

**Avera's Response to the PTAC Preliminary Review Team's Questions on
*Intensive Care Management in Skilled Nursing Facilities Alternative Payment Model***

November 10th, 2017

Response to Questions

- 1. Please clarify whether this model is intended for facilities providing SNF services, NF (long-term care) services, assisted living (AL) services, or all three (or other settings). Which type(s) of facility is (are) most likely to participate and why? What unique challenges do they face and how would the proposed model address them?**

The Intensive Care Management in Skilled Nursing Facilities Alternative Payment Model (ICM SNF APM, hereafter the "Model") is intended for facilities providing Skilled Nursing Facilities (SNF) and Nursing Facilities (long-term care or NF) services. It is not currently proposed for assisted living (AL) services because of differences in the population, care model, and regulatory framework, but the Model could potentially be adjusted and extended to AL services over time. In order to include AL, the Model would have to be adjusted to:

- 1) Recognize most AL facilities operate in a "social model" rather than a "medical model," and will be challenged adapting to proactive care management for their residents especially since only 20% of AL facilities have an electronic medical record, complicating coordination.
- 2) Address quality metric and reporting requirements, as AL facilities do not participate in mandatory federal reporting, such as CMS Nursing Home Compare, and these measures may or may not be appropriate for the AL resident population considering the scope of services an AL facility provides, typically defined under state statute.
- 3) Recognize that Avera Health's experience within the Health Care Innovation Award did not include this population, and so cost savings estimates do not include this group.

The program is very appealing to SNFs because of the emphasis on care transitions which occur frequently, –for example, hospital to SNF and SNF to home. Additionally, patient acuity in SNFs is rising because of changes in practices across the care continuum, such as shorter hospital stays. This points to a growing need for timely, proactive care. However, the model also appeals strongly to NF services because their population has less frequent federally mandated visits with a physician or provider. In reality, most SNFs are also NFs so they are typically one and the same; over 90% of SNFs are dually certified for Medicare and Medicaid.¹ Thus, since our model is so dependent on facility-wide adoption for the necessary culture shift, any combination of SNF and NF beds should work well.

¹ Centers for Medicare & Medicaid Services. (2015). Nursing Home Data Compendium 2015 Edition. Retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/nursinghomedatacompendium_508-2015.pdf

Avera's experience strongly suggests the Model will appeal to facilities which do not have sufficient access to timely physician care or do not have access to physicians specializing in the care of nursing facility patients. Facilities that employ or contract with onsite providers available for the majority of the day are less likely to participate unless their onsite providers choose to operate within this Model. However, of note, we have successfully implemented this care delivery model in several such facilities because 24/7 access often is still problematic. Other facilities that work with a large cohort of dispersed community physicians appear to have a high degree of interest in the Model services. Such facilities have increased challenges effectively coordinating with a large and diverse group of attending primary care physicians (PCPs) for whom nursing facility care is a small part of their practice.² Additionally, physicians who do not specialize in nursing home care may not be knowledgeable of or sensitive to nursing facility regulations (e.g., use of anti-psychotics or restraints) and/or be less familiar with the treatment of common nursing home syndromes such as falls, incontinence, and dementia-related behaviors.

Avera has seen success in rural and urban locations because both have challenges with timely access to physicians and standardization of care across the population at the facility. Urban SNFs may struggle to find the physician who will take their prospective SNF resident because of the patient's complexity and physician availability. Rural facilities may find their Medical Director or residents' attending physician clinic is an hour away in the next county. Similarly, both urban and rural facilities struggle to find geriatricians, knowledgeable of the needs of a nursing facility and available to care for their residents. The Levy, et al (2006) Health and Human Services (HHS) report lists:

“Benefits cited by stakeholders regarding specialist nursing home physicians included: (1) greater accessibility of physicians to patients, family, and nursing home staff; (2) improved knowledge of and sensitivity by physicians to challenges faced by nursing homes (e.g., regulations regarding use of anti-psychotics); and (3) enhanced medical management of common syndromes faced by nursing home residents (e.g., falls, urinary incontinence, agitated behaviors associated with dementia). The literature review also suggested that selected outcomes are better among patients of physicians specializing in geriatric medicine.”

For both urban and rural nursing facilities, physicians face real challenges in delivering timely care and current payment models do not provide meaningful incentives towards addressing these challenges.

This model would address these challenges by providing both SNFs and NFs with a payment methodology supporting physician accountability through smart incentives which encourage high performance based on outcome and quality criteria. The Model will prevent avoidable escalation of illness and deterioration of health for residents, resulting in better quality, better patient experience, and lower costs. This is accomplished through three Model drivers:

² Levy, C., Epstein, A., Landry, L., & Kramer, A. (2006, April 4). Physician Practices in Nursing Homes: Final Report. U.S. Department of Health and Human Services. Retrieved from <http://aspe.hhs.gov/daltcp/reports/2006/phypracfr.htm>

³ *Ibid*

- 1) Providing timely, 24/7 access to a geriatrician-led care team through telemedicine
- 2) Delivering geriatric care management and management of care transitions
- 3) Mentoring and training long term care staff to improve early identification of resident change in health status

2. Are there facilities that may not need the proposed model or where the model should not be deployed? Please describe. In particular, is it possible that the model could encourage some facilities to replace effective on-site care with telemedicine?

There may be facilities that believe they do not need the proposed Model, for example, facilities that employ a full-time provider. Depending on the extent of their full-time provider practice and access to multidisciplinary resources, these facilities may find it advantageous to adopt the Model and augment their day time coverage with telemedicine to ensure overnight and surge capacity access to practitioners specializing in geriatric medicine. These facilities could use telemedicine among their existing practitioners to provide the 24/7 support detailed in the Model. Perhaps with few changes to their current daytime practice, they could meet the Model's minimum standards and quality for participation. In this instance, the Model would pay for the spectrum of onsite and telemedicine services that fit under the care model. Participation in the Model restricts the practitioner's ability to charge for other services as outlined in the proposal in Table 7. This reduces the concern about duplication of services and payment.

It is not the intention of the Model to replace effective on-site care with telemedicine, rather to support the majority of facilities that do not have the level of access required by residents. Additionally, we are not proposing to assume primary care for the residents. They will still all have access to their existing primary care provider. The use of telemedicine is intended to leverage a scarce group of specialist geriatricians across a wider panel of patients in a manner that improves care quality and reduces costs. CMS has reported that 95.8% of nursing homes have less than 200 beds. These facilities likely do not have the resident population or financial means to support robust access to physician services. Telemedicine is a practical solution to allow specialized geriatric practitioners to effectively and efficiently care for hundreds or even thousands of residents distributed across multiple nursing facilities.

3. Is the payment model intended only to support the particular care model used in the HCIA Round 2 project or could it be used more flexibly? If the former, then what specific minimum standards would you envision the recipient having to meet in order to receive the payment? If the latter, what are the different ways in which the service might be organized with the flexibility of the payment?

The payment model is intended to support a care model which is flexible to the needs of the resident population, yet meets specific minimum standards derived from the evidence-base and Avera's HCIA Round 2 project experience. Avera considered other payment models, such as Patient Centered Medical Homes, Comprehensive Primary Care Plus (CPC+), and Chronic Care Management codes in identifying these minimum standards which are detailed below. Within these standards the geriatrician practice is given the flexibility to determine

how the care will be delivered, for example, determining how transitional care support will occur. The Shared Savings Model may offer additional flexibility by sharing more of the risk with the geriatrician.

Minimum Standards:

- Geriatric Care Management
 - Geriatrician-led, multidisciplinary team (e.g., RN, social worker, pharmacist) monitoring of a resident's care during their nursing home stay, in close collaboration with the attending PCP
 - Risk stratification of the patient population
 - Development of care plans for high risk residents
 - Medication management in coordination with the PCP
 - Evidence-based disease management
 - Behavioral health support, including addressing medications, behaviors, and crises
 - Advance Care Planning
 - Transitional Care Support from the hospital into the nursing facility within 48 hours
 - Medication reconciliation by the multidisciplinary care team
 - Transitional Care Follow-up with patients after SNF/NF discharge within 72 hours
- Timely Access to Care
 - 24 hours a day, 7 days a week telemedicine access to a physician or Advance Practice Providers (APP) on the geriatrician-led team who has real-time access to resident's medical records
 - Real-time provider response to a resident's change in health status

An important part of the Model is partnering effectively with nursing facility staff and attending PCPs. The advocacy and ongoing engagement of these stakeholders has proven critical to success in similar projects. In addition to the Intensive Care Management services Participants would be expected to meet "Model Participation Criteria" which would include articulating strategies for:

- PCP Care Coordination and Assessment of Satisfaction
- Nursing home engagement and measurement of staff satisfaction
- Assessment of beneficiary satisfaction
- Use of appropriate health information technology to coordinate care between the Geriatric Care Team and the nursing home care team, including telemedicine access
- Nursing home staff coaching and mentorship
- Provision of didactic Continuing Education Credits targeted at identified knowledge and skills gaps
- Use of data to drive continuous quality improvement

4. **The proposal notes that the Geriatric Care Team could choose from two options: 1) a performance-based payment or 2) a shared savings model. Would the scope or scale of services provided vary by option? Would anything else vary by option?**

Our proposal suggests PTAC or other representatives from HHS would choose and finalize the Model based on preferences and priorities; it is not intended for the Geriatric Care Team to choose. The *Performance-Based Payment* is a simplified option which encourages broader participation in the program, especially among smaller practices which may not be able to weather the financial risk in a shared savings arrangement and is the preferred option. The *Shared Savings Model* incorporates engagement for Participants by shifting performance risk to the provider in order to potentially achieve more significant cost savings. In both cases, the payment methodology exists to support the same care delivery model, although it may be possible to be more flexible in designing the minimum standards under the Shared Savings Model. Likewise, a small geriatric practice may be able to participate in the Performance-Based Payment for a small group of residents, for example the 100 residents in an average-sized facility. Under this Model, practices would have flexibility into the scale of their participation. The Shared Savings Model may require a minimum number of residents, similar to the Medicare Shared Savings Program (MSSP).

5. **According to the proposal, the suggested composition of the Geriatric Care Team includes a geriatrician as well as gerontology trained or certified advance practice providers, pharmacists, social workers, nurses, and behavioral health practitioners. Some patients may require wound care, podiatry, PT, OT, or nutritionist services. How do these or other variable services impact the payment model?**

The composition of the Geriatric Care Team is left up to the geriatrician and their understanding of the needs of their residents. Avera suggests it might include gerontology trained or certified advanced practice providers, pharmacists, social workers, nurses, and behavioral health practitioners based on our HCIA experience and offer flexibility to each practice to determine team composition in order to meet the minimum standards of the Model.

Avera understands therapy and nutrition is an indispensable part of the overall care for SNF/NF residents, but because of existing reimbursement Avera has not found residents lacking access to these services. This may vary in other regions. Therefore, the Model gives flexibility to the geriatrician to determine care team composition.

The Geriatric Care Team's role is to ensure residents receive needed services. In many cases, the Geriatric Care Team can provide first-line response to wound care or other care needs. The Geriatrician Care Team can write orders for additional care or coordinate a specialty consult to ensure appropriate care is accessible to the resident. In general, the payment and delivery Model cover the core services that are not traditionally reimbursed by Medicare. The proposed payment for the Model is intended to cover geriatrician access, care management and care coordination as outlined in the minimum standards. Other critical services such as specialty wound care, therapy, podiatry and nutrition services are provided under the

traditional Medicare fee schedule. These other variable services do not impact the payment model. In Avera's experience, these additional services can be provided to residents via onsite care, travel to the clinic, or in rural situations, potentially via telemedicine.

6. What is the Geriatric Care Team's expected relationship with the medical director (if there is one) and the residents' primary care physicians? How would responsibilities be delineated? Could the proposed payment go to the existing medical director of the facility to provide enhanced services?

The Geriatric Care Team does not replace the residents' PCP or the facility Medical Director, but must work collaboratively with these individuals in caring for residents and assisting facilities. Participating geriatric practices would be expected to meet "Model Participation Criteria" which would include articulating strategies for Primary Care Physician Care Coordination and Assessment of Satisfaction.

The PCP retains ultimate oversight and management of the residents' care, and should be made aware of any orders or recommendations by the Geriatric Care Team. The PCP retains the right to modify care plans or decisions. The PCP must complete the federally mandated certification and recertification visits required for admission and ongoing stay within the facility. The Geriatric Care Team should notify the PCP of any unplanned transfers to the emergency room or admissions to the hospital.

Each SNF/NF is required to have a Medical Director responsible for physician leadership, clinical leadership, and quality of care. In addition, the Medical Director is charged with educational and communication responsibilities for the facility staff and community providers who interact with the residents. The Medical Director's role is based on fulfilling specific regulatory requirements and each facility has a contractual relationship with the Medical Director which further details the specific role and its responsibilities. Given this, the Geriatric Care Team must have an excellent working relationship with the facility Medical Director, who likely serves as the PCP for several of the residents in the facility as well. In Avera's experience, many of the Medical Directors are PCPs who appreciate the availability of geriatric specialists for consultation on issues, support of process improvement projects, expertise on specific resident concerns, and assistance with staff training.

The Geriatric Care Team supports these roles by completing tasks the PCP and/or Medical Director may not be able to do in a timely manner. Avera's experience is most PCPs do not have the availability in their current practice to be as responsive to the needs of the residents as a telemedicine-based Geriatric Care Team. Therefore, it is the responsibility of the Geriatric Care Team to ensure there is a real-time provider response to a resident's change in health status. This prevents delays in care (e.g., while the PCP tries to work a resident into his or her schedule) and it prevents the tendency to send the resident to the emergency room for further assessment after a hard-to-interpret call from the nursing facility clinical staff. The Geriatric Care Team ensures residents are monitored throughout their stay and provided with transitional care support, evidence-based disease management, timely medication reconciliation, and ongoing medication management. Additionally, the team provides access to behavioral health support and advance care planning resources as needed. The geriatrician

leads the development of the individualized care plans for high risk beneficiaries as well as providing direct specialty geriatric care in coordination with the PCP. The geriatricians will need to demonstrate their value to PCPs through responsiveness to patient concerns, expertise in geriatric medicine, and ability to communicate effectively with physicians.

Based on the above, we would not expect that most Medical Directors or PCPs would be doing the necessary services to qualify for the payment. However, if the Medical Director or PCP meets the Model criteria or specified minimum standards, the payment could go to practitioners in these roles. These physicians would need to develop the multidisciplinary teams and 24/7 access to meet the Model criteria. The Medical Director or PCP would retain their primary role and would take on additional responsibilities under this Model.

7. The PRT wants to better understand what the services needed for success would cost.

a. What are the proposed payments of \$252 per new admit and \$55 per month based on?

The proposed payments are based on projections of costs to operate the clinical Model. Specifically, the proposed payments are based upon Avera's operating costs per beneficiary during the three year CMMI HCIA II award. Avera's experience was that the clinical resources required for a new admission was roughly five times that of a stable, nursing home resident. Therefore, the proposed fee recognizes the workload differences and the amount of time spent on new admissions. Avera's estimates were based on an ongoing resident population of 5,000 or more. This included the assumption that key clinicians, such as the geriatrician, would be employed nearly full time in the clinical work of the Model. In reality, other geriatrician practices may find it more practical to engage a portion of their time in the model, and scale down the number of beneficiaries accordingly. Finally, these proposed payments of \$252 per new admit and \$55 per month were benchmarked against anticipated savings to CMS and priced to be a catalyst for change, appropriately incentivizing practices to invest in clinical practice transformation.

Avera submitted these numbers with the recognition that if approved for consideration, CMS will utilize its considerable internal expertise and analytics to determine the final payment level for the Model.

b. What minimum number of patients would be required to make the service viable at those payment rates?

In general, Avera's calculations were based off of a resident population of 5,000. The Model is designed to be most cost effective practiced at a larger scale, which is true of most health care services. However, the Performance Based Payment recommendation to PTAC was designed as an alternative to allow smaller scale deployments, say of 100 residents.

c. What does the telemedicine setup cost? Could the model be done without that or does the minimum number of patients require that there be multiple facilities sharing the same geriatric team resources?

Avera's experience has shown the most cost effective means to ensure 24/7 access to geriatric care and to daily access to a multidisciplinary team is via telemedicine, at any scale of patients. This is because over 90% of SNF/NFs have fewer than 200 beds. In order to provide services at scale telemedicine equipment is required, but even for a single facility, averaging 100 beds, telemedicine offers the most practical solution for 24/7/365 access to a provider. Telemedicine affords the advantage of allowing a care team member to quickly lay eyes on a resident and work collaboratively with the onsite care team while having access to the medical record. Because of this, telemedicine is required to execute the proposed model.

The cost of telemedicine equipment varies greatly. There are many options available on the market, some as low as \$250 for a monthly subscription that use a basic webcam and laptop or tablet. Avera uses a \$12,000 mobile, wireless video cart because it provides high definition video and the ability to use peripheral telemedicine equipment such as a high quality telephonic stethoscope. There are similar models available on the market from \$10,000 - \$30,000. Newer technologies may bring the cost of the technology down over time. CMS could allow for a variety of technologies under their current definition of telemedicine: "...interactive audio and video telecommunications system that permits real-time communication between [the practitioner], at the distant site, and the beneficiary, at the originating site."³

8. Please clarify why it is up to the Geriatric Care Team to determine whether to share revenue with a facility as part of the model. Would the revenue sharing impact facility fees?

Avera requested the flexibility to allow the participating entity to determine how to work most effectively with the facilities, including the option to share revenue with the facility. However, in Avera's experience financial incentives to nursing homes were less effective than other engagement strategies in gaining long-term project advocacy and support. Similar to MSSP, where revenue sharing is allowed, revenue sharing under the ICM SNF APM would not impact facility or resident fees in any fashion.

There are other, non-financial incentives for the facility. Through the adoption of the Model, facilities are connected 24/7 with a Geriatric Care Team ready and able to promptly assist in care questions and concerns. By creating a quick and simple way to access the care team, the Model supports preventive treatment and provides an outlet for changing the culture and accepted protocol in the facility toward proactive, team-based, around-the-clock care. Additionally, the Model's outcome and quality metrics mirror the Nursing Home Compare

³ Centers for Medicare & Medicaid Services. (2017). Medicare Learning Network: Telehealth Services. Retrieved from <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctshst.pdf>

and Value Based Purchasing programs, thereby aligning physician and nursing home incentives.

9. What happens from a payment perspective if a patient opts out of the Geriatric Care Team, especially if the shared savings model was selected?

Much like MSSP, Avera proposes patients can opt out of data sharing and any individual treatment/episodes of care, but the beneficiary remains in the model and the participating entity is accountable for the care model and expected improvements in cost and quality. The Model is intended to be implemented across entire facilities in order to ensure clinical practice transformation and the effective collaboration with the bedside team in providing urgent care, proactive transition management, and identifying residents' change in health status. As such, all patient expenditure data would factor into reconciliation in Shared Savings.

In Avera's experience, very rarely have patients opted out of either data sharing or individual treatment.

10. Which patients would be included in calculating the facility level quality measure scores?

Avera proposes to mirror the patient population included in Nursing Home Compare and Value Based Purchasing programs to limit the administrative burden on CMS. Depending on the metric, these measures generally include either: 1) only Medicare Fee for Service residents or 2) all residents in the facility.

11. The PRT would like to explore the incentives for facilities to admit patients. If a NF patient gets admitted and then qualifies for SNF services and the nursing facility offers both, the admission could be financially advantageous. A nursing facility will get a bed-hold payment for a hospitalized patient without the need to care for them, so keeping them in the facility is not financially rewarded. Do you believe these potential incentives are problematic? How does the model address them?

Avera agrees these potential incentives could be problematic; however the Model does not introduce this as a new or increased unintended incentive.

In reality, the financial incentives are complex and somewhat mitigated by other factors. For example, bed hold payment rules vary by state. Medicare does not pay for a bed hold, and Medicaid may require high building occupancy before covering the fee or limit the number of days each year that bed hold reimbursement is available. Private pay residents or their assigned durable power of attorney can choose whether or not to pay the bed hold knowing the bed may not be available upon return to the facility.

Hospitalizations and transfers back to the SNF can also cost the facility. The paperwork and staff time to support the transitions are significant, and there is no guarantee residents will

meet qualifications for a SNF stay while at the hospital. Additionally, the SNF/NF is responsible for the increased cost of any medications, therapy time, and supplies brought on by the qualifying Medicare Part A time frame. Finally, avoidable or unnecessary transfers and hospitalizations can negatively impact family and resident satisfaction as well as the facility's "5 Star" status.

While the Model does not directly address financial incentives for NFs, the Value Based Purchasing program better aligns incentives to reduce unnecessary readmissions to the hospital from the SNF, which is supportive of practice change in the facility. Also, other community programs, such as ACOs, may provide incentives to SNF/NFs to aim to be a preferred provider (high quality/low cost) in the region.

12. The model creates incentives to keep patients out of the hospital. How does the model guard against patients being kept out of the hospital inappropriately?

The PCP remains the party ultimately responsible for coordinating care and has no monetary incentive via this payment model to inappropriately keep patients out of the hospital. If the Geriatric Care Team is inappropriately not admitting patients, the PCP can override that decision and follow-up with the geriatrician. There are malpractice implications to the geriatrician, should they stint care. This double-physician review of care decisions provides integrity to the Model and significantly reduces potential for stinting care.

The Model includes a robust set of quality metrics to protect beneficiaries. Also, the Model leans on existing infrastructure within SNF/NFs to protect residents including the Ombudsman protection and state survey of facilities, particularly survey review of timeliness of appropriate care. If CMS adopts standard satisfaction surveying in SNFs/NFs, such as the Consumer Assessment of Healthcare Providers and Systems Nursing Home Survey, this could also be a good mechanism to monitor for stinting of care.

13. Do you anticipate any pushback that the addition of the Geriatric Care Team could lead to a reduction in billable services for the primary care physician?

There could be some pushback from the perception that the Model may reduce billable services from the primary care physician, but Avera's experience has been that most of the impact to the clinic has been in reduction of faxes and phone calls. It can take time to win over physicians concerned about this, but they quickly see that revenue for diagnostics and other higher level care remain with their practice and are appropriate for the needs of the residents. The PCP is still ultimately responsible for the care of the resident including completion of all federally mandated recertification visits, and any other clinic appointments. Interestingly, more push back has come from the local hospital whose leadership is concerned about reduction in emergency visits, hospitalizations, and swing bed stays. However, the ultimate goal is to move all providers to a value over volume framework over time, and the proposed Model is consistent with that aim. The payment methodologies recognize it will take time to gain the full buy-in of community providers, and increases the financial risk to the geriatrician practice over time.

14. Can you offer any insight into why this approach is not being pursued by Medicare Shared Savings ACOs? How might existing models such as ACOs impact the proposed model?

Avera considered the Medicare Shared Savings Program ACO prior to drafting the ICM SNF APM proposal. The primary challenge is that the Model is intended to be implemented across entire facilities in order to ensure clinical practice transformation and the effective collaboration with the bedside team.

SNF/NFs deal with two distinct populations which make the ACO model difficult. One population is represented by the rehabilitation patient, with a short, 27-day stay covered by Medicare before they return home. The other is a long-stay resident who perhaps moved from their Part-A stay to a Medicaid benefit, and will remain in the facility for 30 months or more, likely living out their life in the facility. These populations may be distinct, but beneficiaries move fluidly from one to the other as their health needs change. Additionally, the facility staff that serve these two populations are likely the same nurses and nurse aids. The ACO model and its one year attribution period do not fit the short-stay residents well.

Additionally, the geriatricians involved in the Model will not likely be the primary care providers, removing the ability for primary attribution into an ACO. The Model retains the role of the existing PCPs who should be attributed these beneficiaries.

Partnering with an existing ACO for the Model would be problematic. Few ACOs will have a significant share of the building population, reducing their desire to pay for a facility-wide intervention.

The ICM SNF AMP Model can co-exist and complement MSSP ACOs. In facilities where ACOs cover some but not all of the residents, this Model would provide intensive case management while in the SNF. Model payments made under either option would be counted in the ACO's total cost of care. Savings under the Shared Savings Model would not be double paid because the financial reconciliation only applies to beneficiaries not already attributed to another program.

Avera's Response to the PTAC Preliminary Review Team's Questions on *Intensive Care Management in Skilled Nursing Facilities Alternative Payment Model (ICM SNF APM)*

December 13, 2017

Response to Questions

- 1. The PRT would like to better understand how this model might work in practice. Can you provide a hypothetical example that you think would be representative of sites where this model would likely be implemented, showing the costs of the services, the revenues through the payment model, and the flow of funds?**

To illustrate the costs of this model showing the cost of the services it is easiest to take a sample population of 5,000 residents to show the required time and costs associated. In this model there are two fees. The initial fee of \$252 is based on:

- 16% of residents are new every month (800 new admits)
- 20 minutes per resident to conduct standard review
- 40% of new admits require an extended review that takes up to an hour each
- A total of 587 hours per month to bring on new patients

The blended cost for a new admission breaks down to these costs per resident:

Geriatrician	\$ 82
Pharmacist	\$ 72
Social Worker (MSW)	\$ 28
RN	\$ 25
Nurse Practitioner	\$ 46
Total	\$ 252

This includes Avera's estimated overhead for staffing these positions as well as observed estimates for productivity, given paid time off, education, and other unplanned downtime or unproductive time. Similar math goes into the \$55 ongoing fee:

- 13% of residents require a video consult per month with the average call length time of 20 minutes.
- 88% of residents require a phone consult per month with an average call length time of 10 minutes.
- A total of 950 hours per month to serve longer term patients

The blended cost for this population for ongoing support is:

Geriatrician	\$ 18
Pharmacist	\$ 14
Social Worker (MSW)	\$ 7
RN	\$ 7

Nurse Practitioner	\$ 9
Total	\$ 55

2. In your responses to the PRT questions, you indicated that risk stratification of the population would be a minimum standard. Is there a particular risk stratification method (or methods) that you believe should be required?

Unfortunately, there are no current, well-validated risk-stratification models for the long-term care population. Avera has trialed several including CMS-HCC (Centers for Medicare & Medicaid Hierarchical Condition Category) and LACE Index Scoring Tool (Length of stay, Acuity of admission, Comorbidities, Emergency visits). In the case of HCC, we have found that the model is intended to evaluate population risk but cannot appropriately identify individual risk. The LACE Index Scoring Tool for Risk Assessment was built on an outpatient population pool to predict risk for readmission or death within 30 days of hospital discharge. In trialing LACE, Avera found almost all residents stratified into the high-risk population. The tool was not able to significantly distinguish between the severity levels present in the nursing facility and there was little stratification of the population.

Risk stratification is a key component of many population health models. We think that it is important to continue to try to risk stratify this population to encourage appropriate care to the most acute/fragile subpopulation; however, we do not have enough evidence to suggest a single best method. We recommend leaving the option open to the Participants. This might be something as straightforward as completing a comprehensive clinical review of new patients including presence of chronic conditions, falls, high-risk medication and ER/hospitalization history and using the geriatrician's complex clinical decision making skills to stratify patients. Or it might include purchasing proprietary risk stratification software.

3. You indicate that your calculations of payment amounts were based on a resident population of 5,000. However, you indicate that the Performance Based Payment might allow smaller scale deployments (e.g., 100 residents). There are presumably fixed costs for the service that would increase the cost per resident if the model were deployed with smaller populations. What is the minimum number of residents that would be necessary for financial viability at the payment rates you recommend? Could you estimate what payment rates might be necessary to support the service with a smaller population and whether there could still be net savings at those payment rates?

It is difficult to assume what the fixed costs would be for every Participant. In Avera's case, we have invested in staffing our Geriatric Care Team with dedicated professionals, including 1 fulltime Geriatrician, 4.2 FTE Certified Nurse Practitioners, 0.8 FTE Certified Nurse Practitioner of Psychiatry, 2.0 FTE Pharmacists, 2.4 FTE Registered Nurses, 1.0 FTE Social Worker, and 4.2 FTE Support Specialists. This group's current capacity is 5,000 nursing facility beds. Some of the clinical staff have the potential to serve more residents, but as a team, they appear to be at capacity at 5,000 with Avera's current clinical and operational model.

Other practices might find it easier to look at the psychiatry, pharmacy, and social work or similar support as a variable cost, working with professionals or teams within their clinic or community to buy time as needed. The practice may choose either nursing or support specialist staff to support the physician and multidisciplinary team in working with residents, and concentrate on hiring dedicated staff for daytime hours. In this case, the largest fixed costs would likely be the 24/7 access to a provider. At a minimum, this would be the advanced practice provider available 8,760 hours per year.

A very small, independent practice might find it possible to rotate call responsibilities to ensure 24/7 access and may choose not to compensate the physician for their call time. Historically, this has been a common model. In this case, perhaps the Participant has assigned a nurse to be fully or partially dedicated to the program and may consider the nurse to be a fixed expense.

In short, it is difficult to assume a fixed expense that would fit most Participants.

It is also difficult at this time to know if a practice serving a small population will have the same impact and net savings as a practice serving a large population. This would require further testing and comparison of sites. If HHS chose the Shared Savings Model, they would be sheltered from some of this uncertainty by passing greater financial risk on to the practice.

Given our experience, we believe a Participant needs a certain number of residents enrolled in the model to become proficient and efficient. However, we recognize there is significant variation and creativity in physician practices and how they might be able to implement the model for their own population.

4. The 2018 Medicare Physician Fee rule added new codes for telehealth services. Of the services that would be delivered under the proposed model, which of them would be billable under 2018 MPFS codes and which would not? What proportion of the costs of the services could be covered through billing standard MPFS codes?

Medicare Telemedicine Reimbursement rules pose unique restrictions on providers. Telemedicine services are only reimbursed for beneficiaries receiving care in rural originating sites. Urban and suburban nursing facilities would not be eligible to participate in the proposed model because of the telemedicine restrictions. While the percentage of rural nursing homes or rural nursing home occupancy was not easily available, the U.S. Census reports that only 25.5 percent of the nation's seniors live in rural areas.

Medicare telemedicine services must be provided by a limited set of clinicians, which does not include pharmacists and nurses or social workers not meeting the definition of "clinical social worker." These members of the interdisciplinary team would not be reimbursed for their efforts, as opportunities like "incident to" billing used in many outpatient clinics is not allowed over telemedicine.

In 2018, Medicare will add some new codes for telemedicine. These are not particularly helpful to the proposed model because of several issues outlined in the table below.

Table 1: 2018 Medicare Physician Fee New Codes for Telehealth Services

Code	Description	Challenges Applying to the ICM SNF APM
HCPCS code G0296	Counseling visit to discuss need for lung cancer screening using low dose CT scan	Not applicable
CPT codes 90839 and 90840	Psychotherapy for crisis; first 60 minutes and Psychotherapy for crisis; each additional 30 minutes	These codes are generally not applicable. Any psychiatric services would be considered specialty services reimbursed under the traditional Medicare fee schedule and not included in the Model.
CPT code 90785	Interactive Complexity, Psychiatric Add On Code, refers to 4 specific communication factors during a visit that complicate delivery of the primary psychiatric procedure.	Not applicable. Any psychiatric services would be considered specialty services reimbursed under the traditional Medicare fee schedule and not included in the Model.
CPT codes 96160 and 96161	Administration of patient-focused or caregiver-focused health risk assessment with scoring and documentation, per standardized instrument	This type of standardized risk assessment is typically covered in the facility care and not required to be duplicated by the care team.
HCPCS code G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services	As stated in the initial proposal, Chronic Care Management (CCM) codes have many requirements that do not fit with the nursing facility care model or cannot be fulfilled by a virtual geriatric care team. Typically CCM are intended for the primary care physician and include a requirement for a comprehensive care plan. The Geriatric Care Team could be supportive to the primary care physician in complementing the care plan. CCM also requires advanced beneficiary consent because of the beneficiary cost-sharing, creating a barrier to adoption, particularly across a meaningful number of beneficiaries in any one facility. Finally, the CCM code cannot pay for beneficiaries receiving Medicare Part A services, including all short-stay residents.

As stated in the initial proposal, geriatricians participating in the Model would not be allowed to bill the following codes for residents under the Model during the covered period. This would not preclude PCPs or other geriatricians from billing these codes for residents.

Table 2: Codes Not Allowed with the Model

Codes	Short Description
99487, 99489	Chronic Care Management
G0506	Assessment/care planning for patients requiring CCM services
G0507	Care management services for behavioral health conditions
99358-99359	Prolonged non-face-to-face evaluation and management services
99307–99310	Subsequent nursing facility services, limit of 1 telemedicine visit every 30 days

5. Please describe further why the model must be deployed facility wide rather than to a subset of patients with particular needs.

The ICM SNF AMP model requires true culture change. It asks bedside nursing staff to work proactively with physicians to evaluate residents and prevent avoidable hospitalizations. The interaction of the whole population allows us to train the nursing population, enhance their skill set and engage them in meaningful care transformation. Avera’s clear experience is that if we can only care for a small subset of patients in a facility, the staff are not likely to engage for help on any of the patients.

In 2012, Avera received funding from the Health Resources and Services Administration (HRSA) to launch a telemedicine pilot in several nursing facilities with hopes of reducing unnecessary hospitalizations and emergency room visits. The pilot included 24/7 telemedicine access to an emergency physician for acute care concerns and questions on transfer. While this model had some recorded success with avoided transfer to the emergency room, the volumes at the facility were much lower than anticipated because nursing facility engagement was lacking. Nursing staff reported that they often forgot about the telemedicine option since it only came to mind after the transfer decision had been made. Others reported that they lacked confidence in using the service because they had little regular experience interacting with the telemedicine staff or technology. These staff felt they might use the system as a last resort, when their usual avenues of support were exhausted.

During the Health Care Innovation Award (HCIA), Avera actively addressed many of these issues by building a comprehensive geriatric program that interacted with staff on a daily basis and became part of the bedside care team. More frequent interaction with the facility generated more interest and opportunity to engage deeply with the bedside team on both everyday care questions and complex patients. Engagement, in turn, led to more volumes and further opportunities to proactively address patient changes in condition, to ensure consistent application of evidence-based practice, and eventually, to a consistent response and culture change regarding consideration of transferring patients to the hospital.

This experience and the differences in patient volumes, quality outcomes and cost of care underscored the importance of working with a critical mass of patients at the facility to affect true culture change.

- 6. Did you consider risk adjusting the one-time payment or ongoing monthly payment? If so, why did you decide against it? Is there a possibility that a flat payment could cause the entity receiving the payments to “cherry pick” facilities that are better staffed (e.g., due to a more favorable payer mix) or that have patients who are less likely to be hospitalized, and if so, is there any way to prevent that? Could the risk stratification methods you recommend as standards be used to risk stratify payments?**

Avera considered risk adjusting the payment, but has initially chosen a flat payment for simplicity. We recognize the concerns about cherry picking, but feel nursing facilities are homogeneous enough to mitigate that concern. Further, a facility-wide intervention prevents cherry picking of patients within a facility. The quality metrics also address cherry picking by including incentives for performing above 50th or 60th percentiles or, importantly, for working with facilities to improve scores by 5 percentiles annually. This counters the risk of cherry picking only better staffed facilities or facilities with patients who are less likely to be hospitalized.

If CMS was interested in risk adjustment, prospective HCC scores would be an appropriate methodology. This would require additional work for CMS, perhaps evaluated annually. On the other hand, the Model is intended to be preventive, so the HCC score may not identify or incentivize opportunities to prevent further health decline.

- 7. SNFs that are delivering services to patients who are part of bundled/episode payment models such as the Bundled Payments for Care Improvement (BPCI) initiative and the Comprehensive Care for Joint Replacement (CJR) model will likely be receiving a different mix of patients than SNFs that are not, and there will likely already be efforts to reduce rates of hospitalization for these patients as part of the bundled/payment initiative. How do you see the proposed model complementing or conflicting with these types of payment models?**

The ICM SNF APM model will complement and reinforce interventions delivered as a part of these bundled payment models with aligned goals of reducing hospitalizations and care costs. The Model would provide intensive case management while in the nursing facility, as well as 24/7 access to geriatric care for earlier intervention. It may address gaps in current BPCI program results which have shown limited improvements in reducing rehospitalizations.¹

¹ Lewin Group. (2017, October). CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 3 Evaluation & Monitoring Annual Report. Retrieved from <https://downloads.cms.gov/files/cmimi/bpci-models2-4yr3evalrpt.pdf>

Avera's HCIA project was tested in several facilities participating in BPCI and the teams worked effectively and supportively. Similar to other preventive services, the BPCI participants found it was in their best interest to include services shown to reduce hospitalizations and emergency room visits.

Model payments made under either option would be counted in the bundle's total cost of care. Savings under the Shared Savings Model would not be double paid because the financial reconciliation only applies to beneficiaries that are not already attributed to another program.

- 8. The proposal offers a performance based payment option and a shared savings model option. Since you recommend that HHS choose between the two, on what basis would you recommend that HHS make the choice? What do you see as the advantages and disadvantages for HHS, the entity receiving the payment, and the facilities and patients receiving the services? How important are shared savings in making the model financially viable?**

The Performance-Based Payment offers simplicity to Participants. It allows providers to potentially participate in a limited fashion for a smaller cohort of patients. Smaller, independent practices are more likely to participate in this payment model. It likely will be more palatable to providers and attract a larger group of Participants earlier on. The Performance-Based Payment will allow providers in long-term care to learn and develop the comprehensive geriatric care model and further develop best practices in this space. However, CMS likely will have to develop specific standards and regulation to ensure providers are held accountable to the Model.

The Shared Savings Model provides more flexibility to providers and likely less administrative burden and regulation for CMS. It allows providers to flex the care model to the needs of their residents and to share in savings if they meet quality and cost-performance requirements. Shared Savings is more advanced on the alternative payment model spectrum. It shifts risk from CMS to the Participants and provides more potential upside to participants who perform well. Shared Savings would appeal to larger groups or health systems that can bear the risk of the program.

If HHS is open to considering both models, Avera recommends beginning with the Performance-Based Payment to encourage early engagement by a broader group of participants and then maintain the opportunity to flex into Shared Savings and potentially see even more savings as the environment matures.

Either model should be financially viable to Participants. The viability of the program was initially built on the Performance-Based Payment Model and Shared Savings provides additional incentives to providers to achieve cost of care targets.

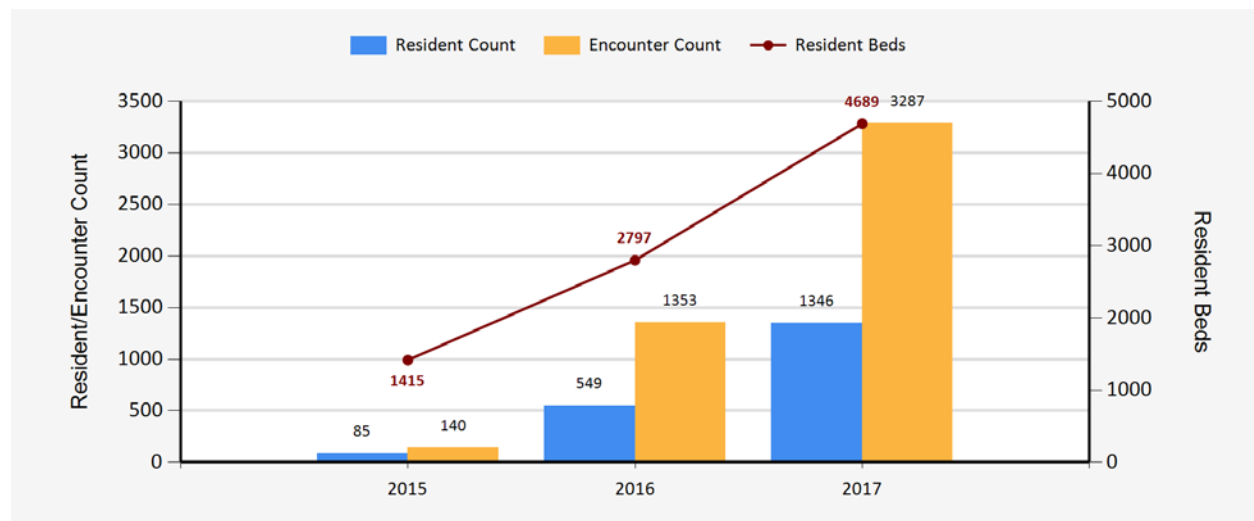
9. Could you further describe your HCIA experience? What is the volume of calls received per patient? How many geriatricians and other staff are needed to manage a particular volume of calls? Based on your experience, what characteristics lead to higher rates of hospitalizations?

Over three years, Avera’s CMMI HCIA project implemented the Avera eLTC model in 45 facilities in four states, covering a total of 3,600 licensed beds and serving approximately 11,000 beneficiaries. The facilities represented are both rural and urban, nonprofit and for-profit, chain/system affiliated and independent and range from 38 to 187 beds. In addition to the CMMI award locations, Avera eLTC has been implemented in 20 additional locations covering an additional 1,100 licensed beds.

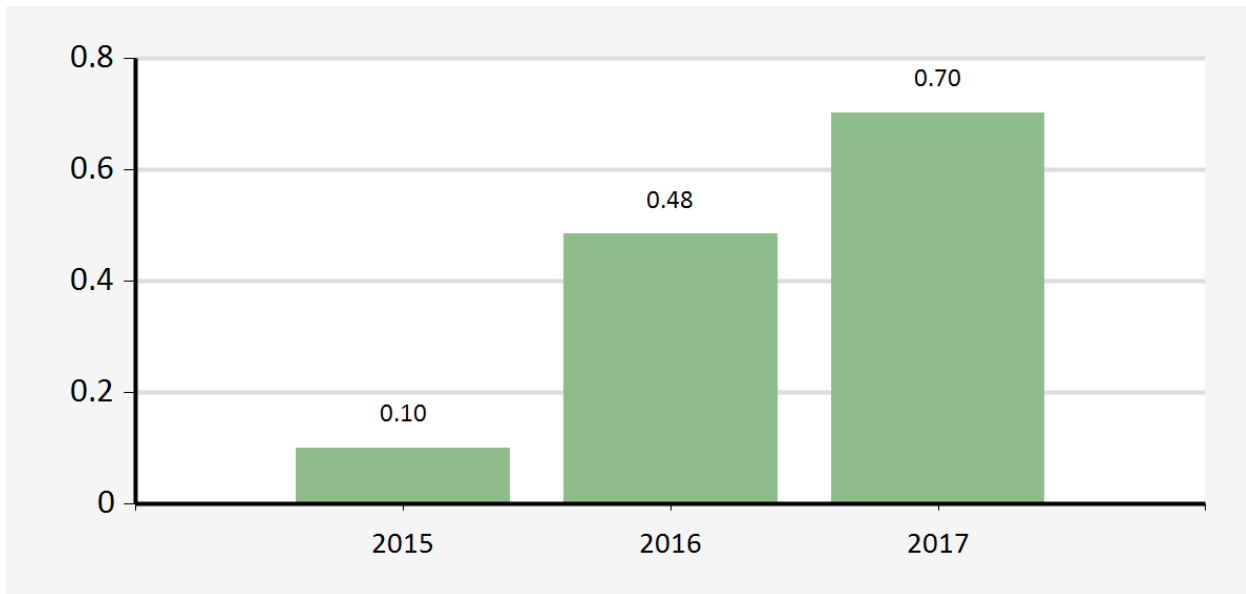
Throughout the three-year award period with HCIA, Avera saw an upward trend in call volumes and clinical interactions. This trend happened as more sites initiated services with the program. However, even once all sites were live, growth in volume of calls per patient continued. This continued upward trend was internally validated as increased engagement with the nursing facility sites – the more they used the program the more comfortable the stakeholders became (residents, families, staff, site leadership, local physicians, etc.) and the more likely they were to use the program again.

Graph 1 below illustrates the growth in participating nursing facilities, and relays the average number of residents directly seen by the program each month along with average monthly call volumes per month. Graph 2 illustrates the growth in facility engagement as the number of calls per bed per month increased throughout the HCIA award period. Finally, Graph 3 demonstrates the improvement in Unplanned Transfers per 1,000 resident days over the same time period.

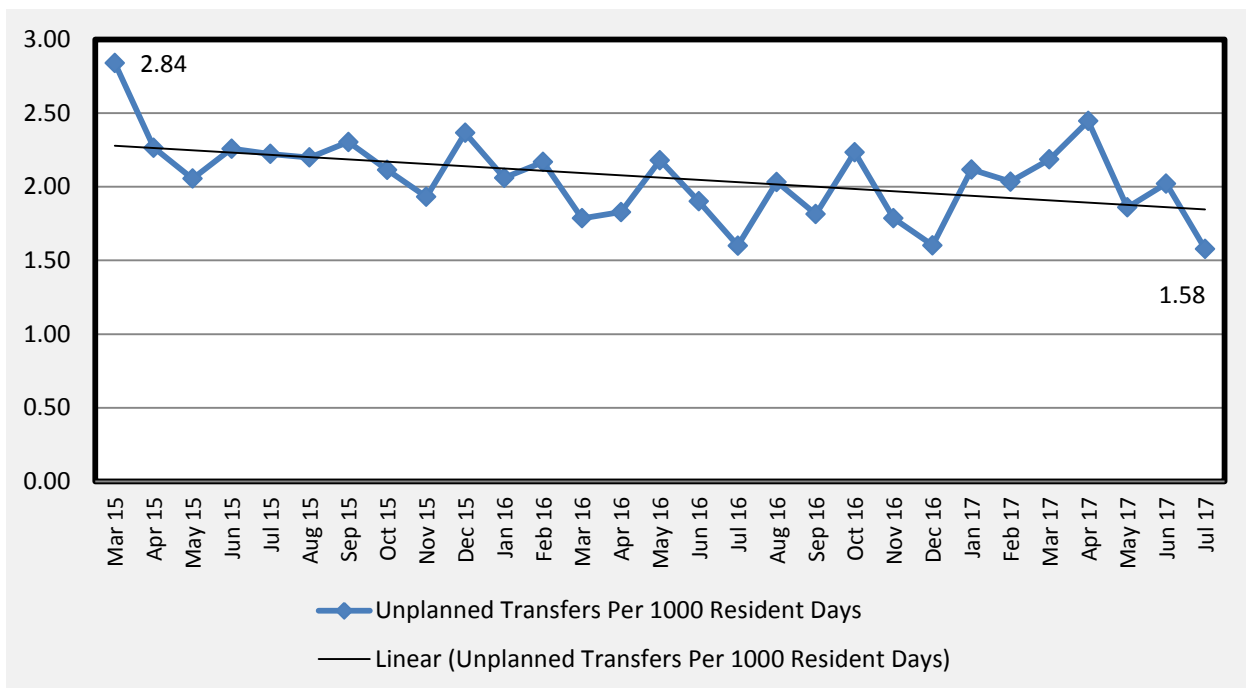
Graph 1: Average Monthly Patient Encounters



Graph 2: Average Monthly Encounters per Nursing Facility Bed



Graph 3: Unplanned Transfers Per 1000 Resident Days



Currently the number of encounters seen here and the number of residents involved is managed by the following team composition:

- 1.0 FTE Geriatrician
- 4.2 FTE Certified Nurse Practitioner
- 0.8 FTE Certified Nurse Practitioner of Psychiatry

- 2.0 FTE Pharmacist
- 2.4 FTE Registered Nurse
- 1.0 FTE Licensed Social Worker
- Administrative and Support Staff for Operations and Facility Relations

Avera estimates that existing team composition could serve up to 5,000 nursing facility beds, by possibly adding another part-time licensed social worker. Estimated capacity by clinician FTEs, given Avera’s current team structure, is listed in Table 3.

Table 3: Estimated Capacity Clinician Capacity by Nursing Facility Bed

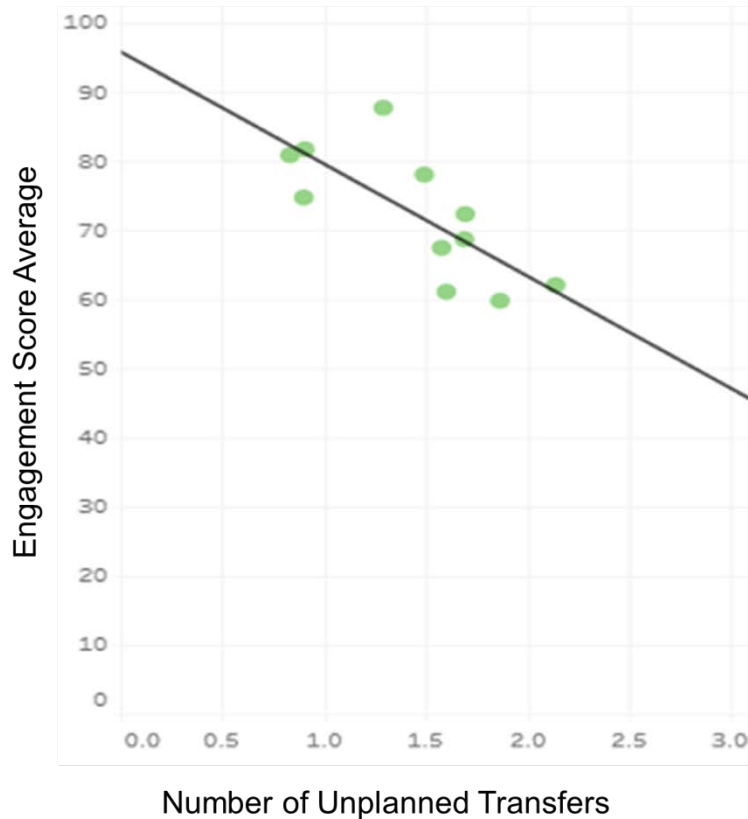
Clinician	Monthly Bed Capacity
1.0 FTE Geriatrician	5000
4.2 FTE Certified Nurse Practitioner	9000
0.8 FTE Certified Nurse Practitioner of Psychiatry	5000
2.0 FTE Pharmacist	7000
2.4 FTE Registered Nurse	5000
1.0 FTE Licensed Social Worker	3500
Administrative and Support Staff	9000

In working with 65 nursing facilities, Avera has identified several factors that may lead to higher hospitalization rates:

- Increased number of Part A/short-stay residents at a facility
- Increased level of acuity at a facility
- Lack of necessary education for caregivers at the facility
- Lack of engagement in the Model caused by:
 - o High turnover of key leadership positions at the facility
 - o High turnover of frontline caregivers, especially the RN and CNA positions
 - o Resistance from local providers for the facility using telemedicine services
 - o High levels of agency staffing

In looking at Avera HCIA experience, there was a correlation between facility engagement (measured by service utilization) and the number of unplanned transfers out of the facility. A simple linear regression was conducted to predict unplanned transfer rates (dependent variable) in rural communities based on facility engagement through telemedicine utilization (independent variable). The results of the simple linear regression suggest that site engagement accounted for over half of the variance in unplanned transfers ($R^2 = .59$), which was significant, ($F(1,9) = 12.99$, $p < .006$). (Figure 1: Rural Engagement).

Graph 4: Linear Regression of Facility Engagement and Number of Unplanned Transfers



Avera worked through the HCIA project to develop strategies to counteract these factors that led to higher rates of hospitalization. These practices have been included in the Model's Minimum Standards.

Minimum Standards:

- Geriatric Care Management
 - Geriatrician-led, multidisciplinary team (e.g., RN, social worker, pharmacist) monitoring of a resident's care during their nursing home stay, in close collaboration with the attending PCP
 - Risk stratification of the patient population
 - Development of care plans for high risk residents
 - Medication management in coordination with the PCP
 - Evidence-based disease management
 - Behavioral health support, including addressing medications, behaviors, and crises
 - Advance Care Planning
 - Transitional Care Support from the hospital into the nursing facility within 48 hours
 - Medication reconciliation by the multidisciplinary care team

- Transitional Care Follow-up with patients after SNF/NF discharge within 72 hours
- Timely Access to Care
 - 24 hours a day, 7 days a week telemedicine access to a physician or Advance Practice Providers (APP) on the geriatrician-led team who has real-time access to resident's medical records
 - Real-time provider response to a resident's change in health status

Avera's Response to the PTAC Preliminary Review Team's Questions on *Intensive Care Management in Skilled Nursing Facilities Alternative Payment Model* (ICM SNF APM)

January 12, 2018

Response to Questions

- 1. One of the ten criteria for evaluating proposals for physician-focused payment models is patient choice (encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients). Can you further describe how patient choice would be reflected in the model and how the unique needs and preferences of individual patients would be incorporated? Do you have a standardized approach for shared decision making? Also, while the proposal highlights advance care planning, the performance metrics do not seem to address advance care planning, shared decision making, or satisfaction. Why is that?**

Under our model, patient choice is reflected through the regulations the Skilled Nursing Facility (SNF) is required to follow when it comes to resident rights. As part of implementing this program in a SNF, education is provided to staff, residents, and family so they are aware of services that are offered. At the time of a resident's decline in health or the need for a Provider visit, the resident or surrogate decision maker would work with the staff at the SNF to determine the best choice with the available resources at the time of the need, with one choice being the program. Like any medical service, the patient is always free to choose whether to be seen or not.

From a disparity standpoint, nursing facility residents are at risk as a whole of receiving disparate care due to their advanced age and higher morbidity. Certain groups within nursing facilities face even higher risk of disparate care due to decreased access secondary to geographic and socioeconomic conditions. This model will help decrease disparity in access to care, especially due to geography, socio-economic status, and disabilities by increasing access to care by a vulnerable group of residents who have not before received this. The access is available to all residents in a SNF regardless of any specific criteria.

The Avera eLTC program certainly encourages shared decision making and is evident in the advance care planning component of the program, as well as, is a component of geriatric medicine in general. This is a reason why having this model led by a Geriatrician is very key as it is an integral part of geriatric medicine as a part of the core curriculum and standards. Advance Care Planning by its design is shared decision making as it helps identify the residents personal values and thoughts about their current state of health and future healthcare decisions they are likely to face. Supportive documentation to help the resident identify their values include national tools such as The Conversation Project, Careing-Conversations, The American Bar Association's tool kit.

State specific durable power of attorney forms would also be used to ensure the resident's choices are properly and legally communicated and surrogate decision makers identified.

While we agree the metrics regarding advance care planning, shared decision making, and satisfaction are important, we wanted to select metrics that are already a part of SNF criteria in other programs such as value-based purchasing and Nursing Home Compare. Currently, CMS does not measure resident satisfaction, advance care planning, nor shared decision making in the SNF setting. Part of the minimum standards in the proposal includes articulation of strategy to measure satisfaction for SNF staff and beneficiaries.

- 2. During the call with PRT on January 3, 2018, we indicated we would provide further information in regards to a question from Mr. Harold Miller in regards to the difference in levels of payment. He had asked, would it make sense that there could be a smaller payment (core payment) designed to support the geriatrician/provider, and then have an opportunity to participate in the shared savings model and add other team members? Essentially, there would be two different levels of payment; lower for performance based and then higher for bigger teams in the shared savings model.**

This methodology causes concern for us as we worry it may push back towards the current status quo of the SNF industry without guidance to inform on impact. There is no evidence based on our experience that the effect would be the same with a stripped down model. Avera had a stripped down model during a HRSA award prior to the HCIA CMMI award, and found it to be considerably less impactful. Throughout the HRSA award and the HCIA CMMI award it continued to become evident there was a need for a geriatrician-led team of subject matter experts.

In terms of payment, while the shared savings option would potentially result in additional revenue to a program without necessarily adding more team members, there is also additional downside financial risk in the shared savings model. As in all more advanced APMs, this higher level of upside is essential to incentivize providers to take on this additional downside risk. Additionally, as in other Advanced APMs this additional revenue ideally would be re-invested to help further improve care and sustain savings.

PHYSICIAN-FOCUSED PAYMENT MODEL
TECHNICAL ADVISORY COMMITTEE (PTAC)

PRELIMINARY REVIEW TEAM (PRT)
CONFERENCE CALL WITH AVERA HEALTH

Wednesday, January 3, 2018
4:00 p.m.

PRESENT:

GRACE TERRELL, MD, MMM, PTAC Committee Member
HAROLD D. MILLER, PTAC Committee Member
KAVITA PATEL, MD, MSHS, PTAC Committee Member

SARAH SELENICH, Office of the Assistant Secretary for
Planning and Evaluation (ASPE)
ANJALI JAIN, MD, Social & Scientific Systems, Inc. (SSS)

DAVID BASEL, MD, Vice President, Avera Medical Group
Clinical Quality
MANDY BELL, Quality and Innovation Officer, Avera eCARE
JOSHUA HOFMEYER, Senior Care Officer, Avera eCARE
DEANNA LARSON, President, Avera eCARE Telehealth Services

P R O C E E D I N G S

[4:03 p.m.]

MS. SELENICH: Grace, perhaps we should just do introductions while we're waiting? --

DR. TERRELL: Sure. Yep, absolutely.

So good afternoon, and Happy New Year to everybody. I am Grace Terrell. I am the Chairman of this PRT Committee. And so I'll let -- Thank you for making the time to talk with us this afternoon. Let me let each of you give an introduction, and then we'll follow it with Harold Miller and the ASPE team. And then maybe by then, Kavita Patel will be on the call.

So I think I heard a David Basel. Do you want to start?

DR. BASEL: Great. So this is Dave Basel. I am a practicing internist, and I am vice president of Clinical Quality for Avera Medical Group, and I was the principal investigator for the HCIA grant that led to this payment model.

DR. TERRELL: Okay. And for the rest of you, is [unintelligible] Deanna?

MS. LARSON: Yes. Good afternoon. This is Deanna Larson, I am the president of Avera eCARE

1 Telehealth Services. Thank you for your time
2 today.

3 DR. TERRELL: Absolutely.

4 And, a Josh?

5 MR. HOFMEYER: Yes. Good afternoon. This
6 is Josh Hofmeyer. I am the senior care officer for
7 Avera eCARE, so I oversee all of the senior care
8 services that we provide here.

9 DR. TERRELL: Okay. And then I think
10 there was a Mandy; is that right?

11 MS. BELL: Right. This is Mandy Bell. I
12 am the Quality and Innovation Officer for eCARE,
13 our telemedicine offering within Avera Health.

14 DR. TERRELL: Okay. So I believe those
15 were the four that were on from Avera.

16 Harold, if you want to give an
17 introduction and then the ASPE folks, and I think I
18 may have heard Kavita join us, hopefully.

19 DR. PATEL: I did. Hi, Grace.

20 DR. TERRELL: Hi.

21 MR. MILLER: Hi. This is Harold Miller
22 from the Center for Healthcare Quality and Payment
23 Reform, and I'm a member of PTAC and a member of
24 this PRT group.

1 DR. PATEL: And I'm Kavita Patel. I'm at
2 the Brookings Institution, where I work on health
3 policy, and at Johns Hopkins, where I work as a
4 primary care doctor.

5 DR. TERRELL: ASPE, if you could say who's
6 on the phone?

7 MS. SELENICH: Sure. It's just me. It's
8 Sarah Selenich today, Grace.

9 DR. TERRELL: Okay.

10 MS. SELENICH: And I am a policy analyst
11 in the Assistant Secretary for Planning and
12 Evaluation at the U.S. Department of Health and
13 Human Services.

14 DR. TERRELL: And from S cubed?

15 DR. JAIN: Hi. It's Anjali Jain. I'm a
16 contractor with S cubed and a physician.

17 DR. TERRELL: And I think I heard somebody
18 else join the phone call?

19 [No response.]

20 DR. TERRELL: Perhaps not.

21 Well, thank you all for the opportunity to
22 talk to you in person about your application. I
23 was excited to see that there was application with
24 respect to nursing home care. So my background is

1 I'm also a general internist, practice about three
2 days a month, and I am also the CEO of a company
3 called Envision Genomics, which is in the precision
4 health space, and have run a population health
5 company in North Carolina called CHESS as well as a
6 background as the CEO of a medical group called
7 Cornerstone Health Care that did a lot of work.

8 But the most important thing from your
9 point of view to hear is that my very first job in
10 high school was washing dishes in a nursing home,
11 and I had a -- I was medical director of the
12 nursing home for about 10 years and had a team-
13 based approach with that.

14 And when I was first in practice, I would
15 be on call for sometimes eight nursing homes at a
16 time as well as hospital and my practice and
17 several other physicians. So I had great empathy
18 for what you're trying to accomplish, and what
19 we're trying to do today is to really hone in on
20 the details.

21 So just so you know, the way that the PRTs
22 work is that three are appointed. It always has at
23 least one physician on it. In this case, it's two,
24 me and Dr. Patel, and we evaluate the proposal, and

1 we've had a couple of conversations with one
2 another.

3 We send out questions related to the
4 questions that we had after reading the proposal.
5 There's also a significant amount of work that is
6 done from a background point of view. If we had
7 things that we believe our associates can do at
8 ASPE or with S3, which supports us, to give us
9 background information so we can do a better job
10 evaluating it.

11 Then what we do typically is to actually
12 have a conversation directly with the proposals'
13 writers so that we can get a better sense of
14 things. So that's what this hour will be.

15 And then after that, we will have some
16 further conversations, and we will then put our
17 thoughts together as to whether your proposal meets
18 each of the 10 criteria that was set forth by the
19 Secretary of Health and Human Services for this.
20 And then that will be sent to the entire PTAC to
21 consider. So we don't make a specific
22 recommendation. We just basically say whether we,
23 the three of us, think it does or does not meet the
24 criteria.

1 And then after that, the full PTAC in a
2 public meeting will deliberate on it after they've
3 seen what we've written as well as materials that
4 have been produced by you all and our researchers,
5 and you will be invited to answer our questions in
6 public there. So you may know all of that, but I
7 thought I'd go over it. So today is really
8 informal.

9 What I thought I would do now is let you
10 all communicate anything you wanted to specifically
11 say to us before we get started, and then I'm going
12 to ask each of my other counterparts to start with
13 the questions that they might have for you.

14 Does that sound like an okay plan?

15 DR. BASEL: That sounds great. This is
16 Dave Basel, and thank you for the opportunity to
17 speak with you guys today. And we have been
18 following along the public hearings pretty closely,
19 and so we are relatively familiar with the process
20 at least from the public view.

21 DR. TERRELL: So would you like to -- do
22 you have any particular comments that you all would
23 like to make before we sort of dive into things?

24 DR. BASEL: Maybe start out just briefly

1 giving the background of this project. We've got
2 two practicing internists on the call, so near and
3 dear to my heart. So I am a [unintelligible]
4 physician in taking care of nursing home patients
5 for many years, and I'm also the medical director
6 of our three MSSP ACOs. And so, going back six,
7 eight years ago, we were seeing value-based care on
8 the horizon and knowing that post-acute was
9 probably going to be one of the most important
10 parts to address, and that hadn't necessarily come
11 along with a value-based journey as much as many of
12 the other areas, like hospital and stuff. And so
13 we were looking at ways that we could address both
14 quality and cost in that setting and what a lot of
15 what some of the literature was showing at the
16 time, and then that led to a HRSA grant, which led
17 to the HCIA grant, which brought us to where we
18 are.

19 And, you know, the single underlying
20 problem that -- that we're trying to address with
21 this, well, care delivery system and then the
22 payment model to make it sustainable is really one
23 of access in the nursing homes.

24 Nursing homes have been, as you guys know

1 if you spend any time in them -- you know, the
2 profit margins are pretty slim in nursing home
3 industry. There's a wide variety of ownership in
4 nursing homes, and from a physician standpoint,
5 since this is physician focused and from thinking
6 as a physician, you know, it's not usually the
7 first place most of us think about in our practice
8 models.

9 And so what ends up happening too often is
10 you get that call in the middle of the night, and I
11 don't know. I can't see the patient. She's short
12 of breath. Well, I don't know the nurse. The
13 nurse is turned over frequently in nursing homes.
14 I can't see the patient. So, you really, the only
15 option is I can either get up in the middle of the
16 night and drive in and spend a couple hours seeing
17 the patient, or I can send them to the ER. So the
18 path of least resistance is always to the ER, which
19 then more often than not leads to a
20 hospitalization.

21 And, you know, we all know that's not
22 where you really want the patients to end up if
23 they don't need to be there and --

24 DR. TERRELL: Right.

1 DR. BASEL: You know, so we went through
2 that process and a couple iterations of this care
3 delivery model and realized that not only do you
4 need to have somebody access 24/7 in there, but you
5 also needed that skill set a lot more proactively
6 earlier in the stream. And you really needed to
7 change the whole culture in that nursing home
8 because it's gotten to be so much that just wait,
9 wait, wait, try to batch everything until, well,
10 let's wait till Monday when the doc's back in the
11 office and then everything's percolated. And
12 they're either septic or the cellulitis has spread
13 or whatever, and it's just too late to intervene it
14 then.

15 And so we've got to intervene both
16 systematically from a process and performance
17 improvement stand point earlier as well as on a
18 care delivery earlier and get that in, which is
19 kind of the major emphasis behind the care delivery
20 part to this.

21 DR. TERRELL: Thank you. That's very
22 helpful.

23 Anyone else on your team would like to
24 respond?

1 MS. LARSON: This is Deanna, and I think
2 that was very well stated by Dr. Basel.

3 I guess I would add in that all of --
4 Avera has a couple of decades of experience in
5 telehealth, and as we were really looking at this
6 population of patients and understanding that they
7 have the needs that Dr. Basel described and the
8 importance of having a group of providers who are
9 very interested in that care and very focused
10 around the needs of the residents living there, we
11 really have done a lot of work to try to help with
12 identifying the team members and supporting the
13 providers with the telemedicine program and really
14 have found that that 24-hour support that you're
15 describing, on call, is certainly very important to
16 make sure we address acuity as it -- as it starts
17 to develop and make sure that we don't end into a
18 spiral of a hospitalization.

19 So our background work, we kind of come
20 from some humble roots here, where we really needed
21 telemedicine in our beginnings to even ensure care
22 across geography, but through these last 10 years
23 or so, we really understand that leveraging high-
24 performing providers and making sure that they're

1 surrounded with the multidisciplinary team to
2 support care of residents living in those
3 facilities, we really discovered that that's key
4 and important, and this methodology that we've
5 described here, we hope would be of interest to
6 more providers to spend their time and talents
7 working at the top of their license to really make
8 sure we can have the greatest impact on patients.

9 DR. TERRELL: Thank you.

10 Kavita, are you ready to ask some
11 questions? Are you prepared now?

12 DR. PATEL: Yes, I am. And would it be
13 helpful to go through some of the responses, just
14 if there's some clarifications as well as
15 additional questions, Grace, or --

16 DR. TERRELL: Would you like to do that?
17 Okay.

18 DR. PATEL: Is that okay?

19 DR. TERRELL: Yep.

20 DR. PATEL: Okay. So I wanted to spend
21 time -- and then I have a feeling this will trigger
22 just a couple other questions I've been thinking
23 about. I wanted to just ask like one philosophical
24 question that ties into what both of you just kind

1 of touched on in terms of really recruiting like a
2 strong team.

3 You had in your response to the question
4 kind of an outline of the breakdown of the types of
5 kind of flows for workers, you know, everything
6 from a geriatrician, social worker, pharmacist, et
7 cetera.

8 A philosophical question is, Do you feel
9 like you currently have the workforce to actually
10 do this, or -- in other words, does this team
11 exist? You talked about your HCIA experience, but
12 when we asked the question about smaller scale, I
13 know that in a response, it was really difficult to
14 assess that because you put forward a certain
15 estimation of patients in a model.

16 So I'm wondering about kind of the
17 workforce that you outline in your very first
18 response with kind of the cost breakdown, and
19 philosophically, does that exist? Actually, not
20 philosophically. Realistically, does that exist?
21 And if not, is the idea that such a financial model
22 might help to recruit kind of members of the team,
23 and which of those members would you see kind of in
24 -- in the most need?

1 So I'll stop there because I have some
2 other questions to ask as well.

3 DR. BASEL: Certainly. This is Dave
4 again, and I'll take the first crack at that.

5 Philosophically and realistically, this
6 team absolutely exists, from the HCIA project and
7 has continued past the HCIA project. And you know
8 from a care delivery model perspective of the HCIA
9 project, we set up the team, as we did, because we
10 did feel that team and through the experience that
11 we adjusted the team members as we went through the
12 HCIA project, has the most likelihood of success,
13 in our opinion, underneath this type of a care
14 delivery model.

15 So I'll give you an example of when as
16 sort of going through the HCIA project, part of it
17 that we do and still continue to do is we review
18 all of the unplanned admissions from each one of
19 our facilities and looking for common trends and
20 underlying root cause of those -- of the
21 preventable ones.

22 And after the first year of that project,
23 we realized that there was one -- not surprising to
24 anybody. This isn't rocket science. You know, one

1 of the problems was lack of as intensive advanced-
2 care planning as we'd like to see in patients who
3 are ending up in the hospital who that really
4 wasn't consistent with their wishes. And then two,
5 was a lot of dementia, behavioral health type of
6 concerns -- depression, dementia, and other
7 behavioral health concerns. And so we added two
8 more members to our team, and so we have pretty
9 specific ideas with our own team of what it takes
10 to be successful in this model.

11 So with that being said, from having the
12 highest chance of success of this care delivery
13 model under this payment problem, we have pretty
14 specific expectations and best practice of what we
15 think should be implemented. However, we don't
16 want to be arrogant about that and realize that
17 there are a lot of entrepreneurial people out there
18 and especially a lot of small practices out there
19 that potentially could do the same thing as, you'd
20 say, a small geriatric practice with two or three
21 geriatricians who might be able to do it on a lot
22 smaller scale, value their labor cheaply, and still
23 provide much of the same services.

24 Now, my worry on that model is that you

1 start to dilute out the benefit of the care
2 delivery model that we had, and that, you know, it
3 starts being where we're not getting that culture
4 change in the nursing home, and that they're
5 starting to batch the calls again, not being as
6 responsive. The access isn't as good as we'd like.

7 However, we don't want to totally prohibit
8 that possibility that there are good people, good
9 smaller groups out there that can do it. If you
10 ask us, we'll tell you absolutely this should be a
11 multidisciplinary team with a pharmacist, and a
12 behavioral health expert, and a geriatrician and
13 several other members, a nurse, and what have you.
14 And we can give the exact projections of what size
15 of scale that means, how many beds it can handle
16 and stuff like that, but we wanted to be sensitive
17 to the fact that there are other ways of thinking
18 that smaller groups might be able to implement
19 something. But it does worry us on whether they
20 would be able to guarantee the same effect.

21 DR. PATEL: Okay, great. And I'm not
22 going to monopolize a ton of time because we only
23 have a limited time with you.

24 So then I'm going to jump into something.

1 I have a lot of different little questions, Grace,
2 but I have a feeling that between you, me, and
3 Harold, we'll cover pieces of this.

4 So then my next question is in the context
5 of your -- building on your HCIA experience. I am
6 assuming that's where some of the financial
7 modeling has come from, where you kind of talk
8 about the very -- again, kind of in Response Number
9 1, the numbers of hours, the cost per type of
10 worker. Is that correct, Dave, or am I assuming
11 the wrong thing?

12 DR. BASEL: That's --

13 DR. PATEL: You have a hypothetical
14 example that you gave us, but is that built off of
15 kind of actual experience or just kind of --
16 there's not a wrong answer. It's just I want to
17 understand where the estimates came from.

18 DR. BASEL: Josh and Mandy, do you want to
19 take that one?

20 MS. BELL: Yes. That's correct. It was
21 based off of our HCIA experience, and I should say
22 we had about 45 facilities that participated as a
23 part of that. And we had another 15 that worked
24 outside of that funding instrument, so it's a

1 combined experience over the past three years.

2 DR. BASEL: Okay.

3 DR. PATEL: And do you have any sense --
4 especially with -- because you talk also later in
5 some of your responses about the challenges with
6 kind of the telemedicine reimbursement and kind of
7 what I would just roughly describe as some of the
8 inappropriateness for some of the new codes around
9 telehealth services? Do you see some of what you
10 have in your potential cost, like the -- I think
11 it's like the \$55 ongoing fee that kind of
12 basically covers staffing for a phone consult and a
13 video consult?

14 If we had to turn this question around and
15 ask, could you imagine a more appropriate code
16 potentially to cover some of those fees? So I'm
17 just -- it sounds like it does not exist in a
18 current code, but could part of this -- and I know
19 that that's not your whole proposal, but especially
20 with that proportion that really focuses on novel
21 use of telemedicine, have you ever thought about
22 kind of a more -- you know, a more adequate code or
23 giving feedback to CMS around something that might
24 be potentially more useful?

1 DR. BASEL: So maybe I can take --

2 MS. BELL: We'd be --

3 DR. BASEL: Can I take first crack at
4 that?

5 MS. BELL: Sure.

6 DR. BASEL: Because I just want to make --
7 before you get into the specifics of the codes, I
8 want to make a philosophical point around the fact
9 of why we're going the route of the PTAC instead of
10 going the route of the annual payment updates or
11 just trying to get a new fee-for-service code to
12 pay for these services. And that is around the
13 fact that we truly do think this is going to work
14 best as an alternate payment model, where there is
15 the accountability for the quality and value built
16 in for that.

17 DR. PATEL: Got it.

18 DR. BASEL: If you don't have that
19 accountability piece, then you've got to have a lot
20 higher stringent regulations, a lot higher bars
21 that you're going to make everybody jump over, and
22 it's going to end up being like the DPP program
23 that I think in the last 2018 fee schedule update,
24 final update, Diabetes Prevention Program started

1 on page -- about 750 and ended up on page 1,150 of
2 the regs, so, you know, enable to enact that. And
3 so the more accountability and the more you can
4 make this into an alternate payment model, you can
5 allow more flexibility in the care delivery model.
6 And that's why we think -- yes, we think it works
7 best with, you know, the very specific care
8 delivery team that we had, but if you had that
9 accountability, then that gives the ability to have
10 additional flexibility to deliver that care in a
11 little bit different way, and small independent
12 practices are more able to get into it and that
13 sort of thing.

14 So, philosophically, we would much rather
15 see this in alternate payment model rather than
16 just opening up some fee-for-service codes or
17 adapting existing codes to pay for it.

18 DR. PATEL: That's very helpful. I don't
19 know if we want to go into that any more.

20 And then I guess a final question that
21 ties back just to -- you had mentioned -- I think
22 it was somewhere -- I could be wrong. I read the
23 responses kind of when they came in. You mentioned
24 something about -- actually, I think it was in your

1 rationale for why like the CCM or complex CCM is
2 inappropriate because that really is more of a
3 primary care basis. How do you think about -- and
4 it might just be the unique structure of Avera
5 which is something, Dave, you kind of touched on,
6 that you don't want to exclude this from being open
7 to different types of models.

8 But I just don't know enough about the
9 Avera model. What is, if any, kind of a dynamic
10 interaction with like the patient's primary care
11 physician? And I'll say that I'm on usually the
12 receiving end, where I have variable experience,
13 depending on the facility, some very intense and
14 very integrated and some not.

15 Can you tell me kind of in general what
16 that experience is like? And then maybe --
17 actually, let me not limit it to primary care
18 physicians. I'll just say any physician for whom
19 that patient's particular set of conditions or
20 diagnoses are pretty critical. So it could be the
21 oncologist. It could be a cardiologist, but I'll
22 just leave it at that.

23 And then, Grace, I'll be done because I
24 will save --

1 DR. TERRELL: Yes.

2 DR. PATEL: If we have time, I'll save
3 some of my more pedantic questions for later.

4 DR. BASEL: So, when we started this care
5 delivery model, we were very particular that two
6 things that we wanted to make absolutely sure of,
7 is that we preserve the primary care physician-to-
8 patient relationship, and, two, that we -- didn't
9 affect the specialist referral patterns. You know,
10 we knew that with something new like this, that if
11 we threatened either one of those two things, one,
12 that it wouldn't it be good for patient care, and
13 two, we wanted to develop the acceptance and the
14 rapport that we needed in there. And so we've
15 always been very careful on both of those things as
16 we go in not to disrupt that.

17 And so especially from a primary care
18 physician standpoint, there's a lot of phone calls
19 that go back and forth as we change things. They
20 get a -- unfortunately, because it's the way they
21 want it, they get a fax most of the time --

22 DR. PATEL: Right.

23 DR. BASEL: -- within an hour of every
24 time that we see one of the patients and what we

1 did, and there's a lot of communication that goes
2 back and forth there, because the one or two places
3 where this has not gone well out of those 65 places
4 is because we haven't managed that primary care
5 relationship as well as we should. And so that is
6 one of the keys for success of this model, is
7 keeping that relationship between our group and the
8 PCPs.

9 DR. PATEL: And are there metrics to kind
10 of -- you have some metrics later about what kind
11 of resulted your HCIA kind of -- you know, what
12 some of the results were in looking at what led to
13 higher hospitalization rates, and those were more
14 internal kind of facing.

15 Do you think -- or would you have -- any
16 of you have kind of a thought about how to promote
17 that same sense of accountability for that
18 coordination?

19 DR. BASEL: Well, the real way -- and one
20 of the reasons I -- one of the questions you asked
21 of one of these rounds is from an accountability
22 standpoint of how do you make sure -- let's say how
23 do you make sure that we aren't being -- putting up
24 such a wall to a patient being admitted to the

1 hospital, that we're actually taking it too far,
2 and patients are suffering because they're not
3 being appropriately admitted to the hospital. And
4 so this is kind of that same sort of a question,
5 and it goes back to because we've maintained that
6 primary care physician, primary relationship, just
7 like any other specialist, if that primary care
8 physician feels that we are mismanaging his
9 patients in the facility, they're going to kick us
10 out of that facility in a hurry. And at that
11 level, accountability of primary care, that still
12 guarantees that that's not going to happen.

13 If we're not keeping them happy, it is not
14 going to go well, and we are not going to be long
15 in that facility, I guarantee.

16 DR. TERRELL: Thank you.

17 DR. PATEL: Great. Thank you.

18 Thanks, Grace, for the time.

19 DR. TERRELL: Harold, have you got some
20 specific questions?

21 MR. MILLER: Yeah, I do.

22 Hi, everybody, and congratulations on your
23 work. I think what you're trying to do makes a lot
24 of sense. I think all of us who have been involved

1 in long-term care all see this problem of a cycling
2 of people back and forth from the hospital.

3 What I wanted to understand a little bit
4 better was just the scalability of this and
5 particularly this issue of can it be done by
6 smaller practices. Because as a practical matter,
7 if this only works for groups that can assemble
8 5,000 or more patients, it's going to really limit
9 the ability to spread it, which is going to, I
10 think, limit the willingness of CMS to implement it
11 and the interest of a lot of other practitioners to
12 participate in it.

13 So I was trying to understand. You used
14 in several cases the reference, the notion that you
15 thought that this could be done for 100 patients,
16 but all of your examples in staffing and everything
17 described the capacity of 5,000 or more, which is,
18 you know, quite a difference.

19 When I went through the numbers that you
20 had in your response to the first -- to our second
21 set of questions, on the very first page where you
22 talked about the number of people that would need a
23 contact, you know, new patients per month and how
24 many contacts they would need per month and how

1 much time would be involved, and I sort of just ran
2 through the calculations with those numbers. And
3 this may or may not be right, but what I came up
4 with an estimate was that for 100 residents, it
5 would really involve around four to five hours per
6 week of time, both sort of introducing the new
7 residents and assessing them as well as responding
8 to the folks who needed consults.

9 And if I'm understanding the way you have
10 it structured, you sort of assumed that in these
11 20-minute new resident reviews and the calls, that
12 essentially you were having the whole team
13 available for that and potentially participating in
14 that.

15 But collectively, the amount of time
16 given, that you were talking about the 20 minutes
17 and the average calling time, et cetera, et cetera,
18 et cetera, amounted to about -- at least what I
19 calculated was four to five hours a week, which
20 struck me as being certainly feasible to do for
21 somebody if you had a small geriatric practice and
22 you said how would you like to do this for a
23 particular nursing home or two and what's the level
24 of time commitment that would be involved. That

1 would certainly seem reasonable.

2 Now, obviously, you want to be available
3 24/7, which raises all the associated concerns
4 about that, but you have to have 24-hour staffing
5 in order to be able to do that because you're doing
6 it at a high volume, but somebody else is willing
7 to do it on call to do it less.

8 So I guess I'm just wondering, does that
9 sound right? So that's part one of the question,
10 and then part two of the question, I guess, is,
11 what really do you think you would lose by not
12 having all the other members of the
13 interdisciplinary care team?

14 I mean I -- clearly, you can see the
15 advantages of doing that, but even if you couldn't
16 get quite as much of an impact in terms of
17 hospitalizations, et cetera, if you were paying for
18 less, you know, and the fee was lower because you
19 were basically supporting a geriatrician and a
20 nurse practitioner or whatever you were supporting,
21 then you could also -- you could pay less, and you
22 wouldn't have to achieve quite as much savings.

23 So help me just think through a little bit
24 more how this would really work at the small, small

1 number of patient level.

2 DR. BASEL: Right. So let's say you go
3 back to the sample. Let's say we had three
4 geriatricians in the private group practice --

5 MR. MILLER: Uh-huh.

6 DR. BASEL: -- that wanted to do this for
7 100 beds. Now, could those geriatricians do all
8 the pharmacy components? Certainly. They have
9 geriatric pharmacy capabilities, that they could
10 provide that component.

11 Could they provide the behavioral health
12 component? Certainly, they understand geriatric,
13 depression, and dementia and behavior control and
14 all those things.

15 So could they help with the -- you know,
16 some of the things other nurses do? We've had
17 places that have started being able to put in IVs
18 and do IV antibiotic therapy because of the backup
19 that we provide. It makes them comfortable of
20 being able to dose that. Could the geriatrician
21 provide those services as well? Absolutely.

22 Now, we feel that, you know, there's
23 certainly economies of scale, everybody working to
24 the highest part of their license, that it makes a

1 lot of sense of broadening that scale, but again,
2 from an entrepreneurial standpoint, you could
3 certainly do that in a smaller one.

4 I would worry, again, back to
5 philosophically, if this was a straight fee-for-
6 service mechanism that was doing this without the
7 accountability of whether you'd get the dilution
8 and get the outcomes you wanted, but if you do it
9 as a --

10 MR. MILLER: Well, I'm assuming that the
11 accountability would be there.

12 What I'm trying to understand is, you
13 know, maybe the standard to achieve in terms of
14 reduction in hospitalizations might be a bit lower,
15 but maybe the payment might be a bit lower too. I
16 have a second part to this question when I would
17 talk about payment model.

18 So I'm not -- I'm not saying that the
19 accountability is gone. What I'm asking is, in
20 effect, do you think you could achieve most of what
21 you achieved just with some sort of geriatricians
22 doing it in a small, smaller volume of patients?
23 You know, maybe not quite what you can do at the
24 scale you're doing it, but still something that

1 would be -- have an impact.

2 DR. BASEL: Possibly. We don't know, and
3 again, it's a slippery slope a little bit where
4 you're then, all of a sudden -- in reality,
5 theoretically, this should be how primary care
6 practices work in general. You should have that
7 24/7 access, and so the closer you get back to that
8 other model, the more -- the less likely you're
9 going to be able to change the culture at the
10 nursing home, is our fear.

11 Now, are there great practices that could
12 do this on a small scale and do it well?
13 Absolutely. So if that accountability piece was
14 there, I wouldn't be against it being tried that
15 way.

16 MR. MILLER: So the second part to the
17 question, the overall question, is -- you keep
18 talking in your responses about it -- could be
19 either the performance-based payment or the shared
20 savings, and you mentioned a couple of times the
21 notion that the shared savings payment would
22 provide additional flexibility. But you never
23 explained exactly what you meant by "additional
24 flexibility" and how it would be used. Could you

1 explain that?

2 DR. BASEL: So it goes back again to that
3 tradeoff, of the accountability tradeoff.

4 So when -- if it's more of a Class 2
5 alternate payment model where it is tied somewhat
6 and there is some accountability to quality and
7 value, but not as much as if there's a level of
8 degree of accountability inherent in a shared
9 savings type of approach, then the less
10 accountability there is, the more strings you have
11 to -- but, you know, again, going back to if we're
12 doing this in pure fee-for-service, you'd have to
13 put all kinds of regulations and strings. You
14 know, the team has to consist of X, Y, and Z. You
15 have to do these things for 30 minutes every month.
16 You have to do these things for 15 minutes every
17 month and create a whole long laundry list of
18 things that somebody would have to do to make sure
19 that they're likely to get the results that you
20 want. Whereas if you go to higher accountability,
21 like a shared savings type of model, then that does
22 allow you flexibility from the standpoint of not
23 having to put so many regulations around it.
24 People can structure their care delivery model a

1 little bit differently, and CMS can be more
2 comfortable that, well, the groups have skin in the
3 game, so they're going to be with that additional
4 accountability. They don't have to put as many
5 regulations is our philosophical --

6 MR. MILLER: So, in your mind, when you
7 have the list of minimum standards that you've
8 cited in the proposal and in the responses to us,
9 you would imagine that those minimum standards
10 would be more flexible under the shared savings
11 model than not, that you would have them --

12 DR. BASEL: Absolutely.

13 MR. MILLER: Okay.

14 DR. BASEL: Absolutely.

15 MR. MILLER: And then the final question,
16 I guess -- and I'll turn it back to you, Grace --
17 is so along those lines, because the way you
18 described the model was it would be the same
19 payment essentially for the same services under
20 either the performance-based payment or shared
21 savings. And I guess I'm wondering whether -- do
22 you think it would make sense to say, "Okay. There
23 could be a smaller payment, kind of a core payment
24 that would be something that would be designed to

1 support the geriatrician nurse practitioner,"
2 because that's kind of the thing that you said
3 really has to be essentially available 24/7, and
4 then have the opportunity to say, "Well, you could
5 -- if you participated in a shared savings model,
6 then you would have the flexibility to add
7 additional members of the team to it, if you
8 thought that that was effective," because you would
9 be able to potentially generate more savings, more
10 avoided hospitalizations, with the broader-skilled
11 team. So, essentially, you kind of have two
12 different levels of payment -- or a lower level of
13 payment for the performance-based payment and then
14 the opportunity to be able to pay for more staff
15 through the shared savings model.

16 Does that make any sense to you?

17 DR. BASEL: You know, I haven't -- we
18 really haven't thought of it in that framework
19 before, and so I'd have to mull over the
20 implications of that a little bit before I'd be
21 willing to answer on that.

22 I don't know, Deanna, Josh, Mandy, do you
23 have any thoughts on that one?

24 MR. MILLER: Because the thing that is

1 sort of perplexing me is you're saying that under
2 the shared savings model, you would be getting more
3 flexibility, meaning you'd be sort of losing the
4 standards to some extent, but there's no clear
5 explanation of what you'd be doing with the extra
6 money that you would be getting under the shared
7 savings model.

8 So I guess what I'm saying is, if in fact
9 there's two different ways to approach this, one
10 would be you would have a smaller core staff of
11 geriatricians, but you'd want to have some stricter
12 accountability for them in terms of standards, and
13 then if you felt that having the broader team would
14 actually achieve better results, go ahead and try.
15 But you'd do it under the shared savings model.

16 DR. BASEL: Well, I see the point you're
17 making.

18 MR. MILLER: Yeah, okay. Well, give some
19 thought to that, but I'm just still a little
20 perplexed by you proposing two models, but it isn't
21 quite clear one of them potentially would generate
22 more money for whoever is doing this. But it
23 doesn't say where that would go other than pure
24 profit. So I'm sort of wondering whether there is

1 some way to make this maybe more affordable and
2 more accessible for smaller practices and then give
3 some greater incentive to try the different
4 approaches for the groups that are larger.

5 But, anyway, I'll stop there, Grace. I'll
6 turn it back to you.

7 DR. BASEL: As a follow-up, could we
8 commit to mulling that over --

9 MR. MILLER: Yes.

10 DR. BASEL: -- and preparing some thoughts
11 on that matter to give back to the PTAC Committee?

12 MR. MILLER: I think that would be fine if
13 that's --

14 DR. TERRELL: Get it back to the PRT.

15 DR. BASEL: Yeah.

16 DR. TERRELL: Yeah, so that we can
17 evaluate it and think about it within the context
18 of the report.

19 One of the things that's sometimes a
20 problem is if we get -- if we get things after
21 we've submitted our report, we don't have time to
22 actually make that a -- you know, something that's
23 sort of integrated into an overall something to
24 help educate the PTAC. So it would be helpful to

1 get it back to us.

2 And Sarah can work with you all on the
3 timing of that to make to such that we can be as
4 efficient as possible. We'd like to have your
5 proposal ready to go for the March meeting of the
6 PTAC, but, you know, she can help you with that.

7 DR. BASEL: Well, I think we could -- we
8 could commit to a pretty quick turnaround on
9 something like that.

10 DR. TERRELL: Okay.

11 DR. BASEL: So that shouldn't be a
12 problem.

13 MR. MILLER: Okay. Thank you.

14 DR. TERRELL: All right. A lot of my
15 questions were actually answered one way or the
16 other in the stuff that Kavita and Harold brought
17 up, but there's a couple of them that you addressed
18 in your report I just wanted to get a little more
19 clarity on.

20 One is the concept of opting out, and you
21 had made -- which is rational within the context of
22 patient choice, and you made the point in your
23 response back that in reality, that that's rarely
24 seen because patients want this service.

1 Have you had experience with people opting
2 out at all and what that actually did in terms of
3 disrupting your -- the ability of a facility to --
4 you know, to use your services, or have you not?

5 DR. BASEL: I mean, out of, what, 10,000-
6 odd patients done, I think -- Josh, correct me --
7 it's probably been single digits, the number of
8 times that we've had somebody not wish to be seen.

9 You know, I kind of liken it to, you know,
10 if a nursing home has gone the extra mile and has,
11 say, a nurse practitioner available in-house, an
12 individual resident could always decline to see
13 that nurse practitioner. But they're still going
14 to benefit by all of these performance improvements
15 and -- sort of thing that a full-time nurse
16 practitioner can accomplish in a nursing home type
17 of setting.

18 And so it's the same thing. Even if they
19 decline to see us on a day-to-day basis, we still
20 -- they are going to get the benefits from us doing
21 the training back of all of the nurses on
22 recognizing cellulitis and assisting with their
23 performance improvement efforts and yada yada yada.

24 DR. TERRELL: Okay. My next question is

1 related to -- another one related to complexity,
2 and that is in North Carolina, where I still
3 practice, there is an increasing amount of Medicare
4 Advantage that is part of the nursing home
5 population, and you had -- I think in one of your
6 responses, it talked about, you know, most nursing
7 home patients are traditional Medicare, which is
8 true, but that's changing.

9 Do you all have any experience right now
10 in facilities where there's both of those payment
11 systems in place to the extent that you're not able
12 to fully work -- work sort of at a scale level for
13 an individual facility, or is most of the patients
14 that you're taking care of just in -- do you have
15 that much, you know, background with the Medicare
16 Advantage?

17 DR. BASEL: Yeah. Our facilities are all
18 pretty much 90 percent-plus traditional Medicare at
19 this point. So, it hasn't reached a critical mass
20 where it's hampered the overall effectiveness of
21 the programs and the regions that we've gone into.

22 And we have been -- we have been in
23 contact with Medicare Advantage programs in our
24 area and Medicare replacement. One of our actual

1 primary partners has a nursing home-only Medicare
2 replacement product that they're rolling out that
3 we'd be part of, and so, you know, there's
4 certainly that interest. And our intent would be
5 that with CMS approval of this, that that would
6 naturally then open the door to Medicare Advantage
7 ideally to approve this model, too, so that you can
8 do that whole facility-level culture change and get
9 that critical mass at each facility that way,
10 because I think that would be important, because I
11 agree with you. I think Medicare Advantage numbers
12 are going to increase over the years.

13 DR. TERRELL: Okay. My next question is
14 just having massive experience in my practice life
15 with nursing homes. Both being the physician, as
16 you so eloquently talked about initially, getting
17 that call in the middle of the night, and it may be
18 one of my partner's patients, and I have no idea
19 what's going on. And, you know, the sort of pre-
20 hospitalist world was, if I said send them to the
21 hospital, I was the one that was going to have to
22 see them. And then after hospitalists were in
23 place, it sure was easy just to say send them to
24 the hospital when it was awfully difficult not to

1 just in terms of the way things flow.

2 So as that's the case, I'm thinking -- I'm
3 trying to think through in my mind what you all
4 provide as a service, and it sounds wonderful at a
5 certain level, which is I'm on call. I'm a primary
6 care physician. Either me or my partners have
7 patients who are residents of a SNF or an LTCH or
8 something like that, and I don't get a call at
9 night because they're using your services. So it
10 makes -- therefore, there can be better access for,
11 in our area of the country, people even willing to
12 see nursing home patients. I get all that.

13 The next place, though, that my head goes
14 are the medical directors of nursing homes and how
15 that interacts with what you all were doing. So my
16 personal experience is that where there's access
17 issues, they typically will hire a medical director
18 of a nursing home who will end up with a majority
19 of patients in a particular nursing home being
20 reassigned from a primary care physician to he or
21 she because that's been sort of the default in the
22 past.

23 If that's been your experience, what has
24 your actual experience been addressing your

1 interactions with medical home nursing directors --
2 excuse me -- medical directors? Because they have
3 a lot of the patients. They would have to be
4 really bought into this, and I would think that
5 that would be a pretty crucial relationship.

6 DR. BASEL: Yeah. No, I would agree with
7 that, and actually, our favorite nursing homes to
8 go into is one that has a strong, committed medical
9 director. Too often, you know, some of our nursing
10 homes, we've gone into the medical director, see
11 their responsibility to show up an hour a month to
12 the quality committee meeting --

13 DR. TERRELL: Yeah.

14 DR. BASEL: -- and that's about all they
15 do. And then in those cases, sometimes we even act
16 somewhat as the de facto medical director. You
17 know, we end up being the ones that write the
18 influenza prophylaxis when it starts going through
19 the facility and things like that.

20 But when we do have a strong medical
21 director -- and some of our locations, where it
22 even has some full day coverage of nurse
23 practitioners or something in the facility, those
24 are ones that we can really do kind of higher-order

1 levels of performance improvement by combining with
2 them, and those medical directors, by and large,
3 love to have us there.

4 I can think of maybe one facility where
5 the medical directors felt a little bit threatened
6 by us, but by and large, you know, we do a pretty
7 good job of saying, "Okay. What are your quality
8 performance things you're working on so we can
9 support there?" And we keep a little bio on each
10 one of the facilities we're in, so we can make
11 sure, okay, their medical director has got a real
12 emphasis on diabetic foot this month. Let's make
13 sure, you know, we support the nurses being able to
14 evaluate those diabetic feet in their patients and
15 stuff, and so we can really partner quite a bit
16 with a strong medical director. And it's actually
17 some of the most rewarding places we get to go into
18 when that happens.

19 DR. TERRELL: Okay. Thank you for that.

20 My next question, maybe with the HCIA
21 award, you didn't have to deal with this, but one
22 of the biggest things in my experience was the
23 level of perpetual surveys and inspections at the
24 state level, at the federal level, at the -- this

1 family is angry, and they call in social services
2 level, is extremely high at nursing homes relative
3 to other health care settings.

4 Have you got any data showing any change
5 in any of that or any interaction with the various
6 oversight bodies for the facilities that you've
7 been involved with?

8 DR. BASEL: Now, that was one of the first
9 things that we thought about with this project is
10 the impact on those inspections and stuff, and so
11 one of the first things we did of every state we go
12 into is we actually meet with the state and the
13 actual inspectors and let them know what we're
14 doing. And by and large, they get real excited
15 about that.

16 I'll give an example in the State of Iowa.
17 The inspectors there, you know, after seeing us at
18 work, they started lobbying saying, "Hey, can we
19 make this as a part of the corrective action plan
20 mandatory? We've got a site that is really
21 struggling that one of our corrective action plans
22 be thou shalt use e-long-term care to help correct
23 it," or something like that. You know, I don't --
24 I don't think that's going to fly politically, type

1 of stuff, but the inspectors have really loved our
2 presence, by and large, and we've had a good track
3 record of not getting citations because of that and
4 stuff.

5 DR. TERRELL: That's important, I would
6 think, and it leads to my final inquiry. And that
7 is in the public documents that came back, I
8 believe it was the physical therapist and/or the
9 occupational therapist who said, "We want to be
10 involved too." We asked you a question about that.
11 You answered it.

12 There's also been the theme that you could
13 -- you know, you could potentially share some of
14 your funds with a nursing home or some other --
15 some other health care provider entity that would
16 be part of the ecosystem in these facilities to
17 help with this.

18 My question for you is related to your
19 experience with that. Was that just saying this
20 could be done in our model, or have you had any
21 experience where you've had different types of
22 relationships either with physical therapists,
23 occupational therapists, the facility themselves,
24 medical directors, et cetera, where they have been

1 part of your payment process?

2 DR. BASEL: In regards to the PT/OT, I'll
3 hit that one first. You know, from my standpoint,
4 there's not necessarily an access problem. Most of
5 the places we go into have pretty darn good PT/OT.
6 That's how they make their living and stuff, and so
7 as we're reviewing unplanned admissions and stuff,
8 very rarely do we label one, "Boy, if they'd only
9 had PT/OT, they would have stayed out of the
10 hospital," type of thing.

11 DR. TERRELL: Okay.

12 DR. BASEL: And so we didn't see a problem
13 to be solved there and so just kind of continued to
14 let status quo run with PT and OT in that sort of
15 stuff. Certainly, strengthening and preventing
16 falls and stuff are all good things, but that's not
17 the primary problem that we were trying to solve
18 for.

19 In regards to more globally, we haven't
20 kind of shared-the-wealth type of thing because the
21 selling points for our program to the primary care
22 physicians is as you spoke of. You know, I'm from
23 -- from a primary care perspective position, they
24 see it as, "Boy, they are saving me from all those

1 nuisance calls in the middle of the night, all
2 those faxes over to my office that are clogging up
3 my day," and I'm having to stay till seven o'clock
4 at night to take care of all the nursing home faxes
5 and all of that type of stuff because we're helping
6 assist with that.

7 And so we kind of joke a little bit.
8 We're kind of a little bit like a crack dealer that
9 we give the primary care physicians a little taste
10 of this, and they learn to like us really quickly
11 --

12 [Laughter.]

13 DR. BASEL: -- for that reason, and so
14 there hasn't been a real need to further
15 incentivize them to utilize our services.

16 Similarly, with the nursing home, they're
17 seeing the quality improvements and starting to see
18 the increase in their quality performance, which
19 will improve their reimbursement but will reduce
20 their -- improve their star rating, make them a
21 better physician to be a partner of choice in their
22 market and those sorts of things. And so that's
23 the big motivation for them. And again, by the time
24 -- when we were coming off of HCIA, the nurses in

1 general were our bigger supporters, "Don't you dare
2 take e-long-term care away because I went from not
3 feeling like I didn't have any support overnight
4 and I didn't dare want to wake up my nursing
5 supervisor during the middle of the night, ask
6 silly questions, where if I know if I call e-long-
7 term care, it's, 'Hi. E-long-term care. How can
8 we help you?'" and they feel a lot more support.
9 And so it kind of solves itself.

10 We don't have a big enough in yet to prove
11 that it cuts down on turnover, but anecdotally, it
12 seems like it's improving staff satisfaction and
13 reducing turnover, is our contention. And so
14 that's kind of the selling point there to where we
15 don't necessarily have to provide additional
16 financial incentive over and beyond the improvement
17 of volumes and market share and value-based
18 payments --

19 DR. TERRELL: Okay.

20 DR. BASEL: -- anyway that they're
21 getting.

22 DR. TERRELL: That's useful.

23 This may not be true, but one of the
24 things that I speculated on was that one of the

1 reasons physical therapy commented publicly is
2 because they are a provider under MACRA, and
3 they're going to be subject to some of the same
4 quality performance standards, MIPS, and the
5 potential to opt out of that if there's an
6 advantaged alternative payment model for which they
7 can participate in the future.

8 And it may be that what was -- they were
9 focusing on, is the concept that they would like to
10 be part of something like this too because it has
11 other things that it would do for them. I don't
12 know that that's the case, but they are also
13 regulated by the same legislation that put PTAC in
14 place, and, you know, that may be --

15 DR. BASEL: And I've certainly heard them
16 comment on several other of your proposals as well.

17 DR. TERRELL: Yeah.

18 DR. BASEL: So, definitely, they've shown
19 that interest.

20 DR. TERRELL: So, that may be something
21 that if there was a question at the public meeting,
22 it would be useful for you to think through how
23 that may or may not.

24 I think you've answered it quite

1 effectively here, which is you didn't think that
2 there was a need for it with respect to the access
3 to services, but there may be another component to
4 it that is interesting to people, which is an
5 alternative payment model to get them out of MIPS
6 or whatever. So that's just something to think
7 about.

8 That is really all the questions, per se,
9 that I had.

10 Sarah, we've got about five minutes left
11 on this phone call. Are there logistic things that
12 you all need to do?

13 MR. MILLER: Can I -- can I ask one more
14 question, Grace?

15 DR. TERRELL: Yeah, sure.

16 MR. MILLER: If you take the different
17 sites that you have, because you have the advantage
18 to have done this now on a wide range of areas, and
19 you took -- throw out the ones where the PCP didn't
20 get along and everything, and the ones that you
21 would all say that you've been able to kind of get
22 culture change, et cetera, how much variation do
23 you still see in the rates of hospitalizations
24 amongst them? I'm assuming that you've reduced

1 them all, but do you still see a lot of variation?

2 And if you do, what do you attribute it to?

3 DR. BASEL: Probably the number one
4 variation we see is on the -- this is going to open
5 up another question, I know -- is that on the
6 acuity of patients they admit -- and so we still
7 see some variation there. So the ones that do IV
8 antibiotics are getting a little bit sicker
9 patients than the ones that do not or the ones that
10 have a dementia wing are going to have, you know,
11 naturally bigger opportunities there. The ones
12 that have more --

13 DR. TERRELL: Bariatric patients is
14 something I would see. There was a weight limit on
15 some of the nursing homes.

16 DR. BASEL: Yep. A number of SNF beds get
17 certainly that first, you know, couple of weeks,
18 that golden time where readmissions occur and
19 stuff, and so the more throughput they have, the
20 more likely they are to have readmissions and that
21 type of stuff. So those are the type of
22 characteristics that we still see.

23 And then there's a -- there is some
24 structural systematic thing. A couple of our

1 worst-performing sites initially are the ones that
2 -- the killer in my mind, one of the preventable
3 killers is the turnover. We had a couple
4 facilities in one of our communities that Josh in
5 Rapid -- was it like 11 directors of nursing and
6 administrators in that one facility that went
7 through in a single year, and how can you have any
8 continuity of a quality program and stuff with that
9 kind of administrative turnover?

10 MR. MILLER: Mm-hmm. So I just -- I mean,
11 it obviously leads to the question about the risk
12 adjustment and the payment.

13 DR. BASEL: I knew that.

14 MR. MILLER: And it sounds to me --
15 because you said there aren't any, but it seems as
16 though you would actually have some knowledge based
17 on this for at least a crude risk adjustor. You
18 know what I mean? Crude risk adjustors actually
19 work a whole lot better in many ways than
20 sophisticated risk adjustors, right? If you know
21 that there's three categories of patients, which
22 really are significantly higher risk, then simply
23 factoring that in, in some fashion, you know, would
24 really address the problem of not having who -- and

1 again, I'm particularly thinking you'd have the
2 ability at your scale to kind of average that out.
3 But when you talk about doing this in smaller
4 practices, if it turns out, right, that the nursing
5 homes that the geriatric practice picks happened to
6 have IV therapy in dementia patients and whatever,
7 you know, then they could potentially fail simply
8 because, you know, the standard that they were
9 supposed to meet was not realistic given the
10 patient population they had.

11 DR. BASEL: Yeah. And certainly, the
12 obvious choice to risk adjust is the HCC Risk
13 Adjust -- that Medicare, as you well know, go to
14 risk adjustor.

15 The problem -- it's the same thing as the
16 problem of the LACE tool being a risk
17 stratification, not a risk adjustment, but a risk
18 stratification tool, is that every patient in the
19 nursing home has a high LACE score.

20 MR. MILLER: Sure.

21 DR. BASEL: Every patient in a nursing
22 home has a high HCC score.

23 MR. MILLER: But that's what I'm saying.
24 What you just described to me was not HCC scores.

1 You described to me certain sets of patients which
2 you thought were much higher acuity and much higher
3 risk.

4 DR. BASEL: Yep.

5 MR. MILLER: And if you could identify
6 those, you would do a whole lot better than the
7 complexity of the HCC system. So, again, that
8 would be something just to think about, not
9 necessarily for us right now, but I do think -- one
10 of my concerns, I'll just say is, I think we need
11 to find a way to do this at a smaller scale, and if
12 we do it at a smaller scale, we have to find some
13 way to identify whether there are any significant
14 reasons why particular patient populations would be
15 at higher risk of admission and how to adjust for
16 that.

17 So, anyway -- but I think your knowledge
18 has been helpful.

19 DR. BASEL: I agree. Yep. That makes
20 sense.

21 MR. MILLER: Okay.

22 DR. TERRELL: Okay. So that is our hour.

23 Kavita, anything else from you since
24 Howard -- Harold -- I'm sorry. The guy in the room

1 next door is Howard. Harold had some follow-up.
2 Do you? And then, again, I was asking ASPE if
3 there's any logistics or things that they need to
4 do before we --

5 DR. PATEL: No, I'm good. Thanks, Grace.

6 DR. TERRELL: Okay.

7 MS. SELENICH: Grace, this is Sarah. The
8 only thing I wanted to remind you is that there is
9 a separate call-in line for the second portion.

10 DR. TERRELL: Right. Okay.

11 Well, thank you for your attention,
12 everybody. We look forward to continuing our work
13 with you all and look forward to meeting you in
14 person at the public meeting when that occurs,
15 hopefully, in March.

16 DR. BASEL: Excellent.

17 MR. MILLER: Thank you all.

18 DR. TERRELL: Thank you. Bye-bye.

19 [Whereupon, at 5:02 p.m., the PRT
20 conference call concluded.]

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