

# Physician-Focused Payment Model Technical Advisory Committee

## Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)

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In accordance with the Physician-Focused Payment Model Technical Advisory Committee's (PTAC's) Proposal Review Process described in *Physician-Focused Payment Models: PTAC Proposal Submission Instructions* (available on the PTAC [website](#)), physician-focused payment models (PFPMs) that contain the information requested by PTAC's *Proposal Submission Instructions* will be assigned to a Preliminary Review Team (PRT). The PRT will draft a report containing findings regarding the proposal for discussion by the full PTAC. This PRT report is preparatory work for the full PTAC and is not binding on PTAC. This report is provided by the PRT to the full PTAC for the proposal identified below.

### A. Proposal Information

- 1. Proposal Name:** Medicare 3 Year Value Based Payment Plan (Medicare 3VBPP)
- 2. Submitting Organization or Individual:** Zhou Yang, Ph.D. MPH
- 3. Submitter's Abstract:**

"The Medicare 3 Year Value Based Payment Plan (Medicare 3VBPP) is a highly innovative Medicare alternative payment plan (APM). The purpose of this plan is to unleash the energy of innovation among the physicians in the field by providing them unprecedented power and flexibility to negotiate alternative reimbursement channel and rate with Medicare.

Within a 3 year budget constraint adjusted by age, demographics, geographic areas, and existing conditions, Medicare 3VBPP will allow the Medicare beneficiaries to choose innovative reimbursement plans that are either offered by physicians in the community, or through a benefit carrier. The proposed APM includes several powerful financing tools to incentivize preventive services, chronic disease management, and care coordination.

All the physicians and other health care providers who are serving Medicare beneficiaries could participate in Medicare 3VBPP. If scaled up nation wide, Medicare 3VBPP will lead to increase in income among all the physicians (both independent and employed), alleviate the

financial risks of independent and small practices, protect and promote patient’s autonomy in decision making, strengthen the patient-physician trust, and stimulate technology innovation.

By promoting competition on value of care in the community, Medicare 3VBPP will lead to better quality (lower mortality rate, higher patients satisfaction) and lower cost (lower Per Member Per Year Medicare expenditures).

Medicare 3VBPP is different from both Fee For Service (FFS) and Accountable Care Organization (ACO) payment model which is the major APM implemented by Center for Medicare and Medicaid Services (CMS) in the field to date. The proposed APM returns the power of choices of medical care to physicians and patients by facilitating fair reimbursement to the physicians based on their training, effort, dedication, local demand, and market environment. Meanwhile, the proposed APM will encourage more patients’ engagement in the medical decision-making and chronic disease management. Medicare 3VBPP also makes a giant step forward with unprecedented transparency of Medicare spending to the beneficiaries.”

## B. Summary of the PRT Review

<b>Criteria Specified by the Secretary (at 42 CFR§414.1465)</b>	<b>PRT Conclusion</b>	<b>Unanimous or Majority Conclusion</b>
<b>1. Scope of Proposed PFFM (High Priority)</b>	Not Applicable	Unanimous
<b>2. Quality and Cost (High Priority)</b>	Not Applicable	Unanimous
<b>3. Payment Methodology (High Priority)</b>	Not Applicable	Unanimous
<b>4. Value over Volume</b>	Not Applicable	Unanimous
<b>5. Flexibility</b>	Not Applicable	Unanimous
<b>6. Ability to be Evaluated</b>	Not Applicable	Unanimous
<b>7. Integration and Care Coordination</b>	Not Applicable	Unanimous
<b>8. Patient Choice</b>	Not Applicable	Unanimous
<b>9. Patient Safety</b>	Not Applicable	Unanimous
<b>10. Health Information Technology</b>	Not Applicable	Unanimous

## C. PRT Process

The proposal, “*Medicare 3 Year Value Based Payment Plan (Medicare 3VBPP)*” (available on the PTAC [website](#)) was received by PTAC on June 23, 2017. The PRT conducted its work between August 31, 2017 and October 24, 2017. During this time, the PRT reviewed the proposal and all public comment letters received on the proposal.

The PRT's summary of the proposal and evaluation of the proposal compared to the Secretary's criteria for physician-focused payment models (PFPMs) are below. All letters received from the public are available at the PTAC [website](#).

## 1. Proposal Summary:

The *Medicare 3 Year Value Based Payment Plan (Medicare 3VBPP)* would work as follows:

1. **Enrollment.** Community-dwelling (non-nursing home resident) beneficiaries who are age 85 or younger and without cognitive disability or severe mental illness would choose between staying with Medicare's traditional, defined-benefit, fee-for-service plan or joining a Medicare 3VBPP private carrier that would provide Medicare-covered services through several defined-contribution plan options.
2. **Use of Spending Accounts.** Each Medicare 3VBPP participant would be given a Medicare Account to spend on Medicare-covered services over three years. The starting balance of the Medicare Account would equal three times the average annual Medicare expenditures of FFS patients adjusted by inflation, age, gender, existing chronic diseases, and geographic area.
3. **Plan selection.** Each participant would be given the choice to spend Medicare Account funds to enroll in one of several CMS-approved plans that private carriers or physician groups would provide. These plans would be of four types:
  - a. **A capitated HMO plan.** The Medicare Account would be used to contribute to the capitation. The reimbursement rate of care will be negotiated between the carriers and providers.
  - b. **A PPO plan.** The Medicare Account will be used to contribute to the premium. The reimbursement rate of clinical care will be negotiated between the carriers and the providers. The private carriers are allowed to charge out-of-pocket copayment, deductibles, or coinsurance for all the inpatient and outpatient clinical events.
  - c. **A high deductible PPO plan.** The Medicare Account will be used to pay for a low premium (e.g. \$1,000 – \$1,500) and costs above the deductible with a low copayment rate, for example, at 5 – 10%. There is no annual limitation on Medicare contribution to the high deductible plan.
  - d. **A low premium FFS plan.** This plan would have rates of reimbursement for services that are negotiated between the providers and the patients. The Medicare Account could be used to contribute to both the premiums and the reimbursement of each clinical service under Part A and Part B. The beneficiaries share out-of-pocket copayment or coinsurance of the clinical services. There is no annual limitation on Medicare contribution.

4. **Covered Services.** All plans would cover current Medicare Part A and B services. Medicare 3VBPP participants could choose either a plan that provides integrated prescription drugs (Part D) benefits or an existing stand-alone Part D carrier. In addition, Medicare 3VBPP will cover an annual physical examination and a wellness counseling session to all enrollees without out-of-pocket copayment. All wellness care that is prescribed by primary care doctors or wellness counselors also would be fully covered by the benefit carriers. CMS, however, would regulate inclusion criteria for wellness care that would be covered.
5. **Option to waive some premiums and deductibles.** To incentivize beneficiary participation, there would be an option to waive out-of-pocket Part B premiums and/or Part A deductibles for all the participating plans.
6. **Financial reward for wellness care.** If a beneficiary uses the free annual physical and wellness counseling session and pursues the preventive or wellness care that is prescribed by a primary care physician or counselor, the beneficiary is rewarded with an age-adjusted credit to the Medicare Account per year. All the preventive and wellness care will be fully covered by the Medicare benefit carriers without copayment or coinsurance from the beneficiaries.
7. **Reduced Medicare contribution to the premiums or reimbursement after the initial Medicare Account balance is exhausted.** If a beneficiary exhausts the balance of the initial Medicare Account (with or without the wellness reward being deemed) before the end of the third year and would like to remain in the demonstration, Medicare will continue to contribute to the premiums and reimbursement to clinical care, but at a lower percentage. The wellness care will still be fully covered by the carriers. Meanwhile, such beneficiaries would be responsible for a higher percentage of means-tested, out-of-pocket contributions to the premiums for the HMO, PPO plans, as well as the copayment to the clinical services under the low premium PPO FFS and High Deductible plans.
8. **Catastrophic coverage:** Instead of annual catastrophic coverage, Medicare 3VBPP will provide catastrophic coverage over 3 years if the three-year total exceeds certain amounts during the demonstration period. The beneficiaries' out-of-pocket responsibility of premiums, copayment, and coinsurance will all be waived above the catastrophic coverage cap.
9. **Handling of plan balances.** If there is balance left within the lower cap of the Medicare Account by the end of the third year, the savings will be credited to the beneficiaries to pay for the premiums, copayment, or deductibles of their Medicare-covered services under FFS or Medicare MA financing plan in the future. The remaining balance on the Medicare Account, however, will not be deemed as cash to be paid to the patients, the

providers, or the Medicare benefit carriers. If the beneficiary dies before the lower cap of Medicare Account is exhausted, the remaining balance will be paid back to Medicare.

10. **Opt-Out provisions.** Medicare beneficiaries participating in Medicare 3VBPP would have the ability to opt out of the payment models at any time and return to the traditional FFS payment model without any financial or legal obligations. To prevent fraud of Medicare 3VBPP or abuse of Medicare contribution, for all participants who choose to switch back to FFS or Medicare MA before the beneficiaries exhaust the lower cap of the Medicare Account, the remaining balance will not be credited to the beneficiaries, but paid back to Medicare.

11. **There would be a financial reward for postponing Medicare initiation until after age 65.** The proposal identifies this as one of its major parts, but does not otherwise elaborate on it.

CMS would be responsible for monitoring quality of care and patient safety by measuring: per member per year (PMPY) Medicare contribution/expenditures, PMPY out-of-pocket expenditures, PMPY emergency department visits, PMPY hospital nights, PMPY Medicare prescription drug costs, preventive screening and wellness care utilization, annual mortality rate, and (through a patient survey) getting needed care, getting care quickly, how well doctors communicate, plan's customer choice, coordinated care, and perceived value of care.

## **2. Additional Information Reviewed by the PRT: Environmental Scan and Literature Review**

ASPE, through its contractor, conducted an abbreviated environmental scan related to this proposal. Documents comprising the environmental scan were primarily identified using Google and PubMed search engines. Key words guiding the environmental scan and literature review were directly identified from the Letter of Intent (LOI). The key word and combination of key words were utilized to identify documents and material regarding the submitting organization, the proposed model in the LOI, features of the proposed model in the LOI, or subject matter identified in the LOI. Key terms used included "lifetime value-based payment," "Medicare Advantage," "Medicare premium support," "Medicare 3VBPP," "payment model," and "Zhou Yang." This search produced six documents from the gray literature and two peer-reviewed articles. These documents are not intended to be comprehensive and are limited to documents that met predetermined research parameters including a five-year look back period, a primary focus on U.S. based literature and documents, and relevancy to the LOI.

## D. Evaluation of Proposal Against Criteria

**Criterion 1. Scope of Proposed PFPM (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.

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**PRT Qualitative Rating: Not Applicable**

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See discussion under Criterion 3, below.

**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.

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**PRT Qualitative Rating: Not Applicable**

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See discussion under Criterion 3, below.

**Criterion 3. Payment Methodology (High Priority Criterion).** Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the Physician-Focused Payment Model cannot be tested under current payment methodologies.

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**PRT Qualitative Rating: Not Applicable**

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The PRT found that the Medicare 3VBPP proposal focuses on Medicare coverage and benefits rather than on a payment methodology, and because of this the PRT does not consider it a physician payment method. The submission proposes multiple fundamental changes to the structure and operation of the Medicare program overall including: 1) restructuring the Medicare program to be a defined contribution benefit, supported by creation of health spending accounts, and in doing so altering the statutory framework for Medicare Parts A, B, and C; 2) substantially changing the package of Medicare benefits available to beneficiaries; 3) deploying expenditure thresholds that would trigger changes in copayments or coinsurance payments by beneficiaries; and 4) changing Medicare eligibility rules to provide a financial reward for postponing Medicare initiation age after 65.

Because the breadth of the proposal goes well beyond proposed changes to Medicare payment, the PRT determined that it would be inappropriate for the PRT and PTAC to evaluate the proposal as a proposed change in Medicare payment methodology. The PRT similarly determined that the Secretary's criteria for PFPMs are not applicable to this

proposal, and so rated this criterion (and each of the nine additional Secretarial criteria) as “Not Applicable” to this proposal.

**Criterion 4. Value over Volume. Provide incentives to practitioners to deliver high-quality health care.**

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**PRT Qualitative Rating: Not Applicable**

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See discussion under Criterion 3, above.

**Criterion 5. Flexibility. Provide the flexibility needed for practitioners to deliver high-quality health care.**

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**PRT Qualitative Rating: Not Applicable**

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See discussion under Criterion 3, above.

**Criterion 6. Ability to be Evaluated. Have evaluable goals for quality of care, cost, and any other goals of the PFPM.**

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**PRT Qualitative Rating: Not Applicable**

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See discussion under Criterion 3, above.

**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.**

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**PRT Qualitative Rating: Not Applicable**

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See discussion under Criterion 3, above.

**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.**

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**PRT Qualitative Rating: Not Applicable**

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See discussion under Criterion 3, above.

**Criterion 9. Patient Safety. Aim to maintain or improve standards of patient safety.**

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**PRT Qualitative Rating: Not Applicable**

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See discussion under Criterion 3, above.

**Criterion 10. Health Information Technology. Encourage use of health information technology to inform care.**

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**PRT Qualitative Rating: Not Applicable**

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See discussion under Criterion 3, above.

**E. PRT Comments**

The PRT considers this proposal to present a fundamental restructuring of the Medicare program (as opposed to a physician payment model), and accordingly PTAC cannot consider it. The PRT's determination that it would be inappropriate for the PRT and PTAC to evaluate the Medicare 3VBPP proposal is not meant to imply any qualitative opinion about the merits of the proposal. While the PRT concluded that PTAC is not the best vehicle for responding to such a proposal, the concepts and approaches articulated in this proposal may receive attention from other more appropriate entities that are working to improve the Medicare program.

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