

November 7, 2016

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary of Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201
PTAC@hhs.gov

Letter of Intent

Lawrence R. Kosinski, MD, MBA - Project Sonar

Dear Committee Members,

On behalf of SonarMD, LLC., I would like to express intent to submit a Physician-Focused Payment Model for PTAC review on December 7, 2016.

Payment Model Overview

Project Sonar (PS) is an Intensive Medical Home deployed into the specialty care provided for patients with chronic disease. Beginning in 2013, PS has been deployed by the Illinois Gastroenterology Group, a specialty practice with 48 physicians and 4 midlevel providers. For patients with Inflammatory Bowel Diseases, cost savings of 9.87% has been realized using normalized Medicare payment rates. Cost savings were the result of a 56% reduction in inpatient expenses and 53% reduction in Emergency Room payments. It has now been implemented in multiple other GI practices across the country.

The success of PS is based on patient engagement and guideline driven risk assessment, clinical decision support based on specialty society guidelines, and constant feedback to all participants. We anticipate that similar results would be applicable to other high-cost/high-cost variability conditions which we have termed “high-beta chronic illnesses”, where the potential to avoid unnecessary emergency department and inpatient utilization through patient engagement and provider adherence to “best practices” is significant. Representative conditions include chronic obstructive pulmonary disease, asthma, heart failure, uncontrolled diabetes mellitus, and advanced chronic liver disease with portosystemic encephalopathy / ascites. It is therefore anticipated that PS can be expanded to other “high-beta” chronic illnesses through its deployment as a Physician Focused Payment Model Advanced APM.

The key components of PS include:

- Attribution of patients based on type of chronic disease
- Clinical Biopsychosocial Risk assessment with treatment based on evidence-based guidelines
- Deployment of Clinical Decision Support Tools in CEHRT EMRs designed to capture data fields from MIPS derived measures as well as other specialty quality outcomes measures
- Patient Reported Outcomes Measures captured using telecommunication on a web-based platform, which form the basis of the communications system of PS.

- A monthly care management payment that is adjusted based upon the practice's performance.
- Downside risk if the actual expenditures exceed the projected expenditures, with reduced payment to the PS eligible clinicians equal to 8% of the average estimated total Medicare Part A and B revenues for performance below benchmarks for the clinical conditions.

Goals of the Model

Improved care of patients with chronic disease demonstrated by reductions in:

- Hospitalization rates
- Emergency Rooms visit rates
- Total cost of Medicare Part A and B revenues

And improvements in:

- Patient Satisfaction
- Provider Satisfaction
- Outcome-based Quality metrics based upon the specific disease.

Expected Participants

Primary Care and Specialty Practices using a team based approach involving physicians, physician assistants, nurse practitioners, Nurse Care Managers and other clinical personnel as necessary.

Implementation Strategy

Initial deployment would be to the 20 Gastroenterology practices, which encompass 1,000+ Gastroenterologists in 13 states, which represent the SonarMD Group for this APM. These practices are committed to expanding management of the 3.1M patients and beneficiaries with Inflammatory Bowel Disease – Crohn's Disease and Ulcerative Colitis using a common expandable national platform.

We envision that PS would be expanded to other high-beta chronic diseases as identified earlier in this LOI using a similar patient engagement and clinical platform, and by making appropriate changes in clinical content.

Timeline

As noted above, PS is already in use in multiple Gastroenterology practices across the country. Thus, the timeline for deployment of this PFPM APM could be as early as 2017. Expansion to at least one other high-beta clinical condition would be accomplished by the end of 2017.

Sincerely,



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