



THE UNIVERSITY OF  
**CHICAGO**  
MEDICINE

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DEPARTMENT OF MEDICINE

*Section of Hospital Medicine*

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May 25, 2018

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

**Re: Preliminary Review Team Questions Pertaining to The Comprehensive Care Physician Payment Model (CCP-PM)**

Dear Committee Members:

Thank you for your thorough review of our proposed Physician-Focused Payment Model, *The Comprehensive Care Physician Model (CCP-PM)*. Enclosed, please find our responses to the committee's questions.

We look forward to further discussing our proposal by phone in the near future.

Sincerely,

David O. Meltzer, MD, PhD  
Chief, Section of Hospital Medicine  
University of Chicago Medicine

- 1. Page 5 of the proposal states, “We expect that the vast majority of physicians participating in the CCP-PM would be general internal medicine physicians, hospitalists or family practitioners...” The PRT would like to better understand how this model would work for different types of physicians, particularly those that are in different business arrangements (private practice, employed, affiliated). Please describe how the model would change the patient volume and workflow of a hospitalist. How would the model change the patient volume and workflow of a community-based primary care doctor in a typical fee-for-service environment? It would be useful to describe a typical day or week for each.**

We expect that CCP physicians would spend all or the majority of each weekday morning caring for their own patients in the hospital and spend the weekday afternoons in clinic. In the University of Chicago (UC) CCP program, CCP clinicians see up to five patients in the morning before clinic in the afternoon. This is about half of the patients seen by a typical University of Chicago hospitalist. Some CCP physicians may also provide hospital care for some patients in the hospital who are not their primary care patients if their inpatient volume of their own patients leaves them capacity to care for more patients in the mornings. In some settings, CCPs might rotate with other CCPs serving as the “hospitalist” for their colleagues, covering the inpatient service in the weekday afternoons when their colleagues are in clinic and covering for their colleagues when they are off on the weekend. At UC, the 5 CCPs rotate in this role 1 in 5 weeks.

For CCPs who may previously have been hospitalists, adopting a CCP practice model would change their workflow by having them work in the hospital more days of their year, but fewer hours each day and with a lower census of patients. For CCPs who were previously primary care physicians, adopting a CCP practice model would mean reducing clinic hours in the morning so they can work in the hospital and gradually transitioning their practice towards patients at increased risk of hospitalization by facilitating their lower acuity patients in getting care from providers who are not practicing as a CCP.

From the perspective of a hospitalist, inpatient volumes would decrease to allow a clinician to round on his or her hospitalized patients in the morning while still having sufficient time for an outpatient clinic session in the afternoon.

We also do not necessarily anticipate the workflow of a participating clinician to vary dramatically with regard to overall business arrangement (private practice, employed, affiliated). What is likely to vary within these models is the structure for off-hours coverage. At the University of Chicago and many other academic medical centers, off-hours coverage (afternoons, nights, weekends) is typically provided by a covering physician (i.e., a hospitalist working overnight). Specifically, in the University of Chicago model, a participating physician’s patients are covered by another member of the Comprehensive Care Physician group in the afternoons and on weekends. Overnight coverage is provided by other hospitalists working at night. In community settings, it is more common for physicians to cover their patients independently 24/7. We anticipate that the CCP-PM could apply in either practice setting.

We have also designed the CCP-PM to work across different business arrangements from an economic perspective. Regardless of whether physicians are directly receiving care continuity fees (as in the case of private practice physicians) or the fees are going to a larger organization (as in the case of employed physicians), the same incentives will be in place to encourage continuity across inpatient and outpatient practice settings, as we would expect employed physicians participating in the CCP-PM to have incentive plans based on meeting CCP-PM criteria.

2. **Page 3 of the proposal states, “Physician participants would include any primary care physician who (1) opts into the CCP-PM, (2) is willing to provide inpatient and outpatient care for patients enrolled in his/her CCP-PM panel, and (3) receives CMS approval to participate.” Please provide additional detail on how the physician enrollment and patient empanelment processes would work. Include a proposed description of the CMS approval process (e.g., any criteria for approval).**

First, with regard to the physician enrollment and patient empanelment process, we propose that physicians enroll in the CCP-PM at the beginning of any month of the year by signing a contract with CMS. We defer to CMS with regard to the technical logistics of the contract process and assume that it will parallel those of other alternative payment models. After physician enrollment, physicians or their representative would enroll eligible patients by submitting an agreement signed by both the participating patient or his / her proxy and the participating physician or his / her proxy. This agreement would specify that the patient would like to receive his or her inpatient and outpatient general medical care from the participating provider.

Second, regarding CMS approval of participants, this condition was included to provide CMS a mechanism to limit the number of CCP-PM participants, especially during a pilot period. If CMS chooses to limit the number of CCP-PM participants during such a trial period, criteria for inclusion could include submission of a practice plan to CMS detailing how the physician would adapt his or her practice to utilize the CCP-PM. Priority might also be given to programs that propose a rigorous plan to evaluate the model. CMS might also consider prioritizing proposals that demonstrate clinician experience caring for patients in both the inpatient and outpatient setting (i.e., prior Medicare billing for both types of encounters), or the number of eligible patients (i.e., number of patient hospitalized within the prior year) for providers with a current patient panel,

3. **Do you have a sense of how many physicians and patients might be eligible as well as interested in participating? The proposal identifies a potentially large addressable market, but it is not clear what the numbers of physicians might be and where they might be drawn from. Are there barriers to recruitment of physicians or patients?**

First, with regard to physician eligibility, as noted in our proposal, we estimate that 10% of the Medicare population would qualify as at increased risk of hospitalization. Given traditional Medicare’s covered population of 38.3 million people, we would expect about 3.83 million eligible patient participants nationally at full scale. Assuming that a participating physician’s panel includes an average of 200 patients, up to 19,150 clinicians could participate if the model were expanded to full scale nationally.

According to Agency for Healthcare Research and Quality (AHRQ) data, in 2010 there were 209,000 practicing primary care physicians in the United States.<sup>1</sup> In addition to the estimate of 50,000 hospitalists in 2016,<sup>2</sup> we anticipate that over 250,000 clinicians could be eligible to participate in the model.

However, for an initial Medicare pilot of the CCP-PM, we propose including a much smaller number of physicians. Specifically, we suggest a pilot of up to 22 sites including up to 10 physicians at each site.

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<sup>1</sup> <https://www.ahrq.gov/research/findings/factsheets/primary/pcwork1/index.html>

<sup>2</sup> Wachter RM. Zero to 50,000 – The 20th Anniversary of the Hospital. NEJM. September 15, 2016; 375:1009–1011.

Given our experience, we would more likely expect an average of five physicians at each site for a total of about 100 physicians.

Regarding clinician interest in participation, many organizations from across the country have expressed significant interest in developing CCP-like programs, and we anticipate interest increasing as more data becomes available regarding the model's success. It is unclear whether the small incentive proposed in the CCP-PM will be enough to encourage even more practice model evolution. Accordingly, we hope to test the efficacy of the CCP-PM incentive through the proposed pilot.

With regard to patient recruitment, we have found the CCP model to be highly attractive to patients, especially those who are frequently hospitalized.

- 4. Page 13 of the proposal states, “To be eligible for the program, patients must have been hospitalized (either for observation or for a full inpatient stay) at least once in the 12 months before enrollment...” Does this include all admissions (including scheduled admission stays) or just urgent admissions?**

In the University of Chicago pilot of the CCP model, we have included all admissions. Even scheduled admissions denote significant medical risk of future hospitalizations. Because the cost of the model is so low, we allow for less restrictive inclusion criteria. Furthermore, the limited panel size of the CCP-PM is designed to encourage providers to focus on including patients with the greatest need, and thus the highest potential for shared savings.

- 5. The PRT is interested in better understanding the rationale for capping patient enrollment in a participating physician’s panel at 300 patients. Is this cap unique to the Chicago practice area?**

The rationale for capping physician panels at 300 patients is to focus payment model participation and expenditure on patients most likely to benefit from it, specifically those most likely to be hospitalized.

For the the CCP model to be economically sustainable and justify physicians setting aside time each morning to round on patients admitted to the hospital, a physician needs a panel of enough high risk patients. In the UC CCP program, physicians care for a panel of approximately 200 high-risk patients. Given the complexity of these patients, our physicians typically have 2-5 patients admitted to the hospital on whom they round in the morning and full clinic sessions in the afternoon. Once that threshold is reached, one could imagine gaming the system by adding low-risk patients who need infrequent medical care. We propose a cap to avoid this problem. We chose to expand the patient cap to 300 patients to enable both practice-level flexibility as well as transition of practice panels from patients at average risk of hospitalization to those at high risk of hospitalization.

- 6. Please provide additional detail on how the participating physician will interact with other specialists and clinicians relevant to the patient’s care both in and out of the hospital.**

We envision participating physicians interacting with specialists using similar structures to current practice, i.e., inpatient and outpatient consultation and specialty visits. We do, however, believe that the model of care incentivized by the CCP-PM will lead to more effective and judicious integration of specialty feedback. Given that the comprehensive care physician model facilitates seamless transfer of information between the inpatient and outpatient settings, an outpatient specialists’s perspective can be more effectively integrated into inpatient management of a patient. Similarly, an inpatient specialist’s

perspective can be more effectively integrated into outpatient management of a patient. We would expect that such integration would reduce both duplicative consultation (inpatient and outpatient) and duplicative testing. It is also expected that specialty workup started during an inpatient stay could be more easily transitioned to the outpatient setting given increased provider continuity.

In addition to the interaction described above, we also envision some program participants developing panels focused on a particular specialty. For example, we believe that this model could work quite well for oncology patients. In this case, it is likely that participating physicians would develop especially strong relationships with collaborating specialists. We also do not exclude the possibility of specialists participating in the CCP-PM directly. For example, we could imagine a model where a nephrologist takes care of ESRD patients at increased risk of hospitalization in the clinic, at a dialysis center, and in the hospital.

**7. How would this model relate to the high-risk care coordination programs that some hospitals have already deployed?**

Like many other medical centers, the University of Chicago has also started a high-risk care coordination program. In developing the CCP-PM, we have worked closely with Raj Krishnamorthy our Chief Clinical Transformation Officer who is helping the University of Chicago implement a care coordination model based on Tim Ferris' work at Partners as part of the Pioneer ACO. We view the CCP-PM and the practice model it supports as an adjunct to such programs. While traditional care coordination programs require a significant resource investment, the CCP model is relatively inexpensive and has let the University of Chicago extend dedicated services to a larger group of patients at increased risk of hospitalization. In addition, the University is currently studying the relative benefits of the CCP model compared to traditional care coordination; in some instances we are planning to compare traditional care coordination to CCP and in others we are planning to assess whether the addition of CCP to a care coordination model affects outcomes and reduces the costs of traditional care coordination

**8. The proposal describes the model as an “add-on’ PFPM overlaid on existing payment models.” Does this mean that the PFPM is not intended to satisfy the requirements for an Advanced APM?**

We believe that the the CCP-PM will satisfy the three major requirements of an Advanced APM. First, the CCP-PM requires participants to bear the risk of more than nominal financial losses from both fines and the risk of practice restructuring. Second, the requirements of the underlying payment model would meet the Advanced APM criteria of quality metrics consistent with the Merit-Based Incentive Program (MIPS). To ensure that these requirements are met, we would support additional specification from Medicare regarding which payment models the CCP-PM could be coupled with to qualify as an Advanced APM. Third, we would support a requirement to use certified electronic health record technology (CEHRT) as a requirement of the CCP-PM.

**9. Could the proposed care model be supported using existing codes for chronic care management services or transitional care management services?**

Although chronic care management and transitional care management codes do support transitions of care from the inpatient to outpatient setting, they do not support the provider continuity between

inpatient and outpatient care that we have found to be critical to the success of the CCP model.<sup>3</sup> Both chronic care management and transitional care management codes are only billed in the outpatient setting and do not facilitate provider continuity across both settings.

For patients at the highest risk of hospitalization, we would encourage CMS to support both the activities promoted by chronic care management services codes, transitional care management services codes, and the CCP-PM. Both chronic care management services and transitional care management services are billed by many traditional primary care groups. The CCP-PM is designed to promote the development of a different model of care.

- 10. On page 8, the proposal states, “We propose that the CCP-PM offers its care continuity fees only when patients are empaneled on the panel of a physician who has structured their care to be able to care for that patient in clinic and in the hospital. The empanelment process itself is therefore a structural measure of quality.” Please further describe this measure and the structural changes that would need to take place to meet it.**

Prospectively empaneling a set of patients serves a structural measure of care, because it requires a mutually agreed upon 1:1 relationship between a participating physician and a participating patient and organizes care around this relationship. Without this defined relationship, the care continuity fee proposed by the CCP-PM cannot be billed. If a patient or physician leaves the program, the care continuity fee cannot be billed until a new relationship is established.

With regard to structural changes required, by empaneling a set of patients, participating physicians are committing to structuring their practices such that they can care for the patients in both the inpatient and outpatient settings. For outpatient clinicians, the structural implication is that they would block time from clinic schedules to enable rounding in the hospital. For inpatient clinicians, the structural implication is that they would manage fewer patients in the hospital to facilitate time to open a clinic.

- 11. On page 8, the proposal states, “we propose that the CCP-PM condition the care continuity fees based on reaching established benchmarks for the percentage of inpatient and outpatient general medical care provided by the participating clinician,” and on page 12, the proposal indicates that this will be calculated using “the total number of patient-days of inpatient care...provided by participating physicians...divided by the total number of patient-days of inpatient care.” Please describe further whether this will be determined by claims or other encounter data and whether any level of contact/management of the patient will count toward the numerator.**

We propose that this percentage be calculated based on verified claims data for billable encounters using the billing codes referenced in Appendix B: Calculation of Inpatient and Outpatient Care of the proposal.

- 12. On page 8, the proposal states, “within the CCP-PM, we propose that quality measures be established specific to the model with respect to the structure and process of care, and that outcome measures within the CCP-PM be limited, restricted to measures incorporated within current payment models to allow for increased flexibility, simplicity and ease of implementation,**

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<sup>3</sup> Tingley K. Trying to Put a Value on the Doctor-Patient Relationship. The New York Times. May 16, 2018. <https://www.nytimes.com/interactive/2018/05/16/magazine/health-issue-reinvention-of-primary-care-delivery.html>

**and to avoid distorting incentives established by other payment models.” Did you consider adding measures specific to hospital care? If so, did you not include them because you expect them to be part of the payment models that the CCP-PM is added onto?**

In developing the CCP-PM, we spent significant time debating whether to specify outcome metrics specific to the program. Our eventual decision to exclude such measures was based on three key issues. First and most significantly, risk adjusting quality metrics for high risk populations poses significant challenges. We did not want to propose metrics that were not adequately risk adjusted and could be manipulated or distort behavior in unintended ways. As Medicare continues to develop risk adjusted quality metrics for patients at high risk of hospitalization, we would welcome the inclusion of such metrics as part of the CCP-PM. We believe that the CCP-PM is most likely to positively impact risk adjusted measures of cost of care and patient experience.

Second, we did not feel as though any of the metrics available in MIPS were more likely to be impacted by the CCP-PM than others thereby warranting a specific focus. With regard to hospital-based measures, we reviewed the following MIPS measures attributed to hospitalists on CMS’ quality payment program website:<sup>4</sup>

- Appropriate Treatment of Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteremia
- Care Plan
- Closing the Referral Loop: Receipt of Specialist Report
- Documentation of Current Medications in the Medical Record
- Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
- Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy
- Tobacco Use and Help with Quitting Among Adolescents

With the exception of the metric of documentation of a care plan, we did not think that the CCP-PM would significantly impact a specific set of metrics more than others, so opted not to recommend inclusion of a specific set of MIPS measures. Were we to recommend any MIPS measure be required, it would be the documentation of a care plan.

However, third, as you note above, we expect that most relevant quality metrics will already be incorporated into baseline payment models. We did not want to increase the reporting burden on organizations by adding additional metrics or distort incentives by penalizing or rewarding providers twice for the same metric.

**13. Page 14 of the proposal states, “Patients may be enrolled as a ‘continued enrollee’ with the same provider after two years for additional two year periods if they have not been hospitalized during that two-year period.” What happens to these continued enrollee patients after that two year**

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<sup>4</sup> <https://qpp.cms.gov/mips/quality-measures>

**continuation period is up if they have not been hospitalized? Would they continue to see the same physician?**

The intent of the CCP-PM model is that patients continue to receive care from the same physician. The low cost of the model facilitates this possibility. To promote long-term continuity of care, patients may continue to be re-enrolled in the CCP-PM as continued enrollees indefinitely. Given the significant mortality rate of patients at high risk of hospitalization, we do not believe that allowing patients whose acuity decreases to remain in the program does not significantly prohibit access for new patients to enter.

**14. How would the model counteract incentives to admit patients to the hospital inappropriately? And alternatively, if a practice or entity is successful at decreasing hospitalizations over time, what incentives exist to continue to stay in the model (what would mitigate against a potential practice enrolling one year, then disenrolling the next, then enrolling again)?**

We believe that there are multiple reasons to expect that the CCP-PM would not incentivize inappropriate hospitalization. First, many expected participants in the CCP-PM would also be part of larger ACO-type payment models. For these clinicians, any gain in revenue from care continuity fees would be significantly outweighed by reductions in or eligibility for shared savings. If CMS is particularly concerned about such gaming, the CCP-PM could be limited to physicians participating in an ACO, but we would advocate for a less restrictive approach to increase access to the model.

Second, the CCP-PM was specifically designed to prevent the possibility of gaming through overutilization. We deliberately chose to structure the CCP-PM to incorporate a stand-alone care continuity fee rather than a supplement to current inpatient or outpatient charges to minimize any incentives for overutilization of a particular service. To game the model through over-hospitalization as asked above, a physician would first have to know that he or she was at risk of falling below the inpatient care continuity threshold. He or she would then hospitalize and bill for patients to improve his or her ratio. It is unlikely that a physician would have such information in real-time and be able to improve his or her ratio dramatically through such gaming. Furthermore, the strong relationships between patients and the physicians that care for them fostered by CCP-like models is thought to further reduce the impact of any perverse incentives.

It is also unlikely that practices would find it economically beneficial to come in and out of the program. If a practice were successful at reducing hospitalization for a particular patient such that the patient was only eligible for the continued enrollee fee, it would not benefit the practice economically to leave the program then return, as the patient would not be eligible for any care continuity fee given that he or she had not been hospitalized in the prior year. We further discourage enrollment and disenrollment by barring physicians who disenroll from the CCP-PM from re-entering the program for 12 months.

**15. The proposal indicates that the CCP model was developed as part of a randomized control trial, which the PRT understands was part of the Health Care Innovation Awards (HCIA) Round One. There seem to be some changes between what is proposed and what was done as part of the HCIA project (e.g., patient eligibility criteria). The PRT is interested in better understanding any major changes and the rationale behind them.**

In developing the CCP model for the Health Care Innovation Awards (HCIA) Round One program, we found that the most significant predictor of hospitalization in an upcoming year was hospitalization in the year prior. As such, we propose this single criteria for participation in the the CCP-PM. As part of



the HCIA project, we also enrolled patients who presented to the emergency room for care as well as via referral from primary care physicians. We chose to exclude these patient eligibility criteria given their more subjective nature and lack of data-driven evidence. We would, however, welcome the inclusion of any additional criteria CMS might propose as indicating a high likelihood of future hospitalization.

**16. Page 8 of the proposal states, “CCP patients compared to control patients and hospitalizations are 15-20% lower, corresponding to savings of about \$3,000/patient/year...” Can you please provide more details on how you arrived at that savings amount? Do these savings take into account added costs of the model, i.e., the HCIA award amount or proposed care continuity fees?**

These numbers were based on a randomized controlled trial at the University of Chicago comparing the CCP model to standard care. Preliminary results of this trial will be presented at AcademyHealth in June 2018. The abstract to be presented detailing our methodology is available via the following link:

<https://academyhealth.confex.com/academyhealth/2018arm/meetingapp.cgi/Paper/23609>

As noted in Appendix A: Actuarial Impact of the CCP-PM, the savings per patient are described prior to the care continuity fees. Assuming an average care continuity fee of \$25 / month (assumes half of panel is new or renewed enrollees and half of panel is continued enrollees), average savings to Medicare in the context of a traditional fee for service agreement would be \$2,700/patient/year. Please see the appendix for more detailed modeling of the actuarial impact of the CCP-PM under the MSSP Track 1+ ACO payment model.

The savings and reduced hospitalization rates are based on a comparison of the intervention and control arm of patients enrolled in the HCIA study. Given that HCIA funding would not be provided as part of the CCP-PM, the costs associated with the study were not incorporated into the savings calculation.



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July 17, 2018

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

**Re: Preliminary Review Team Questions Pertaining to The Comprehensive Care Physician Payment Model (CCP-PM)**

Dear Committee Members:

Thank you for your continued review of our proposed Physician-Focused Payment Model, *The Comprehensive Care Physician Model (CCP-PM)*. Enclosed, please find our responses to the committee's additional questions.

Please do not hesitate to reach out if further questions arise.

Sincerely,

David O. Meltzer, MD, PhD  
Chief, Section of Hospital Medicine  
University of Chicago Medicine

- 1. Page 12 of the proposal indicates that participating physicians will be subject to a penalty based on the following: 1) the percent provision of inpatient care for their panel of enrolled patients falls below 25%, 2) the percent provision of outpatient general medical care for their panel of enrolled patients falls below 33%. Do both conditions need to be met or only one for participating physicians to be subject to a penalty? For example, if the percent provision of inpatient care is more than 25% but the percent provision of outpatient general medical care is below 33%, would a participating physician be subject to a penalty?**

In order to most strongly incentivize a commitment to both inpatient and outpatient care continuity, physicians participating in the CCP-PM would be subject to a penalty if either of the above conditions are met. Conversely, both fee conditions would need to be met in order for a clinician to earn the proposed care continuity fee.

- 2. Would telemedicine services count toward the percent provision of care calculations for participating physicians?**

Given that telemedicine services are not currently billable, and, therefore, not easily trackable using current systems, they would not count toward the percent provision of care calculations for participating physicians. When and if telemedicine services become billable and trackable, we would strongly support their inclusion in the calculation of outpatient percent provision of care. Furthermore, if Medicare were to propose a way to easily track telemedicine visits using current systems, we would certainly support their inclusion at the outset. The strong longitudinal relationship between CCP clinicians and their patients would make this population highly appropriate for telemedicine intervention. Even without including these visits in the calculation of care figures, we would not be surprised if significant telemedicine innovation take places under the CCP-PM given the strength of the doctor-patient relationship fostered by the model.

- 3. Under the proposed model, how would participating physicians coordinate care with other specialists?**

As discussed in question 6 of the PRT's initial set of follow-up questions, participating clinicians would coordinate care with other specialists using similar consultative interactions as those currently taking place.

With respect to the number of consultations, we expect that the most frequent forms of consultation will be requests by the CCP for consultation by a specialists on an outpatient basis and when the patient is hospitalized under the care of the CCP. We do not have a strong reason to believe that these consultations will be dramatically different for CCP vs. non-CCP care.

Given the increased physical presence of CCPs in the inpatient setting, we do expect that CCPs would be more likely to consult on their patients when they are hospitalized and receiving care on a specialty service. We believe that this sort of consultation will promote continuity of care and facilitate the patient's transition to the outpatient setting. Since participating physicians will already be spending mornings in the hospital caring for patients directly, spending time consulting on their patients who may be on specialty services would not pose a significant burden and be much more likely to occur than in a traditional model. We considered explicitly incentivizing these consultations by including standards for their rate as a condition of receipt of the care coordination payment, but chose not to do so for several reasons. First, this is not under direct control of the CCP or the patient. Second, both the CCP and the patient are already motivated to have this sort of consultation occur as part of their ongoing relationship

and the added professional fees for this consultation, especially given the CCP's presence in the hospital. Third, there is the potential to drive unnecessary consultation, especially over the course of a hospitalization, as daily visits by the CCP may not be needed when the patient is receiving care on a specialty service. Despite these reasons for not incentivizing these consultations, we would be open to developing a specific incentive for this sort of consultation if desired by CMS.

In addition to effects on the number of consultations with or by specialists, we also think it is important to consider the effects of the CCP model on the strength of CCP- specialist relationships. Given the engagement of the CCP physicians in the inpatient and outpatient settings, we would also expect PCP- specialist relationships to be stronger than those that currently exist, as participating physicians would be able to coordinate with specialists throughout the continuum of care. We think this may be yet another reason why specialists would tend to consult CCPs in the inpatient setting when needed, and why specific incentives for specialists to consult CCPs may not be needed. At the University of Chicago, multiple specialty groups have approached the CCP program asking to partner and enroll their patients at high risk of hospitalization. This suggests that the longitudinal relationship supported by the CCP-PM provides significant value from the specialist perspective as well.

PHYSICIAN-FOCUSED PAYMENT MODEL  
TECHNICAL ADVISORY COMMITTEE (PTAC)

PRELIMINARY REVIEW TEAM (PRT)

CONFERENCE CALL WITH  
UNIVERSITY OF CHICAGO MEDICINE  
COMPREHENSIVE CARE PHYSICIAN PAYMENT MODEL (CCP-PM)

Tuesday, May 29, 2018

11:00 a.m.

PRESENT:

KAVITA PATEL, MD, PTAC Committee Member  
PAUL CASALE, MD, MPH, PTAC Committee Member  
TIM FERRIS, MD, PTAC Committee Member

SARAH SELENICH, Assistant Secretary for Planning  
and Evaluation (ASPE)  
SALLY C. STEARNS, PhD, ASPE  
ANJALI JAIN, MD, Social & Scientific Systems (SSS)

DAVID O. MELTZER, MD, PhD, Chief of the Section of  
Hospital Medicine, University of Chicago Medicine  
EMILY PERISH, Director, Operations and Business  
Development, University of Chicago Medicine  
ANDREW SCHRAM, MD, Assistant Professor of Medicine,  
Department of Medicine, University of Chicago Medicine

## P R O C E E D I N G S

[11:02 a.m.]

DR. PATEL: David, hi. It's Kavita Patel.

So I think let me -- let me just for the sake -- I think you know everybody, but for the sake of the recorder and knowing kind of what our roles are, let's just do a brief round of introductions.

So I'll start, and then I'll have -- I'm pretty confident you know Tim Ferris and Paul Casale, my co-PRT leads. But I'm Kavita Patel, and I am a fellow at the Brookings Institution and also work at Johns Hopkins as a primary care internist. And I have the distinct pleasure of chairing this Preliminary Review Team committee.

DR. MELTZER: Great.

DR. PATEL: Tim?

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

DR. MELTZER: Hey.

DR. PATEL: Tim, are you on? I heard Tim, right?

[No response.]

1 DR. PATEL: Oh. Sarah, was Tim on?

2 MS. SELENICH: Yeah, I thought so.

3 DR. FERRIS: Yes.

4 MS. SELENICH: Hey, Tim.

5 DR. PATEL: Oh. Hey, Tim, we're just  
6 doing intros. Do you want to -- I know you know  
7 David, but just to do a -- just for documentation,  
8 do an intro, and then we'll move on to the rest of  
9 the ASPE team.

10 DR. FERRIS: Tim Ferris, CEO of the Mass  
11 General Physicians Organization.

12 Hi David.

13 DR. MELTZER: Hey. Greetings.

14 MS. SELENICH: Okay. And then I'm Sarah  
15 Selenich, and I am the ASPE, Assistant Secretary  
16 for Planning and Evaluation, staff member  
17 supporting this Preliminary Review Team.

18 DR. STEARNS: And I'm Sally Stearns. My  
19 usual position is in the -- as a professor in the  
20 Department of Health Policy and Management at  
21 University of North Carolina-Chapel Hill, but I'm  
22 spending some time at ASPE on an IPA, an  
23 Interagency Personnel Agreement, and working with  
24 the PTAC staff.

25 MS. SELENICH: And then Mary Ellen has not

1 -- hasn't joined us yet.

2           Anjali, did you want to introduce  
3 yourself?

4           DR. JAIN: Sure. I'm Anjali Jain, and I  
5 know you too, David. Hi. And I'm at Social &  
6 Scientific Systems, and we're the contractor  
7 supporting this project.

8           DR. PATEL: And then, David, you've got  
9 some people on your team. Did you want to  
10 introduce anybody? I think I saw Emily's name on  
11 this --

12           DR. MELTZER: Yeah, yeah. And Andrew.

13           DR. PATEL: -- proposal, but --

14           DR. MELTZER: Should -- I'll take -- I'm  
15 David Meltzer, a general internist, economist,  
16 Chief of Hospital Medicine at UofC.

17           And, Andrew and Emily, in which ever order  
18 you like?

19           DR. SCHRAM: I'm Andrew Schram, assistant  
20 professor of Medicine at University of Chicago. I  
21 am a hospitalist, and I am helping to further build  
22 out the CCP program.

23           MS. PERISH: And I'm Emily Perish. I'm  
24 the director of Operations and Business Development  
25 with CCP program.



1 DR. PATEL: Okay, great. Thanks,  
2 everyone. And this is Kavita.

3 We've got a little bit of awkwardness in  
4 the conversation in that we -- each person who is  
5 talking should just say their name for the sake of  
6 our recorder who doesn't know all of us and our  
7 voices just yet.

8 So I'll go ahead and kick off with  
9 thanking David, you and Emily -- the whole team,  
10 actually, for turning around our questions so  
11 quickly and so thoughtfully. So thanks for that,  
12 and we're really excited to kind of dive in.

13 I do -- I do think that a number of us,  
14 probably all three of us on the PRT -- it's rather  
15 unique in that I think we've interacted in some  
16 form or fashion with the idea behind your model at  
17 some point in our careers. So it's great to see it  
18 all in one place.

19 I'll go ahead, and I'll say that I had in  
20 my mind, after reading through your responses,  
21 which were very helpful, by the way -- one thing I  
22 still came away with was understanding a little bit  
23 more about -- I'll call it accountability, David,  
24 and actually for all three of you, just -- so I'll  
25 personally want to dive in a little bit more, and

1 I'm framing accountability as having some  
2 understanding.

3           It might be these process measures you're  
4 discussing. It might be the actual structure that  
5 kind of a CCP-PM physician or clinician would do to  
6 kind of take care of patients in the mornings, but  
7 I'm looking to kind of think through how does this  
8 model really reflect a difference from the fee  
9 schedule that's currently in existence that can  
10 also be aligned with -- and you saw our questions  
11 are on quality measures. That's one way to achieve  
12 alignment. Another can be through the enrollment  
13 process you discussed, et cetera.

14           So let me stop there because I think -- I  
15 know Tim and Paul might also have some clarifying  
16 questions, but we didn't want to have you just walk  
17 through what you wrote. I just more wanted to  
18 verbalize things that I was still left questioning  
19 even after I read the responses.

20           So, Tim or Paul, any thoughts?

21           DR. FERRIS: This is Tim.

22           I think just I'm interested in that same  
23 line of thinking, and I'm -- I guess one way, a  
24 different way to articulate your question, Kavita,  
25 would be to say in addition to sort of how the

1 finance -- well, I guess a clinical care model in  
2 response to the questions, which I also found very  
3 helpful, but I'm still thinking about, for example,  
4 the intersection between a financial model and a  
5 clinical model that allows for different types of  
6 structural setups.

7           And because it's specific and I'm familiar  
8 with it, for example, we have for a decade now had  
9 a program here where -- where at MGH -- where we  
10 take our sickest, most complex patients and put  
11 them in a sort of standard primary care-based care  
12 management program, and then the sickest of the  
13 sick go into a program where like in your program  
14 they are managed both as inpatients and as  
15 outpatients by the same people in order to create  
16 that continuity.

17           DR. MELTZER: Wow.

18           DR. FERRIS: But they -- but they -- it's  
19 not -- it's not actually hospitalists who are doing  
20 it. It's sort of PCPs who also spend a lot of time  
21 on inpatient medicine, and you can break this up  
22 lots of different ways. But because they're doing  
23 the ambulatory and primary care -- and we pay for  
24 all of this using a -- the standard billable  
25 things.

1           Like in the fee-for-service system, they  
2 bill as outpatients and they bill as inpatients,  
3 and so that's just -- I think, if I'm correct, it's  
4 just highlighting Kavita's question but giving it a  
5 little bit more specificity possibly.

6           DR. MELTZER: Okay, okay. Good.

7           DR. PATEL: Paul, any top-of-mind, just  
8 themes or questions? And we can -- certainly, all  
9 three of us can follow up with more with David and  
10 his team.

11           DR. CASALE: Yeah. I think starting with  
12 -- starting with what you've outlined would be a  
13 great start, and then, you know, we can go from  
14 there. Thanks.

15           DR. PATEL: Okay, great.

16           DR. MELTZER: Okay. Okay, good. And  
17 we've got an hour, right? So just to frame how  
18 much time we have to talk --

19           DR. PATEL: Yeah.

20           DR. MELTZER: -- so we can make sure we  
21 get through everything.

22           So let me take the first shot, and others  
23 can add. I mean, this will just be a conversation,  
24 obviously.

25           So let me start with Kavita's question

1 about kind of accountability. I tried to get this  
2 through a little better in the revisions than I  
3 think it came through in the proposal, but I really  
4 want to emphasize that I think on the ground, the  
5 true measure of accountability in this program is  
6 really to the patient themselves. And it happens by  
7 virtue of the fact that the doctors and the  
8 patients are interacting again and again and again  
9 in the inpatient setting and in the outpatient  
10 setting, and it creates these bonds between the  
11 patients and the doctors, between the doctors among  
12 the doctors in the team, between the doctors and  
13 the staff. That really forces you to address the  
14 patient where they are, to try to understand their  
15 needs, to try to do everything in your power to try  
16 to make them better.

17           And I think it's manifest in a very strong  
18 relationship between the doctor and the patient and  
19 in very good care ratings. It's manifest in sort  
20 of, you know, good health outcomes for the patient,  
21 and it's manifest in decreased utilization for  
22 unnecessary hospitalizations and things like that.

23           Not all of those things are -- some of  
24 those things are already measured in a number of  
25 the advanced alternative payment models. Some of

1 them, like the quality of relationship with the  
2 physician, probably could be better measured even  
3 in some of those, those models, but on the ground,  
4 that's what's really happening.

5           And in that sense, we wanted not to sort  
6 of privilege one little measure or one particular  
7 measure because we think it's the flexibility of  
8 the whole bundle that really captures things, and  
9 that it's a direct outcome of the process.

10           So we sort of privileged process measures  
11 around this, bridging the inpatient and outpatient  
12 side of things, but we also left open that plans  
13 could choose any measure that added on top or was  
14 consistent with their current payment models.

15           So, you know, we thought about adding more  
16 things, like the relationship between the doctor  
17 and the patient and having that be measured. In  
18 some of our research, we measure even more subtle  
19 things like goal attainment, but we didn't want to  
20 put a burden on those people potentially adopting  
21 this that would generate the need for a new  
22 separate data collection. And that was our -- that  
23 was our challenge.

24           I mean, I know how hard CMS and CMMI are  
25 always working on developing new measures of

1 quality of care, and, you know, that work is  
2 continuing because it is challenging. But these  
3 are the things I think that we really believed, you  
4 know, best captured within the set of measures that  
5 are out there and warrant new data collection, the  
6 things that reflect the core element of the model.

7           Maybe we could stop there and let Andrew  
8 and Emily comment too -- they probably have things  
9 to add -- then discuss this and then turn to Tim's  
10 question maybe about sort of, you know, the  
11 continuity and need for special payments for this.

12           I don't know. Andrew? Emily?

13           DR. SCHRAM: I think the other thing that  
14 we were really thinking through as we were trying  
15 to -- this is Andrew. The other thing we were  
16 trying to figure out as we tried to think about  
17 what metrics might fit was the notion of risk-  
18 adjusting metrics for such a complex patient  
19 population and really wanting to make sure that if  
20 we select particular metrics that those truly are  
21 risk-adjusted, especially around the things like  
22 cost.

23           We found that the model saves money, but  
24 trying to prove that each individual situation and  
25 circumstance without adequate risk adjustment, we

1 thought would be quite challenging.

2 DR. MELTZER: And, Emily?

3 MS. PERISH: I think that covers -- yeah.

4 DR. MELTZER: Yeah. I mean, just does  
5 that help? I mean, we'd love advice, I mean, if  
6 there are ideas that you have that could help us  
7 think about this.

8 What we know is that the patients love  
9 being in this model. They really value the  
10 relationship. We have multiple stories of kind of  
11 personal transformation from this, and, you know,  
12 things like a patient experience measure, we think  
13 -- we're pretty confident we're going to be off the  
14 charts on. We think we could hit goal attainment.

15 The issue is we don't want to do something  
16 that, you know, is outside of the easy ability of  
17 programs to collect in an empirically valid way,  
18 and that's why we didn't push on it.

19 And we also sort of I think in the  
20 proposal suggested that, you know, were this to be  
21 approved, there could be approval of specific  
22 programs with specific measures that they thought  
23 were practical and that you approved of.

24 Like in our setting, it would be totally  
25 easy for us to measure patient experience. Like we



1 can do that because we do quarterly surveys. We're  
2 doing evaluation, but our goal was to set something  
3 up that we thought could be used by, you know,  
4 eventually many, many practices all around the  
5 country.

6           Now, maybe in the context of something  
7 like this, which I would view as a pilot of a  
8 payment model, one could require more things and  
9 force more evaluation. In fact, I think I -- we  
10 said somewhere in this, I think in the comments,  
11 that as, you know, one thought about how to expand  
12 this and test it, which sites one would prefer, one  
13 could make a case that early on, one might want to  
14 adopt this in places that have the greatest  
15 stability to do formal evaluation of it. And that  
16 could then go very well with deep quarterly  
17 measures of patient experience, things like that of  
18 goal attainment. Like we would embrace that as  
19 part of a research project.

20           But we were trying to kind of think ahead  
21 in terms of something that would be a true pilot of  
22 a system that then people could adopt in a whole  
23 variety of settings and then would be replicable.

24           So, I mean, you know, one could design a  
25 more intensive monitoring system that we could

1 easily implement in a research context, but I guess  
2 you could also then push back and say, you know, is  
3 that then a generalizable result to try to move it  
4 to other settings.

5           So that's kind of the balance we've been  
6 walking, and again, we'd love your advice.

7           DR. PATEL: This is Kavita.

8           That's helpful, David, and I think we  
9 completely respect that tension of trying that to  
10 over-architect the model without actually having  
11 the proof points, you know, beyond kind of the  
12 scale you've already achieved, which is a great  
13 achievement in and of itself, but trying to do  
14 something at the level of Medicare, even in a  
15 small, you know, geographic region is actually  
16 pretty large, so I --

17           DR. MELTZER: Yeah. We recognize we're  
18 kind of small.

19           DR. PATEL: Right. No, no, no. It's not  
20 a -- it's not a slight. It's just we -- we've been  
21 learning kind of over our years of doing -- this  
22 work has been kind of the issues with scale.

23           And I'll just say something briefly about  
24 the quality metrics. I think some of this  
25 translates into -- I think, Andrew, your comment

1 about risk adjustment about the measures eventually  
2 all translates into potentially, you know, risk  
3 adjusting even the payments, which is already  
4 implemented in certain models.

5 I'm not stating that that's kind of where  
6 everything should go. I think that that's --  
7 people are still struggling with, you know, how  
8 much do we try to also -- how much do we also try  
9 to think through like negative consequences when  
10 certain goals are not achieved. And I think you  
11 all have covered some of that in your submission,  
12 but we wanted to probe a little further.

13 Why don't we turn to Tim's question  
14 because we also kind of touched on something that  
15 our PRT, the three of us -- Paul, Tim, and myself -  
16 - had discussed regarding, you know, how could you  
17 actually take the current physician fee schedule  
18 with its inpatient and outpatient components. You  
19 already responded to kind of the CCM program in  
20 your responses, but I think Tim's question brings  
21 up some of the similar issues regarding kind of  
22 model design and how you think about -- how you  
23 think about this versus the status quo, et cetera.

24 DR. MELTZER: Yeah.

25 DR. FERRIS: Before you get started, David

1 -- Kavita, do you mind if I -- if I just --

2 DR. PATEL: No. Go ahead. Go ahead.

3 DR. FERRIS: Because on this past topic,  
4 the other -- just so you guys understand some of  
5 the things we struggle with, one of the other  
6 things that comes up when we talk about risk-  
7 adjusting quality measures and having standard  
8 quality measures is how rigorous to be about  
9 selection criteria.

10 And in your program in particular, it  
11 strikes me that this is a particularly tricky thing  
12 because, obviously, the more objective you are in  
13 selection criteria, the easier it is to compare  
14 across organizations and sites, the more flexible  
15 you are is potentially allowing for greater -- you  
16 used the word "appropriateness."

17 DR. MELTZER: Yeah, yeah.

18 DR. FERRIS: Clinical appropriateness.

19 But then you -- that's the other pull in the  
20 tension with standardized quality metrics, right?  
21 Because if they are different, if the people who  
22 are in the program have a different mix of reasons  
23 for why they are in the program, then that's what -  
24 - that's what creates the situation where your  
25 quality measures aren't valid.

1 DR. MELTZER: Yeah, yeah.

2 DR. FERRIS: So I'm sure you've talked  
3 about this.

4 DR. MELTZER: Yeah. Yeah, yeah.

5 First of all, let me just interrupt and  
6 say it's such a pleasure and honor to have folks  
7 like all of you giving us such careful comments.  
8 It's just extraordinary.

9 So I think that this issue that you've  
10 highlighted, Tim, is exactly right and really is  
11 particularly critical for this program.

12 So one of the tensions in the program is  
13 that there -- we're trying to select out of the  
14 part we can tell where there's huge heterogeneity,  
15 right? And there are people who may spend \$200,000  
16 a year and \$100,000 and \$50,000 a year, and we're  
17 often selecting them at moments when they're about  
18 to have a huge increase in expenditure rather than  
19 a decrease. And so there's huge heterogeneity.

20 Moreover, it is inherent in the model that  
21 people be able to choose whether they want to be in  
22 this program. We're not pulling anyone away from  
23 their primary care doctor who wants to be there.  
24 We're not forcing anyone into this model. We are  
25 making an offer to people of a model, which we hope

1 they will take, and, you know, how one goes about  
2 finding such people and how one goes about making  
3 the pitch to them to join could incredibly affect  
4 the underlying risk of the people --

5 DR. FERRIS: Right.

6 DR. MELTZER: -- that you have in this  
7 program, and therefore, you know, could  
8 potentially, you know, if you overemphasized the  
9 sort of risk selection part of this, could really  
10 bed a problem.

11 And that was one of the reasons we didn't  
12 want to design this as a sort of standalone shared  
13 sort of savings model. We didn't want to create  
14 selection in or out of this program as opposed to  
15 in or out of any other program.

16 And the same thing sort of, you know,  
17 carries over to quality. Our idea was that, you  
18 know, the primary incentive here is to look at the  
19 pool of people you're already taking risk on, that  
20 you've already engaged with for the most part, and  
21 ask, you know, within those people, can we nudge  
22 them into this model, and can we nudge the health  
23 system into adopting this model that, you know,  
24 based on our studies so far really seems like it --  
25 like it makes a difference.

1           And so we tried to get away from things  
2 that would force us to do a huge amount of kind of  
3 incremental risk adjustment, although there's risk  
4 adjustment already in whatever underlying payment  
5 plan there might be.

6           And when we thought about, you know,  
7 paying people to -- incentivizing providers and  
8 health systems to do this, we thought about the  
9 idea of a small incremental per member per month  
10 payment for committing to see your patients in and  
11 out of the hospital on top of fee-for-service.

12           The reason we, you know, chose it on top  
13 of fee-for-service was that it minimizes the  
14 incentives for risk selection around underlying  
15 risk. So that protects us from this selection  
16 problem that we described already.

17           And the reason we thought the payment  
18 should be as small as it is is that the incremental  
19 cost of running this model, once you're up and  
20 doing it, is fairly small. There's obviously a  
21 setup cost. You have to build up a panel. There's  
22 some variability in volume, which persists, even  
23 once you get set up. There are costs of recruiting  
24 people into the model and things like this.

25           But our estimate was that this would be

1 enough money to nudge some people into doing this  
2 and small enough amount of money that CMS would  
3 more than easily make the money back in terms of  
4 savings.

5           What the payment model that we propose  
6 doesn't do is, per se, create a mechanism for the  
7 provider side or health system side to collect any  
8 shared savings. That is left to the underlying  
9 payment model, and so we like this because we  
10 thought that it sort of integrated with a whole  
11 bunch of other things. And as much as like we  
12 think CCP is super awesome and powerful and going  
13 to change the world and all of that, we recognize  
14 that it's not the only driver of quality or the  
15 only part of an incentive system, and that these  
16 are constantly going to be changing in a whole  
17 variety of ways.

18           And that's why, you know, it took us  
19 actually many months to kind of get to the point of  
20 thinking, "Oh, this add-on is really the way to  
21 go."

22           So, anyway, I hope that helps.

23           DR. FERRIS: Yeah, it does. It does help.  
24 It helps a lot.

25           And by the way, David, I was remiss in



1 starting my comments by not congratulating you on  
2 your -- the New York Times last week, your --

3 DR. MELTZER: Oh. Oh, thanks. Thanks.

4 It's really with a -- it was a great thing, and  
5 it's got -- if you ever get a chance to have Kim  
6 Tingley write a story about something you're  
7 working on, leap on it because she is -- she is  
8 amazing. And she did the kind of journalism you  
9 sort of hear about, but, you know, I guess doesn't  
10 happen like it used to. I mean, she literally was  
11 here for five weeks with us, you know, meeting all  
12 the patients and meeting the team. And I don't  
13 know. I want her to write a book.

14 DR. FERRIS: That's great.

15 Well, by the way, I sent that article to  
16 all of my board members at Mass General.

17 DR. MELTZER: That's great. Oh, that's  
18 wonderful. Well, you know, it was a beautiful  
19 article, and, I mean, it reflects just some things  
20 about strong doctor-patient relationships, which  
21 are, you know, true in so many places and yet also  
22 challenged in so many. And she did a wonderful  
23 job.

24 I should also tell you the article was her  
25 idea. It was -- the way it happened was that she

1 got interested in writing about the doctor-patient  
2 relationship and called folks around the country  
3 who she knew in health policy to see if anyone was  
4 working on this, and she called Ashish Jha. Ashish  
5 knew that we were working on this, and so I have  
6 thanked Ashish profusely for sending her our way.

7 DR. FERRIS: Yeah.

8 So we should turn probably to that, to the  
9 -- to more the financial model question, which  
10 you've already been addressing, but sort of the  
11 intersection with fee-for-service.

12 DR. MELTZER: Mm-hmm.

13 DR. SCHRAM: Yes. I think targeting that  
14 a little bit more specifically, if I'm  
15 understanding your question correctly, one of the  
16 things -- concerns is whether this could -- this  
17 model could play out under the current system and  
18 whether we actually need this add-on payment model.

19 DR. FERRIS: Right, right.

20 DR. SCHRAM: And as you mention, you're  
21 currently doing aspects of this at MGH, and we've  
22 certainly seen other organizations around the  
23 country start to do similar things.

24 But I think the reason that we think the  
25 payment model is so important is to promote the

1 growth of these types of programs.

2 I think there certainly are mechanisms,  
3 especially when organizations are part of ACOs, to  
4 do this on their own, but I think getting here is  
5 something that's a challenge.

6 DR. MELTZER: Yeah.

7 DR. SCHRAM: If you're not nudged, then I  
8 think it's difficult for an organization to realize  
9 that this is something that they need, and it's  
10 certainly very difficult for an organization that's  
11 not part of an ACO to develop such a model.

12 DR. MELTZER: Yeah. And, you know, I want  
13 to just sort of elaborate on that a little bit.  
14 You know, we -- the idea for this, you know, came a  
15 couple of years before we started the program. I  
16 wrote an NBER working paper, you know, that sort of  
17 laid out the idea, and so the idea was out there,  
18 you know, for me. But then it was only when CMMI  
19 came into being and we were fortunate enough to get  
20 one of these first-round Innovation Awards that --  
21 I mean, I remember my dean signing the letter of  
22 support, and I don't think he had any thought that  
23 we'd actually get the award, you know. And then  
24 when he did, he's like, "Okay, great. Let's go."  
25 And so these nudges are just super important.

1           I think now, you know, people have heard  
2 about it, and, you know, we've begun to work with  
3 places, and, you know, it's beginning to happen.  
4 But there are certain setup costs of getting this  
5 thing going, you know.

6           In fact, I just got an email today from  
7 someone from Medical College of Wisconsin basically  
8 asking me how we went from, you know, zero to one,  
9 two to three or four doctors and kind of how to do  
10 it. And there are -- there's no question that in  
11 the first few years, there are setup costs of a  
12 model like this.

13           I've learned a ton about like how to  
14 backfill volume because I run the hospitalist  
15 service, and like there are better and worse ways  
16 to do that. And, you know, of course, we're happy  
17 to share those and work with people to try to do  
18 it.

19           But those added payments really create a  
20 kind of predictable model, and I also think it  
21 keeps people true to the model because, you know,  
22 you need to be disciplined in who you bring in the  
23 practice if it's going to continue to work. And  
24 the payment model was set up to also help it  
25 maintain.

1           I think we alluded to this a little bit in  
2 the -- in the proposal, but we've also been working  
3 most recently with a community hospital, Ingalls,  
4 which is now part of our network.

5           It turns out that Emily has a family  
6 connection there. Her mom is a primary care doctor  
7 there, and her mom, like many of the doctors there,  
8 are still seeing patients in the hospital and in  
9 clinic. But they're finding it harder and harder  
10 to maintain because their inpatient volumes are  
11 low, and so it's hard to block out the morning and  
12 continue to do that.

13           And so, I mean, one of the other things we  
14 really like about this model is that, you know, it  
15 then nudges those folks at the margin to try to  
16 focus on taking some patients who are going to be  
17 more likely to be hospitalized. They can get the  
18 payment, and then that sort of helps them maintain  
19 this model and grow it into one that's even more  
20 impactful by having more patients who would benefit  
21 from the continuity that they can provide in the  
22 inpatient and outpatient setting.

23           So that was also something that we kind of  
24 liked about this model. It seems to us, based on  
25 this experience with Ingalls, where we think we're

1 going to be able to start a CCP program, you know,  
2 as early as sort of late summer this year that  
3 these little nudges can help.

4           And, you know, in our case, you know,  
5 they've got a lot of extra support because, you  
6 know, we're busy writing grants and doing stuff  
7 like that, but we think it's really -- it's really  
8 a useful and important nudge.

9           DR. CASALE: This is Paul. I'm sorry to  
10 interrupt. This is Paul.

11           Just to add just on that scenario of the  
12 smaller community hospital where the primary care  
13 physician is still, you know, seeing some patients,  
14 if you could just -- so I'm just trying to  
15 understand in those smaller community hospitals if  
16 they're -- if they set this up and they are seeing  
17 -- you know, they're getting some payment around  
18 seeing that patient, but then they're back in their  
19 clinic, in these smaller community hospitals, who  
20 is then providing the ongoing hospital care?

21           I mean, I know you said in there that  
22 there would be coverage with hospitalists, et  
23 cetera, but I'm still trying to get a complete  
24 picture of how this works, not so much at the -- at  
25 an academic medical center, but at some of these

1 smaller communities.

2 DR. MELTZER: Yeah. I mean, I think  
3 there's a spectrum of community hospitals and how  
4 they manage things.

5 So Ingalls, which is the hospital we're  
6 working with, has a hospitalist program, and that  
7 hospitalist program is there to provide nighttime  
8 coverage. You know, many hospitals have an  
9 emergency room physician or a house physician or  
10 something like that at night.

11 Hospitals differ in how they handle sort  
12 of care during the day when things arrive.  
13 Typically, if it's a true emergency, there's  
14 someone in-house who can run and see someone, but  
15 there are other times when the primary care doctor  
16 will effectively be providing that care remotely or  
17 a nurse will be providing that care.

18 We're agnostic about which of those models  
19 someone, you know, may have in their hospital. We  
20 do think that over time, if hospitals adopt a model  
21 like this, it becomes natural that the CCPs play  
22 some sort of hybrid hospitalist role and CCP role.

23 So the way it works in our place is that  
24 we have five CCPs, and every morning, they each see  
25 their own patients in the hospital. And then one

1 out of five weeks, each one of them stays through  
2 the afternoon and handles the weekend, so they  
3 become the in-house hospitalist for the afternoon  
4 and for the weekend. And then at night, we have  
5 our usual nighttime coverage.

6 We think that model works incredibly well  
7 for us. We think that in many community hospitals,  
8 they could move towards a model like that.

9 But we didn't want to over-engineer it  
10 because we think that there are lots and lots of  
11 different ways to run this model.

12 We allude to in the proposal briefly also  
13 the idea of a rounder model, a model where you can  
14 have a hospitalist who instead of working sort of  
15 12-hour days for six months a year works a smaller  
16 number of hours but kind of throughout the year,  
17 but they're not the primary care doctor. And that  
18 model doesn't have the advantages of inpatient-  
19 outpatient continuity, but does have the advantages  
20 of continuity on the inpatient side for people who  
21 were repeatedly hospitalized and also for the  
22 primary care doctor to be able to work with the  
23 same inpatient doctor all the time.

24 I mention that because there are hybrid  
25 models where you combine the CCP model with the



1 rounder model, and that can help in hospitals where  
2 it might be hard to get enough volume to work as a  
3 CCP alone on the inpatient side. But if you did  
4 the CCP and rounder model together, you could do  
5 this.

6           And I'm telling you all of this detail  
7 only to explain that we think hospitals differ a  
8 lot in their volumes and environments, and they  
9 even change over time as these practices develop.  
10 And so we've really developed a whole suite of  
11 strategies that we think are complementary and  
12 allow you to make this practical in various  
13 settings.

14           We have an R01 under review right now at  
15 NIH, which is an agent-based simulation model to  
16 sort of illustrate how some of these different  
17 models could be used together to help adapt this to  
18 different practice settings.

19           I hope that helps. It's hard to give you  
20 a single answer because in fact there are many  
21 different practice models that are used for  
22 inpatient coverage. We think we can work with any  
23 of them.

24           DR. PATEL: So, David --

25           DR. CASALE: Yeah.

1 DR. PATEL: -- this is Kavita.

2 Maybe, Paul, do you mind if I actually  
3 tack on a question to that so that --

4 DR. CASALE: Yeah.

5 DR. PATEL: -- we can just maybe give --  
6 so just to give it a little bit more kind of  
7 specificity. I'm in a community-based employed  
8 setting through Hopkins that's three days a week,  
9 and I have a patient panel. I went back to look at  
10 my latest kind of attributed numbers. We're in an  
11 MSSP, so it's easier to do that. 1,100 patients.  
12 If I were five days a week, that number would bump  
13 up to probably about 1,700 or 1,800 patients.

14 How -- can you walk through -- and maybe  
15 it might be applicable in this Ingalls Hospital  
16 you're discussing, because one of the questions we  
17 asked, you kind of responded to that model as like  
18 the mornings, there's a CCP clinician, et cetera.  
19 How do you transition -- and maybe you can walk  
20 through how you've helped transition, even in an  
21 employed setting, even in an ACO, how you  
22 transition from kind of that volume of a very  
23 typical primary care patient panel to what you've  
24 targeted, which I think you said was ideally a  
25 panel of 200 patients? I don't know if you meant

1 for that to be the complete panel or just the  
2 Medicare part of the panel and then the regular  
3 panel size, which they'll be kind of in line with  
4 like, you know, I'll say industry standards.

5 DR. MELTZER: Yeah, yeah. No, no. We  
6 meant that, and sometimes we say 200 or 300. We  
7 really meant that to be the complete panel, and the  
8 idea is to, you know, decrease the demand on the  
9 outpatient service time so that people would have  
10 the mornings free to do that.

11 And just to be clear, people hear that  
12 number sometimes and think the doctors aren't busy,  
13 but they actually really are. It's just that  
14 there's that 2- or 300 people is the set of people  
15 who are having a lot of encounters, you know,  
16 certainly on the ambulatory side, but then also on  
17 the inpatient side, so RVU generations, you know,  
18 fairly, fairly comparable. How do you --

19 DR. PATEL: Okay. So that you have looked  
20 at that, the RVU.

21 DR. MELTZER: Yeah, yeah. It's a little  
22 less, but it's not, you know, wildly less.

23 DR. PATEL: Okay.

24 DR. MELTZER: But in terms of the  
25 transition -- so when we did this at the UofC, it

1 was very easy because we basically were starting  
2 new people into their practice. And there's no  
3 question that, you know, one could pull some  
4 hospitalists looking to do this, you know, into the  
5 model, and that then is very straightforward.

6           It's also true that many of these doctors  
7 actually have capacity in their schedules, anyway.  
8 So Emily's mom is a great example because she's had  
9 to block her mornings to be able to provide her  
10 patients with care. Her mornings are just very  
11 inefficiently spent right now, and so there's waste  
12 there really. I mean, I think there's still value,  
13 but there is -- there is unused capacity. So  
14 that's one part of it.

15           The other thing is sort of have, you know,  
16 pulling into that practice an APN or partnering  
17 with another physician who might be able to take on  
18 some of the encounters for some of the low-acuity  
19 patients or even some fraction of them for the  
20 high-acuity patients. That would mean less demand  
21 on ambulatory time and more opportunities to see  
22 those patients in the mornings.

23           It also doesn't have to happen overnight.  
24 It can happen over time, and one of the things  
25 we've learned that's really interesting is that

1 even within the population of patients who are  
2 eligible, there are particularly high utilizers.  
3 And so, you know, if you're trying to build up a  
4 practice like that and you have quite limited  
5 ambulatory capacity because of your preexisting  
6 panel, really targeting some of the highest  
7 utilizers is a great way to get your inpatient  
8 volume up without tremendously increasing your  
9 outpatient volume, and so that's sort of a path  
10 towards doing it.

11           And, you know, it's actually painfully  
12 easy to identify those folks. You know, they're  
13 the people who've been in the hospital many, many  
14 times, and, you know, they -- we think they're also  
15 the group, as I think we said in the proposal, who  
16 benefit the most from the program.

17           So we've really managed to see it work  
18 here. Ingalls will be a new learning experience  
19 for us, but the more time we spent talking to  
20 people there, the sort of less worried we are about  
21 it.

22           We've also seen sort of conversations  
23 bubbling up from the Ingalls staff. Some of the  
24 folks who are sort of doing the hybrid model are at  
25 points in their career where they'd actually like

1 to get rid of the hospital part. A lot of them are  
2 older physicians who just are finding that's no  
3 longer something they want to do, even though they  
4 like keeping their ambulatory practice. So they're  
5 sometimes happy to take on some of the other  
6 patients.

7 A lot of these doctors, some of them are  
8 in groups, and there's natural patient sharing  
9 there. Many of them have long-standing  
10 partnerships, and, you know, there are  
11 relationships there that they can build on.

12 So it seems to us there are actually lots  
13 of solutions here.

14 DR. FERRIS: Dave, this is Tim.

15 Kavita, can I ask a follow-up question?

16 DR. PATEL: Yeah, go ahead, and then,  
17 Paul, I know you wanted to ask something.

18 DR. FERRIS: Well, I just want to -- and,  
19 David, this is -- because this is an unfortunate  
20 consequence of the obligations we've taken on, the  
21 commitment we've taken on in this committee, but  
22 I'm going to turn everything that you said on its  
23 head from a cynical perspective because that's --  
24 we have to do that, and --

25 DR. MELTZER: No, no, no. We get it. Not

1 to worry.

2 DR. FERRIS: And so I guess I would  
3 summarize the rationale for the additional payment  
4 really is that under current fee-for-service  
5 system, if you were to serve these patients who are  
6 incredibly sick, that the -- even if you were  
7 billing as an inpatient and an outpatient at a  
8 Level 5 all the time, that still wouldn't basically  
9 compensate physicians for the value of the work  
10 that they are providing to these -- to these really  
11 frail and complex patients.

12 And so if that's true -- and I guess I'm  
13 looking for confirmation that that's the summary on  
14 a purely -- like the value-of-work basis, then the  
15 extra -- why would any doctor not want to just  
16 chuck in their current role for this role? Do you  
17 see what I'm saying? Like this looks like better  
18 work and, you know, better compensated for the hard  
19 work. Is one of the unintended consequences here  
20 that this model would be overly attractive?

21 DR. MELTZER: So I don't think it's  
22 possible for it in the long run to be overly  
23 attractive to so many people that it's overwhelmed  
24 because there just aren't enough patients who are  
25 hospitalized to do that.

1           I mean, the payments are per person, and  
2 if you take a group of people who aren't  
3 hospitalized in this model, you end up not really  
4 qualifying in the end or the -- for the payments  
5 and the savings. And so -- and there's -- and in  
6 terms of the value of the model, it's not -- again,  
7 it's not captured by the -- by the payment model  
8 that we're suggesting. It's captured by the  
9 underlying advanced payment model.

10           DR. FERRIS: Okay.

11           DR. MELTZER: So, I mean, I don't think  
12 people would stream into this. I don't think even  
13 most -- many people are going to want to do this  
14 work. I think that it's going to take a group --  
15 you know, it's going to take a group of people who  
16 are motivated to take care of the most complex  
17 patients who are willing to organize their practice  
18 to do this, and then, you know, once they organize  
19 their practice to do this, they then have to  
20 succeed in doing it in terms of attracting the  
21 right mix of patients to qualify for it and then  
22 actually producing savings that are substantial.

23           I mean, we don't think there's enough  
24 money in the supplemental payments, you know, to  
25 sort of, you know, make it a super profitable model



1 if left to its own devices. We think it's a nudge,  
2 and we think people will incur real costs in  
3 setting up their practices and moving this way.

4 I'll also just point out that it's not  
5 every doctor who's prepared to do this sort of work  
6 on the inpatient setting or to do --

7 DR. FERRIS: Yeah.

8 DR. MELTZER: -- primary care.

9 DR. FERRIS: Right.

10 DR. MELTZER: We think they're out there.

11 We know they're out there.

12 And, I mean, I guess, you know, the other  
13 thing just to point out is if the model is  
14 successful in attracting people in the pilot at  
15 this payment rate and it really works and one  
16 wanted to lower the payment rate because it's too  
17 much, one could do it and try again. But, you  
18 know, my guess is going to be that if it's found to  
19 work and produces the types of benefits we think,  
20 then, you know, this payment is just small potatoes  
21 compared to the -- you know, the benefits that are  
22 -- that are being produced.

23 I mean, the only, I guess, real downside I  
24 could imagine is if the payment were so large that  
25 it encouraged everyone to hold onto these patients,

1 but if you don't -- if you're not doing it for a  
2 substantial number of patients, the amount of money  
3 involved in doing this is nothing. And if you're  
4 doing it at the wrong scale, then it's really  
5 inefficient.

6           Like one of the key things that came out  
7 of that National Bureau of Economic Research  
8 working paper is that travel to the hospital on a  
9 daily basis are blocking your time as a fixed cost,  
10 right?

11           DR. FERRIS: Right.

12           DR. MELTZER: So if your volume isn't  
13 adequate, it just doesn't make sense to incur that  
14 fixed cost.

15           So we think that what's likely to happen  
16 is, you know, people will -- there will be sort of  
17 a knife edge. People will either go to sort of,  
18 you know, doing, you know, sort of mostly primary  
19 care or they'll move to a model like this, and, you  
20 know, I do think it will attract some new people  
21 into this model. I also think it will keep the  
22 sort of older generation of folks who are doing  
23 this, continuing to do it as opposed to dropping  
24 out, which is the pattern we've seen.

25           Does that help?

1 DR. FERRIS: Yes.

2 Paul, did you -- I'm afraid I've  
3 monopolized David's --

4 DR. CASALE: No, no, no, no, no.  
5 Actually, that was on -- I think David really  
6 answered my -- you know, again, as part of I guess  
7 what I'm wondering is, you know, we -- and I think  
8 you've answered. We've sort of evolved away from  
9 what was the traditional system, which is what you  
10 described, where the primary care physician would  
11 come in rounds and sort of manage things over the  
12 phone during the day and evolved into this, you  
13 know, separation of hospitalist and outpatient, and  
14 this, you know, brings back, you know -- and for  
15 select patients, this model.

16 I was just -- part of what I was thinking  
17 is how many primary care physicians are -- do you  
18 think actually would be interested in -- and your  
19 sort of answered a little bit.

20 DR. MELTZER: Yeah.

21 DR. CASALE: It's probably a pretty select  
22 group because --

23 DR. MELTZER: It's a pretty select group,  
24 but it's not a zero-set. I mean, you know, we only  
25 know -- we know Ingalls. You know, we know the

1 folks who we've talked to around the country.  
2 There's definitely a group of doctors who are still  
3 seeing their patients on the inpatient side, and we  
4 -- and we do think that will pull people in.

5           But, again, you know, it's really -- you  
6 know, this is a pilot. It's limited in terms of  
7 the number of doctors and limited in terms of the  
8 number of practices, and although, you know -- I  
9 mean, I think it would be much worse if we made the  
10 payments too low and no one was willing to do it.  
11 I think the most important -- because I said even  
12 at the payment level we're talking about, it seems  
13 tiny compared to the savings.

14           But I could totally imagine that over  
15 time, these payments might not have to go up and  
16 might even go down in real terms because once  
17 people start to switch into this model and it gets  
18 established, you could really see it being, you  
19 know, self-perpetuating.

20           DR. PATEL: All right. We've got -- this  
21 is Kavita. We've got about seven minutes. I just  
22 wanted to -- I have one clarifying question and  
23 then want to let Tim and Paul do any other  
24 clarifying questions as well as our ASPE team.

25           David, you've commented and then in your

1 response you also kind of have mentioned several  
2 places that kind of ideal is if this is nested  
3 within an organization that's already undergoing  
4 some sort of alternative payment model, most likely  
5 an ACO. Is that -- is that really where you --  
6 what you pretty much focus in on implementing this  
7 only in those organizations and just say a bit more  
8 about the pros and cons briefly, if you don't mind?

9 DR. MELTZER: Sure.

10 DR. PATEL: Or did I misread? I don't  
11 want to --

12 DR. MELTZER: Yeah, yeah. So I think what  
13 we said or tried, hoped to say was that if it's  
14 working within an ACO environment, there are these  
15 opportunities for shared savings, which really  
16 allow the organization to capture the genuine  
17 increase in value that comes from this, and so  
18 that's clearly a place where the incentives should  
19 be enhanced to do this and where things are  
20 aligned.

21 We also think that outside of the ACO  
22 environment that these sorts of payments could  
23 incentivize this sort of activity, and that the  
24 model would be valuable there, even if the  
25 organization weren't benefiting from these savings.

1 I also will add that I think that this  
2 might in fact encourage organizations to move into  
3 shared savings, and one of the reasons I think that  
4 is that, you know, if you sort of switch from the  
5 old model to a shared savings model, right now  
6 typically you've got to come up with a care  
7 management strategy, which means you've got to put  
8 out a lot of capital and hire a bunch of people  
9 typically for care coordination.

10 DR. FERRIS: Right.

11 DR. MELTZER: Right? And with a model  
12 like this, that's really not the case in the same  
13 way. I don't know if it comes through clearly in  
14 the program, but our team of care coordinators, you  
15 know, people who surround the physicians is  
16 incredibly lean compared to most care coordination  
17 programs that you see. And the reason is that we  
18 don't have to spend staff effort communicating  
19 between inpatient and outpatient physicians because  
20 they're the same person, right? Same person.

21 And so we actually -- I think that there  
22 may be hospitals -- Ingalls, as it turns out, is in  
23 a shared savings arrangement, but we think that  
24 there are lots of other hospitals that aren't and  
25 for which a model like this could better situate

1 them to have a core group of people, particularly  
2 their high utilizers, who are really well cared for  
3 without a lot of incremental investment in care  
4 coordination or at least, you know, then could have  
5 a smaller incremental investment in care  
6 coordination making the switch to an advanced  
7 payment model that much more attractive.

8           So, look, we would be happy to see this  
9 happen in any of these environments, but we think  
10 that there are -- there is value of the model, both  
11 in the shared savings setting and in the more  
12 traditional fee-for-service setting.

13           DR. PATEL: Tim, Paul, any other  
14 questions?

15           DR. CASALE: I don't have any others.  
16 Thank you.

17           DR. FERRIS: I just want to say that this  
18 was really very, very helpful to me. It's amazing  
19 how much the conversation can enhance understanding  
20 compared to words on a page.

21           DR. MELTZER: That's great. We keep  
22 taking writing classes, but somehow it's never  
23 quite the same.

24           DR. FERRIS: No, no. I didn't mean it  
25 that way. I -- you're --

1 DR. MELTZER: I know you didn't. I just  
2 know it's true.

3 So, no, no. Thank you. And what I said  
4 earlier really holds. Wow. What an amazing group  
5 of people to be able to comment on this and help us  
6 think this through. It's just really a pleasure  
7 and privilege.

8 DR. PATEL: Sarah?

9 Thank you so much, David.

10 Sarah, anything else?

11 MS. SELENICH: No. I think we're all set.  
12 This has been really interesting.

13 DR. MELTZER: Great. Good.

14 DR. PATEL: And, David, do you have any  
15 questions for us? I know -- I'm not sure how much  
16 you are aware about our timeline or process or what  
17 we're going to --

18 DR. MELTZER: It would be great if you  
19 would just tell us, just so we know. We've read,  
20 but again, words are better than paper.

21 DR. PATEL: Of course. Yeah.

22 So we're aiming to have this review -- and  
23 by the way, just so you know, this was incredibly  
24 helpful. If there are additional questions that  
25 arise, we may reach out to contact you.



1 DR. MELTZER: Of course.

2 DR. PATEL: So just so you know that, but  
3 we --

4 MS. SELENICH: Kavita, this is Sarah. I  
5 actually did have one quick question that I had  
6 written down --

7 DR. PATEL: Okay.

8 MS. SELENICH: -- about patient cost --

9 DR. PATEL: Well, then why don't you,  
10 Sarah --

11 MS. SELENICH: Yes.

12 DR. PATEL: -- and then why don't you tell  
13 him what the timeline is, since you actually have  
14 the official like --

15 MS. SELENICH: Yeah.

16 DR. PATEL: -- dates, et cetera.

17 MS. SELENICH: Yep. So my quick question  
18 is regarding patient cost sharing. I couldn't  
19 remember if you addressed that in the proposal,  
20 like how -- if the patient would share in the costs  
21 of the -- I guess the monthly fee.

22 DR. PATEL: Much like the current CCM,  
23 David, where they have to pay part of that as part  
24 -- as a Part B co-share.

25 DR. SCHRAM: We did not think that the

1 patient should have to share in the cost of --

2 MS. SELENICH: Okay. Thank you.

3 DR. SCHRAM: But it was important that any  
4 patient who would significantly benefit from this  
5 program was able to be a part of that.

6 DR. MELTZER: Yeah. And just one thing, I  
7 mean, we'll say as our experience doing this at the  
8 UofC, our median family income is like 15- to  
9 \$20,000 a year, and, you know, we see patients who,  
10 you know, don't get a generic drug because of a \$1  
11 and \$2 copay. And we really think that the  
12 relationship is critical, and obviously if the  
13 patient is on Medicaid, which is about half of our  
14 population, you know, they don't pay those copays.  
15 But, you know, our Medicare patients are barely  
16 much better off than the Medicaid patients. So  
17 that would be our thought.

18 At least for a pilot, I imagine one could,  
19 you know, think about it differently over time if  
20 one wanted, but that was -- that was our thought.

21 MS. SELENICH: Okay.

22 And then just in terms of timeline, as  
23 Kavita said, there's -- so there's obviously -- the  
24 PRT will meet a couple more times to talk,  
25 obviously discuss what they heard, and then also to

1 look at other aspects of the proposal. So some of  
2 it's contingent on that, and if they have  
3 additional questions for you and how quickly you're  
4 able to respond.

5 I don't want to, you know, promise, I  
6 guess, anything in terms of timeline right now, but  
7 the --

8 DR. PATEL: Here, let me help you, Sarah.

9 We're aiming to have this on the docket  
10 for the September public meeting, and so, David, if  
11 you work backwards from that. We can't guarantee  
12 anything. I'm sure that's why Sarah can't say  
13 that, so that we don't get -- so that we don't get  
14 anyone in trouble. Our ideal will be that we have  
15 this for our public discussion scheduled in  
16 September, but, you know -- and then working  
17 backwards, if the -- have like, you know, documents  
18 kind of ready and finalized, including for you to  
19 be able to attend either on the phone or in person  
20 as well as have a chance to review our PRT, our  
21 Preliminary Review Team's report.

22 So if you work backwards from that, we  
23 need to have things wrapped up, you know, a month  
24 or two in advance of that September date, which  
25 puts us around July, August. So that's what we're

1 working with. That we're -- I'm hopeful and very  
2 confident that we can get to that date.

3 DR. MELTZER: Okay. That's wonderful.

4 Can I just ask you? Does anyone know  
5 offhand what day in September that meeting is?

6 MS. SELENICH: So the dates are the --  
7 September 6th and 7th.

8 DR. MELTZER: Okay, great. Okay. It  
9 would take a great act for us not to be there.

10 [Laughter.]

11 DR. FERRIS: Great. Looking forward to  
12 it.

13 DR. MELTZER: Good.

14 DR. PATEL: We're looking forward -- we're  
15 looking forward to it. Thanks so much to --

16 DR. MELTZER: Okay, good.

17 DR. PATEL: -- you and Emily and Andrew.

18 DR. MELTZER: Great. Thank you all so  
19 much. We're really grateful.

20 DR. FERRIS: Thank you.

21 DR. MELTZER: Okay, great. Thank you.

22 MS. SELENICH: Bye.

23 DR. MELTZER: Bye.

24 [Whereupon, at 12:02 p.m., the conference  
25 call concluded.]