Physician-Focused Payment Model Technical Advisory Committee

October 20, 2017

Eric D. Hargan
Acting Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Hargan:

On behalf of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), I am pleased to submit PTAC's comments and recommendation to you on a Physician-Focused Payment Model (PFPM) submitted by the Icahn School of Medicine at Mount Sinai entitled "*HaH-Plus" (Hospital at Home Plus) Provider-Focused Payment Model*. These comments and recommendation are required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) which directs PTAC to: 1) review PFPM models submitted to PTAC by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (Secretary, HHS); and 3) submit these comments and recommendations to the Secretary.

With the assistance of HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE), PTAC's members carefully reviewed Icahn School of Medicine at Mount Sinai's proposed model (submitted to PTAC on May 4, 2017), additional information on the model provided by the submitters in response to questions from a PTAC Preliminary Review Team and PTAC as a whole, and public comments on the proposal. At a public meeting of PTAC held on September 7, 2017, the Committee deliberated on the extent to which this proposal meets the criteria established by the Secretary in regulations at 42 CFR § 414.1465 and whether it should be recommended.

PTAC recommends the Secretary implement the *HaH-Plus* model. The Committee finds there is a need for a Medicare payment model to provide home-based hospital-level acute care for carefully selected patients and supports the proposed PFPM.

PTAC recognizes several strengths of the *HaH-Plus* model. *HaH-Plus* would provide a new alternative to hospitalization for eligible Medicare beneficiaries. Eligible patients, in consultation with their families and physicians, may choose to receive either *HaH-Plus* services or traditional inpatient admission. The model also promotes integrated and coordinated care by delivering acute and post-acute care in the home and using the same team of providers to direct care in both phases.

PTAC also notes some weaknesses in the proposal. Safeguards for patient safety could be strengthened with formalized training for participating *HaH-Plus* providers and external monitoring for adverse events and appropriate admission to *HaH-Plus*. Additionally, the payment methodology could benefit from refinement, particularly on setting the value for the DRG-like bundled payment and adjusting the payment for quality. However, PTAC believes these weaknesses are feasible to resolve prior to model implementation and encourages the Secretary to direct the Center for Medicare and Medicaid Innovation (CMMI) to work with the submitter to do so. PTAC concludes *HaH-Plus* is a model that should be implemented in the Medicare program and is likely to be of interest to many physicians, patients, and families.

The members of PTAC appreciate your support of our shared goal to improve the Medicare program for both beneficiaries and the physicians who care for them. The Committee looks forward to your detailed response posted on the CMS website and would be happy to answer questions about this proposal as you develop your response. If you need additional information, please have your staff contact me at Jeff.Bailet@blueshieldca.com.

Sincerely,

Jeffrey Bailet, MD
Chair

Attachments

Physician-Focused Payment Model Technical Advisory Committee

REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

Comments and Recommendation on

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

October 20, 2017

About This Report

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to: 1) review physician-focused payment models (PFPMs) submitted by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (Secretary, HHS); and 3) submit these comments and recommendations to the Secretary. PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR § 414.1465.

This report contains PTAC's comments and recommendation on a PFPM submitted by the Icahn School of Medicine at Mount Sinai entitled *"HaH-Plus" (Hospital at Home Plus) Provider-Focused Payment Model*. This report also includes: 1) a summary of PTAC's review of this proposal; 2) a summary of the "*HaH-Plus" (Hospital at Home Plus) Provider-Focused Payment Model*; 3) PTAC's comments on the proposed model and its recommendation to the Secretary; and 4) PTAC's evaluation of the proposed PFPM against each of the Secretary's criteria for PFPMs. The appendices to this report include a record of the voting by PTAC on this proposal; the proposal submitted by the Icahn School of Medicine at Mount Sinai; and additional information on the proposal submitted by the Icahn School of Medicine at Mount Sinai subsequent to the initial proposal submission.

SUMMARY STATEMENT

PTAC recommends the Secretary implement the proposed PFPM, "*HaH-Plus" (Hospital at Home Plus) Provider-Focused Payment Model*. The Committee believes there is a need for a Medicare payment model to provide home-based hospital-level acute care for carefully selected patients and believes the model will be of interest to many physicians, patients, and families. PTAC recognizes several strengths of the *HaH-Plus* model, including broadening the scope of APMs in the CMS portfolio and promoting patient choice and integrated and coordinated care. While PTAC finds some alterations to the payment methodology and additional safeguards for patient safety are needed, it believes the shortcomings within the currently proposed PFPM can be addressed with modifications prior to model implementation. The submitter has already offered some augmentations to strengthen the model, and PTAC encourages the Secretary to direct the Center for Medicare and Medicaid Innovation (CMMI) to work with the submitter to address any remaining concerns.

PTAC REVIEW OF THE *HAH-PLUS* PROPOSAL

The *HaH-Plus* proposal was submitted to PTAC on May 4, 2017. The proposal was first reviewed by a PTAC Preliminary Review Team (PRT) composed of three PTAC members, including at least one physician. These members requested additional data and information to assist in their review. The proposal was also posted for public comment. The PRT's findings were documented in a "Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)," dated August 16, 2017. At a public meeting held on September 7, 2017, PTAC deliberated on the extent to which the proposal meets the criteria established by the Secretary in regulations at 42 CFR § 414.1465 and whether it should be recommended to the Secretary for implementation.[1] The submitter and members of the public were given an opportunity to make statements to the Committee at the public meeting. Below are a summary of the *HaH-Plus* model*,* PTAC's comments and recommendation to the Secretary on this proposal, and the results of PTAC's evaluation of the proposal using the Secretary's criteria for PFPMs.

PROPOSAL SUMMARY

The proposed *HaH-Plus* model allows Medicare beneficiaries with acute illness or exacerbated chronic disease, who would otherwise require inpatient hospitalization, to receive hospital-level acute care services in the home plus 30 days of transition services following "discharge"

[1]PTAC member Grace Terrell, MD, MMM, was not in attendance.

from the acute care phase. The proposal also describes two variants of the model called Observation at Home and Palliative Care at Home. The goal of *HaH-Plus* is to improve quality of care and reduce costs by reducing complications and readmissions.

The submitter indicates that patients presenting with conditions that would generally fall into one of 44 Medicare Severity Diagnosis Related Groups (MS-DRGs) could potentially be admitted to *HaH-Plus*. Medicare beneficiaries would be carefully screened to ensure they could safely receive care at home prior to admission to the program. The submitter estimates approximately 21% of patients classified into the 44 MS-DRGs would be eligible for *HaH-Plus*. The acute care phase of *HaH-Plus* involves daily (or more frequent) visits by a physician or advanced practice nurse, daily (or more frequent) visits by a registered nurse, and in-home radiology, labs, and pharmacy as needed. The 30 days of post-acute transition services include post-discharge visits and care coordination with the patient's regular care providers.

The Medicare program does not currently pay for hospital-level acute care in the home. *HaH-Plus* is a payment encompassing the acute (hospital-level) phase of care plus 30 days of post-acute transition services. The *HaH-Plus* payment is composed of two parts: (1) a bundled payment equal to 95% of the sum of (a) the DRG payment that would have been paid to a hospital and (b) the average professional fees that would have been paid to physicians had the patient been admitted to a hospital and (2) a performance-based payment (shared savings/shared losses) based on (a) total spending during both the acute care phase and 30 days afterward relative to a target price and (b) performance on quality measures. Some services would still be billed under standard Medicare payment systems (including professional fees for consultations; post-acute labs/diagnostics; post-acute skilled nursing, outpatient, and home health services; post-acute ED services and hospital readmissions), but these services would be included in the measure of spending used for calculating shared savings/losses. The target price would be based on average spending during the episode (the acute care phase plus 30 days post-discharge) for hospitalized patients in the same geographic region who had matching DRGs. The APM Entity would only be responsible for savings and losses up to 10% of the target price, with CMS entitled to the first 3% of any savings and the remainder paid to the APM Entity. In the case of losses, the APM Entity would pay CMS.

RECOMMENDATION AND COMMENTS TO THE SECRETARY

PTAC recommends the Secretary implement the *HaH-Plus* model. The Committee believes there is a need for a Medicare payment model to provide home-based hospital-level acute care for carefully selected patients and supports the goals of the proposed PFPM. PTAC recognizes several strengths of the *HaH-Plus* model, including expanding the CMS APM portfolio and

promoting patient choice and integrated and coordinated care. PTAC also identifies weaknesses in some aspects of the proposal, particularly with respect to patient safety and payment methodology. However, PTAC believes these weaknesses could be resolved prior to model implementation and encourages the Secretary to direct CMMI to work with the submitter to do so. PTAC concludes *HaH-Plus* is a model that should be implemented in the Medicare program and is likely to be of interest to many physicians, patients, and families.

The goal of the *HaH-Plus* model is to improve patient outcomes and reduce program costs by providing hospital-level acute care in the home for eligible patients. *HaH-Plus* would support broader efforts to move care out of the hospital setting appropriately. As noted in the proposal, patients often experience adverse events during hospitalization and many patients and their families prefer to receive care in the home when it is appropriate. The submitter notes some private payers and individual health systems in the U.S. are currently implementing care delivery programs similar to the *HaH-Plus* model and such programs are associated with improved patient satisfaction, lower adverse event rates, and reduced spending.

PTAC recognizes many strengths of the proposed PFPM. First, *HaH-Plus* would provide a new service for Medicare beneficiaries. Neither standard Medicare payment systems nor existing CMS APMs provide direct support for hospital-level acute care in the home. PTAC believes home-based hospital-level care may improve quality and reduce costs for eligible patients. Second, *HaH-Plus* provides eligible patients with a new choice about where to receive care. Patients, in consultation with their families and their physicians, may elect participation in *HaH-Plus* if they qualify; otherwise, they may choose traditional inpatient admission. Third, *HaH-Plus* promotes integrated and coordinated care. Because the same providers direct care in the home during the acute and post-acute phases, fewer transitions occur among providers or care settings. Such continuity of care around the critical post-discharge period may improve patient outcomes and reduce spending. Fourth, the proposed bundled payment includes the hospital-level acute phase plus an additional 30 days of post-acute transition services to prevent cost-shifting from the acute to the post-acute phase. The bundle also affords providers flexibility to tailor services to individual beneficiaries, including offering services not currently billable under the Medicare Physician Fee Schedule.

PTAC also believes some aspects of the proposed PFPM should be strengthened prior to model implementation. Of foremost concern is ensuring patient safety within a home-based program targeted to patients sick enough to require hospital-level care. The financial incentives and risks of the proposed PFPM inherently require caution on the part of entities implementing the program to ensure only patients who both require hospitalization and can be safely cared for at home are admitted to *HaH-Plus*. However, PTAC members believe additional safeguards are

needed beyond what was described in the proposal. Monitoring external to the APM Entity, rather than internal monitoring as proposed, would be critical to ensuring that patients are appropriately admitted to *HaH-Plus* and that adverse events are tracked and root causes addressed. Additionally, PTAC members believe formalized training should be required for all *HaH-Plus* providers to ensure patients who would otherwise receive care in the hospital are safely cared for at home.

PTAC also identifies several concerns in the proposed payment methodology. In particular, PTAC members believe that a larger discount to the current MS-DRG payment amount may be appropriate for the proposed *HaH Plus* payment, which covers the bundle of acute and post-acute care, since the intensity of services required for *HaH-Plus* patients may be lower than for those patients who would need to be cared for in the hospital. PTAC members also suggest making the DRG-like payment contingent on quality. Emphasizing the DRG-like payment over the shared savings and shared losses component may mitigate some challenges with implementing the model, such as identifying an appropriate comparison group for establishing the target price, and may smooth the path for a prospectively paid bundle in the future. Additionally, decreasing the amount of risk the APM Entity bears at the beginning of the model and increasing it over time may lower barriers to participation, particularly for smaller organizations. PTAC can envision CMMI testing multiple versions of *HaH-Plus* with varied payment methodologies. PTAC members believe it may be worthwhile to begin testing *HaH-Plus* within Accountable Care Organizations under existing advanced APMs that bear responsibility for total medical expenditures within attributed populations and thus have additional incentives to ensure appropriateness of admission and patient safety. This could speed implementation of the proposed PFPM while enabling CMMI to address some of the concerns PTAC raises for implementing this program in a FFS context.

EVALUATION OF PROPOSAL USING SECRETARY'S CRITERIA

PTAC Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary (at 42 CFR §414.1465)	Rating
1. Scope (High Priority)[1]	Meets criterion and deserves priority consideration
2. Quality and Cost (High Priority)	Meets criterion
3. Payment Methodology (High Priority)	Meets criterion
4. Value over Volume	Meets criterion
5. Flexibility	Meets criterion
6. Ability to be Evaluated	Meets criterion
7. Integration and Care Coordination	Meets criterion and deserves priority consideration
8. Patient Choice	Meets criterion and deserves priority consideration
9. Patient Safety	Meets criterion
10. Health Information Technology	Meets criterion

Criterion 1. Scope (High Priority Criterion)

Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.

Rating: Meets Criterion and Deserves Priority Consideration

PTAC concludes the proposed PFPM meets the criterion and deserves priority consideration. None of the existing CMS APMs offer hospital-level care in the home. *HaH-Plus* provides a new avenue for appropriately moving care out of the hospital and may provide a building block for additional home-based care services in the future. PTAC believes *HaH-Plus* is a model that should be implemented in the Medicare program and notes the model is likely to be of interest to many physicians. PTAC also appreciates the model's financial viability depends on achieving sufficient patient volume; consequently, expanding the number of eligible MS-DRGs and offering a multi-payer option may make the model more feasible for organizations with lower Medicare FFS patient volume.

[1]Criteria designated as "high priority" are those PTAC believes are of greatest importance in the overall review of the payment model proposal.

Criterion 2. Quality and Cost (High Priority Criterion)

Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

Rating: Meets Criterion

PTAC concludes the proposed PFPM meets the criterion. PTAC believes *HaH-Plus* could improve patient outcomes and reduce costs to Medicare while offering a new way to deliver patient-centered care. As noted in the proposal, multiple studies have demonstrated the Hospital at Home care model improves quality and reduces costs. PTAC also finds certain aspects of quality could be strengthened within the proposed PFPM. The proposed quality metrics could be expanded, potentially to include external monitoring for admission appropriateness and an expanded list of adverse events. Additionally, PTAC suggests the amount of the DRG-like payment for the bundle of acute and post-acute care services be linked to performance on quality measures.

Criterion 3. Payment Methodology (High Priority Criterion)

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 Physician-Focused Payment Model cannot be tested under current payment methodologies.

Rating: Meets Criterion

PTAC concludes the proposed PFPM meets the criterion. PTAC appreciates the strengths of the proposed bundled payment. Bundling acute and post-acute care mitigates cost-shifting from the acute to the post-acute phase. The bundle also affords providers flexibility to tailor services to the needs of individual beneficiaries, including services not currently covered by the Medicare Physician Fee Schedule. PTAC also believes the payment methodology would benefit from some modifications. PTAC suggests several specific changes: (1) adjust the DRG-like payment based on performance on quality measures; (2) modify the magnitude of the discount to the MS-DRG based on the intensity of services required by patients in the *HaH-Plus* model relative to those patients who continue to be served in the inpatient unit; (3) refine the benchmarking methodology to account for baseline differences between the *HaH-Plus* and inpatient populations. Emphasizing the DRG-like payment over the shared savings and shared losses component may mitigate some challenges with implementing the model, such as identifying an appropriate comparison group for establishing the target price, and may smooth the path for a prospectively paid bundle in the future. Additionally, PTAC recommends the

amount of risk the APM Entity bears start at a lower level and increase over time to reflect the APM Entity's startup costs and its increased experience in managing patient care over time.

Criterion 4. Value over Volume

Provide incentives to practitioners to deliver high-quality health care.

Rating: Meets Criterion

PTAC concludes the proposed PFPM meets this criterion. The proposed PFPM includes incentives for providers to deliver high-value care to patients participating in the model. Because patients actively choose participation in *HaH-Plus* and the model's payment structure financially penalizes providers delivering poor-quality or inappropriate care, providers are incentivized to deliver high-quality care to appropriate patients. PTAC also notes the minimum volume of patients required to maintain financial viability of the model may create an undesirable, countervailing incentive to inappropriately admit patients. However, PTAC believes this concern could be mitigated, potentially by making the DRG-like payment contingent on quality and/or adding an all-payer option. Additionally, PTAC recommends external monitoring for admission appropriateness and adverse events to ensure delivery of high-quality care in *HaH-Plus*.

Criterion 5. Flexibility

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

Rating: Meets Criterion

PTAC concludes the proposed PFPM meets this criterion. The bundled payment for acute and post-acute care affords providers flexibility to tailor services to individual beneficiaries, including services not currently paid under the Medicare Physician Fee Schedule. Providers would have flexibility to determine the number and types of services patients need and the individuals or organizations best positioned to deliver those services. Furthermore, providers would have flexibility to deliver more services to some patients than others, based on patient need, as long as the overall costs for all patients served was less than the revenue generated by the payments.

Criterion 6. Ability to be Evaluated

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

Rating: Meets Criterion

PTAC concludes the proposed PFPM meets this criterion. The proposed PFPM describes evaluable goals for quality of care and cost. Mount Sinai's Health Care Innovation Award, which forms the basis for this proposed PFPM, is currently being evaluated, and lessons learned from that experience could inform the evaluation of this proposed PFPM. Additionally, as a number of other Hospital at Home programs have previously been evaluated, the results of those evaluations could be combined with the evaluation of this proposed PFPM to facilitate more robust conclusions about the impact of the care model. PTAC also notes the *HaH-Plus* model requires substantial up-front investment to deliver acute-level services in the home. As such, PTAC recommends the evaluation of the *HaH-Plus* model include whether and how smaller organizations or those with limited capital reserves are able to participate. PTAC also suggests examining the impacts of the proposed PFPM on *HaH-Plus* eligible MS-DRGs for patients who continue to receive treatment in the hospital.

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.

Rating: Meets Criterion and Deserves Priority Consideration

PTAC concludes the proposed PFPM meets this criterion and deserves priority consideration. Because the same providers direct care during the acute and post-acute phases, and the acute and post-acute care is delivered in the home, fewer transitions occur among providers or care settings. Such continuity of care around the critical post-discharge period may improve quality and reduce costs. Additionally, *HaH-Plus* has several mechanisms in place to ensure patients' usual providers are aware of patient 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.

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.

Rating: Meets Criterion and Deserves Priority Consideration

PTAC concludes the proposed PFPM meets this criterion and deserves priority consideration. *HaH-Plus* offers a new home-based care alternative to hospitalization for patients sick enough to require hospital-level acute care and stable enough to receive care at home safely. In consultation with their families and physicians, eligible patients may elect to receive hospital-

level care at home through *HaH-Plus* or to receive traditional hospital admission. PTAC believes the *HaH-Plus* model emphasizes patient choice and could provide a new patient-centered care model for Medicare beneficiaries.

Criterion 9. Patient Safety

Aim to maintain or improve standards of patient safety.

Rating: Meets Criterion

PTAC concludes the proposed PFPM meets this criterion. PTAC recognizes the critical need to ensure hospital-level care is delivered at home safely under the *HaH-Plus* model. PTAC believes the financial incentives and risks of the proposed PFPM inherently require caution on the part of entities implementing the program to ensure only patients who both require hospitalization and can be cared for at home safely are admitted to *HaH-Plus*. However, PTAC also believes the PFPM should include additional safeguards for patient safety beyond what were proposed. PTAC makes several specific recommendations to ensure patient safety in the *HaH-Plus* model: (1) monitoring external to the APM Entity, rather than internal monitoring as proposed, for admission appropriateness; (2) tracking adverse events with plans to address root causes; and (3) requiring formalized training for all *HaH-Plus* providers.

Criterion 10. Health Information Technology

Encourage use of health information technology to inform care.

Rating: Meets Criterion

PTAC concludes the proposed PFPM meets this criterion. PTAC believes implementation of programs such as *HaH-Plus* may encourage electronic health record (EHR) vendors to develop better cross-setting and interoperability capabilities, since information sharing is critical to coordinating care delivered by multiple providers. Although current EHR capabilities may pose challenges to *HaH-Plus* model implementation, PTAC believes that individual *HaH-Plus* models likely could be implemented given their relatively small scale.

APPENDIX 1. COMMITTEE MEMBERS AND TERMS

Jeffrey Bailet, MD, *Chair*

Elizabeth Mitchell, *Vice-Chair*

Term Expires October 2018

Jeffrey Bailet, MD
Blue Shield of California
San Francisco, CA

Elizabeth Mitchell
Network for Regional Healthcare Improvement
Portland, ME

Robert Berenson, MD
Urban Institute
Washington, DC

Kavita Patel, MD
Brookings Institution
Washington, DC

Term Expires October 2019

Paul N. Casale, MD, MPH
NewYork Quality Care
NewYork-Presbyterian, Columbia University College of Physicians and Surgeons, Weill Cornell Medicine
New York, NY

Bruce Steinwald, MBA
Independent Consultant
Washington, DC

Tim Ferris, MD, MPH
Massachusetts General Physicians Organization
Boston, MA

Term Expires October 2020

Rhonda M. Medows, MD
Providence Health & Services
Seattle, WA

Len M. Nichols, PhD
Center for Health Policy Research and Ethics
George Mason University
Fairfax, VA

Harold D. Miller
Center for Healthcare Quality and Payment Reform
Pittsburgh, PA

Grace Terrell, MD, MMM
Envision Genomics
Huntsville, AL

APPENDIX 2. PFPM CRITERIA ESTABLISHED BY THE SECRETARY

PFPM CRITERIA ESTABLISHED BY THE SECRETARY
1. Scope. Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.
2. Quality and Cost. Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.
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 Physician-Focused Payment Model cannot be tested under current payment methodologies.
4. Value over Volume. Provide incentives to practitioners to deliver high-quality health care.
5. Flexibility. Provide the flexibility needed for practitioners to deliver high-quality health care.
6. Ability to be Evaluated. Have evaluable goals for quality of care, cost, and any other goals of the PFPM.
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.
8. Patient Choice. Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.
9. Patient Safety. Aim to maintain or improve standards of patient safety.
10. Health Information Technology. Encourage use of health information technology to inform care.

APPENDIX 3. DISTRIBUTION OF MEMBER VOTES ON EXTENT TO WHICH PROPOSAL MEETS CRITERIA AND OVERALL RECOMMENDATION[1]

Criteria Specified by the Secretary (at 42 CFR §414.1465)	Does not meet		Meets		Priority consideration		Rating
	1	2	3	4	5	6	
1. Scope of Proposed PFPM (High Priority)[2]				2	7	1	Meets and deserves priority consideration
2. Quality and Cost (High Priority)			2	4	4		Meets criterion
3. Payment Methodology (High Priority)		1	3	4	1	1	Meets criterion
4. Value over Volume			1	8	1		Meets criterion
5. Flexibility			2	3	5		Meets criterion
6. Ability to be Evaluated			3	7			Meets criterion
7. Integration and Care Coordination			1	3	5	1	Meets and deserves priority consideration
8. Patient Choice				1	7	2	Meets and deserves priority consideration
9. Patient Safety			8	2			Meets criterion
10. Health Information Technology			6	4			Meets criterion

Do not recommend	Recommend for limited-scale testing	Recommend for implementation	Recommend for implementation as a high priority	Recommendation
		4	6	**Recommend for implementation**

[1]PTAC member Grace Terrell, MD, MMM, was not in attendance.

[2]Criteria designated as "high priority" are those PTAC believes are of greatest importance in the overall review of the payment model proposal.