

V-BID GUIDING PRINCIPLES

The V-BID guiding principles serve as the foundation from which V-BID plans should be built. The template reflects these principles, and the implementation and communication strategies provide guidance around how to implement a plan design that incorporates these principles. The principles were developed with input from the V-BID Consortium.

1. V-BID options are clinically nuanced, i.e. medical services differ in the benefit provided and the clinical benefit derived from a specific service depends on the patient using it, as well as when, where, and by whom the service is provided.
2. V-BID options should be flexible, allowing for adoption of select provisions, or all provisions, in order to meet diverse employers' needs and readiness for adoption.
3. V-BID is promoted as part of a comprehensive approach to benefit design that also includes provider-side reforms (e.g. value based payments, alternative payment methodologies, etc.).
4. V-BID options recognize that that all health plans must comply with state and federal regulations, including mental health parity regulations and health plan nondiscrimination laws.
5. V-BID plans are implemented as part of a consumer-centric approach that incorporates:
 - a. A collaborative care model focused on quality and accessibility of high value providers, effective patient communication, and shared decision making between the provider and patient;
 - b. Alignment of consumer benefits and incentives with provider incentives;
 - c. Health navigation services and coordination of community services across the care continuum; and
 - d. Consumer engagement strategies that provide patients with resources and education materials on V-BID, *Choosing Wisely*[®] examples of low value services, health monitoring tools, and flexible communication methods.
6. In this initial phase, high-value providers are identified using transparent cost and quality of care metrics.² Future iterations may measure other dimensions, such as provider accessibility, patient-centeredness, and care collaboration. In identifying high value providers:
 - a. Method is transparent;
 - b. Data are shared with providers;
 - c. Definition of high value includes both cost of care and quality of care;
 - d. Cost should not be determined solely as price, but rather as a reflection of total cost of care (incorporating both price and utilization rates);
 - e. Quality measurement should use validated and accepted measures; and
 - f. Quality measures should address clinical quality and patient experience, as well as other domains that are accepted as valid and important.
7. V-BID recommended options are varied for different types of employers to help meet employers where they are at and promote specific V-BID benefits for various employer types and cultures.
 - a. V-BID options take into account various employer perspectives, including recognizing regulatory barriers for innovative plan design, and how V-BID designs may affect short and long-term cost savings and Return on Investment.
 - b. Examples of V-BID variations may include small group v. large group, self-insured v. fully insured, employers with Health Reimbursement Account or Health Savings Account-eligible High Deductible Health Plans v. traditional cost sharing models.

² While this initiative does not define the specific metrics that should be used to identify high value providers, the concept of high value provider is being constructed by the CT SIM Quality Council under the guidance of the CT SIM Steering Committee, including specific criteria for measuring providers. Refer to Appendix E on page 44 for the complete criteria under consideration.