

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

Friday, September 7, 2018
8:30 a.m.

COMMITTEE MEMBERS PRESENT:

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

STAFF PRESENT:

Ann Page, Office of the Assistant Secretary for Planning
and Evaluation (ASPE)
Sarah Selenich, Designated Federal Officer (DFO), ASPE
Steve Sheingold, PhD, ASPE
Sally Stearns, PhD, ASPE

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**Comprehensive Care Physician Payment Model (CCP-PM)
Submitted by the University of Chicago Medicine**

PRT: Kavita Patel, MD, MSHS (Lead),
Paul N. Casale, MD, MPH, and Tim Ferris, MD, MPH
Staff Lead: Sally Stearns

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P R O C E E D I N G S

[8:40 a.m.]

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3 * CHAIR BAILET: All right. Good morning,
4 everyone, and welcome to the second day of this public
5 meeting of the Physician-Focused Payment Technical Advisory
6 Committee, or PTAC.

7 We began our work yesterday with remarks from the
8 Secretary, CMS Administrator, and CMMI Director.

9 The physician community has responded
10 impressively to the opportunity for creating physician-
11 focused payment models that Congress established under
12 MACRA.

13 Over the past two years, PTAC fully reviewed 18
14 proposals and recommended 10 of these models to the
15 Secretary of HHS to test or implement.

16 The members of PTAC and many members of the
17 stakeholder community have been disappointed that none of
18 these models are being actively tested. We believe that
19 significant savings could be achieved for the Medicare
20 program, and that care could be improved for a large number
21 of beneficiaries by implementing the payment models that
22 PTAC has recommended so far.

23 We are encouraged by the comments made yesterday

1 by Secretary Azar, Administrator Verma, and Deputy
2 Administrator Boehler. They acknowledged that more
3 alternative payment models are needed. Clearly, the
4 payment models that we have recommended are consistent with
5 the vision and priorities for value-based health care they
6 described.

7 We are pleased to hear that the Innovation Center
8 is working actively and aggressively on several models
9 based on the recommendations PTAC has made. We feel
10 strongly that in order for these models to succeed,
11 refinements in the models and planning for implementation
12 must be done in close collaboration with the physician
13 practices and organizations that propose them.

14 We fear that stakeholders will not continue to
15 participate in the PTAC process unless rapid progress is
16 made in implementing the models they have proposed and we
17 have recommended.

18 Based on the comments made yesterday, we foresee
19 hearing from both stakeholders in CMMI over the next
20 several months that they're actively working together to
21 finalize the designs of these models and that a plan for
22 implementation of one or more models will be announced by
23 the end of 2018. We will report on the status of

1 implementation at our December meeting.

2 What I would like to do, starting with Dr.
3 Ferris, is I would just like to go around to each Committee
4 member and ask if they concur with the statement.

5 DR. FERRIS: I concur.

6 DR. TERRELL: I concur.

7 MR. MILLER: I concur with the statement you
8 made.

9 DR. CASALE: I concur.

10 MR. STEINWALD: I concur.

11 DR. NICHOLS: I concur.

12 DR. PATEL: I concur.

13 DR. BERENSON: And I concur.

14 DR. MEDOWS: I concur.

15 CHAIR BAILET: Thank you.

16 * **Comprehensive Care Physician Payment Model**
17 **(CCP-PM). Submitted by the University of Chicago**
18 **Medicine**

19 CHAIR BAILET: So now we're going to continue
20 with our agenda. Today, we will review the proposal
21 submitted by the University of Chicago Medicine called the
22 Comprehensive Care Physician Payment Model, also known as
23 the CCP-PM.

1 In addition, after we conclude our deliberations,
2 there will be an opportunity for stakeholders to make
3 public comments on PTAC's processes.

4 * **Committee Member Disclosures**

5 CHAIR BAILET: To begin with, we'll go around the
6 room and introduce ourselves and to clear any potential
7 conflicts of interest.

8 I'll start with myself. Dr. Jeffrey Bailet. I'm
9 the executive vice president of Blue Shield of California
10 for Health Care Quality and Affordability, and I have no
11 conflicts to declare.

12 Rhonda.

13 DR. MEDOWS: I'm Dr. Rhonda Medows, president,
14 Population Health Management at Providence St. Joseph
15 Health.

16 I have no conflicts, no disclosures.

17 DR. BERENSON: My name is Bob Berenson. I'm an
18 institute fellow at the Urban Institute.

19 I want to disclose that a couple of years ago, I
20 participated on a panel with David Meltzer at a National
21 Health Policy Forum. He presented the results of his HCIA
22 project supported by an accompanying Health Affairs article
23 that presented the concept, and I remember correctly some -

1 - and if I remember correctly, some initial findings from
2 that HCIA award.

3 I commented that the model seemed to fill an
4 important void in the primary care delivery related to care
5 for sick patients and sounded promising.

6 That's it. I've had no contact with Dr. Meltzer
7 or the University of Chicago since then.

8 [Laughter.]

9 DR. NICHOLS: Good god. That's impressive. I'm
10 amazed you remembered your comment.

11 DR. BERENSON: No, no. I read it. I read it.

12 DR. PATEL: Kavita Patel, primary care physician
13 at Johns Hopkins at a fellow at the Brookings Institution.

14 I have no conflicts.

15 DR. NICHOLS: Len Nichols. I direct the Center
16 for Health Policy Research and Ethics at George Mason
17 University.

18 And I know and like David Meltzer, but I have no
19 conflict.

20 MR. STEINWALD: Bruce Steinwald, health economist
21 here in Washington, D.C.

22 I have no conflicts.

23 DR. CASALE: Paul Casale, cardiologist and

1 executive director of New York Quality Care, the ACO for
2 New York-Presbyterian, Weill Cornell, and Columbia.

3 I have no conflicts.

4 MR. MILLER: Good morning. Harold Miller, CEO of
5 the Center for Healthcare Quality and Payment Reform. I
6 have no conflicts or disclosures.

7 DR. TERRELL: Good morning. I'm Grace Terrell.
8 I'm a practicing general internist at Wake Forest Baptist
9 Health and the chief executive officer of Envision
10 Genomics, a board member and founder of CHESS, a population
11 health management company.

12 And I have no conflicts.

13 DR. FERRIS: Tim Ferris, a primary care physician
14 and CEO of the physicians organization at Mass General
15 Hospital. I'm on the board of Health Catalyst, a data
16 analytics company, and the board of the National Health
17 Service of England.

18 No conflicts or disclosures.

19 CHAIR BAILET: All right. Thank you.

20 I am going to go ahead and turn it over to our --

21 DR. PATEL: To me.

22 CHAIR BAILET: Right.

23 DR. PATEL: All right. Yeah, that's fine.

1 Please go ahead, Kavita. Dr. Patel.

2 * **PRT Report to the Full PTAC**

3 DR. PATEL: I was going to say which one of us.
4 We had a -- it was myself and Paul and Tim, so we had
5 probably three people. Uniquely for a PRT, we have
6 actually served in many of the care delivery roles
7 described by this model. So if the Chair will allow, I
8 think the three of us on the PRT, there was so much that
9 was so much that we just couldn't put into PowerPoint
10 slides. So I'm just going to try to encapsulate and then
11 go ahead and move through our slides fairly quickly so that
12 we can spend some time with the submitter themselves to
13 talk about this. I'm going to go through the usual
14 formality and get to kind of the proposal.

15 What I wanted to do a little off script for the
16 three of us, not speaking for Paul and Tim, but it's so
17 clear that when we got this proposal, it addressed such an
18 important clinical problem. And just as a sidebar, I was
19 just teasing Bob because I just reviewed his Annals of
20 Internal Medicine article that he wrote with Eric Coleman
21 from 15 years ago about transitions of care in hospital
22 medicine and how that's been one of the few areas where
23 some of the prescriptions made in 2003 or '4 have come to

1 fruition; for example, bundling of episodes, having some
2 things in the fee schedule that directly address
3 transitions.

4 But as the PRT came to this proposal, we were
5 still faced with such an important clinical area that I
6 think that the CCP at its heart, if you think about it,
7 it's called a "comprehensive care physician." So those of
8 us who -- all three of us know Dr. Meltzer kind of by
9 reputation and scholarly achievement. This is really
10 trying to pioneer a way of thinking about medicine that we
11 definitely need, and so we came to this trying to think
12 about an important clinical care concept that is
13 transitions in care, but then kind of aligning this with
14 the elements of a physician payment model.

15 And so, hopefully, what you see in our proposal
16 overview is this equipoise, the struggle with thinking
17 through methodological issues, some of the permutations of
18 putting a payment model on top of a very important clinical
19 care issue, and how do we then bring that forward.

20 At its heart, the proposal -- you'll see a couple
21 of things in our slides. I'm just going to highlight the
22 core elements, and those of you who are familiar with the
23 CCP model, whether it's in some of the trade publications,

1 the New York Times, popular press, Health Affairs article
2 that Bob referenced, as well as the HCIA award, you can
3 look to various sources. But at its heart, it's a
4 mechanism to take care of patients who are identified for
5 being at risk for either rehospitalization or at risk for
6 complications upon discharge from hospitalization.

7 It's important to remember that kind of the
8 essential trigger or qualifying criteria is one
9 hospitalization in the last year, but as the submitters
10 will tell you, there's some flexibility around considering
11 that criteria.

12 But the other strength of this has been in their
13 HCIA award. It is the use of a very elegant randomized
14 control trial design in order to carry out something that
15 Tim referenced yesterday, a little bit of beta testing.

16 So this is a HCIA award, RCT trial, evaluation
17 results that are highlighted in our full proposal, in the
18 full PTAC packet, but the actual payment model that goes
19 with it -- and I'll forward to that -- is around
20 participating physicians, usually inpatient physicians, but
21 could also be from the outpatient setting, taking care of
22 someone who has been hospitalized in the last year to
23 receive monthly fees. And there are both kind of penalties

1 and rewards in the amount of those monthly fees for keeping
2 up with current standards of care.

3 Another note that the PRT wants to acknowledge --
4 we'll get into individual criterion -- is that unlike some
5 of the other payment models that we've seen before that
6 tend to be a little bit more standalone, a feature of this
7 payment model that's proposed is that it could actually be
8 nested easily within other models, offering some
9 flexibility for existing alternative payment models, but as
10 you'll see from some of our comments, that can pose some
11 challenges as well.

12 So it might just be worth to -- we tried to put a
13 graphic to this, but it was a little difficult. So we just
14 put it into these boxes to illustrate what the dollars and
15 how the payment would align for a patient and physician
16 participating in this model.

17 There's a \$40-per-month fee for a new or renewed
18 patient, and that's a care continuity fee, a \$10 for kind
19 of currently continued enrolled patients per month, and
20 those are payable at the end of the year, again, with some
21 flexibility if there needs to be other intermittent payment
22 periods for reasons that CMS might identify.

23 And the kicker here is on the right, and I would

1 say that for us, it was important to understand the
2 difference between the care continuity fee criteria that
3 you must meet in order to receive these monthly fees.
4 That's in the top right box, meaning -- and just bear with
5 me. In order to continue to receive these fees, you have
6 to meet both criteria of a threshold of inpatient care for
7 your panel of enrolled patients that exceeds 50 percent and
8 the provision of your outpatient general medical care for
9 your panel of enrolled patients exceeds 67 percent. So
10 what you see is really trying to put into place kind of
11 threshold and proportional amounts, which would translate
12 to having any sort of internist, family physician. There's
13 flexibility. It could be a specialist that does this,
14 provide both inpatient and outpatient care, and clearly
15 from the percentages, they're trying to offer that in this
16 model, you wouldn't do too much of one or too little of the
17 other.

18 Now, those are the two criteria in order to
19 receive these fees, and then there are penalty criteria
20 where there are additional fines, and the penalty fines
21 that were proposed were \$10 per patient per month, which
22 are also payable at the end of each year if either of the
23 penalty criterion occur, so again bear with us. The

1 penalty criterion is just one of these, unlike the payment
2 criterion, where you have to meet both. If one of these
3 were to occur, you trigger kind of an incidental payment
4 penalty, percent provision of inpatient care that falls
5 below 25 percent, or percent provision of outpatient care
6 that falls below 33 percent. So you can see how they're
7 highly complementary, obviously, the penalty and payment
8 criteria, but it's important to designate that there was an
9 implicit assumption about their proportions of which
10 amounts would qualify for both the payment as well as what
11 would qualify for someone who was penalized.

12 And something that we also had to kind of spend
13 some time with the proposal, in the proposal, everything
14 refers to an enrolled panel of patients. There is not an
15 assumption that any physician participating in this would
16 have their entire kind of physician panel of these
17 patients, but there have been some suggested amounts for
18 caps, potentially, within a typical panel of patients, such
19 that the entire panel -- my panel, Tim's panel, Paul's
20 panel -- would not necessarily all be CCP patients. And,
21 again, that reflects the fact that not every single patient
22 in one of the person's typical panels or hospitalist panels
23 would actually be a high-risk patient.

1 So that's a little bit of an overview, and again,
2 remember kind of the clinical care model that's being
3 proposed is one that's triggered by an inpatient
4 hospitalization, and the goal really is for continuity of
5 care. And for illustrative purposes, it helped us to just
6 understand what would this look like in real life, so a
7 little bit off script again, if the Chair doesn't mind.

8 But you would imagine that as a patient who is
9 identified either in the outpatient or inpatient setting
10 would actually be the candidate for the CCP program,
11 there's a set of enrollment criteria and kind of patient
12 consent that's actually been pretty robustly tested in
13 their randomized control trial, and that would trigger
14 basically a hospitalist or another type of physician, then
15 assuming the care for that patient on a longitudinal basis,
16 and if that patient has a preexisting relationship with
17 other specialists or other doctors, that CCP physician
18 would kind of play the role of quarterback and help
19 coordinate the care for all those other physicians.

20 But we did bring up in our PRT discussion some
21 tensions that could occur if there are already longstanding
22 relationships, particularly in community-based settings
23 that might not be as highly integrated and what would that

1 communication look like, and again, these penalty and
2 payment criteria would apply for that CCP physician, and
3 you could imagine if that CCP physician is an internist,
4 that's a hospitalist, they would actually physically be
5 seeing these patients potentially in an outpatient setting
6 or some sort of clinic office-based setting for some of
7 those subsequent visits after a hospital discharge and vice
8 versa. A community-based outpatient physician might be
9 coming into the hospital to help do part of a discharge
10 visit.

11 So, in a way, the PRT kind of commented that this
12 brings us back to a model of medicine that we actually --
13 some of us actually started training in and did for a
14 number of years until we started moving into a little bit
15 more siloed models.

16 You'll see from -- all of you have our packet,
17 and you will see that we did have some unanimity around
18 several of our criteria, particularly an overall sentiment
19 that there was this tension between the clinical model and
20 then actually the criterion for the PFPM and particularly
21 the high-priority criterion. I want to underscore that the
22 discussion was pretty rich, and you'll see that there were
23 several instances where we did not reach unanimity and in

1 particular the scope criterion. So I do want to just kind
2 of highlight what I felt like were the key issues and then
3 have my colleagues add in.

4 It's incredibly -- and I think that for us, this
5 issue between where does outpatient care kind of start,
6 where does inpatient care kind of end is incredibly
7 difficult for complex patients that are described in the
8 CCP model.

9 So what we know and as I referenced this 2004
10 article that Bob wrote, we know that the needs of these
11 patients, despite advances, are still not being met.
12 However, we think that what we're trying to struggle with
13 is do we have enough assurance in the proposed payment
14 model by just simply replicating this very rigorous kind of
15 RCT-based high-quality clinical standard, will we find the
16 same kind of replicability across other settings.

17 And then because of some of the findings in the
18 HCIA evaluation -- and I'll just highlight several -- one,
19 that it did not show significant savings and then, two,
20 that there were actually a slight increase in emergency
21 department visits, we wanted to make sure that there were
22 sufficient quality measures as well as potentially areas
23 that could be added for accountability so that the

1 financial model could be applied more broadly.

2 I want to make sure I'm going on the right slide.

3 And we highlighted at the last bullet point
4 there, is that you'll see that one of the questions we ask
5 are, Are the workflows and career paths, what I described
6 to you about this kind of throwback almost to when
7 internists like myself went in and out of hospitals much
8 more fluidly -- is this actually something that's likely to
9 be adopted outside of a highly integrated setting or even
10 within an integrated setting? And then could there be
11 other ways to do this that actually address the important
12 clinical challenges?

13 The next slide, I mentioned already some of the
14 HCIA issues. I do want to just cite that the qualitative
15 findings done in focus groups, although limited because
16 there were smaller numbers, were so strong for the
17 patients' kind of positive sentiments about being in this
18 model, and then the provider satisfaction, which has been
19 shown in several studies that are in your PRT packet, are
20 pretty compelling for a satisfaction of the providers who
21 participate in this model, understanding again this is all
22 voluntary, which is what the submitter would propose.

23 That we did feel like there were some pretty

1 significant issues around this possibility of discontinuity
2 if a primary care physician kind of stopped following a
3 patient that was enrolled in CCP and then potentially vice
4 versa, and so it almost felt like how could we avoid the
5 inevitable delay of that transition that has to occur at
6 some point.

7 And then we also wanted to understand a little
8 bit more about how to match the kind of qualitative
9 findings that I highlighted with some of the other -- the
10 lack of quantitative findings, not just from the HCIA
11 evaluation, but some of the concerns around achievability
12 of savings as well as a positive result in clinical
13 outcomes.

14 So for that scope, high priority, which we had a
15 majority opinion that it did not meet, we were not -- and
16 we had a lot of discussion. So I will just try to say that
17 between the potential for limited feasibility, which might
18 just be a -- this might really not apply outside of highly
19 integrated or even academic settings as well as kind of how
20 little we knew about the potential to lower the cost of
21 care.

22 There are estimates within the proposal of the
23 potential for savings in Medicare, but there might be other

1 ways to more directly achieve those savings. And, in
2 particular, the strength of this proposal, which is that it
3 could be within an ACO or in a bundled payment program,
4 brought up the fact that those programs, as standalone
5 programs, already have in place inherent financial and
6 clinical incentives to lower cost of care. So is this
7 really adding to the opportunity for participation in an
8 APM, or are we simply putting more into what's already
9 existing and not necessarily expanding scope?

10 So those are a little bit of the highlights for
11 where we had a very robust back-and-forth. We did not
12 achieve unanimity on this, but we felt it did not pass that
13 criterion.

14 For quality and cost, we all felt that it did not
15 meet this criterion, and this again was from this opacity
16 related to what savings were estimated on the cost side as
17 well as kind of very concrete and tangible quality measures
18 for tracking and comparison to peers.

19 Now, one would say -- and the submitter should
20 have an opportunity to weigh in -- we looked very careful
21 at this proportional threshold issue and had a conversation
22 about what those -- those thresholds inherently represent
23 quality metrics, if you will, because you have to -- in

1 order to get money or in order to avoid paying a penalty,
2 you have to meet these thresholds. So we did not feel that
3 the submitter had zero quality measures.

4 However, it isn't clear if those thresholds
5 correlate to individual or population-based quality
6 measures, and while we respected the fact that the
7 submitted did not want to necessarily do what is pretty
8 common in hospital-based medicine and in outpatient-based
9 medicine, which is to have this long laundry list of
10 quality measures, many of which do not apply to your
11 particular patient -- so we wanted to applaud the strength
12 of being flexible. We still felt like it was very
13 difficult to actually tackle the central question in this
14 criterion that we could say that this payment model would
15 improve health care quality.

16 So I'm saying these things because you can only
17 imagine how difficult it was for us to try to wrestle with
18 what in concept would seem to indicate high quality, that
19 is, a physician who is balancing their outpatient and
20 inpatient load proportionately and has kind of robust
21 experience in both, and yet we still felt like there was a
22 lack of some of these metrics.

23 And then just as a final note, the patient

1 empanelment part as part of a randomized clinical trial and
2 the HCIA award was pretty clearly delineated. If you even
3 go on the CCP website at the University of Chicago, you
4 will see very clear criteria that are patient-facing for
5 participating in this program, but in their proposal, we
6 felt like it was not entirely clear how robust patient
7 empanelment could be implemented to avoid adverse risk
8 selection. And that was something that we also wrestled
9 with in that criterion.

10 And then the third, high-priority payment
11 methodology criterion, another one where we had a unanimous
12 opinion that it did not meet the criterion, there's a very
13 obvious -- from that slide I showed you with the boxes,
14 there's a clear payment mechanism here. So it's actually
15 pretty easy, unlike some of the other payment models that
16 we're all experienced with, to understand what the outlays
17 in the fiscal spending might be based on your own
18 institution or your own practice's past admission patterns.
19 And we acknowledge that this could be standalone nested
20 within another alternative payment model, but at the end of
21 the day, as something that we felt like could be an
22 opportunity for improvement would be a way to actually
23 improve. And sometimes we shudder at saying "financial

1 risk." So I'll just deconstruct that a little bit. We
2 felt like there could be a more clear linkage between the
3 payment methodology and some of those patient-specific or
4 panel-specific outcomes of interest, and that's where we
5 felt like the payment methodology was ultimately a little
6 weaker.

7 And, currently, just as a note, we spent a lot of
8 time between the Office of the Actuary, CMMI, and some
9 other experts to understand what would this look like if
10 you had multiple institutions with different financial
11 arrangements, again, bringing up kind of a feasibility or
12 generalizability issue. So we did not feel with the
13 information we were given that we would have a confident
14 way of describing the kind of reproducibility or
15 generalizability of both reductions of spending as well as
16 the alignment with the suggested payment methodology.

17 And then I'll go through the other criterion. We
18 had another set of pretty robust discussions. You'll see
19 that we did not reach unanimity on the value over volume,
20 but we did feel overall like it did meet the criterion.
21 And I think this is a harkening to the premise of this
22 model, which is really to offer comprehensive continuity
23 for a group of high-risk patients, and we felt ultimately

1 that if that clinical model can be better aligned with a
2 payment model that that does offer significant value.

3 And just to note in that slide, we did talk about
4 that one of the comments in the HCIA evaluation was that
5 the empanelment or enrollment process proceeded a little
6 slower than anticipated. We wanted to acknowledge that
7 that might be different, depending on your institution,
8 both either higher or lower. And that could pose
9 additional barriers or obstacles, which could actually make
10 the value proposition even greater. So we just wanted to
11 point out that much of our data comes from kind of an
12 institutional experience, which might not also be
13 generalizable.

14 The fifth criterion, flexibility, for all the
15 reasons we said, various physicians can participate in
16 this. You can be community-based. You can be hospital-
17 based. You can be a cardiologist. You can be an
18 internist. You can be a pediatrician. There is so much
19 flexibility here. So we unanimously thought that that met
20 the criterion.

21 On the ability to be evaluated, we also felt that
22 -- if anything, we felt like this RCT design offered what
23 we felt like was almost a gold standard for how do you

1 think about evaluability, and much of that credit goes to
2 the submitters and being pretty thoughtful and rigorous
3 about that element of design.

4 Now, we will say that we're so -- having said
5 that, the RCT trial is so compelling that we did have a
6 little bit of opacity in understanding the difference
7 between the HCIA evaluation results, which I've highlighted
8 to death, and also what we know is in the submitter's
9 proposal. And there have been some unpublished results to
10 date. As of this day, it may have changed, but when the
11 PRT meant and deliberated over several weeks, we did not
12 have any of those results. They were a little different
13 than the HCIA evaluation and are in the submitter's
14 proposal. So I'll just highlight that as something that
15 the PRT would like to have better insight on.

16 Integration and care coordination. Anytime you
17 see a majority and lack of unanimity, you can tell that
18 there's evidence that there's a robust deliberation that
19 went on, and I think that if I had to summarize where we
20 had just some back-and-forth, it was understanding the
21 roles and interactions -- or more clearly defining how that
22 leadership role for the CCP physician, that comprehensive
23 care physician, would actually be executed with all the

1 different touch points that any high-risk patient would
2 inevitably have.

3 So how do we make sure that even though we know
4 that in kind of an ideal world that that CCP physician is
5 kind of handling and maintaining, even physically doing
6 home visits or seeing patients in the clinic while also
7 being in the hospital-based setting, we did not have the
8 specific kind of process measures or some of the explicit
9 expectations for those physicians, other than those
10 thresholds and the penalty criteria that we described in
11 the earlier slide.

12 So we did want to flag that as a potential
13 problem for care coordination, but I think the reason we
14 did not have unanimity around this is because it's so
15 clearly important to have this continuity of care,
16 especially around a hospitalization period, that we were
17 trying to understand how could there be more certainty that
18 that continuity would be achieved.

19 Next criterion, patient choice. We had a
20 majority opinion, did not achieve unanimity, but we did
21 think it met this criterion.

22 We did want to make sure -- I had mentioned that
23 there was a potential risk for adverse risk selection, and

1 so we wanted to also -- it would have made us feel more
2 comfortable if there were additional mechanisms to avoid --
3 and I hate to say this. This has come up in many of our
4 PTAC discussions, but we would love to acknowledge that
5 everybody is trying to do their best, but we would have
6 loved to have also seen, and we felt like the proposal
7 could be improved with some acknowledgment of how to avoid
8 adverse gaming or doing something where you unintentionally
9 disenroll a patient, wait for them to be hospitalized, and
10 then reenroll a patient. And you could imagine very
11 perverse scenarios which we would like to have had more
12 explicitly acknowledged, and that was part of the kind of
13 robust discussion. But we did think that ultimately this
14 is a really patient-central model.

15 Patient safety. We felt like that unanimously
16 met that criterion. In this case, we had a conversation
17 about those very same unintended consequences, but we were
18 trying to really acknowledge that if you have continuity of
19 care -- and the literature in transitions of care have long
20 offered the adverse events are kind of the chief
21 complication of a lack of kind of continuity and
22 transition. So we felt like this model head on dealt with
23 some of what I feel like has been decades-old health

1 services research that showed that adverse events in a lack
2 of transitions -- and that's actually Eric Coleman's kind
3 of body of work over his life -- has illustrated how this
4 could be a more patient-safe model.

5 And then, finally, my favorite criterion, health
6 information technology, also felt like it unanimously met
7 that criterion. There are issues of interoperability, et
8 cetera; however, in their HCIA evaluation and award,
9 they've been trying to deal with some of those technology
10 barriers. And we felt like this model offered a novel way
11 to approach some of that.

12 So let me stop and ask if Paul or Tim have any
13 additional comments.

14 DR. CASALE: You know, that was a very
15 comprehensive overview, Kavita. I think you've captured
16 really our discussions well.

17 I'd just highlight two. One is at least the
18 concerns we discussed around applicability broadly, and
19 certainly in more integrated health systems, this might be
20 easier to implement, still having concerns around in some
21 more community-based, whether this is really feasible.

22 And the second was around our discussion our
23 integration and care coordination, and we even mentioned

1 yesterday we never passed this one on anything. On the
2 surface, you'd say, "Well, how could you not?" because
3 you're actually addressing this care coordination by having
4 the same clinician seeing the patient, inpatient and
5 outpatient. I mean, how more coordinated can you get?

6 But I think our concerns, as you reflected, were
7 really beyond that in terms of assuring that integration
8 coordination beyond that hospitalization period and how
9 would we do that.

10 So I'll just highlight those two. Thank you.

11 DR. FERRIS: Great. Thanks, Kavita. That was a
12 terrific review.

13 So I wanted to just reflect on a couple of things
14 to highlight and emphasize things that you said, Kavita,
15 and it seems increasingly that we as a group are discussing
16 the care model and the financial model. And looking at a
17 care model that's been developed, yes, Grace, you're the
18 one that first pointed that out.

19 And here, what we have is a care model that -- I
20 will read what I said here -- "More frail Americans with
21 complex illness should have access to this clinical model,"
22 no question. It's fantastic.

23 The question is, Does the financial model that's

1 proposed here necessarily result in the care model that's
2 been created by applicants? And I wonder is -- you could
3 also turn that question around and say is it possible to
4 create that care model using other financial models, and I
5 would say in answer to both of those questions, I have
6 significant concerns, questions, about asking that question
7 both ways.

8 And part of this has to do with personal
9 experience because in my institution at Mass General, we
10 noticed about five years ago, maybe a little more, that
11 there was a subset of patients who really needed high
12 levels of continuity between inpatient and outpatient, and
13 we have a group of, interestingly, primary care doctors who
14 never stop rounding on their inpatients and are not
15 participating in the hospital service, which vast majority
16 of primary care doctors do now use the hospitalist service.

17 But there was this core group, and we started
18 assigning our most complex, frail patients to that group.
19 They get paid as primary care doctors and for their
20 inpatient rounding under the current payment system, and I
21 can't say precisely that they have all the bells and
22 whistles that are here. But they do provide -- in terms of
23 continuity, we think of continuity in three domains, thanks

1 to Barbara Starfield's work. We think of it as you want
2 information continuity, you want management continuity, and
3 you want relationship continuity.

4 So there are multiple ways of providing
5 continuity of those three things, but certainly, the model
6 that we have, without claiming anything like as good as
7 what Chicago has, seems to be working on checking the boxes
8 on those three elements of continuity. They're so critical
9 for complex, frail elders.

10 Now, if you think about it, primary care in my
11 organization is heavily subsidized by the organization. So
12 it is not actually standing on its own. It's subsidized,
13 and so to generalize outside of our organization would be
14 highly problematic.

15 But the importance of what I'm trying to say here
16 is one could imagine alternative financial models
17 supporting this, and one could also imagine, I would say,
18 this financial model not resulting in the care model that's
19 been at least with the controls that are proposed in this
20 application.

21 So sorry for that long -- you said all that,
22 Kavita. I'm just emphasizing that, so thanks.

23 * **Clarifying Questions from PTAC to PRT**

1 CHAIR BAILET: Harold.

2 MR. MILLER: Thank you. Great report, Kavita.

3 I have several questions for the applicant, but I
4 wanted to ask one to you guys since you dug into this in
5 detail. I was a little perplexed by this payment model
6 where there's a threshold where you have to meet, and then
7 there's a lower threshold where there's a penalty. And I
8 was a little bit -- I wasn't quite clear on what exactly
9 happens in the middle. So you have to be 50 and 67 percent
10 to get the payment. You get a penalty if you're below 25
11 and 33 or whatever it is. In the middle, do you get
12 nothing? And then you literally -- so you get something,
13 you get nothing, and then you get nothing and you pay a
14 penalty? Is that what your understanding was?

15 DR. PATEL: Yes. That's our understanding.

16 MR. MILLER: And then the other question was it
17 sounded like the calculation was going to be made at the
18 whole panel level, which I thought was sort of interesting
19 given that this was all about continuity at the individual
20 patient level, and you could argue that you could measure
21 this at the individual patient level. You could say did
22 each patient get the full continuity of care, and you could
23 potentially penalize you for not doing it on an individual

1 patient basis and then add it up. And I wondered if you
2 thought about that because if you just do it at the panel
3 level, then you have the potential for some patients are
4 getting left behind, but as long as enough patients are
5 getting completely continuous care, it ends up being 50 or
6 67 percent, even though some patients are really falling
7 away as opposed to saying a true outcome-based payment that
8 would say, "We will pay you, for you, the individual
9 patient. You got this." Did you talk about that issue at
10 all?

11 DR. PATEL: We did. We touched on it, and I
12 think certainly we should hear from the submitter about
13 their thoughts further.

14 I would just say, if anything, I think the reason
15 you see this panel design inherently of these thresholds is
16 really to offer almost an antithesis to like the current
17 kind of -- you know, having to measure every little thing
18 for every little patient and this feeling like I'm just not
19 able to deliver the care that I want to deliver.

20 So, if anything, you're correct. We thought that
21 some of those, whether they're individual or at least more
22 specific metrics, might be more useful, but we also really
23 respected or tried to understand that there was a desire to

1 simply make this a lot more flexible to be part of either
2 another payment model.

3 So you could imagine that if this were -- there's
4 a scenario in their appendix where they actually walk
5 through the finances of what this would look like inside an
6 ACO. That's inherently assuming that that ACO -- Tim's
7 ACO, my ACO, Paul's ACO -- were doing all those ACO
8 measure.

9 So I think that the answer would be not that
10 they're all going to be inside of an ACO, but these tend to
11 be organizations that are doing other things. Those other
12 things are still not tackling this clinical problem. It
13 keeps coming back to the fact that there's this unmet need
14 identified clinically for high-risk patients, and that's
15 why you see some of the -- kind of the lack of those
16 specific measures.

17 MR. MILLER: Just to be clear, I was not asking
18 about other kinds of measures.

19 DR. PATEL: I agree.

20 MR. MILLER: I was merely asking specifically
21 about this thing because --

22 DR. PATEL: It is panel -- correct.

23 MR. MILLER: -- it seemed to me it gets at the

1 issue you were raising about sort of the gaming and
2 whatever it is, that if you have the calculation is made at
3 the individual patient level, then you know I'm getting the
4 \$40 because I gave that patient continuous care, not
5 because I somehow on average gave a group of patients
6 something better than --

7 DR. PATEL: You're correct. That's correct.

8 CHAIR BAILET: Grace.

9 DR. TERRELL: So, as I'm listening to you, I have
10 a couple of things I wanted to sort of flesh out with you
11 all before we get the speakers to probably reflect on it
12 too, so that it may come about in their comments.

13 First of it was the comments that you've made
14 about the potential applicability across a broad, you know,
15 non -- a different setting than what the particular setting
16 was that the University of Chicago's medical system was
17 involved with.

18 So did you all in the research that was done look
19 at other places where there's been what we called
20 "extensivist models" that were very, very different, so
21 where there have been various issues?

22 So I'm thinking of the CareMore, which in
23 Medicare Advantage was essentially a model where they were

1 seeing inpatients and doing those. The work we did at
2 Cornerstone Health Care in the past was a somewhat
3 different model.

4 And then the third one I'm thinking about is the
5 Holston Medical Group in eastern Tennessee, which was an
6 independent group and an ACO. They had what they called
7 their "extensivist model," which was in the hospitalist
8 with a continuity clinic.

9 So all of those were in different financial
10 models, okay, but a very similar -- potentially similar
11 sort of comprehensive around the time of care, and there's
12 been a fair amount published on all of that. So was that -
13 - did that inform your opinions that you all concluded that
14 this might not be applicable in other settings or not?

15 DR. PATEL: I think it actually supported kind of
16 what Tim identified, that you can find other financial
17 models potentially, which could help you get to the same --
18 tackle the same care issue.

19 So, yes, you are correct, not those specific --
20 CareMore, yes, but not some of the exact specifics.

21 DR. TERRELL: Yes.

22 DR. PATEL: But that extensivist literature was
23 something we were familiar with.

1 DR. TERRELL: Okay. So that leads me to my
2 second point because that's where I thought you all were.
3 When you made the point there's other ways of paying for
4 it, by the way, we supplement our primary care, I disagree
5 with your conclusions, I think, based on my experience.

6 So, "Payments under the model are intended to be
7 supplementary to other APMs, but it seems providers
8 participating in other APMs could implement aspects of the
9 CCP independently without additional payments." So you all
10 put that in there as being something that you were
11 concerned about this particular payment model. So I'm not
12 talking about whether I agree with the intricacies of this
13 payment model, but you said it could be done elsewhere.

14 So I'm going to talk a little bit about my
15 experience and what I know about that. Within the context
16 of experience that I've had in Medicare shared savings as
17 well as NextGen, when you get the large health system CFOs
18 looking at this, they see this as a loss, just like they do
19 primary care. And you can make, as have many of these
20 extensivist care model studies -- show evidence that there
21 is clear savings at the total cost of care level, which is
22 what you're wanting to see at the ACO level.

23 But there is still a mentality that each

1 individual unit within a total cost of care risk
2 organization still has to sort of make it on its own, if
3 you will, and so a lot of what I think, the work that we've
4 been doing at the PTAC level, is trying to figure that
5 peace out for various specialists trying to move the value
6 because the current health care ecosystem doesn't by that.
7 They won't unless they're CareMore. Okay. So CareMore
8 basically said, "We're going to pay these doctors who are
9 giving really good care because we know it's going to save
10 money, and we're going to have some margin on that."

11 Okay. We did some of that work at Cornerstone,
12 but when we became part of a larger system, the consultants
13 who came in, Marsal & Alvarez, basically said no. What's
14 going to happen is every single thing has to make its own
15 profit or we're going to cut it and hack it because we
16 don't believe in the total cost of care as part of an
17 accounting system.

18 My point in all this is how we actually think
19 about making something look like it breaks even within the
20 individual unit is what I think is a lot of what we're
21 doing right now at PTAC because this is sort of, in many
22 ways, Harold's approach to things where each thing that's
23 important to do has to kind of be -- has to kind of

1 actually be paid for the value that it does to the point
2 that it can stay in business, right?

3 So, anyway, I want to sort of see if you all
4 could comment a little bit about the statement you all made
5 with respect to other -- it could be done in other ways,
6 because I think this is a crucial, crucial issue that we've
7 got to understand not only for this particular proposal but
8 for everything we see.

9 DR. PATEL: So I'll start, and I'm confident Paul
10 and Tim will weigh in.

11 I'll say that you're correct, as usual. I mean,
12 your knowledge of what not just happened at Cornerstone,
13 happens in my -- happens in all of our institutions, which
14 is why I always show primary care in red on our CFO's
15 tablet sheet. So it's constantly.

16 So I think my answer to you -- and we did not
17 have that level of a discussion in any of our PRT
18 discussions to that extent; however, we did talk about the
19 reason we put that in black and white is not only did we
20 kind of talk through extensivist model, what Tim is doing
21 in the current fee schedule. I kind of offered from a
22 community-based primary care side, how aggressively -- may
23 not be the right thing to do. We're trying to aggressively

1 increase our utilization of TCM and CCM codes to accomplish
2 our continuity. So that's how we've answered that issue.

3 And so in your Cornerstone example, where my unit
4 would need to find a way to get into the black, that's
5 actually how we're doing it, and I'm not so sure that this
6 would offer -- first of all, if I actually tried to do
7 this, our hospitalists who are not integrated with us would
8 completely mutiny and wouldn't allow for me to do this and
9 would actually make things more difficult.

10 And then I think Tim and Paul have kind of the
11 other experience of running hospital-based or hospital-led
12 payment models that have a component of what you're
13 describing as well.

14 DR. TERRELL: So to be clear, we couldn't get our
15 hospitalists to do it either. We created a new specialty
16 called "extensivist" and ended up having a relationship
17 where some of them were hospital-based and some of them
18 were clinic-based, and they work together.

19 Holston Medical Group did what I think these guys
20 are doing, which is they basically took hospitalists and
21 expanded them, and that's actually what Wake is trying to
22 do now, with our old model, for that very reason.

23 DR. FERRIS: I agree, as usual, Grace. It was a

1 very insightful observation.

2 I would interpret what we wrote there as -- for
3 an example -- and this came up yesterday -- I agree that
4 the payment system should better line up costs with
5 payment, and we have lots and lots of examples in the
6 health care system where costs and payment are not lined
7 up.

8 But, specifically, there are a number of codes --
9 TCM and CCM. We're doing the exact same thing. So right
10 now, billing for the various services, if you add them up,
11 don't quite cover the costs of doing this, but that's not a
12 payment policy design issue. That's an allegation of
13 resources to the proper codes issue.

14 So one of the other things we get to think about
15 in this setting is this issue of simplicity versus
16 complexity, and if codes exist that are actually
17 specifically designed to provide the resources to get this
18 work done, why aren't people using them? Well, there's
19 administrative reasons because they're so difficult to
20 comply with, and that's actually improved lately. And they
21 may be not valued correctly. That doesn't necessarily mean
22 we need a new payment model, and so do you see what we're -
23 -

1 DR. TERRELL: Okay.

2 DR. PATEL: We actually talked about the recently
3 implemented complex CCM code as an example of that. Like,
4 there was this perception potentially that CCM itself was
5 not valued for that subset of complex patients, and now
6 there's additional dollars for a complex CCM. So that was
7 part of our response.

8 DR. TERRELL: So the way I was inferring -- and
9 I'm hoping that you'll comment on this later -- is that the
10 reason they're talking about this percent and that percent,
11 inpatient, outpatient, is they're not thinking of a general
12 internist like I used to be who is going an occasional
13 inpatient case but still has his vast primary care practice
14 and then sees within the month, the 30 days or whatever.
15 They're thinking about a new specialty that has evolved
16 from the hospitalist that's called a comprehensivist that's
17 basically taking a patient during a really crucial time and
18 figuring out how to define that group and how it might work
19 best for them.

20 And so I guess the real question -- and this is
21 why I want you all to hear this now, so I can understand
22 what they're thinking and then go with where you might be -
23 - is just a transition of care code with the usual

1 inpatient fee-for-service and the usual outpatient fee-for-
2 service on top of that adequate to support that care model
3 and what I would call as a new evolving developing
4 specialty?

5 DR. PATEL: Grace, let me answer that first.
6 What you described is in theory what this is.

7 DR. TERRELL: Okay.

8 DR. PATEL: I would say that that's absolutely
9 the intentionality of it. However, it gets back to what I
10 think all three of us have said now.

11 DR. TERRELL: [Speaking off microphone.]

12 DR. PATEL: I don't see evidence to reflect that
13 if you simply reproduce this payment model that you would
14 achieve that, so let me --

15 DR. TERRELL: But that's your beef, though,
16 right?

17 DR. PATEL: Let me tell you --

18 DR. TERRELL: Because that's what I --

19 DR. PATEL: -- that that's probably the crux --

20 DR. TERRELL: That's what I think too.

21 DR. PATEL: -- of our issue.

22 DR. TERRELL: Okay.

23 DR. PATEL: Those of us that have any clinical

1 care experience know that that's what we want to get to.

2 DR. TERRELL: Okay.

3 DR. PATEL: It's not clear that this is the
4 mechanism --

5 DR. TERRELL: That this does it, okay.

6 DR. PATEL: -- to do it.

7 DR. TERRELL: All right.

8 DR. PATEL: Does that help?

9 DR. TERRELL: So that's what I thought this was,
10 which is they have defined a new way of thinking about a
11 payment for a new way of providing care for what's an
12 evolving new specialty, and your argument -- and here is --
13 there may be other ways of getting there that are already
14 out there that could be tweaked -- and their argument is
15 this is the way we think it might, could be done. That's
16 your understanding of it.

17 DR. PATEL: Right. And we --

18 DR. TERRELL: Okay. But we disagree.

19 DR. PATEL: And, for example, in that
20 comprehensivist model, there could be a comprehensivist of
21 the day, and it could be Tim Ferris on a Monday, Kavita
22 Patel on a Tuesday, Paul Casale on a Wednesday, and we're
23 kind of the comprehensivist --

1 DR. TERRELL: Yeah. That's called a hospitalist
2 service.

3 DR. PATEL: Right. I'm just offering to you a
4 little bit of where I see some loopholes in this current
5 design.

6 DR. TERRELL: Thank you

7 DR. FERRIS: I also want to respond. Sorry. I
8 can tell Jeff is like -- wants us to get on to the show
9 here, to the real --

10 CHAIR BAILET: [Speaking off microphone.]

11 DR. FERRIS: But I do want to, one thing you
12 said, just clarify. So one of the issues that we discussed
13 was the creation of this model seems to add an additional
14 level of complexity to the number of transitions that occur
15 because you described it as a hospitalist that becomes an
16 extensivist. Actually, the model that we have is -- and
17 it's not of limited duration and then you pass it on.

18 We have primary care doctors who have smaller
19 panels who round.

20 DR. TERRELL: Okay.

21 DR. FERRIS: And they found on their patients.
22 So it is not sort of a rotation basis. They actually --
23 specifically, those frail, complex patients don't get

1 admitted to the hospitalist service when they get admitted.
2 They get admitted to that person, unless they're away on
3 vacation, and so you really are creating.

4 And there is no transition on the other end,
5 after a year or six months or whatever it is. They are
6 their primary care doctor, and they are their hospital
7 doctor.

8 DR. TERRELL: Okay. That's why I wanted this
9 conversation to happen now, so we could understand what you
10 guys were thinking this was because I want to hear if they
11 think it's the same thing or not, so that we can flesh it
12 out, one way or the other.

13 CHAIR BAILET: All right. Thank you.

14 Len, please.

15 DR. NICHOLS: So having now heard four doctors
16 talk for an hour --

17 DR. PATEL: We're used to economists.

18 [Laughter.]

19 DR. NICHOLS: -- I'm ready to point out that this
20 PRT had three docs. I know there's a rule against having
21 three non-docs. You might want to just think about that.

22 [Laughter.]

23 DR. NICHOLS: And here's why I'm confused, among

1 other things. Every single one of you on the PRT, first
2 thing out of your mouth was more people need this, and then
3 you imagine 87,000 things that might go wrong because it's
4 not documented in the quality measures they put forward
5 because they're trying to do it simple.

6 So here's what's going on from an economist point
7 of view. These guys are trying to incentivize a style of
8 care, and the style of care has to do with this mix of in,
9 out, all that. Call it whatever "incivist" you want. It's
10 about a style of care that doesn't exist now at very many
11 places.

12 Apparently, there's 12 people in your world who
13 voluntarily, because God knows you all wouldn't make them -
14 - they are voluntarily doing this, right? And I would
15 submit this subsidy that's going on is actually -- CFO
16 knows damn well they're getting total cost of care down
17 because of it. So it's not a subsidy. It's just -- okay.

18 But here's the question. It seems like the
19 assertion of the applicants is this style of care will
20 generate all the good stuff and savings, and it seems to
21 come down to a factual dispute about whether the HCIA
22 evaluation that I guess after, somebody did, whether those
23 results are, if you will, dispositive or whether the recent

1 results are dispositive. So I think that's the thing we
2 want to understand, okay? That's sort of the way I see it.

3 And to me, it's quite analogous to what Chris
4 Koller was trying to do when he was insurance commissioner
5 of Rhode Island. Let's just make them spend 10 percent on
6 primary care and see what happens, and it turns out there's
7 recent results you may know about that Bruce Landon and his
8 team did that would suggest these styles of care actually
9 can have impact.

10 You know, everybody is talking about anecdotes.
11 It reminds me of a doc I once knew who ran one of these
12 early on Medicare Advantage products, and he required -- he
13 had a practice that was treating non-Medicare patients and
14 Medicare patients. He built a new building for the
15 Medicare patient world, and he made his doctors spend 30
16 minutes with them. And the first six months, the doctors
17 went crazy, "What am I going to do with 30 minutes? I
18 usually spend 11. What am I going to talk about? Their
19 grandchildren?" He said, "That's the frigging point. You
20 learn everything about them." Utilization went down by 20
21 percent.

22 So, fundamentally, it's about a style of care,
23 right? And the question is, Does the style produce it if

1 indeed it's being done by the right kind of people? Yes,
2 it doesn't exist very many places. Yes, there's a serious
3 question about if you set this up, how many people would
4 join it? But it seems to me the question is, Have there
5 been results that go with this style of care enough to
6 justify beta testing?

7 Am I wrong? You're nodding yes. Am I wrong?

8 DR. MEDOWS: So I think he's on to us.

9 DR. NICHOLS: Okay. Rhonda, go ahead.

10 CHAIR BAILET: Bob.

11 DR. BERENSON: Well, now that we've heard from
12 the economist, let's get another clinician in this.

13 [Laughter.]

14 DR. BERENSON: First, I want to say that Tim's
15 comments, I'm shocked, shocked to hear there's missed
16 valuation in the physician fee schedule.

17 [Laughter.]

18 DR. BERENSON: But we'll leave that aside. We
19 have nothing to say about the fee schedule here.

20 I followed this conversation, and I have a
21 concern about the fact that lots of organizations have
22 figured out how to do this sort of naturally, and would we
23 be by deciding that we would support this model somehow be

1 then adding lots of money to the pot for everybody else
2 who's doing it?

3 A lot of groups, as Tim has emphasized, just have
4 a normal triage function, where some of the docs are the
5 hospital docs, and they follow the patients for the
6 practice, maybe the first time, and then the patient moves
7 their care from Doctor A to Doctor B who is taking care of
8 -- who is expert at COPD or some serious illness.

9 So my question is really to try to estimate the
10 magnitude of what we might be talking about. We've gone in
11 20 years from having physicians when I was practicing
12 following our own patients in the hospital to an assumption
13 that nobody follows their own patients in the hospital, and
14 I don't think that's right.

15 So the question is, Is there any data? I mean, I
16 could imagine looking at TINs and place of service or
17 whatever that would -- so that we actually know how many
18 patients are followed by an office-based doctor, I guess is
19 what I'm saying. I mean, how big is the potential
20 universe? Did you guys look for that at all? Is this a
21 rare event that doctors follow patients in the hospital
22 from their practice? Or as I suspect, it's happening a lot
23 more than sort of the mythology -- not the mythology --

1 than the assumption that hospitalists have just taken over
2 all hospital care. Do we know anything about that?

3 DR. PATEL: As you know, we could run kind of
4 secondary data, but we did not do that specific level. We
5 did not do those data analyses, no, but we also looked at
6 the literature. Then I think aside from what's in the
7 packet, the three of us have tried to look for some sort of
8 quantitative evidence of that and did not -- I did not find
9 that, no.

10 DR. BERENSON: Okay.

11 DR. PATEL: But we would concur with your
12 impression with no data to support it, that there is
13 probably trends, and they're largely probably geographical
14 and correlated with institutional type potentially that
15 would predict some of that rural, urban, et cetera.

16 So we would support your hypothesis, but we
17 didn't do anything to explore it.

18 DR. BERENSON: Yeah. I mean, I'm guessing that
19 rural docs are largely following their own patients.

20 DR. PATEL: And we feel like yesterday we had a
21 PTAC submitter that probably echoed some of that.

22 DR. BERENSON: And that was going to be my final
23 comment, is this is just a different version of what

1 yesterday's proposal was about, is that people get lost in
2 the emergency department, in the hospital, without any
3 natural follow-up. So to emphasize, this is a real
4 important issue, and there may need to be a few different
5 approaches to trying to deal with it. But I think it
6 raises the issue of taking proposals one by one rather than
7 taking a topic and then trying to figure out what are the
8 various ways of attacking. You know, for future work for
9 PTAC, it might be something to think about, is to offer
10 proposals on particular topics that we find compelling.
11 Whether CMMI would find that compelling is a whole
12 different story.

13 But I just find this is a recurring important
14 topic: Is the patient lost between the hospital and the
15 home?

16 CHAIR BAILET: So, as another clinician, I feel
17 compelled to pile on, and this is -- in part, I'd like to
18 hear from the applicants. But, also, we're talking about
19 applicability, and I'm not an internist but a surgeon. But
20 I did lead a large physician group in an integrated
21 delivery system.

22 My experience, where people are wanting to really
23 focus on being hospital-intensive, so they were laborists,

1 surgicalists, intensivists, hospitalists, recruited a lot
2 of primary care physicians every year, and there were
3 primary care physician candidates that wouldn't even
4 entertain our organization. And we had hospitals that were
5 as small as 30-bed in 10,000-population communities. They
6 wouldn't even entertain looking at us unless we had a
7 robust hospitalist program.

8 So we talked about application, and any great
9 model, if you can't get people to engage -- and I think
10 that's the question that really Bob was trying to get, is
11 what does the universe of potentiality look like. And I
12 understand what's experience in Tim's organization, and
13 that kind of thing is happening both in these large
14 integrated multispecialty medical groups, also in rural
15 communities, where they don't have any options. They have
16 to -- they just don't have that ability to recruit a robust
17 hospitalist team because they don't have the inpatient
18 volume, so that's a question I'd like to understand. And I
19 think, Kavita, it sounds like your committee discussed
20 that.

21 The other point is in your proposal, you
22 commented on the fact that you needed enough complex
23 patients in a panel to make it worthwhile for this

1 individual to be in the hospital, but at the same time,
2 they also have to be in the clinic. So it's kind of like
3 "Back to the Future."

4 My question is, Is that creating the same kinds
5 of challenges that drove us to be a hospitalist kind of
6 delivery system now? Because things don't happen just in
7 the morning, and they don't happen just at night. So if
8 the individual is in the hospital and one of these sicker
9 patients shows up in the clinic and they have an acute
10 problem, they could be addressed ambulatory, in an
11 ambulatory environment, but they're in the hospital.

12 You understand where I'm going, and that's my
13 concern is this is a very -- I'm not talking about the
14 payment side of the business. I'm now talking about the
15 actual clinical applicability of doing this.

16 And then if you strip these patients out of the
17 hospitalist community, then you're turning that dynamic on
18 because the hospitalist is staffed with a typical number of
19 hospitalists to support a population of patients, which now
20 this particular model is impugning.

21 So those are my thoughts, and I'm hopeful that
22 you'll be able to share those. But I'm also for the -- you
23 guys, Paul and Tim.

1 DR. CASALE: So you sounded a little apologetic,
2 but you're a surgeon. I don't know where you --

3 CHAIR BAILET: Did I?

4 [Laughter.]

5 CHAIR BAILET: Well, because I know if I didn't,
6 you guys would make me -- you would remind me of that,
7 okay?

8 DR. CASALE: But just to emphasize that was
9 certainly -- we had a lot of robust discussion around that,
10 those particular points, and we look forward to hearing
11 some more from the submitter around that.

12 DR. PATEL: And we did talk with a clinical
13 expert, a hospitalist based in a large integrated setting.
14 The transcript is here, and he very bluntly -- we wanted to
15 do a little gut check and make sure we weren't just in
16 group-speak.

17 And he said, "It would be potentially hard for me
18 to even recruit, from my own hospitalist group, people who
19 would want to do this, because a lot of the people who came
20 into hospitalist medicine just wanted to do dedicated --

21 DR. CASALE: Right.

22 DR. PATEL: -- discrete, you know, shifts, hours,
23 et cetera."

1 CHAIR BAILET: Right.

2 And can I just -- my last comment is there were a
3 number of candidates who said, "I don't feel comfortable.
4 I've been out of inpatient medicine. I don't feel
5 comfortable now working in an inpatient environment," and I
6 know you guys, I think, were supportive of the patient
7 safety issue. But that's another question that I'd like
8 the proposer to comment on.

9 Thank you.

10 Bruce.

11 MR. STEINWALD: Since all the docs have been
12 piling on each other, I feel the need to pile on with Len a
13 little bit. Yeah.

14 DR. NICHOLS: [Speaking off microphone.]

15 MR. STEINWALD: Oh, okay. All right.

16 [Laughter.]

17 MR. STEINWALD: So I thought it was kind of
18 ironic in the PRT report. I mean, you know, clearly,
19 there's lots of evidence that handoffs are often a problem,
20 right? Bad things happen when handoffs aren't handled
21 appropriately, and their proposal proposes to deal with an
22 important handoff situation when the patient is
23 hospitalized and then what happens next.

1 The irony is that the PRT was concerned about,
2 well, what happens 30 days later whenever there has to be a
3 handoff back to the delivery system that the patient was a
4 part of, and I guess my response to that would be, well,
5 okay. I mean, that's obviously a situation that needs to
6 be dealt with.

7 But if the more important handoffs from both a
8 clinical and economic perspective occurs at the point
9 that's been highlighted in this proposal, then maybe the
10 fact that there's another handoff situation that has to be
11 dealt with is sort of a secondary concern if the more
12 important, both clinically and economically handoff is the
13 one that they're focusing on in what you call the in peri-
14 hospital situation.

15 DR. PATEL: I guess we would need some data to
16 support that that delay in handoff doesn't create --
17 obviously, the peri-hospital time has been what's studied
18 because that's been the area with the most numbers of
19 handoffs.

20 Our point was simply that you could potentially
21 be creating additional adverse effects by delaying those
22 handoffs for this population of patients.

23 It's not to say that that delay is in and of

1 itself, you know, a disaster. It's just that we don't have
2 data to support what that would look like, but a handoff
3 would need to occur.

4 DR. TERRELL: Happy to provide it for you.

5 DR. PATEL: You can feel free to submit to PTAC
6 at hhs.gov during your spare time.

7 DR. NICHOLS: Is this the public comment period?

8 [Laughter.]

9 DR. PATEL: But that's just the point to bring
10 up. That was largely hypothetical but something we didn't
11 know.

12 CHAIR BAILET: All right. Thank you. Great
13 discussion.

14 I'd like to now have our applicants please come
15 to the table. I believe you have prepared remarks. I'd
16 like to keep those to 10 minutes, if possible, and then,
17 clearly, you're heard the dialogue, so addressing
18 questions, and then I'm sure there will be more.

19 Thank you very much.

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

22 DR. MELTZER: Great. First of all, thank you so
23 much for having us here. We are incredibly excited to talk

1 to you about this work, and we're grateful for the
2 attention you've all given to it and how hard you've
3 worked. We saw it yesterday, so we know what tough work
4 this is.

5 I come to you as a general internist by training,
6 but also an economist and also as the chief of hospital
7 medicine. So I run our hospitalist group, but also a
8 practicing primary care physician. I have had my own panel
9 of patients for 20 years. The average age at this point is
10 probably 85-plus. I have a deep understanding of what it
11 means to know a patient and work with them over time, and
12 that at the core is really what this proposal is about.

13 With me, I have Andrew Schram, who is a physician
14 in our hospitalist group who is leading a new form of the
15 CCP program that we may talk about at some point and is
16 also an MBA; and on my left, Emily Perish, who is a
17 graduate of our Public Policy School, and she directs
18 innovation and sort of program development for the CCP
19 program.

20 She also has another very critical qualification
21 I didn't know about until I had worked with her for over a
22 year, which is that her mom is a primary care physician at
23 a local community hospital, one who still sees her own

1 patients in clinic and the hospital. And I think not just
2 because she's Emily's mom, it's actually helping us develop
3 this same program in a community hospital. So we'll
4 address that very directly.

5 As I mentioned, the CCP model itself and the
6 payment model, at its core fundamentally about promoting
7 continuity and the doctor-patient relationship, this idea,
8 which I think -- and the value of the doctor-patient
9 relationship is of incredible importance.

10 I always go back to Francis Peabody's classic
11 1927 article on the care of the patient, which by the way
12 was in his last year of life. He wrote very personally in
13 that year, and he writes, "The secret in the care of the
14 patient is in caring for the patient." That statement,
15 which is so elegant it's often been misattributed to
16 William Osler, really states the value of truly knowing the
17 patient, and there are similar things in Marcus Welby and
18 popular culture. Today, we probably would call this
19 patient-centered care, but it's an idea that goes way back.

20 And I think this is an idea that all of you
21 believe in. If you've had personal experiences as patients
22 or family members or certainly as clinicians, you've seen
23 the challenges of discontinuity, but just to solidify the

1 role of John Wasson as this sort of hidden hero of this
2 PTAC meeting, I want to remind you not just of his What
3 Matters Index and What's Your Health? work, but a paper
4 that wasn't mentioned in your excellent review of the
5 literature on continuity, which is a 1984 paper done in the
6 VA, published in JAMA, where he randomized 800 complex
7 patients in the VA, either to get primary care from the
8 same doctor in every primary care visit or a completely
9 different one, okay? This is an amazingly important study.

10 The continuous care group had 49 percent lower
11 emergent hospitalizations, 38 percent lower hospital days,
12 74 percent lower ICU days. RCT only changed continuity,
13 okay?

14 So, nevertheless, since the 1980s, medical care
15 has become increasingly more fragmented, and nowhere is
16 that more true than the division between hospital care and
17 ambulatory care in general medicine.

18 And it's particularly bad for the most frequently
19 hospitalized patients who get a different doctor every time
20 they come in the hospital, okay? And this is not a small
21 niche problem. This is a huge fraction of medical
22 expenditures.

23 Okay. So this is what led us to this idea of a

1 comprehensive care program. I want to be very clear about
2 it. This is not an extensivist model. We do not care for
3 the patients just when they leave the hospital for that
4 short period afterwards. We take over all their care on a
5 continuing basis, both in the hospital. It's much more
6 like the model that Dr. Ferris described, okay? So this is
7 continuing care in the hospital and out of the hospital.

8 So that's the key idea, and we're really grateful
9 for the thoughtful review. We were pleased we met six of
10 the ten criteria. Unfortunately, three of the four that we
11 failed were the high-priority ones. So I really want to
12 focus on those high-priority criteria and in general the
13 four that it was assessed we didn't meet. And if I fail to
14 answer any questions that have been raised, I ask you all
15 to remind me of them.

16 The first criterion, expanding the scope of the
17 physician-focused payment model. I want to emphasize,
18 first of all, this is a model that's open not just to PCPs
19 in an ACO but to PCPs who are not in an ACO. So that alone
20 is an expansion beyond the existing models.

21 So that is -- I also want to emphasize that we
22 are asking physicians to change their own practice panel,
23 to take on a different set of patients. This isn't

1 something you do contracting with someone for a year. This
2 is a lifestyle decision, and it's very durable. And with
3 all the turnover in ACOs and contracting arrangements, the
4 stability of this incentive, we think is key.

5 I also want to emphasize that there was this
6 argument that while ACOs could do this anyway and should we
7 really be paying them more to do this, and I would argue
8 that we should. And one of the reasons is we want to
9 increase the incentive to do this, and I was trying to
10 think how to describe this. And the best example I could
11 come up with to describe, my four-year-old.

12 So I have a four-year-old daughter. She's a
13 pretty good eater, but sometimes she just doesn't want to
14 eat her dinner. I being a rational economist tell her,
15 "You should really eat. You need the nutrition. You're
16 going to grow up and be big and strong, and you need to do
17 that."

18 My wife is a much more practical parent, okay?
19 She's like, "If you eat dinner, you can have dessert." She
20 should be doing it, anyway. That's the daddy approach, but
21 it's the mommy approach that gets her to eat.

22 And I would point out that Tim described an
23 organization where a rational process was made to adopt the

1 model like this. Most ACOs are not in the position to sort
2 of think about things this easily. I would argue even if
3 they are, this has a cost of about \$300 per patient and a
4 return of about \$3,000 per patient per year. So it is
5 worth spending a little more money to make sure this
6 happens, particularly if you're doing it in a context of
7 evaluation, where you can prove it happens, and then reduce
8 that change on an ongoing basis.

9 I also think that your endorsement of this would
10 increase awareness of it. I think your control of this
11 process and CMS's control of this process would increase
12 the knowledge that is generated. We're proposing a beta
13 test to generate knowledge with evaluation metrics,
14 including things like improvements in care experience,
15 improved health, improved cost, decreased hospitalizations.
16 Those are not payment criteria, but they're evaluation
17 criteria.

18 I also think this is novel in creating a cross-
19 cutting APM that overlays other APMs, so that extends the
20 scope of physician-focused payment models.

21 There's worry that people wouldn't -- that
22 patients wouldn't enroll in this. I can tell you we've
23 enrolled 2,000 people -- 4,000 people in a randomized --

1 sorry. Let me get this right. 2,000 people in a
2 randomized trial at the University of Chicago over several
3 years. We easily could have enrolled twice as many people
4 if we didn't have to do it in a trial.

5 We got great help from CMS and HCA in sort of
6 learning how to enroll. We know how to do it.

7 I will also point out if no one enrolls in this
8 program, it costs CMS nothing because the payment is per
9 patient.

10 There's worries places won't adopt it. As I
11 said, we've done it at University of Chicago. We're
12 learning how to do it at Ingalls Hospital, this community
13 hospital. We're finding other local hospitals in the
14 Chicago area that are interested in doing it. Vanderbilt
15 has adopted a model like this. Kaiser is doing it. We've
16 gotten interest from Blue Cross Blue Shield Association.
17 I'm going to be presenting at the medical directors meeting
18 next month. I think Ryan Graysen was very clear that he
19 was interested in this model and wondered if Penn could do
20 it. We've had interest internationally. We really think
21 people will adopt this.

22 I also want to point out that in terms of
23 recruiting physicians to do this, we have found residents

1 who are interested in coming into this. We have found
2 mature doctors who are willing to do it. It does not need
3 to be for everyone. My guess is that if 5 or 10 percent of
4 internists in the United States did this, you'd saturate
5 the vast majority of needs -- or plenty of people to do it.

6 Second criteria, does it improve cost or quality?
7 I'll point out we have these strong results from an RCT
8 with big improvements in patient satisfaction scores, self-
9 rated mental health status, and reductions in
10 hospitalizations. I will point out those are all patient-
11 reported measures.

12 The claims data which the HCIA evaluation looked
13 at has a series of limitations. First of all, it was only
14 for a part of the period. More importantly, there was a
15 fundamental bias that arose in it, and the bias arose
16 because in Illinois during this period, there was a very
17 strong push to push Medicaid patients into managed care.
18 When they go into managed care, we lose their claims data
19 from the claims data, and HCIA loses it.

20 Who went into managed care? They were the lower-
21 utilizing people. The high-utilizing people stayed in that
22 program, in our program, because they wanted really good
23 care. The data for this is in our August 27th memo to you.

1 You can take a look at it.

2 I will also tell you that the data we have from
3 claims data and self-report for the period for which we
4 have complete claims data, albeit incomplete, align very
5 well. We are getting the claims data. It's just going to
6 take a while. For those of you who know the RedDAC
7 process, we are working through it.

8 Quality. I want to point out that, again, we
9 have the structural and process measures. We think they
10 are of value. We also want to point out that in terms of
11 outcome measures, we require all the measures from the
12 additional payment model. So if you're in an ACO, you have
13 to still have all the quality measures that you would have
14 in that ACO. They're all still measured.

15 We didn't want to force additional measures on
16 top because we know there's some issues there.

17 I know I just have a minute more. Can I run over
18 a tiny bit on that?

19 CHAIR BAILET: Yes.

20 DR. MELTZER: Okay. I'll take that as a yes.

21 CHAIR BAILET: Yes.

22 DR. MELTZER: There's concerns about -- and we're
23 open to adding more measures. We worry about sort of risk

1 selection we should have, the more measures we choose. We
2 try to take the sickest patients. Their measures look
3 terrible. We don't want to be penalized for taking the
4 sick people. We want to care for them.

5 Empanelment. There's a concern about selection
6 risk. With the way we've got it, I don't think that is a
7 problem. I'll come back to that with more time.

8 For the payment methodology, which is the third
9 high-priority criterion, we've already addressed the issue
10 of whether an incentive really is needed. We think it is.
11 We do think there is financial risk, not just the 24,000,
12 but the fact that you have to block off your clinic every
13 morning to be able to care for these patients in the
14 hospital. That's a huge financial issue.

15 There are cash flow issues about payment. We
16 think those are easily addressable.

17 And there's one argument that ACOs are already
18 incentivized to increase continuity. This just isn't
19 happening in most places. In fact, the State of Illinois,
20 our Republican governor signed just this past week, I
21 believe, a bill requiring that patients be allowed to opt
22 out of managed care organizations at any point in time if
23 their PCP leaves because continuity is such a terrible

1 problem.

2 Finally, integration and care coordination. We
3 have developed a strategy in this so that people -- the
4 CCPs see their specialists and actually relationships
5 deeper. We do think we sort of nailed preventive care,
6 although the prevention I would talk about is tertiary
7 prevention, keeping people out of the hospital. That's
8 what matters for this group.

9 We've talked about quality measures already. I
10 want to add one more that I think is critical for you to
11 hear. The real incentive to provide good care for patients
12 in this model is that they are your patient. If you screw
13 up their outpatient care because you don't answer their
14 call and they end up in the ER, you have to look them in
15 the face the next day, explain why you didn't answer the
16 phone, and explain to all your colleagues why that
17 happened, okay? And I see that as the leader all the time,
18 and I think that is just absolutely essential.

19 One last thing, I think we've talked about sort
20 of this issue of delaying inevitable handoffs as
21 hospitalization risk falls. Again, we don't think that
22 these handoffs are inevitable. We've managed for five
23 years to have people enrolled in this program. We have

1 never taken anyone out of the program because they're not
2 sick enough, okay? We just make them well and keep caring
3 for them.

4 So let me just conclude. I think these are
5 important responses to the important criticisms that were
6 raised.

7 We heard additional criteria of the
8 administration yesterday around transparency, simplicity,
9 accountability. I think this is very simple. We're going
10 to pay someone to be your doctor and take care of you, and
11 if you're unhappy with that, you talk to them about it, and
12 if you don't like it, you leave.

13 We also heard about the four P's: patients,
14 physicians, payment for outcomes, and prevention. I think
15 we nail all of those.

16 I will also add that we've had additional funding
17 recently from the Robert Wood Johnson Foundation to add
18 another component to prevention, which is social
19 prevention, which is addressing unmet social needs. Some
20 of that involves additional resources, but what is the
21 foundation of it? It's that relationship between the
22 doctor and the patients.

23 Our doctors know when their patients are having

1 trouble applying for benefits. They know when their family
2 is experiencing an issue, and they use that to make them
3 better.

4 Let me stop there.

5 CHAIR BAILET: Thank you.

6 Harold and then Grace.

7 MR. MILLER: Thank you. Thank you for your
8 passion for this. It's exactly the kind of thing that I
9 think PTAC was created to try to help people who are doing
10 things like this get a venue to be able to make them work.

11 I guess I would preface this by saying that I
12 absolutely support the idea that you're trying to get to,
13 which is more continuity of care.

14 Just as a very quick anecdote, I had an
15 experience several years ago. I was working with a medium-
16 sized multispecialty group, mostly primary care, on a
17 readmission reduction project, and they at that point
18 decided to move to a hospitalist model because the PCPs
19 were basically saying, "We just can't afford to keep going
20 to the hospital every day."

21 So they made the switch. Two of the doctors who
22 had been basically primary care physicians like every other
23 primary care physician that practiced, dedicated themselves

1 to the hospital, and all the other PCPs then immediately
2 started to complain about how those two guys never, ever
3 called them, were changing everything about the way their
4 patients were being managed, et cetera, et cetera, et
5 cetera. So it's clear that all of a sudden where you stand
6 depends on where you sit.

7 So I have a couple of questions, if you'll bear
8 with me, Jeff, because they're kind of interrelated, and
9 the first one is you've sort of characterized this payment
10 model as an incentive, as a nudge. And the first thing I
11 want to understand better, though, is -- that's why I told
12 that story -- is that people have moved to this model that
13 exists today, this undesirable model, because they felt
14 that the payment model did not support them being able to
15 see patients in the community and see patients at the
16 hospital.

17 So my first interest in a payment model is, Does
18 it actually remove the barriers that exist in the payment
19 model today, and does it create any undesirable incentives?

20 So I guess the question is -- and it's useful to
21 talk to you because you've actually done work in terms of
22 what does it cost, et cetera.

23 I'm trying to understand, first of all -- so if

1 somebody sets up their practice the way you're suggesting -
2 - and forget the \$40 for a second. If I understand this
3 correctly, it's an add-on. So they're still billing for
4 E&M's, outpatient. They're still building for E&M's in the
5 hospital, et cetera. If they did that, would they be able
6 to essentially do better, do worse, et cetera, revenue-wise
7 than they would otherwise?

8 DR. MELTZER: Can I answer that?

9 MR. MILLER: Yes. Yes, absolutely.

10 DR. MELTZER: Perfect. Okay. So this is a great
11 question. With more time, I would have started at the very
12 beginning of this story which began with why is it that
13 hospitalists grew, okay? And one story was they're better,
14 but, you know, probably not. The other story that we came
15 to -- and this, again, was with funding from the Robert
16 Wood Johnson Foundation -- is that hospitalists grew
17 because primary care doctors could no longer do the job
18 they used to do of seeing their own patients in the
19 hospital in the morning. And the reason for that is not
20 that the payment model changed, but that the epidemiology
21 of illness changed.

22 It used to be that people went to the doctor
23 because they were sick, and if you saw a fair number of

1 people in the day, a fair number of those people would be
2 in the hospital the next morning.

3 Over time, what happened is people started going
4 to the doctor to stay well. So you could be busy all day
5 long, checking blood pressures and mammograms, PAP smears
6 and all that good stuff, which should be done, but the
7 consequence would be very few patients were in the
8 hospital. So you couldn't block out your morning only to
9 have one or two patients in the hospital. This is, in
10 fact, exactly what Emily's mom is struggling with and many
11 primary care doctors.

12 So the fundamental change is a reorganization of
13 the practice --

14 MR. MILLER: Yes. I understand that.

15 DR. MELTZER: -- to focus on those patients at
16 high risk of hospitalization.

17 So once you get to that point, the RVU generation
18 is not wildly different than someone who just does one or
19 just does the other. It's really a sort of hybrid --

20 MR. MILLER: So, in other words, the answer to my
21 question is, if you structured the practice the way you're
22 suggesting and focused on the patients, that you would
23 basically be able to do the same revenue-wise. There is on

1 gap that the \$40 is trying to fill.

2 DR. MELTZER: So what I would argue is -- so I
3 think that -- I mean, it's a little bit of a hypothesis to
4 see what we get to at the end. We're kind of maturing now,
5 but it is not wildly different.

6 However, there is a big transition that needs to
7 take place during that period where you got to block out
8 your time in order to do this. You've got to build up the
9 volume to make this work.

10 So the way this model is set up, we sort of pay
11 the \$40 right when people are sick, and at some point, it
12 drops down to the \$10. And that's a much smaller number,
13 obviously, over time, but we think that these payments are
14 critical.

15 If you asked me you could do this, do it for a
16 period of time and then maybe have someone down at a lower
17 level.

18 MR. MILLER: So you're saying this is a bit like
19 a new startup business, is that you go through sort of the
20 Valley of Death, and then you'll be back and you'll be
21 okay.

22 DR. MELTZER: Yeah.

23 MR. MILLER: So, in other words, there's a short-

1 term thing, but in the long run --

2 DR. MELTZER: Absolutely.

3 MR. MILLER: -- you'll be able to do okay. Okay.

4 So --

5 DR. MELTZER: Can I say one other thing?

6 MR. MILLER: Yeah.

7 DR. MELTZER: It's just related. This is a more
8 complicated idea, but I think it's worth describing, which
9 is that when CMS makes payments, they make payments to a
10 bunch of specialties, right? It may be that this is an
11 important payment, and maybe later on, we don't have to
12 raise pro fees quite as much to get people attracted into
13 this specialty because this payment to doing this is
14 already there. In that sense, the cost of this is zero.
15 So I realize it's sort of theoretical, I think.

16 MR. MILLER: So part two to the question -- so
17 there's no sort of in the long run, a cost gap. There's a
18 cost gap in the short run that you have to fill, and
19 whether the \$40 is enough to do that or not, we can discuss
20 separately, so a short-term gap.

21 The second part of the question, then, about the
22 payment model is one of the interesting things about the
23 current structure is that it's sort of neutral to whether

1 the patient is in the hospital or not because if I see the
2 patient in the outpatient clinic, I get an E&M. If I see
3 them in the hospital, I get an E&M. Now, organizing your
4 time is a different issue, but you basically get paid
5 either place.

6 You've introduced an interesting situation here
7 where it seems as though you've actually created a penalty
8 for somebody to keep them out of the hospital because if
9 you in fact get the patient healthier, manage them better,
10 and they stay out of the hospital, you lose your \$40
11 because the patient is no longer being in the hospital
12 anymore. And if I've structured my practice around being
13 at the hospital every morning and I'm keeping my patients
14 out of the hospital, then all of a sudden, I'm losing all
15 my hospital E&M's because I'm not seeing the patient in the
16 clinic.

17 And it seems to me that it's sort of perverse in
18 that sense, and I guess I wonder what you think about that.
19 But I'm wondering why you wouldn't just sort of pay what
20 we're trying to do in a lot of other models, is pay a PMPM
21 to the doctor, regardless of where the patient is, so that
22 all of a sudden -- because you've left the underlying fee-
23 for-service structure in place, which now all of a sudden

1 says, "If I keep you out of the hospital, you lose all the
2 hospital E&M's," and you're not going to make them up in
3 the clinic because you're not going to be in the clinic.

4 DR. MELTZER: Yeah. So two things. First of
5 all, I mean, I understand the theory behind what you're
6 describing. In practice, we're not that good at keeping
7 people out of the hospital. We have like a 30 percent
8 mortality rate and 20 percent mortality rate one year, sort
9 of more like 30 in two years. So we're constantly getting
10 in new patients.

11 We've been doing this for five years, and the
12 problem you've described, it really hasn't gone away.

13 Now, why didn't we just go to a pay, per patient
14 per month kind of capitation thing? And the reason gets
15 back to risk adjustment and selection. We are trying to
16 take care of the sickest people. We go down to the ER
17 every day. We try to find the sickest people. Risk
18 adjustment is not that good. If I told my dead, I wanted
19 to go after and find those people, I'm not sure I would be
20 sitting here with the University of Chicago affiliation.

21 I mean, we are trying to create a model that is
22 not victim to the incentives to cherry-pick, and it affects
23 our quality measurement approach. It affects our payment

1 model approach.

2 I mean, I am an economist. I get it. Capitation
3 and all that stuff. But I'm also a realist, and we have
4 serious problems in risk adjustment. And this is the sweet
5 spot of the ultimate failure of risk adjustment.

6 MR. MILLER: But if I understand it correctly,
7 you're then relying on the fee-for-service structure to
8 risk-adjust for you by paying more if a patient needs to be
9 seen more, but it seems to me that you create a perverse
10 incentive in the other direction, which is that success --
11 so let me just -- because in the interest of time, let me
12 just move on.

13 So the third related question to this is I'm
14 trying to understand better who these patients are because
15 when I first started reading the proposal, my immediate
16 reaction was it's sort of our standard chronic disease
17 population that we basically end up, you know, send -- they
18 go to the hospital periodically for exacerbations, and we
19 want to make sure that they're not getting sort of screwed
20 up by somebody else when they're in the hospital. And if
21 you keep them out, all is a wonderful thing.

22 As I read more, I understood the model, and I saw
23 Tim's compliment about the New York Times story. I hadn't

1 seen the New York Times story, so I read the New York Times
2 story, which then gave me a better sense. And I suddenly
3 realized that these were very different patients than that,
4 but it seemed to me that they could potentially fall into
5 multiple categories. I mean, you had everything from what
6 you might call end-of-life patients to patients with
7 extraordinarily severe diseases that might need periodic
8 planned hospitalizations for treatment, et cetera.

9 And you don't seem to have made any distinction
10 like that in the model, and I was surprised that it was
11 triggered by one hospitalization because when I was reading
12 the story, I was reading about patients who don't just --
13 their characteristic is not that they just happened to be
14 hospitalized ones, but that they really have kind of a
15 disease complex that is causing them to be a high risk of
16 constant hospitalization. But you didn't define the
17 criteria that way.

18 So I'm wondering if there really is a
19 segmentation, whether you group them all together because
20 you need to get enough volume to be able to make it work or
21 what.

22 DR. MELTZER: You just hit it, so a couple of
23 answers. Great, great question.

1 So, first of all, yes, some of these people are
2 at end of life. Some of them have COPD. Some of them have
3 diabetes. Some of them have end-stage renal disease. Many
4 of them have most of these things. So chronic interlocking
5 illness is key. I'd also add sort of social determinants
6 of health there. So those are big reasons that we don't go
7 sort of disease by disease.

8 But the other issue that you raised is really
9 critical, which is one of volume. We wanted to have enough
10 patients in this program to make it feasible, so that we
11 would be able to have enough volume in the hospital. We
12 have to do an RCT; we needed to power for it. I mean,
13 these were very practical concerns, and it makes it more
14 scalable.

15 And getting back to your earlier question about
16 kind of what's the long-run cost, if someone ends up a low
17 volume kind of person in this model, the costs become very
18 minimal of having them in it. And, again, the returns
19 particularly for an ACO were biggest the sicker, and what
20 we find is even though this threshold is one
21 hospitalization, the vast majority of people who enroll
22 have many more than that because people don't want to
23 change their doctor for nothing. They change it when they

1 see a compelling reason, and that's also how we talk to
2 them about it. So that's a minimum criteria, but the
3 average is substantially more.

4 MR. MILLER: And final question is it's -- I
5 guess the notion of the model of care is certainly
6 desirable, but you've created a model which essentially
7 mandates a process. You've mandated a particular
8 structure, and a randomized control trial might say, yes,
9 it's better on average than something else. But you've
10 essentially taken away the flexibility for physicians or
11 practices to figure out how to do it differently by saying
12 they have to be at 67 percent and 50 percent, et cetera.
13 And I'm wondering why not just hold people accountable for
14 the outcome. If you think that there is an outcome that
15 they can achieve, if they think that they can reduce
16 hospitalizations, then say, "Hey, we'll pay you whatever
17 the different payment is," whether it's \$40 or whether it's
18 a PMPM or whatever it is that needs to fill the gap to be
19 able to get through the Valley of Death, whatever to be
20 able to get to this, to say, "We'll pay you that," but the
21 outcome, which is essentially what we need to be able to do
22 to show Medicare and MACRA that there are savings, is that
23 you actually have reduced something.

1 And then if this works, if people sign up for it,
2 they would say, well, the best way to do that is obviously
3 to have continuity of care and to schedule myself around
4 this, et cetera, but I wouldn't be all of a sudden worrying
5 that, you know, in certain cases, when I went on vacation,
6 I was going to fall short of the 67 percent threshold.

7 DR. MELTZER: Yeah, yeah. So we tried to build
8 in as much flexibility as we could to make the model
9 broadly applicable so that's why we didn't get even more
10 specific in that area.

11 Why didn't we condition this on outcomes? It's
12 because we believe that it's too tempting to want to avoid
13 taking on the hardest, hardest patients on these. One or
14 two patients like that kind of destroys your statistics,
15 and those are the people we think we help most. We don't
16 want to be penalized for taking the sickest people. That's
17 who we want.

18 And I'll point out that to the extent the
19 organization has already taken on the responsibility for
20 those people at NACO, that incentive is already there.
21 Okay? So we didn't want to add on top of it. We didn't
22 object to its existence, but we didn't want to saddle this
23 model with that obligation, because we think that it is --

1 risk adjustment just doesn't support the discrimination
2 needed to avoid having you be penalized for taking on
3 these, you know, very, very complex patients.

4 CHAIR BAILET: Grace.

5 DR. TERRELL: So I'm going to ask my questions to
6 give you some context. As I mentioned, I'm a general
7 internist, and when I started practicing in 1993, in what
8 was, at the time, pre-electronic medical record, pre-
9 hospitalist practice, I would be on call for eight
10 physicians, see patients in the hospital, had a nursing
11 home practice as well, as well as an outpatient practice,
12 and loved to take care of sick people. And I was the last
13 one in town who actually gave up my hospital practice. So
14 to my mind, my ideal practice would be exactly what you're
15 doing and achieving. It's exactly what I like to do when
16 I'm seeing patients.

17 But it got too darn hard. It got too darn hard.
18 So you've spoken of other incentives that are out there.
19 The first people to go to a hospitalist program were the
20 family physicians who discovered that if they focused on
21 all the things you mentioned -- prevention, lots of quick
22 E&M visit in an outpatient setting -- they could make \$30--
23 , \$40--, \$50,000 more a year, and not have all the concerns

1 about being on call at night, and not have to worry about
2 the sickest of the sick patients.

3 Then, in our community, you started seeing the
4 internists dropping out of call, because of the motivation
5 on the part of the hospital to go a hospitalist system,
6 because then they could pay RVUs and do a lot of DRGs and
7 churn inpatient volume. And so there was, I think, a
8 larger reason that we got to where we want. It was in the
9 hospital's interest to have efficiency at the level of
10 hospital care, and then you ended up with a bifurcated
11 system where, for many clinicians they had a better
12 lifestyle -- and I'm talking a much better lifestyle.

13 So what you're trying to solve for is what was
14 created as a result of how hard it was to do what you and I
15 both know is just a much better way of practice. So a lot
16 of what we've been doing since then is trying to sort of
17 fix what we broke, right?

18 DR. MELTZER: Right.

19 DR. TERRELL: So I want some very specific
20 questions so I can understand what it takes to fix that, at
21 least as you understand it. Number one is, if we use the
22 term "panel size," okay, how many patients does it take for
23 a clinician practicing like this to have in his or her

1 panel, to make a living, and not have such a horrible
2 lifestyle that they leave this program? Okay. And then
3 the other two -- and the other one related to that is, is
4 there a call group size --

5 DR. MELTZER: Yeah, yeah.

6 DR. TERRELL: -- that has to be done. So these
7 are very practical things.

8 DR. MELTZER: Yeah, yeah. I've got them.

9 DR. TERRELL: What's the answer to those two
10 things, and I'll go to the other things.

11 DR. MELTZER: Okay. Thanks for not constraining
12 my cognitive ability.

13 [Laughter.]

14 DR. TERRELL: Yeah.

15 DR. MELTZER: So first of all, there are some
16 underlying theories behind this. There is this idea called
17 an adaptive organization perspective --

18 DR. TERRELL: Yeah.

19 DR. MELTZER: -- to sort of design. Clay
20 Christensen has written about this idea of sort of solution
21 shops.

22 DR. TERRELL: Yep.

23 DR. MELTZER: And what fundamentally makes this

1 manageable, and what's the difference from probably the job
2 that you had, is you're only focused on this group of high-
3 risk patients, so you don't have this overwhelmingly large
4 clinic that is impossible to manage. So that's the
5 fundamental and theoretical insight that makes this doable.

6 We have done that with a pure CCP model at a
7 panel size of about 200 patients.

8 DR. TERRELL: That's what I thought.

9 DR. MELTZER: We go a little above it sometimes,
10 but the longer they're in the program, kind of they get
11 more stable, and the doctors get better and know them
12 better so they can get a little bigger. I don't think you
13 have to have a panel size of 200 to make it work. One of
14 the reasons why a smaller one might work is if you have
15 other ways to backfill inpatient volume. One way to do
16 that is by being what we're starting to call a rounder
17 model, which actually was something, when I was in Boston,
18 we saw at the time at the Harvard Community Health Plan,
19 where basically you round on your colleagues' patients. So
20 that's a way to do it. Andrew is working on developing
21 that model at the UFC right now. We think that could work
22 in community and rural settings where volumes were lower.
23 So that answers one of the generalizability questions.

1 Small group size, we do it with five docs.

2 DR. TERRELL: Five. Okay.

3 DR. MELTZER: And the way it works is everyone
4 sees their own patients in the hospital every morning,
5 Monday through Friday. They have multidisciplinary rounds
6 in the late morning. One of them stays through the
7 afternoon and is sort of the hospitalist for that group,
8 that day, seeing them on the evenings, and they cover,
9 then, the weekend.

10 In terms of long-term career sustainability, this
11 actually is great, because one of the really hard things
12 about being a hospitalist is being, you know, 50-some-odd
13 years old and working half the weekends.

14 DR. TERRELL: Right.

15 DR. MELTZER: It just doesn't work. These
16 doctors are working one in five weekends. This is a
17 totally lifestyle sustainable job, and we've gotten great
18 people to do it, and honestly, more applicants than we can
19 hire.

20 DR. TERRELL: Okay.

21 DR. MELTZER: So I do believe we can find people
22 who will do this. It's not a job for everyone but it does
23 not need to be. Maybe if 5, 10 percent of internists did

1 this, we'd have all we need.

2 DR. TERRELL: Okay. So then let's get to the
3 economics and the payment of it, because, all right. So
4 you've got a panel of 200 patients that are in and out of
5 the hospital and you're needing to see them relatively
6 frequently, just because of the acuity that's out there.
7 You can bill a little bit higher on the fee schedule, at
8 least on the outpatient, because they're --

9 DR. MELTZER: Complex.

10 DR. TERRELL: -- you know, they're complex
11 patients. So with that, without your incentive that's in
12 here, without the constraints about your proportion of
13 inpatient to outpatient, does this break even at the
14 University of Chicago or not?

15 DR. MELTZER: So the way I would say is we are no
16 -- we lose no -- I don't think we lose a lot more money
17 than our primary care loses money, but our primary care
18 loses money.

19 DR. TERRELL: But I don't want to solve for that.

20 DR. MELTZER: Okay. Well, but if I go to my dean
21 and say, "I want to expand primary care," he's going to,
22 you know --

23 DR. TERRELL: Yeah. I'm not worried about your

1 dean. I'm worried about the United States of America, and
2 it's completely screwed right now.

3 DR. MELTZER: Right. Unfortunately the decisions
4 they make influence the United States of America.

5 But, yes, we think we are probably maybe slightly
6 less productive in RVUs than the typical, you know, person
7 who does it, but it's not a huge difference, and, you know,
8 we're still learning how to do this and getting better at
9 it. But there is -- you know, as I said there's the
10 transition part of it that's a very important part of it as
11 well --

12 DR. TERRELL: Okay.

13 DR. MELTZER: -- and probably, you know, there's
14 added coordination time and things like that, taking care
15 of these patients.

16 DR. TERRELL: Are you doing transition of care
17 codes right now?

18 DR. MELTZER: We're trying.

19 DR. TERRELL: Yeah.

20 DR. MELTZER: As people know, it's not easy. I
21 mean, I track it every week, and we're doing the best we
22 can. But, I mean, my dean's not looking at this as a cash
23 cow in and of itself. I promise you that. And I think

1 that getting other places to do it, you know, this
2 incentive would make a meaningful difference.

3 DR. TERRELL: So, I mean, this is -- I'm trying
4 to get to the point I was making earlier, which is if we
5 want this to be sustainable, it ought to be sustainable,
6 not cross-subsidization or anything else, necessarily. So
7 with a panel size -- because this is a great model of care
8 -- with a panel size of 150, which we what we've done, to
9 250, okay, with a group size of five on call, which means
10 there's a certain size of community --

11 DR. MELTZER: Yeah, yeah.

12 DR. TERRELL: -- that this would have to be to do
13 that. So it may not be the rule, but for many communities
14 it would be. If you're sharing E&M codes, figure out, or
15 not, to do transition of care codes, you're still not going
16 to break even on it.

17 DR. MELTZER: No.

18 DR. TERRELL: So with \$40 added to that, as you
19 see incentive, does that take care of it or not?

20 DR. MELTZER: We think it makes a big difference.

21 DR. TERRELL: Okay.

22 DR. MELTZER: So if you take 200, you know,
23 patients, and it's about \$500 a year, it's like \$100,000.

1 That's a pretty decent piece of a doctor's salary. I think
2 it fills the hole, and that assumes the maximum, right? In
3 reality it's going to be more like 25, because it's going
4 to be this mix of the \$40 for the newly enacted people and
5 the \$10 for the people who haven't been hospitalized. And,
6 you know, we've done this at one place.

7 DR. TERRELL: Right.

8 DR. MELTZER: We need to do this at many more
9 places. That's the point of sort of trying to get it out
10 to the PTAC and get it in CMS's hand and do a demonstration
11 project, and figure out how to do it in various places.

12 DR. TERRELL: So you mentioned Clay Christiansen,
13 and, you know, within the context of channeling Clay
14 Christiansen right now, the other thing is to think about
15 lower cost of care settings. So are you adding home visits
16 and home care directly, or are you making the house calls,
17 as opposed to making them come into that expensive clinic?

18 DR. MELTZER: Absolutely.

19 DR. TERRELL: Okay.

20 DR. MELTZER: One of our --

21 DR. TERRELL: So you've got those codes in there
22 right now too?

23 DR. MELTZER: Absolutely. One of our five

1 doctors does home visits. We're adding an APN capability
2 to try to make that a little more cost effective.

3 DR. TERRELL: Okay.

4 DR. MELTZER: You know, it's always challenging
5 to do things in small scales.

6 DR. TERRELL: So in your hospital there is not a
7 disincentive to do this --

8 DR. MELTZER: They're letting us do it.

9 DR. TERRELL: -- because that's the final issue,
10 is I think the hospitalist program, part of the reason they
11 developed is in a DRG-based system there is a lot of
12 reasons, based on volume, that for the hospitals
13 disincentive to basically do continuity of care. So do you
14 think that this particular type of funding takes care of
15 the hospital disincentive for this, or not?

16 DR. MELTZER: I mean, again, I don't 100 percent
17 know.

18 DR. TERRELL: Okay.

19 DR. MELTZER: I mean, we know one hospital -- I
20 mean, that's the reason to do a demonstration project, to
21 see it in different places. It seems plausible to us. You
22 know, we tried to present some numbers. If the savings are
23 what we think they are in the ACO environment, that should

1 really help too.

2 DR. TERRELL: You don't have those numbers, do
3 you?

4 DR. MELTZER: It's impossible to know.

5 DR. TERRELL: Okay.

6 DR. MELTZER: You know, I mean, we think it's
7 credible.

8 DR. TERRELL: Thank you. I wish you were in the
9 South. I'd probably join your practice.

10 [Laughter.]

11 DR. MELTZER: Vanderbilt.

12 CHAIR BAILET: Tim, you had a comment?

13 DR. FERRIS: Yeah, just on this point. Sorry,
14 Rhonda. I just wanted to say that you spoke very quickly
15 about a point that I think just for clarification for
16 people listening, you said the addition to the doctor, the
17 \$100,000 addition to the doctor's salary. Actually, the
18 payments support the doctor and the doctor's practice.
19 Doctors take home about half of what, on average, they take
20 home. So I just wanted to clarify that, because a lot of
21 people might not know.

22 CHAIR BAILET: Rhonda.

23 DR. MEDOWS: So I'll be the last doc added to the

1 pile, but I'm an old doc, family medicine, did home visits,
2 did inpatient care, did deliveries, did all that wonderful
3 thing, quite a while ago. It was challenging. It was also
4 rewarding.

5 There are a couple of questions that I have about
6 what type, or what physician would agree to do this now, in
7 today's world, and kind of address some of the logistics
8 that they would have to overcome. Not only panel size but
9 how many partners they would have to share call with.

10 One of the comments in the PRT report I think may
11 have been addressed in some of your questions, was which
12 physician community do you think would be most easily
13 amenable to be able to do this? Is it really academic
14 medicine? Is it rural practice? Where would it be? You
15 get where I'm going with this, right?

16 DR. MELTZER: Yeah.

17 DR. MEDOWS: Who would have an easier time
18 adapting to this, from your experience? And then the
19 second question is really more of a request. I understand
20 wanting to focus on patient-reported outcomes. That's
21 great. And I understand for those populations that are
22 already in an ACO, not wanting to add on even more
23 measures. But for the population that's not in an ACO,

1 just consider -- and I think you're open to the idea --
2 there should be some type of patient safety measure, some
3 type of quality measures.

4 Even if you're not tying it to payment it needs
5 to at least be part of the model reported on, because,
6 quite frankly, even in a demonstration, even when we're
7 trying to figure out whether not this is doable, that is
8 something that needs to be highlighted in the beginning.
9 What is the outcome to the patient? Are they safe in the
10 model? What is the response rate to the physicians when
11 the patient just calls, because the assumption is that this
12 is going to be their end-all, be-all provider of care?

13 But if you would speak a little bit about who do
14 you think would be easier to adapt something like this,
15 that would be great.

16 DR. MELTZER: Yeah, yeah. So a couple of things.
17 Let me do the measure one first, and then I'll go to the
18 panel size and community hospital one.

19 So we are very much open to measures. We don't
20 object to them. We're worried about practicality. Like
21 the questions that came up yesterday about who's going to
22 ensure people answer the survey questions, we didn't know
23 how comfortable CMS was with requiring things like that,

1 and we didn't want to build something on top of it that we
2 didn't know the -- like we measure everything imaginable in
3 this study, and we can give you a whole list of what's
4 moving and not moving. Like we're totally open to that.
5 So that's that.

6 For the panel size, I think we talked about it
7 enough and I think you have an idea at this point.
8 Community hospitals. So, you know, working with Emily and
9 her mom at Ingalls Community Hospital, which is now an
10 affiliate of the University of Chicago, we have discovered
11 a large number of physicians who, like the ones that Tim
12 found at Harvard, were still caring for their own patients
13 in the hospital because they believe in it, and no one made
14 them stop you. And they're struggling because they don't
15 have enough patients.

16 And so we've actually been partnering with those
17 doctors who are already there to help them form a group,
18 work to do this, and then help them find patients at higher
19 risk of hospitalization so that we can solve the Clay
20 Christensen problem. It's exactly what Tim's done, getting
21 the high-risk patients to the doctors who want to do this.

22 I've gone to rural hospitals in Illinois. I've
23 gotten phone calls from, you know, folks in tiny community

1 hospitals in vulnerable urban, rural communities. I think
2 people will do this. I think the demonstration will prove
3 that people are interested in this. I think that is reason
4 to do it. I also think in academic medical centers there
5 are doctors who want to do this. There are young trainees.
6 There are people who have been general internists. We've
7 gone and had people who have just been a ward attending but
8 not providing direct patient care, and we've helped them
9 retrain and retool. Like we think this is doable.

10 DR. SCHRAM: And I just want to speak to the
11 pipeline as a fairly recent internal medicine residency
12 graduate. So many of my colleagues were looking for jobs
13 that would allow them to continue to take care of patients
14 in both the inpatient and outpatient setting, and there
15 really just weren't those jobs available. So I think there
16 are going to be a lot of younger doctors who are interested
17 in this type of model as well.

18 CHAIR BAILET: I want to just follow that train
19 of thought, because a lot of what I see as the younger
20 generation of physicians who are coming out today,
21 lifestyle is very important to them, being able to be
22 predictive. They don't want to get up in the middle of the
23 night and go to the hospital. And I understand that this

1 doesn't have to apply to everybody. I get that. But I
2 also am sensitive to the ecosystems that have been
3 constructed and the challenges that this could present to
4 those systems, particularly in the smaller communities
5 where not everybody wants to do this, and so you still need
6 that hospitalist backbone, right?

7 Do you have some -- and I understand you've done
8 it in one place and you're working in a rural hospital. I
9 get that. But do you have some sense of how you think that
10 will play through in a larger ecosystem? Because what
11 we're talking about is something ultimately that will be
12 scaled across the country.

13 DR. MELTZER: Yeah.

14 CHAIR BAILET: So could you help me with that?

15 DR. MELTZER: Yeah. So, you know, I think we've
16 been through the issues. There are certainly some
17 physicians who this is not good for, and, you know, there
18 are some for whom it is. I think there are enough. Within
19 these ecosystems, hospitalist programs need a certain
20 volume. They're used to a certain volume and they are sort
21 of practicing at a given level. They also have a fair bit
22 of turnover, so that there are often jobs coming open.
23 These doctors who are CCPs can also essentially function as

1 hospitalists as they're getting started. They can care for
2 patients on the inpatient.

3 When I started the HCIA award, I actually just
4 intercalated the people we hired into our hospitalist
5 program. And at first we had, I think, two, and then
6 three, and it was actually several years until we reached
7 five. So there are ways to do this practically. We
8 actually underspent our HCIA award in the first few years
9 because we didn't need as much clinical resource to launch
10 as we thought we did.

11 There are a lot of really practical ways to solve
12 these problems, and I think part of the beauty of, you
13 know, having CMS deeply involved in this is the technical
14 assistance that CMS can provide to advise places about how
15 to do this well. You know, we're already running a TCPI
16 learning collaborative around CCP. You know, stuff like
17 that could be dramatically expanded, particularly in the
18 context of this payment model, but more generally. And, I
19 mean, we think there's a lot of very practical solutions to
20 all these problems. We don't think any of this is
21 unmanageable.

22 DR. SCHRAM: And one specific example, to
23 highlight is at University of Chicago we actually partnered

1 this program with the hospitalist program. So if a patient
2 does come in in the middle of the night, that night they
3 are admitted by a hospitalist and then seen by their
4 comprehensive care physician the next day. There are
5 opportunities to integrate with systems that are already in
6 place.

7 CHAIR BAILET: Okay. Thank you. That's helpful.
8 Bob.

9 DR. BERENSON: Yeah. So earlier, David, you
10 mentioned that, pointing to us, saying concerns about
11 generalizability. My concern is about limiting
12 generalizability. The entrance criteria seem like
13 virtually any rural physician who is seeing their own
14 patients in the hospital would meet the qualifications,
15 unless I'm missing something, and would be eligible for
16 additional payments. I didn't see a minimum threshold.

17 I'm not saying that's necessarily a bad thing.
18 I'm just wondering whether this is a much larger scope
19 issue than you -- and this is my specific question. We
20 estimate that up to 3.8 million Medicare beneficiaries
21 would be eligible. Could you give me a little sense of
22 where that comes from? I guess what I'm suggesting is it's
23 a lot more than 5 to 10 percent of doctors, either now or

1 would be seeing their own patients in the hospital.

2 DR. MELTZER: Yeah, yeah. Yeah. So our estimate
3 was based on the idea that people were really focusing
4 their practice on this rather than doing it as a tiny piece
5 of it. So, you know, you're right. It could well be that
6 a rural physician would look at this and they might bill
7 for it, and in that sense we'd be paying them more for
8 something they were already doing. But we'd be fine with
9 some minimum number, if you were to recommend that.

10 The only thing I would just say is, you know,
11 even those rural physicians are abandoning this model, and
12 it's unfortunate for them. And sometimes it's not
13 impractical for them to do it. There's a lot of capacity
14 in some rural environments, ironically, and that's a longer
15 conversation.

16 But anyway, we'd be totally open to that.

17 DR. BERENSON: No, I mean, I'm not necessarily
18 taking a position. I'm just trying to clarify it. In my
19 view it's one way to partly address the maldistribution of
20 money across the specialties, which maybe this would be a
21 way to do that, and if the returns are what you're
22 suggesting, in different practice environments, range of
23 practice environments, then that might be a very good

1 investment.

2 DR. MELTZER: Right.

3 DR. BERENSON: But that's what I wanted to
4 clarify, that right now there would be nothing about the
5 way you've established this that would prevent a rural
6 physician who is caring for their own patients to bill for
7 this service.

8 DR. MELTZER: Although let me just mention one
9 thing. I believe the way we described this, as a sort of
10 beta test, where CMS would actually get applications and
11 review sites. So if CMS were to get such an application
12 from someone who says, "I'm a rural physician. I care for
13 Mrs. Jones every time she's in the hospital, but I don't do
14 that for anyone else. I want to get another \$40 from Mrs.
15 Jones," you know, you probably wouldn't approve that. But
16 they also wouldn't apply for \$40, because I'm pretty sure
17 the application process --

18 DR. BERENSON: Yeah, but if I were at CMMI, and
19 thankfully I'm not, I would want to have some of those
20 practices in there, to know what the sort of behavioral
21 response is going to be to this.

22 DR. MELTZER: Yeah. I mean, in my more
23 optimistic moments about this process I think, you know,

1 maybe it should be more than 20, you know, institutions and
2 practices. But again, we are very happy --

3 DR. BERENSON: So the 3.8 was based on --

4 DR. MELTZER: That was based on calculating how
5 many people in Medicare would be hospitalized in a given
6 year, and potentially would be eligible, and then I don't
7 remember whether we discounted it for what fraction would,
8 you know, potentially go into this or not. But anyway --

9 DR. BERENSON: But looking at sort of University
10 of Chicago kinds of locations and figuring out who would be
11 capable putting on such a program, that kind of thing?

12 DR. MELTZER: Absolutely, and I'll just say, you
13 know, I think we're like a 500-beddish hospital, something
14 like that, and we have had more than an adequate patient
15 volume, not just to support a program but to support a
16 program and randomize half the people away, and have
17 another bunch of people refuse because they don't like to
18 do research.

19 So, like, and then you have the rounder model. I
20 think scale is totally solvable on this.

21 DR. BERENSON: yeah, and the other thing, which I
22 just want to clarify, just sort of was whispering to
23 Kavita, but when you talk about enrollment or empanelment,

1 there's no limitation on patient choice here. It's simply
2 as a basis for doing the calculations? I mean, what is the
3 purpose of enrollment, I guess is my question.

4 DR. MELTZER: The purpose of enrollment is to
5 make it clear both to the patient and to the doctor that
6 this person is responsible for them. It is also to make
7 sure that the patient meets the criteria. So there is a
8 limitation of patient choice in the following sense, which
9 is that if you haven't been hospitalized or meet whatever
10 criteria we end up deciding that predict risk of
11 hospitalization then you can't enroll with this fee.
12 Right? But that's really sort of medical indication for a
13 service, I would argue, just like you can't get dialysis if
14 you don't have --

15 DR. BERENSON: Right. But there's no limitation
16 on patient choice.

17 DR. MELTZER: No.

18 CHAIR BAILET: Thank you. Tim and then Harold.

19 DR. FERRIS: Sorry, I didn't see you. It's like
20 a tennis match here, for crying out loud.

21 So this is a pretty wonky question, but you
22 referred several times, I think quite accurately, to the
23 risk adjustment problem. We're dealing with outliers of

1 outliers, and so huge regression to the mean issues.

2 DR. MELTZER: Yes.

3 DR. FERRIS: And I just want to ask, how, then,
4 with the very open criteria for enrollment, in your
5 proposed beta test with 20 sites, help me understand the
6 evaluation --

7 DR. MELTZER: Yeah, yeah. Great question.

8 DR. FERRIS: -- because there's -- you could have
9 really different pools in each of the sites, because there
10 are really open enrollment criteria, and how would you know
11 --

12 DR. MELTZER: Yeah, yeah.

13 DR. FERRIS: -- given the risk adjustment
14 problems that you very accurately --

15 DR. MELTZER: Yeah. So, I mean, if I were a
16 foundation president or something like that and interested
17 in this area, you know, my ideal would be to fund more
18 RCTs, probably, at some level, right, because we've got
19 this very clean intervention and control group, and I think
20 that's great. I recognize CMS doesn't do that sort of
21 stuff so much.

22 So thinking about things like a sort of stepped
23 wedge design, where, for example, you take a group of

1 people who meet eligibility criteria and they sort of
2 define at least a chunk of your denominator, and then --
3 so, for example, people who have been hospitalized in the
4 past year -- and then you're sort of following them over
5 time, and then, you know, boom, the program gets approved,
6 and then you look at the people who now are eligible for
7 that by virtue of having been hospitalized. Some fraction
8 of them are going to go in. You're going to have to deal
9 with the, you know, sort of intention to treat analysis
10 issues and uptake issue that comes there, but that's all
11 statistically manageable. And then, you know, you would
12 have a series of things like that where you would gradually
13 put them in over time. We talked about this a little bit
14 in the program, the idea of a stepped wedge design. I
15 think that's something CMS has done before and is
16 reasonable.

17 So those are the things that come to mind. We
18 were very grateful that HCIA allowed us to do an RCT, and,
19 you know, it's the gold standard, and I would like to
20 imagine that it's possible to do that. But I do think a
21 stepped wedge design with, you know, sort of reasonable
22 denominators that focus on an eligible population could
23 make a lot of sense.

1 DR. FERRIS: That's a great response, and I guess
2 I would just say that having some experience with
3 implementation of demonstration projects, I've been
4 impressed at how you can give a really big binder about how
5 to do it to multiple sites and have phone calls and check-
6 ins and everything, and then a year later everyone is doing
7 something completely different.

8 DR. MELTZER: Absolutely, and I'm very familiar
9 with how much work you have put into this because I have
10 read a lot of it, and so I agree with you. But again, I
11 think this is where there are real opportunities with
12 leadership from CMMI and CMS to, you know, give the very
13 best technical assistance, and we learn from our
14 experiences. So, you know, I'm sure you would have a lot
15 of advice about how, if you did it again, you might do it a
16 little differently, and I would hope that if we're
17 fortunate enough to reach that point that we benefit from
18 that.

19 DR. FERRIS: Thank you.

20 CHAIR BAILET: Harold. No, Len. Jeepers, Wally.
21 All right. Len, please.

22 DR. NICHOLS: So you remember when I was talking
23 before y'all came up. I think that one of the big issues

1 is going to come down to this \$3,000 versus what the
2 evaluation that the official HCIA gets. So tell me why you
3 believe \$3,000.

4 DR. MELTZER: Yeah. So again, the HCIA
5 evaluation was based on CMS traditional claims data. Why
6 the \$3,000? Two reasons I believe the \$3,000. The first
7 thing is in the CMS data that we have from the period that
8 we have so far, that is the mean estimate that we see in
9 our cost data for the first year and a half, in the
10 traditional Medicare population, which isn't biased by the
11 dropout in the dual eligible. Okay?

12 The second thing is that if you take the
13 estimates we see of patient-reported hospitalization, which
14 actually aligns very well with what we see in the claims
15 data, and then we take reasonable estimates of the cost of
16 hospitalization, we get that same number.

17 I also want to say that in the patient-reported
18 outcome, one of the things you always worry about is that
19 there's bias and that there's not, you know, high reporting
20 rates, and that maybe only some patients are answering. We
21 get like 95 percent completion rates of data. We have --
22 as everyone will attest, I torture our students to keep
23 calling and calling. One patient actually said, "Will I

1 have to die before you stop calling me?" I mean, we get
2 incredibly high response rates. And then we've used
3 patterned extra modeling to try to deal with dropouts so
4 that we're dealing with the selection issues around this.

5 I mean, I can't know 100 percent it's going to
6 come out exactly there, but it is my best scientific
7 judgment that those numbers are pretty reasonable
8 estimates.

9 DR. PATEL: Jeff, do you mind if I just --

10 CHAIR BAILET: Please.

11 DR. PATEL: I'm sorry. Just two very quick
12 follow-ups to that, David. Number one, you just described
13 what I think had been a conundrum for us, not just these
14 disparities. You talked about the correlation with
15 utilization claims-based measures. That's what really all
16 CMS is going to have. And to get to that 95 percent, I'd
17 even take, you know, 40 percent at this point, but
18 whatever. To get that percent you had to put in quite a
19 bit of energy, and those processes, as well as that
20 structure and the Donabedian kind of framework is not
21 necessarily reflected in what we have.

22 So my concern is that anybody else who would try
23 to do this, even in those 20 beta sites that are just as

1 great as yours, would need to find a way to get to that
2 level of excellence. I guess that's just one point I
3 wanted to make, and that's the concern.

4 DR. MELTZER: Can I --

5 DR. PATEL: Yeah, please. And then the second
6 you can answer without straining your brain, hopefully.
7 Have you actually talked to CMS since the HCIA, about any
8 of this, and what has that resulted in?

9 DR. MELTZER: So it's been a long morning.

10 DR. PATEL: I know, and now I'm straining.

11 DR. MELTZER: So let me talk about -- so I talked
12 to Patrick Conway. It was actually because of Patrick that
13 we applied.

14 DR. PATEL: Who is that?

15 [Laughter.]

16 DR. MELTZER: He used to work here. And so it
17 was Patrick who suggested -- I wasn't even aware, frankly,
18 embarrassingly, of the whole process, so he told me about
19 it. And it was on the basis of that that we started
20 talking about this, and that was really my main contact.
21 And so we read about it and learned and so on. So that was
22 the main thing.

23 And, I'm sorry -- it's been a long --

1 DR. PATEL: Just a concern, to Len's point.

2 DR. MELTZER: Oh, the evaluation. Yeah, yeah.

3 DR. PATEL: And not even an evaluation. I'm
4 concerned that there's this structural process elements
5 that are not quite articulated to achieve the success that
6 would ultimately lead to these savings.

7 DR. MELTZER: Yeah. So let me just say we have
8 really two very separate operations. One is our clinical
9 operation, where we talk to patients and care for them and
10 interact with them. Another is our research and evaluation
11 operation, and it's basically a bunch of undergraduates,
12 frankly, who call, and they'll call and call and call and
13 call. And, you know, I'm not sure. I mean, if anything I
14 think all the calling we do makes the worse for them,
15 because they get tired of being called so much.

16 But I want to be clear. Outside of the Medicaid
17 group, you know, we had pretty good retention because we
18 haven't had a lot of people moving into Medicare Advantage
19 in our environment, so the claims data is actually really
20 quite good. And I would also argue -- and I don't
21 understand enough about what data CMS has or doesn't have
22 right now, but, like, if you could do an evaluation that
23 included, you know, Medicare Advantage claims and

1 utilization too, that would be a really big plus in some of
2 this. And I think some of that data exists, but I don't
3 know enough to know whether it's really usable. And you
4 could make some of that a condition of how you designed the
5 programs, some possibilities.

6 CHAIR BAILET: Harold. Take us home.

7 MR. MILLER: A final question. This is really a
8 follow-up the question that Bob was asking. We get a
9 number of applicants who have what they believe is a
10 desirable care model, and they have no way to prove that
11 it's really impactful because they need to get a number of
12 other sites to be able to do it and they're looking for
13 some way to enable or encourage other sites to do it, which
14 just sounds like what you're trying to do.

15 But the issue is, we're not approving research
16 projects. We're supposed to be looking at payment models
17 that could potentially be expanded nationally. And so I
18 guess I'm curious as to how you envision, if somehow the
19 evaluation gets done and it shows what you believe it's
20 going to show, and this is going to be expanded, how people
21 would participate and get paid in the future. Would
22 practices -- would there be a new billing code that they
23 would say I'm going to bill \$40 for a patient and somebody

1 is going to then calculate -- CMS is going to calculate
2 some -- retrospectively determine whether they saw their
3 patients enough and penalize them? Would they have to
4 apply as a practice and say, "I am structured in the
5 following way, and therefore I'm going to get paid this
6 way?" How would you envision that working?

7 DR. MELTZER: I think what you described. You
8 know, there would be some way to apply to be part of this,
9 and if you apply, then were accepted, based on, you know,
10 some internal review process that CMS thought made sense,
11 you would then begin to empanel people and then bill using
12 these codes in the process of them having agreed to do
13 this.

14 My understanding of -- and I think this was
15 partially from my conversations with Patrick -- is that the
16 PTAC could sort of, you know, scale things up as the
17 evidence for them increased, and that it was wiser to come
18 in with a proposal that was more limited rather than global
19 at first, so that there could be learning from that. And
20 then, you know, perhaps in a year or whatever, come back
21 and say, "Look, the initial data looks very promising. We
22 had a bunch of questions about whether, for example, rural
23 or small practice would be interested. Look, we got 200

1 applications for this. You know, we were only set to do
2 20."

3 MR. MILLER: We would not scale it up. That
4 would be up to CMS to do. I guess the question is whether
5 or not you think that sort of the \$40 model is something
6 that is, in fact, would be the permanent model, or whether
7 it's enough to be able to simply do something in the short
8 run. Because I guess I'm wondering, if it's going to be an
9 application process then all of a sudden a whole bunch of
10 rules are going to have to be established about how big you
11 have to be, and then, you know, how do we make an exception
12 for this rural practice --

13 DR. MELTZER: Sure.

14 MR. MILLER: -- that only has 149 patients --

15 DR. MELTZER: Yeah, yeah.

16 MR. MILLER: -- et cetera, et cetera. I just
17 wondered -- but you're at least, at the moment, envisioning
18 that if it works, the \$40 is the payment model that
19 everybody would be using in the long run.

20 DR. MELTZER: I mean, could be it \$30? Could it
21 be \$50?

22 MR. MILLER: No, but I'm talking about something
23 like that model.

1 DR. MELTZER: I think it's a reasonable place to
2 start.

3 MR. MILLER: It's not just something you believe
4 it's something necessary just to get a research project
5 underway.

6 DR. MELTZER: No. No. I think this is a very
7 credible model that could potentially be scalable, and we
8 proposed it as a smaller thing only as a first step. I
9 mean, I think we all know that health care delivery is
10 woefully short on high-quality evidence, and this was our
11 strategy to generate some high-quality evidence.

12 And, you know, I also, you know, feel a sense of
13 urgency. You know, like we have big problems in this
14 country with respect to health care and want us to move
15 quickly, but I want us to move quickly to something that
16 works. And, you know, we have an experience, you know, in
17 our site at UFC, and Vanderbilt is doing it, and a couple
18 of other places. But it's so early, and, you know, but
19 this could really help us move that process ahead.

20 DR. FERRIS: So I want to personally thank all of
21 you for your diligence and patience with us. This has been
22 very, very helpful. And thank you for putting this
23 proposal forward and attending today. We're not done, but

1 I'm going to -- I know you guys probably are. So thank
2 you. If you could take your seats.

3 DR. MELTZER: Thank you all so much. It was
4 really great.

5 CHAIR BAILET: You bet.

6 * **Comments from the Public**

7 CHAIR BAILET: So what I'd like to do is I
8 understand that there's no one on the phone to make public
9 comments about the proposal, and I'd like to take a break.
10 But I want to confirm with the operator, before we break,
11 that there isn't anybody on the phone registered to speak.
12 Operator?

13 OPERATOR: We have no one registered at this
14 time, sir.

15 CHAIR BAILET: Very good. So what I'd like to do
16 then is take a 10-minute break and we will reconvene.
17 Thank you.

18 [Recess.]

19 CHAIR BAILET: All right. If everybody could
20 take their seats we're going to go ahead and continue on
21 here.

22 So I ask my colleagues, are we ready to vote
23 electronically on the individual criteria.

1 MULTIPLE SPEAKERS: Yes.

2 * **Voting**

3 CHAIR BAILET: All right. Then let's go ahead
4 and get started.

5 Criterion 1, scope. High-priority criterion.
6 Aim to either directly address an issue in payment policy
7 that broadens and expands the CMS APM portfolio or include
8 APM entities whose opportunities to participate in APMS
9 have been limited.

10 Please vote.

11 [Electronic Voting.]

12 * **Criterion 1**

13 MS. SELENICH: So one member voted 6, meets and
14 deserves priority consideration; zero members voted 5,
15 meets and deserves priority consideration; four members
16 voted 4, meets; two members voted 3, meets; two members
17 voted 2, does not meet; one member voted 1, does not meet;
18 and zero members voted not applicable. A simple majority
19 is needed and we will down so that the finding of the
20 Committee is that the proposal meets Criterion 1, scope.

21 CHAIR BAILET: Thank you. Criterion 2 is quality
22 and cost, a high-priority criterion. Anticipated to
23 improve health care quality at no additional cost, maintain

1 health care quality while decreasing cost, or both improve
2 health care quality and decrease cost.

3 Please vote.

4 [Electronic Voting.]

5 * **Criterion 2**

6 MS. SELENICH: So zero members vote 6, meets and
7 deserves priority consideration; two members vote 5, meets
8 and deserves priority consideration; zero members vote 4,
9 meets; five members vote 3, meets; two members vote 2, does
10 not meet; one member votes 1, does not meet; and zero
11 members vote not applicable. Therefore, the finding of the
12 Committee is the proposal meets Criterion 2, quality and
13 cost.

14 CHAIR BAILET: Thank you. Criterion 3 is payment
15 methodology, another high-priority criterion. Pay APM
16 entities with a payment methodology designed to achieve the
17 goals of the PFPM criteria. Addresses in detail through
18 this methodology how Medicare and other payers, if
19 applicable, pay APM entities and how the payment
20 methodology differs from current payment methodologies.
21 And lastly, why the physician-focused payment model cannot
22 be tested under current payment methodologies.

23 High priority. Please vote.

1 [Electronic Voting.]

2 * **Criterion 3**

3 MS. SELENICH: Zero members vote 6, meets and
4 deserves priority consideration; one member votes 5, meets
5 and deserves priority consideration; zero members vote 4,
6 meets; two members vote 3, meets; five members vote 2, does
7 not meet; two members vote 1, does not meet; and zero
8 members vote not applicable. Therefore, the finding of the
9 Committee is that the proposal does not meets Criterion 3,
10 payment methodology.

11 CHAIR BAILET: Thank you, Sarah. Value over
12 volume. Provide incentives to practitioners to deliver
13 high-quality health care.

14 Please vote.

15 [Electronic Voting.]

16 * **Criterion 4**

17 MS. SELENICH: Zero members vote 6, meets and
18 deserves priority consideration; one member votes 5, meets
19 and deserves priority consideration; three members vote 4,
20 meets; six members vote 3, meets; zero members vote 1 or 2,
21 does not meet; and zero members vote not applicable.
22 Therefore, the finding of the Committee is the proposal
23 meets Criterion 4, value over volume.

1 CHAIR BAILET: Thank you. And Criterion 5 is
2 flexibility. Provide the flexibility needed for
3 practitioners to deliver high-quality health care.

4 Please vote.

5 [Electronic Voting.]

6 * **Criterion 5**

7 MS. SELENICH: One member votes 6, meets and
8 deserves priority consideration; one member votes 5, meets
9 and deserves priority consideration; three members vote 4,
10 meets; four members vote 3, meets; one member votes 2, does
11 not meet; zero members vote 1, does not meet; and zero
12 members vote not applicable. Therefore, the finding of the
13 Committee is the proposal meets Criterion 5, flexibility.

14 CHAIR BAILET: Thank you. Criterion 6, ability
15 to be evaluated. Have evaluable goals for quality of care
16 cost and any other goals of the PFPM.

17 Please vote.

18 [Electronic Voting.]

19 * **Criterion 6**

20 MS. SELENICH: Zero members vote 6, meets and
21 deserves priority consideration; three members vote 5,
22 meets and deserves priority consideration; one member votes
23 4, meets; four members vote 3, meets; two members vote 2,

1 does not meet; zero members vote 1, does not meet; and zero
2 members vote not applicable. Therefore, the finding of the
3 Committee is the proposal meets Criterion 6, ability to be
4 evaluated.

5 CHAIR BAILET: Criterion 7 is integration and
6 care coordination. Encourage greater integration and care
7 coordination among practitioners and across settings where
8 multiple practitioners or settings are relevant to
9 delivering care to the population treated under the PFPM.

10 Please vote.

11 [Electronic Voting.]

12 * **Criterion 7**

13 MS. SELENICH: Zero members vote 6, meets and
14 deserves priority consideration; three members vote 5,
15 meets and deserves priority consideration; zero members
16 vote 4, meets; five members vote 3, meets; one member votes
17 2, does not meet; one member votes 1, does not meet; and
18 zero members vote not applicable. Therefore, the finding
19 of the Committee is the proposal meets Criterion 7,
20 integration and care coordination.

21 CHAIR BAILET: Criterion 8, patient choice.
22 Encourage greater attention to the health of the population
23 served while also supporting the unique needs and

1 preferences of individual patients.

2 Please vote.

3 [Electronic Voting.]

4 * **Criterion 8**

5 MS. SELENICH: Zero members vote 6, meets and
6 deserves priority consideration; two members vote 5, meets
7 and deserves priority consideration; five members vote 4,
8 meets; three members vote 3, meets; zero members vote 1 or
9 2, does not meet; and zero members vote not applicable.
10 Therefore, the finding of the Committee is the proposal
11 meets Criterion 8, patient choice.

12 CHAIR BAILET: Criterion 9 is patient safety.
13 Aim to maintain or improve standards of patient safety.

14 Please vote.

15 [Electronic Voting.]

16 * **Criterion 9**

17 MS. SELENICH: One member votes 6, meets and
18 deserves priority consideration; zero members vote 5, meets
19 and deserves priority consideration; one member votes 4,
20 meets; seven members vote 3, meets; one member votes 2,
21 does not meet; zero members vote 1, does not meet; and zero
22 members vote not applicable. Therefore, the finding of the
23 Committee is the proposal meets Criterion 9, patient

1 safety.

2 CHAIR BAILET: And the last criterion, 10, health
3 information technology. Encourage use of health
4 information technology to inform care.

5 Please vote.

6 [Electronic Voting.]

7 * **Criterion 10**

8 MS. SELENICH: Zero members vote 5 or 6, meets
9 and deserves priority consideration; one member votes 4,
10 meets; nine members vote 3, meets; zero members vote 1 or
11 2, does not meet; and zero members vote not applicable.
12 Therefore, the finding of the Committee is the proposal
13 meets Criterion 10, health information technology.

14 CHAIR BAILET: Thank you, Sarah. So do you want
15 to summarize for us, please?

16 MS. SELENICH: Sure. So the proposal found that
17 -- or the Committee found that the proposal met all of the
18 criteria except for Criterion 3, payment methodology, where
19 it found that the proposal did not meet that criterion.

20 CHAIR BAILET: Thank you. Any more discussion
21 among the Committee members before we vote on the
22 recommendation?

23 DR. PATEL: Can I just, on the recommendations,

1 will you clarify whether that new option is --

2 CHAIR BAILET: Yeah, yeah. If we're ready then I
3 think that's the next body of work, is to actually go
4 through. If you could put up the slide on, yeah.

5 So yesterday the language -- we removed "not
6 applicable" and we put language in there that required -- I
7 think "required attention" or what can you guys remember
8 the phraseology?

9 MR. MILLER: Recommend for attention.

10 CHAIR BAILET: Recommend for attention, which
11 could be, in this instance, another --

12 DR. PATEL: And that would be a zero vote, right?

13 CHAIR BAILET: Yeah, zero vote.

14 DR. PATEL: Just as a reminder.

15 CHAIR BAILET: So I guess I'll make a motion that
16 that would be an option. Second?

17 DR. FERRIS: Second.

18 CHAIR BAILET: All in favor.

19 [Chorus of ayes.]

20 CHAIR BAILET: Okay. So we're going to go ahead
21 then and vote, and again, to be clear, that's a zero. That
22 option is a zero.

23 DR. BERENSON: And we're still using the limited

1 scale testing language for number 2.

2 CHAIR BAILET: Correct.

3 DR. BERENSON: Okay.

4 CHAIR BAILET: So please vote.

5 [Electronic Voting.]

6 * **Final Vote**

7 MS. SELENICH: So zero members vote 4, recommend
8 the proposed payment model for implementation as a high
9 priority; one member votes 3, recommend the proposed
10 payment model for implementation; six members vote 2,
11 recommend the proposed payment model for limited scale
12 testing; zero members vote 1, do not recommend; and three
13 members vote recommend for attention. A two-thirds
14 majority is needed, and, therefore, we will down, so that
15 the finding of the Committee is recommend proposed payment
16 model to the Secretary for limited scale testing.

17 * **Instructions on Report to the Secretary**

18 CHAIR BAILET: Okay. So what we'd like to do is
19 go around individually and comment, and then think about
20 when you make your comments for Sally to capture to put in
21 the letter of our recommendation. So we'll start with you,
22 Tim, please.

23 DR. FERRIS: Great. So I voted to limited scale

1 testing. I want to have my comments in two different, one
2 is about the proposal and the other one is about the
3 categories that we're voting on.

4 About the proposal, important problem, simple,
5 not simple-minded but simple payment model that is
6 scalable. I think it's unlikely to be gameable.
7 Everything is gameable at some level, but I think,
8 actually, the simplicity of it and the population selection
9 issues. I am concerned about the openness of the
10 population selection issues, but I actually think that's an
11 addressable problem.

12 And I actually -- just a comment on the process.
13 It is remarkable how much, even after the PRT -- and we
14 spent a lot of time talking and thinking about this -- how
15 much this additional process, especially the comments and
16 questions of my colleagues, helped me process this, to come
17 to this conclusion, that this is something that is very
18 important to the health and safety of patients in the
19 United States and should be tested.

20 Having said that, I did think it would be --
21 greater testing is the right thing to do here. And I guess
22 we have had some frustration over feedback from CMS, that
23 they are not in a position to do limited scale testing. I

1 think that took -- to my mind, that shouldn't dissuade us
2 from making a recommendation for limited-scale testing,
3 because, thanks to you, Jeff, and reading our definition of
4 limited scale testing, this seems to me to fall precisely
5 into the category of really good idea, can't possibly work
6 out the details without a larger scale. And so this does
7 actually, to me, fit into that, and we should continue this
8 very healthy dialogue we're having with CMS and the
9 Secretary around the importance of this.

10 I will just point out, for the record, since at
11 least the early '80s, and maybe the late '70s, CMS has been
12 doing demonstration projects. I ran one for nine years.
13 And I think this is precisely the kind of idea that would
14 benefit from that kind of deployment, to generate the
15 knowledge necessary here.

16 And so that was both my comments about the model
17 and about the categories that we vote under.

18 CHAIR BAILET: Thank you, Tim. Grace.

19 DR. TERRELL: I was the one who had my thumb on
20 the scale towards the 6s and positive directions for most
21 of the criteria, and the reason I did that, although I
22 don't disagree with probably most of the logic of what Tim
23 just said and what the rest of you are going to say, that

1 sort of landed you at limited scale testing, I do think
2 that this is probably the most crucial issue, that if we
3 can solve it in a simple way, in a way that I think would
4 be easily scalable, could be revolutionary and would be one
5 of the best quick wins for PTAC, as well as the health care
6 system in the country.

7 So I say that within the context of being trained
8 as, and a practicing general internist. And what I thought
9 I was being trained to do, and what I would love to do, is
10 exactly what these guys have designed their care model to
11 do. But what happened between the time of my training at
12 Duke in the mid-1980s and my beginning private practice in
13 the early 1990s, is that what a general internist was
14 changed as a result of the payment policy change, and that
15 was when we morphed into something called primary care
16 physicians, which was about a copay system.

17 And so suddenly you had family physicians and
18 general internists and pediatricians, occasionally OB-GYNs,
19 that basically had a model of care that was about seeing as
20 many patients as you could, in an efficient outpatient
21 setting, and then trying to scramble to do everything else.
22 And you really couldn't concentrate on what general
23 internists were trained to do, which was to take care of

1 sicker patients, elderly patients, frail patients, and do
2 it in a way that would require more than a 99213 and an
3 office visit that was 15 minutes.

4 Then we ended up with hospitalists as a result of
5 that, and the hospitalist was about another payment system.
6 It was called the DRG system, where you needed to have
7 really efficient RVU-based care at hospitals. And so we
8 ended up with a divided system.

9 Most of what I think value-based care has been,
10 at the level of redesigning health care over the last few
11 years, as it relates to my specialty, has been trying to
12 solve, in a new payment system, those problems that were
13 solving their own problems at the time, that we've now
14 grown beyond.

15 So I don't see that a \$40 payment defining around
16 a few percentage groupings is going to be such a scary
17 thing that if we just didn't implement it in some sort of
18 controlled but widespread scalable way right now, we
19 couldn't see some changes very quickly that could actually
20 be pretty profound in terms of basically taking care of the
21 Medicare population that is increasing and growing, for
22 which we have a shortage of qualified health care
23 professionals to take care of, and this could be an

1 ultimate design element that could make a great deal of
2 difference for that population. And it would actually
3 bring the joy back into the practice of general internal
4 medicine. So what they're now calling a comprehensivist is
5 actually what I thought I was going to be 30 years ago when
6 I went to medical school.

7 Anyway, I hope that as we're thinking about the
8 limited scale testing concept that our colleagues at CMMI
9 and CMS have dissed us on, that they will understand that
10 we're talking about getting it right so that we can do
11 something that's actually quite, quite important.

12 CHAIR BAILET: Grace, could you just clarify how
13 you voted, for the record?

14 DR. TERRELL: I voted -- I'm the 3 there and I'm
15 the 6 on everything else. Okay?

16 CHAIR BAILET: All right. Very good. Thank you.
17 Harold.

18 MR. MILLER: So I voted too for limited scale
19 testing. I think this is a very desirable method of care
20 that we should find ways to support. I think that the fact
21 that it is not being delivered today reflects the fact that
22 there are some severe problems with the fee-for-service
23 structure that exists. We are essentially paying people

1 for very short visits in offices and not enough at that
2 level, and, therefore, it makes it impossible, impractical
3 financially to be able to do this kind of care.

4 So that says to me that there's something
5 fundamentally wrong with the payment system, which we know
6 that there is. I don't think that the right way to fix
7 that is to simply leave the payment system in place in all
8 respects except to add on a \$40 add-on to it in this
9 particular structure. I think that, as I mentioned earlier
10 in my questioning, it seems to me that it leaves a lot of
11 problematic incentives in place, et cetera, and that this
12 problem is important enough to try to solve, and to be able
13 to broadly, across the country, that we need to have a more
14 fundamental payment model change than what is in this
15 proposal.

16 It sounds to me, like the applicant said,
17 understandably, we don't have the right kinds of
18 information and tools to be able to develop such a thing.
19 We would need to have good, better risk adjustment models,
20 et cetera, to be able to do that. And so, therefore, it
21 seems to me that it falls perfectly into the category of
22 the limited scale testing, which is that we would actually
23 need to do a bunch more work to get the payment model

1 worked out and that we would have to figure out this model
2 would work in a variety of settings other than the
3 University of Chicago, to be able to do that.

4 There is a second sort of purpose, though, that
5 the proposal came to us as, which is to be able to do a
6 better evaluation of the care model. And there is any
7 evaluation of the care model, because of a Health Care
8 Innovation Award that they received, a grant that CMMI made
9 to them, which was authorized under the legislation that
10 allows testing of models, because the law, for the
11 innovation center, doesn't talk about payment models. It
12 talks about testing care models.

13 And for some reason, the attitude about the
14 Health Care Innovation Award seems to be negative, which
15 surprises me, given that most of the good models that we
16 have been having come to us have emerged from Health Care
17 Innovation Awards. And it certainly seems to me that if
18 the real next step needs to be to try out this approach at
19 multiple institutions, that it would be a whole lot easier,
20 particularly if the innovation center has limited bandwidth
21 and clearance issues, to simply select an additional set of
22 institutions and make a grant to them, to enable them to do
23 what it is the University of Chicago did, which it seems to

1 me would achieve the goals that David and company are
2 trying to achieve, without having to go through all the
3 rigmarole of trying to create payment codes and methods, et
4 cetera, if that's the purpose of that.

5 So I think there are two separate things that
6 essentially need to go on. One is to do this in more
7 institutions, to do a more robust evaluation of the care
8 model, and second, to do more work to be able to develop a
9 better payment model than a \$40 add-on, and both of those
10 things seem to me to fit squarely into limited scale
11 testing, although, potentially, one sort of developing a
12 payment model and one simply that could be done through
13 grants, and I think that the grant model could certainly be
14 done much more quickly, almost immediately, if one wanted
15 to, than the other approach.

16 So that's why I voted how I voted and what I hope
17 we might be able to say something about in our
18 recommendations.

19 CHAIR BAILET: Paul.

20 DR. CASALE: So I voted recommend for further
21 consideration, and I think there's no question --

22 DR. NICHOLS: Attention.

23 CHAIR BAILET: For attention.

1 DR. CASALE: Excuse me, attention. Sorry. What
2 is the wording, just so I make sure I've got this? For --

3 MS. SELENICH: It's recommend the proposal for
4 attention.

5 DR. CASALE: Yeah, for attention, yeah.

6 So again, there's no question that this is, in
7 terms of a model -- and again, I'm of the same era where
8 this is how I practiced, like forever. And, you know, as a
9 cardiologist in my practice we never actually used a
10 hospitalists. We just had our cardiology group. And so
11 not always the same person rounded on that patient during
12 the day as in the office, but still the continuity was much
13 better. And that evolved into identifying high-risk
14 groups, like the heart failure patients, who this is ideal
15 for, where we had a heart failure floor, we had heart
16 failure doctors who saw the same patients in and out, and
17 clearly the outcomes were much better. In that model, we
18 leveraged, as we alluded to, now the transition of care,
19 the chronic care management, the complex. We leveraged
20 those codes to help support this.

21 So -- sorry. I think it certainly deserves
22 further attention. I'm not convinced we need a separate
23 payment model specifically for this, as opposed to really

1 paying for this kind of care, and then people, I think,
2 will continue to evolve, because I think it's self-evident
3 that this, for those high-risk patients, is a preferable
4 way to care for them.

5 CHAIR BAILET: Thank you, Paul. Bruce.

6 DR. STEINWALD: I voted for limited scale
7 testing. I won't -- I agree with Tim. I think this is a
8 model and a proposal that are suitable for that, and I
9 think we need to kind of resurrect this option as one
10 that's entirely suitable, despite the negative feedback
11 we've gotten.

12 I think we can confront that negative feedback,
13 in part, by emphasizing in our discussion the importance of
14 the population, both clinically and economically, that this
15 model would serve, and also the scalability of the model.
16 Even if it started in a limited scale, its potential to be
17 expanded up to the point where anyone would recognize that
18 it's, as Dr. Meltzer said, it's addressing the four P's.
19 And, by the way, congratulations for getting the four P's
20 right, and then the subsequent, you know, simplicity, et
21 cetera, et cetera. You obviously were paying attention
22 yesterday, probably better than many of our Committee
23 members were.

1 And then, finally, I would like to support what
2 Grace said and maybe emphasize that this model presents and
3 emphasizes the crucial role that primary care physicians
4 can and should play in the movement toward value-based
5 case. I mean, this is a model that relies on -- and it
6 provides an opportunity for primary care physicians if it's
7 scaled up, and then a result of their participation in
8 having a really crucial role in advancement of payment
9 reform.

10 CHAIR BAILET: Thank you, Bruce. So I voted to
11 recommend further attention, for reasons that Paul spoke
12 to. I think there's a soft spot relative to the payment
13 methodology. I think that because -- let me back up. I
14 think this is an incredibly important delivery care model
15 that should be further evaluated and refined for testing,
16 because I think even with additional refinement it's going
17 to require testing, I think, before large-scale deployment,
18 because there's a lot of things that you just won't know,
19 relative to the downstream ramifications of putting a
20 system like this in different communities and how to adjust
21 for that to protect the safety of the patients who are
22 being seen by people who are not in this model.

23 That said, I want this model to be successful,

1 and I think with further attention and further evaluation
2 to try and get ahead of some of those issues which could
3 require further evaluation before it's put in a testing
4 environment, I think will serve this model well.

5 So that's why I voted with the required further
6 attention.

7 I guess the last piece is clearly part of the
8 evaluation on the Secretary's side of the house is going to
9 be how does this impact cost, and I think, intuitively, and
10 to some degree based on the experience of the submitter, it
11 does demonstrate cost savings. But there is that disparity
12 relative to the incongruency that was pointed out by the
13 PRT, that I think still is another piece that needs to get
14 addressed before this gets released into the environment,
15 even in the testing circumstance, in my opinion.

16 So thank you.

17 Len.

18 DR. NICHOLS: So I voted for limited scale. I
19 would observe that, as far as I can remember, and unlike
20 Harold, I can't remember every single proposal that we got
21 in all the detail, but this is the only one I can remember
22 that ever had their own RCT already functioning. I mean,
23 the guy uses random tests to feed his daughter. I think we

1 can trust him.

2 I would say this is the perfect model for beta
3 testing, as we discussed yesterday, and Tim's eloquent
4 articulation, precisely because we've had an alpha test
5 already. To me, it is about incentivizing a different
6 style of medicine, and as far as I can tell every single
7 clinician, which may also be unique in our history, agrees
8 this style of practice needs to be encouraged, indeed,
9 remembered from what you did or hoped you would be doing
10 and turned out not to be doing, given what capitalism has
11 done to our profession.

12 But the final thing I would say is I agree with
13 Jeff that the evaluation disparity is going to be an issue.
14 I would want the letter to reflect what we learned about
15 the bias in the APT -- or whoever it was; I think it was
16 APT that did this HCIA evaluation -- and talk about how
17 that's prima, and given the results that have been
18 experienced, that's prima facie evidence of a need for a
19 beta test, that I do think the letter should reflect what
20 we think we know, what was not, you know, not malintent,
21 just they didn't have the data from the Medicaid dual
22 eligibles and so they lost a lot of those claims in there,
23 and created this bias.

1 DR. PATEL: I voted for whatever the category is
2 that's not listed.

3 CHAIR BAILET: Further attention.

4 DR. PATEL: Further attention. Thank you. And I
5 also -- Tim and Paul and I, I'm always happy to see when
6 the PTAC does not agree with the PRT's findings, mostly
7 because I didn't even -- I changed my own voting, based on
8 our conversation.

9 So I want to emphasize several aspects in the
10 Secretary's letter. I did not vote for limited scale
11 testing, because of all the kind of weight that that
12 category seems to not be dealt with by CMS, and I feel so
13 strongly that this should not be relegated to just an APM.
14 To me, this actually highlights what I would say is an
15 important critical mission of the Centers for Medicare, or
16 CM, as we describe it, in thinking through the existing set
17 of codes that I tossed around as the ones I have to live on
18 a little hamster wheel to address important continuity of
19 care.

20 So for that reason I wanted to highlight this for
21 attention. And for the Secretary, I would say this goes
22 well beyond, in my opinion, CMMI. This has applications in
23 almost every aspect of Medicare and Medicaid, because the

1 issues that are brought up clinically are not limited, in
2 my opinion.

3 The second point to bring up for the Secretary's
4 letter is that we've highlighted some of the limitations,
5 weaknesses, et cetera. I think you heard it from David
6 Meltzer that it's exactly the technical assistance and
7 thinking through the constructs that we need time and
8 space, in whatever format that is, and having heard from
9 the Deputy Administrator yesterday, that we are going to be
10 moving forward with a serious illness model, a chronic
11 kidney disease model of some kind, and a primary care
12 model. I could think of each of those three models having
13 some element that builds back on what has been described
14 here today. So I would hope that some of today's
15 discussion is reflected in those three models, which we've
16 already heard are kind of in the formation process, et
17 cetera.

18 And then my third point, which is not necessarily
19 just for the Secretary's letter but for my colleagues, as a
20 full-time community-based primary care physician, if you
21 look at AMGA or kind of indices, as an internist I can
22 make, in the D.C. area, average salary, average take-home
23 around \$185,000. My hospitalist colleagues in my very same

1 geography -- in fact, I was recruited in our hospitalist
2 program based on the fact that people thought I was smart
3 enough to do it and I would make more money -- they make
4 approximately \$250,000 to \$265,000. So I would argue that
5 this is exactly the kind of model I want to be in. I am
6 worried that people will use that as an excuse to just pay
7 less for what I think is critically important, and I would
8 say that, to me, it speaks again to my point number one.
9 We have to look at the valuation of this work. We know
10 what the right work is. It's a little bit like
11 pornography. We know it when we see it. We know good care
12 when we see it. We have no way of evaluating it, and I
13 think that's why this -- I worry that if this gets
14 relegated to limited scale or something smaller, we haven't
15 appreciated the full opportunity of what we can do here.

16 DR. BERENSON: Well, having just heard Kavita, if
17 we could change the rule so I could vote for both. It
18 needs more attention.

19 CHAIR BAILET: This is your last meeting, so
20 maybe we --

21 DR. BERENSON: It needs more attention because
22 it's fundamentally a fee schedule opportunity to increase
23 value in the fee schedule, and it also needs to be

1 demonstrated. And one of the amazing things -- I find it
2 amazing -- is that we do demos of alternative payment
3 models and we don't do anything comparable on the fee
4 schedule side.

5 So CMS has this absurd proposal out right now to
6 move to a single payment level in order to get rid of the
7 documentation guidelines, with absolutely no empirical
8 evidence of what the behavioral response is going to be
9 from anybody. So we spend about \$90 billion a year in the
10 Medicare fee schedule and we don't demonstrate nothing, and
11 here we are doing APMs.

12 I had difficulty deciding whether to give this a
13 2 or 3 on payment, because using the criteria that Tim and
14 Len -- and I wrestled with, once on our PRT -- we're not
15 measuring quality and we're not rewarding reduced spending
16 and they're not taking risk. So it's not an APM and yet
17 it's a new payment model. But it doesn't qualify as a
18 MACRA payment model and certainly not advanced MACRA
19 payment model, and yet it needs to be demoed.

20 And so I'm with Kavita completely, that we need
21 to elevate this as it's not just here's an opportunity to
22 do a limited scale testing in a demo but that it also
23 points to the need to -- well, I don't know. I mean, I

1 don't want to oversell what we can in a letter to the
2 Secretary, but I see this fundamentally -- I actually think
3 it could be done either way.

4 Harold raises some good points about maybe this
5 should be through a PMPM and with risk adjustment. David
6 makes some good points, I actually think very important
7 points, that we're not really ready, because of the failure
8 of risk adjustment, to make as much progress as we would
9 like through APMs, and we maybe need to continue to focus
10 on improving value in the fee schedule. I think this is
11 sort of the exemplary situation of making the case that the
12 fee schedule actually needs more attention, and with that
13 I'll stop.

14 CHAIR BAILET: Bob. How did you vote?

15 DR. BERENSON: I happily voted for 2, but I'm
16 very sympathetic to the asterisk.

17 CHAIR BAILET: Very good. Thank you. And
18 Rhonda.

19 DR. MEDOWS: I'll be short. I voted for 2. I
20 agree with most of the comments already made so I'm not
21 going to repeat them. I would just like to make sure that
22 in the Secretary's letter the notice that the option, this
23 model of care needs further study but it also needs the

1 attention and support to go forward. It is important that
2 the option be made available for the benefit of both the
3 physicians, the providers of care, as well as the
4 populations who will greatly benefit from it.

5 I am very happy to be hear the submitters talk
6 about their willingness to include, or at least consider
7 some quality measures for those populations that are not in
8 ACOs, particularly around quality and patient safety. I
9 think the payment model needs a little bit more work, a
10 little bit more fine-tuning, as I already listed it, as I
11 will not say anything more, and thank you very much, Mr.
12 Chair.

13 CHAIR BAILET: Thank you. Sally. Oh, Bruce.
14 Sorry.

15 DR. STEINWALD: I know we need to go through
16 that, so maybe this isn't the right time, but I think it
17 needs to be done in public. I was going to propose that we
18 change the categories of recommendations to the Secretary
19 and make what's the asterisk actually number 2, and then
20 move everyone below number 2 to 3, to 4, to 5. Do you see
21 what I'm saying?

22 DR. CASALE: No.

23 DR. STEINWALD: No? Well, you don't --

1 DR. NICHOLS: You're going to revote? For what
2 purpose?

3 MR. MILLER: You mean for the future, Bruce?

4 DR. STEINWALD: Yeah, for the future.

5 DR. NICHOLS: Let's do that in December.

6 DR. STEINWALD: Well, I think it needs to be done
7 in public.

8 DR. NICHOLS: Yeah, we can do it in December.

9 DR. STEINWALD: We can do it in December? All
10 right.

11 CHAIR BAILET: Thank you, Bruce.

12 UNIDENTIFIED SPEAKER: Sorry I'm going to miss
13 that one.

14 [Laughter.]

15 CHAIR BAILET: Okay. So I'm going to let Sally
16 give us a readback here. Thank you.

17 MS. STEARNS: Sure. All right. And I'm going to
18 thank the group for the two very different models. I've
19 been involved in the two very different processes. It's
20 been fascinating.

21 All right. So I'm going to frame it a little bit
22 more, I think, in terms of how the letter will deal with
23 the vote, or how I envision the letter dealing with the

1 vote, in that regardless of how people voted, there was
2 substantial enthusiasm for the model. There was a very
3 strong feeling that there's a population of patients and
4 physicians that need this model to improve quality of care.
5 There were really no doubts about that. There were some
6 beneficial things, like an acknowledgment that more quality
7 measures could be incorporated, and we'll add details like
8 that.

9 Okay. I think that where we get into the issue,
10 and the most important change -- although there were some
11 changes in the categories of voting, I think really the
12 most important point is that the payment methodology does
13 not meet.

14 MR. MILLER: Sally, just let me be clear. When
15 you say "the model," can you say "the care model," because
16 I think what you're referring to is the care model.

17 MS. STEARNS: Yes. I'm sorry. I do mean the
18 care model. I absolutely mean the care model.

19 MR. MILLER: But then you're going to distinguish
20 the care model.

21 MS. STEARNS: So the care model is very
22 positively received by everybody, and I'll pull in a number
23 of points, but I don't know that we need to spend time on

1 that because I think there was unanimity on that.

2 The issue really comes up for the payment model,
3 and I think where that comes up is really pretty much the
4 split of the vote. I think there is some support, and I've
5 got it for the different members, in terms of trying this
6 model further. I'll call it a beta test. We'll try to get
7 the words right. But that for what is working in Chicago
8 there's interest in knowing if that model would have
9 similar effects in different settings. And there are
10 several members of the group who feel that way.

11 On the other hand, I think the "needs attention"
12 group largely felt that it wasn't clear -- here, Bob, I
13 actually was not sure how you voted at first, but that --

14 DR. BERENSON: I went rogue.

15 MS. STEARNS: Yeah. You actually mentioned all
16 three, and I thought, woo, which one?

17 I think the point is that the reason why it
18 doesn't meet the payment methodology is reflected by the
19 split in the vote, that there are some people who would
20 like to see this model tested more, see if giving this
21 payment just to help the practices restructure how they're
22 providing care, enable them to focus on the patient in both
23 inpatient and outpatient settings, that since it's working

1 well in Chicago -- well, I'll make a comment in a minute
2 about the HCIA evaluation. But since at least it is
3 reported to be working well in Chicago, since it found very
4 positive quality improvement in the HCIA evaluation, and
5 since it's uniform -- whatever, majority patient
6 satisfaction, physician satisfaction, and interest by other
7 providers in the model, that there are a number of members
8 who feel that further testing of that model would be very
9 beneficial.

10 Then I think -- and this is sort of the split in
11 the vote, primarily, in terms of needing attention, what is
12 the best way to get the care model, giving the agreement on
13 the care model? Are there other approaches? Could working
14 on the fee schedule, instead of an APM, be the best
15 approach here? And that certainly came up in the comments.

16 I want to make a point about the HCIA evaluation,
17 and that is that David Meltzer emphasized some of the
18 reasons why he believes his results are different from the
19 HCIA evaluation. But my reading of the material he has
20 provided, and other members have that material to look at,
21 is that it's not proven conclusively, and so the letter
22 does need -- there needs to be attention in the letter to
23 the importance of lack of conclusive finding, in terms of

1 implication of the model -- I will say the "care model" --
2 on the cost of care.

3 DR. NICHOLS: I think that's fair. I think it's
4 also true that you want to indicate that there's a good
5 reason to believe that the evaluation that was done for the
6 HCIA was actually flawed, not by intent but by the data
7 availability. And so I think that point is important as
8 context for what you said about the need for further
9 evaluation.

10 MS. STEARNS: Absolutely, and we can expand on
11 that, both with what David Meltzer provided as well as, you
12 know, some of the specific points.

13 CHAIR BAILET: Harold.

14 MR. MILLER: So I like your summary. I would
15 maybe, just feedback on sort of the structure that I see,
16 and see if other people agree with this, is the first layer
17 is good care model, the second layer is we agree it needs
18 to be replicated in more sites, because it needs to be
19 evaluated -- additional evaluation needs to be done, and
20 then to me there's sort of a third layer that has two parts
21 to it. One is there needs to be a way to enable those
22 additional sites to happen, and then there needs to be some
23 sort of a way of paying that will support this care model,

1 if, in fact, it's demonstrated that it works, as people
2 believe it is, and that we're not convinced about what
3 exactly is the right way to pay for it. We're not
4 convinced that this is the right way to pay. There could
5 be changes to the fee schedule. There could be add-ons.
6 There could be whatever. But there are multiple ways to do
7 that.

8 But I would just suggest that we think about
9 those two sort of pieces, because I believe that there's a
10 way to get this tested in several different more places
11 without necessarily having to have a new payment model to
12 do it, a la making grants, et cetera. Because this model
13 did not have the payment model as part of it. It's not
14 that they did this with a \$40 add-on and now the question
15 is can we do it in some more places. They did this with a
16 grant. And the payment model that they're proposing has
17 not been tried anywhere at all. So the issue is, if there
18 are two different purposes, one is see if we can get this
19 in more sites so that we can evaluate it, and second of
20 all, how do you pay to be able to support the approach to
21 care? Those are sort of two different -- interrelated but
22 two different things. At least that's my suggestion as to
23 how to frame that.

1 CHAIR BAILET: Len.

2 DR. NICHOLS: So that made me think that it's
3 probably worth including that, at the end of the day,
4 there's -- we want to move this above the objection of
5 limited scale before, and what I would invite you to try to
6 do -- and I'm not sure how to say it at this moment, but I
7 was really struck that the PRT failed it on scope, and yet
8 when we talked about it in scope, now we've got some 6s and
9 5s. I know Grace got excited. But the point is, the
10 people who voted against it in the PRT voted for it this
11 time, so scope is really important, and scope, I think the
12 potential of what this could be needs to be emphasized to
13 get it above this limited scale frame in which we have it.

14 MR. MILLER: I think that's a good point. I'm
15 sorry, to reinforce what we were saying yesterday, is that
16 whenever we say anything about the limited scale testing,
17 we need to talk about what we think the ultimate impact
18 might be, just to be clear about that.

19 DR. NICHOLS: Tim.

20 DR. FERRIS: I might suggest, since it comes up
21 so frequently, the category of scope, because I need to
22 raise Kant at least one more time in this session. The
23 category of scope has been problematic right from the

1 start, because there are so many different concepts
2 included in that one category that when each of us is
3 voting it's obvious that we often have -- are emphasizing a
4 different piece of what is included under scope.

5 And I might suggest that we, as a Committee,
6 relook at that category and think about a way to help us be
7 clearer, both with ourselves and with the public, about
8 when we are voting on that criteria, what exactly are we
9 voting on? So a future process point.

10 CHAIR BAILET: Thank you, and thank everybody for
11 a great discussion. And I think that the fact that the PRT
12 had the point of view, almost the same thing happened
13 yesterday, and through this dialogue and deliberation,
14 which was exactly the purpose of our standing up the
15 process the way we did, it allows the insights for us to
16 guide our ultimate recommendation to the Secretary. So I
17 think that ensures that the recommendations are as rich as
18 possible.

19 I want to thank the applicants for hanging with
20 us the entire time. I think your contribution really
21 helped shape the dialogue and where we landed, so I want to
22 thank you for that, and all the patients that your program
23 touches today and the future patients that will be touched

1 by this model, ultimately, in the future. So thank you for
2 that.

3 We are not going to close out. We're closing out
4 this session for the evaluation of the model, but we're now
5 going to move into the next portion of our meeting, which
6 is hearing public comments regarding our process.

7 And so we have one person here in person. Like I
8 said -- two? Where's the second person. Oh.

9 * **Public Comment**

10 CHAIR BAILET: And so we have one person here in
11 person. Like I said -- two? Where's the second person.
12 Oh. Got it. Okay. I'm sorry.

13 So we have Sandy, Sandy Marks here.

14 Sorry. I didn't see your name there, Sandy.
15 Sorry about that.

16 MS. MARKS: Hello again.

17 CHAIR BAILET: Hi.

18 MS. MARKS: Hi. I'm Sandy Marks with the
19 American Medical Association. Thank you for the
20 opportunity to provide comments on PTAC's practices. The
21 AMA commends and thanks the PTAC members for the many hours
22 you have devoted to reviewing, commenting, and making
23 recommendations on proposals. We have been very impressed

1 with the speed, thoroughness, objectivity, flexibility, and
2 transparency with which you've carried out your work to
3 date, and we always appreciate your openness to feedback,
4 which is why we're always here providing it.

5 In a recent letter to the AMA CEO, and then a
6 one-on-one meeting, Director Boehler said that he and HHS
7 agree with the AMA that "the contributions of practicing
8 physicians in driving this transformation are
9 indispensable" and they "respect the good proposals
10 submitted to PTAC by individuals and stakeholders thus
11 far."

12 However, physicians are trained to diagnose and
13 treat patients, not to design APMS. It is not surprising
14 that many proposals to PTAC contain great ideas for
15 improving the delivery of care but have some weaknesses in
16 the proposed payment models.

17 To address this, the PTAC has often discussed the
18 need to provide technical assistance to applicants. The
19 AMA successfully urged Congress to amend the statute to
20 clarify that PTAC could do this. Unfortunately, under
21 PTAC's new initial feedback process, you plan to tell
22 applicants what is wrong with their proposals but not help
23 them to correct the problem. This is not consistent with

1 congressional intent and doesn't fill the need that was
2 identified.

3 We recommend expanding the initial feedback
4 process in three ways. First, PTAC should provide initial
5 feedback on proposals without requiring submission of a
6 complete proposal. The PTAC has preliminary review teams
7 and they should be able to provide feedback on preliminary,
8 or less than complete and final proposals.

9 Second, if there are problems with the details of
10 a proposed model, PTAC should suggest potential alternative
11 approaches the applicant can consider. You do not need to
12 be prescriptive, nor does this obligate PTAC to recommend
13 the proposal if one of the alternatives is selected, but
14 the suggestions could help people see how to develop a
15 better approach.

16 Third, the biggest barrier most applicants face -
17 - and we hear about this constantly -- I'm surprised
18 there's only two of us here, frankly, because people are
19 always talking about the PTAC and new models. Maybe
20 they're shy and they're going to send you letters or
21 something. I don't know.

22 The biggest barrier most applicants face is the
23 inability to obtain Medicare claims data, to quantify the

1 savings opportunities and create a business case for the
2 APM. PTAC generates extensive data analyses for its
3 proposals but these need to be provided to applicants much
4 earlier in the process so they can use them to improve
5 their proposals.

6 We strongly support the PTAC process and
7 encourage you to provide as much assistance to applicants
8 as possible so you'll get the best proposals possible. The
9 AMA also wants to make sure you know we are available to
10 help you in any way that you need. We have been continuing
11 to advocate, with Congress and the administration, on the
12 need for a robust APM pathway under the quality payment
13 program, and we feel physician-focused APMs continue to be
14 a key missing element.

15 Thank you.

16 CHAIR BAILET: Thank you, Sandy. And now Anne
17 Hubbard with ASTRO. Thank you, Anne.

18 MS. HUBBARD: Thank you. Good afternoon again.
19 I'm Anne Hubbard with the American Society for Radiation
20 Oncology. I really appreciate this opportunity.

21 ASTRO wishes to thank the PTAC for its continued
22 interest in public input and dialogue with regard to the
23 development of PFPs. We appreciate the opportunities that

1 have been established to provide PTAC with updates on
2 ASTRO's radiation oncology APM initiative as well as input
3 on PTAC PFPM criteria development.

4 ASTRO appreciates that PTAC is moving forward
5 with establishing a framework for initial feedback on PFPM
6 proposals. It's important for the preliminary review team
7 to provide feedback on the extent to which a proposal meets
8 the Secretary's criteria and an explanation on the basis of
9 the feedback.

10 However, the immediate feedback proposal includes
11 qualifiers for what the PRT will not provide, which include
12 instructions on how to remedy or address any identified
13 shortcomings, data or analysis to further develop a
14 proposal, individualized consultation or technical
15 assistance with regard to the development of a proposed
16 model.

17 The limitations that PTAC has set forth with
18 regard to the initial feedback run contrary to concerns
19 that PTAC raised in communications with CMS in an August 4,
20 2017, letter. In the letter, PTAC recognized a significant
21 need among PFPM submitters for additional technical
22 assistance, access to data and analysis, and data-sharing
23 capabilities for physician submitters.

1 PTAC aptly recognized that physicians are experts
2 at delivering care but not necessarily designing payment
3 models and recommended the establishment of public
4 workshops, access to data and technical assistance on data
5 sharing as potential opportunities to assist with the
6 development of stronger PFPM submissions.

7 ASTRO is concerned that the limiting factors
8 described in the PTAC proposal may diminish the value of
9 initial feedback. We urge PTAC to establish immediate
10 feedback criteria that are more in alignment with the
11 recommendation shared in the August 4, 2017, letter. We
12 believe that this will result in PFPMs that can be
13 successfully implemented and serve as a beneficial tool for
14 PFPM development and refinement.

15 Again, thank you for the opportunity.

16 CHAIR BAILET: Thank you, Anne. Do we have
17 anyone else in the audience who didn't register, who wants
18 to make a public comment regarding our process?

19 [No response.]

20 CHAIR BAILET: I'd like to ask the operator if
21 there is someone on the phone who wants to make a public
22 comment.

23 OPERATOR: Nobody has queued up on the phone.

1 CHAIR BAILET: Then I wanted to also note that
2 there are eight public comments that have been submitted by
3 email, and we are going to go ahead and take a look at
4 those.

5 Harold and Len? Len?

6 DR. NICHOLS: So, Mr. Chairman, I wondered if it
7 might not be a good time to have you, or maybe Sarah, or
8 Anne or somebody explain why we can't do technical
9 assistance in the way we actually wanted to for quite some
10 time, because I think maybe not everybody understands the
11 limits. Yes, the law was changed and I believe the
12 language started out as technical assistance and it got
13 changed into something like initial feedback or whatever,
14 because of constraints that are perceived that most people
15 don't know about. And I certainly didn't know about it and
16 we didn't know about it the first year when we were trying
17 to find out how to do it. And HHS was helping us until
18 they were told to stop.

19 CHAIR BAILET: All right. So we'll just -- I
20 don't know, Anne. I mean, Sarah, if you --

21 MS. SELENICH: I'm comfortable just reading the
22 statutory language that was added by the Bipartisan Budget
23 Act of 2018.

1 So it added a language that the Committee shall
2 review models submitted under Paragraph B and that it may
3 provide individuals and stakeholder entities who submitted
4 such models-- so that's submitters -- with initial feedback
5 on such models regarding the extent to which such models
6 meet the criteria described in Paragraph A, and an
7 explanation of the basis for the feedback provided under
8 that subclause.

9 So that's the additional, this initial feedback
10 that is the additional language on the authority that PTAC
11 has been granted.

12 DR. NICHOLS: Right, but I think what we need to
13 convey to the public is what we were told about why we
14 can't do technical assistance, because it's not that we're
15 choosing not to. It is that we are prevented from it.

16 MS. SELENICH: So this particular statutory
17 language change does not include technical assistance.

18 DR. NICHOLS: Why? That's the point.

19 MS. SELENICH: I'm not sure that I can answer
20 that one. It just says initial feedback.

21 CHAIR BAILET: Harold.

22 MR. MILLER: So I'm just going to say sort of the
23 same thing that Len said. I guess I just want to say to

1 Sandy and Anne and anyone else who may be wondering the
2 same thing, I will speak for myself and others can add on.
3 I am not happy with the way we have structured the initial
4 feedback process. I believe that the initial feedback
5 process should have more assistance to applicants than what
6 is provided there, and that we should not simply be telling
7 people what is wrong, and we should not be limited in the
8 data that we can provide.

9 However, we have been told by the Office of
10 General Counsel at the Department of Health and Human
11 Services that we cannot do those things because their
12 interpretation of the law is that it is not permissible for
13 us to do those things. I believe that is an overly narrow
14 interpretation and I believe that it could be interpreted
15 more broadly, but it is what it is.

16 And so I think it's important for people to
17 understand that if, in fact, you would like that kind of
18 assistance, the law will have to be changed again, because
19 what was done to the law does not go any farther than -- we
20 went as far as we could go, in my opinion, in terms of what
21 we were told we could do, in those initial feedback
22 guidelines.

23 So if anybody wants to clarify that, they can.

1 But so everyone is clear, that is not because the PTAC
2 decided it did not want to do those things. It was because
3 we were told we could not do those things.

4 CHAIR BAILET: Any other comments from the
5 Committee?

6 [No response.]

7 CHAIR BAILET: I want to thank the members of the
8 public, the folks who emailed us, the folks who came today
9 to share their perspectives. We're going to take this
10 input in, and clearly this an interactive process, so your
11 feedback we will continue to seek and we greatly appreciate
12 it. And we will continue to internally evaluate our
13 processes and see where there are opportunities to
14 strengthen them to make this more efficient and effective.

15 So again, thank you, everybody.

16 I have one additional comment that I'd like to
17 make as I conclude the meeting. In addition to thanking
18 the members of the public in their interest of our
19 deliberations on the proposals, and the stakeholders who
20 took the time to submit them, I want to thank my colleagues
21 who really bend with the strain of the work that's
22 required, and the diligence, and the critical thought and
23 engagement that's required to deliver the disciplined

1 analyses that you are experiencing here play out. I really
2 appreciate that, and the support that they give me in my
3 leadership role to help this Committee be positioned to be
4 generating the kind of influence that ultimately the
5 stakeholders expect and deserve.

6 I also want to particularly thank Dr. Bob
7 Berenson and Elizabeth Mitchell, who unfortunately couldn't
8 be here for this meeting, as these two individuals are
9 departing in September. They are stepping off the
10 Committee. It's been an absolute privilege, Bob, to work
11 with you, and the contributions that you have made will
12 certainly transcend your tenure on this Committee. And you
13 made tremendous contributions, as has Elizabeth, and I just
14 want to thank you and Elizabeth, in spirit, who is not here
15 today.

16 DR. BERENSON: Thank you.

17 [Applause and standing ovation.]

18 CHAIR BAILET: And on that -- that's a hard act
19 to follow -- I think we're going to go ahead and adjourn.
20 Do I have a motion?

21 DR. TERRELL: So moved.

22 DR. TERRELL: Second?

23 UNIDENTIFIED SPEAKER: Second.

1 CHAIR BAILET: All right. We are adjourned.

2 [Whereupon, at 12:12 p.m. the meeting was
3 adjourned.]

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