

February 8,2017

Physician Focused Payment Model Technical Advisory Committee
C/o U.S. DHHS Assistant Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue, S.W.
Washington D.C, 20201

Letter of Intent - Edward Bumetta, MD, LLC (Submitter)
Physiatrist Led Post-Acute Micro-Bundle

Dear Committee Members,

On behalf of Edward Bumetta, MD, LLC, we would like to express intent to submit a Physician- Focused Payment Model for PTAC review on February 8,2017.

Payment Model Overview

- The Physiatrist Led Post-Acute Micro-Bundle model is focused on patients in the Post-Acute rehabilitation setting. This model is initiated when a patient becomes admitted to a skilled nursing facility (SNF) and concludes when the patient is discharged from a home health care company (HHCC). Both the SNF and HHCC entities are partnered with a physiatrist and a physical therapist.
- The basis of this model comes from the acute inpatient rehabilitation facility setting where physiatrists have a well-established role in the leadership and medical management of the program and work to assure the highest quality of rehabilitative care in the most cost effective manner so patients will achieve the highest level of functional ability and quality of life.
- This model is to formerly bring the physiatrist leadership role to both the SNF and HHCC to ensure patient needs are met, provide quality healthcare, and control costs. This plan utilizing a physical therapist to act as a liaison between the physiatrist and healthcare organizations to guide therapy goals, discharge planning, and ensure communication/interaction with in-house therapy team providing care to the patient. This process would transition from the SNF to the partnered HHCC to promote consistency of care, improve communication and collaboration between healthcare providers, and improve patient outcomes.

Goals of the Model

1. Improve clinical quality measures and patient outcomes (FIM, Quality of Life, patient satisfaction, pain control, hospital re-admissions, etc.) during this phase of care.
2. Deliver a bundle service at or below CMS established targets resulting in reduction of healthcare costs in terms of length of stay and therapy encounters in both SNF and HHCC settings secondary to collaborating with a Physiatrist consistently

throughout process. (These tend to be the largest percentage cost centers in a majority of current bundles.)

3. Development of integrated care pathways, care management tools, transition resources, and information systems for a diverse group of patients
4. To initiate a program of a post-acute micro-bundle that can be replicated throughout the country with patients with similar or other diagnoses.

Expected Participants (alpha test group)

- Psychiatrist - Edward Bumetta, MD, FAAPMR
- Director of Therapy - Michele Pierry, PT, DPT, MBA
- Skilled Nursing Facilities
 - o Wesley Enhanced Living Pennypack Park,
 - o Glendale Uptown Home
- Home Health Care Company - Southeastern Home Health Services
- Convener / Data Analytics - Archway / Remedy Partners /iHealth

Implementation Strategy

- Approach SNF Nursing Home Administrators to participate (Completed)
- Approach HHCC to participate (Completed)
- Communicated with Convener - outlined data collection relevant to this plan and monitor quantifiable quality and cost savings (in process)
- Initiate an alpha program with two or three SNFs and initiate weekly team meetings /consults on the specific Medicare patients admitted to the facility and enlisted in the program. (Could be started within weeks of approval.)

Time-line

- Submission of Letter of Intent to PTAC - February 8, 2017
- Submission of Proposal - March 15, 2017
- With approval by PTAC and secretary, Plan can be implemented by start of the next quarter (July, 2017)
- Quarterly and annual results compared to regional cohorts by July, 2018.

Respectfully submitted,

 MD, FAPMR
Edward C. Bumetta, MD

 Michele Pierry, PT, DPT, MBA
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