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MEDICINE

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

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 patient 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.¹ In addition to the estimate of 50,000 hospitalists in 2016,² 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.

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

² 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.³ 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,**

³ 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:⁴

- 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

⁴ <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
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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.



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August 27, 2018

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C/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
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Re: Preliminary Review Team Initial Feedback Regarding 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 response to the committee's initial feedback. For ease of review, we present the review criteria in underlined text, the most recent PTAC comments in *italics* and our responses in plain text, with some critical highlights in **bold** face.

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

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.

- *Existing programs through CMS and CMMI, such as ACOs and Bundled Payment for Care Improvement (BPCI), could enable physicians to establish similar processes for bridging care between inpatient and ambulatory settings.*

We appreciate that to the extent that ACOs and BPCI could enable physicians to establish similar processes for bridging care, then CCP-PM model could be viewed as failing to broaden or expand the CMS APM portfolio. Nevertheless, we believe that the CCP-PM meets this criterion for the following reasons:

1. **The CCP-PM is designed to be sufficiently simple to allow such entities, such as physicians in a solo or small group practice or small hospitals, that have had limited opportunities to participate in an APM to participate in an APM even if they are not prepared to participate in an ACO or BCPI.** Indeed, there are many physicians and hospitals that do not currently participate in a CMS ACO or BPCI or APM and face substantial barriers to doing so for a wide range of reasons, including small scale of practice and associated ability to manage the required data streams or potential financial risk. The far more limited requirements of the CCP-PM compared to an ACO or BPCI would make it possible for such smaller entities to participate in an APM.
2. **Even for entities that do participate in an ACO or BCPI, participation in the ACO or BCPI may not be continuous over time, so the CCP-PM provides such entities a way to stabilize their incentives to arrange their practice around the CCP model of continuing, integrated inpatient and outpatient care for high risk patients.** This advantage of the CCP-PM is especially important because the continuing relationships of patients and providers are highly valuable, promoting knowledge, trust, communication and interpersonal relationships that improve care and reduce costs. Creating durable incentives to adopt the CCP model is also important because patients and providers may incur up-front costs in rearranging their care and practices to realize the benefits of CCP care, so that having a payment model that rewards such efforts over time even as other payment models may evolve is an important broadening and expansion beyond existing APMs. With regard to BPCI specifically, we note also that episodic payment is unlikely to facilitate the continuity of care encouraged by the CCP-PM given that payments only focus on an episode of care.
3. **Even for entities that do participate in an ACO or BCPI, the CCP-PM would be likely to increase use of the CCP model by increasing incentives for its adoption.** The payments we propose of a maximum of \$40/month for patients who have been hospitalized in the past year would result in CMS payments of less than \$500 per participating patient per year, and a net cost to CMS of even less for entities engaged in shared savings, while reducing costs of care by an estimated \$3,000 per patient per year. Based on these numbers, we think that it is strongly in the interest of CMS that the CCP model be more broadly adopted, and though we are seeing broader adoption of the model in a very small number of entities (e.g., University of Chicago and Vanderbilt University Medical Center), adoption could be far faster. We believe the added incentive proposed will accelerate adoption by providing extra payment for the adoption of the CCP model.
4. **Even for entities that do participate in an ACO or BCPI, the CCP-PM would be likely to increase use of the CCP model by increasing awareness of its benefits.** We have promoted awareness of our findings about the benefits of the CCP model through reporting our findings at this year's Academy Health meeting and active efforts to soon publish our findings in the academic literature and through a learning

collaborative organized under the CMS TCPI. However, we think that CMS approval of the CCP-PM would direct provider attention towards this evidence and opportunities to learn how to implement this model.

5. **Even for entities that do participate in an ACO or BCPI, the CCP-PM would be likely to increase use of the CCP model by increasing knowledge about its benefits.** As we discuss in our initial proposal, we think the CCP-PM could be rigorously evaluated, increasing knowledge about the value of the CCP model. It is less clear to us how to rigorously evaluate spontaneous adoption of the CCP model outside of CCP as there might be more variability in how the model might be implemented and less ability to capture relevant data on program design, operation and outcomes deemed important by CMS.
6. **As a proposed add-on to existing APMs, the CCP-PM would broaden and expand the CMS-APM portfolio by demonstrating how a new APM that cuts across a wide range of health conditions with relevance for many existing APMs could be integrated with a range of other APMs.**

We believe that each of these reasons individually are sufficient suggest that the CCP-PM meet Medicare's proposed criteria for PFFPM scope. Together they make an even stronger argument.

- *The feasibility of the CCP-PM both within and beyond academic settings may be limited.*
 - *While some hospitalists in academic settings may be enthusiastic about participating, other hospitalists may not be interested, so it may be challenging for some academic settings to sustain a program of sufficient size.*
 - *The program may be even more of a stretch for hospitalists who are not employed by community-based hospitals and primary care physicians in private practices serving those patients.*
 - *The strongest business case is for initiation within a hospital. Otherwise, structural issues arise for financial feasibility, as some mechanism is needed for stand-alone primary care practices to initiate a program with a hospital and follow their patients into that hospital.*

With respect to the first of these identified weaknesses, we agree that some hospitalists may not be interested in this model. However, **we only require a small fraction of physicians must be interested in this model in order to successfully scale it and we are confident based on the successful experiences implementing CCP at the University of Chicago and at Vanderbilt that there are sufficient numbers of physicians interested in practicing in this model to allow it to be meaningfully scaled.** We have not found it difficult to recruit or retain physicians for these roles at the University of Chicago. Interest for our CCP program in an academic setting has been strong among hospitalists, general internists and new residency program graduates; in the context of a nationwide shortage of primary care physicians, we find it striking that we have consistently had more excellent applicants for CCP positions than we have had openings. We also note that while we think that a CCP program operates ideally with a team of 5 physicians or some multiple of that, we have developed approaches to start or sustain a program with as few as 2-3 physicians so we think the model is highly robust even to temporary local variations in the availability of physicians interested in CCP practice. **With respect to the idea that interest in CCP might be greater among physicians in academic medical centers, we note that the CCP model could benefit a large fraction of complex patients nationally even if it were limited to academic medical center. Moreover, in response to this point, we note that we have had great interest in the model from community-based physicians locally and nationally, especially among PCPs who are still trying to see their own patients when they are hospitalized; we disagree that interest in the CCP model is likely to be greater among physicians in academic medical centers than among physicians in community hospitals.** Indeed a significant number of physicians in community hospitals are still trying to manage to see their patients both in clinic and the hospital because they believe in the value of that sort of continuing care for their patients. But without sufficient numbers of patients at increased risk of hospitalization in their practices, as would be incentivized by the CCP-PM, they are struggling to maintain that inpatient-outpatient continuity. This is precisely the case at our local-community hospital affiliate, Ingalls Hospital, where we have already

identified a sufficient number of existing PCPs who see their patients in and out of the hospital and are now working with us to transition their practices to CCP practices. We are confident that similar transformations of clinical practice could happen at hundreds if not thousands of community hospitals across America.

With regard to point 2, we agree that incentives and business models may be more complex when the PCPs and/or hospitalists are not employed by the hospital, but our experience working with Ingalls to start a CCP program suggests to us that hospitals and practices can successfully address these challenges. In our experience, many or all of the issues that must be addressed in developing a CCP model under a non-employed model must be addressed to address inpatient and outpatient coverage issues even in the absence of the CCP model. One example is how to ensure coverage of new uninsured admissions from the emergency department . If the CCP-PM is funded, we would gladly work with participating organizations to help them address these issues.

With regard to point 3, a mechanism does need to be in-place for an independent physician to practice at an affiliated hospital. It is common, however, especially at community hospitals, for local PCPs to have hospital privileges. Currently existing credentialing process would continue to enable the development of CCP-like models in this setting. In addition, we note that if uptake of the CCP-PM were to be slow, Medicare would experience minimal cost, since the CCP-PM requires enrollment for payments to be made.

- *Hospitals or community practices that initiate a program may still need to overcome potential barriers for patient enrollment (a comment which was cited by evaluators of the HCIA program as well). Some community-based physicians will not want to relinquish patients to CCP-PM. While the CCP-PM is appropriately targeted to high-risk patients and has provisions against cherry-picking low risk patients, high-risk patients may have established relationships with certain physicians that they do not want to drop.*

We agree that some patients do not want to switch from their current primary care physician (PCP). However, many patients do not have a PCP and many are not fully satisfied with their PCP, including around the extent of their involvement with their care if they are hospitalized. Participation in the CCP model also does not require that patients change specialists, which for some patients may be important relationships. The bottom line is that **the experience at the University of Chicago, and similar programs at Vanderbilt and Kaiser, suggests that enough patients at high risk of hospitalization are willing to switch to make the model sustainable.**

We also agree that some PCPs will not want to relinquish patients to a CCP. We had to address this issue in recruiting for the CCP Program at the University of Chicago and also in developing our plans for recruitment at Ingalls in a community hospital setting. In both settings, **we have developed and successfully implemented effective patient recruitment strategies that are respectful and protective of successful existing physician-patient relationships, including prospective contact with clinicians before patient recruitment when possible and special efforts to engage patients who lack a PCP or are losing their PCP.**

CRITERION 2. QUALITY AND COST (HIGH PRIORITY CRITERION)

Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

- *The proposal provides unpublished statistics that are different from the HCIA final evaluation. The HCIA evaluation finds non-significant increases in total spending and ED visits, and a non-significant decrease in admissions*
- *Differences between the proposal and the HCIA evaluation could be due to slow patient recruitment for the trial. The HCIA evaluation indicates: “Only in the last two quarters of the HCIA funding period did the accumulated number of patients reach the goal of 1,167 per study arm, and the funded study period ended*

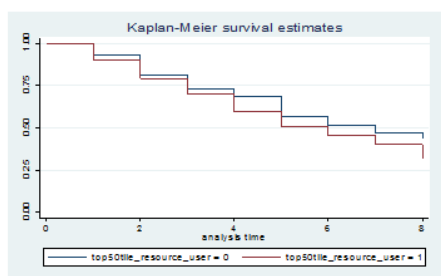
soon afterward. It is possible that with a longer intervention period, additional impact would have been achieved (although we saw no evidence that longer tenure in the program achieved greater improvement in health care utilization or Medicare spending).”

- In total, the feasibility as well as the reality of the savings projected in the proposal is not clear.

The following outline reasons that we believe explain the differences between the evaluation of the HCIA CCP intervention described in the proposal that we think strongly supports substantial improvements in outcomes and reductions in costs and the HCIA evaluation of the intervention:

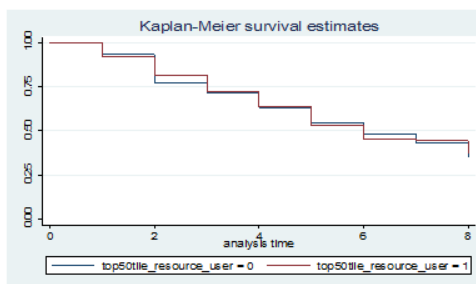
1. **The critical explanation for the difference is that the HCIA evaluation only included fee-for-service Medicare claims and not costs in Medicare managed care, which led to artifactual decrease in the HCIA estimates of savings because of greater retention of high-risk patients in traditional Medicare as opposed to Medicare managed care by the CCP program as compared to standard care (SC), especially for dual-eligible patients because of the State of Illinois Medicare-Medicaid Alignment Initiative (MMAI).** MMAI was initiated in January 2014 to encourage enrollment of Illinois Dual Eligibles in managed care. Patients were auto-enrolled in the program unless they opted out. The result was that a large fraction of dual eligible patients enrolled in the CCP study (whose enrollment began in November 2012) ended up leaving traditional Medicare coverage. The following two figures illustrate this phenomenon for up to 8 quarters (2 years) after randomization in the dual-eligibles enrolled in the HCIA study based on data for the first 3 years of the study.

Survival Analysis of Transition to MA Plans:
SC: Starting with Dual Eligibility and Non-HMO



By study quarters for any type of transition. Log-rank test for equality of survivor functions: P=0.12

Survival Analysis of Transition to MA Plans:
CCP: Starting with Dual Eligibility and Non-HMO



By study quarters for any type of transition. Log-rank test for equality of survivor functions: P=0.87

The figure on the left shows the rate at which dual-eligibles remain in traditional Medicare (and hence have costs reported in Medicare claims data) in the standard care arm. The figure on the right is the same for for the CCP arm. Overall one can see in both figures that by about 4 quarters after randomization that about one third of the subjects have left traditional Medicare and by 8 quarters it is almost one half. This compares to rates of leaving traditional Medicare (for managed care) for non-duals of one quarter or less at 8 quarters (data not shown). Each of these two figures contains two survival curves: one for beneficiaries in each arm in the top half of spending in that year prior to randomization and one for beneficiaries in that arm in the bottom half of spending in the year prior to randomization. This stratification is made because prior year utilization is a strong predictor of future utilization. In the SC figure one can see that retention in traditional Medicare is higher for the low utilizers at baseline (top line) than for the high utilizers at baseline (bottom line) (p=0.12 for difference), with an absolute difference of about 5% higher retention for the low utilizers in SC in year 1 and 10% in year 2. This implies that greater movement of high utilizers out of traditional Medicare to Medicaid Managed care likely artificially decreased observed average spending in the SC arm, effectively pushing those costs to MMAI. In contrast, in the CCP arm there is no difference in retention between the high utilizers at baseline and the low

utilizers at baseline, which we think is the case because higher utilizers were more likely to highly value the care in the CCP program. The result of this is that there is no corresponding artificial reduction in traditional Medicare spending in the CCP arm, and the comparison of the traditional Medicare spending in CCP vs control estimated by the HCCI analysis is likely to underestimate savings by CCP vs. SC.

We cannot currently precisely estimate the magnitude of these effects but believe they are likely large. For example, with average spending in the high utilizers of \$135,000 per year and spending in the low utilizers of \$15,000 per year for an average of \$75,000, with 90% of spending in the top half of utilizers, retention in the first year of follow up of 85% for SC low utilizers vs. 80% for SC high utilizers would yield average spending in SC of $(0.85 * \$15,000 + 0.8 * \$135,000) / (0.85 + 0.8) = \$73,181$, which is about \$1,800 less than the true average of \$75,000 in year 1. With retention over the second year of follow up of 60% for SC low utilizers vs. 50% for SC high utilizers would yield average spending in SC of $(0.6 * \$15,000 + 0.5 * \$135,000) / (0.6 + 0.5) = \$69,545$, which is about \$5,500 less than the true average of \$75,000. Averaging the \$1,800 and \$5,500 estimates yield estimate of \$3,600 per beneficiary artificial reduction in average spending in the SC dual eligible group vs. CCP dual eligible group. Since dual eligibles are about half of the sample, this would be expected to reduce the estimate treatment effect on total costs based on claims data artificially by about \$1,800. We think this could easily be an underestimate of the total effect of this bias because we know the very highest utilizers (e.g. top 10%) may easily account for well over half of spending. If the differential retention in CCP vs. SC is fully attributed to this highest utilizing subgroup then this could produce an artificial reduction in estimates of savings of \$35,000 per year. **In summary, it is highly possible that the magnitude of bias due to greater retention of high utilizers in the CCP program could fully explain the discrepancy between the savings we estimate based on patient reported hospitalizations and the HCIA estimates.**

2. **We also agree with the PTAC subcommittee that the shorter duration of follow-up for the HCIA evaluation may contribute to the lower estimates of savings.** Because a substantial fraction of participants in the study were recruited in the last year of our funding, follow-up time in the HCIA evaluation was more limited, decreasing power for that analysis compared to our analysis based on patient self-report of hospitalization.

3. Finally, we reinforce our current estimates of decreased utilization by providing the full text of the following abstract which was presented at Academy Health on June 26, 2018 reflecting the patient-reported outcomes obtained by follow-up directly with patients through surveys during the two years after the HCIA evaluation.

[Effects of a Comprehensive Care Physician \(CCP\) Program on Patient Satisfaction, Health Status, and Hospital Admissions in Medicare Patients at Increased Risk of Hospitalization: Initial Findings of a Randomized Trial](#)

Research Objective: Coordination of inpatient and outpatient care is an important challenge in improving population health but evidence examining the effectiveness of existing care coordination programs is mixed. The Comprehensive Care Physician (CCP) Program at the University of Chicago provides patients at increased risk of hospitalization the opportunity to receive inpatient and outpatient care from the same physician. We compared patient satisfaction, self-related health general and mental health status, and self-reported hospitalization rates of Medicare patients randomly assigned to the CCP program vs. standard care (SC) in which patients receive inpatient care from hospitalists and outpatient care from a primary care physician who does not care for them in the hospital.

Study Design: Randomized two-arm longitudinal study. Patients were surveyed every 3 months by telephone for a minimum of 1 year and maximum of 5 years to assess patient experience with their primary physician,

general and mental health status, and hospitalization rate. Longitudinal outcomes were analyzed using mixed-effect regression models.

Population Studied: Two-thousand Medicare patients with at least 1 hospitalization in the past year or in the emergency department at the time of recruitment were randomly assigned in equal proportions to CCP or SC between November 2012 and June 2016.

Principal Findings: At baseline, mean age was 63 years, 62% were female, 88% were black, and 45% were dual-eligible. There were no statistically significant differences in demographic or health measures between CCP and SC patients at baseline. Follow-up rates to 1 year were 95% for CCP and 85% for SC. Mean HCAHPS ratings of their physicians were 0.27 points higher for CCP vs. SC patients ($p < 0.0001$, 95%-CI:[0.16, 0.37]), corresponding to the difference between the 80th percentile and 95th percentile in such scores nationally. Mean self-rated health status measured from 1 (poor) to 5 (excellent), was not significantly different for CCP vs SC for general health (DCCP-SC=-0.001, $p=0.9701$, 95%CI:[-0.06, 0.06]), but were 0.11 higher for CCP compared to SC mental health ($p=0.0033$, 95%CI:[0.03, 0.18]). Using a zero-inflated Poisson mixed-model, the rate of hospitalization was 22% lower and statistically significant ($p=0.030$, event rate ratio 0.78, 95%CI:[0.62,0.98]) for CCP compared to the SC at the first 3-month follow-up wave and remained at least 15% below SC and statistically significant up to the minimum 1 year follow-up.

Conclusions: Patient-reported experience with their physician and mental health status were significantly higher, and patient-reported hospitalization rates were substantially lower for CCP patients vs. SC patients over the year following randomization to CCP vs. SC. Correlation of these findings with objective measures of utilization, such as claims data, and further follow-up are warranted.

Implications for Policy or Practice: The CCP program may improve patient experience and health status while substantially reducing utilization for patients at increased risk of hospitalization. Given the limited evidence supporting the effectiveness of existing care coordination programs in improving outcomes and reducing costs and given the need for effective approaches to population health management, the CCP model warrants further exploration through efforts to implement it in additional settings and rigorously evaluate its effects on outcomes and costs.

- *The proposal discusses quality within a “structure, process, outcome” framework but does not provide specific measures or benchmarks other than thresholds for the percentage of inpatient and outpatient care provided by participating physicians. For example, the proposal (p. 8) maintains that the empaneling of physicians who structure their care to be delivered in both the clinic and hospital is a measure of structural quality, but quality measures for tracking or comparison to peers are not proposed. Evaluation would require specific benchmarks.*

As discussed in our proposal and earlier responses, we spent significant time considering whether to specify outcomes measures specific to the CCP-PM as a condition of payment and decided to exclude such metrics given issues related to risk adjustment, currently available metrics, and the incorporation of metrics into baseline payment models.

We do, however, agree with the comment above that evaluation would require specific benchmarks and strongly support the evaluation of the CCP-PM program using additional metrics related to quality and cost. We expect most of these metrics to be available in Medicare databases (total cost of care, hospitalization rates, HCAPS scores), facilitating evaluation. Such an evaluation would likely take the form of either a stepped wedge or case control analysis comparing groups that adopt the CCP-PM to those who do not.

- *The patient empanelment is not well defined. Therefore, there is a risk of patient selection and unintended consequences.*

The proposed patient empanelment process was designed to reduce these risks as much as possible. To avoid gaming, we specifically limit potential reasons for physician-driven disenrollment. We welcome CMS input either prior to or after a trial period to further minimize the risk of adverse selection. In particular, we welcome suggestions for additional criteria to identify patients at high risk of hospitalization who are most likely to benefit from the CCP-PM.

CRITERION 3. PAYMENT METHODOLOGY (HIGH PRIORITY CRITERION)

Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.

- *While the payment could be a supplement for hospital-based ACOs, the current payment methodology for ACOs already includes incentives to better coordinate care across settings. Therefore, the CCP-PM might simply end up increasing payments to hospital-based ACOs for something they are already supposed to be doing.*
- *Since ACOs and other models are already trying to increase continuity, it is not clear that model would not simply create an extra payment for a pattern of care that is already being delivered within ACOs.*

Although ACO incentive structures do provide incentives for care coordination via shared savings and specified metrics, many struggle to establish programs that work. The CCP-PM is designed to promote a proven intervention. Any payments to an ACO organization via the CCP-PM would count towards an organization's total cost of care, and add to net revenues for organizations receiving shared savings only in proportion of savings shared and that proportion of any increase in shared savings. Therefore, such payments would not adversely affect an organization's broad incentive to reduce cost. In addition, the CCP-PM is designed to serve as a bridge for organizations considering becoming ACOs but not yet ready to assume the risk of a full ACO model.

- *The payment model lacks financial risk, which results in a weak linkage between payment methodology and intended outcomes (reduced total expenditures and improved health outcomes for the patient).*
- *The financial risk in the model may be insufficient to generate savings unless there is some downside risk aside from meeting the penalty criteria. Only a \$10 penalty per patient per month (e.g., \$24,000 total per year for a panel of 200 patients) is at risk in a stand-alone model. Providers who lose money may simply leave the program.*

In addition to the monetary risk provided by the penalty, the CCP-PM introduces significant financial risk for providers by forcing practices to restructure and cancel morning clinics to provide time to see patients in the hospital. Depending on how much time providers set aside, such a reorganization could place up to half of a provider's revenue at risk.

- *The role of some services such as telehealth in calculating the penalty has not been clarified or standardized.*

As telehealth services become billable and trackable, we would encourage their inclusion in the calculation of outpatient percent provision of care. We would envision counting each telehealth visit as equivalent to a traditional office visit in calculating the outpatient percent provision of care.

- *The cash flow diagram (p. 14) raises some feasibility issues, as it is not clear that CMS has a mechanism for making the payments as drawn. Physicians affiliated with institutions have different financial arrangements than other physicians who are not similarly employed/affiliated, including independent practices. The diagram tries to get at attribution of patients that might not work well in mixed arrangements where different physicians see the same patient rather than using an approach such as a convener model (e.g., as with BPCI, or a model where a third party takes risk and deals with Medicare reimbursement).*

The CCP-PM is not designed to alter current cash flows. Entities who are currently being paid by Medicare would continue to be paid with funds flowing to physicians using existing arrangements. If an organization allowed its physicians to sign up for the CCP-PM, we would expect internal incentives to be developed to encourage its success. Similar to BPCI models, we could envision conveners playing a role in mitigating some of the risk of participating in the CCP-PM.

- *The CCP may have an experience similar to other models being tried in the sense that the model may improve quality but does not have sufficient mechanisms to result in measurable reductions in spending. The existing literature does not provide strong evidence that improving continuity of care reduces spending or results in savings sufficient to cover the fees/cost of the program.*

Data presented above from the CCP Program at the University of Chicago strongly suggests the ability of the CCP intervention to significantly reduce cost of care. We also propose studying the CCP-PM during early stages of implementation to determine whether the payment model yields similar results. More broadly, we think there is compelling evidence that continuity can improve costs/outcomes of care. Some of our favorites:

- Observational studies show lower costs, better outcomes with continuity of care
 - Care by PCP for > 10 years: 15% lower Medicare costs (Weiss et al AJP 1996)
 - Lung CA patients cared for by own doctor in terminal hospitalization have 25% lower (OR=0.74, p<0.01) odds ICU use (Sharma et al, Annals, 2009)
- One experimental study
 - Wasson et al (JAMA, 1984) randomized 776 complex VA patients to see same physician vs. different physician in each primary care visit. Continuous care group:
 - 49% lower emergent hospitalizations (20% vs. 39%, p<0.002)
 - 38% lower hospital days (6.6 vs. 9.1, p<0.02)
 - 74% lower ICU days (0.4 vs. 1.4, p<0.01)

CRITERION 4. VALUE OVER VOLUME

Provide incentives to practitioners to deliver high-quality health care.

- *The results cited in the proposal were not documented in the HCIA evaluation.*

We have already discussed this above.

- *The presence of CCP-PM may not be sufficient to drive behavior change to attain value over volume in other settings. Community-based office settings might have barriers or lack of enthusiasm for the scheduling and logistical changes needed to attain the value-based care envisioned under CCP-PM. Therefore, the proposed model as written might not be sufficient to drive care to be different in other settings.*

As we have disseminated the CCP model, we have engaged with numerous community-based physicians who have expressed significant interest in practicing under the CCP model. Many such physicians still care for their

patients in the hospital and the clinic. With a traditional panel, there are economic challenges to this model. Specifically, these physicians are likely to experience low and/or sporadic volumes of patients in the hospital each day. Focusing a panel on patients at increased risk of hospitalization solves many of these challenges, as it increases the volume of patients in the hospital at any given time. In addition, many internal medicine residency graduates express interest in continuing both inpatient and outpatient practice, suggesting that interest in this type of a model will be sustained over time if structured in an economically feasible way.

Moreover, it is important to note that this model is designed to incentivize change for some physicians, but not for all. We expect patients who are not at increased risk of hospitalization to continue to be cared for by traditional primary care physicians. Further, since the CCP-PM only pays care coordination fees if a physician signs up, Medicare would only be responsible for paying for the program as uptake occurs.

- *Selection of patients in other settings might be different from the patients enrolled in the University of Chicago's HCIA award. Patient enrollment under the HCIA award proceeded slowly, and the extra efforts to recruit patients might mean the patients enrolled in an ongoing program could be different (though the value over volume could improve or decline). For example, patients with significant language barriers or those that might require additional intensive coordination for social services.*

In developing the CCP program at the University of Chicago, we found that the single greatest predictor of future hospitalization was past hospitalization. Our model also specifically improves inpatient-outpatient continuity of care. Hence, we propose this as the sole criterion for CCP-PM eligibility. We welcome the inclusion of new criteria as more data allows Medicare to identify patients most likely to benefit from this intervention. In addition, core to the CCP model are relationships with the physicians and the multidisciplinary team, which means the program is better equipped to address patients with a range of more intensive needs.

CRITERION 5. FLEXIBILITY

Provide the flexibility needed for practitioners to deliver high-quality health care.

- *No evidence is available indicating that specialists would be willing to participate as a CCP-PM provider.*

At the University of Chicago, many specialty groups, including cardiology, oncology, and neurosurgery, have approached the CCP Program asking for their specialty patients to be cared for by the CCP Program. The strong interest from specialists suggests significant value to caring for specialty patients using this model.

- *The experience to date does not include an independent community-based provider who has tried to implement a model like CCP without a willing hospital partner.*

In the case that an independent community-based provider participated in this model, he or she would only need to obtain privileges at a nearby hospital. This infrastructure already exists, as many community-based providers currently care for the patients in both the hospital and clinic.

CRITERION 6. ABILITY TO BE EVALUATED

Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

- *The lack of definition of measures for some components (structure, process and outcome measures) means their evaluation is not clearly defined. Lack of objective criteria for empanelment is particularly problematic.*

We expect that a future evaluation of a CCP-PM would include more measures than those involved in the payment model itself. We welcome working with CMS to define an appropriate set of metrics to evaluate this model. Similarly, we would be open to different objective criteria for patient empanelment as the CCP-PM develops.

- *Although the proposal advocates for wider testing in additional sites, other trends such as decreased patient participation due to increased Medicare Advantage enrollment could complicate such evaluation.*

Although participation in Medicare Advantage plans continues to grow, traditional Medicare still represents a vast majority of the Medicare population. Additionally, we expect learnings from this model to apply to future, improved Medicare Advantage plans.

- *The PRT would like to have better understood why the unpublished results in the proposal differ from the HCIA evaluation results.*

As mentioned above, additional time and data have led to these differences.

CRITERION 7. 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.

- *The model as described focuses on hospital care and primary care. The proposal did not provide a clear understanding of the role of and interactions with specialists other than the expectation for coordination with specialists, which was noted in subsequent communication with the submitter.*

As described in prior responses to PTAC questions, the interaction of CCP-PM participants with specialists is likely to be similar in nature to those currently taking place. It is important to note, however, that many speciality groups including cardiology, oncology, and neurosurgery have approached the University of Chicago CCP Program with strong interest in having their patients participate. This suggests significant value from the specialist perspective in having a single physician care for patients in both the inpatient and outpatient settings. In addition to providing continuity for patients, the model also provides continuity for providers in their interactions.

- *There does not appear to be a mechanism in the model for making sure the patient is getting the right care (e.g., that certain conditions that would be monitored in a primary care setting are followed). The model does not clarify broadly how patient standards pertaining to basic screening and preventive care will be met.*

The CCP-PM is a supplemental model that integrates with the existing payment models at a given institution. Any metrics and quality-based incentives included in the underlying payment model (i.e., MIPS, MSSP track 1) would also be applied to a provider participating in the CCP-PM.

- *Some ACO metrics that would be useful for assessing integration and care coordinate are not incorporated, which could be problematic for a stand-alone primary care practice even if working in conjunction with a hospital.*

If needed, participation in CCP-PM could be contingent on reporting additional metrics for program evaluation, especially in the early stages. Other metrics could be tracked using Medicare databases.

- *The PRT has some concern that this model is going back to an approach used previously (i.e., a community doctor follows patient into hospital) that became problematic for care when an office-based physician spends less time inside the hospital, etc.*

As more conditions could be treated in the outpatient setting, many traditional primary care physicians who had previously cared for patients in both the hospital and the clinic found that they had too few patients hospitalized at any one time and that their clinics were becoming increasingly busy. Because of this, many physicians found caring for their patients in both settings less economically feasible. By focusing panels on patients at increased risk of hospitalization, CCP-like programs can ensure that their clinicians have enough patients hospitalized at any given time, making the trip to the hospital economically feasible. By limiting the panel size, participating physicians are able to care for a manageable number of patients in the clinic as well.

In addition to the economic benefits, this model is well suited for patients with complex medical and social needs as it encourages the creation of a strong relationship between the patient and the provider.

- *Some patients may also not want to leave their existing primary care physician in order to participate.*

This model is not designed to disrupt strong existing doctor-patient relationships. We strongly believe that it is important for patients to consent to participate in the CCP-PM.

- *Furthermore, the model may only be delaying an inevitable handoff for a patient who is no longer at risk for hospitalization.*

To avoid this problem, the CCP-PM is designed to allow patients to continue with the same provider.

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.

- *Despite the advantages of prospective enrollment, efficient ways to ensure sufficient and appropriate patient empanelment are not known. Enrollment in the RCT was slower than expected, and the investigators had to implement additional recruitment efforts. Appropriate patient enrollment is important for the payment methodology to be able to achieve reductions in the total cost of care while ensuring quality care.*

We have enrolled 2,500 patients in our RCTs at UCM over the past 6 years through a range of methods in the inpatient, emergency department, ambulatory and community settings. Recruiting for an RCT is typically much more difficult than recruiting for an effective clinical intervention. We have extensive experience that could be shared with other institutions hoping to disseminate CCP.

- *It may be important to address any barriers to empanelment (limited language proficiency, health literacy, etc.) to ensure that patients understand the fact that a single provider or provider group will be seeing them in both ambulatory and inpatient settings, which may be different from what they are used to. Patient choice to go to other providers must be respected, but continuation of visits to all existing providers could reduce ability to achieve program savings.*

The CCP-PM is designed to respect patient choice. Patients are able to stay with the CCP physician or receive care from other providers at any time. Our experience with the CCP model at The University of Chicago has suggested that patient satisfaction is high, and very few patients choose to leave.

- *The model does not include specific provisions beyond the penalty payment to reduce the likelihood of selection in enrollment by patients who are less seriously ill but willing to change their providers, because such “favorable” selection could mean that only relatively lower rather than higher risk patients may be willing to enroll. Since the penalty payment pertains to the average experience for a potentially large group of patients, the model does not have a patient-specific mechanism to discourage enrollment of relatively low-risk patients.*

We have designed CCP-PM enrollment criteria to identify high-risk patients. However, additional criteria could be added if deemed appropriate, such as requiring that patients have been hospitalized for a chronic condition.

- *The proposal does not seem to include sufficient mechanisms to avoid unintended consequences such as perverse gaming (e.g., hospitalization of a patient to be able to re-enroll the patient with a higher payment) do not occur. In response to questions, the submitter indicated that such a mechanism inherently exists within ACOs (because any gain in revenue from care continuity fees would be significantly outweighed by reductions in or eligibility for shared savings), but other non-ACO settings would not necessarily embody such a provision. The submitters indicated that physicians would be unlikely to know their ratios for the penalty in real time and therefore unlikely to game the system, and they also noted that the relationships fostered by CCP would reduce the likelihood of gaming; however, the lack of a specific mechanism means that gaming could occur.*

We acknowledge that this is a possibility, but do not believe that it is likely.

CRITERION 9. PATIENT SAFETY

Aim to maintain or improve standards of patient safety.

- *The lack of monitoring of specific outcomes means that whether patient safety is improved or worsened may not be known.*
- *Concerns about patient safety may be particularly pertinent for standard aspects of primary care involving prevention or monitoring of other disease conditions beyond the particular disease that caused a hospitalization that triggered enrollment in the CCP-PM. It may be difficult to assess whether or not the patient is getting the right care since quality transitional care following discharge may differ from aspects on ongoing primary or general medical care. As noted in other points, appropriate safeguards may be more feasible within organizations such as ACOs than in stand-alone practices.*

As noted above, we strongly encourage monitoring of metrics that include those related to patient safety as part of the CCP-PM evaluation process. We expect the metrics of underlying payment models and Medicare databases to support this analysis.

- *Unintended consequences or potentially perverse incentives to rehospitalize patients mentioned above also may threaten to reduce rather than improve patient safety.*

We acknowledge that gaming could occur as noted, but do not believe that it is likely.

CRITERION 10. HEALTH INFORMATION TECHNOLOGY

Encourage use of health information technology to inform care.

- *Lack of similar health information technologies for providers outside of integrated systems or academic medical centers could compromise communication and coordination of care. Many patients and providers, especially in some geographic areas, currently experience frustration when attempting to transfer*

information across different providers; e.g., the lack of interoperability and limitation of health exchange efforts.

We agree that integrating electronic medical record systems is a challenge, which is why the CCP model is so important. In this model, the individual physician is able to provide inter-network connectivity in real time.

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.]