Physician-Focused Payment Model Technical Advisory Committee

May 7, 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 proposed Physician-Focused Payment Model (PFPM), *Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home (HH-APM),* submitted by Personalized Recovery Care, LLC (PRC). 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 PRC's proposed model, submitted to PTAC on October 27, 2017, along with additional information provided subsequently by PRC. At a public meeting of PTAC held on March 26, 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 concluded that the proposal meets all of the Secretary's ten criteria and that it should be recommended to the Secretary for implementation.

Because the PRC HH-APM model addresses the important need of providing home-based hospital-level acute care for eligible patients, and the differences from the HaH-Plus APM model that we previously recommended could enable more and different physician practices to participate and more patients to benefit, implementation of both models would be desirable to enable a better understanding of the relative advantages of the different approaches. While the HH-APM proposal has some weaknesses, described below and in the Preliminary Review Team (PRT) report, PTAC believes that the strengths of this proposal outweigh the weaknesses, and that the weaknesses can be addressed with relatively modest changes, PTAC therefore recommends the proposed model for implementation.

PTAC appreciates 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 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

Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home

May 7, 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 (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 proposal, *Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home*, submitted by Personalized Recovery Care, LLC (PRC). This report also includes: 1) a summary of PTAC's review of this 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 PRC; additional information provided by PRC in response to written questions from the PRT during its deliberation process; and a response by PRC to the PRT report.

SUMMARY STATEMENT

PTAC concluded that *Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home (HH-APM)* meets all ten criteria for PFPMs established by the Secretary and recommends that it be implemented. This is the second model for home hospitalization that PTAC has reviewed and recommended for implementation. (The first was the"HaH Plus" (Hospital at Home Plus) Provider-Focused Payment Model submitted by the Icahn School of Medicine at Mount Sinai.) PTAC believes that not only does the PRC HH-APM model also address the important need of providing home-based hospital-level acute care for eligible patients, but its differences from the "HaH Plus" Payment Model could enable more and different physician practices to participate and more patients to benefit. Implementation of multiple models would also enable a better understanding of the relative advantages of the different approaches. While the HH-APM proposal has some weaknesses (described below) and in the Preliminary Review Team (PRT) report, PTAC believes that the strengths of this proposal outweigh the weaknesses, and that the weaknesses can be addressed with relatively modest changes. Therefore, PTAC recommends the proposed model for implementation.

PTAC REVIEW OF THE PROPOSAL

The *Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home* proposal was submitted to PTAC on October 27, 2017. The proposal was first reviewed by a PTAC Preliminary Review Team (PRT) composed of three PTAC members, including one physician. The proposal was posted for public comment. The PRT members requested additional written information from the submitter to assist in their review and held a telephone call with the submitter to obtain additional information. The PRT's findings were documented in the "Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)," dated February 23, 2018. The submitter provided PTAC with a written response to the PRT report. At a public meeting held on March 26, 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. The submitter and members of the public were given an opportunity to make statements to the Committee at the public meeting, and the submitter responded to questions from PTAC members. Below are a summary of the *Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home* 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 PRC HH-APM would provide new payments designed to allow 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 transition services (akin to post-acute care) for a total of 30 days.

Patients with over 40 different health conditions that would be classified into any of more than 150 MS-DRGs would be eligible for home hospitalization services supported by the PRC HH-APM if they met three conditions: (a) they met clinical criteria for an inpatient admission, (b) an assessment of their specific clinical conditions and home environment prior to admission indicated that they could safely receive care at home instead of in the hospital, and (c) the patient agreed to accept care in the home instead of in the hospital. (The original proposal included more than 160 MS-DRGs, but the submitter indicates it now would remove 13 of those MS-DRGs based on experience.) The submitter's experience to-date shows that the percentage of beneficiaries who qualify for home hospitalization varies significantly by MS-DRG.

During the acute care phase, the APM Entity (the organization receiving the PRC HH-APM payments) would be expected to: 1) have the admitting physician hold telehealth visits with the patient at least daily; 2) have a registered nurse make visits to the patient's home at least twice daily; 3) provide for 24/7 phone response by a Recovery Care Coordinator (who would be a registered nurse); and 4) have 24/7 on-call physician access. In addition, the patient could initially receive acute care in a hospital or skilled nursing facility before being transferred home for the remainder of the acute phase of care. All of these services would be supported by the Home Hospitalization Payment component of the PRC HH-APM. As needed during the acute care phase, the patient also would receive in-home infusion services; speech, physical, and occupational therapy; visits with specialists; transportation services; durable medical equipment; and radiology studies, laboratory tests, and medications. If these ancillary services or specialist visits are delivered, or if the patient had an unplanned service such as an Emergency Department visit, those services would be billed directly to Medicare and paid according to standard Medicare payment rules.

During the post-acute care phase, the APM Entity would be expected to have the Recovery Care Coordinator monitor and coordinate the patient's care. This service would be supported by the Home Hospitalization Payment. If the patient needed home health services or other types of post-acute care services, these would be billed directly to Medicare and paid according to standard Medicare payment rules, as would the patient's visits to their primary care physician, specialist visits, emergency department (ED) visits, and other services that the patient may need.

There would be two parts to the PRC HH-APM payments to the APM Entity:

- A bundled Home Hospitalization Payment equal to 70% of the MS-DRG payment for which a hospital would have been eligible under the Medicare Inpatient Prospective Payment System (IPPS) had the patient been admitted for inpatient care. The MS-

DRG would be determined based on the patient's diagnoses and procedures using the standard Medicare MS-DRG grouper. The APM Entity would use this payment for any types of service needed by the patient that are not eligible for payment under existing Medicare payment systems.

- A performance-based payment (shared savings/shared losses) based on (a) total spending during the 30 day period beginning with the patient's admission to acute (hospital-level) care at home and (b) the APM Entity's performance on five quality measures. A "Target Bundled Rate" would be established for each MS-DRG equal to 97% of the "Benchmark Rate," which is the average 30-day Medicare spending for the subset of patients who had been discharged from hospitals under the same MS-DRG and would have been eligible for home hospitalization. Medicare spending on all services the patient received during the acute phase (including the Home Hospitalization Payment equal to 70% of the MS-DRG amount and all services received by the patient that were billed directly to Medicare) and Medicare spending on related services the patient received during the 30-day period (including post-acute care services related to the acute diagnosis, but excluding ED visits or hospitalizations for new, unrelated conditions) would be totaled. If that total exceeds the Target Bundled Rate, the APM Entity will be responsible for paying Medicare for the difference or 10% of the Benchmark Rate, whichever is less. If the total Medicare spending is below the Target Bundled Rate, the APM Entity would be eligible to receive a performance-based payment of up to 100% of the difference or 10% of the Benchmark Rate, whichever is less. The performance-based payment would be reduced by 20% for each of the five quality measures where the performance standard for that measure was not met.

The proposal has many similarities to the HaH-Plus Provider-Focused Payment Model that PTAC recommended for implementation in 2017. Most of the same strengths and weaknesses that PTAC identified with respect to HaH-Plus also apply to the PRC HH-APM. However, the PRC HH-APM also has several important differences from the HaH-Plus model:

- **Patient Eligibility.** In the PRC HH-APM, patients in over 150 different MS-DRG categories would be eligible to participate, whereas the HaH-Plus model is designed for patients in fewer than 50 MS-DRGs. Since PTAC had concerns about whether there would be a sufficient number of patients in the HaH-Plus model to make it financially viable in small and rural communities, the broader eligibility criteria in the PRC HH-APM could help to increase patient volume. However, the greater diversity of patients in the larger number of MS-DRGs could also make it more challenging for a small home hospitalization program to deliver appropriate care safely to every patient.
- **Services Included in Bundled Payment.** In the HaH-Plus model, the home hospitalization provider would receive a single bundled payment to cover virtually all of the services the patient would receive, similar to the way in which a hospital DRG payment covers all of the services the patient receives during an inpatient admission. In contrast, in the PRC HH-APM, the provider would receive a smaller payment designed to only cover home nursing, social work, and physician telehealth services; the provider or other providers

would continue to bill Medicare for infusion services, DME, laboratory tests, therapy services, and other ancillary services under standard Medicare payment systems. In both models, the home hospitalization provider would be accountable for the total amount spent during the episode through a financial reconciliation process. By allowing continued billing for ancillary services under current payment systems, the PRC HH-APM could be simpler for both CMS and small providers to implement, but this could also potentially increase the financial risks for small providers during the reconciliation process.

- **Relationship of Payments to Costs.** In the PRC HH-APM, the home hospitalization provider would receive a payment equal to 70% of the MS-DRG payment that would have been paid to a hospital if the patient had been admitted. Since ancillaries would be billed separately, it is not clear how often the costs of the nursing and other services would be proportional to the amount of the MS-DRG payment. Since payment amounts would differ significantly across the MS-DRGs that would be included in the model, and since only a small percentage of patients in many of the MS-DRGs would likely be eligible for home hospitalization, this could create a perverse financial incentive for the provider to focus on patients in the MS-DRGs that would result in higher payments, even though the higher severity and complexity of these patients might make them more challenging to manage in the home. Small providers could also face financial challenges if the cost of home nursing services is higher than 70% of the MS-DRG payments for the patients they serve, even though the cost is lower than what the full MS-DRG payment to a hospital would have been if the patient had been admitted to the hospital.

The table below shows key differences between the PRC HH-APM and the HaH-Plus APM:

Dimension	PRC HH-APM	HaH-Plus APM
Patient Eligibility	Patients in more than 150 MS-DRGs	Patients in approximately 50 MS-DRGs
Episode Length	30 days from the date of admission to home hospitalization	Length of acute care plus 30 days following the date of discharge from acute care
Amount of Bundled Payment	70% of the MS-DRG payment under the IPPS	95% of the MS-DRG payment under the IPPS plus average professional fees billed during an inpatient admission
Payment for Ancillary Services During Acute Phase	Would be billed directly to Medicare for payment under existing payment systems	Would be supported through the bundled payment, not billed directly to Medicare

RECOMMENDATION AND COMMENTS TO THE SECRETARY

PTAC concluded that the proposal should be recommended to the Secretary for implementation. This is the second model for home hospitalization that PTAC has reviewed and recommended for implementation (see the comparison of the two models, above). PTAC believes that not only does the PRC HH-APM model address the important need of providing home-based hospital-level acute care for eligible patients, but its differences from the HaH-Plus APM model that PTAC previously recommended could enable more and different physician practices to participate and more patients to benefit. Implementation of both models would also enable a better understanding of the relative advantages of the different approaches. While the HH-APM proposal has some weaknesses, described below and in the Preliminary Review Team (PRT) report, PTAC believes that the strengths of this proposal outweigh the weaknesses, and that the weaknesses can be addressed with relatively modest changes. PTAC therefore recommends the proposed model for implementation.

In its review of the HaH-Plus proposal, PTAC concluded that there was a need for Medicare to create a payment model to support home-based, hospital-level, acute care for appropriate patients. However, PTAC also felt that the differences described above could increase the kinds of safety risks for patients and financial risks for providers that PTAC had identified with respect to the HaH-Plus model. PTAC believes that these issues could be addressed through: (a) formal monitoring and review of the frequency of home visits and rate of subsequent inpatient admissions; (b) a formal adverse event reporting mechanism, including a 1-800 line; (c) a requirement for 24/7 availability of care; and (d) a training program for home care professionals. Additionally, tying payments to quality measures and expanding the number of quality measures would provide greater assurances about patient safety.

The proposed modifications that PRC submitted to PTAC may address many of these issues, but PTAC did not have adequate time prior to the public meeting to review these proposed modifications to determine whether they were sufficient to adequately address all of the issues.

In addition, PTAC felt that it could be desirable for providers participating in the PRC HH-APM to focus initially on patients in a narrower range of MS-DRGs and phase in services to a broader range of patients over time. Adjustments to the payment amounts and risk levels may be needed to allow this phased approach.

PTAC members concluded that the payment amount should be adjusted for the likely lower spending on patients in the PRC HH-APM relative to patients admitted to inpatient units, and the amount of payment for the acute phase should be tied to quality measures. Additionally, PTAC members expressed concern that patient selection criteria may make models such as these easy for participants to financially “game,” and recommended that any patient selection issues be addressed before any version of this model is tested.

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
2. Quality and Cost (High Priority)	Meets
3. Payment Methodology (High Priority)	Meets
4. Value over Volume	Meets
5. Flexibility	Meets
6. Ability to be Evaluated	Meets
7. Integration and Care Coordination	Meets
8. Patient Choice	Meets with Priority Consideration
9. Patient Safety	Meets
10. Health Information Technology	Meets

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

PTAC concludes that the proposal meets the criterion. There are no current Medicare payments or APMs that support a home-based alternative for patients requiring inpatient-level care at the point when they are facing a hospital admission or observation stay. While the CMMI Independence at Home program provides intensive home-based services to chronic disease patients at risk of hospitalization, the PRC HH-APM would also serve patients with acute conditions. The CMMI Bundled Payments for Care Improvement (BPCI) initiative and the new BPCI Advanced program include patients who would be eligible for the PRC HH-APM, but BPCI and BPCI Advanced require an inpatient admission for all of the conditions eligible for the PRC HH-APM conditions, so the PRC HH-APM would provide an additional opportunity for savings and quality improvement.

The ability to use existing payment systems for ancillary providers and the broad and flexible eligibility criteria could make it more feasible for the model to be implemented in smaller communities than the Hospital at Home Plus model recommended previously by PTAC.

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

However, it could also be more difficult for smaller practices to serve patients with such a wide range of clinical needs, particularly initially.

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 that the proposal meets the criterion. Multiple studies of similar programs in other countries and at several sites in the U.S. have found that home hospitalization programs achieve better outcomes for eligible patients and have lower costs than traditional hospitalization. The PRC HH-APM is specifically designed to deliver care for inpatient-eligible patients at a cost below normal Medicare payment amounts for inpatient care. Post-acute care costs are included in the target spending amount for which the APM Entity is accountable, which discourages cost-shifting from the acute phase of home hospitalization care to the post-discharge period. Additionally, the same providers are involved during both the acute and post-acute phases, which may reduce complications and readmissions during the critical post-discharge period.

While providing care to patients in the home should reduce hospital-associated morbidity (and associated costs), this care model may have risks for patients if they are not carefully selected for participation. Under the proposed payment model, revenues will depend on the number of patients participating, so financial pressures could result in (a) enrolling patients who would be better served in an inpatient unit or not admitted at all or (b) providing less intensive home services than patients need, which could lead to poorer outcomes. Before testing the model, modifications should be made to ensure patient selection is based on clinical rather than financial considerations and to adjust the proposed payment for the likely lower spending on patients in the PRC HH-APM relative to patients admitted to inpatient units. The amount of payment for the acute phase should be tied to quality measures, and measures of all adverse events and admissions to the inpatient unit should be reported and monitored through a standardized plan for review.

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: Meets Criterion

PTAC concludes that the proposal meets the criterion. The proposed payment methodology would provide payments for several types of home-based services that are not currently paid for (or not adequately paid for) under the Medicare Physician Fee Schedule or other Medicare payment systems. Paying for in-home alternatives to hospital care could also assist ACOs in reducing spending by filling a gap in the current FFS payment structure. The payment methodology is based on spending during a 30-day episode starting with the admission date — which protects against cost-shifting from the acute (inpatient) phase to the post-acute care phase, and helps avoid readmissions and unnecessary and unnecessarily expensive post-acute care. By allowing continued billing for ancillary services under current payment systems, the PRC HH-APM could be simpler for both CMS and small providers to implement. Some PTAC members expressed concern over the breadth of DRGs included in the proposed model. Starting with a smaller number of DRGs and broadening as evidence permits is preferable.

As noted above, PTAC members concluded that the payment amount should be adjusted for the likely lower spending on patients in the PRC HH-APM relative to patients admitted to inpatient units, the potential for favorable selection should be addressed, and the amount of payment for the acute phase should be tied to quality measures. In addition, the benchmarking methodology would need to be refined to account for likely differences in post-acute care costs between patients who can be cared for at home and the overall inpatient population.

Criterion 4. Value over Volume

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

Rating: Meets Criterion

PTAC concludes that the proposal meets the criterion. Since patient participation is voluntary, and since patients generally require a referral from a physician, the program would likely have difficulty attracting sufficient participation to remain operational if it did not deliver high-quality care. Additionally, the proposed PFPM includes incentives to providers to deliver high value care to patients participating in the model; shared savings payments are reduced if quality performance is low.

Because this model depends upon sufficient patient volume to make the program financially viable, PTAC members discussed that there are still risks that physicians would be incentivized to admit patients inappropriately. Consequently, monitoring for admission appropriateness and patient safety will be critical.

Criterion 5. Flexibility

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

Rating: Meets Criterion

PTAC concludes that the proposal meets the criterion. The bundled payment based on 70 percent of the MS-DRG payment would give the APM Entity significant flexibility to deliver different types of services to patients, including use of inpatient hospital or skilled nursing facility services and home services when appropriate. Although the APM Entity would have the flexibility to order ancillary services and specialist visits as long as the overall spending on the patients served was less than the target prices established for those patients, the flexibility to deliver different services in different ways would be more limited than with a single bundled payment for all services.

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 that the proposal meets the criterion. The proposal specifies goals for quality of care and costs that can be evaluated. Additionally, because a number of other similar Hospital at Home programs have previously been evaluated, the results of those evaluations could be combined with the evaluation of this PFPM to allow more robust conclusions about the impact of the care model. The Health Care Innovation Award for the Mt. Sinai Hospital at Home program is currently being evaluated, and the methods for drawing valid comparison groups in that evaluation should be helpful in designing an evaluation of the PRC HH-APM. However, because the patient's home environment will be a major factor in determining the patient's eligibility for home hospitalization, and information about the home environment is not available in claims data or standard clinical data, special effort would be needed to develop a comparison group of patients that are similar on the characteristics affecting eligibility for home hospitalization.

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

PTAC concludes that the proposal meets the criterion. The same team manages the patient during the acute care and post-acute care phases (up to 30 days), and the model includes explicit mechanisms for ensuring connections to the patient's primary care physician.

Under the PRC HH-APM, the APM Entity would be financially responsible for the cost of inpatient care for patients who need to be taken to the ED or admitted to the hospital during a home hospitalization episode, and it would be responsible for the cost of post-acute care for patients following discharge. This will require the Entity to develop relationships with hospitals and post-acute care providers if those relationships do not already exist. Upon discharge from the acute phase of home hospitalization, the patient's PCP would be sent a discharge summary within 48 hours and an appointment with the patient's PCP would be scheduled within 5-7 days. There is a quality measure and explicit financial incentive for connecting patients with their PCPs after the acute phase.

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 with Priority Consideration

PTAC concludes that the proposal meets the criterion with priority consideration. The program would provide a significant new home care option for eligible patients, which evaluations have shown is preferred by many patients and their families. Admission to the program would be voluntary on the part of the patient, and the payment model would provide flexibility to the care team to deliver non-traditional services to patients.

Criterion 9. Patient Safety

Aim to maintain or improve standards of patient safety.

Rating: Meets Criterion

PTAC concludes that the proposal meets the criterion. Participation in the program is intended to be limited to patients with diagnoses and other characteristics that can be cared for safely in the home. Patients can be escalated to an inpatient unit at any time, either at the patient's request or the clinician's judgment. The same team provides care during the acute and post-acute phases, which may help to reduce complications during the post-discharge period.

However, before testing the model, additional safeguards should specifically be included in the model, including: (a) formal monitoring and review of the frequency of home visits and rate of inpatient admissions, (b) a formal adverse event reporting mechanism, including a 1-800 line; (c) requirement for 24/7 availability of care; and (d) a training program for home care

professionals. Additionally, tying payments to quality measures and expanding the number of quality measures would provide greater assurances about patient safety.

Criterion 10. Health Information Technology

Encourage use of health information technology to inform care.

Rating: Meets Criterion

PTAC concludes that the proposal meets the criterion. Participants in the PRC HH-APM will be required to use Electronic Health Record (EHR) systems. While current EHR capabilities pose challenges to implementation of home hospitalization services, the proposed model encourages use of Health Information Technology. Implementation of home hospitalization programs supported by the PRC HH-APM could encourage EHR vendors to develop better cross-setting and interoperability capabilities. Although PRC uses a proprietary software system to support management of patients in its program, APM Entities would not be required to use this system, nor would use of the system be necessary for success.

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
Blue Shield of California[1]
San Francisco, CA

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

[1]Ms. Mitchell was President and CEO, Network for Regional Healthcare Improvement, when PTAC deliberated and voted on this proposal.

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)	Not Applicable	Does Not Meet Criterion		Meets Criterion		Priority Consideration		Rating
	*	1	2	3	4	5	6	
1. Scope (High Priority)[2]	0	0	0	3	4	1	3	Meets
2. Quality and Cost (High Priority)	0	0	1	3	3	3	1	Meets
3. Payment Methodology (High Priority)	0	0	1	5	3	1	1	Meets
4. Value over Volume	0	0	0	4	5	1	1	Meets
5. Flexibility	0	0	1	2	5	1	2	Meets
6. Ability to be Evaluated	0	0	0	6	4	0	1	Meets
7. Integration and Care Coordination	0	0	0	5	3	2	1	Meets
8. Patient Choice	0	0	0	2	3	4	2	Meets with Priority Consideration
9. Patient Safety	0	0	3	5	2	1	0	Meets
10. Health Information Technology	0	0	0	6	3	2	0	Meets

Not Applicable	Do Not Recommend	Recommend for Limited-scale Testing	Recommend for Implementation	Recommend for Implementation as a High Priority	Recommendation
0	0	3	5	3	Recommend for Implementation

[1]PTAC member Rhonda M. Medows, MD, 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.