EPSTEIN BECKER GREEN

Emerging Issues in Value Based Case: Medicare and Commercial Payors

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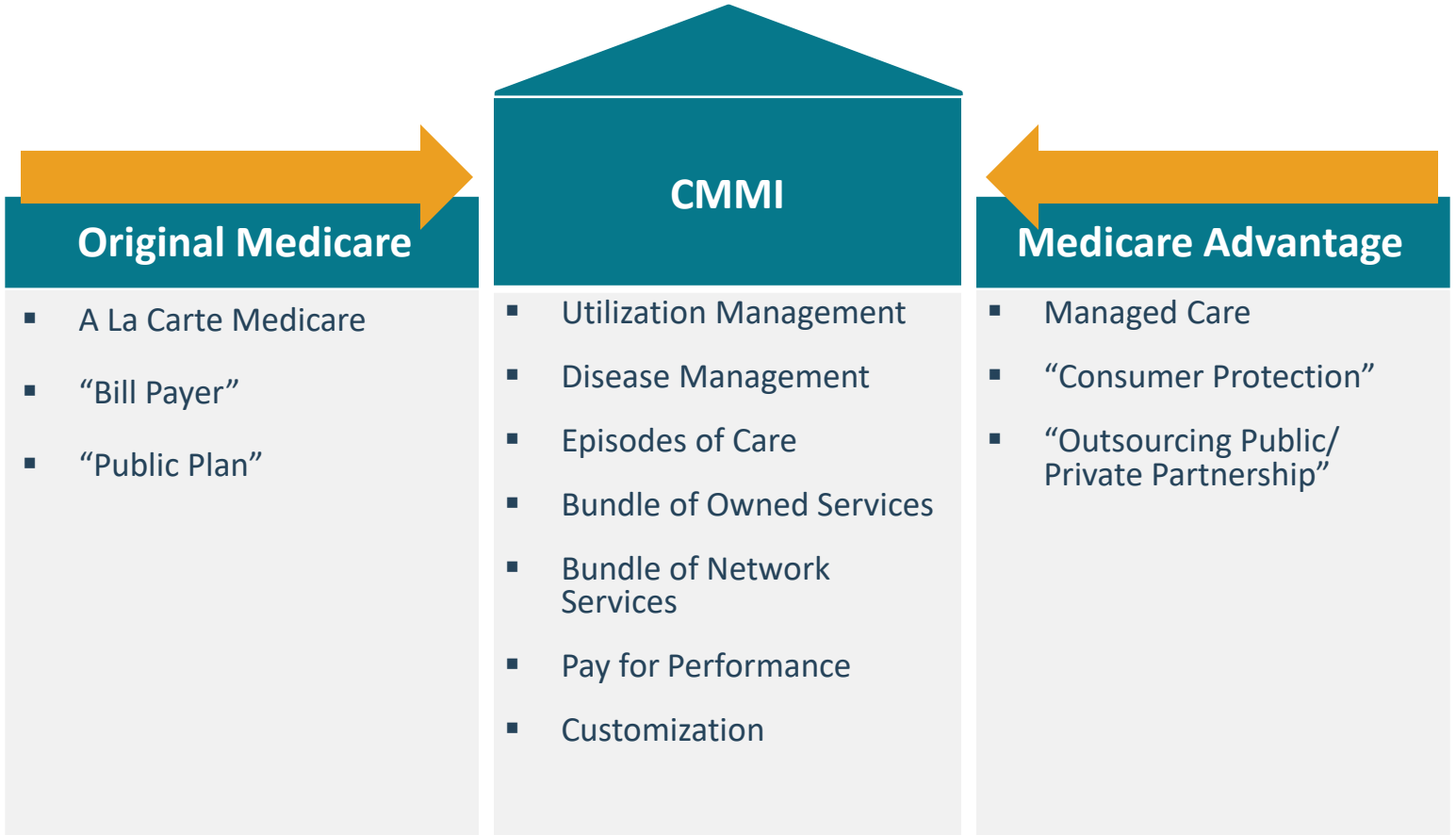
Medicare-For-All

Support for Medicare-for-all is on the Rise

- On Tuesday Feb. 26, 2019, lead sponsor Rep. Pramila Jayapal (D-Wash.) introduced a Medicare-For-All bill
  - Creates a single-payer, government-funded health-care program within two years, eliminating the age 65 threshold for Medicare eligibility.
  - It would not charge beneficiaries copays, premiums or deductibles.
  - The plan would cover prescription drugs, vision, dental, mental health, substance abuse, and maternal care. It would also provide universal coverage for long-term care for people with disabilities.
  - The proposal notably does not include methods to pay for the health-care overhaul.
- Medicare for All will be an issue in the Presidential 2020 Election. Several Democratic contenders have embraced the concept.

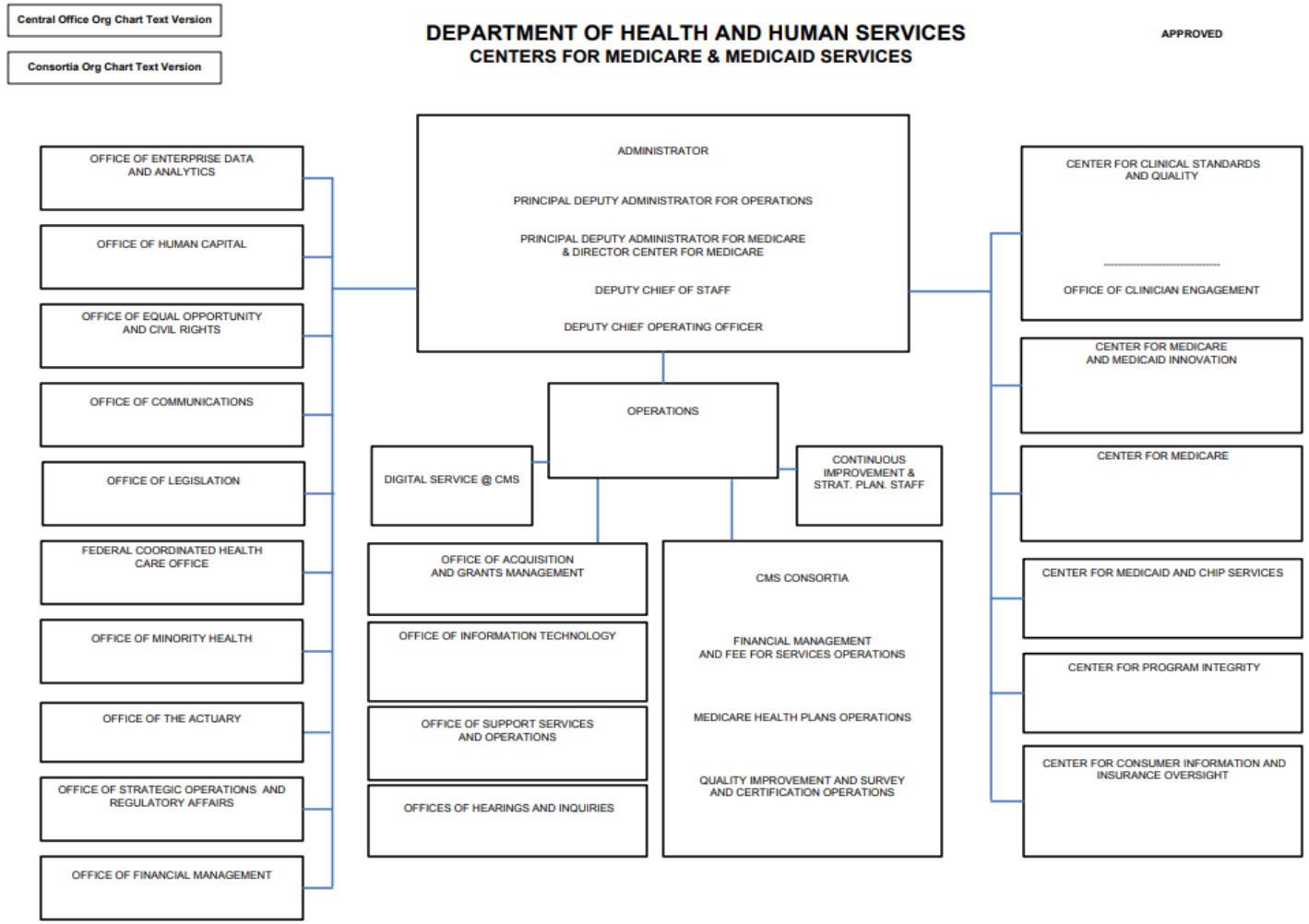
Medicare Value-Based Payment Initiatives

Three Unofficial Medicare Program Structures



Center for Medicare & Medicaid Services

Organizational Chart



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Center for Medicare and Medicaid Innovation ("CMMI")

The Affordable Care Act and MACRA Created CMMI – Legal Authority

- Created by the Affordable Care Act ("ACA") in 2010
  - The Center is to test innovative payment and delivery system models that seek to maintain or improve the quality of care in Medicare, Medicaid, and the Children's Health Insurance Program ("CHIP"), while slowing the rate of growth in program costs
- Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA")
  - CMMI implements Quality Payment Programs. Clinicians may earn incentive payments by participating to a sufficient extent in Advanced Alternative Payment Models ("APMs")
  - In Advanced APMs clinicians accept some risk for their patients' quality and cost outcomes and meet other specified criteria.

When Can Models Expand Nationally?

Model Must Meet Certain Requirements for Expansion

- The Secretary can expand a model on a "nationwide basis" if:
  - The Model reduces spending under applicable title without reducing the quality of care; or
  - The Model improves the quality of patient care without increasing spending
  - The Secretary determines that such expansion would not deny or limit the coverage or provisions of benefits under the applicable title for applicable individuals.
- The Chief Actuary of Centers of Medicare & Medicaid Services certifies that such expansion would reduce (or would not result in any increase in net program spending under applicable titles).
- Medicare is not limted to medicare, all payer initiative. It can affect commercial payers

The CMMI Innovation Center

Innovation Models Are Organized Into Seven Categories

- Accountable Care
- Episode Based Payment Initiatives
- Primary Care Transformation
- Initiatives Focused on the Medicaid and CHIP Population
- Initiatives Focus on Medicare-Medicaid Enrollees
- Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models
- Initiatives to Speed the Adoption of Best Practices

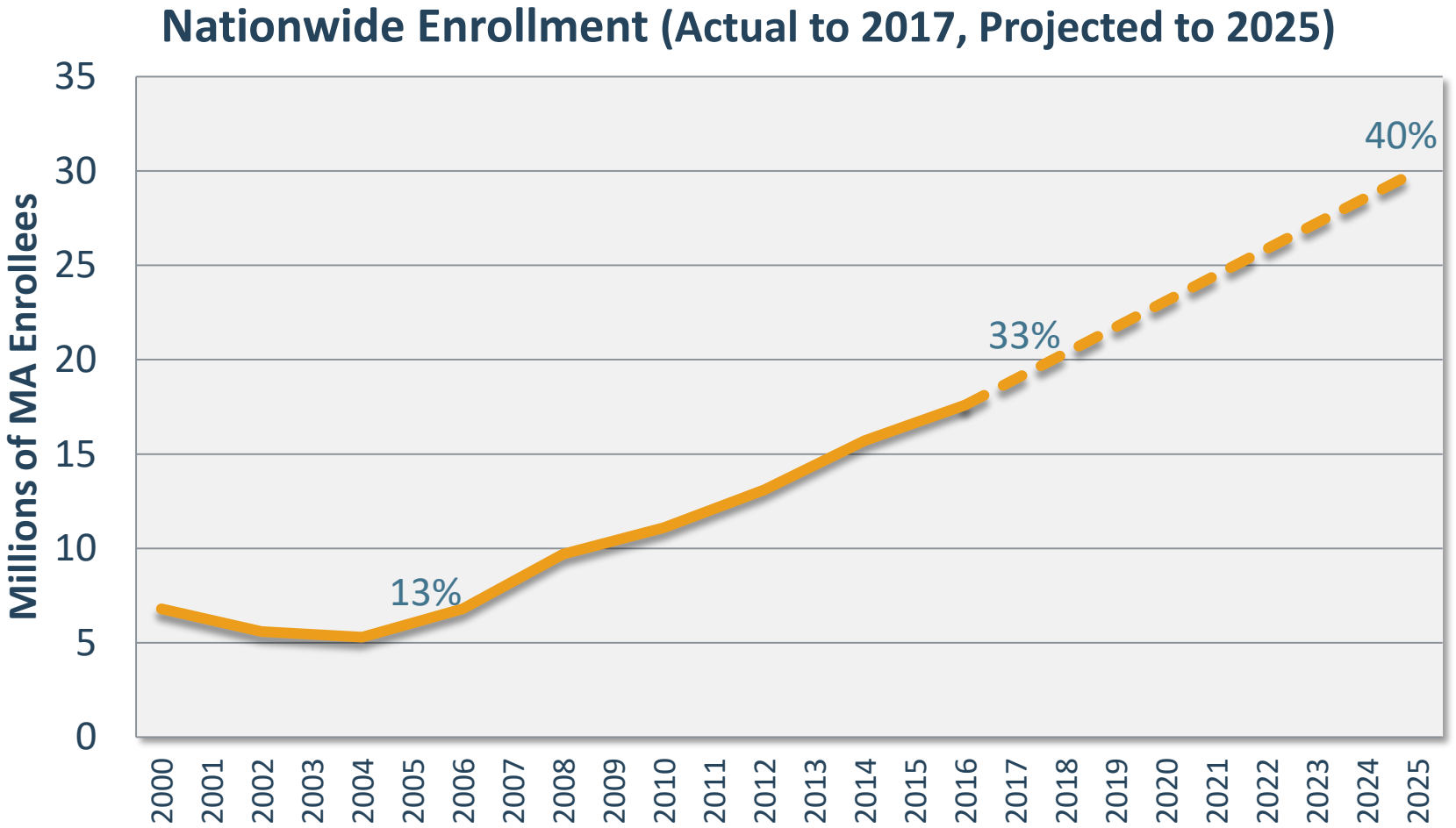
AAHKS'S Experience with CMMI

Episode Based Payment Initiatives

- The Bundled Payments for Care Improvement ("BPCI") initiative is comprised of four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care (Episode-based Payment Initiatives)
  - Model One: No longer active
  - Model Two: Ongoing
  - Model Three: Ongoing
  - Model Four: Ongoing
- Bundled Payments for Care Improvement Advanced ("BPCI-A")
  - **Stage:** *Participants Announced* (Started on October 1, 2018, and the Model Performance Period will run through December 31, 2023)
    Category: *Episode-based Payment Initiatives*
- The Comprehensive Care for Joint Replacement Model
  - **Stage:** *Ongoing* (Started on April 1, 2016 and will run through December 31, 2020).
    Category: *Episode-based Payment Initiatives*

In the Meantime, Medicare Advantage Rises Steadily

MA PLANS NOW SERVE 1 of 3 MEDICARE BENEFICIARIES



Sources: CMS, Congressional Budget Office

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CMMI and MA Plans and Medicaid

- Recent CMMI Models
  - **Medicare Advantage Value Based Insurance Design Model [Next Generation Model]**
  - Emergency Triage, Treat, and Transport (ET3) Model
  - Part D Payment Modernization Model
  - Comprehensive ESRD Care Model
  - Integrated Care for Kids Model
  - Maternal Opioid Misuse (MOM) Model
  - Physician- Focused Payment Models (PFPMs)
- Under Development
  - Artificial Intelligence (AI) Health Outcomes Challenge
  - Pediatric Alternative Payments Model Opportunities
  - Direct Provider Contracting Models
  - Health Plan Innovation Initiatives
  - International Pricing Index Model

A Focus On Medicare Advantage (MA) Value-Based Insurance Design (VBID)

MA PLANS (INSURERS) IMPROVE HEALTH OUTCOMES AND REDUCE EXPENDITURES FOR MA ENROLLEES

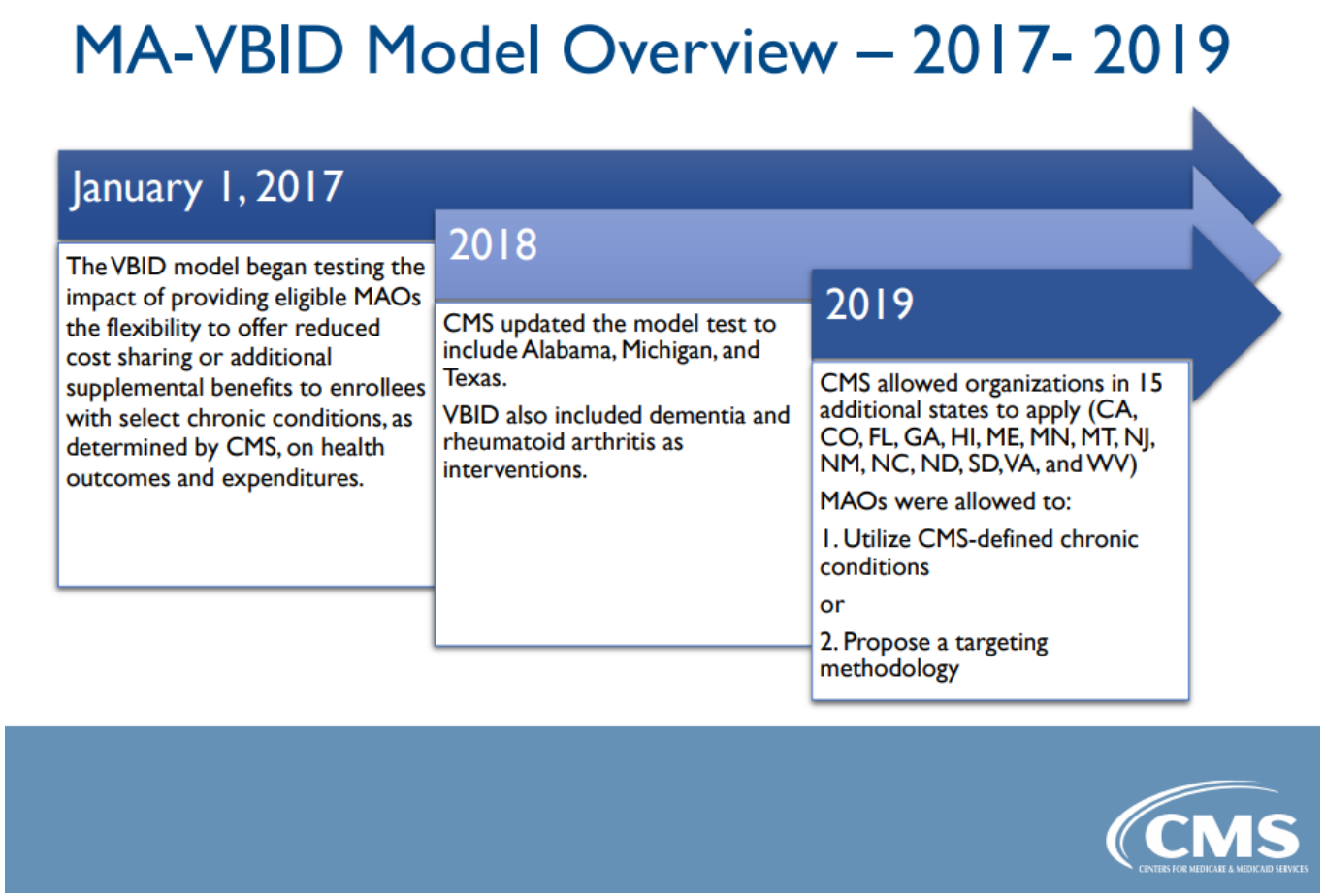
- Allows insurers to offer beneficiaries with chronic disease incentives to use high-value services (e.g. eye exams for those with diabetes).
- Participating insurers can offer reduced cost-sharing for high-value services or providers, reduced cost-sharing contingent on beneficiary participation in disease management, or provision of additional supplemental benefits

- Insurers targeted beneficiaries with 4 out of 7 allowed conditions:
  - Chronic obstructive pulmonary disease)
  - Congestive heart failure
  - Diabetes
  - Hypertension
  - Some targeted co-morbid conditions (e.g. diabetes and CHF combined)
- Over 96,000 MA beneficiaries with specified target conditions were eligible for the VBID model; across all participating MA Parent Organizations 61 percent of eligible MA beneficiaries actually received VBID benefits.
- While most 2017 MA plan data was not complete in time for a full impact analysis for this first report, they will be included in future reports.

Insurers	State
Aetna	PA
Geisinger	PA
Highmark	PA
IBX	PA
UPMC	PA
BCBSMA	MA
Fallon	MA
Tufts	MA
IUHP	IN

Medicare Advantage Value-Based Insurance Design Model

The Progress of the MA-VBID Model



Value-Based Insurance Design Model Interventions

2020 VBID Model Components and How it Differs from Standard MA Offerings

VBID Benefit Packages	VBID allows/requires	Standard MA
Wellness and Health Care Planning	VBID plans **must offer** enrollees **wellness and health care planning**, including advance care planning	Not required of standard MA plans
Telehealth Services	VBID Plans may rely on telehealth services to meet MA network adequacy requirements	Standard MA plans may not rely on telehealth services to meet MA network adequacy requirements
Medicare Advantage and Part D Rewards and Incentives Programs (R&I)	VBID plans may offer meaningful and focused MA and Part D R&I that more closely reflect the expected value of the health related service or activity (up to $600 annually)	MA/PD plans may ***not*** provide Part D R&I; standard R & I programs are only allowed under MA and may not exceed the value of the health-related service or activity
Supplemental Benefits	VBID plans may offer supplemental benefits that are not "primarily health related"	Supplemental benefits offered by MA plans must be "primarily health related," in that the benefit must "diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization"
Value-Based Insurance Design by Condition, Socioeconomic Status, or both	VBID plans may vary cost sharing or provide additional supplemental benefits based on health care condition and/or socioeconomic status ((i.e. low-income subsidy eligibility or dual-eligible)	Standard MA plans may vary cost sharing or provide supplemental benefits by plan benefit package, plan segment or by health care condition

Considerations and Implications for AAHKS