Center for Medicare & Medicaid Innovation
Request for Information on Health Plan Innovation Initiatives at CMS

Agency/Office: Department of Health and Human Services
Centers for Medicare & Medicaid Services (CMS)
Center for Medicare and Medicaid Innovation (CMMI)

Type of Notice: Request for Information (RFI)

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is seeking input on initiatives to test innovations in (1) plan design, including but not limited to value-based insurance design (VBID); (2) care delivery; (3) beneficiary and provider incentives and engagement; and/or (4) network design in Medicare health plans and Medigap and Retiree Supplemental health plans. CMS seeks input from stakeholders about their experiences with and perspectives about the following types of products that are made available to Medicare and/or Medicaid beneficiaries:

1. Stand-alone Medicare Prescription Drug Plans (PDPs)
2. Medigap and Retiree Supplemental health plans
3. Medicare Advantage and Medicare Advantage Prescription Drug (MA and MA-PD) plans
4. Medicaid managed care plans (Medicaid plans)

DATES: *Comment Date:* To be assured consideration, comments must be received by November 3, 2014.

ADDRESSES: Comments should be submitted electronically to HealthPlanInnovationRFI@cms.hhs.gov.

FOR FURTHER INFORMATION CONTACT: HealthPlanInnovationRFI@cms.hhs.gov

Respondents are encouraged to provide complete but concise responses to the questions listed in the sections outlined below. Please note that a response to every question is not required.

BACKGROUND: Section 1115A of the Social Security Act, as added by Section 3021 of the Affordable Care Act, created the Center for Medicare and Medicaid Innovation (the "Innovation Center") and authorized the Secretary of Health and Human Services to test models of innovative payment and service delivery that have the potential to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries.

Health plans increasingly have responded to market developments and fiscal pressures with innovations in care delivery, plan design, beneficiary and provider incentives, and network design. Though evidence suggests that these innovations may reduce cost, improve quality, and enhance beneficiary satisfaction, adoption of some of these innovations has been limited in stand-alone Medicare Prescription Drug Plans (PDP), Medicare Advantage (MA) and Medicare

Advantage Prescription Drug plans (MA-PD), Medicaid managed care plans (Medicaid plans), Medigap plans, and Retiree Supplemental health plans.

CMS is interested in in exploring the potential of models to test innovations in PDPs, MA and MA-PD plans, Medigap and Retiree Supplemental plans, and Medicaid plans, related to (1) plan design, including but not limited to value-based insurance design (VBID); (2) care delivery, (3) beneficiary and provider incentives; and/or (4) network design. Testing models of these types of innovations will require collaboration with health plans, states, and other stakeholders. These models will complement the Innovation Center's existing portfolio of models that use innovative methods of payment to improve health care quality and reduce costs. For more information on the Innovation Center's models, please see http://innovation.cms.gov.

CMS seeks responses to this RFI from beneficiaries, health plans, states, employers, providers, research and policy experts, industry associations, professional associations, advocacy organizations, and other members of the public. There are four sections in the RFI:

I. PDPs
II. Medigap plans and Retiree Supplemental plans
III. MA and MA-PD plans
IV. Medicaid plans

CONTACT INFORMATION: Please provide the name and address of the commenter.

QUESTIONS: Commenters are requested to provide responses to the following questions that are most relevant to their interest and experience. ***A response to every question is not required.***

Section I: Stand-alone Medicare Prescription Drug Plans (PDPs)

Medicare Part D Prescription Drug Plan (PDP) sponsors have flexibility in designing benefits for PDPs, including the ability to establish formularies (subject to CMS formulary and benefit rules), determine the cost sharing structure other than the statutorily defined structure (subject to certain actuarial tests), and to offer supplemental benefits (subject to CMS benefit rules). While the Part D program has been successful in keeping beneficiary premiums stable, and certain PDP sponsors have demonstrated some success in promoting medication adherence and improving drug therapy through medication therapy management programs, we are interested in learning whether additional flexibility would further control costs and improve quality.

CMS is considering a PDP model that will test the impact of robust medication therapy management (MTM) programs and cost sharing differentials that effectively target Part D

beneficiaries and will better coordinate care, manage health care costs, and improve outcomes. Research based on private sector drug plans for commercial populations suggests success in moderating expenses and improving health outcomes through the use of tools such as evidence-based benefit design, drug comparative effectiveness research, and financial incentives. These programs could involve strategies that vary the intensity and delivery of MTM services based on beneficiary risk level, and could provide reinforcing financial incentives, including beneficiary/provider incentives and performance-based payment to stand-alone PDPs, based on total cost of care.

1. If you offer a Medicare PDP:
   - Do you offer MTM services to a broader population than required by 42 C.F.R. § 423.153(d) – Medication Therapy Management Program (which details population eligibility requirements for MTM)? Please choose:
     If yes, please describe.
   - Do you employ value-added services that go beyond the requirements in 42 C.F.R. § 423.153(d) – Medication Therapy Management Program? Please choose:
     If yes, please describe.
   - Do you have an interest in expanding or continuing to expand your MTM programs? Please choose:
     Why or why not?
2. What challenges do you see, if any, within the current MTM program and/or benefit structure guidelines?
3. Do you recommend greater flexibility for MTM targeting and/or service requirements under an enhanced MTM program to improve outcomes for beneficiaries and Medicare? Please choose:
   If yes, what revisions would you recommend?
4. If CMS were to develop a PDP model test combining MTM strategies and financial incentives, how would you recommend this model be designed? Please include a description of how (by what mechanism) your proposed model design will produce net savings and preserve or enhance quality. Consider quality/outcomes measures, beneficiary protections, financial incentives, and partnership and/or implementation timelines.

5. If you are a PDP sponsor, would your organization consider or have a possible interest in participating in such a model test if it were developed by CMS? Choose one:
   What factors would influence your decision?

6. Are there any other issues or factors that CMS should take into account when considering collaboration with PDPs to develop a model that combines MTM strategies, risk stratification, differential cost sharing, and financial incentives?

7. Would it be useful to test the success of these initiatives among MA-PD plans? What aspects might be different between a model test in MA-PD versus stand-alone PDP?

8. Are there any other innovations in Part D that you would like to see tested by CMS? If so, please describe.

Section II: Medigap and Retiree Supplemental health plans

Supplemental insurance pays for some of the health care expenditures that Original (fee-for-service) Medicare does not cover, such as deductibles, coinsurance, and inpatient days beyond certain covered limits. Supplemental insurance coverage includes Medigap, which is purchased by individual Medicare beneficiaries from private insurance companies, and retiree group health (Retiree Supplemental), which is provided to some Medicare beneficiaries by their former employers or unions (or their spouse's former employers or unions).

Medicare is generally the primary payer in these circumstances and bears the lion's share of Medicare beneficiary health costs. Thus, in contrast to other private health plans, some stakeholders have identified the generally limited incentives Medigap and Retiree Supplemental plans have to manage the cost and quality of care, despite the higher average total cost of care associated with their enrollees compared to beneficiaries with no supplemental coverage.

CMS is exploring potential initiatives to collaborate with Medigap and Retiree Supplemental plans on models to manage the care of complex, high-cost beneficiaries.

9. If you are an insurance company or an employer that offers a Medigap or Retiree Supplemental plan, do you currently have (or have you had) any specific program(s) that provide case management and related care coordination services to manage the cost of care, qualitv of care. and/or the health of your Medigap or Retiree Supplemental plan enrollees? Choose one:
   If yes, please describe the elements of the program(s). Please include details on the

qualifications of the practitioners providing these services, as well as any state regulatory filings and approvals required to provide these programs.

10. If CMS were to develop a model test in Medigap or Retiree Supplemental health plans to provide case management and related care coordination services to high-cost, medically-complex beneficiaries, how would you recommend this model be designed? Please include a description of how (by what mechanism) your proposed model design would produce net savings and preserve or enhance quality. Consider quality/outcomes measures, beneficiary protections, financial incentives, population characteristics, and partnership and/or implementation timelines. Please include information about how CMS could coordinate with state regulators for Medigap plans.
11. If CMS were to develop such a model test, what support from CMS would be necessary to make participation attractive to insurers and employers (e.g. financial, operational, data support)? For Medigap, what support could CMS provide in coordinating with state regulators?
12. Are there any other issues or factors that CMS should take into account when considering possible opportunities to collaborate with Medigap and Retiree Supplemental plans to develop programs to provide case management and related care coordination services to beneficiaries?
13. Are there any other innovations that you would like CMS to consider with regard to Medigap and Retiree Supplemental plans? If so, please describe.

Section III: Medicare Advantage and Medicare Advantage Prescription Drug (MA and MA-PD) Plans

MA and MA-PD plans are privately-run managed care plan options for Medicare beneficiaries. The number of Medicare Advantage enrollees has grown steadily since the launch of the program and currently account for approximately 30% of the Medicare population. CMS is considering a potential model(s) to test innovations in MA and MA-PD health plan design for Medicare beneficiaries, including:

- Value-based insurance design focused on beneficiary health status
- The inclusion of remote access technologies beyond what is covered by Original Medicare in the basic benefit package

- The integration of hospice care benefits concurrently with curative care in the basic benefit package
- Other potential model opportunities

Value-Based Insurance Design (VBID)

Commercial plans use VBID to incentivize beneficiaries with specific health conditions to use high-value (high-quality, low-cost) health care services and/or providers.

CMS is researching the potential for allowing MA and MA-PD plans to offer VBID approaches to encourage beneficiaries with specific chronic conditions to seek high-value care through cost sharing incentives, including changes in cost sharing, such as co-pays, deductibles, and/or maximum out-of-pocket (MOOP) costs, and reduced premiums.

14. Would you recommend that CMS implement a model test that would allow VBID for beneficiaries with specific chronic conditions? Choose one:
    Why or why not?

15. What factors and design principles should CMS consider if it were to develop such a model test? Some potential factors to consider are which chronic conditions and characteristics of the population to target, which quality measures to track, and what beneficiary protections to include.

16. What changes in cost sharing elements, such as co-pays, MOOPs, deductibles, and/or premiums, (cost sharing) should be varied and what would be the intended impact of these changes? Should there be any restrictions on the magnitude of such changes? What existing requirements or standards present a barrier to implement such changes?

17. Please include a description of how (by what mechanism) your proposed model design would produce net savings to CMS without adversely impacting patient care or outcomes.

18. Are there other flexibilities or changes to Medicare policies or regulations (in addition to changes to cost sharing) that you believe could enhance plans' abilities to successfully implement VBID?

19. If you operate MA and MA-PD plans and your organization were interested in submitting a VBID design through a model such as the one described above, how much lead time would your organization need to prepare the bid given the need to submit annual bids in June of each year?

20. Are there other considerations that CMS should take into account when designing a VBID model?

Remote Access Technologies

Technologies that enable health care providers to furnish care to patients in locations remote from providers are increasingly used to complement and supplement face-to-face patient-provider encounters. The use of remote access technologies as a care delivery option for MA enrollees may improve the accessibility and timeliness of needed care, increase communication between providers and patients, and enhance care coordination. However, the statutory coverage parameters for telehealth services covered by Original Medicare limit the range of remote access technologies that may be offered in the basic benefit package. As a result of this limitation, some MA and MA-PD plans use their rebate dollars to cover a broader array of remote access technologies as mandatory supplemental benefits.

21. What factors should CMS consider if it were to develop a model test that allows plans to include a broader range of remote access technologies in the basic benefit package, beyond the telehealth technologies that are covered in Original Medicare? In your response, please consider the technology mode (e.g. real time interactive audio and video telecommunications, asynchronous store-and-forward technology, remote monitoring, etc.), services to be covered (e.g. CPT codes), quality and outcomes metrics, beneficiary protections, and additional design factors you think are important.

22. Please include a description of how (by what mechanism) your proposed model design would produce net savings to CMS without adversely impacting patient care or outcomes.

23. If CMS were to implement a model that allows plans to include a broader range of remote access technologies in the basic benefit package, and your organization was interested in participating in such a model, how much lead time would you need to prepare the bid in view of the June bid cycle? What (if any) advantages would be associated with including remote access technologies in the basic benefit package, as opposed to offering such technologies as a supplemental benefit?

Hospice Care

Currently, the Medicare hospice benefit is "carved out" of the MA and MA-PD benefit package. When an eligible MA beneficiary elects the hospice benefit, all Medicare-covered services the beneficiary receives while in hospice care are covered by Original Medicare. Consequently, Medicare beneficiaries are required to forgo curative care to receive access to palliative care services offered by hospices. CMS is researching interest in approaches that would give participating MA and MA-PD plans the option to offer hospice benefits concurrently with curative care to plan enrollees.

24. What factors should CMS consider if it were to develop a model that integrates hospice benefits concurrently with curative care in the MA population? In your response, please consider quality and outcomes metrics, beneficiary protections, and any other design factors you think are important.

25. If CMS were to implement a model that allows plans to integrate hospice benefits concurrently with curative care in the MA populations, and your organization was interested in participating in such a model, how much lead time would you need to prepare the bid in view of the June bid cycle?

Other Potential Innovations

26. Is there anything CMS should do to enable cooperation and better care coordination between provider organizations such as ACOs and MA and MA-PD health plans?

27. Are there other innovations not described above that you would like to implement in MA and/or MA-PD, but cannot because of regulatory or other structural barriers?

    Choose one:

    If so, what are those innovations and/or barriers (e.g., please be specific about the regulatory, financial, and/or marketing constraints)? Please describe how these innovations would produce net savings to CMS without adversely impacting patient care or outcomes.

Section IV: Medicaid Managed Care

Medicaid has a long history in managed care for selected segments of service delivery and for some Medicaid populations. Fifty-one percent of Medicaid beneficiaries are enrolled in comprehensive risk-based managed care plans. Moreover, in implementing the expansion of Medicaid authorized by the Affordable Care Act, a number of states have elected managed care delivery systems.

28. Would you recommend that CMS implement a Medicaid managed care model test in any of the areas listed below? Choose one:
    - o Pharmacy and medication therapy management
    - o Value-based insurance design (as described in Section III)
    - o Remote access technologies
    - o Hospice care
    - o Long term services and supports
    - o Behavioral health
    - o Provider incentive arrangements such as accountable care organizations

    Why or why not?

29. Please describe any other areas not listed above that you would to like CMS to test in Medicaid managed care.

30. What factors and design principles should CMS consider if it were to develop a model in the areas of interest that you identified above? In responding to this question, please first list the area for model development. Some potential factors to consider are characteristics of the population to target, which quality measures to track, and what beneficiary protections to include.

31. Please briefly describe significant regulatory or other structural barriers (e.g., contractual, financial, market constraints) that you believe impede innovation in your identified areas of interest. In responding to this question, please first list the area for model development.

32. Please briefly describe how innovations in the areas that you described above would produce net savings to CMS. In responding to this question, please first list the areas for model development.

33. Please briefly describe successful models in states that are implementing incentives for plans in promoting value based purchasing, such as withholds or other financial incentives in the contract between states and managed care plans.

34. Please briefly describe successful efforts in states that are promoting alignment of provider incentives and quality metrics across managed care plans, as well as fee-for-service, including contract provisions between managed care plans and providers.

SPECIAL NOTE TO RESPONDENTS: Whenever possible, respondents are asked to draw their responses from objective, empirical, and actionable evidence and to cite this evidence within their responses.

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY. This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal, applications, proposal abstracts, or quotations. This RFI does not commit the Government to contract for any supplies or services or make a grant award. Further, CMS is not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request.

Please note that CMS will not respond to questions about the policy issues raised in this RFI. CMS may or may not choose to contact individual responders. Such communications would only serve to further clarify written responses. Contractor support personnel may be used to review RFI responses.

Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become Government property and will not be returned. CMS may publically post the comments received, or a summary thereof.

PRIMARY POINT OF CONTACT:

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