



Narayana S. Murali, M.D., FACP
Executive Director

Marshfield Clinic®

April 17, 2017

Physician-Focused Payment Model Technical Advisory Committee
C/o U.S. DHHS Asst. Sec. of Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, DC 20201
PTAC@hhs.gov

Letter of Support to PTAC for a Physician-Focused Payment Model (PFPM) for Hospital at Home Plus (HaH-Plus)

Dear PTAC Members:

The Marshfield Clinic Health System (MCHS) expresses its enthusiastic support for Mount Sinai's proposal for a 30-day care and payment bundle for Hospital at Home Plus (HaH-Plus).

Informed by our own efforts to operate a home hospitalization program with a comparable 30-day care and payment bundle, we at MCHS believe Mount Sinai's Hospital at Home model has the ability to improve patient experiences and clinical outcomes while reducing costs.

As we operationalize and expand our own program, we see first-hand how the lack of an effective payment mechanism for fee-for-service Medicare prevents provider networks from enrolling the volume of eligible patients required to sustain optimal cost efficiencies. PTAC's approval of Mount Sinai's proposed payment model would fill this gap and thus enable the scaling of home hospitalization programs not only at MCHS and Mount Sinai but throughout the the country as well.

MCHS serves patients across more than 50 locations in Wisconsin and I firmly believe home hospitalization programs create an opportunity to effectively deliver acute care in patients' homes and communities. Such programs can effectively deliver this acute care while protecting vulnerable populations, the elderly for example, from unintended risks associated with traditional inpatient hospitalizations such as infection.

If the PTAC were to approve the proposed PFPM for HaH-Plus, I would hope to be able to offer MCHS' own program to eligible Medicare beneficiaries across Wisconsin. I would also be eager to support creation and expansion of such home hospitalization programs wherever providers seek to leverage such programs to achieve the Triple Aim for U.S. health care: improving the patient experience of care, improving the health of populations and reducing the per capita health care spend.

Sincerely,

Narayana S. Murali, MD, FACP
Executive Director, Marshfield Clinic
President & CEO, MCHS Hosp. Inc.
Chief Clinical Strategy Officer, Marshfield Clinic Health System

I am in favor of implementation, but I find some of the assumptions around the proposal and discussion to be questionable. For all of history, many patients and their physicians (and their associated teams) have treated persons at home, even though they meet “Milliman criteria” for legitimate treatment in the hospital. I have no estimate of the frequency, and I’d guess that the rates would vary geographically (as does most everything else in Medicare). However, in the SUPPORT study in the early 1990’s, the Marshfield Clinic followed illnesses and survival for all persons living in their area. We were surprised to find that around half of the people who appeared to have multiple organ system failure did not come to the hospital at all. About half of them died – out of the hospital.

In roughly the same time frame, the geriatric clinical practice at George Washington University served the most frail and sick in Washington, DC. We found that our hospitalization rate was about one-quarter of the prevailing rate for these patients – just by providing 24/7 care at home by physicians, nurses, and others and offering this as an option for very old or very sick Medicare beneficiaries. I’d expect both that the rate of providing 24/7 care by primary care physicians has declined and that many physicians in practice still provide that level of support for their elderly and infirm patients.

What would be the impact if those who are already providing care at home for persons “eligible” for hospitalization move into this reimbursement? Rather than concerns over inadequate safety protections and low volume, the concerns might be that unexpectedly substantial numbers of physician practices start using this APM. That may be a good thing, but it is not the focus in the review.

Joanne Lynn, MD

Director | Center for Elder Care and Advanced Illness

ALTARUM | Washington, DC



May 16, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Assistant Secretary of Planning and Evaluation Office of Health
Policy
200 Independence Ave S.W.
Washington, D.C. 20201

55 West 125th Street
13th Floor
New York, NY 10027
TEL 212-201-2670
FAX 212-426-1369
capc.org

Via: PTAC@hhs.gov

RE: **Letter of Support—Hospital at Home-Plus (HaH-Plus)**

Dear Committee Members,

I am writing on behalf of the Center to Advance Palliative Care (CAPC) to express our support for the Hospital at Home Plus (HaH-Plus) advanced alternative payment model. CAPC is a national organization dedicated to ensuring that all persons with serious illness have access to quality palliative care, regardless of diagnosis, prognosis, care setting, or state of the disease.

The original Mount Sinai Hospital at Home award – supported by the Center for Medicare and Medicaid Innovation (CMMI) – has proven the feasibility, cost-effectiveness and positive outcomes of home-based acute care. Scaling this model requires an episode-based payment to ensure that such care delivery is available to all eligible Medicare beneficiaries with serious illness. The HaH-Plus proposal presents a necessary alternative for these patients, who are prone to complications and often decompensate after an acute care hospital stay.

We appreciate the HaH-Plus's patient-centered approach; the proposed payment structure and quality measures will ensure the flexibility to meet individual needs while protecting against under-treatment. We also appreciate the extension of the bundled payment to cover post-acute transitions. As noted in the proposal, patients with serious illness often require continuing care after an acute illness. The inclusion of 30 days post-discharge in the episode payment can ensure adequate resources to plan these complex transitions with the patient and family.

As the Director of CAPC, I appreciate the opportunity to comment on HaH-Plus payment model and would be willing to speak to the Committee to answer any questions.

Sincerely,

A handwritten signature in black ink that reads "Diane e. Meier". The signature is written in a cursive, slightly slanted style.

Diane E. Meier, MD
Director
Center to Advance Palliative Care
55 West 125th Street, Suite 1302
New York, NY 10027
Diane.Meier@mssm.edu
(212) 201-2675

From: Alexis Coulourides <acoulour@usc.edu>
Sent: Friday, May 19, 2017 5:17 PM
To: PTAC (OS/ASPE)
Subject: Public comment: "HaH Plus" (Hospital at Home Plus) Provider-Focused Payment Model

I am writing in strong support of this proposal. The science and work presented here is the future of health care and high quality patient care that has the potential to impact healthcare spending.

I hope you see the tremendous value in this too.

Sincerely,

Alexis Coulourides Kogan, PhD

From: Aval Green <naree27@gmail.com>
Sent: Friday, May 19, 2017 5:16 PM
To: PTAC (OS/ASPE)
Subject: Public Comment- HaH

Hospital at Home is an amazing program that should be funded and replicated across our healthcare system.

Thank you,

Sent from my iPhone

From: Janeen Marshall <janeen_marshall@me.com>
Sent: Saturday, May 20, 2017 12:42 PM
To: PTAC (OS/ASPE)
Subject: Hospital at Home proposal

This is a game changing model of care that deserves funding. It improves outcomes and costs and is the way of the future of hospitalization.

From: Juanita Smith <jlynsmith@icloud.com>
Sent: Friday, May 19, 2017 5:20 PM
To: PTAC (OS/ASPE)
Subject: Public comment-HaH Plus

Hospital at home represents a novel approach to care that reduces costs, delirium and is patient centered. As a board certified internist, Palliative Medicine Physician and current Geriatrics Fellow, I strongly urge HHS to move toward this innovative model of care for our elders. I very much support Hospital at Home.

Sincerely,

Juanita Smith, MD

From: Monica Vandivort <mrv1@deptofmed.arizona.edu>
Sent: Friday, May 19, 2017 5:50 PM
To: PTAC (OS/ASPE)
Subject: Public Comment on Hospital At Home Plus Provider Focused Payment Model

Dear Sir/Madam:

I am a practicing academic Geriatrician who does house calls in both rural and urban areas of Arizona. I completely and fully support the Hospital At Home proposal and encourage your committee to approve it.

Monica Vandivort, M.D.
Home Care Medicine Director
Assistant Professor, University of Arizona
Department of Medicine
Division of Geriatrics, General Internal Medicine, and Palliative Medicine
mrv1@deptofmed.arizona.edu

Sierra Vista Geriatrics Clinic and Housecalls
3533 Canyon de Flores, Suite C
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Phone 520-458-2000
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Tucson South Campus Clinic and Housecalls
2800 E. Ajo Way
Tucson AZ 86716
Phone 520-874-2778
Fax 520-874-3456

From: Sophia Chen <sophischen@gmail.com>
Sent: Friday, May 19, 2017 5:29 PM
To: PTAC (OS/ASPE)
Subject: HaH

This program is great! Please keep supporting and finding it!

-Sophia Chen, DO, MPH

From: Steve Samandar <family.doctor@hotmail.com>
Sent: Friday, May 19, 2017 5:28 PM
To: PTAC (OS/ASPE)
Subject: Hospital at home

My name is Steve Samandar. I am a physician that has been doing house calls for about 7-8 years. I just was at a conference and learned about the hospital at home pilot that Mount Sinai is doing. In looking back at my short career making Housecalls this sounds like an absolutely great idea. I think it will benefit patients and keep costs down and improve clinical outcomes. I absolutely endorse this program and idea. President Trump and Secretary Price, please look at this very carefully as this will help a lot of people.

Steve Samandar, MD



May 22, 2017

Physician Focused Payment Model Technical Advisory Committee
C/O U.S. DHHS Assistant Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue
Washington, DC 20201
PTAC@HHS.gov

Re: Letter of Support for the Hospital at Home Plus (HaH-Plus) Physician Focused Payment Model

Dear Committee Members:

On behalf of the American Academy of Home Care Medicine (Academy), we write to offer our enthusiastic support for the Hospital at Home Plus (HaH-Plus) physician-focused payment model proposal. The Academy is the professional association that represents physicians, nurse practitioners, physician assistants, social workers, and others working in the field of home-based medical care.

Our support for HaH-Plus aligns with the mission of the Academy to deliver on the promise of interdisciplinary, team-based, high-value health care in the home for all people in need – especially the most vulnerable. The HaH-Plus model is patient focused, interdisciplinary, home-based, and of highvalue (i.e. projected to save in costs).

Specifically, the HaH-Plus proposal:

- Provides and manages hospital-level services at home for beneficiaries with selected acute illnesses and acuity levels;
 - These services are traditionally very costly in the hospital setting;
 - Care in the hospital setting can be hazardous for vulnerable older populations;
- Pays for care in a creative method that traditional FFS Medicare does not;
- A portion of payment is performance-based, based on quality outcome goals and cost savings and
- Includes an integrated team of mobile providers.

We believe the implementation of HaH-Plus will improve patient care outcomes, enhance the experience for patients and families, and reduce total costs. These three outcomes are the focus of the Medicare Access and CHIP Reauthorization Act (MACRA), as well as core elements of the nation's Triple Aim goals.

To advance the PTAC's objectives, the Hospital at Home Plus proposal:

- Is a patient-centered approach. HaH-Plus provides essential services where patients most desire care – in their own home.
- Features an innovative DRG bundled payment approach. This will support the development of the field of home care medicine as Home-Based providers will be core part of the HaH-Plus care team.
- Provides anew professional option for physicians and members of the care team other than facility - based settings by delivering acute care to the home. This is important as it will encourage the development of the workforce needed to provide services in the community in the future.
- HaH-Plus has been shown in randomized trials to “improve patient safety, reduce mortality, enhance quality, and reduce the costs of providing acute care for medical illness”, as cited in the proposal. Estimates for potential growth include 575,000 annual Medicare FFS discharges, and 7,000 physician full-time FTEs, to save up to \$720 million for CMS and the APM entities.
- Strengthens health systems' capacity to serve their communities through a financially sustainable HaH-Plus model.
- Can build on support by Medicare to generate interest in the HaH-Plus model in the private market.

In conclusion, HaH-Plus meets a major patient care need that is currently not being met. It also pays providers for services in an innovative, yet practical manner through an outcomes-based model that satisfies the PTAC criteria.

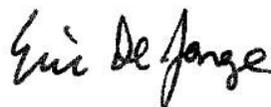
Together with other models, such as Independence at Home (IAH), which support the care of patients in the home, HaH-Plus will be part of the national transformation showing that appropriate and safe care in the home is a best practice and of high value..

The Academy strongly supports the Hospital at Home Plus proposal, and appreciates your consideration of its advancement.

Sincerely,



Mindy Fain, M.D.
President, AAHCM



K. Eric DeJonge, M.D.
President-Elect, AAHCM

From: Carmen Morano <cmorano@hunter.cuny.edu>
Sent: Tuesday, May 23, 2017 5:17 PM
To: PTAC (OS/ASPE)
Subject: Public Comment - ³HaH Plus² (Hospital at Home Plus) Provider-Focused Payment Model

The HaH Plus program has already facilitated improvement in the critical linkage between medical to community based medical and social systems of care. Sustainability of this proven model of interdisciplinary care requires access to reimbursement, especially as reimbursement at this level of care is more cost effective than current institutionally based models of service delivery. I fully endorse this PTAC proposal and associated Medicare payment reform.

Carmen Morano, Ph.D.
Professor, Silberman School of Social Work at Hunter College
2180 Third Avenue
New York, NY 10035
Phone: 212-396-7547
cmorano@hunter.cuny.edu

From: Intrator, Orna <Orna_Intrator@URMC.Rochester.edu>
Sent: Wednesday, May 24, 2017 10:17 PM
To: PTAC (OS/ASPE)
Subject: Public comment

Follow Up Flag: Follow up
Flag Status: Completed

I fully support the proposal: **“HaH Plus” (Hospital at Home Plus) Provider-Focused Payment Model** submitted by the Icahn School of Medicine at Mount Sinai-

We have studied several Hospital at Home programs in the VA and all have proven to be cost saving. In addition there was better reported satisfaction with care and fewer rehospitalizations. One paper is forthcoming:

Cai S, Laurel P, Makineni R, Marks ML, Kinosian B, Phibbs C, **Intrator O**. Evaluation of A Hospital-in-Home Program Implemented Among Veterans. To Appear American Journal of Managed Care, 2017.

Another is being prepared for review.

Orna Intrator, PhD
Professor
Department of Public Health Sciences
University of Rochester
Email: orna_intrator@urmc.rochester.edu
Phone: 585.276.6892
And
Research Health Scientist
Director, Geriatrics & Extended Care Data & Analyses Center (GEC DAC)
Canandaigua VAMC
Email: orna.intrator@va.gov
Phone: 585.393.7164



From: Scott Vasey <Scott.Vasey@vnsny.org>
Sent: Thursday, May 25, 2017 8:27 AM
To: PTAC (OS/ASPE)
Subject: Public Comment - "HaH Plus" (Hospital at Home Plus) Provider-Focused Payment Model

Dear PTAC Committee Members,

On behalf of Visiting Nurse Service of New York, we would like to offer our support for the review and consideration of the Mount Sinai "HaH-Plus" (Hospital at Home-Plus) Provider-Focused Payment Model. As the oldest and largest non-profit homecare agency in the U.S., we welcome the chance to collaborate with hospitals on payment innovation.

Homecare is under substantial pressure from payment reductions, increased operating expenses, changes to conditions of participation, pre-claim review, and service models provided by unlicensed entities, paraprofessionals, as well as replacement technologies. However, when hospitals partner with homecare agencies under alternative payment models to address avoidable admissions, reduce total cost of care, and improve the quality of care and patient experience, we can then recognize a community of caring rather than siloed institutions of illness.

Mount Sinai has long been a leader in innovation and community partnerships to advance and promote the health of New Yorkers and patients around the world. We fully expect that, with the approval of PTAC, the HaH-Plus model and its associated alternative payment vehicle will drive how we, as a health care community, treat at-risk patients who do not require an inpatient level of care.

Sincerely,

Christopher T. Olivia, MD
President and Chief Executive Officer
Visiting Nurse Service of New York

Scott A. Vasey
Senior Vice President, Strategy
Visiting Nurse Service of New York
1250 Broadway
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From: Rocco, Thomas (Canandaigua) <Thomas.Rocco2@va.gov>
Sent: Thursday, May 25, 2017 1:19 PM
To: PTAC (OS/ASPE)
Subject: Public Comment on "HaH Plus" (Hospital at Home Plus)

Follow Up Flag: Follow up
Flag Status: Completed

I support the proposal: **“HaH Plus” (Hospital at Home Plus) Provider-Focused Payment Model** submitted by the Icahn School of Medicine at Mount Sinai-

We have reviewed several programs in Europe and the US; and studied several Hospital at Home programs in the VA. All have proven to be cost saving. In addition, there was better reported satisfaction with care and fewer re-hospitalizations.

Thomas A. Rocco, Jr., MD, FACP, FACC
Clinical Associate Professor of Medicine
URMC/University of Rochester School of Medicine & Dentistry
Research Program Coordinator and Research Integrity Officer
Canandaigua VA Medical Center/ROPC
Rochester, NY, USA

From: Xu, Huiwen <Huiwen_Xu@URMC.Rochester.edu>
Sent: Thursday, May 25, 2017 9:47 PM
To: PTAC (OS/ASPE)
Subject: Public comment

I fully support the proposal: **“HaH Plus” (Hospital at Home Plus) Provider-Focused Payment Model** submitted by the Icahn School of Medicine at Mount Sinai.

I have completed a literature review about Hospital at Home program and find that the major challenge faced by HAH is the lack of payment method. Therefore, adding HAH into the Medicare or Medicaid will be extremely helpful for expanding this services to providers and patients.

Xu H, Intrator O, Cai S et al.: Hospital At Home: Information on Indirect and Implementation Costs is Needed to Design Payment Methods. **Academy Health 2017 Annual Research Meeting**, June 2017, New Orland, LA.

Thanks for considering.

Huiwen

Huiwen Xu, MHA

PhD Candidate in Health Services Research and Policy

Data Analyst at Wilmot Cancer Center

Co-Founder, Rochester Data Science Society

University of Rochester Medical Center

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Rochester, NY 14642

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Linkedin: <https://www.linkedin.com/in/huiwenxu>

From: Edes, Thomas <thomas.edes@va.gov>
Sent: Thursday, May 25, 2017 11:41 PM
To: PTAC (OS/ASPE)
Subject: Public Comment - HaH Plus" (Hospital at Home Plus) Provider-Focused Payment Model

Public Comment – [HaH Plus" \(Hospital at Home Plus\) Provider-Focused Payment Model](#)

I am writing to express my enthusiastic support of the proposal for Hospital at Home Plus. I am a geriatrician and the Executive Director of Geriatrics & Extended Care Clinical Operations for the US Department of Veterans Affairs (VA), and while I am not representing VA nor conveying an official position of VA, I am expressing my personal opinions based on considerable experience of Hospital at Home in VA and in other health systems. VA continues to have strong and successful Hospital at Home programs, currently at 8 locations in 7 states, with interest in expanding to another 5 states. VA based its programs on the model developed by Bruce Leff, and mutual learning and advances continue to occur through the expansion in multiple health care systems. I have also personally visited the Hospital at Home program based out of the national health system at Sydney, Australia. The very strong program at Sydney impressed me for its combined clinical and economic outcomes and added to my confidence that this alternative to hospitalization is scalable and successful in a variety of healthcare systems and geographic settings. The VA experience has been highly favorable to Veterans and their families, with outcomes similar to those reported in other systems – very high satisfaction, lower cost, and most importantly a reduced incidence of significant adverse consequences in the older population, particularly delirium, deconditioning, and serious infections. Hospital at Home is a very important component of an effective strategy for meeting the healthcare needs of the growing population of older Americans through options that are safer, preferable to patients and lower cost. This proposal will also make a valuable contribution in addressing palliative care needs earlier and increasing access to palliative care. Our nation needs alternative models of care and payment to meet the challenges of rising health care needs and health care costs – this proposal addresses both the innovative care model and payment system. We need to evaluate the success of Hospital at Home in emerging payment models, and I strongly urge PTAC and HHS to support this proposal. Thomas Edes, MD, MS

From: Jesus R. Ortiz <Jesus.Ortiz@valleybaptist.net>
Sent: Friday, May 26, 2017 12:23 PM
To: PTAC (OS/ASPE)
Subject: Hospital at home

Hi I am a physician working in Rio Grande Valley. I went to AGS conferences and here about this proposal. (hospital at home) I am a Geriatric and Palliative care Physician working in the hospital and doing house calls and I am very excited to here that this can be a reality in the near future I strongly feel and think that we need it to do it. Thanks

J. Roberto Ortiz MD

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May 31, 2017

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
c/o U.S. Department of Health and Human Services Asst. Secretary for Planning and Evaluation
Office of Health Policy
200 Independence Avenue, SW
Washington, DC 20201

RE: “HaH-Plus” (Hospital at Home Plus) Provider-Focused Payment Model

Dear Committee Members:

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 191,500 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. ASHA has carefully reviewed the Icahn School of Medicine at Mount Sinai’s (Mount Sinai) proposal titled “HaH-Plus” (Hospital at Home Plus) Provider Focused Payment Model (PFPM) and would like to offer comments related to the following.

- Type of Physicians or Other Eligible Professionals’ Practices Targeted
- Appendix B: Proposed Metrics to Assess Model Performance

Type of Physicians or Other Eligible Professionals’ Practices Targeted

Mount Sinai is proposing that the HaH-Plus bundle (acute episode and 30 days of transition services at home) be considered an Advanced Alternative Payment Model (APM) under the Quality Payment Program (QPP) and would be targeted towards physicians and nurse practitioners who deliver, manage, and coordinate hospital, transition, and home care services. According to the proposal, it appears that only physicians and nurse practitioners would be recognized as eligible professionals participating in the advanced APM HaH-Plus bundle. However, under the QPP, speech-language pathologists are also eligible professionals who can participate in advanced APMs. In addition, ASHA noticed that the proposal specifically mentions that the core HaH-Plus services will consist of physical, occupational, and speech therapy, as needed, to preserve functional status related to illnesses including pneumonia, respiratory infections, chronic obstructive pulmonary disease and major gastrointestinal (GI) disorders.

For the aforementioned reasons, it is unclear why the proposal does not consider speech-language pathologists as eligible professionals given that: 1) the Centers for Medicare & Medicaid Services (CMS) recognizes speech-language pathologists as those who are eligible to participate in advanced APMs, and 2) speech-language pathologists could be directly involved in treating patients who have been assigned DRGs related to the conditions outlined in the proposal. **If the PTAC approves the HaH-Plus bundle as an advanced APM, ASHA respectfully requests that the bundle not be restricted to only physicians and nurse practitioners, but**

also be inclusive of other eligible professionals whose services are deemed integral to the bundle.

Appendix B: Proposed Metrics to Assess Model Performance

Mount Sinai proposes that functional outcomes will be measured using the AM-PAC Inpatient Basic Mobility Short Form and Inpatient Daily Activity Short Form. However, these assessments do not adequately evaluate services related to cognition that are provided by speech-language pathologists. At a minimum, a cognition assessment should include problem-solving, memory, and attention. The Care-C Tool includes these items. We have provided the specific items in Appendix A for PTAC's reference. To ensure items associated with cognitive function are only completed when necessary based on patient presentation, Mount Sinai should consider using a screening tool, such as the Montreal Cognitive Assessment (MoCA) or a similar screening tool, to determine the need for these services. If the results of the screening tool indicate that the patient needs cognitive treatment, then the suggested items from the CARE-C would be completed. The CARE-C elements are appropriate outcome measures that meet the purpose of the IMPACT Act; they would provide an indication of treatment outcomes, which screeners or intake items do not.

Furthermore, we recognize that it is critically important to capture information on patients with swallowing and altered diet needs, and items from the CARE-C can prove useful information as a basis for capturing swallow information. An assessment should describe: 1) the patient's usual ability with swallowing regular food (solids and liquids swallowed safely without supervision and without modified food or liquid consistency); 2) modified food consistency/supervision (patient requires modified food or liquid consistency and/or needs supervision during eating for safety); and 3) tube/parental feeding.

Thank you for your consideration of ASHA's comments on the HaH-Plus PFPM. If you require further information or clarification, please contact Daneen Grooms, MHSA, ASHA's director of health reform analysis and advocacy, at 301-296-5651 or dgrooms@asha.org.

Sincerely,



Gail J. Richard, PhD, CCC-SLP
2017 ASHA President

Appendix Attached

Appendix A

ADMISSION – CARE C – SECTION III: Provider Information

III. Provider Information (cont.)					
H.5a Cognitive Status Answer only if you answered "Yes" to H.5 "Does the patient have any problems with memory, attention, problem solving, planning, organizing or judgment?" and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.					
H.5b Please describe the patient's problems with: <ul style="list-style-type: none"> • Memory • Attention • Problem Solving • Planning • Organizing • Judgment 	<input type="checkbox"/> Mildly impaired: Demonstrates some difficulty with one or more of these cognitive abilities. <input type="checkbox"/> Moderately impaired: Demonstrates marked difficulty with one or more of these cognitive abilities. <input type="checkbox"/> Severely impaired: Demonstrates extreme difficulty with one or more of these cognitive abilities.				
H.6a Problem Solving Answer only if you answered "Yes" to H.6 "Does the patient have any problems with memory, attention, problem solving, planning, organizing or judgment?" and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.					
The patient solves: Simple Problems: Following basic schedules; requesting assistance; using a call bell; identifying basic wants/needs; preparing a simple cold meal Complex problems: Working on a computer; managing personal, medical, and financial affairs; preparing a complex hot meal; grocery shopping; route finding and map reading		Simple Problems		Complex Problems	
		H.6b Without Assistance	H.6c With Assistance	H.6d Without Assistance	H.6e With Assistance
Never or Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Usually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Always	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Level of Assistance:</u> Without Assistance: Patient performance without cueing, assistive device, or other compensatory augmentative intervention With Assistance: Patient performance with cueing, assistive device, or other compensatory augmentative intervention					
<u>Frequency of problem solving:</u> Never or Rarely: Less than 20% of the time Sometimes: Between 20% and 49% of the time Usually: Between 50% and 79% of the time Always: At least 80% of the time					

ADMISSION – CARE C – SECTION III: Provider Information

III. Provider Information (cont.)

H.7a Memory

Answer only if you answered "Yes" to H.7 "Does the patient have any problems with memory, attention, problem solving, planning, organizing or judgment?" and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.

The patient recalls:	Basic Information		Complex Information	
	H.7b Without Assistance	H.7c With Assistance	H.7d Without Assistance	H.7e With Assistance
Basic Information: Personal information (e.g., family members, biographical information, physical location); basic schedules; names of familiar staff; location of therapy area	Never or Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Complex Information: Complex and novel information (e.g., carry out multiple-step activities, follow a plan); anticipate future events (e.g., keeping appointments)	Usually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Always	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Level of Assistance:

Without Assistance: Patient performance **without** cueing, assistive device, or other compensatory augmentative intervention

With Assistance: Patient performance **with** cueing, assistive device, or other compensatory augmentative intervention

Frequency of memory:

Never or Rarely: Less than 20% of the time

Sometimes: Between 20% and 49% of the time

Usually: Between 50% and 79% of the time

Always: At least 80% of the time

H.8a Attention

Answer only if you answered "Yes" to H.8 "Does the patient have any problems with memory, attention, problem solving, planning, organizing or judgment?" and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.

The patient maintains attention for:	Simple Activities		Complex Activities	
	H.8b Without Assistance	H.8c With Assistance	H.8d Without Assistance	H.8e With Assistance
Simple Activities: Following simple directions; reading environmental signs or short newspaper/magazine/ book passage; eating a meal; completing personal hygiene; dressing	Never or Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Complex Activities: Watching a news program; reading a book; planning and preparing a meal; managing one's own medical, financial, and personal affairs	Usually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Always	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Level of Assistance:

Without Assistance: Patient performance **without** cueing, assistive device, or other compensatory augmentative intervention

With Assistance: Patient performance **with** cueing, assistive device, or other compensatory augmentative intervention

Frequency of maintaining attention:

Never or Rarely: Less than 20% of the time

Sometimes: Between 20% and 49% of the time

Usually: Between 50% and 79% of the time

Always: At least 80% of the time

May 25, 2017

PTAC
c/o Angela Tejada
ASPE
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Bailet:

Visiting Nurse Association Health Group (VNAHG) appreciates the opportunity to submit a letter of support for the Ichan School of Medicine and Mount Sinai proposal “HaH Plus” (*Hospital at Home Plus Provider-Focused Payment Model*).

VNA Health Group is New Jersey’s largest not-for-profit visiting nurse association and visiting physician service that helps individuals and families achieve their best level of health and well-being by providing home health, hospice, palliative, and community-based care and operating private-pay personal care services. Our unique services and programs rely heavily on the Medicare free-for services (FFS) benefit to be able to provide care for our patients and their families. VNA Health Group also provides primary care services through three Federally Qualified Health Centers throughout Monmouth County, New Jersey.

The Hospital at Home Plus supports the engagement of physicians and other professionals in ordering and management hospital-level services at home for Medicare beneficiaries with acute illnesses that would otherwise cause hospitalization. As a leading home care provider and a participant of the Comprehensive Primary Care Plus (CPC+) model through our Visiting Physician Services home-based primary care model, VNAHG strongly supports this unique program to help transform the U.S. healthcare delivery by allowing providers to deliver hospital-level services that are currently out of the scope of the Medicare program.

By providing acute medical services for the serious and chronically ill high-cost patients in the home, you are allowing for patient-centered care and family collaboration which increases quality of life and decreases cost spending. The Hospital at Home Plus proposal aligns with the mission and value of home-based services and allows the aging population to receive care in their homes while increasing value and decreasing costs to the healthcare system.

Sincerely,





ST PETER'S HEALTH
PARTNERS

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Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue
Washington D.C. 20201

Re: "HaH-Plus (Hospital at Home Plus)
Provider-Focused Payment Model

Dear Committee Members:

I am VP Legal Services for St. Peter's Health Partners, a not for profit health care system in New York's Capitol Region, with 5 hospitals, 7 nursing homes, 2 home care agencies, hospice, PACE, a large physician practice, and other health care facilities and services. I am writing in support of the proposal. "HaH-Plus (Hospital at Home Plus) Provider-Focused Payment Model.

Like other health care systems, we are trying to identify innovative approaches to improve the delivery of health care, i.e., to reduce inpatient readmissions, improve patient satisfaction, control costs, and integrate inpatient and outpatient services. HaH-Plus draws upon the most promising population health concepts and describes a promising model to further those objectives,

The proposal is quite well-thought out:

- It recognizes that care at home both meets patient preferences and reduces the expense and risks of inpatient care;
- It further recognizes that hospital level care at home is needed in select cases to avoid re-hospitalization
- It crafts a reimbursement approach that appears both cost-effective from a payer perspective and financially feasible from a provider perspective.
- It gives appropriate priority to the critical issues of patient safety, reduced mortality and quality.

The is a highly promising model. Approval by the Committee will enable health care systems such as St. Peter's Health Partners to see how this model works in practice, and quite possibly seek to emulate it.

Yours truly,

Robert N. Swidler

May 30, 2017

Physician-Focused Payment Model Technical Advisory Committee
DHHS Planning and Evaluation Office of Health Policy
200 Independence Avenue SW
Washington, DC 20201
Via e-mail PTAC@hhs.gov

Re: Comment in support Hospital at Home Plus (HaH-Plus) proposal

Dear PTAC Members:

It is with enthusiasm that the National Patient Advocate Foundation (NPAF) submits this comment letter supporting Mount Sinai's proposal for a 30-day care and payment bundle for Hospital at Home Plus (HaH-Plus).

Patients and families require reliable and affordable access to high quality therapies and supportive health care services throughout the care continuum in the settings that they feel are best for them. Importantly, the HaH-Plus model is particularly person-centered and family-focused because it facilitates honoring the preferences of patients who choose to remain at home while also helping reduce caregiver burden. Moreover, the model's inclusion of specific patient reported outcomes pertaining to communication and function reinforces the importance of involving patients and their caregivers as partners in health care transformation, giving them the power to measure the performance of the system and its services across a range of domains that matter to them.

We are also pleased that this model would disproportionately assist low income and other underserved populations, also noting plans to pilot a Children's HaH for vulnerable pediatric patients enrolled in Medicaid. The enhanced care coordination and integration of palliative care services that would be delivered through this model is highly likely to improve patient and family experiences and outcomes while lowering costs. For these reasons, NPAF offers its strong support for this proposal without reservation.

Respectfully submitted,



Rebecca A. Kirch

Executive Vice President, Healthcare Quality and Value

From: Alanna Goldstein <agoldstein@americangeriatrics.org>
Sent: Wednesday, May 31, 2017 2:46 PM
To: PTAC (OS/ASPE)
Subject: Public Comment - "HaH Plus" (Hospital at Home Plus) Provider-Focused Payment Model

On behalf of the American Geriatrics Society (AGS), thank you for the opportunity to comment on the *Hospital at Home Plus Provider-Focused Payment Model* submitted by the Icahn School of Medicine at Mount Sinai.

The American Geriatrics Society (AGS) strongly supports this proposal and would be happy to provide additional information requested by the committee or CMS.

Alanna Goldstein
Director, Public Affairs & Advocacy
The American Geriatrics Society
212-308-1414
agoldstein@americangeriatrics.org
www.americangeriatrics.org

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May 31, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Assistant Secretary of Planning and Evaluation
Office of Health Policy
200 Independence Ave S.W. Washington, D.C. 20201
Via: PTAC@hhs.gov

RE: **Letter of Support—Hospital at Home-Plus (HaH-Plus)**

Dear Committee Members,

The National Coalition for Hospice and Palliative Care (Coalition) appreciates the opportunity to submit a letter of support for the Hospital at Home Plus (HaH-Plus) advanced alternative payment model. The Coalition recommends the Physician Focused Payment Model Technical Advisory Committee approve this model that allows carefully selected Medicare beneficiaries to remain in their homes and receive acute hospital-level care and 30 days of transition services.

The Coalition is composed of the leading national hospice and palliative care organizations dedicated to advancing care of patients, families and caregivers living with serious illness, as well as those facing the end of life. The organizations that form the Coalition represent more than 5,000 physicians, 11,000 nurses, 5,000 professional chaplains, more than 5,000 social workers, researchers, 1,600 palliative care programs, and over 5,300 hospice programs and related personnel, caring for millions of patients and families. Our combined membership represents the interdisciplinary hospice and palliative care team which is person and caregiver centered.

A previous version of this model (HaH), supported by the Center for Medicare and Medicaid Innovation (CMMI), has proven the feasibility, cost-effectiveness and positive outcomes of home-based acute care. HaH-Plus is a physician-focused payment model designed to engage physicians and other interdisciplinary professionals in ordering, providing and managing hospital-level services at home for beneficiaries with select acute illnesses who would otherwise be hospitalized. Traditional fee-for-service Medicare does not currently provide adequate payment for this transitional care beyond the current scope and intensity of Medicare skilled home health care services and physician home visits.

Approving this model will ensure that such care delivery is available to all eligible Medicare beneficiaries with serious illness. The HaH-Plus proposal presents a necessary alternative for patients with serious illness who are prone to complications and often decompensate after an acute care hospital stay. Providing acute hospital level care in a patient's home for carefully selected patients is patient centered and, as the proposal submitted has documented, has demonstrated in multiple randomized trials to improve patient safety, reduce mortality, enhance quality, and reduce the costs of providing acute care for serious illness.

The Coalition supports the HaH-Plus's patient-centered approach, proposed payment structure and quality measures that will ensure the flexibility to meet individual needs while protecting against under-treatment. We also support the extension of the bundled payment to cover post-acute transitions. As noted in the proposal, patients with serious illness often require continuing care after an acute illness. The inclusion of services for up to 30 days post-discharge in the episode payment can ensure adequate resources to plan these complex transitions with the patient and family.

On behalf of our Coalition, I appreciate the opportunity to submit this letter of support for the HaH-Plus payment model and would be happy to arrange a conference call of experts from our Coalition with PTAC's staff if you would like to discuss this in more detail.

Sincerely,



Amy Melnick, MPA
Executive Director
National Coalition for Hospice and Palliative Care
202.406.3590
amym@nationalcoalitionhpc.org

Current National Coalition for Hospice and Palliative Care member organizations are:

- [American Academy of Hospice and Palliative Medicine](#) (AAHPM)
- [Association for Professional Chaplains](#) (APC)
- [Center to Advance Palliative Care](#) (CAPC)
- [Health Care Chaplaincy Network](#) (HCCN)
- [Hospice and Palliative Nurses Association](#) (HPNA)
- [National Hospice and Palliative Care Organization](#) (NHPCO)
- [National Palliative Care Research Center](#) (NPCRC)
- [Physicians Assistants in Hospice and Palliative Medicine](#) (PAHPM)
- [Social Work Hospice and Palliative Care Network](#) (SWHPN)

From: bklynboy60@comcast.net [mailto:bklynboy60@comcast.net]
Sent: Friday, June 02, 2017 11:03 AM
To: PTAC (OS/ASPE)
Cc: Goldstein, Alanna
Subject: Fwd: AGS Request for Feedback on APMs - due to PTAC May 30th

Hello:

I am a member of the American Geriatric Society's Quality and Performance Measurement Committee. I would like to submit my comments on the Hospital at Home proposal from Mount Sinai School of Medicine. Apparently my comments arrived too late at the AGS desk to submit with the rest of the committee's comments, so our administrator, Ms. Alanna Goldstein, suggested that I email you directly and submit my comments as an individual.

My comments are below, in two formats: 1) within the body of the email; 2) as a Word document attachment. Please use whichever form is easier for you.

Please contact me to confirm that you have received my comments and they will be considered.

Thank you

Lloyd Roberts MD
425-301-7218 (cell)
bklynboy60@comcast.net
(hospitalist for Everett Clinic in Everett, Washington)

To: "Alanna Goldstein" <agoldstein@americangeriatrics.org>

Sent: Wednesday, May 31, 2017 1:58:19 AM

Subject: Re: AGS Request for Feedback on APMs - due to PTAC May 30th

Hi Alanna

As promised, attached are my (1-day tardy) comments (they are in body below and I am also sending them as a Word document; use whichever is easier for you). Thanks for being patient and I hope PTAC will accept these:

What about liability issue? If patient is sufficiently ill to warrant inpatient hospitalization but chooses to do HaH, if there is bad outcome b/c there is not frequent nurse supervision (as there is in hospital), who is responsible? Should the care providers be concerned about legal ramifications? E.g. Being sued?

As a corollary, are the quality standards for a patient being treated at home for say, cellulitis, any different than for that same caliber of patient being treated in the hospital?

I don't think the proposal does a good job explaining how the HaH patient would access ancillary services that are quite easy to obtain in the hospital, e.g. Labs, radiology. Would these individuals go to the patient's house? Lab maybe, but I don't see an imaging group bringing a CT scanner to a patient's home.

As the proposal mentions, b/c the HaH model requires extensive care management and coordination or resources, this model seems to have the best fit in a large group or academic practice. I would have reservations about its ability to succeed in a small medical practice. However, I would surmise that small rural practices, b/c of the relative scarcity of hospitals, de facto would function as a HaH model.

The HaH appears to be a wonderful teaching tool on several levels with several different disciplines: medical students, residents, geriatric fellows; nursing students and residents; social work students and interns.

The HaH appears to require intensive support at home. In short, if a patient would qualify for inpatient admission and chooses to be treated at home, s/he would need 24/7 caregivers at least for that initial period when they were most ill. In addition, they may require specialized DME such as a multi-positional hospital bed, such as for the diagnosis of acute congestive heart failure. These resources would have to be moved in and out of patients' homes on an almost daily basis, depending on the patient load and acuity on a given day. Given the required manpower and DME, I wonder if Mount Sinai's HaH usage projections are a bit over-reaching.

In summary, while I think the HaH is a laudable idea, the Mount Sinai description of their HaH-Plus program sounds like a home health agency program with slightly more acutely ill clients. Would like to see more of a description how it provides a model of care similar to an acutely care hospital.

Regards,

Lloyd Roberts