

# Physician-Focused Payment Model Technical Advisory Committee

## Committee Members

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Elizabeth Mitchell, *Vice  
Chair*

Robert Berenson, MD

Paul N. Casale, MD, MPH

Tim Ferris, MD, MPH

Rhonda M. Medows, MD

Harold D. Miller

Len M. Nichols, PhD

Kavita Patel, MD, MSHS

Bruce Steinwald, MBA

Grace Terrell, MD, MMM

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 submitting PTAC's comments to you on a proposed Physician-Focused Payment Model (PFPM) submitted by Zhou Yang, PhD, MPH, entitled, *Medicare 3 Year Value Based Payment Plan (Medicare 3VBPP)*. These comments 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 Dr. Yang's proposed model (submitted to PTAC on June 23, 2017), additional information submitted by Dr. Yang, 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 concluded that the criteria for PFPMs established by the Secretary are not applicable to the *Medicare 3 Year Value Based Payment Plan (Medicare 3VBPP)* proposal because it does not contain an approach to physician payment. PTAC therefore was unable to evaluate this proposal or to make a recommendation to you with respect to it.

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. If you need additional information, please have your staff contact me at [Jeff.Bailet@blueshieldca.com](mailto:Jeff.Bailet@blueshieldca.com).

Sincerely,

A handwritten signature in black ink, appearing to read "Jeffrey Bailet", written over a horizontal line.

Jeffrey Bailet, MD  
Chair

Attachments

# Physician-Focused Payment Model Technical Advisory Committee

## REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

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Comments on

Medicare 3 Year Value Based Payment Plan (Medicare 3VBPP)

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's 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 the proposed PFPM submitted by Zhou Yang, PhD, MPH, entitled *Medicare 3 Year Value Based Payment Plan (Medicare 3VBPP)*; 2) a summary of this model; 3) PTAC's comments on the proposed model; 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 Dr. Yang (Appendix 4); and additional information on the proposal submitted by Dr. Yang subsequent to the initial proposal submission (Appendix 5).

## SUMMARY STATEMENT

PTAC concluded that the Secretary's criteria are not applicable to the proposal because the proposed model does not include an approach to physician payment. Rather, the proposal outlines a fundamental restructuring of the Medicare program including substantial redesign of Medicare benefits and use of defined contribution plans. Because PTAC determined that the Secretary's criteria for PFPMs do not apply to this proposal, PTAC was not able to evaluate the proposal or to make a recommendation to the Secretary.

## PTAC REVIEW OF PROPOSAL

The *Medicare 3 Year Value Based Payment Plan (Medicare 3VBPP)* proposal was submitted to PTAC by Zhou Yang, PhD, MPH on June 23, 2017. The proposal was first reviewed by a PTAC Preliminary Review Team (PRT) composed of three PTAC members, one of whom is a physician. These members reviewed the proposal, the results of an environmental scan, and all comments on the proposal submitted by the public. 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 October 26, 2017 and sent to the full PTAC on 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 should be recommended.<sup>1</sup> Below are a summary of the *Medicare 3 Year Value Based Payment Plan (Medicare 3VBPP)* proposal, and PTAC’s comments to the Secretary on this proposal.

## **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 copayments, 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.

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<sup>1</sup>PTAC member Kavita Patel, MD, MSHS, was not in attendance and did not participate in deliberations or voting.

- 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 drug (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.

#### **COMMENTS TO THE SECRETARY**

PTAC considers this proposal to present a fundamental restructuring of the Medicare program (as opposed to a payment model for physicians or other eligible professionals), and accordingly it would be inappropriate for PTAC to evaluate the extent to which the proposal meets the Secretary's criteria for PFPMs. However, PTAC's determination that it would be inappropriate for PTAC to evaluate the Medicare 3VBPP proposal using the Secretary's criteria for PFPMs is not meant to imply any qualitative opinion about the merits of the proposal. PTAC concluded that any evaluation of the concepts and approaches articulated in this proposal would need to be performed by other entities with appropriate expertise.

## 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 of Proposed PFPM (High Priority) <sup>1</sup>	Criterion not applicable to proposal
2. Quality and Cost (High Priority)	Criterion not applicable to proposal
3. Payment Methodology (High Priority)	Criterion not applicable to proposal
4. Value over Volume	Criterion not applicable to proposal
5. Flexibility	Criterion not applicable to proposal
6. Ability to be Evaluated	Criterion not applicable to proposal
7. Integration and Care Coordination	Criterion not applicable to proposal
8. Patient Choice	Criterion not applicable to proposal
9. Patient Safety	Criterion not applicable to proposal
10. Health Information Technology	Criterion not applicable to proposal

#### **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: Criterion not applicable to proposal**

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.*

**Rating: Criterion not applicable to proposal**

See discussion under Criterion 3, below.

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<sup>1</sup>Criteria designated as “high priority” are those PTAC believes are of greatest importance in the overall review of the payment model proposal.



### **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: Criterion not applicable to proposal**

PTAC found that the Medicare 3VBPP proposal focuses on Medicare coverage and benefits rather than on a physician or eligible provider payment methodology, and because of this PTAC was unable to evaluate it as a physician payment model. 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 proposal goes well beyond proposed changes to physician payment and provides little discussion of physician payment, PTAC concludes that it would be inappropriate for PTAC to evaluate the proposal as a proposed change in Medicare’s physician payment methodology. PTAC 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 other Secretarial criteria) as “Not Applicable” to this proposal.

### **Criterion 4. Value over Volume**

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

**Rating: Criterion not applicable to proposal**

See discussion under Criterion 3, above.

### **Criterion 5. Flexibility**

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

**Rating: Criterion not applicable to proposal**

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 PFP.*

**Rating: Criterion not applicable to proposal**

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 PFP.*

**Rating: Criterion not applicable to proposal**

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.*

**Rating: Criterion not applicable to proposal**

See discussion under Criterion 3, above.

## **Criterion 9. Patient Safety**

*Aim to maintain or improve standards of patient safety.*

**Rating: Criterion not applicable to proposal**

See discussion under Criterion 3, above.

## **Criterion 10. Health Information Technology**

*Encourage use of health information technology to inform care.*

**Rating: Criterion not applicable to proposal**

See discussion under Criterion 3, above.

## APPENDIX 1. COMMITTEE MEMBERS AND TERMS

**Jeffrey Bailet, MD, Chair**

**Elizabeth Mitchell, Vice-Chair**

Term Expires October 2018

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

**Elizabeth Mitchell**  
*Network for Regional Healthcare Improvement*  
Portland, ME

**Robert Berenson, MD**  
*Urban Institute*  
Washington, DC

**Kavita Patel, MD**  
*Brookings Institution*  
Washington, DC

Term Expires October 2019

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**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

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**Rhonda M. Medows, MD**  
*Providence St. Joseph Health*  
Renton, 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<sup>1</sup>**

Criteria Specified by the Secretary (at 42 CFR §414.1465)	Not Applicable	Does not meet		Meets		Priority consideration		Rating
	*	1	2	3	4	5	6	
1. Scope of Proposed PFFM (High Priority) <sup>2</sup>	9	1	0	0	0	0	0	Criterion not applicable to proposal
2. Quality and Cost (High Priority)	7	3	0	0	0	0	0	Criterion not applicable to proposal
3. Payment Methodology (High Priority)	7	3	0	0	0	0	0	Criterion not applicable to proposal
4. Value over Volume	7	3	0	0	0	0	0	Criterion not applicable to proposal
5. Flexibility	9	1	0	0	0	0	0	Criterion not applicable to proposal
6. Ability to be Evaluated	8	2	0	0	0	0	0	Criterion not applicable to proposal
7. Integration and Care Coordination	7	3	0	0	0	0	0	Criterion not applicable to proposal
8. Patient Choice	8	0	2	0	0	0	0	Criterion not applicable to proposal
9. Patient Safety	7	3	0	0	0	0	0	Criterion not applicable to proposal
10. Health Information Technology	7	3	0	0	0	0	0	Criterion not applicable to proposal

Not Applicable	Do not recommend	Recommend for limited-scale testing	Recommend for implementation	Recommend for implementation as a high priority	Recommendation
7	3	0	0	0	None

<sup>1</sup>PTAC member Kavita Patel, MD was not in attendance.

<sup>2</sup>Criteria designated as “high priority” are those PTAC believes are of greatest importance in the overall review of the payment model proposal.