Physician-Focused Payment Model Technical Advisory Committee
LOI: Environmental Scan and Relevant Literature

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Zhou Yang, PhD is an Assistant Professor in the Department of Health Policy and Management at Emory University's Rollins School of Public Health. She is proposing a three year defined contribution model, entitled the Medicare 3 Year Value Based Payment Plan (Medicare 3VBPP). With the goal of promoting payment equity to the physicians, increasing system efficiency, and improving health status of the patients, Medicare 3VBPP is a scaled-down version of Medicare Lifetime Value Based Payment Plan (Medicate LVBPP), which was developed in 2014 by Dr. Yang. It includes six components:

1. Beneficiaries' free choice between staying with a traditional defined benefit Fee for Service (FFS) plan and joining a private carrier, which provides Medicare covered services with several options of a defined contribution plan.
2. A lifetime (or long-term) expenditure threshold that triggers additional means tested copayment or co-insurance charges 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.
6. Financial reward for postponed Medicare initiation age after 65.

Key Search Terms

Lifetime value-based payment; Medicare Advantage; Medicare premium support; Medicare 3VBPP; payment model; Zhou Yang

Research Task	Section	Contents
Environmental Scan	Section 1	Key documents, timely reports, grey literature, and other materials gathered from internet searches (6).
Relevant Literature	Section 2	Relevant literature materials (1).
Related Literature	Section 3	Related literature materials (1).
References	Section 4	References to both relevant and related literature.

NOTE: This literature review and environmental scan was limited due to the relevant key terms identified in the LOI.

Section 1. Environmental Scan

Environmental Scan		
Key words: Medicare Advantage payment models		
Organization	**Title**	**Date**
Centers for Medicare & Medicaid Services (CMS)	Report to Congress: Alternative Payment Models & Medicare Advantage	4/6/2015 Accessed: 7/10/2017
Purpose/Abstract		
Background: Medicare's payments to Medicare Advantage Organizations (MAOs) under current law are population-based payments that link financial incentives for MAOs to the total cost and quality of care furnished by the MAO's network of contracted providers. As a result, the MA program today effectively functions as an APM-like arrangement between the Centers for Medicare & Medicaid Services (CMS) and MAOs. However, the value-based incentives for insurers under MA may not always reach the provider(s) of care. Therefore, the MAO-provider relationship may be more relevant rather than the Medicare and the MAO. ***Summary:*** This report explores several options for the use of APM arrangements between MAOs and providers, including a review of potential financial and/or rules-based incentives that could be awarded to MAOs that commit to APM adoption. A similar approach is considered for including a VBM in the MA program, which, this report concludes, could, like APMs, potentially be designed for use under MA and in a budget neutral manner. However, current program parameters, including statutory constraints, generally limit the tools available to CMS to encourage further APM adoption. In particular, the non-interference clause precludes CMS from using incentives in these ways. However, CMS maintains some regulatory discretion and 1115A waiver authority.		
Additional Notes/Comments		

Environmental Scan

Key words: Medicare premium support

Organization	Title	Date
AARP Public Policy Institute	Premium Support and the Impact on Medicare Beneficiaries	1/2017

Purpose/Abstract

Background: Under a premium support system, the federal government would replace Medicare beneficiaries' guaranteed benefit package with a fixed dollar amount, or "defined contribution," that beneficiaries would apply toward their health care coverage. In most premium support models, Medicare beneficiaries would choose between competing private health plans and traditional Medicare fee-for-service coverage. A beneficiary's premium would be the difference between the government's defined contribution, or "voucher" value, and the cost of the insurance plan he or she chooses. This approach raises a number of beneficiary-related concerns.

Summary: The concerns outlined in this fact sheet include: (1) premium support could end the promise of the guaranteed set of Medicare benefits and leave fewer healthy beneficiaries in traditional Medicare and drive up costs; (2) beneficiaries in traditional Medicare could pay more; (3) premium support could shift more costs to beneficiaries over time; (4) most Medicare beneficiaries cannot afford to pay more for their health care; (5) premium support could lead to reduced access and higher risk of catastrophic out-of-pocket medical expenses for Medicare beneficiaries with lower incomes; (6) premium support assumes that beneficiaries are willing and able to make complex health care coverage decisions; and (7) "grandfathered" beneficiaries could still pay higher Medicare premiums.

Additional Notes/Comments

Environmental Scan

Key words: Medicare premium support

Organization	Title	Date
Congressional Budget Office (CBO)	A Premium Support System for Medicare: Analysis of Illustrative Options	9/2013

Purpose/Abstract

Background: Over the past two decades, numerous proposals have been advanced for the establishment of a premium support system for Medicare. Under such a program, beneficiaries would purchase health insurance from one of a number of competing plans, and the federal government would pay part of the cost of the coverage. The various proposals have differed in many respects, including the way in which the federal contribution would be set and how that contribution might change over time.

Summary: This Congressional Budget Office (CBO) report presents a preliminary analysis of the ways two illustrative options for a premium support system would affect federal spending and beneficiaries' choices and payments. The CBO's analysis indicated the following:

(1) Both options would reduce federal spending for Medicare net of beneficiaries' premiums and other offsetting receipts.

(2) Under the second-lowest-bid option, the option with the greater reduction in net federal spending, beneficiaries' premiums and total payments for Medicare's Part A and Part B benefits would each be higher on average than they would be under current law. Under the average-bid option, those amounts would each be lower on average than they would be under the current law.

(3) Both options would have less combined spending by the federal government and by beneficiaries (for premiums and out-of-pocket costs) compared to the current law.

(4) Under both options, effects on premiums and total payments for some beneficiaries would differ greatly from the national averages. In particular, in most regions, the premiums and total payments of beneficiaries enrolled in the fee-for-service (FFS) program would be higher than they would be under current law.

(5) Alternative specifications for key features of a premium support system would yield different results.

Additional Notes/Comments

Environmental Scan

Key words: Medicare Advantage payment model

Organization	Title	Date
Centers for Medicare & Medicaid Services (CMS)	Medicare Advantage Value-Based Insurance Design Model	8/10/2016 Accessed on: 7/6/2017

Purpose/Abstract

Background: CMS announced refinements to the design of the second year of the Medicare Advantage Value-Based Insurance Design (MA-VBID) model. The MA-VBID model is an opportunity for Medicare Advantage (MA) plans, including those offering Part D benefits (MA-PD plans), to offer clinically nuanced benefit packages aimed at improving quality of care while also reducing costs. The model will test the hypothesis that giving MA plans flexibility to offer supplemental benefits, or reduced cost sharing to targeted groups of enrollees with CMS-specified chronic conditions in order to encourage the use of services that are of highest value to them, will lead to higher-quality and more cost-efficient care. The model is also intended to improve outcomes and reduce costs by encouraging targeted enrollees to obtain care from high-value providers and by providing new supplemental benefits specifically tailored to targeted enrollees' clinical needs.

Summary: In the second year of the model, beginning January 1, 2018, CMS will: open the model test to new applicants; conduct the model test in three new states - Alabama, Michigan, and Texas; add rheumatoid arthritis and dementia to the clinical categories for which participants may offer benefits; make adjustments to existing clinical categories; and change the minimum enrollment size for some MA and MA-PD plan participants.

Additional Notes/Comments

CMS Medicare Advantage Value-Based Insurance Design Model Web Page

HealthPayer Intelligence, CMS Redesigns Value-Based Model for Medicare Advantage Plans

Environmental Scan

Key words: Zhou Yang; payment model

Organization	Title	Date
Health Affairs Blog	A Lifetime Value-Based Proposal for Medicare Payment Reform	3/14/2014

Purpose/Abstract

Background: Dr. Zhou Yang discussed how Medicare reform policy proposals fail to recognize Medicare as a lifetime plan that covers beneficiaries from age 65 to death. She proposed a Lifetime Value-Based Payment Plan (LVBPP) for Medicare reform. LVBPP aims to achieve efficient use of the government contribution to Medicare for each beneficiary from age 65 to death and features shared responsibility among beneficiaries, providers, and the federal government.

Summary: Six key elements are at the core of LVBPP; these include: (1) free choice between traditional government "defined benefit" plan and private insurance carriers; (2) a lifetime expenditure threshold that triggers an additional copayment charge based on means testing; (3) a health promotion reward to encourage behavioral change and competition on preventive care; (4) increased reimbursement rate for preventive care and innovative chronic disease management models within the threshold; (5) catastrophic coverage protection; and (6) flexibility in Medicare initiation age. Simulations conducted to ascertain the potential impact of the LVBPP suggests that the model could lead to better health in terms of longer longevity and lower disability rate, save up to $70 billion over 10 years, and save up to $164 billion for the federal government over the lifetime of the cohort of upcoming beneficiaries age 55 to 59.

Additional Notes/Comments

http://news.emory.edu/stories/2014/04/medicare_reform_proposal/index.html

Environmental Scan

Key words:

Organization	Title	Date
RAND	Health Insurance Experiment Series – Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment	1987

Purpose/Abstract

Background: The proposal indicates a quasi-experimental study design as 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 a two-part model that was introduced in the Rand Health Insurance Experiment (Rand HIE).

Summary: This report examines the effects of varying levels of cost-sharing on the demand for medical care and other health services. It presents the final results of the RAND HIE with respect to annual utilization of medical services in the FFS system. The experiment was a large-scale social experiment designed to investigate the effects of alternative health insurance plans on the utilization of health services, health statute, the quality of care, and patient satisfaction.

Additional Notes/Comments

This was included as a reference in the proposal.

Section 2. Relevant Literature

Relevant Literature		
Key words: Medicare Advantage, payment model		
Journal	**Title**	**Date**
The American Journal of Managed Care (AJMC)	Value-Based Contracting Innovated Medicare Advantage Healthcare Delivery and Improved Survival	2/2017

Purpose/Abstract

Objective: In Medicare Advantage (MA), with its CMS Hierarchical Condition Categories (CMS-HCC) payment model, CMS reimburses private plans (Medicare Advantage Organizations [MAOs]) with prospective, monthly, health-based or risk-adjusted, capitated payments. The effect of this payment methodology on healthcare delivery remains debatable. This article discusses how value-based contracting generates cost efficiencies and improves clinical outcomes in MA.
Study Design: A difference in contracting arrangements between an MAO and 2 provider groups facilitated an intervention-control, pre-intervention-post-intervention, difference-in-differences approach among statistically similar, elderly, community-dwelling MA enrollees within one metropolitan statistical area.
Methods: Starting in 2009, for intervention-group MA enrollees, the MAO and a provider group agreed to full-risk capitation combined with a revenue gainshare. The gainshare was based on increases in the Risk Adjustment Factor (RAF), which modified the CMS-HCC payments. For the control group, the MAO continued to reimburse another provider group through fee-for-service. RAF, utilization, and survival were followed until December 31, 2012.
Results: The intervention group's mean RAF increased significantly (P <.001), estimating $2,519,544 per 1,000 members of additional revenue. The intervention increased office-based visits (P <.001). Emergency department visits (P <.001) and inpatient hospital admissions (P = .002) decreased. This change in utilization saved $2,071,293 per 1,000 enrollees. By intensifying office-based care for these MA enrollees with multiple comorbidities, a 6% survival benefit with a 32.8% lower hazard of death (P <.001) was achieved.
Conclusion: Value-based contracting can drive utilization patterns and improve clinical outcomes among chronically ill, elderly MA members.

Additional Notes/Comments

Section 3. Related Literature

Related Literature		
Key words:		
Journal	**Title**	**Date**
The Milibank Quarterly	How successful is Medicare Advantage?	6/2014
Purpose/Abstract		
Context: Medicare Part C, or Medicare Advantage (MA), now almost 30 years old, has generally been viewed as a policy disappointment. Enrollment has vacillated but has never come close to the penetration of managed care plans in the commercial insurance market or in Medicaid, and because of payment policy decisions and selection, the MA program is viewed as having added to cost rather than saving funds for the Medicare program. Recent changes in Medicare policy, including improved risk adjustment, however, may have changed this picture. ***Methods:*** This article summarizes findings from the authors' group's work evaluating MA's recent performance and investigating payment options for improving its performance even more. They studied the behavior of both beneficiaries and plans, as well as the effects of Medicare policy. ***Findings:*** Beneficiaries make "mistakes" in their choice of MA plan options that can be explained by behavioral economics. Few beneficiaries make an active choice after they enroll in Medicare. The high prevalence of "zero-premium" plans signals inefficiency in plan design and in the market's functioning. That is, Medicare premium policies interfere with economically efficient choices. The adverse selection problem, in which healthier, lower-cost beneficiaries tend to join MA, appears much diminished. The available measures, while limited, suggest that, on average, MA plans offer care of equal or higher quality and for less cost than traditional Medicare (TM). In counties, greater MA penetration appears to improve TM's performance. ***Conclusions:*** Medicare policies regarding lock-in provisions and risk adjustment that were adopted in the mid-2000s have mitigated the adverse selection problem previously plaguing MA. On average, MA plans appear to offer higher value than TM, and positive spillovers from MA into TM imply that reimbursement should not necessarily be neutral. Policy changes in Medicare that reform the way that beneficiaries are charged for MA plan membership are warranted to move more beneficiaries into MA.		
Additional Notes/Comments		
This was included as a reference in the proposal.		

Section 4. References

1. Mandal, A.K., Tagomori, G.K., Felix, R.V., & Howell, S.C. (2017). Value-Based Contracting Innovated Medicare Advantage Healthcare Delivery and Improved Survival. *The American Journal of Managed Care*. 23(2), e41-e49.
2. Newhouse, J.P. & McGuire, T.G. (2014). How successful is Medicare Advantage? *The Milibank Quarterly*. 92(2), 351-394.