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Physician-Focused Payment Model Technical Advisory Committee
C/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy 200 Independence Avenue, S.W.
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Dear Committee Members:

I am submitting the proposal **Medicare 3 Year Value Based Payment Plan (Medicare 3VBPP)** on behalf of myself.

I appreciate the opportunity to share my idea with PTAC and am looking forward to working collaboratively with PTAC to upgrade the Medicare system for better quality and higher efficiency.

If you have any questions related to the model, please contact me at:

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Medicare 3 Year Value Based Payment Plan

(Medicare 3VBPP)

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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.

I. Background and Model Overview

A. Background:

Medicare 3 Year Value Based Payment Plan (Medicare 3VBPP) is a scaled down version of Medicare Lifetime Value Based Payment Plan (Medicare LVBPP) that I developed in 2014.[1] I shortened the timeframe from lifetime to 3 years to accommodate the convenience of the initial stage of the field implementation and/or demonstration, and evaluation.

The cornerstone of Medicare legislation, as well as any other health coverage funded by Federal government, is how does the government regulate the cash flow of federal spending to the providers of the covered services that will improve the health status of the beneficiaries. Washington, therefore, has tremendous power and responsibility to influence providers' as well as patients' behavior through Medicare payment legislations and regulations.

Aiming at facilitating and protecting fair reimbursement to the physicians, increasing system efficiency, and improving health status of the patients, Medicare LVBPP includes six major parts: **1.** Beneficiaries' free choice between staying with traditional defined benefit FFS plan and joining a private carrier who provides Medicare covered services with several options of defined contribution plan. **2.** A lifetime (or long-term) expenditure threshold that triggers additional means tested copayment or co-insurance charge on Medicare reimbursement rate or contribution to private carriers **3.** A Health Promotion Reward to encourage behavioral change and competition on preventive care **4.** Expanded and more flexible reimbursement for preventive care and innovative chronic disease management models under FFS or primate carrier plans **5.** Catastrophic coverage protection, and **6.** Financial reward for postponed Medicare initiation age after 65.

The cap, copayment, reward, and catastrophic protection are the key financing tools of Medicare LVBPP to realign the financial incentives between the health care providers, the beneficiaries, and the federal government.

For the health care providers, Medicare LVBPP will allow the hospitals, physicians, and benefit carriers to gradually adjust to the new financing system based on their local demand and resources. On the contrary to the "one fits all" top-down mechanism to implement sophisticated reimbursement rules nationwide, Medicare LVBPP encourages the providers to develop their own innovative care models to meet the need of their community, and negotiate the reimbursement mechanisms with the benefit carriers or beneficiaries directly conditional on the approval of CMS. Instead of creating new bureaucratic or administrative burden, Medicare LVBPP will simplify enrollment and reimbursement paperwork, provide easy transition from private insurance to Medicare carrier, and hence will maintain the continuity of the coverage of the same high quality

[1] Yang Z "A Lifetime Value-Based Proposal For Medicare Payment Reform" 2014 Health Affairs Blog http://healthaffairs.org/blog/2014/03/14/a-lifetime-value-based-proposal-for-medicare-payment-reform/

providers at community level. Most importantly, Medicare LVBPP will stimulate the demand and development of cutting edge technology that makes the diagnoses, treatment, and management of chronic diseases less costly, easier, and more personalized.

For the beneficiaries, instead of leaving the consumers out of the decision making process regarding benefit package, choices of providers, and the comparative effectiveness of services, Medicare LVBPP releases the power of choices to the beneficiaries to pick the physicians, physician groups, or benefit carriers that fit their personal need and retirement financing plan the best. The precious trust between the consumers and providers that could only be established under continuity of coverage and services will be protected when the beneficiaries retire and start tapping in Medicare support. In addition, Medicare LVBPP provides financial incentives for the consumers to work with the providers to maintain good health through prevention and chronic disease management. It also creates motivations for the healthy workers to stay in the workforce longer, as well as to save and plan for retirement wisely in advance. With the catastrophic coverage, Medicare LVBPP will eliminate the financial uncertainty of catastrophic medical care event, liberate the beneficiaries from their dependence on supplemental insurances.

B. Model Overview

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 physician groups in the community, or through a benefit carrier. The key elements of the model are listed below, other technical and policy details are explained in the subsequent sections.

a. Voluntary participation of Medicare 3VBPP among community dwelling beneficiaries

b. Each participant is provided a Medicare Account to spend on Medicare covered services, the starting balance of the Medicare Account is risk adjusted by age, demographics, geographic area, and existing conditions. The starting balance should equal to three times of the average annual Medicare expenditures of FFS patients with the same risk adjustment characteristics.

c. Each participant is given the choices to spend the balance on the Medicare Account to enroll in one of the plans below:

    i. Capitated HMO plan that Medicare Account contributes to the capitation
    ii. PPO plan that Medicare Account contributes to the premium
    iii. High deductible PPO plan that Medicare Account contributes to the services above the deductible
    iv. Low premiums FFS model that Medicare Account contributes to both premiums and FFS

Physicians negotiate reimbursement method and rate with the carriers under model i., ii, and iii, but engage in direct transaction with patients with CMS approval under model iv.

d. Financial reward for wellness care and preventive care
e. Means tested copayment rate after the initial Medicare Account balance is exhausted
f. Catastrophic coverage over 3 years.

All the physicians and other health care providers who are serving Medicare beneficiaries could participate in Medicare 3VBPP.

Medicare 3VBPP will lead to increase in income among all the physicians if scaled up nationwide. It will alleviate the financial risks of independent and small practices, reduce waste, protect and promote patient's autonomy in decision making, strengthen the patient-physician trust, and stimulate technology innovation.

The unique financing and payment model of Medicare 3VBPP returns the power of choices of medical care to the patients and encourages competition on value of care in the community. Therefore, Medicare 3VBPP will lead to better quality (lower mortality rate, better patients satisfaction) and lower cost (lower Per Member Per Year Medicare expenditures). In addition, Medicare 3VBPP will reduce health disparity by encouraging higher value of care in rural, low income, and minority communities.

Medicare 3VBPP is different from both Fee For Service (FFS) and Accountable Care Organization (ACO) payment model which is the major APM implemented by CMS in the field to date. The proposed APM facilitates 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.

II. Scope of Proposed PFPM

The Medicare 3VBPP could be scaled up to be a national model, physicians and eligible professionals, such as nurses, physician practitioners etc. will be able to participate in the payment model. If this payment model is implemented in the field nation wide, all the physicians and professionals who currently provide care to Medicare beneficiaries under the traditional Fee For Service (FFS) mechanism as well as all the care providers who participate in the Medicare Advantage (Medicare MA) plans are eligible to participate.

Both the physicians who are employed and those who are independent could participate in this model, the payment model could lead to increase in the compensation of both types of physicians, but will less likely influence the employed physicians immediately.

Medicare 3VBPP will *not* bring additional financial risks for small practices or single practice. On the contrary, the proposed APM will facilitate the small practices to serve their communities better with less administrative burden, more flexible payment channels, and stronger incentives to build and sustain the patient-physician trust that is crucial for the survival of small practices.

The proposed payment model has not been implemented by other payers before. However, other model that reflects and emphasizes the key financing principles of Medicare 3VBPP, for example the Federal Employee Health Benefit Plans (FEHBP), has been implemented in the field for more than three decades. FEHBP is the health insurance plan that is financed by federal government to cover millions of federal employees and their families with great diversity in age, gender, race, and health status. It is featured by sustainable budget and limited bureaucracy. FEHBP is efficient, adaptable to new technology, and has received high satisfaction rate among the federal employees, retirees, as well as the participating physicians and other care providers.[2]

The common feature of the proposed Medicare 3VBPP and FEHBP is their financing principle regarding the mechanisms of federal contribution in health care coverage and reimbursement to the providers. Medicare and FEHBP face the same federal spending issue: one big federal payer is reimbursing/subsidizing the health care of millions of customers. The critical element of federal health care financing plan, therefore, is its ability and capacity to align the incentives of the big federal payer, millions of customers, and thousands of care providers to pursue a common goal: a transparent, efficient, and sustainable system that guarantees consumers' choices of high quality care supported by the up-to-date technology within a responsible budget.

Technically, the financial incentives of Medicare 3VBPP are different from those of FEHBP due to the nature of Medicare being an entitlement program for the retirees. The financial incentives of FEHBP hinge on the federal employees' annual income, individual premium contribution, and out of pocket expenses. Medicare 3VBPP, on the other hand, aims to encourage both the providers and beneficiaries to be aware of the patients' budget and health trajectory when making choices of Medicare covered services to maintain their physical health as well as a healthy balance of their Medicare Account.

Medicare 3VBPP cherishes and purposefully protects patients' autonomy in medical decision-making to strengthen the patient-physician trust in the community.

All the Medicare beneficiaries could potentially benefit from Medicare 3VBPP if it is scaled up nationwide and over a *lifetime* framework. At its initial stages, the patients with chronic diseases, in particular those with multiple chronic diseases and in dear need of sophisticated management of prescription drugs and integrated care will benefit the most from this model. Among them, African Americans, females, and low-income

2 Francis W, 2009, Putting Medicare Consumers in Charge: Lesson from the FEHBP, AEI Press

beneficiaries will benefit even more due to the option of almost zero out of pocket payment in the benefit design choices and flexibility in prescription drugs coverage.[3]

The participating patients will benefit from higher quality of integrated care, more engagement in chronic disease prevention, lower out of pocket payment and catastrophic coverage. To protect the patients, the participants have the choice to opt out of the APM at anytime and return to the traditional FFS payment model without any financial or legal obligations.

Medicare spending trajectory will be more optimistic if Medicare 3VBPP is scaled up across the entire beneficiary population and be expanded to a lifetime model. It will bend the cost curve and make the federal budget more manageable.

If tested successful in the field, Medicare 3VBPP will definitely bring spill over effect to Medicaid, TRICARE/VA and private sector to explore innovative payment models to manage chronic diseases. More importantly, if scaled up, Medicare 3VBPP will stimulate technology innovation that will modernize the health care system in general to fight chronic diseases, improve efficiency, and benefit all the society members.

III. Quality and Cost

Medicare 3VBPP will both improve health care quality and decrease per capita cost per year as well as per capita cost longitudinally.

The proposed APM will improve quality and save health care cost through two major routes:

1) Encourage competition on the value of continuous, integrated, and personalized health care for patients with chronic diseases. The innovative payment model will cut waste and motivate both the patients and physicians to adopt delivery models with the best value and replace the fragmented FFS model.

2) Focus on preventive care to reduce acute care expenditures. Medicare 3VBPP will greatly encourage the participation of primary, secondary and tertiary preventive care to reduce the probability of acute medical event and per capita cost at both cross-sectional level and longitudinally.

[3] Harvard Professors Newhouse and McGuire summarizes the success of Medicare MA in their publication "How Successful is Medicare Advantage" on *Milbank Quarterly* 2014, 92(2) 351-394. They found that zero premiums and out of pocket payment of Medicare MA greatly improve access to and quality of care for the minority population, and helped ameliorate disparities. Medicare 3VBPP continues to provide the option of health plans with zero or very limited out of pocket payment responsibility, it will greatly benefit the minority and low income seniors.

The biggest challenge of this payment model is to collaborate with competent and responsible providers and carriers in the private sector when implementing the model in the field. Health insurance companies that carry Medicare MA plans or FEHBP plans, and/or comprehensive physician groups are good candidates to implement this APM. The carriers should have good physicians (both primary care doctors and specialists) on board, reliable reputation in the community, and mature health IT infrastructures.

CMS will play a key role in the implementation to build trust with the patients and providers. Meanwhile, CMS shoulders the responsibility to monitor the quality of care and patient safety. Accurate actuary assistance, ample resources of consulting or academic experts, up-to-date health IT support, and smooth communication between CMS and the carriers will be critical to guarantee the success of this APM.

Table 1 summarizes the metrics of measurements and statistical/econometric models to evaluate if Medicare 3VBPP leads to higher value of care reimbursed by Medicare. There are four domains of measurements, and within each domain, there are several measurements for the evaluation and quality monitoring.

Concerning the cost and clinical care utilization, the measurements include Per Member Per Year (PMPY) Medicare contribution or expenditures, PMPY out of pocket expenditures, PMPY ED visits, PMPY hospital nights, and PMPY prescription drugs expenditures. The preventive service utilization domain includes the utilization of preventive services and wellness care, such as annual physical examination and diabetes prevention program is recommended. I suggest use the most straightforward measurement of annual mortality rate in the domain of Health Outcomes. The domain of patients' satisfaction will include measures of self-reported satisfaction over the care experiences (access, communication, coordination) and self-perceived value of care experiences.

For the purpose of value estimation, I suggest use Medicare claims data merged with electronic medical records for FFS patients, electronic medical records and Medicare account information for Medicare 3VBPP patients, electronic medical records and monthly capitation payment from CMS for Medicare MA enrollees.

A quasi-experimental study design is appropriate for the evaluation to match Medicare 3VBPP enrollees with Medicare FFS patients and/or Medicare MA enrollees. A series of sophisticated regression models and rigorous econometric tools will be used to obtain the most robust estimates of the net impact of the proposed APM. The econometric models include ordinary least square (OLS) regression, Logit regression, as well as two-part model that was introduced in the Rand Health Insurance Experiment (Rand HIE). [4]

[4] Manning WG, Newhouse JP, Duan N, Keeler EB, Leibowitz A 1987 "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment" American Economic Review 77(3): 251-277

I suggest control demographics (age, gender, race, educational level etc.) smoking status, existing chronic diseases, rural vs. urban area etc. in the regression analysis as independent variables.

To address possible self-selection issue, I propose use propensity score matching and/or instrumental variable. Possible instrumental variables include local supply of medical services at county level (e.g. number of hospital beds and MDs per capita), Medicare MA penetration at county level, broadband inter-net service coverage at country level, distance to major teaching hospital vs. to wellness service or gym etc.

Table 1: Metrics and Statistical Models for Quality and Cost Evaluation

Outcome Domain	Dependent Variable	Statistical Model
Cost and Clinical Care Utilization	PMPY Medicare Contribution/Expenditures	OLS or two-part model
	PMPY Out of Pocket Expenditures	OLS or two-part model
	PMPY ED visits	Two-part model
	PMPY Hospital Nights	Two-part model
	PMPY Medicare prescription drugs cost	Two-part model
Preventive Service Utilization	Preventive screening and wellness care utilization	Logit or Probit model
Health Outcomes	Annual Mortality Rate	Logit or Probit Model
Patients Satisfaction	Patient survey regarding Getting needed care Getting care quickly How well doctors communicate Plan's customer choice Coordinated care Perceived value of care	OLS, Multinomial Logit or Ordered Logit model

If Medicare 3VBPP is estimated to lead to lower PMPY Medicare cost, higher utilization of preventive services, lower utilization of ED and acute clinical care, lower mortality rate, higher patients' satisfaction and perceived value, we can come to the conclusion that this particular APM delivers higher value than the traditional FFS.

IV. Payment Methodology

Medicare 3VBPP will unleash the energy of innovation in the field to reimburse physicians that is fair for their training, effort, dedication, and market environment. Meanwhile, such payment method creates strong incentives for preventive care, integrated care, and adoption of modern technology.

A. Outline of Medicare 3VBPP financing plan:

a. Voluntary participation into the Medicare 3VBPP among the community dwelling beneficiaries (exclude nursing home residents) age 85 or lower without cognitive disability or severe mental illness.

b. Each participant is given a Medicare Account to spend on Medicare covered services over three years. The starting balance of the Medicare Account is set to equal to three times of the average annual Medicare expenditures of the FFS patients adjusted by inflation, age, gender, existing chronic diseases, and geographic area.

c. Each participant is given the choices to spend the balance on the Medicare Account to enroll in one of the plans that CMS approves and the participating private carriers or physician groups provide. All the participants are allowed to switch back to FFS, or Medicare MA at any time without legal or financial obligations. [5]

   All the plans provided by the carriers will cover the services under current Medicare Part A and B within one plan. Medicare 3VBPP will allow the beneficiaries to choose either a plan that provides integrated prescription drugs (Part D) service with Part A and B, or an existing stand-alone Part D carrier. For the plans that provide integrated Part D coverage, they should be granted not only more power to negotiate reimbursement rate, formulas etc. than the stand-alone Part D plans, but also the freedom to determine the annual limit of prescription drugs expenditures. Therefore, the carriers will have more flexibility to design innovative care coordination models that help patients with chronic diseases, in particular, those with multiple chronic diseases and complex demand for prescription drugs.

   In addition to the standard Medicare covered services, Medicare 3VBPP will cover annual physical examination and a wellness counseling session to all the enrollees without out of pocket copayment, all the wellness care that is prescribed by the primary care doctors or the wellness counselors will also be fully covered by the benefit carriers. CMS, however, has the authority to regulate the inclusion criteria of wellness care that will be covered under this APM.

   To incentivize beneficiary participation, with the federal support, it is an option to waive the out of pocket Part B premiums and/or Part A deductibles for all the participating plans. [6] Such arrangement will likely lead to adverse

[5] Medicare MA requires a 6-months "locked in" period that significantly reduced the adverse selection into Medicare MA. Therefore, I highly suggest a requirement of 6-months "locked in" period for Medicare 3VBPP. Please refer to the summary by Newhouse and McGuire "How Successful is Medicare Advantage" Milbank Quarterly 2014 92(2): 351-394

[6] Such suggestion is the most generous offer, advice is welcome regarding this criteria.

selection and attract sicker or poorer patients. However, if the self-selection issue is appropriately controlled in the evaluation, any estimated results of better quality and lower cost of the proposed APM will be more robust and convincing. In addition, regarding social benefit, combining the cost of Medicare and out-of-pocket cost together, this APM will benefit the patients, in particular the low-income patients.

d. These four types of plans are offered to reimburse physicians and other providers. Participating beneficiaries are free to join any one of these:

i. A capitated HMO plan that the Medicare Account will be used to contribute to the capitation. The reimbursement rate of care will be negotiated between the carriers and providers. Medicare MA plans could naturally offer this plan with adjustment in the capitation rate.

ii. A PPO plan that 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 co-insurance for all the inpatient and outpatient clinical events.

iii. A high deductible PPO plan that Medicare Account will be used to pay for a low premium (e.g. $1,000-$1,500) and 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. [7] Annual physical examination and all the wellness care are still fully covered.

iv. A low premium FFS plan with negotiated rate of reimbursement 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. However, there is no annual limitation on Medicare contribution. [8]

Both independent practice physicians and salary-based physicians can be paid under all the plans above. Comprehensive physician clinics and other large comprehensive providers are at better position to adopt the low premium FFS plan (plan iv).

[7] The high deductible plan is highly innovative, therefore, advice and discussion from PTAC colleagues are welcome. Such financing method could be linked to Health Savings Account to roll over. The mechanism is to encourage the comparatively healthier and wealthier participants to be prudent in health care consumption to avoid out of pocket or unnecessary Medicare expenditures except major unexpected medical events.

[8] CMS has the authority to regulate the payment plan that is initiated by the physicians.

For the HMO, PPO, and low premium FFS plans, the Part D benefit could be integrated with Part A and B services as "one package" plan, or offered as an stand alone plan. It is also the beneficiaries' choice to choose any stand-alone part D plans on the market outside of the demo carriers' network. For the high deductible PPO plan, Part D services will *not* be integrated with Part A and B services.

e. Financial reward for wellness care. If the beneficiaries use the free annual physical and wellness counseling session and pursue the preventive or wellness care that is prescribed by the primary care physicians or counselors, the beneficiaries are 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. As mentioned above in point A of section IV, CMS has the authority to regulate the inclusion criteria of wellness care that will be covered under this APM.

f. Reduced Medicare contribution to the premiums or reimbursement after the initial Medicare Account balance is exhausted. If the beneficiaries exhaust the balance of the initial Medicare Account (with or without the wellness reward being deemed) before the end of 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, the beneficiaries share higher percentage of means tested out of pocket contribution 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.

g. Catastrophic coverage: instead of annual catastrophic coverage, Medicare 3VP will provide a catastrophic coverage over 3 years if the cross year total exceeds certain amount during the demonstration period. The beneficiaries' out of pocket responsibility of premiums, copayment, and coinsurance will all be waived above the catastrophic coverage cap.

   Under the most generous offer scenario that Medicare 3VBPP waives part A deductible and Part B premiums, when compared with FFS, the out of pocket payment below the first cap is minimal except the wealthier beneficiaries who likely will self-select into more expensive plans or clinical procedures. Besides, the wellness reward will help shrink the gap between the first cap and the catastrophic coverage, and therefore, will create another strong financial reward for the beneficiaries to stay healthy.

   Hence, mathematically, I expect the average means tested copayment between the lower cap and catastrophic coverage to be lower than the average out of pocket cost under FFS over three years, in particular for the low income

enrollees who usually are more likely to choose the capitation plans with very low copayment or coinsurance charge.

In addition, the catastrophic coverage over 3 years will eliminates the uncertainty of out of pocket payment from year to year under FFS.

h. 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.

i. 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.

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

B. Implications to physicians and providers.

Instead of a one-fit-all procedure based physician payment schedule, Medicare 3VBPP gives the providers unprecedented flexibility to negotiate reimbursement method and rate for Medicare covered services based on the local demand and market for medical care. Under this proposed APM, it is ultimately the patients' choice to pick the providers that provide the best value of the Medicare's contribution in health care. The diversity in financing design under a 3 yr budget constraint and the means tested copayment above the first expenditure cap enable different carriers and providers to compete on both the objective health outcomes as well as the perceived value of services for patients in different income levels and with different expectations on care experiences.

Medicare 3VBPP will allow the hospitals, physicians, and benefit carriers to gradually adjust to the new financing system based on their local demand and resources. On the contrary to the top-down mechanism to implement sophisticated reimbursement rules nationwide, Medicare 3VBPP encourages the providers to develop their own innovative care models to meet the need of their community, and negotiate the reimbursement mechanisms with the benefit carriers or patients directly.

The financing mechanism and payment schedule of this APM will support and nurture the small practices physicians with brighter perspective and higher sustainability, in particular for those who work in the rural or underserved areas. Small practices can taylor their specialty and service model to meet the particular areas they are practicing, and avoid the administrative burden of rigid and sophisticated reimbursement rules that

do not fit the market they are practicting. The poposed alternative reimbursement method is more innovative to meet the demand for the patients, but is more simplified in coding and processing. It will reduce waste, increase efficiency, and protect the best interests of both the patients and physicians.

Instead of creating new bureaucratic or administrative burden, Medicare 3VBPP will provide easy transition from private insurance to Medicare when the beneficiaries retire and start to tap in Medicare contribution, and hence will maintain the continuity of the coverage of the same high quality providers at community level.

Most importantly, Medicare LVBPP will stimulate the demand and development of cutting edge technology that makes the diagnoses, treatment, and management of chronic diseases less costly, easier, and more personalized.

Phycisians will not bear the financial risks of Medicare 3VBPP, on the contrary, this APM will provide the peace of mind that physicans are longing for by simplifying the transaction of health care to be between patients and providers in the community. The majority of physicians, in particular those in private practice, will not only secure, but also expand their portion of care within this framework.

C. Major differences with existing CMMI models and statutory challenges.

The Medicare Access and CHIP Reauthorization Act (MACRA) creates two pathways to pay for performance: the Merit-based Incentive Payment System (MIPS) and APMs. Medicare 3VBPP falls into the APM category.

To date, CMMI has approved limited number of APMs, and the majority of these models are Accountable Care Organization (ACO) that was introduced by section 3022 of the Patient Protection and Affordable Care Act (ACA).[9] The success of ACO is it promotes quality monitoring and preventive care utilization. However, there is a lack of evidence that Medicare ACO could lead to health care savings.[10] For 2017, CMS estimates that 70,000 to 120,000 clinicians (approximately 10-15 percent) participates in ACOs and qualify for bonus. [11]

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[9] Tianna Tu, David Muhlestein, S. Lawrence Kocot, and Ross White, *The Impact of Accountable Care: Origins and Future of Accountable Care Organizations*, Leavitt Partners and The Brookings Institution, May 2015, https://www.brookings.edu/wp-content/uploads/2016/06/Impact-of-Accountable-CareOrigins-052015.pdf (accessed June 8, 2017).

[10] Ashish Jha, "ACO Winners and Losers: A Quick Take," August 30, 2016, An Ounce of Evidence | Health Policy blog, https://blogs.sph.harvard.edu/ashish-jha/2016/08/30/aco-winners-and-losers-a-quick-take/ (accessed June 8, 2017).

[11] The Centers for Medicare and Medicaid Services, "The Quality Payment Program Overview Fact Sheet," https://qpp.cms.gov/docs/Quality_Payment_Program_Overview_Fact_Sheet.pdf (accessed June 8, 2017).

Hence, if the providers choose to opt out of MIPS which is a highly sophisticated pay for performance FFS mechanism, there is unlimited space to expand APM models such as Medicare 3VBPP to facilitate simpler transactions of health care services that meet the specific need of local community better.

I am not aware of any barriers that exist in state or federal laws or regulations that prevent or discourage the change in care delivery as proposed by the APM. If PTAC committee and Department of Health and Human Services colleagues notice there are barriers, I am more than glad to work with the committee and HHS colleagues to modify the model and overcome the barriers.

V. Value over Volume:

Medicare 3VBPP provides strong incentives for providers to upgrade their delivery models with higher value to compete for the services of patients with chronic diseases. The 3 year financing plan and means tested cost sharing encourage both the physicians and patients to focus on the long-term perspective of the patients health, as well as financial wellbeing. Medicare 3VBPP re-aligns the financial incentives of both the providers and the patients, and opens up new channels to reimburse integrated care in the community. The providers, especially the primary care or family physicians, therefore, will play a more important role in monitoring, managing and coordinating the care for patients with chronic diseases to boost the efficiency and value of care.

The wellness reward of Medicare 3VBPP will greatly incentivize the patients to participant and engage in preventive services, such as Diabetes Prevention Program, self-monitoring of blood pressure and weight etc. Therefore, patients will coordinate with physicians better to proactively pursue health, instead of health care, to improve value.

The proposed APM features less third party payer intrusion but strong encouragement of direct transaction between the patients and physicians, both the patients' autonomy and patient-physician trust are strengthened and enhanced. The trust between physicians and patients is strong behavioral incentive for the providers, especially primary care doctors, to provide higher value of care to nurture long-term relationship and quality.

VI. Flexibility

The proposed model can be adapted to a wide range of clinical settings and patient groups. Providers in rural area, the under-served area, minority or immigrants concentrated communities can all join this model. Based on the field experiences of FEHBP and Medicare MA. Rural providers and providers for under-served areas welcome the opportunity to negotiate the reimbursement rate with the payers or carriers directly, and national plans usually have more advantage.

Medicare 3VBPP will not only adapt the changing technology, including new drug therapies and devices well, but also stimulate the development of new technology to

facilitate integrated care and coordinated care. Because the practitioners will be given the choices to negotiate with Medicare of innovative models in the field, as long as the technology will improve the efficiency of care, Medicare 3VBPP will make it easier and faster for the adaptation of modern technology at community level.

The practitioners will not endure addition operational burdens, on the contrary, Medicare 3VBPP will alleviate their burden and reporting requirements, and encourage the physicians to focus on their practice and interaction with patients.

The participants should have up-to-date Health IT system in house to handle the contract and billing, the additional infrastructure investment is minimal.

VII. Ability to Evaluate

In the section of "Quality and Cost", I summarized the domains of metrics that will be evaluated for the overall value of Medicare 3VBPP. In addition to the four domains listed in Table 1 (Cost and Clinical Care Utilization, Preventive Service Utilization, Health Outcomes, and Patients Satisfaction). I suggest conduct another survey among the participating providers about their satisfaction with the payment model, including the fairness of the reimbursement rate, effect on time spent with patients, effect on physician-patient relationship, and incentives for technology upgrade.

The evaluable goals are at population level. Because the goal of the APM model is to be scaled up to the entire Medicare population, at the initial stage of the model, all the evaluation should be conducted at population level to support later decisions to scale it up.

Qualitative investigations, such as in-depth investigative case study among hospital CEOs, carrier CEOs, and physician group leaders are optional to better understand how the health care provider community respond to the APM and what's their feedbacks to improve or modify the model in the field.

VIII. Integration and care coordination

Both primary care doctors and specialists, physician practitioner, nurses, nutritionist, wellness counselors or coaches would likely be included in the implementation of this model to achieve desire outcome. Because of the strong emphasis on wellness care and care coordination of Medicare 3VBPP, a large spectrum of providers, in particular the nonmedical providers of wellness care will be involved.

The dilemma for Medicare FFS is: On one hand, FFS by design encourages the fragmented system, doesn't accommodate integrated or coordinated care. On the other hand, however, many existing APMs, such as bundled payment are still centered on procedure and episode. Due to the complexity of management of chronic diseases, in particular multiple chronic disease, its extremely challenging to replicate a procedure or episode based AMP that is as clean cut as knee replacement and create a reimbursement code nationwide.

Therefore, Medicare 3VBPP takes a different approach to unleash the power of innovation to among physicians in the community. Although CMS will continue to play an important role regarding the inclusion or exclusion criteria of reimbursement rule, that role will be more similar to an umpire to make sure that the game is fair and call off the bad balls, instead of playing both the umpire and the pitcher to manipulate the game.

The proposed model will give the independent and small practices more power to revitalize the physician workforce, as well as to regain and strengthen the social status of physicians as independent professionals.

The care coordination team members' share of payment or loss is up to their voluntary agreement within the boundary of law of medical and wellness practice in each community.

IX. Patient Choice:

Medicare 3VBPP will not only preserve, but also enhance the individuality and diversity in care delivery to meet the heterogeneous demand of patients in different demographics, geographic areas, religious beliefs, income, health conditions, and the most importantly the expectations of health care experiences.

Medicare 3VBPP will provide more generous and simplified reimbursement method for the dedicated providers who are serving rural, under served, and low income urban areas. These providers often face more complex situation, play more crucial roles in care integration and coordination, are required to think out of box and take initiatives to deal with unexpected patients or situation. The proposed APM will provide alleviation of administration and coding burden for these providers who are shouldering the responsibility of reducing health disparities.

Medicare 3VBPP will attract more rural, minority, southern, and immigrants population beyond existing CMS models. The current CMMI models, in particular ACOs, rely heavily on the large teaching or comprehensive hospitals or hospital chains to achieve the aims of integrated care and cost savings. These providers are usually concentrated in heavily populated urban or suburban areas. Medicare 3VBPP, however, is more flexible in the financial agreement between the providers, CMS, and carriers, and therefore, will attract more diversified patients population and provider groups.

X. Patient Safety:

Participation of Medicare 3VBPP is voluntary, and patients have the choice to opt out of the model at any time without financial or legal obligation.

Besides, CMS will play a key role in monitoring the implementation or demonstration process to ensure patients safety is protected and not abused.

XI. Health Information Technology:

Patients' privacy will be protected under the HIPPA law. The share of patients' information among providers or care givers will follow the protocol of HIPPA law and regulation.

The Medicare Account provides unprecedented transparency to the patients regarding how Medicare money is spent for their health care, each patient is informed of every single transactions that Medicare reimburses. Concerning the quality, the patients satisfactory survey results at population level for all the providers should be published to the public. FEHBP has conducted similar survey for years to help patients make wise and savvy choices of benefit carriers, and it has been very successful.

Inteoperability of electronic health records is a decision for the providers and carriers to make jointly, my expectation is some will prefer and some will not, depending on the market and population characteristics.

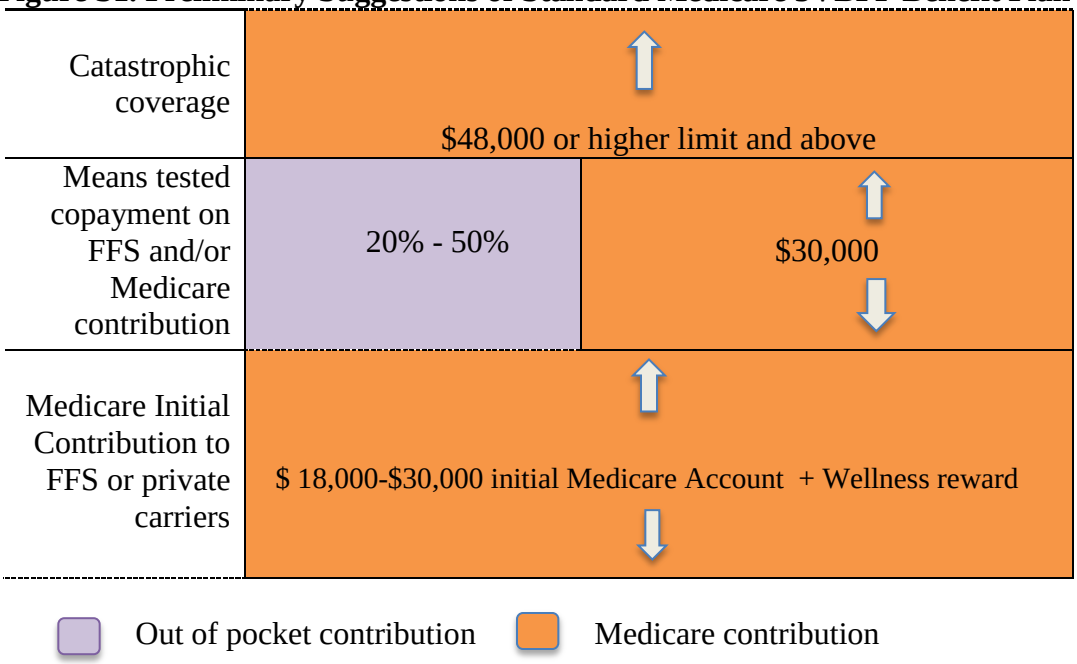
The proposed APM will incentivize providers to use all the heath IT tools available to improve quality and efficiency of care models that will not only deliver better health outcomes, but also lift the health care experiences to higher social value with more respect of patients autonomy, dignity, and independence.

Supplemental Information

Preliminary Numbers for the Design of Medicare 3VBPP

I used the recently released nationally representative Medicare Current Beneficiary Survey (MCBS) from 2006 to 2010 as reference to construct a prelim design regarding the caps, reward, and catastrophic coverage of Medicare 3VBPP that only covers Part A and Part B services. MCBS contains two major parts: 1. Survey File of demographics, general health status, and supplemental insurances of the beneficiaries and 2. Claim files that contain information regarding the charge and payment from different payers for all Medicare covered services. MCBS, however, doesn't provide information about Part B premiums or Part A deductibles. Figure S1 illustrates the structure of the prelim design of the financing model with the major cut off points.

Figure S1. Preliminary Suggestions of Standard Medicare 3VBPP Benefit Plan



a. The initial Medicare account balance at the beginning of the demonstration.

In Table S1 below, I list the key numbers by 5 years age group from 65 to 85. Because MCBS is national representative data, the numbers I suggest serve as a generic reference for the design of the demonstration. The specific amount of the initial Medicare Account balance should be negotiated between CMS and local Medicare benefit carriers with the assistance of actuary expert.

Based on MCBS, the Per Member Per Year (PMPY) Medicare expenditures for Part A and B services combined increase with age, it is at around $5,800

for those between age 65 and 69, and approximately $11,000 (2010 value) for those between age 80 and 85.

Taking the most simplistic risk adjustment approach using age as the only factor, I suggest the age adjusted Medicare account be set at 100% of the three times of the average annual total Medicare expenditures by age, and please refer to Table S1 for the specific numbers.

If Part D is integrated into the plan, the starting balance should be at least $7,500 higher than the current level, considering the lower cap of Part D donut hole is $2,500 per year.

b. Wellness reward

I suggest the wellness reward be set at 15%-30% of the age adjusted average annual Medicare expenditures for Part A and B combined, considering the wellness care and health maintenance could reduce the clinical care incidence. In Table S1 below, I set the reward rate at 15%.

c. Catastrophic coverage

Based on MCBS, the average annual out of pocket (OOP) expenditures for Medicare Part A and Part B services is at $1,528, with the median at $690. However, MCBS only contains information of the copay and coinsurance of the clinical services covered by Medicare, but doesn't include the cost of Part B premiums or Part A deductible. At national average, more than 90% of the beneficiaries enrolled in both Part A and Part B, and the average probability of Part A service use is 20%. Therefore, adding Part B premiums ($109 per month) and 20% chance of paying the $1,500 Part A deductible, the real average annual OOP cost for Medicare beneficiaries should be approximately at $3,300.

I suggest the 3 year catastrophic coverage cap be set at $30,000 higher than the initial Medicare account balance is exhausted, and I set the minimum hike of copayment rate of premiums and clinical services at 20% when the initial Medicare account balance is exhaused and be means tested.

d. Copayment between the lower cap and catastrophic coverage

The beneficiaries are required to pay 20% or more of Medicare contribution above the initial balance plus wellness reward. The copayment is means tested with higher income people paying more than 20%, but lower than 50% for the $30,000 increase in total benefit expenditures. Under such scenario, the hike of out of pocket payment for the lowest income population over 3 years will be $6,000 maximum, which is significantly lower than three times of the average out-of-pocket expenditures of Part A and B combined under FFS at

approximately $10,000 ($3,300*3). In addition, $6,000 out of pocket payment is predictable. It eliminates the uncertainty of out of pocket payment for Medicare covered service.

Based on the preliminary numbers suggested above, I calculated the average total Per Member Per Year (PMPY) cost that includes both Medicare and beneficiaries' OOP contribution to Medicare 3VBPP under the most conservative assumption: the total Medicare contribution won't exceed the catastrophic coverage limit and the wellness reward is deemed. The last row of Table S1 lists the estimates: the average PMPY cost for those 65 to 85 is between $10,480 and $15,058. If the Medicare 3VBPP Demo is truly rolled out in the field, there will be more variations in the annual costs due to the variations in beneficiaries' characteristics, choices of private carriers, and local health care resources.

Table S1: The Key Cut-off Points for Medicare VBPP3

	Age 65-70	**Age 70-75**	**Age 75-80**	**Age 80-85**
Initial Balance	$18,000	$19,950	24,810	$30,000
Wellness Reward	$700	$900	$1,000	$1,200
Catastrophic Coverage Cap	$48,000	$49,950	$54,810	$30,000
Average PMPY cost (total)	$10,480	$11,353	$13,084	$15,058

For the physicians and providers, they have the flexibility to negotiate payment format and amount through a carrier or a group with CMS, but are subject to the constraint of a financing structure as illustrated above in the most simplistic design.