

Responses to questions

PTAC

Jean Antonucci

Questions on “An Innovative Model for Primary Care Office Payment” PFPM Proposal Submitted by Jean Antonucci MD

Changes in Services

1. What do you see as the most likely changes in service delivery that would be made by practices participating in the payment model that is described in this proposal?

Practices unchained from FFS can offer many different service delivery models particular to the practice-group visits/home visits/ nurse visits/ portals/faxes/ calls to family/ telephonic and e visits etc. Patients should see enhanced continuity and access through these and other unique opportunities(in the author's office there are free drop -in visits to the medical assistant for coaching and problems), because in this model practices will not be driven by volume. Delivery of services that would not now be financially rewarded would let flexibility blossom.

2. On page 6, the proposal says that “patients ... would see no difference ...in how they interact with the practice currently.” Please provide some additional information explaining why this would be the case under this proposal.

Apologies. That sentence was meant to describe that the practices participating in the pilot would still show themselves to the patient unchanged, with the same hrs., staff and phone numbers etc. , as opposed to some corporate/project entity. In fact, patients will see differences of enhanced access via varied entry points -see# 1.They should see enhanced continuity and enhanced engagement.

3. On page 6, the proposal says that “...other providers would see no difference ...in how they interact with the practice currently.” Is it possible to improve coordination of care for patients without changing the way the primary care practice interacts with specialists, hospitals, and other providers?

It should be possible to improve care coordination even if practices are stuck with current systems; if practices with breathing room redesign their own systems to, say, automatize receipt or not of specialty notes and do reconciliation of new meds or therapies prescribed by the specialty. My practice used to call every patient after they were seen by a consultant to ask if they go what they needed, were there any new meds, would they take them, etc. but it became financially unfeasible to do that work.

Starfield described care coordination as the ability to ACT ON the communications received. In other words, increased coordination is a byproduct of enhanced continuity, and number of "touches" the patient receives from the practice.

4. Can you provide some examples of how the information on social determinants of health obtained through the How's Your Health (HYH) tool would be used by primary care practices to change the way they deliver services?

People struggling with behavior change or chronic disease management describe the global negative impact of social and other non-medical determinants as "lack of confidence."

HYH enables systematic unmasking of health confidence, and provides insight into actions that can mitigate the impact of pain, emotional stress, personal capacity, etc. that contribute to health confidence. PCPs who act on these mitigating factors are more likely to have patients who improve their capacity to effectively manage healthy behavior change and/or chronic condition management.

The author's practice has found:

1. Lack of confidence that is often well disguised in person, which opens the door to a conversation about that.

2. Financial trouble .Then we come to understand that they may not be taking their med or, not regularly. Sometimes the author has kept people out of the office with weekly or bi weekly calls for insulin adjustment when the person has no money to come in.

3. From a PCP in RI:

"So for example if patient states problems with finances, check the medications - can you find cheaper? can you change them, check to see if they can afford them, offer other services, i.e. free mammogram and pap through state women's cancer screening program

-do they need a referral to social worker for housing, food, insurance issues?

-I have done all these in response to that question plus being mindful of treatments medications and referrals that patient may need

-Also finding out they are in pain leads to exploration of modalities to help offering pt etc. ancillary services"

4. The author has a diabetic who would not check her blood sugar, so we did it for her at no charge and we hold her test strips (no charge for us to buy them ,then) in the office and see her on a free drop in basis with the MA. She also related better to the MA than the doc. Her bs and bps are now dead on perfect AND she checks her own sugar now.

Quality Measurement

5. Would the quality of care delivered by the practice be assessed primarily using the What Matters Index (WMI) or a broader range of questions from the HYH survey?

Quality would use a broad array .Let's look at HYH while on the phone together. Some of the best measurements are the overall ones in the "care summary"- access and confidence, as well as visits to ER or hospital. I sent you this but it may seem overwhelming. It is likely split easy when I talk you through it.

HYH also measures whether people got mammograms and other preventative measures.

WMI is for risk stratifying not measuring quality.

6. What benchmark would CMS use to determine if a practice was providing "good" quality care under this proposal?

The exactly (I get exactly what and when I need it= single measure for care) and access questions and the confidence question are best. We can look at HYH together- a care quality chart for any one provider is below.

	All Records	Income Pro
Attributes of Care	399	44
Single Measure for Patient Centered Medical Care	84.81	58.14
Very Good Communication for Chronic Disease	92.18	78.95
Aware of Functional Limits	85.51	65.05
Desirable Outcomes	399	44
Patient Confidence	63.40	37.21
Practitioner Benchmark	77.25	60.83
Wellness Activities	77.48	66.09
No Hospital or ED use for chronic disease	95.03	94.74
Medication making it	88.27	77.78
Measures Often Requested by Regulators	399	44
Efficiency of Care (Does not waste time)	96.83	95.35
Any Sick Day in 3 Months	39.90	43.18
Any Stay in Hospital in One Year	7.18	18.60
Continuity (Personal Doctor or Nurse)	96.42	95.45
Any Current Specialist Care	27.52	27.08
One Clinician in Charge	97.62	88.89
Medical Care Perfect (Nothing needs improvement)	71.69	68.47
Very Easy Access	76.48	61.36

HYH tells us what the national medians and upper tertiles are for these metrics

Interpreting the HYH Numbers:

100 is best. As a measure of equity of care, the Quality Summary lists all patients and those who have financial problems. The difference should be less than 10 absolute points.

In all Tables, "too few" indicates 6 or fewer measures in a cell. Measures are very stable when there are 60 or more; reasonably stable for 20 or more; and crude estimates when < 20.

For the period 2014-2017 the median and cutoff for the top third of over 100 typical clinical settings (in which about half of the patients have a chronic disease or bothersome functional limit) are shown below:

Exactly the Care...: median 40; upper third over 50.

Excellent Information for Chronic Disease(s): median 70; upper third 80.

Aware of Functional Limits: median 50; upper third 65.

Patient Confident with Self-Management: median 55; upper third 60.

Preventive and Clinical Benchmarks: median 75; upper third 80.

Patient Habits Generally Healthy: median 70; upper third 75.

No ED or Hospital Use in Year: median 90; upper third 92.

Patient Convinced Medications for Chronic Disease(s) Not Causing Illness: median 80; upper third 85.

7. On page 13, the proposal says that obtaining HYH surveys on 100% of patients is not necessary. If the HYH tool is intended to help the practice identify and respond to patient needs, why wouldn't it be a priority for the practice to obtain responses from every patient?

It is not necessary to sample 100% of the practice to get statistically valid data.

HYH has examined this and 60-100.yr is sufficient for data analysis. One ideally would sample the entire practice to get individual actionable data (data to help those patients). 100% is not realistic given human nature. Practices should get 3 months prior to the payment to obtain 100 surveys then 50% of the practice surveyed by the end of year one.

8. If not all patients will complete the HYH survey tool, would anything be done to ensure that a representative set of patients completes the survey? Would there be any requirement for participating practices to make proactive contact with patients who do not complete the HYH survey?

Practices would be expected to describe how they integrated HYH into the practice in such a way as to maximize response .See # 7 above.

9. Is it correct that the entire 15% withhold would be paid or lost based on whether the practice achieved the quality benchmarks? Why do you believe it is preferable for practices that fall slightly short of the benchmark to file an appeal in order to receive the withhold, rather than paying different proportions of the withhold based on different levels of performance? How would Medicare or other payers determine whether to grant an appeal? What kinds of extenuating circumstances are you envisioning would count for award of the withhold?

Yes, the entire 15 % is either withheld or paid. Complexity is designed out of this pilot. Attempting to set rules for say 13% payment, or for appeals, only makes for higher administrative costs and more frustration. Appeals could be for rare exceptions - a practice flooded out by a hurricane, and closed for 4 months, might appeal. There should be few appeals. The author and colleagues would need to refine these details and be retained as consultants so that this does not become a bureaucratic mess

I do understand an objection would be: well what if a practice is 1% under the benchmarks, are they really any worse and why shouldn't they get the bonus? Most practices will either achieve or fail and few will be "almost there."

10. Please explain why you believe the HYH/WMI would provide equal or better assurance that high quality of care is being delivered than using MIPS measures for three types of patients:

- (a) patients with diabetes,
- (b) patients with heart failure, and
- (c) patients with stable coronary artery disease.

(Sorry formatting trouble as we crossed a page)

The answer is the same for all three conditions.

Disease management has not proven to save money and might induce across the board rationing as money spent on so called high- risk people can take resources away from lower risk folks.

MIPS measures are 1. chosen by the doc so one signs up for what one either does well and 2. / or what is easy to do in the EMR and probably have little to do with" quality."

HYH gives us the patient's voice as well as metrics.

Stratifying patients by confidence and social need (inherent metrics of HYH) eliminates the sort of rationing by disease that is occurring in other pilots. What is quality? An A1 c<9? But some people need it under 7. Percent of people screened for colon cancer? What is the right percent? Why do I stop screening for colon cancer at age 75? Etc.

11. Please explain how the use of the HYH/WMI would provide equal or better assurance that patients were receiving recommended preventive care than MIPS measures do.

The answer is the same as # 10- preventative care must be entered by the doc with MIPS .This can be complex, as EMRs make MIPS measures easier or harder to enter -I have entered a MIPS measure that did not take for reasons the vendor cannot explain. HYH asks the patients. Patients know when they had a colonoscopy, John Wasson has validated HYH with chart reviews repeatedly.

The question conflates process and outcomes, disease prevention measures, and quality. If the goal is to assure PCP adherence to detailed process measures then we continue in the current state of crushing primary care with reporting burdens that fail to address fundamental person and population level quality.

PMPM Payments

12. Since practices would receive the monthly payment regardless of how many visits they have with a patient, should there be any minimum standard for the frequency of visits or patient contacts?

An annual assessment would be a minimum, with the assessment occurring via a varied set of tools.

13. Is it correct that the PMPM payments you are proposing would replace not only Evaluation & Management (E/M) payments, but also payments for minor procedures and tests that do not require the use of expensive supplies? Approximately how much current annual fee revenue per patient do you estimate would be replaced in this way?

Yes it is correct. Approx. \$ 200.00. Practices will vary -some may do fracture care or many derm procedures but most of us will do 1-2 abscess I and d, bx, excision/yr. on a patient costing 200.00 roughly.

14. If the PMPM payments are intended to include minor procedures and tests, would there be any requirement that the practice deliver those procedures and tests itself rather than referring or encouraging the patients to obtain those procedures/tests from a specialist, a hospital, an urgent care center, etc.?

This is an important question. I did suggest in the proposal that counting referrals is not a bad idea. Some PCPs refer as they feel too busy. This will take some time to change and there may be a way to look at some risk adjusted standard.

15. Why did you propose two risk-stratified levels of payment rather than three, i.e., why did you group "low" and "moderate" risk patients into a single tier?

Because most patients are low and medium risk and cost about the same to take care of, and as well to offer less complexity in payment. I am after adequate pay, breathing room and sustainability. Low and medium risk people come in < 1 time/yr. to, say, 2-3 times a yr. High risk patients are not only in 3-5 times a year they need many calls, nurse visits, family calls, prior auths ("touches") etc.

Payment Amounts

16. Could you provide a calculation for your practice or for a hypothetical practice showing that the proposed PMPM payment amounts are necessary to support the costs of delivering high-quality primary care services? Please show as explicitly as possible how the higher revenue compared to current fee-for-service payments would be used, i.e., what additional staff would be hired, what personnel would receive higher compensation, etc.

The Stanford Chronic care program that reduced ER visits by 59% spent \$230.00/mo./patient. (more than twice what my proposal asks for.)

Here is a chart (next page) with numbers as bite sized as I can make it: I cannot tell you, of course, how practices would use money. Urban vs rural areas ,high tech patients vs not, will all vary .I suspect that every practice will spend more time on the phone or portal with patients than in person, and most will lengthen in person visits either just with the doc or with staff, as well. Some will increase their overhead and get more care management or social work staff, some may extend their hrs. Adequate reimbursement with less frustration chained to it, frees up practices to have more time .With less patients physically in the office we can actually see more people or spend more time with each.

	Patient visits/yr./patient	Cost/yr./patient	Touches (letters, calls, etc.)
Low /medium risk patient	2	G0439 + 99213 x1 = Cost/yr total \$209.00	1(\$0)

High risk patient	4	G0439 + 99214 x3= \$439 Cost/yr. total \$883	\$148 x 3=\$444*

*The \$148 is care coordination code maximum 2 hrs. /mo. Assume practice bills for this 3x /yr. Most practices do not bill for this. It is nonface to face work; I made some assumptions.

High risk patients cost more than quadruple the others

 Reimbursement presently:

1500 patients

15% high risk=225 (1275 low risk)

1275 x 209=\$266,475

225 x 883 =\$198, 675

Total revenue \$475,150 divided by at least 50% overhead. Standard is higher= revenue/PCP

\$ 237,575 PCP income

Reimbursement (actually prospective payment) Proposed:

1500 patients 15% high risk

1275x730=\$ 930,750

225x1095=\$ 246, 375

Total revenue \$1,177,125 minus 50% overhead is PCP salary of \$ **588 562**

This revenue will lower the overhead for billing costs but allow raising the overhead to spend money on offering more services / training more staff etc.

17. Would practices find it beneficial to receive a PMPM payment rather than fee-for-service payments if the PMPM payment amounts were equal to the average of current Medicare fee-for-service payments per patient rather than the amounts you propose?

If the cost of billing (8% is standard) was removed and we were paid PMPM, yes we would indeed save thousands of dollars every yr. But it is still inadequate. My practice might get \$10,000. Orthopedics makes three or more times what I make. Too many practices are opting out of Medicare, not just because of inadequate fees but because of the complexity of payment, punishments and penalties. FFS is just not enough dollars for the work we do. The non-face to face work is huge; we can bill for some of it if we meet certain conditions, but it is inadequate and time consuming and not worth it.

In addition, Medicare is only part of any practice so billing costs would not be gone. The Alice in Wonderland absurdity of coding for billing is only part of the issue; we need simple as well as fair. PCPs are historically underfunded so receiving my income as PPM equal to what I get now but without the billing holds out just a small carrot.

18. You have proposed that the payment for the high-risk patients would be 50% higher than the payment for low/moderate risk patients, which is similar to the ratio of your estimates of current average fee-for-service revenues in the two groups. Do you believe that under a flexible, non-visit-based payment system, the high-risk patients would require about 50% more time and resources from the practice?

Yes. See table above. 50% is an underestimate.

19. Why did you choose 15% as the withhold percentage amount? If a practice failed to receive the withhold, what impact would that have on the practice's ability to continue delivering high-quality care?

To encourage quality, safety, efficiency, and patient-centered care and a reward for superb work. See ref below.

The second part of this question may be part of the experiment in practices' ability to manage prospective payments and overhead. After many initiatives end and the coaches go away, most practices revert to old ways. I doubt that without the bonus that practices would fail financially, and I suspect the 15% would be bonus to strive for, a reward for superior work and a withhold when goal were not achieved. Practices that are given support, not rules; room to breathe and innovate, not check

boxes to check; tend to commit despite money. The Ideal Medical Practices practices taught us this. Milstein talks about it in the reference Medical Home Runs.

REF: [J Gen Intern Med](#). 2007 Mar; 22(3): 410–415. **Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care** [Allan H. Goroll](#), MD,¹ [Robert A. Berenson](#), MD,² [Stephen C. Schoenbaum](#), MD,³ and [Laurence B. Gardner](#), MD⁴

Patient Attribution

20. Please explain what patients would need to do in order to formally choose the primary care practice so that the practice could receive the monthly payment for them.

I do understand this is important and widely discussed currently .CMS may need to develop an infrastructure around this because my easy answer of patients designating their PCP during an annual enrollment period, I suspect, meets up with political issues?

It should be prospective and it should be assignment to one physician not a group. If a patient does not receive services from primary care they cannot be in the project.

21. What information would patients receive about how the practice is being paid and what services the patients should expect to receive?

Transparency is crucial, and you certainly could tell them their doctor is no longer being paid only when they come in, thus they may have had limited access to him/ her on the phone-I hear this all the time- and this should now improve. An information sheet describing the work we are doing made available to all beneficiaries in the pilot makes sense, as spending The Peoples money should be done responsibly.

Impact on Spending

23. The evaluation of the Comprehensive Primary Care (CPC) Initiative concluded that participating practices had not reduced spending sufficiently to offset the higher payments to the practices. Why do you believe practices in the proposed model will be able to achieve more savings than the CPC practices?

Savings may not offset the higher spending for a while. The health care world in the USA is so dynamic right now that there are some unknowns. I expect we could stop the rate of rise. CPC+ had a lot of rules I believe like embedding a social worker in the office- increasing overhead unnecessarily and restricting some practices from both participating if they knew they could not meet the rules and restricting practices from innovating according to their practices' needs. I do not know the details of CPC+ financing or payment so I cannot comment on it.

We are up against prices that we do not control, and lack of choice for labs or which specialist to use. I cannot afford to treat poison ivy anymore! We do know our approach works- The Ideal Medical Practice doctors and in fact small practices in general tend to do better on metrics that cost a lot like ER use. (ref Casalino in the proposal). The Stanford Chronic Care model reduced ER visits by 59%- with the same albeit more expensive approach -and they reduced 20%+ in hospitalizations.

One ER visit for sinusitis is \$600.00 here- one **ER visit less pays the doc for almost a year for one low risk patient**. We can track ER use and hospitalizations. Practices have little ability to track or influence costs they incur outside their offices.

I called several CPC+ practice to find out firsthand what the project was like. Only one actually answered the phone but the manager never returned the call. The others had messages I could not get past mostly "closed at lunch time." These practices may not save money because they don't get primary care 101 -which is access. I mentioned above about the residency where I have worked-an NCQA level 3 on paper but one cannot get through on the phone.

What I know is how well the small practices are doing. They are cut out of many of these projects. It is possible that no initiative has worked well because our approach is different- simple and elegant, nimble practices.

Panel Size Limit

24. If lower-risk patients require less time from the physician and practice staff, wouldn't a practice that has a high proportion of lower-risk patients be capable of managing a larger patient panel? Wouldn't that practice be financially disadvantaged by a fixed panel size cap?

Good point! We might make the panel size cap risk adjusted as 1500 person equivalents not persons where the low and medium risk are .8 persons and high risk is 1.5(made up numbers)

25. On page 16, you say that limiting a practice's panel size is "unlikely to induce any further primary care shortage." Wouldn't the limit on practice panel size make it more difficult for patients to get access to primary care services in the short run, particularly in rural areas?

Possibly .But, we are in a crisis in primary care; we can either go on as we are now and face worsening shortages or begin to do what needs to be done.

- Unlimited panel size caps are what make access impossible, not the other way round. You are saying "some patients could not get a doc if the practices were closed." Presently they may "have "a doc ---and get sent to the er! They have one they cannot see. An over paneled PCP deflects care through waits and delay and shorter encounters etc.; it cannot be the PCPs job to see "everyone because there is no one else" -that is a political problem.
- It is also true that paying me more to cover phone calls and e visits INCREASES my ability to see more people as I can care for some with 10 min e- visits or phone care and the simple sinusitis takes 10 min not a longer visit- thus the clinic time is freed up

Patient Cost-Sharing

26. Is it correct that you propose that patients be charged a fixed copay amount for individual services they receive from the practice? Would the copays be revenues to the practice in addition to the \$60-\$90 PMPM, or would the practice only bill Medicare for the difference between the PMPM and any copay revenues?

Nope.

A copay happens IN THE OFFICE

The 20% that Medicare does not cover would not change for the patient.

The practices are not going to bill Medicare for payment -they will submit encounter forms for data and patients' out of pocket expenses will not change.

If this project extends to commercials, I presume patient' rates of payment would not change- but we would eliminate copays since, yes the docs already paid by the pmpm fee.

27. Would copays be charged for every service the practice provides, including phone calls and other non-face-to-face services that are not currently billable?

There are no copays- no fees collected at time of service. If a physician bills for a service, the patients will have this go to their secondary or pay 20% as usual. There will be no difference from the patients' point of view compared to the present and much of the work we would be freer to do may not generate an encounter form. I suspect that physicians who do not need encounter forms to be paid will be not bothering with transitional and care coordination and cpo codes, thus they have their work reduced and patients might have less billed.

Level of Practice Interest in the Payment Model

28. There were no letters of support from other practices included with your proposal and we did not receive any public comments supporting it. How many practices do you believe would be interested in participating in this model if it were made available by CMS?

Those who read the PTAC material may do not know what to make of such a project (see my comments about Penn and other large practices)

I have a list of about 30 docs that I have gathered just by asking around. Easily 5000 Medicare patients (enough for reasonable stats). If CMS proposes this carefully, clearly and without adding complexity, docs tell me they would jump at this. When I talk about this idea docs respond enthusiastically. I have no doubt you would have dozens or hundreds of small practices asking to engage in this project.

29. Do you believe that all practices would prefer your proposed model compared to CPC+ and the AAFP model, or would only solo or very small practices find it preferable?

Any practice would love this. However large practices will not "get it" at first. The U Penn people e.g., who review things for you, will have no idea what I am talking about because they are very divorced from how the phone is answered, how MIPS measures are entered etc. Penn is not exactly a bastion of Primary Care either.

I have no real information about CPC+ payments (it looks quite complicated) or requirements, but I imagine it is like many initiatives that I have been in. Projects require accountability and this begets rules and the rules bog down the work force who may not need a patient family council or an embedded LCSW or who have to fill out quarterly reports. If payment were simple and it cost less to extract "reimbursement" all practices would benefit.

Those who run a practice know what the administrative burden of MIPS /Meaningful Use /NCQA is like. As a long term preceptor in a good residency and as current head of the Primary Care Service-- I see that other practices are so embedded inside the box that it takes a long time, a steep learning curve, to "see" their practices from the outside in and to even consider change. The residency cares for the poor and challenged but will not answer the phone for patients noon- 1, or Tuesday afternoon, at their practice! Yet they can submit reports and get NCQA level 3 access! In addition to the prices (Uwe Reinhardt is right, I cannot save money when prices go up so dramatically) Don't ask Penn to look at this Ask Drs. Robert Bowman, Ed Bujold, Lynn Ho, Jim Bloomer ,Michael Barron all stars at running great practices.

22. If a patient wants to receive specific services from a primary care practice but the patient does not want to choose the practice as its primary care provider, would the practice be able to deliver and be paid for services to that patient on a fee-for-service basis?

This would probably be unusual but might be possible. Would that patient have any designated PCP at all? Are they unwilling to have a PCP? Are they wanting to have walk in acute visits only?

We would develop a short checklist but there is nothing in this model to exclude patients from care. The tenets of primary care are such that Joe Smith who only wants to come in for sore knees and sinusitis is going to get his bp taken and offered colon cancer screening anyway. If he does not choose primary care he would be FFS, but he would get primary care anyway. This is a pilot project.

PTAC

Responses to the PRT team in preparation for September meeting

The author's responses are in italics¹

I look forward to elaborating in September in person Responding in less than 1 week while dealing with a very busy week in the office left great challenges!

JA MD

**Initial Feedback from PTAC Preliminary Review Team on
“An Innovative Model for Primary Care Office Payment”
Submitted by Jean Antonucci, MD**

July 30, 2018

Disclaimer Regarding Initial Feedback:

- Initial feedback is preliminary feedback from a Preliminary Review Team (PRT) subcommittee of the PTAC and does not represent the consensus or position of the full PTAC;
- Initial feedback is not binding on the full Committee. PTAC may reach different conclusions from that communicated from the PRT as initial feedback;
- Provision of initial feedback will not limit the PRT or PTAC from identifying additional weaknesses in a submitted proposal after the feedback is provided; and

Revising a proposal to respond to the initial feedback from a PRT does not guarantee a favorable recommendation from the full PTAC to the Secretary of Health and Human Services (HHS).

Summary of PRT Assessment Relative to Criteria:

Criteria Specified by the Secretary (at 42 CFR§414.1465)	PRT Rating	Unanimous or Majority Conclusion
1. Scope (High Priority)	Does Not Meet	Majority
2. Quality and Cost (High Priority)	Does Not Meet	Unanimous
3. Payment Methodology (High Priority)	Does Not Meet	Unanimous
4. Value over Volume	Meets	Unanimous

¹ Note: Additional italicized formatting has been added where appropriate to distinguish the author's responses.

5. Flexibility	Meets	Unanimous
6. Ability to be Evaluated	Does Not Meet	Majority
7. Integration and Care Coordination	Does Not Meet	Unanimous
8. Patient Choice	Does Not Meet	Unanimous
9. Patient Safety	Does Not Meet	Unanimous
10. Health Information Technology	Meets	Unanimous

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.

Does Not Meet Criterion (Majority)

Although more primary care physicians need the ability to participate in a Medicare APM, multiple models are already being tested or proposed for testing. This proposal incorporates some potentially important innovations in quality measurement, but also has many similarities to other primary care medical home payment models, and it is not clear that enough primary care physicians would find the proposed approach sufficiently superior to other models to warrant testing it separately. It would be desirable to find a way to further develop and test this approach as an option within other primary care models or ACOs, rather than as a completely separate model.

Strengths:

- The proposed payment model for primary care practices is significantly different than the payment models that have been previously tested by CMMI and that are being tested in the CMS Comprehensive Primary Care Plus (CPC+) model.
- The structure of the payment model is specifically designed to be less complex and more administratively feasible for solo and very small primary care practices.
- The proposed payment method uses a completely different approach to risk stratification of payments and quality measurement than any other CMS payment model and any other PFFM proposal that PTAC has previously recommended.

Weaknesses:

- The stratified monthly payment in the proposed payment model is similar to the payment structure in the PFFM for primary care submitted by the AAFP that PTAC previously recommended for testing. Although the monthly payment in the proposed model is simpler than the payments in the AAFP model, and the methods of accountability for quality and spending are different, it is not clear that these differences would lead to sufficiently different or better results to warrant creating a separate model.

- Because of the innovative nature of the quality measurement approach, additional development work would be needed in order to implement this with a large number of practices.
- It is not clear how many primary care practices would be interested in participating in this model or how many would prefer it over other approaches. No letters of support were included, and no public comments (positive or negative) were received. The applicant indicates that she has identified over two dozen interested physicians/practices that care for at least 5,000 Medicare beneficiaries, which would be equivalent to the smallest number of beneficiaries permitted to participate in the Medicare Shared Savings Program as an ACO.

Stratified monthly payment in this model is purported to be similar to that in the AAFP model, however the AAFP model is complex and not transparent, and therefore the author contends it is not similar. Regarding the lack of clarity that this model would lead to sufficiently different or better results to warrant creating a separate model-we do know from practices in the Ideal Medical Practices Project that practices using HYH were able to identify issues that drove ER and hospital use. Additionally, though a separate model of payment would be needed, the built in simplicity here should not incur much in the way of administrative costs. Remember that Dr Antonucci is paid similarly to this by one payer, that payer pays only Dr A this way and there was not a bit of problem setting it up (precedent)

I note the complexity in finding payers then practices to participate in CPC+; we do not have that running in Maine (AND even if that project is available, small practices are cut out of it .The idea to find another way to test it does not seem likely, and a PTAC goal is to work with smaller practices.)

With regard to the how many practices would be interested: the author has already acquired 30+ practices that would be interested in this, with minimal effort on two listservs-the response was immediate and strong. If there were widespread notification, the author has no doubt that practices would jump at this; informal conversations with friends in the policy world support this.

I respectfully submit that recruitment of practices is not a barrier.

It is not surprising that no small practices commented. In fact the author missed the open comment period herself, too busy with doing the work that to even ask others to write in. Small practices are likely unaware of PTAC, barely keeping their heads above water. They are not looking to involvement in Washington .I have not met any other physician who has heard of PTAC. It never occurred to this author that comments to PTAC was of significance to the criterion of the proposal

Thirty practices may be a drop in the bucket statistically but if I can do this with 30min worth of time- there really is no doubt that the proposal meets the important criteria of attractiveness to small and independent practices -though it can enroll any and all.

2. QUALITY AND COST (HIGH PRIORITY)

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.

Does Not Meet Criterion (Unanimous)

Based on available data, the proposed payment amounts would represent almost a tripling of Medicare payments for participating practices compared to what they would receive under the current system. The only justification provided for this is to increase earnings for primary care physicians, rather than to cover costs of explicitly identified additional services for patients.

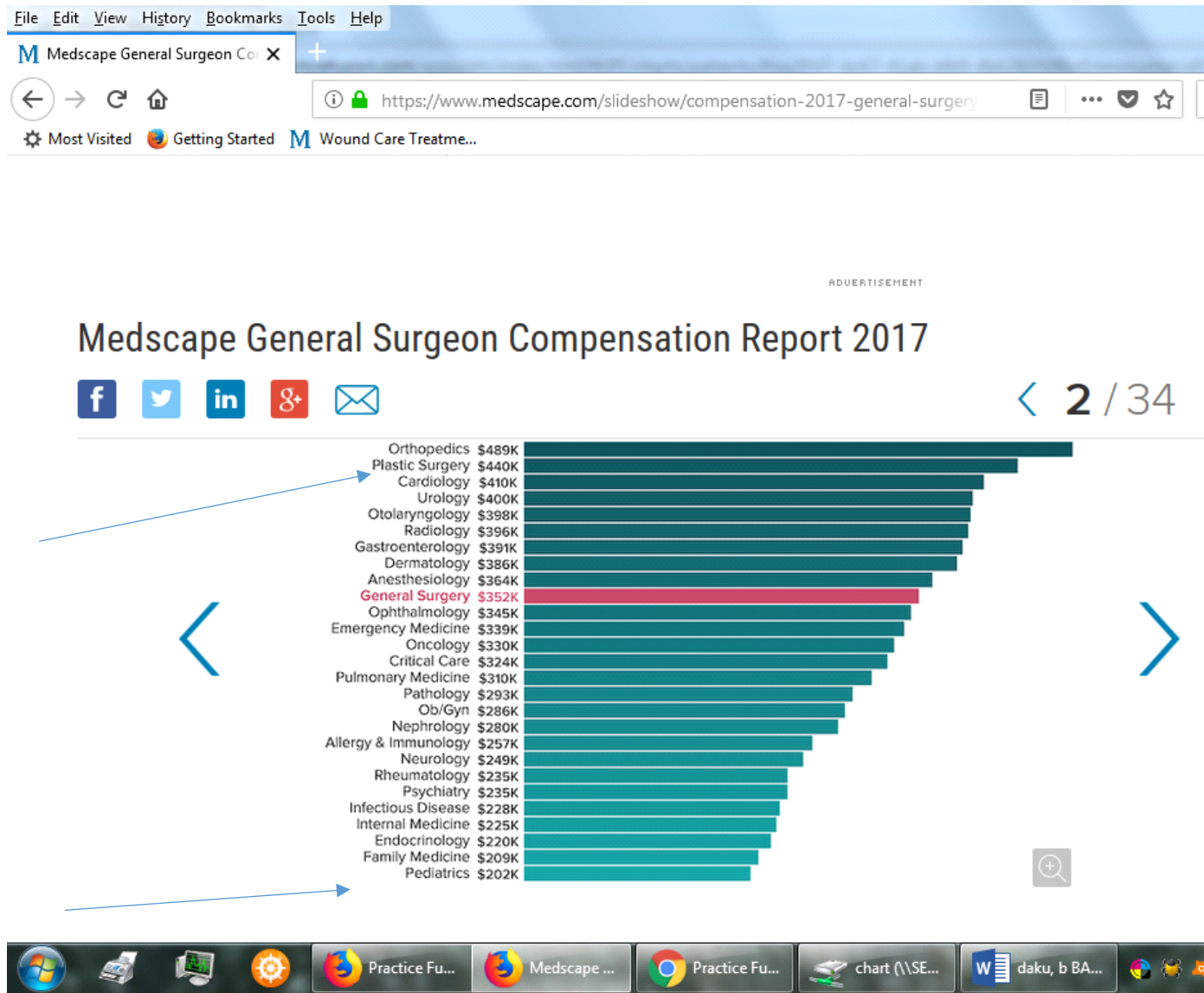
This statement is inaccurate. We are asking to be paid for services we currently either do not provide because we are under FFS constraints or are providing at no cost if we do. It is the author's impression that the AAFP asked for more money without any greater benefit. This proposal is the only one out there that dives into the Social determinants of health(SDH) which are large drivers of costs.

Based on my numbers below the increase is under 2.5 times current payment. The country seems content to pay many specialities large salaries...

This author is not advocating for anything more than fair payment to allow us to do our work

Payment is not everything PCPs need there are other problems but PTAC is about payment

In fact we spend significant time getting ortho and PT derm and optometry paid by doing unpaid referrals We know that much of the day spent on non-patient care (No reference immediate at hand I believe the work of C Sinsky)



Additionally I was explicit in explaining what costs need to be covered. This proposal is not a request for a raise- which is quite frankly owed to PCPs-, but I explicitly point out what we do and the cost to provide services,, costs that are currently unreimbursable or poorly reimbursable

Here you go:

Current maximal possible reimbursement

	<i>Patient visits/yr./patient</i>	<i>Cost/yr./patient</i>	<i>"Touches "(letters, calls, etc.)</i>
<i>Low /medium risk patient</i>	2	G0439 + 99213 x1 = Cost/yr total \$209.00	1(\$0)

<i>High risk patient</i>	4	G0439 + 99214 x3= \$439 Cost/yr. total \$883	\$148 x 3=\$444*

**The \$148 is care coordination code maximum 2 hrs. /mo. Assume practice bills for this 3x /yr. Most practices do not bill for this at all so all of that is done now for free or not done because of some constraining rules and so on .It is nonface to face work; I made some assumptions.*

High risk patients cost more than quadruple low and medium risk patients

So: Reimbursement presently:

1500 patients

15% high risk=225 (1275 low risk)

1275 x 209=\$266,475

225 x 883 =\$198, 675

Total revenue \$475,150 divided by at least 50% overhead. Standard is higher → revenue/PCP

\$ 237,575 PCP income (this is not a common salary froPCPS however we can talk about examples and literature search

Prospective payment) Proposed:

1500 patients 15% high risk

1275x730=\$ 930,750

225x1095=\$ 246, 375

Total revenue \$1,177,125 minus 50% overhead is PCP salary of \$ 588 562

This revenue will lower the overhead for billing costs but allow raising the overhead to spend money on offering more services / training more staff etc.

The applicant indicates that the practice could benefit financially from the payment model, such as through reductions in administrative costs, even if the payment amounts from Medicare were set on a budget-neutral basis.

True but minimally. Minimal is inadequate .PCPs need real change. If the cost of billing (8% is standard) was removed, and we were paid PMPM, yes we would indeed save money. My practice might get \$10,000. Orthopedics makes three or more times what I currently make. Too many practices are opting out of Medicare, not just because of inadequate fees but because of the complexity of payment, punishments and penalties.PCPs have been historically underfunded for a long time

FFS is just not enough dollars for the work we do. The non-face to face work is huge; we can bill for some of it if we meet certain conditions, but it is inadequate and time consuming and not worth it.

In addition, Medicare is only part of any practice so billing costs would not be gone .The Alice in Wonderland absurdity of coding for billing is only part of the issue; we need simple as well as fair. Receiving my income as PPM equal to what I get now but without the billing, holds out just a small carrot.

The author achieved a 98% rating on her 2017 MIPS work and will earn a grand total of \$1,000 more in 2019 for that work, it is clear that PCPs cannot be content with huge burdens of work for tiny carrots

There is mixed evidence as to how much savings can be achieved by changing or increasing payments to primary care practices. It is possible that some practices could achieve sufficient savings to offset the significantly higher payments that are proposed if they are caring for patients who are at a high risk of hospitalizations and if they use the additional funds to provide effective care management services for those patients, but the model would not be restricted to practices with such patients, nor would there be any requirement that participating practices use evidence-based approaches for reducing avoidable hospitalizations or other expensive services.

I the Stanford chronic care project did it for a lot higher payment that this author would dream of needing, they reduced hospitalizations by over 50% and folks in the IdealMedical Practices Project did it .

It is not a mystery how to do it. I was on a IHI phone call 10 yrs. ago where physicians described care management and follow up for CHF folks. It takes time phone calls monitoring and more time.I realize some of you will say this is naïve as there have been some demonstration projects with phone calls etc My understanding is that those projects failed because they were disconnected from the PCP.

2 the author reduced hospitalizations by 33% See below data from HYH. I chose the two periods randomly,just looking at early work and later work

Patients with high risk score-high WMI / high burden of disease: High

2005-2007

No Hospital or ED use for chronic disease	88.89	Too Few
Meds not making ill	88.89	Too Few
	All Records	Income Problems
Measures Often Requested by Regulators	16	4
Efficiency of Care (Does not waste time)	87.50	Too Few
Any Sick Day in 3 Months	56.25	Too Few
Any Stay in Hospital in One Year	21.43	



Same population 2016-1018

Practice Benchmark	50.00	30.00
Wellness Activities	64.29	Too Few
No Hospital or ED use for chronic disease	Too Few	Too Few
Meds not making ill	Too Few	Too Few
	All Records	Income Problems
Measures Often Requested by Regulators	7	3
Efficiency of Care (Does not waste time)	85.71	Too Few
Any Sick Day in 3 Months	14.29	Too Few

Any Stay in Hospital in One Year	14.29	Too Few
Continuity (Personal Doctor or Nurse)	85.71	Too Few
Any Current Specialist Care	28.57	Too Few
One Clinician in Charge	Too Few	Too Few
Medical Care Perfect (Nothing needs improvement)	14.29	Too Few
Very Easy Access	28.57	

We view HYH as evidence based When one unmask the SDH and has the ability to act on them one can make major impacts on patients' lives .The problem is that this is different than the standard measures of so called quality and this looks to be a tough sticking point for this project I hear that the PRT likes HYH but on the other hand does not trust it to measure quality

If the change in payment method or amount encourages more primary care physicians to enter or remain in practice in rural and underserved areas, the improved access to care could generate additional savings for patients living in those communities. However, the proposed limits on practice panel size have the potential for reducing access to primary care services in the short run, which could increase Medicare spending

Access to primary care is already poor, and limited access diverts patients to the ER. We don't agree with this hypothesis. Limiting panel size and adequate payment lets practices do group visits, telehealth, e visits (the author has done e visits for 13 yrs.) and these expand access.

The flexibility provided in the payment model and the focus on improving performance on patient-centered quality measures would enable and encourage physicians to deliver more responsive, higher-quality care. However, experience with practice capitation payment systems indicates that some practices could be less responsive to patients who need to be seen by the physician, and nothing in the payment model is explicitly designed to prevent that.

There are also capitation projects that work. I am respectful of the fears around this but I have put some safeguards in place. Safeguards incl benchmarks, panels size, and not only a requirement for access but remember the patients tell you if they have access

Although the payment model includes a significant penalty for a practice that fails to meet quality targets, and that penalty is greater than what the practice could experience under MIPS or other CMS primary care models, the large increase in monthly payments would mean the practice would still be receiving significantly more revenue than it would under the current system even if it failed to receive the 15% withhold, which could reduce the incentive to deliver high-quality care.

This comment misses a key part of the innovation here and is derived from the usual measurement of quality. Because the patients are measuring quality here the practice could only receive the revenue until an assessment came around. And it could equally well incentivize physicians to do what they are trying desperately to do.

The proposal's focus on patient-reported outcomes using the How's Your Health tool is innovative and is very desirable in many ways, including reducing administrative burden on physicians for collecting and reporting multiple quality measures and ensuring attention to the issues that matter to patients. Although patient-reported measures have many advantages over process measures and claims-based measures, they can also create burden

for patients and the potential for disparities in care due to low response rates for patients with limited health literacy, language barriers, and lack of computer/internet access.

*John Wasson who developed HYH did this work- asking patients about taking the survey
The patients who were more than willing to do it once a year were the sickest. 15min a year
is not a burden.*

*John describes this in detail and may I have him on the phone at the September mtg? What
are the burdens for CAPHS and the response rates? We can do better.*

Moreover, the How's Your Health tool and risk adjustment through the What Matters Index have not been tested or validated for performance evaluation or payment?

True

*However HYH metrics drive tools to address problems and there is a relationship between
its' reporting and cost (therefore payment)*

*"the WMI can be used to place patients into groups associated with levels of costly services, but
neither is likely to forecast costly service use for individuals. However, unlike risk-designation
models, the WMI is based on measures that will immediately guide care for every patient."*

Reference given Wasson Solway Moore Ho

And the impacts on patient access and measure reliability from tying the results to payment would need to be carefully assessed.

*Which is what we would do although Dr Wasson has done this work and I see he needs to
explain it to you*

In order to use the results of the How's Your Health Tool as part of a performance-based payment, a standardized sampling frame and mode of administration would be needed in order to insure consistency and comparability of results and to avoid the possibility of manipulation of results, and this would be very different than the proposed method of data collection for use in quality improvement and patient care.

*Sure HYH is done before preventative visits. Wasson has done all this work. The proposal
was limited in length -these are details well looked at and doable*

Strengths:

- The practice would have more flexibility and more resources to deliver more and different services to patients.
- The proposed quality and risk stratification tool is more directly tied to patient characteristics and issues that a primary care practice can directly address than typical diagnosis-based risk tools and outcome measures.
- The proposed quality/risk stratification system is being actively used by the applicant and by some other practices to improve the quality of care they deliver.
- The patient surveys identify barriers to adherence and social determinants of health so that practices will be aware of these and can try to address them.

Weaknesses:

- Because the monthly payment would incorporate payments that would otherwise be made for minor procedures and office-based tests, it is possible that some practices could send patients to specialists or urgent care centers for these services rather than performing them directly, which would increase Medicare spending.

As stated we could measure that . This comes under the concern of gaming the system which I respect but seems that nothing can be 100% certain Oh heavens except death and taxes and perhaps the speed of light . Safeguards about the withhold and pane lsize were built into help

- Using a completely different quality metric for practices participating in this model will make it difficult for patients and CMS to determine whether the quality of care is better than in non-participating practices.

The value to society from primary care as written by Starfield did not describe measuring metrics, and she warns us about disease centric care etc. I suggest a broader definition of quality But, Medicare has claims based data on a few MIPS measures that it can compare There is also the model of using batched groups of practices to look at some data yes?

It is not clear what level of quality the participants will be expected to achieve

The proposal made an outline. Details were left out due to length. HYH has well established benchmarks. The right approach is to pick a measure, is and you have samples of somewhat over 300,000 to compare to. Crucial measures of quality that improve care and reduce costs are first and foremost access. Another is confidence- the work on which PTAC members may not know about

Here are the basic measures, that have updated median and tertiles: HYH has extensive experience used in Canada and in Iowa etc. with median and tertiles quite clearly spelled out in the HYH materials

	All Records	Income Problems
<i>Attributes of Care</i>	384	43
<i>Single Measure for Patient Centered Medical Care</i>	65.04	57.14
<i>Very Good Communication for Chronic Disease</i>	92.57	77.78
<i>Aware of Functional Limits</i>	85.78	82.46
	All Records	Income Problems
<i>Desirable Outcomes</i>	384	43
→ <i>Patient Confidence</i>	63.32	35.71
<i>Practice Benchmark</i>	77.12	82.42
<i>Wellness Activities</i>	73.70	67.26
→ <i>No Hospital or ED use for chronic disease</i>	94.92	94.44
<i>Meds not making ill</i>	87.97	76.47
	All Records	Income Problems
<i>Measures Often Requested by Regulators</i>	384	43
<i>Efficiency of Care (Does not waste time)</i>	96.76	95.24
<i>Any Sick Day in 3 Months</i>	19.58	41.86
→ <i>Any Stay in Hospital in One Year</i>	7.35	19.05
<i>Continuity (Personal Doctor or Nurse)</i>	96.34	95.35
<i>Any Current Specialist Care</i>	27.67	25.00
<i>One Clinician in Charge</i>	97.56	87.50
<i>Medical Care Perfect (Nothing needs improvement)</i>	71.54	59.52
→ <i>Very Easy Access</i>	76.72	60.47

Interpreting the Numbers

100 is best. As a measure of equity of care, the Quality Summary lists all patients and those who have financial problems. The difference should be less than 10 absolute points.

In all Tables, "too few" indicates 6 or fewer measures in a cell. Measures are very stable when there are 60 or more; reasonably stable for 20 or more; and crude estimates when < 20.

For the period 2014-2017 the median and cutoff for the top third of over 100 typical clinical settings (in which about half of the patients have a chronic disease or bothersome functional limit) are shown below:

Exactly the Care...: median 40; upper third over 50.

Excellent Information for Chronic Disease(s): median 70; upper third 80.

Aware of Functional Limits: median 50; upper third 65.

Patient Confident with Self-Management: median 55; upper third 60.

Preventive and Clinical Benchmarks: median 75; upper third 80.

Patient Habits Generally Healthy: median 70; upper third 75.

No ED or Hospital Use in Year: median 90; upper third 92.

*Patient Convinced Medications for Chronic Disease(s) Not Causing Illness:
median 80; upper third 85.*

Certifiers and Regulators Turn Toward Patient Report

As certifiers and regulators for the Patient-Centered Medical Home have increasingly become aware of the extreme inefficiency and lack of face validity of process-of-care documentation, they are gradually accepting the summary measure from HowsYourHealth.org to overcome these deficiencies. (HowsYourHealth.org meets NCQA criteria as an "approved" health risk assessment). As an example, for NCQA documentation of medical care access, continuity and coordination the HowsYourHealth.org patient-reported measures may obviate the need for excessive documentation of their processes. A crosswalk between HYH measures that may substitute for NCQA requirements is [posted here](#).

Continuity: median 85; upper third 90.

In Charge (Coordination if 2 or more clinicians): median 90; upper third 95.

Very Easy Access: median 50; upper third 60.

- The proposed payment amounts would represent an approximately 150-200% increase in Medicare spending for a practice with the mix of patient characteristics and visit frequencies described in the proposal. This would represent approximately \$150,000 for a practice with 300 Medicare patients. Based on average emergency department (ED) visit and hospitalization rates for the Medicare population, the participating practices would need to completely eliminate ED visits or reduce the total number of

hospitalizations by approximately 20% in order to offset the higher payments to the practice.

The author understands that given the historical underfunding of primary care that large increases in pay are being discussed here and this is a tough topic. All we can say from out here on the ground is that the country sees fit to pay dermatology far more than primary care when our value to society is great, and there is less and less primary care around. There are constraints on PTAC and political issues but the case for this proposal is strong.

Reducing hospitalizations was addressed above as was a detailed clear itemization about Payment is one small part. Someone needs to get Merck and Sanofi to sell unit doses of vaccines and we need to stop the prior auth nonsense that is out of control. We need a great many things. The country will not be able to recruit PCPS who could bring their ingenuity and heart if we do not pay them.

Political will would pay for this by reducing payments to derm and radiology, anesthesia and ortho that is not the topic here. History calls folks.

Based on available data I submitted to you, the proposed payment amount would represent 2 1/2 times what practices concurrently recoup although probably less because as panel size goes up, overhead goes up.

Participating practices would in fact be using the evidence-based approach of HYH to reduce avoidable hospitalizations -- although the staff at PTAC shows interest in HYH it is clear that they do not yet have a deep understanding of how the tool is useful. It will take a deep dive into some of the work regarding confidence and access to see that how's your health gives an approach to reduce avoidable hospitalizations and expensive services.

A recurrent theme throughout the feedback report is the concern about measuring quality. In this project we are measuring quality in a different way and probably a way that is better. The feedback seems to lead back to quality as measured by disease centric metrics and some process measures. Measuring AI C is a clinical tool is not necessarily a measure of quality, this is one of the challenges I face in this proposal.

Measuring access from the patient's point of view is innovative (access drives ER use) and I think this is not well understood so far by the PTAC staff. When you assess access from the patients' point of view you will know if the practice was responsive to the patient-- this is very different and I think it's being overlooked.

In addition I note that there have been successful models with capitation and I call to your attention the model referenced in New York, a Blue Cross model from several years ago.

Concern for gaming the system exists. Physicians currently game the system now to get paid for services they otherwise have to deliver for free - we can talk in person about TB testing.

However since we are measuring from the patients' point of view, I call out to you how incredibly different that is, and access will be one of our benchmark measures.

Being paid more might reduce the incentive to deliver high-quality care however frankly I'm banking on the fact that practices would like to provide high-quality care.

Using a completely different quality metric may not make it difficult to determine whether the quality is better or not; the country cannot settle on what quality metrics should be, however without getting into that discussion CMS has plenty of data coming from claims data -practices will have to do nothing- we can have some of the "standard" quality metrics looked at to compare

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

Does Not Meet Criterion (Unanimous)

The proposed payment methodology would provide better support for primary care practices that want to deliver higher-quality, more efficient care for Medicare beneficiaries. However, it could also enable primary care practices to deliver lower-quality, less efficient care.

It could but this comment seems overly cautious given that patient reported measures of care as an assessment are expected to hold practices feet o the fire

NCQA pcmh and other current so called initiatives have pushed practices to DPC reducing access and tiering care, I believe this proposal may make primary care a logical career choice once again, and with more PCPs we improve care

Capitation has long been criticized for this potential reason of taking the money and not doing work I believe there are safeguards here to address this

The quality component of the methodology is significantly different from the methodology used in any other Medicare payment program, and it would be challenging for CMS to ensure that the quality of care for beneficiaries was being maintained or improved.

Again there are claims based measure in MIPS yse? Comparisons can be done, the authors advisors say.

The theme of measuring quality in this project runs through all the comments This proposal looks at quality differently and the PTAc members supportive of payment innovation are perhaps embedded in the usual disease oriented metrics as quality The author indeed proposes innovative simple well tested measures of quality

Strengths:

- The practice would receive a risk-stratified monthly payment that would replace virtually all of the practice's fee-for-service revenues and provide complete flexibility as to how services should be delivered to patients.
- Higher payments would be paid for patients whose characteristics would be expected to increase the amount of time and resources the practice would need to spend in caring for the patients; this would discourage cherry-picking of patients.
- There would also be greater opportunities to reduce spending on the patients receiving higher payments, since the risk stratification tool has also been shown to have equivalent ability to predict utilization and spending as claims-based risk adjustment systems.
- The payment system would be relatively simple for practices and payers to implement.
- A significant portion (15%) of the practice's revenues would be at risk based on quality performance.

Weaknesses:

- It would be possible for a practice to reduce access for patients and to reduce the number of services it delivered with no immediate/short-run impact on the practice's revenues.
That is true only in the short run A safeguard would be to review data monthly and consider action
- The proposal does not define whether patients could continue to receive primary care services from other practices, or whether any adjustment to the proposed payments would be made if they did.
Patient choice is important ,Patients can choose to enroll with a primary care doctor or not, and then agree to receive their care form that practice Patients that travel to Fla for the winter would be disenrolled or enrolled elsewhere Monthly attribution would be done

- The proposed payment amounts are almost triple current payment levels based on Medicare spending for a practice with the mix of patient characteristics and visit frequencies described in the proposal. There are no data provided showing that the proposed amounts are needed to cover specific costs required to deliver high-quality care.
IN fact the payments are 2.3times what we can now be paid(257,00 vs 588)
If it pleases the nation to pay ortho 3-5 times what primary care makes and continue to have us providing 1/2 of our day unpaid then there is no hope for primary care, and there may not be any in this country. If asking for a raise is met with the answer that we are not entitled to earn what our colleagues earn there is no hope. We all know there is plenty of money in the system More belongs to primary care; the constraints in the system do not appear to let us move money around.
I provided specific data to show you what it costs to take care ofpatients see above

- The penalty for any shortfall in quality would be complete loss of the withhold, rather than a more graduated penalty based on relative levels of performance, which could increase the resistance to setting high goals for quality.
The author disagrees Graduated levels of performance and the administrative costs and bureaucracy rule setting associated with such ideas has plague many initiatives. The fact is that practices are likley to succeed or not. After some trying I doubt we will see practice come close to benchmarks but not achieve Possible, but, one must live in a real world .Complexity causes higher costs and more frustration out here on the ground The authors MIPS work for 2017 cannot even be understood Very complex yet a 98% score was achieved For that she gets about 1, 000 next yr. Graduated payments are not very enticing to the real boots on the ground docs who have been through lots of projects.It is reasonable to go forward as designed

Specific criteria for awarding the withhold have not been defined.

The benchmarks have been mentioned See above John Wasson would like to discuss this with you in September

CRITERION 4. VALUE OVER VOLUME

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

Meets Criterion (Unanimous)

The payments to the practice would no longer be based on the number or type of services delivered, but would instead be based on the number of patients managed, the level of need for those patients, and the practice's performance on quality and utilization.

The proposed cap on patient panel size would discourage the practice from taking on an excessive number of patients without being able to adequately serve them. Although the risk-adjusted payment and the cap on panel size would encourage the practice to take on higher-need patients, it could discourage the practice from accepting healthier patients who need good preventive care. The applicant has suggested that modifications to the cap could be made to ensure that all types of patients could access services.

Strengths:

- The payment to the practice would no longer be tied to the number or types of services it delivers.
- Practices would be paid more for patients with characteristics that typically indicate a need for more proactive or intensive services.
- A significant portion (15%) of the practice's revenues would be at risk based on quality performance.

Weaknesses:

- The lack of a direct connection between payments and services could lead to stinting on aspects of care that would not be readily detectable through the proposed quality measures.

This a repeated comment and addressed above

- The high payments per patient and the proposed cap on panel size could discourage the practice from accepting healthier patients.

Yes it could but accepting new patients is a highly variable process Most of us take whoever calls unless we don't accept their insurance This project pays so fairly their would be no incentive to cherry pick .

In some ways it is a delight to have low risk patients

Docs are overwhelmed by the complexity of current work It is a joke among us that we would kill for a uti to come in. The joke used to be that PCPs were going to just take care of colds while patients went to their real docs A cold is delightful break in days filled with htn ,,dm , morbid obesity, anxiety and depression This has been written about esp in the context of the influx of NPs replacing physician positons and often siphoning off the simpler cases leaving PCPs only with complex cases.

I disagree

CRITERION 5. FLEXIBILITY

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

Meets Criterion (Unanimous)

A participating practice would have substantially greater resources to deliver services and greater flexibility regarding the types of services it could deliver to patients than under the current payment system. Even more resources would be available for higher-need patients.

Strengths:

- The primary care practice would have complete flexibility as to which services it would deliver using the revenues from monthly per-patient payments.
- The practice would receive a higher payment for patients with higher-need/risk characteristics, giving it the flexibility to deliver additional services to those patients.
- The proposed payments are much higher than what the practice currently receives, which could enable the delivery of many more or different services to patients.

Weaknesses:

- The practice's flexibility would be limited to the services that it could deliver itself; there would be no changes in payment for any services delivered by other providers.

Agree

This is proposal for primary care payment .I mention above that payment models need to change for specialties, but that is not the scope of this proposal therefore it is not a weakness Did I understand your meaning?

- There is no assurance in the model that higher payments would be used to deliver more or different services to patients, rather than simply increasing physicians' income for the same services as they are delivering today.

This gets mentioned again and again The assurance is that patient tell you access They tell you if they know who is in charge

CRITERION 6. ABILITY TO BE EVALUATED

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

Does Not Meet Criterion (Majority)

The majority of the PRT members felt that because the proposed model would use a completely different method of assessing quality than in the rest of the Medicare program, and because there would be no direct way of tracking how the practice's services to patients

had changed, it would be very difficult to assess whether the quality of care had been maintained or improved.

A minority view was that more innovative payment models will inherently be more difficult to evaluate, and since it would be feasible to evaluate the model's impact on standard measures of utilization and spending, the proposal can at least minimally meet this criterion.

The author appreciates the minority

As stated above over and over the problem is what the majority calls quality

Strengths:

- Because most aspects of utilization and spending occur outside of the primary care practice, it would be straightforward to calculate utilization and spending per patient for patients assigned to the practices in the model, and then to compare that to utilization and spending for patients attributed to non-participating practices.

Weaknesses:

- Because the practices would be using a different tool for measuring quality, it would be difficult to assess the differences in quality between participating and non-participating practices. If participating practices were required to report standard MIPS quality measures as well as the patient-reported measures in order to facilitate evaluation, it would increase their administrative burden rather than reduce it

I addressed this above PTAC's def of quality may need to move I am not aware of a broad consensus that the country's current measures actually find quality But as stated again use some claims data.

- Because risk stratification is based on a tool that would only be used by practices participating in the model, it would be difficult to separately measure differences in utilization and spending for patients in each of the risk tiers.

This confuses the author as total cost of care is being measured many places incl. CMS as part of MIPS If CMS can report costs and if patients are reporting utilization- and claims will be also be used AND as stated encounter forms for the services provided will be submitted just not connected to payment then this should be possible

- It would be difficult to evaluate the extent to which favorable impacts on cost and quality resulted because (1) the practice began using the HYH tool and was more effectively able to identify patient problems, or (2) because of the different services that could be provided due to the increased payments and greater flexibility

Possible true However as PTAC itself states there isn't clear evidence that improving payment in primary care improves care -these two may be inextricably tied together

Because payments would no longer be based on service-specific claims, it would be difficult to determine what services are actually being delivered unless practices agree to submit encounter forms for services.

The proposal is quite clear that that exactly WOULD be expected

Depending on how many practices would participate and where they were located, it could be difficult to find comparison practices that are not participating in CPC+ or other payment models.

There are lots of practices excluded from payment models because of their size; even if in an area where there are other models Practices I talk to JUMP at this model and would jump ship from the unhelpful burdensome ACOs etc. to trial simplicity and fair payment One practice I accidentally encountered and did not discuss money with was just thrilled at HYH: "this is exactly what we need to know",

We must balance overestimating the bad guy system gamers with underestimating those needing a chance to be good guys

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.

Does Not Meet Criterion (Unanimous)

Although the proposed model would give the primary care practice more flexibility to carry out care coordination activities, there are no specific mechanisms defined for assuring that it would do so.

Strengths:

- The payment model would provide more resources and flexibility to a primary care practice to enable it to carry out care coordination activities for its patients.
- Use of the How's Your Health survey would help the practice identify patients who do not feel their care is being effectively coordinated and to measure whether the practice's services had resulted in improved coordination from the patient's perspective.

Weaknesses:

- The proposal does not establish any specific standards or goals related to care coordination.

*There is not much literature around this- but HYH specially asks does the patient have specialists and know who is in charge that's care coordination
And it also asks whether their meds make them sick*

- While the proposed payment model would provide more resources and flexibility to the primary care practice to support care coordination activities, it does not directly affect the willingness or ability of other providers to support coordinated services.

Starfield tells us there is a structure and a function to care coordination The structure is the templates etc to get info to the specialist That is the action we can do well on our end

The behaviors are around following up, reading the report, seeing that a patient on mevacor was given lovastatin etc Practices approach this in various ways What counts the most is the referral happening, reducing unnecessary ones , and when possible using specialists who act in the PCPs' and patient's best interest.Affecting the behavior of the specialist is beyond the scope of this initiative.

What practices do when there's more time is cultivate the relationships with certain providers .Practices would have time to follow up on referrals; this is measured in mips but I have not seen an automated function in an emr to remind and ensure follow-up after a referral . I find this objection tough as what we are after is payment for primary care that is innovative and efficient and sensible Many providers have no choice what urologist is available to them and changing that behavior is beyond the scope of this project

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.

Does Not Meet Criterion (Unanimous)

The payment model would enable primary care practices to deliver services in different ways based on their patients' needs. Depending on the types of changes a practice makes, the changes could be beneficial to patients or harmful to patients. The proposal does not describe how patients would be informed about the differences between the proposed payment model and the current payment system and what information and assurances the patient would receive about the types of services and the quality of the care they would receive. Consequently, it is impossible to say for sure that the model would *improve* the patient's choices.

In the response to questions the author did address providing a handout to patients This is important .Patients could chose to be in project that was designed to improve access care

coordination etc I did not think the actual details were to be included in the proposal, sorry, I can produce a draft of a handout to patients for the Sept mtg.

If the payment model encourages more physicians to enter or remain in primary care, patients would have more choices about where to receive their primary care in the long run. However, the proposed limit on practice panel size could potentially reduce access to primary care in underserved areas in the short run.

This is a real concern that already exists Access is poor now Big panel sizes deflect care to the ER. There was an absurd (to Dr A) article a few years ago in Family Practice Management detailing how to prescribe for people you could not see because your panel was too big! Hours spent with a committee and a process to give meds to people no doc was assessing! Remember above I discuss e visits and group visits,etc Practices will offer things they cannot do now, and offer things sensible to their geography and panel base, and improve access and choice .

- The payment model could encourage more physicians to enter or remain in primary care, thereby increasing the number of primary care physicians that patients have to choose from, particularly in rural areas.
- The use of the How's Your Health survey and What Matters Index would create a direct way for patients to notify the practice of their needs and would encourage practices to respond to individual needs.

Weaknesses:

- The proposal does not define or set standards for the information that would need to be provided to patients to enable them to make an informed choice about whether to enroll in a practice that is being paid in this way. This is a minor obstacle
And I will bring some information to Sept
- The higher payments per patient and the proposed limits on practice size could reduce access to primary care in the short run.

Already answered I disagree

CRITERION 9. PATIENT SAFETY

Aim to maintain or improve standards of patient safety.

Does Not Meet Criterion (Unanimous)

There is no assurance that individual patients would receive the care they need. The practice would be paid the same amount regardless of how many services were provided, as long as an annual assessment was conducted, and there is no requirement that every patient would complete the How's Your Health survey, so it is possible that the practice could receive its full payment for every patient even if a subset of patients is receiving poor-quality care.

Strengths:

- The How's Your Health survey and the What Matters Index would help practices identify patients with potential medication safety issues and other safety issues.

Weaknesses:

- There is no requirement that the How's Your Health survey be completed by all patients.

There is a requirement that practices establish a method to offer hyh to everyone It is not possible to have all patients do any one thing. The proposal requires a minimum number that is a very stable metric based on 2or 3 decades of work by John Wasson.

Could doctors game system and ask certain patients to do HYH? Yes but a pre visit HYH not done in the presence of the physician has proven not be so gameable Patients report access or efficiency or confidence in surprising and not so predictable ways

- The highest-risk patients may be the least able or willing to complete an online survey.
Sure I did not address the details in the proposal due lack of space The approach is to ask every patient once a yr or once every two years. I will ask Wasson to be available in Sept for this and this issue above

- Because the practice's revenues would not depend at all on the number of face-to-face visits with the patient, a practice could be paid even though it failed to see patients who needed visits.

This is the same as answered multiple times " you will take the money and not do the work "addressed above!

Patients report the access Practices could not take the money for very long and not see patients because that is a benchmark measure

CRITERION 10. HEALTH INFORMATION TECHNOLOGY

Encourage use of health information technology to inform care

Meets Criterion (Unanimous)

The model is premised on the use of an online system for patient-reported outcomes and analysis of practice performance.

Strengths:

- Patients in participating practices would be encouraged or required to complete an on-line survey tool assessing health-related issues and satisfaction with the practice's services.

Weaknesses:

- The proposal says that at least "50% of qualifying participants are expected to use CEHRT" (Certified Electronic Health Records Technology), but there is no mechanism for assuring that.

Good point Pretty easy to measure on enrollment in the project

Also:

[Health Affairs Vol. 32, No. 8: Health IT, Payment & Practice Reforms](#)

Office-Based Physicians Are Responding To Incentives And Assistance By Adopting And Using Electronic Health Records

- [Chun-Ju Hsiao](#)¹[Ashish K. Jha](#)²[Jennifer King](#)[Vaishali Patel](#)⁴

PUBLISHED: August 2013 Free Access

Abstract

Expanding the use of interoperable electronic health record (EHR) systems to improve health care delivery is a national policy priority. We used the 2010–12 National Ambulatory Medical Care Survey—Electronic Health Records Survey to examine which physicians in what types of practices are implementing the systems, and how they are using them. We found that 72 percent of physicians had adopted some type of system and that 40 percent had adopted capabilities required for a basic EHR system.

PHYSICIAN-FOCUSED PAYMENT MODEL
TECHNICAL ADVISORY COMMITTEE (PTAC)

PRELIMINARY REVIEW TEAM (PRT)

CONFERENCE CALL WITH JEAN ANTONUCCI, MD
SUBMITTER

Friday, July 27, 2018

1:00 p.m.

PRESENT:

HAROLD D. MILLER, Lead, PTAC Committee Member
TIM FERRIS, MD, MPH PTAC Committee Member
KAVITA PATEL, MD, MSHS, PTAC Committee Member

AUDREY McDOWELL, Assistant Secretary for
Planning and Evaluation (ASPE)

SARAH SELENICH, ASPE

CRAIG LISK, Social & Scientific Systems, Inc. (SSS)

JEAN ANTONUCCI, MD

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

2 [1:03 p.m.]

3 MS. McDOWELL: Okay. Thank you, everyone,
4 for joining us.5 So, as we know, Dr. Antonucci, who -- Dr.
6 Jean Antonucci, who we're going to be calling
7 "Jean," submitted a proposal to PTAC regarding "An
8 Innovative Model for Primary Care Office Payment,"
9 and this is a meeting that has been called by the
10 PRT that is reviewing this proposal in order to ask
11 some additional follow-up questions to Jean
12 regarding this proposal.13 And so my name is Audrey McDowell. I'm on
14 the ASPE staff, and I am supporting this particular
15 PRT, and later on, the members of the PRT will be
16 introducing themselves, but we want to just
17 reiterate that this call is being recorded and
18 transcribed, and so for purposes of the
19 transcription, please be sure that you state your
20 name as you speak, so that it will be easier for
21 the transcriptionist to be aware of who's speaking
22 as we are going through the discussion.23 And I'm going to now turn it over to
24 Harold.

1 MR. MILLER: Great. So I'm Harold Miller,
2 CEO of the Center for Healthcare Quality and
3 Payment Reform. I am not a physician, but I will
4 ask my two colleagues who are physicians, primary
5 care physicians, to introduce themselves.

6 Kavita?

7 DR. PATEL: Hi. Kavita Patel. I am a
8 primary care internist in employed ambulatory
9 setting in the D.C. area and also do health policy
10 work at the Brookings Institution.

11 MR. MILLER: Tim?

12 [No response.]

13 MR. MILLER: Tim is on mute. Tim
14 disappeared.

15 DR. FERRIS: Oh, yeah. I was speaking
16 while on mute.

17 MR. MILLER: Yes.

18 DR. FERRIS: So sorry. Tim Ferris, Med-
19 Peds doc at Mass General Hospital and the CEO of
20 the physicians organization at Mass General.

21 MR. MILLER: Great.

22 And, Jean, just for the record, do you
23 want to introduce yourself so we have that on the
24 transcript?

1 DR. ANTONUCCI: Sure. I am Jean
2 Antonucci. I'm a family doc in rural Maine, where
3 I have a solo practice in Farmington, Maine.

4 MR. MILLER: Great.

5 So, Jean, first of all, thank you very
6 much for making the effort to put together a
7 payment model proposal. We very much appreciate
8 that. All of the folks who are on the PTAC, who
9 are all volunteers, did that and have volunteered
10 because of our desire to see physicians and
11 particularly small physician practices like you be
12 able to actually develop payment models and get a
13 hearing for them. So we appreciate you doing the
14 work on that.

15 Let me just briefly explain -- and you may
16 know all this already, but let me just briefly
17 explain sort of who we are and what we're trying to
18 do. The three of us are essentially a subcommittee
19 of the full PTAC, which has 11 members on it, and
20 our three-person subcommittee does -- which we call
21 the PRT -- does data gathering really for the full
22 PTAC to try to make sure that questions get
23 answered before the full PTAC comes together.

24 It's important to understand that the full

1 11 members of the PTAC have not discussed your
2 proposal at all yet, and because we are legally
3 constrained, that we only do that in public. So
4 what you are hearing, the questions you are hearing
5 and the discussion is just with the three of us
6 right now, and we will -- ultimately, that will be
7 -- your proposal would be discussed by the full
8 PTAC.

9 But we do ask lots of questions to try to
10 facilitate that whole process, and we start off
11 with written questions, just to try to get stuff
12 down on paper, and then we ordinarily, as we're
13 doing today, have a phone call with the applicant
14 to try to understand better some of the areas that
15 don't really work as well in terms of written
16 responses. And we appreciate all of the work that
17 you've done so far to answer our many questions.

18 I do want to assure you, because you -- I
19 think you had some skepticism about that. We have
20 all read your proposal, and the questions that you
21 got were written by us, not by anybody at Penn or
22 anyplace else. So it's really the three of us that
23 are doing the thinking and the questioning here.
24 So these are all questions coming from us.

1 I have personally read your proposal about
2 five times.

3 DR. ANTONUCCI: I'm sorry that --

4 MR. MILLER: No, that's okay. Just so you
5 know, we are -- we take this incredibly seriously.

6 DR. ANTONUCCI: Thank you.

7 MR. MILLER: One thing, though, I think,
8 final thing to make it clear is this is not sort of
9 a matter for us of personal preference, whether we
10 like the proposal or the concept or not. What we
11 do under the law is review the proposal against
12 these 10 criteria that were established by the
13 Secretary of Health and Human Services. So that's
14 really why we've structured our questions that way,
15 and we really have to dig into to try to figure out
16 what is a fair evaluation of that.

17 So before we start, any questions that you
18 have about the process? And this is just one step
19 in the process today. This is hardly the final,
20 the final step.

21 DR. ANTONUCCI: No, I don't have any
22 questions, but I would comment that I can see one
23 reason I may have confused you. We may get to that
24 at the -- the use of the word "copay" got

1 confusing, I think, and --

2 MR. MILLER: Yeah. Well, the "copay" was
3 referenced to your proposal. I mean, you had. You
4 had referenced it.

5 DR. ANTONUCCI: Well, I think I used the
6 word wrong and confused people, and I can tell you
7 why. But in some of these questions --

8 MR. MILLER: That's okay.

9 DR. ANTONUCCI: -- we'll get back to that.

10 MR. MILLER: So what we were going to do
11 today, I believe, was -- you wanted to start by
12 answering some of the questions that we had sort
13 of, you know, in real time with us in front of the
14 computer and the HowsYourHealth website.

15 DR. ANTONUCCI: Mm-hmm.

16 MR. MILLER: And we can do that, and so
17 we'll do that first.

18 DR. ANTONUCCI: Okay.

19 MR. MILLER: And then we will do some of
20 the other questions that we wanted to follow up on.

21 DR. ANTONUCCI: Oh, cool. Okay. I
22 thought it just might help you, rather than
23 screenshots.

24 So everybody has the internet in front of

1 them, do they?

2 MR. MILLER: I am. Tom, Kavita, are you
3 in front of the website?

4 DR. PATEL: Yes.

5 DR. ANTONUCCI: Okay.

6 DR. PATEL: I've already loaded it up,
7 HowsYourHealth.com.

8 MR. MILLER: Yep.

9 DR. FERRIS: Me too.

10 DR. ANTONUCCI: Cool. Okay. So what I'm
11 going to do is I'm going to -- let me load it up.
12 I'm going to pretend -- you're all going to pretend
13 that you're me, and -- let me get there. Mine went
14 right in.

15 Did it ask you for a password?

16 MR. MILLER: No. Because we're just
17 general people here.

18 DR. ANTONUCCI: Yes. But I'm going to get
19 you in. Wait a second.

20 MR. MILLER: Oh, okay.

21 DR. ANTONUCCI: All right.

22 DR. PATEL: Where are we going in, though?
23 Are we going on Choose Your Full Health Check-Up or
24 Choose Your Quick Health Check-Up?

1 DR. ANTONUCCI: Okay. So what you want to
2 do, please, is scroll down to the bottom of that
3 field, and -- okay. Way down near the bottom where
4 it -- under -- in the big heading, you see New News
5 - 2018. Way below that, where the print gets
6 smaller, if you would click on Order and Customize:
7 for Clinical Practices.

8 MR. MILLER: Okay.

9 DR. ANTONUCCI: And there will be two blue
10 -- three blue buttons across the top. Could you
11 click on Summaries and Reports?

12 MR. MILLER: Okay.

13 DR. ANTONUCCI: So now you're going to
14 pretend you're me. We're going to look at my
15 practice's work, and that's a good way you can see
16 how this works.

17 So we're going to click on the box in
18 front of Adult. We'll do Adult Only Patients. So
19 you know I don't see --

20 MR. MILLER: Wait. I've got -- I've --

21 DR. PATEL: Sorry, Jean. Mine is asking
22 for a Username and Password. Is that --

23 DR. ANTONUCCI: Okay. I was afraid it
24 might. So the Username, the first one you're asked

1 should be [REDACTED].

2 MR. MILLER: Okay.

3 DR. ANTONUCCI: And then the Password
4 would be [REDACTED].

5 DR. PATEL: Jean, are we -- we're not
6 getting access to any PHI or anything, are we?

7 DR. ANTONUCCI: No, you're not.

8 DR. PATEL: Okay. All right.

9 MR. MILLER: Okay. I have a Produce
10 Summary Report.

11 DR. ANTONUCCI: Well, I better wait until
12 -- is everyone in the place where they -- you've
13 got texts with three blue buttons on the top, and
14 you click on Summaries and Reports?

15 DR. PATEL: Yes. Yeah, I'm where Harold
16 is at.

17 DR. FERRIS: Yep.

18 DR. ANTONUCCI: So, Tim, you're at Produce
19 Summary Reports?

20 DR. FERRIS: I am.

21 DR. ANTONUCCI: Cool. Okay. Click on the
22 box to the left of Adult, please. You can see that
23 we can ask for various surveys. We're just going
24 to do adults, and we're not -- where the box says

1 Choose WMI level, you don't have to choose anything
2 right now. But you can. That's what matters in
3 this. You can choose to look at only your high-
4 level patients.

5 MR. MILLER: And they're all clicked.

6 DR. ANTONUCCI: They're all clicked, so
7 you can leave it there.

8 MR. MILLER: Okay.

9 DR. ANTONUCCI: So we're going to look at,
10 say, the last few years of my reports. So where it
11 says, further down, Choose Data Since, we'll just
12 sort of pick a year. I'm not a high user of this,
13 so you won't see huge numbers. So pick something
14 like 2012, and then -- but before, go down and pick
15 2018, and we'll be able to see about six years'
16 worth of reports.

17 MR. MILLER: Okay. So that's the first
18 click on click box, is the year.

19 DR. ANTONUCCI: Correct.

20 So mine now says choose data since 2012
21 January 1, but before 2018 January 1.

22 MR. MILLER: Yep.

23 DR. ANTONUCCI: And then All Items, you
24 click on that, and I'm waiting.

1 MR. MILLER: So are we.

2 DR. ANTONUCCI: We're all waiting.

3 Electrons come more slowly to me.

4 DR. FERRIS: That poor server at Dartmouth
5 is working overtime right now.

6 MR. MILLER: Not used to having three
7 people -- or maybe eight people trying to do it at
8 the same time.

9 Okay. I'm there. Anonymous Summary
10 Report.

11 DR. ANTONUCCI: Correct. Is everyone
12 there?

13 DR. FERRIS: Yep.

14 DR. PATEL: Yes.

15 DR. ANTONUCCI: Okay. Hi. Thank you.

16 So I'll walk you through this. This is
17 very lengthy. You could scroll down quite a ways,
18 and I'll make it somewhat brief. But you're
19 welcome to login and look at this if you want to
20 remember [REDACTED]. You can't cause any trouble.
21 You may want to look at this later or something.
22 Feel free.

23 So these are my reports. So what this is
24 telling us, "attributes of care," this is sort of a

1 general term. This is telling you that for the
2 time period we chose, there are 171 patients who
3 took the survey, 21 of which have income problems,
4 and then there are these general measures, which
5 are very nice.

6 And below this, if we scroll down, it even
7 explains these measures, and it tells you the
8 national medians, the national tertiles and
9 quartiles.

10 So this is one of the same. This big
11 complex box, the summary report with all the bold
12 heading on the left, would be where we would get
13 benchmarks from, because you've asked me about
14 benchmarks, and so the really important benchmarks,
15 I think, are things like very easy access to care,
16 if they're using a hospital or not, and you can use
17 -- we can talk more about this. It could be a lot
18 to talk about, so I'm going to be -- err on the
19 side of a little brief now because you can always
20 ask me more later.

21 Patient confidence is a very important
22 driver of health care usage that John Wasson, the
23 developer of HowsYourHealth, has taught me about.
24 So we look at patient confidence. This is where

1 you can get benchmarks. How are we going to
2 measure? Should this pilot go forward -- and I
3 know the head of DHHS hasn't implemented any event,
4 to everybody's crabbiness, but let's pretend he
5 likes this one and it goes forward. I'll hand out
6 the Haldol later.

7 So let's assume this is totally wonderful,
8 but we have to have benchmarks to compare pre-
9 intervention and then after you're in the study,
10 and what's the benchmark we want people to aim for
11 and so forth.

12 So this is where you'd basically get your
13 benchmarks from because these are the important
14 things, and you can read about them more. Some of
15 them will duplicate themselves as we scroll down
16 further, but these are the big important benchmarks
17 that are quality --

18 MR. MILLER: Let me interrupt you for a
19 second. When you say benchmarks, what I'm thinking
20 when you say the word "benchmark" is that you're
21 comparing it to something else outside of your
22 practice.

23 DR. ANTONUCCI: Okay. Well, I think we're
24 comparing to all primary care practices.

1 MR. MILLER: Yes. So I'm saying -- so
2 when I'm -- what I'm looking at on the screen are
3 your records.

4 DR. ANTONUCCI: Yes.

5 MR. MILLER: Okay. So where is the
6 benchmark for these, then?

7 DR. ANTONUCCI: Scroll down.

8 MR. MILLER: Okay.

9 DR. ANTONUCCI: That was perfect. I was
10 about to pause and tell you that.

11 MR. MILLER: Okay. That was a segue,
12 because if you could just pick one of these
13 measures, maybe, and focus on that first, just so
14 we can kind of see the whole picture here?

15 DR. ANTONUCCI: Okay. So I'll focus on
16 patients. Are they self-confident with management?
17 The median nationally for year of study in this is
18 55. The other third if over 60. My patient
19 confidence level is 69, although it's really low in
20 people with income problems.

21 MR. MILLER: Okay.

22 DR. PATEL: Okay.

23 DR. ANTONUCCI: When I started my practice
24 and started measuring this, it was at 45. Moving

1 patients' confidence is very difficult.

2 So, but for the whole bunch of these
3 records, I'm above whatever I just said. It was at
4 the -- I even forgot what I said. I'm so demented.
5 Patient confident -- over a third is 60.

6 MR. MILLER: So I see that when I scroll
7 down into the more text area down there. In the
8 middle of that, I see a line that says "Patient
9 Confident with Self-Management: median 55; upper
10 third 60." Is that what you are referring to?

11 DR. ANTONUCCI: That's right.

12 MR. MILLER: Okay. Tim and Kavita, do you
13 see that?

14 DR. FERRIS: Yep.

15 MR. MILLER: So this --

16 DR. PATEL: Sorry. I'm very -- I must be
17 --

18 MR. MILLER: That's okay.

19 DR. PATEL: Where --

20 MR. MILLER: Scroll down, as Quality
21 Summary Table and to Interpreting --

22 DR. PATEL: Uh-huh.

23 MR. MILLER: -- the Numbers --

24 DR. PATEL: A, yes. Okay. Oh, there it

1 is. Okay. Sorry. It's buried in that tight block
2 face.

3 MR. MILLER: Yes. Okay, right.

4 DR. FERRIS: Exactly.

5 DR. PATEL: Okay. Got it. Okay, okay.
6 Got it. Got it. Okay, got it.

7 DR. ANTONUCCI: So that's a benchmark to
8 compare practices against each other with.

9 DR. PATEL: And the denominator, Jean, is
10 how many people have contributed to this? I'm
11 sorry. Just I'm trying to understand.

12 DR. ANTONUCCI: Yeah. So it didn't -- let
13 me make sure I understand that.

14 DR. FERRIS: It looks like it's 171.

15 DR. ANTONUCCI: Yes.

16 DR. PATEL: Okay. That's what I was going
17 to say, so --

18 MR. MILLER: That's her data, but how many
19 people? When you're saying it's median 55, what's
20 that?

21 DR. PATEL: Right.

22 MR. MILLER: Who is in that?

23 DR. PATEL: That's what I'm trying to
24 figure out.

1 DR. ANTONUCCI: That's nationally, 55
2 percent of practices.

3 MR. MILLER: But who is in nationally?

4 DR. ANTONUCCI: Fifty-five percent is the
5 number of practices achieved for confidence.

6 MR. MILLER: But who is in the -- when you
7 say nationally, who --

8 DR. PATEL: What is -- yeah. How many
9 people participate in the national HowsYourHealth
10 reporting?

11 DR. ANTONUCCI: So this is over years and
12 years and years. There's thousands of people who
13 have used this. So it explains it right above --

14 DR. PATEL: Okay.

15 DR. ANTONUCCI: -- where you saw that
16 typing block.

17 DR. PATEL: Uh-huh.

18 DR. ANTONUCCI: For the period 2014 to
19 '17, these are the median cutoff or the top one-
20 third of over 100 typical clinical settings.

21 MR. MILLER: So does that mean that
22 there's 100 practices that serve as the benchmark?
23 What does that mean, 100 typical clinical settings?

24 DR. ANTONUCCI: 100 typical clinical

1 settings have had their patients use this survey,
2 and then the median number for patient confidence
3 has been 55. I think I'm right.

4 DR. FERRIS: Yeah.

5 MR. MILLER: Okay.

6 So, in other words, these data here don't
7 get updated in real time based on what your
8 patients do. This is periodically some set of
9 participating practices. Their results are
10 compiled, and then these benchmark lines here get
11 updated because this --

12 DR. ANTONUCCI: That would be correct.

13 MR. MILLER: Okay.

14 DR. ANTONUCCI: And I think I got myself
15 muddled. The number 55 or 69 is the percent of
16 patients who say they are confident in self-
17 management of their chronic diseases. That's what
18 the number is, because patients who are confident
19 basically cost less. They go to the ER less. They
20 do better. So the number is patients who say they
21 are confident in managing their care.

22 MR. MILLER: Mm-hmm.

23 DR. PATEL: Mm-hmm, mm-hmm.

24 DR. ANTONUCCI: And one thing you might

1 want to do also, not that you have not got millions
2 of other things to do, but you can take the survey
3 yourself. So that's -- you can see how the
4 question is asked.

5 MR. MILLER: Mm-hmm.

6 DR. ANTONUCCI: And --

7 DR. PATEL: I've actually done that.
8 That's how I was -- I was introduced to this -- I
9 don't know by who. I can't remember. It might
10 have been Rushika at Iora. Anyway, I feel like
11 I've -- I've done this myself. It seemed really --
12 just so you know, it seems like it was extremely,
13 obviously patient-centered and very geared towards
14 those kinds of just self-management.

15 But I remember, Jean, there were some --
16 at that time, several years ago, there was some
17 criticism from the quality measurement community,
18 which I used to be more a part of, about why this
19 wasn't useful as a broader metric; for example, in
20 Medicare. And I don't know if you might want to
21 shed some light on that, or does that sound
22 familiar to you?

23 DR. ANTONUCCI: I think what it might have
24 been is that there's a mistrust that we can ask

1 patients about quality. That quality --

2 DR. PATEL: Okay.

3 DR. ANTONUCCI: -- is the thing that we're
4 supposed to, as physicians, put into the
5 checkboxes. That's what I have heard for a long
6 time.

7 And John Wasson has validated this with
8 actual chart audits for years. I think that it
9 doesn't come naturally to think that patients
10 actually know when they've had a mammogram or a
11 colonoscopy.

12 It is very -- it is patient centered, and
13 it's a little mind-bending. It's very different
14 from what we do, but patients do know, and they get
15 this very quickly. They know who's in charge.
16 They know if they've been sick.

17 DR. FERRIS: Yeah.

18 DR. ANTONUCCI: I think that's what the
19 complaint has been.

20 DR. FERRIS: Yeah. I guess -- this is
21 Tim, Jean. So for the -- for the quality
22 measurement-type people who have gotten past that
23 issue -- and I agree with you. That's a pretty big
24 issue for people sort of outside of the quality

1 measurement field.

2 DR. ANTONUCCI: Mm-hmm.

3 DR. FERRIS: But I think most people
4 inside the quality measurement field --

5 DR. PATEL: Yeah.

6 DR. FERRIS: -- are huge supporters of
7 patient-reported data as a -- not only legitimate,
8 but the best possible, not for answering every
9 question, but for answering a lot of questions.

10 The critique, though, that I've heard --
11 and I, too, have taken -- I've actually take this
12 back first when John Wasson first invented it. I
13 was an early beta user. That was a really long
14 time ago, I have to say. I actually haven't seen
15 what you're showing us, which is really, really
16 cool, and I'm really pleased to be walked through
17 this because this is a -- this is an evolution of
18 HowsYourHealth that I was unaware of and very
19 pleased to be introduced to this.

20 But the critique that has been sort of
21 longstanding of HowsYourHealth is the survey burden
22 on patients. Among surveys of patient-reported
23 outcomes, this is among the very longest, and the
24 sort of frequency -- the operational

1 characteristics necessary to demonstrate that you
2 can do this survey frequently enough in a -- at a
3 scale that would be required for using it for the
4 kinds of purposes that you're proposing, do you
5 have -- or does John or anyone associated with
6 HowsYourHealth have just data that indicates that
7 you could incorporate this into practice at scale?

8 Maybe let me just pause there.

9 MR. MILLER: Jean, describe how it works
10 in your practice. I mean, how are you -- how often
11 are you using it, and what burden do you see?

12 DR. ANTONUCCI: Yeah. So those are really
13 good questions. Most of us as doctors love this
14 because it's a lot less burden even to introduce it
15 in the practice and other things we're doing, so
16 there's a variety of answers.

17 One is what is scale. Once you get to 50
18 or more of these surveys per practice, the data --
19 and it does say that a little bit if you scroll
20 down. The data becomes really very stable because
21 -- and I am not a statistical maven, but because
22 he's surveying things that matter across practices,
23 you don't have to have thousands of surveys to get
24 a statistical validity. So 60 -- I was trying to

1 find where that says -- I'll have to find it for
2 you, but --

3 DR. FERRIS: See, I've got his papers.
4 Actually, I'm scrolling through his papers right
5 now, and I'm looking at the denominators in the
6 published papers.

7 DR. ANTONUCCI: Yeah.

8 DR. FERRIS: And they're in this sort of
9 4,000-to-6,000 range.

10 DR. ANTONUCCI: However, here's the
11 sentence under Interpreting the Numbers: "Measures
12 are very stable when there are 60 or more." And I
13 didn't understand that for years, but it's
14 basically because you're surveying things that are
15 so general that matter across all patients. And I
16 can have John come and talk to you or say it better
17 than I would.

18 So if you're measuring your practice,
19 which is all I've done -- I haven't used it to get
20 money or anything. I've kind of just used it for
21 my own purposes. I generally have been pretty slow
22 about it. I only do about 30 or 40 a year.
23 Nevertheless, that is enough, John says, for me to
24 learn about my practice.

1 Now, having said that, I have friends who
2 have used it hundreds of times, and here's the ways
3 you put it into your practice. It takes about 15
4 minutes to do, and so I don't think doing that once
5 a year is a big burden for patients. There are
6 always going to be some patients who will do it.

7 And it depends a little bit on your
8 practice. I have a screenshot, basically, of the
9 front page of it, and I have my passcode. And when
10 people come for a preventive visit, I ask them to
11 do it, and they do it.

12 I have friends who are high tech who have
13 an iPad or a computer in the waiting room, and
14 patients just come in and sit down and do it. You
15 can have a volunteer do it. You could even have
16 them do it over the phone with your MA.

17 It isn't that hard to put into your
18 workflow once you simply think about it. Many
19 practices have automated reminders for
20 appointments. So I don't, but my friends who do,
21 it's right in there: "Please do your
22 HowsYourHealth survey before you come in."
23 Sometimes they team it up with instant medical
24 history.

1 And so for patients that are a little bit
2 more high tech or practices that are, it's sent out
3 as a reminder with the appointment.

4 I simply ask when they're here. Sometimes
5 I've had people sit with the medical assistant and
6 do it. It is -- I find there's hardly any burden
7 at all. It's much less burdensome than anything
8 else I do. I think it's pretty easy. It's
9 different. People would get used to it.

10 MR. MILLER: So could you explain -- one
11 of the things I've been having trouble
12 understanding is whether you're just trying to get
13 a sample to give you some general indication about
14 how you're doing as a practice or whether you're
15 using this to actually help you manage the
16 individual patient.

17 DR. ANTONUCCI: Oh, so that's a brilliant
18 question. I mean, it's really both, isn't it?

19 If I get enough, I kind of get a sense
20 that, well, maybe I'm not doing very good with
21 access when I think I am because any one patient
22 may not be happy with access. So I'm using it as a
23 practice aggregate, but I'm certainly using it for
24 a particular patient because for each time you take

1 the survey -- when each patient takes the survey, I
2 get a form right away, and it tells me if they're
3 confident or not. And it tells me what they know
4 or don't know, or they don't think, for instance,
5 they've had their cholesterol checked. And I write
6 to them and say, "Yes, you have," or, "Holy smokes,
7 I'm a horrible doctor. No, we haven't. Thank you
8 for reminding me." So --

9 MR. MILLER: Well, are you trying to get
10 it then for every patient?

11 DR. ANTONUCCI: Well, I would like to. I
12 have not achieved that. My patients are low income
13 and low tech, and sometimes --

14 MR. MILLER: Yeah. But my question was
15 are you trying.

16 DR. ANTONUCCI: We'd like to.

17 MR. MILLER: I mean, so you are
18 systematically trying to get it --

19 DR. ANTONUCCI: Yeah.

20 MR. MILLER: -- for every patient?

21 DR. ANTONUCCI: Sure.

22 MR. MILLER: Okay. Because that was one
23 thing that I was confused about in your answers --

24 DR. ANTONUCCI: Oh.

1 MR. MILLER: -- because it didn't -- I
2 couldn't tell whether you weren't trying or whether
3 you were saying, "I would really like to have it.
4 I'm just not successful in getting it currently."

5 DR. ANTONUCCI: I see. Okay. Well, I --
6 and thank you for helping me know how I have to
7 clarify.

8 Yeah. I'd like to have it for virtually
9 every patient because then you get feedback for
10 them plus practice-wide aggregate data that helps
11 you improve. So you can improve per patient and
12 improve your practice in general.

13 MR. MILLER: Mm-hmm. Can you just say
14 then a word about -- because we're looking at just
15 the aggregate data here. So if you -- for the
16 patients that you get it on, do you then have some
17 other screen, which we obviously don't want to see
18 here, but you go to, to see -- so, for example, if
19 you see 35 percent of the income problem patients
20 lack confidence, do you go to see those patients'
21 forms to try to understand better what's behind
22 that, or do you then just talk to the patient?

23 DR. ANTONUCCI: Well, I've gotten their
24 form when they did the survey.

1 MR. MILLER: Mm-hmm.

2 DR. ANTONUCCI: And there's a registry
3 that we can get where we can ask for that. We
4 might end up seeing patients' names, so I don't
5 think we want to do -- we would see patients'
6 names, so we don't want to do that.

7 MR. MILLER: Yeah. We don't want to do
8 that. But I meant more asking what you do.

9 DR. ANTONUCCI: Yes.

10 MR. MILLER: You do look at that
11 individually?

12 DR. ANTONUCCI: Correct. And the practice
13 registry can let me pick not only by income but by
14 pain or disease burden. So I do get a registry and
15 can go look at those patients, or I have already
16 gotten it when I got their individual report, which
17 I think I sent you an example of in the proposal,
18 not in the questions. I showed you patients, a
19 report of what we get each time a patient does it.
20 I think I sent you a female's report.

21 MR. MILLER: Mm-hmm.

22 DR. ANTONUCCI: So you get lots of ways
23 that you have actionable data.

24 MR. MILLER: Okay.

1 DR. ANTONUCCI: Does that help you?

2 MR. MILLER: Yes.

3 DR. ANTONUCCI: Okay.

4 You can scroll down a little bit more.

5 You may want to talk about other things, but I'll
6 take you briefly. I want you to start to scroll
7 way down until it looks like charts full of
8 complicated numbers, Summary for Individual Survey
9 Items.

10 MR. MILLER: Yes.

11 DR. ANTONUCCI: And you can see how it
12 separated women, men, different age groups, but
13 I'll just take you through it. Just stick to the
14 column on the left. It's easier for now. It's all
15 the records. We're looking at 171 survey results,
16 and this is patients who know if they have
17 hypertension, hardening of the arteries, diabetes.

18 And then as we scroll down later, we see
19 what they're bothered by -- feelings, social
20 support. It goes on and on. Are they concerned
21 about violence or abuse, AIDS, STDs?

22 We go down to the current smokers and what
23 percent of them are ready to quit. So only 8
24 percent of the 11 percent of smokers are ready to

1 quit.

2 You see all these things. It goes on and
3 on. There's lots of aggregate stuff. This is
4 where you can see with your patients that, "Gee, in
5 this practice, maybe I'm not giving enough males
6 information about a bowel cancer test." You can
7 see how many of them have had a PAP test
8 appropriately, and then many of these things -- so
9 they're disease metric-oriented, and if you go --

10 MR. MILLER: How about picking just one of
11 those lines for us and just sort of explaining kind
12 of -- because I'm having trouble understanding what
13 all those numbers mean and how you would use them.
14 So pick -- pick one, you know, about whatever you
15 would think would think would be something that you
16 would focus on managing.

17 DR. ANTONUCCI: Well, let's see. I was
18 going to take you all the way down to the bottom to
19 something that wasn't a disease. If you can --
20 your --

21 MR. MILLER: Well, it would help us, I
22 think, if we could understand a little bit about
23 some of the diseases --

24 DR. ANTONUCCI: Okay.

1 MR. MILLER: -- because one of the issues
2 here is how does this compare to using HbA1c levels
3 and LDL levels and, you know, blood pressure
4 levels, et cetera, and standard MIPS measures.

5 DR. ANTONUCCI: So see if you can scroll
6 down. My cursor on the left is about three-
7 quarters of the way down the page to where it says
8 If Diabetes.

9 MR. MILLER: "If Diabetes." Oh, okay. I
10 see it. There's a whole bunch of "Ifs," so you're
11 in the middle of all the "Ifs."

12 DR. ANTONUCCI: Yes. I'm in the middle of
13 all the "Ifs."

14 MR. MILLER: Okay. So when -- this is for
15 Tim and Kavita. Once you see the "Ifs," then it's
16 in there.

17 DR. PATEL: I got it. I'm there.

18 MR. MILLER: Okay. "If Diabetes." I got
19 it. Tim, are you there?

20 DR. FERRIS: Yep.

21 MR. MILLER: Okay.

22 DR. ANTONUCCI: Okay. So 171, if they
23 have diabetes, what percent of them has their blood
24 sugar often at this level? Seventy-three percent

1 of them know that their blood sure is between 80
2 and 150.

3 MR. MILLER: And that's their report?

4 DR. ANTONUCCI: Yes.

5 MR. MILLER: So it could be completely
6 wrong, but that's their report?

7 DR. ANTONUCCI: That's correct.

8 MR. MILLER: Okay.

9 DR. ANTONUCCI: What percent of the
10 diabetics have good explanation for an eye exam,
11 good explanation for foot care?

12 MR. MILLER: What does that mean,
13 explanation for eye exam?

14 DR. ANTONUCCI: That they know they need
15 to go get one. Have you had an eye exam in the
16 last year? I'd have to go look at what the exact
17 question is, but that they know that they need to
18 know and why.

19 MR. MILLER: Okay.

20 DR. FERRIS: Yeah.

21 We should probably -- this is incredibly
22 helpful, and it answers a lot of questions. It
23 also services a bunch more, but I wonder if we
24 shouldn't, now having this experience, move to the

1 other sort of items in our set of questions.

2 MR. MILLER: Well, if I could just stay
3 one on this --

4 DR. ANTONUCCI: Yes.

5 MR. MILLER: -- because I wanted just to
6 sort of close the loop on this MIPS measure thing.

7 So, Jean, so let's suppose that you looked
8 at this data, and it said that you had some number
9 of patients that were not reporting that their
10 blood sugar was being controlled appropriately or
11 whatever.

12 DR. ANTONUCCI: Mm-hmm.

13 MR. MILLER: And when you -- would you
14 then go and look at those patients, and would you
15 then look at their actual lab data to see --

16 DR. ANTONUCCI: Yes.

17 MR. MILLER: -- if that was true, et
18 cetera, to try to really kind of diagnose what you
19 think is really going on?

20 DR. ANTONUCCI: Exactly right.

21 MR. MILLER: Okay. So you don't -- you
22 wouldn't just act on the survey results, but the
23 survey results would tell you that.

24 So let me just ask, then, the reverse

1 question really quickly. So the patients all say
2 they're fine. Do you ever do anything to find out
3 whether in fact they're right?

4 DR. ANTONUCCI: Sure. Every single -- I
5 can go look at the registry and pull out all my
6 diabetics. I can do that periodically, and I get
7 it individually when they do a report. And that's
8 the place I do it --

9 MR. MILLER: No, I'm saying do you look at
10 -- for example, do you actually look at their
11 actual test results?

12 DR. ANTONUCCI: Yeah, absolutely.

13 MR. MILLER: Okay. So, in other words,
14 you're not just relying on the HowsYourHealth data
15 as the sole measure of quality. You are also
16 looking at some of those other results?

17 DR. ANTONUCCI: Absolutely. Generally, it
18 turns out to be valid, what the patients say, but
19 sure, you look and double-check.

20 And if I may say, using this doesn't mean
21 I somehow think we don't do Alc's just because the
22 patients say their sugars are controlled. You
23 know, they're both tools, but they're both tools
24 that get us separate things. What the patients

1 report and what they know is really valuable and
2 their education about it, but it doesn't mean that
3 we don't do Alc's.

4 MR. MILLER: Mm-hmm.

5 DR. ANTONUCCI: Okay.

6 MR. MILLER: Okay, good.

7 Tim, let me just switch to --

8 DR. PATEL: Can I --

9 MR. MILLER: Yeah.

10 DR. PATEL: This actually helps us switch
11 gears, but so, Jean, you clearly -- you know,
12 you're cited even in the kind of footnotes around
13 some of the references for some of your work. If I
14 were to -- can I just ask you? I think Tim was
15 kind of alluding to this was like -- or sorry --
16 Harold, you were alluding to this, but like the
17 goal might be to give this to all patients. Have
18 you found or do you have concerns about respondent
19 bias as due to literacy issues or, you know, any
20 sort of like logistical barriers that have come up
21 and potentially thinking beyond your practice where
22 there might be unintended consequences?

23 DR. ANTONUCCI: So I guess the thing that
24 comes up for me is lack of access to the internet.

1 I get the, you know --

2 MR. MILLER: Okay.

3 DR. ANTONUCCI: -- "I wouldn't know a
4 computer if I saw one." So, in that case, if I
5 really wanted to go after this and get it from all
6 my patients, I would have somebody do it verbally
7 with them.

8 John Wasson says you really don't get as
9 good results if you interview them yourself because
10 you get a biased answer. They may say different
11 things to me in front of me.

12 I usually will ask them to go to their
13 son's or granddaughter's and get on the computer or
14 go to the library. So that's a potential issue.

15 And then there would be language. Maine
16 is remarkably un-diverse, but I think John Wasson
17 has done some work about other languages. The
18 literacy level is pretty basic, and he reviews
19 that.

20 I can't remember about other languages.

21 DR. PATEL: Okay.

22 DR. ANTONUCCI: But those would be
23 barriers to think about --

24 DR. PATEL: Okay, great.

1 DR. ANTONUCCI: -- I guess.

2 MR. MILLER: There are different language
3 versions I saw when I was digging around on the
4 website, too, so --

5 DR. PATEL: I was more thinking about
6 health literacy, so yeah. I mean --

7 DR. ANTONUCCI: You know -- right.

8 DR. PATEL: -- language is certainly an
9 issue --

10 DR. ANTONUCCI: It's a good question.

11 DR. PATEL: -- but health literacy.

12 MR. MILLER: Okay.

13 Tim, why don't we jump to what would be
14 next on your list.

15 DR. FERRIS: Well, I guess it's the
16 general topic of how specifically you take this
17 information and fold it into a payment model, and
18 while you had a description of how you would
19 approach that, I think we had a whole set of
20 questions about the mechanics of that.

21 And do you want to -- one way to approach
22 it would just -- for you to explain in your own
23 words how you would do that.

24 DR. ANTONUCCI: Well, I hope I know what

1 you're asking.

2 MR. MILLER: Let me -- and, Tim, if this
3 is not what you're getting at -- so, for example,
4 you said there would be a 15 percent withhold that
5 you'd get back for something. What would be the
6 definition of the something that would get you the
7 15 percent back?

8 DR. ANTONUCCI: Oh, right. So there would
9 have to -- now, let me see if I did confuse people.
10 So that would be about reaching benchmarks, and the
11 benchmarks would be set based on the HowsYourHealth
12 numbers. So I was thinking if you pay people
13 prospectively and you give them a little breathing
14 room and time and pay them adequately and you use
15 these as measurements, that's how you would achieve
16 good outcomes and lower cost overall, and that we,
17 you or whoever, would administer such a thing, the
18 project, if it happened, would choose benchmarks
19 based on the excellence of benchmarks in
20 HowsYourHealth to choose what you would have to
21 achieve to get your whole 15 percent not withheld
22 from you.

23 I'm thinking -- I'm hesitating because I'm
24 thinking out loud, "Here, hmm, maybe I didn't think

1 of something. Who would I let even stay in the
2 practice if they don't reach the benchmarks?" So
3 I'd have to talk about that. What if you really
4 weren't doing well the first year or so? Well, you
5 might not, and over time, though, you want everyone
6 to reach the benchmark. But if we set the
7 benchmarks and say you picked the access and it had
8 to be that 90 percent of patients said they had
9 good access, then you'd get your whole withhold,
10 your whole 100 percent of payment.

11 And if you -- your access numbers were
12 only 75 percent, 15 percent would be withheld
13 because you didn't reach the benchmarks. Does that
14 make sense?

15 MR. MILLER: Mm-hmm. So just to take the
16 example we were using before, if patient confidence
17 happened to be one of the measures that was being
18 used, you would say you're at 69.41 and the
19 benchmark for that is 55 or 60. You're okay, or if
20 it's --

21 DR. ANTONUCCI: Yes.

22 MR. MILLER: And if the low-income patient
23 confidence is an issue and you were below that,
24 then you'd have to have some way of weighting all

1 those things together because you're basically
2 making it all or nothing under you proposal.

3 DR. ANTONUCCI: Right. Well, so I think
4 that I wouldn't separate out the income patients,
5 but yeah, I think if you hit the benchmark, you get
6 the whole salary. And if you don't hit the
7 benchmark -- and we might use those two benchmarks,
8 the median and the upper tertile.

9 I think that practices will probably self-
10 select, and they will be doing poorly. And they
11 will probably get very close, and then some will
12 hit the benchmark and get the whole 15 percent.

13 I was trying to make it simple, and I hear
14 myself sounding like I'm not answering this
15 question well and confusing you.

16 MR. MILLER: Well, I would just say I
17 think you're confronting what everybody who has
18 tried to do things confronts, is that you want to
19 keep it simple, and then whenever you would get
20 into the weeds, you suddenly discover that there's
21 all these things that tend to make it more
22 complicated, but --

23 DR. ANTONUCCI: Yeah.

24 MR. MILLER: But we wanted to understand

1 at least how you were thinking about doing that.
2 So you're saying basically the benchmarks would be
3 derived from those who do HowsYourHealth --

4 DR. ANTONUCCI: Mm-hmm.

5 MR. MILLER: -- and then that would be
6 what that would be based on.

7 And one of our questions was -- because,
8 again, this is one of the criteria that we have to
9 assess and that CMS will be interested in is -- so
10 how do they know that the practices that are
11 participating in this are doing better or worse
12 than practices that aren't because if you're
13 measuring your quality differently than everybody
14 else is -- now, what I heard you saying, I think,
15 was that you actually would be still measuring your
16 quality also the same way that other people would
17 being -- using some of the more traditional lab
18 results, et cetera. You just think that this is a
19 better way to determine how you're doing.

20 DR. ANTONUCCI: So what I wanted to do
21 with the project is to use this as a way to both
22 determine risk and quality with this one tool. So
23 you raise the question of how are you going to
24 compare the quality of the practices who would be

1 in this pilot with practices who are reporting,
2 say, MIPS and mammogram rates. I have to think
3 about that a little bit. I probably know the
4 answer, but --

5 MR. MILLER: Well, my question was your --
6 so, for example, if CMS is evaluating other
7 practices based on HbA1c --

8 DR. ANTONUCCI: Mm-hmm.

9 MR. MILLER: -- you would actually have
10 data on HbA1c.

11 DR. ANTONUCCI: Sure.

12 MR. MILLER: Okay.

13 DR. ANTONUCCI: But I am trying also to
14 minimize the reporting, so I'd have to see -- but
15 practically, what would probably happen, that
16 practices probably would be reporting. I mean,
17 this would be a pilot. So practices might also
18 need to be reporting the standard data. I don't
19 know that I can take that away from them, so that
20 would be a basis of comparison.

21 MR. MILLER: Mm-hmm.

22 DR. FERRIS: Yeah. And let me just --

23 DR. PATEL: And -- okay.

24 DR. FERRIS: Go ahead, Kavita.

1 DR. PATEL: Oh, no, I was just going to
2 add to just a question about -- I keep going back
3 to just kind of unintended consequences, so not
4 anything that anyone wanted to do, you know,
5 intentionally.

6 But, Jean, what you propose could -- how
7 would you also think about avoiding people who just
8 don't come in, or how would you think about, you
9 know -- what have you done in your own practice to
10 kind of prevent people who might say, "You know,
11 I'm taking my -- I'm doing my HowsYourHealth, and
12 it looks like I'm doing pretty well, or I feel like
13 I'm doing pretty well," and people don't come in.

14 DR. ANTONUCCI: Right. That's a really
15 good question, and I think that is the practice's
16 responsibility, the business of how we attribute
17 patients, and patients would have to be themselves
18 accessed at least once a year, if not by a visit,
19 by something, maybe an e-visit or something. I
20 think you do have to make an effort.

21 If you're in a project like this, you have
22 to make every effort to get every patient access to
23 get as many HowsYourHealth as --

24 DR. PATEL: And I'll just say that for me

1 -- and I, like Harold, also had to read this -- I
2 can't remember if it was four or five, maybe even
3 more times, certain sections. I didn't feel like I
4 saw those specifics in a way that made me feel
5 comfortable that I could go out to like my fellow
6 internists and know that everyone was applying
7 those same standards.

8 DR. ANTONUCCI: So you're saying that we
9 would have to check on people and see that -- or
10 make a requirement that X percent of their practice
11 had HowsYourHealth.

12 MR. MILLER: Well, yeah. I mean, just I
13 would say, in general, one of the things we
14 struggle with, Jean, is we get proposals brought to
15 us by really good, committed physicians. So, you
16 know, you're one of those. And it's hard for them
17 to think about sort of, you know, the bad doc being
18 in something like this or whatever.

19 DR. PATEL: But not even bad doctors.
20 Just a lack of infrastructure.

21 Jean, most practices, including my own
22 practice, don't have any of those standards set up,
23 so they would need to have very specific
24 instructions on how to do something like this.

1 DR. ANTONUCCI: Mm-hmm.

2 DR. PATEL: And I guess I don't -- I feel
3 like I can't understand how to make the leap of
4 faith with some of these payment model elements
5 without seeing those details sufficiently, and I'll
6 speak for myself for that feedback.

7 DR. ANTONUCCI: Can you say a little bit
8 more what -- what would have to happen?

9 DR. PATEL: Yes. Let me be even more
10 clear. I feel like there would need to be very
11 specific -- we can call them practice requirements
12 or practice, you know, capabilities to ensure that
13 access is not being minimized --

14 MR. MILLER: Cautious --

15 DR. PATEL: -- in order for me to feel
16 comfortable.

17 MR. MILLER: -- about providing --

18 DR. ANTONUCCI: Oh, yes, I get that.

19 MR. MILLER: -- about providing advice on
20 how to write the proposal, Kavita.

21 DR. ANTONUCCI: Oh, I absolutely get that.

22 DR. PATEL: Oh, I'm sorry.

23 DR. ANTONUCCI: I've thought a lot about
24 that.

1 DR. PATEL: Okay.

2 DR. ANTONUCCI: No, it's a very good
3 question. I mean, what's to -- I think it's been
4 asked a bunch of ways. What's to prevent me from
5 taking a bunch of money and sending them to urgent
6 care or not seeing these patients?

7 DR. PATEL: Right.

8 DR. ANTONUCCI: Yeah. No, that's a
9 legitimate question, but I --

10 MR. MILLER: So how do you think about
11 that, Jean? I mean, so we're talking about
12 designing a payment model that somebody could --
13 that's one of the concerns is there have been
14 practice capitation systems, like what you're
15 proposing essentially in the past --

16 DR. ANTONUCCI: Yeah.

17 MR. MILLER: -- that have been, you know,
18 shut down because physicians weren't seeing
19 patients. So how do you see that being avoided?

20 DR. ANTONUCCI: Well, I think that one of
21 the things that I've mentioned is you do have to
22 figure -- I don't know exactly how we'd prove it,
23 but we do have to have a practice specify what
24 would be their mechanisms to access their panels.

1 They would know what patients were in this panel,
2 and how do they plan -- and practices would all be
3 different. How do they plan to touch each of these
4 patients at least once a year and not have anybody
5 -- because Kavita is so healthy and -- oh, we
6 haven't heard from her in three years. Who cares?
7 -- knows she would have to be -- I call it
8 "touches" sometimes. Somebody would have to touch
9 her.

10 So I think that they would have to have a
11 panel, and they'd have to tell us what their
12 process is as a practice to manage their panel.

13 More and more of that is happening. It
14 hasn't been something practices have done, but more
15 and more of us are thinking about it.

16 I think that's reasonable that you have a
17 process that you can say here's how we try and make
18 sure everybody gets HowsYourHealth, but everybody
19 is seen or touched by us once a year.

20 In addition, then, there's kind of a part
21 two of that, which is what if you're just sending
22 them to specialists, what if you're just sending
23 them to urgent care, and those are really hard
24 questions. But I have a few thoughts.

1 One is that that's not where the great
2 expense is, anyway, in health care. Doctors'
3 offices aren't huge. I don't want my patients in
4 the ER. I don't want them admitted. That they go
5 to the cardiologist because they insist or I'm a
6 little overwhelmed is a little bit of a fine line.
7 I should be doing as much as possible, but that's
8 not a huge cost.

9 And then there was something I think --
10 Dr. Berenson, I think, said this when the AAFP
11 proposal was being evaluated, and it's not a bad
12 thought, but I, you don't have a benchmark for it.
13 And that is maybe to count referrals and how many
14 people are being referred and try and sort that
15 out.

16 But it's not the doctors' offices that
17 bother me so much. It's whether they're being sent
18 to the ER, and that is measured in HowsYourHealth.
19 So we've got the benchmark for it.

20 So, Kavita -- I can call you "Kavita,"
21 right? -- there would be a little bit of work when
22 a practice enrolled in this project, but when
23 practices enroll in any project, there's huge
24 amounts of work. I mean, I have personally done

1 NCQA's PCMH, which is a nightmare. It did not help
2 any of my practice or my patients.

3 So when you sign on for something, there
4 would be an onboarding experience. In the first
5 few months, patients -- excuse me. The first few
6 months, practices would be collecting
7 HowsYourHealth and really learning how to put it
8 into their workflow, after which it's easy. But,
9 sure, there would be a little bit of a learning
10 curve.

11 However, having done all this and being an
12 inveterate whiner, it's nothing compared to other
13 things we've had to do. I think it's eminently
14 possible once practices begin to look at this.

15 I'll say one more thing. I showed this
16 tool and this practice idea to a practice up the
17 street from me, and they just thought this was just
18 wonderful and just sat there and began to think
19 about how they could get HowsYourHealth surveys.
20 It seems to engage physicians. So I don't think
21 the learning curve would be very steep, but, yes,
22 practices would have to have a process in place to
23 make sure they touched every patient. Sure.

24 MR. MILLER: Could you say a few words

1 about -- one of the questions we asked you was who
2 do you see as being interested in this. Why didn't
3 you have more people sort of as part of the group
4 submitting this or sending letters of support or
5 whatever?

6 DR. ANTONUCCI: Well, I didn't have
7 anybody else submitting it because nobody had any
8 time. Everybody I know through a couple of
9 national listservs are required. They won't do
10 anything. They won't write letters. They won't do
11 anything. They're exhausted. That's why I did it.

12 I had people make a few comments, but
13 they're just exhausted, and nobody really thinks
14 anything is going to be done. There's a lot of
15 learned hopelessness.

16 As to practices that would want to do
17 that, there's enormous enthusiasm as I ask around.
18 Without even trying, I collected about 30 or 35
19 practice names. I mean, it remains to be seen, but
20 when I explain this idea, a few people object.
21 They don't like the idea of capitation, but most
22 small practices are very burdened by things that
23 they don't think matter and have a lot of trouble
24 with finances. And I have explained this to a lot

1 of people, and there is some things that may need
2 to be picked at or revised or tuned up. But
3 there's enormous enthusiasm for this.

4 MR. MILLER: Okay. Let me see if Kavita
5 or Tim have other questions because we're running
6 down on our time. Kavita, other questions?

7 DR. PATEL: No, I'm good.

8 MR. MILLER: Okay. Tim?

9 DR. FERRIS: No, but I do want to thank
10 you, Jean, for -- well, first of all, you just seem
11 like an inspiring clinician and really appreciate
12 your -- your dedication to both your work and your
13 commitment to improving your work through what
14 could only have been incredibly difficult, which is
15 to submit this application.

16 And I just want you to know -- repeat
17 something that Harold said at the beginning, which
18 is we take this very seriously, and we have these
19 objective criteria against which we have to assess
20 what you've submitted, and that you -- you're to be
21 applauded for what you do.

22 And we will -- and so I guess, Harold,
23 you'll explain sort of next steps in the process?

24 MR. MILLER: Yeah. Thanks. So thank you

1 for saying that, Tim, because I echo that.

2 And, Jean, if there's any way we're going
3 to start getting some of these things approved,
4 it's because people like you, you know, continue to
5 devote the energy to keep coming, coming with
6 proposals, you know, and not being deterred by the
7 brick walls that we sometimes face in doing this.

8 What is most likely to happen next or I'll
9 tell you what's going to happen or what's most
10 likely -- we, the three of us on the PRT, will get
11 together after this call and review what you told
12 us. We have to prepare a report to the PTAC
13 members.

14 One of the things that we have the ability
15 to do now, which we didn't up until this past
16 spring, is the law got changed. So we're allowed
17 to give what is called initial feedback.

18 DR. ANTONUCCI: Oh.

19 MR. MILLER: So what we will likely do --
20 we have to discuss this amongst the three of us,
21 but what we will likely do is to give you sort of a
22 draft document that indicates where we think we can
23 come down on these criteria right now. And, again,
24 we have to evaluate it criteria by criteria, and we

1 have a lot of trouble sometimes trying to
2 understand exactly where to come down on that.

3 What you will be getting, though, to be
4 clear -- and we will -- probably, we will then
5 likely send that to you to see, and there's two
6 purposes to that. One is that when you see that,
7 you might decide that you want to revise the
8 proposal in some fashion based on that, which would
9 require sort of withdrawing, resubmitting to make
10 it better, or you might want to simply respond to
11 us and say, you know, "I guess I didn't get it
12 through your thick heads yet. Here is what I'm
13 really trying to say," you know, once you see what
14 our interpretation of that is. So that will be
15 your choice as to what to do there.

16 We do have to make a decision. Right now,
17 we would ordinarily be moving forward with your
18 proposal at the September meeting.

19 DR. ANTONUCCI: Mm-hmm.

20 MR. MILLER: The feedback that you will
21 get will be the three of us. It is not necessarily
22 indicative of where the rest of the PTAC would come
23 down.

24 DR. ANTONUCCI: Okay.

1 MR. MILLER: The fact that we love it
2 doesn't mean that other people wouldn't hate it,
3 and that the fact that we hate it doesn't mean that
4 other people wouldn't love it. So the experience
5 in the past has been the PRT does an initial
6 review, and then there's discussion at the PTAC
7 meeting in September.

8 So when you get this, if we decide it's
9 appropriate to give you this initial feedback
10 document, when you look at it, then you can decide
11 how you want to proceed. We can either proceed as
12 normally and go to the September meeting, or if you
13 see that, if you think that in fact there are some
14 areas that you would like to redo in some fashion,
15 you can either -- some of it may simply be
16 clarification, and you can send us clarification.
17 But if you think that there are pieces that you
18 would want to redo, then it might make sense for
19 you to say, "Let me try to revise my proposal and
20 resubmit it," because it gets very confusing
21 whenever we have lots and lots and lots of
22 amendments to things, and people say, "Well, I said
23 this in the proposal, but I'd like to change that
24 now."

1 So I think you'll have to decide when you
2 see kind of where we come down whether you think --
3 which of those you think is appropriate to do.

4 DR. ANTONUCCI: Sure.

5 MR. MILLER: The one thing I would ask is
6 we will try to get you that, if we do that, by the
7 beginning of next week, and we need to hear back
8 fairly quickly from you. And, again, it's entirely
9 up to you as to how you want to proceed, so that we
10 can then finish the work that we need to do in
11 order to be able to have this ready for September
12 if we decide to move forward that way.

13 DR. ANTONUCCI: Got it.

14 MR. MILLER: Okay.

15 DR. ANTONUCCI: Cool.

16 MR. MILLER: Any final questions for us
17 about what we're up to and how this is going to
18 work?

19 DR. ANTONUCCI: No. I thank you just for
20 existing. There is no venue I can think of where
21 physicians like me can have significant input, so
22 I'm glad that you exist, and I thank you for
23 volunteering.

24 MR. MILLER: We appreciate that, and we

1 appreciate your interest. And thank you for all
2 the work that you're doing, and thank you for the
3 good care you're taking care of your patients.

4 DR. ANTONUCCI: All right. Well --

5 MR. MILLER: So thanks. Thanks for
6 joining us today. We appreciate it.

7 DR. ANTONUCCI: Have a good weekend.

8 MR. MILLER: Okay. You too. Thanks.

9 DR. ANTONUCCI: Goodbye.

10 DR. FERRIS: Goodbye.

11 MR. MILLER: Okay. We'll talk to you at
12 3:15, guys.

13 DR. FERRIS: Bye-bye.

14 MR. MILLER: Thanks.

15 [Whereupon, at 1:59 p.m., the conference
16 call concluded.]

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