Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

September 6, 2018
8:30 a.m. – 6:30 p.m. EDT
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attendance

Physician-Focused Payment Model Technical Advisory Committee (PTAC) Members In-Person

Jeffrey W. Bailet, MD (PTAC Chair; Executive Vice President of Health Care Quality and Affordability, Blue Shield of California)
Robert Berenson, MD (Institute Fellow, Urban Institute)
Paul N. Casale, MD, MPH (Executive Director, New York Quality Care)
Tim Ferris, MD, MPH (CEO, Massachusetts General Physicians Organization)
Rhonda M. Medows, MD (Executive Vice President of Population Health, Providence Health & Services)
Harold D. Miller (President and CEO, Center for Healthcare Quality and Payment Reform)
Len M. Nichols, PhD (Director, Center for Health Policy Research and Ethics, George Mason University)
Kavita Patel, MD, MSHS (Nonresident Senior Fellow, Brookings Institution)
Bruce Steinwald, MBA (Consultant, Bruce Steinwald Consulting)
Grace Terrell, MD, MMM (CEO, Envision Genomics)

PTAC Member Not in Attendance

Elizabeth Mitchell (Senior Vice President of Healthcare and Community Health Transformation, Blue Shield of California)

U.S. Department of Health and Human Services (HHS) Guest Speakers

Alex M. Azar II (HHS Secretary)
Seema Verma (Administrator, Centers for Medicare & Medicaid Services [CMS])
Adam Boehler (Deputy Administrator, CMS and Director, Center for Medicare & Medicaid Innovation [CMMI]; Senior Advisor to the Secretary on Value-Based Transformation and Innovation)

Office of the Assistant Secretary for Planning and Evaluation (ASPE) Staff

Susan Bogasky
Audrey McDowell
Ann Page
Sarah Selenich, Designated Federal Officer (DFO)
Steve Sheingold, PhD
Sally Stearns, PhD

List of Proposals, Submitters, Public Commenters, and Handouts

1. **American College of Emergency Physicians (ACEP): Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions**

Submitter Representatives
Jeffrey Bettinger, MD, FACEP (Co-Chair, ACEP Alternative Payment Model Task Force)
Susan Nedza, MD, MBA (Senior Vice President of Clinical Outcomes, MPA Healthcare Solutions)
Randy Pilgrim, MD, FACEP (Co-Chair, ACEP Alternative Payment Model Task Force)

Public Commenters
Kevin Biese, MD, MAT (Vice-Chair of Academic Affairs; Co-Director of Geriatric Emergency Medicine; Director of Emergency Medicine Residency Program, UNC Healthcare and West Health)
Sandra Marks, MBA (Assistant Director of Federal Affairs, American Medical Association)
Bing Pao, MD, FACEP (Chair-Elect, Emergency Department Practice Management Association [EDPMA])

Handouts

- Letter of Intent
- Proposal
- Preliminary Review Team (PRT) Report
- Committee Member Disclosures
- Public Comments
- Additional Information from Submitter
- Additional Information or Analyses
- Additional Information or Analyses – Data Tables

2. Jean Antonucci, MD: An Innovative Model for Primary Care Office Payment

Submitter Representatives
Jean Antonucci, MD (Physician, Family Practice)
John Wasson, MD (Emeritus Professor of Community & Family Medicine, Medicine, and The Dartmouth Institute; Associate Director, Centers for Health & Aging) – by teleconference

Public Commenters
None

Handouts

- Letter of Intent
- Proposal
- PRT Report
- Initial Feedback from PRT
- Committee Member Disclosures
- Public Comments
- Additional Information from Submitter
- Additional Information or Analyses

3. **Dialyze Direct: APM for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities**

Submitter Representatives

Alice Hellebrand, MSN, RN, CNN (Chief Nursing Officer, Senior Vice President of Education, Dialyze Direct)

Allen Kaufman, MD (Chief Medical Officer, Senior Vice President Clinical & Scientific Affairs, Dialyze Direct)

Nathan Levin, MD (Chairman of the Medical Advisory Board, Director of Research, Dialyze Direct; Clinical Professor of Medicine, Icahn School of Medicine at Mount Sinai Health System) – by teleconference

Jonathan Paull (General Counsel, Chief Compliance Officer, Dialyze Direct)

Joshua Rothenberg (Chief Operating Officer, Dialyze Direct)

Public Commenters

None

Handouts

- Letter of Intent
- Proposal
- PRT Report
- Initial Feedback from PRT
- Committee Member Disclosures
- Public Comments
- Additional Information from Submitter
- Additional Information or Analyses
- Additional Information or Analyses – Data Tables

NOTE: A transcript of all statements made by PTAC members, submitter representatives, and public commenters at this meeting is available on the ASPE PTAC website located at: https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.

The website also includes copies of all presentation slides and a video recording of the September 6, 2018 PTAC public meeting.

Welcome and Deliberations and Voting Procedures

Jeffrey Bailet, PTAC Chair, welcomed the public to the fifth PTAC meeting at which PTAC will have deliberated and voted on submitted proposals. He thanked the public for its interest and stakeholders for their hard work and dedication to payment reform. He noted that since December 1, 2016, PTAC has received 25 proposals and an additional 15 letters of intent (LOIs). The PTAC Chair indicated that at this meeting they would be reviewing four proposals.

The PTAC Chair informed the public that three leaders within HHS would be making public remarks today, including HHS Secretary Alex Azar; Seema Verma, Administrator, CMS and Adam Boehler, Deputy Administrator, CMS and Director, CMMI and Senior Advisor to the Secretary on Value-Based

Transformation and Innovation. The PTAC Chair thanked HHS leadership for participating in today's meeting.

The PTAC Chair also informed the public that PTAC has been exercising its authority to provide initial feedback to submitters, which was granted by the recently enacted Bipartisan Budget Act of 2018. The PTAC Chair reminded the public to submit any concerns or questions to the PTAC email box. The PTAC Chair stated that the Committee will hear feedback from stakeholders, on PTAC's processes, on Friday, September 7, 2018 after deliberations have concluded on the proposals.

The PTAC Chair noted that the Committee deliberates and discusses proposals only during public meetings and informed the public that the deliberations and voting procedures would occur in the following order:

1. PTAC members will introduce themselves and disclose any potential conflicts of interests and threats to impartiality.
2. The designated PRT for each proposal will present their report to the full Committee.
3. PTAC members will have an opportunity to ask PRT members questions concerning the reviewed proposal.
4. The submitter representatives will be invited to make a statement to PTAC, if desired.
5. PTAC members will have an opportunity to ask questions and hear responses from submitter representatives concerning their proposal.
6. Public comments will be permitted.
7. PTAC will deliberate and vote on the extent to which the proposal meets each of the Secretary's criteria.
8. PTAC will deliberate and vote on a final recommendation to the Secretary.
9. PTAC will provide instructions to ASPE PTAC staff regarding comments to be included within the report accompanying their recommendation to the Secretary.

HHS Speakers' Remarks

Introduction of the HHS Secretary

The PTAC Chair introduced HHS Secretary Alex Azar stating an appreciation for the Secretary's combination of public and private sector experience. He noted that members of PTAC had the privilege of speaking with the Secretary in June 2018, a conversation that helped strengthen the partnership and helped PTAC understand his vision on value-based care and how the Committee's work can best move this vision forward.

The HHS Secretary's Remarks

Secretary Azar thanked PTAC for its work, as well as the work of those supporting PTAC members. The Secretary recognized the extensive time commitment and rigor of analysis conducted by PTAC and expressed gratitude for the Committee's work.

The Secretary indicated that one of his priorities is transforming the health care system into one that pays for health and wellness rather than sickness and procedures. He indicated that how we deliver that outcome is much more complicated, but noted there has been some progress on the tools needed to execute this transformation with more alternative payment models, more coordinated care, and more value-based compensation. The Secretary acknowledged the efforts of HHS Secretaries Leavitt, Sebelius, and Burwell in moving value-based transformation forward.

The Secretary spoke about how recent CMS analysis showed that Accountable Care Organizations (ACOs) have not delivered significant savings after all costs and incentives are taken into account. He mentioned promising results from ACOs taking up two-sided risk and that results from physician-run ACOs have been better than those run by hospitals. He indicated that without real accountability, we are offering bonuses on top of payments that may be too high and that is why they have proposed to simplify the ACO system into two tracks, requiring them to take on risk much sooner. The Secretary pointed to a need for strategies and models that provide better care at a lower price, not just new models for the sake of new models and not new systems of payment for old systems that are not open to real change. The Secretary suggested that this might also mean mandatory models and other mandatory reforms.

The Secretary also pointed out that what matters to patients is outcomes, not processes. He discussed a broad view of how providers can take on risks that would not just be episodic care models, but also longitudinal models that reward providers for keeping patients healthy. He discussed the four P's of driving toward value:

- Patients as empowered consumers,
- Physicians as accountable navigators,
- Payments for outcomes, and
- Prevention of disease.

The Secretary stated that CMMI will soon be launching new models that fall into these areas, and hopes that PTAC will use them as guideposts. He indicated that getting better value from the health system and paying for value requires empowering patients to be consumers, but physicians will need to help patients navigate the health care system so there is interest in ideas that can help physicians fill this gap.

The Secretary indicated that PTAC's perspective is critical on these matters and looks forward to a close partnership in the years to come. The Secretary thanked the Committee for having him.

Introduction of the CMS Administrator

The PTAC Chair welcomed Seema Verma, the 15th Administrator of CMS. He noted that Ms. Verma is the architect of the historical *Healthy Indiana Plan*, where she helped to create and implement the nation's first consumer-directed Medicaid program. He also noted how Ms. Verma has made it a priority to collaborate with PTAC, speaking and spending time discussing how PTAC's work fits into CMS's ongoing efforts with value-based care.

The CMS Administrator's Remarks

Administrator Verma indicated that value-based care is a top priority for CMS and there is consideration of how to remove barriers for providers from delivering value to the health care system. She discussed regulatory burden and two related initiatives—"Patients over Paperwork" and "Meaningful Measures." The latter initiative is designed to eliminate time-consuming, process-oriented measures and instead use electronic medical records, registries, and claims data for measuring provider quality, eliminating the need for providers to actively do anything for producing quality measures.

The Administrator explained that consideration is being given to how patients can be included and empowered in alternative payment models (APMs) by providing cost and quality data to enable patients to seek high-quality value-based care. She mentioned the concern that only 14% of providers in

Medicare programs are taking on risk and that the intention is to create opportunities for providers to participate in two-sided risk models through incentives and waivers from regulatory burdens.

The Administrator indicated that CMS is looking at models that PTAC recommended, including models for end-stage renal disease, cancer care, chronic disease, and individuals with serious medical conditions. She mentioned that a significant amount of PTAC's work has contributed to the development of these models and she expressed appreciation for PTAC's efforts. The Administrator thanked the Committee for their service, experience, and technical insight in reviewing additional models.

Introduction of the CMS Deputy Administrator and CMMI Director

The PTAC Chair welcomed Adam Boehler, Deputy Administrator, CMS, and Director, CMMI and Senior Advisor to the Secretary on Value-Based Transformation and Innovation. He noted that Mr. Boehler brings extensive experience with many innovative ventures across multiple facets of the private health care industry and that he founded and led one of the largest home-based medical groups in the country. The PTAC Chair also indicated that Mr. Boehler met with PTAC in June 2018 and July 2018 to share his vision for the Innovation Center and how he will engage with PTAC.

The CMS Deputy Administrator and CMMI Director's Remarks

Mr. Boehler discussed the four components to the Administration's value-based strategy, (the four P's):

- Patients as empowered consumers—using transparent and competitive markets to promote access and choice for patients;
- Physicians as accountable navigators—creating new arrangements for physicians to take accountability for their patients and take away burdens that do not add value and let physicians focus on their patients;
- Payments for outcomes—modernizing outdated payment rules and pay for results; and
- Prevention of disease—preventing disease before it occurs.

Mr. Boehler indicated that physician-focused payment models and the work done by PTAC are critical to this strategy. He stated that he spent a lot of time initially at CMMI with his team looking at the existing model portfolio, and focused on how to improve or end models that are not seeing good results. He noted three things that lead to successful models: transparency, simplicity, and accountability.

Mr. Boehler discussed a number of the ideas that PTAC has brought forward and expressed appreciation for the work that PTAC has done in the past and what will be done in the future. He indicated eagerness to implement the models that are proposed, and to evaluate them in terms of ability to improve quality outcomes, reduce cost, and to drive a transparent, simple, and accountable future. Mr. Boehler mentioned work that is being aggressively done on several models that have been recommended by PTAC in the areas of chronic kidney disease, primary care redesign, and serious illness, and conversations with the Icahn School of Medicine at Mount Sinai and the Marshfield Clinic about services delivered in the home.

Mr. Boehler noted that CMS has benefitted directly from PTAC's recommendations and comments on proposals and recommended that prospective submitters of physician-focused payment models continue their work with PTAC because the Committee's recommendations will weigh very heavily on the Administration. He then thanked PTAC members for their ongoing hard work and commitment.

The public meeting recessed at 9:27 a.m. and reconvened at 9:35 a.m.

American College of Emergency Physicians (ACEP): Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions

Committee Member Disclosures
Harold Miller stated that he provided assistance to ACEP as they were considering developing payment model concepts. One such concept they discussed was similar to the one being presented today, although he never specifically consulted on this proposal. He stated he would recuse himself from voting and deliberating on this proposal.

Robert Berenson stated he has had professional interactions with ACEP in the past in his capacity as a senior CMS official and as a consultant, but not specific to this or any other proposal.

No additional PTAC members had disclosures related to this proposal.

PRT Report to the Full PTAC
The PRT for the *AUCM: Enhancing Appropriate Admissions* proposal consisted of Tim Ferris (the PRT Lead), Jeffrey Bailet, and Len Nichols.

Tim Ferris summarized and presented the PRT's report to PTAC and summarized the proposed model, saying that it would:

- Create an incentive system focused on the episode of care following an emergency department (ED) stay.
- Calculate a facility-specific episode target price based on historic claims data.
- Initially focus on four high-volume ED conditions (abdominal pain, chest pain, altered mental status, and syncope) with additional conditions added in subsequent years.
- Achieve savings by holding Medicare spending below facility-specific 30-day episode targets for the condition; reduced admissions for the target condition would provide the greatest opportunity for savings.
- Provide three option tracks for participants in terms of risk sharing, pay-for-reporting transitioning to pay-for-performance, and stop-gain/stop-loss thresholds.
- Ensure safe home discharge and follow-up care through an ED-based care coordinator.

Key issues identified by the PRT included:

- Exclusion of non-ED physician care for observation patients admitted through the ED.
- Lack of process quality metrics to ensure best practices.
- Use of facility-specific pricing instead of regional or national benchmarks.

The PRT unanimously agreed that the proposed model met seven out of 10 of the Secretary's criteria ("Scope", "Value over Volume", "Flexibility", "Ability to be Evaluated", "Patient Choice", "Patient Safety", and "Health Information Technology") and a majority of the PRT felt that it met one additional

criterion ("Quality and Cost"). A majority of the PRT felt that the model did not meet the two remaining criteria ("Payment Methodology" and "Integration and Care Coordination").

[NOTE: The PRT's presentation slides and full report are available on the ASPE PTAC website located at: https://aspe.hhs.gov/proposal-submissions-physician-focused-payment-model-technical-advisory-committee.]

Clarifying Questions from PTAC to the PRT
The PTAC Chair thanked the proposal submitters and then opened the floor for PTAC members' questions to the PRT. Topics discussed included:

- Concerns that the model would only incentivize independent ED groups, not employed ED groups.
- How care coordination would occur under this model.
- The need for a distinction between ED observation and non-ED observation stays and the circumstances surrounding admittance to each.
- The definition of an ED physician, and the distinction between ED physicians and physicians who mostly work in the ED.
- Whether model incentives conflict with patient choice.

Submitter's Statement
The PTAC Chair invited the submitter representatives to make a statement to PTAC. They introduced themselves as Jeffrey Bettinger, Susan Nedza, and Randy Pilgrim.

The submitter representatives stated the model was designed to provide additional resources to enable emergency physicians to achieve high-quality care at a lower cost for patients following an ED visit. The submitter representatives agreed with the PRT that the model should treat all observation stays the same, eliminating the distinction between ED-based observation and non-ED based observation stays. The submitter representatives also indicated they were open to using blended regional and national benchmarks in the future. Finally, the submitter representatives proposed that discharge assessments should be shared through electronic health records to enhance future observation and inpatient services and ensure patient safety.

PTAC and Submitter Questions and Answers (Q&A) and Discussion
PTAC and submitters engaged in Q&A and discussion on the following topics:

- The need for an alternative to the facility-specific methodology proposed, and openness of the submitter to have the model transition to using regional and national benchmarks.
- Criteria for admission, quality metrics, financial incentives, and their impact on patient safety for common ED conditions like syncope.
- Interactions between post-discharge events and admittance rates of ED patients.
- Potential conflicts between financial incentives and patient safety.
- Ability of ED physicians to be responsible for 30-day cost of care following ED visits and to generate savings during that period.
- Infrastructure requirements for patient follow-up during 30-day cost of care episodes
- How and where care coordination would occur.

- How to inform the patient of potential financial incentives for ED physicians participating.

Public Comments
The Chair thanked the submitter representatives and opened the floor for public comments, which were made by:

1. Kevin Biese, UNC Healthcare and West Health
2. Sandra Marks, American Medical Association
3. Bing Pao, EDPMA

[NOTE: A transcript of these commenters' remarks is available on the ASPE PTAC website located at: https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

PTAC Criterion Voting
PTAC discussed and voted on the extent to which the *AUCM: Enhancing Appropriate Admissions* proposal meets each of the Secretary's criteria.

[NOTE: PTAC's "*Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary for the Department of Health and Human Services"* state that a simple majority vote will establish PTAC's determination for each of the Secretary's criteria. The PTAC criterion votes remained anonymous and are presented in the table below. Individual member comments also are available in the meeting transcript located on the ASPE PTAC website at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

Given that nine PTAC members participated in deliberation and voting on the proposal, five PTAC votes constituted a simple majority.

PTAC Member Votes on the *AUCM: Enhancing Appropriate Admissions* Model

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
1. Scope (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	3
	4 – Meets the criterion	1
	5 – Meets the criterion and deserves priority consideration	3
	6 – Meets the criterion and deserves priority consideration	2
PTAC DECISION: Proposal Meets and Deserves Priority Consideration for Criterion 1.		
2. Quality and Cost (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	1
	3 – Meets the criterion	5
	4 – Meets the criterion	2

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 2.		
3. Payment Methodology (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	3
	3 – Meets the criterion	4
	4 – Meets the criterion	1
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 3.		
4. Value over Volume	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	2
	4 – Meets the criterion	5
	5 – Meets the criterion and deserves priority consideration	2
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 4.		
5. Flexibility	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	3
	4 – Meets the criterion	4
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Meets Criterion 5.		
6. Ability to be Evaluated	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	2
	4 – Meets the criterion	6
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
PTAC DECISION: Proposal Meets Criterion 6.		
7. Integration and Care Coordination	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	2
	3 – Meets the criterion	5
	4 – Meets the criterion	1
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 7.		
8. Patient Choice	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	4
	4 – Meets the criterion	4
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 8.		
9. Patient Safety	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	1
	3 – Meets the criterion	3
	4 – Meets the criterion	4
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 9.		
10. Health Information Technology	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	6
	4 – Meets the criterion	3
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 10.		

PTAC Vote on Recommendation to the Secretary
[NOTE: PTAC members' votes on the recommendation to the Secretary are presented in the table below. PTAC's "*Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary for the Department of Health and Human Services"* state that a two-thirds majority vote will determine PTAC's recommendation to the Secretary.]

Given that nine PTAC members participated in deliberation and voting on the proposal, six PTAC votes were required for the final PTAC recommendation vote.

PTAC Recommendation Category	PTAC Member Recommendation Vote
Not Applicable	*No PTAC members voted for this recommendation category*
Do not recommend proposed payment model to the Secretary	*No PTAC members voted for this recommendation category*
Recommend proposed payment model to the Secretary for limited-scale testing (2)	Robert Berenson Paul Casale
Recommend proposed payment model to the Secretary for implementation (5)	Jeffrey Bailet Tim Ferris Rhonda Medows Kavita Patel Bruce Steinwald
Recommend proposed payment model to the Secretary for implementation as a high priority (2)	Len Nichols Grace Terrell

As a result of the vote, PTAC recommended the *AUCM*: *Enhancing Appropriate Admissions* proposal to the Secretary for implementation.

Instructions on the Report to the Secretary
After PTAC voting, individual PTAC members made comments for incorporation into PTAC's Report to the Secretary. All comments of individual members can be found in full in the meeting transcript located on the ASPE PTAC website at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.

PTAC members suggested that comments in PTAC's Report to the Secretary indicate the willingness of the submitter to make changes to the model, including the removal of distinction between observation types and the potential transition to blended, regional, or national benchmarks. In addition, recommendations were made to expand the number of conditions included in locations where the model is successfully implemented. It was suggested that it would be desirable to implement this model in conjunction with models for home-based care and primary care. The care coordination process also needs to be addressed in more detail, including resource allocation. The language of the recommendation should also take into consideration the size and location of EDs to ensure the model benefits smaller, rural sites as well. There was concern expressed by some PTAC members about the ability of ED physicians to take responsibility for the cost of care for 30-day episodes, but this concern was mitigated by the amount of risk involved and the use of facility-specific historical data. It was suggested that the recommendation indicate the scope of the model could go far beyond the four conditions that initially would be tested.

The public meeting recessed at 11:47 a.m. and reconvened at 12:30 p.m.

Jean Antonucci, MD: An Innovative Model for Primary Care Office Payment

Committee Member Disclosures
Bob Berensen stated that he has known Dr. Antonucci for many years; has spoken at conferences related to her organization, Ideal Medical Practices; and spoke with her as she was developing the payment model. He stated that he would recuse himself from voting and deliberation on this proposal.

No additional PTAC members had disclosures related to this proposal.

PRT Report to the Full PTAC
The PRT for the *Innovative Model for Primary Care Office Payment* model consisted of Harold Miller (the PRT Lead), Tim Ferris, and Kavita Patel.

Harold Miller summarized the PRT's review of the proposal, stating that the proposal would:

- Support primary care practices through a risk-stratified per beneficiary per month payment (PBPM) that would replace the primary care physician's fee-for service payments for office visits and minor procedures.
- Involve two payment amounts, $60 PBPM for low- and medium-risk patients and $90 PBPM for high-risk patients.
- Incorporate a performance-based payment incentive by withholding 15 percent of the payment and returning that amount to the practice only if it meets a quality and utilization performance standard.
- Utilize a web-based health survey called "How's Your Health" to measure quality of care.
- Incorporate five factors from the survey to create a "What Matters Index" to determine risk-stratification.
- Require patients to sign up to be part of the payment model, though there could also be some retrospective attribution based on visiting the practice.

Key issues identified by the PRT included:

- There are some similarities to the model titled***,*** *Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care*, submitted by the American Academy of Family Physicians, that PTAC recommended in December 2017, but the current proposal is significantly more simple, which could make it easier to implement for solo and small practices.
- There is potential for under-treatment of patients due to monthly payments replacing all current payments.
- The move to patient-reported measures would require a standardized sampling frame and mode of administration, which is not described in the proposal.
- Lack of specifics related to which quality measures would be used to determine payment withholding.
- Inability to conclusively determine whether Medicare spending would decrease.

The PRT agreed that there was a lot of merit to the model and that PTAC should consider how this might be part of a broader effort to test different models for primary care.

The PRT unanimously agreed that the proposed model met three out of 10 of the Secretary's criteria ("Value over Volume", "Flexibility", and "Health Information Technology"). The PRT unanimously agreed that the proposal did not meet five of the criteria ("Quality and Cost", "Payment Methodology", "Integration and Care Coordination", "Patient Choice", and "Patient Safety"). A majority of the PRT felt that the proposed model did not meet two of the Secretary's criteria ("Scope" and "Ability to be Evaluated").

[NOTE: The PRT's presentation slides and full report are available on the ASPE PTAC website located at: https://aspe.hhs.gov/proposal-submissions-physician-focused-payment-model-technical-advisory-committee.]

Clarifying Questions from PTAC to the PRT

The PTAC Chair opened the floor for PTAC members' questions to the PRT. Topics discussed included:

- Concerns about the potential for undertreatment of patients under the model in light of experiences when primary care capitation has been used in the past
- The challenges of obtaining patient self-reported responses and ways to improve patient response rates.
- The unique needs of rural practices.
- The strengths and weaknesses of "How's Your Health" compared to MIPS quality measures, and its ability to serve as the basis for a federal payment program.
- Differences between the proposed model and "concierge medicine practices" and "direct primary care" models.
- Potential for beta-testing in pilot practices in order to refine the proposal.

Submitter's Statement

The Chair invited the submitter representatives Jean Antonucci and John Wasson to make a statement to PTAC.

Dr. Antonucci explained that she submitted this proposal because primary care is in need of innovation. The model is intended to improve the sustainability of primary care for both doctors and patients while reducing the burden of payment on primary care physicians.

The submitter representatives also elaborated on "How's Your Health," its features, and the timeliness of feedback regarding gaps in patient healthcare. They further explained that by having patients provide feedback on their healthcare through the "How's Your Health" system, the risk of undertreatment of patients would be greatly diminished.

PTAC and Submitter Q&A and Discussion

PTAC and submitters engaged in Q&A and discussion on the following topics:

- Whether the submitter had approached insurers to test their willingness to move forward on a capitation model for primary care.
- The ability to ensure patients complete their surveys and examples of processes used to ensure compliance.
- Ensuring patients are not underserved through "How's Your Health" registry measures and that they view it as a valuable service.

- Requirements for a certain threshold of patients to participate in the "How's Your Health" system to achieve valid measures of quality.
- Justification for higher reimbursement of primary care physicians.
- Implications of differing proportions of low- and high-risk patients in different practices.

Public Comments
The PTAC Chair thanked the submitter representatives and opened the floor for public comments, of which there were none.

PTAC Criterion Voting
Before voting, the Committee had an extensive discussion on how to vote on this proposal given its innovations and potential appeal to primary care physicians but also the need for beta testing to refine the model. The Committee considered how best to communicate its thought process on this to the Secretary.

PTAC then discussed and voted on the extent to which the *Innovative Model for Primary Care Office Payment* proposal meets each of the Secretary's criteria.

[NOTE: PTAC's "*Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary for the Department of Health and Human Services"* state that a simple majority vote will establish PTAC's determination for each of the Secretary's criteria. The PTAC criterion votes remained anonymous and are presented in the table below. Individual member comments also are available in the meeting transcript located on the ASPE PTAC website at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

Given that nine PTAC members participated in deliberation and voting on the proposal, five PTAC votes constituted a simple majority.

PTAC Member Votes on the *Innovative Model for Primary Care Office Payment*

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
1. Scope (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	1
	3 – Meets the criterion	5
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	2
PTAC DECISION: Proposal Meets Criterion 1.		

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
2. Quality and Cost (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	1
	2 – Does not meet criterion	5
	3 – Meets the criterion	3
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does not Meet Criterion 2.		
3. Payment Methodology (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	6
	3 – Meets the criterion	2
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does not Meet Criterion 3.		
4. Value over Volume	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	1
	3 – Meets the criterion	2
	4 – Meets the criterion	5
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Meets Criterion 4.		
5. Flexibility	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	1
	3 – Meets the criterion	2
	4 – Meets the criterion	4
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Meets Criterion 5.		

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
6. Ability to be Evaluated	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	4
	3 – Meets the criterion	4
	4 – Meets the criterion	1
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 6.		
7. Integration and Care Coordination	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	6
	3 – Meets the criterion	3
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 7.		
8. Patient Choice	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	2
	3 – Meets the criterion	6
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 8.		
9. Patient Safety	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	6
	3 – Meets the criterion	2
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Does Not Meet Criterion 9.		

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
10. Health Information Technology	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	7
	4 – Meets the criterion	1
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 10.		

PTAC Vote on Recommendation to the Secretary

[NOTE: PTAC members' votes on the recommendation to the Secretary are presented in the table below. PTAC's "*Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary for the Department of Health and Human Services"* state that a two-thirds majority vote will determine PTAC's recommendation to the Secretary.]

Before voting, the Committee discussed the meaning of a vote to "recommend proposed payment model for limited-scale testing." The Chair reviewed the Committee's criteria for this category and indicated that it may be used when PTAC determines a proposal meets all or most of the Secretary's criteria, but lacks sufficient data to 1) estimate potential cost savings and/or impacts of the payment model and/or, 2) specify key parameters in the payment model, such as risk adjustment or stratification, and PTAC believes the only effective way to obtain those data would be through implementation of the payment model in a limited number of settings.

Given that nine PTAC members participated in deliberation and voting on the proposal, six PTAC votes were required for the final PTAC recommendation vote.

PTAC Recommendation Category	PTAC Member Recommendation Vote
Not Applicable	*No PTAC members voted for this recommendation category*
Do not recommend proposed payment model to the Secretary (2)	Jeffrey Bailet Rhonda Medows
Recommend proposed payment model to the Secretary for limited-scale testing (6)	Paul Casale Tim Ferris Harold Miller Len Nichols Kavita Patel Grace Terrell
Recommend proposed payment model to the Secretary for implementation (1)	Bruce Steinwald
Recommend proposed payment model to the Secretary for implementation as a high priority	*No PTAC members voted for this recommendation category*

As a result of the vote, PTAC recommended the *Innovative Model for Primary Care Office Payment* proposal to the Secretary for limited-scale testing.

Instructions on the Report to the Secretary
After PTAC voting, individual PTAC members made comments for incorporation into PTAC's Report to the Secretary. All comments of individual members can be found in full in the meeting transcript located on the ASPE PTAC website at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.

PTAC members requested the comments in PTAC's Report to the Secretary emphasize the desirability of testing a model using patient-reported outcomes and alternative ways to do risk adjustment. In addition, PTAC indicated the importance of explaining the Committee's rationale for recommending limited-scale testing in order to strengthen the proposal. PTAC members indicated the report should capture that the model would have significant impact on primary care if it works properly. PTAC believes this model aligns with the Secretary's "four P's" framework identified by the HHS leadership earlier in the meeting.

The public meeting recessed at 3:35 p.m. and reconvened at 3:45 p.m.

Dialyze Direct: APM for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities

Committee Member Disclosures
The PTAC members had nothing to disclose.

PRT Report to the Full PTAC
The PRT for the *APM for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities* proposal consisted of Harold Miller (the PRT Lead), Jeffrey Bailet, and Rhonda Medows.

Harold Miller summarized and presented the PRT's report to PTAC, stating that the proposed model would:

- Encourage delivery of on-site dialysis to short- or long-term skilled nursing facility (SNF) patients with end-stage renal disease.
- Increase the frequency of dialysis for patients from three days a week to five days a week.
- Provide a one-time $500 payment to nephrologists for educating patients about the service, as well as an additional payment for 90 percent of the savings resulting from avoided transportation costs associated with the nephrologist seeing the patient in the SNF rather than their office.
- Require no change in how Medicare pays for dialysis treatments.

Key issues identified by the PRT included:

- No mechanism exists in the proposal to ensure that there would be savings through reduction in transportation costs, hospitalizations, or shorter SNF stays that would offset the higher payments for dialysis because patients would have more frequent dialysis sessions.
- The proposal does not address all of the barriers that exist in the payment system, such as the lack of financial sustainability of the model at current Medicare payment rates.

The PRT unanimously agreed the proposal met three of 10 of the Secretary's criteria ("Value over Volume", "Ability to be Evaluated", and "Patient Choice".) The PRT unanimously agreed that the proposal did not meet six categories of the Secretary's criteria ("Quality and Cost", "Payment Methodology", "Flexibility", "Integration and Care Coordination", "Patient Safety", and "Health Information Technology"). A majority of the PRT felt the proposal did not meet the remaining criterion ("Scope").

[NOTE: The PRT's presentation slides and full report are available on the ASPE PTAC website located at: https://aspe.hhs.gov/proposal-submissions-physician-focused-payment-model-technical-advisory-committee.]

Clarifying Questions from PTAC to the PRT
The PTAC Chair opened the floor for PTAC members' questions to the PRT. Topics discussed included:

- The length of time that most patients would be able to receive more frequent dialysis under the model.
- The number of patients required to make delivery of the services financially viable.
- The eligibility of patients to receive more frequent dialysis and the increase in Medicare spending associated with that.
- How the education bonus payment to nephrologists was calculated.

Submitter's Statement
The PTAC Chair invited the submitter representatives to make a statement to PTAC. They introduced themselves as Alice Hellebrand, Allen Kaufman, Nathan Levin, Jonathan Paull, and Joshua Rothenberg.

The submitter representatives stated that the model was created to help patients who would benefit significantly from home dialysis, which is generally underused in the United States. The model is designed to reduce barriers to entry, including availability of home dialysis and willingness of practitioners to participate. The submitter has had no problems recruiting the necessary number of patients to make a dialysis den financially viable, with the primary barrier being recruiting enough physicians for the model. They discussed how SNF patients are able to participate in SNF rehabilitation programs on a daily basis because their dialysis recovery time is reduced from half a day to 30 to 60 minutes.

PTAC and Submitter Q&A and Discussion
PTAC and submitters engaged in Q&A and discussion on the following topics:

- Potential for accountability for spending to be incorporated into the model.
- The staffing ratios required to meet patients' needs, number of patients required in a facility, and minimum size of SNFs to participate.
- How to best encourage the dissemination and rapid adoption of a better model of care.
- The importance of the continuity of care.
- Whether new current procedural terminology (CPT) codes could better support these treatments.

- Financial barriers for nephrologists in seeing patients in a SNF and the payment changes nephrologists need for patients who receive home dialysis in a SNF.
- The extent to which telehealth visits would change nephrologists' willingness to participate.
- Regulatory barriers on directly reimbursing nephrologists for participating.
- Availability of quality metrics for SNF dialysis patients.

The PTAC Chair suggested that PTAC might not the best venue for evaluating this model. The submitters indicated that staff from the Center for Medicare and Medicaid Innovation had recommended they come to PTAC. PTAC discussed a number of alternatives to voting on the proposal before proceeding.

Public Comments
There were no public comments.

PTAC Criterion Voting
PTAC discussed and voted on the extent to which the *APM for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities* proposal meets each of the Secretary's criteria.

[NOTE: PTAC's "*Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary for the Department of Health and Human Services"* state that a simple majority vote will establish PTAC's determination for each of the Secretary's criteria. The PTAC criterion votes remained anonymous and are presented in the table below. Individual member comments also are available in the meeting transcript located on the ASPE PTAC website at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

Given that 10 PTAC members participated in deliberation and voting on the proposal, six PTAC votes constituted a simple majority.

PTAC Member Votes on the *APM for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities*

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
1. Scope (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	3
	2 – Does not meet criterion	4
	3 – Meets the criterion	3
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 1.		

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
2. Quality and Cost (High Priority)	* – Not Applicable	1
	1 – Does not meet criterion	3
	2 – Does not meet criterion	4
	3 – Meets the criterion	2
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 2.		
3. Payment Methodology (High Priority)	* – Not Applicable	2
	1 – Does not meet criterion	7
	2 – Does not meet criterion	1
	3 – Meets the criterion	0
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 3.		
4. Value over Volume	* – Not Applicable	0
	1 – Does not meet criterion	1
	2 – Does not meet criterion	1
	3 – Meets the criterion	6
	4 – Meets the criterion	2
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 4.		
5. Flexibility	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	4
	3 – Meets the criterion	6
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 5.		

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
6. Ability to be Evaluated	* – Not Applicable	1
	1 – Does not meet criterion	1
	2 – Does not meet criterion	4
	3 – Meets the criterion	4
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 6.		
7. Integration and Care Coordination	* – Not Applicable	0
	1 – Does not meet criterion	3
	2 – Does not meet criterion	2
	3 – Meets the criterion	5
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 7.		
8. Patient Choice	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	6
	4 – Meets the criterion	2
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Meets Criterion 8.		
9. Patient Safety	* – Not Applicable	0
	1 – Does not meet criterion	1
	2 – Does not meet criterion	2
	3 – Meets the criterion	4
	4 – Meets the criterion	1
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Meets Criterion 9.		

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
10. Health Information Technology	* – Not Applicable	0
	1 – Does not meet criterion	2
	2 – Does not meet criterion	6
	3 – Meets the criterion	2
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 10.		

PTAC Vote on Recommendation to the Secretary

[NOTE: PTAC members' votes on the recommendation to the Secretary are presented in the table below. PTAC's "*Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary for the Department of Health and Human Services"* state that a two-thirds majority vote will determine PTAC's recommendation to the Secretary.]

Prior to voting, the Committee voted in favor of replacing the voting category of "Not Applicable" with "Recommend for attention" for the purposes of the recommendation to the Secretary. PTAC further clarified and voted to approve that this was a recommendation of the "proposal" for attention, not the "model" for attention, making the final category "Recommend proposal for attention."

Given that 10 PTAC members participated in deliberation and voting on the proposal, seven PTAC votes were required for the final PTAC recommendation vote.

PTAC Recommendation Category	PTAC Member Recommendation Vote
Recommend proposal for attention (10)	Jeffrey Bailet Bob Berenson Paul Casale Tim Ferris Rhonda Medows Harold Miller Len Nichols Kavita Patel Bruce Steinwald Grace Terrell
Do not recommend proposed payment model to the Secretary	*No PTAC members voted for this recommendation category*
Recommend proposed payment model to the Secretary for limited-scale testing	*No PTAC members voted for this recommendation category*
Recommend proposed payment model to the Secretary for implementation	*No PTAC members voted for this recommendation category*
Recommend proposed payment model to the Secretary for implementation as a high priority	*No PTAC members voted for this recommendation category*

As a result of the vote, PTAC recommended the *APM for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities* proposal to the Secretary for attention.

Instructions on the Report to the Secretary
After PTAC voting, individual PTAC members made comments for incorporation into PTAC's Report to the Secretary. All comments of individual members can be found in full in the meeting transcript located on the ASPE PTAC website at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.

Committee members expressed support for facilitating more frequent dialysis for patients in nursing home settings. It was recommended that the report describe the importance of ensuring quality of care since there is no data that substantiates the improvements in dialysis patients undergoing home dialysis in the nursing home. The Committee wanted to indicate in its letter to the Secretary that other alternatives to support the approach should be considered, such as a billing code or a waiver to allow payments to physicians. The report should also state that the problem should be addressed comprehensively, since Dialyze Direct does not have a way to use savings on total cost of care to support the services. Additionally, the report should state that there are two different populations that need to be considered: both short- and long-term SNF patients.

The meeting adjourned at 6:11 p.m. EDT.

Approved and certified by:

/Sarah Selenich/ 12/10/2018

Sarah Selenich, Designated Federal Officer
Physician-Focused Payment Model Technical
Advisory Committee

Date

/Jeffrey Bailet/ 12/10/2018

Jeffrey W. Bailet, MD, Chair
Physician-Focused Payment Model Technical
Advisory Committee

Date