

# Replies to Questions on Hospital at Home Plus PFPM Proposal

Thank you for the comprehensive review of the HaH-Plus payment model proposal. We include below the original questions along with our responses.

## Criterion 1. Scope of Proposed PFPM

**The proposal aims to broaden or expand CMS' APM portfolio by either: (1) addressing an issue in payment policy in a new way, or (2) including APM entities whose opportunities to participate in APMs have been limited.**

- The proposal states that the principal focus of HaH-Plus will be to provide treatment in the home for patients who would otherwise require hospital admission, but it also states that HaH-Plus will include Observation at Home and Palliative Care at Home programs.
  - Do you see these three programs as essential components of one single PFPM or as standalone options for participating APM Entities? If they are standalone options, would an APM Entity be able to implement the Observation or Palliative Care components without the Hospital at Home component?

*Reply: The regular hospital at home program could be operated as a standalone program. We do not expect that observation at home and palliative care at home would be standalone programs except under exceptional conditions. For example, an oncology focused practice might be able to do a standalone palliative care at home program. The three programs are not essential components of one single PFPM. Rather, they are options to be considered for implementation.*
  - To what extent is the goal of the additional components to provide a sufficient volume of patients vs. to provide more seamless care options for patients?

*Reply: The combination of components are intended to provide seamless care options for patients rather than to provide sufficient program volume.*
  - How many patients in your existing programs are in each of these three components?

*Reply: In our existing program, the vast majority of patients are in regular hospital at home. Only 15.9 and 6.7%, respectively, are in observation at home and palliative care at home.*
- Please describe in more detail the role of hospitals in the program and in the APM Entity. In Section 6.2, the proposal indicates that the program is designed to be used whether or not the APM Entity operates a hospital, but Section 2.4 suggests that the hospital would retain the majority of the savings under the program.

*Reply: In the proposed PFPM, hospitals have a key role that will necessarily vary depending upon the structure of physician hospital relationships in the given community. At a minimum, the APM entity must have an agreement with one or more hospitals that addresses physician credentialing, access to the emergency department for possible enrollment of patients, plans for handling escalations of hospital care, and DSH and GME payments when applicable. Depending on the structure of the physician hospital relationship, such an agreement may include payments between the parties. The PRT is correct in noting an error in section 2.4. In our edits to meet the page limit requirements, we erroneously indicated that the hospital would retain the majority of savings on the program. The savings*

would actually go to the APM entity which may have agreements with the hospital for a distribution of payments, if any. The financial considerations for hospitals will depend on the circumstances. Hospitals operating at or near capacity could benefit financially from not admitting many of the patients served by hospital at home. In most cases, the Medicare margins for the involved DRGs are fairly small, at best. By reducing overcrowding, hospital at home could improve patient flow and operations in a hospital.

- Please provide more detailed information on the calculations for the number of episodes estimated nationally if all payers participated.
  - Please provide sensitivity analyses to show how variation in patient acceptance could impact these estimates.

*Reply: Our proposal provided two estimates of the number of episodes. First, we used the 2010 National Hospital Discharge Survey which reported 35,079,000 all payer discharges (13,591,000 for patients 65 and over) with ALOS 4.8 for a total of 168,379,200 days. In Victoria, Australia where robust hospital at home programs exist, an estimated 2.3% of admissions or 5% of inpatient days are thought to be averted by hospital at home; we do not know the patient acceptance rate in these estimates. 5% of the hospital days (assuming 4.8 days/discharge) leads to the estimate of 1,753,950 discharges provided in the proposal. If we assume that 3% of hospital days are averted instead, this would lead to an alternative estimate of 1,052,370 discharges. If we instead assumed that 2.3% of discharges were averted, the estimate would be 806,817.*

*For the second estimate, we used a different approach and started with the diagnoses and DRGs. From HCUP data, we estimated the annual volume of discharges in the 18 diagnoses and 50 DRGs that are common candidates for HaH-Plus (7,538,938). We excluded patients under the age of 18, patients with a LOS of five days or more, stays involving ICU days, and discharges with admission sources that would have been excluded (e.g., admissions from nursing homes). We then applied exclusions based on likely medical appropriateness based on our physicians' estimates of the percentage of clinically appropriate patients by each DRG. Of the remaining 1,736,163 discharges, the estimated number of cases would be 1.5M, 1.2M, or 0.9M cases, assuming either 90%, 70%, or 50% patient acceptance respectively.*

- Does the overall estimate depend on how many episodes are in Hospital at Home, Palliative Care, and Observation variants? What are the estimated number of episodes for each of these variants?

*Reply: These estimates are for regular hospital at home alone and do not include the two variants. As noted earlier, the variants are not included for volume, and we do not have sufficient experience with the two variants to yield reliable estimates.*

- Please provide more information on the types of physicians and staff that would be required to implement HaH-Plus:
  - The proposal indicates that the services required for HaH-Plus would likely be beyond the scope of solo practices. What is the smallest number of physicians,

nurse practitioners, and other clinicians that could form an APM Entity and successfully implement the HaH-Plus program under the proposed payment model? What relationship would these providers need to have with a hospital to implement the model?

*Reply: Although we would not bar physicians in solo practice from this PFPM, we do not believe they are the primary target for this PFPM due to the staffing and operational complexities of the model. We estimate that the smallest number of staff that could form an APM entity would include one physician FTE, one nurse practitioner FTE, two full-time registered nurses (plus per diem nursing), one part-time social worker, other rehabilitation services available on a per diem basis, and 1.5 FTE of an administrative assistant/coordinator/practice manager. Coverage for these individuals would also need to be available after hours, weekends, and for vacations, in addition to the FTE estimates. The relationship these providers would need to have with a hospital is addressed in a previous section.*

- Would the specialty training for physicians/clinicians need to differ in order to include the Palliative Care at Home component?

*Reply: The staff currently involved in delivering palliative care at home in our program have not received formal specialty training in palliative care. Some the staff have had exposure to palliative care as part of their training. Such experience is a minimum qualification for palliative care at home. Access to specialty consultation in palliative medicine would be useful. Online training in palliative care, in particular goals of care discussions, would be desirable such as those available through the Center to Advance Palliative Care.*

- In your proposal, you indicated that you used hospitalist workload statistics to estimate the number of physicians that would be required to serve eligible patients. Please provide the complete details on how you made this calculation. Since there would be significant travel time involved for home visits that are not needed for patients in the hospital, wouldn't hospitalist workload statistics underestimate the amount of time that a physician would need to spend with each patient and thereby underestimate both the number of physicians needed to care for a given number of HaH-Plus patients and the physician cost per patient?

*Reply: By basing our estimates of physician involvement in part on hospitalist workload statistics, the estimates are conservative estimates of the number of physicians involved. A lower workload as the PRT has suggested would increase the number of physicians potentially involved. The PRT is correct in noting that this would also lead to a higher cost per patient. However, we did not base our cost estimates provided in the appendix using hospitalist workload. The cost estimates are based on our actual physician workload. The PRT is correct in pointing out this disconnect.*

*In our experience, workload estimates are likely to evolve over time as programs refine the role of the physicians. The physician role in the program can be compartmentalized into four components that can be combined in various ways: initial assessment for medical appropriateness and initial workup and orders to be done on relatively short notice often in the emergency department; follow-up*

*home visits that are often scheduled in advance and occur over the course of the workday; availability for short consultations and conversations with patients over the course of the day; and after hour coverage on evenings and weekends. These four components can be divided in different combinations between individual physicians. Workload estimates depend in part on how these various roles are combined and divided among individuals and on the use of technology.*

- The proposal states that “many physicians would have this activity as only part of their professional effort.” What other activities do you expect the attending HaH-Plus physicians to be engaged in? Would community-based primary care specialty practices be able to serve as attending physicians in HaH-Plus in addition to caring for ambulatory care patients? Is there a minimum proportion of a physician’s time/effort that would need to be dedicated to HaH-Plus services? What types of physicians are participating in your existing program?

*Reply: How these four activities are combined will also affect what other activities an attending engaged in this program only part-time can also engage in for professional effort. The physician engaged in initial assessments on short notice would need to be engaged in other activities that would make the attending available on short notice. This could include a traditional hospitalist role, or attending in urgent or emergency care. A physician whose primary role was doing scheduled follow-up home visits could also be engaged in other primary care or office or other office-based activities during the rest of the day. The minimum proportion of a physician's time and effort that would need to be dedicated would vary depending upon the combination of those roles, but we believe that at least a 25% effort should be devoted to this activity either year round or in blocks of time. Our current program involves physicians with primary training in either internal medicine, family medicine, and geriatric medicine. Some, but not all, have started the program with established competencies in home-based medical care.*

- Would all of the non-physician personnel described in Appendix C need to be employed by the APM Entity? Would it be better if they were employed?

*Reply: We do not believe that all of the non-physician personnel needed to implement need to be employed by the APM entity. Some of the staff can be employed by other entities, particularly staff that are less frequently used such as physical therapists. For the core staff, including physicians, nurse practitioners, registered nurses, and social workers, we believe that it is important that dedicated staff be identified for the program whether employed by the APM entity or by another entity.*

- What proportion of the total physician/clinician services your HaH-Plus patients have received were delivered by non-primary care specialists or hospitalists (e.g., cardiologists, oncologists, pulmonologists, etc.)? To what extent were these the same physicians who would have delivered services if the patients had been in the hospital?

*Reply: During the 30-day postacute period, 23% of patients have had specialist visits—most commonly to cardiology, pulmonary, oncology, endocrine,*

*dermatology, gastroenterology, and podiatry. During the acute care period (generally the initial 3-5 days), the use of non-primary care specialists in physician visits has been limited. This is in part because the subspecialists are generally not available for home visits in our community. We have had a urologist who has made an occasional visit to the home, and we have used an ophthalmologist to make a home visit. Rather, we have used specialists as programmatic consultants for care in the acute phase. For example, we have consulted with infectious disease specialists on preferred antibiotic protocols for our most common infectious disease problems. Our physicians have also communicated with specialists for consultation on selected clinical issues during the acute period or on specific patients. If a face to face visit is required, consultation in the office can be arranged by transporting the patient. Our plan is to extend our current video visit capability to enable specialty consultations at home but done remotely.*

- Please provide more information on the types of communities in which you believe the program would be financially viable:

- If only traditional Medicare beneficiaries were participating, what is the minimum number of patients who would need to receive services under HaH-Plus in order to make the program financially viable for an APM Entity that is using the minimum number of physicians/clinicians you defined in response to the previous question?

*Reply: Under the minimum number of physicians-clinicians defined in response to the earlier question, we estimate that approximately 200 traditional Medicare beneficiaries would need to participate in the program annually for the program to be financially viable.*

- The proposal refers to the ability to have geographically clustered patients with a sufficiently large patient population. What is the largest geographic area over which the minimum number of patients could be served by the minimum number of physicians/clinicians?

*Reply: Our discussion of geographic clustering in the proposal was intended to illustrate how cost efficiencies might be achieved in the future by additional clustering of patients and reducing travel time. It was not intended to indicate a minimum geographic area for an APM entity to cover. Having said that, we believe that the size of that geographic area is a function of travel time in that area and the use of video technology and thus would likely evolve over time. Our current program in New York City covers the geographic area of Manhattan (23 square miles and 238,000 persons over the age of 65). We are limited by public transportation and taxis, and almost no use of private vehicles by our staff, and using subways allows us to fairly efficiently cover this geographic area. Our plans call for near-term program expansion to other boroughs of New York City starting with parts of Brooklyn and the Bronx. Other successful hospital at home programs have been implemented in communities with lower population density. Presbyterian Health System in New Mexico has operated a hospital at home program for a number of years and that program serves patients within 30 miles*

of any Presbyterian hospital or a geographic area of approximately 1500-2000 square miles.

- What proportion of Medicare beneficiaries living in a community would you expect to use the HaH-Plus program during the course of a year, assuming the beneficiaries in the community have characteristics similar to the national beneficiary population?

*Reply: We estimate that around 1.6% of beneficiaries nationally would use the HaH-Plus program if it were implemented on a national scale, and if a community had characteristics similar to the national population, a similar proportion of beneficiaries could be expected to use the HaH-Plus program in that community. We calculated this by identifying unique beneficiaries in the 10-month national comparison cohort and increasing that figure by a ratio of 12/10 to account for the fact that the national comparison cohort only covers 10 months. We then divided this number of beneficiaries by the number of beneficiaries in the 2015 100% Medicare Limited Data Set (LDS) membership files that met criteria for inclusion in HaH-Plus other than having an inpatient admission that started with an emergency department (ED) visit for one of the proposed HaH-Plus MS-DRGs. Table 1 Below shows both the numerator and denominator for the calculation.*

**TABLE 1. PROPORTION OF MEDICARE BENEFICIARIES THAT COULD BEGIN HAH-PLUS EPISODES**

	SCOPE OF PROPOSED PFPM	
(1)	UNIQUE BENEFICIARIES IN COMPARISON COHORT	518,000
(2)	TOTAL MEDICARE COHORT	33,090,540
(3)	<b>PERCENT OF TOTAL MEDICARE COHORT (1)/(2)</b>	<b>1.6%</b>

*Source: Calculations based on analysis of 2015 100% Medicare LDS claims files.*

- What proportion of the patients in your HaH-Plus program have been residents of nursing homes or assisted living facilities vs. private homes?

*Reply: None of the patients in the HaH-Plus program have been residents of nursing homes. We considered providing HaH-Plus in the nursing home to nursing home residents. We encountered several barriers including 1) having to use a nursing facility's staff in place of the HaH-Plus staff specifically trained to care for HaH patients; 2) use of the facility's lab, radiology, and pharmacy services; and 3) documenting in the facility's electronic record (in addition to documenting in the HaH-Plus electronic record). In the case of assisted living, one assisted living facility where we attempted to serve patients with HaH-Plus also operated its own home care agency, and we encountered resistance from the facility. However, we are open to serving beneficiaries in assisted living facilities as long as outside nurses and physician visits are allowed. We estimate that 4% of HaH-Plus cases have been for beneficiaries residing in three assisted living facilities.*

- Do you envision that consulting physicians or the patients' regular primary care physicians would be paid differently if their patients are participating in HaH-Plus?

*Reply: We envision that consulting physicians or the patients regular primary care physicians could be involved but that they would be paid fee-for-service for their visits. Those charges would be reconciled along with other charges in the 30 day period.*

- Please provide the number of patients in each of the DRG categories described in Appendix A who participated in each year of your existing program.

*Reply: The Table below shows the number of individuals by DRG (November 2014 through May 2017).*

<i>Illness</i>	<i>DRG</i>	<i>Total</i>
<i>Kidney &amp; Urinary Tract Infections</i>	<i>689, 690, 698, 699</i>	<i>78</i>
<i>Simple Pneumonia</i>	<i>193, 194, 195</i>	<i>71</i>
<i>Cellulitis</i>	<i>602, 603</i>	<i>47</i>
<i>Heart Failure &amp; Shock</i>	<i>291, 292, 293</i>	<i>40</i>
<i>Dehydration</i>	<i>640, 641</i>	<i>30</i>
<i>Chronic obstructive pulmonary disease</i>	<i>190, 191, 192</i>	<i>26</i>
<i>Esophagitis &amp; Other Digestive Diagnoses</i>	<i>392, 393, 394, 395</i>	<i>24</i>
<i>Asthma</i>	<i>202, 203</i>	<i>17</i>
<i>Diabetes</i>	<i>637, 638, 639</i>	<i>6</i>
<i>Bronchitis</i>	<i>202, 203</i>	<i>2</i>
<i>Hypoglycemia</i>	<i>643, 644, 645</i>	<i>2</i>
<i>Peripheral Vascular Disorders</i>	<i>299, 300, 301</i>	<i>2</i>
<i>Respiratory Infections</i>	<i>177, 178, 179</i>	<i>2</i>
<i>Atrial Fibrillation</i>	<i>308, 309, 310</i>	<i>1</i>
<i>Compression Fracture</i>	<i>551, 552</i>	<i>1</i>
<i>Fever or Viral Illness</i>	<i>864, 866, 948</i>	<i>1</i>
<i>Major GI Disorders</i>	<i>371</i>	<i>1</i>
<i>Pulmonary Embolism</i>	<i>176</i>	<i>1</i>
<i>Respiratory Signs &amp; Symptoms</i>	<i>204, 206</i>	<i>1</i>
<b><i>Total</i></b>		<b><i>353</i></b>

## **Criterion 2. Quality and Cost**

**The proposal is anticipated to (1) improve health care quality at no additional cost, (2) maintain health care quality while decreasing cost, or (3) both improve health care quality and decrease cost.**

- The proposal lists six quality measures, three of which are process measures. All of the measures would be given equal weight. What is the justification for giving each of the measures equal weight?

*Reply: We should clarify that the proposal listed 10 quality measures: (1) documentation of a care plan; (2) documentation of current medications; (3)*

medication reconciliation; (4) documentation of physical function; (5) adverse events; (6) beneficiary experience with care—communication with nurses; (7) beneficiary experience with care—communication with doctors; (8) beneficiary experience with care—about medicines; (9) beneficiary experience with care—care transitions; and, (10) beneficiary experience with care—overall rating of the care experience.

*Our proposal for performance-based payment reflects the nascent state of the HaH experience and an anticipation that the model for payment in HaH will evolve. The HaH-Plus performance-based payment proposal is guided in part by Hospital Value Based Purchasing (HVBP) program design. The rationale is to have HaH metrics that are widely accepted and with which health systems have experience collecting, and to have metrics with national benchmarks. We believe this approach will facilitate adoption of the HaH-Plus model. There are fundamental differences between HVBP and the HaH-Plus program, however, which preclude a direct replication of the incentive structure to HaH-Plus. Many HVBP measures are not applicable to the home environment because various clinical conditions (e.g., acute coronary syndromes) or clinical services (e.g., central line placement) are not treated or provided in HaH-Plus. Additionally, quality metrics have not been established for hospital at home. Where applicable, we have adopted HVBP quality metrics but the number of such measures is small, limiting our ability to establish an incentive model that can follow the weighting rubric of HVBP. We are also limited by the fact that HaH involves many different conditions so condition-specific metrics would be difficult to apply. Accordingly, we focus on metrics that apply to a range of conditions and we endeavored to include measures, not only of process, but also outcomes (including a patient reported outcome), and patient experience. Not having any established method for weighting, we chose to weight them equally for simplicity; however, we would be willing to discuss alternative weighting methods.*

- Why do you not have mortality or a broader range of adverse events included in the quality measures, including measures that have been included in past evaluations? Why would the additional measures in Section 10.2 only be “tracked” rather than included in the payment methodology?

*Reply: We considered including mortality for patients with pneumonia and congestive heart failure for the HaH-Plus payment incentive model. However, the number of events would be too small for most HaH-Plus programs in any quarter or year to serve as a meaningful measure. Regarding inclusion of a broader range of adverse events, we selected measures that we believe are most appropriate to the age of HaH-Plus patients and the conditions for which they are admitted. There are no established quality metrics for HaH and only a few of the HVBP adverse event metrics are applicable to HaH.*

*The metrics we proposed to track are intended for internal quality improvement rather than determining payment. Many are inappropriate for a payment model*



*because the event rates are very small. Others may not be feasible or may be overly burdensome for some APM entities to collect. However, several of the measures we propose to track are potential candidates for future iterations of the HaH-Plus payment model.*

- What is the rationale for excluding adverse event and beneficiary experience measures from the shared savings calculations in the Palliative Care at Home variant?

*Reply: We excluded palliative care patients from the shared savings calculation owing to their small numbers and systematic differences with regular acute patients. Palliative care patients made up only 6.7% of our HaH patient population. Since they are patients with terminal illness, they are systematically different from non-terminal patients receiving acute hospital level care. For example, they are older (mean 87 years vs. 76 years) and are more likely to report fair to poor general health (85% vs. 65%). For these patients, the beneficiary and family experience is highly relevant, but it needs to be measured in different ways and at a different time (interviews after death with the bereaved) such that it would have been administratively cumbersome to implement for this particular context. Similarly, we believe that the adverse event metric requires more nuanced consideration given the differences in patient characteristics for this subsample and the more complex goals of care in these patients.*

- Please provide a more detailed breakdown of the calculations in Appendix G comparing the costs of HaH-Plus and current spending, particularly how the estimate of \$394 savings for Medicare was derived. Please also include additional examples showing the calculations when (1) the actual spending is higher than the target price and (2) patients were escalated to the hospital.

*Reply: Table 1 of Appendix I in the PTAC proposal shows a comprehensive comparison of average allowed amounts for an episode in the comparison cohort as well as what the average allowed amount would be in under HaH-Plus. Additionally, Tables 3 and 4 of Appendix I provide information on the cost per episode for the different services furnished by the HaH-Plus team, and Table 5 provides information on the conversion in hourly wages between the New York City metropolitan area and the national average for select core team occupations. The text of Appendix I further describes the calculations, data sources, and reliance. In the comparison cohort, average episode spending was \$13,133, and a 3% discount on that amount equals the \$394 that CMS would retain on average as savings. All told, per episode spending is expected to be around \$1,259 less per episode on average under HaH-Plus relative to the existing FFS payment systems, or a 10% reduction. Table 2 of Appendix I in the PTAC proposal shows how the \$1,259 per episode would be split between CMS and the APM entity. Specifically, CMS would retain \$394 as savings on average, and the APM entity would receive \$865 (\$1,259 - \$394) per episode, if it achieved all quality metric performance targets. If not, CMS would retain more than \$394 as savings, and the APM entity would receive less than \$865 per episode.*

The financial modeling in Appendix I of the PTAC proposal shows average spending, and for any given episode, it is possible that spending could be much higher or lower than average spending. Table 2 below shows an example in which the APM entity does not reduce any utilization in the post-acute portion of a HaH-Plus episode. In that case, the only change in spending would be that CMS would pay 95% of the DRG payment and expected Part B payments for the acute portion of the HaH-Plus episode. This would still reduce spending for the total episode by more than \$400, on average. In such a scenario CMS would still retain \$394 as savings – 3% of \$13,133 – and the APM entity would achieve \$30 (\$424 - \$394) per episode as a performance-based payment (assuming it met all quality metric performance targets).

**TABLE 2. HAH-PLUS FINANCIAL FEASIBILITY EXHIBIT WITH NO POST-ACUTE REDUCTION, NATIONAL 2015 COMPARISON COHORT**

(A)	COMPARISON COHORT		HYPOTHETICAL HAH-PLUS		
	(B)	(C)	(D)	(E)	(F)
	AVERAGE ALLOWED PER EPISODE	% OF TOTAL EPISODE COST	ESTIMATED AVERAGE ALLOWED OR PROGRAM COST PER EPISODE	CHANGE FROM CURRENT	% OF TOTAL EPISODE COST
<b>INITIAL INPATIENT / HAH ACUTE PAYMENT</b>	<b>\$8,010</b>	<b>61.0%</b>	<b>\$7,585</b>	<b>(\$424)</b>	<b>59.7%</b>
<b>POST-ACUTE</b>					
READMISSION INPATIENT FACILITY	\$2,505	19.1%	\$2,505	\$0	19.7%
SKILLED NURSING FACILITY	\$685	5.2%	\$685	\$0	5.4%
HOME HEALTH	\$333	2.5%	\$333	\$0	2.6%
HOSPICE	\$46	0.3%	\$46	\$0	0.4%
OUTPATIENT FACILITY - ED	\$81	0.6%	\$81	\$0	0.6%
OUTPATIENT FACILITY - OTHER	\$372	2.8%	\$372	\$0	2.9%
PROFESSIONAL SERVICES – IP READMISSION	\$387	2.9%	\$387	\$0	3.0%
PROFESSIONAL SERVICES - OTHER	\$618	4.7%	\$618	\$0	4.9%
DURABLE MEDICAL EQUIPMENT	\$98	0.7%	\$98	\$0	0.8%
<b>POST-ACUTE TOTAL</b>	<b>\$5,124</b>	<b>39.0%</b>	<b>\$5,124</b>	<b>\$0</b>	<b>40.3%</b>
<b>TOTAL AVERAGE EPISODE COSTS</b>	<b>\$13,133</b>	<b>100.0%</b>	<b>\$12,709</b>	<b>(\$424)</b>	<b>100.0%</b>

Source: Calculations based on analysis of 2015 100% and 5% Medicare LDS claims files, Mount Sinai cost data, and 2015 BLS Occupational Employment Statistics data.

Table 3 shows another scenario in which the post-acute spending increases relative to the current utilization by 50% in home health and 5% across the board in all other categories. In that scenario, spending for a comparison cohort episode would be \$13,133, and spending for the HaH-Plus episode would be \$13,115, \$18 less than the comparison cohort episode spending. CMS would retain \$394 as savings – 3% of \$13,133 – and the APM entity would be required to repay \$376 (\$394 - \$18) per episode because spending of \$13,115 exceeded the discounted target price of \$12,739 (\$13,133 - \$394).

**TABLE 3. HAH-PLUS FINANCIAL FEASIBILITY EXHIBIT WITH INCREASED POST-ACUTE UTILIZATION, NATIONAL 2015 COMPARISON COHORT**

	COMPARISON COHORT	HYPOTHETICAL HAH-PLUS
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(A)	(B)	(C)	(D)	(E)	(F)
	AVERAGE ALLOWED PER EPISODE	% OF TOTAL EPISODE COST	ESTIMATED AVERAGE ALLOWED OR PROGRAM COST PER EPISODE	CHANGE FROM CURRENT	% OF TOTAL EPISODE COST
<i>INITIAL INPATIENT / HAH ACUTE PAYMENT</i>	\$8,010	61.0%	\$7,585	(\$424)	59.7%
<i>POST-ACUTE</i>					
<i>READMISSION INPATIENT FACILITY</i>	\$2,505	19.1%	\$2,630	\$125	20.1%
<i>SKILLED NURSING FACILITY</i>	\$685	5.2%	\$719	\$34	5.5%
<i>HOME HEALTH</i>	\$333	2.5%	\$500	\$167	3.8%
<i>HOSPICE</i>	\$46	0.3%	\$48	\$2	0.4%
<i>OUTPATIENT FACILITY - ED</i>	\$81	0.6%	\$85	\$4	0.7%
<i>OUTPATIENT FACILITY - OTHER</i>	\$372	2.8%	\$390	\$19	3.0%
<i>PROFESSIONAL SERVICES – IP READMISSION</i>	\$387	2.9%	\$406	\$19	3.1%
<i>PROFESSIONAL SERVICES - OTHER</i>	\$618	4.7%	\$649	\$31	4.9%
<i>DURABLE MEDICAL EQUIPMENT</i>	\$98	0.7%	\$103	\$5	0.8%
<i>POST-ACUTE TOTAL</i>	\$5,124	39.0%	\$5,530	\$406	42.2%
<i>TOTAL AVERAGE EPISODE COSTS</i>	\$13,133	100.0%	\$13,115	(\$18)	100.0%

Source: Calculations based on analysis of 2015 100% and 5% Medicare LDS claims files, Mount Sinai cost data, and 2015 BLS Occupational Employment Statistics data.

*As described in the PTAC proposal, if an episode escalated to an inpatient admission, the APM entity would receive a partial HaH-Plus acute payment equal to 25% of the normal HaH-Plus acute payment, the admitting hospital would receive a full MS-DRG payment, and other services would be paid fee-for-service (FFS). In such cases, the episode would not be canceled, rather the episode would continue, and all episode spending, including the partial HaH-Plus acute payment, would be reconciled against a target price. Table 4 below presents that scenario based on an episode in which the beneficiary begins a HaH-Plus episode and is then escalated to an inpatient admission for MS-DRG 292 – heart failure and shock with complications or comorbidities. In the scenario, we also assume the same reductions in post-acute utilization from Table 1 of Appendix I in the PTAC proposal. In this scenario, the comparison cohort spending would be \$14,423 on average, and HaH-Plus episode spending would be \$15,225 – \$802 higher. The \$802 is the result of the partial HaH-Plus acute payment of \$1,901, which is offset by \$1,099 in reduced post-acute utilization that would occur if the beneficiary continues to receive HaH-Plus services after discharge from the inpatient admission. In this case, CMS would still receive a 3% discount of \$433 (\$14,423 x 3%), and the APM entity would be required to pay back \$1,235 (\$802 + \$433). If post-acute utilization did not decrease, the APM entity would be required to pay back more money.*

**TABLE 4. HAH-PLUS FINANCIAL FEASIBILITY EXHIBIT WITH ESCALATION TO AN INPATIENT ADMISSION FOR MS-DRG 292, NATIONAL 2015 COMPARISON COHORT**

	COMPARISON COHORT		HYPOTHETICAL HAH-PLUS		
(A)	(B)	(C)	(D)	(E)	(F)

	AVERAGE ALLOWED PER EPISODE	% OF TOTAL EPISODE COST	ESTIMATED AVERAGE ALLOWED OR PROGRAM COST PER EPISODE	CHANGE FROM CURRENT	% OF TOTAL EPISODE COST
Partial HaH Acute Payment	\$0	0.0%	\$1,901	\$1,901	12.5%
Services Provided in Initial Inpatient Stay	\$6,851	47.5%	\$6,851	\$0	45.0%
Professional Services (NP+MD)	\$1,211	8.4%	\$1,211	\$0	8.0%
<b>INITIAL INPATIENT / HAH ACUTE PAYMENT</b>	<b>\$8,062</b>	<b>55.9%</b>	<b>\$9,963</b>	<b>\$1,901</b>	<b>65.4%</b>
<b>POST-ACUTE</b>					
READMISSION INPATIENT FACILITY	\$3,370	23.4%	\$2,527	(\$842)	16.6%
SKILLED NURSING FACILITY	\$677	4.7%	\$677	\$0	4.4%
HOME HEALTH	\$410	2.8%	\$410	\$0	2.7%
HOSPICE	\$57	0.4%	\$57	\$0	0.4%
OUTPATIENT FACILITY – ED	\$82	0.6%	\$61	(\$20)	0.4%
OUTPATIENT FACILITY – OTHER	\$476	3.3%	\$429	(\$48)	2.8%
PROFESSIONAL SERVICES – IP READMISSION	\$530	3.7%	\$398	(\$133)	2.6%
PROFESSIONAL SERVICES – OTHER	\$638	4.4%	\$582	(\$56)	3.8%
DURABLE MEDICAL EQUIPMENT	\$121	0.8%	\$121	\$0	0.8%
<b>POST-ACUTE TOTAL</b>	<b>\$6,361</b>	<b>44.1%</b>	<b>\$5,262</b>	<b>(\$1,099)</b>	<b>34.6%</b>
<b>TOTAL AVERAGE EPISODE COSTS</b>	<b>\$14,423</b>	<b>100.0%</b>	<b>\$15,225</b>	<b>\$802</b>	<b>100.0%</b>

Source: Calculations based on analysis of 2015 100% and 5% Medicare LDS claims files, Mount Sinai cost data, and 2015 BLS Occupational Employment Statistics data.

- To what extent would the patients deemed appropriate for HaH-Plus services have had a lower-than-average cost of inpatient care or lower-than-average length of stay than other patients in the same DRG if they had been admitted to the hospital? If their costs would have been lower, then the savings attributable to HaH-Plus would also be lower. In the evaluation of savings from your program, how have you controlled for the variation in patient needs within a DRG? You describe matching patients by HCC scores; have you found that HaH-Plus patients differ significantly from admitted patients on HCC scores or other characteristics?

*Reply: We have explicitly controlled for variation in service utilization within MS-DRG, but the analysis in Appendix I of the PTAC proposal did include eligibility criteria that excluded some beneficiaries with particularly high resource utilization. For example, the analysis limited the index inpatient length of stay to be more than 1 day and less than 8 days. The analysis also excluded beneficiaries with a readmission in the 30 days preceding the index admission. Additionally, we believe the focus should be on the amount Medicare would pay rather than the cost incurred by the hospital or the APM entity to furnish services. If Medicare would have paid the full MS-DRG payment, even for a lower-acuity beneficiary, and instead pays the HaH-Plus acute payment, there would still be savings attributable to the HaH-Plus model.*

- The proposal indicates that expansion to scale would likely not occur “in the first few years” but “could occur over time.” Please describe in more detail how you define

“scale,” explain what aspects of the program would take time to implement and why, and provide your estimate of how many years it would take to achieve a scale sufficient for financial viability.

*Reply: By scale, we referred to the delivering of a robust high quality and efficient program of hospital at home to a substantial proportion of the medically eligible population in those regions of the country with sufficient population density where it is likely to be feasible. There are several aspects of the program that will take time to implement. Critical patient and staffing mass is a critical issue. This can be challenging in a multi-payer system, particularly given the increasing penetration of Medicare Advantage. Also 24/7 coverage needs to be in place from the beginning, 24/7 availability for patient intake can be challenging on nights and weekends but is essential given that this is a program for acute illness that can occur at any time. Nights and weekends have been a particularly challenging because of the availability of community-based services provided by vendors who are more accustomed to the more typical nonacute medical needs of home care. Apart from the issues of critical mass, we believe that substantial technical assistance and training will also be needed to help APM entities launch and then to actually deliver hospital at home services. For many entities, this will be a relatively new and different line of business that does not conform to the typical hospital, outpatient, or homecare regulations, clinical policies, and administrative procedures encountered in these areas. These issues can all be overcome in our experience, but require the development of workarounds of existing policies and procedures. Finally, we believe that some form of certification procedure should be developed to certify APM entities interested in establishing such programs. We have begun discussions around that topic in relation to this PFPM proposal, but the mechanism will require some time to put into place. Based on our experience, to date, in implementing hospital at home, we believe that it would take 12 to 24 months from the point of initiation to develop a small to moderate size program that breaks even. We estimate that it would take an additional 24 to 36 months to grow that small program to the size of what would approach “scale”.*

- Are the transition services under HaH-Plus more effective at reducing hospital readmissions and post-acute care visits than other post-discharge transition programs, and if so, why?

*Reply: The effectiveness of our transition programs could be traced to one or more of several elements. First, our transition program is inextricably tied to the acute program. The same team is involved in delivering both acute and transition services, and the same medical record is used to track medical care. The same team involved in both acute care and transition can more effectively perform medication reconciliation in the home. Further, social determinants of health are more easily identified. Second, we employ telephonic follow-up during transition, but we also include home visits by the social worker as well as home visits by other staff as clinically indicated. Third, we include services that are not traditionally billable under Medicare during this 30 day transition. This includes the aforementioned social work care coordination, but also community paramedic*

*visits as needed and physician video televisits as needed. Fourth, if necessary, we have been willing to restart hospital at home services in lieu of hospitalization if clinically indicated. This would not trigger a new HaH payment or new bundle in that it would be “nested” within an existing bundle. Finally, we make extensive efforts to connect patients to subsequent follow-up care since services end after 30 days.*

- In Appendix H, you have outlined standards that an APM Entity should meet to deliver Hospital at Home Plus. How do you envision the certification process for APM Entities would work? Are there existing entities that could provide certification? Would this require on-site inspection? How often would an APM Entity need to be re-certified or monitored? How much would this cost?

*Reply: The standards in appendix H are modeled off of NCQA’s patient-centered practice recognition criteria with adaptations made to align with the Hospital at Home care model. Should the proposal succeed, NCQA has committed to establishing the recognition process to allow practices to demonstrate their capabilities. NCQA’s process uses a combination of desktop review and virtual ‘check-ins’ where the evaluator interviews practice team members and shares screens to see how the systems and processes work in practice. NCQA has recently changed their recognition model so that once recognized the practice is responsible for annual reporting to demonstrate they are continuing to operate consistent with the standards rather than a renewal survey every three years. NCQA has not yet established a price for this program but it would be similar to the pricing of other recognition programs. For example, for an eight-clinician single site patient centered medical home practice, the initial survey is \$4000, with annual updates at \$960. Pricing is also available for multisite practices.*

- Would there be a credentialing process for providers in Hospital at Home? Please describe which providers would be included in such a credentialing process (e.g., core care team, consultants)?

*Reply: Credentialing for physicians in the core team will be performed locally by the relevant healthcare organization or provider network depending on the APM’s usual procedures. This will also include review and approval for clinical privileges. Insurance credentialing will also be conducted as needed for individual plans or on a delegated basis. Other members of the team will have personnel credentialing done at the time of employment and reappointment.*

- How is the need for flexibility in staffing and care delivery balanced against the need for standards and certification adherence?

*Reply: Our vision of HaH-Plus allows practices to flex staffing through contracts with home health agencies and other providers, as either substitutes or replacement of actual employees of the practices. We see no conflict between standards and certification adherence and the need for flexibility in staffing and care delivery. There is no single correct staffing model or ratio of certain providers to patients for HaH-Plus. NCQA standards are written to*

*assess whether required functions are being performed adequately, not whether the numbers and types of providers or other resources are correct.*

- What might be minimum criteria for hospital participation in Hospital at Home? Would participation by a minimum percentage of patients in each DRG or other criteria be required for continued participation in the model?

*Reply: A participating APM entity will need to establish a formal linkage to one or more hospitals. In the case where more than one hospital is involved, each new case admitted by the APM entity will be linked to the hospital to which the patient would otherwise have been admitted. At a minimum, hospitals will need to credential and privilege the APM physician staff, the hospital will enable access to the emergency department for possible enrollment of patients, and the hospital will need to agree to receiving admissions for escalations of care from the program. The APM entity and the hospital will need to agree to financial arrangements by which the APM entity can reimburse the hospital for any emergency department and observation unit costs incurred in the HaH-plus episode but that would be bundled into the HaH-Plus payment (as would be the case with an inpatient DRG payment if the patient had been hospitalized). Participation in the model would not be tied to a minimum percentage of patients in each DRG.*

- Why were the Milliman criteria for appropriateness of hospitalization chosen for the model? Could other criteria be used instead?

*Reply: MCG evidence-based care guidelines are quite common care guidelines that are in use at more than 1,600 hospitals and eight of the ten largest hospital systems in the country (see <https://www.mcg.com/care-guidelines/overview/>). APM entities could use other care guidelines to achieve the same goal, this point is just to demonstrate that all of the beneficiaries in the HaH-Plus program have met criteria for hospitalization.*

### **Criterion 3. Payment Methodology**

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

- In the proposal, you refer to services “that currently cannot be billed adequately under Medicare FFS.” Please list these services and explain in more detail the restrictions in current Medicare payment systems that preclude adequate payment for them.

*Reply: The services include:*

- *Nursing services furnished in the home setting by an RN – Medicare does pay for these services under FFS only as a Home Health episode. Yet, a Home Health Episode will not adequately cover some necessary services*

*(for example, rapid deployment of a nurse to a home, two or three visits of nursing per day, and late day admissions).*

- *Daily physician visits. Physician home visits are covered, but the frequency and intensity of daily visits would draw audits from intermediaries*
  - *Other hospital-level services furnished in the home setting with rapid on-demand availability and delivery, including home phlebotomy, DME delivery (without prior authorization), IV antibiotics without prior authorization*
  - *HaH-Plus transition services. Medicare pays FFS for limited transitional care management services after discharge from an inpatient admission, but none is in person as we are providing if needed*
  - *Community paramedicine services – Medicare does not pay for these services under FFS*
  - *The cost of provider transportation – Medicare does not pay for these costs*
- 
- Please provide a step-by-step explanation of how the payment amount for HaH-Plus core services would be calculated, with at least one specific example using current Medicare IPPS and MPFS payment amounts. In particular, please explain how the “expected professional Part B billings” would be calculated for each DRG or patient.  
*Reply: Appendix I in the PTAC proposal presents the methodology for the proposed HaH-Plus acute payment amount of 95% of the average initial inpatient allowed amount for both the MS-DRG payment and professional billings, and Tables 1, 3, 4, and 5 in Appendix I show the dollar amounts that were used for the calculations in the national comparison cohort. When determining the 95% payment amount for the HaH-Plus acute payment, we did not base the calculation of the cost of core HaH-Plus team members on Medicare Physician Fee Schedule payment rates. Rather, we based these on:*
    - *The estimated number of full-time equivalent positions necessary to operate the HaH-Plus model under an assumption of 300 episodes per year – see Table 3 of Appendix I in the PTAC proposal*
    - *Mount Sinai wage and benefit information for core HaH-Plus team member occupations and Mount Sinai cost data for other services – see Tables 3 and 4 of Appendix I in the PTAC proposal*
    - *Hourly wage differentials between New York City and the entire nation – see Table 5 of Appendix I in the PTAC proposal*

*Because not all of the services furnished during the HaH-Plus episodes would be separately billable under existing Medicare payment systems, we do not believe it would be feasible to calculate the HaH-Plus payment rate solely from existing Medicare payment rates.*

*If the model were implemented, CMS could calculate expected professional Part B billings based on historical Part B payments during inpatient admissions for*



*HaH-Plus DRGs in the comparison group that would be used for reconciliation. CMS would then set the HaH-Plus acute payment at 95% of the sum of the MS-DRG payment and estimated professional Part B billings that would have occurred.*

*In the national comparison cohort, congestive heart failure (MS-DRGs 291-293) accounts for the most episodes – almost 71,000 of the nearly 479,000 episodes. Based on that observation, we prepared an example for MS-DRG 292 – heart failure and shock with complications or comorbidities based on data from the 2015 Medicare 100% and 5% LDS claims files, shown in Table 5. All amounts for the comparison cohort are calculated from actual claims data for 2015, including the average MS-DRG allowed amount of \$6,851 and average professional Part B allowed amount of \$1,211 during the initial inpatient stay. Estimated costs for the hypothetical HaH-Plus stay are based on the methodology described in Appendix I of the PTAC proposal. For MS-DRG 292, the costs of the acute portion of the HaH-Plus episode total \$7,603. This amount is slightly higher than the \$7,585 shown in Table 1 of Appendix I of the PTAC proposal and is driven by a slightly higher cost estimate of the initial ED visit for these beneficiaries – \$667 compared to \$649 across all beneficiaries in the comparison cohort. \$7,603 is 94% of the average initial inpatient allowed cost for MS-DRG 292 admissions in the comparison cohort of \$8,062. Under this scenario, episode spending would decrease by \$1,558 in HaH-Plus, with CMS receiving a 3% discount of \$433 (\$14,423 x .03) and the APM entity receiving up to \$1,125 (\$1,558 - \$433) as a performance-based payment. If episode spending were higher because of an inpatient readmission or a SNF stay, the APM entity would receive a smaller performance-based payment or, if spending exceeded the target, be required to repay CMS the difference.*

**TABLE 5. HAH-PLUS FINANCIAL FEASIBILITY EXHIBIT FOR MS-DRG 292, NATIONAL 2015 COMPARISON COHORT**

NUMBER OF EPISODES	33,866				
MINIMUM PATIENT AGE	19				
AVERAGE PATIENT AGE	78				
MAXIMUM PATIENT AGE	98				
	COMPARISON COHORT		HYPOTHETICAL HAH-PLUS		
(A)	(B)	(C)	(D)	(E)	(F)
	AVERAGE ALLOWED PER EPISODE	% OF TOTAL EPISODE COST	ESTIMATED AVERAGE ALLOWED OR PROGRAM COST PER EPISODE	CHANGE FROM CURRENT	% OF TOTAL EPISODE COST
SERVICES PROVIDED IN INITIAL INPATIENT STAY	\$6,851	47.5%	\$0	(\$6,851)	0.0%
SERVICES OVERLAPPING WITH DRG					
INITIAL ED VISIT	\$0	0.0%	\$667	\$667	5.2%
NURSING (AND RN SUPERVISOR)	\$0	0.0%	\$2,078	\$2,078	16.2%
SOCIAL WORK (AND SW SUPERVISOR)	\$0	0.0%	\$347	\$347	2.7%
ADMINISTRATIVE ASSISTANCE	\$0	0.0%	\$454	\$454	3.5%
PT/OT/ST	\$0	0.0%	\$12	\$12	0.1%
HOSPITAL BED	\$0	0.0%	\$68	\$68	0.5%
OTHER DME/EQUIPMENT	\$0	0.0%	\$33	\$33	0.3%
DRUGS	\$0	0.0%	\$94	\$94	0.7%

RADIOLOGY	\$0	0.0%	\$21	\$21	0.2%
MEDICAL SUPPLIES	\$0	0.0%	\$108	\$108	0.8%
LABS	\$0	0.0%	\$96	\$96	0.7%
OTHER	\$0	0.0%	\$40	\$40	0.3%
SERVICES NOT OVERLAPPING WITH DRG					
PROFESSIONAL SERVICES (NP+MD)	\$1,211	8.4%	\$2,517	\$1,306	19.6%
MEDICAL DIRECTOR	\$0	0.0%	\$278	\$278	2.2%
PRACTICE MANAGER	\$0	0.0%	\$229	\$229	1.8%
PROGRAM OPERATIONS	\$0	0.0%	\$25	\$25	0.2%
PATIENT TRANSPORTATION	\$0	0.0%	\$108	\$108	0.8%
PROVIDER TRANSPORTATION	\$0	0.0%	\$271	\$271	2.1%
HOME ATTENDANT	\$0	0.0%	\$17	\$17	0.1%
COMMUNITY PARAMEDICINE	\$0	0.0%	\$140	\$140	1.1%
INITIAL INPATIENT / HAH ACUTE	\$8,062	55.9%	\$7,603	(\$459)	59.1%
POST-ACUTE					
READMISSION INPATIENT FACILITY	\$3,370	23.4%	\$2,527	(\$842)	19.6%
SKILLED NURSING FACILITY	\$677	4.7%	\$677	\$0	5.3%
HOME HEALTH	\$410	2.8%	\$410	\$0	3.2%
HOSPICE	\$57	0.4%	\$57	\$0	0.4%
OUTPATIENT FACILITY – ED	\$82	0.6%	\$61	(\$20)	0.5%
OUTPATIENT FACILITY – OTHER	\$476	3.3%	\$429	(\$48)	3.3%
PROFESSIONAL SERVICES – IP READMISSION	\$530	3.7%	\$398	(\$133)	3.1%
PROFESSIONAL SERVICES - OTHER	\$638	4.4%	\$582	(\$56)	4.5%
DURABLE MEDICAL EQUIPMENT	\$121	0.8%	\$121	\$0	0.9%
POST-ACUTE TOTAL	\$6,361	44.1%	\$5,262	(\$1,099)	40.9%
<b>TOTAL AVERAGE EPISODE COSTS</b>	<b>\$14,423</b>	<b>100.0%</b>	<b>\$12,865</b>	<b>(\$1,558)</b>	<b>100.0%</b>

Source: Calculations based on analysis of 2015 100% and 5% Medicare LDS claims files, Mount Sinai cost data, and 2015 BLS Occupational

- Please explain in more detail what medications would be covered under the HaH-Plus payment and which would be paid for separately. The proposal refers to medications the patient “would already have at home” and “medications the beneficiary is not already taking.” What happens if the patient does not have a sufficient supply of an existing medication to last for the HaH-Plus acute episode? What if the attending physician believes that a similar medication would be better in combination with any newly prescribed medications? How would new medications be obtained and paid for if they are covered under Part D?

*Reply: All medications would be covered under the HaH-plus payment with the exception of long-term or chronic medications that the beneficiary is already taking and has at home. This is done in part to facilitate the rapid transition of the patient to home. Introducing new prescriptions for existing medications is redundant, and potentially increases the risk of medication errors. At the time of the patient referral and acceptance into the program, there is also a relatively small window of time to arrange preparations for care in the home. Although the staff may know what medications are noted in the medical records, it is not possible at the time to reconcile medications with what is actually in the home and being taken. For that reason, we prioritize the ordering and preparation of new medications for the acute episode of illness. New medications for the acute episode would be covered under the HaH-plus payment and not under part D. At*

*the time of the first home visit later that day, the opportunity arises for the registered nurse to reconcile medications actually in the home. Ordering those medications at that time for the HaH-plus episode could be done, but ordering those medications at that time would be duplicative and potentially confusing to the patients.*

*If a patient has an insufficient supply of an existing medication to last for the HaH-plus acute episode, we would assist the patient with an appropriate refill of that medication. On a short-term basis, we could obtain a limited supply of the medications to be covered as part of the HaH-Plus episode in the case of any delay in obtaining the refill. If the attending physician believes that a similar medication would be better in combination with any newly prescribed medications, we would obtain such medication as part of the HaH-plus episode payment (although this is what we would do, this has actually never happened in our program). If such a change involves a long-term change in a chronic medication, we would discuss such a change with the patient's primary care physician before making a change, and the long-term prescription would be covered under Part D. If a patient is prescribed a new medication during the acute HaH-plus, but the medication needs to be continued for a course that extends beyond the acute period, such medications would be covered as part of the HaH-plus payment.*

- Please explain in more detail which “unrelated procedures” would be paid for separately from the HaH-Plus payment. The BPCI exclusions are defined in terms of DRGs, but the HaH-Plus patient would be receiving procedures on an outpatient basis.  
*Reply: In addition to exclusions based on MS-DRGs, BPCI also excludes Part B services on the basis of ICD-9/10 diagnosis codes. We propose that those exclusions lists would be applied to services furnished in settings other than inpatient.*

- What is the basis for the proposed 5% and 3% discounts, given that the proposal indicates that total savings of 19-34% have been achieved in the past?  
*Reply: Other studies that find higher savings in the inpatient setting do not include transition services, which are included in the HaH-Plus estimates for the acute portion of the episode. The 5% discount on the acute portion of the stay is derived from the cost work up shown in tables 1, 3, 4, and 5 of Appendix I, which is based in large part on Mount Sinai’s experience implementing its hospital at home model to-date.*

*With regard to the 3% discount, that is CMS’ share of savings. The estimated overall reduction for the acute and post-acute portion of the episode is \$1,259 per episode, or 9.6%, on average. CMS would retain 3% of the savings, which is in line with existing CMS episode payment models. If APM entities do not achieve all quality performance targets, CMS would retain additional savings by not paying out full performance-based payments to APM entities.*

*With regard to the 19-34% total savings, these estimates are based on comparisons of the inpatient episode alone. In the case of HaH-Plus, the costs of the 30-day transition services (including social work, clinician follow up and visits, community paramedicine services, and readmissions into the HaH-Plus program if needed) are “funded” out of the expected savings on the inpatient episode.*

- Are you proposing that all of the limitations and exclusions described on page 11 be included in the calculation of the benchmark? Do all of these limitations and exclusions correspond to limits and exclusions for the HaH-Plus program, or could some patients be included in the HaH-Plus program that would be excluded from the comparison group?

*Reply: Some of the limitations and exclusions described on page 11 correspond exactly to exclusions from the HaH-plus program. Specifically, HaH-Plus excluded beneficiaries under the age of 18, those transferred from another hospital, those who were residents of skilled nursing facilities, and those with lengths of stay of less than one day. Similarly, the full HaH payment does not apply to patients who receive Observation at Home services for only one day; hence, the comparison group excludes those with one day stays. The other limitations and exclusions are intended to draw a comparison sample that would approximate the HaH-plus patient sample even though a few could theoretically be included in HaH-Plus. For example, HaH-Plus patients have had one of among 50 DRGs, and the comparison group will be limited to the 50 DRGs. At the time of enrollment into HaH-Plus, however, we do not know what DRG will be assigned. Indeed, a DRG might be assigned outside of the 50 DRGs. Thus, this limitation is intended to approximate the patients in HaH-Plus. Similarly, the majority of program admissions have come from emergency departments, have had short length of stay, and have not died; therefore, we limited the comparison group to admissions from the emergency department with lengths of stay of 8 days or less, and no death in the 30 days.*

- If the hospitals or health systems participating in HaH-Plus provide most or all of the care in a CBSA for some of the DRGs, how would you adjust the comparison group for the shared savings/shared risk component? If all hospitals in the country ultimately participated in HaH-Plus, how would you propose to calculate the shared savings/shared risk component?

*Reply: If an APM entity provides most or all of the care in a CBSA for some MS-DRGs, it would be possible to utilize a broader geographic area to construct the comparison group, like state. CMS could set thresholds prospectively such that if an APM entity cares for more than X% of beneficiaries in an MS-DRG or group of MS-DRGs, then the comparison group is set at the state level.*

*If all hospitals were to participate, the payment could potentially become a single prospective payment that covered the entire episode rather than a retrospective reconciliation. The payment could still be increased or decreased based on past quality performance.*

- If HaH-Plus is implemented for patients who would otherwise be admitted to a hospital that is participating in the Bundled Payments for Care Improvement initiative, the Comprehensive Care for Joint Replacement program, or another CMS episode payment model for inpatient and post-acute care, should any adjustments be made to the spending targets for HaH-Plus or those other programs?

*Reply:* This is unlikely to be an issue for any procedural BPCI episode or CJR episode given that the HaH-Plus episodes are currently triggered by medical conditions. However, if a beneficiary were to initiate a HaH-plus episode at a BPCI hospital, that episode would not be considered a BPCI triggering event because it would not be a full inpatient admission. We would also propose that if a beneficiary initiated a HaH-Plus episode and had a subsequent admission to a BPCI hospital, the second admission would only trigger a BPCI episode if that admission were for a DRG that is excluded from the HaH-Plus episode. Otherwise, the second admission would not trigger an episode and would be included in the HaH-Plus episode.

- The proposal indicates that the episode length, method of reconciliation of costs, and number of beneficiaries served by the APM entity are modeled after the Oncology Care Model and the Bundled Payments for Care Improvement program. Do you believe that is the best way to define those elements, or were you simply trying to use existing CMMI methodologies wherever possible?

*Reply:* The latter – we believe that this approach is a feasible way to implement the HaH-Plus model in the near term. If CMS payment systems evolve in the future, it may be possible to create a single prospective payment for the entire HaH-plus episode, rather than the proposed approach of a prospective payment for the acute portion of the HaH-Plus episode with a retrospective reconciliation of total episode spending against a target price.

- The proposal indicates that other payers are not interested in the transition services or the shared savings component. Please describe what you see as the advantages and disadvantages for payers and providers from excluding these components.

*Reply:* Payers have actually been quite interested in the transition and other services, but they want to start initially with the more discrete hospital at home services. The hospital at home concept is new to all the payers, and they have spent time modeling the financial impact of the program on their products. The program necessitates changes in claims processing procedures. For this reason, they have opted to start with the discrete hospital at home episode and to consider transition services at the time of contract renewal.

- How could physicians in practices not affiliated with a hospital participate in this model?

*Reply:* Physicians who are not affiliated with the APM or the hospital would be able to participate in the model by seeing patients and billing traditional Medicare by fee for service. These services and reimbursements would not be

*part of the HaH payment, but they would be part of the reconciliation process. Consultants and other physicians who are not part of the HaH-plus team but who are involved in video visits to the home (as discussed under criterion 1) would be paid for the services by the APM entity under a fee schedule.*

- *How would Observation at Home and Palliative Care at Home payments be calculated? Please provide a detailed calculation example for each.*

*Reply: Cases of Observation at Home that are converted to a Hospital at Home episode (approximately 40% of cases in our program) would not be paid separately for the observation care. The entire episode would be paid as a regular hospital at home episode as detailed in the proposal (i.e., at 95% of the sum of the DRG payment and expected professional payments that would have occurred if the patient had been hospitalized). This is identical to how observation stays are treated if the patient is admitted to the hospital. The charges for observation unit stays are suppressed and the hospital is paid the DRG. For the remaining observation cases that are not converted to hospital at home, the partial payment would be made as described in the proposal. Specifically, a partial HaH payment would initially be set at \$2,500 (approximating the cost of an observation stay to Medicare) and then pegged to 25% of the average HaH-Plus payment after the first year.*

*For Palliative Care at Home, we propose that the initial HaH episode be paid as a regular HaH episode (i.e., at 95% of the sum of the DRG payment and expected professional payments that would have occurred if the patient had been hospitalized). Thus, the HaH payment is unchanged; however, we propose that certain quality metrics (the beneficiary experience and adverse event quality metrics, and the functional outcome collection metric on further consideration) be excluded for these patients in determining the performance-based payment. For these patients, the beneficiary experience, while relevant, is best measured with after-death surveys of bereaved parties; the adverse event and functional outcomes metrics require more nuanced consideration given the more complex goals of care in palliative care. Thus, for these patients, only the process measures would be included in the summary of the APM entity's performance measures for consideration of shared savings or repayment per the proposed formula.*

#### **Criterion 4. Value Over Volume**

**The proposal is anticipated to provide incentives to practitioners to deliver high-quality health care**

- The proposal acknowledges the potential for having patients admitted to the HaH-Plus program who would not have been admitted to the hospital.
  - Please explain in more detail who would carry out the auditing of clinical appropriateness, and how much this service would cost.

*Reply: The auditing of charts would be carried out by the APM entity, e.g. in the case that the hospital is the APM entity, the*

*hospital's case managers or utilization management staff can review the patient's record. In any case, we suggest that the auditing of clinical appropriateness be carried out for HaH-Plus patients in an equivalent manner as for patients who are admitted to traditional hospital care. In our market, we estimate the cost of such audits to be approximately \$30 per case.*

- Although clinical appropriateness criteria could prevent serving patients who would clearly be inappropriate for hospital admission, there is still the possibility that admission-appropriate patients who would otherwise have been discharged to their home or other residential arrangement with less intensive services would now be admitted to HaH-Plus. This could be particularly true for patients in nursing facilities or assisted living facilities. Appendix F describes a measure to monitor for this, but it indicates only that CMS could “track” the measure. Can you propose any mechanisms for incorporating this measure into the payment model? Wouldn't a broader population measure be a better denominator than ED visits?

*Reply: While it is conceivable that admission-appropriate patients may have been discharged to their home or other residential arrangement such as nursing facilities or assisted living facilities, we do not believe that this will be a significant issue. Our experience to date is that due to clinical staffing issues and payment issues at the nexus of Medicare and Medicaid payment, the vast majority of nursing homes are not amenable to accepting acutely ill admission-appropriate patients from emergency departments. Similarly, the vast majority of assisted living facilities are similarly disinclined to keep acutely ill patients in their facilities when they are acutely ill and require hospital-level services such as intravenous medications and the like. Further, our experience in discussing the implementation of HaH type models with nursing facilities is that they are resistant to having non-nursing facility nurses, social workers, and skilled therapists render care in their facilities, often for fear they might be in violation of regulatory issues related to care provision. However, the ability for assisted living facilities to care for acutely ill older adults may be enhanced by the ability to bring HaH-Plus to the facility and thereby help such patients avoid the high risk of iatrogenic illness and mortality associated with hospital care.*

*Regarding the ability to incorporate the measure in Appendix F into the payment model, we believe that the measure could be implemented as a “flag.” That is, if the measure is not met, and depending upon the magnitude of the gap in performance, it would trigger quality improvement efforts by the HaH-Plus team and or an audit by CMS to determine the nature of the underlying problem. Remedies to address the problem could include: 1) shutting down the program if the gap was large and not amenable to quality improvement efforts or indicative of abuse; 2) renegotiation of the rate of payment from CMS to the APM entity*

*Regarding a broader population measure than using ED visits as the denominator. A broader population measure may be possible, but if the goal is to have a measure that is associated with cherry picking, we submit that most*

*“picking” and “cherry picking” occurs in the ED and that this should be the focus of the monitoring measure.*

- The proposal indicates that an APM Entity “can choose to link physician salary to performance” and recommends “site-specific” methods for compensating physicians. Please provide at least one detailed example of how you think the attending physicians and clinicians could or should be compensated under the proposed payment model in order to support the goals of the program and create the appropriate incentives for physician participation and delivery of high-quality, appropriate care. Should there be any minimum standards for the compensation methods an APM Entity should use in order to achieve the effects described in Section 5.2a of the proposal? Please describe the structural flow of financial incentives from the APM Entity to the providers delivering the Hospital at Home care at Mount Sinai. How does Mount Sinai currently compensate its providers in Hospital at Home? Would Mount Sinai compensate its providers differently if the proposed payment system were implemented?

*Reply: We provide an example of how the attending physicians and clinicians could be compensated under the proposed payment model in order to support the goals of the program and create the appropriate incentives for physician participation and delivery of high-quality, appropriate care.*

*Compensation related to APM could be prorated for physician effort devoted to the APM. The APM portion would have a fixed compensation component, in this example 80%. There would be a 10% compensation supplement based on having managed  $\geq 80\%$  of the number of patients expected to be enrolled in HaH-Plus and another 10% supplement based on process, outcome and patient experience metrics detailed in the proposal.*

*Currently, Mount Sinai compensates its Hospital at Home providers in a manner comparable to other Mount Sinai providers. Providers receive a base salary plus bonus. The salary bonus is tied to quality and patient satisfaction metrics.*

## **Criterion 5. Flexibility**

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

- Would there be any limitations or incentives regarding the number or types of additional services that the HaH-Plus physician/clinicians ordered, since those services would be paid for separately and create the potential for exceeding the target spending level?

*Reply: The APM entity will be accountable for managing service using utilization review, incentives, and other techniques, but the model does not specify how this function is performed. In our current program, we have tracked utilization, including escalation in care resulting in hospital use. We have avoided basing provider incentives on these measures and have instead based incentives on quality and the patient experience. To manage utilization, we have relied on interventions at the program level. For example, we intensified our transition services for higher risk patients to reduce*



*readmissions rather than relying on incentives operating at the level of individual providers.*

- Would there be any mechanism for compensating consulting physicians differently, since they would need to visit patients in the home rather than the hospital?

*Reply: As noted in replies to related questions under criteria 1 and 3, home visits by consulting physicians have been infrequent. When they occur, they are billed to traditional Medicare by fee for service, and we are unable to alter these rates. These services and reimbursements would not be part of the HaH payment, but they would be part of the reconciliation process. Consultants and other physicians who are not part of the HaH-plus team but who are involved in video visits to the home (as discussed under criterion 1) would be paid for the services by the APM entity under a fee schedule, but this would not involve physical visits to the home.*

- Would there be any mechanism for adjusting the HaH-Plus payment amount or the spending benchmark based on the remoteness of the patient's home or other factors that are not captured in the DRG calculation?

*Reply: Although we have not envisioned such adjustments, such adjustments could be considered depending on feasibility and policy goals. We aver, however, that "remoteness" can take many forms. Transporting a patient and medical equipment such as oxygen up 5 flights of stairs to an apartment in a New York City brownstone can take significant time and effort even if the address is physically proximate.*

- Who is coordinating the full range of services the patient receives (e.g., scheduling and verifying provision of services)? Who coordinates and verifies the provision of services by consultants? Does a member of the core team directly supervise consultant-patient interactions in the home?

*Reply: The APM entity is accountable for coordinating the range of services, but how this function is performed can vary. In our program, we tested different methods of performing this task before arriving at our current approach where the plan of care is developed by the team under physician leadership, and a clinical nurse manager is responsible for managing overseeing execution of the care plan. The nurse manager is also involved in monitoring the day to day workload of clinical staff, scheduling accordingly, triage of patient related calls, and overseeing the scheduling of tests and consultants.*

- What does 24/7 access entail? How often would someone from the core care team be in the home around the clock? Would patient eligibility require availability of family members or others in the home?

*Reply: An HaH-Plus physician is available on call 24 hours a day, 7 days a week. Calls are returned in less than 20 minutes. Back up provisions are made for circumstances where someone may not be reachable (e.g., in the subway system). From morning to early evening hours, urgent home visits by the staff can be arranged. Additionally, we have arranged for 24/7 access to community*

*paramedicine providers who can see patients within 30-45 minutes maximum response time for clinical evaluation supervised by our HaH-Plus providers.*

*Family members or other caregivers in the home are not required. If patients do not have family or caregivers who are with them 24/7, they must be able call the HaH-Plus team in the event of an emergent clinical issue.*

- Could residents in skilled nursing facilities be enrolled in the Hospital at Home program? If so, would any modifications to the model be needed to accommodate these patients? What percentage of your current patients are residents of SNFs or Assisted Living Facilities?

*Reply: We replied to this question earlier under Criterion 1, but we include the answer here as well to facilitate reading. We have previously explored the feasibility of enrolling patients from nursing homes. We encountered several barriers, that while surmountable, would require significant program adaptation for each facility used. These issues include 1) having to use a nursing facility's staff in place of the HaH-Plus staff specifically trained to care for HaH patients; 2) use of the facility's lab, radiology, and pharmacy services; and 3) documenting in the facility's electronic record (in addition to documenting in the HaH-Plus electronic record. For now, we have excluded patients residing in nursing homes. In the case of assisted living, one assisted living facility where we attempted to serve patients with HaH-Plus also operated its own home care agency, and we encountered resistance from the facility. However, we are open to serving beneficiaries in assisted living facilities as long as outside nurses and physician visits are allowed. We estimate that 4% of HaH-Plus cases have been for beneficiaries residing in three assisted living facilities.*

## **Criterion 6. Ability to Be Evaluated**

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

- How could an evaluator determine whether APM Entities in HaH Plus were primarily hospitals that were admitting patients which other hospitals would have discharged? How would the model monitor and prevent inappropriate admissions to HaH Plus?

*Reply: We believe that comparisons to other hospitals may not be worth the effort due to differences in payer mix, patient mix, sociodemographics, and practice patterns apart from any efforts to inappropriately enroll patients in HaH-Plus. Rather, we believe that tracking the monitoring measure presented in the appendix to the proposal would be a more effective mechanism of tracking such behavior over time:*

$$\frac{\text{HaH Plus Episodes} + \text{HaH Observation Episodes} + \text{IP Admits} + \text{Obs Stays}}{\text{Total ED Visits}}$$

*Against the historical ratio of*

$$\frac{IP\ Admits + Obs\ Stays}{Total\ ED\ Visits}$$

*The numerators in both parts of the above ratio would be defined as IP admits and Obs stays starting with an ED visit. If comparisons were to be made to other hospitals, we suggest that the monitoring measure be used at both program and comparison hospitals and that the measure be tracked for change over time. As noted in the proposal, we also propose that all cases of HaH-Plus be reviewed using hospitalization criteria in common use. In our program, all cases managed in HaH-Plus have met such criteria.*

- What are the characteristics of hospitals that are likely to participate in this model? How might those characteristics impact the ability to evaluate the model, particularly the model's effects on increasing quality and reducing costs among Medicare beneficiaries?

*Reply: Based on our informal observations of organizations that have expressed an interest in our work (some of whom have provided letters of interest in the appendix to the proposal), we believe that organizations more likely to participate in the model would likely fall into one of the following two categories:*

- *An organized primary care or multispecialty physician group or IPA with a population health focus*
- *An integrated health system with a population health focus and/or issues with inpatient capacity.*

*For the purposes of evaluation, these features could be used to select a comparison group.*

- Would any minimum level of patient enrollment be required at each site? How will these targets be monitored?

*Reply: based on our experience and observations of other hospital at home programs, we suggest that a minimum patient enrollment of 200 cases per year across all payers is a reasonable goal. Programs should be allowed two years for start up to reach this level, and allowances should be made for variances (e.g., for programs with smaller population bases). Because all payers should be considered, these targets cannot be obtained from Medicare claims alone. We suggest that these targets be reported by the APM entity by payer and that the Medicare portion of the target be verified from claims.*

### **Criterion 7. Integration and Care Coordination**

**Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.**

- How would the HaH-Plus team engage with a patient's primary care physician in determining whether the patient was appropriate for HaH-Plus, in planning the type of home care they would need, and in making decisions about care during the

HaH-Plus stay? Would there be any compensation for the time the PCP spends providing information or advice to the HaH-Plus team?

*Reply: There are multiple ways the HaH-plus team may engage with the primary care providers of our patients – if a patient is in the emergency room we reach out to the primary care provider to notify them of the admission to our program, learn more about the patient, and discuss our plan. In addition, on discharge all primary care providers receive an email or call on discharge and a discharge summary within 48 hours. If the patient is being referred directly from the primary care provider's office then the PCP would be the one notifying us and we will discuss the case with them and again on discharge send them the two notifications. There is no direct compensation for the PCP time, however if the patient is appropriate and has consented to chronic care management this time spend by the PCP can count toward that monthly time total. In addition any face to face visits would be billed as usual. During the HaH stay the primary care provider is not making decisions about their care, but they can participate as much as they would like to. Lastly, Primary care providers who are not part of the HaH-plus team but who are involved in video visits to the home (as discussed under criterion 1) would be paid for the services by the APM entity under a fee schedule, but this would not involve physical visits to the home.*

- How would integration and care coordination be ensured when patients are escalated from Hospital at Home to the hospital?

*Reply: When patients are escalated to the hospital the HaH-plus team notifies the ED attending about the case and then discusses with them once the ED physician has fully evaluated them. The same medical records are used for the HaH-plus team and the Mount Sinai Hospital ED. If it is determined that the patient can return home to finish with HaH-plus then the ED and HAH-Plus attending will discuss the transfer back home and if the patient needs to be admitted, then the HaH-plus team will talk with the inpatient hospitalist and also the social worker assigned to the patient as the HaH-plus program still will follow the patient once they are discharged home.*

- How does the model ensure integration and care coordination with specialists not in the model (e.g., consultants)? How is information exchanged between providers within the model and outside the model?

*Reply: Just like referrals come from PCP, specialist such as cardiologist, have referred to the HaH –Plus program and we have communicated with them in the same way as the primary care provider. Since we are all on the same EMR all our notes are visible to them. On discharge from our program all patients get a Primary care provider appointment and if applicable also a specialist. We would fax the discharge summary in the same manner to an outside consultant if they are not part of our health system.*

## **Criterion 8. Patient Choice**

**Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients**

- The proposal indicates that patients and family would have the choice of electing HaH- Plus services instead of a hospital admission or observation stay.
- When and how would the patient or family be made aware that this option was available?

*Reply: Once a patient is determined to need or likely need admission to the hospital we are notified. The HaH-plus provider reviews the medical record for appropriate geographic location, insurance and any medical conditions that would not be appropriate for our program. Then we discuss with the ED attending or referring provider and approach the patient and family about our program. We first tell them about our services, making them aware of the option but that we need to evaluate further before we can approve them for the program. If agreeable we evaluate the patient with a home safety screen and a clinical assessment. Once it is determined that the patient is appropriate the formal consent is presented to them or their health care proxy.*

- Can you provide copies of information materials and informed consent forms that you use to explain the choice?

*Reply: See attached consent form (in English, Spanish, and Chinese) and patient brochures (in English and Spanish). Please note that the forms refer to the Mobile Acute Care Team, the name we were using at Mount Sinai for the program delivering what is referred to as HaH-Plus in the proposal. The inset box on page 2 of the brochure indicates that the patient can “choose to participate” and the first paragraph of the consent addresses the issue of patient choice.*

- Please provide any data you have on (1) the proportion of patients in each DRG category that you have found would be appropriate for HaH services and the most common reasons why patients are determined not to be appropriate, and (2) the proportion of the appropriate patients in each DRG category who actually elect to receive HaH services and the most common reasons why patients who are appropriate do not elect to receive HaH services.

*Reply: (1) We provide estimates for our health system’s Manhattan facilities that we have used for our planning purposes. The denominator in these estimates are Medicare FFS, Manhattan resident, DRG on accepted list, Manhattan facilities. To approximate the HaH-Plus population, we limit the numerator to LOS < 5 days, no ICU, no dialysis, appropriate admit/discharge source, % assumed appropriate home setting (assumed 95%), our clinicians’ estimates of the percent clinically appropriate by DRG.*

<b>Denominator</b>	<b>3,643</b>	<b>% of Denominator Still Eligible after criteria of row &amp; above applied</b>
LOS < 5 days	2,512	69%

No ICU	2,449	67%
No dialysis	2,315	64%
Appropriate admit source	2,314	64%
Appropriate discharge location	2,291	63%
% assumed clinically eligible within each DRG	793	22%
% assumed appropriate home setting	754	21%

(2) once we offer the HaH-Plus services 71% have accepted our program, we do not have the data broken down by diagnosis. The most common reasons that patients/families decline include 33% prefer to stay in hospital, 16% concern about impact on family member/caregiving responsibility, 11% did not want providers coming to their home 8% concerned about symptom control, 5% patients primary care or consultant physician recommended against it, 3% concern about safety in the home and 24% refusal with no reason or other.

- To what extent would the proportion of patients who are appropriate for HaH-Plus services depend on the number of patients participating in the HaH-Plus program? For example, would more patients allow a larger staff or different staff skills that would enable a broader range of patients to be cared for at home?

*Reply: The proportion of patient appropriate for HaH-plus would not depend on the number of patients participating in the program. However a larger staff would allow admission hours to expand to 7 days a week and later into the nights and potentially 24/7. In addition, the expanded staff would expand the geography. We are actively working on other DRGs that could be added in the future to the program and developing treatment protocols for them. Some of those newer DRGs (including pediatric DRGS) would require staff with different skill sets and thus a broader range of patients can be cared for in the home.*

## **Criterion 9. Patient Safety**

### **How well does the proposal aim to maintain or improve standards of patient safety?**

- In your current program, do you do proactive monitoring for patient problems, and how is that done? What kind of equipment is routinely available for monitoring patients in the home? Do patients who need continuous monitoring participate in HaH-Plus? How is a determination made that a patient is too complex to be cared for at home? How is this documented?

*Reply: In our program, all adverse events are reported using a formal Adverse Even reporter. These are reported by all of our staff including AA, SW, nurses, providers, etc. when anything goes wrong including medication errors, delivery problems, falls, escalations of care, etc. etc. Our medical director reviews all adverse events and reports all serious events to our Department of Medicine Vice Chair for Quality. We perform root cause analyses on all adverse events and have all-staff quarterly M&M meetings to review serious events, systemic issues and revise best practices and workflows.*

*Proactive monitoring occurs when the patients are visited by our providers –*

*patients get 1 physician/NP visit per day, often 2 RN visits, usual one other discipline – a SW or PT visit, plus often a phlebotomy. At each touch point we can be alerted to issues.*

*Patients have thermometers, pulse oximeters, blood pressure cuffs to use as directed in their homes. Patients who need telemetry are not admitted into HaH-Plus.*

*Every patient eligible/referred to HaH-Plus is evaluated for clinical criteria to determine if clinically appropriate for enrollment. Each clinical diagnosis has clinical exclusion criteria. For example, general clinical exclusion criteria regardless of diagnosis include: need for critical care unit; O<sub>2</sub> saturation is less than 90% or PO<sub>2</sub><60 on arterial blood gas after initial treatment and cannot be corrected with O<sub>2</sub> nasal cannula at rate of 6 liters/min or less; need for bronchodilation at interval of every 2 hours or less; EKG evidence of ischemia or chest pain suggestive of ischemia; Ketoacidosis; Systolic blood pressure <90 after treatment; Homelessness; Need for daily observed methadone administration. If a patient is not appropriate clinically for the program, a brief evaluation note is placed in their chart indicating that. If a patient is appropriate then then physician documents a full admission note (history/physical and admission orders).*

- In your current program, how quickly can you respond if a patient needs help? Are patients who live alone admitted to HaH-Plus, and how does a patient signal a need for help if they are alone and unable to make a phone call?

*Reply: HaH-Plus providers are available 24/7 by telephone and must respond to patients' calls within 20 minutes maximum. We have 24/7 access to community paramedicine providers who can see patients within 30-45 minutes maximum response time for clinical evaluation supervised by our providers. For less urgent issues, we can see patients within 24 hours of issues arising through house calls. We are considering adding remote vital sign monitoring, not because we have encountered problems, but rather to extend the types of patients we could enroll.*

*If patients do not have family or caregivers who are with them 24/7, they must call us to notify our team of an emergent clinical issue. If we feel someone may not be able to make a call, our SW team can explore getting them a LifeAlert button to use. We trigger our responses as outlined above with respect to response times.*

- The certification standards proposed in Appendix H include “responding to urgent calls 24 hours a day” and “ability to deliver same-day service,” but they do not include any measure or standard for actual response time. Do you measure your response time, and do you have any standards for response time that you seek to meet?

*Reply: We track our telephonic response time and aim for all clinical urgent calls to be answered within 20 minutes maximum. If the on call provider doesn't answer the call, the primary on call provider is paged twice 10 minutes apart. Then the answering service will page the back up call providers or medical*

*director to ensure patient safety. We currently do not monitor response time but are building capacity to do so. Our goal will be 100% of callbacks occurring within 20 minutes.*

- The proposal indicates that 7.1% of your patients have been “escalated” to the inpatient setting and that patients have the right to request an escalation. How many of the escalations were initiated by the patient or family? What kinds of factors prompted the escalation? How often are patients in each of the three variants (Hospital at Home, Observation, and Palliative Care) escalated to the inpatient unit?

*Reply: Two of 29 escalations (7%) were prompted by the patient or a family member: a patient who experienced shortness of breath that was considered manageable at home by the clinical team, and a patient who expressed discomfort with being home alone in the evening.*

*The 29 escalations occurred among 377 HaH patients. These rates are similar to those in the international literature on hospital at home. The reasons for our program’s escalations are as follows: clinical decompensation (66%), multiple concerns (10%; various combinations of inability to obtain IV access, mental status change, failure to improve, fall), inability to achieve intravenous access (7%), failure to improve (7%; wound infection and pneumonia), more advanced disease than originally identified (3%; pathology results demonstrating osteomyelitis returned after patient was transferred home), and inability to participate in the therapeutic plan (3%; patient with an upper extremity cellulitis was unable to maintain elevation of the arm). The nature of the decompensations were: shortness of breath or hypoxia (56%), delirium or other mental status change (17%), possible sepsis or systemic inflammatory response syndrome (17%), lethargy (6%), and a worsening wound infection (6%).*

*The percentage of patients escalated during HaH, Observation, and Palliative Care stays was 8%, 5%, and 0%, respectively.*

- Is it possible for patients to be escalated to settings other than a hospital inpatient unit? Can a patient in Observation be escalated to Hospital at Home? If so, how is payment determined for each of those phases of care?

*Reply: Patients admitted to Observation Unit at Home can be escalated to Hospital at Home if their clinical status does not improve as expected within 2 midnights of their presentation/admission, similar to the inpatient workflow. This is sometimes difficult to predict upon admission, and we base this decision on clinical criteria and Milliman admission criteria for the specific diagnosis. If a patient is discharged from Observation Unit at Home, the payment will reflect that model. If the patient is escalated to a Hospital at Home admission, the payment will reflect a Hospital at Home charge (with the Observation portion included within that, not a separate charge).*

- The proposal indicates that you have a system for independent review of adverse events



by an external committee. How are adverse events identified for this review? How many and what types of adverse events have you experienced in your program?

*Reply: All adverse events are reported and reviewed by our clinical director. They are identified by our clinical team including nursing staff, providers, social workers, physical therapists, and administrative staff depending on the issue. Events have ranged from more minor events such as delivery errors, delays to medication delivery, transportation issues to more serious events such as falls and medication errors. All major adverse events reported are reviewed by our medical director and then by our Mount Sinai Department of Medicine Vice Chair for Quality for review as well. Any deaths or hospital escalations are also reported to our medical director and the department for review as well. The rates are as follows: all cause mortality (excludes patients in palliative care at home since near term death is expected for patients in this group) 0.9% during the HaH acute period plus 2.3% in the postacute 30-day period (all these deaths have been reviewed and no quality issues were identified; deaths have occurred in patients with serious underlying illness; note that HaH-Plus includes patients who could meet hospice eligibility criteria apart from those in palliative care at home); pressure ulcers, 0.0%; falls, 1.6%; use of sedative medications, 0.2%; use of chemical restraints, 0.4%; use of physical restraints, 0.0%; use of Foley catheters, 1.6%; and nosocomial infections, 0.0%.*

- The proposal refers to licensing barriers in state and federal laws. Would any of the components of the HaH-Plus program require waivers of state professional licensure requirements?

*Reply: No, we have not required waivers of state professional licensure requirements. There have been some licensing barriers related to facility licensure that have limited our flexibility in an operating structure for the model. For example, New York State hospital licensing does not permit hospitals to send registered nurses into the home, so the program's nurses instead must be employed by our faculty physicians' practice. We have been in active discussions with the New York State Department of Health to ensure their understanding of our program.*

## **Criterion 10. Health Information Technology**

### **Encourage use of health information technology to inform care**

- You refer to using “an EHR adapted specifically for HAH-Plus” and describe a number of the changes you made to your EHR to make it functional for your goals. How feasible/how expensive would it be for other APM Entities to make these adaptations?

*Reply: There are a few key components that make HAH-plus EMR most functional. The reason for the unique needs is that the HaH-Plus program is an inpatient program functioning in the outpatient arena. Therefore in the EMR we use at our institution we had to pick either an inpatient or outpatient version to start with. Since the inpatient version was linked to too many parts of the hospital (bed control, inpatient pharmacy, inpatient lab draws), we had*

*to start with an outpatient version, which is mostly used for outpatient discrete visits.*

*We started with just the basic outpatient version and we did not have all of these upgrades at the start of our program. We feel they are not essential, but allow for better workflows as a program gets larger. 1) Active Orders list – so it is clear to all clinicians what the active orders are for the patient, 2) medication administration record – one of the great aspects of a hospital at home program is that the nurses can see in the home what the patient is actually taking for medications and there are less errors at the time of discharge. However, during the acute HaH portion we also need to see clearly what medications the patient has taken and has not taken – a Medication administration record is how inpatient medicine nurses document this. We did not have this functionality at first and just reviewed the active medication list daily, but once this was created for us, it greatly enhanced our workflow. The last key EMR feature was a sign out system that was linked or part of the EMR. Prior we used a HIPAA compliant program that allowed us to develop a sign out to hand off between nurses and doctors at the start and end of shifts, but it had to be retyped from the EMR. Once the EMR was able to develop a sign out function with in the EMR it enhanced the program. Therefore, none of these EMR enhancements were essential, but as a program grows they became key for patient safety and safe handoffs between providers.*

- Based on your experience, how have providers within and outside the model (e.g., consultants) managed to share information and ensure access to data in real time, particularly if providers use different EHR systems? What barriers have you experienced with information sharing, and what solutions could you envision?

*Reply: For any provider within the same EMR patient information can be shared in real time. We alert primary care providers when the discharge summary is ready to view, and also send to key specialists involved in a patients care. Due to the fact the discharge summary may take a day to complete, all primary care providers receive an email or call on the day of discharge to ensure a smooth transition.*

*For providers (PCP and specialists) outside of our EMR we fax information and have communicated provider to provider for real time questions. This is no different than in the hospital when providers outside of our network are notified.*

*In the future, it would be ideal if at Hospital at Home admission could be flagged in the RHIO (Regional health information organizations) which would allow real time triggers to those subscribed.*

- In the proposal, you acknowledge challenges with the home health care agency accessing and documenting care in the EHR. Please provide more detailed information on what the challenges were, what solution was employed for the Mount Sinai model, and how other model participants could surmount this challenge.

*Reply: This involved two main challenges: 1) double documenting – the nursing agency needed documentation in their records for compliance with*

*state regulations and for internal communications, but also the HaH- Plus program requires documentation in our EMR that is accessible in real time by our interdisciplinary staff. We were ultimately able to have the entire team is documenting in the main EMR (the HaH-plus EMR) and the nursing agency gets scanned copies or an administrative data entering in. 2) compliance within Mount Sinai for outside nurses documenting in the Mount Sinai EMR. We regularly allow outside agencies to have a read only access if appropriate for the relationship however in this situation it was a full access for documentation. We were able to work with our compliance to approve the staff and allow them to document with important chart audits etc. in place.*

*After both of the above challenges were resolved, for other reasons, we decided to internalize the nurses, and hire our own nurses who are not part of a home health agency and therefore we were able to document in only one EMR.*

# Replies to Additional PTAC PRT Questions on the Hospital at Home Plus PFPM Proposal

## *FOLLOW UP ON DISCUSSION ON JULY 21 CONFERENCE CALL*

We would like to provide the PTAC with additional information in response to the discussion on July 21 with the PRT and ASPE staff. The PRT expressed interest in two issues about which we would like to expand on the proposed approach to the payment modeled described in our proposal.

*1. The PRT was concerned about APM entities that might not be well prepared to manage acutely ill patients at home and was interested in steps that could be taken to prevent such problems and to detect their occurrence. We have given this further consideration, and we propose an additional monitoring process for the PTAC's consideration:*

- APM entities be required to identify and report all patients who a) die during the full HaH-Plus episode, excepting patients in palliative care at home; b) experience a serious fall contributing to an ED visit or hospitalization during the HaH-Plus acute period, or c) experience an escalation that includes any ICU stay.*
- Identified cases will be reviewed internally by the HaH-Plus team, as well as by mutually-agreed (with CMS) reviewer(s) or review committee external to the HaH-Plus team (e.g., a hospital or department mortality and morbidity review committee). A report will be finalized within 60 days of occurrence of the event and will include conclusions, recommendations, and actions taken if warranted.*
- Reports will be available, if requested, to the payor and to the certifying organization, including at the time of (re)certification.*
- APM entities will be expected to engage in quality review of other cases and episodes and this reporting requirement should not be interpreted as a minimum level of engagement in quality improvement.*

*The three types of events included in this monitoring process are expected to occur in the care of HaH-Plus patients but infrequently. These events were selected due to their potential seriousness but also because they could be detected and verified independently from beneficiary files (in the case of mortality) or claims, and thus, would not be solely dependent on voluntary reporting by an APM entity. Diagnostic codes are available for identifying fall-related injuries with reasonable accuracy, and ICU use is recorded on inpatient claims. The payor or designee would be able to verify completeness of reporting, inquire about cases identified from administrative data but not reported, initiate a review of the APM entity's reports if an APM entity has an aberrant number of events relative to other HaH-Plus programs, and take appropriate steps to remediate problems.*

*2. The PRT had questions about the payment model comparison group. In our proposal of how to set target prices, we selected a process that was administratively feasible and that would identify a comparison group that would approximate the characteristics of beneficiary episodes in HaH-Plus. The proposal included some potential adjustments that could be made when identifying the comparison cohort, including weighting based on DRGs represented in HaH-Plus, limiting the inpatient admissions to stays less than 8 days, and matching on HCC scores. If cherry picking remains a concern, this methodology could be extended to incorporate additional*

*adjustments to ensure that the comparison group (whether historical or contemporaneous) was appropriate. For example, it would be possible to limit the comparison group by excluding cases with SNF length of stay beyond a certain threshold (such as the median) when calculating target prices. Alternatively, it would be possible to develop a claims-based risk adjustment methodology using a historical comparison cohort that incorporates characteristics such as HCC scores, pre-admission utilization, and beneficiary characteristics.*

## **QUESTIONS FOR WRITTEN RESPONSE (NEEDED BY JULY 27)**

1. On page 5 of your response to the PRT's questions, you estimate that approximately 200 traditional Medicare beneficiaries would need to participate in the program annually in order for the program to be financially viable. Please provide us with the details of the methodology you used to make this estimate.

*Reply: Our estimate for program size and financial viability was driven in part by finances, but also by the need to have adequate staffing to maintain coverage and patient safety. The methodology for the finances for a program at 300 patients was provided in the appendix to the proposal and response to the PRT. However, that original model was not created to address the issue of "minimum size". In responding to the PRT request, we did not believe that 300 patients was necessary as a minimum for financial viability. We thought, however, that the assumptions in the model would largely apply for a slightly smaller program. Thus, we felt that the model supported the financial viability for a program of 200 patients once the inputs were pro-rated accordingly. Based on our experience as well as observations of other programs around the country, we felt that approximately 200 was a better estimate for the minimum size of program that would be needed to maintain a stable team and adequate staffing to support coverage and patient safety. The estimated 200 beneficiaries per year averaged to about four new patients per week. This would lead to approximately 3 to 4 patients in the acute phase of the program at any point in time, plus an additional 15 or so patients in postacute follow-up. We estimated that this was the workload that could be supported by the minimum staffing proposed in the response. We estimated that the revenue generated by this workload could support the staffing, supplies, and contracted services based on our projections in the model.*

2. In the proposal, you identified 44 DRGs in Appendix A as the targets for the program. However, in the participation data you provided on page 7 of your response to the PRT's questions, approximately 10% of the patients were in ten DRGs that were not listed in Appendix A – Dehydration (DRGs 640 and 641), Atrial Fibrillation (DRGs 308, 309, 310), Hypoglycemia (DRGs 643, 644, and 645), and Compression Fracture (DRGs 551 and 552). Most of the additional patients were in DRGs 640 and 641. Do you believe these additional DRGs should be included or excluded from the Hospital at Home Plus program? What led to the addition of these DRGs?

*Reply: The PRT is correct in noting the discrepancy between appendix A and the table provided on page 7 of our response. The proposed APM targets patients on initial presentation with acute illness. At the time of initial presentation, we focus on selected diagnoses and plans for medical treatment that we believe could be safely delivered at home. A DRG is not assigned to the case till after the services have been completed. As such, in many cases the final DRG assigned may fall outside of an expected list of DRGs.*

*Appendix A was a list of DRGs for patients that had been seen in our program as of some point in 2016. When the PRT requested additional information, we repeated that tabulation with our most recent list of cases. For that reason, approximately 10% of patients were in 10 DRGs that were not listed in appendix A. As noted in the proposal, we started our program in 2014 with a focus on eight specific diagnoses that other programs had targeted for the services. As we gained experience with our model; however, we were able to expand beyond the initial diagnoses as described in the proposal. This was an organic process. It made clinical sense to expand into these additional diagnoses as long as the patient needed to be hospitalized, met admission criteria, and the planned medical services could be safely delivered at home. Therefore, we do believe that these additional diagnoses and their eventual DRGs should be included in the plans for an APM.*

3. On page 9, you stated palliative care patients were excluded from the shared savings calculation due to their small numbers and systematic differences from regular acute care patients. Could you please clarify if these patients are excluded from the shared savings calculation entirely, or are only the adverse event and beneficiary experience measures excluded from the shared savings calculation for palliative care patients? Additionally, what measures would you propose instead to assess the quality of palliative care?

*Reply: Our intent was to exclude the palliative care at home patients from the adverse event and beneficiary experience measures only. We intended that these patients be included in the shared savings calculation (just as patients in observation at home who convert to hospital at home and patients who are escalated are included in the shared savings calculation).*

*In the current proposal, palliative care at home would include three of the proposed measures proposed for the performance-based portion of the APM. These three measures are: measures of care plan including advance directives, documentation of current medications in the medical record, and medication reconciliation post-discharge. We believe that these three measures are important and salient in the palliative care population. As the PRT indicates, the adverse event and beneficiary experience measures are excluded from the calculation. There are other measures that could be used to assess the quality of palliative care. These include surveys of bereaved family members, measures related to control of symptoms, and measures related to hospice enrollment over the 30 day period. Collection of these measures is possible, but they pose more difficult data collection considerations (e.g., the collection of survey data from the bereaved or the collection of data on symptom burden in actively dying patients). The challenge of including separate measures for the palliative care population relates to the small expected number of these patients for any proposed reporting period. Recall that the palliative care at home segment of this program is only a subset of patients with serious illness in the proposed HaH-Plus program, since other patients who may be hospice eligible can be included in the regular program and only those patients with hospice eligible conditions who would not otherwise be admitted to the regular program are included in palliative care at home. For this reason, we believe that quality measures for palliative care at home should be done by programs for quality improvement purposes at this time. At a later date, further consideration can be made for inclusion of such measures in the actual APM.*

4. Please provide the actual average inpatient acute spending for your patients, disaggregated into the categories shown in Table 5.
5. Please provide the actual average post-acute care spending for your patients, disaggregated into the categories of post-acute care services shown in Tables 2, 3, 4, and 5.

*Reply: We provide the table below as a combined response to questions 4 and 5. The table shows the costs of care of HaH patients (acute, observation at home converted to acute stays, and palliative care at home) for whom we have complete Medicare claims data, admitted into the program on or after January 1, 2015 and who completed care on or before December 1, 2016 (n=123). The number of episodes of HaH care presented in the table differs from the counts reported elsewhere. This table excludes observation at home patients who did not convert to acute HaH, as well as patients insured by Medicare Advantage and non-Medicare managed care plans. Additionally, claims data are not available at this time for several fee-for-service Medicare beneficiaries.*

*Costs were calculated from Medicare claims, the HaH program financial ledgers, and vendor invoices. The per episode total costs are less than HaH costs estimated by Milliman in the proposal: \$10,232 vs. \$11,875 and reported in our Hospital at Home Plus Provider-Focused Payment Model proposal. The major contributors to the difference are the lower costs of nursing (\$1,344 vs. \$2,078), skilled nursing facility care (\$86 vs. \$685) and 30-day readmissions (\$1,004 vs. \$1,878). Please note that costs associated with escalations of care that occurred during the acute period of care are reported as “Other” under “Services overlapping with DRG.” Readmission and skilled nursing facility costs were lower reflecting favorable utilization in the 30-day period (e.g., the observed readmission rate was lower than the 25% reduction entered into the model). Regarding nursing, the cost difference is likely due to several factors, including staffing during program ramp up, transition from using an outside nursing agency to our own program staff, changes in our nursing triaging function over time, and supervision costs.*

Number is episodes, 123 Minimum patient age, 19 years Average patient age, 79 years Maximum patient age, 105 years		
	<b><u>Estimated Average Allowed or Program Cost Per Episode</u></b>	<b><u>% of Total Episode Cost</u></b>
<b><u>Services Provided in Initial Inpatient Stay</u></b>		
Services overlapping with DRG		
Initial ED visit	\$411	4.0%
Nursing (and RN supervisor)	\$1,344	13.1%
Social work (and SW supervisor)	\$317	3.1%
Administrative assistance	\$195	1.9%
PT/OT/ST	\$24	0.2%
Hospital bed	\$3	0.0%
Other DME/equipment	\$58	0.6%
Drugs	\$65	0.6%
Radiology	\$11	0.1%
Medical supplies	\$35	0.3%
Labs	\$61	0.6%

Other	\$1,362	13.3%
Services not overlapping with DRG		
Professional services (NP+MD)	\$2,655	25.9%
Medical director	\$148	1.4%
Practice manager	\$147	1.4%
Program operations	\$52	0.5%
Patient transportation	\$105	1.0%
Provider transportation	\$124	1.2%
Home attendant	\$88	0.9%
Community paramedicine	\$2	0.0%
<b><u>Initial inpatient/HaH acute</u></b>	<b><u>\$7,209</u></b>	<b><u>70.5%</u></b>
<b><u>Post-acute</u></b>		
Readmission inpatient facility	\$1,004	9.8%
Skilled nursing facility	\$86	0.8%
Home health	\$674	6.6%
Hospice	\$209	2.0%
Outpatient facility – ED	\$64	0.6%
Outpatient facility – Other	\$200	2.0%
Professional services – IP readmission	\$192	1.9%
Professional services – Other	\$474	4.6%
Durable medical equipment	\$120	1.2%
<b><u>Post-acute total</u></b>	<b><u>\$3,023</u></b>	<b><u>29.5%</u></b>
<b><u>Total Average Episode Costs</u></b>	<b><u>\$10,232</u></b>	<b><u>100.0%</u></b>

6. For both palliative care at home and observation at home variants, please provide more description of the 30-day transition services provided, particularly for those palliative care patients transferred to hospice. Are the same transition services provided to these patients as for the acute care patients? If palliative care and observation at home patients do not receive the same transition services as acute care patients, how does the payment reflect that difference?

*Reply: Palliative Care at Home and Observation at Home both receive the same level of 30-day transition services as our acute care patients which ensures formal hand-offs to community-based services, as well as addressing any medical needs that may arise. The Social Worker is usually the lead during this post-acute period in order to fully address all psychosocial needs are met, follow-up with primary care physicians has occurred, and the patient and family understand the medication regime and have knowledge of red flags signaling when to call the physician. Nurses can also assume the lead role in this post-acute period as well depending on the presence of any unaddressed nursing needs including patient education. Because of the clinical differences with the Palliative Care at Home cohort, the focus in this post-acute period is targeted on goals of care and other end-of-life issues. Services during this 30 day post-acute period of time is at a similar level to all other Hospital at Home participants however for this group of patients services are front-loaded with most services being provided in the initial 7 days in order to assist patients/families with decisions regarding hospice services. Approximately 20% of Palliative Care at Home patients are referred to and enrolled in a Hospice program during the acute phase. Although these few patients do not receive formal transition services, our experience has been that the HaH team is called on and is available to the patient, family, and hospice team to provide continuity.*



7. On page 11, you provide a detailed response on how payments are made for patients escalated to the hospital. From this response, it appears that the APM Entity would always owe CMS money in those cases where patients are escalated. If this is correct, it appears there is a financial disincentive to escalate care. What safeguards are in place to ensure that escalation when appropriate or requested is done and how can this be monitored?

*Reply: The issue of how to handle care escalations vis a vis payment and incentives is challenging. An ideal system will honor patient and caregiver preferences and also create incentives to provide the high-quality, safe care in the correct setting, whether that be at home or to have care escalated to the acute care hospital, when necessary.*

*We believe that there needs to be some disincentive built into the payment model that discourages providers from shifting the costs of care from the APM entity to the acute care hospital. If such providers were simply able to send any and all HaH-Plus cases that turned out to be more expensive than initially anticipated to the acute care hospital, and not experience any adverse financial consequence, then we would likely see inappropriate and significantly higher rates of care escalations compared with historic norms when HaH-Plus is disseminated at scale.*

*We agree that it is likely that the APM entity would experience a loss on a case basis for the acute phase of the HaH-Plus episode of most patients whose care is escalated to the acute care hospital. However, we note that: 1) while the costs of the acute phase of the HaH-Plus case will be higher, the APM entity will be able to mitigate those losses by providing robust transitional in the post-acute care phase of the care episode thereby ensuring a lower readmission rate for the 30-day episode; 2) the rate of case escalations is relatively predictable (reported ranges from 2% [U.S. study] to 12% [U.K. study] (Leff B, Burton L, Mader SL, Naughton B, Burl J, Inouye SK, Greenough WB 3rd, Guido S, Langston C, Frick KD, Steinwachs D, Burton JR. Hospital at home: feasibility and outcomes of a program to provide hospital-level care at home for acutely ill older patients. *Ann Intern Med.* 2005 Dec 6;143(11):798-808 and Wilson A, Parker H, Wynn A, Jagger C, Spiers N, Jones J, Parker G. Randomized controlled trial of effectiveness of Leicester hospital at home scheme is hospital care. *BMJ.* 1999 Dec 11;319(7224):1542-6) based on the HaH literature and is a rate that can be accommodated under the proposed payment model.*

*We think of escalations as somewhat comparable to a situation hospitals face when a patient requires care that costs more than what may be reimbursed by a DRG. Hospitals do not make a margin on every case they care for, but that does not stop them from providing appropriate and sometimes very expensive care when patients require it.*

*With respect to safeguards, we believe that the payment model has some safeguards. Such patients would be more likely to be readmitted and/or experience an adverse event included in the quality metrics. Readmissions would increase the program's Medicare spending relative to the comparison sample and lead to either smaller shared savings or to repayment, and poor performance on quality metrics would affect shared the savings and repayment calculations. Please also see our discussion on page 1 following up on the conference call.*

8. Our question on page 12 about whether the patients deemed appropriate for HaH-Plus services would have a lower-than-average cost of inpatient care was intended to help us understand the financial impact of the program on the hospital, not Medicare. Under HaH-Plus, the hospital would have fewer admissions and we presume that the average cost and length of stay would be higher for the patients who would still be admitted to the hospital, but since Medicare would pay the hospital the same amount for the admitted patients as it did before, the hospital's operating margins would presumably decrease. Is this analysis correct? Do you believe this could discourage hospitals from participating?

*Reply: The PRT is probably correct in indicating that the hospital would have fewer admissions of the type admitted to HaH-Plus. For hospitals operating under risk arrangements, this may not be a concern. Further, for hospitals with capacity issues, fewer admissions of this type (which are generally lower margin admissions) would create an opportunity to fill the beds with higher margin cases. Further, creating capacity, may obviate need for future capital spending on additional inpatient facilities. This effect has been seen in Australia where the use of HaH in the state of Victoria (largest city is Melbourne) obviated the need to build a 500-bed hospital (Montalto M. The 500-bed hospital that isn't there: the Victorian Department of Health review of the Hospital in the Home program. Med J Aust. 2010 Nov 15;193(10):598-601. PubMed PMID: 21077817). Considering the cost of capitalizing a hospital bed (approximately \$2M in U.S.), this could represent substantial savings for health systems.*

*The PRT's presumption that the average cost and length of stay would be higher for the patients who would still be admitted to the hospital may or may not be true. The extent, if any, to which this occurs may be mitigated by a number of factors. The majority of DRGs involved in this program are trifurcated for severity of illness, and this would mitigate the extent to which such selection occurred for a given diagnosis in that selection could only occur within other cases with similar severity. Of note, contrary to this expectation, many HaH-Plus cases are in higher severity DRGs. Also, consideration should be given to the fact that avoiding these admissions should improve hospital throughput and that this will provide operational benefits to the hospital as well.*

*Further, even under circumstances where the hospital's operating margins would decrease slightly based on participation in HaH-Plus, the hospital would weigh the decrease in operating margins against the potential for increased revenue from HaH-Plus performance-based payments – either as a direct participant or through collaboration with a physician group practice that was the APM entity.*

*Finally we have fielded many requests for information from other hospitals and health systems or physician groups closely aligned with hospitals. Many have written letters of support provided in the appendix. This would suggest that many hospitals and health systems are actually encouraged rather than discouraged from participating.*

9. Please tell us how many all-cause hospital readmissions you have experienced and how the rate of readmissions compares to both standard all-cause readmission rates and the rates other hospitals have achieved under special transitional support programs.

*Reply: The total number of all cause 30-day readmissions in the hospital at home program was 28 through May 2017 (readmission rate, 7.8%). In comparison, a cohort of control patients who were eligible for HaH but refused to participate or were seen in an emergency department during hours when HaH was not identifying new patients (late evenings and weekends) had a 30-day all cause readmission rate of 16%. This is similar to the nationally representative estimated readmission rate of 18.4% among individuals similar to HaH patients who meet HaH eligibility criteria. This was calculated based on analysis of the 2015 Medicare 100% Limited Data Set claims files at hospitals with at least 500 inpatient admissions in the proposed HaH-Plus MS-DRGs. It is worth noting that some of the control cohort received transition services (not from HaH-Plus but) from Mount Sinai's transitions program described in the next paragraph.*

*In order to reduce hospital readmissions among individuals admitted with readmission penalty-eligible conditions (CHF, CAD, pneumonia), Mount Sinai developed a care transitions program called the Preventing Admissions Care Team (PACT). The program received funding from CMMI in 2012 and was renamed the Community-PACT program (CPACT). Patients are identified for CPACT during hospitalizations and receive an intensive, social work directed intervention that emphasizes close post-discharge follow-up with primary and specialty care and services to mitigate psychosocial barriers to disease management and control. The 30-day all cause readmission rate for CPACT was 17.8% in 2016 (445 readmissions among 2499 total patients). In comparison, patients in a comprehensive care transitions program for elderly Medicare beneficiaries that provided education, medication reconciliation, follow-up telephone calls, and linkage to community resources in the greater New Haven, CT area experienced readmission rates of 19.5% (Jeng G et al. JAMA Intern Med, 2016;176(5):681-90). Brock and colleagues reported an all-cause 30-day readmission rate of 18.9% for Medicare beneficiaries in hospitals that employed a care transition program that involved community-wide quality improvement activities to implement evidence-based improvements in care transitions by community organizing, technical assistance, and monitoring of participation, implementation, effectiveness, and adverse effects (Brock J et al. JAMA. 2013;309(4):381-91).*

10. The responses on page 24 appear to indicate that the APM entity would take responsibility for making the HaH-Plus program financially successful, that the physicians would have no direct accountability for program spending, and there would be no incentives in the physicians' compensation structure with respect to utilization or spending, only with respect to quality and patient experience. . Is that correct?

*Reply: We did not intend for the line between the APM entity and the physicians to be quite as stark as it may have come across in the response. Indeed, these APM programs are likely to involve a small group of physicians. As such, it would be difficult to separate the physicians from the APM entity with respect to incentives, accountability, and responsibility. Further, the group of physicians will certainly understand that compensation is tied to the APM entity's financial success. The intent of our response was to note that in our experience, interventions with respect to utilization and spending could be undertaken at the group level rather than targeting individual physicians.*

*Having said that, there is nothing in the APM structure that would prevent an entity from instituting incentives at the individual level.*

11. How do you believe the APM Entity should be structured organizationally in order to ensure success of the program? In particular, what role do you believe physicians should play in decision-making by the APM Entity and how would physicians be expected to participate in the costs, financial risks, and profits of the APM Entity?

*Reply: In traditional Medicare skilled home health care, which is very different from HaH-Plus, physician engagement is quite limited. HaH-Plus requires a high level of physician engagement to be successful. In all HaH adoptions in the Veterans Affairs health system and those under Medicare Advantage, physician engagement has been uniformly high. We have structured issues related to the APM entity as we have in order to ensure that this will occur in the context of our proposal. We expect that the APM entity will undoubtedly have physician leadership involved in governance, development, and implementation of the HaH-Plus clinical program and specifics related to financial considerations as to how physicians will be expected to participate in the costs, financial risk, and profits of the APM entity. We anticipate that local factors and local culture of the adopting organization will be highly influential in determining the specific parameters surrounding each of those issues.*

12. Please provide additional details on the arrangements you have for 24/7 access to community paramedicine providers. What organizations do you contract with for this service? Do only paramedics provide the home visits or do other types of personnel also provide visits through these organizations? Do the personnel receive any special training to support the HaH+ program? How much do you pay for this service? How often has it been used? Can you provide some examples of the types of patient needs that prompted use of paramedicine providers and what exactly did was done for the patients when they received these visits?

*Reply: We have a vendor agreement with an ambulance company who provides us 24/7 access to paramedic supervisors to go out on visits for us as part of a community paramedicine program. The only providers who do these visits are paramedics. They all have received special training through a full day course that we provide and then do 2 days of home visits through the Hospital at Home program or the House calls program. In addition our HaH program's physicians are certified by the Regional Medical Services Council of New York City (REMSCO) as telemedicine doctors to provide these services. Certification requires a special 4 hour course and an observation shift with a fully certified REMSCO doctors. We pay for a 1 hour visit and additionally for extra time the paramedic is on site. We launched this new arrangement in 2/17 and have had 16 encounters in the 10 months the program was active.*

*Example #1: 86 year old male admitted for Cellulitis. During HaH admission patient was found by wife laying on the bathroom's floor, awake but unable to get up with wife's assistance. This occurred minutes before the HaH SW arrived for a scheduled visit who then called the HaH MD and the HaH MD initiated CP call. Paramedics were able to assess patient, check vital signs and EKG, and assist patient back to bed. Since patient had no signs of injury, and fall was determined to be mechanical in nature, this case was appropriately managed at home.*

*Example #2: 82 year old male admitted for Congestive heart failure. In the late evening of day #3 patient's family called that he was more short of breath. He had been seen 3 times during the day and noted to have been diuresing well with decrease in weight appropriately. MD on call initiated a community paramedicine encounter, where he got an EKG and evaluation. He reported improvement in symptoms with out intervention, and was determined stable. He was encouraged to take his evening oral diuretic as planned. Patient was seen again first thing the next morning by the doctor and nurse and remained stable.*

13. On page 26, you recommend using “Total ED Visits” as the denominator of the monitoring measure. While we understand your rationale for this, are you not concerned that other programs designed to reduce avoidable ED visits, such as primary care medical home programs, could cause a spurious increase in the monitoring measure?

*Reply: It is theoretically possible that other initiatives could decrease the number of ED visits and thus create a spurious increase in the proposed HaH-Plus monitoring measure. If the APM entity participated in both HaH-Plus and other initiatives, and the APM entity experienced a decrease in total ED visits, we believe that it would be possible to adjust the denominator of the HaH-Plus monitoring measure to account for the decrease based on the change in ED visits attributable to the other initiatives. Specifically, this could be done by analyzing the change in ED visits across all entities participating in the other initiatives, regardless of whether those entities also participated in HaH-Plus.*

14. We had several questions about the eligibility calculation on pages 29-30:

- The table indicates that 754 patients were determined to be eligible, and then the response says that 71% of eligible individuals have accepted the program, which would suggest that about 535 individuals participated. However, Table 7 indicates that there were 353 total participants in the program, and the response on page 32 indicates there were 377 participants. Please explain the differences in these numbers.

*Reply: The numbers are different because we used different samples of patients (the larger pool of potentially eligible patients versus actual patients enrolled in the program) from different hospitals (all Manhattan Mount Sinai Health System hospitals versus hospitals where the program may have actually been active) for different time frames (calendar year versus years of program activity) to answer different PRT questions. It would be impractical and in some cases impossible to answer the PRT questions using the same set of patients from the same hospital and the same timeframe.*

*The 754 patients number was a response to a PRT request for the proportion of patients that would have been found to be appropriate for HaH services from the pool of potentially eligible patients. The only practical way to answer this question was to draw a sample of patients admitted to hospitals based upon DRGs that were retrospectively assigned. This was done for our health system's*

*Manhattan hospitals for a given timeframe. The 71% of eligible individuals that accepted the program was drawn from a sample of potentially eligible patients who were actually approached by the project team at the hospital where they would actually have been otherwise admitted at the time of initial presentation and before a principal diagnosis and DRG were assigned. The 353 participants in the program on page (not table) 7 was in response to a specific PRT request for the number of patients seen for the DRG list presented in the original proposal appendix A. The 377 participants noted on page 32 was part of the response to a PRT question about escalations in the program and reflected the number of patients whose escalations (if they occurred) had already been reviewed.*

- The table seems to indicate that 31% of the patients would be ineligible due to a LOS of 5 days or longer. How is it determined what the LOS will be before the patient is admitted?

*Reply: The PRT asked for the proportion of patients in each DRG that would have been appropriate for HaH services and the common reasons why patients were determined not to be appropriate. The query as phrased cannot be answered prospectively because DRGs are assigned retrospectively. Neither could the question be answered retrospectively because much of the information necessary to determine reasons for appropriateness could not be determined retrospectively. We answered the question assuming the PRT's intent was to understand the proportion of patients that could be potentially eligible for HaH services and the reasons why patients might not be eligible. As indicated in our response, we used data from our health system's Manhattan facilities, and the analysis attempted to approximate the HaH population that would be eligible. To approximate our decision to exclude patients who were too sick to be safely cared for at home, we limited the patient sample to those cases with the length of stay less than five days and excluded cases with any ICU days.*

- The table indicates that 41% of the patients would be ineligible due to clinical criteria – can you provide more details on the most frequent reasons for these exclusions?

*Reply: This was based on a clinical determination – each DRG was reviewed independently by 2 clinicians to determine the percent within each DRG that would meet eligibility criteria for treatment in hospital at home – for example DRG 603 cellulitis without major complications and comorbidities it was felt that 90% of the time that would meet criteria for admission to hospital at home, while DRG 292, heart failure with complication and comorbidity, which may need telemetry monitoring or include patients who require BIPAP or other respiratory support it was felt that 30% would meet admission criteria. After averaging the two clinicians predictions across all DRGs, the overall ineligibility for all the DRGs combined was 41%. It is theoretically possible that as the model evolves to include various telemonitoring options, a higher number would meet criteria for admission.*

- If possible, we would appreciate seeing the same calculation specifically for patients in one or more of the larger DRG categories.

*Reply: Below is an analysis of data from Mount Sinai Health System billing data from calendar year 2015, using 3 DRGs 193, 194, and 195. Across the three DRGs we'd expect 103 pneumonia admissions to be eligible for home hospitalization. You can see that for DRG 195 (SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC), a net of 79% of admissions are expected to be eligible for hospital at home (higher than the overall 21% of admissions expected to be eligible for hospital at home), but with DRG 193 (SIMPLE PNEUMONIA & PLEURISY W MCC) only 14% are expected to be eligible for hospital at home (lower than the overall 21% of admissions expected to be eligible for hospital at home). The difference is driven by the LOS cut and the % assumed clinically eligible cut (30% assumed clinically eligible for 193 vs. 95% assumed clinically eligible for 195).*

**Analysis details and output:**

- *Cuts already applied: Medicare FFS only, Manhattan residents, Mount Sinai Health System Manhattan facilities (Mount Sinai Hospital, Mount Sinai West, Mount Sinai St. Luke's, Mount Sinai Beth Israel)*
- *Analysis of 2015 billing data, inpatient admissions*
- *For "Overall" category, DRG row includes all eligible DRGs*
- *% still eligible = % still eligible after criteria of row & above applied*

	Overall		DRG 193: SIMPLE PNEUMONIA & PLEURISY W MCC		DRG 194: SIMPLE PNEUMONIA & PLEURISY W CC		DRG 195: SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	
	# IP Admissions	% Still Eligible	# IP Admissions	% Still Eligible	# IP Admissions	% Still Eligible	# IP Admissions	% Still Eligible
<b>DRG</b>	<b>3,643</b>		<b>95</b>		<b>133</b>		<b>41</b>	
<b>LOS &lt;5 days</b>	<b>2,512</b>	<b>69%</b>	<b>54</b>	<b>57%</b>	<b>103</b>	<b>77%</b>	<b>36</b>	<b>88%</b>
<b>No ICU</b>	<b>2,449</b>	<b>67%</b>	<b>52</b>	<b>55%</b>	<b>103</b>	<b>77%</b>	<b>36</b>	<b>88%</b>
<b>No dialysis</b>	<b>2,315</b>	<b>64%</b>	<b>45</b>	<b>47%</b>	<b>103</b>	<b>77%</b>	<b>36</b>	<b>88%</b>
<b>Appropriate admit source</b>	<b>2,314</b>	<b>64%</b>	<b>45</b>	<b>47%</b>	<b>103</b>	<b>77%</b>	<b>36</b>	<b>88%</b>
<b>Appropriate discharge location</b>	<b>2,291</b>	<b>63%</b>	<b>45</b>	<b>47%</b>	<b>101</b>	<b>76%</b>	<b>36</b>	<b>88%</b>
<b>% assumed clinically eligible within each DRG</b>	<b>793</b>	<b>22%</b>	<b>14</b>	<b>14%</b>	<b>61</b>	<b>46%</b>	<b>34</b>	<b>83%</b>
<b>% assumed appropriate</b>	<b>754</b>	<b>21%</b>	<b>13</b>	<b>14%</b>	<b>58</b>	<b>43%</b>	<b>32</b>	<b>79%</b>

home setting								
Net expected admissions	754	21%	13	14%	58	43%	32	79%

15. Please provide the monthly number of participants in the HaH+ program from the beginning in 2014 through the present.

*Reply: The number of participants shown in the table that follows needs to be understood with respect to 1) our initial plans; 2) what we encountered during implementation; and 3) implications for future enrollment here and by other APM entities.*

- The first year of our project was devoted to initial piloting and initial roll out. Year 2 was devoted to a program ramp up, and Year 3 (which we are concluding) was for implementation in three hospitals. Thus, our enrollment was always intended to be heavily weighted toward the third and current year, and most of our enrollment has come from only one (our first) hospital site.*
- We encountered some unanticipated issues as we moved to take a new program (that disrupts existing practices) from “proof of concept” to “implementation” in a multipayer system, particularly for patients who may present to the health system at any time of the day on any day of the week. We initially could not enroll patients presenting after hours, and we identified many eligible patients at all hours that had coverage that we were not able to serve (most Medicare Advantage plans or coverage other than traditional Medicare). The only way to serve all the potential Medicare patients would have required staffing beyond business hours that could only be justified if we were serving patients from multiple payers. Therefore, we decided to expand the scope of our services by enabling the enrollment of patients after hours and weekends but only if they were referred to us (with little active recruitment or enrollment on our program’s part). This enabled us to expand our services to at least some potential patients during evenings and weekends with little incremental staffing.*
- To tap into the full potential of the program requires a strategy that includes 1) having a payment model that can be adapted to different and multiple payers; and/or 2) using the program infrastructure and staff to support other related programs, including but not limited to home-based primary care. We have taken these steps for our program—steps that will pave the way for future APM entities. The proposed PFPM for traditional Medicare is part of that strategy.*

Month	HaH	Palliative Care Unit at Home	Observation Converted to HaH	Observation Not Unconverted to HaH	Rehabilitation at Home	Other home-based acute services
Nov-14	1	0	0	0	0	0



Dec-14	1	0	0	0	0	0
Jan-15	2	0	0	0	0	0
Feb-15	3	0	0	0	0	0
Mar-15	2	0	0	0	0	0
Apr-15	5	0	0	0	0	1
May-15	4	0	0	0	0	0
Jun-15	6	2	0	0	0	0
Jul-15	10	1	0	0	0	1
Aug-15	7	1	0	0	0	1
Sep-15	2	0	0	0	0	1
Oct-15	4	0	0	0	13	2
Nov-15	5	2	0	0	13	1
Dec-15	7	0	2	0	14	0
Jan-16	5	2	0	1	12	1
Feb-16	3	0	2	0	12	1
Mar-16	8	1	0	0	13	3
Apr-16	16	1	0	0	14	3
May-16	18	0	1	1	15	1
Jun-16	13	3	0	0	12	2
Jul-16	13	1	2	4	7	0
Aug-16	15	1	1	4	7	1
Sep-16	9	1	2	2	8	0
Oct-16	15	3	0	5	6	2
Nov-16	11	0	0	1	15	0
Dec-16	13	1	2	1	14	1
Jan-17	15	3	3	5	12	1
Feb-17	16	0	2	2	7	2
Mar-17	12	2	1	5	16	2
Apr-17	13	0	1	3	10	2
May-17	8	2	1	4	16	0
	<b>262</b>	<b>27</b>	<b>20</b>	<b>38</b>	<b>236</b>	<b>29</b>

16. On page 30, you indicate that you are developing treatment protocols in order to include additional DRGs in the program. Do you have treatment protocols for each of the existing DRGs? Could you describe generally how detailed the protocols are and how the protocols were developed? (Please do not submit any information that you do not want made available publicly.)

*Reply: We do have treatment protocols for 8 admitting diagnoses. Those were derived from existing inpatient order sets (from evidence based protocols) for conditions like Pneumonia and UTI and then modified by group consensus, including a Pharm D specializing in infectious disease protocols, for the home use. Many of our patients have more than one condition active or have comorbidities that alter the protocol (such as*

*renal impairment), so the protocols are used as guidelines for treatments but need to be customized for each case. Some are very detailed, especially for cellulitis, due to multidrug resistances and allergies. And some are more straight forward for pneumonia with only a few branching algorithms (community acquired vs nosocomial vs aspiration).*

17. On page 30, you indicate that adverse events are reported by program staff. Is there any mechanism for patients or family members to report adverse events?

*Reply: Patient/family calls with complaints or reports of an adverse event are triaged as any of our calls are triaged during the day time – with some messages going directly to the physician on call for the day. At night all issues go to the physician on call. All adverse events are recorded on an adverse event form by the staff and all are submitted to the clinical director for review.*

18. Please tell us how many adverse events have you experienced to date, what were they, and what was the response at the time the event occurred? In addition, please tell us how often an HaH+ patient had any of the following events:

- taken to an ED but not admitted to the hospital;
- admitted to a hospital for sepsis (either as an escalation or a readmission following discharge);
- experienced a fall;
- developed a pressure sore.

*Reply: Few patients in the HaH program have experienced adverse events to date. There have been no secondary (nosocomial) infections, no cases of pressure sores, and no use of physical restraints. Only 1.6% of patients had a Foley catheter insertion and 0.4% received a medication intended to treat agitation. In a review of 50 patient charts, one individual was identified as having experienced reversible acute kidney injury associated with use of furosemide. No other serious adverse drug events have been reported in the program. Falls were experienced by 6 patients. The number of individuals admitted to a hospital for sepsis is 2. Both cases occurred in the post-active period and are considered readmissions. The number of individuals taken to an emergency department but not admitted to the hospital is 15.*

19. On page 31, you indicate that you are considering adding remote vital sign monitoring because it could extend the types of patients you could enroll. What kinds of patients would you plan to enroll if you had this capability?

*Reply: If we had more frequent remote vital sign monitoring, it might allow us to catch any complications earlier, for example impending sepsis or worsening heart failure. Patient safety and oversight would likely be the largest potential advantage. In terms of expanding our possible patient population, it might allow us to enroll patients*

*with more blood pressure lability or hypotension or hypoxia than we do now, or allow us to take a patient directly home who the ED currently keeps in the observation unit for a night.*

## Submitter Comments on the PRT's Report on Hospital at Home Plus PFPM Proposal

We thank the PRT for its consideration. In the following table, we show the full PRT's Summaries of Rating for each of the ten criteria. We identify specific issues in each summary (bolded) and provide brief comments for each of these issues in the accompanying grid. On the right, we have included page references to prior discussions with the PRT that inform or further elaborate our comments here. 'Q&A1' refers to our initial written response to the PRT questions about the proposal. 'Q&A2' refers to our written response to additional questions the PRT requested. 'Call' refers, unsurprisingly, to the transcript of the July 21<sup>st</sup> call between the PRT and members of the HaH-Plus team.

<p>1. The proposed PFPM meets the criterion because the proposed services and eligible patients are significantly different from what is currently supported under standard Medicare payments and other Alternative Payment Models. However, the minimum number of patients needed to make the program financially viable will <b>likely limit the model to large communities</b>. An <b>all-payer option for the model could increase the number of potentially eligible patients</b>, particularly in regions with high Medicare Advantage penetration, to increase the number of geographies with sufficient patient volume. While the total savings to Medicare may be limited for the DRGs the submitter has currently identified, <b>the model could potentially be expanded to include other DRGs or other types of services</b>, such as the proposed Observation at Home and Palliative Care at Home variants, which could increase the potential savings.</p>		
Specific PRT Issues	Submitter Comment	Reference:
<p>"However, the minimum number of patients needed to make the program financially viable will likely limit the model to large communities"</p>	<ul style="list-style-type: none"> <li>We agree that the model is most suited to large communities; however, the VA and other programs such as the Presbyterian Health System in New Mexico have had success implementing this in less densely populated communities.</li> </ul>	<p>Q&amp;A1 pg. 5, 12-13 Q&amp;A2 pg. 2</p>
<p>"An all-payer option for the model could increase the number of potentially eligible patients, particularly in regions with high Medicare Advantage penetration, to increase the number of geographies with sufficient patient volume"</p>	<ul style="list-style-type: none"> <li>We agree that engaging other payers is important. As we mentioned in the PRT conference call, we have formed a partnership with Contessa Health to enable contracting and claims processing with other health plans. This would provide a mechanism by which other APMs could engage other payers in their market.</li> </ul>	<p>Q&amp;A1 pg. 12-13 Q&amp;A2 pg. 13 Call pg. 39-45</p>
<p>"While the total savings to Medicare may be limited for the DRGs the submitter has currently identified, the model could potentially be expanded to include other DRGs or other types of services, such as the proposed Observation at Home and Palliative Care at Home variants, which could increase the potential savings."</p>	<ul style="list-style-type: none"> <li>We agree with the PRT on the point that HaH-Plus is a foundation that could be used to provide other services that could potentially increase the potential savings. We have done such a process in the Mount Sinai Health System.</li> </ul>	<p>Q&amp;A1 pg. 1, 22 Q&amp;A2 pg. 3, 5</p>

2. The proposed PFPM meets the criterion. Multiple studies have demonstrated that the Hospital at Home care model improves quality and reduces costs, and the proposed PFPM seeks to improve quality of care for patients while reducing costs to Medicare. The PRT believes the model would benefit from modifications to ensure **patient selection is based on clinical rather than financial considerations** and to adjust the proposed payment for the likely lower spending on HaH-Plus patients relative to patients admitted to inpatient units. Also, **although the performance-based payments are tied to quality measures, there is no quality-based adjustment to the payment for the acute (inpatient) phase; the PRT believes the payment model would be strengthened by also tying the amount of payment for the acute phase to quality measures.** The PRT believes the payment model would be stronger if **measures of all adverse events and escalations to the inpatient unit were reported and monitored through a standardized plan for review.** Given the expected low rate of these events, the measures would not need to be used for payment adjustments but could be used to ensure appropriateness of admissions and quality of care. An option could be to adjust an individual payment to an APM Entity if an adverse event occurred and a review showed that inadequate steps were taken to prevent or respond to that event. The payment model could also be strengthened if there were an **auditing mechanism** (e.g., through a Quality Improvement Organization or Medicare Administrative Contractor) in place to further assure appropriateness for hospital admission, as is already done with inpatient admissions. Finally, **the PRT believes that the target price could likely be discounted further to account for the fact that HaH-Plus patients are less likely to have expensive post-acute care** (e.g., less likely to require skilled nursing) than their comparison group, but the data necessary to do this would not be available until after the PFPM had been in place for some years.

Summary of PRT Comment	Submitter Comment	Reference:
<p>“The PRT believes the model would benefit from modifications to ensure patient selection is based on clinical rather than financial considerations and to adjust the proposed payment for the likely lower spending on HaH-Plus patients relative to patients admitted to inpatient units.”</p>	<ul style="list-style-type: none"> <li>• We agree with the PRT that patient selection should be based on clinical appropriateness. We address the PRT’s suggestion that proposed payment be adjusted for lower acuity patients under Criteria 3, where our thinking is substantively discussed.</li> </ul>	<p>Q&amp;A1 pg. 12, 22-23 Q&amp;A2 pg. 7</p>
<p>“Also, although the performance-based payments are tied to quality measures, there is no quality-based adjustment to the payment for the acute (inpatient) phase; the PRT believes the payment model would be strengthened by also tying the amount of payment for the acute phase to quality measures.”</p>	<ul style="list-style-type: none"> <li>• We are open to considering quality-adjusted payment for the acute phase of HaH-Plus. We considered various methods for doing this, including adjusting future HaH-Plus payments based on prior-year performance. However, in the end we decided these mechanisms were either cumbersome (e.g., adjustments would be off cycle) or unnecessarily complicated, given that quality adjustments are already included in shared savings calculations as described in the PFPM. Additionally, further discounting at this time might pose barriers to entry, as providers will weigh the chance of achieving savings for their systems to take on the work of HaH development.</li> </ul>	<p>Call pg. 46-50</p>
<p>“The payment model could also be strengthened if there were an auditing mechanism”</p>	<ul style="list-style-type: none"> <li>• We have formulated two remedies to PRT concerns about measures and auditing. First, we have worked with NCQA to develop a certification process that includes in the accreditation criteria an expectation that HaH+ entities have processes and procedures in place for provider reporting of adverse events as well as accepting and handling patient reports of adverse events.</li> </ul>	<p>Q&amp;A1 pg. 14, 22, 30-31 Q&amp;A2 pg. 1, 6 Call pg. 26-27</p>

	<p>This should also include communicating the process to report such events to patients. Second, we have proposed required reporting to the payer or designee on falls, escalations to ICU, and deaths, as well as independent identification and confirmation of these events by payer/designee. These events are to be reviewed by the HaH-Plus entity and by a hospital committee or equivalent external to the APM entity. We propose that a report of each incident be finalized within 60 days, with conclusions and remedies if warranted. NCQA can include in its accreditation criteria that HaH-Plus entities have such processes in place. At the time of recertification, these reports can be requested for review by NCQA.</p>	
<p>“Finally, the PRT believes that the target price could likely be discounted further to account for the fact that HaH-Plus patients are less likely to have expensive post-acute care (e.g., less likely to require skilled nursing) than their comparison group, but the data necessary to do this would not be available until after the PFPM had been in place for some years.”</p>	<ul style="list-style-type: none"> <li>• We agree with the PRT that the target (benchmark) price can be adjusted in the future when more data is available. Having said this, we also believe our HaH-Plus program has demonstrated reduced complications that would otherwise have led to SNF stays. Additionally, we note that the benchmark derived from the financial model in Appendix G already assumes lower SNF use than the average Medicare population (12% vs. 20% postacute SNF use).</li> </ul>	<p>Q&amp;A1 pg. 19-20</p>

3. The proposed PFFM meets this criterion for the Hospital at Home component. The proposed payment methodology would fill the gaps in current Medicare payment systems that preclude delivering Hospital at Home services, and it is designed to achieve the goals of the PFFM criteria. However, the PRT believes the payment methodology would benefit from some modifications. **The DRG-like HaH-Plus payment should be adjusted based on performance on quality measures, and the magnitude of the discount should be set based on the costs of serving patients in the HaH-Plus program relative to the inpatient unit.** Additionally, the **benchmarking methodology requires refinement to account for differences between the HaH-Plus and inpatient populations.** The PRT also believes that the amount of risk the APM Entity bears should start at a lower level and be increased over time to reflect the APM Entity’s startup costs and its increased experience in managing patient care over time.

The PRT believes that the proposed components for “Observation at Home” and “Palliative Care at Home” are desirable services but the payment models for them are not sufficiently well described for a determination as to whether they meet this criterion. **The PRT does not believe the HaH-Plus program requires either “Observation at Home” or “Palliative Care at Home” to be successful,** though with further development these two components could potentially be added to the HaH-Plus program.

Summary of PRT Comment	Submitter Comment	Reference:
<p>“The DRG-like HaH-Plus payment should be adjusted based on performance on quality measures, and the magnitude of the discount should be set based on the costs of serving patients in the HaH-Plus program relative to the inpatient unit.”</p>	<ul style="list-style-type: none"> <li>• Adjustment of the HaH-Plus payment is addressed earlier under Criterion 2. With respect to basing the magnitude of the discount on the program costs, our proposal is to peg the HaH-payment to the DRG payment with a 5% discount, thereby adjusting for diagnosis. This discounted payment is to support the APM entity in providing HaH-Plus services for <b>both</b> the acute stay and <b>the 30-day transition services</b>. No separate payment is requested for the services over the 30 days. In our model, this has included transition visits, but also clinician home visits and community paramedic visits if clinically indicated. In some circumstances, we have initiated another HaH episode in lieu of a hospital readmission (in the proposed payment model this second HaH episode would not initiate a new bundle but would be part of the 30-day services for the index case). We decided against arbitrarily choosing a larger discount and/or proposing a separate payment for the 30-day services. A larger discount without payment for the transition services would likely result in less robust transition services and in discouraging APM entities from participating due to significant startup costs.</li> </ul>	<p>Q&amp;A1 pg. 19-20 Q&amp;A2 pg. 6 Call pg. 46-50</p>
<p>“The benchmarking methodology requires refinement to account for differences between the HaH-Plus and inpatient populations.”</p>	<ul style="list-style-type: none"> <li>• We previously discussed this in our response to the Criteria 2 findings, but we agree that the target (benchmark) price can be refined in the future with more data.</li> </ul>	<p>Q&amp;A1 pg. 12, 19-20 Q&amp;A2 pg. 7</p>

<p>“The amount of risk the APM Entity bears should start at a lower level and be increased over time to reflect the APM Entity’s startup costs and its increased experience in managing patient care over time.”</p>	<ul style="list-style-type: none"> <li>• We have no objection to this recommendation and agree that it can lower barriers to participation in the APM.</li> </ul>	
<p>“The PRT does not believe the HaH-Plus program requires either ‘Observation at Home’ or ‘Palliative Care at Home’ to be successful”</p>	<ul style="list-style-type: none"> <li>• It is correct that the model does not <i>require</i> Observation at Home to be viable, but we believe it is important to support HaH-Plus enrollment and reduce patient risks of hospital observation. Roughly 40% of Observation at Home episodes convert to HaH-Plus episodes, and in our experience, we have had trouble enrolling patients in HaH-Plus after 24 hours in a hospital observation unit due to patient and caregiver fatigue after spending more than 24 hours in the hospital. In the case of Palliative Care at Home, our proposal is to incorporate these cases into the HaH payment and Performance-based payments in the APM, only excluding them from the APM entity’s calculation of selected performance-based metrics due to their higher risk of mortality.</li> </ul>	<p>Q&amp;A1 pg. 1, 9, 22 Q&amp;A2 pg. 3, 6</p>



4. The proposed PFPM meets the criterion. The proposed PFPM includes incentives to providers to deliver high value care to patients participating in the model. However, because this model depends upon sufficient patient volume to make the program financially viable, there are still **risks that physicians would be incentivized to admit patients inappropriately**. The PRT believes that one way to mitigate this concern would be to **make the DRG-like payment contingent on quality**. Additionally, **monitoring for admission appropriateness and escalation will be critical**, and **adding an all-payer option may help to relieve some of the concerns around achieving a minimum volume**.

Summary of PRT Comment	Submitter Comment	Reference:
<p>“There are still risks that physicians would be incentivized to admit patients inappropriately. The PRT believes that one way to mitigate this concern would be to make the DRG-like payment contingent on quality”</p>	<ul style="list-style-type: none"> <li>• We discuss our thinking on linking the magnitude of the DRG-like payment discount to quality in our Criteria 3 discussion. The performance-based payment provisions putting the entities at financial risk for cost and quality also provide safeguards.</li> </ul>	<p>Call pg. 46-50 Q&amp;A2 pg. 6</p>
<p>“Additionally, monitoring for admission appropriateness and escalation will be critical”</p>	<ul style="list-style-type: none"> <li>• We agree - monitoring will be absolutely critical. As previously mentioned in our Criteria 2 discussion, we have revised our proposal after conversations with the PRT to include additional reporting on escalations to ICU, falls, and deaths to be reviewed by the HaH+ entity and by a hospital committee outside the entity. We propose a report of each incident be finalized within 60 days, with conclusions and remedies if warranted, and that these reports be available to auditing and re-certification bodies. We also outline substantive reporting in our original proposal aimed at ensuring clinically appropriate admissions.</li> </ul>	<p>Q&amp;A1 pg. 22-23, 30-31 Q&amp;A2 pg. 1 Call pg. 30-36</p>
<p>“adding an all-payer option may help to relieve some of the concerns around achieving a minimum volume.”</p>	<ul style="list-style-type: none"> <li>• As discussed in our Criteria 1 comments, we completely agree that engaging other payers is important. We have formed a partnership with Contessa Health to enable contracting and claims processing with other health plans. This would provide a mechanism by which other APMs could engage other payers in their market.</li> </ul>	<p>Q&amp;A1 pg. 12-13 Q&amp;A2 pg. 13 Call pg. 39-45</p>

5. The proposed PFPM meets the criterion. The single bundled payment for acute and post-acute care offers flexibility to redesign the delivery of care to achieve reduced spending and maintain or improve quality.

Summary of PRT Comment	Submitter Comment	Reference:
The single bundled payment for acute and post-acute care offers flexibility to redesign the delivery of care to achieve reduced spending and maintain or improve quality.	We thank the PRT for its assessment.	Proposal pg. 14-15

6. The proposed PFPM meets the criterion. The model describes evaluable goals for quality of care and cost. The Mount Sinai HCIA, which forms the basis for this proposed PFPM, is currently being evaluated, and lessons learned from that experience can inform the evaluation of this proposed PFPM.

Summary of PRT Comment	Submitter Comment	Reference:
The model describes evaluable goals for quality of care and cost.	We thank the PRT for its assessment.	Proposal pg. 15-16

7. The proposed PFPM meets the criterion. The HaH-Plus has several mechanisms in place to ensure that the patient's usual providers are aware of the patient's participation in HaH-Plus and are involved in care planning as appropriate. By providing care in the home, HaH-Plus providers can provide insights into the patient's home situation, which may be particularly useful for care planning.

Summary of PRT Comment	Submitter Comment	Reference:
The HaH-Plus has several mechanisms in place to ensure that the patient's usual providers are aware of the patient's participation in HaH-Plus and are involved in care planning as appropriate. By providing care in the home, HaH-Plus providers can provide insights into the patient's home situation, which may be particularly useful for care planning.	We thank the PRT for its assessment.	Proposal pg. 16-17

8. The proposed PFPM meets the criterion. Eligible patients may decide to participate in HaH-Plus or to receive traditional inpatient admission. Serving patients in their home affords patients and their families more control over the environment in which care is delivered.

Summary of PRT Comment	Submitter Comment	Reference:
Eligible patients may decide to participate in HaH-Plus or to receive traditional inpatient admission. Serving patients in their home affords patients and their families more control over the environment in which care is delivered.	We thank the PRT for its assessment.	Proposal pg. 17

9. The proposed PFPM does not meet the criterion. Although the HaH-Plus program would likely improve patient safety by reducing complications associated with hospitalization, the PRT believes that the proposed PFPM does not have adequate safeguards to assure patient safety in the home. The program specifies a minimum number of daily provider visits during the acute phase, and a patient can be escalated to an inpatient unit at any time. However, the PRT believes that further safeguards are necessary, such as (a) formal monitoring and review of the frequency of provider visits, (b) monitoring and review of the rate of escalation to the inpatient unit, and (c) monitoring and review of adverse events. Additionally, tying payment for the acute (inpatient) phase to quality may provide further incentives to assure patient safety.

Summary of PRT Comment	Submitter Comment	Reference:
“the PRT believes that further safeguards are necessary, such as (a) formal monitoring and review of the frequency of provider visits,	This is an understandable request, and after speaking with NCQA about whether this could be included in their certification process, they have confirmed that this can be incorporated into their review.	Q&A1 pg. 14
“(b) monitoring and review of the rate of escalation to the inpatient unit	As described in our discussions regarding Criteria 2 and 4, we have incorporated PRT feedback relating to items (b) and (c) into our proposal to ensure sufficient safeguards against these items.	Q&A2 pg. 1
“(c) monitoring and review of adverse events”	See above.	Q&A2 pg. 1
“Tying payment for the acute (inpatient) phase to quality may provide further incentives to assure patient safety.”	As previously discussed in Criteria 3 comments.	Q&A2 pg. 6 Call pg. 46-50

10. The proposed PFPM meets the criterion. While current EHR capabilities pose challenges to HaH-Plus program implementation, the proposed model encourages use of HIT. Implementation of programs such as HaH-Plus could encourage EHR vendors to develop better cross-setting and interoperability capabilities. Given their relatively small scale, individual HaH-Plus programs likely could be successfully implemented even in the absence of optimal EHR functionality.

Summary of PRT Comment	Submitter Comment	Reference:
While current EHR capabilities pose challenges to HaH-Plus program implementation, the proposed model encourages use of HIT. Implementation of programs such as HaH-Plus could encourage EHR vendors to develop better cross-setting and interoperability capabilities. Given their relatively small scale, individual HaH-Plus programs likely could be successfully implemented even in the absence of optimal EHR functionality.	We thank the PRT for its assessment. We should also note that we have provided feedback to our EHR partner. They are aware of the issues and are considering how their products can better address population health management needs.	Q&A1 pg. 33-35

PHYSICIAN-FOCUSED PAYMENT MODEL  
TECHNICAL ADVISORY COMMITTEE (PTAC)

PRELIMINARY REVIEW TEAM (PRT)

CONFERENCE CALL

Call with the proposal Submitter /  
Icahn School of Medicine at Mount Sinai

Friday, July 21, 2017  
11:00 a.m.

PRESENT:

HAROLD MILLER, PTAC Committee Member

LEN M. NICHOLS, PhD, PTAC Committee Member

ANN PAGE, Designated Federal Officer, Office of the  
Assistant Secretary for Planning and Evaluation (ASPE)

KATHERINE SAPRA, PHD, MPH, (ASPE)

ALBERT SIU, MD, MSPH, Icahn School of Medicine at Mount  
Sinai

ANIA WAJNBERG, MD, Icahn School of Medicine at Mount Sinai

NIYUM GANDHI, Mount Sinai Health System

BRUCE LEFF, MD, Johns Hopkins University School of Medicine

PAMELA PELIZZARI, MPH, Milliman, Inc.

DANIEL MULDOON, MA, Milliman, Inc.

DAN WALDO, Vice President, Economist, Actuarial Research  
Corporation (ARC)

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

[11:00 a.m.]

1  
2  
3 DR. SAPRA: So my name is Kate Sapra. I  
4 am the staff lead for this PRT (Preliminary Review  
5 Team) proposal. I'm joined in the room by Ann  
6 Page, who is another member of the ASPE (Office of  
7 the Assistant Secretary for Planning and  
8 Evaluation) PTAC (Physician-Focused Payment Model  
9 Technical Advisory Committee) staff.

10 And then the PRT members who are on the  
11 line, could you please introduce yourselves.

12 MR. MILLER: Hi. This is Harold Miller.  
13 I'm from the Center for Healthcare Quality and  
14 Payment Reform (CHQPR), and I'm the lead for this  
15 PRT.

16 DR. NICHOLS: Hi. I'm Len Nichols,  
17 Director of the Center for Health Policy Research  
18 and Ethics (CHPRE), at George Mason University. And  
19 I'm on the PRT.

20 DR. SAPRA: Fabulous.

21 And Rhonda Medows is another PRT member  
22 who, unfortunately, is not going to be able to join  
23 us today, but she did send some questions ahead of  
24 time. So we will try to include her voice here as

1 well.

2           So just I want to do a final reminder,  
3 since this call is being transcribed, it's most  
4 helpful to the court reporter if you can, in fact,  
5 identify yourself when you speak.

6           With that, I'm going to go ahead and turn  
7 it over to Harold Miller.

8           MR. MILLER: Thanks, Kate, and thanks to  
9 everybody from Mount Sinai and partners for joining  
10 us.

11           And as Kate said, Rhonda Medows is very  
12 sorry she couldn't join, had a last-minute schedule  
13 conflict, and we decided that it was in everybody's  
14 interest of time and trying to stay on schedule to  
15 proceed. But she'll be able to benefit from the  
16 conversation from the transcription.

17           Let me first thank all the folks from  
18 Mount Sinai for all the work you've been doing to  
19 improve care for patients and do work at home,  
20 patients' care at home, and I guess also to Dr.  
21 Leff, who's been a longtime advocate and pioneer in  
22 this area.

23           And thank you also for making the effort  
24 to develop a payment model to try to support this



1 care. It's one of the whole reasons why the PTAC  
2 was created, because there are a lot of  
3 opportunities to try to improve care for patients,  
4 but there aren't good payment models to support.  
5 And I suspect all of us have experienced personally  
6 the challenges of somebody who ended up having to  
7 be admitted to the hospital and we said why  
8 couldn't we just, you know, care for them at home  
9 if the right services and supports were there, so  
10 thank you for all the work to try to put together  
11 the payment model and the care model.

12           And thank you also for the work that  
13 you've done on the proposal so far. You've given  
14 us very clear, very detailed information, very  
15 concise information, and we appreciate that. And  
16 we appreciate the same kind of detail and clarity  
17 in the responses that you gave us to our initial  
18 questions.

19           Today is really just one step in our  
20 effort to try to make sure we fully understand what  
21 you're proposing, both in terms of the care model  
22 but also the payment model in particular, since  
23 that's really what our function is. And we wanted  
24 a chance to really hear from you in person about

1 that rather than just through written  
2 communication, and so we picked some issues to  
3 discuss that we thought would, in fact, really be  
4 easier to try to address through a dialogue rather  
5 than just written communication.

6           But if there's other information you want  
7 to convey on the call, feel free to do so. We'll  
8 talk through the questions that we sent you in  
9 advance, but if there's other issues you want to  
10 make sure we understand, we'd be happy to hear  
11 that. And if you have questions for us, feel free  
12 to ask those also.

13           And if there's specifics that come up  
14 during the call that you feel you need more time to  
15 respond to, you're welcome to just say, "We don't  
16 know that right now," and send us that information  
17 after the call.

18           So, this is really, as I said, one step in  
19 the process. So we have some other questions that  
20 we've sent to you that we're hoping for responses  
21 to, but if other issues come up on the call today  
22 that you want to send us supplemental information  
23 on, that would be fine, too.

24           So before we start, let me just see, Dr.

1 Siu and anybody else, any questions that you have  
2 for us about what we're trying to do today?

3 DR. SIU: No. I also want to take this  
4 opportunity to thank the Preliminary Review Team of  
5 the PTAC and the ASPE for what has obviously been a  
6 very thorough review of -- you know, of what we've  
7 submitted as well as for their very quick  
8 turnaround on various things. We are very  
9 appreciative of the effort that you all have -- are  
10 putting into -- into this as well.

11 MR. MILLER: Well, thank you in return for  
12 that. We feel sometimes like we are imposing on  
13 trying -- you, trying to ask lots of questions and  
14 have quick turnaround, but I think we all have the  
15 interest of trying to get something in place, a  
16 decision in terms of -- about this as quickly as  
17 possible.

18 So let me -- let me start. The first  
19 issue we wanted to explore was just the issue  
20 fundamentally of the safety of patients and how  
21 that gets assured through the project, what your  
22 experience has been with that so far, and what  
23 assurances you see as being built into the model.  
24 And we thought it could be helpful to us just to

1 explain a couple of hypothetical scenarios of  
2 patients experiencing problems and how you would  
3 respond to them, because there's clearly -- from  
4 the write-up, there are different types of staff  
5 and components designed to respond, so we wanted to  
6 understand kind of how those would all be mobilized  
7 and what circumstances and how patients -- how the  
8 problem gets identified, how people respond to it,  
9 et cetera.

10           So I'll turn it over to you, and if you  
11 need any clarification on that, feel free to ask.

12           DR. SIU: Okay. So feel free to interrupt  
13 with questions, if you have them.

14           MR. MILLER: Okay.

15           DR. SIU: We appreciate, you know, the  
16 PRT's concern about patient safety. Before going  
17 into four specific scenarios, which I'll ask Dr.  
18 Wajnberg to describe, let me just provide some  
19 background.

20           First of all, you know, all of our  
21 patients are screened at the time of intake for  
22 having a safe home environment in terms of having  
23 social supports, having meals in place, having  
24 access to telephone, et cetera, for -- for them to

1 reach us.

2           And, additionally, the patients have many,  
3 many touchpoints with us over the course of their  
4 acute period. All patients get either one MD  
5 (medical doctor) or a nurse practitioner (NP) visit  
6 or one RN (registered nurse) visit daily -- and one  
7 RN visit daily. However, they often get a second  
8 RN visit as well, particularly if they're getting  
9 infusions, for which many of our patients are  
10 receiving. They may get social work visits as  
11 well. Some patients get physical therapy visits,  
12 and some patients, you know, have visits with home  
13 health aides.

14           MR. MILLER: Can I -- can I interrupt for  
15 one second? So is it a -- is it a standard for you  
16 that is monitored, that there is, in fact, every  
17 day a physician or NP visit and an RN visit, and  
18 there is some mechanism for ensuring that that  
19 happens?

20           DR. SIU: That is true, with few  
21 exceptions. So that, for example, on the day of  
22 discharge, you know, if an MD or NP sees the  
23 patient, you know, and clears the patient for  
24 discharge, we may not have the RN visit on that

1 day, for example.

2 MR. MILLER: Mm-hmm. Sure.

3 But what's the mechanism that's used for  
4 quality assurance on that, so, you know, that  
5 somehow, you know, everybody thinks somebody else  
6 went, and they didn't?

7 DR. SIU: We actually have a nurse  
8 practitioner who is staffed with the function of  
9 being the traffic cop, if you will, who knows the  
10 status of every single patient, you know, where  
11 they live, you know, who happens to be nearby,  
12 because we can track all of our staff out in the  
13 field with an app, and is aware of who needs to be  
14 visited, who may need an urgent visit, you know,  
15 and when those things have occurred.

16 MR. MILLER: Okay, great. So keep -- go  
17 ahead. Keep going. Great answer.

18 DR. SIU: Yep.

19 In addition to that, you know, we're  
20 available to them by phone. You know, we actually,  
21 you know, keep encounter data on all of this and  
22 can estimate, you know, that there are about -- you  
23 know, about one-and-a-half calls on average for  
24 each episode with patients and family members, and

1 in addition to that, patients and family members  
2 initiate calls to us, you know, on average, a  
3 little less than one over, you know, each acute  
4 period.

5           And in addition to that, we have 24/7  
6 availability of our physicians and a protocol for  
7 backup, you know, if they happen to be in the  
8 subway and unreachable, et cetera, so that we can  
9 reach and answer any call within 20 minutes.

10           So there are really many in-person and  
11 telephone touchpoints that occur daily. I'm not  
12 even counting the administrative calls, you know,  
13 that we may make to ensure the deliveries have been  
14 made, to ensure, you know, that things have been  
15 scheduled, et cetera, you know, by our  
16 administrative staff.

17           So there are many touchpoints. That's  
18 just some background to a number of cases that we  
19 want to just present to you. These are real cases  
20 where we've changed some of the facts because of  
21 PHI (protected health information).

22           MR. MILLER: Okay.

23           DR. SIU: But Dr. Wajnberg will walk you  
24 through, you know, a couple of cases, and again,

1 feel free to interrupt.

2 MR. MILLER: Okay. Thanks.

3 DR. WAJNBERG: Hi, everyone. This is Ania  
4 Wajnberg speaking. I'm one of the physicians on  
5 the team.

6 So, as Dr. Siu highlighted, there are many  
7 different ways that clinical issues come to our  
8 attention, and these cases will give you examples  
9 of those. Happy to answer any questions.

10 The first example is a 63-year-old woman  
11 who we admitted for acute care in her home for both  
12 heart failure and COPD (chronic obstructive  
13 pulmonary disease) exacerbation and was being  
14 treated as such.

15 On her second day of admission, she  
16 herself called our office complaining of a  
17 nosebleed, and we were able to assess over the  
18 phone with a provider in real time. The provider  
19 stayed on the phone with the patient for about 20  
20 minutes, instructing her how to apply pressure,  
21 ice, et cetera, until the bleed stopped. She was  
22 able to report that.

23 We were able to advise her on a nasal  
24 spray that she could start that day. We instructed



1 her on how to use it, and she was seen shortly  
2 thereafter for her regularly scheduled nursing  
3 visit where no further bleeding was noted during  
4 the episode. So that's an example of someone who  
5 brought an issue to our attention and was able to  
6 be managed by phone with a regular scheduled  
7 follow-up.

8 MR. MILLER: Okay, great.

9 DR. SIU: And the vast majority of the  
10 queries that we get from patients and families can  
11 be addressed by phone.

12 MR. MILLER: In that particular case, when  
13 you said the nasal spray, is that something that  
14 she would have had that you knew she had already?

15 DR. WAJNBERG: Sometimes it is, and  
16 sometimes it isn't. In this case, it wasn't. A  
17 nosebleed wasn't sort of an expected part of this  
18 course, but it was something that we could quickly  
19 ensure that she got from a local pharmacy or that  
20 some -- in some cases, another example, something  
21 we could provide quickly for follow-up.

22 MR. MILLER: Okay.

23 DR. NICHOLS: So this is Len.

24 This all sounds very good, and I guess I

1 just want to follow up on the nasal spray thing.  
2 You mentioned at the outset that you screen  
3 patients for a supportive home environment. Does  
4 that include like having someone who can run and  
5 get the nasal spray, or in kind of worst case,  
6 would y'all deliver it?

7 DR. WAJNBERG: Yes and yes. So we  
8 definitely assess what their home supports are,  
9 both, you know, paid, unpaid, living with them,  
10 nearby. So we know -- we know all that going into  
11 it.

12 But, certainly, in some cases -- and maybe  
13 nasal spray is not the best example, but in some  
14 cases, we will deliver, we will pick up, or we will  
15 provide from our own office whatever they need.

16 DR. NICHOLS: Great. Thank you.

17 MR. MILLER: Well, let me -- let me also --  
18 - this is Harold again. Let me follow up on that,  
19 and you may be getting to an example of this. But  
20 it would help just to clarify -- under what  
21 circumstances would a patient who lives alone -- no  
22 spouse, no one else in the, you know, house or  
23 apartment living with them -- under what  
24 circumstances would you determine that they were a

1 candidate for this?

2 DR. WAJNBERG: When we enroll any patient,  
3 we assess their level of function. The majority of  
4 patients that we enroll do have some caregiver in  
5 the picture. A minority of patients are alone.  
6 They don't have to have a caregiver, but if they  
7 are alone, we need to assess and feel confident  
8 that their level of function allows them to contact  
9 us whenever they need anything, to feed themselves,  
10 to be able to transfer to the bathroom, and some  
11 other basic functional assessments that we make.

12 In those cases, if a medication were  
13 necessary, we would almost always be able to  
14 arrange for delivery of that medication or bring  
15 that medication ourselves to that patient.

16 MR. MILLER: And I -- well, let me -- I  
17 won't -- I was going to say I'll assume, but I'll  
18 ask. So in what circumstances would the particular  
19 health problem that they have intersect that? So  
20 are there health problems that you would say are  
21 too at risk of a sudden problem arising that might  
22 make them unable to contact you that you would then  
23 rule out on that basis?

24 DR. WAJNBERG: Yes. That's something that

1 goes into our consideration when we are enrolling  
2 them. Also, some of the cases might highlight a  
3 situation where we decide that based on something  
4 happening in the home or that we assess by phone or  
5 on our visit, we decide that that patient is no  
6 longer safe. I think that's what you're getting  
7 at.

8 MR. MILLER: Mm-hmm. Okay, great.  
9 Thanks.

10 I'll let you keep going with your  
11 hypothetical.

12 DR. SIU: And while we're on the subject  
13 of living alone, I don't know if Dr. Leff wants to  
14 chime in with something relating to his previous  
15 experience on this issue.

16 DR. LEFF: Yeah. Hi. This is Bruce Leff.  
17 So, Harold, Len, just to reflect back on  
18 some of the work that we did in our national  
19 demonstration studies a while back where we tested  
20 Hospital at Home (HaH) model in several Medicare  
21 Advantage-type plans, in our trial, actually 40  
22 percent of the people lived alone. And, you know,  
23 we had fantastic clinical outcomes. There are some  
24 people who live alone who need assistance with

1 activities of daily living, and we found that for  
2 those people, we could provide an aide in the home  
3 when they needed that. And it's a -- you know,  
4 compared to the cost of a -- of the hotel cost of  
5 the hospital, it's actually a very inexpensive  
6 input to be able to keep someone at home.

7           And, you know, the people who are being  
8 selected for care in the home, as Ania described,  
9 meet medical eligibility criteria, which were  
10 developed and validated to appropriately choose  
11 people who need to be in the -- need hospital-level  
12 care but who could be safely cared for at home and  
13 actually have a low risk of that sort of  
14 decompensation that you're describing. And that's  
15 been seen in, you know, many, many studies in the  
16 literature on that score.

17           MR. MILLER: Mm-hmm. Thank you. That's  
18 helpful.

19           I mean, we all know that being in the  
20 hospital is not always a guarantee that one is  
21 going to get what one needs immediately either, so,  
22 anyway --

23           DR. SIU: Let's go on to a case -- a  
24 second case.

1 DR. WAJNBERG: Okay. So the second case  
2 is to highlight some of our capabilities in terms  
3 of a more urgent type of response. So this is an  
4 86-year-old male who we admitted to home for  
5 cellulitis, and during the course of his acute  
6 admission, he was found by his wife lying on the  
7 bathroom floor, awake, alert, but unable to get up.  
8 And the wife couldn't help him get up.

9 This happened to occur minutes before a  
10 scheduled social work visit. So the social worker  
11 arrived, called the MD on call, and our MD was able  
12 to initiate something called a community  
13 paramedicine call, which I'll describe briefly.

14 Our MD's have 24/7 access to a paramedic  
15 in the field who can respond within about 45  
16 minutes to any call. Paramedics were able to  
17 assess this patient, check vital signs, do an exam,  
18 an EKG (electrocardiogram), review all of that with  
19 our physician, and assist the patient back into  
20 bed.

21 Since the clinical assessment was stable  
22 of the patient, and the fall was determined to be  
23 mechanical without any serious injury, we were able  
24 to keep that patient at home and continue

1 management of his issues.

2 DR. NICHOLS: And that's great.

3 The paramedics, are they on Mount Sinai's  
4 payroll? Is this a special deal you've got with  
5 New York City paramedics? How does -- how are they  
6 compensated?

7 DR. WAJNBERG: We have a program that is  
8 part of Mount Sinai, but the actual paramedics are  
9 through a third-party partner (TPP).

10 DR. NICHOLS: Okay. But are the costs for  
11 this kind of on-call service -- would that be baked  
12 into the bundled price?

13 DR. WAJNBERG: Yes.

14 DR. NICHOLS: Okay, good.

15 DR. WAJNBERG: Yes. And we're able to pay  
16 per call.

17 DR. NICHOLS: Just varying for that.

18 Okay, great. Thank you.

19 MR. MILLER: Yeah. Well, that was part of  
20 the question, was, you are actually paying for that  
21 visit yourself. In other words, it's not sort of  
22 an EMS (emergency medical services) call that would  
23 be covered sort of through a standard community EMS  
24 visit. You're -- you would actually be billed by

1 them for that. Is that correct?

2 DR. WAJNBERG: Correct.

3 DR. SIU: Correct.

4 And they would not be able to bill  
5 Medicare because Medicare does not reimburse for  
6 this.

7 DR. NICHOLS: Great.

8 MR. MILLER: Mm-hmm.

9 And in that -- just to stay on that case  
10 for one second, because earlier you suggested that  
11 the physicians were on call and would respond  
12 quickly. So why in a particular case like this do  
13 you call the community paramedicine service rather  
14 than having a physician or a nurse go there?

15 DR. WAJNBERG: Good question. Often --  
16 there's a few reasons. The paramedic is often able  
17 to respond quickly and more quickly than perhaps a  
18 member of our team, who might be with another  
19 patient or on something else, you know, doing  
20 something else at that moment. So that guarantees  
21 us the ability to respond within an hour to any  
22 urgent complaint, no matter what the staff is doing  
23 or what neighborhood they're in at that time.

24 Also, a paramedic is able to bring with



1 them and employ some treatment services in real  
2 time that we can use that we may or may not have  
3 with us, with an MD or nurse response.

4 Right now, what that includes is anything  
5 that a paramedic always carries with them. There  
6 are various examples of that, but we are able to  
7 quickly employ treatment modalities through the  
8 paramedic service that we might not be able to do  
9 with an MD follow-up visit, for example.

10 MR. MILLER: So does that include starting  
11 an IV (intravenous) solution for rehydration, if  
12 that was necessary, which you, the doctor, doesn't  
13 carry around with them, or what -- what kind of  
14 thing are you speaking of?

15 DR. WAJNBERG: Yes. Various IV treatments  
16 -- again, not everything -- limited to what they're  
17 allowed to do, IV Lasix, IV hydration, oxygen,  
18 nebulizer treatments, a host of things that they  
19 can do and automatically bring with them.

20 We'd have to know what to bring to be  
21 prepared, and sometimes we are, and sometimes  
22 they're able to have all of that quickly.

23 MR. MILLER: Mm-hmm. Okay, good. Yeah,  
24 yeah. Very helpful. Thanks.

1 DR. SIU: They are also able to transport  
2 if a decision is made to transport.

3 DR. NICHOLS: Yeah. I was going to say,  
4 in a sense and given their experience, they could  
5 decide on the spot, this person needs to be in the  
6 hospital and here they come. Right? I mean --

7 DR. SIU: That's right.

8 DR. NICHOLS: Yeah. Okay, good.

9 DR. SIU: Right.  
10 So let's move on to case number 3.

11 DR. WAJNBERG: Okay. So this gets at a  
12 little bit what we spoke about perhaps in the first  
13 discussion. This is an example of an 84-year-old  
14 woman with asthma and venous stasis ulcers who was  
15 admitted to home for cellulitis. The patient had  
16 tried oral antibiotics, failed, and was admitted to  
17 our program for IV antibiotics, which she received  
18 for four days, with some improvement. But on  
19 multiple visits, scheduled visits into her home, it  
20 was noted that she was not adherent with elevating  
21 her legs. She would elevate them briefly when  
22 someone was in the home, but then her aides and  
23 caregivers were unable to get her to do that while  
24 home.

1           Because of that, and because her  
2 improvement wasn't as rapid as we hoped it would  
3 be, we escalated her to the hospital where she  
4 would be more closely monitored for her adherence  
5 with the treatment plan, and then she was brought  
6 in by ambulance. She was in the hospital for four  
7 more days, did well, and was able to go home.

8           MR. MILLER: Okay.

9           DR. WAJNBERG: Any questions on that one?

10          MR. MILLER: Nope.

11          DR. NICHOLS: So did you teach her to  
12 adhere a second time? I mean --

13          MR. MILLER: It sounds to me like it was  
14 probably not a teaching exercise in the hospital.  
15 It was more of a, you know, continuous, monitoring.

16          DR. WAJNBERG: Right.

17          So, really, the goal there is to highlight  
18 that we have a lot of eyes and ears  
19 [unintelligible], and when things aren't going the  
20 way we expect, patient safety is really paramount.  
21 And we will escalate if the -- either the outcome  
22 is not improving rapidly or if just the plan, we're  
23 not able to keep that plan going for whatever  
24 reason, including adherence.

1 MR. MILLER: Okay. Case 4.

2 DR. WAJNBERG: Okay. So another example,  
3 75-year-old man admitted for heart failure  
4 exacerbation, admitted really for IV diuresis.  
5 Patient was doing well, diuresing well, improving  
6 symptoms, and was already seen that day by their  
7 nurse and by their nurse practitioner. However,  
8 later in the afternoon, the patient complained of  
9 abdominal pain and distension. We were able to  
10 deploy an urgent nurse visit, and the nurse was  
11 able to conference back with the physician in real  
12 time. Those symptoms were thought to be due to  
13 fluid retention in the abdominal area, and it was  
14 noted on the afternoon visit that the patient had  
15 gained weight even since that morning. Diuretics  
16 were titrated, and the patient's symptoms were able  
17 -- we were able to resolve those symptoms over the  
18 next day or two at home. So that highlights what  
19 you brought up earlier. Instead of a community  
20 paramedicine visit, we were able to handle that  
21 with the treatment team.

22 MR. MILLER: So in a situation like that,  
23 though, one might say, "Okay, we think we know what  
24 the appropriate intervention is, but if you were in

1 the hospital in theory, someone would be  
2 continuously monitoring, you know, or frequently  
3 monitoring to see whether or not the diuretic was,  
4 in fact, resolving the symptoms, et cetera. How do  
5 you deal with that in a situation like this, where  
6 it's not, per se, a need to escalate to the  
7 hospital? Somebody comes, designs an intervention,  
8 but the person would, in theory, need now more  
9 intensive follow-up monitoring to make sure that  
10 that intervention worked.

11 DR. WAJNBERG: Mm-hmm. We're able to use,  
12 I mean, in this case, a lot of modalities that, for  
13 example, would be used in a hospital to monitor how  
14 much urine output there is, to monitor, you know,  
15 vital signs and whatever else is relevant to the  
16 patient. Remember this person is getting at least  
17 two visits, often more than that, in the course of  
18 a day, where we can follow up on all those issues.

19 In a case like this, our treatment team  
20 would -- would decide that more than the two  
21 morning visits were necessary and schedule this  
22 person for at least follow-up throughout the day to  
23 make sure that they were improving.

24 MR. MILLER: Would she get a call sort of

1 frequently from someone afterwards to monitor the  
2 symptoms? I'm sort of curious as to how you're  
3 doing the output measurement, you know, when there  
4 isn't somebody there to actually measure urine  
5 output.

6 DR. WAJNBERG: Yeah. Yes. Certainly, we  
7 frequently call to follow up on how things are  
8 going during an acute period, and like I mentioned  
9 before, usually we have a partner on the other end  
10 that can help report a lot of things. But even for  
11 those who might not be able to report certain  
12 things or certain clinical things, we schedule  
13 enough visits during the day that we have a  
14 clinical person in the home monitoring it, so both.

15 MR. MILLER: Okay.

16 So let me -- let me jump kind of to the --  
17 I guess the -- the bigger question, in some ways,  
18 about this is, it clearly sounds like you've  
19 thought this all through. You are really committed  
20 to patient safety. You have the mechanisms in  
21 place to be able to make this work. The question  
22 that we face in many cases is, well, how do we know  
23 that everyone else who would be in the program  
24 would be similarly committed once there is a

1 payment to support this? And you've suggested in  
2 the application that there should be some kind of a  
3 certification program, but those tend to be a once-  
4 a-year process of somebody coming and, you know,  
5 checking to make sure you have all the policies in  
6 place, et cetera, and making -- maybe making a  
7 visit. Everybody knows the -- you know, the Joint  
8 Commission visit scramble kinds of things.

9           So how do you -- do you feel comfortable  
10 with the way you've structured the model that if  
11 other people were to do -- take this payment and do  
12 this program that there's adequate protections for  
13 the patient?

14           DR. SIU: Well, we thought about this a  
15 great deal. I mean, the idea of putting together a  
16 certification process, you know, through some  
17 group, such as NCQA (National Committee for Quality  
18 Assurance), you know, occurred to us as being one  
19 mechanism by which we could assure at least, you  
20 know, character and competence, licensing, you  
21 know, et cetera, those sorts of things.

22           The -- I think that the other mechanisms,  
23 you know, include the quality metrics. They're  
24 included as part of the payment model. You know,

1 someone who -- a group that might not put as much  
2 attention would not perhaps do as well in terms of  
3 the -- the patient experience measures, you know,  
4 that we collect. That -- higher adverse event  
5 rates, you know, which is another one of the  
6 quality metrics, you know, might be noted.

7           You also stand a risk, I think, that if  
8 you don't pay attention to these things, then  
9 you're going to need to escalate the patient, and  
10 that there is, as the PRT has, you know, noted, a  
11 small financial penalty associated with  
12 escalations.

13           So I think that those were kind of the --  
14 you know, the -- you know, the safety checks, you  
15 know, that we had in mind.

16           MR. MILLER: Mm-hmm. So you gave us four  
17 case studies where everything worked well. Have  
18 you had situations in which the process fell apart  
19 and you said, "Uh-oh. We screwed that up"?

20           DR. WAJNBERG: Yes. Unfortunately, yes,  
21 though thankfully not very many.

22           I can give you an example of that, too.

23           MR. MILLER: Yeah. Could you, please?

24           DR. WAJNBERG: Yeah, of course.



1           So a 75-year-old woman admitted to home  
2 for dehydration. Over the first three days, things  
3 seemed to be going well, but on the third day of  
4 admission, the patient was found by the provider  
5 visit to have a change in mental status, was  
6 hypotensive, tachycardic, and febrile again. She  
7 lived with her husband who had noted when they went  
8 to bed that the patient was at baseline, but in the  
9 morning, it was clear to everyone that she was  
10 confused. That happened a little bit prior to the  
11 first RN visit for the day. When the RN arrived,  
12 saw the patient, noticed a worsening in vital  
13 signs, notified the doctor, and given the patient's  
14 status and goals of care, we urgently escalated her  
15 to the hospital using 911.

16           MR. MILLER: I'm not sure why you consider  
17 that to be a screw-up.

18           DR. WAJNBERG: Well, the clinical course  
19 didn't go as expected, let's say.

20           MR. MILLER: Well, no, I'm -- I'm asking  
21 really about the situation in which you'd -- you  
22 know, you followed your protocols, but somebody  
23 died. Somebody -- have there been cases where  
24 somebody dies, where somebody ended up they were

1 admitted sufficiently late, that it was difficult  
2 to get an adequate outcome, you know, that if they  
3 had been in the hospital sooner, or all along,  
4 would have been avoided?

5 DR. SIU: We've had a few deaths. All  
6 deaths, you know, get reviewed independently. I  
7 mean, they're reviewed by us and then also reviewed  
8 independently by the Department of Medicine Quality  
9 of Care Committee, in this case, and I think that  
10 you have to remember that many of these patients  
11 have serious illness to begin with.

12 MR. MILLER: Well, I wasn't -- don't  
13 misunderstand my question. I wasn't suggesting  
14 that somehow no one will ever have a problem. What  
15 I was wondering was what is the mechanism for  
16 identifying and providing feedback on that and,  
17 again, really to think about if there's  
18 implementation elsewhere.

19 So you have a -- I guess we could call it  
20 a semi-independent review process, which was in  
21 your own institution. Other -- other entities may  
22 or may not have that same -- if you talk about an  
23 independent physician practice setting up and  
24 trying to do this, there might not be a similar

1 mechanism, and that -- maybe that needs to be built  
2 into this.

3 DR. NICHOLS: So, Harold, if I could -- if  
4 I could interject. This is Len.

5 I think what might be helpful is to  
6 restate, we're pretty sure you all can do this.  
7 What we're concerned about are two different, if  
8 you will, directional incentives. One is, the  
9 incentive to keep people at home past, if you will,  
10 the wise point, because you lose financially when  
11 you put them back in. And the other is the  
12 incentive to perhaps overenroll people who would be  
13 less likely to go in than a peer population, and,  
14 therefore, you kind of sandbag.

15 And, again, given your experience, given  
16 what we know about your commitment, that we can  
17 hear on the phone, you're not the problem. We're  
18 worried about -- let's just say other parts of the  
19 country, which are more entrepreneurial and less  
20 experienced in this incredibly subtle set of  
21 ongoing and ever-changing clinical evaluations. So  
22 help us deal with how you would protect against  
23 those two selection risks.

24 DR. SIU: Right. So we appreciate that

1 concern and have thought about that concern a great  
2 deal and have baked some things into the payment  
3 model, I think, you know, to try to address that.

4           Now, this, I think, gets to some of -- a  
5 question that was raised for a written response,  
6 and I think, Bruce, you may have had some hand --  
7 we've been talking about this -- in terms of how we  
8 would do the written response on this. I don't  
9 know if you want to chime in.

10           DR. LEFF: Yeah, I'm happy to chime in,  
11 and I would -- before I dig in on that issue  
12 specifically, I would just talk about the question  
13 that was asked a few moments ago, the notion of,  
14 you know, Sinai being a trusted entity and the  
15 concern about other entities, and I can tell you  
16 that that question was posed to us at Hopkins  
17 almost a quarter century ago when we approached CMS  
18 (Centers for Medicare and Medicaid Services) for a  
19 -- you know, a waiver, back in the days when you  
20 could walk into CMS and ask for those kinds of  
21 things and actually get them, and it was exactly  
22 the same question.

23           I would just say that one thing that we  
24 have seen at Hopkins is we have helped adopting

1 organizations, usually in the context of a Medicare  
2 Advantage context or helping Veterans Affairs  
3 medical centers start their Hospital at Home  
4 programs.

5           You know, people don't enter into this  
6 kind of model, you know, flippantly. I mean, they  
7 usually enter with a great deal of thought because  
8 they really have to build this model, and it has to  
9 be quite intentional. So it's not something that  
10 you can develop on the fly. It's not something you  
11 can paste together with duct tape overnight. It  
12 really takes a fair bit of intention, and I think  
13 that is actually one organizational check on that.

14           You know, in terms of the issue of  
15 escalations themselves, as Al said, we've really  
16 thought about this quite a bit, and -- and, you  
17 know, we felt that an ideal system would honor  
18 patient and caregiver preferences but also create  
19 incentives to provide, you know, the kind of care  
20 that we're talking about, high-quality, safe care  
21 in the correct setting, whether that's at home or  
22 the need to have that care escalated to the  
23 hospital when that needs to happen.

24           We've thought that there's a need to have

1 some disincentive built into the payment model that  
2 would discourage providers from shifting the cost  
3 of care from the APM (Alternative Payment Model)  
4 Entity to the acute care hospital because, in that  
5 case, you know, every time the going got tough, the  
6 providers that -- you know, that you're -- that you  
7 have questions about might shift, might escalate  
8 that patient to the acute hospital. And, you know,  
9 the idea is to understand that there's probably a  
10 natural rate of escalations, and we've looked at  
11 the literature, you know -- and there's a pretty  
12 vast international literature on Hospital at Home,  
13 dozens of randomized controlled trials, and the  
14 escalation rates not always reported, but when they  
15 are reported, they seem to be -- you know, we found  
16 some as low as two percent and some as high as 12  
17 percent. And the 12 percent one came from a study  
18 in the UK (United Kingdom). The two percent number  
19 came from our study done about a decade ago.

20           You know, so it's certainly possible that  
21 if under our payment model, when a case is  
22 escalated on a case basis, the APM Entity might  
23 sustain a loss, but while the cost of the acute  
24 phase of the care might go up, remember the

1 Hospital at Home Plus model also includes that  
2 post-acute period for that 30-day episode. And,  
3 you know, we would hypothesize that we could make  
4 up some of that loss for the escalation on the  
5 post-acute side with lower readmission rates.

6 MR. MILLER: So let me -- let me, if I  
7 can, shift, because I don't want to -- I want to  
8 make sure we stay as close to time as we can. I  
9 want to shift to the second incentive that Len  
10 raised, which was the second question that we had,  
11 which is kind of going the other direction.

12 DR. LEFF: Right. And I think the -- you  
13 know, the check there is -- and we've -- this  
14 question always comes up as well. You know, there  
15 are mechanisms of, you know, re utilization review  
16 to make sure that cases actually meet requirements  
17 for hospital admission. Those standards exist, and  
18 we would suggest applying them in the case of  
19 Hospital at Home, the same way they're applied in  
20 the -- you know, in the typical traditional acute  
21 care hospital-use case.

22 MR. MILLER: Well, you mentioned in the  
23 application an independent review, but I can't  
24 recall whether you said exactly who and how that

1 occurs.

2 DR. LEFF: I'm trying to remember that.

3 DR. SIU: What we mentioned was that every  
4 case should be reviewed by -- for adherence to  
5 admission criteria using either Milliman Clinical  
6 Guidelines or any other, you know, similar products  
7 that are in the market, you know, for that purpose.

8 MR. MILLER: But I think you said  
9 independent review. You said, "In our CMMI (Center  
10 for Medicare & Medicaid Innovation) project, all cases  
11 have undergone independent review and met Milliman  
12 criteria for hospitalization."

13 DR. SIU: Right.

14 So, in our case, you know, these were  
15 reviews that were done, you know, independent of  
16 our internal group, okay, by a group that does --  
17 by individuals who do this for Mount Sinai Hospital  
18 separately.

19 I think that we can -- I don't think that  
20 we specified how to do -- how to do the independent  
21 review, but that was something, you know, that we  
22 thought could be hashed out.

23 MR. MILLER: Well, sure. I guess I was  
24 asking how you, in fact, did it when you said you



1 had an independent review.

2 DR. SIU: Oh. That's how we did it.

3 MR. MILLER: Okay. So what -- what kind  
4 of an entity is this?

5 DR. NICHOLS: I'm sorry. Just to clarify,  
6 those are people who work for Mount Sinai, but  
7 they're not in your unit?

8 DR. WAJNBERG: They're people that do  
9 coding and billing for our institution, and we ask  
10 them to review our documentation with the same eye  
11 that they would to a hospitalization.

12 DR. NICHOLS: Okay, great. Thank you.  
13 Just -- just clarifying for -- okay, good.

14 DR. SIU: And as far as an APM is  
15 concerned, you know, we could hash that out in  
16 terms of, you know, who -- how independent, you  
17 know, that should be, whether, you know -- whether  
18 that is good enough and whether it needs to be  
19 independently audited, you know, or you can -- I  
20 mean, there are various ways that that could be  
21 done.

22 MR. MILLER: So talk a bit about the  
23 transition phase, which is sort of the initiation  
24 of a program like this, which it seemed -- would

1 seem to be where the incentives might be most  
2 powerful.

3           Bruce, you've written an article talking  
4 about how it really takes a lot of effort to get  
5 something like this up and running, more than a  
6 year. My reading of the first evaluation of the --  
7 of your Health Care Innovation Award suggested that  
8 you struggled to be able to get volume. How would  
9 you think about that in terms of if this were made  
10 available nationally, that you would -- because  
11 there's no -- there's no ramp-up money built into  
12 this. It's basically you get paid this amount from  
13 the very beginning, which might be too little to  
14 start with, might be fine later on, and which then  
15 creates a potential incentive to overenroll. Plus,  
16 it may be a deterrent for people to start.

17           DR. SIU: Right, right.

18           So, Harold, if I may, let me first  
19 address, you know, the question about enrollment  
20 that has come up. You -- you mentioned the first --  
21 -- the first annual review of -- of our program.

22           MR. MILLER: Mm-hmm.

23           DR. SIU: I think that our enrollment  
24 issue needs to be understood with respect to three

1 things: what our initial plans were, what we  
2 encountered during implementation, and what the  
3 implications of this are for future enrollment not  
4 only here at Mount Sinai but for other APM  
5 Entities.

6 MR. MILLER: Okay.

7 DR. SIU: So, number one, the first -- the  
8 first year of our project was devoted to initial  
9 piloting and initial roll-out. Year Two was really  
10 devoted to program ramp-up going to a second  
11 hospital, and it's only Year Three, which we are  
12 currently concluding, which was intended from  
13 implementation, you know, at three of our  
14 hospitals. Thus, our enrollment was really  
15 intended to be heavily weighted towards the final  
16 year throughout.

17 We had a hard time, frankly, you know,  
18 getting our evaluators to understand where we were  
19 relative to where we projected to be, you know, at  
20 any one time.

21 Now, having said that, okay, we  
22 encountered issues during the initial  
23 implementation that we perhaps should have  
24 anticipated, you know, but did not, and those were

1 the challenges in terms of taking a new program,  
2 that to some extent disrupts existing practices  
3 from the proof-of-concept stage to the  
4 implementation stage, in the context of a  
5 multipayer system, where many of the patients that  
6 we identified as being eligible for us had the  
7 wrong payer, often Medicare Advantage, and where  
8 patients presented to our health system at any time  
9 of the day on any day of the week. So, as I  
10 indicated, you know, we identified many patients,  
11 you know, with Medicare Advantage or other plans.  
12 We could not enroll them.

13           There were also many patients who were  
14 admitted or a decision wasn't made to admit them to  
15 a hospital, but it was made after hours, after  
16 hours when it became really very difficult for us  
17 to have the required staffing and resources to  
18 enroll them. Therefore, we decided, you know, to  
19 expand the scope of our services to nights and  
20 weekends, primarily by enabling those referrals,  
21 meaning that if they came to us and referred to us,  
22 with very little intervention, recruitment or  
23 enrollment assistance on our part after hours. So  
24 this enabled us to expand our services to evenings

1 and weekends with little incremental staffing.

2           Now, as for, you know, future potential  
3 for the program, what we have learned is that we  
4 believe that this requires a multipart strategy.  
5 The physician-focused payment model is one very  
6 important part of that strategy, but I think that  
7 we also need to have a plan for multipayer  
8 engagement. And we also have to have a plan for  
9 using the program infrastructure to support staff  
10 who may be doing other related programs such as,  
11 you know, home-based primary care, for example.

12           DR. NICHOLS: Yeah.

13           DR. SIU: Now, we have taken steps in our  
14 program to try to pave the way for others to do  
15 both the multipayer engagement as well as build  
16 that infrastructure, and we can spend a little bit  
17 of time talking about that.

18           Niyum, if you're still on the line, I  
19 don't know whether you can comment on what we've  
20 done in terms of trying to engage other payers.

21           MR. GANDHI: Sure. This is Niyum Gandhi  
22 here.

23           We've done a couple of things in terms of  
24 engaging other payers. From basically the start of

1 the program, we got up and running quickly with one  
2 of our payer partners who has a large Medicare  
3 Advantage and managed Medicaid book of business.  
4 So that was, you know, a little bit easier to get  
5 up and running, as I think you've probably seen in  
6 some of the other programs when there's a -- when  
7 there's a provider-owned health plan or a full-risk  
8 arrangement that's, you know, the payment model of  
9 how the actual dollars flow can be -- can be much  
10 more flexible, and so with -- with Healthfirst,  
11 we're in a full-risk arrangement, percent of  
12 premium, and so we were able to get up and running  
13 quickly with them.

14           We have -- about a year and a half into  
15 the program, we started engaging other payers, with  
16 whom we are not in a percent-of-premium arrangement  
17 for all of our lives, on constructing something  
18 that basically mirrors what we have proposed to --  
19 to PTAC.

20           We have one health plan up and running in  
21 that sort of model now as well, and then we've  
22 recently finalized that partnership with a -- with  
23 an outside TPA (third-party administrator) that can  
24 basically process all the -- you know, we found --

1 administratively, it ended up being a fairly manual  
2 process for some of the health plans, which was --  
3 which was challenging for them.

4 MR. MILLER: [Unintelligible.] MR.  
5 GANDHI: We've finalized the partnership with the  
6 TPA, who has basically structured this such that it  
7 can be done as a prospective bundle, and they have  
8 all the interfaces built to -- to take in the --  
9 the right payment models. And, basically, for a --  
10 for a third-party payer, now what they would do is  
11 it function almost -- actually exactly mechanically  
12 like a -- like a cap payment would. So they pay  
13 the full prospective bundle at the point of  
14 admission. Our TPA in the middle takes that  
15 payment in, pays all of the downstream providers  
16 who submit claims to the TPA, and then the TPA  
17 passes zero-dollar claims back to the original  
18 payer.

19 They are -- they are implemented with a  
20 different health plan out of our market and a  
21 different provider for a Hospital at Home program,  
22 as they kind of built all that interface out in a  
23 different program, and we've just settled on a  
24 partnership with them to do that in our market.

1 And we're getting very good reception from our --  
2 from our local payers. We'll also have one or two  
3 more up and running beyond the two that we already  
4 have by the end of the year.

5 DR. NICHOLS: So I don't want to put words  
6 in your mouth. This is Len. But I just want to be  
7 sure I got this, because this sounds really  
8 interesting. But, essentially, this TPA has made  
9 the spread of this thing modular for other payers.  
10 They can plug to this mechanism --

11 MR. GANDHI: Yes, exactly.

12 DR. NICHOLS: -- as long as they take  
13 [unintelligible] structure that, essentially, you  
14 proposed to PTAC?

15 MR. GANDHI: Exactly. And the one  
16 difference between the structure that we're using  
17 with the private payers and -- well, the structure  
18 that we proposed to PTAC is what we're using with  
19 the private payers that we're up and running with  
20 now.

21 DR. NICHOLS: Yep.

22 MR. GANDHI: With this TPA, it's almost  
23 identical. The only difference is that,  
24 administratively, for the other commercial payers,



1 it's easier to do a prospective bundle than to do  
2 the retrospective true-up, because there's just so  
3 much time spent in reconciliation given their  
4 system. And they're often [unintelligible] to be  
5 able to pay cap, anyways. You know, they all  
6 either do PCP (primary care physician) cap or  
7 global cap in various markets, and so they  
8 basically just need to load in the episode  
9 definitions so they can do it as a -- as a cap  
10 payment. So it's -- that's the only difference, is  
11 that it's done as a -- as a prospective cap bundle  
12 payment rather than the -- rather than the exact  
13 same model we proposed to PTAC, though the math  
14 works out exactly the same.

15 DR. NICHOLS: Yeah. I was going to say  
16 the math is the same. Great. Thank you.

17 MR. MILLER: So it sounds like, to some  
18 extent, you're saying the lessons that you have  
19 learned in terms of how to get started, how to  
20 staff, better to have employed people than some  
21 contracted staff, et cetera, could be accelerators  
22 for other sites to basically -- you know, it  
23 doesn't say that they have to do it that way, but  
24 would get them started faster than if they were

1 inventing it from scratch. And that it would, in  
2 many cases, be desirable and/or essential for other  
3 sites to have a multipayer approach rather than  
4 just assuming that they could do this just solely  
5 with Medicare fee-for-service, and that your  
6 experience in trying to put payment models in place  
7 with other payers could -- that's just a could,  
8 but could then serve as a template or model for  
9 other private payers in other parts of the country  
10 to sign on, because somebody else has already done  
11 it and it works, then that might make others more  
12 willing to sign on quicker. Is that a reasonable  
13 statement?

14 DR. SIU: I think you said it well. This  
15 is Al Siu again.

16 And the only other thing that I would add  
17 is that there has been also considerable interest  
18 by a number of other parties in terms of starting  
19 up programs, so it's not just the experience we've  
20 had.

21 I would say, you know, that we probably  
22 have had more experience than many of these other  
23 start-ups, but that we actually -- you know, and I  
24 don't know where we are in this process -- has been

1 talking about forming a learning collaborative with  
2 a number of other, you know, organizations, you  
3 know, that are at earlier phases in start-up to  
4 share these learnings.

5 MR. MILLER: Mm-hmm. So let me -- let me  
6 transition to the third question that we wanted to  
7 just spend a few minutes on today, which was the  
8 payment model you proposed, how you decided that.

9 In the first round of questions that we  
10 asked, we asked about why you were using things  
11 like BPCI (Bundled Payments for Care Improvement)  
12 and OCM (Oncology Care Model) and whether you  
13 thought that was the right, best way to do it or  
14 you were using it because that was existing CMS  
15 programs, and you said, essentially, the latter.

16 So we wanted to explore a little bit more  
17 what you thought the right approach would be if, in  
18 fact, you thought you had the flexibility to be  
19 able to do the right approach, and -- and I'll just  
20 enhance that by saying, particularly, at least I'm  
21 interested in understanding the post-acute care  
22 component of this, because you're essentially  
23 proposing a full episode, including post-acute care  
24 costs, even though your -- your program is really

1 designed for sort of the inpatient and a transition  
2 phase. And it complicates the whole issue of how  
3 are you setting the benchmark and whether you're  
4 really picking patients who would have low post-  
5 acute care costs, anyway.

6           So both the general and the specific  
7 question, why -- why do you think this is the best  
8 approach for a payment? How did you decide on the  
9 thing that you proposed, and why specifically is  
10 that in there?

11           DR. SIU: Right. So we've been talking  
12 about various different payment models for over  
13 three years. The problem here is that the absence  
14 of a payment model has really been the major  
15 impediment to dissemination of hospital  
16 [unintelligible] in this country. Before going  
17 into, you know, some options that we considered,  
18 let me talk -- let me tell you a little bit about  
19 the criteria and the features that we were looking  
20 for in a payment model.

21           MR. MILLER: Okay.

22           DR. SIU: First, we needed to be able to  
23 have a payment model that assured adequate payment  
24 to enable, you know, rapid on-demand services for

1 patients at home and also supportive of the  
2 considerable infrastructure, you know, the traffic  
3 cop function that I mentioned earlier, et cetera,  
4 that would be required to provide the service  
5 safely.

6 MR. MILLER: Mm-hmm.

7 DR. SIU: And as a corollary, we realized  
8 that in the current environment that such a payment  
9 model would need to be tied to financial  
10 accountability and quality, and we accept that.

11 The second feature that we were looking  
12 for was that we found -- we wanted something that  
13 was sufficiently flexible so it could be adapted to  
14 different payers. You know, as Niyum describes,  
15 you know, our experience going out into the market,  
16 you know, payers, you know, all wanted slightly  
17 different things, and we wanted a payment model  
18 that could be adapted to different payers as well  
19 as to different shapes of the sponsoring  
20 organization, et cetera, because this -- for this  
21 to work, this could not be a payment model that  
22 worked for Mount Sinai only.

23 Third, you know, we wanted a payment model  
24 that could account and allow for payment for

1 clinically important but currently non-reimbursed  
2 services, such as the community paramedicine that  
3 Dr. Wajnberg, you know, described to you as well as  
4 video visits, which we have been doing, you know,  
5 which we have not had the time to talk about.

6 Fourth, we felt that whatever payment  
7 model we chose, that patient cost sharing at worst  
8 needed to be neutral to what it would have been if  
9 the patient had been hospitalized.

10 Fifth, you know, we thought, you know,  
11 that a payment model needed to be realistic about  
12 what happens in medical practice, where outside  
13 physicians, hospitals, and services might be used,  
14 you know, as well, in addition to whatever might be  
15 happening in a Hospital at Home. And we also  
16 recognized that the payment model would need to  
17 have a mechanism to -- to certify APM Entities, to  
18 maintain patient safety, and to mitigate, you know,  
19 against possible abuses. So those were kind of  
20 like, you know, the broad-strokes, things that we  
21 were looking for in a payment model.

22 We considered, you know, just doing a  
23 payment model for the acute portion only, you know.  
24 And, Harold, I think that your point -- your

1 question suggests that. However, we believed that  
2 there was really substantial value to the  
3 transition services and the services that we were  
4 doing to ensure continuity and avoid readmissions,  
5 and that certainly has been our experience in the  
6 last three years. We've cut readmissions in half  
7 in this population, so that we decided that our  
8 preferred alternative payment model really included  
9 both the acute as well as the transition in post-  
10 acute services.

11 MR. MILLER: Could you just pause and  
12 separate for me the issue of transition versus  
13 post-acute? Because I'm -- I'm fully supportive of  
14 the idea of transition. Where I got a little  
15 confused in reading the proposal is you keep  
16 talking about your transition services, but then  
17 the payment model really focuses on all post-acute  
18 services after 30 days. And I'm trying to  
19 understand -- because you are then putting yourself  
20 at risk for a skilled nursing facility stay, et  
21 cetera, even though that's not necessarily what  
22 you're focusing on in terms of trying to do  
23 transition and trying to avoid readmissions.

24 DR. SIU: Right, right.

1           So we could have, I suppose, kept this as  
2 acute only, you know, and a, you know -- a fixed  
3 payment for transition services. I'm not sure that  
4 we had a mechanism of making that fixed payment  
5 enough to really incent the entity into doing what  
6 it takes in terms of preventing, you know, all  
7 these readmissions.

8           Many of our community paramedicine visits,  
9 you know, actually occur in the post-acute period,  
10 as opposed -- as opposed to acute period, and we  
11 would never be able to do that, you know, with a  
12 small transition payment, for example.

13           MR. MILLER: Could you just pause and say  
14 a word about that? Because when you say most of  
15 them are occurring in the post, is that because the  
16 patients are still essentially at risk, but that  
17 you no longer have the physician, nurse services at  
18 the same level of intensity, or what?

19           DR. SIU: We could trigger that, the  
20 physician and nursing services. I think that these  
21 patients are sick, you know, and we have them in  
22 the post-acute period for longer. We have them for  
23 30 days in the post-acute period, whereas the acute  
24 period is generally three to five days.



1 MR. MILLER: Mm-hmm.

2 DR. SIU: Ania, you wanted to jump in  
3 here?

4 DR. WAJNBERG: Yeah. Just to clarify or  
5 give some more examples, they have the same 24/7 --  
6 24/7 access to our staff that they have during the  
7 acute period, but they're not scheduled for the  
8 same level of daily visits during that period  
9 because their -- their acute issue is over.

10 We have some protocols on what type of  
11 follow-up they do receive based on their diagnosis,  
12 and we also ensure through various mechanisms,  
13 tying them back to their own prior care. So we're  
14 -- we're taking a lot of steps in that post-acute  
15 period, as well as they have the ability to reach  
16 us for urgent issues to supplement their acute  
17 period.

18 MR. MILLER: Okay.

19 DR. SIU: I mean, you raised the  
20 possibility, Harold, which we had never really  
21 considered, you know, in terms of breaking out and  
22 not putting the APM Entity at risk for traditional,  
23 quote/unquote, "post-acute services" -- skilled  
24 nursing, you know, et cetera, and --

1 MR. MILLER: Well, you're -- you're  
2 clarifying for me that you really are viewing  
3 yourselves as providing post-acute care in that 30-  
4 day period in the home. I mean, that -- that's --  
5 I was not understanding when you talked about  
6 transition, you know, which is typically kind of a  
7 how do you simply make sure that after the patient  
8 leaves the post-acute -- you know, their acute  
9 phase, you know, that they get back home, get their  
10 medication, get an appointment with their PCP, et  
11 cetera. And you're really talking about this is as  
12 post-acute care, a service, and that the nurse and  
13 physician visits and the paramedicine providers --  
14 it sounds like what you're saying is really -- is  
15 essentially a home-based post-acute care option  
16 that doesn't exist today.

17 DR. NICHOLS: Well, that's the thing,  
18 Harold. I think when they say transition, remember  
19 it's 30 days, and it is, in essence, substituting  
20 for all the exacerbations, escalations, whatever  
21 that would occur normally.

22 MR. MILLER: Yeah. But, typically,  
23 transition programs say, "We're going to facilitate  
24 transition. We're going to be accountable for a

1 readmission rate to the hospital because we're  
2 trying to prevent that, but they're not providing  
3 any more intensive services." That's -- I think  
4 that's --

5 DR. NICHOLS: Right.

6 MR. MILLER: -- a helpful clarification  
7 here.

8 DR. NICHOLS: I agree.

9 DR. SIU: Right.

10 So our preference was to include both the  
11 acute and the 30-day services. We considered  
12 various models, including, perhaps, billing, fee-  
13 for-service, for many of the component services to  
14 be supplemented perhaps by a Hospital at Home Plus-  
15 specific payment akin to, you know, what's done  
16 with the Oncology Care Model.

17 In some ways, we attempted something like  
18 this with one health plan, and such a model is  
19 certainly technically feasible. But it's  
20 administratively complex and had -- and we found  
21 that it had potential to create gaps in care. If  
22 we did this in traditional Medicare, if we did fee-  
23 for-service billing for daily physician's visits,  
24 we would almost certainly be scrutinized and

1 audited, you know.

2 DR. NICHOLS: Yeah.

3 MR. MILLER: Well, the difficulty, I  
4 think, that comes up, though, is the benchmark  
5 because, essentially, everybody would have gotten  
6 the DRG (diagnosis-related group) payment if they  
7 went to the hospital, whether they were -- needed  
8 less or more care in the hospital, but not  
9 everybody would get the same payment post-acute,  
10 depending on whether they went home or whether they  
11 went to a SNF (skilled nursing facility).

12 You're -- the way your proposal is  
13 structured, you're benchmarking yourself against  
14 the average post-acute care spending for a  
15 population of patients, which isn't quite the whole  
16 hospital admission population, but also is probably  
17 broader than the patients you would admit to your  
18 program. And there would be some questions, I  
19 think very legitimate questions, about whether  
20 you're inherently always going to beat the  
21 benchmark, because you will have taken patients  
22 that almost by definition have better home  
23 supports.

24 Does that make sense to you?

1

2 DR. SIU: Yeah. So we've struggled with  
3 the question of benchmarks, you know, and we  
4 actually, you know, separate, you know, from what -  
5 - from what we proposed in terms of the payment  
6 model, actually have a control group that we are  
7 pulling together of patients who would otherwise  
8 look just like the patients that we would take into  
9 our program, but who were not admitted into  
10 Hospital at Home because they came at the wrong  
11 time of day or they refused, you know, or whatever  
12 into our health system hospitals. And we'll be  
13 able to look to see, you know, just how different -  
14 -

15 MR. MILLER: Mm-hmm. Okay.

16 DR. SIU: -- they are.

17 MR. MILLER: Okay. Well, that's -- that  
18 at least helped. I understand better now that you  
19 really are viewing yourself as providing 30 days of  
20 post-acute care, not just a short-term transition  
21 service with an accountability for a readmission.  
22 Okay.

23 Do you have other questions on that point,  
24 Len?

1 DR. NICHOLS: Nope. I'm good.

2 MR. MILLER: Okay. Len, anything else you  
3 wanted to ask beyond what we had otherwise planned  
4 to?

5 DR. NICHOLS: No. I think we've had a  
6 very productive hour, Harold.

7 MR. MILLER: Great.

8 DR. NICHOLS: Let these people get back to  
9 patient care.

10 MR. MILLER: Yes.

11 Well, let me -- Al or anybody else,  
12 anything you want to ask us or tell us that you  
13 haven't told us that would -- you think is  
14 important to convey?

15 DR. SIU: We're busy preparing responses  
16 to your other questions that are expected next week  
17 and --

18 MR. MILLER: We're sorry those aren't  
19 billable hours for you.

20 DR. SIU: [Laughs.] And this was a good  
21 conversation on our part. Thank you.

22 MR. MILLER: Well, thank you. Thank you.  
23 This was, I think, very, very, very helpful. We  
24 appreciate your spending so much time to prepare

1 for, with identifying the case studies, and  
2 assembling so many people on the call. So thank  
3 you very much, and we will look forward to your  
4 responses. And we will look forward, hopefully, to  
5 seeing you in September.

6 DR. SIU: Great.

7 DR. WAJNBERG: Thank you.

8 MR. MILLER: Great. Thanks very much.

9

10 [Whereupon, at 12:10 p.m., the conference  
11 call concluded.]

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