The PTAC Preliminary Review Team's Questions on

Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home

by Personalized Recovery Care, LLC

Questions for the Submitter

1. You have proposed that Home Hospitalization services could be provided to patients in over 160 MS-DRGs, including many types of patients who are not typically included in other hospital at home programs. How was the expanded list of MS-DRG conditions and illnesses selected? Please describe the analysis that was done to determine which MS-DRGs to include and exclude. Is there any research demonstrating the effectiveness and safety of treating patients with all of these conditions at home?

   The expanded list of MS-DRG conditions and illnesses were selected by conducting a detailed review of historical claims data. The goal of this analysis was to construct a list of inpatient conditions and illnesses that can be safely treated using the home hospitalization model. The multi-step review began with: 1) identification of the associated diagnoses of patients admitted as an inpatient, non-observation status 2) removal of patients requiring ICU level treatment during the hospitalization and those patients who expired during the hospitalization, and 3) review of each diagnosis code by a team of clinicians to determine the services required to treat the patient during the hospitalization. Diagnoses requiring treatment or monitoring outside the capabilities of the home hospitalization services were excluded from the expanded list of MS-DRGs. Exclusions include, but are not limited to: level of nursing care required, continuous monitoring (both invasive and non-invasive), continuous infusions (e.g. heparin or insulin, etc.) or non-invasive mechanical ventilation. The remaining diagnosis codes were included in the expanded list of MS-DRGs.

   Home Hospitalization research has historically focused on a limited number of conditions and illnesses. In the landmark research study "Hospital at Home: Feasibility and Outcomes of a Program to Provider Hospital-Level Care at Home for Acutely Ill Older Patients", Dr. Bruce Leff demonstrated the effectiveness and efficacy of the delivery of hospital-level care services in the home to patients. These services include intravenous hydration and infusion of antibiotics, radiological studies, extended acute care nursing services, physician oversight, etc. We believe the same level of patient safety and outcomes demonstrated by Dr. Leff's team and others can be delivered to the expanded list of MS-DRGs.

   As part of the PRC Operators' ongoing clinical review of the initial list of MS-DRGS, 13 MS-DRGs were determined to not be appropriate for the Home Hospitalization program due to the acuity of the patients or the services required.

2. What are the clinical criteria and home environment standards used to determine which acutely ill patient in an MS-DRG is appropriate for the Home Hospitalization services?

   The PRC utilizes two assessment tools as standards for determining which patients are appropriate to be safely treated in the program. These tools cover both clinical and home assessments that are necessary for ensuring patient safety and appropriate site of care for treatment.

   The Clinical Eligibility Guidelines are defined as the clinical inclusion and exclusion criteria for patient admission in the general medical model. These guidelines were developed collaboratively with partner providers and are part of the initial and ongoing education for the care team. The Clinical Eligibility Guidelines are completed by the Recovery Care Coordinator (RCC) and signed by the admitting physician upon patient admission to the program.

   The Admission Health and Home Assessment is the patient intake tool for assessment of all health and home risk factors. The goal of this assessment is to screen patients on more in-depth, detailed health and home topics to ensure patient safety and PRC eligibility. Examples of health assessment risk factors include comorbidities, diet, medication adherence, and activity level. Examples of home risk factors include caregiver support, activities of daily livings, and use of DME in the home.

   Please see the attached documents in Appendix 1 and Appendix 2.

3. How many patients in each of the proposed MS-DRGs have received home hospitalization services in the PRC program? In each MS-DRG, what percentage of the total patients eligible for hospitalization was admitted to Home Hospitalization versus traditional inpatient care? Among those not admitted, what percentage was due to the exclusion criteria PRC identifies in the proposal, compared to other reasons?

   The PRC Operators believe it would be helpful to provide context for this question as well as the direct response in Table 3.1 below, as the experience illustrates learning opportunities for potential APM organizations as they implement the PRC.

   The PRC Operators implemented Home Hospitalization in specific physician practices within Marshfield Clinic in September 2016. The program expanded to admit patients from the Emergency Department of Ministry St. Joseph's Hospital (now called Marshfield Medical Center) in April of 2017. The most significant impact to patient volume came in October of 2017 when the PRC Operators expanded the list of DRGs for admission into the program. This shift allowed physicians to consider whether patients could be treated safely in their homes upon determining patients' need for acute inpatient hospitalization, rather than committing to a principal diagnosis prior to admission. The following Table 3.1 shows the PRC Operators' implementation of Home Hospitalization and respective volume averages:

Table 3.1

Event	***Date***	***Average Resulting Monthly Volume***
PRC Operators implement Home Hospitalization with select physician practices	*September 2016*	*3*
Implementation of Home Hospitalization in Ministry St. Joseph's Hospital Emergency Department	*April 2017*	*5*
Implementation of broader scope of DRGs for Home Hospitalization	*October 2017*	*15*

The PRC Operators gradually expanded the hours of operation to admit patients during more weekday hours but have not admitted patients on weekends as of the date of this response. As the program expanded, the PRC Operators have admitted up to 15 patients per month.

PRC Operators used Security Health Plan claims data for dates of service between September 2016 through November 30, 2017 to provide the total number of patients that were admitted to Ministry St. Joseph's Hospital within the DRGs provided in the PRC Operators' proposal. Figure 3.2 provides the percentage of total patients that the PRC Operators admitted during the periods identified in Table 3.1. Admissions and claims for patients that were admitted in December 2017 are excluded from Figure 3.2 below since claims completion is too low to allow an accurate measurement. Ability to admit patients to Home Hospitalization was limited by the hours of operation of the program, which varied over the periods reported herein. Current admitting hours are from 7:00 AM through 10:00 PM Monday through Friday and include holidays. Since DRGs were coded retrospectively, the data contains some patients in DRGs that were not targeted DRGs at the time the patients were admitted. When admissions happened in those DRGs, the PRC Operators included the potential of all patients in that DRG in the denominator. All patients that were treated in the ICU were excluded from this data, which is consistent with the PRC Operators proposal to PTAC.

Figure 3.1

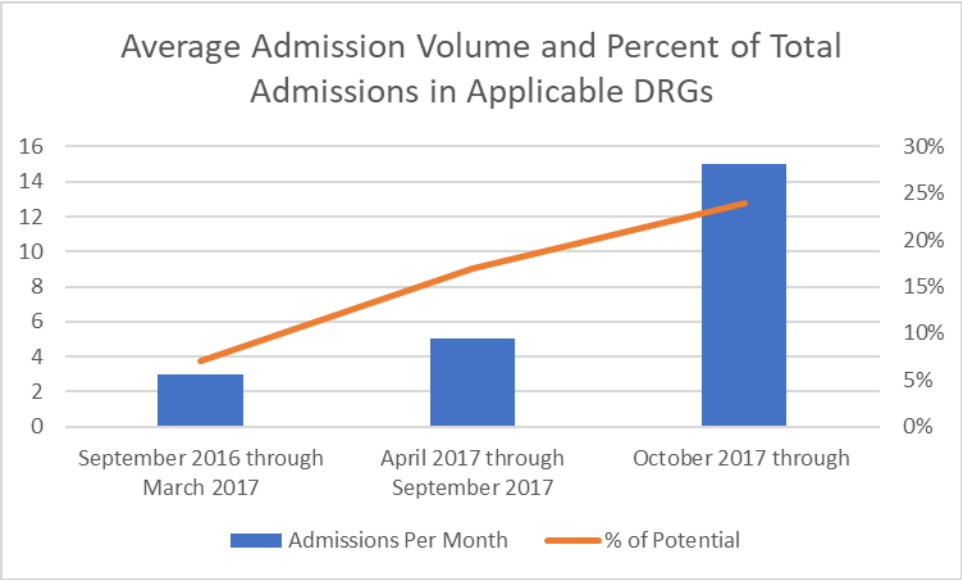


Table 3.2 is the raw volume of DRGs and the potential admissions that applied at the time of the admission.

Table 3.2

DRG	DRG Description	Claims	Admitted	Total	% Admitted
291	HEART FAILURE & SHOCK W MCC	106	3	109	3%
194	SIMPLE PNEUMONIA & PLEURISY W CC	55	5	60	8%
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	47	9	56	16%
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	30	2	32	6%
683	RENAL FAILURE W CC	27	0	27	0%
292	HEART FAILURE & SHOCK W CC	46	7	53	13%
603	CELLULITIS W/O MCC	24	21	45	47%
191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	25	1	26	4%
299	PERIPHERAL VASCULAR DISORDERS W MCC	14	0	14	0%
195	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	20	6	26	23%
293	HEART FAILURE & SHOCK W/O CC/MCC	15	3	18	17%
312	SYNCOPE & COLLAPSE	5	0	5	0%
176	PULMONARY EMBOLISM W/O MCC	9	1	10	10%
193	SIMPLE PNEUMONIA & PLEURISY W MCC	14	0	14	0%
689	KIDNEY & URINARY TRACT INFECTIONS W MCC	10	0	10	0%
177	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	16	0	16	0%
149	DYSEQUILIBRIUM	0	1	1	100%
175	PULMONARY EMBOLISM W MCC	9	0	9	0%

300	PERIPHERAL VASCULAR DISORDERS W CC	10	1	11	9%
372	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	3	0	3	0%
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	1	2	3	67%
445	DISORDERS OF THE BILIARY TRACT W CC	0	0	0	0%
602	CELLULITIS W MCC	5	1	6	17%
682	RENAL FAILURE W MCC	1	0	1	0%
699	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	6	0	6	0%
154	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	1	0	1	0%
178	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	11	2	13	15%
301	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	9	3	12	25%
305	HYPERTENSION W/O MCC	0	0	0	0%
552	MEDICAL BACK PROBLEMS W/O MCC	1	1	2	50%
558	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	0	2	2	100%
563	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	0	0	0	0%
641	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	0	0	0	0%
694	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	6	2	8	25%
868	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC	2	0	2	0%
948	SIGNS & SYMPTOMS W/O MCC	0	0	0	0%
121	ACUTE MAJOR EYE INFECTIONS W CC/MCC	0	0	0	0%
123	NEUROLOGICAL EYE DISORDERS	1	0	1	0%
153	OTITIS MEDIA & URI W/O MCC	0	0	0	0%
187	PLEURAL EFFUSION W CC	1	0	1	0%
202	BRONCHITIS & ASTHMA W CC/MCC	0	0	0	0%
391	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	0	0	0	0%
394	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	1	0	1	0%
395	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC	0	0	0	0%
432	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	0	0	0	0%
440	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	0	0	0	0%
444	DISORDERS OF THE BILIARY TRACT W MCC	0	0	0	0%
536	FRACTURES OF HIP & PELVIS W/O MCC	1	0	1	0%
554	BONE DISEASES & ARTHROPATHIES W/O MCC	0	0	0	0%
643	ENDOCRINE DISORDERS W MCC	0	0	0	0%
644	ENDOCRINE DISORDERS W CC	0	0	0	0%
693	URINARY STONES W/O ESW LITHOTRIPSY W MCC	1	0	1	0%
696	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	3	0	3	0%

864	FEVER	0	0	0	0%
192	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	4	5	9	56%
593	SKIN ULCERS W CC	1	2	3	67%
179	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	1	1	2	50%
189	PULMONARY EDEMA & RESPIRATORY FAILURE	0	1	1	100%
203	BRONCHITIS & ASTHMA W/O CC/MCC	0	1	1	100%
206	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	1	1	2	50%
594	SKIN ULCERS W/O CC/MCC	0	1	1	100%
811	RED BLOOD CELL DISORDERS W MCC	0	1	1	100%
871	Septicemia w/o MV > 96 Hours W MCC	0	0	0	0%
872	Septicemia w/o MV > 96 Hours W/o MCC	0	1	1	100%
Total		**543**	**87**	**630**	**14%**

4. What results have you experienced for the patients you have treated at home in each of MS-DRGs to date, e.g., how many adverse events have there been, how many readmissions, etc.?

The PRC Operators track quality and process measures for Home Hospitalization patients. As of December 31, 2017, the PRC Operators treated 99 patients. Table 4.1 is a list of clinical reporting measures for the DRGs; these DRGs are reported as a composite, as to date there are not enough episodes within each DRG to have statistical significance. As the number of episodes within each DRG grow over time, a sub-analysis by DRG will be possible. The PRC Operators provided details requested in Appendix 3, including Escalations and Readmissions by DRG, in the event that the PRT finds this useful.

The table below illustrates a list of the key measures that the PRC Operators track.

Table 4.1

Clinical Quality Measures	Metric
% of Episodes with Follow-Up PCP Appointment Scheduled Within 7 Days	100%
% of Episodes with Medication Reconciliation	100%
Patient Safety - % of Episodes with Adverse Events	2%
Patient Experience - % of Questions Answered with Top Box Response	95%
Functional Status Assessments (Using PROMIS) - % of Episodes with Functional Status Assessments Completed for Each Patient	100%

The PRC Operators also track the events described in Table 4.2 below. To help ensure understanding the categories, see the correlating definitions.

Table 4.2

Adverse Event	An adverse event is defined as a preventable injury to a patient caused by medical management (rather than the underlying disease) resulting in hospitalization, disability, or death.
Related Escalation	A related escalation is defined as a hospitalization related to episode of care that occurred in the acute phase of the program. Not all escalations are adverse events.
Related Readmission	A related readmission is defined as a hospitalization related to the episode of care that occurred after the acute phase of the program. Not all readmissions are adverse events.
Unrelated Readmission	An unrelated readmission is defined as a hospitalization not related to the episode of care that occurred in the post-acute phase of the program.
Referral to Hospice	A referral to hospice is defined as a patient who fails to complete the 30 day episode due to the appropriate referral.
Expected Death	An expected death is defined as a patient who expires within the 30-day episode, not related to an adverse event. Such patients typically have DNR status.

Please see Appendix 3 for a summary table including volume of cases by DRG type and associated adverse events, readmissions, escalations, hospice referrals and expected deaths.

5. How would CMS assure that participants in the payment model are not "cherry-picking" patients who need the least intensive services?

   The PRC Operators will admit patients in a broad list of conditions that are categorized into DRGs that are on page 27 in Appendix F: Diagnoses Related Groups, in the PRC submission to PTAC dated October 27, 2017 (the "PRC Submission"). Similar to the model presented by the Icahn School of Medicine at Mount Sinai, "HaH Plus" (Hospital at Home Plus) Provider-Focused Payment, patients' clinical eligibility will vary by DRG.

   The PRC Operators believe that the PRT's concern is related to CMS overpaying an APM for patients that may be less acute than the patients included in the rate set by CMS. In order to mitigate the risk of this occurring, the PRC Operators recommend that CMS work with an APM to establish the appropriate baseline costs by DRG. The baseline costs could include universal exclusion criteria, such as the restrictions set forth in the PRC Submission on page 16 (patients that received ICU-level care and patients that were diagnosed with ESRD and received hemodialysis) or exclusion criteria that is specific to a DRG.

Benchmarks could be established at a regional or partner-hospital level if the APM expects a disproportionate share of its admissions to be admitted to a specific hospital. This is especially important when the APM is partnered with a high-cost institution.

The PRC Operators recommend that reimbursement be evaluated periodically by CMS following implementation to adjust the payments as CMS and APMs gain more experience. The PRC Operators would point to the implementation of the Inpatient Prospective Payment System in which CMS made changes to better align hospital costs in caring for patients that are grouped into DRGs. Such future system may include using an acuity adjusted payment incorporating Hierarchical Condition Categories (HCCs) or All Patient Refined DRGs (APR-DRGs).

The PRC Operators recommend using caution in using a retrospective analysis of patient acuity. Specifically, the PRC Operators agree with comments made by Dr. Bruce Leff at PTAC's meeting on September 7 in PTAC's consideration of the Icahn School of Medicine at Mount Sinai's Hospital at Home Plus presentation. Dr. Leff highlighted that determination of patient acuity in a retrospective review may be the outcome of treating patients in a Home Hospitalization and not low patient acuity on presentation to a clinician for admission into a Home Hospitalization program.

6. Please describe more specifically what services you envision being delivered to the patient in the home and which types of personnel would deliver those services during (a) the acute phase of care, and (b) the post-acute phase. Explain how the services would differ from (1) other hospital at home programs, (2) physicians making home visits, (3) care management/care coordination programs using nurses with physician oversight.
Under coordination of the Recovery Care Coordinator, services delivered by key providers to the patient in the home during the acute phase include the following:

Admitting provider (hospitalist) patient care management
Acute Care RN home nursing care
Infusion services delivered through a contracted partner
Transportation services delivered through a contracted partner
Physical therapy, speech therapy, occupational therapy by licensed therapists
Pharmacy services delivered through a contracted partner
Durable medical equipment (DME) delivered through a contracted partner
Laboratory and imaging services delivered through a contracted partner
Consults by specialists as needed

All services and personnel noted above are available and provided during the post-acute phase as well, with the exception being that physician management is transitioned from the admitting physician to the primary care physician.

The PRC model is different from other Hospital at Home programs in two key areas: partnering with providers to perform key activities of the model and the broader scope of the conditions that it admits. The PRC Operators made the decision to partner using existing provider resources, such as hospitalists with capacity for additional work, because it was a more natural extension of the existing health system rather than adding a new type of provider that could add to the complexity of a patient navigating the health system. The partnering approach also enables greater scale and a smaller direct investment by physician groups that may want to implement the model, as it is inclusive of the use of a telehealth platform to enable virtual patient visits. The partnering approach focuses on providing clinical and administrative support, training and selection of clinicians and vendors, collection and reporting of quality measures and the overall administration of the program, all led by the physician groups that may or may not be owned by a health system.

The PRC Operators also recommend a more robust list of clinical conditions that it believes may be safely treated at home. A list of conditions that are categorized into DRGs that are on page 27 in Appendix F: Diagnoses Related Groups, in the PRC Submission to PTAC dated October 27, 2017 (the "PRC Submission"). Similar to the model presented by the Icahn School of Medicine at Mount Sinai, "HaH Plus" (Hospital at Home Plus) Provider-Focused Payment, patients' clinical eligibility will vary by DRG.

The PRC Operators believe that by adopting a broader list of DRGs, APM organizations will be able to better incorporate the PRC into practice patterns as the model becomes the standard of care. The DRGs in Appendix F represented 42% of Medicare's IPPS hospital discharges and 55% of discharges that were in medical (non-surgical) DRGs (Medicare "Inpatient Prospective Payment System, IPPS, Provider Summary for All Diagnosis-Related Groups (DRG) – FY2015", last updated October 31, 2017, data.cms.gov). Not only will it allow APM organizations to think more universally about the applicability of Home Hospitalization, it will also provide more choice for Medicare beneficiaries that may desire to be treated at home, reduction of iatrogenic conditions and cost savings for Medicare.

The PRC Operators value the increasing availability of home visits by physicians and other practitioners associated with physician practices. These programs enhance access for a portion of the population that may otherwise not be able to obtain primary care services. It is the PRC Operators' experience that these programs generally provide primary care, including the management of chronic illness and episodic treatment for lower acuity ailments. Home Hospitalization is for patients that meet acute inpatient hospital criteria and require more frequent and time-consuming visits as well as involvement from other disciplines that make up a care team. The PRC Operators believe that not all physicians that treat patients at home will be comfortable providing acute-level care outside of a hospital.

The PRC Operators appreciate the value of private sector payer and CMS care coordination programs; the PRC Operators believe its model differs significantly. the functions, work effort and qualifications of the Recovery Care Coordinators (RCC) are generally different from health plans' provider-based and payer-based care management programs. Contessa Health has also engaged health systems that have care coordinators, and those systems have similarly acknowledged the difference between these programs, specifically the roles of their nurses.

The role of the RCC begins when patients are screened for admission into the PRC, working with physicians to admit patients at the access point of physicians determining that patients have qualifying clinical conditions and may be safely treated in patients' homes. Once patients are admitted, the RCC acts like a charge nurse in an acute inpatient hospital; the RCC manages and coordinates all services that patients receive. The most intensive portion of an episode is the acute phase in which patients receive services in lieu of inpatient acute hospital stays. The RCC speaks daily or more frequently with patients during the first two weeks of the admission and attends treatment and care plan meetings virtually with physicians and nurses that are providing care in patients' homes.

The area of similarity in Medicare's Chronic Care Management (CCM) and Transitional Care Management (TCM) is the transition period when patients move from the acute phase to the post-acute phase of an episode. A key strength of the PRC model in this area is maintaining the same RCC throughout the episode so that it is far more likely that best practices of transition management are executed. The PRC agrees with Dr. Al Siu's remarks during his September 7 presentation to PTAC in consideration of the Icahn School of Medicine at Mount Sinai's Hospital at Home Plus submission. The discharge day may be "kind of arbitrary" in that it could be phased and may not result in a complete cessation of services being rendered as it would in the acute inpatient hospital. The RCC is accountable to work with patients, families, physicians and other providers to have care continued in a way that is patient-centered and not dependent on whose purview and what setting patients may be in throughout acute and post-acute events.

7. During the acute care phase, who is responsible for ordering, supervising, and coordinating any specialist and ancillary services? Would there be one person responsible for the patient's overall care during the entire episode?

   The admitting physician is responsible for the care delivered to the patient in the home during the Acute Phase. Similar to an in-patient hospitalization, the patient has one identified physician that is responsible for the overall care for the patient. The admitting physician orders and supervises any specialist consultation and/or ancillary service. The RCC helps coordinate and facilitate the scheduling of specialist appointments. If an ancillary service need is identified, the RCC is responsible for coordinating the services (infusion services, DME, PT services, etc.) in the home. The RCC is responsible for completing all documentation that is required to facilitate admitting physician's referral orders.

During the Post-Acute phase, the admitting physician transitions the management of care to the primary care physician. The RCC monitors patient activity in the Post-Acute phase via the telehealth system (daily biometric data and disease specific pathway assessments) and daily follow up phone calls. In this monitoring phase, the RCC is the primary point of contact and ensures the patient is compliant with follow-up appointments, medication regimen, and treatment plan. The Social Worker and administrative staff assist the RCC with scheduling and coordination of services during the Post-Acute Phase. As noted, the RCC is a consistent point of contact for the patient throughout the entire care episode.

8. Please provide detailed descriptions of how you would envision Home Hospitalization services being provided to a hypothetical patient in each of the following MS-DRGs:

   Potential patients undergo rigorous screening (see question #2 for screening tools) to determine program eligibility. The admitting physician confirms program eligibility, completes a history and physical and writes admission orders during the initial face-to-face patient encounter. The admitting physician conducts daily rounds on the patient, completing a progress note, adjusting the treatment plan and provides direct oversight of all patient care delivery. The RCC coordinates provider orders and schedule services with all ancillary providers (infusion services, DME, therapy services, etc.). During each home visit, the Acute Care RN completes and documents a nursing assessment, executes provider orders, and assists the patient with activities of daily living, as needed.

   Below are examples of hypothetical case studies illustrating the services rendered during a Home Hospitalization episode.

   - 57: Degenerative Nervous System Disorders without MCCs

     85 year-old female presented to the ED with history of Alzheimer's, and CHF. The family reported increased confusion from baseline, agitation and poor oral intake for the previous 3 days. The patient was tachycardic and mildly hypotensive. Significant laboratory findings included: BNP 115, Sodium 126, Potassium 3.7, BUN 22, and Creatinine 1.4. The treatment plan goals focused on reducing the patient's agitation and improving the electrolyte imbalance. Medications included Riseperidone 2mg by mouth daily, Normal Saline with 20mEq KCL at 100mL/hour and enoxaparin 40mg SQ daily. Each day of the Acute Phase, the patient received; 1 provider visit, 2 Acute Care RN visits and, 2 visits from the infusion services nurse.

   - 291: Heart Failure with MCCs

     82 year-old male presented to the primary care clinic with history of CHF, hypothyroidism and chronic myeloid leukemia. Patient complained of non-productive cough and shortness of breath. The patient was hypertensive and febrile. Significant laboratory findings include: BNP 487 and WBC 13.4. Chest x-ray impression: bilateral infiltrates consistent with mild CHF exacerbation and right lung pneumonia. Treatment plan focused on excess fluid reduction and treatment of pneumonia. Medications included Lasix 40mg IV BID,

ceftriaxone 1gram IV daily, doxycycline 100mg by mouth daily, and enoxaparin 40mg SQ daily. Each day of the Acute Phase, the patient received 1 provider visit, 2 Acute Care RN visits, and 1 visit from the infusion services nurse.

- 293: Heart Failure without CCs, MCCs
  - *89 year-old male presented to the ED with history of CHF and renal insufficiency. Patient complained of non-productive cough and shortness of breath. Significant laboratory findings included: BNP 764, BUN 26, Cr 1.3, and eGFR 39.4. Chest x-ray impression: Mild pulmonary vascular congestion. Treatment plan focused on excess fluid reduction. Medications included Lasix 40mg IV BID, Potassium Chloride 20mEq by mouth daily and enoxaparin 40mg SQ daily. Each day of the Acute Phase, the patient received 1 provider visit, and 2 Acute Care RN visits.*
- 536: Fractures of the Hip & Pelvis with MCCs

  78 year-old male presented to the ED with left hip pain. Patient had a history of diabetes and metastatic prostate cancer. Glucose 314, Hgb A1C 9.4. AP and Lateral x-ray of the pelvis indicated left non-displaced acetabular fracture. Surgical intervention was not indicated. Treatment plan focused on pain management and blood sugar control. Medications included hydrocodone/acetaminophen 10/325 1 to 2 tablets by mouth every 4 hours as needed for pain, sliding scale insulin, and enoxaparin 40mg SQ daily. Each day of the Acute Phase, the patient received 1 provider visit, 3 Acute Care RN visits for glucose and pain management, and assistance with ADLs, and daily physical therapy visits for gait training and strengthening.

9. What staffing and other quality standards should an organization be required to meet in order to receive Home Hospitalization payments?

   The PRC ensures that all individuals and program practices are met with quality standards that are defined by both individual performance qualifications and program quality metrics. The performance qualifications for individuals are defined based on industry standards for a given role. The review of performance qualifications and quality metrics is ongoing and provides feedback for both individuals and the program at large. The PRC emphasizes key performance metrics which are applied to organizations and providers in the program that conform to national quality standards. Examples of these performance metrics include:

   - *% of episodes with follow-up PCP appointment scheduled within 7 days*
   - *% of episodes with medication reconciliation*
   - *Patient Safety - % of episodes with adverse events*
   - *Patient Experience - % of questions answered with top box response*
   - *Functional Status Assessments (using PROMIS) - % of episodes with functional status assessments completed for each patient*

The PRC Operators ensure all ancillary providers are educated on the type of role and responsibilities required for participation in the program. The following roles provide a detailed description for the staffing and quality standards required for program participation:

- *The admitting physician is a hospitalist with board certification in internal medicine or family medicine. He/she participates in rigorous PRC onboarding and continued education inclusive of telehealth training to support the delivery of virtual patient care. Provider performance is assessed on an ongoing basis and feedback is delivered to the practitioner. They are also subject to the local peer review system.*

- *The Acute Care RN is a registered nurse with acute care experience (ICU or ED, for critical thinking and triage skills). He/she also has home health experience and excellent communication and coordination skills. He/she participates in rigorous PRC onboarding and continued education. Ongoing performance feedback is provided to the Acute Care RN and compliance with services level agreements for their contracting agency are maintained.*

- *The Recovery Care Coordinator is a registered nurse with acute care experience. The RCC has excellent communication, coordination, and documentation skills. He/she participates in rigorous PRC onboarding and continued education. As an employee of PRC, they have annual performance goals assigned and receive an annual performance review.*

All PRC clinical participants are required to complete patient safety and clinical risk management training.

10. How many home visits do you believe participants in the model should be required to make, and what types of personnel should be required to make those visits? Should any minimum number of face-to-face visits in the home with a physician or other clinician be required in order to receive a Home Hospitalization payment for a patient?

    Through the acute phase, the patient receives a minimum of 1 visit by the admitting physician, upon the initial encounter in person, followed by virtual (audio and video) daily visits. Through the acute phase, the Acute Care RN provides 2 in-person visits daily. Depending on the time of admission (i.e. evening) or day of discharge, the Acute Care RN may only provide 1 in-person visit on that day. The admitting physician orders services by ancillary personnel. When ordered, daily visits are made by an infusion nurse and physical, speech or occupational therapist. Additional visits are available from pharmacy, DME, lab and imaging services. The minimum number of visits noted above is required to receive Home Hospitalization payment.

11. The Abstract indicates that patients would agree to receive acute care treatment "in their homes or a skilled nursing facility," but the rest of the proposal refers to services in the patients' homes. Do you envision that some patients would receive home

hospitalization services in a skilled nursing facility (or other institutional residence) instead of their own home? If so, how many such patients would there be, how would they be selected, and how would the payment model work for those patients? Do you envision that Home Hospitalization services would be provided to patients who reside in a nursing facility or other institutional residence in addition to patients who live in a private residence? If so, what services would be provided by the nursing home staff versus the Home Hospitalization program?

The reference to patients being able to receive treatment in a skilled nursing facility (SNF) is intended to provide an alternative to the home as it relates to site of service delivery. The PRC Operators envision that patients could receive home hospitalization services in a skilled nursing facility under certain circumstances, specifically unique clinical, behavioral or environmental circumstances. It has been the experience of the PRC Operators that there are various factors that impede the comfort of either caregivers or patients to utilize the home hospitalization model upon the time of admission. Having the option to utilize a skilled nursing facility as a site of service for the model could further contribute to adoption of the model. For clarity, this was a primary reason that the PRC Operators requested a waiver for the 3-day SNF rule. Note: The PRC Operators will utilize the Home Hospitalization payment to reimburse the SNF for the services rendered.

Examples of circumstances that support the rationale to have the option to use a skilled nursing facility include:

- *Clinical – In some cases it may be optimal to initiate the acute phase of the patient's care in a SNF based on their clinical presentation. Specifically, a patient who presents in the late evening hours and requires more frequent monitoring might benefit from an overnight SNF stay prior to being transported home for the remainder of the patient's care.*
- *Behavioral – Given the lack of public knowledge about the model, patients sometimes feel more comfortable in an institutional setting than in their home, yet they still do not want to stay in an acute care facility, causing many patients to leave against medical advice. Being able to receive care in a SNF could provide patients an alternative to the acute care setting, with the comfort of caregivers being nearby.*
- *Environmental – In many instances, patients live too far from the acute care facility to safely admit directly to home due to logistical issues. Having the SNF as an option allows the caregivers to improve the condition of the patient prior to discharging to home.*

It is difficult to assess the quantity of patients that would be treated in this manner. While the primary goal would be to admit directly to home, this would simply be a back-up alternative. Selection would be no different than the criteria established for direct-to-home admissions and the payment model would be the same given the parity of per diem rates that would need to be paid to the SNF operators and the cost of rendering care in the direct-to-home pathway.

We do not intend to treat patients that are full-time residents of skilled nursing facilities due to the difficulty in allocating responsibilities amongst nursing staffs, and the payment from Medicare or other payers covering room and board as well as skilled nursing. The PRC would be able to treat residents of Assisted Living Facilities (ALFs) due to assisted living facility services and reimbursement not including skilled nursing care. Such facilities operate more as an apartment environment with personal care support; any payments to the facility for skilled or medical care are separate from the per diem payment for housing.

12. The proposal indicates that PRC has implemented Home Hospitalization services for patients in a Medicare Advantage plan. What was the nature of that model—a term of network participation, or voluntary? Were there any aspects of the benefit design or provider contracts in that plan that facilitated implementation of the Home Hospitalization services but that would not be available in traditional Medicare fee-for-service? Do you believe that provider participants in a FFS environment (not at risk for drug spend) will behave the same way that a managed care plan can impose on its contracted network? What difference in beneficiary populations, model performance, and participation rates do you expect in a FFS environment compared to MAPD enrollees?

    Patients in the Medicare Advantage plan voluntarily opted into the home hospitalization program upon the physician securing informed consent. Likewise, physicians providing services within the program are employees of Marshfield Clinic that voluntarily chose to participate. The MA plan benefit design did not include the 3-day hospital rule for SNF eligibility, allowing the home hospitalization services to utilize a SNF as well as home environment for admissions. Also, the current Medicare fee-for-service prohibition against recognizing a home setting as an originating site for telehealth is problematic for home hospitalization services. Allowing a waiver of this limitation, similar to what is currently allowed for telehealth by Next Generation ACOs, would assist successful implementation.

    Provider participants under the current MA program are encouraged to use a specific formulary related to the clinical pathways developed. The formulary is designed to guide the providers to the most efficient and effective drugs appropriate for the condition based on evidence within the medical literature; however, note that providers are not at risk for drug spend in the MA environment, as Part D has been excluded from the bundled payment in the home hospitalization program for the MA plan. Given the clinical pathways and practice patterns of physicians working to achieve high quality outcomes across all payer mixes, we anticipate that physicians would prescribe and behave similarly in a FFS environment as they do in the MA plan. In terms of variance between the MAPD and FFS population, we anticipate both would be an older population with multiple comorbidities. The populations, performance of the model and participation rates would not be anticipated to differ significantly.

13. What data and analyses did you use to determine that 70% of the standard MS-DRG payment was the correct amount to pay for the acute care portion of services that would not be billed separately?

The PRC Operators used estimates of costs consistent with its care model and estimated the expected average length of stay of 4 days and included its historical costs for administrative and clinical costs to manage the episode of care. The PRC Operators included an additional accrual for nursing and support services beyond the utilization that it was budgeted in Table13.2. It was the view of the PRC Operators that this methodology would provide the financial support to APM organizations, especially physician groups, to implement PRC prior to being able to share in any savings that may result from the APM organization's care. The PRC Operators will admit many of its patients from the emergency department of Marshfield Medical Center, formerly known as Ministry Saint Joseph's Hospital in Marshfield, Wisconsin. Table 13.1 below illustrates how the PRC derived the 70% of the standard MS-DRG. The PRC Operators used publicly available data for Ministry Saint Joseph's Hospital's IPPS reimbursement ("Medicare Provider Utilization and Payment Data: Inpatient." CMS.gov Centers for Medicare & Medicaid Services, Centers for Medicare and Medicaid Services, 30 Aug. 2017, 12:31 PM, www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient.html). The table below incorporates the top 10 DRGs by volume that were included in the PRC Submission in Appendix F. These DRGs made up 50% of discharges at Ministry Saint Joseph's Hospital (now called Marshfield Medical Center) in 2015.

Table 13.1

MS-DRG	2015 Average Medicare Allowed	2015 Medicare Discharges	Total Allowed
292 - HEART FAILURE & SHOCK W CC	7,288	82	597,615
291 - HEART FAILURE & SHOCK W MCC	11,265	75	844,838
392 - ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	5,499	73	401,419
683 - RENAL FAILURE W CC	7,018	60	421,065
190 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	8,613	59	508,180
194 - SIMPLE PNEUMONIA & PLEURISY W CC	7,328	56	410,359
191 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	6,843	49	335,295
690 - KIDNEY & URINARY TRACT INFECTIONS W/O MCC	5,751	45	258,797
682 - RENAL FAILURE W MCC	12,014	41	492,587

193 - SIMPLE PNEUMONIA & PLEURISY W MCC	10,665	40	426,599
Top 10 DRG Total	**8,098**	**580**	**4,696,754**

70% of the DRG payment will compensate the PRC Operators (and any other APM organization) for the nursing, care coordination and social work activities, telehealth physician visits, and patient transportation, as well as the administrative overhead associated with operating the PFPM, in the instance the APM needs to contract for the aforementioned services. It is important to note that physician telehealth services are included in the Home Hospitalization payment since those services are currently not reimbursed by CMS. If an exemption were granted for the PRC to allow the use of telehealth services similar to those allowed under Next Generation ACOs (as discussed under Question 12), the PRC Operators expect the home hospitalization payment amount would be adjusted accordingly. Further, the telehealth physician services are replacing traditional hospitalist fee-for-service billing that will result in savings from the overall episode expenses. The average expected expenses for the Acute Phase are detailed in Table 13.2 below.

Table 13.2

Expense Line Item	**Calculations**	**Expenses**
Care Model Direct Expenses Per Episode		1,753
Patient Transportation		150
Nursing Services Provided by APM Org or Partner		
Average Length of Stay x	4	
Nursing Visits/Day x	2	
Hours per Visit With Travel x	3	
Amount Per Hour =	80	1,920
Nursing Services Variability	10%	2,112
Telehealth Costs		
Telehealth Physician Visits		
Average Length of Stay x	4	
Physician Visits/Day x	1	
Amount Per Visit =	125	500
Technology		178
Subtotal Telehealth Costs		678
Medical Director		264
Administrative Overhead (Anticipated)		700
Total		**5,657**

Payment Calculation: Average Expense ($5657) divided by Average Medicare Allowed Amount for the DRG ($8,098) = 70%

14. How much do the Home Hospitalization services being delivered in the PRC program cost, and how does that cost compare to the proposed payment amounts?

The PRC Operators are including Table 14.1 to illustrate the PRC Operator's historical costs. The amounts listed below are run-rate costs as of December 2017. The PRC Operators expect some variation from the costs that are included in Table 13.2 mainly due to a change to the amount of DRGs that the PRC Operators addressed in the model and the ability to allow physicians to determine whether patients could be treated at home rather than trying to finalize the diagnosis before admitting a patient that was eligible for acute care hospitalization. The PRC Operators are confident that the PRC Operators' experience in the model could reduce the learning curve for other APM organizations to mitigate against higher than desirable variable costs.

Table 14.1

Expense Line Item	**Expenses**
Care Model Direct Expenses Per Episode	1,753
Care Model Variable Tech Cost Per Episode	178
Nursing Services Provided by APM Org or Partner	1,555
Medical Director	264
Hospitalist telehealth services @ 4 day average length of stay	500
Administrative Overhead (Historical Experience)	765
Total	**5,015**

15. Please explain more clearly what services you believe should be included in the total costs of the 30-day episode. For example, in the event an ED visit or hospital admission is needed, which reasons for the visit/admission would be included and excluded in the "bundled payment" for the participating physician/providers? Please use examples based on MS-DRGs that are not included in the BPCI program.

Similar to BPCI, the PRC Operators believe that the episode would include related expenses for acute inpatient hospital stays, care by post-acute providers and other Medicare Part A and Part B covered services. Part B covered services would include services such as care by physician and non-physician practitioners, laboratory, durable medical equipment and Part B drugs. Unrelated or excluded expenses are defined in CMS's BPCI Models 2-4 Part A & B Exclusions for 2018 ("Bundled Payments for Care Improvement Learning & Resources Area." Bundled Payments for Care Improvement Learning & Resources Area, Centers for Medicare and Medicaid Services, 6 Dec. 2017, innovation.cms.gov/initiatives/Bundled-Payments/learning-area.html).

The PRC Operators propose to include all services rendered in the setting from which the patient was admitted on the date of admission. Settings from which patients may be admitted include emergency departments, urgent care centers and physician

offices. These services would have been paid by Medicare upon patients' admission into an acute care hospital. Specifically, emergency department facility fees would have been included in the acute care hospital's IPPS claims submission.

Table 15.1 below provides examples of services that would be included or excluded using CMS's BPCI Models 2-4 Part A & B Exclusions for 2018 for MS-DRGs 444, 445 and 446 for Disorders of the Biliary Tract. The PRC proposed mapping these DRGs to BPCI episode Esophagitis, gastroenteritis and other digestive disorders, which only include DRGs 391 and 392, which was the closest BPCI definition. Mapping PRC DRGs to the closest BPCI definition when the PRC DRGs were not included in BPCI is consistent with the model presented by the Icahn School of Medicine at Mount Sinai, "HaH Plus" (Hospital at Home Plus) Provider-Focused Payment that is detailed on Page 10 of the submission dated May 2, 2017.

Table 15.1

Included		***Excluded***	
Procedure	***Diagnosis***	***Procedure***	***Diagnosis***
47562, Cholecystectomy	*K8010, Calculus of the gallbladder w chronic cholecystitis without obstruction*	*C6561, Insertion of central venous access device*	*C132, Malignant neoplasm of posterior wall of hypopharynx*
43235, Endoscopy esophagogastroduodenoscopy procedure	*R1013, Epigastric pain*	*J9264, Injection, paclitaxel protein-bound particles, 1 mg (Oncology chemotherapeutic)*	*C3431, Malignant neoplasm of the lower lob, right bronchus or lung*

16. How do you propose the payment model interact with current hospital quality payment and value-based purchasing programs? Would patients in the Home Hospitalization program be counted as inpatients for the calculations in those programs, and if so, which hospital would be treated as the admitting facility? Would the Home Hospitalization program be accountable for any portion of the penalties that the hospital received?

    We propose that PRC be excluded from the current hospital quality payment and value-based purchasing programs ("Hospital VBP"). The primary reasons center upon the fact that: 1) not all measures in those programs are applicable to the Home Hospitalization care model, 2) the proposal by the PRC Operators includes its own quality and process driven metrics to which the program would be accountable, and in many instances, certain metrics are not included in the Hospital VBP programs, 3) the PRC includes penalties for not meeting quality metrics, and 4) if independent physicians were to adopt the PRC, there would be tremendous difficulty in identifying a hospital as an admitting facility.

17. What is the expected total episode cost for Home Hospitalizations as a percent of current total episode cost? Shouldn't the total episode cost for Home Hospitalization

patients be significantly less than 97% of the current episode costs for admitted patients in the same MS-DRG?

The PRC Operators expect that the Home Hospitalization period of the episode will be as much as 65% to 70% of the total episode cost based on the experience of analyzing multiple Medicare Advantage data sets. The PRC Operators did an environmental analysis of similar programs and proposals in arriving at the 3% guarantee to CMS, such as BPCI and the Icahn School of Medicine at Mount Sinai, the "HaH Plus" (Hospital at Home Plus) Provider-Focused Payment presentation on September 7, 2017. There are additional expenses that were not included in the 70% APM organization payment that are critical to the model to replace hospital services. Those services are listed below in Table 17.1 and Table 17.2. One important note is that whenever patients are admitted from an emergency department, the APM organization will bear the expense of all institutional emergency department claims in the episode, similar to how those costs are included in IPPS hospital payments.

Table 17.1 – *Estimate of Emergency Department Expenses*

Expense Line Item	**Calculations**	**Expenses**
Emergency Department		511
Radiology		60
Drug Costs		200
Laboratory		
Supplies		10
Transportation		0
Total		**781**

Costs for services in Table 17.1 are estimated to be 10% of the DRG.

Table 17.2 *– Other Home Hospitalization Expenses*

Expense Line Item	**Calculations**	**Expenses**
DME		50
Drugs		500
Radiology		100
Labs		100
Total		**750**

Costs for services in Table 17.2 are estimated to be 9% of the DRG.

All Home Hospitalization costs are estimated to be about 89% of the Medicare allowed for the DRG. If Home Hospitalization expenses represent 65% of the total episode cost, the estimated impact on the total episode expense is 7%. The PRC Operators agree with PTAC's comments in its review of the model presented by the Icahn School of Medicine at Mount Sinai, the "HaH Plus" (Hospital at Home Plus) Provider-Focused Payment that Home Hospitalization that payments for Home

Hospitalization services should be evaluated periodically by CMS similar to the implementation of DRGs in the IPPS. The PRC Operators tried to balance the savings that CMS achieves up front with the level of potential APM organization risk-tolerance in considering the PFPM and, as stated above, leveraged market information on expected savings in comparable programs.

18. How do you propose the initial benchmark payment rate should be established – based on the model participant's historical average, the regional average, the national average for the MS-DRG, or something else? How do you propose the benchmark should be adjusted over time?

    The PRC recommends that initial benchmark payment rates be based on DRGs, since the care and medical expense risk is expected to vary by DRG. This is similar to CMS's existing Inpatient Prospective Payment System (IPPS). The PRC submitted a list of DRGs that are addressed in the PRC Submission on page 27 in Appendix F: Diagnoses Related Groups. Benchmarks should be established at a regional or partner-hospital level if the APM expects a disproportionate share of its admissions to be admittedfrom a specific hospital. This is especially important when the APM is partnered with a high-cost institution.

    The baseline costs should eliminate expenses for patients that meet universal exclusion criteria, such as the restrictions set forth in the PRC Submission on page 16 (e.g. patients that received ICU-level care and patients that were diagnosed with ESRD and received hemodialysis) and exclude expenses for not meeting the criteria set for in the BPCI episode definitions applicable to the specific episode.

    The PRC Operators recommend that reimbursement be evaluated periodically by CMS following implementation to adjust the payments as CMS and APMs gain more experience. The PRC Operators would point to the implementation of the Inpatient Prospective Payment System in which CMS made changes to better align hospital costs in caring for patients that are grouped into DRGs. Such future system may include using an acuity adjusted payment incorporating Hierarchical Condition Categories (HCCs) or All Patient Refined DRGs (APR-DRGs).

    The PRC Operators recommend using caution in using a retrospective analysis of patient acuity given the rationale set forth in the PRC's response in question 5. There is the potential in retrospective review to understate patient acuity given the significantly better outcomes for patients in Home Hospitalization.

19. Participants in this model might also be participants in other models such as ACOs or the BPCI program. How would payments under the proposed model be adjusted in those cases?

    The payment methodology detailed in Section III, paragraph D of the PRC Submission provides participants in both the BPCI program and various ACO models the opportunity to participate in this program without adjusting payments for those programs.

In the instance where a participant is also participating in BPCI, the risk-bearing entity only triggers an episode when a patient has an index admission to an inpatient facility. The claim submitted by the BPCI risk-bearing entity will utilize the traditional DRG code for services rendered. As stated in the PRC Submission, utilizing the unused HCPCS codes would clearly delineate a patient admitted to the home hospitalization program, vs. one that would be captured under the BPCI program. The rate would not need to be adjusted, under either program, because both programs would be able to independently attribute claims to specific episodes, be it for BPCI or the Home Hospitalization APM. There are circumstances where a hospital participating in BPCI could have a patient that was admitted to home hospitalization subsequently need admission to an inpatient facility for a related DRG that is also one of the 44 bundles covered under BPCI. In the event that the BPCI participant has taken bundled risk for the same DRG, we propose that the financial responsibility for the related inpatient hospitalization be maintained by the home hospitalization APM. Therefore, the likely losses associated with the inpatient hospitalization would accrue to the home hospitalization APM and this would not trigger a BPCI episode.

In the instance where a participant is also an ACO, we would propose using the same methodology currently deployed by CMS when a BPCI participant treats a patient that is attributed to an ACO. That calls for the bundle participant that treats an ACO patient to maintain financial responsibility for the episode. Any gains or losses during the episode accrue to the bundle participant and are removed from the ACO results in a year-end financial reconciliation.

Given that the Benchmark Rate for Home Hospitalization would be lower than the rates set in either an ACO or BPCI model, due to the adjustments that would be made to the Target Bundled Rate as detailed in Section III, Paragraph A of the PRC Submission, CMS would benefit from any patient admitted to the PRC Operators program. There is a possibility that the baseline rates set for BPCI or ACOs would need to be adjusted downward for future years if a provider participates in both home hospitalization and one of the other risk models deployed by CMS once enough patients have been treated in this model, thus reducing the market spend.

20. Please describe the smallest organization that you believe could successfully implement the Home Hospitalization APM and the minimum number of patients that organization would need to succeed.

    In the PRT's initial review of the model presented by the Icahn School of Medicine at Mount Sinai, the "HaH Plus" (Hospital at Home Plus) Provider-Focused Payment, it is the PRC's understanding that there was concern about physician group's admitting patients to cover its staffing expenses and investments to implement. The PRC Operators believe that the PRC submission mitigates this risk by encouraging APM organizations to partner with home health agencies instead of having to hire all of their own home nursing. Further, this recommendation would likely be more in line

with many state laws that require nursing that visit patients at home to have a home health license in that state.

We believe it is possible for an independent physician practice to successfully implement the Home Hospitalization APM. An organization should be able to treat a minimum of 150 – 200 patients per year to achieve what we deem to be a successful program. In order to achieve the aforementioned case load, an organization that has approximately 10 physicians should be able to successfully implement the program.

At 150 patients per year, we determined that number by assuming that the DRGs listed in the PRC Submission account for roughly 40% of hospitalizations, with a 30% - 40% eligibility rate, that yields a pool of approximately 937 historical admits. With an assumed hospitalization rate of 25%, a practice would need a Medicare panel of roughly 3,750. While a PCP panel size of 2,000 is a reasonable assumption, the administrative requirements to run the program, combined with the need to be on call for patients, would make it difficult for a practice of 2 – 5 physicians to successfully operate the PRC independently.

21. Would small organizations need to have a relationship with Contessa in order to succeed? How large would an organization need to be to succeed without support from an organization such as Contessa?

    We do not believe that small organizations would need to have a relationship with Contessa or any other organization that operates home hospitalization programs. We believe that physicians will approach the home hospitalization model in a manner similar to physicians that participate in Ambulatory Surgical Centers (ASCs). There are certain physician practices that operate ASCs independently while other practices partner with organizations such as Surgery Partners or United Surgical Partners International, which specialize in operating ASCs.

    Different organizations have different capabilities and, as with any partnering decision, any party interested in launching PRC would need to complete a build vs. partner analysis to determine if the return is worth the capital to build the program independently. An organization with 10 physicians should have the infrastructure to succeed without partnering with an organization such as Contessa. However, there will likely be a need to bring on incremental staff in the form of care coordinators / administrators to ease the burden on the physicians. With the case volume depicted above, a practice should be able to make this financially successful with minimal hires.

22. Do you believe that an organization would be able to serve patients in all of the proposed DRGs immediately, or would it need to start with a subset of MS-DRGs? Would patients in some of the MS-DRGs require specialized services that could only be provided by a larger provider organization?

The PRC operators feel strongly that an organization would be able to treat patients in all of the DRGs upon launching the PRC. The medical protocols that are required to operate this program can be fairly standardized into a general medical model that does not require specialized services that could only be provided by a larger organization. Such protocols focus on the treatment of patients that would otherwise be considered for admission to a hospital general medical unit. This excludes patients that require high acuity services (i.e. step-down unit or intensive care) or continuous monitoring (i.e. cardiac telemetry), but includes the resources necessary to treat all patients in all proposed DRGs.

In addition to not needing specialized services, the ability to start broadly and treat patients across the complete DRG set contributes meaningfully to the ability to treat the aforementioned number of patients required to have a successful program. The PRC Operators began its operations with a limited set of DRGs and encountered tremendous operational challenges. The primary challenge can be attributed to the fact that the overwhelming majority of patients do not present with a clear diagnosis. When limited to a specific set of DRGs, a physician will not be able to admit a patient to the Home Hospitalization program unless it is completely clear that the patient is having an exacerbation associated with one of the DRGs for which the risk-bearing entity is contracted. By having reimbursement for the broader set of DRGs, a physician leads with the question, "can I safely treat this patient at home?" as opposed to "does this patient have one of the limited conditions that we can treat?"

In the first year of the PRC Operators' program, a retrospective analysis identified 37 patients that were discharged from the acute care facility with a DRG classification for which the program was originally contracted. The patients were screened out of the program due to inability to clearly classify the patient with one of the contracted DRGs in the limited set at the time of admission.

23. Why are there not more measures of the quality of the acute care portion of the episode?

Due to the limited national use of Home Hospitalization services to date, quality measures have yet to be formally standardized. Our approach has focused on the development of an initial list of core quality measures for the acute care portion of the episode that is incorporated into a performance dashboard as outlined in our submission. A sample of additional clinical measures tracked beyond the performance dashboard include:

- *Use of ACEI or ARB in CHF patients*
- *Use of Beta Blocker therapy for left ventricular systolic dysfunction*
- *Use of inhaled bronchodilator therapy for COPD patients*
- *Rate of use of sedative medications*

We recognize the assessment of quality is ongoing and work closely with our partner providers and the market Clinical Quality Council to evaluate and update measures being tracked.

24. Is it correct that the APM participant would receive the same payment for the acute care phase (the 70% of MS-DRG payment) regardless of performance on the quality measures? Why is performance on quality measures only tied to shared savings or shared risk payments?

    The PRC Submission's intent was for the APM participant to receive the full payment for the acute phase (70% of MS-DRG payment) regardless of performance on the quality measures. The home hospitalization payment is the equivalent of the DRG payment to a traditional acute care facility and is needed to pay for services rendered to the patient during the home hospitalization. If the APM participant failed to provide quality care during the acute phase, the APM participant would most likely be penalized in the down-side risk taken due to increased medical spend from either excess utilization during the post-acute phase or a readmission. It was the PRC Operators' objective for the home hospitalization payment to cover the APM organization's cost of administering the nursing and social work components of the home hospitalization episode.

25. Why do you believe the rate of adverse events should receive the same weighting as process measures in evaluating quality?

    The PRC Operators have considerable experience with prior risk-based initiatives including ACOs, BPCI and patient-centered medical homes. In every instance, it was the experience of the PRC Operators that high-quality outcomes were a byproduct of behavior change associated with improved processes. In order to change behavior, operators must ensure that providers are adhering to the process that was deemed appropriate for the new model. If APM participants are held equally accountable for process and outcomes, they will be incentivized to implement the necessary protocols to achieve a high-quality outcome, as opposed to blindly managing to an outcome.

26. How would CMS assure that participants in the payment model are not admitting patients to Home Hospitalization who would not have been admitted to the hospital at all?

    The PRC uses Milliman Care Guidelines ("MCG") to determine clinical appropriateness of any admission. MCG Guidelines are nationally accepted, evidenced-based criteria designed to help clinicians determine the most appropriate, medically-necessary level of care and treatment pathways. The guidelines list specific criteria that meet medical necessity for a patient to be admitted for inpatient care. The PRC further recommends that any APM entity participating in this PFPM, be required to perform this screening upon being admitted into the APM's service.

    While MCG is a good indicator of whether a patient should be admitted under inpatient status, the PRC Operators recognize that there are other determining factors that an APM should consider as an alternative to inpatient care. Therefore, the PRC Operators recommend CMS extend the existing Medicare Fee for Service (FFS) Recovery Audit Program authorized under Section 1893(h) of the Social Security Act

to oversee this program after developing criteria that may be applicable specifically to Home Hospitalization.

27. How would patients know whether the "preferred provider partners" were those that delivered the highest quality care?

    The PRC Operators only contract with downstream entities enrolled in Medicare and that currently treat Medicare beneficiaries. Due to the unique timeframes and needs of a home hospitalization program, the PRC Operators select providers that are motivated and willing to meet stricter time frames for delivery of services. The preferred partners are integral to the PRC Operators satisfying the clinical quality metrics. For example, while a normal DME delivery time might be a 24-hour turnaround, preferred providers will commit to delivering essential equipment within four hours from the time of physician order. Failure to properly deliver equipment within the time frame would impact the patient experience of the program and potentially influence patient safety (increase of falls, other adverse events). The PRC Operator will be responsible for screening and monitoring its vendors. As part of the patient consent and education process prior to admission to the program, the PRC Operators supply the list of preferred providers to the patient, so that the patient has full knowledge of the participating providers in advance of enrolling in the program. In addition, patients enrolled in home hospitalization will always have the choice of selecting specific providers if they have a preference for a given provider.

28. What mechanisms for preventing, monitoring, and responding to adverse events do you believe entities should be required to establish in order to participate in the Home Hospitalization model?

    The PRC Operators are dedicated to the prevention of adverse events and require all care team participants to complete an in-depth orientation that includes patient safety and error prevention training. All members of the team must be knowledgeable on PRC clinical risk management and risk mitigation strategies.

    During the Acute Phase, telehealth monitoring is used for biometric data and to capture the nursing assessments performed by the Acute Care RN. The telehealth system is used for daily safety huddles in which the Acute Care RN, admitting physician, RCC, and patient participate to assess and update the plan of care. The RCC is available to answer patient calls at any time (24 hours a day/7 days per week). If the patient is experiencing new or worsening signs/symptoms, the patient's vital signs are monitored and a huddle with the RCC and admitting physician is initiated. The RCC is responsible for coordinating any additional required care. The patient is required to enter biometric data and participate in pathway assessments throughout the acute phase which may trigger an alert. If data is not entered into the system, the patient is contacted to ensure completion of this important function. The RCC is responsible for triaging all alerts. An example of a trigger would be a high blood pressure alert. The RCC would call the patient, initiating a virtual visit with the admitting physician, and dispatching the Acute Care RN to the patient's home for further evaluation as needed.

In the Post-Acute Phase, the telehealth system continues to be used for capturing daily biometric data and pathway assessments. The Acute Care RN is available as needed for further assessment of the patient in their home.

The PRC has an escalation policy to direct all necessary steps for managing and responding to adverse events, escalations, and necessary hospitalizations. In addition to the escalation policy, the PRC team conducts a weekly chart review of patients that complete their episode. The purpose of this chart review is to assess any potential gaps in care or areas of improvement. If an adverse event or escalation/hospitalization occurs, the RCC coordinates a root cause analysis with the details and logistics of the event communicated to the admitting physician, PCP, referring provider, Medical Director and the PRC Clinical Quality Council. The Council meets regularly to review quality metrics, patient case studies, patient safety issues, gaps in care, and any relevant topics related to clinical operations.

All APM clinical participants are required to complete patient safety and clinical risk management training that includes the prevention, monitoring and response to adverse events.

29. How many and what types of adverse events have occurred in the PRC program, and what actions were taken in response to them?

    To date, we have had two adverse events occur: a medication adverse reaction and a lagging diagnostic lab value resulting in patient transfer to the hospital. For both of these events, the Clinical Team performed a root cause analysis to determine the cause of the event and develop risk mitigation strategies.

    The medication adverse reaction was related to a self-administration error by the patient and was identified by the Recovery Care Coordinator during the monitoring phase of post-acute care. Based on the patient's symptoms, the RCC facilitated the patient being transported to the medical center for further evaluation. The RCC coordinated the logistics of the transfer and communicated the situation to the team. Upon review, the team identified gaps in the discharge education process from the acute phase. The care team worked with the acute care nursing partner to ensure proper education and handoff of care was accomplished.

    The second adverse event involved a lagging diagnostic lab result. When the patient was admitted to the program, the labs were pending. Once the results were finalized, it was determined by the admitting physician that the patient required transfer to the hospital. In response to this event the care team implemented a process to expedite the processing and notification of all PRC patient lab reports.

30. Do you believe that a physician practice that does not have an EHR could successfully participate in the Home Hospitalization model? If so, please describe how such a practice and CMS would both ensure that high-quality care was being delivered to patients.

No. We believe in order to effectively provide excellent quality of care, providers must have access at all time to a medical record; therefore, they would need to have an EHR. EHRs also allow for efficient collection of quality data.

31. Please describe each of the differences between the model you have proposed and the Hospital at Home proposal that was recommended by the PTAC in September, and explain the reasons for those differences.

The differences can best be divided into three categories: care delivery, payment and other. In care delivery, while both models contemplate use of ancillaries, the PRC model emphasizes physician utilization of ancillary provider resources in its market. DME, laboratory, infusion and any specialty professional services need not be directly provided by the APM entity but can be provided under contract or through referral relationships. In the PRC model, the APM entity must coordinate the care, but flexibility exists in what providers and ancillaries deliver all necessary services. This allows a variety of sizes of physician practices and health care entities to engage in the model. In the Hospital at Home model, the APM entity provides the core services, including all professional services, infusion, DME, laboratory and imaging. While the Hospital at Home model also includes contemplation of use of contracted entities, its experience and design emphasizes implementation by a large health system; the payment differences below further support this distinction.

The payment methodology employed during the episode differsbetween the proposals. In the PRC model, CMS makes a home hospitalization payment to the APM participant to cover the nursing and social work services provided in lieu of the inpatient admission. This payment is 70% of the historical DRG payment that would have been attributed to the inpatient admission. The rest of the clinical services, including but not limited to, DME, professional services, labs, imaging and infusion drugs provided during the episode are billed directly to CMS as providers currently do today in their workflows. The Hospital at Home proposal contemplates a similar home hospitalization payment to the APM participant of 95% of the DRG. In the latter model, such payment covers all part B services, including all professional services, and Part A services (if incurred) during the episode. The APM entity receives the payment from CMS for those services and either provides those services directly or needs a contractual relationship wherein the APM entity would pay any downstream providers.

A few additional differences exist between the two models. First, the PRC model sets the proposed episode at 30 days from the date of admission, whereas the Hospital at Home proposal sets the episode period at 30 days from the day of discharge from the home hospitalization admission. Other differences are more minor in nature. For example, the PRC program utilizes a smaller list of quality metrics than Hospital at Home; however, the content of the metrics is comparable. PRC uses telephone patient satisfaction surveys whereas mailed questionnaires are employed by the Hospital at Home program. Finally, the PRC model describes 44 conditions mapped to 151 MS-DRGs, whereas the Hospital at Home program proposal listed only those conditions actually treated in its experience at the time of submission which were 18 conditions

mapped to approximately 50 DRGs. This distinction may not be substantive, as Hospital at Home continues to expand along-side its experience while PRC Operators included those DRGs clinically appropriate rather than basing the list on historical experience.

Appendix 1
Clinical Eligibility Guidelines

- *Adequate home environment and support and is not a resident of SNF*
- *Must meet utilization criteria for an inpatient (i.e. the patient's severity of illness excludes ambulatory treatment)*
- *No end stage renal disease (Stage 5) on hemodialysis, peritoneal dialysis can be considered*
- *Absence of need for acute inpatient surgical intervention*
- *Absence of suspected cardiac chest pain or acute MI*
- *Absence of need for ICU or telemetry services*
- *Absence of hemodynamic instability*
- *Absence of acute mental status changes*
- *Patient was not discharged within 24 hours from an acute care facility*
- *Not pregnant*
- *Absence of additional significant clinical factors not described above as determined by the admitting physician*

Appendix 2
Health and Home Assessment

Admission Health and Home Assessment

Patient Name: _____ Date: _____ MHN: _____

Cellular connectivity: Does your cell phone work in your home? ☐ Yes ☐ No ☐ Sometimes
☐ I don't own a cell phone

If so, do you have good reception? ☐ Yes ☐ No Cellular provider?
_____

If not or "I don't own a cell phone", do you live in a remote area? ☐ Yes ☐ No

Best number to reach you? _____ Type of Phone: ☐mobile ☐home ☐work
Alternative number: _____ Type of Phone: ☐mobile ☐home ☐work

What is your email address?
_____

Preferred time of day to be called? ☐8-10 ☐10-noon ☐noon-2 ☐2-4 ☐4-6

Preferred name to be called?
_____

Home safety: Do you feel safe in your home? ☐ Yes ☐ No

If no, please explain:
_____

Do you have firearms in your home? ☐ Yes ☐ No

If yes, are they stored in a safe place?
_____

Residence: Describe where you live: ☐House ☐Apartment/Condo
☐Skilled Nursing Facility ☐Assisted Living ☐ Other_____
Home is ☐ One level ☐ 2-story ☐ Split level If more than one story, do you access multiple floors during the day? ☐ Yes ☐ No
Do you have: ☐electricity ☐telephone ☐heating system ☐running water ☐air conditioning
Inside Pets? ☐ Yes ☐ No _____

Do you currently have any concerns regarding your home? ☐ Yes ☐ No
If yes, please describe: _____

Travel: Do you have plans to travel in the next 30 days? ☐ Yes ☐ No

If yes, where?
_____

Advanced Directive: Do you have an Advanced Directive? ☐ Yes ☐ No ☐ I don't know

Would you like more information on who to contact for help with an Advanced Directive? ☐ Yes ☐ No

Do you have a Power of Attorney/Health Care Agent/Conservator? ☐ Yes ☐ No ☐ I don't know

If no, would you like additional information about POA/Health Care Agent/Conservator? ☐ Yes ☐ No

Prior ED/UC visits: How many times have you been to the ED or UC in the last 90 days, 6 or 12 months (not including this visit)?

☐1-3 in 90 days ☐>/+ 3 in 6 months ☐>/= 6 in 12 months ☐Other or n/a

Please describe the ED or UC visits:
_____

_____
____

Prior unplanned hospitalizations (including current): How many times have you been admitted to the hospital in the last 90 days, 6 or 12 months?

☐1-2 in 90 days ☐>/+ 3 in 6 months ☐>/= 6 in 12 months ☐Other or n/a

Please describe the hospitalizations:
_____

_____
____

Relevant surgical history:
_____

_____
____

Comorbidities: Can you tell me all of your medical conditions?

0-1 _____ 2-3
_____

4 or more
_____

Do you have any pressure ulcers to date? ☐ Yes ☐ No

If yes, please describe location and size:
_____

Height: _____ Weight: _____

Allergies:
_____

Medications:

Do you currently have any problems taking your medications? ☐ Yes ☐ No ☐ Sometimes
If "yes" or "sometimes", please explain:
_____
_____
What tools (if any) do you use to help you remember to take your medications? _____
_____
Are you able to fill and pick up your medications and refills? _____
What pharmacy do you typically use? _____
_____

Nutrition:

Has your provider recommended a special diet? ☐ Yes ☐ No
Are you compliant with your diet? What helps with compliance? _____
_____
_____

Alcohol:

Do you drink alcohol regularly? ☐ Yes ☐ No
If yes, how often/how much in a typical week/day?
_____

Smoking:

Do you currently use tobacco products? ☐ Yes ☐ No
If yes, please describe: _____
(What type of tobacco do you use? How much or how often do you use tobacco on a typical day/week?)

Sleep:

Describe your sleep patterns (Where do you sleep? Do you have trouble falling asleep? Do you have trouble staying asleep? Do you feel well rested when you wake up? _____
_____
_____
Do you snore? Have you ever been told you have sleep apnea? _____
_____

Pain:

Are you currently experiencing any pain? ☐ Yes ☐ No
If yes, please describe (location, intensity, pain scale, duration): _____
_____
_____
Do you have chronic pain? Are you in a pain management program? What helps relieve your pain? ___
_____
_____

Finance:

Do you currently receive financial assistance? ☐ Yes ☐ No
If not, are you interested in receiving financial assistance? ☐ Yes ☐ No
Are you anticipating a change in health insurance in the next 30 days? ☐ Yes ☐ No
Do you currently have transportation (car, carpool, public transportation, taxi)? ☐ Yes ☐ No
If yes, please describe_____
Are you currently able to utilize this mode of transportation? ☐ Yes ☐ No

Health Care Team:

Do you know your PCP? ☐ Yes ☐ No
Have you had a follow up appointment with your PCP in the last 30 days? ☐ Yes ☐ No
If yes, was it: ☐ routine/scheduled ☐ follow-up from an episode ☐ unplanned/new problem
Do you have a history of mental illness? ☐ Yes ☐ No
If yes, who is the provider managing this care? _____

Primary Caregiver: Who is your primary caregiver? ☐ I am my primary caregiver ☐ spouse/partner/family member/friend ☐ home health aid/nurse or hired caregiver
If you are your primary caregiver, do you live alone? ☐ Yes ☐ No
If you do not live alone, are you responsible for the care of someone else? ☐ Yes ☐ No
If yes, please describe: _____
Is your primary caregiver able to take care of your needs? ☐ Yes ☐ No ☐ Sometimes

If "no" or "sometimes", please explain: _____
_____
_____

Special needs: Do you use any assistant devices or equipment to help you in your home? If yes, please describe: _____
_____

☐ Wheelchair	☐ Wheeled walker	☐ Rollator	☐ Crutches	☐Other _____
☐ Cane	☐ Transfer bench	☐ Oxygen	☐ Bipap/Cpap	☐Other _____
☐ Specialty bed	☐ Bedside commode	☐ Bath seat	☐ Nebulizers	☐Other _____
	☐ Leg lifter			
	☐ Reacher			

Do you need any further assistance with or education about your DME? ☐ Yes ☐ No
If yes, please explain: _____

Falls: Have you fallen in the last year? ☐ Yes ☐ No
If yes, how many times and how recent was the fall? Please describe: _____
_____

ADL's: Do you need assistance with the following? If yes, minimum, moderate, or maximum assist?

☐ Grooming: Minimum Moderate Maximum
☐Laundry: Minimum Moderate Maximum
☐Dressing: Minimum Moderate Maximum
☐Shopping: Minimum Moderate Maximum
☐Bathing: Minimum Moderate Maximum
☐Transfers in/out of chair: Minimum Moderate Maximum
☐Transfers in/out of bed: Minimum Moderate Maximum
☐Transfers in/out of shower/bath: Minimum Moderate Maximum
☐Driving: Minimum Moderate Maximum
☐Yard Work: Minimum Moderate Maximum
☐Household work: Minimum Moderate Maximum
☐Meal Prep: Minimum Moderate Maximum

Are these existing needs or new because of this most recent illness? _____
_____

Language/Literacy: Do any of the following apply to you?
☐Unable to read ☐Unable to write ☐Learning disabilities ☐Non-English speaking
☐Deaf ☐Blind ☐Hearing impaired ☐Vision impaired
If yes, what helps you manage this/these? _____
_____
If non-English speaking, what is your primary language? _____ Ethnicity: _____
If non-English speaking, would you like to use interpreter services? ☐ Yes ☐ No

Do any of the following apply to your caregiver?

☐Unable to read ☐Unable to write ☐Learning disabilities ☐Non-English speaking
☐Deaf ☐Blind ☐Hearing impaired ☐Vision impaired

If yes, what helps you manage this/these? _____
_____

Other: Any other relevant information you feel is important to document regarding this patient's care?
_____
_____
_____

Appendix 3

Summary Table: Events by DRG

DRG	# of Patients per DRG	Adverse Event	Related Escalation	Related Readmission	Unrelated Readmission	Referral to Hospice	Expected Death
603 - CELLULITIS W/O MCC	22		2	1	1		
194 - SIMPLE PNEUMONIA & PLEURISY W CC	9	1		1			
690 - KIDNEY & URINARY TRACT INFECTIONS W/O MCC	9					1	
195 - SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	7						
292 - HEART FAILURE & SHOCK W CC	7			1		1	
192 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	5						
293 - HEART FAILURE & SHOCK W/O CC/MCC	4					1	
191 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	3			1			
291 - HEART FAILURE AND SHOCK W MCC	3	1	1				
301 - PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	3						

176 - PULMONARY EMBOLISM W MCC	2						
178 - RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	2						1
190 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	2						
392 - ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	2						
558 - TENDONITIS, MYOSITIS & BURSITIS W/O MCC	2						
593 - SKIN ULCERS W CC	2						
694 - URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	2						
149 - DYSEQUILIBRIUM	1						
179 - RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	1						
189 - PULMONARY EDEMA & RESPIRATORY FAILURE	1						
202 - BRONCHITIS & ASTHMA W CC/MCC	1						
203 - BRONCHITIS & ASTHMA W/O CC/MCC	1				1		
206 - OTHER RESPIRATORY	1					1	

SYSTEM DIAGNOSES W/O MCC							
300 - PERIPHERAL VASCULAR DISEASE W MCC	1						
552 - MEDICAL BACK PROBLEMS W/O MCC	1						
594 - SKIN ULCERS W/O CC/MCC	1						
602 - CELLULITIS W MCC	1						
811 - RED BLOOD CELL DISORDERS W MCC	1						
871 - SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	1		1				
872 - SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	1						

Additional Questions Regarding
PRC Home Hospitalization Proposal

1. At the bottom of page 1, the response says "As part of the PRC Operators' ongoing clinical review of the initial list of MS-DRGs, 13 MS-DRGs were determined not to be appropriate for the Home Hospitalization program due to the acuity of the patients or the services required." What are these 13 MS-DRGs? Does this mean that the list of MS-DRGs in the proposal is no longer valid?

   The list of MS-DRGs submitted in the proposal are valid but the PRC Operators would advocate removing the 13 from the list. At the time of submission, we had just begun admitting patients from the emergency department with the broader list of DRGs. In the months since, as we screened patients, we discovered that the conditions listed below did not meet clinical eligibility criteria for treatment in the home. Frankly, the PRC Operators discussed internally the best method and timing for addressing changes such as this and decided that transparency regarding the evolution of the program is important for this proposal. Just as we recommend that CMS evaluate reimbursement periodically, so we would recommend a systematic review of the MS-DRGs to be added or removed from the Program.

   The 13 MS-DRGS that the PRC recommends removing are:

   - *67 NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC*
   - *68 NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC*
   - *189 PULMONARY EDEMA & RESPIRATORY FAILURE*
   - *314 OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC*
   - *315 OTHER CIRCULATORY SYSTEM DIAGNOSES W CC*
   - *316 OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC*
   - *600 NON-MALIGNANT BREAST DISORDERS W CC/MCC*
   - *601 NON-MALIGNANT BREAST DISORDERS W/O CC/MCC*
   - *919 COMPLICATIONS OF TREATMENT W MCC*
   - *920 COMPLICATIONS OF TREATMENT W CC*
   - *921 COMPLICATIONS OF TREATMENT W/O CC/MCC*
   - *949 AFTERCARE W CC/MCC*
   - *950 AFTERCARE W/O CC/MCC*

2. How would participants be expected to address patient needs that occur during the night? Would a home hospitalization program be required to have nurses or physicians available to respond to patient needs on a 24/7 basis?

   It is a requirement of the PRC home hospitalization program to have nurses and physicians available 24/7/365 for coverage of patient issues that occur day or night throughout the entire episode of care. Just as we have in our current program, the PRC Operators recommend that in order to participate APMs be required to have escalation processes in place to address any change

in patient status, new or changing symptoms, concerning biometric data, or questions/concerns raised by the patient. This is similar to how many large practices operate, especially those that have delegated risk arrangements with payers. Upon admission, the participating entities would provide the patient with a 24-hour phone number to call, answered promptly by the RCC in response to concerns, similar to a call button used in a hospital. In our current program, the RCC serves as the primary point of contract, responding to concerns, alerting the acute care nurse if appropriate, and/or escalating to a physician when necessary. In addition, we have a physician serving on call available to the PRC Program on a 24/7 basis. The PRC Operators recommend that the RCC serve as the primary point of contact in responding to concerns and triage additional follow up, as appropriate, to the physician and/or the acute care (home health) nurse. It is our opinion that it must be a requirement for any home hospitalization program in order to operate safely to have such a coverage plan in place.

3. If a patient needed a consultation from a specialist during the home hospitalization, how would that consultation be delivered and paid for under the proposed payment model?

Specialty consultations are arranged during the home hospitalization upon the order of the treating physician and coordination by the RCC. Any APM implementing this program should have a roster of such physicians to whom they would refer; in the PRC Operator's experience, larger physician organizations, such as Marshfield Clinic, have many specialists to whom the patient could be referred. If the patient requires specialist care during the acute phase of an episode, the care coordinator schedules the appointment and if necessary, arranges medical transportation for the patient to the specialist's office for care in-person. Additional follow-up with the specialist can either be done in-person or can be arranged via telehealth enabled virtual visits. The cost of any specialist in-person consultation would be included in the total cost of the episode and the transportation and telehealth rounding during the home hospitalization is included in the Home Hospitalization payment; the PRC Operators included patient transportation in the budget submitted for Question 13 in the response to the PRTs questions submitted by the PRC on 1/18/2018.

4. Please describe what types of training you believe should be required for nurses who deliver care in the home.

Nurses who deliver care in the home must have training in both home health care delivery and acute care nursing, which could include previous experience working in a hospital Emergency Department. When an APM contracts for these services, its home health partner must identify nurses with this background and experience. In addition, all nurses and physicians that deliver care in the model would be required to participate in an extensive PRC onboarding curriculum. The PRC Operators recommend the following as minimum required elements in an onboarding curriculum.

- *Patient safety and error-prevention training*
- *Clinical workflows applicable to the specific provider's program*
- *Evidence-based clinical protocols*
- *Escalation protocols and contingencies*

- *Quality metric collection and review*
- *Information technology, including EMR and telehealth technology*
- *Patient experience and service level metrics*
- *Face-to-face introductions with physicians who will act as attending physicians in home hospitalization*

The PRC Operators also recommend participation in regular care team meetings and case reviews.

5. The response to question 10 seems to only apply to the acute phase of care. Please clarify (a) whether you believe any minimum number of home visits should be required during the post-acute care phase, (b) whether participants should be required to make home visits during the post-acute phase if needed, and (c) which services delivered during the post-acute care phase would be paid for through the DRG-based payment versus separate billing under standard payment systems.

   a. *The minimum visit requirement stated in question 10 applies only to the acute phase of an episode. At minimum, during the post-acute phase, participating organizations should arrange for patients to visit their primary care physicians within seven days of discharge from the acute phase of the episode. Physician visits after discharge from the acute phase would be separately billable to Medicare.*
   b. *The PRC Operators do not recommend a requirement for home visits following discharge from the acute phase. However, some patients will require services in the post-acute phase, such as traditional home health, similar to when a patient is discharged from an acute care hospital. Those services would be separately billable to Medicare using the applicable payment methodology and member benefit rules would apply.*
   c. *The DRG-based payment would include the Recovery Care Coordinator for the entire 30-day period in addition to those services outlined in the PRC Operators proposal for the acute phase of the episode. The PRC Operators recommend frequent interactions with patients by the Recovery Care Coordinator. The following table illustrates a follow-up schedule that the PRC Operators recommend. All services in the following schedule are covered under the DRG-based payment and are not separately billable to Medicare.*

Time in the Episode (Days)	***Frequency of Recovery Care Coordinator Engagement***
1-4 (Acute Phase)	*Daily*
5-14	*Daily to every other day, depending on condition*
15-21	*Daily to every three days, depending on condition*
22-30	*Daily to every three days depending on condition*

6. The answer to question 11 states "the PRC Operators requested a waiver for the 3-day SNF rule" but also states "The PRC Operators will utilize the Home Hospitalization payment to reimburse the SNF for the services rendered." Please list the different situations in which a Skilled Nursing Facility would be used for a home hospitalization patient, how the SNF would be paid in each of those situations, and whether the SNF payment would be included in the 30-day episode spending.

   The PRC Operators envision a Skilled Nursing Facility being used at the time of admission into the program under two primary scenarios: 1) as a temporary placement for 24 hours or less before the

patient moves to home to complete the acute phase of treatment or 2) a setting for the acute care phase of the program.

A SNF could be used for a home hospitalization patient who upon admission to the program could receive care in a SNF for the first twenty-four hours or less of the care. Examples are a patient admitted in late evening hours such that ancillary services such as DME and acute care nursing cannot be secured until the following day. Utilizing the SNF allows the patient to be admitted to Home Hospitalization and avoids a hospitalization while providing a safety net for care and supplies until the direct to home arrangements are secure and the physician has examined the patient in-person beyond the initial admission.

The second use of SNF would be for patients or physicians where the comfort level with treatment at home is inadequate. This could be for several reasons: 1) a patient could prefer to be monitored in facility setting but not want to be in the hospital itself; 2) the patient's home could be physically located too far from an acute care facility to safely admit to home; or 3) physicians are uncomfortable with delivering care in this method such that SNF provides a way for them to experience Home Hospitalization (work with the RCCs, etc.) prior to admitting directly to the home.

In each of these situations, the SNF would be paid by the participating organization out of the Home Hospitalization Payment. Either partially or for the entire Home Hospitalization phase, the SNF stay is replacing of the acute care nursing in the home. The Home Hospitalization Payment is included in the total cost of care calculation used to determine spending for the 30-day episode and the participating organization will pay for the SNF care out of the DRG-based payment.

7. To help us understand the extent to which home hospitalization care costs are correlated with DRG weights/payments, please provide whatever data you can on the average length of stay in the acute care phase by DRG and the variance in the LOS by DRG for the patients who have participated in your home hospitalization program.

   Because of the variation of DRGs treated thus far, in follow-up to our call on February 14, 2018, we did not find statistically credible support given the distribution of the admissions by DRG; therefore, we took an alternative approach outlined below. We believe that the methodology outlined in our proposal, or a similar resource-based payment, would be fair to APMs.

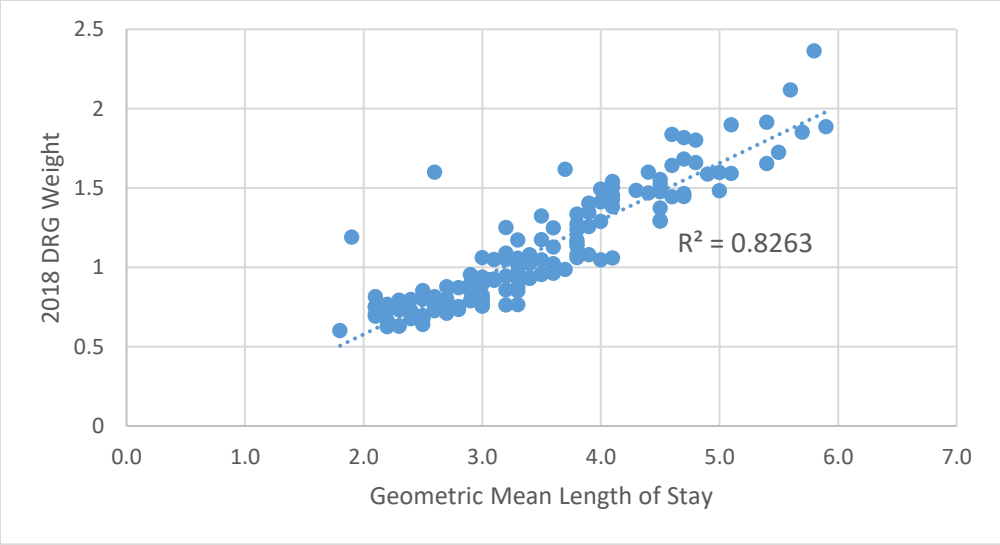
   a. *Illustrative example: Table 7.1 highlights 19 admissions providing an example of the PRC Operators' actual results in 3 DRGs. This information is not statistically credible and is being provided for illustration purposes only.*

DRG and Description	*Number of Episodes*	*2018 DRG Weight*	*PRC Average Length of Stay*	*Medicare Geometric Mean Length of Stay*
690 – Kidney & Urinary Tract	*10*	*0.7945*	*2.5*	*3.0*

DRG and Description	*Number of Episodes*	*2018 DRG Weight*	*PRC Average Length of Stay*	*Medicare Geometric Mean Length of Stay*
Infections W/O MCC				
292- Heart Failure & Shock W CC	*7*	*0.9588*	*2.3*	*3.5*
178 – Respiratory Infections & Inflammations W CC	*2*	*1.2952*	*3.5*	*4.5*

b. *2018 Medicare MS-DRGs and Geometric Mean Length of Stay (GMLOS): The PRC Operators thought it would be informative to provide a Graph 7.1 of Medicare's 2018 GMLOS and MS-DRG Weights, specifically for the MS-DRGs that are included in its proposal. Medicare data is both credible and in the public domain and supports the approach that the PRC Operators recommend. The PRC Operators used Table 5 of the Correction Notice for this analysis*[1].

The PRC Operators found that for the MS-DRGs in its proposal, these GMLOS more closely aligned with the proposed methodology than for MS-DRGs that were not included in the proposal.



Graph 7.1

1. [1] *"Details for Title: FY 2018 Final Rule and Correction Notice Tables." CMS.gov Centers for Medicare & Medicaid Services, Centers for Medicare and Medicaid Services, 8 Sept. 2017, 3:59 PM,* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

The PRC Operators appreciate the PRT's perspective on the payment methodology and trying to determine if it potentially could expose physician groups to more risk if the average or geometric mean length of stay were longer than anticipated. In proposing the 70% of the current Medicare payment for the respective MS-DRGs, the PRC Operators were attempting to put reasonable average expenses per episode and would look forward to having the opportunity to work with PTAC and CMS to arrive at a payment that addressed concerns of all stakeholders.

8. The answers to questions 15 and 17 are confusing with respect to ED visits. Please clarify whether an ED visit that occurs during the 30-day episode after admission to the program but does not result in a hospitalization is always included in the episode spending amount.

   An ED visit that occurs during the 30- day episode is always included in the episode spending amount provided the ED visit is care related to episode as set forth in the definition. For example, if a COPD patient was involved in a minor car accident and brought to the ED for a broken leg, those ED costs would not be included in the spending amount. However, any ED visit related to the admitting condition would be included in the episode.

9. Please elaborate on the answer to question 23 by describing all of the quality measures that you believe a participant should be required to track for home hospitalization patients. Please also explain why you selected the five measures listed in the proposal as those that will affect payments.

   In addition to the five measures referenced in the proposal, other relevant quality metrics that the PRC Operators current track include the following:

   - *% of episodes with escalations (hospitalizations that occur during acute care phase)*
   - *% of episodes with hospital admissions, "readmissions" in the post-acute phase*
   - *% of patients with unexpected mortality*
   - *% of Care Coordinator contacts complete*
   - *% of episodes where a detailed health assessment and care plan have been completed*
   - *% of episodes where an antibiotic was indicated and first dose was given within 6 hours*
   - *% of episodes where the patient was transitioned to a CCM or TCM nurse*

   We intentionally selected the five measures to include in the initial proposal based on our desire to have a concise group of process and outcome measures that are actionable and have the most significant impact on patient care and overall program performance. We believe this list captures the patient's experience, functional outcomes from the patient's perspective and key processes that impact the overall quality of the care provided in the episode.

10. The answer to question 28 states that "telehealth monitoring is used for biometric data" but then states "the patient is required to enter biometric data" and "if data is not entered into the system, the patient is contacted to ensure completion of this important function." Please clarify how you believe participants should be required to monitor patient vital signs in this program.

    The telehealth monitoring system serves as enabling technology for biometric data tracking on PRC patients. Upon admission, patients are educated on the use of the telehealth tablet that includes their participation in gathering necessary biometric data (for example, putting pulse oximeter on finger, etc.) on a schedule as ordered by the admitting provider. Since the device is blue tooth enabled, the data is automatically uploaded to the telehealth technology. The telehealth system is set on a schedule to generate an audio and visual prompt for the patient to connect the appropriate biometric device and complete the data capture. In the event the patient has failed to connect the biometric device within one hour of the prompt, a second reminder is generated by the system. The RCC monitors the patient's biometric data and in the event the patient fails to enter the data in the scheduled time frame, an alert is sent and the RCC follows up with the patient to ensure the process is completed. The RCC may also dispatch the acute care RN to the patient's home wherein assistance with completion of the task is required. The process outlined above is required to ensure the timely tracking of vital signs and other key biometric data on patients throughout the entire care episode.

11. The answer to question 28 describes the policy that PRC uses for dealing with adverse events. What do you believe all participants in the proposed APM should be required to do to avoid and respond to adverse events, and what should the penalty be for failure to comply?

    All participants in the APM should be required to actively participate in error prevention training as well as a survey process to assess potential areas of clinical risk. Through this survey, areas of risk are identified and prioritized through targeted action plans to proactively avoid adverse events. Members of the patient care team must participate in care team safety huddles to review any areas of potential concern and take necessary steps to mitigate clinical risk on a daily basis.

    In the event of an adverse event occurrence, the patient care team, under the direction of a lead physician, will conduct a root cause analysis to determine why the event happened and what action steps are to be implemented to avoid a reoccurrence. Through the root cause analysis, system issues are identified and process improvement steps applied to close any gaps in patient care. Individual performance issues that are uncovered through the process are addressed through education and counseling as required.

    Failure to put in place and follow appropriate processes as described above should result in disciplinary warnings, formal correction active plans and potential expulsion from participating in the PRC Program.

12. In the answer to question 31, why do you define the episode length as 30 days from admission rather than 30 days from discharge from the acute phase? Also, how would CMS or others be able to determine when the acute phase of care had ended?

Calculating the episode length from date of admission creates a clear, non-disputable start date for the episode. The date of discharge from the acute phase is determined by the treating physician and is documented through the medical record of the patient. While a formal discharge date is recorded, the discharge can be somewhat arbitrary in comparison to an acute care hospital in that the discharge may be phased in terms of nursing and therapy services coming to the home, physician follow-up via telehealth visits, etc. continuing in the home post-charge. Due to this possibility of a more progressive removal of services in the home, setting the episode length based on admission as opposed to discharge appears administratively advantageous.

The PRC Operators propose that APMs be required to submit a claim with the appropriate code corresponding to the episode DRG upon discharge from the acute phase. This process would be similar to an acute in-patient hospital billing process, where the MS-DRG is finalized upon discharge.

Final Commentary, Clarification and Refinements to the PRC Home Hospitalization Proposal

The PRC Operators would like to provide the following points of clarification and modifications (collectively, the "Supplemental Modifications") to our prior submissions, based on feedback received from the Preliminary Review Team's Report that was provided on March 5, 2018 (the "PRT Report"). The PRC Operators believe that the following modifications and clarifications address the perceived safety risks for patients and financial risks for providers, thus making the proposal more attractive for implementation with communities and providers across the country.

The following refinements address noted weaknesses and items that did not meet the specified criteria, per the PRT Report.

1. **Quality Adjustment to Home Hospitalization Payment**

   The PRC Operators would like to modify its original proposal per the recommendations of the PRT Report noted on pages 9, 10, and 11 by including an adjustment to Home Hospitalization payment should specific quality metrics noted not be achieved. The PRC Operators wish to amend the proposal such that should the APM Entity not achieve the updated quality metrics, outlined in response 2 below, the Home Hospitalization Payment will be reduced by up to 3%. For illustrative purposes, if a Home Hospitalization Payment was equal to $5,000 (representing 70% of a historical MS-DRG payment) and all of the quality metrics were not met, there would be a retrospective deduction applied during the reconciliation equal to $150. The PRC Operators strongly believe this adjustment to the Home Hospitalization Payment provides further safeguards for patient safety and reduces the perverse incentives to admit patients inappropriately as noted on pages 11 and 16 of the PRT report. It also provides a direct financial penalty for poor performance on quality measures, as suggested on page 11. The PRC Operators recommend that this total amount be subtracted from the Targeted Bundled Rate so that the impact of the deduction is preserved in the reconciliation process. If the actual Total Medical Spend is 110% of the Targeted Bundled Rate, the PRC Operators recommend that the APM Entity be required to pay the full amount of the payment reduction back to CMS.

   The PRC Operators feel this approach aligns with Medicare's Readmission Reduction Program in subpart I of 42 CFR part 412 applicable to IPPS hospitals and this initiative. The PRC Operators would like to note that it took under consideration a greater reduction applied to the Home Hospital Payment (as suggested on page 9 of the PRT Report) but ultimately decided that action would further exacerbate the concerns identified on pages 10 that small providers could face financial challenges if the cost of home nursing services ultimately are higher than the Home Hospitalization Payment.

2. **Expansion of Metrics to Track For Quality Purposes**

   The PRC Operators would like to amend its original proposal and expand the number of quality metrics that would be applied to the overall payment to better tie payments to quality measurements, as noted on page 11, 15 and 16 of the PRT Report.

The PRC Operators would like to have the following quality metrics apply to the overall payment and the adjustment to the Home Hospitalization Payment.

Clinical Quality Measures	Link to Payment	Satisfaction Results in % of Savings - Overall Payment	Satisfaction Results in % of Reduction to the Home Hospitalization Payment
% of Episodes with Follow-Up PCP Appointment Scheduled Within 7 Days	Target >90%	10%	
Patient Experience - % of Questions Answered with Top Box Response	Target >90%	10%	
Functional Status Assessments (Using PROMIS) - % of Episodes with Functional Status Assessments Completed for Each Patient	Target >90%	10%	
% of Episodes with Unexpected Mortality *	Target <3%	20%	
% of Episodes with Medication Reconciliation	Target >90%	10%	25%
Patient Safety - % of Episodes with Adverse Events (DVT, Pressure Ulcer and Falls with Injury)	Target <3%	20%	25%
% of Episodes with Completed Care Plans *	Target >95%	10%	25%
% of Episodes with Initial Antibiotic Infusion Started within 6 hours of admission if in the Treatment Plan *	Target >95%	10%	25%

* Recommended additional measures to the original proposal

3. **Confirmation of Clinical Visits During Program**

The PRC Operators would like to strengthen its original proposal by adding a requirement of monitoring and confirming the number of visits completed as suggested on pages 15 and 16 of the PRT Report. The APM Entity must record all visits by physicians (be they in person or via telehealth) through the progress notes of the EMR. The nursing visits will be recorded in the nursing notes.

4. **Formal Review of Escalations and Adverse Events**

The PRC Operators would like to strengthen its original proposal by clarifying a requirement to have a formal process to review all escalations and adverse events, as suggested on pages 9 and 16. The PRC Operators would have the previously referenced Clinical Quality Council (see page 8 of the PRC Operators proposal submitted on October 27, 2017) provide oversight in the review of

any adverse event or escalation and the associated corrective action plan necessary to remedy any deficiencies in the care model.

The PRC Operators took under consideration adding a financial penalty for an escalation however, the conclusion at which we arrived was that adding such a penalty would further exacerbate the financial disincentive to escalate care to the inpatient unit, as noted on page 15 of the PRT Report.

5. **Auditing Mechanism to Assure Appropriateness for Hospital Admission**

The PRC Operators would like to strengthen its original proposal by incorporating an auditing mechanism to assure appropriateness for hospital admission, as noted on page 9 of the PRT Report. The PRC Operators propose a system for reviewing inpatient status by CMS or its related entity overseeing the Program. One option would be adherence to CMS's current process of allowing the relevant Medicare Administrative Contractor (the "MAC") to review admissions into the Program. At the conclusion of the first year of an APM Entity operating the model, if the MAC determines that the APM Entity had an admission rate of 20% or greater where home hospitalization patients did not meet traditional inpatient criteria (the "Inpatient Eligibility Threshold Cap"), then the APM Entity would be required to develop and implement a corrective action plan to lower its admission rates below the Inpatient Eligibility Threshold Cap, in order to be eligible to continue participating in the home hospitalization APM. The 20% threshold would be lowered as CMS gains more experience with the program. There would be a subsequent review by CMS or the appropriate oversight body 6 months after receiving the initial finding, at which time it would be determined if the corrective action plan was appropriately implemented, and thus eligibility for the APM entity to continue operating the APM would be decided. In addition, financial penalties for inappropriate admission could be established for entities that exceed the Inpatient Eligibility Threshold Cap.

6. **Mechanism for Patients and Families to Report Adverse Events**

The PRC Operators would like to strengthen its original proposal by adding a formal mechanism for patients and families to report adverse events and safety concerns, as noted on pages 15 and 16 of the PRT Report. The PRC Operators propose that one of the following two options be required by an APM Entity operating a Home Hospitalization program to provide a mechanism for patients to report concerns:

1) *Provide a compliance phone number to patients admitted to the program. Note that the PRC Operators provide all patients a 1 (800) phone number to all admitted patients that is monitored by a 3rd party.*
2) *Provide all patients with the 800-Medicare phone number to report any concerns, similar to CMS's Complaints Tracking Module ("CTM") currently used with Medicare Advantage plans.*

All complaints could be captured annually by CMS or whatever oversight body is most appropriate for the Program. For each complaint received, an in-depth and systematic evaluation would be performed by a physician led root cause analysis team under the guidance of the Clinical Quality Council and a corrective action plan submitted to the oversight body . Similar to the Inpatient Eligibility Threshold Cap, there would be a review 6 months following the receipt of the report to determine appropriate implementation of the corrective action plan.

The following statements are meant to clarify previously submitted responses.

7. **In-Person Visits by Physicians**

   The PRT Report noted on pg. 15 that "The payment model is not intended to support any in-person home visits by a physician or other clinician." This statement is not correct. The PRC Operators allow for providers to make visits in-person, if it is needed. The PRC Operators merely prefer to rely on telehealth capabilities to address the stated weakness that a minimum volume of patients is needed for financial viability. This enables clinicians to visit patients virtually, when clinically appropriate, and avoid driving to and from a patient's house which significantly hinders volume. To reiterate, the PRC Operators do allow for in-person visits during the acute phase and that would be covered under the Home Hospitalization Payment.

8. **Potential Risk-Exposure to Small Practices Due to Breadth of Conditions Covered**

   The PRC Operators took under consideration the comments on pages 7, 10, 16 and 17, that small providers may have greater exposure to risk (both related to financial risk and patient safety risk), due to the ability to treat patients in a larger number of MS-DRGs and the possibility of having costs for select nursing services greater than the Home Hospitalization Payment. Ultimately, the PRC Operators felt that tiering either a) the financial risk exposure or b) the ability to treat a larger number of MS-DRGs, would materially complicate the administration of the proposed APM.

   It is the understanding of the PRC Operators that the addressable MS-DRGs covered by the Mount Sinai CMMI grant grew organically, beginning with the traditional MS-DRGs of Hospital at Home, and then ultimately expanding to the approximately 50 MS-DRGs identified in the Mount Sinai HaH-Plus APM proposal to PTAC. Small provider groups could implement a similar strategy, creating protocols for a self-imposed smaller number of MS-DRGs to deliver appropriate care safely to every patient at the outset of a program, without a limitation being created by either PTAC or CMS. This would also address potential financial risks as the smaller program would initially focus on MS-DRGs that constitute less-complex and lower-risk patients, thus reducing the likelihood that costs for the acute phase would exceed the home hospitalization payment. Upon gaining experience with the home hospitalization care model, smaller providers could self-select to expand clinical coverage capabilities without seeking approval from the appropriate governing body.

   Given the recommended changes included in this Supplemental Modifications response, patient safety would be better addressed as more quality metrics would be tied to financial performance; therefore, providers would be less-inclined to rapidly expand a home hospitalization program due to increased financial risk associated with having to achieve quality outcomes for patients in MS-DRGs that may be more complex and higher-risk patients.

The PRC Operators appreciate the feedback provided by the PRT Report and are confident that the refinements as outlined in this Supplemental Modifications report meaningfully improve the proposal by addressing the issues related to patient safety and financial risk for providers. These refinements enhance the service delivery standards by implementing the proposed items reflected in responses 3 – 6, expand the quality measures as reflected in response 2, and improve the payment methodology with the proposed changes identified in response 1.

PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

PRELIMINARY REVIEW TEAM (PRT)

CONFERENCE CALL WITH PERSONALIZED RECOVERY CARE, LLC (PRC) SUBMITTER

Wednesday, February 14, 2018

4:30 p.m.

PRESENT:

HAROLD D. MILLER, PTAC Committee Member
LEN M. NICHOLS, PhD, PTAC Committee Member
RHONDA M. MEDOWS, MD, PTAC Committee Member

TIMOTHY DUBE, Office of the Assistant Secretary for Planning and Evaluation (ASPE)
MARY ELLEN STAHLMAN, ASPE

ANJALI JAIN, MD, Social & Scientific Systems, Inc. (SSS)

TRAVIS MESSINA, Chief Executive Officer, Contessa Health
MARK MONTONEY, MD, Chief Medical Officer, Contessa Health
NARAYANA S. MURALI, MD, Marshfield Clinic
AARON STEIN, Chief Operating Officer, Contessa Health

P R O C E E D I N G S

[4:31 p.m.]

MR. DUBE: So my name is Tim Dube. I'm with the Health and Human Services -- Department of Health and Human Services, ASPE. I'm supporting the PTAC on this particular proposal.

I'm joined by Mary Ellen Stahlman as well.

We would like to do a round of introductions so that our transcription service can pick up the names and learn our voices, and as a reminder, because this call is being transcribed, please start every question you ask, or answer you provide, with your name to help her out so that we can easily trace back who said what. The transcription of this call will be posted on our public website as soon as it's edited through and finalized.

So let's start with our review team. If you could introduce yourselves?

MR. MILLER: Hi, everybody. This is Harold Miller from the Center for Healthcare Quality and Payment Reform. I'm a member of the PTAC, and I'm chairing this review team.

DR. MEDOWS: Hi. This is Rhonda Medows.

I'm a family physician and the executive vice president of Pop Health at Providence St. Joseph Health and a member of the review team.

MR. MILLER: Len?

MR. NICHOLS: Oh, sorry. Hi. This is Len Nichols. I'm a health economist from George Mason University and a member of the review team.

MR. DUBE: Great. And how about our submitters? Who do we have on the line today?

DR. MURALI: This is Dr. Murali here. I'm the Executive Vice President of Care Delivery and the Chief Clinical Strategy Officer of the Marshfield Clinic Health System.

In that role, I serve as the President and CEO of all of the Marshfield Clinic Health System hospitals and the 55 clinical locations of the Marshfield Clinic. Thirty-one of them happen to be Level 3 tertiary patient-centered medical homes, and I assume that CMS knows us as an entity because we have been involved in the first transitional demo and subsequently in much of what we have done in the ACO world.

With me, I have Travis Messina.

MR. MESSINA: Hello, everyone. Thank you

for your time today. This is Travis Messina. I am the CEO of Contessa Health, the partner to the Marshfield Clinic on its Personalized Recovery Care model.

MR. STEIN: And this is Aaron Stein, COO of Contessa Health.

DR. MONTONEY: And Mark Montoney, Chief Medical Officer for Contessa Health.

DR. MEDOWS: Excellent. [Unintelligible.]

MR. MILLER: Is there anybody else from Marshfield or Contessa on the call?

DR. MURALI: No. That’s the four of us.

MR. MILLER: Okay, great.

And let me ask the transcriptionist, do you want some spellings of the names?

MS. STAHLMAN: Yeah. I think we gave a list.

MR. MILLER: Okay. We got that. All right. Great.

Okay. So this is Harold Miller, and I'll kick us off. First of all, Happy Valentine's Day to everyone. I'm sure talking about this is not necessarily the best way you could spend your Valentine's Day, but we appreciate you doing that.

Just a brief, brief overview so everybody understands. So we are three members of the PTAC that constitute what we call the Preliminary Review Team, and there's 11 members in total on the PTAC. What the PRTs do is basically some data gathering on behalf of the full PTAC. The PTAC members are all volunteers, and I think while everybody would love to dig into all these things in detail themselves, there's just not enough time to be able to do that.

So we do data gathering, and we do some preliminary thinking about the criteria and what we think may make sense in terms of the criteria ratings. But we are just really a first step. We do not make any decisions for the PTAC as a whole. We're just a subcommittee, and in fact, there is no deliberation about any of the actual decisions that the PTAC will make until the public meeting of the PTAC.

So you will see a report from us that is basically the opinion of the three of us, and I only emphasize this because people sometimes think that the report is a report from the entire PTAC. It is only a report from the three of us, and it is

often the case that the full PTAC disagrees with what the members of the PRT say. So we're really doing an initial detailed review to try to facilitate the discussions at the PTAC meetings, so that's what we're in the process of trying to do.

And we appreciate all of the responses that you gave us to the many, many questions that we have asked you already, and we appreciate you taking the time to do that and giving such clear and detailed answers.

This call today is really designed to dig into a few of the issues, not to revisit all of those things, and we've all read the proposal and read the answers and everything. So we don't need to rehash all of that.

What we want to do is dig into a few of the issues where we still have some questions and where we thought that a back-and-forth would be more helpful than simply trying to do written responses back and forth, and we only have an hour today, so please don't be offended if I try to keep things moving because we want to be able to cover as many topics as we can.

And as Tim mentioned, the call is being

transcribed partly so that the other PTAC members can actually read what we went through and benefit from it, as well as the public being able to see that, but it is important to identify yourself. And I may interrupt you if it's not clear who is speaking.

Also, I will just say this is really just one more step in the process. If something comes up today on the call that you can't answer or that you want to provide a more detailed answer to after the call, just say so, and you can certainly send us that information after the call. And we may also be sending you some additional questions after the call of things that may have come up but that we didn't have time to be able to go through.

So any questions before we start from the folks from Marshfield or Contessa?

DR. MURALI: No. Really, I think we are ready.

MR. MILLER: Okay.

DR. MURALI: We are ready to proceed. We don't want to take more of your time.

MR. MILLER: Okay.

DR. MURALI: And we'll be happy to make

this as quick or as long as you choose it to be.

MR. MILLER: Okay. Well, so let me start by asking about -- one of the things that -- and we -- we're all involved in reviewing the hospital-at-home program proposal from Mount Sinai, as you're aware. One of the things that's clear is your proposal has a much broader range of the patients in DRGs than other hospital-at-home programs than the Mount Sinai program did, and my sense is that that's because you believe that there are patients in many different diagnosis categories that could be managed at home. And there would seem to be some clear advantages to being able to reach more broadly across different DRGs, both in terms of being able to get adequate volume to support the program and also not denying patients the option of having home care.

But it raises some questions for us in terms of exactly how it is that you're going to do the evaluation to determine who is appropriate for going home. It wasn't quite clear, at least to me, in reading the home assessment form how it really got into the questions about that for all these different types of patients and how you could have

care protocols for all those different conditions and whether the staff could be trained appropriately to deal with all those different conditions, particularly patients who might end up in the major complications and comorbidities category.

So if you could just spend a few minutes talking about how that’s -- how it's working for you and how you would see us making sure that if this model were implemented more broadly that it was done appropriately at other institutions.

DR. MURALI: So what I'll do is -- this is Dr. Murali here. What I'll do is I'll just set the tone and then have some of the details answered by Dr. Mark Montoney, who is our Chief Medical Officer overseeing the PRC.

MR. MILLER: Okay.

DR. MURALI: Basically, I think from the standpoint of the organization, we are a rural integrated health system, and we cover approximately 25- to 30,000 square miles. So in terms of our management, we've been involved in telehealth and virtual health going back to 1998, thanks to the support that we have had from CMS as

well as NIH for some of these pieces.

So I do take care of the nephrology, so the little old lady who lives 200 miles from here in that world, and we have been doing that for a long time.

What we recognized as we started the pilot models is that it becomes a huge patient convenience factor for patients when they come into the ER, traveling 50 miles, 100 miles for care, and when we can provide what we generally do in the general medical flow outside the home setting, it becomes effective for multiple reasons and generates value. Also, in terms of identifying the social determinants of health, that becomes critical from the value piece. So that's number one issue to keep in mind.

Second, as we expanded our services into the emergency room, we realized that there is a significant volume of patients that we could provide the service outside the hospital setting because the care models are the same.

And third, when we started the first pilot, we did the pilot in our skilled nursing facility, which we had a contracted relationship

with, so that our hospitalists could actually make sure that safety comes first and quality pieces are addressed.

And as we got the trained complement of hospitalists who could do this, we realized that, you know what, it doesn't have to be restricted to these six or seven types of DRGs. We can actually provide much of the same care in a very protocalized fashion, with the highest quality, safety, and patient experience outside the hospital setting.

But I will toss the question to Mark to take it from here to share his experience because he is closer to the nuts and bolts.

DR. MONTONEY: Yeah. Thanks, Murali. This is Mark Montoney.

And, indeed, we did start with the initial six clinical conditions that were kind of the root of hospital-at-home, going back to the Johns Hopkins, Bruce Leff model, and expanded that into dehydration and asthma.

So those initial eight clinical conditions, we started with -- and while that was a great place to start, it proved to be a little bit

limiting in the fact that patients don't always come through the emergency department, or physician office, or urgent care and clearly put themselves in one of those six or eight categories. Usually, it's more presentation of shortness of breath. It could be, you know, they've got a history of congestive heart failure, and perhaps they've got a low-grade temperature; there's an infiltrate; it might be pneumonia. And being able to construct a general medical protocol allowed us a bit more flexibility in terms of being able to funnel more potential patients in the program.

But the common thread here is, number one, these are patients that would otherwise meet inpatient criteria. We use Milliman Care Guidelines, MCG criteria, to ensure that their acuity level is appropriate for this level of care, but at the same time, we apply clinical eligibility criteria to filter out those patients that are high acuity that would not be safe to bring into the program.

So we look at this as patients that would be appropriate for a general medical bed in a hospital, essentially, not requiring telemetry,

certainly not requiring stepdown care or ICU-level care, and we've been able to -- and I should also add that we're able to do a lot of the diagnostics on the front end actually before the patient leaves the portal of entry, which 70 percent of the time, that's the emergency department, and be able to initiate treatment at that point of care and then transport the patient home.

And then, of course, when they're at home, we're still able to do virtually all labs, plain films, ultrasound. Obviously, if they need a higher-end diagnostic study, such as a CT scan or MRI, we would bring them back to the medical center, but even there, we're really focused, if that's an appropriate diagnostic test that is going to determine our treatment plan, typically getting that before they leave the medical center.

MR. MILLER: So, is it accurate to say in some ways that what you're trying to find are patients who are more similar in terms of being able to be cared for at home than their DRGs would suggest?

DR. MONTONEY: That's correct.

You know, I will add this comment too.

Despite the fact that we've been able to expand into the general medical protocol -- and this shouldn't be a surprise -- those initial six or eight still are the dominant diagnoses because, when you think about it, those are the patients that fill general medical beds in hospitals. That would be certainly the 80/20.

MR. MILLER: So I guess maybe just one follow-on, and then I'll ask Len and Rhonda to weigh in, if they have questions on this particular point. But it wasn't clear to me in reading the home assessment. It seemed like a very generic and very lengthy -- addressing lots of issues, which weren't clear to me were really relevant to, “Can the patient be safely taken care of at home?” And didn't seem to address the questions of, well, “Does this patient who might live on their own ordinarily, can they manage on their own at home, or do they have someone to take care of them now? Are they going to be potentially bed-bound during this illness or not?” And I didn't sort of see -- and does that exist somewhere that we didn't see, or are you simply doing that in addition to that survey?

DR. MONTONEY: Yeah. Well, again, the health-in-home assessment is where we start. We also add --

[Audio break.]

DR. MONTONEY: This is Mark Montoney again.

The health-in-home assessment, which you commented on, is where we start. We also add risk stratification into this, and it’s really all focused on understanding what the patient support system is. And it's variable because a patient could be living alone but be very self-sufficient and not require a lot of additional care support at home versus another patient who may require that, and that's a determiner whether we would accept a patient into the program or not.

So indeed, we're looking on the front end very, very carefully to understand what their home environment is like, is it safe, is it conducive to a safe experience for them, and what the level of support in the home is.

MR. MILLER: Okay. Let me see if Rhonda or Len have follow-up questions on that.

MR. NICHOLS: No --

DR. MURALI: Sorry. This is Dr. Murali here.

I assume that the team has read our health-in-home assessment on the Appendix 2?

MR. MILLER: Yes.

DR. MURALI: Yes. So --

MR. MILLER: That's exactly why I was asking because, when I read that, I didn't see the kind of information that I would have expected you to be asking about the home.

DR. MURALI: Okay. What did you find missing, if I could ask a pointed question? What did you find missing? Because we used this to determine what kind of support is required in the home situation as the patient is moved to the home.

MR. MILLER: Well, what I -- for example, what I didn't see was any questions asking whether -- who was there to take care of you now. It said, "Who is your primary caregiver?" "I am my private caregiver." "If you are your primary caregiver, do you live alone? Are you responsible --" It doesn't say, "Do you have someone available now to help you, if you're going to be at home sick?" I mean, that's just one example, but that, to me, would be

an important issue, is if somebody is going to be at home, are they by themselves? Are they ambulatory?

DR. MURALI: That's a great question.

So what happens in much of this instance -- and maybe we should make sure that we document that on the home assessment piece, but the recovery care coordinator goes through this process in the ER. Those are specific things that trigger off what support is required.

But I think your point is a very good point, and we should make sure that we document it and send it back in terms of the requirements.

MR. MILLER: Okay.

Rhonda, did I hear you weigh in?

DR. MEDOWS: Yeah. [Unintelligible] in the response that the candidate sent in, talking about this very, very topic.

So I heard you talk about using Milliman criteria. I heard you talk about risk stratifications of industry standards that we do, and I would assume that in the ER, somebody would be doing that home risk assessment.

But I had looked at the two documents that

you have attached. You sent the sample -- the clinical eligibility guidelines and the admission home health assessment. I saw the appendices. I know what's in it. You just answered the first question that Harold had that actually was really relevant, the documentation of who is going to be there to help them.

But can you tell me about the two guidelines that you created? Are those proprietary? Are those things that you created with other industry leaders with clinical eligibility guideline and the admission home health assessment?

DR. MONTONEY: Yeah. This is Mark Montoney again.

Indeed, we developed the clinical eligibility criteria with our provider partner here at Marshfield, and certainly we've been able to look at others in this space.

As you know, we have a joint venture with Mount Sinai, so we've been able to learn a lot from their experience. So we've been able to sort of compare notes in that area. And that would be true for the health-in-home assessment as well.

DR. MEDOWS: Okay. And you've already -- have you already had these in place, they're in use, you've been using them for a wide variety of DRGs?

DR. MONTONEY: Yes, indeed, we have. That's Mark again.

DR. MEDOWS: Any lessons learned from their use that you want to share, just out of curiosity?

DR. MONTONEY: I would say that -- you know, we were kind of just chatting about this a moment ago -- that, you know, whether an individual has a caregiver support in the home or not, it really is dependent upon their overall clinical condition and their presenting diagnosis. I mean, it's not the fact that they don't have a -- they may be living alone doesn't exclude them from the program.

So we've been able to use the tool to really be able to drill down and understand the patient's environment.

Now, the other thing I would add is it is a screening tool. As you know, it's a survey, and this would be rare where we would actually

transport the patient home and the answers they've given us in the survey don't match up with our observations. That would be a rare occurrence, but if that's the case, then certainly, if need be, we bring the patient back to the medical center.

DR. MEDOWS: Okay. And so let's say that this model is approved and used. Would those tools be available for other practices?

DR. MONTONEY: Yes. Of course.

MR. MESSINA: This is Travis Messina speaking.

I just wanted to echo Mark's -- Dr. Montoney's comments there. I mean, absolutely, I mean, because the goal of this partnership is really to, hopefully, make hospital-at-home or hospital-level care in the home an industry standard. So, absolutely, to the extent that we can help other practices, we're a tremendous advocate to that.

DR. MURALI: This may not be relevant to this particular piece, but in terms of the design structure of what the Marshfield Clinic Health System is doing with the footprint of the hospital sizes for the future, we have moved away from

legacy sizes. We have started to go onto a very small footprint with the purpose of actually using our telehealth know-how, as well as our physicians and our quality protocols to take all of that care, as much as is practically possible, safely to the home environment.

We are realizing that that is the most effective way of providing rural health care in -- in some of these areas.

MR. MILLER: So let me move on to a related question, then. This gets to the payment methodology, which is you're basing the payment for each patient on what their DRG would have been, but there's a pretty wide range of payments associated with the different DRGs that you have in here, a factor of two or more in terms of what the DRG payment would be.

But it seems as though what you're doing -- again, this is my earlier point -- is you're sort of taking patients that are more similar in terms of what they need at home than what the DRG would suggest, and it’s -- if I understand it correctly, all that the 70 percent of the DRG payment is supporting is really the nursing care

and the telehealth visits from the physician. Other things are being billed -- like infusions, et cetera, are being billed separately.

So I was a little perplexed as to why the payment should be proportional to the DRG, given all of that, and the cost analysis that you showed and the examples that you gave suggested fairly similar staffing patterns across a wide range of cases, which would not be proportional to their DRG weight.

So can you explain why you think that a 70 percent of DRG payment is the right way to structure the payment model?

MR. STEIN: So this is Aaron Stein.

So, first of all, the 70 percent of DRG was meant to capture variability in the different level of service that patients get over time, and so while they all get nursing services, just like they would in a hospital, medication frequency, et cetera, is different at times. And sometimes the length of stay on some of these individuals also tends to drag on. So while on average, we would expect the length of stay anywhere from three to four days, it's certainly possible to have somebody

in the program for much longer in the, quote/unquote, acute phase.

And we would actually -- I know we cited this in the response, but we'd actually agree to some of the comments that Dr. Al Siu made related to the fact that sometimes this sort of drags on, and the fact that there's no hard discharge date, per se, that are in the hospital, we actually think it's a real benefit to the program, and in that, some of these DRGs, obviously the payment is commensurate with the level of risk and the level of intensity that would be involved in caring for those individuals.

So in that, for those longer lengths of stay, we would expect that there would be a higher payment and a higher nursing and other types of intensity during the episode.

MR. MILLER: So when I was looking at your examples and your responses to us on pages 11 and 12, you had some DRGs of pretty significant differences in terms of payment, but you were showing them all as having basically one provider visit a day, two acute RN visits per day in at least three of the examples.

So you're saying you think the difference between those examples would likely be the length of stay, not the intensity of care per day?

MR. STEIN: Certainly. So this is Aaron Stein. Certainly, it could be two things. So one would certainly be the level of intensity of the nursing services that may be provided in any one day, and what we've tried to summarize for the Committee is the -- on the average, what we would generally accept.

And certainly, the cases that we provided in response to those questions that you referenced, that probably followed more of the average. But we have had over the course of the last year, cases that were well beyond the average. So the purpose was to certainly capture that.

Now, that said, I think you've pointed out something interesting, and is it a perfect marker for exactly what the intensity would be? I think, certainly, that there is a valid argument that there could be better markers. It's one that we felt, just given that that's how generally the hospital reimbursement had shaped up over the years since IPPS was implemented -- we thought it would

most directly measure the amount of intensity for those.

MR. MILLER: Yeah. It doesn't have to be perfect.

I guess so I'll ask you the follow-on questions, though, which is it doesn't have to be exactly proportional, but if it's really uncorrelated that -- in the sense the patients are going to get one provider visit and two acute RN visits per day in general, and on general, they're going to be in the acute phase for four days, then you'd say on average, the patients -- the cost of each patient is about the same. But the DRG payment would differ dramatically.

So the question is -- or the concern would be doesn't that create a perverse incentive to go find the patients in the more expensive DRGs because the payment is going to be much higher than their cost would be?

MR. STEIN: It certainly -- again, I certainly want to acknowledge that is a very valid point. Again, the intent was certainly to align the resources.

Now, that said, I'm wondering in follow-up

here if we could provide the Committee with a couple of examples where some of these cases did go on for a long time.

You know, again, it's -- is it perfect? No. Is it a reasonable proxy in our minds as to whether or not the resources are correlated with the amount of money paid on a DRG? We certainly felt so, and in our experience -- and although we acknowledge that at this point of the program, we've treated about 122 patients, I think, and our response was somewhere around 90, we have certainly experienced this. And we have certainly experienced these aberrant lengths of stay correlated specifically with the complexity of the individual and the DRG into which they coded.

MR. MILLER: Yeah. I think a follow-up would be helpful.

Let me just say I don't think it would be as useful to see a few aberrant examples as it would be to see some statistics on how the average length of stay and maybe the variance in the length of stay differs.

I understand these are still small samples, but it would just be -- you know, I'm not

sure I could draw a conclusion from the fact that you had a couple of aberrant cases.

MR. STEIN: Sure.

MR. MILLER: I think the issue is going to be what it's going to be overall.

Len, did you want to ask some more about this particular topic?

MR. NICHOLS: Well, no. I think you've covered it well, Harold. I was just going to suggest they consider in their reply, or addendum, or whatever that part of what we're worried about here is the risk you're bearing. So I think the degree to which we can hone in on the importance of this variance question and how to structure the payment, the kind of better off we'll all be.

MR. MILLER: Right.

Because the counter to that is -- I looked at your calculations in here, the calculations that you had on pages 16 and 17, where you calculated the average DRG payment, which is then how you calculated the 70 percent number. But those -- if I understand it -- and correct me if I'm wrong -- the weighting in Table 13.1 was based on your total discharges, not based on the admissions to the

program.

And when I went back and re-weighted those DRG-allowed amounts based on the volumes that you reported back in Table 3.2, I came out with something more like an average of $7,000, not $8,000.

So to Len's point, if it turned out that you got a case mix that was more weighted towards the low-weight DRGs, you could end up with insufficient money to be able to support the costs.

MR. STEIN: Yeah. Very – so, very reasonable.

Oh, sorry. This is Aaron Stein. I forgot. Sorry about that.

So, yeah. So, again, very reasonable thoughts, and we were -- as we were looking at this, our intention wasn't to reinvent the wheel. It was sort of to leverage what was out there today, and just given, again, how hospitals were paid on this, that's the reason why we thought that this would be a reasonable proxy for the amount of resources that were going into the patient.

Now, that said, we agreed with the Committee's prior findings or comments, rather, and

we felt the same way. That we know this reimbursement structure is going to change over time, and what we were trying to do is figure out what's the balance that we could achieve with getting something into the market where beneficiaries could access this and enjoy the same results that we've seen so far that we're very proud of with the goal of obviously, eventually, getting this much more solidified and standardized, so that practices wouldn't necessarily have that level of risk down the line and that CMS would be comfortable that its payment really reflects the resources going into the case.

MR. MILLER: Mm-hmm. Okay.

Rhonda, any questions for you on that, on this particular line?

DR. MEDOWS: No. I'm ready for quality.

MR. MILLER: Okay.

So we want to ask about, just to understand better, what the level of patient support and safety is, and let me divide this into two categories.

First is just a little bit more clarification from you about the staffing model,

and I would say one of the things that we're trying to deal with is we're not necessarily trying to understand exactly how you staff it, but what is supportable under the payment model -- right? -- Because it's -- how you do it is not as relevant as to how everybody else would do it.

But when I look at Table 13.2, which is where you sort of essentially laid out the budget, there were a couple things that were not clear to me. One was, what is that care model direct expenses per episode supposed to cover? Is that covering the RCC? What is that covering?

It wasn't clear where there was any post-acute care in this. It seemed to be all based on average length of stay and nursing visits per day, et cetera, but it wasn't clear what happened in the 30 days afterwards, so that post-acute care time. So if you could explain that?

And then the other thing was -- that wasn't clear was you had talked about the standard being that there would be a provider visit every day, but it wasn't -- it seemed as though there were no actual face-to-face visits with a physician once the patient went home. So if you could

explain sort of what's the physician's role in this, what's happened in the post-acute care phase, et cetera, that would be helpful, and then we can dig in a little bit more on that.

MR. STEIN: Sure. This is Aaron Stein again.

So first of all, to answer the question on the care model direct expense -- and what we had done here was we essentially took our payroll over the course of the 2017 calendar year and amortized that expense over each one of the episodes.

So we assumed that over time and as we continued to grow, the amount of admissions in the program, obviously the amount of staff is going to have to increase because obviously there's only a certain amount of patients that a nurse would handle.

In addition to that, the nurse expense that's coordinating the care, there are also social workers and administrative people that back up the nurse to assist with various tasks. So for example, if we have a patient that had some social needs, they didn't realize they qualified for Medicaid, we have a social worker to be able to

help somebody and facilitate the application to the state, or if there's coordination of DME and other things, we try to keep our nurses face-to-face or talking with patients at least on the telemedicine units rather than having them coordinate administrative tasks, if possible. Again, not a perfect world, but generally that's the goal here. And that's what's in the 1753.

MR. MILLER: Where is the physician payment?

MR. STEIN: Yeah. So the physician payments in here are on the telehealth side.

So first of all, there's the initial visit from the physician. That generally happens 70 percent of the time in the emergency department. We've been lucky in that when we started the program, we were actually able to admit patients from the urgent care setting as well prior to their being admitted because we had some good interventions that we put in place from a process perspective. And so the physician that would see the patient the first time would generally be either the primary care physician in the model that would follow the patient through an episode.

In our case here at Marshfield Clinic, it's actually the hospitalist that sees the patient face-to-face in the emergency department or the urgent care, whatever environment that would be. Thereafter, the visits are happening through telehealth, and we put the telehealth cost into the budget separately. We assumed that the initial visit that was happening by the hospitalist on a face-to-face would be submitted directly to Medicare and compensated as part of the episode, but certainly be submitted and paid for in the usual mechanism.

We specifically included the telehealth visit here, and we again assumed an average length of stay of four, but we put the telehealth visit separately because today it's not recognized the way that we use it because the site of the origination and the distant site are both not medical clinics. One site would certainly be the patient's house, and the site from which the call would originate would actually come from either inside a hospital or inside a physician's office.

MR. MILLER: And what about the post-acute care phase?

MR. STEIN: Yeah. So the post-acute care phase, I'll certainly ask Dr. Montoney or Dr. Murali to jump in here, but the post-acute phase, most of what's happening here is our model, we feel very strongly about transitioning the person's care like they would a good discharge planning from the acute setting back to the primary care physician to manage that person's care.

So right after they are discharged from the acute episode, we at that point are communicating and before then in part of the discharge plan with the primary care physician, and the care coordinator, social worker, and the administrative personnel that I identified earlier would continue to monitor and interact with that patient, including collecting vital signs remotely, so all the biometric data, they would talk to the specialist. They're setting up appointments with various physicians.

Dr. Montoney, do you want to add anything?

DR. MONTONEY: Yeah. Mark Montoney.

So the primary care physician is kept in the loop from beginning to end of the episode. At the point of admission, they're aware obviously

that their patient is being admitted into this program. At the end of the acute phase, they're given a discharge summary, and then the patient is transitioned to their care. And we work very, very hard to get the patient at the point of discharge from the acute phase into the primary care physician's office within seven days, and we're hitting about 100 percent on that.

Now, in that interim period, that sort of bridge, if you will, between the acute phase, discharge, moving to the post-acute, and the PCP picking the patient back up, our hospitalist, of course, continues to be the covering physician, but we're very tightly coordinated on communication around this.

MR. STEIN: And this is Aaron Stein.

One more response, because I think one of the questions you're asking is where is it represented in the budget, and the answer is it's not represented in the question. It's represented in the historical claims expense that we would get -- or any provider that would participate would get from CMS, and then they would evaluate what those costs are, but our vision here was how do we get

scalable and how do we allow more physician groups to do it. And the way that we thought about them doing it was that those claims for those post-acute part of the episode would go directly to CMS.

MR. MILLER: So just to be clear, though, so the PCP who is -- you're doing all this wonderful coordination with is not getting anything different than they would ordinarily be able to get through the Medicare Physician Fee Schedule?

MR. STEIN: That's correct.

MR. MILLER: Okay.

DR. MEDOWS: And neither does the hospitalist during the acute phase? I think I am a little bit confused.

MR. STEIN: Sure. So the --

DR. MEDOWS: So I think -- yeah.

MR. STEIN: I'm sorry, Dr. Medows.

DR. MEDOWS: Oh, it's okay. I want to make sure that I am really clear. At the time of the person being admitted into this program, they are admitted by somebody either in the ER or the urgent care actually weighing them, seeing them, diagnosing them, and then admitting them into the program with their consent? And then they're

followed through telehealth while they're home by a physician, right?

MR. STEIN: Yes.

DR. MEDOWS: The physician never actually goes to the house. It's all telehealth, correct?

DR. MONTONEY: Yeah. Yeah. This is Mark Montoney. You're correct.

DR. MEDOWS: Okay.

DR. MONTONEY: The admitting provider is a hospitalist. That hospitalist then -- after the patient is transported home -- subsequent daily visits are made virtually by the hospitalist.

Now, this is coordinated through our recovery care coordinator, and it's coordinated at the same time our acute care RN is in the patient's home at their bedside. So there is a virtual round that is conducted once a day.

DR. MEDOWS: Okay.

DR. MONTONEY: Certainly, we reserve the right to come back a second time, if necessary, and we've got a pretty sophisticated system that actually not only is incorporating all the biometric data that Aaron referred to a moment ago, we've also got a virtual stethoscope that allows

auscultation of heart, lungs, et cetera. So it works really, really quite effectively, and it allows us to take the original hospital-at-home model and scale it very effectively.

DR. MEDOWS: Okay. And so when the hospitalist is doing a telehealth visit every day with the RN present in the home, are they -- are they billing CMS separately? Are they billing Medicare separately, or is it part of the package?

MR. STEIN: This is Aaron Stein.

It would be part of the 70 percent of the DRG, and again, the reason why we had done that is today the telehealth is not a recognized benefit in the way that we're doing it.

DR. MEDOWS: That's correct. Yeah.

MR. STEIN: So we want it as part of the episode so that we could reimburse for it outside of the fee-for-service system.

By the way, if there were a way, as part of this, to have it run through Medicare and do it in a way that would be more direct, we would be open to that. We just wanted, again, to figure out what could be easier to administer.

DR. MEDOWS: You know, most of the DRGs

that you have, quite of few of them, I'm thinking okay, I think I could do this. I think I could feel the patient's safety, effectiveness, and the efficacy of treatment would work.

I could tell you that I'm trying to imagine pulmonary embolism on the first 24 hours. That's a little touchy as a medical matter.

DR. MURALI: Yeah. So, Dr. Medows, this is Dr. Murali here.

So that -- those are the cases that in many ways are important. So when they come into the ER and we talked about the skilled nursing facility doing 30 percent of the work at this point in time -- so when we start that initial evaluation and we start the heparin infusion and management, you're having the hospitalist see that patient in the skilled nursing facility as a SNF-ist, if I can use that word.

So technically, there is a physician touchpoint in some of the patients who for the third day, second day, or onwards can go to the home setting, but do request some care to make sure that it is safe because ultimately for us, patient safety, high reliability, and quality are the key

metrics because I am not going to put the reputation of Marshfield Clinic in harm's way in this process, so that's really how we thought about it.

As the program was created, in terms of the APM, we realized that this program has to be applicable beyond an integrated health system across the nation for your team to even think about it. So we tried to structure the program in a fashion where a group of 10 physicians can do this outside an integrated health system in terms of having a relationship with other home health programs, which will actually change the behavior of practice, so as we kind of tried to focus on the process changing the behavior and the outcomes.

It also goes back to the prior question that was raised related to the DRG because we were still thinking about the DRG as the basis to make the transition across the nation, so that people can change their practice and the hospital systems are willing to have that care be provided outside the hospital entity.

MR. MILLER: So if I'm understanding what you're saying correctly, you are imagining or

actually doing -- in some cases, the patient goes to a SNF for a day or two first or potentially is admitted to the hospital for a day or two first before they go home. Is that right?

MR. MESSINA: Sorry. This is Travis Messina.

It's only in very select instances -- sorry. I believe that was Harold. Was that Harold?

MR. MILLER: Yes, it's Harold. Mm-hmm.

MR. MESSINA: Sorry, Harold. This is Travis Messina.

Yeah. Only in select instances, as Dr. Murali had mentioned, when maybe there would be some logistical challenges as it relates to, you know, perhaps the patient presents later in the evening and bringing the necessary resources to bear in the patient's home, or their acuity is such that, you know, there is an issue as it relates to safety for the patient. So it's only in those specific instances would they receive SNF-level care for that, like you said, first day or so.

DR. MURALI: This is Dr. Murali.

That's right. I was responding to Dr.

Medows' concern about pulmonary embolism and it being tricky to do that in the home environment. So in that particular instance, the physician would make the call as to where they would like to see the patient for that next 12 hours to make sure oxygen saturations are maintained, we address all the pieces that are necessary, and we know it is safe to manage the rest of the infusion outside that environment.

DR. MEDOWS: Thank you.

MR. MILLER: So what you're saying, if I understand it, is so you assess the patient in the ED and you decide what makes sense. They could either be admitted to the hospital. They could be potentially admitted temporarily or sent to a SNF temporarily, or they could be sent at home. And part of the decision about that will be based on whether the physician is willing and able to see them in the home during the initial days, if that's necessary.

DR. MURALI: Yes. Safety and high reliability come ahead of everything else.

MR. MILLER: Okay. And --

DR. MURALI: If you go back to your

Question 1, which we responded, we said that, first, the patient who comes to the ER, the decision should be made that that patient is going to go into an inpatient bed. It is only when that decision has happened, then the next step comes in terms of saying, "Well, should we manage this patient in the home or in the hospital?"

MR. MILLER: Mm-hmm. And in your mind, this -- the payment that you're getting would cover -- 56, 50 -- the 70 percent of the DRG number would cover -- would be -- would have to pay for that SNF stay or that hospital day or whatever it would be for the patients who needed that. Is that right?

MR. MESSINA: This is Travis Messina.

That's correct.

MR. MILLER: Okay. So can we move on, then, a little bit to sort of what happens when it doesn't go well? And when an adverse event occurs, you described a couple of them, but I guess the question is always that we face is you guys may be wonderful, you know, and patient safety is first, and you would never do anything dangerous, but we want to think about what happens if this was rolled out nationally.

And it doesn't feel like there is really enough protections built into this to try to ensure that adverse events are being avoided, responded to quickly, or that a participant in this program is terminated if they don't do well.

So could you talk a little bit about, again, not necessarily what you do, but how you see this model as assuring that the patients will, in fact, be safe?

DR. MONTONEY: Yeah. This is Mark Montoney.

I think, you know, obviously, building upon our experience but being able to extrapolate it, I think given the fact that we've got a scenario wherein we're essentially having a patient in the home with the ability to be able to monitor them through biometric data on an ongoing basis, that they've got 24/7 coverage through an RN with significant acute care experience and triage experience and our care coordinators, that they're having visits at least twice a day by an acute care RN who is spending generally a considerable amount of time in each one of those visits, and it's under the oversight of an admitting physician, in this

case, as I said, a hospitalist.

And given the fact that we anticipate -- you know, it's not a question of if, but when the patient's condition changes, we've got escalation protocols to be able to -- and would range anywhere from the patient's perhaps blood pressure is moving up a little bit or outside of control limits, and it requires an acute care RN visit to the home, which may not have been anticipated initially, but we do that on an ad hoc basis. If the --

MR. MILLER: But let me -- let me turn it around, though. I think that's kind of, you know, if an anticipated event like that occurs, I mean, you are anticipating that the patient's status might change and you're prepared, what happens if you're talking about contracting with a home health agency, the home health agency doesn't show up? How do you know that the home health agency showed up? How do you know -- when I read this, I was a little confused about the biometric data because you had a reference in the one question that said the patient is required to enter biometric data, and you contact the patient if it's not entered, which didn't sound to me like it was an automatic

process.

So how do we know the patient isn't like -- you know, nobody showed up, and you can't get in touch with the patient, and then what happens?

DR. MONTONEY: Yeah. Again, this Mark Montoney.

There is a participative part on the patient -- that is correct -- in terms of biometric data acquisition.

First, we have service-level agreements with our ancillary providers. Our care coordinators are constantly following in terms of if the particular provider is supposed to be there at a certain hour, ensuring, doing the follow-up calls with the patient and/or their family member, if it's appropriate, to ensure that indeed that service has arrived and is on time.

As I said, we've got the telehealth capability, so we're able to camera into the patient's home to be able to do a virtual visit, essentially ad hoc on the spot in addition to the typical daily rounds that we're doing.

And again, you know, we've got triggers that would potentially escalate if a patient's

biometric data is trending outside of acceptable limits.

MR. MESSINA: And this is Travis Messina here.

And, Harold, just to add on to what Dr. Montoney has said, I mean, a couple of things I think are important here. I would say that the partnership is very supportive of the ability to create some sort of standards. I know that that's been discussed with some of the other subcommittees and committees for other proposals so that you ensure the appropriate protocols are in place in the event that that does happen, that very example that you used where the patient is sent home and a nurse is not waiting there.

And so the first thing that I wanted to say is that I think that we are supportive, and we'd love to find a way to work together with PTAC to -- if it's an option, to create those standards.

Secondly, I'd say the reason -- and I hope that this was gleaned from the responses that we provided -- the reason that we rely on partners is so that, as Dr. Murali said, this could be scaled across the country to smaller practices, and not

all of them would be able to staff those individuals to treat patients in a hospital-at-home or a hospital-in-a-home methodology. And so having these contracts in place and having the ability to leverage partners -- I mean, there is a training aspect that can be implemented so that the appropriate level of care is given to the patient.

MR. MILLER: And that's an attractive feature, but we did hear also from Mount Sinai that they tried that and found that it was not reliable, and that's why they went to staffing it themselves. So I'm sure that that's site-dependent, and I would guess that would mean that Marshfield has enough power in this area that people are not going to ignore what Marshfield says. But a smaller provider might have more trouble with that.

MR. STEIN: This is Aaron Stein.

So, you know, we spent a lot of time -- I think, first of all, our model is different than Mount Sinai. They've done really incredible work, and they have all of our deep admiration around the table.

At the same time, as I think we were looking for a little bit of a different way to

expand home hospitalization that hasn't been done before, and so as we've approached -- we've got one national home health provider here, and as we approached them, they view this as something that is some innovative and something that they want to be a part of.

So we actually put together formal training programs and asked for nurses to go through those training programs in order to make that happen, and I have intimate knowledge of some of what Mount Sinai had done too. And they certainly have come across what I would probably say could be common in some home health agencies.

At the same time, we found a good amount of national companies certainly and certainly local ones as well to whom we're speaking that we think could carry this out well, and when we put structure around it, which again is some of -- we're willing to share that because we feel that this is something really important for the country. We put the structure around it that we can help use, so that when a provider engages a home health company, they know the questions to ask. The home health company has to make certain commitments up

front so that they don't get into experimenting and finding out that it doesn't work.

MR. MESSINA: And this is Travis Messina.

Just to add one more point, I think one of our letters of support came from a national home health operator and them expressing their desire to support practices and the deployment of the model -- to Harold, that's your point -- for practices that don't have the clout of a Mount Sinai or a Marshfield Clinic or other large health systems in their respective areas.

DR. MURALI: But the other pieces to also share is that we've had other institutions around us, like Gundersen and UW, who are interested, the University of Wisconsin as well as the Gundersen Health System, who have given us a letter of support.

The other piece to share, which I think may -- I don't know whether we need to put that on the documents, but in the health system conferences that we've had, both with the home health pieces as well as large health systems, Travis and I have presented this on the instructor's track which has been of great interest, and as evidenced people who

have come out and reached out to us to see how they could actually create these models.

So if it is structured and if it is very carefully shared, we believe that it can be safely executed and -- but it's a belief at this point in time.

MR. MILLER: Okay. Let me go to -- let me go to Len. Len, the questions you might want to ask that we haven't covered?

MR. NICHOLS: So the only one that has come back up in my head, Harold, is the question of the assessment of home readiness as being part of the admission decision, and I totally get why it makes perfect sense.

What I wonder about, though, is that, in a way, that says you're only going to admit people into your hospital-at-home program if they have, if you will, a good home environment that would be, let's just say, not suffering from social determinant kinds of vulnerabilities or deficits, and therefore, you're getting a kind of a selective slice of the patients.

And so if you compare, then, the cost that would occur to the average of all patients with

this DRG, then I think you might need to adjust that, and I just wonder if you all have thought about that. I know you talked about universal application and exclusions and so forth, but I just wonder what you -- how you think about this issue.

DR. MONTONEY: Yes. Mark Montoney.

I'll start and press my colleagues may add. I mean, the health-in-home assessment is really designed to identify a basic level of safety, and going back to Dr. Murali's comments, that's where we start, to ensure that, indeed, the home environment is safe and adequate for a high-quality care experience for the patient.

Now, that being said, you know, we have essentially an audience of 30 days with the patient and their family, and we have the opportunity to actually be in their home. And believe me, we identify a lot of opportunities, psycho-social gaps and opportunities that we're able to identify and work with the primary care physician in a longitudinal manner to be able to address those, whether it be nutritional support or transportation, or just frankly, you know, help with cleaning the apartment or the home where they

live and that sort of thing.

So while we're certainly attending to the patient's acute care needs, given the fact that we have got a 30-day episode and we're following up very closely throughout that post-acute period, we're able to identify some of those gaps.

And, Aaron, you may add on to that.

MR. STEIN: Yeah. So this is Aaron Stein.

I mean, the only thing I would add -- I think you said it well -- is that even though in theory, you don't have homeless people going through hospital-at-home or home hospitalization. At the same time, as I think we've actually cared for a good amount of folks that probably have less than ideal home environments -- and that's when we get in their home, we actually believe it's an overall better experience and a path to better health because, to Dr. Montoney's point, the nurse now has the opportunity to be able to look in somebody's refrigerator and see if they have the resources they need to make sure that they are eating correctly.

And so we're finding out, as we get into patients' homes, that they're certainly a lot of

those patients that do have those social needs, and so I don't believe we're actually getting a selection bias, per se, other than -- again, I'll concede the point -- certainly, we're not taking folks that may be homeless into the program, and certainly those homeless folks may be draining on an inpatient acute care hospital.

MR. NICHOLS: Well, let me be clear. I am quite happy you guys are going in their homes. I think this is a good thing, and I totally get that the patients are ultimately benefiting from this.

What I'm trying to get to is a fair way to assess, and it may be minimal, but it's certainly worth, I think, checking if there is an inherent bias in the sample that you have because of this. So that's all I was wondering, if you have thought about a way to quantify it.

What I would suggest will happen probably is, you know, adjust over time if it's observed ex-post.

MR. STEIN: Yeah. Len, this is Aaron again.

So we certainly agree. So in answer -- direct answer to your question is we have not yet

quantified exactly what that difference is to look at selection bias, but we do agree in principle with the fact that as the model evolves and more folks are doing it, we do have an opportunity to collect more data, and we certainly, again, would intend on aligning the payment to what the acuity or intensity of the patient's needs are.

MR. MILLER: Rhonda, final question?

DR. MEDOWS: Yeah. On the quality measures, page 6 of your response, Table 4.1, do you list them, just the list of your quality measures?

DR. MURALI: Could you repeat the question, Rhonda? You cut out. Is this the --

DR. MEDOWS: Oh, I'm sorry. It's Table 4.1. You have a list of your quality metrics, your clinic quality metrics, page 6. Is this your complete list, or is this the next steps? I see [unintelligible] the follow up with the PCP, all those are good, but are there other quality measures that you are asking and following in terms of diagnosis or condition-specific?

DR. MONTONEY: Yeah. Rhonda, this is Mark Montoney.

Indeed, this is just sort of a snippet, if you will, that we're tracking on a scorecard.

In addition to this, I'll just rattle off some other measures. We track escalations, which would be when the patient's in the acute phase, if they would need to come back to the hospital and be hospitalized. We track hospital admissions. We actually call them "readmissions." It would be when the patient is in the post-acute phase and if they need to actually come back and be hospitalized. I mean, technically, it's not a readmission in the sense of as we know readmissions because technically they were never admitted to the hospital in the first place.

We track mortality, and in particular unexpected mortality. You know, we've got patients that are in the program that are DNR status or palliative care, and frankly, we've had some situations wherein we've been able to work with the patient, get them into hospice, and ensure that they can avoid coming into the hospital as they're in their last days.

And then we have a host of other, you know, sort of -- I'll call them process measures,

patient's acceptance rate for the program. Our care coordinator communication, we track that, health assessments, transition to health plan care manager, gaps in care. So there's a host of other measures.

MR. MILLER: But these are the five you're proposing to use for the payment model, right?

DR. MONTONEY: Yes, that's correct.

DR. MEDOWS: So they're specifically tied to the payment, or they're just included in the payment model as something that's recorded?

MR. STEIN: This is Aaron.

They are tied to the payment. So we have in the document that it is divided. The five quality measures are divided, and they have equal weighting, 20 percent per quality measure, and the physician organization would not be able to share in the savings if they didn't achieve the quality measures.

DR. MEDOWS: Gotcha. That's excellent.

So talk about the hospital readmission or pseudo-hospital readmission. Are you benchmarking that or comparing it with if the patient had been in the inpatient readmission rates? What are you

using as a benchmark? Do you have that worked out?

MR. STEIN: Hi. This is Aaron again.

So because right now the patients that we're seeing are from Security Health Plan, we have the historical claims data, so we would actually do the same and recommend that CMS would do the same in looking at historical experience and being able to benchmark off of that.

Similar to the way Johns Hopkins did the original study for hospital-at-home -- and Mount Sinai did the same -- we've looked at this, and we're able to compare the impact of our program with the actual results and historical from the claims.

So, you know, we've been able to measure over time very significantly. You saw the document. I think we're running just more updated information, about 58 percent less than the historical claims analysis would indicate.

DR. MEDOWS: For hospital readmission? That's excellent.

MR. STEIN: That's correct.

DR. MEDOWS: Is that ED? Same thing, ED also? You're knocking it out of the park?

MR. STEIN: Well, this is Aaron.

I'll have to admit I don't have the ED stat with me.

Do you, Dr. Montoney?

DR. MONTONEY: Could you clarify the E -- I'm sorry. The --

DR. MURALI: Readmission rate is what she's --

DR. MONTONEY: Oh, visits. Oh, I'm sorry.

MR. MILLER: Return to the ED.

DR. MONTONEY: I gotcha. Return to the ED. I'm sorry. I don't have that at our fingertips.

DR. MURALI: But we can get you the data.

DR. MONTONEY: We can follow up on that.

DR. MURALI: We will get you the data.

MR. MILLER: Yeah, that's good.

DR. MEDOWS: So I would just, you know, think about -- I am a strong proponent of doing as much care as possible outside of a hospital wall, but I know that you're going to have to make sure that we address lots of people's concerns about the safety, efficacy, because it's still -- even though you've been working on it for like a decade or so,

it's still relatively new.

So in your proposal, I'm just going to suggest that the things that you talk with us about today, kind of formalize it as an addendum to your proposal. You talked about training nurses and training -- changing the way that they view things, training the staff. I don't know that that was part of your original document.

I'm not trying to tell you what to do. I'm just telling you that there are things that you said today that were very helpful.

DR. MURALI: We absolutely appreciate that input. In fact, when you are sending us the document, if there is other suggestions that you have, please do, so that we can make sure that we as a team review it and incorporate that into the document --

DR. MEDOWS: Definitely.

DR. MURALI: -- to make sure that that is addressed.

MR. MILLER: Well, at this stage, what we would most appreciate is if you want to make a proposal as to how you think this should be addressed as a supplement, you send it to us

because we're not right now in the position of advising you how to structure your proposal. We are simply trying to evaluate what you send us.

And as Rhonda was saying, there are things that you have in mind that you described to us verbally that are not recorded anywhere. So what we're trying to do is to get that documented so that we can -- we can evaluate it.

MR. MESSINA: This is Travis Messina.

The last question that I would have, is there a specific timing that you can guide us to, knowing that we have scheduled the meeting on March 26th, to get that to you in time for your consideration?

MR. MILLER: Well, the sooner the better. I'll let Tim talk to you about that after the call because have to wrap up for today --

MR. MESSINA: Okay.

MR. MILLER: -- and try to work out those things, but, I mean, anything -- anything that we get, you know, up to a week or two before the meeting will at least be able to be used at the meeting itself, but the sooner we get it as the PRT, the more likely we will be able to incorporate

it into our report.

So we are at this point out of time. Let me thank you all for spending so much time with us, giving very, very helpful answers. This was very useful, I believe, and let me also commend you for the work that you're doing and for in terms of taking care of patients and for taking the time to put this proposal together. It's why PTAC was created, was to be able to, you know -- and we're happy to see that people out there do -- are doing things and have proposals and are sending them in. So we appreciate you taking the time to do that.

So, with that, we will adjourn for the day. Thank you all, and, Len and Rhonda, if you could dial back into our other number, that would be great.

DR. MURALI: Thank you. Thanks for giving us the opportunity to submit the application.

MR. MILLER: You're most welcome. We appreciate it. Thanks.

[Whereupon, at 5:35 p.m., the conference call concluded.]