1. Do you have any comments on the guiding principles or focus areas?

Value-Based Insurance Design (V-BID) is a bipartisan approach to consumer cost-sharing that can enhance the patient experience, improve quality of care, and lower costs in the Medicare Program. The Medicare Advantage V-BID Model is designed with the tenants of clinical nuance, recognizing that 1) medical services differ in the amount of health produced, and 2) the clinical benefit derived from a specific service depends on the consumer using it, as well as when, where and by whom the service is provided. V-BID aims to make Medicare beneficiary cost-sharing more patient-centered, and thereby encompasses the Innovation Center’s 6 guiding principles: choice and competition in the market, provider choice and incentives, patient-centered care, benefit design and price transparency, transparent model design and evaluation, and small scale testing.

The Medicare Advantage V-BID model test was implemented to address cost and quality consequences of cost-related non-adherence for high-value medical services among Medicare beneficiaries. This non-adherence can be seen across the entire continuum of clinical care, including preventive screenings, clinician visits, and prescription medications. In settings with non-V-BID plans, the suboptimal use of high-value clinical services and providers can result in negative clinical outcomes and, in some clinical scenarios, higher aggregate costs to the Medicare program. These undesirable clinical and financial effects of cost-related nonadherence are more pronounced for individuals with multiple chronic conditions and/or the most financially vulnerable. V-BID focuses on aligning provider choice and incentives in a patient-centered model by encouraging the utilization of high-value providers and services based on specific patient needs. The targeting of enhanced benefit designs to members with defined clinical conditions provides Medicare Advantage plans the flexibility to be more consumer-centered, and aligned with ‘personalized’ medical delivery.

Applying clinically nuanced strategies in benefit design and payment reform presents an enormous opportunity for the Medicare program. Driven largely by the private sector, the implementation of V-BID in Medicare and other public programs (e.g., Medicaid and TRICARE) has garnered broad multi-stakeholder and bipartisan political support. In September 2017, the U.S. Senate Finance Committee unanimously passed S.870, Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act (CHRONIC) of 2017, a bipartisan bill that specifically calls for the expansion of the V-BID MA demonstration to all 50 states. Mirroring the Senate version of the legislation, Representative Diane Black (R-TN), along with cosponsors Earl Blumenauer (D-OR), Cathy McMorris Rodgers (R-WA), and Debbie Dingell (D-MI), introduced the V-BID for Better Care Act of 2017 (H.R.1995) in the House, which also seeks to provide national testing of the MA V-BID Model.

It is critical for reform efforts to have strong support from a variety of stakeholders and go hand-in-hand with a focus on quality. The MA V-BID model is aligned with other CMMI initiatives, particularly the guiding principles that inform the design of alternative payment models. Currently, these models offer a critical opportunity to combine both provider-facing initiatives and consumer-driven strategies, thereby improving consumer access to services on which their providers are benchmarked and financially rewarded for providing. V-BID offers an opportunity to align consumer and provider incentives, resulting in better care outcomes and smarter spending.

1) NEJM. 2008;358:375-383.
3) Health Affairs. 2014;33(8):1435-1443
2. What model designs should the Innovation Center consider that are consistent with the guiding principles?

On January 1st, 2017, the Center for Medicare and Medicaid Services (CMS) launched the Medicare Advantage Value-Based Insurance Design (MA V-BID) Model Test—a small-scale test to assess the utility of structuring consumer cost-sharing and plan elements to encourage the use of high-value clinical services and providers. Offered initially in 7 states (expanded to 10 states in 2018), the incorporation of V-BID principles is a viable and fiscally feasible option for Medicare that is consistent with the Innovation Center’s six guiding principles.

The implementation of clinically-nuanced benefit designs to copayments, coinsurance and deductibles, for the purpose of targeting high-risk or high-spending beneficiaries, would give Medicare Advantage plans a necessary tool to incentivize those individuals to visit high-performing providers and receive more clinically indicated high-value services. Through this alignment of patients’ out-of-pocket costs with the clinical value of services, V-BID increases the quality of patient-centered care by lowering the financial barriers to essential, high-value clinical services and subsequently reducing cost-related nonadherence for prescription drugs. We feel that a more engaged beneficiary is significantly more likely to receive coordinated, evidence-based care, leading to improved patient-centered outcomes, better quality and lower costs.

A key tenet of the V-BID demonstration is to provide MA plans greater flexibility to lower beneficiary cost-sharing for recognized high-value, evidence-based services, clinicians, facilities, and supplemental benefits. By offering plans these additional options, the V-BID model allows for immense choice, as participating organizations are able to decide on the manner and extent to which the V-BID demonstration will be implemented. Participating organizations can choose which services and providers are eligible for cost-sharing reductions as long as they are defined in advance and are available to all enrollees within the target population. As a result, this flexibility in plan design will increase market competition amongst participating plans and provide greater consumer choice.

The flexibility to target enrollee cost-sharing based on clinical information (e.g., diagnosis, clinical risk factors, etc.) is a crucial element to the safe and efficient allocation of Medicare expenditures. Thus, applying techniques that are successfully utilized in the commercial health insurance market into an MA V-BID model test plan offers an opportunity to increase utilization of evidence-based services, enhance patient-centered outcomes, lower aggregate health care costs, and reduce healthcare disparities among a target-rich population.

3. Do you have suggestions on the structure, approach, and design of potential models? Please also identify potential challenges or risks associated with any of these suggested models.

To successfully implement proposed V-BID models into plans that do not currently incorporate these principles, the Innovation Center should ensure that efforts focus on initiatives that apply V-BID principles to conditions and services with strong clinical evidence of material improvement in patient health status and enhance consumer awareness of services deemed high-value. Selected conditions should be paired with robust actuarial analysis that demonstrates a strong likelihood of realizing costs savings within the plan’s risk pool.

Because the practice of V-BID principles relies on strong patient engagement to fully realize health gains and cost savings, the Innovation Center should make the communication of cost-sharing reductions for high-value services a priority. These efforts would focus mostly on informing patients with selected conditions of these enhanced benefits. To date, marketing efforts of the MA V-BID demo are limited due to concerns regarding the possibility of adverse selection, such that a large influx of chronically ill beneficiaries would impact the evaluability of a plan’s ability to decrease spending. In order to better inform those who might benefit and mitigate adverse selection concerns, Medicare Advantage plans included in the demo should be permitted to

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focus marketing efforts on eligible patients already enrolled in selected plans. Special Needs Plans (SNPs) serve as examples of similar, successful models that already utilize marketing in practice. SNPs do not have to follow traditional Medicare Advantage marketing restrictions in favor of consumer education. In addition to consumer awareness of reduced cost-sharing for high-value services and providers, an integral part of informed-consumer decision making is a robust data forum that allows patients to easily access needed information. As a stipulation of adopting V-BID principles into plans, the Innovation Center should develop data transparency criteria for MA vendors, which leverage existing online patient platforms to increase awareness of potential cost-savings based on patient actions.

For example, existing patient platforms which contain data on current initiatives around value-based cost-sharing could be utilized to help inform consumer choice. Disease selection criteria should remain tied to evidence-based, actuarially-sound data that incorporates dynamic clinical nuance. The V-BID Center – in collaboration with Aetna – has researched conditions that have met this criteria, which include:

1. Diabetes Mellitus (DM)
2. Chronic Obstructive Pulmonary Disease (COPD)
3. Congestive Heart Failure (CHF)¹

To allow for evaluability of the quality improvement and cost savings impact of V-BID principles in Medicare Advantage plans, the Innovation Center should look to establish comparisons between V-BID plans and “control plans” that do not adopt value-based principles. Ideally, these plans would serve similar patient populations and provide otherwise comparable benefit structures, with the exception of selected V-BID applications. In addition to assessing the impact on individual and population health, such evaluations would focus on comparing the three primary cost-savings mechanisms realized when V-BID principles are applied: the shift effect, expansion effect, and offset effect.² Specifically, patient cost-sharing reductions should result in increased utilization of high-value services, and net-reduced costs for V-BID plans in comparison to control plans.

Previous proposals to apply V-BID principles to high-value prescription drug benefits have encountered concerns that savings for beneficiaries with high-drug costs would be immaterial to Medicare and patients, resulting in no meaningful change in patient incentives. Described as the “5% savings problem,” this refers specifically to beneficiaries who have high drug costs that surpass the coverage gap and are now covered as high-cost patients. Prior to implementing V-BID principles in plans utilized by this population, CMMI should evaluate how reductions in cost-sharing for high-value drugs will impact these patients’ adherence and consumer behavior. Enhanced marketing and data transparency efforts, combined with the implementation of a more nuanced prescription drug benefit, will further the success of V-BID’s MA applications.

2) IBID, p.13

5. How can CMS further engage beneficiaries in development of these models and/or participate in new models?

As health care expenditures continue to rise, it is increasingly important that CMS and individual MA plans focus on engaging beneficiaries as responsible consumers. MA beneficiaries have seen their out-of-pocket costs – including premiums and out-of-pocket cost-sharing at the point of service – grow in proportion to greater industry cost growth, making them more invested in their own health choices. Between 2011 and 2016, the average MA-PD plan’s out-of-pocket spending limit increased nearly $1,000 (from $4,281 to $5,257), leading many beneficiaries to look for ways to cut costs.¹ The V-BID MA Model Test offers a unique opportunity to implement consumer engagement practices that can help MA beneficiaries in making more
informed health care decisions. Participating plans encourage the use of high-value care, while realizing cost-savings, largely from preventing hospitalizations and emergency room visits. Two areas in which the V-BID MA Model Test may be improved to encourage beneficiary engagement and participation are marketing and plan incentives.

**Marketing**

Though considered in the design of the ongoing V-BID Model Test, participating plans are currently not permitted to market their V-BID benefits due to concerns of adverse selection and beneficiary confusion over eligibility. However, from the consumer engagement perspective, MA plans could further enhance their ability to serve beneficiaries if permitted to use clinically nuanced cost-sharing to promote value. As previously stated, these efforts should start with a focus on educating beneficiaries currently enrolled in participating plans with specified conditions, followed eventually by expanded marketing efforts to include members of the general public. Allowing plans to market their V-BID benefits would support transparency in benefit design and promote consumer choice and competition in the MA market.

Furthermore, marketing of benefits in the V-BID MA Model Test encourages beneficiaries to find plans that best suit their clinical and financial needs. Analyses of the potential impact of V-BID in MA suggest that beneficiaries with targeted, chronic conditions – including Diabetes Mellitus, COPD, and Chronic Heart Failure – would see both decreases in cost-sharing and improvements in clinical outcomes, if enrolled in V-BID plans.

With the potential for MA plans to benefit financially from these improved health outcomes, it is in the best interest of both payers and consumers to increase marketing efforts and enroll more beneficiaries in MA V-BID plans.

**Beneficiary Incentives**

By definition, V-BID uses beneficiary incentives to improve quality and reduce health care costs. V-BID uses the levers of traditional insurance design, including co-pays, deductibles, and co-insurance, to steer consumers toward higher value services and providers, depending on their health status and clinical needs. Such benefit designs have been shown to alter consumers’ utilization of services in several ways, including increased medication adherence and decreased emergency department admissions and hospitalizations.

Ultimately, V-BID principles, and the MA-VBID model test specifically, afford flexibility to MA plans in choosing which incentives to implement and flexibility to beneficiaries in choosing which incentives work best for them. A number of plan design tools can be used to incentivize patient behaviors in V-BID programs and achieve the MA V-BID Model’s goals of improving health outcomes and lowering expenditures for MA enrollees. However, current CMS regulations restrict the types of incentives that MA plans are able to employ in the MA V-BID Model Test to the following: 1) reduced cost-sharing for high-value services; 2) reduced cost-sharing for high-value providers; 3) reduced cost-sharing for enrollees participating in disease management or related programs; and 4) coverage of additional supplemental benefits. While cost-sharing reductions and supplemental benefits are an important component of value-based insurance design, additional examples of beneficiary incentives that have proven effective include:

- Premium reductions
- Deductible waivers
- HSA contributions
- Access to enhanced benefits or programs
- Other financial rewards (gift cards, raffle entries, etc.)

These types of incentives are currently either not permitted by CMS or not practiced in MA due to complicated approval processes for new benefit designs. Accelerating the approval of incentive designs and reducing the need for plans to apply for special considerations, such as anti-kickback waivers, would encourage greater innovation and flexibility in the MA V-BID Model Test.
Because V-BID differentiates between high- and low-value services and providers, and also adds the concept of medical necessity into the mix, consumers need to understand quality, price, and medical necessity. Thus, it is imperative that consumers understand how their benefit design relates to how much a given service can improve their health and are given access to transparent price information to help them choose which services and providers are right for them. Many studies have shown that health care purchasers can get better value for their health care dollars when they create benefit designs that couple consumer incentives with quality and price transparency. For example, if a V-BID plan eliminates co-payments for diabetes medication, testing supplies, and eye examinations, consumers should also get information about why those services are important and why the cost has been reduced. Disclosing this information to beneficiaries encourages cost- and health-conscious decision making in the context of a complicated health care system.

Engaging beneficiaries in choosing the plans, providers, and services that are best for them is an integral step in improving quality and reducing aggregate costs in any health care delivery system. In the context of the MA V-BID demo, beneficiary engagement through transparent benefit marketing and incentive design is necessary for MA V-BID plans to realize their full quality improvement and cost-saving potential. By combining transparency with consumer incentives, more appropriate care will be provided in the most appropriate venue, and both beneficiaries and plans will benefit.


7. Are there any other comments or suggestions related to the future direction of the Innovation Center?

Many of the ongoing value-based CMMI programs focus on either provider-facing (e.g. ACOs) or beneficiary-facing (e.g. V-BID) initiatives. The alignment of consumer and provider incentives around coordinated, evidence-based care can provide a framework to enhance the patient experience, improve quality, and allow more efficient expenditures of our increasingly scarce health care dollars.