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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**PROCEEDINGS**

[8:40 a.m.]

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

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

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

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

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

We are encouraged by the comments made yesterday

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

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

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

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

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

DR. FERRIS: I concur.

DR. TERRELL: I concur.

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

DR. CASALE: I concur.

MR. STEINWALD: I concur.

DR. NICHOLS: I concur.

DR. PATEL: I concur.

DR. BERNESON: And I concur.

DR. MEDOWS: I concur.

CHAIR BAILET: Thank you.

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

CHAIR BAILET: So now we're going to continue with our agenda. Today, we will review the proposal submitted by the University of Chicago Medicine called the Comprehensive Care Physician Payment Model, also known as the CCP-PM.
In addition, after we conclude our deliberations, there will be an opportunity for stakeholders to make public comments on PTAC's processes.

* Committee Member Disclosures

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

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

Rhonda.

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

I have no conflicts, no disclosures.

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

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

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

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

[Laughter.]

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

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

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

I have no conflicts.

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

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

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

I have no conflicts.

DR. CASALE: Paul Casale, cardiologist and
executive director of New York Quality Care, the ACO for New York-Presbyterian, Weill Cornell, and Columbia.

I have no conflicts.

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

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

And I have no conflicts.

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

No conflicts or disclosures.

CHAIR BAILET: All right. Thank you.

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

DR. PATEL: To me.

CHAIR BAILET: Right.

DR. PATEL: All right. Yeah, that's fine.
Please go ahead, Kavita. Dr. Patel.

* PRT Report to the Full PTAC

DR. PATEL: I was going to say which one of us.

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

What I wanted to do a little off script for the three of us, not speaking for Paul and Tim, but it's so clear that when we got this proposal, it addressed such an important clinical problem. And just as a sidebar, I was just teasing Bob because I just reviewed his Annals of Internal Medicine article that he wrote with Eric Coleman from 15 years ago about transitions of care in hospital medicine and how that's been one of the few areas where some of the prescriptions made in 2003 or '04 have come to
fruition; for example, bundling of episodes, having some things in the fee schedule that directly address transitions.

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

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

At its heart, the proposal -- you'll see a couple of things in our slides. I'm just going to highlight the core elements, and those of you who are familiar with the CCP model, whether it's in some of the trade publications,
the New York Times, popular press, Health Affairs article that Bob referenced, as well as the HCIA award, you can look to various sources. But at its heart, it's a mechanism to take care of patients who are identified for being at risk for either rehospitalization or at risk for complications upon discharge from hospitalization.

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

But the other strength of this has been in their HCIA award. It is the use of a very elegant randomized control trial design in order to carry out something that Tim referenced yesterday, a little bit of beta testing. So this is a HCIA award, RCT trial, evaluation results that are highlighted in our full proposal, in the full PTAC packet, but the actual payment model that goes with it -- and I'll forward to that -- is around participating physicians, usually inpatient physicians, but could also be from the outpatient setting, taking care of someone who has been hospitalized in the last year to receive monthly fees. And there are both kind of penalties
and rewards in the amount of those monthly fees for keeping up with current standards of care.

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

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

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

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

Now, those are the two criteria in order to receive these fees, and then there are penalty criteria where there are additional fines, and the penalty fines that were proposed were $10 per patient per month, which are also payable at the end of each year if either of the penalty criterion occur, so again bear with us. The
penalty criterion is just one of these, unlike the payment
criterion, where you have to meet both. If one of these
were to occur, you trigger kind of an incidental payment
penalty, percent provision of inpatient care that falls
below 25 percent, or percent provision of outpatient care
that falls below 33 percent. So you can see how they're
highly complementary, obviously, the penalty and payment
criteria, but it's important to designate that there was an
implicit assumption about their proportions of which
amounts would qualify for both the payment as well as what
would qualify for someone who was penalized.

And something that we also had to kind of spend
some time with the proposal, in the proposal, everything
refers to an enrolled panel of patients. There is not an
assumption that any physician participating in this would
have their entire kind of physician panel of these
patients, but there have been some suggested amounts for
caps, potentially, within a typical panel of patients, such
that the entire panel -- my panel, Tim's panel, Paul's
panel -- would not necessarily all be CCP patients. And,
again, that reflects the fact that not every single patient
in one of the person's typical panels or hospitalist panels
would actually be a high-risk patient.
So that's a little bit of an overview, and again, remember kind of the clinical care model that's being proposed is one that's triggered by an inpatient hospitalization, and the goal really is for continuity of care. And for illustrative purposes, it helped us to just understand what would this look like in real life, so a little bit off script again, if the Chair doesn't mind.

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

But we did bring up in our PRT discussion some tensions that could occur if there are already longstanding relationships, particularly in community-based settings that might not be as highly integrated and what would that
communication look like, and again, these penalty and payment criteria would apply for that CCP physician, and you could imagine if that CCP physician is an internist, that's a hospitalist, they would actually physically be seeing these patients potentially in an outpatient setting or some sort of clinic office-based setting for some of those subsequent visits after a hospital discharge and vice versa. A community-based outpatient physician might be coming into the hospital to help do part of a discharge visit.

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

You'll see from -- all of you have our packet, and you will see that we did have some unanimity around several of our criteria, particularly an overall sentiment that there was this tension between the clinical model and then actually the criterion for the PFPM and particularly the high-priority criterion. I want to underscore that the discussion was pretty rich, and you'll see that there were several instances where we did not reach unanimity and in
particular the scope criterion. So I do want to just kind of highlight what I felt like were the key issues and then have my colleagues add in.

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

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

And then because of some of the findings in the HCIA evaluation -- and I'll just highlight several -- one, that it did not show significant savings and then, two, that there were actually a slight increase in emergency department visits, we wanted to make sure that there were sufficient quality measures as well as potentially areas that could be added for accountability so that the
The financial model could be applied more broadly.

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

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

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

That we did feel like there were some pretty
significant issues around this possibility of discontinuity if a primary care physician kind of stopped following a patient that was enrolled in CCP and then potentially vice versa, and so it almost felt like how could we avoid the inevitable delay of that transition that has to occur at some point.

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

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

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

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

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

Now, one would say -- and the submitter should have an opportunity to weigh in -- we looked very careful at this proportional threshold issue and had a conversation about what those -- those thresholds inherently represent quality metrics, if you will, because you have to -- in
order to get money or in order to avoid paying a penalty, you have to meet these thresholds. So we did not feel that the submitter had zero quality measures.

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

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

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

And then the third, high-priority payment
methodology criterion, another one where we had a unanimous
opinion that it did not meet the criterion, there's a very
obvious -- from that slide I showed you with the boxes,
there's a clear payment mechanism here. So it's actually
pretty easy, unlike some of the other payment models that
we're all experienced with, to understand what the outlays
in the fiscal spending might be based on your own
institution or your own practice's past admission patterns.
And we acknowledge that this could be standalone nested
within another alternative payment model, but at the end of
the day, as something that we felt like could be an
opportunity for improvement would be a way to actually
improve. And sometimes we shudder at saying "financial
risk." So I'll just deconstruct that a little bit. We felt like there could be a more clear linkage between the payment methodology and some of those patient-specific or panel-specific outcomes of interest, and that's where we felt like the payment methodology was ultimately a little weaker.

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

And then I'll go through the other criterion. We had another set of pretty robust discussions. You'll see that we did not reach unanimity on the value over volume, but we did feel overall like it did meet the criterion. And I think this is a harkening to the premise of this model, which is really to offer comprehensive continuity for a group of high-risk patients, and we felt ultimately
that if that clinical model can be better aligned with a
payment model that that does offer significant value.

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

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

On the ability to be evaluated, we also felt that
-- if anything, we felt like this RCT design offered what
we felt like was almost a gold standard for how do you
think about evaluability, and much of that credit goes to
the submitters and being pretty thoughtful and rigorous
about that element of design.

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

Integration and care coordination. Anytime you
see a majority and lack of unanimity, you can tell that
there's evidence that there's a robust deliberation that
went on, and I think that if I had to summarize where we
had just some back-and-forth, it was understanding the
roles and interactions -- or more clearly defining how that
leadership role for the CCP physician, that comprehensive
care physician, would actually be executed with all the
different touch points that any high-risk patient would inevitably have.

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

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

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

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

Patient safety. We felt like that unanimously met that criterion. In this case, we had a conversation about those very same unintended consequences, but we were trying to really acknowledge that if you have continuity of care -- and the literature in transitions of care have long offered the adverse events are kind of the chief complication of a lack of kind of continuity and transition. So we felt like this model head on dealt with some of what I feel like has been decades-old health
services research that showed that adverse events in a lack of transitions -- and that's actually Eric Coleman's kind of body of work over his life -- has illustrated how this could be a more patient-safe model.

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

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

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

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

And the second was around our discussion our integration and care coordination, and we even mentioned
yesterday we never passed this one on anything. On the surface, you'd say, "Well, how could you not?" because you're actually addressing this care coordination by having the same clinician seeing the patient, inpatient and outpatient. I mean, how more coordinated can you get? But I think our concerns, as you reflected, were really beyond that in terms of assuring that integration coordination beyond that hospitalization period and how would we do that.

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

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

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

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

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

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

But there was this core group, and we started
assigning our most complex, frail patients to that group.
They get paid as primary care doctors and for their
inpatient rounding under the current payment system, and I
can't say precisely that they have all the bells and
whistles that are here. But they do provide -- in terms of
continuity, we think of continuity in three domains, thanks
to Barbara Starfield's work. We think of it as you want information continuity, you want management continuity, and you want relationship continuity.

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

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

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

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

* Clarifying Questions from PTAC to PRT
CHAIR BAILEY: Harold.

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

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

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

MR. MILLER: And then the other question was it sounded like the calculation was going to be made at the whole panel level, which I thought was sort of interesting given that this was all about continuity at the individual patient level, and you could argue that you could measure this at the individual patient level. You could say did each patient get the full continuity of care, and you could potentially penalize you for not doing it on an individual
patient basis and then add it up. And I wondered if you
thought about that because if you just do it at the panel
level, then you have the potential for some patients are
getting left behind, but as long as enough patients are
getting completely continuous care, it ends up being 50 or
67 percent, even though some patients are really falling
away as opposed to saying a true outcome-based payment that
would say, "We will pay you, for you, the individual
patient. You got this." Did you talk about that issue at
all?

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

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

So, if anything, you're correct. We thought that
some of those, whether they're individual or at least more
specific metrics, might be more useful, but we also really
respected or tried to understand that there was a desire to
simply make this a lot more flexible to be part of either another payment model.

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

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

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

DR. PATEL: I agree.

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

DR. PATEL: It is panel -- correct.

MR. MILLER: -- it seemed to me it gets at the
issue you were raising about sort of the gaming and 
whatever it is, that if you have the calculation is made at 
the individual patient level, then you know I'm getting the 
$40 because I gave that patient continuous care, not 
because I somehow on average gave a group of patients 
something better than --

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

CHAIR BAILET: Grace.

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

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

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

So I'm thinking of the CareMore, which in 
Medicare Advantage was essentially a model where they were
seeing inpatients and doing those. The work we did at Cornerstone Health Care in the past was a somewhat different model.

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

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

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

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

DR. TERRELL: Yes.

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

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

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

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

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

My point in all this is how we actually think
about making something look like it breaks even within the
individual unit is what I think is a lot of what we're
doing right now at PTAC because this is sort of, in many
ways, Harold's approach to things where each thing that's
important to do has to kind of be -- has to kind of
actually be paid for the value that it does to the point
that it can stay in business, right?

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

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

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

So I think my answer to you -- and we did not
have that level of a discussion in any of our PRT
discussions to that extent; however, we did talk about the
reason we put that in black and white is not only did we
kind of talk through extensivist model, what Tim is doing
in the current fee schedule. I kind of offered from a
community-based primary care side, how aggressively -- may
not be the right thing to do. We're trying to aggressively
increase our utilization of TCM and CCM codes to accomplish our continuity. So that's how we've answered that issue.

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

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

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

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

DR. FERRIS: I agree, as usual, Grace. It was a
very insightful observation.

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

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

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

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

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

And so I guess the real question -- and this is why I want you all to hear this now, so I can understand what they're thinking and then go with where you might be -- is just a transition of care code with the usual
inpatient fee-for-service and the usual outpatient fee-for-
service on top of that adequate to support that care model
and what I would call as a new evolving developing
specialty?

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

DR. TERRELL: Okay.

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

DR. TERRELL: [Speaking off microphone.]

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

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

DR. PATEL: Let me tell you --

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

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

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

DR. PATEL: -- of our issue.

DR. TERRELL: Okay.

DR. PATEL: Those of us that have any clinical
care experience know that that's what we want to get to.

    DR. TERRELL: Okay.

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

    DR. TERRELL: That this does it, okay.

    DR. PATEL: -- to do it.

    DR. TERRELL: All right.

    DR. PATEL: Does that help?

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

    DR. PATEL: Right. And we --

    DR. TERRELL: Okay. But we disagree.

    DR. PATEL: And, for example, in that comprehensivist model, there could be a comprehensivist of the day, and it could be Tim Ferris on a Monday, Kavita Patel on a Tuesday, Paul Casale on a Wednesday, and we're kind of the comprehensivist --
DR. TERRELL: Yeah. That's called a hospitalist service.

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

DR. TERRELL: Thank you

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

CHAIR BAILET: [Speaking off microphone.]

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

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

DR. TERRELL: Okay.

DR. FERRIS: And they found on their patients. So it is not sort of a rotation basis. They actually -- specifically, those frail, complex patients don't get
admitted to the hospitalist service when they get admitted. They get admitted to that person, unless they're away on vacation, and so you really are creating.

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

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

CHAIR BAILET: All right. Thank you.

Len, please.

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

DR. PATEL: We're used to economists.

[Laughter.]

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

[Laughter.]

DR. NICHOLS: And here's why I'm confused, among
other things. Every single one of you on the PRT, first
ting out of your mouth was more people need this, and then
you imagine 87,000 things that might go wrong because it's
not documented in the quality measures they put forward
because they're trying to do it simple.

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

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

But here's the question. It seems like the
assertion of the applicants is this style of care will
generate all the good stuff and savings, and it seems to
come down to a factual dispute about whether the HCIA
evaluation that I guess after, somebody did, whether those
results are, if you will, dispositive or whether the recent
results are dispositive. So I think that's the thing we want to understand, okay? That's sort of the way I see it.

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

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

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

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

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

DR. NICHOLS: Okay. Rhonda, go ahead.

CHAIR BAILET: Bob.

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

[Laughter.]

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

[Laughter.]

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

I followed this conversation, and I have a concern about the fact that lots of organizations have figured out how to do this sort of naturally, and would we be by deciding that we would support this model somehow be
then adding lots of money to the pot for everybody else
who's doing it?

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

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

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

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

DR. BERENSON: Okay.

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

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

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

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

DR. BERENSON: And that was going to be my final comment, is this is just a different version of what
yesterday's proposal was about, is that people get lost in the emergency department, in the hospital, without any natural follow-up. So to emphasize, this is a real important issue, and there may need to be a few different approaches to trying to deal with it. But I think it raises the issue of taking proposals one by one rather than taking a topic and then trying to figure out what are the various ways of attacking. You know, for future work for PTAC, it might be something to think about, is to offer proposals on particular topics that we find compelling. Whether CMMI would find that compelling is a whole different story.

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

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

My experience, where people are wanting to really focus on being hospital-intensive, so they were laborists,
surgicalists, extensivists, hospitalists, recruited a lot of primary care physicians every year, and there were primary care physician candidates that wouldn't even entertain our organization. And we had hospitals that were as small as 30-bed in 10,000-population communities. They wouldn't even entertain looking at us unless we had a robust hospitalist program.

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

The other point is in your proposal, you commented on the fact that you needed enough complex patients in a panel to make it worthwhile for this
individual to be in the hospital, but at the same time, they also have to be in the clinic. So it's kind of like "Back to the Future."

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

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

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

So those are my thoughts, and I'm hopeful that you'll be able to share those. But I'm also for the -- you guys, Paul and Tim.
DR. CASALE: So you sounded a little apologetic, but you're a surgeon. I don't know where you --

CHAIR BAILET: Did I?

[Laughter.]

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

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

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

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

DR. CASALE: Right.

DR. PATEL: -- discrete, you know, shifts, hours, et cetera."
CHAIR BAILET: Right.

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

Thank you.

Bruce.

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

DR. NICHOLS: [Speaking off microphone.]

MR. STEINWALD: Oh, okay. All right.

[Laughter.]

MR. STEINWALD: So I thought it was kind of ironic in the PRT report. I mean, you know, clearly, there's lots of evidence that handoffs are often a problem, right? Bad things happen when handoffs aren't handled appropriately, and their proposal proposes to deal with an important handoff situation when the patient is hospitalized and then what happens next.
The irony is that the PRT was concerned about, well, what happens 30 days later whenever there has to be a handoff back to the delivery system that the patient was a part of, and I guess my response to that would be, well, okay. I mean, that's obviously a situation that needs to be dealt with.

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

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

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

It's not to say that that delay is in and of
itself, you know, a disaster. It's just that we don't have
data to support what that would look like, but a handoff
would need to occur.

   DR. TERRELL: Happy to provide it for you.

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

   DR. NICHOLS: Is this the public comment period?
   [Laughter.]

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

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

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

   Thank you very much.

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

   DR. MELTZER: Great. First of all, thank you so
much for having us here. We are incredibly excited to talk
to you about this work, and we're grateful for the attention you've all given to it and how hard you've worked. We saw it yesterday, so we know what tough work this is.

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

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

She also has another very critical qualification I didn't know about until I had worked with her for over a year, which is that her mom is a primary care physician at a local community hospital, one who still sees her own
patients in clinic and the hospital. And I think not just
because she's Emily's mom, it's actually helping us develop
this same program in a community hospital. So we'll
tackle that very directly.

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

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

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

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

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

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

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

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

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

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

So that is -- I also want to emphasize that we are asking physicians to change their own practice panel, to take on a different set of patients. This isn't
something you do contracting with someone for a year. This 
is a lifestyle decision, and it's very durable. And with 
all the turnover in ACOs and contracting arrangements, the 
stability of this incentive, we think is key.

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

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

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

And I would point out that Tim described an 
organization where a rational process was made to adopt the
model like this. Most ACOs are not in the position to sort of think about things this easily. I would argue even if they are, this has a cost of about $300 per patient and a return of about $3,000 per patient per year. So it is worth spending a little more money to make sure this happens, particularly if you're doing it in a context of evaluation, where you can prove it happens, and then reduce that change on an ongoing basis.

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

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

There's worry that people wouldn't -- that patients wouldn't enroll in this. I can tell you we've enrolled 2,000 people -- 4,000 people in a randomized --
sorry. Let me get this right. 2,000 people in a randomized trial at the University of Chicago over several years. We easily could have enrolled twice as many people if we didn't have to do it in a trial.

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

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

There's worries places won't adopt it. As I said, we've done it at University of Chicago. We're learning how to do it at Ingalls Hospital, this community hospital. We're finding other local hospitals in the Chicago area that are interested in doing it. Vanderbilt has adopted a model like this. Kaiser is doing it. We've gotten interest from Blue Cross Blue Shield Association.

I'm going to be presenting at the medical directors meeting next month. I think Ryan Graysen was very clear that he was interested in this model and wondered if Penn could do it. We've had interest internationally. We really think people will adopt this.

I also want to point out that in terms of recruiting physicians to do this, we have found residents
who are interested in coming into this. We have found
mature doctors who are willing to do it. It does not need
to be for everyone. My guess is that if 5 or 10 percent of
internists in the United States did this, you'd saturate
the vast majority of needs -- or plenty of people to do it.

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

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

Who went into managed care? They were the lower-
utilizing people. The high-utilizing people stayed in that
program, in our program, because they wanted really good
care. The data for this is in our August 27th memo to you.
You can take a look at it.

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

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

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

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

CHAIR BAILET: Yes.

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

CHAIR BAILET: Yes.

DR. MELTZER: There's concerns about -- and we're open to adding more measures. We worry about sort of risk
selection we should have, the more measures we choose. We try to take the sickest patients. Their measures look terrible. We don't want to be penalized for taking the sick people. We want to care for them.

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

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

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

And there's one argument that ACOs are already incentivized to increase continuity. This just isn't happening in most places. In fact, the State of Illinois, our Republican governor signed just this past week, I believe, a bill requiring that patients be allowed to opt out of managed care organizations at any point in time if their PCP leaves because continuity is such a terrible
Finally, integration and care coordination. We have developed a strategy in this so that people -- the CCPs see their specialists and actually relationships deeper. We do think we sort of nailed preventive care, although the prevention I would talk about is tertiary prevention, keeping people out of the hospital. That's what matters for this group.

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

One last thing, I think we've talked about sort of this issue of delaying inevitable handoffs as hospitalization risk falls. Again, we don't think that these handoffs are inevitable. We've managed for five years to have people enrolled in this program. We have
never taken anyone out of the program because they're not sick enough, okay? We just make them well and keep caring for them.

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

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

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

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

Our doctors know when their patients are having
trouble applying for benefits. They know when their family is experiencing an issue, and they use that to make them better.

Let me stop there.

CHAIR BAILET: Thank you.

Harold and then Grace.

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

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

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

So they made the switch. Two of the doctors who had been basically primary care physicians like every other primary care physician that practiced, dedicated themselves
to the hospital, and all the other PCPs then immediately started to complain about how those two guys never, ever called them, were changing everything about the way their patients were being managed, et cetera, et cetera, et cetera. So it's clear that all of a sudden where you stand depends on where you sit.

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

So my first interest in a payment model is, Does it actually remove the barriers that exist in the payment model today, and does it create any undesirable incentives? So I guess the question is -- and it's useful to talk to you because you've actually done work in terms of what does it cost, et cetera.

I'm trying to understand, first of all -- so if
sombody sets up their practice the way you're suggesting -- and forget the $40 for a second. If I understand this correctly, it's an add-on. So they're still billing for E&M's, outpatient. They're still building for E&M's in the hospital, et cetera. If they did that, would they be able to essentially do better, do worse, et cetera, revenue-wise than they would otherwise?

DR. MELTZER: Can I answer that?

MR. MILLER: Yes. Yes, absolutely.

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

It used to be that people went to the doctor because they were sick, and if you saw a fair number of
people in the day, a fair number of those people would be in the hospital the next morning.

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

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

MR. MILLER: Yes. I understand that.

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

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

MR. MILLER: So, in other words, the answer to my question is, if you structured the practice the way you're suggesting and focused on the patients, that you would basically be able to do the same revenue-wise. There is on
gap that the $40 is trying to fill.

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

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

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

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

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

DR. MELTZER: Yeah.

MR. MILLER: So, in other words, there's a short-
term thing, but in the long run --

DR. MELTZER: Absolutely.

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

So --

DR. MELTZER: Can I say one other thing?

MR. MILLER: Yeah.

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

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

The second part of the question, then, about the payment model is one of the interesting things about the current structure is that it's sort of neutral to whether
the patient is in the hospital or not because if I see the
patient in the outpatient clinic, I get an E&M. If I see
them in the hospital, I get an E&M. Now, organizing your
time is a different issue, but you basically get paid
either place.

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

And it seems to me that it's sort of perverse in
that sense, and I guess I wonder what you think about that.
But I'm wondering why you wouldn't just sort of pay what
we're trying to do in a lot of other models, is pay a PMPM
to the doctor, regardless of where the patient is, so that
all of a sudden -- because you've left the underlying fee-
for-service structure in place, which now all of a sudden
says, "If I keep you out of the hospital, you lose all the hospital E&M's," and you're not going to make them up in the clinic because you're not going to be in the clinic.

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

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

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

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

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

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

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

As I read more, I understood the model, and I saw Tim's compliment about the New York Times story. I hadn't
seen the New York Times story, so I read the New York Times story, which then gave me a better sense. And I suddenly realized that these were very different patients than that, but it seemed to me that they could potentially fall into multiple categories. I mean, you had everything from what you might call end-of-life patients to patients with extraordinarily severe diseases that might need periodic planned hospitalizations for treatment, et cetera.

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

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

DR. MELTZER: You just hit it, so a couple of answers. Great, great question.
So, first of all, yes, some of these people are at end of life. Some of them have COPD. Some of them have diabetes. Some of them have end-stage renal disease. Many of them have most of these things. So chronic interlocking illness is key. I'd also add sort of social determinants of health there. So those are big reasons that we don't go sort of disease by disease.

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

And getting back to your earlier question about kind of what's the long-run cost, if someone ends up a low volume kind of person in this model, the costs become very minimal of having them in it. And, again, the returns particularly for an ACO were biggest the sicker, and what we find is even though this threshold is one hospitalization, the vast majority of people who enroll have many more than that because people don't want to change their doctor for nothing. They change it when they
see a compelling reason, and that's also how we talk to
them about it. So that's a minimum criteria, but the
average is substantially more.

MR. MILLER: And final question is it's -- I
guess the notion of the model of care is certainly
desirable, but you've created a model which essentially
mandates a process. You've mandated a particular
structure, and a randomized control trial might say, yes,
it's better on average than something else. But you've
essentially taken away the flexibility for physicians or
practices to figure out how to do it differently by saying
they have to be at 67 percent and 50 percent, et cetera.
And I'm wondering why not just hold people accountable for
the outcome. If you think that there is an outcome that
they can achieve, if they think that they can reduce
hospitalizations, then say, "Hey, we'll pay you whatever
the different payment is," whether it's $40 or whether it's
a PMPM or whatever it is that needs to fill the gap to be
able to get through the Valley of Death, whatever to be
able to get to this, to say, "We'll pay you that," but the
outcome, which is essentially what we need to be able to do
to show Medicare and MACRA that there are savings, is that
you actually have reduced something.
And then if this works, if people sign up for it, they would say, well, the best way to do that is obviously to have continuity of care and to schedule myself around this, et cetera, but I wouldn't be all of a sudden worrying that, you know, in certain cases, when I went on vacation, I was going to fall short of the 67 percent threshold.

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

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

And I'll point out that to the extent the organization has already taken on the responsibility for those people at NACO, that incentive is already there. Okay? So we didn't want to add on top of it. We didn't object to its existence, but we didn't want to saddle this model with that obligation, because we think that it is --
risk adjustment just doesn't support the discrimination
needed to avoid having you be penalized for taking on
these, you know, very, very complex patients.

CHAIR BAILET: Grace.

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

But it got too darn hard. It got too darn hard.
So you've spoken of other incentives that are out there.
The first people to go to a hospitalist program were the
family physicians who discovered that if they focused on
all the things you mentioned -- prevention, lots of quick
E&M visit in an outpatient setting -- they could make $30--
, $40--, $50,000 more a year, and not have all the concerns
about being on call at night, and not have to worry about
the sickest of the sick patients.

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

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

DR. MELTZER: Right.

DR. TERRELL: So I want some very specific
questions so I can understand what it takes to fix that, at
least as you understand it. Number one is, if we use the
term "panel size," okay, how many patients does it take for
a clinician practicing like this to have in his or her
panel, to make a living, and not have such a horrible lifestyle that they leave this program? Okay. And then the other two -- and the other one related to that is, is there a call group size --

   DR. MELTZER: Yeah, yeah.
   DR. TERRELL: -- that has to be done. So these are very practical things.

   DR. MELTZER: Yeah, yeah. I've got them.
   DR. TERRELL: What's the answer to those two things, and I'll go to the other things.

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

   [Laughter.]

   DR. TERRELL: Yeah.

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

   DR. TERRELL: Yeah.

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

   DR. TERRELL: Yep.

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

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

DR. TERRELL: That's what I thought.

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

DR. TERRELL: Five. Okay.

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

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

DR. TERRELL: Right.

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

DR. TERRELL: Okay.

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

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

DR. MELTZER: Complex.

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

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

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

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

DR. TERRELL: Yeah. I'm not worried about your
dean. I'm worried about the United States of America, and it's completely screwed right now.

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

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

DR. TERRELL: Okay.

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

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

DR. MELTZER: We're trying.

DR. TERRELL: Yeah.

DR. MELTZER: As people know, it's not easy. I mean, I track it every week, and we're doing the best we can. But, I mean, my dean's not looking at this as a cash cow in and of itself. I promise you that. And I think
that getting other places to do it, you know, this
incentive would make a meaningful difference.

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

DR. MELTZER: Yeah, yeah.

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

DR. MELTZER: No.

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

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

DR. TERRELL: Okay.

DR. MELTZER: So if you take 200, you know,
patients, and it's about $500 a year, it's like $100,000.
That's a pretty decent piece of a doctor's salary. I think it fills the hole, and that assumes the maximum, right? In reality it's going to be more like 25, because it's going to be this mix of the $40 for the newly enacted people and the $10 for the people who haven't been hospitalized. And, you know, we've done this at one place.

DR. TERRELL: Right.

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

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

DR. MELTZER: Absolutely.

DR. TERRELL: Okay.

DR. MELTZER: One of our --

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

DR. MELTZER: Absolutely. One of our five
doctors does home visits. We're adding an APN capability
to try to make that a little more cost effective.

    DR. TERRELL: Okay.

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

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

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

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

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

    DR. TERRELL: Okay.

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

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

DR. MELTZER: It's impossible to know.

DR. TERRELL: Okay.

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

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

[Laughter.]

DR. MELTZER: Vanderbilt.

CHAIR BAILET: Tim, you had a comment?

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

CHAIR BAILET: Rhonda.

DR. MEDOWS: So I'll be the last doc added to the
pile, but I'm an old doc, family medicine, did home visits, did inpatient care, did deliveries, did all that wonderful thing, quite a while ago. It was challenging. It was also rewarding.

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

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

DR. MELTZER: Yeah.

DR. MEDOWS: Who would have an easier time adapting to this, from your experience? And then the second question is really more of a request. I understand wanting to focus on patient-reported outcomes. That's great. And I understand for those populations that are already in an ACO, not wanting to add on even more measures. But for the population that's not in an ACO,
just consider -- and I think you're open to the idea --
there should be some type of patient safety measure, some
type of quality measures.

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

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

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

So we are very much open to measures. We don't
object to them. We're worried about practicality. Like
the questions that came up yesterday about who's going to
ensure people answer the survey questions, we didn't know
how comfortable CMS was with requiring things like that,
and we didn't want to build something on top of it that we didn't know the -- like we measure everything imaginable in this study, and we can give you a whole list of what's moving and not moving. Like we're totally open to that. So that's that.

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

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

I've gone to rural hospitals in Illinois. I've gotten phone calls from, you know, folks in tiny community
hospitals in vulnerable urban, rural communities. I think people will do this. I think the demonstration will prove that people are interested in this. I think that is reason to do it. I also think in academic medical centers there are doctors who want to do this. There are young trainees. There are people who have been general internists. We've gone and had people who have just been a ward attending but not providing direct patient care, and we've helped them retrain and retool. Like we think this is doable.

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

CHAIR BAILET: I want to just follow that train of thought, because a lot of what I see as the younger generation of physicians who are coming out today, lifestyle is very important to them, being able to be predictive. They don't want to get up in the middle of the night and go to the hospital. And I understand that this
doesn't have to apply to everybody. I get that. But I also am sensitive to the ecosystems that have been constructed and the challenges that this could present to those systems, particularly in the smaller communities where not everybody wants to do this, and so you still need that hospitalist backbone, right?

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

DR. MELTZER: Yeah.

CHAIR BAILET: So could you help me with that?

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

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

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

DR. SCHRAM: And one specific example, to
highlight is at University of Chicago we actually partnered
This program with the hospitalist program. So if a patient
does come in in the middle of the night, that night they
are admitted by a hospitalist and then seen by their
comprehensive care physician the next day. There are
opportunities to integrate with systems that are already in
place.

CHAIR BAILET: Okay. Thank you. That's helpful.

Bob.

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

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

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

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

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

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

DR. MELTZER: Right.

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

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

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

DR. MELTZER: Yeah. I mean, in my more optimistic moments about this process I think, you know,
maybe it should be more than 20, you know, institutions and practices. But again, we are very happy --

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

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

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

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

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

DR. BERENSON: Yeah, and the other thing, which I just want to clarify, just sort of was whispering to Kavita, but when you talk about enrollment or empanelment,
there's no limitation on patient choice here. It's simply as a basis for doing the calculations? I mean, what is the purpose of enrollment, I guess is my question.

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

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

DR. MELTZER: No.

CHAIR BAILET: Thank you. Tim and then Harold.

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

So this is a pretty wonky question, but you referred several times, I think quite accurately, to the risk adjustment problem. We're dealing with outliers of
outliers, and so huge regression to the mean issues.

DR. MELTZER: Yes.

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

DR. MELTZER: Yeah, yeah. Great question.

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

DR. MELTZER: Yeah, yeah.

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

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

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

So those are the things that come to mind. We were very grateful that HCIA allowed us to do an RCT, and, you know, it's the gold standard, and I would like to imagine that it's possible to do that. But I do think a stepped wedge design with, you know, sort of reasonable denominators that focus on an eligible population could make a lot of sense.
DR. FERRIS: That's a great response, and I guess I would just say that having some experience with implementation of demonstration projects, I've been impressed at how you can give a really big binder about how to do it to multiple sites and have phone calls and check-ins and everything, and then a year later everyone is doing something completely different.

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

DR. FERRIS: Thank you.


DR. NICHOLS: So you remember when I was talking before y'all came up. I think that one of the big issues
is going to come down to this $3,000 versus what the
evaluation that the official HCIA gets. So tell me why you
believe $3,000.

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

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

I also want to say that in the patient-reported
outcome, one of the things you always worry about is that
there's bias and that there's not, you know, high reporting
rates, and that maybe only some patients are answering. We
get like 95 percent completion rates of data. We have --
as everyone will attest, I torture our students to keep
calling and calling. One patient actually said, "Will I
have to die before you stop calling me?" I mean, we get incredibly high response rates. And then we've used patterned extra modeling to try to deal with dropouts so that we're dealing with the selection issues around this.

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

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

CHAIR BAILET: Please.

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

So my concern is that anybody else who would try to do this, even in those 20 beta sites that are just as
great as yours, would need to find a way to get to that level of excellence. I guess that's just one point I wanted to make, and that's the concern.

DR. MELTZER: Can I --

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

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

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

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

DR. PATEL: Who is that?

[Laughter.]

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

And, I'm sorry -- it's been a long --
DR. PATEL: Just a concern, to Len's point.

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

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

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

But I want to be clear. Outside of the Medicaid group, you know, we had pretty good retention because we haven't had a lot of people moving into Medicare Advantage in our environment, so the claims data is actually really quite good. And I would also argue -- and I don't understand enough about what data CMS has or doesn't have right now, but, like, if you could do an evaluation that included, you know, Medicare Advantage claims and
utilization too, that would be a really big plus in some of this. And I think some of that data exists, but I don't know enough to know whether it's really usable. And you could make some of that a condition of how you designed the programs, some possibilities.

CHAIR BAILET: Harold. Take us home.

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

But the issue is, we're not approving research projects. We're supposed to be looking at payment models that could potentially be expanded nationally. And so I guess I'm curious as to how you envision, if somehow the evaluation gets done and it shows what you believe it's going to show, and this is going to be expanded, how people would participate and get paid in the future. Would practices -- would there be a new billing code that they would say I'm going to bill $40 for a patient and somebody
is going to then calculate -- CMS is going to calculate some -- retrospectively determine whether they saw their patients enough and penalize them? Would they have to apply as a practice and say, "I am structured in the following way, and therefore I'm going to get paid this way?" How would you envision that working?

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

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

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

DR. MELTZER: Sure.

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

DR. MELTZER: Yeah, yeah.

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

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

MR. MILLER: No, but I'm talking about something like that model.
DR. MELTZER: I think it's a reasonable place to start.

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

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

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

DR. FERRIS: So I want to personally thank all of you for your diligence and patience with us. This has been very, very helpful. And thank you for putting this proposal forward and attending today. We're not done, but
I'm going to -- I know you guys probably are. So thank you. If you could take your seats.

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

CHAIR BAILET: You bet.

* Comments from the Public

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

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

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

[Recess.]

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

So I ask my colleagues, are we ready to vote electronically on the individual criteria.
MULTIPLE SPEAKERS: Yes.

* Voting

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

Criterion 1, scope. High-priority criterion.

Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM entities whose opportunities to participate in APMS have been limited.

Please vote.

[Electronic Voting.]

* Criterion 1

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

CHAIR BAILET: Thank you. Criterion 2 is quality and cost, a high-priority criterion. Anticipated to improve health care quality at no additional cost, maintain
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[Electronic Voting.]

* **Criterion 3**

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

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

Please vote.

[Electronic Voting.]

* **Criterion 4**

MS. SELENICH: Zero members vote 6, meets and deserves priority consideration; one member votes 5, meets and deserves priority consideration; three members vote 4, meets; six members vote 3, meets; zero members vote 1 or 2, does not meet; and zero members vote not applicable. Therefore, the finding of the Committee is the proposal meets Criterion 4, value over volume.
CHAIR BAILET: Thank you. And Criterion 5 is flexibility. Provide the flexibility needed for practitioners to deliver high-quality health care.

Please vote.

[Electronic Voting.]

Criterion 5

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

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

Please vote.

[Electronic Voting.]

Criterion 6

MS. SELENICH: Zero members vote 6, meets and deserves priority consideration; three members vote 5, meets and deserves priority consideration; one member votes 4, meets; four members vote 3, meets; two members vote 2,
does not meet; zero members vote 1, does not meet; and zero members vote not applicable. Therefore, the finding of the Committee is the proposal meets Criterion 6, ability to be evaluated.

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

Please vote.

[Electronic Voting.]

* Criterion 7

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

CHAIR BAILET: Criterion 8, patient choice.

Encourage greater attention to the health of the population served while also supporting the unique needs and
preferences of individual patients.

Please vote.

[Electronic Voting.]

* Criterion 8

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

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

Please vote.

[Electronic Voting.]

* Criterion 9

MS. SELENICH: One member votes 6, meets and deserves priority consideration; zero members vote 5, meets and deserves priority consideration; one member votes 4, meets; seven members vote 3, meets; one member votes 2, does not meet; zero members vote 1, does not meet; and zero members vote not applicable. Therefore, the finding of the Committee is the proposal meets Criterion 9, patient choice.
CHAIR BAILET: And the last criterion, 10, health information technology. Encourage use of health information technology to inform care.

Please vote.

[Electronic Voting.]

* Criterion 10

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

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

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

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

DR. PATEL: Can I just, on the recommendations,
will you clarify whether that new option is —

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

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

MR. MILLER: Recommend for attention.

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

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

CHAIR BAILET: Yeah, zero vote.

DR. PATEL: Just as a reminder.

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

DR. FERRIS: Second.

CHAIR BAILET: All in favor.

[Chorus of ayes.]

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

DR. BERENSON: And we're still using the limited
scale testing language for number 2.

CHAIR BAILET: Correct.

DR. BERENSON: Okay.

CHAIR BAILET: So please vote.

[Electronic Voting.]

* Final Vote

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

* Instructions on Report to the Secretary

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

DR. FERRIS: Great. So I voted to limited scale
testing. I want to have my comments in two different, one is about the proposal and the other one is about the categories that we're voting on.

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

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

Having said that, I did think it would be -- greater testing is the right thing to do here. And I guess we have had some frustration over feedback from CMS, that they are not in a position to do limited scale testing. I
think that took -- to my mind, that shouldn't dissuade us from making a recommendation for limited-scale testing, because, thanks to you, Jeff, and reading our definition of limited scale testing, this seems to me to fall precisely into the category of really good idea, can't possibly work out the details without a larger scale. And so this does actually, to me, fit into that, and we should continue this very healthy dialogue we're having with CMS and the Secretary around the importance of this.

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

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

CHAIR BAILET: Thank you, Tim. Grace.

DR. TERRELL: I was the one who had my thumb on the scale towards the 6s and positive directions for most of the criteria, and the reason I did that, although I don't disagree with probably most of the logic of what Tim just said and what the rest of you are going to say, that
sort of landed you at limited scale testing, I do think that this is probably the most crucial issue, that if we can solve it in a simple way, in a way that I think would be easily scalable, could be revolutionary and would be one of the best quick wins for PTAC, as well as the health care system in the country.

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

And so suddenly you had family physicians and general internists and pediatricians, occasionally OB-GYNs, that basically had a model of care that was about seeing as many patients as you could, in an efficient outpatient setting, and then trying to scramble to do everything else. And you really couldn't concentrate on what general internists were trained to do, which was to take care of
sicker patients, elderly patients, frail patients, and do it in a way that would require more than a 99213 and an office visit that was 15 minutes.

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

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

So I don't see that a $40 payment defining around a few percentage groupings is going to be such a scary thing that if we just didn't implement it in some sort of controlled but widespread scalable way right now, we couldn't see some changes very quickly that could actually be pretty profound in terms of basically taking care of the Medicare population that is increasing and growing, for which we have a shortage of qualified health care professionals to take care of, and this could be an
ultimate design element that could make a great deal of
difference for that population. And it would actually
bring the joy back into the practice of general internal
medicine. So what they're now calling a comprehensivist is
actually what I thought I was going to be 30 years ago when
I went to medical school.

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

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

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

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

Harold.

MR. MILLER: So I voted too for limited scale
testing. I think this is a very desirable method of care
that we should find ways to support. I think that the fact
that it is not being delivered today reflects the fact that
there are some severe problems with the fee-for-service
structure that exists. We are essentially paying people
for very short visits in offices and not enough at that level, and, therefore, it makes it impossible, impractical financially to be able to do this kind of care.

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

It sounds to me, like the applicant said, understandably, we don't have the right kinds of information and tools to be able to develop such a thing. We would need to have good, better risk adjustment models, et cetera, to be able to do that. And so, therefore, it seems to me that it falls perfectly into the category of the limited scale testing, which is that we would actually need to do a bunch more work to get the payment model
worked out and that we would have to figure out this model would work in a variety of settings other than the University of Chicago, to be able to do that.

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

And for some reason, the attitude about the Health Care Innovation Award seems to be negative, which surprises me, given that most of the good models that we have been having come to us have emerged from Health Care Innovation Awards. And it certainly seems to me that if the real next step needs to be to try out this approach at multiple institutions, that it would be a whole lot easier, particularly if the innovation center has limited bandwidth and clearance issues, to simply select an additional set of institutions and make a grant to them, to enable them to do what it is the University of Chicago did, which it seems to
me would achieve the goals that David and company are
trying to achieve, without having to go through all the
rigmarole of trying to create payment codes and methods, et
cetera, if that's the purpose of that.

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

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

CHAIR BAILET: Paul.

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

DR. NICHOLS: Attention.

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

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

DR. CASALE: Yeah, for attention, yeah.

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

So -- sorry. I think it certainly deserves further attention. I'm not convinced we need a separate payment model specifically for this, as opposed to really
paying for this kind of care, and then people, I think, will continue to evolve, because I think it's self-evident that this, for those high-risk patients, is a preferable way to care for them.

CHAIR BAILET: Thank you, Paul. Bruce.

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

I think we can confront that negative feedback, in part, by emphasizing in our discussion the importance of the population, both clinically and economically, that this model would serve, and also the scalability of the model. Even if it started in a limited scale, its potential to be expanded up to the point where anyone would recognize that it's, as Dr. Meltzer said, it's addressing the four P's. And, by the way, congratulations for getting the four P's right, and then the subsequent, you know, simplicity, et cetera, et cetera. You obviously were paying attention yesterday, probably better than many of our Committee members were.
And then, finally, I would like to support what Grace said and maybe emphasize that this model presents and emphasizes the crucial role that primary care physicians can and should play in the movement toward value-based case. I mean, this is a model that relies on -- and it provides an opportunity for primary care physicians if it's scaled up, and then a result of their participation in having a really crucial role in advancement of payment reform.

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

That said, I want this model to be successful,
and I think with further attention and further evaluation
to try and get ahead of some of those issues which could
require further evaluation before it's put in a testing
environment, I think will serve this model well.

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

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

So thank you.

Len.

DR. NICHOLS: So I voted for limited scale. I
would observe that, as far as I can remember, and unlike
Harold, I can't remember every single proposal that we got
in all the detail, but this is the only one I can remember
that ever had their own RCT already functioning. I mean,
the guy uses random tests to feed his daughter. I think we
I would say this is the perfect model for beta testing, as we discussed yesterday, and Tim's eloquent articulation, precisely because we've had an alpha test already. To me, it is about incentivizing a different style of medicine, and as far as I can tell every single clinician, which may also be unique in our history, agrees this style of practice needs to be encouraged, indeed, remembered from what you did or hoped you would be doing and turned out not to be doing, given what capitalism has done to our profession.

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

CHAIR BAILET: Further attention.

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

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

So for that reason I wanted to highlight this for attention. And for the Secretary, I would say this goes well beyond, in my opinion, CMMI. This has applications in almost every aspect of Medicare and Medicaid, because the
issues that are brought up clinically are not limited, in my opinion.

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

And then my third point, which is not necessarily just for the Secretary's letter but for my colleagues, as a full-time community-based primary care physician, if you look at AMGA or kind of indices, as an internist I can make, in the D.C. area, average salary, average take-home around $185,000. My hospitalist colleagues in my very same
geography -- in fact, I was recruited in our hospitalist program based on the fact that people thought I was smart enough to do it and I would make more money -- they make approximately $250,000 to $265,000. So I would argue that this is exactly the kind of model I want to be in. I am worried that people will use that as an excuse to just pay less for what I think is critically important, and I would say that, to me, it speaks again to my point number one. We have to look at the valuation of this work. We know what the right work is. It's a little bit like pornography. We know it when we see it. We know good care when we see it. We have no way of evaluating it, and I think that's why this -- I worry that if this gets relegated to limited scale or something smaller, we haven't appreciated the full opportunity of what we can do here.

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

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

DR. BERENSON: It needs more attention because it's fundamentally a fee schedule opportunity to increase value in the fee schedule, and it also needs to be
demonstrated. And one of the amazing things -- I find it amazing -- is that we do demos of alternative payment models and we don't do anything comparable on the fee schedule side.

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

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

And so I'm with Kavita completely, that we need to elevate this as it's not just here's an opportunity to do a limited scale testing in a demo but that it also points to the need to -- well, I don't know. I mean, I
don't want to oversell what we can in a letter to the Secretary, but I see this fundamentally -- I actually think it could be done either way.

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

CHAIR BAILET: Bob. How did you vote?

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

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

DR. MEDOWS: I'll be short. I voted for 2. I agree with most of the comments already made so I'm not going to repeat them. I would just like to make sure that in the Secretary's letter the notice that the option, this model of care needs further study but it also needs the
attention and support to go forward. It is important that the option be made available for the benefit of both the physicians, the providers of care, as well as the populations who will greatly benefit from it.

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

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

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

DR. CASALE: No.

DR. STEINWALD: No? Well, you don't --
DR. NICHOLS: You're going to revote? For what purpose?

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

DR. STEINWALD: Yeah, for the future.

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

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

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

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

CHAIR BAILET: Thank you, Bruce.

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

[Laughter.]

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

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

All right. So I'm going to frame it a little bit more, I think, in terms of how the letter will deal with the vote, or how I envision the letter dealing with the
vote, in that regardless of how people voted, there was substantial enthusiasm for the model. There was a very strong feeling that there's a population of patients and physicians that need this model to improve quality of care. There were really no doubts about that. There were some beneficial things, like an acknowledgment that more quality measures could be incorporated, and we'll add details like that.

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

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

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

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

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

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

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

DR. BERENSON: I went rogue.

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

I think the point is that the reason why it doesn't meet the payment methodology is reflected by the split in the vote, that there are some people who would like to see this model tested more, see if giving this payment just to help the practices restructure how they're providing care, enable them to focus on the patient in both inpatient and outpatient settings, that since it's working
well in Chicago -- well, I'll make a comment in a minute about the HCIA evaluation. But since at least it is reported to be working well in Chicago, since it found very positive quality improvement in the HCIA evaluation, and since it's uniform -- whatever, majority patient satisfaction, physician satisfaction, and interest by other providers in the model, that there are a number of members who feel that further testing of that model would be very beneficial.

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

I want to make a point about the HCIA evaluation, and that is that David Meltzer emphasized some of the reasons why he believes his results are different from the HCIA evaluation. But my reading of the material he has provided, and other members have that material to look at, is that it's not proven conclusively, and so the letter does need -- there needs to be attention in the letter to the importance of lack of conclusive finding, in terms of
implication of the model -- I will say the "care model" --
on the cost of care.

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

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

CHAIR BAILET: Harold.

MR. MILLER: So I like your summary. I would
maybe, just feedback on sort of the structure that I see,
and see if other people agree with this, is the first layer
is good care model, the second layer is we agree it needs
to be replicated in more sites, because it needs to be
evaluated -- additional evaluation needs to be done, and
then to me there's sort of a third layer that has two parts
to it. One is there needs to be a way to enable those
additional sites to happen, and then there needs to be some
sort of a way of paying that will support this care model,
if, in fact, it's demonstrated that it works, as people believe it is, and that we're not convinced about what exactly is the right way to pay for it. We're not convinced that this is the right way to pay. There could be changes to the fee schedule. There could be add-ons. There could be whatever. But there are multiple ways to do that.

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

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

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

DR. NICHOLS: Tim.

DR. FERRIS: I might suggest, since it comes up so frequently, the category of scope, because I need to raise Kant at least one more time in this session. The category of scope has been problematic right from the
start, because there are so many different concepts included in that one category that when each of us is voting it's obvious that we often have -- are emphasizing a different piece of what is included under scope.

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

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

I want to thank the applicants for hanging with us the entire time. I think your contribution really helped shape the dialogue and where we landed, so I want to thank you for that, and all the patients that your program touches today and the future patients that will be touched
by this model, ultimately, in the future. So thank you for that.

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

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

* Public Comment

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

So we have Sandy, Sandy Marks here.

Sorry. I didn't see your name there, Sandy.

Sorry about that.

MS. MARKS: Hello again.

CHAIR BAILET: Hi.

MS. MARKS: Hi. I'm Sandy Marks with the American Medical Association. Thank you for the opportunity to provide comments on PTAC's practices. The AMA commends and thanks the PTAC members for the many hours you have devoted to reviewing, commenting, and making recommendations on proposals. We have been very impressed
with the speed, thoroughness, objectivity, flexibility, and
transparency with which you've carried out your work to
date, and we always appreciate your openness to feedback,
which is why we're always here providing it.

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

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

To address this, the PTAC has often discussed the
need to provide technical assistance to applicants. The
AMA successfully urged Congress to amend the statute to
clarify that PTAC could do this. Unfortunately, under
PTAC's new initial feedback process, you plan to tell
applicants what is wrong with their proposals but not help
them to correct the problem. This is not consistent with
congressional intent and doesn't fill the need that was identified.

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

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

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

The biggest barrier most applicants face is the inability to obtain Medicare claims data, to quantify the
savings opportunities and create a business case for the
APM. PTAC generates extensive data analyses for its
proposals but these need to be provided to applicants much
earlier in the process so they can use them to improve
their proposals.

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

Thank you.

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

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

ASTRO wishes to thank the PTAC for its continued
interest in public input and dialogue with regard to the
development of PFPMs. We appreciate the opportunities that
have been established to provide PTAC with updates on
ASTRO's radiation oncology APM initiative as well as input
on PTAC PFPM criteria development.

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

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

The limitations that PTAC has set forth with
regard to the initial feedback run contrary to concerns
that PTAC raised in communications with CMS in an August 4,
2017, letter. In the letter, PTAC recognized a significant
need among PFPM submitters for additional technical
assistance, access to data and analysis, and data-sharing
capabilities for physician submitters.
PTAC aptly recognized that physicians are experts at delivering care but not necessarily designing payment models and recommended the establishment of public workshops, access to data and technical assistance on data sharing as potential opportunities to assist with the development of stronger PFPM submissions.

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

Again, thank you for the opportunity.

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

[No response.]

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

OPERATOR: Nobody has queued up on the phone.
CHAIR BAILET: Then I wanted to also note that there are eight public comments that have been submitted by email, and we are going to go ahead and take a look at those.

Harold and Len? Len?

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

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

MS. SELENICH: I’m comfortable just reading the statutory language that was added by the Bipartisan Budget Act of 2018.
So it added a language that the Committee shall review models submitted under Paragraph B and that it may provide individuals and stakeholder entities who submitted such models—so that's submitters—with initial feedback on such models regarding the extent to which such models meet the criteria described in Paragraph A, and an explanation of the basis for the feedback provided under that subclause.

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

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

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

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

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

CHAIR BAILET: Harold.

MR. MILLER: So I'm just going to say sort of the same thing that Len said. I guess I just want to say to
Sandy and Anne and anyone else who may be wondering the same thing, I will speak for myself and others can add on. I am not happy with the way we have structured the initial feedback process. I believe that the initial feedback process should have more assistance to applicants than what is provided there, and that we should not simply be telling people what is wrong, and we should not be limited in the data that we can provide.

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

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

So if anybody wants to clarify that, they can.
But so everyone is clear, that is not because the PTAC decided it did not want to do those things. It was because we were told we could not do those things.

CHAIR BAILET: Any other comments from the Committee?

[No response.]

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

So again, thank you, everybody.

I have one additional comment that I'd like to make as I conclude the meeting. In addition to thanking the members of the public in their interest of our deliberations on the proposals, and the stakeholders who took the time to submit them, I want to thank my colleagues who really bend with the strain of the work that's required, and the diligence, and the critical thought and engagement that's required to deliver the disciplined
analyses that you are experiencing here play out. I really appreciate that, and the support that they give me in my leadership role to help this Committee be positioned to be generating the kind of influence that ultimately the stakeholders expect and deserve.

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

DR. BERENSON: Thank you.

[Applause and standing ovation.]

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

DR. TERRELL: So moved.

DR. TERRELL: Second?

UNIDENTIFIED SPEAKER: Second.
CHAIR BAILET: All right. We are adjourned.

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