

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 13, 2017  
1:02 p.m.

COMMITTEE MEMBERS PRESENT:

JEFFREY BAILET, MD, Chair  
ELIZABETH MITCHELL, Vice Chair (via telephone)

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

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[1:02 p.m.]

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CHAIR BAILET: Okay. We are going to go ahead and start the meeting. Welcome. Thank you everybody. This is our March 13th PTAC public meeting. We're very happy to be here. I'll introduce myself, and then I'll ask the committee members to introduce themselves as well.

My name is Dr. Jeff Bailet. I am the Chair of the PTAC committee, and my position recently changed. I was the President of the Aurora Health Care Medical Group in Wisconsin. I recently took a position as the Executive Vice President of Health Care Quality and Affordability with Blue Shield of California, so I've relocated to San Francisco as of January 1st. So, I know some people -- I just think I heard, "Sorry to hear that," but I can just tell you there's plenty of people who said I went to the dark side, but there's plenty of light at Blue Shield.

On that note, we have the PTAC Vice Chair, Elizabeth Mitchell, who I believe is on the phone, so I'm going to ask her, before we go around the room with the committee members here, if she could introduce herself.

VICE CHAIR MITCHELL: Thank you, Jeff, and I'm sorry not to be there. Elizabeth Mitchell, President and CEO of the Network for Regional Healthcare Improvement.

1 CHAIR BAILET: Thank you.

2 Do you want to start, Bruce?

3 MR. STEINWALD: I'm Bruce Steinwald. I'm retired  
4 from government service. I have a little consulting  
5 practice right here in Northwest Washington.

6 DR. PATEL: Hi. Kavita Patel, Brookings  
7 Institution and Johns Hopkins, where I'm an internist.

8 DR. MEDOWS: Dr. Rhonda Medows, Providence, St.  
9 Joseph Health.

10 DR. BERENSON: I'm Bob Berenson. I'm an  
11 Institute Fellow at the Urban Institute.

12 DR. CASALE: Paul Casale, New York Presbyterian.

13 DR. KAHVECIOGLU: Daver Kahvecioglu, Centers for  
14 Medicare & Medicaid Innovation.

15 MS. MENTNECH: Renee Mentnech, Centers for  
16 Medicare & Medicaid Services, CMMI.

17 MS. RITTER: Chris Ritter, same place.

18 [Laughter.]

19 DR. FERRIS: Tim Ferris, internal medicine and  
20 pediatrics at Mass. General in Boston.

21 DR. NICHOLS: Len Nichols, health economist from  
22 George Mason University.

23 DR. TERRELL: Grace Terrell, internist at  
24 Cornerstone Health Care, currently founder and strategist

1 for CHESS, which is a population health management company,  
2 and in two more weeks CEO of Envision Genomics.

3 CHAIR BAILET: Ann?

4 MS. PAGE: Ann Page, Designated Federal Officer  
5 for the PTAC. I'm with ASPE.

6 MS. STAHLMAN: Mary Ellen Stahlman with ASPE and  
7 Staff Director for PTAC.

8 MR. MILLER: And I'm Harold Miller from the  
9 Center for Healthcare Quality and Payment Reform.

10 CHAIR BAILET: Great. Thank you. So I'm going  
11 to start by providing a brief update, and then we'll walk  
12 through the agenda and proceed from there.

13 So, the PTAC just to level set was created by  
14 MACRA in April of 2015 to make comments and recommendations  
15 to the Secretary on proposals for physician-focused payment  
16 models submitted by individuals and stakeholder entities.  
17 PTAC is dedicated to transparent operations that encourage  
18 and incorporate feedback from the public. PTAC began  
19 receiving letters of intent on October 1st, 2016, and full  
20 proposals on December 1st of 2016.

21 Update as it relates to -- we're going to first  
22 talk about update on proposals and letters of intent that  
23 we've received, and we actually got a letter of intent --  
24 another one - today, which I will summarize. We're going

1 to talk about upcoming PTAC meetings and events, publicly  
2 available documents related to the proposals, and then  
3 we're going to finally end up on today's agenda.

4 So we have 21 letters of intent, and we have  
5 received five formal complete proposals, which the  
6 committee is actively reviewing. They're listed here:

7 "The COPD and Asthma Monitoring Project,"  
8 submitted by Pulmonary Medicine, Infectious Disease, and  
9 Critical Care Consultants Medical Group Inc. of Sacramento  
10 California;

11 "The Comprehensive Colonoscopy Advanced  
12 Alternative Payment Model for Colorectal Cancer Screening,  
13 Diagnosis, and Surveillance," submitted by the Digestive  
14 Health Network;

15 "Project Sonar," submitted by the Illinois  
16 Gastroenterology Group and SonarMD, LLC;

17 "The American College of Surgeons-Brandeis  
18 Advanced APM," submitted by the American College of  
19 Surgeons;

20 And, finally, "The Advanced Care Model (ACM)  
21 Service Delivery and Advanced Alternative Payment Model,"  
22 submitted by the Coalition to Transform Advanced Care.

23 So all of these proposals and letters are posted  
24 on the PTAC's website, and the PTAC website is appearing on

1 the screen behind me.

2           The letters of intent that we have received, I'm  
3 not going to review them all, but they are here and part of  
4 the record for your review. But I do think it's worthy of  
5 note that there's a broad spectrum of specialty activity  
6 here, which is exactly what Congress was hoping when they  
7 stood up our committee, was to really illuminate and elicit  
8 a broad range of specialty and primary care proposals. And  
9 I believe based on the letters of intent that that  
10 preference is being met. This is the second bolus of  
11 proposals.

12           Now, again, letters of intent are not binding,  
13 but they need to be submitted 30 days prior to the  
14 submission of the full proposal, and the reason behind that  
15 is we as a committee need to know directionally how to  
16 allocate our resources, and having that heads up on the  
17 numbers of LOIs has helped guide our work.

18           This is the PTAC calendar. There is a public  
19 meeting April 10th through the 11th, and at that point the  
20 four proposals listed here -- COPD, the American College of  
21 Surgeons Advanced APM, Project Sonar, and the Comprehensive  
22 Colonoscopy AAPM for Colorectal Cancer Screening,  
23 Diagnosis, and Surveillance -- these four will be  
24 deliberated, discussed, and voted on in April.

1           There is another public meeting in June.  
2     Deliberations and voting on proposals at that time will be  
3     ready based on when the Proposal Review Teams have  
4     completed their work and the committee is ready to do a  
5     full deliberation.

6           There will be ongoing quarterly public meetings  
7     thereafter -- September, December, and March of 2018 --  
8     and, again, the committee always reserves the right to add  
9     meetings if they feel, based on the numbers of proposals  
10    that are submitted, that we need to meet more often for  
11    deliberation.

12           As we said earlier, transparency is very  
13    important to the committee, and getting feedback and input  
14    from stakeholders is critical. So we are making publicly  
15    available documents related to these proposals 2 weeks  
16    prior to the public meeting. We will have the Preliminary  
17    Review Teams report. We will have questions to the  
18    submitter and the submitter responses available for public  
19    review. And then any additional analyses used in the  
20    Proposal Review Team's decision-making, that will all be  
21    public and shared for comment. Again, the spirit of that  
22    is to help us guide our thinking and ultimately our  
23    deliberations when it comes time to vote.

24           Letters of intent and full proposals are also



1 posted on the website at the time that they are received.  
2 Public comments on the proposals will be posted one week  
3 following the conclusion of the comment period and updated  
4 weekly to include comments received after the deadline.

5 Submitters are invited to make a statement at the  
6 public meetings, so for the four that will be reviewed in  
7 April, those stakeholders have been invited to participate  
8 in the meeting. And we also welcome additional public  
9 comments and questions at all of our public meetings.

10 So today's agenda, quickly, CMMI presentation.  
11 They will overview the Bundled Payments for Care  
12 Improvement, or BPCI, Initiative and Evaluation Results,  
13 and then BPCI Initiative Participants' Perspective:  
14 Success and Challenges. CMS Updates on Health Care  
15 Innovation Award Initiative, so the HCIA Initiative, and  
16 then time will be set aside for public comments and  
17 questions from 3:15 to 3:45 p.m.

18 I'm going to now turn it over to my colleague  
19 Harold Miller, who is going to introduce our guests.

20 MR. MILLER: Thanks, Jeff.

21 So just a bit of background on why we put this  
22 next item on the agenda. If you've read the PTAC RFP --  
23 and I'm sure everyone has studied the PTAC RFP and has  
24 memorized it - but it has in it 10 criteria that we are

1 evaluating proposals against, and the 10 criteria are  
2 really derived from the regulations that were established  
3 by the Secretary of Health and Human Services under the  
4 MACRA statute.

5           And the first of those criteria is related to the  
6 scope of the model, and there are two elements to that:  
7 one is that the model needs to in some fashion expand the  
8 portfolio of payment models that CMS has today by  
9 addressing an issue, a payment issue, in some new way; or  
10 it is supposed to in some fashion be able to provide an  
11 opportunity for physicians/providers who have not had  
12 adequate opportunity in the past to participate.

13           So one of the things that we have to do whenever  
14 we review proposals is to determine whether a proposal, in  
15 fact, meets that criterion, and that we have defined as a  
16 high-priority criterion because the goal is to try to  
17 provide additional opportunities rather than to simply  
18 replicate what has already been done.

19           The Bundled Payment for Care Improvement  
20 Initiative from CMMI is really, I would say, the broadest  
21 and most diverse of the whole set of programs that CMMI has  
22 implemented. I don't think people actually recognize how  
23 broad it is. There are, at least as it was initially  
24 implemented, four different payment models within it that

1 could be applied to 48 different diagnosis or procedure  
2 groups and was open to participation by a wide range of  
3 provider groups, whether it be physician practices or  
4 hospitals or home health agencies or skilled nursing  
5 facilities.

6           So there is really a lot of things going on, and  
7 there are a lot of people participating in it. So we  
8 really wanted to understand, first of all, more clearly  
9 ourselves as well as those who may be listening exactly  
10 what it is doing and what it isn't doing, what the  
11 structure is, who has been participating and who has not  
12 been participating so that we can more clearly identify  
13 what models would fill gaps both for participants and  
14 payment model, and what's working and what's not working so  
15 that both we and potential applicants can learn from that  
16 as they prepare their own proposals.

17           So that was why we put that on the agenda today,  
18 and we broke the agenda into two pieces. One is first  
19 we'll be hearing from CMMI that is managing the program and  
20 also evaluating it to find out both what they intended and  
21 what they are learning from it; and then we wanted to hear  
22 from participants in the program.

23           Now, there are a lot of different participants in  
24 the program, and it would be difficult to hear from all of

1 them. So what we did today is ask two of the conveners  
2 that have been helping a wide variety of participants in  
3 the program to come and share their perspectives on that.

4 We recognized that that may not reflect the full  
5 range of thoughts about the program, and so during the  
6 public comment period, if anyone here wants to provide  
7 additional comments, they have an opportunity to do so, as  
8 well as to send us comments about the program and what we  
9 should learn from it after the meeting. So that's  
10 basically the structure that we're going to follow today.

11 So we're going to first start off with CMMI, and  
12 we have with us today Renee Mentnech and Chris Ritter --  
13 Chris Ritter from the same place as Renee is -- but both of  
14 them are veterans of CMS for a long time, have a wide range  
15 of experience, as well as playing senior roles at CMMI.  
16 They will probably do a better job of explaining who they  
17 are than I can, so I will let them move on.

18 Now, one other word of advice both to our  
19 presenters and to the audience. We have a fairly limited  
20 amount of time today, and these are big programs with lots  
21 of issues associated with them. So it's going to be, as a  
22 practical matter, very difficult to cover everything that  
23 we might like. So we've asked the presenters to give us as  
24 concise as possible a presentation, and we want to leave

1 enough time for questions from the PTAC members. So I just  
2 say that in advance so that if I end up having to shorten  
3 someone because it's running long, that no one will be  
4 offended, because we do want to allow enough time for  
5 discussions. And thanks to Mother Nature, we have a little  
6 bit less time today than we had originally expected.

7 So with that, I'm going to turn it over to Chris  
8 and Renee to give us the CMMI side of how the program is  
9 working and what you've been seeing so far.

10 MS. RITTER: Thank you so much for having us.  
11 We're really excited to be here. We work with the BPCI  
12 program every day, so it's kind of fun to come in and talk  
13 about it.

14 The Bundled Payments for Care Initiative -- let  
15 me make sure I know how to do this -- is the Granddaddy of  
16 bundled models. It's been in place -- was the first real  
17 bundled model that came out of the Innovation Center, and  
18 certainly has been a tremendous learning experience for us,  
19 and I hope, as you hear from the participants in the  
20 program, a great learning experience for them as well. And  
21 there's plenty of stuff that we've learned that we might  
22 not do the same again, but overall a very good model for  
23 getting our feet wet in terms of what bundles do and don't  
24 do and how to operationalize them.

1           We have here at the beginning of the slides just  
2 an overview of the authority that's afforded to the  
3 Innovation Center, and folks are probably familiar with  
4 that.

5           The bundled payments here, obviously the case for  
6 bundled payments, we may not need to go into that here in a  
7 committee dedicated to talking about models, but obviously  
8 the goal is to have the eagle's-eye view of the entire  
9 episode of care and look for places to both improve the  
10 quality and reduce the costs, which is not something that  
11 would traditionally be done under the fee-for-service  
12 system kind of systematically. Clearly, each individual  
13 practitioner or facility brings their own overview, but the  
14 requirement there, that's also embedded in a payment  
15 incentive.

16           So here's BPCI. It's a single payment for the  
17 episode of care, and it's designed to take into account, as  
18 we say here, accountability for both cost and quality. I  
19 would say the initial Bundled Payments for Care Initiative,  
20 it does not uniformly include quality metrics the way we're  
21 talking about them now. At the time that it was begun, the  
22 requirement is for each hospital -- or at the time, it was  
23 hospitals. It's since been expanded, as Harold talked  
24 about, to many different entities. They do put together

1 their own internal improvement plan, but the link between  
2 pay for performance that we will talk about under advanced  
3 alternative payment models, that's not part of the Bundled  
4 Payments for Care Initiative. So it is looking at  
5 streamlining the care and is requiring folks to look at the  
6 entire episode under a self-designed improvement plan, but  
7 there's no formal quality metrics that are tied back to the  
8 payment.

9           We know from many of our participants they take  
10 those performance plans very seriously, and I think you'll  
11 hear from some of our folks that are going to present today  
12 that they've spent quite a bit of time looking at how to  
13 incorporate quality into the delivery of care.

14           It does have four models. Model 1 has ended this  
15 past December, and it was solely based in the inpatient  
16 setting. We have 2, 3, and 4. Our biggest models are 2  
17 and 3. They are both retrospective models that look at the  
18 entire episode of care for the hospitalization and the 90-  
19 day post-discharge period, and they include -- they are  
20 done for either the admission to the hospital or begin in  
21 Model 3 with the admission to the post-acute-care facility.

22           I found this design very confusing when I first  
23 started at CMMI because I couldn't quite figure out who was  
24 doing what. And I think that has to do with the number of

1 individual categories of providers and practitioners that  
2 have been added as the program has evolved. I would say  
3 the key piece here that we have, maybe starting at the  
4 bottom, is the episode initiators. These are the entities  
5 that are actually furnishing the care, the hospital or the  
6 practitioner, the skilled nursing facility.

7           Some of these are also risk-bearing entities, but  
8 others, many of our physician group practices work through  
9 an awardee convener, and the awardee convener is the risk-  
10 bearing entity. And so mostly it comes down to the  
11 difference between who's bearing the risk and ultimately  
12 who's initiating the episode and providing the care. And  
13 as we'll talk about in a minute, there are provisions made  
14 for how the dollars can flow down through the different  
15 participants at each level of the arrangement.

16           So here's another quick overview on Models 1, 2,  
17 3, and 4 -- 2 and 3 being our biggest -- and as you can see  
18 just from the participants and something Dr. Miller alluded  
19 to when we got underway, the number of participants, many  
20 more skilled nursing facilities and home health in the  
21 post-acute space under Model 3, but more dollars  
22 concentrated under Model 2.

23           And here is a breakdown for you of our most  
24 recent data on who is participating.



1           It might be worth backing up and noting a big  
2 part of the Bundled Payments for Care Initiative has to do  
3 with what we call the "precedence rules," which is, since  
4 there are so many overlapping participants, providers,  
5 skilled nursing facilities, home health agencies, and we  
6 have some IRF as well as the short-stay acute-care  
7 hospital, we have created rules that have developed over  
8 the course of the model, which just began with hospitals  
9 and has expanded as it has been implemented as to which  
10 type of entity garners an episode if there's overlap  
11 between the facility, the physician group practice, or the  
12 skilled nursing facility and the hospital. And they are  
13 complicated. They have somewhat to do with which entity  
14 began the program and also with the preference towards the  
15 physician group practices.

16           I'll just make a note because it is and it  
17 remains a contentious issue among the different  
18 participants, obviously, as to who would garner from the  
19 investments that are being put in to participate in the  
20 bundled care.

21           Here are the 48 episodes that are currently  
22 covered under the Bundled Payments for Care Initiative.  
23 They are many, both medical and surgical, and constitute  
24 somewhere in the vicinity -- Daver would know -- 70

1 percent, roughly, of the inpatient spend.

2           So the baseline prices are a target price that  
3 was derived from the historical data between '09 and '12,  
4 and it's updated quarterly using an annual trend factor.  
5 So we calculate -- basically we trend up each year to its  
6 current year and then apply a trend factor to bring that  
7 base episode price forward. Lately, I will note, we are  
8 trending the entire episode, which includes all of the  
9 post-acute care, which has been declining with all of the  
10 focus on readmissions, and so our trend factor in the  
11 program has been declining. I think that was not expected.  
12 It was expected that it might increase. It's not inflation  
13 adjustment. It is a growth factor that's designed to  
14 maintain the episode cost to be consistent with the other  
15 care provided in the Medicare program. And then here we  
16 have that the final target price is the baseline price with  
17 an adjustment for 2 to 3 percent, depending on the risk in  
18 the model.

19           So the net payment reconciliation amount is the  
20 amount that goes to each convener, each entity that's  
21 bearing risk. We do not pay the episode initiators  
22 directly if they are not also bearing risk. And here,  
23 obviously, if it's greater than zero, we issue a payment;  
24 and if it's less than zero, we send a demand letter. And

1 we have gainsharing savings. Folks are familiar with  
2 these. These are the waivers for fraud and abuse that have  
3 to be put in place so that arrangements can be made between  
4 the various entities competing in the marketplace.  
5 Gainsharing is used by 50 percent, roughly, of our  
6 awardees, and they are specifically allowed to share  
7 positive NPRA dollars and any funds they can demonstrate  
8 were created from internal cost savings. That's  
9 particularly true for the hospitals where changes to care  
10 pathways may result in internal cost savings for the  
11 episode.

12           And the other waivers, the CMMI under the  
13 Affordable Care Act is allowed to waive certain regulatory  
14 requirements, the ones that are in place here for the  
15 Bundled Payments for Care Initiative, and ones we use  
16 generally across our models a lot of times are the waiver  
17 for the three-day hospital stay, which is, I have to say,  
18 not used a lot at all -- I think folks are nervous about  
19 using it, among other things; our telehealth, the  
20 originating site; and then there's a payment for a post-  
21 discharge home visit where the supervision rules are  
22 waived, the nurse can attend on their own.

23           We also have other waivers for fraud and abuse,  
24 such as patient engagement incentives where transportation

1 and other types of incentives can be furnished. And I  
2 think Daver is going to walk you through -- or maybe Renee  
3 is going to talk a little bit. I can do them here, which  
4 is at a very high level, and then Renee should chime in.  
5 Certainly the most prominent finding from the Bundled  
6 Payments for Care Initiative certainly in the early years  
7 and one of the bases for the joint replacement model is the  
8 success in the lower extremity joint replacement episodes,  
9 which have demonstrated good evidence -- maybe not "good";  
10 I'll let Renee comment on the evidence -- evidence of  
11 savings -- that's her job -- throughout the first part of  
12 the analysis. The current evaluation reports that are  
13 public are not as timely as we would like. I think that  
14 we've also provided some self-reported experiences from  
15 different participants where they talk about their  
16 experiences of the program, and you'll hear about some of  
17 those here.

18           But we also have some evidence of -- nothing  
19 statistically significant in the cardiovascular arena,  
20 that's what I would say. And generally speaking, we see  
21 concentration in several -- maybe seven or eight episodes  
22 that are very high volume, others not so much, and we feel  
23 like the participants tend to move around to find the best  
24 place where they can really dig in and focus.

1           Maybe I should stop there and let Renee go ahead  
2 and talk, and here's the results, the very early results,  
3 the Model 3 evaluation results.

4           MS. MENTNECH: This is Renee Mentnech. I also  
5 want to thank you for the chance to come here to speak. I  
6 have along with me -- to my right is Daver Kahvecioglu. He  
7 is actually the lead on our staff overseeing the evaluation  
8 of the bundled payment initiative Models 2 through 4.

9           Chris gave you a very brief overview of the  
10 results from the evaluation that are currently public. I  
11 think what we're finding is that the models where there is  
12 an opportunity to make decisions about post-acute care  
13 placement seem to be the ones where we're experiencing the  
14 best results, and mostly, it seems to be associated with a  
15 shift away from institutional post-acute care services  
16 towards home health.

17           The evaluation report that is currently available  
18 was very early on in the evaluation. So the results are  
19 fairly limited. We are in the process right now of  
20 drafting the next report, and while I can't speak to the  
21 results that will be in that report, I am going to give you  
22 a very quick overview of what you can expect to see in the  
23 report in terms of the topics that it covers. And we  
24 expect that report to be available towards the summertime,

1 hopefully no later than the fall. It will be much more  
2 extensive than the report that we've issued so far.

3           It will include an analysis of all the episodes  
4 that we had from the first 2 years from Models 2, 3, and 4.  
5 We will be covering a comprehensive description of the  
6 characteristics of the initiative and the participants as  
7 well as a section on the impacts of all these bundled  
8 payment initiatives on cost and quality, also looking at  
9 unintended consequences. There will be in the report, 20  
10 fuller clinical issue briefs that I think we did not have  
11 in the last report.

12           Regarding the characteristics of the initiative  
13 and the participants, the report will summarize the  
14 participants' readiness and entry decisions as well as the  
15 episode lengths and the selections that they made in terms  
16 of which episodes to focus on.

17           We plan to explore considerations for  
18 participation as a convener of the various partnerships  
19 that the conveners have established. So this will be the  
20 qualitative analysis that we present.

21           We'll be comparing characteristics of the markets  
22 with BPCI participants to those without bundled payment  
23 participants.

24           We'll be exploring in depth the various waivers

1 that were available, including, as Chris mentioned, the 3-  
2 day hospital stay waiver for SNF care, the beneficiary  
3 incentive waivers, the gainsharing agreement waivers, the  
4 telehealth waivers, and any home health service waivers.

5 We'll be looking at summarizing the care redesign  
6 efforts that the participants put in place and the  
7 challenges that they experienced and a little bit about the  
8 participants who exited the model and why they exited.

9 In terms of the quantitative impact analyses,  
10 this report will have a lot more than the past reports. We  
11 anticipate 140,000 episodes, covering 39 different, unique  
12 combinations of model episode initiator type and clinical  
13 episodes, and I think Harold mentioned that there are 48 of  
14 them. So this will be a very long and comprehensive  
15 report.

16 MR. MILLER: Harold will also mention that we  
17 should wrap up so we can ask some questions.

18 MS. MENTNECH: Very quickly, then, we will be  
19 looking at the quality of care, looking at claims-based  
20 measures, assessment-based measures, patient experience  
21 measures, looking at impacts on cost and expenditures,  
22 changes in patient mix, shifts in patient mix, market  
23 volume, and factors contributing to the variation in the  
24 monetary gains that various participants were able to

1 garner.

2 MR. MILLER: So thank you both.

3 We're going to open up for questions from the  
4 PTAC members.

5 Let me just ask you one question to get it  
6 started. Can you say something briefly about who in terms  
7 of physician groups you see participating and not  
8 participating? What kinds of physicians groups aren't  
9 participating, and what's the nature of their involvement  
10 on the ones where the hospital is the initiator?

11 MS. RITTER: So we have among our physician  
12 groups -- many hospitalist groups are participating in the  
13 model, and they work very closely with the hospitals with  
14 whom they are working, and/or in the reverse, if the  
15 hospital is the initiator, frequently hospitalists are with  
16 whom they are working.

17 We also have several participating orthopedic  
18 groups. That is our largest model, participation  
19 generally, and as discussed, one of the ones where people  
20 feel very comfortable.

21 We also have some other multispecialty groups  
22 participating, but predominantly, if you ask me, I would  
23 say hospitalists and orthopedic groups.

24 MR. MILLER: Other questions? Bob?



1 DR. BERENSON: I'm going to start with --

2 MR. MILLER: We'll see how good they are first.

3 DR. BERENSON: Yeah. Okay. Fair enough. I'll  
4 put that down.

5 One of the concerns that some people have raised,  
6 including myself about paying for bundles, is it is a form  
7 of fee for bundle. It is still volume-related. If you  
8 have more bundles, you get more payment.

9 Is there anything in the design of the models  
10 that addresses appropriateness of the episode? And in the  
11 evaluation, my understanding is that you're looking at  
12 what's happened to per-case spending, but is there any look  
13 at per-beneficiary spending associated with those services?  
14 In other words, a volume might increase in the community.  
15 It's much more complicated to do that, but the general  
16 question is, What do we know about the volume of services?

17 MS. RITTER: So I would say, generally, as  
18 pointed out -- and we definitely heard this about the model  
19 -- that there is no appropriateness assessment that's been  
20 built into the bundled payments for care initiative. It  
21 does initiate with the discharge or with the admission. It  
22 includes the hospital stay plus the discharge in Model 2.

23 I think that we have heard that. We know many of  
24 our participants of their own volition spend time looking,

1 but I think that's different. So I would say as a modeled  
2 sign, it does not formally consider appropriateness any  
3 more than any other ordering of reasonable and necessary  
4 services might consider under the fee-for-service program.

5 MS. MENTNECH: The only thing I would add is the  
6 initial analysis that we did in -- I think it's in the JAMA  
7 paper that Chris referred to -- at least for the lower  
8 joint, we did not see evidence of changes in volume at that  
9 point.

10 The analysis that we did, though, was fairly  
11 limited. So, in this next report, we are planning to look  
12 at volume in a couple different ways. One is increases or  
13 changes in volume at the institutions themselves and then  
14 also looking at the market that these BPCI participants are  
15 operating in.

16 DR. BERENSON: So you did that for the ACE's  
17 demo, that's going to be part of the BPCI evaluation also,  
18 is the volume in the community? Because one could argue  
19 from first principles that if you've got now an efficient  
20 place doing, let's say, hip replacements, there might be a  
21 redistribution of cases into that institution, or you could  
22 argue that there might be an increase as the competing  
23 hospitals sort of want to increase their volume or the  
24 index hospital finds that this is a lucrative business. So

1 you're going to be looking carefully at that.

2 MS. MENTNECH: Yes. We're not just looking at  
3 the BPCI participants themselves but also looking at the  
4 market that these BPCI participants are offering --

5 DR. BERENSON: Good.

6 So what I'm confused about then is that Elliott  
7 Fisher has a commentary on the JAMA article suggesting that  
8 volume was up. Was that wrong, volume at the hospitals  
9 that were part of the demo?

10 MS. MENTNECH: Well, since it was Daver's paper, I  
11 should probably let him comment, but I think it's fair to  
12 say that the -- I don't think Daver would disagree with  
13 this, but the volume analysis that we were able to do at  
14 that point was fairly limited. I think there have been  
15 other analyses suggesting that volume at least at the  
16 institutions themselves hasn't changed.

17 MR. KAHVECIOGLU: I don't know that I can say that  
18 Elliott's paper was wrong at this point. I think the next  
19 report will -- I think it was pretty early on in the model  
20 to be able to draw any conclusions at that point.

21 MR. MILLER: Okay. Questions from other members?

22 Paul.

23 DR. CASALE: Thanks for that presentation, and I  
24 know we are going to hear from some others who are

1 implementing these, but I'm just wondering if you can give  
2 us a sense of some of the feedback you've maybe gotten over  
3 the years from some of the people who have participated,  
4 particularly around unintended consequences, things that  
5 they sort of identified that were sort of deficient in the  
6 model or suggestions to change. Do you see some general  
7 themes around that?

8 MS. MENTNECH: Yeah. I think Chris actually had  
9 some plans to talk a little bit about what we had been  
10 hearing from participants.

11 MS. RITTER: Well, I think you have participants  
12 coming, so maybe we should let them do that.

13 I think, in general, folks find as they get into  
14 the model that it is much bigger effort for them to get  
15 under way to figure out exactly -- that's part of the  
16 things, I would say. It is a much bigger undertaking than  
17 they realize to just find out who is where and what's what,  
18 and they feel that coordinating the discharging, reaching  
19 out to the hospital, all of these things become very -- are  
20 much more challenging than I think they thought when they  
21 started. They put a lot in.

22 I think they also find loopholes in their own --  
23 what we hear. I had no idea had the SNF -- all of that is  
24 sort of part and parcel of getting under way, and it's a

1 much bigger lift. And for some of the institutions, it's  
2 too big a lift, and they feel like they can't get there.  
3 And we do see them drop out, and for others that really dig  
4 in and make an investment, we see them go forward.

5 MS. MENTNECH: I think the other thing I would  
6 add is we've recently -- I haven't been directly involved,  
7 but I have heard from the staff -- had opportunities to  
8 reach out to some of the participants to go over with them  
9 the data on their own feedback reports to help them  
10 understand what they're experiencing, and when we point out  
11 to them various patterns of care that we're seeing in their  
12 data, they're often surprised that we're seeing what we're  
13 seeing in the data, that they didn't sort of have a full  
14 handle on what was happening to patients once they sort of  
15 walked out the door and were discharged. However, that's  
16 where the opportunities exist for trying to do a better job  
17 of streamlining care and find efficiencies.

18 MS. RITTER: Yeah. That's a really interesting  
19 point.

20 I would note something that came up in a recent  
21 call they had, and then I know my lead for the project  
22 officers is on, if she wants to throw anything else out.

23 There was a hospital that has an incredibly  
24 efficient and coordinated internal system that had no idea

1 that their downstream wasn't working quite as well, but the  
2 amount of metrics that they could produce internally was  
3 amazing and knew almost nothing about what happened when  
4 they left, even though they were working very hard to  
5 participate in the program.

6           Amy, do you want to add anything else, since  
7 you're on the phone?

8           MS. BASSANO: No. I think in terms of one of the  
9 things that we heard as a point of feedback is just how we  
10 can revise some of the waivers to make them more  
11 advantageous for the awardees, more specifically, a skilled  
12 nursing facility waiver.

13           MR. MILLER: Okay. Let me keep going. I've got  
14 comment -- questions from Kavita, then Tim, then Grace,  
15 then Bob.

16           DR. PATEL: I will just make mine brief. Thank  
17 you.

18           So how -- and I know we'll hear from conveners  
19 and facilitators, but how have you thought about this  
20 dynamic interaction between APMs? Because one of the  
21 things that we'll have to struggle with is people bringing  
22 forward models, and certainly, we've seen a lot on both  
23 sides of the coin about the ACO-BPCI interaction. So maybe  
24 you want to start there, but then thinking broadly about

1 APM interaction, lessons learned, or ideas for the future,  
2 and then briefly kind of the MACRA issue, so kind of the  
3 lack of like a cross-walking to MACRA has also posed  
4 problems in my observation.

5 MS. RITTER: Well, there's no question we've been  
6 struggling for the kind of eureka paradigm that would allow  
7 us to reconcile all of the ACOs and the different bundles  
8 and the potentially new alternative payment models coming  
9 on, and I think that's true from a couple perspectives.

10 One is both operationally and how it relates to  
11 like the day-to-day of the participants in the model, the  
12 beneficiary and where they are and what they understand  
13 them to be in, and I think the evaluation in particular  
14 poses challenges that aren't the same as how, for example,  
15 the payment or quality might get reconciled.

16 You'll see in our recent rulemaking under the  
17 EPM, the episode payment models, that last rule, we took an  
18 approach that identified full-risk ACOs as being first for  
19 identification. So if you were taking full population risk  
20 prospective payment, then that was first, followed by the  
21 bundles, which is a shorter, more intensive period of focus  
22 from the participant and less so than like a kind of  
23 broader population focus retrospective, and then followed  
24 back into the ACOs.

1           I don't know that that's a good answer. That  
2 followed sort of a paradigm of who was doing the most,  
3 paying the closest attention, whether or not that is the  
4 way to reconcile some of these, in a kind of how to get  
5 there in terms of tiering, is difficult. I think each  
6 model that we look at, we have to think about differently  
7 in terms of what it's doing, who should -- how the  
8 population spreads, for example, where the concentration  
9 would be. And that's just operations.

10           Then I think Renee has another huge set of issues  
11 that have to be undertaken -- I should let her address them  
12 -- about needing sample size and being able to make some  
13 conclusions legitimately.

14           MS. MENTNECH: So the overlap issue from an  
15 evaluation perspective is very tricky and is an issue that  
16 we deal with in every single one of our evaluations, and  
17 it's getting trickier figuring out sort of what the right -  
18 - and the sample size issue alone is a big deal. That part  
19 of the reason why we can't look at every single episode is  
20 there's 48 different episodes, and when you look at that in  
21 relationship to the various different episode initiators,  
22 sometimes the sample sizes are just too small to be able to  
23 say anything. And then if you couple that with overlap, it  
24 becomes even more challenging. So figuring out what is the



1 right comparison group is a good part of the reason why it  
2 takes us so long to actually issue results, because if you  
3 don't get the comparison group right, you get the answer  
4 wrong. And so we spend a lot of time thinking about  
5 building a comparison group that is as well matched as  
6 possible, and we take into consideration all these overlap  
7 issues when thinking of how to construct the comparison  
8 group.

9 Up till this point, it hasn't been as big of a  
10 problem, but it's going to be a bigger problem as we go  
11 forward -- or I shouldn't say problem.

12 MR. MILLER: Okay.

13 MS. RITTER: Challenge.

14 MS. MENTNECH: Challenge.

15 MS. RITTER: Challenge.

16 DR. FERRIS: Thanks so much --great presentation  
17 and for your thoughtful answers.

18 You may be challenged by this question because it  
19 asks about the extent to which the design in the model  
20 itself, the payment model itself, provides an equal playing  
21 field for everyone in the country. We have a really big  
22 country, and the country is really diverse in terms of not  
23 -- and I am not talking about practice operations here.  
24 I'm talking about the design and how the design itself may

1 be unequal in terms of what people have to do to be  
2 successful in the model. And I just wondered if you have  
3 thoughts about that.

4 MS. RITTER: Do you have something in mind that  
5 could help? Is this in terms of where the sophistication  
6 of different practices in terms of being able to --

7 DR. FERRIS: No.

8 MS. RITTER: No, okay.

9 DR. FERRIS: No, this is about the model, the  
10 design of the model, and the benchmarks associated. So not  
11 in BPCI, but in other models, there's tension between the  
12 extent to which, for example, regional spend, like where do  
13 you start and how where you start affects your performance  
14 --

15 MS. RITTER: Yes.

16 DR. FERRIS: -- and so if someone has been doing  
17 this really well and has been all over this, are they  
18 relatively disadvantaged compared to someone who is  
19 starting here?

20 MS. RITTER: Yes.

21 DR. FERRIS: So it's in the design related to the  
22 heterogeneity of what --

23 MS. RITTER: Right.

24 DR. FERRIS: -- a practice in our country.

1 MS. RITTER: So absolutely. I think you've seen  
2 in the last two rounds of work that we've done both in next  
3 generation and the shared savings programs, an attempt to  
4 recognize the regional pricing, and so that you recognize  
5 where different organizations or groups of practitioners  
6 have been versus where they are going in an attempt to  
7 recognize kind of how far along each different -- both  
8 region and practice and/or hospital is in its design.

9 I think it is very challenging to find the right  
10 mix to do that. That will give you a pricing incentive  
11 that encourages without discouraging and still gets you all  
12 of the places you need to get. I think you're right, and  
13 we are struggling with it. And those are the two things  
14 that we've done to date, is mix in the regional pricing.  
15 But there's much more that could be done. I think we're  
16 thinking about that, and we'll have to see how it goes, but  
17 yes.

18 MR. MILLER: Grace.

19 DR. TERRELL: Last week, I went to a hospital  
20 bundled payment summit to learn more about this industry  
21 and what's going on in the world that's out there, and as I  
22 am listening to you this morning, I'm thinking about what I  
23 learned there as well as elsewhere, and I've kind of got  
24 several things I wanted to ask you about with relation to

1 my experience last week.

2           One is that a lot of the really innovative things  
3 that are being done that various participants were telling  
4 us about is redesigning things that is impacting the  
5 relationship with vendors in the pharma to a certain extent  
6 and in many ways probably should have been done already.  
7 Well, what that's done for the vendor side is they're  
8 wanting to come up with ways of actually partnering with  
9 the participants in new ways.

10           So one of my questions -- and I've got just four  
11 -- is, Are you all looking at the regulatory environment  
12 with respect to how this will change the relationship  
13 between vendors and participants in ways that might be  
14 conducive to what our goals are in this program, or is that  
15 something that's come up for you yet?

16           I'll just kind of go through my things here, and  
17 then maybe you can pick and choose how you want to answer  
18 these.

19           The second one is one of the things I was hearing  
20 loud and clear from many of the participants last week, was  
21 their frustration that so much of this is just about the  
22 acute hospital stay and therefore is DRG fixed in terms of  
23 the way it's being measured and evaluated, and they believe  
24 that there could be improvement if there was a way of when

1 appropriate to do site-of-service changes but is not  
2 particularly possible in a lot of this type of model. And  
3 there was a hint that perhaps some of that was being  
4 thought about in terms of some changes in this program.  
5 So, if that's true, I'd be interested to hear about it.

6           The third thing that was obvious last week is how  
7 early the industry is in terms of being ready for this.  
8 There was a complaint about a dearth of information.  
9 Obviously, this is still relatively early in your  
10 experience, and the complaints that we were hearing last  
11 week, a lot of it had to do with the time it took to get  
12 information back from the program, so there were a lot of  
13 workarounds going around. As you are trying to figure out  
14 how to do this in ways that are as effective as possible,  
15 what are you doing to engineer your own ability to get  
16 information back to people timely?

17           That's it.

18           MS. MENTNECH: A lot of these, I think apply to  
19 Chris, but I'm going to just take that last one about the  
20 dearth of information.

21           MR. MILLER: She was hoping they applied to you.

22           MS. MENTNECH: So I think you could think about  
23 information back to the participants in two different ways.  
24 One is around their reconciliation reports, and I'll let

1 Chris address that one. The second is around the feedback  
2 reports that get produced for the purpose of monitoring.

3           It's true it takes a while to have enough sample  
4 size that accrues to be able to report on an individual  
5 episode level, and what they really want is information at  
6 the episode level. And because these episodes are a  
7 certain length, you have to wait, one, for there to be  
8 enough accumulation of enough sample size. Then you have  
9 to let the episode end, and then you have to let the claims  
10 run out occur. So by the time that all sort of happens, it  
11 takes about four quarters after the end of a reporting  
12 period where you have enough sample size to report back on  
13 in the beginning. And then we start rolling out. We have  
14 been rolling out reports on a quarterly basis, but that  
15 first report takes a while.

16           We have been using the evaluation for the purpose  
17 of producing those reports, which has an added wrinkle  
18 because of the degree of rigor that we put into those  
19 reports. We believe -- we've been talking about ourselves  
20 -- that there's something sort of more timely but maybe a  
21 little bit less rigorous that we could speed up the  
22 production of those reports in the future, not in this  
23 current environment, but in future bundled payment  
24 initiatives where it would give them the information they

1 need for feedback purposes in a more timely way, maybe a  
2 little bit less rigorous in terms of comparators. But it  
3 does take a while for there to be enough episodes to report  
4 on.

5 But in terms of reconciliation reports, I'll let  
6 Chris talk to that.

7 MS. RITTER: So I guess we'll start -- let's  
8 start there and go backwards. Right now, reconciliation is  
9 occurring on a quarterly basis, and I think you'll hear  
10 from some of our participants that's a favored time frame.

11 We hear from our participants that that's even  
12 too short -- I mean, sorry -- that's way too long for the  
13 time that they have. They said, "If you're working with  
14 doctors, last week is so last week ago. That's like not  
15 close enough." For us, the Medicare program, we don't even  
16 see the claims for 9 months, sometimes. I don't know that  
17 we're ever going to meet in the middle right there. I  
18 think what we've tried to with the VPC -- with the  
19 reconciliation reports, is go quarterly right now. This is  
20 a very, very detailed and intensive process, because we  
21 have to vet gainsharing lists. They have to be looked at  
22 for fraud and abuse issues. We have to update everybody's  
23 episodes, plans. They have to get put in the system. They  
24 have to get run through the claims. So the, kind of,

1 operations involved in maintaining the quarterly structure,  
2 I don't know that we've been on time with that quarterly  
3 structure, and we have a really good team -- government,  
4 though we may be, it's actually pretty efficient -- going  
5 on a quarterly basis. And that's been probably the most  
6 frequent we, at our level, can handle. That's not to say  
7 that there aren't mechanisms that we've thought -- that's  
8 from a payment. Okay. Those are the payments flowing.  
9 That's not to say we haven't tried to think through, as  
10 Renee said, ways where we can improve the timeliness of  
11 data or other pieces of information that can go back to  
12 participants. And I'll just note that the quarterly  
13 process, we are -- we have really struggled under the onus  
14 of that, to keep it moving even with many, many, many folks  
15 helping us out.

16           So that's what I would say, generally, about the  
17 payment feed. But payment information to help you manage  
18 your program, I think those are two things that we look at  
19 to see if there's any way we can make it simple, more  
20 streamlined.

21           Another thing we hear, I'll point out to people,  
22 is that the data files that we provide, and one of the big  
23 benefits of participating in these programs is you get your  
24 own data from us that tells you everybody who is downstream



1 from you. Those -- we, right now, put them out in a file  
2 that's manipulatable by everybody, but we've certainly  
3 heard from participants in different programs that it's  
4 very difficult for them to manipulate them. They don't  
5 love dealing with claims the way Renee and I do.

6           So one thing we've certainly been thinking about,  
7 we've made it available in a form that everybody can use,  
8 but we've been trying to figure out if there's ways we can  
9 improve on that, so that you have something that's a little  
10 more digestible for people. So those are all things we  
11 continue to work on, to try and make that flow of  
12 information as available as possible. That's not to say  
13 we'll meet everyone's expectations, but that would be  
14 certainly a goal, as you guys think about what could go  
15 into programs.

16           For the frustration about being very DRG fixed,  
17 it's true. Certainly one of the things we've said we're  
18 thinking about, as we think about the next version of  
19 bundled payments, is whether we could, for example,  
20 incorporate some outpatient components to it. So I think  
21 that's there. I'm not in a position to say what that will  
22 look like right now, but certainly we've heard those are  
23 areas that we need to start thinking about. Whether that  
24 would be true site-of-service, as in the pricing same, I

1 think those are all issues we've been struggling with, so  
2 that the incentives that are made are appropriate. But,  
3 yes, I think, you know, we definitely hear that.

4           And another one we hear quite a bit about, which  
5 Dr. Berenson already raised, is the appropriateness  
6 component of feeding into the program versus having it  
7 occur at admission.

8           And then I think another thing, to go back to  
9 your first question, which is relationship with vendors, so  
10 some of that has to do with how the gainsharing waivers are  
11 created. In order, for example, I think what you're  
12 alluding to, and we've heard from AdvaMed and others about  
13 creating gainsharing between various vendors, so that they,  
14 too, could benefit from the value relationship. If I give  
15 you something and you benefit, then you could share back  
16 for me, for example, in the lower joint arena. Right now  
17 we're not able to do that with the structure of the fraud  
18 and abuse waivers. We hear that loudly. We think there's  
19 some very good thinking in this area, very creative. For  
20 the record, the Office of the Inspector General is the one  
21 who issues the fraud and abuse waivers and they are their  
22 own entity. I can't speak for them. But we are aware that  
23 that's an area of interest, and it makes sense.

24           MR. MILLER: Okay. One final question from Bob

1 Berenson and one final quick answer to Bob Berenson's  
2 question.

3 DR. BERENSON: Total cost of care and the length  
4 of the episode. I assume that the farther you go from a  
5 hospital discharge towards 90 days, more and more of the  
6 costs of a beneficiary are not related to the, let's say,  
7 joint replacement under Model 2, but to a whole series of  
8 other medical conditions they might have.

9 So the question is, I'm assuming -- but correct  
10 me if I'm wrong -- you're using a total cost of care  
11 analysis on spending. I'm aware of where I am and I don't  
12 want to denigrate orthopedists, necessarily, but are  
13 orthopedists the right people to be accountable for total  
14 cost of care for patients with a myriad of conditions, and  
15 do we know, qualitatively, how they actually attempt to  
16 address total cost of care, unrelated to the joint  
17 replacement?

18 MS. MENTNECH: So I think it's entirely true that  
19 the further you get away from the indexed stay, the less  
20 likely something is related. In this model, the way it's  
21 designed, there are choices that the participants made in  
22 terms of the length of an episode. So we do, actually, in  
23 the evaluation, take an approach where we standardize and  
24 say we're going to look at everybody on the same playing

1 field, so we look 90 days out.

2           Within that episode of time we are looking at  
3 total cost of care. We're not looking at total cost of  
4 care on an annualized basis but we're looking at total cost  
5 of care within a time period of 90 days. We're looking at  
6 things like is there a shift in the kinds of services for  
7 which these expenditure are going towards within that 90-  
8 day period? We are also looking to see if costs are sort  
9 of shifting outside of the window of the bundle.

10           So there's a lot of different ways that we're  
11 looking at cost, but I don't - we're not going to be able  
12 to answer the question about appropriateness in terms of  
13 should the orthopedic surgeon, for example, have been  
14 attributed this cost. The evaluation isn't looking at it  
15 in that way, but we are looking at total cost of care.

16           DR. BERENSON: Do you have a ballpark for, at day  
17 89, what percentage of a beneficiary's spending, who has  
18 had a joint replacement, is associated with the joint  
19 replacement? Do you have a ballpark for that?

20           MS. MENTNECH: Is associated with the --

21           DR. BERENSON: With the --

22           MS. MENTNECH: -- from a clinical perspective is  
23 related?

24           DR. BERENSON: -- joint replacement from a

1 clinical -- yeah.

2 MR. MILLER: During the episode.

3 DR. BERENSON: Using an episode group or  
4 something to just get a sense of how much of that spending  
5 --

6 MS. MENTNECH: We have not applied --

7 DR. BERENSON: -- at that point -- what's that?

8 MS. MENTNECH: We have not applied an episode  
9 grouper that's clinically based, to try to tease out what  
10 proportion of the costs associated with the bundle, or the  
11 time period of 90 days, is attributable back to the  
12 episode, but it's actually an interesting idea.

13 MR. MILLER: Okay. We're going to need to  
14 transition to our next segment. Thank you to the three of  
15 you from CMMI for coming and for providing --

16 DR. BERENSON: Thank you.

17 MR. MILLER: -- very helpful information.

18 So our next speakers, come on up. We're going to  
19 have everybody come up. Danielle Lloyd is here from  
20 Premier, Inc. We have both Steve Wiggins and Carolyn  
21 Magill. Steve is the Founder and Chairman of Remedy  
22 Partners and Carolyn is the CEO of Remedy Partners. They  
23 are both groups are conveners of the -- of various  
24 participants in the BPCI program. I'll let them say what

1 more they want to say about their involvement, but I would  
2 note that they have somewhat different relationships with  
3 their participants. Premier has been involved in the ACO  
4 program heavily, as well as in the BPCI program, but does  
5 not share risk with its participants. Remedy does share  
6 risk with their participants, so they're somewhat different  
7 in that regard, and also has somewhat different types of  
8 participants.

9           So we're going to -- Danielle won the coin toss  
10 so Danielle is going to start. Each of the teams is going  
11 to take 10 minutes each. We'll do both sets of  
12 presentations and then we'll do questions for everybody  
13 afterwards.

14           So Danielle, you're on.

15           MS. LLOYD: Okay. The question is how do we get  
16 to our slides?

17           MR. MILLER: That is beyond my pay grade.

18           [Laughter.]

19           MR. MILLER: Click. Just click. Click, she  
20 says. They should all be in order.

21           MS. LLOYD: We just need the next deck.

22           Okay. So I'll go ahead and start anyway, without  
23 the slides.

24           MR. MILLER: We actually have slides in our books

1 so we can look at those while you start --

2 MS. LLOYD: Okay. Great.

3 MR. MILLER: -- and we'll try to catch up for the  
4 audience.

5 MS. LLOYD: So 2 seconds on Premier. So, first  
6 of all, thank you for having us to share our experiences  
7 and learning from this program. Premier is a unique  
8 organization. We are an alliance of 3,700 hospitals  
9 nationwide, as well as 120,000 alternate sites, so that's  
10 physician groups, skilled nursing facilities, et cetera.  
11 We are -- as Harold said, we are a facilitator convener  
12 within BPCI, but we do also have, as part of our bundling  
13 collaborative, organizations that are part of the CJR,  
14 Comprehensive Care for Joint Replacement; EPM, the Episode  
15 Payment Models; as well as OCM, the Oncology Care Model.  
16 So we've got about 130 providers who are within those  
17 different bundling systems on the ACO side. We've got  
18 about 400 hospitals that are part of ACOs and 45 that are  
19 part of the Medicare Shared Savings Program.

20 So we certainly believe that the value-based  
21 purchasing program, the ACO program, bundles, et cetera,  
22 that with these types of new systems we can really improve  
23 the sustainability of health care as well as -- now she  
24 took the clicker, though, so we can't move them forward.

1 MR. MILLER: You can't have both slides and a  
2 clicker, Danielle.

3 MS. LLOYD: I know. MR. MILLER: You've got to  
4 pick.

5 [Laughter.]

6 MS. LLOYD: I'm asking for too much. I'm sorry.

7 So that with these different types of programs we  
8 can improve health care sustainability as well as quality  
9 of care.

10 So we're starting with the eye test here, so I've  
11 got it printed out myself, too. A lot of folks have asked  
12 us -- thank you -- for -- you know, what conditions are  
13 working, are not working? You know, how is it that you  
14 choose bundles? Why are -- you know, which ones do you  
15 think you're going to be successful at, et cetera. Now,  
16 noting that these are health systems and a small slice of  
17 the full pie, so it is a biased sample here. We didn't put  
18 anything in here that has only one participant, lest you  
19 figure out who they are. So this is just an example, some  
20 examples.

21 But as you can see here, some of the things that  
22 we look at, and we have found as a first for the health  
23 systems, the procedural-based ones are easier. Not  
24 surprising. The other things that we look for is the



1 amount of post-acute care spend in the episode, so anything  
2 that has greater than 50 percent of the episode cost  
3 associated with post-acute care would be something we would  
4 look into, two things that we are obviously trying not to  
5 pick, based on our higher variation of costs within the  
6 episode or the likelihood of outliers, essentially, and  
7 certainly low volume can lead to variability. That's  
8 treated differently in all the different bundling programs  
9 but that's of concern as well.

10           So what you can see here in the green are the  
11 conditions for which we have -- our bundlers have saved  
12 money, the yellow are the ones where they have saved but  
13 not been able to achieve the discount, and then the reds  
14 are the ones where they've actually overspent the target.  
15 So, again, the procedures tend to be ones that the  
16 organizations do better, but also you can see some of the  
17 extreme negatives here, for instance, is diabetes, right, a  
18 medical condition. And you can see on the top end we're  
19 topping out at around 7 percent. So you guys can look at  
20 that later, but I'm not going to use all my time there.

21           So let's go ahead and talk about sort of the kind  
22 of the good, bad, and the ugly from our perspective, as  
23 conveners, and noting, again, that we have participants in  
24 all of the different bundling programs. Our perspective is

1 that we've been very pleased with CMMI in terms of its  
2 ability to now dynamically test and take things that we  
3 learn and build them into the new programs. So we really  
4 see it as an evolution from BPCI to CJR and then the EPM  
5 rules, which, as you know, are on hold, that despite the  
6 fact that some of those are hospital-based models, there  
7 are aspects of the methodologies that we think should be  
8 applied to even the physician-focused models.

9           In terms of the data, which is interesting given  
10 Grace's question, we think that the data feeds have  
11 actually been quite good. This is an unprecedented amount  
12 of data that we're getting through these different  
13 programs. We're getting very large claims files.  
14 Particularly we're pleased with the baseline data in  
15 advance, so that you can really determine whether or not  
16 you should be in the program altogether, let alone which  
17 bundles, and do your care planning.

18           The monthly data feeds have been very valuable.  
19 It went to quarterly for CJR and EPM. We were not  
20 particularly pleased with that. We're hopeful that monthly  
21 will be par for the course going forward.

22           As you might imagine from provider groups, we are  
23 very much supportive of the voluntary nature of BPCI, as  
24 well as your ability to choose which bundles to enter. A

1 lot of the -- you know, the organizations can't boil the  
2 ocean. They look at things where they have a particular  
3 physician champion, et cetera, to decide where to go first.

4 In terms of the gainsharing caps, that's  
5 something that has evolved a bit as well. So this is where  
6 the physicians -- I think Chris may have mentioned this --  
7 but in terms of gainsharing, the physicians can't receive  
8 more than 50 percent of what they otherwise would have been  
9 paid. Initially, in the beginning of the program, there  
10 were organizations, physician groups, who basically  
11 asserted that if you have a dollar come in through BPCI to  
12 a physician group and it is distributed in the same way  
13 that they distribute, essentially, all of the payments that  
14 come into the group, that it's not a gainsharing dollar,  
15 and thus the 50 percent cap would not apply. Once you get  
16 to the EPM rule, it's made clear that those caps should  
17 basically apply in all of the situations for physicians.  
18 And we think that that's valuable because you don't want to  
19 get to the point where, basically, a dollar saved is a  
20 dollar earned, because it creates too much of a perverse  
21 incentive for the physicians.

22 So moving on to some of the barriers, not  
23 surprisingly, I have two slides for barriers and one for  
24 good things.

1 [Laughter.]

2 MS. LLOYD: We think in terms of the target  
3 pricing there are some concerns there. Again, this works a  
4 little bit differently across each of the bundling  
5 programs, but the baseline for BPCI is held fixed for a  
6 three-year period and then during the performance period it  
7 is trended forward quarterly, and so that causes sort of  
8 this race to the bottom to go very quickly. And partially  
9 this is also because the underlying trend is often  
10 decreasing. So if you look at joints, for instance, the  
11 general national trend is for the cost for an episode to go  
12 down. So what started as a 2 to 3 percent discount is  
13 really effectively, by 2016, a 10 percent discount. So  
14 that has been problematic.

15 In terms of the implementation protocol, that  
16 basically is the application. So you think about the  
17 organizations have to apply to be part of these programs,  
18 and they're very extensive, and we think probably could use  
19 some streamlining.

20 In terms of precedence rules, which I know was  
21 mentioned by CMS so I won't go through what that is, it  
22 does create some confusion, both within the program and  
23 among programs. I have a sort of crazy chart that goes  
24 through what goes first -- Who gets the beneficiary first?

1 Right? You get independence at home first, then you have  
2 NextGen, then you have MSSP Track 3, then you have ESCO  
3 First Touch. It's a crazy document. We're not entirely  
4 sure it's accurate either --

5 [Laughter.]

6 MS. LLOYD: -- because it hasn't been truly put  
7 out transparently. We just sort of ask FAQ by FAQ to the  
8 e-mail boxes.

9 So with these precedence rules, you find yourself  
10 in a couple of situations. First, within BPCI, a hospital  
11 may have -- basically, physicians always get precedence  
12 over the hospitals. So even if the hospital has the  
13 surgeon, if the physician group has the attending, the  
14 physician group gets it, with the exception of the very  
15 first cohort within that program.

16 So the second thing is when you look at these  
17 across and you think of CJR, for instance. If you have a  
18 hip replacement patient coming into a CJR hospital, the  
19 hospital thinks it's theirs. Well, if the surgeon or the  
20 attending is a BPCI physician, well, that's not our bundle  
21 anymore. If the patient is discharged to a Model 3 post-  
22 acute care site, that's not our bundle anymore. And so at  
23 some point, you know, how are you going to know who should  
24 be starting the care protocols and who should be calling

1 the beneficiary, for that matter, because they're going to  
2 get confused as we all start to implement these protocols.  
3 And certainly our concern with a number of these is that  
4 the health system-associated physicians are at a  
5 disadvantage to the independent physicians.

6           In terms of discounts, there is a uniform  
7 discount across all of the different conditions, so we find  
8 that that causes some organizations to simply not pick  
9 certain episodes. The other things is risk adjustment.  
10 We're not entirely sure that the risk adjustment system is  
11 adequate as of yet, particularly for the medical conditions  
12 where there are more comorbidities, et cetera.

13           And then also on the quality metrics, there are  
14 no quality metrics applied to payment in BPCI. There are  
15 metrics but not applied to payment, and there are no CEHRT  
16 requirements, which is a concern for becoming an advanced  
17 APM. When you look at something like CJR and EPM, where  
18 there are quality metrics, they're also not ideal. So  
19 within both of those programs, HCAHPS, for instance, the  
20 patient experience instrument, is used, but it's used for  
21 the entire hospital, not for the joints or for the cardiac,  
22 so it's not exactly telling. Or for something like shifts,  
23 the fractures, there are no measures that are specific to  
24 fractures. They use the non-fracture quality measures.

1           So two quick other things. Legal waivers, as  
2 were mentioned, these are very important tools. There have  
3 been some -- We've actually discouraged our participants  
4 from using the skilled nursing facility waiver because of  
5 issues with the process there. You can have episodes that  
6 are cancelled for various reasons, which means you lose the  
7 waiver, and theoretically, the beneficiary is on the hook.  
8 We've had difficulty getting it approved for us to eat the  
9 cost for those beneficiaries, so we don't want to be in the  
10 situation of, you know, of basically lumping that fee onto  
11 the beneficiaries.

12           And transparency, I think, it was -- and I'm sure  
13 Steve will comment on this -- I think it was a bit of a  
14 rough go at the beginning, but I think we've improved quite  
15 a bit. There was a part at the beginning where we had to  
16 meet as conveners and sort of say, "Did you see this in the  
17 data? Did you see this? You know, what's going on here?"  
18 It's a lot better now, but nobody has the national data to  
19 replicate anything, which is troublesome.

20           So if I hadn't gone fast enough, I'm going to zip  
21 through this list very quickly, a few things that we think  
22 are key to moving forward with new bundle programs. We  
23 agree that they should be voluntary, that the transparent  
24 methodologies are important, that there should be more than

1 one opportunity for you to enter the program, like the  
2 current NextGen and CPC, et cetera. We --

3 MR. MILLER: Let me just suggest, focus on the  
4 things that are most relevant to us approving a model,  
5 rather than how CMS should implement the model.

6 MS. LLOYD: Okay. Well, I think these apply to  
7 you in reviewing PTAC as well. So, for instance, as Model  
8 2, that you should be looking at models that are more  
9 broader, that are more inclusive and longer episodes, so 90  
10 days, et cetera.

11 Certainly you want to make sure anything is an  
12 advanced APM. Patient assessment instruments I think are  
13 very important because it does help with some of Bob's  
14 questions on how do you start getting a sense of whether or  
15 not the patient is actually appropriate for this bundle.  
16 It's something that was not built into the workflow with  
17 BPCI and thus was essentially removed. Risk adjustment,  
18 obviously more research is needed there.

19 So I would say in terms of the pricing pieces, we  
20 do believe that regional pricing is appropriate, that the  
21 NextGen way is actually quite elegant, where you're both  
22 looking at your relative costliness within the region, as  
23 well as to the nation, and that also the variability and  
24 the target pricing has been very difficult. So setting the



1 target in advance, or prospectively setting the target --  
2 not prospectively paying us but setting the target, so that  
3 we know what it's going to be, is important. And when  
4 you're trending the target, you should take the bundlers  
5 out of the national trend, because we are helping drive  
6 that down, which is difficult in terms of looking at us  
7 versus, basically, everyone else.

8           The last thing I would just say here is the  
9 overlap piece is a really important one from our  
10 perspective. We think that, again, within the program and  
11 across the program, that we really need to figure out a way  
12 to better account for this, and, in particular, we think  
13 one thing that should be tested, which hopefully we'll be  
14 back here to present on, is a layered model, where you're  
15 intentionally testing partial capitation, inpatient and  
16 outpatient bundling, within an ACO cap, all in one model,  
17 where the providers are choosing to come together to test  
18 this model, where they, themselves, are working out the  
19 overlap within a single, essentially legal organization.

20           MR. MILLER: Thank you, Danielle. I'm going to  
21 turn it over to Steve.

22           MR. WIGGINS: Thank you. Okay.

23           So -- well, first of all, thanks for allowing us  
24 to be here and talk with you and give you our feedback. We

1 appreciate greatly, and we have a lot of things to share,  
2 so I'll jump right into it.

3           But to start, since some people don't know what  
4 an awardee convener is, I just want to cover what an  
5 awardee convener is so that everybody understands. And I  
6 got into this because I volunteered to go to work at CMS.  
7 They didn't take me up on it, and Rick Gilfillan said, "I  
8 need you out there. Providers are going to need help going  
9 into these models, and you've had experience doing that."  
10 And so that's why here I am. I've been doing this part-  
11 time. It's not been my day job. I'm the Chairman.  
12 Carolyn is actually the CEO of Remedy, just to be clear,  
13 but she's new and I don't want to throw her to the wolves  
14 quite yet.

15           [Laughter.]

16           MR. MILLER: Oh, we're not wolves.

17           [Laughter.]

18           MR. WIGGINS: So the objective of an awardee  
19 convener is essentially to enable both CMS and the  
20 providers to succeed. This is complicated. For someone  
21 like myself who got into bundles in the early 1990s, we  
22 built the largest commercial bundle program in the  
23 business. I built Oxford Health Plans in New York. We  
24 grew it to be a very large commercial bundled payment

1 program. One thing we learned is that this is the toughest  
2 contracting challenge that there is. You need a lot of  
3 people to help providers succeed. They need a lot of tools  
4 and technologies surrounding them, so that they can be  
5 successful.

6           If you go to the second slide in my deck, what  
7 exactly an awardee convener does, think of an awardee  
8 convener like an ACO. That's a special purpose entity, or  
9 an IPA, or a physician hospital organization. It's the  
10 entity that enters into the contract with the payer. In  
11 our case, we have a contract with CMS. We're now bringing  
12 commercial insurers into bundled payments, and we're in  
13 active dialogs right now with all of the major commercial  
14 insurers, and you might be interested to hear what they're  
15 doing because it is instructive. They have very strong  
16 views about how their programs should evolve.

17           But as Alan Muney, who is the Medical Director of  
18 Cigna said, he gave a speech recently and asked for a show  
19 of hands of everybody that's willing to take downside  
20 financial risk in bundled payments, and two out of a room  
21 full of providers raised their hands, which provided  
22 evidence to him that you need somebody that sits alongside  
23 for a while. One of the organizations in Premier's program  
24 now is an organization with us for three years. One of our

1 most successful organizations, they can go from working  
2 with us to not working with us, and they are free to do  
3 that. It's voluntary.

4           But essentially what we do is we help CMS and  
5 Medicare bulk up the program because it's hard to recruit  
6 participants. You have to, in some respects, persuade  
7 people, because there's a lot of reasons not to do it.  
8 It's very risky. Risk in bundles is the square root of  
9 program size, so when you go into one bundle in one site,  
10 you're really increasing your relative risk of being in  
11 these programs. As someone that has taken actuarial risk  
12 all my life, all my professional life, I can assure you  
13 these are particularly difficult actuarial challenges at  
14 small scale.

15           And so if you're not going to have systemic  
16 adoption of these payment models, you're adding to your  
17 relative risk as an organization. And so what we do is we  
18 help organizations have the nerve to do 10 or 12, not one  
19 or two, because if you're not making systemic change, then  
20 it's really hard to really make change in a lot of these  
21 organizations. They have a difficult time with that.

22           We also have about 150 people managing software.  
23 We build and deploy software that helps these  
24 organizations. It integrates with their EMRs. We have

1 over 980 integrations where we're pulling the EMR data.  
2 We're sorting through it to figure out which one is their  
3 bundled payment patient.

4 MR. MILLER: Just in the interest of making sure  
5 you get through all your comments, I think we've got a good  
6 advertisement for Remedy now. Let's go on and talk about  
7 the BPCI program.

8 MR. WIGGINS: Actually, that wasn't my point  
9 because what I'm doing, Harold, is the same thing that any  
10 awardee would do. I'm just trying to outline what an  
11 awardee does. So I won't go into it if you've read the  
12 loop there that we have. Right now awardee conveners have  
13 about 62 percent of the BPCI participants, so the program  
14 would be much smaller. You're much less likely to drop out  
15 of the program if you have help; 35 percent of the single  
16 awardee participants dropped out of the program, which, of  
17 course, for all the reasons that Chris just described, this  
18 is very complicated.

19 If you go to the next slide here, just in terms  
20 of scale so that you understand with my comments what I'm  
21 talking about, we are actively managing alongside our  
22 partners programs inside of acute-care settings. We have  
23 partnerships with physician groups and hospitals, so we  
24 work with either. We're agnostic. We don't have a

1 viewpoint, maybe as Danielle might have, of which is better  
2 or -- we'd like to make them all successful. I think  
3 Medicare needs them all to be successful.

4 Right now, the perspective that I offer is based  
5 on about 300,000 episodes annually. We are saving at  
6 Remedy Medicare \$120 million dollars annualized at present  
7 off of the baseline.

8 If you go to page 7, it shows you data that we  
9 got approval from CMS to release, which is our aggregate  
10 savings rates across all that spending on the previous  
11 page. So a very different story than maybe you've heard.  
12 But across this \$5.7 billion dollars of spending, it  
13 doesn't start out necessarily successful right away. I  
14 think the Lumen report, as was mentioned, was reflective of  
15 a time when very few people were in the program yet. It  
16 hadn't really matured. Organizations need a lot of time to  
17 get their change processes in place. But as you can see,  
18 once you do that, it can be rewarding both for Medicare and  
19 for the participants.

20 If you look on the next slide, which is patient  
21 outcomes, you can see that on patient outcomes, as Chris  
22 mentioned and as CMS in the presentation said, SNF  
23 admissions are going down. Readmissions, however, are not  
24 going up; they're going down. So there's a meaningful

1 reduction in readmissions despite more careful use by our  
2 partners in the skilled nursing facility. Part of that is  
3 they're using decision support tools during discharge  
4 rounds that are helping them to have a better idea of what  
5 the patient needs, where they could successfully recover.  
6 And, of course, the goal is a successful recovery.

7           On the next slide, I'd like to address something  
8 that was touched on, which is we believe that bundles and  
9 population health go together. The reason years ago I got  
10 into bundled payments is I had a big -- I had 2.5 million  
11 people in various forms of population health at Oxford, and  
12 I really needed something to manage the care. During that  
13 very intense period of time when the specialists were  
14 dominating the care and the connection to the patient, in a  
15 typical episode of care we will see anywhere from 4 to 14  
16 physician groups. We'll see a large number of physicians  
17 touching the patient. Many times in an episode we will --  
18 we can't find a primary care claim, and so we don't want to  
19 lose that patient during that period of time to the  
20 coordination, and so it's best if these are together. I've  
21 encouraged my ACO brethren -- and we overlap with a lot of  
22 ACOs -- to actually become participants in the next phase  
23 of this.

24           My observations as I think about the program,

1 first of all, I think CMS is doing a fantastic job. This  
2 is hard stuff. They made the right tradeoffs as they  
3 designed these bundles. They've been incredibly  
4 collaborative, and I'm not just trying to suck up to the  
5 CMS people. But I will say I've known everybody that's run  
6 CMS for my career, and I think that they've done as good a  
7 job as I've ever seen CMS do rolling out a program. I was  
8 involved way back in Medicare+Choice and some of those  
9 initiatives. It's having a big impact in the C-Suites of  
10 health care organizations. We've observed that any type of  
11 organization can be successful. Physician groups we find  
12 modify their practices quicker and can be the most  
13 successful early. But all types of organizations succeed,  
14 to the point that maybe bundles are only appropriate for  
15 procedure episodes. Seventy percent of the medical  
16 episodes in our -- I'm sorry, 70 percent of the total  
17 episodes in our program accrete through the ER, which is  
18 why we went out and encouraged hospitalists to participate  
19 so aggressively, because we wanted to be connected to those  
20 organizations that were most meaningfully involved in some  
21 of the key decisions.

22           On the next slide, on the financial slide, it  
23 costs a lot. It generally costs someone that is going into  
24 the program and buying point solutions anywhere between 4



1 and 6 percent. That's published in literature that I'm  
2 sure you can find on the Internet from people that have  
3 published about their experience. When you share it over  
4 large programs, you can get that down to 2 percent, but  
5 it's still expensive. We spent \$100 million. We have  
6 partners that have spent \$30 and \$40 million, individually,  
7 organizations. One large physician organization has spent  
8 very meaningfully on this program.

9           In terms of my principles for what I think is the  
10 right way to go, first of all, I think you need fair and  
11 transparent pricing policies. The baseline prices need to  
12 be stable for three to five years. The biggest reason  
13 providers will say, "I don't want to participate," is  
14 they're afraid of being ratcheted down by their own  
15 performance, and so they're very afraid of that.

16           CMS has done a very nice job of providing  
17 transparency on a lot of things. They give us monthly  
18 claims files, so if you know how to use those, you can  
19 provide response to Grace's concerns of much more  
20 meaningful and immediate feedback.

21           The second point I'd make here is you want to  
22 have a program that meets the needs of Medicare. Medicare  
23 needs to get a lot of spending into these programs that  
24 have the really meaningful savings, and this is proving to

1 have a higher level of savings, at least in our program,  
2 than any of the payment models that we've seen at this  
3 scale.

4           To do that, you need to encourage all types of  
5 organizations to participate. With all due respect to  
6 Premier, I don't think that it should be a hospital  
7 centric. I think any type of organization that's willing  
8 to take the risk should be allowed to do that, much like a  
9 private insurer would view it. Facilitators, awardees --  
10 you're going to need them all. You need to really harness  
11 the power of the free market to succeed here to make a dent  
12 in what some of the Medicare goals are.

13           I think that there should be an incentive for  
14 organizations that take more than 10 episodes or 12  
15 episodes. There should be an increased discount, because  
16 if they're taking that much risk, they're trying to make  
17 that systemic change, it shouldn't be a flat discount  
18 across the board. That's one of the things I've advocated.

19           I would be careful --

20           MR. MILLER: You mean a smaller discount for  
21 people who take on --

22           MR. WIGGINS: Correct. So instead of a 2 percent  
23 discount on Model 2, you might have a 1.5 or a 1.75, or  
24 something that is an incentive for organizations to make

1 the systemic change that this represents.

2 I would avoid some of the things I saw in the  
3 Brandeis piece, which was a very prescriptive approach to  
4 gainsharing. I think you allow that to be more organic. I  
5 don't think it's the role of rulemaking to figure out --

6 MR. MILLER: I'd rather not get comments on other  
7 people's proposals.

8 MR. WIGGINS: Fine.

9 MR. MILLER: This is about the BPCI.

10 MR. WIGGINS: Fair. I wasn't sure based on your  
11 guidance, Harold, to stay on the things that you would do  
12 in a set of recommendations, and so one of the things I  
13 would avoid is prescriptions on gainsharing programs.  
14 That's being handled quite nicely in the market, and to  
15 Danielle's point, even between payment models, I think the  
16 marketplace can do a pretty good job of that.

17 As to precedence rules, the last point I'd make  
18 here, I think if you're an insurance company or if you're  
19 Medicare, any payer needs to retain their flexibility to  
20 innovate on payment reform at the most granular level and  
21 reconcile from there. Just as Medicare has things like  
22 competitive bidding on DME, just like there's home health  
23 resource groups for home health agencies, there's DRGs for  
24 hospitals, bundles are another level up in that lower level

1 granularity. And in all reconciliations, they should  
2 reconcile from granular up. That's generally consistent  
3 with the patient's experience. And a patient-centric view  
4 going up I think is going to lead to the preservation for  
5 Medicare of the greatest degree of flexibility long term in  
6 how they manage these programs. So thank you for that.

7 MR. MILLER: Great. Thank you both.

8 Okay. We're open for questions from PTAC  
9 members. Len?

10 DR. NICHOLS: Yes, I have one for each.  
11 Danielle, I was struck at your slide on risk adjustment,  
12 because one of the issues I'll just say generically we have  
13 observed is that creative people coming up with new ideas  
14 cannot possibly have the data to do risk adjustment ahead  
15 of time. So talk to me about what you knew when your  
16 colleagues entered the BPCI. How clear were the data about  
17 how the risk adjustment was going to work? Were the  
18 parameters all specified ahead of time? Did CMS give that  
19 to you all, or did you all work it out in some kind of what  
20 you might call trial period?

21 MS. LLOYD: Yeah, well, the risk adjustment --  
22 and CMS can get up here and correct me, but the risk  
23 adjustment takes a lot of different forms. There is case  
24 mix adjustment. There is the winterization, the outliers,

1 there's empirical base for low volume. I'm missing  
2 something else. But it's all sort of the exclusions, and  
3 the exclusions are something that is evolving over time of  
4 what exactly needs to be out of the episode.

5           But I think we had a pretty good sense at the  
6 beginning. I think we all sort of struggled a little bit  
7 on the application of the empirical base and such can be  
8 quite complicated. But I think that it's only after a time  
9 that we're starting to realize which episodes that is  
10 becoming more difficult within and which ones we're finding  
11 that comorbidities and complications we think anecdotally -  
12 - this is where the evaluation will come in, and Renee will  
13 be able to tell us with the next pass -- that it is more  
14 cumbersome.

15           But we don't know -- this is not like a magic  
16 bullet thing. It's not like we can just say, oh, go pick  
17 up HCC. We know on the ACO side they use that, but they  
18 also cap it so that you can't -- the continuously assigned  
19 can't grow; they can only -- you can only lose payment, you  
20 cannot gain payment.

21           DR. NICHOLS: Right.

22           MS. LLOYD: Because they're so afraid of code  
23 creep. So there are some other ways to do it like the  
24 Model A episode grouper and such. I don't think that we

1 can say what's the best way to go. We can just say that we  
2 think that this is probably more complicated than it needs  
3 to be, and it's not quite achieving the result we would  
4 like to see.

5 DR. NICHOLS: So that segues into my question for  
6 Steve, and I wonder if there is a role for reinsurance for  
7 providers thinking about entering into these kinds of  
8 arrangements before, that as you put it, they don't feel  
9 ready. They may be ready. What can you tell us about  
10 that?

11 MR. WIGGINS: Well, first of all, on the subject  
12 of risk adjustment, you're talking to the wrong guy because  
13 I don't think we should be risk-adjusting Medicare  
14 Advantage either, because at some scale you have enough  
15 risk under -- you've taken enough risk that you've smoothed  
16 those outliers. And Medicare has done a nice job in their  
17 pricing. The risk adjustment is only the DRG. The  
18 truncation points that were mentioned are the reinsurance.  
19 That's a different point. And they've also offered very  
20 fair free reinsurance. You can't buy free reinsurance in  
21 the market. Medicare's offering free reinsurance. There's  
22 no friction costs. Normally to buy reinsurance, I pay a  
23 dollar, I get 50 cents back. In Medicare, they provide  
24 truncation of the episode. If you think of a bell curve of

1 the financial outcomes, they truncate it at the 99th, the  
2 95th, and the 75th, and you can choose by bundle, by  
3 episode initiator, how much risk you want to take. I think  
4 that's a very fair way to do it. We've suggested that to  
5 all the major payers. We think Medicare's model is one  
6 that should be rolled out as a way to go forward.

7           But risk adjustment shouldn't be confused with  
8 episode definitions. You can adjust the provider's risk by  
9 how you define the episode. Right now, Medicare has done a  
10 good job of getting a lot of dollars in with an acute onset  
11 episode definition, so when the patient hits the hospital,  
12 the episode begins. Most of our commercial insurance  
13 dialogues, we're launching the episode at diagnosis, so we  
14 pick up a variety of other savings opportunities, quality  
15 opportunities.

16           There is a way -- you know, again, this is the  
17 nuance -- where you can adjust episode definition based on  
18 patient pathway, the big things that change for a patient  
19 that were uncontrollable by the provider. You can adjust  
20 payment and have multiple endpoints on your pricing.

21           To CMS' credit -- and I don't mean this  
22 critically -- they started with kind of the training wheels  
23 version of bundles. It's a good way to move the markets  
24 towards bundled payments, to inform people as to how it

1 works. You are taking a lot of risk, and you're taking  
2 period risk. But it's a good way for Medicare to meet  
3 their goals. If you're thoughtful as a participant, you  
4 want to take more episodes in that model, not less. You  
5 don't want to just lower major joint.

6 And so, again, your question touched on risk  
7 adjustment, but Danielle took us into truncate --

8 MS. LLOYD: Yeah.

9 MR. WIGGINS: -- took us into reinsurance, and a  
10 lot of that can be -- in bundles, you can move down to just  
11 performance risk by just how you define the bundle. But  
12 this is a wonderful start. The payers will start to come  
13 out with more nuanced versions of this where the episode's  
14 going to launch at diagnosis. You won't see cardiac -- or  
15 you won't see orthopedic bundles launch at acute admission  
16 in the commercial space.

17 MR. MILLER: So, Danielle, I sense you want to  
18 make a quick enhancement to this point?

19 MS. LLOYD: Yes. I think you have to remember  
20 with the corridors, right, you still have to lose money up  
21 to the corridor, and you still have I think it's a 20  
22 percent share after that, right? So you still can lose  
23 your shirt, right? And that's ultimately my definition of  
24 risk.



1           I think also the thing is it depends on the  
2 context of the program. If it's a mandatory program and  
3 you have to take low volume, that's a very different  
4 situation than having a massive program where you can  
5 smooth the edges. So you have to put it within the  
6 context.

7           MR. MILLER: Paul and then Grace.

8           DR. CASALE: Thank you. Thanks for those  
9 presentations.

10           On the topic of gainsharing -- and we anticipate  
11 as we get models to us there will be a variety of proposals  
12 around, you know, how to share the savings, particularly  
13 with the gainsharing on the physician side. So on your  
14 slide, you said you supported the 50 percent gainsharing  
15 cap on Part B spend. And then, Steve, you started to talk  
16 about gainsharing before Harold --

17           MR. WIGGINS: Put me in my place.

18           [Laughter.]

19           DR. CASALE: Cut you a little short. But I'm  
20 interested to hear a little bit -- because when you talk to  
21 physicians, they'll often say, well, you know, we're sort  
22 of doing the work, we're leading the change, a lot of the  
23 cost is on the hospital side, why shouldn't we, you know,  
24 share in that? And I suspect we're going to see some

1 models that have that.

2           So I just wanted to get some further comments or  
3 your thinking around gainsharing since I suspect we're  
4 going to see a variety of models.

5           MS. LLOYD: Yes, so we have extensive gainsharing  
6 models that we do with our members where they get to choose  
7 how much does the hospital get? How much do the physician  
8 groups get? Within the physicians, how much do you give the  
9 primary care or to the specialist? It's very specific to  
10 the organization and their market, and we think that part  
11 of it in some respects is a good thing. They get to choose  
12 within that gainsharing.

13           But that's not to say that we don't think there  
14 need to be backstops as a beneficiary protection, and in  
15 that case that's what we believe CMS is trying to do with  
16 the 50 percent gainsharing cap.

17           That's not to say, I don't think, that we  
18 couldn't have it set up where the organization who is  
19 administering this can't also get some of the share to hire  
20 the case managers, et cetera, but that the individual  
21 amount given back to the physician is capped at the 50  
22 percent.

23           Does that answer your question?

24           DR. CASALE: Yeah. As I said, it was a matter of

1 trying to share some of the costs on the Part A side in  
2 some way with the physicians or others as opposed to what -  
3 - specifically around the CMMI models.

4 MS. LLOYD: So there are two aspects of it,  
5 right? It can be the dollar you get from CMS or it can be  
6 internal cost savings, right? So if we're working with  
7 somebody on physician preference items and reducing the  
8 costs associated with that in the inpatient stay, the DRG  
9 is the DRG is the DRG. But we might be making a higher  
10 margin at the hospital, and then we can share that with the  
11 physicians, and that is also tracked and allowed to be  
12 within bundles to share with the physicians, and most of  
13 our organizations have that somewhere in their process to  
14 share back.

15 It's something, I will say, is not on the ACO  
16 side. They do not have that waiver, and we think that was  
17 a very important addition on the bundling and should be  
18 retained in models.

19 MR. MILLER: Okay. Steve, did you want to add to  
20 that?

21 MR. WIGGINS: I'd just like to make a point of  
22 clarification. I believe your suggestion was that  
23 physician groups should be capped also. Is that correct?

24 MS. LLOYD: I think what I said specifically is I

1 said the individual physician should be --

2 MR. WIGGINS: Okay.

3 MS. LLOYD: You know, I think there is room to  
4 allow the physician groups to keep, you know,  
5 administration types of funds that are beyond the 50  
6 percent that go to the individual docs.

7 MR. WIGGINS: Yeah, I just want to emphasize that  
8 so much of the innovation is happening with physician  
9 groups, and so you want to retain the ability of  
10 particularly some of the large national groups like Sound  
11 Physicians and Team Health and some of these organizations  
12 that came in and made big financial commitments to the  
13 program, you want to let them make commitments and be the  
14 episode initiator, as long as they can work that out with  
15 their hospital that they're working with, and then still  
16 have the 50 percent gainsharing caps down at the individual  
17 physician level. Most of them don't actually move the  
18 incentive down like that, anyway. They simply have overall  
19 incentives to follow certain protocols. And so it's not  
20 related to profits. It's just did you follow the new set  
21 of protocols and care redesign initiatives that they're  
22 seeking to undertake. And they in particular are doing --  
23 Sound is doing quite an extensive job. We wouldn't want to  
24 keep organizations like that out of these programs.

1 MR. MILLER: Okay. Grace and then Kavita.

2 VICE CHAIR MITCHELL: Harold, I have a question  
3 as well.

4 MR. MILLER: Okay.

5 DR. TERRELL: I want to follow up a little bit on  
6 your comments, Steve, about risk adjustment, because if you  
7 think back to the Medicare Advantage program and how it  
8 started, before there was risk adjustment, the behavior  
9 that people were having is having the insurer on the third  
10 floor with the elevator broken, so only the healthy people  
11 went up the steps, so Medicare put in risk adjustment to  
12 basically have an incentive in place for people to actually  
13 provide appropriate care for beneficiaries who were sicker.  
14 So in every particular situation, there's a potential  
15 cheat. You know, the concern with, you know, the creep of  
16 coding right now is the other side of that that may be  
17 happening if you're over adjusting so you're getting more  
18 of that premium and making people look sicker than they  
19 are.

20 So your comment was that you didn't think that  
21 risk adjustment needed to occur per se in the way that it's  
22 happening right now in the Medicare program. And then you  
23 mentioned you can work around the way that you package the  
24 bundles to sort of deal with that.

1           But I guess my question is a little more basic  
2 than that, because there's already reports out there of  
3 people sort of behaving like the original Medicare  
4 Advantage program again and not -- if they're in a bundled  
5 area, not taking care of some of the sickest patients if it  
6 looks like it's going to be too -- you know, they've got  
7 too many complications even if they need the procedure.

8           So what do you think is a solution for that other  
9 than compliance? Which ought to be the solution at one  
10 level. Either side has a potential moral hazard, if you  
11 will.

12           MR. WIGGINS: Well, that's a philosophical  
13 question, so my philosophical answer is I think our best  
14 regulatory body is the SEC. If you've ever run a public  
15 company, it's amazing that if you have to disclose  
16 everything material and if there's a schedule of things you  
17 have to disclose, and you have to behave in a certain way  
18 and if you don't you go to jail, it engenders enormously  
19 cooperative behavior among those of us that have been in  
20 those seats where you have to sign something every quarter  
21 and you're really having to pay close attention.

22           When I said that about risk adjustment, having  
23 owned a bunch of Medicare Advantage plans and having  
24 founded, you know, some of the first Medicare+Choice

1 programs, I heard all those stories about the second-story  
2 walk-up that you'd set. I don't know anyone that ever did  
3 that, but there is a concern. The problem is now we've  
4 gone the other way, and risk adjustment focuses people on  
5 coding. When you focus people on coding, they're focused  
6 on revenue. When you focus on revenue, you're really  
7 taking your eye off true patient care. And I want to get  
8 back to models that focus people on patient care, and I  
9 think through regulation and rulemaking, I think you can  
10 make sure to set up guardrails around what you called the  
11 "cheats" to make sure that their marketing practices have  
12 to adhere to a certain standard. Now, that's in Medicare  
13 Advantage.

14           As it relates to risk adjustment in bundles, it's  
15 a very hard thing to do. You could get this really wrong.  
16 I'm sure CMS is dealing with it every day. We've modeled  
17 up lots of ways to do it. It's not easy. I think you're  
18 going to orient people towards coding again, particularly  
19 at that moment when there's so much rich opportunity for  
20 coding. You've got all these people involved. I wouldn't  
21 want a model that does that. That would make me nervous.

22           MR. MILLER: I sense that Chris wants to say  
23 something on this point.

24           MS. RITTER: I just wanted to point out, in the

1 bundles model, in BPCI in particular, it is hospital-  
2 specific data. So we find typically your case mix has been  
3 changing and your historic data relative. That's  
4 different. That's not to say there is not a role for risk  
5 adjustment. There is, potentially. But it's a different  
6 situation than when you're dealing with the models we have  
7 where you're basing it on regional pricing or other things  
8 are coming into effect.

9           So for what it's worth, I think there's a  
10 difference between what you might consider appropriate risk  
11 here versus what you might put into a different model.

12           MR. MILLER: Well, I guess I heard Grace's  
13 question being how do you protect patients from -- high-  
14 risk patients from being excluded. You've sort of jumped  
15 into whether it's risk adjustment or not. I'm wondering  
16 what either of you has done in the programs to make sure  
17 that that's not happening.

18           Danielle, did you have any comments on that?

19           MS. LLOYD: Well, I mean I think it is a little  
20 bit different from the health system perspective because  
21 they show up on our doorstep and we take them, right? So I  
22 think that --

23           MR. MILLER: Not for elective knee surgery.

24           MS. LLOYD: Yeah. Well, generally speaking,



1    though, I mean, it's the physician who has credentials who  
2    says, "This is where I'm going to do the surgery." So I  
3    don't think this is as much of an issue with the health  
4    systems.

5               MR. MILLER: Okay. Let me keep moving. Kavita  
6    and then Elizabeth.

7               DR. PATEL: Mine is pretty straightforward.

8               A lot of what we're asking for proposals is to  
9    kind of talk to us about data. You both mentioned that the  
10   monthly process -- can you walk through -- so when -- for  
11   kind of a performance period or whatever you want to call  
12   it, what is the flow and kind of a lag time between when an  
13   episode initiator kind of has their hands on the data? It  
14   sounds like BPCI is probably one of the fastest turnaround  
15   models that I've seen. So could you just walk through like  
16   what the actual release, for what performance period that  
17   covers, and then when that actually hits conveners? And  
18   then I imagine there's a little bit of a lag between  
19   convener to initiator.

20              MR. WIGGINS: Well, the lag -- the first time  
21   that you actually see the first report card on how a  
22   quarter went is essentially nine months later because, if  
23   you think about it, if an episode ends -- if somebody is  
24   hospitalized December 31st, they're in the hospital for

1 five days, and they might be in a 90-day episode, that the  
2 claims are landing all the way through the first quarter,  
3 maybe into the first week of April. And then you have to  
4 wait for all those claims to get paid, and so you're not  
5 going to see the results of that prior quarter. That  
6 fourth quarter of one year, you're not going to see that  
7 until much later, the October reconciliation generally.

8           However, the data feeds that you can still get  
9 are the monthly claims are valuable. There is a lag on  
10 those. There will be a couple months' lag, and so they're  
11 not great, but they're pretty good. In our case, we give  
12 away software to everybody in the program, so they're  
13 tracking in real time. We're also connected to their EMRs.

14           So we're pretty good. We're predicting about --  
15 we're capturing about 95 percent of the people. Our  
16 software predicts about 75 percent of the people accurately  
17 of who is going to eventually be in BPCI because you don't  
18 know until they drop the DRG on the invoice that goes out.  
19 So you just don't know if they're in or out, so you  
20 overserve. You end up serving more patients than you  
21 originally anticipated.

22           So that's the second source of data that you  
23 have, and then the third is the reconciliation. So you  
24 have those three feeds, and they're not -- the claim feeds

1 are admittedly not very timely, but they're right now only  
2 slightly less timely than the commercial insurers deliver  
3 to their risk-contracted pop health or bundled payment  
4 programs.

5 DR. PATEL: And how much time between your  
6 delivery, you receiving the claims, to the initiated --

7 MS. LLOYD: We have a direct access to that  
8 portal in which the providers would download it. So we  
9 immediately get the data as a convener the same time as the  
10 providers do.

11 DR. PATEL: But I imagine they're not -- if  
12 you're doing their data for them, they're not probably  
13 downloading so that --

14 MS. LLOYD: Some of them look at it themselves as  
15 well, but by and large --

16 DR. PATEL: And so what's generally the lag  
17 between --

18 MS. LLOYD: -- it is not for the faint of heart  
19 to try to download a CMS claims file.

20 DR. PATEL: But in general, what's the lag  
21 between convener to initiator? How much time usually?

22 MS. LLOYD: From the convener to --

23 MR. WIGGINS: Two weeks.

24 MS. LLOYD: You mean to give them a report?

1 DR. PATEL: Right.

2 MS. LLOYD: Yeah, about two weeks.

3 MR. WIGGINS: Two weeks.

4 MS. LLOYD: Same for us.

5 MR. MILLER: Okay. Elizabeth Mitchell.

6 VICE CHAIR MITCHELL: Hi. Thank you.

7 My question is sort of around multi-payer  
8 engagement. I have a couple questions. One, are you  
9 seeing any impact on commercial cost either shifting to  
10 commercial, or alternatively, are these typically more  
11 efficient across payers, the participants in the program?

12 And then are you finding distinct benefits of  
13 multi-payer alignment in terms of accelerating more?

14 MR. WIGGINS: A really good question.

15 First, we're seeing payers desire a rollout of  
16 bundled payments that starts with the Medicare 48 episodes,  
17 first for their MA and then for as many commercial  
18 customers as those can help with. The 48 Medicare bundles  
19 capture quite a bit of Medicare Advantage spending, not so  
20 much of commercial spending. Different episodes dominate  
21 spending in a commercial program.

22 And so the sequence with which we're seeing  
23 discussions around adoption go first, the Medicare bundled  
24 payments and then a second wave of bundles that are bundles

1 that consumers have a lot of influence over cost outcomes  
2 and quality outcomes, and then finally adding additional  
3 bundles beyond that. And so we're seeing with the  
4 commercial programs, a significant interest in adoption.

5 As regards to your second question, if I  
6 understood it, benefit design is where they all want to go  
7 with this. They all want to use bundles as a way to drive  
8 consumer patient engagement to select the most appropriate  
9 side of care and to understand what that cost looks like.

10 We're also seeing in the commercial programs,  
11 they want to use bundled payments as a decision support  
12 vehicle for their primary care doctors in population health  
13 programs. They want to give the primary care doctors a  
14 menu of bundle providers that a primary can refer to with  
15 known financial and proven patient outcomes, and so we'll  
16 start to see that in 2018, not 2017. We're talking about  
17 organizations that want to incorporate into their bids for  
18 some of their exchange and other individual enrollment  
19 programs, bundles that drive people to these -- or benefit  
20 plans -- excuse me -- that drive people towards bundles so  
21 they would have higher benefits for people that use a  
22 bundled payment contractor.

23 MS. LLOYD: Yeah. I would agree with what Steve  
24 said. I would also note that we have quite a few providers

1 that are also in -- I believe it's Tennessee, Ohio, and  
2 Arkansas, the Medicaid bundles, and are doing those at the  
3 same time. I use the word "bundles" loosely. It's  
4 obviously a very different structure within that.

5           And then also, our ACOs, as Steve pointed out,  
6 from a population health perspective, some of them are  
7 looking to do what we call "faux bundles," which is it's  
8 not administered by CMS or another payer, but they  
9 basically track bundles within their ACOs so that they have  
10 a more concrete target for their specialist to orient  
11 around to try to drive their ACO savings.

12           MR. MILLER: Let me ask one more question, and  
13 then we have to wrap up. This is a retrospective program  
14 built on the current fee-for-service structure and the  
15 existing Medicare payment structures. Give me one or two  
16 examples of anything that is being paid for that is not  
17 paid for today under Medicare under your bundles as opposed  
18 to simply giving higher payments to physicians. In other  
19 words, are you doing a different kind of post-acute care,  
20 or are you doing a different service?

21           And then part two is, would it be better if, in  
22 fact, those things were paid for directly rather than in a  
23 retrospective reconciliation?

24           But first, I'd like to hear, are there any

1 examples of things being paid for through this?

2 MS. LLOYD: So I can't say specifically for the  
3 bundles, but I can say more broadly for population health  
4 that there is a move towards paying -- trying to pay for  
5 within the extent of the legal waivers, more telehealth  
6 types of services, in-home services, as well as things like  
7 food pantry deliveries and housing, et cetera, but all of  
8 it is very difficult within the current legal waiver  
9 structure. So I think that would really be enhanced if we  
10 had more legal waivers.

11 MR. MILLER: So just to be clear, you're saying  
12 that the things that the waivers are waiving and allowing  
13 to be billed for would be good, except that the waiver  
14 structure is making it difficult to do it?

15 MS. LLOYD: Yeah. So like telehealth, for  
16 instance, right now, there is a very narrow waiver for  
17 certain G-codes in home health services for a non-home-  
18 bound population. So to the extent that that was opened  
19 up, that's one of the ways people want to go.

20 MR. MILLER: Okay. Steve?

21 MR. WIGGINS: Well, Harold, things like in-home  
22 IV therapy where you want to -- you want to avoid a high-  
23 cost facility setting when it's really not necessary, where  
24 the patient's condition is such that they could be just

1 fine at home. They've got wonderful support. They could  
2 have family that is involved, or maybe they just don't need  
3 any help, other than somebody to come in and do the  
4 administration.

5           We have had partners that have said, "We want to  
6 pay for that," but you've got to walk. First you crawl,  
7 then you walk, then you run in these payment models.

8           Saint Luke's, for instance, was very anxious  
9 early on, on this particular point, to pay themselves.  
10 They asked us if we'd split it. We said, "Okay. We'll  
11 split it with you," and we were coming out of pocket, a  
12 year before we were getting any money from Medicare, paying  
13 for some of these things. And it turned out to save money  
14 because you avoided -- that's the sort of thing that we  
15 probably need regulatory relief on to be able to pay for  
16 some of these things.

17           It's too bad that you can't follow the commercial  
18 payer model, which is once you're at risk, let us decide  
19 how to spend the money. You probably won't get to that  
20 until there's prospective, not retrospective, but if you're  
21 taking full downside risk, which these programs are taking,  
22 we have every incentive to get the patient healthy. We're  
23 held responsible for 30 days after the episode ends for  
24 anything that's viewed to maybe have been pushed off until



1 after the episode.

2           So let these organizations that we work with, if  
3 they're willing to come out of their own pocket and we are  
4 willing as their partner -- some of them take 80 percent of  
5 the risk. Some take 50. Let us make those decisions.

6           MR. MILLER: Okay. Great. Thank you all for  
7 coming. We appreciate the excellent input and responses to  
8 the questions.

9           We are going to transition now to our next  
10 segment and invite Renee back up to talk about the Health  
11 Care Innovation Award. She looks like she wants some other  
12 people to come and support her.

13           We put this on the agenda because the Health Care  
14 Innovation Awards was a broad two rounds of CMMI grants to  
15 a variety of projects, and one of the things that was  
16 supposed to happen as part of those projects was that they  
17 were to -- if they were successful, to have a payment  
18 model, develop a payment model proposal to continue the  
19 project. So that may well be leading to applications to  
20 the PTAC at some point in the near future, and we wanted to  
21 get a status report on that program and hear about what  
22 might be happening in terms of the payment model piece.

23           So, Renee, thank you for staying with us.

24           MS. MENTNECH: My pleasure. Glad to be here

1 again.

2           I want to introduce Tim Day, here to my right.  
3 Tim, was the lead of the evaluation under me for bundled  
4 payment. Tim is one of -- he's our sort of team lead. We  
5 have many staff working on these evaluations, but he's been  
6 our team lead, is one of the leads on a specific evaluation  
7 and also the lead on the meta-analysis.

8           So there are many awardees that are part of this  
9 grants program. The first round was 107 separate awardees,  
10 and the second round was, I believe, 39. I might not have  
11 that number exactly right. So there are many. They are  
12 all doing very different things.

13           At this point, the second round of awardees,  
14 there is one annual report that was very early. We're  
15 working on the second annual report. Hopefully, that will  
16 get released later this summer. It will not have impact  
17 analyses at this point for a variety of reasons, including  
18 sample size issues, the time it takes to get the  
19 identifiers from the awardees, and difficulty constructing  
20 comparison groups and the like. So we hope to -- in the  
21 beginning of the first round, we also had this same  
22 experience, and we're now at a better place, a couple years  
23 in, on the first round than we were. So I expect that the  
24 second round awardees, we will also be in a better place in

1 the future, but that means that we won't have impact  
2 analyses on those second round awardees for some time. I  
3 believe there are a couple of them that have actually  
4 submitted LOIs already to the PTAC.

5           So today's discussion really is focused more on  
6 the Round 1 awardees, which was the 107 I mentioned. They  
7 are all completed at this point. I think you will notice -  
8 - I believe you may have been sent some links to some  
9 reports that were just released at the end -- or the  
10 beginning of last week, so about a week ago. The third  
11 annual reports for all of the first round awardees were  
12 just issued last Monday. They are up on our website. They  
13 do have impact analyses, where we were able to produce  
14 them.

15           And we also released four manuscripts in Health  
16 Affairs last week that has specific findings for a few of  
17 the awardees.

18           As I mentioned, the period of performance for all  
19 these awards are now complete, but I am going to focus a  
20 little bit on a few of them. They were diverse. They  
21 focused on a lot of different things, including care  
22 coordination, care management, patient navigation, shared  
23 decision-making, patient-centered medical homes, patient  
24 engagement and support, workflow redesign, telemedicine,

1 and medication therapy management, among the topics.

2           In order to manage this, we grouped these  
3 awardees. So if you have an opportunity to go on our  
4 website and look at the individual reports, we tried to  
5 group these into categories of similar topics. It is the  
6 case that it's a bit of a nuance. Some of the awardees  
7 could have been in more than one global topic, but I do  
8 encourage you to look at the actual reports.

9           With respect to the Health Affairs manuscripts,  
10 there were four covering home visiting models, the oncology  
11 care models, the Y-USA diabetes model program, and then a  
12 meta-analysis of ambulatory care models.

13           The first manuscript covered five awardees that  
14 used home-based care delivered by teams, led by registered  
15 nurses or lay health workers, along with a mix of different  
16 components to strengthen connections to primary care among  
17 fee-for-service Medicare beneficiaries with multiple  
18 chronic conditions.

19           Two of these models achieved significant  
20 reductions in Medicare expenditures, and three models  
21 reduced utilization in the form of emergency department  
22 visits, hospitalizations, or both the beneficiaries  
23 relative to their comparators.

24           The second manuscript examined three awardees

1 that aimed to reduce cost in use of health services and  
2 improve the quality of care for Medicare beneficiaries with  
3 cancer. Each emphasized a different principle: the  
4 oncology medical home, patient navigation, or palliative  
5 care. So they all tried slightly different things, but all  
6 of them focused on caring for cancer patients, some with  
7 more of a focus on end-of-life care than others.

8           The patient navigation model was associated with  
9 fewer emergency department visits in the last 30 days of  
10 life and increased hospice enrollment in that last 2 weeks  
11 of life. The oncology medical home and patient navigation  
12 models were both associated with decreased cost in the last  
13 90 days of life and fewer hospitalizations.

14           The third model, which analyzed the Y-USA award,  
15 provided a diabetes prevention program, certified by the  
16 CDC but run by the Y-USA in 17 different Y-USA locations.  
17 This manuscript, we reported a reduction in total cost of  
18 care for the pre-diabetic patients that participated in the  
19 model.

20           And then, finally, the fourth manuscript analyzed  
21 the results of 43 different awardees at implemented  
22 ambulatory care programs. Using the meta-regression  
23 approach, the authors found that innovations that used  
24 health information technology or employed community health

1 workers achieved the greatest cost savings, and  
2 importantly, savings were also larger in programs targeting  
3 a clinically fragile population.

4           With respect to the third annual report, beyond  
5 sort of the Health Affairs manuscript, it is difficult to  
6 go into the specifics because there's 107 different  
7 awardees to comment on, but just to sort of a few --

8           MR. MILLER: And they are very long reports.

9           MS. MENTNECH: They are long reports.

10           I do want to offer that if at any time you have  
11 specific questions on any given awardee, we'd be happy to  
12 follow up and provide specific information on any one of  
13 the awardees you might be interested in.

14           I did mention earlier when I was talking about  
15 the second round that at this point, we don't have the  
16 impact estimates, and that was the same situation at this  
17 point when we were evaluating the first round. I am happy  
18 to say that we have in these reports, impact estimates for  
19 80 out of the hundred and -- it's different. Some people  
20 say we have 107 awardees; some say 108. So I'm going to  
21 stick with 107.

22           There are a number of awardees that we still  
23 could not generate impact estimates for some of the same  
24 reasons that I alluded to for the second round, either

1 insufficient sample size or we just had unreliable  
2 identifiers from the awardees or we couldn't develop a  
3 comparison group, a reliable comparison group. So there's  
4 a number of reasons why there are still some awardees for  
5 whom we don't have impact estimates.

6           There is an additional report that we will be  
7 creating for the first round that we hope -- oh, I think  
8 another issue is lack of timely data. There's a lag on the  
9 Medicaid side.

10           We're hoping that some of these issues will get  
11 resolved in the next report that we issue, but I am fully  
12 expecting that some of the remaining awardees that we  
13 couldn't generate impact estimates for, we probably won't  
14 be able to again. But they were all evaluated in some way.  
15 For the ones that we couldn't generate impact estimates, we  
16 did do a qualitative analysis.

17           I also want to point out that among the ones that  
18 we were able to generate impact estimates, I'm actually  
19 happy to say 27 of the awardees -- I mean, part of  
20 innovation is not everything is going to work. You test a  
21 lot of things, and the expectation is some things are just  
22 going to fail. That's just part of innovation.

23           I'm pleasantly surprised. I didn't actually  
24 expect this. Twenty-seven of the awardees actually

1 demonstrated promising results. By promising, I don't mean  
2 that all of them were statistically significant. It does  
3 mean that they showed savings in the right direction. So  
4 they were some of them approaching significance, some not  
5 quite so significant, but still showing promise in the  
6 right direction. Of those 27, 19 of them did show  
7 statistically significant savings.

8           A large portion of the 107 are planning to  
9 sustain their models going forward in one way or another,  
10 some in their entirety, some through additional funding  
11 that they have got -- received elsewhere, which was part of  
12 the goal was to see these things sustained.

13           There is an important distinction between Round 1  
14 and Round 2. In Round 1, the awardees were not asked to  
15 think about what it would look like if it was changed to a  
16 payment model. These are grants. So they're not getting  
17 paid. There's nothing changing about the way that Medicare  
18 or Medicaid pay for services under any of these awards, and  
19 in the first round, that wasn't a focus. They weren't  
20 asked to sort of think about the development of a payment  
21 model.

22           The second round awardees were asked to think  
23 about and propose as part of their testing what a payment  
24 model could look like.



1           These findings from the first round have led to a  
2 number of important changes in the innovation center. For  
3 example, I'm sure folks have heard that we have, through  
4 certification, expanded the -- and through rulemaking, the  
5 diabetes prevention program. The results from the Y-USA  
6 evaluation were the trigger for that certification  
7 exercise.

8           It is important to note, though, that unlike most  
9 of the other awardees, for the Y-USA, there was quite a bit  
10 of existing evidence out there from well-done rigorous  
11 randomized control trials that supported the same finding.  
12 So while the evaluation of the Y-USA model helped -- or was  
13 the impetus behind why we were able to engage in a  
14 certification exercise, it wasn't the only evidence that  
15 the actuaries had at their disposal to actually do that  
16 certification. And that's important to keep in mind for  
17 these kinds of programs that are grants programs.

18           It's difficult to think about expanding or  
19 turning into a program, a grant that didn't test anything  
20 related to payment and where the model test is limited to  
21 one or two sites, which is one of the disadvantages of the  
22 Health Care Innovation Awards, is that they were typically  
23 small tests or confined to just a few participants. So  
24 from an evaluation perspective, it presents a challenge

1 when you have -- I tend to call these one-off kinds of  
2 innovations. When you think about what that means from  
3 expansion from an evaluation perspective, we can't reliably  
4 say in the evaluation, what it would look like beyond the  
5 model test. It's not very generalizable when you just have  
6 these very small tests.

7           The Y-USA, as I said, had been widely tested  
8 through other non-CMMI activities, and that's the reason --  
9 or one of the reasons why we felt comfortable with the  
10 generalizable question, but for many of these others, we  
11 don't have that sort of evidence.

12           I also want to point out that one of the oncology  
13 care models, the results from that and the experience and  
14 the things that they were testing were used to inform some  
15 of the decisions in the development of the oncology care  
16 model, and then two awardees, Welvie and MedExpert, which  
17 were testing shared decision-making, the lessons that we  
18 learned from that were also used to inform the design of  
19 the beneficiary engagement model. So even though these  
20 models weren't designed to test a specific change in  
21 payment policy, we are using the lessons that we're  
22 learning from these models as to inform other innovations  
23 as we go forward.

24           I think -- oh, and one other one is the

1 University of Chicago. Their activity was also  
2 instrumental in helping us think about how to structure the  
3 accountable healthy community model, which we hope to  
4 launch very soon.

5           So in terms of next steps, we will be releasing  
6 these -- well, these reports are released. We will be  
7 producing an addendum to each of these reports where we  
8 hope to have even more impact analyses and to hopefully be  
9 able to include impact analyses from the ones that we  
10 haven't been able to do so thus far.

11           And then stay tuned for the results coming for  
12 the HCIA Round 2.

13           MR. MILLER: So we have a few minutes for  
14 questions. Let me ask you first, it sounds like what  
15 you're saying is that you got some number of projects that  
16 had positive results, but they were being done with a  
17 grant, not with a payment model. If you're going to  
18 sustain them you presumably are not going to sustain them  
19 with grants forever. You would need to have some kind of a  
20 payment structure.

21           And it sounds like they were too small to  
22 declare, sort of moving to full scale. Does that argue  
23 that there should be some intermediate step that says that  
24 those projects should be done on a bigger but still small

1 scale, with a payment model to try to work out the details  
2 of a payment model before, then, trying to do them on a  
3 larger scale?

4 MS. MENTNECH: Well, I can only answer from my  
5 evaluation lens. I don't think I can sort of opine on the  
6 policy part of it. But from an evaluation perspective, I  
7 think I'm uncomfortable with the idea that you can  
8 generalize from a grant what behavior would have happened  
9 when it's a payment. I think that, you know, just from a  
10 behavioral economics perspective, if you have a blank check  
11 you may behave one way, versus the incentives that are tied  
12 to something that changes about payment policy. So that  
13 makes me a little uncomfortable. And then the fact that  
14 it's just, you know, these -- the participants in most of  
15 these cases, and some of these the cell size, or the sample  
16 sizes are really, really small. Some of them not so small,  
17 but many of them are. It does make me a little concerned  
18 that, you know, that it might be a microcosm and I can't  
19 say, from a replication perspective, if you were to take  
20 this beyond, you know, the one or two participants in that  
21 model, what it would look like.

22 So I personally believe in sort of testing things  
23 a little bit bigger than a one-off, but that, I think, is  
24 speaking to my evaluation hat and not necessarily --

1 MR. MILLER: Okay.

2 MS. MENTNECH: -- a policy lens.

3 MR. MILLER: Okay. That's good. Bruce and then  
4 Len.

5 MR. STEINWALD: Thanks. Harold, you asked half  
6 of my question, so the other half is, do you have the  
7 capability, especially in the cases where the -- they're  
8 small size, a couple of sites -- do you have the capability  
9 of just scaling it up in order to get more reliable -- even  
10 though it's still in a grant mode and not a payment policy  
11 mode, can you just add scale if you want to?

12 MS. MENTNECH: The way the award structure worked  
13 is no, not directly. You know, these awards were time-  
14 limited and, you know, as in anything in government, when  
15 you're talking about that kind of a funding stream, it's a  
16 competitive process. And there's also language in the  
17 statute that sort of dictates the process that we follow  
18 for expansion.

19 So just to take that awardee and scale it up  
20 isn't -- is not an option that we have available to us, as  
21 far as I know.

22 MR. MILLER: Okay. Len.

23 DR. NICHOLS: So thanks, Renee. For a lot of us,  
24 the Health Care Innovation Awards are among the more

1 exciting parts of the first part of the Affordable Care  
2 Act. And so, if I remember correctly, there were 5,000  
3 letters of intent and 2,000 actual applications, out of  
4 which you picked 107. So I'm impressed you actually still  
5 survived after reading all those proposals.

6 But what I want to ask about is you mentioned how  
7 some in the first round were able to sustain themselves  
8 somehow, I mean, through maybe a deal with the payer or  
9 whatever, and then in the second round explicitly you asked  
10 for what would a payment model look like. Is there a  
11 matrix, or can you point us to a place where we can learn  
12 more about both the survival of those that did in the first  
13 round --

14 MS. MENTNECH: I actually think -- that's a good  
15 question.

16 DR. NICHOLS: -- and this --

17 MS. MENTNECH: I think that the third annual  
18 reports do -- do they contain a section, Tim, on  
19 sustainability?

20 MR. DAY: As well as the second.

21 MS. MENTNECH: Yeah. So I think the actual  
22 reports talk a little bit about --

23 DR. NICHOLS: Okay.

24 MS. MENTNECH: -- the sustainability plans of the

1 awardees.

2 DR. NICHOLS: Okay.

3 MS. MENTNECH: In many cases, they didn't  
4 necessarily sustain their whole, and not all of them  
5 sustained.

6 DR. NICHOLS: Right.

7 MS. MENTNECH: They may have sustained certain  
8 aspects, and it may have been that the institution that  
9 they were collaborating with or operating --

10 DR. NICHOLS: Just decided to do it?

11 MS. MENTNECH: -- may have decided this is  
12 something that we want to continue to do on our own.

13 DR. NICHOLS: Yeah.

14 MS. MENTNECH: So I think that the reports --

15 DR. NICHOLS: Okay.

16 MS. MENTNECH: -- do talk a little bit. I think,  
17 in the second round report, because we don't have any  
18 impact analyses yet, I think there may be more discussion  
19 about this, particularly around sort of what their plans  
20 are for the future.

21 DR. NICHOLS: Okay. Thank you.

22 MR. MILLER: So is it correct then that the only  
23 Round 1 projects that CMS sustained in any fashion,  
24 directly, or the diabetes prevention project and

1 potentially the oncology care model for some of the  
2 oncology projects -- was there anything else that has been  
3 done to actually -- or anything in the works, to try to  
4 sustain any of those projects?

5 MS. MENTNECH: Well, I think the one is  
6 definitely the diabetes prevention, because through  
7 rulemaking we've expanded that, or will be expanding it. I  
8 wouldn't say that the oncology care model is a sustaining.  
9 I would describe it instead as the design of the oncology  
10 care model was informed by --

11 MR. MILLER: Well, what I meant by that was I  
12 know that some of the projects that were in the Round 1  
13 awards in oncology applied for the oncology care model in  
14 order to sustain what they were doing.

15 MS. MENTNECH: I see.

16 MR. MILLER: That's kind of what I was asking, is  
17 are there any things that exist to sustain any of the  
18 others that are either done or in the works?

19 MS. MENTNECH: Well, I think the beneficiary  
20 engagement model, which is around shared decision-making,  
21 is one that the awardees testing shared decision-making  
22 could apply to. I think we're in the application stage at  
23 this point, so I can't say if they did or didn't, but that  
24 is something they could have applied to.



1           Similarly, the accountable health community  
2 model, there were a number of awardees that were testing  
3 that same kind of concept. There's the activity going on  
4 in -- with Jeff Brenner in New Jersey. There was the  
5 Chicago site. So again, I can't comment to who is actually  
6 going to -- who applied and who would get selected, but  
7 those were opportunities that they could have applied to,  
8 because it would have been something similar to what they  
9 were doing.

10           MR. MILLER: Okay. A question from Bob and then  
11 we'll wrap up on this.

12           DR. BERENSON: Very quick, I'll go look at the  
13 list, but except for -- other than oncology, were there  
14 very many specialty-specific things -- grants that could be  
15 turned into a specialty-specific payment model? I mean,  
16 was there much interest?

17           MS. MENTNECH: Tim, what are your thoughts on  
18 that --

19           MR. DAY: You might --

20           MS. MENTNECH: -- on specialty specific --

21           MR. DAY: -- look at the hospital setting report.  
22 There were a number of interventions that focused on  
23 hospital setting. One, in particular, focused on  
24 intensivists, so ICU care, and Emory University, that was

1 one in particular that sticks out that we saw some  
2 favorable results, where they're using tele-ICU to sort of  
3 enhance --

4 MS. MENTNECH: I think that a lot of the  
5 telemedicine kind of interventions had more of a specialty  
6 kind of focus to it, not exclusively, but I think that's  
7 another area where you could look to.

8 MR. MILLER: Great. Thank you, Renee and Tim,  
9 for coming. Appreciate the information.

10 MS. MENTNECH: Thank you for having us.

11 MR. MILLER: So we're going to now transition to  
12 the final part of the agenda, which is the public comment  
13 period. We have a few people who are registered to provide  
14 public comments, and we will go to them first, but then  
15 anybody who is here -- that means all of back there, if you  
16 would like to make a comment, we will have some time to be  
17 able to do that.

18 We also would welcome any questions that you may  
19 have. So if there are not things you want to comment on  
20 but things that you're puzzled by, or want clarification  
21 on, you're welcome to ask those questions. There is no  
22 such thing as a dumb question, so if you would like to ask  
23 a question, my guess is that there's probably a bunch of  
24 other people in the room that will say, "Wow, I'm glad they

1 asked that question because that was very useful."

2 So we're going to go to our scheduled commenters  
3 first. So first we have Sandy Marks from the American  
4 Medical Association.

5 MS. MARKS: [Off microphone.]

6 MR. MILLER: Microphone -- hang on. Hang on.  
7 Yeah, go ahead. Push the button. It works just as well.

8 MS. MARKS: Okay. Thanks for the -- wow, that's  
9 loud.

10 [Laughter.]

11 MS. MARKS: So regarding the Bundled Payments for  
12 Care Initiative, we think it was a really good start, but  
13 it's important for future payment models to also take  
14 advantage of opportunities to improve care for patients  
15 before they go to the hospital. BPCI rewards physicians  
16 for reducing complications, readmissions, and post-acute  
17 care costs for patients following a hospital admission, but  
18 it really doesn't help physicians provide care that could  
19 have prevented the admission from occurring in the first  
20 place.

21 We've met with the Premier and Remedy. We know  
22 that they're taking a number of steps to bring down costs  
23 and improve quality. They share information with the  
24 participants. They provide feedback reports. They help

1 coordinate patients' care. They help patients choose  
2 lower-cost, higher-quality providers for services like  
3 rehabilitation, and those same kind of steps could be  
4 applied to improve care for conditions and prevent patients  
5 from developing health problems or complications that lead  
6 to hospitalizations in the first place.

7           And we've seen this with early implementation,  
8 with private payer support of some of the models that have  
9 been submitted as proposals to you, and also with some of  
10 the models that were supported by Health Care Innovation  
11 Awards. I don't think anyone who received a HCIA award  
12 thought of it as a blank check, but they were certainly  
13 limited and also limited in time, and I think that was kind  
14 of a problem, because it's what happens afterwards. It  
15 just ends.

16           There are number of specialty societies that are  
17 working on models that would help patients better manage  
18 chronic diseases and prevent exacerbations. Others are  
19 focused on improving the speed and accuracy of diagnosis  
20 for symptoms or conditions and improving the process of  
21 selecting an initial treatment plan. The PTAC could  
22 support these efforts and availability of data would be a  
23 huge help to further developing those models. Physicians  
24 need to understand what's driving total spending for their

1 patients, where the opportunities are to identify savings,  
2 and also the potential financial risks that they face due  
3 to costs over which they have no control. And I think it's  
4 clear from that BPCI discussion that it's hard for everyone  
5 to get a good grasp on that kind of data.

6           So we really commend PTAC. I think we mentioned  
7 this in previous comments as well, but we commend PTAC  
8 again for the data tables that you produced late last year,  
9 and would encourage more of that, more condition-specific  
10 data that could be made available to those that are  
11 developing proposals, and really for each of the major  
12 conditions that people are managing, so that they could  
13 think about where the opportunities are for them.

14           Thank you.

15           MR. MILLER: One of the things that you could do,  
16 I think, to help us, perhaps, and everybody in the room, is  
17 we asked for comments on those data tables that are on the  
18 website and we haven't gotten any. And so if there are  
19 people who would like data relative to whatever it is they  
20 may be thinking about or working on, it would be helpful to  
21 know that, and more importantly, to know what detailed kind  
22 of breakdowns you would like to see on the data, because  
23 the fact that we haven't gotten any comments doesn't seem  
24 to reinforce the idea that people are really desperate to

1 be able to get that data. So it would be nice to hear that  
2 people are actually interested in that.

3 Any questions anybody has for Sandy?

4 [No audible response.]

5 MR. MILLER: Sandy, a quick question for you. Do  
6 you -- what's your impression of the feasibility of the  
7 BPCI methodology for small physician practices that may  
8 want to propose alternative payment models? Basically no  
9 change in the current payment system but simply if you save  
10 money you would be able to get a payment somewhere down the  
11 road, whether it's quarterly or annually or whatever -- is  
12 that a feasible methodology for the kinds of specialties  
13 that you were talking about that are interested in changing  
14 the way they deliver care?

15 MS. MARKS: Well, there was some discussion  
16 earlier today about -- I think you brought it up -- that,  
17 you know, being able to save in the savings from Part A, or  
18 from the costs that are incurred for things other than  
19 physician services, and I think that's where most people  
20 see the biggest opportunities. So, as I said, preventing  
21 admission. I noticed sepsis is one of the episodes in the  
22 48. So if you could identify that infection as potentially  
23 leading to sepsis, prevent it from happening, prevent the  
24 ED visit and the hospitalization, that's a huge amount of

1 savings. So, yes.

2 MR. MILLER: Okay. Great. Thank you very much.  
3 Next on the list is Nick Bluhm from Remedy Partners. Are  
4 you here? I've heard of Remedy Partners before, somewhere  
5 today. And Nick is apparently delegating it to Carolyn,  
6 who didn't speak because Steve was speaking before, so  
7 we'll hear from Carolyn on behalf of Nick on behalf of  
8 whomever.

9 Go ahead, Carolyn.

10 MS. MAGILL: We are a team.

11 [Laughter.]

12 MR. MILLER: Yes.

13 MS. MAGILL: The one that -- actually, to build  
14 on what Sandy just spoke about, with respect to the scope  
15 of bundles and the question that we had from Grace around  
16 what commercial providers are thinking, also with respect  
17 to bundles. So we hear frequently that the applicability  
18 should be beyond the existing scope. So as you may be  
19 aware, most of the bundles we focus on right now are acute  
20 to post-acute transitions. There's an opportunity, as  
21 Sandy said, to trigger, prior to an admission, to avoid an  
22 unnecessarily hospitalization.

23 Another one is that we are truly seeking to avoid  
24 fragmentation of care, and one way to do that would be to

1 incorporate drugs. So right now only Part B, as in boy, is  
2 included, not Part D. Another one -- and my background is  
3 in Medicaid so this is something near and dear to my heart  
4 -- relates to behavioral health. So opportunities to think  
5 about patients more holistically, in addition to some of  
6 the chronic care areas that are spoken about.

7 MR. MILLER: So you're saying even in, like,  
8 BPCI, Part D is not there and should be, in your mind?

9 MS. MAGILL: Yeah. Absolutely. There's an  
10 opportunity to expand that scope, and not only -- you know,  
11 and then beyond the 48 bundles as well.

12 MR. MILLER: Okay. Questions from anybody for  
13 Carolyn?

14 [No audible response.]

15 MR. MILLER: So I'm going to go slightly off the  
16 program here and ask Chris, could you say, quickly, a word  
17 -- yes, Chris -- could you say a word about why Part D is  
18 not in the -- and is that something that we should be  
19 looking for when we get models in? Is that operationally  
20 feasible, to be able to do that?

21 MS. RITTER: We include D in some of our models.  
22 We haven't included it in BPCI, because we're looking at  
23 the payments made within the fee-for-service program. But  
24 OCM does look at D. I don't remember exactly how. I think



1 it's --

2 MR. MILLER: Parts of D. It looks at the  
3 catastrophic --

4 MS. RITTER: Yeah, it looks at that piece. I  
5 don't know the whole -- I think we'd have to go back and  
6 think about it. It's very -- it's definitely difficult to  
7 include D. There is the who you're paying, what costs they  
8 have --

9 MR. MILLER: Because D runs through plans rather  
10 than directly, right?

11 MS. RITTER: D runs through plans. We don't do  
12 that, just like Medicare Advantage. But that being said --  
13 so I don't -- but I don't think we'd ever want to say no-  
14 no. I think that the merit of the statement is there, in  
15 terms of what kinds of costs we'd be looking at. I think  
16 operationally, you -- I'll be employed, if you guys go down  
17 that path. So we'd have to think about it.

18 MR. MILLER: Okay. No, I do think it is  
19 challenging and it is something that -- it sounds desirable  
20 but it is challenging to do.

21 MS. RITTER: Very challenging.

22 MR. MILLER: So it's something that we need to  
23 look at carefully to figure out how to be able to do that.

24 Okay, great. Thank you.

1           We have Allison Brennan. Is Allison here? Is  
2 Allison on the phone? Okay, Allison Brennan from National  
3 Association of ACOs has registered to make a public  
4 comment. And we've got a question from Blair Atkinson,  
5 Moffitt Cancer Center.

6           Do I need to ask the operator to pen the phones?

7           OPERATOR: Thank you, ladies and gentlemen. If  
8 you would like to register a question, please press the 1  
9 followed by the 3 -- the 1 followed by the 4, on your  
10 telephone. You will hear a three-tone prompt to  
11 acknowledge your requests. If your question has been  
12 answered and you would like to withdraw your registration,  
13 please press the 1 followed by the 3. And if you are using  
14 a speakerphone, please lift your handset before entering  
15 your request.

16           Once again, ladies and gentlemen, to register for  
17 a question please press 1-4 on your telephone.

18           One moment, please, for the first question.

19           MR. MILLER: So if either Allison or Blair are on  
20 the phone, please press whatever the appropriate buttons  
21 were.

22           [Laughter.]

23           OPERATOR: Our first questions comes from the  
24 line of Blair Atkinson --

1           MR. MILLER:  There's Blair.  Okay, great.  Blair.  
2  Ask your question.

3           OPERATOR:  -- Moffitt Cancer Center.  Please go  
4  ahead.

5           MS. ATKINSON:  Can you all hear me?

6           MR. MILLER:  Yes.

7           MS. ATKINSON:  Great.  Thank you for taking my  
8  question.

9           So when we were looking at submitting proposals  
10  to CMMI and then also to PTAC, one of the questions that  
11  was coming to our mind, and we were just wanting to try and  
12  get some more clarification on, was the scope and the  
13  scalability of the model.  I know that PTAC is looking for  
14  the position focus.  We've talked a lot here today about  
15  large, you know, acute care type of projects.  But I was  
16  just kind of wondering if PTAC would entertain, you know,  
17  projects that might be on a smaller scale with that  
18  position focus, or if we should still try to submit, you  
19  know, proposals with, you know, a larger CMMI emphasis, if  
20  that makes sense.

21           MR. MILLER:  Let me try to answer, and I'll see  
22  if my colleagues have different answers, because I'm not  
23  entirely sure I understand the question.

24           We are looking for things that will fill gaps in

1 what CMMI currently does, or CMS currently does, and we are  
2 looking for -- in terms of payment models -- and we are  
3 looking for projects that will bring in different  
4 physicians, small physician groups than may be able to  
5 participate today. It isn't necessary for someone who is  
6 making a proposal to necessarily bring along with them all  
7 of the people who might be able to implement it, but we are  
8 looking for models, payment models that could be  
9 implemented by a broader array of people. Now that may be  
10 only small practices. It may be only single specialty  
11 practices. It may be whatever is appropriate. But that's  
12 -- we are looking for things that will fill gaps in the  
13 current portfolio.

14           Now, having said that, let me ask you. Did that  
15 answer your question or is there a different dimension of  
16 that that you're interested in?

17           MS. ATKINSON: It does. I think our question is  
18 kind of in -- around the, you know, the scalability. If  
19 we're looking to fill gaps, does that necessarily mean that  
20 it has to be -- you know, that it has a large-scale impact  
21 in terms of those types of gaps, or -- obviously it  
22 wouldn't be something that's, you know, just focused on a  
23 single center or a single region. You're looking for  
24 things that can be implemented nationally. But just trying

1 to get, I guess, a better idea or sense of that  
2 scalability.

3 MR. MILLER: Well, I think it should be something  
4 that could be scaled beyond one site, but if there are a  
5 limited number of -- for example, if it's focused on a  
6 particular condition and there are only a limited number of  
7 patients who have that condition, but it could have a  
8 significant benefit for them, that would be something of  
9 potential interest to us.

10 Ultimately, it's going to be up to CMS to decide  
11 what is feasible for it to implement, and they'll have to  
12 make those decisions, not us. But that doesn't really  
13 weigh into our decision-making.

14 Bob wants to add to that.

15 DR. BERENSON: Yeah. I would just add that in  
16 the final MACRA rule, the secretary exempted almost 400,000  
17 physicians and small practices, many of whom, because their  
18 revenues didn't hit a threshold of \$30,000. One can scale  
19 to lots of practices in small practices -- small,  
20 independent practices. So I think very much the same  
21 answer, is we are very interested in getting payment model  
22 suggestions for primary care and specialty, small,  
23 independent practices. You can scale a lot of patients --  
24 I mean, a lot of beneficiaries in those practices.

1 MR. MILLER: Okay. Thank you, Blair, for the  
2 question.

3 Is Allison Brennan on the phone?

4 [No audible response.]

5 MR. MILLER: Is there anyone else on the --

6 OPERATOR: You may press 1-4 to register for a  
7 question.

8 MR. MILLER: Is there anyone else on the phone  
9 who has either a comment for us or a question?

10 [No audible response.]

11 MR. MILLER: Is there anyone in the audience who  
12 has for us a comment or a question? Yes, sir. Come on  
13 over to the microphone over here and identify yourself, and  
14 press the button there and it will light up, and tell us  
15 who you are and --

16 MR. INTROCASO: Thank you. So I'm David  
17 Introcaso with the American Medical Group Association,  
18 AMGA.

19 So just maybe, first, with two questions. In  
20 December, PTAC took comments on the evaluation, how PTAC  
21 will evaluate proposals. I'm wondering if that went final.  
22 Does anybody know?

23 MR. MILLER: Yes. The document is final.

24 MR. INTROCASO: So your criteria has gone final.

1 MR. MILLER: Yes.

2 MR. INTROCASO: Okay.

3 MR. MILLER: Although I would say "final" is, you  
4 know, a relative term. I mean, we have said that we will,  
5 in fact, continuously reevaluate what we were doing. We  
6 won't necessarily change it every day, obviously, but we do  
7 have a current set of final criteria on the website.

8 MR. INTROCASO: Great. Thank you. And the  
9 second is, in that document it was noted that once a  
10 proposal is posted on the website it's three weeks for  
11 public comment. Is that still the --

12 MR. MILLER: Yes, that's correct, except when we  
13 happen to do it over Christmas and New Year's, and then we  
14 decided that we maybe should be a little bit more flexible  
15 than that. But yes.

16 MR. INTROCASO: Then I would just make two  
17 comments relative to the discussion today. So there was  
18 discussion about this issue of counting for overlap, and if  
19 you remember, when CJR dropped in August of '15, the text  
20 in the proposed rule was, let's just say, challenging to  
21 understand, so I'd encourage the Committee to spend  
22 particular attention as it relates to rolling out these  
23 models and how it accounts for overlap with ACOs and the  
24 various others.

1           The second comment I would make is, there was  
2 discussion as well today about the gainsharing issue, and  
3 my understanding is that the gainsharing rules differ  
4 between the ACO MSSP program, because of the foreign abuse  
5 waivers -- ACOs are permitted -- and how gainsharing is  
6 conducted under BPCI. So relative, at minimum, if this  
7 organization, or PTAC would look towards having some  
8 standard relative to how -- what's allowed relative to  
9 gainsharing and what's not allowed, I think would be  
10 helpful.

11           So those would be my two comments.

12           MR. MILLER: Well, I would just say we don't  
13 necessarily have standards. We have a set of criteria and  
14 we're actually looking for people to come to us and propose  
15 things. If you have suggestions as to how you think what  
16 we think we should be thinking of when we look at them,  
17 that would certainly be welcome comments. But we -- and we  
18 provided some comments in our RFP, in terms of the kinds of  
19 things we described it as, that we would be potentially  
20 more likely to get a recommendation. But we're not trying,  
21 at this point, to preclude proposals from coming in that  
22 may have innovative approaches to things.

23           I don't know if any of my colleagues have any  
24 comments on that. Anybody have any questions for David?



1 [No audible response.]

2 MR. MILLER: Thank you, David.

3 Any other comments or questions from anyone in  
4 the audience?

5 [No audible response.]

6 MR. MILLER: Any questions are welcome. Yes, I  
7 know it's a big room and it's hard to get up, but if you  
8 have a question, this is your opportunity to ask us, or  
9 make a comment.

10 If not, I think we have drawn to the end of our  
11 agenda. Anything else that we should be doing? Anything  
12 else from the other members of the PTAC?

13 [No audible response.]

14 MR. MILLER: Rhonda is saying -- signing off. So  
15 thank you all for attending, and we are now officially  
16 adjourned.

17 [Whereupon, at 3:37 p.m., the meeting was  
18 adjourned.]

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