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Medicare Advantage Value-Based Insurance Design (VBID) Model Update

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CMS Innovation Center Statute

The Innovation Center was established by section 1115A of the Social Security Act.

"The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles."

Three scenarios for success outlined in the Statute:

1. Quality improves and costs are neutral
2. Quality neutral and costs are reduced
3. Quality improves and costs are reduced (best case scenario)

If a model meets one of these three criteria and other statutory prerequisites, the Statute allows the Secretary to expand the duration and scope of a model through rulemaking.

MA Value-Based Insurance Design (VBID) Model Update

- History and Goals of the VBID Model
- 2020 VBID Model Components & Updates
- 2021 VBID Model Component: Deep Dive on Hospice

Goals of the VBID Model

- Testing a broad array of complementary MA health plan innovations designed to:
  1. Reduce Medicare program expenditures
  2. Enhance the quality of care for Medicare beneficiaries, including those with low incomes such as dual-eligibles, and
  3. Improve the coordination and efficiency of health care service delivery
- The VBID Model contributes to the modernization of Medicare Advantage and tests whether these model components improve health outcomes and lower expenditures for Medicare Advantage enrollees.

VBID Model Overview

- **2017**
  - The VBID model began testing the impact of providing eligible MAOs the flexibility to offer reduced cost sharing or additional supplemental benefits to enrollees with select chronic conditions, as determined by CMS, on health outcomes and expenditures.
- **2018**
  - CMS updated the model test to include Alabama, Michigan, and Texas. VBID also included dementia and rheumatoid arthritis as interventions.

VBID Model Overview (cont.)

- **2019**
  - CMS allowed organizations in 15 additional states to apply (CA, CO, FL, GA, HI, ME, MN, MT, NJ, NM, NC, ND, SD, VA, and WV) MAOs were allowed to: 1. Utilize CMS-defined chronic conditions or 2. Propose a targeting methodology
- **2020**
  - Bipartisan Budget Act of 2018 (BBA) allowed eligible MAOs in all 50 states and territories to apply for one or more of the health plan innovations being tested in the VBID model
  - Coordinated care plans (CCPs) – including HMOs and regional PPOs – were able to apply to VBID
  - Regional Preferred Provider Organizations (RPPOs) were able to apply to VBID for 2020
  - Dual Eligible Special Needs Plans (D-SNPs) and Institutional Special Needs Plans (I-SNPs) were able to apply to VBID for 2020

2020 VBID Model Components

- Value-Based Insurance Design by Condition, Socioeconomic Status, or both
- Medicare Advantage and Part D Rewards and Incentives Programs
- Telehealth Networks
- Wellness and Health Care Planning

2021 VBID Model Component

- Through the VBID model, CMS is testing the incorporation of the Medicare Hospice Benefit into MA beginning in 2021 to:
  1. Improve quality and access by increasing appropriate and timely access to care, promoting better care coordination for beneficiaries who choose MA and elect the Medicare Hospice Benefit; and
  2. Enable innovation by fostering partnerships between MA organizations and hospice providers that lead to improved beneficiary experience through a more seamless and integrated continuum of care

How MA Enrollees Access Hospice Today

Coverage for MA-PD Enrollees who Elect Hospice

	FFS Medicare covers	MA-PD covers
Before hospice enrollment		• All Part A, Part B, and Part D services, and any supplemental benefits
MA-PD enrollee elects hospice	• Hospice • Part A and Part B services unrelated to terminal condition	• Part D drugs unrelated to terminal condition • Any supplemental benefits (e.g., reduced cost sharing)
MA–PD enrollee disenrolls from hospice	• Until the end of the month, all Part A and Part B services	• All Part D drugs • Any supplemental benefits (e.g., reduced cost sharing) • Beginning the next month after disenrollment, Part A and Part B services

Source: MedPAC Report to Congress 2014

Current Medicare Hospice Experience

	2000	2017
Election	22.9% of decedents	50.4% of decedents
Length of stay (days)*	Average: 53.5 Median: 17	Average: 88.6 Median: 18
Total Medicare payments	$2.9 billion	$17.9 billion
Beneficiaries	534,000	1,492,000

**Substantial variation in length of stay related to a range of factors and across organizational types*

Source: Medicare Payment Advisory Commission. Report to Congress: Medicare Payment Policy, March 2019.

Furthering the Care Continuum as a Platform for Better Care and Innovation

Vision

Beneficiary access to a seamless and integrated care continuum whether receiving care through MA or Original Medicare (also referred to as "Fee-For-Service" (FFS))

Core Characteristics of Care Continuum

- Accountable to reduce gaps in care caused by fragmentation of responsibility
- Seamless connection to care and supportive services
- High-quality, integrated, and person-centered care
- Focused on bridging beneficiary needs and marshaling and integrating the resources to meet those needs
- Respects beneficiary choice – seeks to enable and support shared decision-making with beneficiaries and their families

Vision for this Component of the Voluntary Model Test

Respects and supports access to the beneficiary's election of hospice benefits and choice of hospice provider, while drawing on the strengths of MA to integrate and bridge forms of care

Pulls upstream a broader range of palliative and supportive care services

Creates better awareness of and access to hospice geared toward supporting beneficiary choice

Reduces issues seen in both "tails" (i.e. short and long lengths of stay issues)

Realigns incentives to support concurrent care as part of a care transition where appropriate

Reflects a partnership between MA plans and hospices, with the model by the CMS Innovation Center

Direction

In developing this model test, the CMS Innovation Center engaged with stakeholders for guidance on goals important to them:

Beneficiaries

- Maintain full scope of hospice services under current benefit and beneficiary choice
- Have greater awareness, access to, and understanding of all care options

Hospices

- Are given a platform to support meeting patient needs through enhanced collaboration with plans and other providers
- Have an opportunity to showcase role of hospice and upstream palliative and supportive services

MA Organizations

- Are the point of accountability and hub for ensuring robust access to seamless continuum of care

Key Policy Considerations for CY 2021 VBID Hospice Benefit

Beneficiary Access

- Ensuring beneficiaries access hospice consistent with their preferences and eligibility, and addressing short and long length of stay issues
- Providing access to and choice of hospice care for MA enrollees in model-participating plans

Payment

- Ensuring both financial stability and sustainability for MA plans and hospice providers, as well as creating opportunities for innovation

Quality

- Measuring and monitoring to ensure that MA hospice beneficiaries are receiving appropriate and high-quality care

Evaluation

- Evaluating the impact of the model on cost and quality, consistent with the CMS Innovation Center's mission and statutory requirements

Collaborative Approaches for Plans and Hospices

- Consideration of different approaches for collaboration and ways in which the CMS Innovation Center can facilitate

Questions?

Please visit the VBID Model Website for more information and announcements:

https://innovation.cms.gov/initiatives/vbid/

Please email all questions to:

VBID@cms.hhs.gov