Physician-Focused Payment Model Technical Advisory Committee

October 20, 2018

Alex M. Azar II, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar:

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), *Alternative Payment Model for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities*, submitted by Dialyze Direct. These comments and recommendation are required by section 1868(c) of the Social Security Act, 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 (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 Dialyze Direct's proposal (submitted to PTAC on March 8, 2018), additional information on the model provided by the submitter in response to questions from the PTAC Preliminary Review Team, information from ASPE contractors about the number of dialysis patients in nursing homes and about the benefits of providing more frequent dialysis, and public comments on the proposal. At a public meeting of PTAC held on September 6, 2018, 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 Dialyze Direct's proposal to the Secretary for attention. The Committee finds that the proposal only meets four of the Secretary's

10 criteria. However, the Committee feels that attention from HHS is warranted because enabling the delivery of staff-assisted home dialysis in skilled nursing facilities (rather than transporting patients to off-site hemodialysis centers) and enabling the delivery of more frequent dialysis (five times per week rather than three times per week) could improve outcomes and reduce spending for Medicare beneficiaries. In addition to avoiding the risks and discomfort inherent in transport to off-site centers, more frequent dialysis has been shown to improve cardiovascular function and fluid management. The current Medicare payment system appears to have barriers that prevent or discourage home hemodialysis in skilled nursing facilities (SNFs) for beneficiaries with end-stage renal disease (ESRD) who reside in such facilities. In considering the potential opportunity highlighted by this proposal, PTAC created this new category of "attention" in order to underscore to the Secretary the opportunity that this proposal represents.

The members of PTAC appreciate your support of our shared goal of improving the Medicare program for both beneficiaries and the physicians who care for them. The Committee looks forward to your detailed 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

Alternative Payment Model for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities

October 20, 2018

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 (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 proposal, *Alternative Payment Model for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities*, submitted by Dialyze Direct. This report also includes: 1) a summary of PTAC's review of the proposal, 2) a summary of the proposed 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 Dialyze Direct, and additional information on the proposal submitted by Dialyze Direct subsequent to the initial proposal submission.

SUMMARY STATEMENT

PTAC recommends the *Alternative Payment Model for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities* proposal for attention by the Secretary. The Committee finds that the proposal only met four of the Secretary's 10 criteria, and it did not meet any of the high-priority criteria. However, the Committee feels that attention from HHS is warranted because the submitters identified an important opportunity to improve outcomes and reduce spending for Medicare beneficiaries with end-stage renal disease (ESRD) who reside in skilled nursing facilities (SNFs) that cannot adequately be pursued today because of barriers in current Medicare payment systems.

PTAC agrees with the submitter that health outcomes for ESRD patients residing in SNFs could be improved if they could receive hemodialysis in the SNF rather than being transported to an off-site hemodialysis center, which is the most common way that Medicare SNF patients receive hemodialysis. In addition, many ESRD patients in SNFs would likely benefit by receiving more frequent hemodialysis, e.g., dialysis five times a week instead of only three times a week. The savings from avoided transportation to off-site centers and fewer hospitalizations from reductions in complications of dialysis could potentially more than offset the higher costs of delivering more frequent, staff-assisted home hemodialysis in the SNF, thereby achieving savings for Medicare as well as better outcomes for the patients.

While PTAC is convinced that there are barriers in the current payment system to achieving these better outcomes and savings, it is not convinced that the payment model proposed by the submitters would overcome the barriers or ensure that higher quality and lower spending would be achieved. However, because of the desirability and feasibility of achieving better outcomes and lower spending for ESRD patients in SNFs, the Committee unanimously felt that attention from HHS is needed to find appropriate ways of achieving these goals. This attention could include an assessment of whether changes in the payments for dialysis delivered in nursing facilities or changes in payments to nephrologists for patients residing in nursing facilities are needed. A review of current policies could identify factors that may inappropriately restrict the use of more frequent dialysis for patients who could benefit from it. Different approaches may be needed to ensure the most appropriate care for individuals who are short-term patients in SNFs versus long-term nursing facility residents.

PTAC REVIEW OF THE PROPOSAL

Dialyze Direct's proposal was submitted to PTAC on March 8, 2018. The proposal was first reviewed by a PTAC Preliminary Review Team (PRT) composed of three PTAC members (Jeffrey Bailet, Rhonda Medows, and Harold Miller), two of whom are physicians. The PRT requested additional data and information from ASPE contractors and from the submitter to assist in its review. The proposal was also posted for public comment; public comments were provided by

the Renal Physicians Association and Fresenius Medical Care North America. The PRT reviewed the Dialyze Direct proposal as well as additional information provided by the submitter in written responses to questions from the PRT. The PRT sent a document with initial feedback to the submitter on July 17, 2018, and the submitter provided a written response. The PRT's findings were documented in the *Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on the "Alternative Payment Model for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities" Payment Model* that was submitted to the full PTAC on August 14, 2018. At a public meeting held on September 6, 2018, 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 proposal, PTAC's comments and recommendation to the Secretary on the proposal, and the results of PTAC's evaluation of the proposal using the Secretary's criteria for PFPMs.

PROPOSAL SUMMARY

The proposed payment model is intended to support a model of care that the submitter indicates it is currently delivering in approximately 30 sites. Under the proposed model, eligible patients with ESRD in SNFs would have the opportunity to receive staff-assisted more frequent (five times per week) dialysis (MFD) at the SNF ("home hemodialysis"), rather than being transported to a renal dialysis facility (RDF) for thrice-weekly hemodialysis (HD). Patients would include both a) Medicare beneficiaries who are temporarily residing in the SNF for post-acute care following a hospital admission, and b) beneficiaries who are long-term residents of the SNF.

Participating SNFs would create a comfortable treatment area or "dialysis den" so that patients could receive staff-assisted MFD in the SNF, thereby avoiding the need for transportation to a separate RDF (typically three times per week). The proposal indicates that the dialysis den would typically be set up for four patients, and 8–10 patients would be treated at each SNF, including some patients who would receive bedside dialysis because they could not be treated in the SNF dialysis den. The dialysis program would provide an on-site interdisciplinary team including a senior registered nurse serving as a home dialysis coordinator, trained home HD caregivers, dietitians, and social workers. The home dialysis coordinator would be highly engaged in care coordination and information-sharing and would serve as a liaison between the

[1]PTAC member Elizabeth Mitchell was not in attendance.

dialysis program staff and the SNF staff. The dialysis program and SNF would work out a detailed delineation of responsibilities for their staffs.

Prior to admission to the SNF, ESRD patients would be screened to see if they meet medical necessity criteria for MFD. Information on the benefits and risks of the program would be provided, and patients would choose whether they wanted to participate. (Patients who do not want to participate could continue to be transported to off-site RDFs.)

Participating patients could continue to be treated by the nephrologist who supervised the patient's care prior to the SNF admission (i.e., while they were receiving dialysis at home or in an off-site RDF) if the nephrologist were willing to do so. The submitters state that they have developed efficient physician credentialing procedures, and the model proposes incentive payments for nephrologists to encourage them to travel to SNFs to see patients.

Under the proposed model, the nephrologist would receive a one-time bonus payment of $500 for providing education to a patient on the proposed dialysis program. Medicare would not pay any other facility or physician home dialysis training fees. The nephrologist would also receive 90% of any savings resulting from avoided transportation costs if the nephrologist sees the patient in the nursing facility rather than in the nephrologist's office. There would be no downside financial risk to the dialysis provider or the nephrologist based on changes in Medicare spending.

The submitters propose a nonrandomized comparison of a prospective cohort of patients in SNFs receiving dialysis through the proposed dialysis program and a matched retrospective cohort receiving conventional, in-center HD. The submitters hypothesize improved patient outcomes, including reduced hospital readmissions, from MFD. Evaluation of the model would be based on comparison of all Medicare Part A and B costs except for those attributable to transplantation.

RECOMMENDATION AND COMMENTS TO THE SECRETARY

PTAC finds that the *Alternative Payment Model for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities* only meets four of the Secretary's ten criteria. However, the Committee unanimously recommends the proposal to the Secretary for attention because of the need to address the opportunities the proposal identifies to improve outcomes and reduce spending for Medicare beneficiaries with ESRD who reside in SNFs and to overcome the barriers to doing so in current Medicare payment systems.

This proposal is intended to 1) encourage the delivery of on-site dialysis and MFD for ESRD

patients and other patients needing dialysis who are residing in SNFs, and 2) enable more nephrologists to participate in an alternative payment model. PTAC members uniformly agree with the desirability of the first objective. Transportation to off-site dialysis centers is expensive for Medicare, reduces the ability of nursing facility residents to participate in therapy and activities at the SNF, and can be dangerous for the residents. Therefore, enabling the delivery of dialysis at the SNF could improve quality and reduce spending. In addition, evidence indicates that more frequent hemodialysis is beneficial to patients in improving cardiovascular function and fluid management. Although this evidence is based on patients who live independently rather than in SNFs, it will be difficult to develop more direct evidence about the benefits for SNF patients until more ESRD patients in SNFs have the opportunity to obtain more frequent dialysis.

The submitter did not propose any changes to Medicare payments for dialysis services, even though it indicated that delivering staff-supported HD in a SNF would cost more than current Medicare payment amounts, even if the dialysis programs receive daily dialysis payments for the patients. The only changes in payment proposed by the submitters were the creation of two incentive payments for nephrologists that the submitter believed would address a different barrier—the current disincentives for nephrologists to visit dialysis patients in SNFs. The submitter met with the Center for Medicare & Medicaid Innovation (CMMI) on this issue and indicated that CMMI referred them to PTAC.

PTAC does not believe that the proposed payment model would adequately address all of the barriers that discourage broader use of staff-supported home hemodialysis in SNFs. Moreover, the Committee feels that the proposal was narrowly focused on one particular approach to dialysis delivery in nursing facilities, rather than other approaches such as peritoneal dialysis. The proposal also did not include adequate mechanisms for ensuring the delivery of quality care. Although payment reductions may occur from reduced transportation and hospitalization, the proposed model did not include any mechanisms for ensuring that those savings would be achieved.

During the public meeting, the submitter noted that CMS has recently taken action to encourage the use of home hemodialysis in nursing homes. Based on a memo issued on August 17, 2018, by CMS (Memo #18-24-ESRD “Survey Process for Reviewing Home Dialysis Services in a Long Term Care Facility”), the state operating manuals now provide guidance regarding the provision of home hemodialysis in nursing homes. This memo updates the ESRD core survey process to include evaluation of home dialysis services provided in nursing homes. However, in their proposal, the submitter also expressed concern about policies by Medicare contractors that make it difficult to deliver more frequent dialysis to patients who could benefit from it.

Therefore, PTAC recommends that attention to this area is needed by HHS. This attention could

include an assessment of whether changes in the payments for dialysis delivered in nursing facilities or changes in payments to nephrologists for patients residing in nursing facilities are needed, as well as a review of current policies that may be inappropriately restricting the use of MFD for patients in SNFs. Different approaches may need to be used in order to ensure the most appropriate care for individuals who are short-term patients in SNFs versus long-term nursing facility residents.

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]	Does Not Meet Criterion
2. Quality and Cost (High Priority)	Does Not Meet Criterion
3. Payment Methodology (High Priority)	Does Not Meet Criterion
4. Value over Volume	Meets Criterion
5. Flexibility	Meets Criterion
6. Ability to Be Evaluated	Does Not Meet Criterion
7. Integration and Care Coordination	Does Not Meet Criterion
8. Patient Choice	Meets Criterion
9. Patient Safety	Meets Criterion
10. Health Information Technology	Does Not Meet 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: Does Not Meet Criterion

PTAC concludes that the proposed model does not meet this criterion. This proposal is intended to 1) encourage the delivery of on-site dialysis and MFD for ESRD patients and other patients needing dialysis who are residing in SNFs, and 2) enable more nephrologists to participate in an alternative payment model (APM). However, the proposal is narrowly focused on one particular approach to dialysis delivery, which may not be the best option for all patients in nursing facilities. It appears that only a small proportion (fewer than 1%) of nursing facilities would have the minimum number of patients that the submitters indicate are needed to make the

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

proposed model financially viable, and the proposal does not address all of the barriers that discourage broader use of staff-supported home HD in nursing facilities.

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: Does Not Meet Criterion

PTAC concludes that the proposed model does not meet this criterion. The Committee agrees that many SNF patients could benefit from receiving home hemodialysis in the SNF and from receiving MFD. This approach would: avoid the significant time, disruption, and risk of transport-related injury to patients involved in ambulance transportation to a dialysis center; reduce the frequency of cardiovascular problems and other complications by using MFD; and reduce the frequency of emergency department (ED) visits or hospital readmissions associated with complications of current modes of dialysis. However, there are also risks to patients from MFD, including higher risks of infection and access failure from more frequent vascular access; patients who are receiving dialysis in the nursing facility would see their nephrologist less frequently, and for patients who are only in the SNF for a short period of time, changing to more frequent dialysis and then back to less frequent dialysis after discharge could also cause medically-related complications. The proposal did not include any explicit mechanisms for avoiding these problems or for ensuring that patients received better quality care or achieved better outcomes than under the current delivery and payment system.

The Committee also agrees that there could be savings to Medicare by reducing ambulance transportation costs to off-site dialysis facilities. Additional saving could occur from reduced hospital admissions and readmissions for ESRD patients, though evidence is not available on the extent of such reductions for SNF dialysis patients. Offsetting these reductions, Medicare dialysis payments would increase if patients receive dialysis five times per week rather than only three times per week. Moreover, the submitter indicated that the current Medicare payment amounts were not sufficient to cover the costs of delivering staff-supported dialysis in SNFs and that a more than 50% increase in Medicare dialysis payments would be needed to sustain the services, with even higher amounts presumably needed if there are fewer than eight patients using the service at an individual facility. Although Medicare could experience net savings from the proposed approach, the model did not include any mechanisms for ensuring that such savings would occur or for taking risk on any increases in total payments.

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 PFPM cannot be tested under current payment methodologies.

Rating: Does Not Meet Criterion

PTAC concludes that the proposed model does not meet this criterion. The proposed changes in payment are intended to encourage nephrologists to support the use of one particular approach to staff-assisted home HD in a nursing facility. It is not clear that the proposed changes would significantly affect nephrologists' willingness to support staff-supported home dialysis in a nursing facility. In addition, payments to the nephrologists would not be affected if the quality of care or outcomes of care are poor.

The submitter indicated that current Medicare payment amounts for dialysis would be insufficient to cover the cost of the staff-assisted home dialysis service in the nursing facility, even with eight patients receiving dialysis in the same facility, but no changes in payments were proposed to address this issue. PTAC suggests that alternative ways of addressing the goals of the proposal should be examined, such as changes in the payment amounts for dialysis and in payments for nephrology care of patients in SNFs.

Criterion 4. Value over Volume

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

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. More frequent dialysis at SNFs could be beneficial for long-stay SNF residents with ESRD, particularly those with multiple conditions and more advanced illnesses. The approach may also be beneficial for ESRD patients who are in SNFs for short-term stays. The one-time payment to the nephrologist would help to encourage use of this approach.

However, if the patient were receiving dialysis in the SNF rather than at a dialysis center, the patient would still need to travel to the nephrologist's office for visits unless the nephrologist were willing to come to the SNF to see them. Current payments for nephrologists may not make it cost-effective for them to visit a patient in a SNF, and it is not clear that the proposed payments are sufficient to address this problem.

Criterion 5. Flexibility

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

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. It is currently difficult for nephrologists to recommend MFD for most nursing home patients because hemodialysis often requires daily off-site transportation, so having MFD available in the SNF would create greater flexibility. However, the flexibility would be limited because the proposed model would only be available in facilities with an adequate number of patients and payer mix.

Criterion 6. Ability to Be Evaluated

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

Rating: Does Not Meet Criterion

PTAC concludes that the proposed model does not meet this criterion. Although it would be feasible to compare spending and some outcomes for patients receiving the services and those who are not, the relatively small number of facilities that are likely to participate could make it difficult to draw conclusions about the results. It also would be difficult to measure many important outcomes or to risk-adjust the results unless both the participants and the comparison group were submitting appropriate quality measures to a patient registry.

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: Does Not Meet Criterion

PTAC concludes that the proposed model does not meet this criterion. Although the ability to receive dialysis care in the facility where the patient is residing could enable more coordinated care for some patients, the proposal does not propose explicit processes for ensuring that coordination occurs nor any process of measuring whether integration and care coordination does occur.

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

PTAC concludes that the proposed model meets this criterion. The proposed model would enable more patients to receive dialysis in the nursing facility where they reside and to receive more frequent dialysis.

Criterion 9. Patient Safety

Aim to maintain or improve standards of patient safety.

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. If a patient requiring dialysis is in a nursing facility that does not have an on-site dialysis center, the nursing home patient is typically transported by ambulance to a dialysis center, which is a lengthy, unpleasant, disruptive, and potentially dangerous process. In addition to avoiding the risks of transport, patients in many cases are much better off being able to get MFD (five days a week rather than three days a week), both because the side effects of dialysis are reduced and because they are able to participate more fully in activities at the SNF. If they are receiving rehabilitation services at the SNF, home HD at the SNF could reduce the length of their SNF stay. However, the proposed payment methodology does not include any explicit mechanism for assuring that patients receive high-quality care or achieve better outcomes than they would under the current delivery and payment system.

Criterion 10. Health Information Technology

Encourage use of health information technology to inform care.

Rating: Does Not Meet Criterion

PTAC concludes that the proposed model does not meet this criterion. There is no discussion of the specific kinds of data that would be collected and how they would be used.

APPENDIX 1. COMMITTEE MEMBERS AND TERMS

Jeffrey Bailet, MD, *Chair*

Term Expires October 2018

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

Robert Berenson, MD
Urban Institute
Washington, DC

Elizabeth Mitchell
Blue Shield of California
San Francisco, CA

Kavita Patel, MD, MSHS
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

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

Bruce Steinwald, MBA
Independent Consultant
Washington, DC

Term Expires October 2020

Rhonda M. Medows, MD
Providence St. Joseph Health
Seattle, WA

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

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

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 PFPM 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)	Not Applicable	Does Not Meet Criterion		Meets Criterion		Priority Consideration		Rating
	*	1	2	3	4	5	6	
1. Scope (High Priority)[2]	-	3	4	3	-	-	-	Does Not Meet Criterion
2. Quality and Cost (High Priority)	1	3	4	2	-	-	-	Does Not Meet Criterion
3. Payment Methodology (High Priority)	2	7	1	-	-	-	-	Does Not Meet Criterion
4. Value over Volume	-	1	1	6	2	-	-	Meets Criterion
5. Flexibility	-	-	4	6	-	-	-	Meets Criterion
6. Ability to be Evaluated	1	1	4	4	-	-	-	Does Not Meet Criterion
7. Integration and Care Coordination	-	3	2	5	-	-	-	Does Not Meet Criterion
8. Patient Choice	-	-	-	6	2	1	1	Meets Criterion
9. Patient Safety	-	1	2	4	1	1	1	Meets Criterion
10. Health Information Technology	-	2	6	2	-	-	-	Does Not Meet Criterion

Do Not Recommend	Recommend for Attention	Recommend for Limited-scale Testing	Recommend for Implementation	Recommend for Implementation as a High Priority	Recommendation
-	10	-	-	-	Recommend for Attention

[1]PTAC member Elizabeth Mitchell 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.