Physician-Focused Payment Model Technical Advisory Committee

February 28, 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 on a Physician-Focused Payment Model (PFPM) submitted by Renal Physicians Association (RPA) entitled *Incident ESRD Clinical Episode Payment Model*. These comments and recommendations 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; 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 members carefully reviewed RPA's proposed model (submitted to PTAC on May 25, 2017), additional information on the model submitted by RPA in response to questions from a PTAC Preliminary Review Team (PRT) and PTAC as a whole, and public comments on the proposal. At a public meeting of PTAC held on December 18, 2017, PTAC 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 *Incident ESRD Clinical Episode Payment Model* for implementation without the transplant bonus component. PTAC believes the model has the potential to improve quality and reduce costs for many individuals with end-stage renal disease (ESRD). PTAC also believes the model can give more nephrologists in the country, including those in small and rural communities, an opportunity to participate in an alternative payment model

(APM). Although the Center for Medicare and Medicaid Innovation is already testing an APM focused on care for ESRD patients (the Comprehensive ESRD Care Model, also known as the CEC Model), PTAC finds that most nephrologists and ESRD patients will not be able to participate in the CEC Model, whereas they would be able to participate in the proposed *Incident ESRD Clinical Episode Model* if it is implemented.

PTAC recommends modifications to the quality scoring to ensure greater accountability for high-quality care and modifications to the shared savings methodology as well as careful monitoring to ensure that small nephrology practices are not financially harmed by caring for patients who have high-cost conditions other than ESRD or by random variation in patient needs. To encourage small nephrology practice participation, PTAC notes that forming virtual groups may be helpful to better manage financial risk.

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 to be posted on the CMS website and would be happy to assist you or your staff 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

Incident ESRD Clinical Episode Payment Model

February 28, 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. (See Appendix 1 for a list of PTAC members and their terms of appointment). PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR § 414.1465. (See Appendix 2 for the Secretary's criteria). As directed by MACRA, HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE) provides operational and technical support to PTAC.

This report includes: 1) a summary of PTAC's review of a PFPM submitted by the Renal Physicians Association entitled *Incident ESRD Clinical Episode Payment Model*; 2) a summary of this 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 the PTAC on this proposal (Appendix 3); the proposal submitted by Renal Physicians Association (Appendix 4); and additional information on the proposal submitted by Renal Physicians Association subsequent to the initial proposal submission (Appendix 5).

SUMMARY STATEMENT

PTAC recommends the *Incident ESRD Clinical Episode Payment Model* for implementation without the transplant bonus component. PTAC believes the model has the potential to improve quality and reduce costs for many individuals with end-stage renal disease (ESRD). PTAC also believes the model can give more nephrologists in the country, including those in small and rural communities, an opportunity to participate in an alternative payment model (APM). Although the Center for Medicare & Medicaid Services' (CMS') Center for Medicare and Medicaid Innovation (CMMI) is already testing an APM focused on care for ESRD patients (the Comprehensive ESRD Care Model, also known as the CEC Model), PTAC finds that most nephrologists and ESRD patients will not be able to participate in the CEC Model, whereas they would be able to participate in the proposed *Incident ESRD Clinical Episode Model* if it is implemented.

PTAC recommends modifications to the quality scoring to ensure greater accountability for high-quality care and modifications to the shared savings methodology as well as careful monitoring to ensure that small nephrology practices are not financially harmed by caring for patients who have high-cost conditions other than ESRD or by random variation in patient needs. To encourage small nephrology practice participation, PTAC notes that forming virtual groups may be helpful to better manage financial risk.

PTAC REVIEW OF PROPOSAL

The *Incident ESRD Clinical Episode Payment Model* was submitted to PTAC by Renal Physicians Association (RPA) on May 25, 2017. The proposal was first reviewed by a PTAC Preliminary Review Team (PRT) composed of three PTAC members, two of whom are physicians. These members reviewed the proposal and related data and information on Medicare beneficiaries with incident ESRD, secured additional clarifying information on the proposal from RPA, reviewed all comments on the proposal submitted by the public, and received and reviewed comments from CMS' Office of the Actuary on the model. The PRT spoke with a clinical expert, a nephrologist at the University of Pennsylvania, about the treatment of incident ESRD. The PRT reviewed data from the U.S. Renal Data System and requested additional analyses of Medicare claims data to better understand the patient population and current use of services. The PRT also talked with CMMI to better understand the differences between the proposed model and CMMI's Comprehensive ESRD Care Model. The PRT's findings and conclusions were documented in a *Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC),* dated November 16, 2017, and sent to the full PTAC November 22, 2017 along with the proposal and all related information. At a public meeting

held on December 18, 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. Below are a summary of the *Incident ESRD Clinical Episode Payment Model*, PTAC's comments and recommendation to the Secretary on this proposal, and PTAC's evaluation of the proposal compared to the Secretary's criteria for PFPMs.

PROPOSAL SUMMARY

The *Incident ESRD Clinical Episode Payment Model* submitted by RPA is a clinical episode payment model for Medicare patients with ESRD who have just begun receiving dialysis for the first time (which is referred to as "incident dialysis"). The proposal seeks to improve 1) upstream preparation for dialysis; 2) equality of access to dialysis modality types and shared decision making; 3) access to renal transplant; 4) healthy, planned transition to dialysis; and 5) patient well-being during the first six months of dialysis. Although the cost of care for all dialysis patients is high, the proposal is focused on addressing the particularly high rates of hospitalizations and associated costs for patients in the first six months of dialysis that are partly due to suboptimal transitions to dialysis. Patients start dialysis by one of several methods, including peritoneal dialysis, hemodialysis with a fistula or graft, or hemodialysis with catheters. The modalities associated with lower rates of complications and higher patient satisfaction require patient education as well as surgical preparation and time for healing that takes at least several weeks before dialysis begins. Dialysis can be performed in a center or in a home, but training for home dialysis can also take several weeks. Thus, most patients begin dialysis with a catheter rather than a fistula, and many patients begin dialysis during an inpatient hospitalization ("crashing into dialysis"). These patients have particularly high rates of morbidity, mortality, hospitalizations, and total Medicare costs.

The proposed APM addresses these concerns with two major elements. The first element is shared savings payments to the nephrologist (or repayments to Medicare for losses) based on 1) the total amount Medicare spends on all services for the nephrologist's patients (including services unrelated to their kidney disease) during the six months following initiation of dialysis, compared to a regional benchmark, and 2) performance on a set of quality metrics. The second major element of the proposal is one-time bonus payments for preemptive transplantation before dialysis ($3,000) or transplantation after dialysis begins but during the clinical episode ($1,500).

In addition to dialysis, treatment options for patients with advanced kidney disease and ESRD include kidney transplants or medical management of their condition without dialysis when appropriate (i.e., when dialysis would not significantly improve their longevity or their quality of

life). The shared savings component of the proposed payment model would only apply to these patients if they initiated dialysis and then transitioned to medical management or had a transplant during the six months after dialysis began.

The population of patients eligible for this proposed model is limited to those patients who are enrolled in Medicare when they begin dialysis or receive a transplant. For the shared savings component, the episode would begin the first day of the month during which dialysis begins, as noted on the Medicare 2728 form (unless dialysis begins on or after the 16th of the month).

In the model, nephrologists would continue to receive fee-for-service payments during the clinical episode. During two annual reconciliation periods, the APM Entity (which could be the nephrology practice or another entity) could receive shared savings (in the upside-only Merit-based Incentive Payment System (MIPS) APM option or the Advanced APM option) or be required to repay losses (only in the two-sided Advanced APM option) based on the comparison of the actual episode-adjusted patient cost to a risk-adjusted regional benchmark. For the purposes of the APM, the episode-adjusted patient cost is calculated by 1) summing total Medicare Parts A and B spending for eligible patients, subject to truncation and some exclusions mirroring the CEC Model methodology; 2) dividing the total by the number of eligible patients; and 3) dividing by the average normalized Hierarchical Condition Category (HCC) score. The regional benchmark is based on the two most recent years of Parts A and B expenditures for incident ESRD cases in the APM participant's health care referral region, divided by the patients' normalized HCC scores.

The amount of money a participating APM Entity could receive as shared savings (or owe to Medicare as shared losses in the two-sided model) depends on whether the APM Entity achieved the required minimum amount of savings (or losses) and how it performed on the quality metrics. If participating providers achieve savings of at least 3% (1% in the two-sided approach) compared to the benchmark, providers would receive 75% of the total savings (the difference in APM per-patient costs compared to the benchmark, multiplied by the number of patients) multiplied by their quality score (expressed as a percentage of the 100 possible quality points). Providers must achieve a quality score of at least 30 (in which case the provider's share of total savings would be multiplied by 0.3) to receive quality-adjusted shared savings payments. For participants in the two-sided risk option, losses would need to be at least 4% compared to the benchmark before repayments are required. Participants would be responsible for 50–75% of the losses, depending on their quality scores.

RECOMMENDATION AND COMMENTS TO THE SECRETARY

PTAC determined that the *Incident ESRD Clinical Episode Payment Model* met all ten of the Secretary's criteria, and it recommends the model for implementation without the transplant bonus component. PTAC believes the model has the potential to improve quality and reduce costs for many individuals with ESRD. PTAC also believes the model can give more nephrologists in the country, including those in small and rural communities, an opportunity to participate in an alternative payment model. Although CMMI is already testing the CEC Model, an APM focused on care for ESRD patients, PTAC finds that most nephrologists and ESRD patients will not be able to participate in that model, whereas they would be able to participate in the proposed *Incident ESRD Clinical Episode Model* if it is implemented.

PTAC recommends modifications to the quality scoring to ensure greater accountability for high-quality care and modifications to the shared savings methodology as well as careful monitoring to ensure that small nephrology practices are not financially harmed by caring for patients who have high-cost conditions other than ESRD or by random variation in patient needs. To encourage small nephrology practice participation, PTAC notes that forming virtual groups may be helpful to better manage financial risk.

Encouraging Transplants Through Means Other Than a Transplant Bonus

PTAC agrees with the submitter that it is desirable to encourage more patients to receive renal transplants instead of dialysis. However, PTAC determined that transplantation rates are affected primarily by the limited supply of organs, which is outside of the nephrologist's control, so awarding bonuses based on whether and when a transplant occurred could lead to unintended consequences.

PTAC concluded, and the submitter agreed, that the transplant bonus was a separable component of the proposed model, and that the transplant bonus could be dropped without diminishing the rest of the proposed payment model. The members of PTAC agreed to evaluate the proposal on the payment methodology criterion (criterion 3, the criterion most affected by the transplant bonus) as if the bonus were excluded from the model. PTAC encourages the Secretary to identify ways to incentivize early, appropriate transplants for ESRD patients.

Encouraging Improved Care for Chronic Kidney Disease (CKD) Patients Prior to Dialysis

The PTAC members discussed that optimal patient outcomes for patients and the savings for Medicare will require patient education and shared decision-making before a patient begins dialysis. In addition to implementing the proposed model, PTAC encourages the Department of

Health and Human Services to pursue other care delivery and payment initiatives designed to avoid or delay the need for dialysis among patients with CKD.

EVALUATION OF THE PROPOSAL USING THE 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
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
8. Patient Choice	Meets Criterion
9. Patient Safety	Meets Criterion
10. Health Information Technology	Meets Criterion

Criterion 1. Scope (High Priority Criterion)

Aim to broaden or expand the CMS APM portfolio by addressing an issue in payment policy in a new way, or including APM Entities whose opportunities to participate in APMs have been limited.

Rating: Meets Criterion

As a payment model for patients with ESRD, this proposal addresses a clinical area already being addressed by CMS' CEC Model. However, PTAC finds several features of the model distinguish it from the CEC model in terms of scope and potential impact. Only 10% of nephrologists currently participate in the CEC model, stemming in part from eligibility requirements (e.g., practice size) and a limited geographic penetration of ESRD Seamless Care Organizations (ESCOs). CMMI confirmed there are no plans to expand the number of ESCOs, limiting the ability of additional nephrologists to participate in the CEC APM. The proposal has the potential to improve quality and reduce cost for a number of ESRD patients and to expand nephrologist participation in APMs. An additional difference from the CEC Model is that the proposal focuses on improving care for incident dialysis patients, a time of particularly high

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

rates of complications and health care spending, and it provides incentives to improve the transition to dialysis. PTAC believes there is great opportunity for improvement for this patient population.

PTAC feels that large-scale implementation rather than limited-scale testing of this model is appropriate because 1) there was sufficient experience with the quality measures and spending levels through the existing ESRD program and the CEC Model to specify the initial parameters of the model, and 2) the diversity of practice structures and referral patterns would require a large number of participants in order to adequately evaluate the types of practices and patients where the model does and does not work well, and to determine what refinements may be necessary.

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 believes the proposed model presents an opportunity to both reduce costs and improve quality for incident ESRD patients. Average annual spending for Medicare ESRD patients is approximately $90,000 per patient, and a significant portion of that spending involves potentially preventable hospitalizations. All ESCOs in the CEC Model achieved savings in the initial year of the program, so it seems likely that nephrologists participating in this model could also achieve savings.

PTAC notes that improvements in quality stem in part from the ability of providers to influence care upstream, before patients begin their dialysis treatments. Providers in different settings experience varying capacities to intervene before dialysis. For example, nephrologists in integrated systems may automatically receive referrals for all CKD Stage 4 patients, thereby providing adequate time to refer for education, discuss patient preferences for dialysis modality, and prepare vascular access. Nephrologists in small and rural communities, and those practicing in less integrated environments, may be more likely to first encounter patients just before or after dialysis starts. While generally supportive of the approach adopted in this proposal, PTAC discussed whether some adjustments in quality benchmarks should be made to recognize the different environments providers face, either at the outset or in response to findings from future evaluations of the model.

The model draws its proposed quality measures from the CEC Model. PTAC believes that experience with the CEC Model helps support the implementation of this model without the

need for an initial phase of limited-scale testing to refine measures. However, PTAC feels that revisions to the performance standards for the quality measures would be desirable. As proposed, providers could achieve the minimum quality score of 30 needed to receive shared savings merely by reporting performance on three 10-point quality measures. PTAC feels that merely reporting on quality measures is too low a standard but understands the proposed measures to be a starting point. PTAC encourages requiring some sort of performance threshold—a minimum level of performance on the quality measures required to receive shared savings—as soon as possible. PTAC also feels the quality metric weights could be adjusted to give greater emphasis to patient experience, such as by giving more weight to the patient satisfaction score or making a minimum score on the patient satisfaction measure a requirement to receive shared savings. Because PTAC recommends that the payment bonus for transplantation be dropped, it suggests that greater emphasis on the referral for transplant metric might be desirable.

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

Although PTAC supports early transplantation as the standard of care for patients with ESRD, it feels that transplantation rates are largely outside of the nephrologist's control and that awarding bonuses based on whether and when a transplant occurred could lead to unintended consequences. PTAC concluded, and the submitter agreed, that the transplant bonus was a separable component of the proposed model, and that the transplant bonus could be dropped without affecting the rest of the proposed payment model. The members of PTAC agreed to evaluate the proposal on the payment methodology criterion (criterion 3, the criterion most affected by the transplant bonus) as if the bonus were excluded from the model.

PTAC discussed whether beginning the episode payment at the onset of dialysis (indicated by the completion of form CM 2728) was appropriate when much of the work necessary to improve care for incident ESRD patients would need to occur well before dialysis begins. The submitters felt that payments triggered by initiation of dialysis would adequately incentivize "upstream" changes, and that using the 2728 form was a more objective way to trigger the episode than using clinical indicators (such as the estimated glomerular filtration rate) that could be affected by medications and other factors. PTAC concluded that the proposed approach has the potential to be successful, but PTAC feels that additional initiatives focused on patients with CKD would also be desirable, such as initiatives to slow the progression of CKD and to educate patients about different options for treatment of ESRD.

PTAC members expressed concern about whether it would be feasible for small practices to make the investments needed for all desirable services without upfront payments to cover the costs of those investments.

PTAC concluded the proposed payment methodology could achieve the goals of the PFPM but identified three areas where modifications would be desirable.

1) Quality Measures: PTAC recommends requiring a minimum level of performance on the quality measures in order to receive shared savings as soon as possible, and weights should be adjusted to give greater emphasis to patient experience.

2) Spending Measure for Shared Savings/Shared Loss: PTAC is concerned that for small nephrology practices, shared savings and shared loss payments could be overly affected by the costs of treatments other than dialysis for patients who have serious illnesses in addition to ESRD, such as cancer. This could inappropriately financially penalize the nephrology practice and create undesirable incentives to avoid treating certain patients or to modify their treatments. PTAC suggests either excluding or capping the spending for patients with significant comorbidities so that savings are driven primarily by improvements in the transition to dialysis for incident ESRD patients and by avoiding complications related to dialysis. In addition, PTAC recommends that the shared savings/shared loss calculations be carefully monitored

3) Virtual Groups: PTAC notes that giving small practices the option of forming virtual groups may reduce the risk associated with random variation in Medicare spending for smaller patient populations.

PTAC also notes the potential for overlap with the CEC model could be complicated, but PTAC recognizes the convergence of multiple models could yield overall improvements in cost and quality.

Criterion 4. Value over Volume

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

Rating: Meets Criterion

The model provides incentives to improve the transition to dialysis for incident ESRD patients, which could reduce the total cost of care. Although the cost of care for all dialysis patients is high, the proposal is focused on addressing the particularly high rates of hospitalizations and associated costs for patients that typically occur in the first six months of dialysis which are partly due to suboptimal transitions to dialysis. Patients start dialysis by one of several

methods, including peritoneal dialysis, hemodialysis with a fistula or graft, or hemodialysis with catheters. The modalities associated with lower rates of complications and higher patient satisfaction—namely, peritoneal dialysis and hemodialysis with a fistula or graft— require patient education as well as surgical preparation and healing for several weeks before dialysis begins. Dialysis can be performed in a center or in a home; training for home dialysis also often takes several weeks. As a result, most patients begin dialysis sub-optimally, with a catheter rather than a fistula, and many patients begin dialysis during an inpatient hospitalization ("crashing into dialysis"). These patients have particularly high rates of morbidity, mortality, hospitalizations, and total Medicare costs. PTAC feels this model would encourage a shift toward dialysis modalities that were better for patients as well as lower cost for Medicare.

Criterion 5. Flexibility

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

Rating: Meets Criterion

The model provides greater flexibility than fee-for-service Medicare or the CEC Model in the types of activities physicians could undertake to deliver high-quality health care. The model does not require participating physicians to perform specific activities to achieve improvements on the quality metrics, but the proposal does offer some suggested activities. Providers could use shared savings payments to support a range of activities to improve quality.

While the model is flexible in the ways in which providers could achieve quality improvements, PTAC questions the extent to which a shared savings model will truly enable providers, particularly small nephrology practices, to deliver care differently. During the episode, provider reimbursement remains the same; only during the reconciliation period can providers potentially recoup their investments and receive rewards for higher performance on quality measures.

In order for nephrologists to deliver unreimbursed services that would improve patient care, they would need to make upfront investments and hope that they could recoup these investments after reconciliation. This could make it more difficult for some practices, particularly small practices, to implement some desirable 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 believes it is feasible to assess changes in spending and quality associated with model implementation; the goals of the model, the quality measures, and potential impact on health care costs are clear and can be evaluated.

In the evaluation, PTAC would like to see a focus on how well the model works for small practices, where the risk of random variation in total Medicare costs for eligible patients is greater. PTAC would also like to assess the extent to which expanded patient choices for dialysis treatments are realized under the model.

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 had concerns that the written proposal did not provide sufficient clarity about how the model would support integration and care coordination between the nephrologist and other providers both prior to and during dialysis. The submitter explained that the proposal intentionally did not specify requirements for integration and care coordination in order to allow for flexibility in different practice settings and to facilitate participation by smaller practices. The submitter also described activities that providers in a variety of settings could undertake to become "principal care providers" for ESRD patients as well as successful participants in the model, such as systematic referral of all CKD stage 4 patients to kidney education, formal coordination with vascular surgeons and interventionists prior to and during the early stages of dialysis, expedited office visits for ill ESRD patients so that they could avoid visiting the Emergency Department for care, and enhanced evaluation following hospitalization. Participants could also emphasize a relatively new technique called "urgent start peritoneal dialysis," which allows patients to leave the hospital with a peritoneal catheter in place and avoid complications related to extended dialysis through a hemodialysis catheter.

The additional detail provided by the submitter addressed PTAC's concerns. As described, the model does have the potential to encourage greater integration and care coordination among practitioners and across settings for ESRD patients.

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 feels this proposal would expand the range and choice of treatment options available to ESRD patients by encouraging earlier education and preparation for vascular access or home-based dialysis modalities. It could give patients meaningful choice for alternatives to in-center

dialysis when those choices are clinically appropriate. In addition, the model encourages providers to identify patients who are unlikely to benefit from dialysis and educate them about medical management for their disease, whereas current financial incentives encourage providers to recommend dialysis for these patients irrespective of the lack of benefit from dialysis. PTAC recommends that the evaluation of the model assess whether those choices are actualized as the model is implemented.

Criterion 9. Patient Safety

Aim to maintain or improve standards of patient safety.

Rating: Meets Criterion

The proposal has a clear focus on avoiding hospitalizations and other problematic outcomes for patients during the first six months of dialysis, which would improve patient safety.

Criterion 10. Health Information Technology

Encourage use of health information technology to inform care.

Rating: Meets Criterion

Although not a centerpiece of this model, the proposal would encourage use of health information technology (HIT) to inform care. For example, all providers would be required to use certified electronic health record technology (CEHRT). Nephrologists and other participating providers would be encouraged to coordinate and monitor care prior to and during dialysis with the aid of health information technology. Participants could use the RPA Qualified Clinical Data Registry (QCDR) to facilitate the collection of patient and disease data. In the experience of PTAC members in integrated systems, HIT is already used to systematically refer patients with poor kidney function (as measured by Estimated Glomerular Filtration Rate, or eGFR) for kidney disease education, and similar HIT-based activities could be adopted in other systems as well.

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, MSHS
Brookings Institution
Washington, DC

Term Expires October 2019

Paul N. Casale, MD, MPH
NewYork Quality Care
NewYork-Presbyterian
Columbia Weill Cornell
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

Criteria Specified by the Secretary (at 42 CFR §414.1465)	N/A	Does not meet		Meets		Priority consideration		Rating
	*	1	2	3	4	5	6	
1. Scope (High Priority)[1]	0	0	0	2	5	3	1	Meets criterion
2. Quality and Cost (High Priority)	0	0	0	4	4	2	1	Meets criterion
3. Payment Methodology (High Priority)	0	0	0	2	9	0	0	Meets criterion
4. Value over Volume	0	0	0	0	8	3	0	Meets criterion
5. Flexibility	0	0	0	2	7	2	0	Meets criterion
6. Ability to be Evaluated	0	0	0	2	9	0	0	Meets criterion
7. Integration and Care Coordination	0	0	1	7	2	1	0	Meets criterion
8. Patient Choice	0	0	0	2	8	1	0	Meets criterion
9. Patient Safety	0	0	0	4	5	1	1	Meets criterion
10. Health Information Technology	0	0	0	8	3	0	0	Meets criterion

Not Applicable	Do not recommend	Recommend for limited-scale testing	Recommend for implementation	Recommend for implementation as a high priority	Recommendation
0	0	1	7	3	Recommend for implementation

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