



**Value-Based Benefit Design for Medicare  
Advantage, Managed Medicaid and Duals**

*Presented by RAM Technologies, Inc.*



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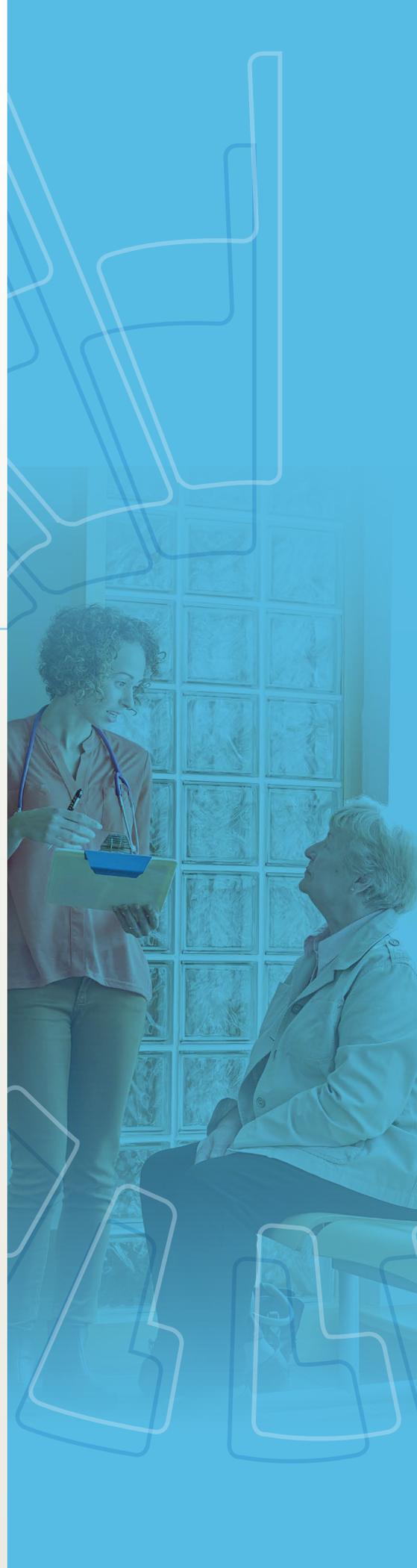
**P**OLICYMAKERS, PROVIDERS AND PAYERS all see value-based healthcare as one of the best mechanisms for reducing costs while improving patient health outcomes. Although performance-linked models show promise, they are not enough on their own. Value-based care is most effective when payers work in partnership with providers, and when cost-effective care choices are incentivized on all sides. Carefully designed, evidence-based payer plans combined with the proper technology have the potential to do just that.

## **MOMENTUM FOR VALUE-BASED CARE** <sup>1,2,3,4</sup>

Because a relatively small population of patients—many covered by Medicare, Medicaid or both—accounts for a significant proportion of healthcare spending, these segments are a natural target for intervention. There is a clear need for efficiency in treating these patients, yet the fee-for-service delivery model encourages duplication of services and provision of unnecessary care while doing little to address the nonadherence and preventable conditions that account for much of the cost.

Insurance plans that reduce cost-sharing for targeted care have consistently realized improved adherence and success in addressing preventable conditions, all without driving up costs. Public programs are exploring ways of applying this concept.

In 2017, the Centers for Medicare and Medicaid Services kicked off a five-year program to test whether value-based insurance design (VBID) can improve outcomes and reduce spending in Medicare Advantage. The pilot began in seven states, with three more states to be added in the program's second year. Medicaid programs are also experimenting with value-based benefit design, with a particular focus on dual-eligibles. The evidence supporting this trend is clear.



## INCENTIVES FOR PAYERS AND PROVIDERS <sup>5, 6, 7, 8, 9, 10</sup>

VBID goes beyond simple pay-for-performance by employing financial incentives and deterrents to encourage the use of evidence-based healthcare. For example, plans that cover preventive care and medications for chronic conditions at low to no cost steer subscribers toward healthy behaviors and save money by averting future medical procedures. Likewise, high cost-sharing can be used to steer subscribers away from unnecessary or duplicate services and other low-value care.

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VBID can also promote cost-effective behavior on the provider side. “One thing that does make medicine turn on a dime is when third-party payers reward certain actions,” says Dr. Amesh Adalja, a senior associate at the Johns Hopkins Center for Health Security. “For conditions like heart attacks and strokes, a surefire path to reward and recognition is through payment models that depend upon following evidence-based practices,” Adalja says. The American College of Physicians also backs the approach, explicitly endorsing VBID, particularly for vulnerable populations.

## THE CRITICAL ROLE OF PARTNERSHIPS <sup>11, 12, 13</sup>

Because VBID prioritizes evidence-based care, it is clear that engaging clinical decision makers is key to success. Providers and carriers share goals related to market share and patient outcomes that present an opportunity to forge mutually beneficial partnerships. For example, providers may be hesitant to accept financial risk in emerging delivery models if patients are free to seek care elsewhere. Pairing a network structure with high-value plans can encourage patients to stay with their network practice, giving providers the confidence they need to invest in new delivery models as well as leverage to make a difference in patient outcomes. Meanwhile, the structure reassures payers that patients are likely to seek care where value is highest.

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Payers can support these partnerships by providing resources that doctors often lack but truly need for effective value-based care, such as access to member data, tools to support engagement, transparency technology and more. Other options for support include assisting as providers phase in new processes and technologies or co-investing in technology to ease the burden of transformation. These steps provide the necessary framework for value, and providers, patients and payers themselves will benefit.

## THE HEALTH PLAN CIO IS CENTRAL TO VBID AND DELIVERY TRANSFORMATION <sup>14</sup>

Technology is the linchpin to effective VBID. In addition to supporting providers with a general value framework, IT tools are critical to development of value-based plans themselves. Insurers must use evidence-based data to determine which services are the most effective and cost-efficient, and to determine the appropriate levels for incentives and disincentives.



Cost-sharing must be carefully set to promote high-value care without encouraging overuse, and to discourage the use of low-value care without creating barriers to needed care. VBID must then be integrated into existing systems such as auto-adjudication and other claims technology. Every process and system must support this effort.

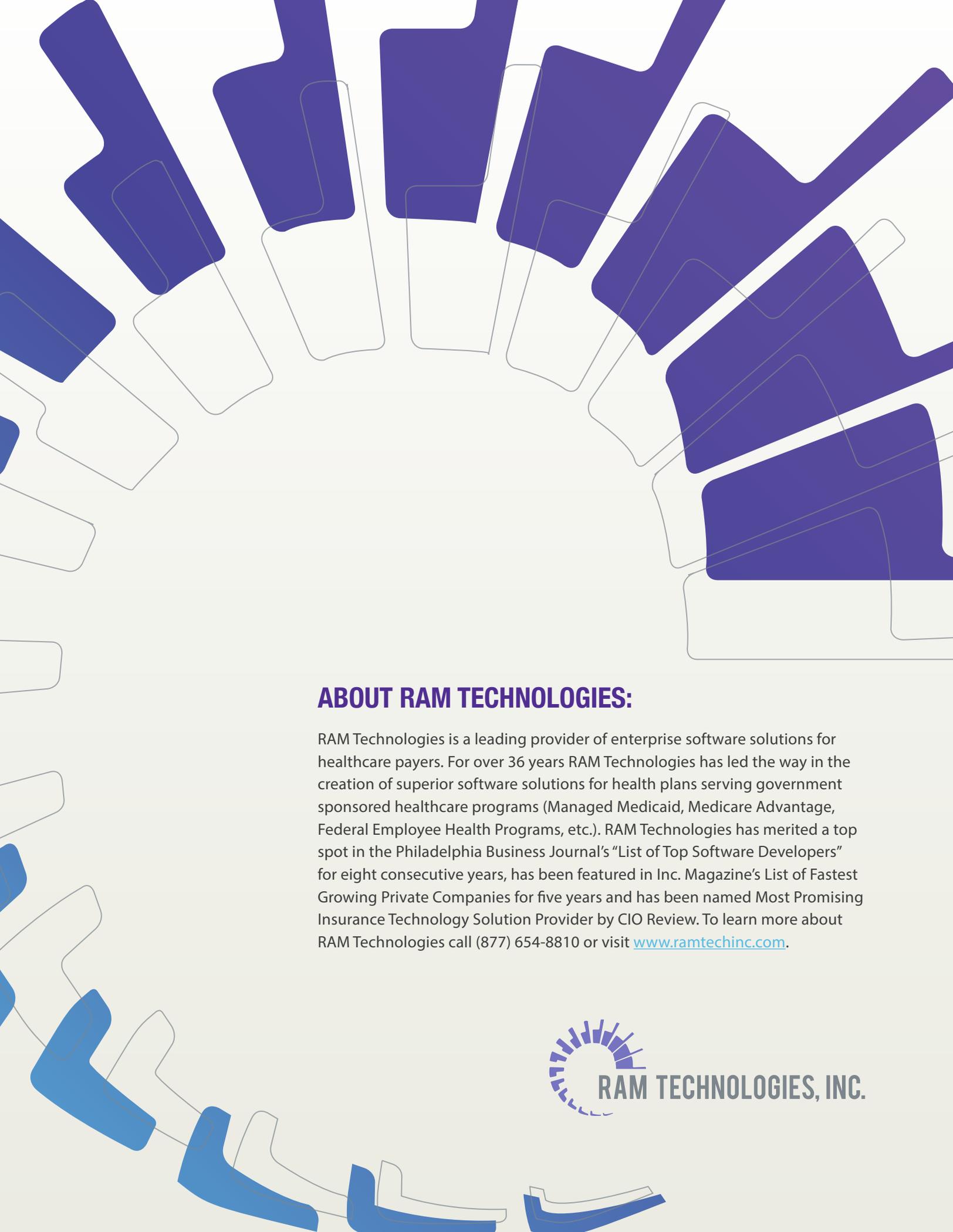
VBID offers potential for significant ROI by incentivizing services that meet the goals of better quality, lower costs and improved satisfaction. But VBID will deliver only if plans can develop the capacity to account for the unique needs of their populations, the characteristics of their provider base and their own early successes and failures. A sensitive framework for analyzing and responding to evidence, plus supporting tools for success will pave the way for value-based design that works for the plan, the provider and the patient.

VBID is the next step on the journey to value-based healthcare in the US. Well-crafted, evidence-based incentives and deterrents align payers' and providers' goals while improving patient health and reducing waste. Payers that employ VBID and build supporting partnerships with providers will accelerate the move to value-based care and reap the rewards in the process.

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