

CHAIR BAILET: Grace.

DR. TERRELL: just a few things. Again, because I wasn't here in September during the Mount Sinai presentation, some of my thoughts may have already sort of been percolated through this Committee.

But one of them is related to the whole concept of hospital at home, which is an old concept. I think I look at the Hopkins model maybe in the early 2000s, in Medicare Advantage products. I know that United Healthcare and one of their MA products had this as a service years ago. I mean 10, 15 years ago. So there ought to be data from that with respect to patient safety, maybe not for 150 DRGs. I think the original one that Hopkins did had three things: community-acquired pneumonia, cellulitis, and one more that I can't think of off the top of my head. But nonetheless, there ought to be pretty robust data from other sources.

So my first question is related to that. What kind of data did you have access to or was provided to you to be thinking about these patient safety issues? Because it seems to me, Rhonda, that you were articulating. Your

concern about patient safety was about the breadth of the proposal and readiness.

The other thing that's related to that is that the whole concept of hospital at home is exactly opposite of the way we think about everything else. Everything else we're talking about, a model of care, and then we're plopping a payment around it, right?

Okay. So we're talking about service first, and then we get concerned and all consternated if we can't come up with how to pay for it to make everybody happy.

This is actually about a way of service has been provided at a facility that we're trying to translate into a new place with the assumption being that there will be possible savings in terms of cost because there's no facility and in terms of their being possibly higher quality because you won't get killed from being admitted to the hospital with all the iatrogenic things that might happen to you and still get the same type of service.

So as we are pondering those things as a PTAC, that to my mind is a really different thing, which means that as you're thinking about data, it ought not to be just things like the Hopkins model of hospital at home, but a broader bundle of services that have been provided before

in settings like that that didn't start with a hospitalization.

So, for example, there's a lot of congestive heart failure models, which have been from care models where somebody didn't pop to the ER that are now part of ACOs, where services are being provided at the home as a continuum of outpatient. So there is all this data out there about ER avoidance.

So I guess my point in all this, as we are thinking about patient safety and the concerns about that, what I don't want us to get into is what used to happen when ambulatory surgery centers were first starting to take cases out of the hospital that were perfectly safe to do in ambulatory surgery centers.

The hospitals shouted safety, safety, safety, safety, safety, when really they were talking about red marks on their bottom line, as we found that it was safer to -- or just as safe or adequately safe to provide things in another setting.

So, as you're thinking about patient safety and the broad things, what kind of data did you have to think about above and beyond just somebody got to the ER and maybe we need protocol? Was there ability to think about

some of these earlier programs like the Hopkins early things or even the data from Mount Sinai, and is there a way of actually thinking about the bundle of services that are provided that happen to be able to be provided as a result of ACO type of behaviors that are the same? They just didn't start with somebody popping at the ED. That could really get at some of these patient safety issues because that's a pretty big amount of information that might be out there.

DR. MEDOWS: So we took in -- or at least I did -- quite a bit of that --

DR. TERRELL: Okay.

DR. MEDOWS: -- into consideration. My concern was more those DRGs and the range of severity that have not been traditionally included in a hospital at home and that are usually not treated in an outpatient or an ambulatory or a home setting for at least until after the original acute treatment and stabilization phase has been in place.

And so I keep going back to the example of the acute pulmonary embolism. That is typically not treated in the hospital at home, and it's typically not something that you in that first 24 hours usually can send them home with the services. After that, you can, and that's been proven

that we can do --

DR. TERRELL: They're not about pulmonary embolisms, though, where there's examples where they have not been admitted, they have to meet certain criteria, and, you know, where there's data out there. And I don't know -- again, of the 150 DRGs that are out there, if there's data out there from other sources now that say these are the criteria for which we don't have to think about hospitalization because there's evidence to support it --

DR. MEDOWS: If there's evidence to support it, I would agree with you, Grace.

DR. TERRELL: Okay. So do we have that --

DR. MEDOWS: If there's not evidence --

DR. TERRELL: -- because if we do --

DR. MEDOWS: If there's not evidence to support it --

DR. TERRELL: Yeah.

DR. MEDOWS: -- I don't think that this is the place to take that risk, without some kind of guidelines, some type of plan to actually do the observation, do the study, and not put people needlessly at risk.

MR. MILLER: So let me clarify.

DR. MEDOWS: All of the other things that are on

that list, that have been tried and true, and we know we have the medical advancement, we know we have the technology, we know we've actually got evidence-based proof of service, not a problem. My concern is that it's broad --

DR. TERRELL: Yeah.

DR. MEDOWS: -- I don't see the information laid out, I don't see the criteria laid out, and giving this -- and taking this and then putting it in different places without those tools in place, without that line of sight, I have a concern with.

DR. TERRELL: So if the data is out there, though -- so, for example, the 150 DRGs, if there happens to be data out there -- I mean, my concern is that innovation in the space of care is always -- there's an arbitrage between patient safety, which I think sometimes is just an economic, you know, battle cry, unless there's evidence one way or the other. I mean, they used to lay women in the hospital for six weeks after having a baby. It wasn't good for them. They had pulmonary embolism and died, but that was the standard of care.

And so it really needs to be about the evidence that's out there with respect to this. And so my question

is, are the 150 DRGs, and the way they provided it, is there levels of evidence out there for which you could get around the concerns about patient safety?

MR. MILLER: So let me clarify.

DR. MEDOWS: Not that I am --

MR. MILLER: We -- we --

DR. MEDOWS: -- not that I am aware of, and I would think that -- I want to make it clear on the record that my comments are not about the economics or the need to actually meet a hospital admission criteria or a quota. It's about the actual patient safety itself.

DR. TERRELL: Suggesting that if you -- I'm just saying that that's often used to slow down things when there's actually no evidence that an admission actually improved safety, and we kind of default to it. But I often think that actually makes things less safe if the services can be provided elsewhere.

DR. MEDOWS: We will agree to disagree.

MR. MILLER: Our evaluation of safety was not about the care model per se. We felt, and we felt this on the Mount Sinai model, that home hospitalization has been shown it works. Australia is doing it in a major way, et cetera. The issue was with respect to the payment

methodology and whether there was appropriate assurance that when somebody new started to do this, particularly in an area where they might be on the margin of financial sustainability with this model, whether or not it would raise patient safety concerns, and there were adequate protections against that.

So it's not -- we were not saying we don't -- we are concerned that home hospitalization is unsafe -- and I'll make two points on this -- that that was unsafe, the issue was how do we know for sure that a particular participant delivering this is not stretching the boundaries inappropriately? Then the second issue was that most of the research that has been done did not extend to the full range of DRGs.

The challenge is what we have seen in Mount Sinai and other places is that they are not restricted either to a particular set of DRGs, but most of them have focused on a certain set of diagnoses, and in most cases, and including the folks at Marshfield who are doing this with a broader range of DRGs, most of the patients they are taking care of are in the more common cellulitis, COPD kinds of categories, et cetera.

So it's hard to know, back to Rhonda's point,

exactly how to assure that the care is being delivered safely and which patients are being picked when you're picking diagnoses that haven't been done routinely, broadly, and evaluated in the home area. So again, that's why we're sort of adding the extra things.

CHAIR BAILET: So, Harold, I'm sorry to jump in but one point in clarification. We did speak with the submitters and we did express a concern about the level of training of the staff for the hospital home model previously. So I just wanted to say that there was concern about the actual safety beyond. It wasn't just centered around the economics, and I believe that was captured in the letter to the Secretary. And I see Paul shaking his head. Is that -- I mean, that's how I remember it. I recall actually having that discussion.

DR. CASALE: Yeah, I remember that as well.

MR. MILLER: The distinction here, again, is that they have a much broader range of diagnoses potentially available than others, and the concern, again, is not about Marshfield or whatever, but if all of a sudden you have some small practice somewhere that wants to do this, and is struggling with the how to make the service financially viable and whether it takes on patients, stretches the

boundaries in terms of who should go home in order to be able to make the numbers work, then how do you protect against that? That's the only issue we were raising.

DR. TERRELL: If I could just finish my point.

CHAIR BAILET: Yeah, that would be great, and then Bruce.

DR. TERRELL: The default assumption in all of that is that the hospital is a safe place, okay, and it's not. If there is at all the possibility that two services can be provided, there is an equally bad economic incentive, under the powers that be, to admit somebody where they get a really high payment for a DRG for services that may well be provided in other non-hospital settings.

So the patient safety concern is asymmetric here, and that's my concern with overemphasizing it, because it's really easy to not realize that if you're too concerned about the patient safety as being a wrong or improper incentive on the part of people trying to keep people out of the hospital, my God, we ought to be able to worry about the patient safety issue of why aren't they doing more of it? Why aren't we expanding every possible DRG that we can possibly keep somebody out of the hospital?

So there has to be a happy medium, and one of my

concerns about the focus of patient safety is almost always under the default that the facility is the safer place, and that it is almost always the case that it is not, if it can be provided elsewhere.

MR. MILLER: Yeah. Can I just -- the other thing that you -- I don't want to lose your earlier point because I think it's important. You also raised a second point, which is that this is sort of narrowly focused on patients who need to be admitted today, and that one of the things we talked about back in the fall was that if, in fact, we could get a broader suite of home care kinds of services available for patients, not just patients who need to be admitted today but patients who need care at home. And the palliative care discussion we were having earlier feeds into that also.

Because one of the things that makes this model challenging is if this is the only patient population you're dealing with then the volume may not be big enough to support those home nurses and everything else. If you, in fact, could be delivering a broader range of home-based services, it might actually be easier and those financial pressures would be lower. But we don't have a comprehensive set in front of us. We have these one-at-a-

time things right now.

VICE CHAIR MITCHELL: I just want to briefly associate myself with Grace's concerns. I wouldn't want the default to be that the hospital is safer, ever. I am wondering if there is data that shows that -- you know, it compares, just sort of hospital safety records versus anything else. And so I just would not --

MR. MILLER: There are.

VICE CHAIR MITCHELL: -- want to start with that assumption that it is safer to be in the hospital, because I'm skeptical.

DR. MEDOWS: I think if you are having a debate about whether or not care is safer in the hospital than at home, let me ask you the question, though. If your child has meningitis, where do you want them to be?

DR. TERRELL: Well, if it's a viral meningitis, there's no evidence of bacterial meningitis --

DR. MEDOWS: I'm talking to her.

DR. TERRELL: -- I don't want them to get into a hospital --

DR. MEDOWS: Thank you.

DR. TERRELL: -- where they're going to give them C. difficile and kill them.

DR. MEDOWS: I'm talking to her.

VICE CHAIR MITCHELL: It clearly depends on the condition, but I would just not want to default to that being the comparator.

DR. MEDOWS: I am not saying default. I'm saying not making assumption that because this is a hospital at home that anybody can just be put in their home and treated at home. I am saying at least have the evidence, at least have the proof, and if you don't have that proof then, no, I would not agree with actually making that change. That's what I'm saying. There's a difference of opinion here and that's simply the way that that is.

CHAIR BAILET: So we have a lot of placards up. This is how I have air traffic control here. Bruce, if you push your button one more time, I mean, I'll feel guilty. So Bruce goes, then Bob, then Kavita, and Elizabeth is done. Okay. And then Paul.

MR. STEINWALD: I want to raise my mundane DRG issue that I raised before, and you did recognize this in your PRT report, and I acknowledge that. But I could not find an answer to the question I'm eventually going to ask here. So you take -- let's say in a given hospital you've got normally 100 patients in an MS-DRG, and you're going to

take 10 of those patients, 20 of those patients and enroll them at hospital at home. Those 20 patients should have been less resource-intensive and therefore less costly to care for in the hospital, if they had been admitted and gotten their care in the hospital. For the very fact that they're eligible to be cared for in the home suggests that they're less severe, they're less resource-intensive.

Now, the entity gets paid only 70 percent of the inpatient DRG payment that they would have gotten if they had been admitted, and yet there are a lot of things that are separately billable, as you pointed out, different from the model in the fall.

So my question is, does that 70 percent in any way relate to the lower severity of the patients and the less resource-intensive they would have been if they had gone into the hospital, or not? And I guess if so, why not? If not, why not?

MR. MILLER: Again, I think that's probably a question best directed to the applicant, but my answer to that, at least my understanding is no, that's not what it's based on. It's based on their estimate of what it is that they would need to provide in terms of nursing support to those patients. The 30 percent -- because that's what the

70 percent is paying for -- the 30 percent is to cover the other services that would be separately billable, and they are trying to -- they are controlling that by the overall episode payment.

This proposal -- I think it's important to be clear -- this proposal is not per se designed to save a lot of money. It's designed to be able to have patients have a home care option and to have better quality as a result of that, at no higher cost. And again, the applicant can clarify if they don't believe that, but that's really the structure of it. It's 97 percent of the episode spending.

We had some concerns about the fact that because, to your broader point, if these patients are lower intensity, particularly on the post-acute care side, then 97 percent of the average -- they wouldn't have really spent 97 percent of the average. They might have spent a lot less than that. But that really applies to the episode spending, not necessarily the hospitalization.

MR. STEINWALD: Okay. So just to clarify, the added 30 percent is intended to cover separately billable items that the hospital would have had to provide if the patient had been admitted.

MR. MILLER: Yes.

MR. STEINWALD: Okay.

DR. NICHOLS: If I could just add, Bruce, I think one thing we haven't talked enough about in proportion to what we have talked about, is this decision that's made to put somebody at home has as much to do with the situation at home as it does with the condition of the patient. So some homes can take it, some homes can't, and that's why, in essence, you don't have the selection driven totally by acuity. It's driven by a combination of SES and --

DR. BERENSON: Yeah, but Bruce raised the issue exactly that I was going to raise. I will just raise the stakes a little more on them, which is, that side-by-side was very helpful, how Mount Sinai worked and how this one works. It seems to me a crucial difference is the different entity that is receiving the money. When it goes to Mount Sinai, it is one pool of patients with pneumonia, and they're making a management decision whether it goes home health -- I mean, hospital at home versus inpatient. Here's you're, in effect, siphoning off the healthier people. What happens to the average DRG for the hospitals remaining in the community I think has to be addressed because they're going to have sicker people.

This is very similar, in my mind, to the

specialty hospital situation, where the heart hospitals or the hip hospitals, the bone hospitals, pick off the healthy people. The community hospital is left with all the sick people. Unless we deal with the observation stay versus the inpatient stay really rigorously, there's the potential for creating more hospitalizations than otherwise would have happened. And I think there's more merit in trying to solve those problems here, because I am a believer in hospital at home, but these are -- I didn't see any attention to.

So that's the issue. What happens to the hospital DRG payments when the ambulatory facility, PRC operators, is getting the revenues from the healthier set? So that's one issue I would raise.

And a related one is this issue. I have now, for a separate activity that I'm involved with, have looked at the data on the distinction between observation stays and inpatient stays, and the OIG did a report prior to the Two-Midnight rule that came out of, you know, two years ago, in which greater than a quarter of the 24-to-48-hour stays were designated as inpatient, about three-quarters designated as observation or outpatient, and there was no clinical difference amongst those patients. It was just a

function of what hospital they were in, and the hospital's decision to call one an inpatient stay and get $5,000 more, on average, for a DRG than they would have gotten for the observation stay.

And so I think that has to be nailed down. I'm very happy that they have now started talking about this issue. This current letter says we'll have the max sort of review, I guess case by case. We'll be asking them about it.

But it is interesting that the CMS -- I had to review the regulatory criteria that CMS has about the distinction -- they're not based on InterQual or Milliman designations. It's a whole different regulatory regime that determines whether something is observation or inpatient. It's useful to have the max involved, but whether that's a practical solution in the long term, I'm skeptical, because they can't do it for inpatient, I mean, currently.

So, in any case, I think that's a huge issue, because if you put the two things together you have -- I won't use the word "cherry-picking" -- they are appropriately siphoning off healthier people within each DRG, and we're not adjusting for the hospital residual

patients, and I think there is an opportunity to call things that otherwise would not have been inpatient stays, inpatient stays. Having it come through the ER is a protection, but maybe that's not the best way to do it, because maybe you do want to have direct admits to hospital at home.

So I think those are two real practical issues that have to be addressed in this model.

MR. MILLER: So I would just observe, first of all, that it's the Marshfield Clinic, which has hospitals, that's bringing this forward, so in that sense they're somewhat parallel to Mount Sinai in the sense that they will also experience that problem. But I think that --

DR. BERENSON: Can I just hang on for a second? I was confused as to whether this was a proposal for Marshfield to do a demo or was this a model that would be more broadly --

MR. MILLER: It's broadly. The same with Mount Sinai, it was broadly. The issue is the people who are doing it now actually do have a hospital.

But I think your point -- we raised this back in the fall -- I think we are spending a lot of time talking about physician payment models. We need to talk about how

to pay hospitals different as part of that.

The concern with respect to this is fundamentally the same as in every one of these models. When we talk about primary care physicians reducing ED visits and hospitalizations, we're talking about taking what are, in effect, the lowest acuity patients out of the hospital. And when we talk about readmission reduction effort we're talking about the same thing. And I'm concerned about particularly the small hospitals.

I just looked at some numbers recently, and this was back in Washington State, I looked at the numbers. And I took the percentage of total discharges from the hospital that were in DRGs for uncomplicated asthma, cellulitis, COPD, heart failure, et cetera. Those represent 25 percent of the admissions at very small hospitals. They represent 3 percent of the admissions at the tertiary and quaternary hospitals. So the people that are going to get hurt by those initiatives are a lot of the small community hospitals which, in fact, are right now on the financial brink.

So I think we do have to find a way to address that overall. That, to me, does not argue against creating a home hospitalization program to benefit the patients, but

I do think that we need to be making that observation that hospital payments need to be fixed too, and not just physician payments.

CHAIR BAILET: Kavita.

DR. PATEL: I had a question about the 70 -- I'm trying to remember -- the DRG. Did you all -- it looked like, in your transcript, you might have gotten into it, but if I look at these DRGs that are in here, I mean, just the variability on them are just pretty wide ranging. So is the 70 percent just trying to be kind of an arbitrary -- almost somewhat arbitrary approximation for where we would hit? And did you all talk about this huge financial interval on both sides?

MR. MILLER: We did raise that issue explicitly, and there's a, you know, two-to-one or more difference between the DRGs. And, theoretically, you're taking, at least we were seeing it, potentially, theoretically the same patient acuity out.

Their argument -- and they admitted that it was not perfect, and we're willing to consider other things. Their argument, which I think is credible too, though, is that in some sense the DRGs differ based on length of stay, and so, in a sense, they're going to be facing the same

issue in terms of cost based on longer length of stay that the hospital would maybe even more so. The hospital might not, you know, might not be more intense at the beginning and less at the end. Who knows for them if they're doing two visits a day? And again, you can ask them that.

But basically the argument was a lot of the higher-weight DRGs also have a longer length of stay associated with them, which would turn into higher cost for them in terms of the number of patient days.

DR. PATEL: Okay. And just one more. Since the kind of payment includes that 30 days but it excludes professional fees, I'm assuming that this would mean that when the patient -- how would, like, a primary care visit for, like, a transitional care management or some sort of follow-up visit from even a hospital-at-home stay be handled?

MR. MILLER: It gets counted towards the episode spending and the model. In that sense it's kind of like BPCI. You know, all those things would be added in. The one thing that they're trying to do here is they're basically saying, there again, it's not restricted to that but the vision is that most of the physician contacts with the patient at home would be by telemedicine, which would

not be billable, and so therefore that's being factored in there in that fashion.

DR. PATEL: And again, an assumption, then, that that entity, PRC, the entity would be kind of almost this ubiquitous entity that could handle both the hospital at home as well as potentially the follow-up. Is that -- did I hear that correctly, or no?

MR. MILLER: Well, the model that they're proposing is that there would be a nurse, a recovery care coordinator, who is sort of overseeing the patient's care for the full 30 days. There's an acute phase and a post-acute care phase. The post-acute care phase, in some sense, is the same as post-acute care today. If the patient would happen to have to go to a SNF for post-acute care, that would be counted towards this episode spending.

Our concern was if the patient could be cared for a home, the likelihood would be that they wouldn't be going to a SNF, so their cost would be lower. But everything sort of post-acute would essentially be billable under standard Medicare payments, other than this recovery care coordinator.

DR. PATEL: And just one point of information. Grace, there was a Cochrane review of, like, the hospital-

at-home model, and it was really around, like, COPD -- it was selected conditions but it did show strong evidence, in a limited number of randomized trials, that it did improve outcomes, in terms of clinical outcomes for these discrete conditions, patient satisfaction, and then it was considered potentially not necessarily cost savings, because they were trying to account for the cost of, like, caregiver time and kind of time like that. So there's been pretty decent reviews.

CHAIR BAILET: Paul.

DR. CASALE: Yes. So just a few comments on the conversation around safety.

Having led quality for a health system for many years, I'm certainly not one who is going to argue about safety around the hospital and certainly issues.

On the other hand, when you look at the support again over this wide set of DRGs of a telehealth visit with a physician and an RN in the home, I have to say that that to me is somewhat untested across all of these DRGs.

And I remember I had this conversation -- and I'll ask the submitters. I had asked Sonar when they were here because I think they were sending out a nurse practitioner to the home, and I asked what's the training

for them. Obviously, there's a variety of abilities, and any of the physicians around the room who have dealt with home health services for many years, you know that there are great home health nurses, and there's some that are not so great.

And so, again, looking at the wide variety of DRGs, I have, I think, similar concerns that Rhonda has raised around ensuring the safety, unless I have a better understanding of sort of the training and the communication.

And to Kavita's point, if you're going to treat cellulitis at home for a few days and it's sort of the team is the ER doc and the -- but how do you get the primary care? You don't need to wait 30 days to get primary care into the -- they're the ones who know the patient. So you'd really like to get them into this sooner.

MR. MILLER: Their model -- again, they can explain it better than we can, but it's not 30 days and then you talk to the primary care physician. The idea was you would -- they would -- again, whether the payment model requires it, the way they do it is they get the primary care involved early, and then there's -- the one thing that's in the model is that there has to be a visit with

the primary care physician scheduled within X number of days after discharge from the acute phase.

Not a requirement that the visit occur. It has a requirement that the visit be scheduled, which was a concern we raised about the quality measure, but it's not like they take over the patient for 30 days and then they go back to the primary care physician. It's more similar to a typical transitional care kind of an approach.

CHAIR BAILET: Grace.

DR. TERRELL: There's a couple of things. In response to what Bob was talking about with respect to if all these people are at home, what's left are the more critical ones, one of the assumptions in there may be that there is a fixed amount of people out there with these needs. But we've got a demographic going on right now where we're going to be needing to take care of an increasing number of people with a limited amount of resource.

Our models over the past few years have been about a DRG, where some of them will have less acuity. Some of them have more acuity. They should all be medically appropriate.

It's 20th century mathematics that's based on

statistical averages from which we figure out a margin of profit based on the expense versus all that. In a world where we end up with the boomers and the demographics, this may be a solution to a problem where the hospital is going to be doing what it ought to be doing, which is taking care of the ones who really ought to be there, if all the appropriate types of work is done around that particular issue of who ought to be in a hospital and who ought not to.

It dawned on me a few weeks ago that most everything that Harold Miller talks about is really precision medicine with respect to payment system, which is this is what this person precisely needs here, and this is how you ought to pay them for that precise service. And this is a broader issue.

Every time we worry about or talk about picking off or cherry-picking or something like that, it's because our financial models had been based upon averages from which we're thinking about payment systems with sort of bundles of people that are in there. As we get better and better, whether we're there now from a patient safety standpoint or not, it's saying this person ought to be in the hospital, this person can certainly not be in the

hospital, number one, it's a way different economic model than anything that we've got set up now.

So a lot of the work that we're doing here has broader implications for everything that's going on right now in oncology and elsewhere with respect to precision medicine, where we're going to be able to say this person needs that, this person doesn't need that. So we probably need to be thinking about that more broadly.

I would also say, though, that what we're talking about with the hospital is not just a hospital issue. Primary care physician practices have been dealing with this for years. It was easy to see a bunch of people with cough and colds. You got paid the same amount than somebody who came in with congestive heart failure and five other chronic conditions, and by having that bundle out there, you were able to sometimes stay in business. But you couldn't just take care of all sick people because of the economics of it.

Just like Clay Christensen has said and all his health care innovators and elsewhere, as stuff moves downstream and out of the place where you don't need those costs, you got to change everything, right?

And so if the issue, Bob, that you're talking

about is, well, we've had this model where there's been these different folks and they're moving elsewhere, that's not just in the hospital. I mean, it's been going on for years -- for hospitals with respect to what outpatient medicine could do has been going on now with primary care with what CVS Minute Clinics can do, and our issue may be to actually do what Harold has been talking about for years, which is to say, okay, if this service moves here, if it's appropriate, how are we going to pay these new people what we ought to pay them or these old folks what we ought to pay them relative to the way we used to do it.

So payment model really has to be looked comprehensively. Every time we move a service out, the way we used to do it changes as well, and it's really going to be having to think about things not so much more as average sort of Bell Curve ways of thinking about it, but precisely what does slicing the pie, the precision level going to do to all the basic economics we're doing. Nothing we've got is set up to do that right now.

CHAIR BAILET: Thank you. That was a good discussion.

I wanted to thank the PRT and the Committee for the engagement and the work that was done up front, which

sets the table for our submitters, who have been patiently standing by, taking it all in. I've watched Murali sort of following word for word.

So if you guys could please just come on up, turn your placards over, introduce yourselves, and you guys have 10 minutes to address the Committee.

[Pause.]

*** Submitter's Statement, Questions and Answers, and Discussion with PTAC**

CHAIR BAILET: Welcome.

DR. MURALI: Thank you, Jeff. Thank you, the entire Committee. This was a very, very interesting exchange, and I'm glad we heard all of this.

I think we'll start this stage by just sharing where we started this proposal. The Marshfield Clinic Health System is a premier rural integrated health delivery system, and our focus has been on the value journey since 2000. We were part of the first transitional demo with CMS, where we saved CMS about $112 million, and then subsequently, we went on to become the Medicare shared savings program. And our present quality scores as of the most recent data is at 98.54 percent, the highest perhaps in terms of the quality measures.

In terms of an organization that has been focusing on how to provide care, where your Medicare to labor ratio is approximately 4 to 1 and we live in a sea of red, you see the older, sicker population. And we were trying to see how best we can advance innovative care outside the standard gambit of how we provided care previously. So that's really where the journey began.

We moved on to the ASC and the comfort and recovery suites model. When we started it, it was essentially said, "You can't do this," and we said, "Well, look, we're going to do this." And as of last year, we did about 800 patients just in one center, where we moved about 30 percent of the hospital volume of bilateral knee procedures up to gall bladder surgeries up to gynecological surgeries and urological surgeries outside the hospital setting in the comfort of recovery suites with phenomenal outcomes. We have one of the best patient experiences in terms of that scores as well as the quality metrics.

The length of stay dropped by approximately 54 percent than what they would be in the hospital.

Now, as the president and CEO of a hospital system which is going to have six hospitals before the end of this year and also overseeing 55 clinical locations, it

is in my best interest to keep those patients in the hospital, but 10 percent of those patients who are in the hospital develop post-hospital syndrome. So they come into the hospital with a different disease than they ever came into the hospital in the first place.

So much of our focus has been how do we improve value for outpatients, and being a physician led organization -- Dr. Montoney, a physician; myself, a physician; and an entire clinic board of physicians -- our focus is how do we provide care different from a hospital system, so that's where the journey began.

Now, going back to telehealth, as a nephrologist, I have used telehealth since the time I joined the Marshfield Clinic Health System back in 2006. We started using telehealth back in 1998, and that was the way I took care of all the little old ladies, 84 years and above, with CKD Stage 5, with significant heart failure, 200 miles from where I was providing care.

So the first visit would be with the patient, where they're physically examined. The second visit, I could manage her edema, her heart failure, her kidney disease to the point of requiring dialysis at her home setting. So there's a lot that can be done in the virtual

ward.

And this model is actually a natural extension of that. So when the patient comes into the ER, after the ER physician decides that that patient needs to be admitted in the hospital, a hospital physician, who is overseeing that patient, examines the patient and decides the prescription. That is the time the patient transitions to the home, and in the home setting, we're able to provide pretty much all of the care that is necessary.

Rhonda did mention about her concerns the last time. The fact that the physician sees the patient by telehealth does not exclude the physician from physically going and seeing and taking care of the patient.

I have the HIPAA permission from my chief medical officer who most recently was admitted with complicated diverticulitis in the hospital at home model, and I happened to be the physician who took care of him the next morning at his home. So these are things that you could do very effectively.

So, with that, I will stop and transition to the rest of the team who are closer to this and should be able to answer many of the questions that you have raised.

MR. MESSINA: Thank you, Dr. Murali.

I want to thank the PTAC and also the PRT for the time that we spent thus far. I know there's been a lot of questions, and it was exciting to hear the extensive dialogue, as Dr. Murali stated.

I am Travis Messina. I am the chief executive officer and co-founder of Contessa, the partner to Marshfield Health System and part of the Personalized Recovery Care, LLC.

The only thing that I would add to Dr. Murali's comments and Aaron Stein, who is with us, and Dr. Montoney as well, we can pretty confidently address a lot of the concerns that were raised during the discussion earlier.

A couple comments that I would make is, first and foremost, I would like to point out that we want to underscore the flexibility that we have as it relates to a submitter to PTAC, and our intent in providing the response to the PRT's report was not to cram something through at the last minute, making modifications, but really, most importantly, hearing the concerns or questions related to patient safety and trying to address those issues, coming up with modifications such that we could address what we feel is the most important part of a home hospitalization program, obviously the patient safety.

Lastly, what I would state is the fact that, Harold, to your comments about the program not being intended to make massive -- I'm paraphrasing -- but generate massive savings, we really did try to balance how do we get higher utilization of home hospitalization clinical models while generating savings for CMS and also balancing the concerns that were expressed in the PRT's report related to excessive risk from a financial perspective being borne by an independent physician practice. So we tried to take that all into consideration as we modified our proposal to generate, like we said, efficient administrative capabilities, while also holding clinicians accountable for the care that they would deliver.

So thank you for the time. I look forward to the discussion.

DR. MURALI: Travis, I think we should share about the fact that we put that 10 percent savings cap because anything that is above that transitions back to CMS.

So, in our model -- because it's unpredictable as to what kind of cost you're going to get. In our risk model, what we've done is we've essentially allowed and put

a cap, and anything above 10 percent that comes in as a savings automatically goes back to CMS.

MR. MESSINA: I think that was clearly stated. I didn't know if it was clear in our response, but the intent was because there could be question around significant reduction cost limiting that savings amount.

CHAIR BAILET: All right. Thank you, guys, for your thoughtful comments.

I open it up to the Committee members starting with Bob and then Grace.

DR. BERENSON: Picking up the issue that Bruce and I raised, shouldn't you be getting paid differentially less because of estimates of favorable selection of the DRG population you'll be caring for at home?

MR. STEIN: Great question. I'm Aaron Stein, COO of Contessa.

So we actually did think about that, and we do agree that there are certain patients that are clearly not going to be appropriate for a hospital at home program.

So in the baselining that we had in our original presentation, we actually said we would exclude certain individuals that would clearly not qualify.

So one example of that is folks that are in the

ICU. So, as we start thinking about this 151 DRGs and then you start thinking about who is in those DRGs, we clearly are not intending on treating an ICU patient in our program. So for those, we would actually take them out of the baseline.

Now, I like the other comment that you had brought up, Grace, before about the fact that ultimately, I think we're in a world of averages, and it certainly wasn't our intent to say we should baseline and just take the average cost for these individuals across the board. And what we've done both with private payers as well as Marshfield Clinic is we looked for what's a reasonableness test for the individuals that would actually be treated in a hospital at home program.

So it could be that because when we look at the set and the average, you end up with a percentile rank of 80 percent, that to me, as a businessperson, would seem unreasonable then to go back to Medicare and say, "You should pay us the average cost for this episode as an 80th percentile. So I think it's about rationalizing both the patient population and also looking at the averages and what may be distorting some of the averages, i.e., do you have a tremendous amount of long-term care patients that

may be treated for something, and clearly, we're not rendering hospital at home in nursing homes.

CHAIR BAILET: Grace.

DR. BERENSON: Let me just follow up.

So I didn't follow that. Are you saying that the model is amenable to continuing -- well, to consider paying less than 70 percent of the DRG because of documentable favorable selection?

MR. STEIN: Yeah. So I would say there's two components, obviously, to the payment that we went through before. I know I heard you guys, some lively debate.

So there is this 70 percent of the DRG, which is meant to really be a cash-flow payment. It's for physician groups to be able to administer the program.

Then there's the episode expenses, and where we focused for the type of analysis about which I just spoke would be really along the episode cost. So we would make sure to rationalize the episode cost.

Now, if the physician group came in above the episode cost and let's say it was the 70 percent of the DRG, obviously the physician group would owe CMS back whatever the excess was. But the intent would be to rationalize the DRG payment up front.

So when we talk about DRG, it would probably be useful to mention when we talk about DRG, we're essentially talking about a link for an episode of care to a measurement of risk, not necessarily what the DRG represents in hospital billing, where essentially all the patients paid the same outside of outliers. So, as we look at this, it's a matter of rationalizing what is the DRG payment that the group would get excluding those folks like the ICU and then taking 70 percent of the DRG and then being able to pay that to the physician group.

DR. BERENSON: Are you basically saying that MS-DRGs are granular enough so that it's a homogeneous population within those DRGs that you don't have to do any additional risk, case-mix adjustment?

MR. STEIN: No. I wouldn't say it's perfectly homogenous. There is no doubt about it. We have certainly seen the variability in analyzing a lot of different Medicare Advantage plans especially and certainly commercial as well. Not every patient looks the same, but again, that's why it comes down to being able to look at the statistics behind the DRG and then be able to make the payment off of that.

DR. FERRIS: Can I Just jump in? Because I

wanted to follow up on the specific point.

So I think in the last two months, two papers have been published that show the costs of home hospitalization are -- the actual costs of delivery of the service are about 80 percent, and actually, that confirms to the number you just said. So are you saying the 70 percent is a discount on the 80 percent? Because it's basically you're saying this is less than -- we're asking for a payment that is less than what our costs are under this model, but we're doing that to acknowledge precisely what Bob is getting at.

Did I understand that correctly?

MR. STEIN: So the intent wouldn't be to -- the intent wouldn't be to charge Medicare below the cost of administering the program, although it's certainly possible that a practice could have a margin on a specific patient or two, and certainly, we would expect it to go the other way around too, where given a large enough population, you would expect that some cases would generate a loss.

I'm familiar admittedly with one of the studies that I know was a small patient volume up to date, but I know it's certainly generated savings, obviously, in the outcome in that study as well. We didn't see at least in

what we reviewed in the escalation, so certainly something that would have been included in that would have been patients that were escalating. So, in those cases, we certainly would expect a negative margin in the episode because Medicare would have had to pay that.

Did that answer --

MR. MILLER: Can I Just jump in, though, to clarify? So whether home hospitalization is 80 percent or 90 percent or 50 percent, their 70 percent is not the whole home hospitalization cost. It's only their subset of the services, and then there would be other things billed.

Except for them -- and they weren't able to give us really any numbers because their numbers had been small so far -- we don't really have any good numbers as to what that looks like right now, what is 70 percent of the DRG plus the billings, the separate billings under Medicare to sort of see how that comes out. And then there is these two pieces. There is the question of what's the cost to keep the patient at home and what's their post-acute care cost going to be.

I'm more concerned on the post-acute care cost side because if these patients can be home in the first place, the chances of them needing to go to a SNF after

they've been at home seems a little bit like a stretch.

MR. MESSINA: Can I respond to that?

And that's where the intent of having that 10 percent cap on the savings comes into play, and that in the event that there is limited pac utilization, those benefits would accrue to CMS. And that was the whole intent. Because of the limited dataset, so to speak, with respect to hospital at home in any market, we wanted to have the ability to appropriately track and identify that spent, whether favorably or negatively.

MR. STEIN: The other thing that I would add is, as we designed our model, there's obviously a lot of coordination that is required here, and what we thought about is the mission of PTAC, and obviously all the activity that's happened since ACA is essentially getting physicians to take more accountability and be able to do more. And as we thought of some of the other models that are out there, like the Johns Hopkins pioneering this in the United States, it is certainly very suitable for a hospital system to be able to render this type of model, and as we thought of how do you make this more mainstream and get more practitioners being able to do this, we started looking at, well, it wasn't reasonable to say that

physician groups are going to start acquiring home health agencies.

So we started bringing all of that together in the episode of care, even though the physician group wouldn't be directly accountable for some of the stuff, especially in the post-acute phase of the episode.

CHAIR BAILET: Grace.

DR. TERRELL: Just a couple quick questions. One is it would seem to me, just like there is now some waivers where you can do a direct SNF admit from home, that there may need to be in the future some work around if you did hospital at home, could you do a direct SNF admit as opposed to having to go back through in your model.

Then the second one is I was wondering if you could comment please on Dr. Medows' concerns with respect to how much you've actually fleshed out the breadth of your proposal with respect to the 150 DRGs in terms of protocolization of the actual criteria that would actually address your concerns about safety.

DR. MONTONEY: Yeah. Hi. This is Mark Montoney. I'm the chief medical officer for Contessa Health, and I really appreciate the concern.

I previously served as a CMO for three health

care systems, and I spent more than my share of time in root-cause analysis and patient safety events. I really put patient safety as paramount.

I would start by saying we were appreciative of Dr. Leff in Johns Hopkins pioneering this 20 years ago and others, including Mount Sinai, following and really gaining experience, and they started really sort of in six clinical conditions, expanded to eight, and that's exactly where we started.

We kind of took the crawl-walk-run attitude, and we thought, okay, we want to get comfortable with this. And we did, but we also found that it was rather limiting because patients don't always come through the emergency department and clearly put themselves in one of those six or eight categories.

So it's more like got a history of diabetes, history of CHF, COPD, they come in. They're got an infiltrate, maybe a low-grade temp. It might be the infiltrates may be their CHF exacerbation. It could be early pneumonia, and we were really challenged because we couldn't clearly put them in one of those categories.

Being able to expand into a general medical protocol, which really asked the question would this

patient be appropriate for a general medical bed, so that's when we started to ask ourselves the question.

And then we had protocols -- I should say have protocols for all eight of those initial clinical conditions, which by the way are still the 80/20. I mean, that's patients -- their final DRG winds up most of the time in one of those buckets.

But we found that this gave us a little bit more latitude that we didn't have to absolutely put them in one of those categories for several hours, and it expanded things. We are able to create a general medical protocol with our provider partner, and look, we exclude any patient that's obviously going to the ICU or step down, any patients going to telemetry, and believe me, physicians use telemetry a lot in hospitals. So we get a lot of patients excluded, frankly, that we think we could have taken, but they're going to telemetry.

So we did not jump into 151, and we continue to look at that list. And I'm glad, Dr. Medows, you brought up the pulmonary embolism. We did talk about this on our call. That would be a situation wherein we could bring the patient in the hospital, start intravenous heparin, get them going, make sure they're stable for the first 24

hours, and then bring them home at an earlier point than they would have otherwise.

I mean, we're not going to run IV heparin at home. We really can't do that safely. I mean, we could try it, but we're not going to try that.

So we're really risk-averse. I can tell you as a physician, I'm risk-averse. All of our physicians are, and that's kind of how it's evolved.

MR. MESSINA: To the question related to the SNF waivers, part of our proposal included a waiver of the three-day SNF rule.

CHAIR BAILET: Kavita.

DR. MURALI: In fact, we do that right now, so of the 150 patients that we have done in the hospital at home model, it's very difficult to predict when a patient comes into the ER. So if 80, 85 -- or a person comes into the ER at 12 o'clock at midnight and we think it's safe for them, we roll them into the SNF for that period. Once we've got everything organized, we send them back home.

DR. TERRELL: It would seem to me that this may well be a solution to that SNF waiver problem that's actually a broader solution. There's so many people that get admitted right now who are not under a waiver situation

because they're just -- they got to do that thing, and probably the type of services that you're providing, if it were done right and safely, could really have broader implications for that particular issue. I don't know what it would do for the cost per se, but it could certainly save that -- all the risk of an acute hospitalization that might not be needed.

MR. STEIN: If I could add just one more thing on the DRGs, because I think that's one of the themes obviously from the group. And so as we looked at it and we started with those eight, I think one of the complexities that we found -- and, by the way, Mount Sinai found the same thing -- is that ultimately it's hard to get an ER doctor to lock down on a diagnosis at the time of admission. It's just not the course of business at a hospital. It's always on the discharge. So it happens over time.

So, you know, if you look at some of what they're doing in Australia where this has been more of a common practice, and then some of what we're doing now, to Mark's point, the 80/20 rule, we essentially eliminated what was an administrative obstacle to being able to treat patients at home. So given the hospitalist, these wide range of

DRGs now, they essentially take off of their shoulders that I have to definitively diagnose this person right this second. What they need to know is: Can this patient be safely treated at home? Is the patient stable enough to be treated at home? And do we have the mechanisms by which to be able to bring the patient back if something does escalate?

CHAIR BAILET: Kavita.

DR. PATEL: Thank you for putting this in. It looks like you also have quite a bit of work that you're doing with Sinai and others, so it seems like from the letter of support that this might be one of those cases where you were developing these things at the same time, and you have more similarities than you do differences. So I'm just going to ask two questions.

Tim started down this pathway. Yours does differ a little bit from the Hospital at Home Model with at least -- and also with even some of the Hopkins demonstrations with how you kind of go into the program or the trigger. I just wanted comments about kind of -- I'm all for bypassing the ER where appropriate, but kind of mitigating a little bit of what could be, you know, kind of overadmissions or inappropriate admissions from that referring physician. So

that's the first question, and I've got a couple others.

DR. MONTONEY: Yeah, I'll start. I realize that MCG or InterQual is not the end-all, be-all, but it is a standard source that we utilize MCG criteria. So the way it works -- and 70 percent of admissions flow through the emergency departments, and the ED doc is the initial point of contact there. And it already sort of has a pretty good idea, you know, does this patient need to be admitted or not?

We then vet the patient against MCG criteria. Our recovery care coordinator actually does that, and then the admitting provider is brought in, and they collectively make a decision, you know, number one, ensuring that the patient is appropriate and meeting inpatient criteria; and, number two, taking them through our clinical eligibility guidelines and ensuring that they're appropriate for home hospitalization. So that's kind of how it flows.

I certainly support the idea, if we can get upstream of the emergency department, I think there's a real advantage there. But most of the volume is currently flowing through the ED.

DR. PATEL: And the recovery care coordinator is a nurse, or I'm just -- I just want to make sure. And then

the admitting provider could be an advanced practitioner or a physician? I'm just clarifying.

DR. MONTONEY: Yeah, just to clarify, the recovery care coordinator is an RN. In fact, it's an RN with significant acute-care experience, ideally ER experience, we find, to make -- probably the best clinical background. The admitting provider indeed can be a mid-level or a physician. What we have found is hospitalists probably make the best clinician for this role because it's acute-care medicine that they're very comfortable with. However, we train them very rigorously in our model. I know that was a question that came up, so let me address that right now.

We take them through a curriculum that starts with an onboarding. For the physicians, it's a half-day. For the recovery care coordinators and the acute-care RNs who come into the home, it's a full day. And it doesn't stop there. We do monthly what we call "Lunch and Learn's." So we're taking them through all aspects of patient safety, our clinical model, service, quality metrics, the gamut. We actually administer a pre- and post-test. And it's not an option. If they're going to participate in the program, they're going to go through

this onboarding, because, look, the hospitalists are very comfortable with acute-care medicine, but this may be their first time using telehealth, you know, a telehealth solution, which, incidentally, I want to add on to that. We've got a pretty sophisticated system that we utilize that actually incorporates a virtual stethoscope as well. So as we commented earlier, we can and will see a patient back in person whenever it need be. But with the technology advancement and the peripheral applications that we're able to integrate, it's really advanced the scalability of the clinician.

DR. PATEL: My final question, you kind of segued into it. You have quite a bit in your -- and I think you even mention in the application or the submission around the proprietary technology. I'm trying to tease out -- there's so much that's been great about what you've invested in a technology platform, obviously this training. Our prerogative is to look at things that are not proprietary, and you even allude to the fact that it doesn't have to be this technology. But I'm going to ask the dangerous question: How much of this could be done without what you've developed on a proprietary basis?

DR. MURALI: I think all of us will go down to

answer this question. Basically the reason why we used Contessa was that we didn't want to reinvent the wheel.

DR. PATEL: Sure.

DR. MURALI: The wheel was available. It seemed an easy way to go ahead and bill it, and that was the reason why we went down. Now, any other organization can do it without the folks from Contessa -- sorry, Travis, but that's the truth.

[Laughter.]

DR. MURALI: So that's -- that is really where we are. And to your prior question, we've had patients who've been admitted from the urgent care or from the primary care physician. My chief medical officer who was recently admitted was from the primary care's office, reached out, he was supposed to be admitted. He was going to go into the hospital for admission, and that's when the discussion came and Mark got involved and took care of it.

MR. MESSINA: Kavita, I'll directly answer the question as it relates to what is proprietary. So, I mean, our platform that we've built really revolves around the ability to centrally document -- in essence, it's a hospital-at-home EMR. But it's not necessary. Mount Sinai didn't have one. I believe they're an EPIC shop. I

believe Partners who ran their program is, I believe, also an EPIC shop. So it's -- again, is it helpful? Absolutely. Is it absolutely mandatory? Definitely not. So we tried to not really accentuate that too much in the submission or the proposal.

DR. PATEL: But it's not just the HIT -- I mean, I think this is a positive. It sounds like it's also the -- because the PRC, I mean, the personnel that really do facilitate this transition, to your point, are not Marshfield kind of system integrated employees, so to speak, but they are people who are serving as connectors. So it's personnel as well as kind of a unique technology and data. Am I correct? I just want to make sure because I think -- I just think for the PTAC, these are essential elements to success, if I'm kind of paraphrasing.

MR. STEIN: Right. So our joint venture together employs the nurses, but at the same time, they identify themselves as Marshfield Clinic nurses. So as far as patients are concerned, they don't know the difference between the two. No, and I think it comes down to, again -- you know, I love our company, but at the same time, we want this to be an industry standard, and I don't think any of us thinks that we should own 100 percent of it. In

fact, if it's going to move faster, I'm sure that we won't.

You know, on the technology front, too, I think it's informative that to date nobody's developed a platform that we did because our business isn't IT. We just needed a platform to help us do our business better. And I think that once something like this becomes more standard, that there probably are entrants from probably Silicon Valley and other places that start jumping into this as well.

MR. MESSINA: And I'll make one last comment, because it goes off a comment that Grace made as it relates to the ASC industry. I think that -- or we are believers that providers, as they pursue hospital at home, the hospital home care model, they're going to pursue it in the exact same manner in which they pursue the ASC industry. So you have providers or companies like United Surgical Partners International where health systems partner with them because they just said, look, we don't want to build this ourselves, we'll partner with someone. I come from a family of physicians, and they built their own, and they were independent practitioners that built their own. And so I think you'll see the exact same dynamic play out across the health care industry as hospital at home becomes sort of a standard of care.

DR. MURALI: So in terms of the ASC and how we went ahead with the comfort and recovery suites, we did exactly the same thing. We partnered with SNFs to make sure that those patients were provided for care in the SNFs. And so we called them SNFAs, which are hospitalists who are trained to take care of that.

CHAIR BAILET: Rhonda and then Bob.

DR. MEDOWS: Please describe the process by which a patient and their caregiver can give you information about adverse events real time and your ability to respond to them.

DR. MONTONEY: Yes, we have a 1-800 number that they're able to call. First, let me back up a step. They will always -- or always have the avenue to be able to report directly into our care team. Our recovery care coordinator is typically the primary point of contact, and, of course, they will sort of triage any of those concerns that come in. But we also provide the opportunity if they want to report something outside of our system, like a compliance line, so an 800 number basically.

DR. MEDOWS: Okay. And will that be included in part of the performance metrics that you would be reporting on -- within the model? I don't mean your facility. I

mean the model itself.

DR. MONTONEY: Yes.

DR. MEDOWS: Okay. Would you answer another question for me? And that is, we talked about the physician could go to the home if they really needed to. Has that happened?

DR. MURALI: Like in the recent incident when I had to go --

DR. MEDOWS: When you went.

DR. MURALI: -- and check, but yes, they could. And, Mark, you're closer to it.

DR. MONTONEY: I would say that as well as bring the patient back to the medical center for evaluation as well.

DR. MEDOWS: Okay.

MR. STEIN: And, by the way, that's part of why in the model you see the transportation cost in there. So in the event that the hospitalist gets a feeling that we need to escalate, we'll have the patient transported back to Marshfield Clinic.

The other thing to note on the -- so if I can add on the families reporting, the families are provided with an 800 number that's actually manned by a third party, if

they had any complaints, and that was something in our later submission, and I know Travis talked about it later. It wasn't to cram down something new. But we just wanted to reemphasize we think that that's important, and I think you may have been the one that said it last time about patient or family concerns. So we recommended that anybody that is going to provide this actually provide the family member or the patient with an 800 number that could be an escalation line manned by a third party.

The other thing we thought would be appropriate as well for consideration is using 1-800-Medicare if somebody wanted to be able to report in any adverse event, similar to how the MA companies have the CTM complaints.

DR. MEDOWS: My concern is about in the middle of the night, 3:00 a.m., they're able to reach somebody. Correct?

MR. STEIN: Yes. 24/7.

DR. MEDOWS: Okay.

CHAIR BAILET: Bob.

DR. BERENSON: Two remaining issues. One, as I was listening to Mr. Stein talk about the reluctance of ER docs sometimes to make a definitive diagnosis and the challenges created by that, it hit me that they have this

perfectly good alternative, which is a lot better than a premature diagnosis, which is observation stay. In some cases, it's to get tests back to see if the patient had the MI or didn't have the MI, and that probably is not a patient you want to take care of at home because they're in the CCU waiting for their results. But the asthmatic or COPD patient, they can see if they're responding to treatment and 24 hours later can make a decision about whether they're going to become an inpatient or not an inpatient.

So, mechanically, how are you dealing with observation? Are you waiting for that 12 -- I mean the 24- to 48-hour period when the hospitalist or somebody is making a decision about admit or discharge? And then if it's admit, then they go to the hospital at home? Or do you have sort of an observation stay at home, which seems like that would be the way to go for at least some conditions? I mean, how does that work? Right now, upwards of 2.5 million Medicare beneficiaries are in observation stays, so how does that work out in your model?

MR. STEIN: So I'll answer the business side of things, and then, Mark or Dr. Murali, if you wouldn't mind chiming in.

So on the business side, we have not taken patients to date from observation. We only take patients once the ER doctor and the hospitalist have said that the person's going to be admitted, or if it's the -- if we get them from the physician office, it would be the physician that is treating the patient along with the hospitalist saying that they would be eligible for the admission. We do use -- I know we talked about it before, but the MCG -- and I know they're not absolute. And then on top of that, you know, our partner right now, even though it's Marshfield Clinic, is Security Health Plan. So, ultimately, even though they're part of the same system, they operate every bit as much as a health plan, as if, you know, it was United Healthcare and somebody outside, you know, that they didn't own. So we are also scrutinized on that side as well, and we have not yet had any issues related to -- bless you -- related to whether or not somebody was appropriate. So maybe one of you -- thanks.

DR. MONTONEY: Yeah, I'll just add a couple of comments. You know, in our experience to date, the two major reasons why patients don't come into the program, the first by far and away is they don't meet criteria. So we have not done observation at home to date, so certainly

consideration is one that we've talked about. But if a patient is considered observation status, we're not bringing them into the program.

The second reason that patients don't qualify for the program is they're too high acuity. They don't meet clinical eligibility criteria. So we find that middle ground.

DR. BERENSON: Okay. So in some cases then the patient's in the hospital for 36 hours and then they go to your program at home?

DR. MURALI: Yes, so if the ER doc says it's an observation patient or if the hospitalist says it's an observation patient, they're all in the observation unit.

DR. BERENSON: Okay. My second question relates to the issue that came up earlier about different kinds of providers. I just found this sentence from Al Siu's letter from Mount Sinai basically recommending that we go forward, but he says, "We advocate that the process for consideration of the Mount Sinai model be separated from the process for considerations of the PRC proposal because they have proposed to serve different types of providers." In other words, sort of a fundamentally different model, which I -- that's, I think, consistent with what I'm

thinking.

So, one, do you agree with that, that we have two different models here because the providers are different? And, number two, other than Marshfield and your consortium that you've developed, are you aware of other medical groups or entities that would want to be part of a demonstration that was not the hospital-based provider but the freestanding or whatever the term would be provider?

DR. MURALI: I think I can speak in terms of what's happening in Wisconsin. There are several hospital entities that are interested in the program. They're big on us to share our program and how they could actually assimilate that program in their setting. In terms of what's happening outside the State of Wisconsin, not yet.

DR. BERENSON: So you don't think there's a fundamental difference based on who the provider is, it's the same model?

DR. MURALI: Yes.

DR. BERENSON: Okay. That's what I wanted to -- your opinion.

MR. STEIN: If I could add also, there are a couple of physician groups with whom Contessa is actually talking where those physician groups have delegated risk

arrangements under managed care agreements, and they're actually in talks with their hospitals and saying we want to do this as a physician group, freestanding group, not at all affiliated with a hospital. So we're actually working on implementing that now.

The second thing I would note is, you know, -- and it's state-specific, by the way -- is whether or not a hospital system or any physician group, for that matter, can send nurses to the home maybe subject to some local legislative or regulatory environmental issue pertaining to whether or not they need a home health license. So I think it's something to think about because I think Mount Sinai has done an amazing job, and we said it in the last with the PRT. We have a lot of respect for what they've done. I think their environment may be different than maybe some of the other states.

MR. MESSINA: The last thing that I would add, one of the support letters that we received was from one of the larger home health agencies in the country saying, "We're a believer in this model, and if there were independent practices," because not everybody is like a Marshfield or a Mount Sinai in that they have all of these resources at their disposal. So having access to providers

like that makes a bit of a difference.

CHAIR BAILET: Harold and then Rhonda.

MR. MILLER: I just wanted to draw out that a little bit more because I'm not sure everybody quite appreciated this. Something that we raised in our review of this, Mount Sinai in its proposal said that they had tried to use the [unintelligible] contract with independent providers and decided that it was too unreliable to do, and they decided to basically bring the services in-house. The challenge with that then is that you have to have all the services in-house.

What the PRC group here has said, which I think is an interesting angle on this, is -- my reaction, first of all, was, well, I'm sure Marshfield Clinic isn't having a problem with that because people will pay attention to the Marshfield Clinic when they say your home health agency damn well better show up at the patient's home. But that there may well be an opportunity for -- rather than these being essentially one-off negotiations between the little primary care practice in this community and the home health agency that's there, that there may well be sort of in a sense almost a master arrangement developed with some national companies that they might help to pioneer, which

might make it easier for some of those practices -- some of those practices, not all those practices -- if they have somebody in that community who's already part of this where poor performance on the Spokane, Washington, branch of the home health agency would reflect badly on the national organization.

So I wonder if you'd just comment on your experience with that and the ability that you think that small practices would have to being able to get DME and home health agencies to pay attention to them whenever they had some at-risk patients at home.

MR. MESSINA: You make a great point in that it's Marshfield and perhaps Mount Sinai and they carry a specific amount of clout in the respective markets.

Our experience to date has not been that, you know, acknowledging that --

MR. MILLER: Well, apparently Mount Sinai didn't carry enough clout in its market, because it gave up on it. Marshfield apparently is a somewhat bigger dog in Marshfield.

MR. MESSINA: Well, what I would -- a couple comments that I would make. First and foremost, as it relates to -- we are partnering for home nursing services,

infusion, and DME. We have had -- I mean, has everything been perfect? Have there been some issues? A few. They haven't been material in any way, shape, or form. So we have been able to successfully manage that. So I think and my personal opinion is that, absolutely, independent practices will have the ability to pursue those same organizations, to which we would be happy to make introductions, to say, look, you are three national providers for those three specific services. They are coming to us seeking out new markets where they can pursue this, because if you think about it, it's actually incremental business for those entities, because right now if someone goes into a hospital, infusion and DME and whatever else is going to be covered under that DRG reimbursement. And so those contracts are set in place. Now they have an incremental business line for them.

So I think -- and we are actually working with -- we haven't announced the partnership yet, but it's an independent practice where they were able to get the attention of specific home nursing services in those markets through a different provider than the one that is currently being utilized in Wisconsin.

I don't know if you have anything to add.

MR. STEIN: No.

CHAIR BAILET: Rhonda.

DR. MEDOWS: It looks like last question. In some of the comments that you made you talked a little bit about training, having a training program, for some of the home care staff, some of the clinical staff. Can you say a little bit about that, and whether or not that's part of the formal proposal or something that's a best practice?

DR. MONTONEY: We consider that part of the proposal. It's a requirement, because, again, it's not as if this model has been around for -- well, technically it's been around for 20 years, but in terms of scalability and really being implemented widely, it's not. So, you know, we take the admitting providers, we take the recovery care coordinators and the acute care RNs who are coming into the home and we take them through a curriculum that is, as I commented earlier, very rigorous in terms of not only introducing them to the technology, which, for many of them it's generally a new experience, but the protocols and immersing them in the approach to, say, the error prevention training, principles of high reliability, you know, how we communicate as a team.

I will say this, and I've got to say this. I say

this a lot when I'm talking about this model. You know, in the industry we use that term "patient-centered care," right? We've been using it for years. And let's be honest -- care has not really been patient-centered in the industry. I mean, at least the systems I was part of it wasn't.

This is as close as I've gotten in my career to patient-centered care because we are bringing the resources to the patient, in their home, with a physician leading, with a care coordinator facilitating that visit, with an RN at the patient's bedside, not off looking for supplies or doing other things. Everybody is there together, including the patient, and perhaps one of their loved ones who is there as well, and we are discussing the plan very clearly with them, and the patient is actually part of the team as well, and their family.

DR. MEDOWS: So this is something that can be scaled? This is proprietary, the training program itself?

DR. MONTONEY: It most definitely can be scaled.

DR. MEDOWS: Okay. So not necessarily proprietary? You're willing to share this part of the model?

DR. MONTONEY: Well, you know, we don't consider

--

DR. MEDOWS: Not your data, but, I mean --

DR. MONTONEY: No, no. No, the approach. We don't consider that to be proprietary. We want to scale that.

DR. MEDOWS: I just wanted to make sure, but that's --

DR. MONTONEY: You know, to the comments that were made earlier, we don't believe we're going to be the only ones doing this. In fact, we're not.

DR. MEDOWS: I think it's an important element --

DR. MONTONEY: Yes.

DR. MEDOWS: -- to ensure some basic quality assurance.

DR. MONTONEY: Absolutely.

DR. MURALI: I think we shared this with you around, Rhonda and Harold, that we talked about it. Our personal belief is that unless you understand the social determinants within that environment, you're not going to be able to change the cost of health care. And the ability of going into the patient's home, spending time with the patient, having a nurse go through the medications, recognize what they're taking, these are all extremely

vital, which a physician doesn't think of in the physician's office. And we believe that this model will actually take us further. Like any models of innovation, the fast and furious leaders always get the bullets. So you go through the process, try to solve it, and refine it.

I completely understand the concerns related to safety, but we are pretty confident that we have been able to deliver this, and patients don't come in packages with discrete diagnoses. So it makes sense to actually expand the DRGs and then manage them systematically, and help our organization move forward in providing that care. I know that you all are looking at it from the same perspective.

CHAIR BAILET: All right. So my compliments to the Marshfield Clinic, the fact that you guys traveled from Wisconsin trying to avoid the weather, but -- almost missed it. So again, thank you guys.

*** Comments from the Public**

CHAIR BAILET: As you transition back to your chairs, I've been told that there are no public comments, at least registered, but perhaps there may be somebody who registered who is in the audience that was not on the sheet. I don't -- if you could raise your hand while these guys are moving back to their chairs that would be helpful.

Otherwise, we, as a Committee, are going to start with our voting on the individual criteria. Thank you. Thank you, guys.

[Pause.]

CHAIR BAILET: Not seeing any response from the audience, are we ready to go ahead and start voting? Yep? Very good. All right. Alrighty then.

* **Committee Deliberation**

* **Voting**

CHAIR BAILET: So let's load up with Criterion 1, Scope. High priority item. Mainly either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM entities whose opportunities to participate in APMs have been limited.

It's a high-priority item. Please vote.

[Electronic voting.]

* **Criterion 1**

CHAIR BAILET: Ann.

MS. PAGE: Three members voted 6, meets and deserves priority consideration; one member voted 5, meets and deserves priority consideration; four members voted 4, meets; three members voted 3, meets; and zero members voted 1 or 2, does not meet. The Committee has concluded that

the proposal meets Criterion 1, Scope.

CHAIR BAILET: Tim.

DR. FERRIS: I don't want to delay our deliberations here but there is a bit of a spread in our voting here. And I wanted to get a little bit of understanding because this is an issue -- I can either raise is now or later, and maybe better now -- which is, in thinking about this criterion I often think about, you know, is there another model in this space. And I wanted to hear maybe from the PRT -- so there is another model, which we did recommend, and how do we -- we don't really have policies and procedures for -- we already recommended a model in this space. It's about scope.

Does the PRT think that this is sufficiently different? And I heard some comments that say it is sufficiently different, or that might suggest that it's sufficiently different, that there should be a second model. Or do we think, like in our prior discussion, this is an issue where there's good parts of both and that we should be recommending them?

So sorry for raising this but I've been wondering about the answer to that question.

CHAIR BAILET: Harold.

MR. MILLER: First of all, I think it's always a good idea that if there is a difference of opinion that it might be worth talking about it and then seeing if we can achieve any kind of conclusion.

I brought along our letter to then Acting Secretary Hargan, October 20th. Our letter said, "PTAC can envision CMMI testing multiple versions of HaH Plus with varied payment methodologies." So we said that explicitly, that we were not convinced that the original model was the model.

I personally think that this is sufficiently different, and not on the DRG side but on the issue of the ability to get a partial payment for the services, the nursing services, et cetera, and then bill the other things, that to me it is worth testing that and to see whether or not that makes it easier for different smaller practices or different parts of the country to be able to do something. That's my opinion.

So from my perspective, I think this model -- and again, this is just me; I'll let the other PRT members speak if you want, give a different opinion -- but my opinion is this could potentially fill a somewhat different gap than just doing the Mount Sinai model, as defined,

would fill.

DR. NICHOLS: I would concur, and I would refer you to Dr. Siu's letter in the original proposal at the back. I think there is complementary here, in particular, from an economist's point of view, different models about putting together teams and partners. And I think, you know, the Mount Sinai version is centrally controlled and this is not, and I think that's fundamentally different.

DR. FERRIS: Thank you.

CHAIR BAILET: Yep. You bet. Criterion 2, Quality and Cost. Anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

High priority. Please vote.

[Electronic voting.]

* **Criterion 2**

CHAIR BAILET: Ann.

MS. PAGE: One member voted 6, meets and deserves priority consideration; three members voted 5, meets and deserves priority consideration; three members voted 4, meets; three members voted 3, meets; one member voted 2, does not meet; and zero members voted 1, does not meet.

The majority finds that the proposal meets Criterion 2.

CHAIR BAILET: Thank you, Ann. So we covered all the real estate in that particular one.

Criterion 3, Payment Methodology. High priority. Pay the alternative payment model entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM entities. How the payment methodology differs from current payment methodologies and why the physician-focused payment model cannot be tested under current payment methodologies.

Please vote.

[Electronic voting.]

* **Criterion 3**

MS. PAGE: One member voted 6, meets and deserves priority consideration; one member voted 5, meets and deserves priority consideration; three members voted 4, meets; five members voted 3, meets; one member voted 2, does not meet; and zero members voted 1, does not meet. The majority finds that the proposal meets Criterion 3, Payment Methodology.

CHAIR BAILET: Thank you, Ann. Let's go to Criterion 4, Value over Volume. Provide incentives to

practitioners to deliver high-quality health care.

Please vote.

[Electronic voting.]

* **Criterion 4**

MS. PAGE: One member voted 6, meets and deserves priority consideration; one member voted 5, meets and deserves priority consideration; five members voted 4, meets; four members voted 3, meets; and zero members voted 1 or 2, does not meet. The majority finds that the proposal meets Criterion 4.

CHAIR BAILET: Thank you, Ann. Let's go to Criterion 5, Flexibility. Provide the flexibility needed for practitioners to deliver high-quality health care.

Please vote.

[Electronic voting.]

* **Criterion 5**

MS. PAGE: Two members voted 6, meets and deserves priority consideration; one member voted 5, meets and deserves priority consideration; five members voted 4, meets; two members voted 3, meets; one member voted 2, does not meet; and zero members voted 1, does not meet. The majority finds that the proposal meets Criterion 5.

CHAIR BAILET: Thank you, Ann. Criterion 6 is

Ability to be Evaluated. Have evaluable goals for quality of care cost and other goals of the PFPM.

Please vote.

[Electronic voting.]

* **Criterion 6**

MS. PAGE: One member voted 6, meets and deserves priority consideration; zero members voted 5, meets and deserves priority consideration; four members voted 4, meets; six members voted 3, meets; and zero members voted 1 or 2, does not meet. The majority finds that the proposal meets Criterion 6.

CHAIR BAILET: Criterion 7 is Integration and Care Coordination. Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to populations treated under the PFPM.

Please vote.

[Electronic voting.]

* **Criterion 7**

MS. PAGE: One member voted 6, meets and deserves priority consideration; two members voted 5, meets and deserves priority consideration; three members voted 4, meets; five members voted 3, meets; and zero members voted

1 1 or 2, does not meet. The majority finds that the
2 proposal meets Criterion 7.
3 CHAIR BAILET: Criterion 8 is Patient Choice.
4 Encourage greater attention to the health of the population
5 served while also supporting the unique needs and
6 preferences of individual patients.
7 Please vote.
8 [Electronic voting.]
9 * **Criterion 8**
10 MS. PAGE: Two members voted 6, meets and
11 deserves priority consideration; four members voted 5,
12 meets and deserves priority consideration; three members
13 voted 4, meets; two members voted 3, meets; and zero
14 members voted 1 or 2, does not meet. The majority finds
15 that the proposal meets and deserves priority consideration
16 on Criterion 8.
17 CHAIR BAILET: Thank you, Ann. And Criterion 9,
18 Patient Safety. Aim to maintain or improve standards of
19 patient safety.
20 [Electronic voting.]
21 * **Criterion 9**
22 MS. PAGE: Zero members voted 6, meets and
23 deserves priority consideration; one member voted 5, meets

and deserves priority consideration; two members voted 4, meets; five members voted 3, meets; three members voted 2, does not meet; and zero members voted 1, does not meet. The majority finds that the proposal meets Criterion 9.

CHAIR BAILET: And finally, Criterion 10, Health Information Technology. Encourage use of health information technology to inform care.

[Electronic voting.]

* **Criterion 10**

MS. PAGE: Zero members voted 6, meets and deserves priority consideration; two members voted 5, meets and deserves priority consideration; three members voted 4, meets; six members voted 3, meets; zero members voted 1 or 2, does not meet. And the Committee has found that the proposal meets Criterion 10.

CHAIR BAILET: Thank you, Ann. If you want to summarize the voting.

MS. PAGE: On one of the 10 criteria, which was Criterion 8, Patient Choice, the Committee found that it meets the criterion and deserves priority consideration. On the remaining 9 of the Secretary's 10 criteria, the Committee found that it meets the criteria.

CHAIR BAILET: Thank you, Ann. So is the

Committee ready to vote on the -- oh. Is the Committee ready to vote on the recommendation to the Secretary? Alrighty then.

So the asterisk is not applicable; 1 is not recommend; 2, recommend for limited-scale testing; 3 is recommend for implementation; and 4 is recommend for implementation with high priority.

Let's go ahead and vote.

MS. PAGE: And since all 11 members are voting on this, and a two-thirds majority determines the Committee's recommendation, that's 8 votes will determine what the Committee's recommendation is.

[Electronic voting.]

* **Final Vote**

MS. PAGE: Three members voted 4, recommend the proposed payment model for implementation as a high priority; five members voted 3, recommend for implementation; three members voted 2, recommend for limited-scale testing; and zero members voted 1, do not recommend. The two-thirds majority of the Committee finds that the proposal should be recommended to the Secretary for implementation.

* **Instructions on Report to the Secretary**

CHAIR BAILET: Okay. We're going to go around the room, starting with Tim.

DR. FERRIS: So I voted for implementation. So in thinking about this, I find the territory a little confusing, with the different proposals and so forth. So I guess what would I like to see happen and then work backwards.

What I would like to see happen is within the next six months CMS propose a payment model for home hospitalization, or actually, what I would like to see is payment models for home hospitalization. We have, in our system, we had two -- the Brigham and Women's Hospital and Mass General Hospital. Actually, both came up with very viable ideas for how to do home hospitalization. They look very much different from each other. We decided, because we don't know what the best way to do home hospitalization is, to do them both. And so we are running them against each other. I think that same sort of thing. Maybe there's two, maybe there's three; I don't know what the number is.

But I think this is a critical issue. It is interesting to me. I'd never thought about it before. But we don't consider patient choice to be a high-priority

criterion. Paying for being hospitalized at home is obviously more choice for Medicare beneficiaries. I have seen, in my own system, how dramatically it can both enhance care, reduce costs, and patients love it. That should be worth an awful lot.

And then the last point it, we are currently negotiating with our commercial payers about paying for this. They are dragging their feet because they, like so often is the case, are waiting for Medicare to define how they're going to pay for this. So Medicare just has to do it, and I don't know exactly what the -- if it's, you know, the Mount Sinai model and the Marshfield model, what it is. But I think it's time to actually do it.

And I said not at a limited scale, because the way we're going to figure this out, in terms of the tweaks, is to get it out there and do it at scale. I can't imagine a future in which we do not pay for the services that are provided in a program like this, so we should just start doing it. So that was the rationale behind mine.

CHAIR BAILET: Thank you, Tim. Grace.

DR. TERRELL: I voted number 4, to implement with priority consideration, for many of the same reasons that you didn't vote for 4 but voted for 3. But I think that

probably several things swayed me. One is the fact that we do have 20 years' experience with this. We've been waiting for Godot, as it relates to this. And I didn't hear anything that concerned me after hearing the conversation today about patient safety that would make not believe we need to proceed with all deliberate speed.

I heard good, rational arguments around the way they were thinking through the payment methodology that said to me that there's enough experience out there that there needs to be a catalyst to what needs to happen.

The third thing is we have spent the last 20 years wringing our hands about the safety and dangers of hospitalization, and I think that this is a real pro-patient safety thing to do, is to figure out how to have hospital at home that works.

And the fourth one is, we did something very similar to this four months, or I guess six months ago, and we haven't heard a word from the Secretary yet so I felt like we needed to up the ante a little bit, because obviously we are still going to be waiting a bit if we don't continue to emphasize the need for implementation of programs that we think are pertinent and relevant and really important.

CHAIR BAILET: Harold.

MR. MILLER: I voted for implementation with priority. I think, just to clarify, to me this does not require what at least we have been talking, in the past, about, limited-scale testing in the sense that key parameters need to be put in place to determine, I think, that all of the relevant parameters can be defined in advance and then refined over time, on a broad scale.

And I think I agree with Tim, strongly. We said in the earlier report that multiple methodologies should be tested. I think that this should be tested, implemented, along with the Mount Sinai model and anything else.

I guess the one thing I would like to recommend that we put into the report, if others agree, is I really don't think that this kind of model, this home care model, should be done as an isolated, independent model, completely disconnected from the other kinds of home care services. I don’t think, shouldn't be -- shouldn't wait for everything else to be done, but I think that CMS should be thinking about, this is a program for people who need to be hospitalized today, to be taken care of at home.

I think it should be complemented with efforts that we've heard from others, to try to help the patient

from developing the condition in the first place, that led to them needing to be hospitalized. And one of those is palliative care for advanced care, that says the patients need something in the home before they reach the point that they have to be hospitalized.

And I think it's important to think about all those things in a coordinated way, for two reasons. One is I don't think that you want to have -- ever have people saying, "Okay, the only way we're going to be able to provide this service to the patient is for them to have to be hospitalized, or to have to the reach the point where they need to be hospitalized, to do that," but I think you want to have that full suite of services available.

The other thing is that I do believe, in a lot of communities, it will be more feasible to do each of those things if they can do all of those things, and that they can develop enough sort of lines of business so that there's home care nurses who can go and do palliative care, who can do home hospitalization, who can do chronic disease management, et cetera, and the smaller the community the more difficult it's going to be to just do one thing.

So I think we should be at least saying that these should be thought about together with other things.

Again, I don't think anybody should be restricted from doing this unless they do the other things, but I think that if CMS defines each payment model with different criteria, and in different regions, and all of that stuff, such that people can't participate in multiple models, it would be more difficult, I think, for participation.

So I would just like to suggest, if others agree, that we at least comment on that, in addition to recommending this particular model.

CHAIR BAILET: So, Harold, is that something that you want the Committee to have an affirmation of your proposed request, or --

MR. MILLER: That was my request, was that other say whether they agree or disagree with that. I just want to make it clear, I'm not saying that someone should only be able to participate in this model if they're doing other things. I'm just saying that when CMS does multiple models that involve home care that they do it in a way that the timing and the eligibility is such that people will be able to participate, rather than saying "you can only be in the comprehensive primary care model if you're in Oregon and Michigan, but you can only be in the home hospitalization model if you're in Alabama and Georgia, and you can be in

the palliative care model if you're in Maryland and Pennsylvania," which would then avoid the opportunity for people to develop some economies of scale and coordination for patient care.

CHAIR BAILET: So I'm going to go back to Tim, and then Grace, to --

DR. FERRIS: No. I think, so, the one concern I would have, Harold, about that, with which I completely agree, is letting the perfect be the enemy of the good. If there were things -- I think what the assertion is that we're trying to make here -- see if you agree with this -- is that we want to scale it as widely as possible, as quickly as possible, and that not knowing what compromises CMS would have to make in order to get there, that would be our strong recommendation. Does that make sense?

MR. MILLER: It makes sense to me. I just -- I am concerned when things -- there ought to be -- these things ought to be synergistic and coordinated at the local level, that if all of -- if every implementation demonstration is defined completely independent of the others, that you won't have that. So I'm just merely trying to add on the notion that this should be done, but it would be really desirable if it could be done in a way

that enables coordination with other kinds of home-based programs, rather than being treated as completely independent demonstration.

CHAIR BAILET: Grace.

DR. TERRELL: This may be a broader issue that we need to take this into account, and that is all of these particular payment models are for a particular unit of the health care system, and there may well need to be some thought, at the level of PTAC, as to whether larger risk-bearing entities, ACOs themselves, could subcontract for components of it such that there could be the ability to have these in a model without there being disruption within the continuity.

I mean, if you really think about what a risk-bearing entity would be at the level of, say, the way a payer does it, right now Medicare Advantage has this because it's subcontracting for this service. And one of the concerns that are in our current infrastructure model is we can't piece them all together. If there was the ability of ACOs, that are taking full risk, to be able to have bundles, to have various types of payment models underneath, it might solve a lot of the anxiety of this ever-perpetual concern that we have, which is an

appropriate one.

So I would suggest we take it off the table of this, other than where it's relevant to this, but maybe bring it up as a broader thing for us to be thinking about.

MR. MILLER: So I'll withdraw that suggestion, unless other people want to put it back on for this thing, but I'd suggest that we may want to make that a separate kind of a communication about all this stuff. I'm just concerned that if we treat all of these payment models completely independent of the others and don't say something about how we think they all connect, that we will be missing something.

CHAIR BAILET: So I think we'll pick that up as a separate item, rather than bake it in here. Okay. Paul.

DR. CASALE: Yeah. I had recommended for implementation and agree with the comments that have already been made. You know, I think several of the places that are doing it now certainly are health systems that also have health plans, and so it's sort of a win-win either way. And so trying to do these models more broadly, I think, is clearly beneficial.

And I think it would also potentially alleviate some of the craziness around Obs, because right now

observation status drive, you know, certainly the provider community crazy, and there's certainly a percentage of patients who now you'd have a comfortable place to manage them, and there would be a clear payment model.

So for lots of reasons already articulated I think I would recommend broad implementation.

CHAIR BAILET: Thank you, Paul. Bruce.

MR. STEINWALD: This is another one where I would have voted limited-scale testing with high priority consideration if I could.

My only reservation, really, is the matter of what Bob called favorable selection, and how that should affect the payment rate, the base payment rate. If the actuaries or other elements of CMS can solve that problem in real time, and roll this out in scale, then I would be very pleased. But I do think it's an issue that needs to be addressed.

CHAIR BAILET: Thank you, Bruce. I voted for implementation. There are a couple of things that have already been said but I think are worth re-emphasizing, from my perspective.

One is the comments around the unintended consequences with hospitals that are, I think, the big

integrated systems with lots of volume can experience this shift without impugning the vibrancy of the organization. But I do think in the smaller circumstances the hospitals that really can't fail, if they fail, the ability to resurrect them in small communities is going to be near impossible.

So I think that there needs to be some thoughtfulness from CMS around the unintended consequences and take a holistic approach to what are the downstream ramifications when models like this are implemented. I don't think it's for the Committee, specifically, to drill into potential remedies but I do think we need to highlight that as a potential challenge.

I do want to talk about safety and training, because I think the patient safety issue, while the Committee agreed that it met -- I think there's divergent views, and I'll share my own personally. You know, it's kind of like that commercial, you know, like "folks, don't try this at home." I think that there will be -- there needs to be a fairly thoughtful, and I would like to see a systematized process for implementation, where, you know, just like when new drugs are introduced or new procedures are introduced, there's a very purposeful listening for

learning, and to get that information out to the clinical community so that if mistakes, or when mistakes happen, or when things go south, that the community is aware quickly and that information is disseminated. So I would like to see that.

I sort of think that some of this harkens to, you know, being a surgeon, when we move things that were historically inpatient surgical procedures and we moved them to the outpatient, if you think about how that was done and how that continues to be done, there are some systematic approaches to it, and typically the higher-performing, sophisticated systems try it first, the organizations, the societies get behind it, there's robust training, et cetera, and then these are done in what I would say a safer transition. And I think we owe it to our beneficiaries to put the same kind of backstop in place. So I would certainly want that in the report.

But clearly, as hospitals struggle with volume, I know the practices in California, particularly, they are out of room. And so I think that this is a remedy to also deal with the changing demographic and ability to manage patients in the settings that are safe, but decompress the hospitals to get the patients who need to get in to a bed,

rather than percolate in the ER for sometimes days, trying to get a bed. I think this is a remedy as well, again, taking a holistic view.

But I applaud the Marshfield Clinic. Again, I have high regard for -- having come from Wisconsin. I think it's great work and I'm glad that you guys are pushing this forward.

VICE CHAIR MITCHELL: Thank you. I voted for implementation. I do have a confession, though. Having been less concerned about patient safety, my anxiety level actually went up with some of the responses about an 800 number. So I would actually ask that our comments reflect sort of greater attention to that.

I also, though, want this to move forward. I think patients want this. I think anything that can be done outside of the hospital, I think there is benefit to that, and I think that it can be done, it's being done around the world. There's no reason not to move this forward.

I wanted to just raise something, though, about the small rural hospital issue. Coming from a state where there are 31 hospitals for 1.2 million people, there are also adverse effects of keeping too many hospitals open,

sometimes when they shouldn't, for safety and other reasons -- cost, pricing, all sorts of things. So I think we just need to take that issue separately. I think if this is the best thing for patients, and if it is the right thing for savings and high value and patient-centered care, we should do it regardless of the consequences for the rest of the system. That's just a separate issue, and it's pretty complicated, so thanks.

CHAIR BAILET: Len.

DR. NICHOLS: So I voted for implementation, and I sort of feel like everything's been said but not everybody said it, so I'll be very brief.

I think this is ready, and I think it could be implemented on a broad scale. What I love is the idea of having two or three models, at least two models, offered to the world and let's see who takes it and what happens.

To speak to the point that both of you have raised in slightly different ways, both Tim and Harold, about multiple models simultaneously, I do think we should address that. I'm not exactly sure this is the letter to do it in, but I definitely think we want to do it, because I fear that that multiple model issue, both in terms of multiple payment models and multiple geographic areas, is

being used as an excuse not to do stuff, and I think we need to address that head on.

CHAIR BAILET: Thank you, Len. Kavita.

DR. PATEL: I voted for number 4, implementation with high priority, almost kind of for the reasons Grace did, just to kind of send a message that we've been talking about this enough.

I would say the only two things I want reflected in the comments, number one, that I don't want HHS or anybody to kind of misinterpret somewhere where the words are "technology" or "proprietary." This is different than a previous submitter's commentary on proprietary technologies. I think the submitters have made it very clear that this is flexible and scalable.

And then the second point would be around refining -- all this conversation about safety is just maybe keep coming back to the fact that I don't think this should be kind of 1,000 flowers and 1,000 DRGs blooming, that we really should try to think about this a very kind of evidence-informed, and we have enough evidence for specific conditions, which just makes sense, along with potentially like we did in BPCI, looking at additional conditions as the evidence develops.

CHAIR BAILET: Thank you, Kavita. Bob.

DR. RODGERS: Yeah, I voted -- I'm reverting back to my curmudgeonly self and I voted for limited testing, although, logically -- well, I have assumed that the hospital-at-home model is eminently adoptable and should be by hospitals. And they have the size, the scale, the capital, the management. They have the same risk pool of patients and they're making a management decision.

I think it gets more complicated when you have a different recipient, a different entity who is not the hospital receiving the money. I'm skeptical that there's actually -- except for some multispecialty group practices like Marshfield, I'm skeptical that most physicians, small practice physicians want to get in the business of managing hospital patients at home.

And so I'm not sure exactly what -- that this should be a priority. I'm concerned that we don't have a good grasp on the selection issues that Bruce and I have been talking about. I'm quite sure that we will be overpaying, based on what I've heard about, while we're underpaying the hospitals who have the residual patients.

And then what Paul described as a virtue I would describe as a problem. This becomes a wonderful outlet for

observation patients. Oh, we'll send them home with a hospitalization, and people who would just have been discharged, out of observation, will become hospital patients for two days at home. Perhaps this can all be addressed. That's why I say this is, to me, as opposed to Harold, I think this is exactly when we want to do limited testing, to try to sort through those kinds of issues. What does it look like that a patient who has been in the hospital for 48 hours in observation now is going, not to complete a stay for one more day but is going home for a full DRG payment?

So, in any case, I do think this is different. I voted fully for the Mount Sinai model getting full implementation. If CMS thinks it's more efficient to them, build this into that and not do limited testing, that's fine with me. But I just wanted to signal that I think this is not just a small variation on the Mount Sinai model, but because it's a different provider, potentially, it's a significant difference.

CHAIR BAILET: Thank you, Bob. Rhonda.

DR. MEDOWS: I voted for limited-scale testing. I support the hospital-at-home model. I supported the previous model as well. I still have concerns about the

wide breadth of DRGs, not for an organization such as Marshfield, which would have resources, expertise at its beck and call. I'm concerned more about other entities trying to implement something if they don't have some basic tools, resources, and support attached to them.

I would ask that the answers that the candidates gave to my questions about adverse reporting, 24/7 availability to access, my question about training, their responses be included in the letter as something to be included in the model itself, not just as a conversation piece.

CHAIR BAILET: Thank you, Rhonda. Tim.

DR. FERRIS: Just touching on Bob's point, so I refer to these as -- and Harold's point -- as adjacency issues, so not the model itself but the implications of the model within the context of the health care system.

And just to point out that I think -- and Bob, I'd be interested in your response to this -- so these issues, these, what I would call adjacency issues, go away in the context of population risk. Because we do this all the time and we don't have to -- it's our decision if they go into observation or SNF waiver or whatever. And we are incented at the population level to just do the right thing

under an ACO model.

But having said that, we take a lot of infrastructure risk, coming back to that earlier conversation, on the creation of these programs that are not currently funded. A system like this, or a payment model around home hospitalization actually helps de-risk some of those, and makes it more likely, I believe, that organizations will want to take on full population risk, because you are actually helping with some of those infrastructure costs that are not currently covered at all, and I will say are very expensive.

So it's one of those things where, in some senses, where we've all advocated for a payment for a set of services. We have articulated that there are issues in the fee-for-service system, associated with the adjacency of those payments. Those issues go away and significantly enhance Medicare's portfolio in population risk, because it de-risks some of the infrastructure cost of actually managing a population.

DR. BERENSON: Since my name was invoked --

CHAIR BAILET: Go ahead, Bob.

DR. BERENSON: So, to me, my hospital ACOs, hospital-based ACOs should be -- as you said, Mass General

and, what is it, the Brigham -- are also already doing -- they have their own models that they're developing. It all is compatible with the ACO risk, and that's happening, and should happen, and we have recommended full implementation of a hospital-based hospital-at-home model.

So the question is whether physician ACOs would benefit from this model, and I think potentially, yes, that they could be the entities, or some partner of them could be the entities that are the entity receiving the money for the hospital at home, and that would benefit them, which is why I want to see this pursued. I just think there's some unique issues that it's different, and we should be doing the limited testing to sort of work through some of the operational challenges, like how to much to adjust the risk and what is the patient flow like. I just think there's some unique issues.

So I do see that potential appeal, why I wouldn't simply say let's forget about it or let's only do this through hospitals.

CHAIR BAILET: Thank you. Paul and then Harold.

DR. CASALE: So just responding to Bob's comment on observation. You know, the current observation system is certainly not patient-centric. You have patients who

sit in Obs for two days. They think they're in the hospital, and then they go home and then they get a list of bills for copays and deductibles, and, yes, there's a requirement that they be told, you know, there's a million, but from a patient's point of view they think they're in the hospital. This, obviously, has the advantage they're clearly not in the hospital, and they are, in fact, in a different model.

And the other comment is, you know, we already have significant infrastructure costs around, you know, concomitant reviews with physician advisors and worried about -- I mean, there's already a lot of expense around observation that, in fact, this model would potentially be advantageous for.

CHAIR BAILET: Thank you, Paul. Take us home, Harold.

MR. MILLER: Well, I don't know about home, but just, quickly, I think it would be useful, in many cases, including this one, to comment specifically that we think that this could be helpful to ACOs, because I think there is this notion that somehow ACOs will just work it all out somehow, and I think that having the right way to pay for certain pieces of care inside the ACO would be a useful

thing, and then we should comment on that.

However, I want to make sure, from my perspective, we should never say that these should only be done in ACOs, because I think that there are many patients who ain't going to be part of any ACO but could be cared for at home, and we should never have to say to them, sorry, you can't get this because you're not -- there's no ACO or these folks haven't signed up for that.

So I think, in some sense, we should be treating these things that we're talking about as workable inside and outside, maybe with modifications, but not somehow only in one or the other, until we get a whole lot farther down the road on payment models and everything else.

DR. FERRIS: Can I just respond? I totally agree, Harold. I did not mean to imply --

MR. MILLER: I think you did but I --

DR. FERRIS: Yep. No, I'm glad you made that clarification.

CHAIR BAILET: Teamwork and respect. It's poetry. Let's go home, Jeff.

No, so listen. I'm struck just by the caliber of the proposals that we're getting, the refinement, the sophistication that the stakeholders are bringing forth

since we first started in 2016. I'm struck by the caliber of the analysis that the PRTs are doing, and the support that the staff have been leaning in. And I just think it's really coming through, and in today's meeting, particularly, just with the engagement, the comments, the caliber of the proposals.

And I'm just really excited about where we are and what's in front of us, and I'm hopeful that the stakeholder community sees what we're seeing, and for those who potentially may have been on the fence, or still are on the fence, whether they should get into the proposal submission pool, I guess I hope that what they're seeing here, played through, is encouraging them, if they're on the fence, to jump in.

Our patients, the members, the beneficiaries, they deserve this innovation, and it's up to us, as the, you know, as not only the reviewers but the clinical stakeholders, we're the spark plug, if you will. We're trying to entice the clinical community to jump in, and we're here, and I hope that you see the discipline and the thoughtfulness of the conversations that this Committee brings to bear. And hopefully the Secretary will not only engage but also, you know, we're looking forward to getting

the feedback, because that will sharpen our process. It will sharpen our thinking as we go forward as well.

So again, well done. Congratulations. And again, a shout-out to the Marshfield Clinic. Thank you, guys.

We're going to adjourn.

* [Whereupon, at 5:06 p.m., the Committee recessed, to reconvene at 8:30 a.m., Tuesday, March 27, 2018.]