RFA Webinar Transcript

Thursday, February 23, 2023

John Cialek:
Hello. Welcome to today's webinar overview of the 2024 Request for Applications, the Hospice Benefit Component Payment Methodology and Application Process. At this point, I'd like to pass to Sibel Ozcelik to get us started with introductions.

Sibel Ozcelik (SO):
Hello everyone thank you for joining us today where we'll we will provide an overview of the Value-Based Insurance Design, or VBID Model, for calendar year 2024. We are so excited to be at this stage, talking to you all about what's in store for 2024. My name is Sibel Ozcelik, and I'm the Deputy Director of the Division of Health Plan Innovation within the Seamless Care Models Group within CMMI. [00:00:56]

Now, before digging in, I want to do my favorite slide which is putting out a disclaimer that this presentation is for educational purposes and general information sharing only, as noted here. Also, I see a couple of questions already coming in the chat. We'll be posting slides and a recording of this presentation on the VBID Model website in the coming weeks. Now, I'll just take a moment here to walk through the agenda that we have in store for you all today. So today we've designed a session to provide attendees with an overview of the VBID Model for CY 2024, calendar year 2024, including what has changed from calendar year 2023. [00:01:42]

As part of today's session, after providing this high-level overview, we'll hear a presentation from the Office of the Actuary on the preliminary actuarial payment methodology for the VBID Model cost-benefit component. We'll then take a moment and shift gears, and review the 2024 application timeline and process. We'll discuss some of the technical assistance opportunities that we have available, as well as applicant resources. And then at the end of our webinar, or informative session of the session of the webinar, we'll offer attendees an opportunity to ask questions during our interactive Q and A, or question and answer session. [00:02:28]

I'm so thrilled to be here today presenting alongside the leads of the VBID Model as shown here, as well as our amazing colleague, Richard Coyle, from the Office of the Actuary. I'd let our Model leads introduce themselves, but no introduction is necessary as they are - as many of you know - incredible beyond words. So, let's dive in to the overview of the VBID Model, and I'll now pass it over to one of the wonderful VBID Model leads, Michael de la Guardia.

Michael de la Guardia (MG):
Thanks, Sibel. As mentioned, I'm Michael de la Guardia, I'm one of the VBID Model co-leads. Before diving straight into the model, let's start with CMMI's mission. CMMI was established by statute to test innovative payment and service delivery models to reduce costs and improve quality. Models that improve quality without increasing costs, reduce costs without negatively affecting quality, or that both improve quality and reduce cost can be scaled by the secretary. [00:03:44]

Through the voluntary VBID models, CMS is testing a broad array of complementary MA health plan innovations designed to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries, and improve the coordination and efficiency of health care service delivery. You'll hear more about how the Model can be used focused on certain beneficiaries like those with low income (such as dual-eligibles) in a bit. Eligible MAOs can choose to apply with their Plan Benefit Packages, PBPs, in all 50 states and territories. And just noting that this Model began in 2017 and is currently set to be tested through 2024. [00:04:37]

So we've seen steady growth in participation in the VBID Model over time. In 2017, we began with nine MAOs in three states. Moving forward to 2022, participation increased to 34 MAOs in 49 states and Puerto Rico. And this year, in CY 2023, we currently have 52 MAOs participating in 49 states, D.C. and Puerto Rico. The CMS Innovation Center tests a number of innovative models, but we thought it would be helpful to highlight the unique and important role of VBID in the overall portfolio of models for this audience. [00:05:28]

VBID is the only model directed at Part C or Medicare Advantage which is an increasingly popular option for our Medicare beneficiaries and beneficiaries who are dually eligible for Medicare and Medicaid. VBID is set up to provide a unique opportunity for CMS to learn about innovative approaches to structure and delivery of high-value services and benefits. And with its unique targeting flexibilities, VBID is well positioned to provide even greater insight into how high-value services and benefits are offered to underserved populations. [00:06:09]

So now to get more into the specifics of the Model. There are now five components offered by the VBID Model. One mandatory component, which is wellness and healthcare planning, and four optional components. The first component here: targeting by condition, socioeconomic status or both. MAOs may propose reduced cost-sharing and/or additional supplemental benefits including non-primarily health-related supplemental benefits for targeted enrollees. [00:06:39]

MAOs may target enrollees based on a chronic condition, by [low-income subsidy status] LIS status, dual status in the territories, or both. MAOs may propose additional eligibility conditions like participation in a disease management program. And benefits can include primarily health-related benefits such as vision, dental, or hearing; or non-primarily health-related benefits such as grocery assistance or non-medical transportation. [00:07:07]

So next, then, we have Rewards and Incentives. As compared to the program, MAOs have the most flexibility to offer higher value RI, or rewards and incentives, where the value of the reward provided to the consumer is capped not by the cost of the service, but rather by its benefit up to $600. RI programs can be targeted to a subset of enrollees and RI programs can be associated with Part D benefit. [00:07:37]

Then Wellness and Health Care Planning, WHP. This is a mandatory component of the Model. Participating MAOs must implement a strategy in 2024 regarding the delivery of WHP services including advanced care planning services to all enrollees in all of the PBPs (Plan Benefit Packages) included in the Model. Broader strategies may include WHP infrastructure investments such as digital platforms to support advanced care planning, provider initiatives

around WHP education, or member focused initiatives such as providing information on how enrollees can access WHP services and the advents of coverage. [00:08:19]

Then we have the Hospice Benefit Component. The Hospice Benefit Component, which is also sometimes called the hospice "carve-in", which includes the hospice benefit in the scope of MA coverage to facilitate care coordination across the care continuum, improved access to palliative care and transitional concurrent care, and hospice specific supplemental benefits. And we'll discuss this component in more depth later in our presentation. [00:08:46]

And, finally, we have new and existing technologies. This allows MAOs to propose to cover new technologies that are FDA approved and that do not fit into any existing benefit category for targeted populations, chronic conditions, and/or LIS status. It would receive the highest value from the new technology. I'll now pass things over to Tzvetomir Gradevski to review how the Model has changed for coverage year 2024.

Tzvetomir Gradevski (TG):
Thank you, Michael. My name is Tzvetomir Gradevski, and I am the lead for the Hospice Benefit Component of the VBID Model. On the next slide we'll go into the changes we've made for 2024. In making updates to the Model for 2024, we were guided by some of the themes in the Innovation Center Strategy Refresh including the focus on health equity. [00:09:36]

The four key updates to the Model for calendar year 2024 are the inclusion of a Health Equity Plan requirement for all MAO applicants, the addition of new reporting requirements for supplemental benefits, simplification of targeting criteria for hospice supplemental benefits, and continuing the implementation of the Phase 2 Network Adequacy requirements. The next slides will provide more detail on each of these updates. [00:10:04]

In the last application cycle, or the cycle for MAOs who wished to participate in calendar year 2023, only applicants for the Hospice Benefit Component needed to answer application questions related to how they would advance health equity as it relates to palliative care, transitional concurrent care, and hospice care. For this application cycle, all MAO applicants must now answer application questions related to how they will advance health equity as it relates to all aspects of their participation in the VBID Model. [00:10:31]

For example, if an MAO applicant wishes to participate in the Hospice Benefit Component and offer an RI program, their responses to the health equity related questions must address how they would advance health equity through their participation in the Hospice Benefit Component and their RI program. For calendar year 2024, participating MAOs will be required to report on a new set of summary-level and beneficiary-level data related to supplemental benefits. [00:11:00]

CMS intends to provide participating MAOs with Model Monitoring Guidelines in the fall of 2023 that will detail what reporting is required per the VBID Contract Addendum during and for Model participation in 2024. The Model Monitoring Guidelines will describe when data should be reported, how data is being collected and should be shared with CMS, and who CMS expects to receive reporting on. [00:11:30]

Next, for 2024, CMS has simplified the targeting criteria to allow for participating MAOs to target supplemental benefits to enrollees with a hospice election. In other words, the only targeting criteria available in 2024 for hospice supplemental benefits will be the presence of a hospice election. All other requirements associated with hospice supplemental benefits remain the same, as described in the 2024 RFA for the hospice benefit component. [00:11:59]

For 2024, CMS will continue to require participating MAOs with at least two years of participation in the Model component to create and maintain networks of hospice providers at the participating MAO level. This requirement is known as the Minimum Number of Providers, or MNP, requirement. For calendar year 2024, CMS will generally not require participating MAOs to resubmit unchanged information associated with the MNP requirement for the counties in the service areas of PBPs that previously satisfied the MNP requirement for calendar year 2023. [00:12:31]

I'll now turn things over to Rich Coyle from the Office of the Actuary to discuss the recently released preliminary Actuarial Methodology for 2024 of the Hospice Benefit Component. Rich?

Richard Coyle (RC):
Yes, thank you, and good afternoon. So, I'll just quickly provide an overview of three aspects of the hospice payment. First is to provide background on the payments from CMS: how they're structured, and how they're integrated into other capitation payments for participating plans. Next, provide an overview of the Hospice Benefit Component rates: how they're developed and what material is available to understand and study the rate development and corresponding levels of rates. And, finally, I'll give an overview of the proposed changes in the methodology and data for the development of 2024 hospice rates. [00:13:45]

Okay, so the methodology we're using has been in place since 2021, so 2024 will be the fourth year, and it's largely remained intact for that period. One of the key components is that we use base experience to develop the rates. For the hospice rates, it's three years of data. We're proposing to use 2019 through 2021. This compares the Medicare Advantage rate book where we use five years of data, but for an analysis, we believe three years is appropriate; that it provides the stability that we're looking for, but it's also more responsive to the changes in experience than, say, a five-year period. [00:14:33]

So, we developed the rates at a local area; we call it applying what's called an "Average Geographic Adjustment". The local areas we use are a core-based statistical area that is limited to [core-based statistical areas] CBSAs within the state. The localized rates reflect localized utilization in the experience, and also reflects wage indices for the most recent hospice regulation. Of course, we take the base experience and we trend it to contract year. Where appropriate, we use the same trending factors as we're using in the Medicare Advantage rates. [00:15:16]

And the experience we're going to talk about in a moment, I'll talk a little bit about that. It's also worth pointing out that unlike Medicare Advantage payment, the capitation rates are not risk adjusted. Rather, as I mentioned, they're adjusted for geography and, also, the payments are

based on duration of stay per month one, and separately month one and month two payments. And, again, we'll talk a little bit more about that. [00:15:47]

Finally, we expect that the rates will be released in April 2023. The Medicare Advantage rates are scheduled to be released by April 3, 2023, and we expect and hope that the hospice rates will follow soon after. This is just a graphic that hopefully will give some idea of how the hospice capitation rates were integrated into the overall MA payment rates for participating plans. The first two rows in this chart show payments when a beneficiary enters hospice status after the first of the month. [00:16:34]

The first column there says, "Enrollee in hospice status as of the first of the month.". These two rows reflect beneficiaries who enter hospice sometime after the first. The first row is for non-participating plans and the second row is for plans participating in the Model. In both cases, a payment is made for the A/B bid. Of course, that's risk adjusted. And in both situations, there's also an MA rebate paid. And jumping to the last column, for both situations, we pay the Part D bid-based payments and prospective payments for reinsurance and LIS subsidies. [00:17:16]

What's different, of course, is the hospice capitation payments. In the case of participating plans, VBID hospice participating plans, we make a capitation payment in addition to these other payments that are made on behalf of the beneficiary. Going down to the last two rows, this is a situation where a beneficiary is in hospice status as of the first of the month. In both cases, whether it's a participating or non-participating plan, there's no A/B bid paid - that should be familiar to everyone - we do pay the MA rebate and the Part D payments for all beneficiaries. And, again, for those participating in the hospice model, we do pay a capitation payment. [00:18:10]

This data here just provides an overview of the level of payments and what drives the different payment levels. The first column indicates the payments whether it's in the first month of hospice admission, or second and later month. You can see for the first month of hospice admission - and, again, this is those who enter after the first of the month - we break out the payments between the duration that they're in hospice. Actually, that first graphic should be one to six days. So, of course, if someone's in hospice one to six days, the payment is relatively low compared to the others because we're providing less coverage. [00:18:50]

Then we have the 7- to 15-day window, and then the 16- or more. Again, you can see that the rates on a national basis go up as we go along. Now, you'll also notice in the last two columns that there's a "year one" and a "mature year" rate. The "year one" rate indicates counties that will be in the first year of hospice for 2024. The "mature [year]" represents counties that had coverage for VBID hospice in 2023. You can see that the "month one" rates are very close between the two - only off by pennies - and the difference has to do with some budget neutrality calculations. [00:19:32]

Now, if you go to the last row of the table, this is for months two and later. So, again, this is an admission that started at least the month prior, and beneficiaries and hospice status as of the first of the month. And the payment rate is very similar to the "16 or more days" in the first month,

and that's just, more or less, by coincidence, not by design. But, you will notice that the "year one" rate is somewhat higher than the "mature [year]" rate. [00:20:03]

And the reason for that is what the experience indicates for hospice is that when a beneficiary stays longer in hospice, generally the per capita costs go down a little bit compared to more recent stays because, generally, they're not receiving the intensity of services; also, the routine home care per diem goes down after 60 days, and that's reflected in the rates, too. I didn't mention these are national rates. As I discussed earlier, they will be adjusted by what we call an average geographic adjustment to reflect local utilization and wage index levels. [00:20:52]

This an actual excerpt from our 2023 rate book for hospice. As you can see, these are counties in the state of Alabama, [and] they're consecutive counties alphabetically. If you look at the fourth column, it says, "CBSA-State Identifier." As I mentioned earlier, the rates are developed at a "CBSA-State" level. This indicates the specific CBSA and state that that rate applies to. For the first entry there, Calhoun, that is an Anniston-Oxford CBSA within the state of Alabama. [00:21:35]

Going over to the next column, you can see that that's a "mature year" rate indicating that there was coverage in that county, Calhoun County, in 2022. So to get that "mature year" rate. And then the last four columns are the specific rates for that county. You go down to the next county, Chambers, and you see the CBSA-State Identifier is 99901. The 999 indicates that it's a rural area within the state. In this particular case, there was no coverage in the prior year, so they're getting the "year one" rate. Again, the rates go across. [00:22:17]

You get a sense for how this is what we publish. Obviously, there's a lot that goes on behind this, but to just get a sense for what the payment levels are, you can go to this file and see what the rates are for specific areas. Wrapping up what we had in place for 2023, here's a listing of some materials that are posted on our website. The first two files are what we call a "data book", which has detailed information, like I said, at the CBSA level, supporting the rate development. [00:22:59]

It has information by CBSA, broken down by the length of duration, again, year one versus "mature year". There's also a wealth information about how the geographic adjustment is developed. This is probably of a lot of interest to the financial folks on the call, particularly actuaries, and CPAs, et cetera. This is a very good resource for those who want to understand the nuts and bolts of what goes into a rate. The third file listed there is the capitation rate book that I just referred to on the prior slide. [00:23:37]

And then the final document is a PDF file that illustrates the methodology, data, and assumptions used to develop the rates for 2023. Again, it's fairly comprehensive in terms of providing insights into how the rates are developed. Okay, so jumping forward to 2024: as some of you may know, last week we released a memo that describes some of the changes we're proposing for 2023. It was released on February 17. For the most part, the rating methodology is similar to 2023. Among the key changes, first of all, we're going to advance the experience period one year. [00:24:43]

The 2023 rates were based on 2018 to 2020 experience; this will now be based on 2019 to 2021. As I mentioned, the “mature [year]” rate versus “year one” rate will be based on whether coverage was offered in the prior year for that county. So that second bullet point just reaffirms that that we’re proposing the “year one” rates will reflect the counties that were not covered in 2023 and a month, and the “mature year” rates will include counties that were covered last year. [00:25:11]

And, again, a key distinction is when we developed the rates for “mature year” counties, we’re including all claims whether they were incurred the prior year, two years prior, three years prior, et cetera. There’s no limit on the data we use, whereas for the “year one” rates we’re only including admissions that began in that calendar year. [This is among a] couple [of] other changes that we’re proposing for 2024. So, we’re going to reprice the claims to the fiscal year 2023 hospice regulation. [00:25:56]

What this involves is reflecting the per diem rates for the various levels of care. That is routine home care, inpatient respite care, continuing home care, and general inpatient care. We start with repricing the 2023 fiscal year rules. We will also reflect the wage indices in place for fiscal year 2023. Again, that’s a key component into the geographic adjusted rates. And then, of course, we will trend everything for the calendar year 2024, and we’ll talk a little bit more about that in a moment. [00:26:38]

That’s the hospice claims themselves. The non-hospice claims, they’ll be trended to 2024, as well, and that’s done a little bit differently, as we’ll talk about. And then we’re also updating the assumption for service day utilization and intensity adjustment which we’ll talk about in a moment. And, finally, on this slide, mentioning that the rates will be loaded for administrative costs similar to the Medicare Advantage Rate Book. [00:27:06]

And listed here is what the loading factors are, which is performed separately for Part A and Part B services. Of course, for the hospice benefit, that’s all Part A, so that gets the lion’s share of the weighting. But for the unrelated care, the primary services, they are driving at our - on the Part A side - inpatient and skilled nursing. And on Part B, physician, outpatient, Part B drugs, et cetera. [00:27:39]

Okay, so this just illustrates what the estimated trends are at this point for the hospice benefit. So, basically, the update for fiscal year 2024 is estimated to be 2.80 percent, and for fiscal year 2025 it’s 3.20 percent. Now, one thing that’s worth mentioning about this is when we reprice the claims, or when we trend the claims, the claims that occurred between January and September 30, they will be projected to fiscal year 2024 because that would be the payment rules in place for those claims under a fee-for-service type model; whereas those claims that are incurred between October 1 through the end of the year, they will be trended to fiscal year 2025. [00:28:31]

In that case, they would get both the 2.80 percent update and the 3.20 percent update. Just for comparison’s sake, the update for fiscal year 2023 was 3.80 percent. Again, these numbers are preliminary; they may change based on more recent data when we publish the final rate in April. [00:29:01]

This data represents the trends that will be applied to the non-hospice benefits, and this data comes from the 2024 Advanced Notice for Medicare Advantage. As you can see, [here are] the experience years - we're showing from 2019 to 2021 - and the experience year, what we call the USPCC, United States Per Capita Cost. That's kind of an indication of what the average cost is in a base year. And then the next column is the "Calendar Year 2024 USPCC". That's an estimate of what the per capita cost will be in a contract year. [00:29:46]

And then the last column is just the trend rate, [which is] basically the third column divided by the second column. That's what ends up being the "update factor". These values will be updated based on the final rate announcement which is scheduled to be released by April 3 of 2023. Okay, and so this is the final slide I was going to present, and this illustrates the development of the proposed trend in service intensity levels. [00:30:30]

That is a trend that reflects both our expectation in changes for service days and the per diems. Well, this is actually all experience. It's not expectation, it's actual data. The column there labeled "A" shows, based on the experience years, 2019 to 2021, what is the average number of days of care? And this is for "mature year", [for] all services. So, you can see, there was a slight decrease from 2019 to 2021, from 23.04 days to 22.95. I mean, it's a fraction of a percent, but it's somewhat of a decrease. [00:31:14]

The next column, "B", indicates what's - on a weighted basis, based on a different mix of services - of a cost. And this is based on fiscal year 2023 per diems. You can see in 2019, this weighted average was $194.66. It went down in 2020 to $192.16, and down a little bit more in 2021 to $191.66. And what's really driving those decreases is a lower use in higher intensity services. That is general inpatient care, respite care, and continuous home care. Each of those services dropped by between 7 and 17 basis points between 2019 to 2021. And so that's what the data's indicating. [00:32:11]

The next column over called "Composite" is basically a product of those two which gives us an indication of what the average cost would be on a national basis using fiscal year 2023 per diems. Again, as the first two columns indicated, the value for 2019 is higher than 2021. And the last column indicates which trend factor is going to be applied to the experience based on those values. The -1.93 percent is basically the value in row 2021, $4,398.49, divided by the value in the row 2019, $4,484.95, minus 1. [00:33:02]

That's the trend we're proposing to apply based on the experience that we're seeing. We're not trending anything down 2021, so effectively what we're saying is that the 2019 and 2020 data will be adjusted by these trend factors. No adjustment for 2021, and no further trending beyond this other than what I mentioned earlier about the hospice trend and the non-hospice trend. Okay, so that's it for the actuarial portion of this. I'll now turn it over to Aurelia to continue the discussion of VBID.

Aurelia Chaudhury (AC):
Thanks so much, Rich, for that very detailed presentation. Now we're going to move on to talking about the 2024 application process timeline including immediate next steps for the

application process. As far as next steps for MAOs: first, if you have any questions or if you want any technical assistance as you are thinking through your VBID interventions and developing your application, the VBID Model team is happy to support you. Please reach out to us with any requests at our email address at VBID@cms.hhs.gov. [00:34:15]

Next, as we heard about earlier, the hospice-specific county-level rate book will be released in mid-April of 2023. We encourage MAOs interested in participating in the Hospice Benefit Component to review that document. Third, MAOs should be ready to submit your applications to CMS via the Qualtrics Portal on April 14, 2023. And in terms of next steps after application submission, CMMI plans to provide notification for MAOs with provisionally approved interventions for model participation in mid to late May of this year. [00:34:47]

And those MAOs with provisional approval for their VBID Model application, they include their VBID interventions in their Medicare Advantage bids which are due on June 5 of 2023. And, finally, step six for organizations that are granted final approval for the model for CY 2024, those MAOs will execute contract addenda for CY 2024 participation in the VBID Model in September 2023. And, just as a reminder to folks, feel free to put any questions that you have about anything in this presentation and the application process into the chat. We'll be looking at those questions and we'll be happy to answer them at the end of presentation. [00:35:28]

To aid in your submission, we have outlined a number of the CY 2024 Application Materials and resources. Materials on this slide are available for download in a zip file of application materials on the VBID Model webpage and, also, within the Qualtrics application which is linked on the VBID Model webpage. Within the zip file that's linked on our website, the PDF of the Application Reference Template is available to aid MAOs in preparing their applications and understanding exactly the questions that are being asked within the Qualtrics application. [00:35:57]

Similarly, the Supplemental Application Instructions document provides helpful tips and application materials. The next few documents are required to be submitted by all MAO applicants. First, the Application Spreadsheet outlines the participating PBPs and interventions to be offered in the model along with plan information and enrollment projections. Second, the Net Savings Template is also required of all applicants and identifies the PMPM projected costs with and without the VBID Model. [00:36:25]

Third, the Financial Application Template requests the projected costs for each VBID model component along with projected savings to Medicare over the life of the VBID model. Finally, the Part D Supplemental File is required only for those MAOs proposing to offer reduced or eliminated cost sharing on certain drugs. MAOs proposing to offer reduced or eliminated cost sharing across all Part D drugs do not need to submit the Part D Supplemental File. It is only those offering reduced or eliminated cost sharing on select drugs within the next year. 00:37:06]

Finally, we have a few tips on how to put together a seamless application submission. First, as we mentioned, you can find all relevant materials on the VBID Model website including the Request for Applications, the link to the Qualtrics application, and all of the additional application materials. You are required to submit a single application per parent organization

including all contracts, PBPs, segments, and Model components that you are proposing to offer in the Model. [00:37:30]

With respect to the Qualtrics application, at the beginning of the Qualtrics survey, you'll be asked to select those Model components that you are proposing to implement for CY 2024. That initial selection will impact the questions that are displayed to you throughout the application, so please make sure that you've selected the correct Model components. And, again, the application reference template available on the zip file will give you a preview of the different questions that you may be asked in the Qualtrics application. [00:37:57]

Finally, I'll mention that CMS is available to help support your application development and submission. Feel free to reach out to us via our website, and feel free to put any questions that you have in the chat for this webinar. With that, we'll now move on to our Q&A session. Tzvetomir? Thank you.

TG:
Thank you, Aurelia. And, as a reminder, please use the Q&A functions to submit any questions you might have about the VBID Model, the application process, the RFAs. We'd like to now take this time to move on to our question and answer and address some of the questions that we received in the Q&A box. First, I wanted to remind folks that the slides will be available on the VBID Model website, and we hope to post those in the coming weeks. So please be sure to check back on our website and the materials will be linked there shortly once we're able to post them online. So be on the lookout for those. [00:39:01]

And now let's dive into some of the other questions we've received. First: "I'd like to see a list of all the questions asked in the RFA to the parent organization's response. Is there a way to view all the application questions without navigating the entire application?" I can take this first one. And yes, applicants may download a PDF of a complete listing of all the application questions, and this PDF file is found in the zip file uploaded on the VBID Model webpage under 2024 materials, and it's titled "Additional VBID Model Application Materials Zip" . [00:39:43]

So please reference that PDF file to see a listing of all the application questions, but I do want to note that when you go to complete your Qualtrics application, the Qualtrics application will be tailored based on which Model components you select to participate in. So, for example, if you choose that you will only be interested in applying for the Hospice Benefit Component, you won't be asked questions about, for example, your rewards and incentives program. [00:40:20]

Next up: "Last year, there was a provisional approval of our VBID plan's proposed benefits. Will we be getting the same provisional approval this year?" Michael, would you like to take this one?

MD:
Yes. One minute here. Sorry, could you repeat that one more time?

TG:

Yes, happy to. So last year plans received provisional approval to offer a VBID plan benefit design, will we be offering that same provisional approval process for 2024?

MD:
So the Model team will be reviewing applications between April 14 and mid-May, and after this review period, the team will notify all applicants regarding the status of their application and/or the provisional approval status.

TG:
Great, thank you, Michael. I see another question in the Q&A box: "Are there special or separate member materials for VBID whose content are incorporated into the CMS Models?" I think this question's maybe referring to the ANOC and EOC that plans must submit, and if it is in the context, yes. So, the VBID Model benefit offerings are incorporated into those existing materials that plans must already send out to their enrollees every year, and we do post instructions specific to the VBID Model as part of the annual updates to the VBID and ANOC EOC instructions, so we encourage plans to reference those updated instructions. [00:42:46]

Next up: "Could you please speak more about the expected scope of the Health Equity Plan? For example, if an organization is proposing healthy food options, does the HEP just need to focus on that group or intervention?" Michael or Aurelia, would either of you like to take that one?

AC:
Sure, I'm happy to take that question. So, you'll see in both the VBID Model - in the CY 2024 RFA and in the Application Reference Template within the zip file that Tzvetomir mentioned - a full listing of the different questions in the Health Equity Plan that MAOs will be asked to fill out in submitting a complete VBID model application for CY 2024. [00:43:26]

In the context of those questions about the Health Equity Plan, plans will be asked to think about the health equity implications of the specific VBID Model interventions that they're undergoing, but also to think about the health equity of the PBP population generally including thinking about how they're going to be assessing, tracking, and intervening across different levels of disparities as they exist in the population with, of course, a focus on how the VBID Model interventions will play a part and how they'll be focusing on doing those VBID Model interventions and actions. So, we encourage you to look through the specific questions in the HEQ as you understand the scope of the Health Equity Plan.

TG:
Thank you, Aurelia. Another question, and this comes from the chat: "Our plan is approved for VBID based on socioeconomic basis for a single-time benefit package which eliminates Part D cost-sharing and offers a flex card. We intend to expand the VBID to another plan benefit package which is also a D-SNP. The question is must we submit a 2024 application to expand our VBID participation to another PBP under the same H Contract Number?" Michael or Aurelia, do you want to take that one?

AC:

I’m happy to take this one, too. I guess I just want to start by making clear to all MAOs that even if you participated in the VBID Model in CY 2023, if you would like to participate in CY 2024, you must submit a new VBID Model Application for CY 2024. Participation does not rollover automatically from one year to the next, and that’s true even if you are doing the same VBID Model intervention for the same PBPs in the same contracts. Every MAO that wants to participate in CY 2024, must submit a new application. [00:45:17]

So, the answer to your question is yes, you must submit a new application both to continue to do the intervention that you’ve already been doing and with respect to a new PBP. Each MAO should submit one application for each parent organization. So, you would submit one application that would cover this application across multiple PBPs, assuming both PBPs are attached to the same parent organization.

TG:
Great, thank you, Aurelia. Pulling up another question from our question pool here: this one is related to [the] Hospice Benefit Component and the wellness and health care planning. The question is: “Am I required to do the wellness and health care planning component as required in the VBID Model if I’m only looking to just apply for the Hospice Benefit Component?” [00:46:23]

And the answer is yes. All VBID Model participants must answer the application questions related to wellness and healthcare planning even if they are choosing to participate in just one component of the VBID Model including the Hospice Benefit Component. So that, across the board, is a required component in participation. The remaining components are all optional for plan applicants. [00:46:59]

Next up, a question: “Did you say that the 2023 hospice payments will be recalculated for contracts or PBPs participating in the VBID Model? If yes, when will that happen?”. Rich, would you like to take this one?

RC:
Sure. No, I did not say that and I apologize if I implied that. The rates for 2023 have been set, and they’re published in the 2023 Rate Book, and there’s no changes to that. What I did say or what I did intend to say is that for 2024, we will be updating the rates to reflect more recent experience, and trending to 2024, and updating to reflect the most recent hospice regulations. So that is what will be happening, but there will be no changes to 2023 rates.

TG:
Great, thank you, Rich. I see we’re getting a fair number of questions relating to the VBID model and its status beyond 2024, namely will there be some sort of extension of the Model beyond December 31, 2024? Sibel, would you like to address some of those questions?

SO:

Yeah, of course. I know that that's a question in mind for all of us, and we're excited to discuss the future of the model as soon as we can, so please be on the lookout for more information in the coming months related to that.

TG:
Great, thank you, Sibel. I see another question: "For the financial template in prior years we submitted an example plan benefit package to demonstrate savings because one, we didn't know all the plans participating yet to put on VBID; and two, we placed some VBIDs on a large number of plans, so providing a template for all of them was onerous. Is this approach still acceptable for the 2024 application?" Aurelia or Michael, do you want to take that one?

AC:
I'm happy to take that. Yes, that approach will still be applicable if you give templates that correspond to each of the groups of interventions that will be applicable to all of the PBPs that will be participating in the VBID Model and include in the VBID Model application summary spreadsheet details with respect to each PBP that you plan to participate with respect to the enrollment projections, etcetera.

TG:
Great, thank you, Aurelia. Next question: "Is the Health Equity Plan required for all VBID applications or only for those that include the Hospice Benefit Component?" So to clarify, all MAO applicants for the VBID model for 2024 must submit and answer the Health Equity Plan questions. So, no matter which combination of components you choose to apply for 2024, you must answer the Health Equity Plan related questions regardless of which components you choose to apply for. [00:50:24]

Another question: "Can a plan offer multiple VBID flexibilities on a single plan benefit package? For example, could a PBP offer targeted benefits such as zero-dollar drugs for LIS members and do the VBID Part D R&I?" Aurelia or Michael, do you want to take that one?

AC:
Sure, I'm happy to take that. Yes, a single PBP can include multiple VBID interventions under different Model components. You'll see that the questions in the Qualtrics application allow for that as does the model application summary spreadsheet. And on a related note, there was another question in a similar vein about whether a plan can offer VBID Model interventions that are similar to interventions offered under the special supplemental benefits for the chronically ill or SSBCI program under Medicare Advantage, the regular Medicare Advantage program, and whether if a plan offers both VBID Model benefits and SSBCI benefits whether it can establish a combined maximum across those for an enrollee that qualifies for both. [00:51:40]

And the answer to that question is yes, plans can offer both VBID Model benefits and SSCBI benefits and there may be enrollees who qualify for both VBID Model targeting criteria and the SSBCI criteria. In such a case, a plan does have the option of offering a combined maximum benefit allowance across those categories.

TG:

Great, thank you, Aurelia. Another question, and this one is related to the Hospice Benefit Component and the network adequacy standards. The question reads: "For the hospice network adequacy MNP, or minimum number of providers requirement, how will CMS be calculating the required number of providers for each participating plan?" We recently, along with the application materials, published updated technical guidance on the VBID Model website for the methodology that we will use to calculate the MNP or the minimum number of providers required for each MAO in a particular service area in one of their PBPs. [00:52:48]

So we highly encourage MAOs to review this updated guidance. We have made a number of key updates to the methodology, so we highly encourage you all to review that. Additionally, we've also made changes in the timeline and structure for how plans will need to submit information to us about demonstrating compliance with the MNP requirement all with the intent of simplifying the information submission process and creating a more step-wise process. [00:53:17]

We highly encourage all the participating MAOs interested in reapplying for 2024 to review this updated guidance. Next, I see a question: "What kinds of data sources are acceptable when submitting your cost savings projections?" Would anyone like to take that one?

AC:
I'm happy to take that one. So, the savings projections that MAOs will be submitting as part of their financial application template will be reviewed for actuarial reasonableness and so we encourage you to use that as the threshold for determining what reasonable sources for what cost savings projections could be. These might include the MAOs past experience in doing these kinds of interventions in similar populations, literature reviews, academic studies, etcetera. And we encourage you to work with your actuaries to figure out the appropriate standard for what data sources to use here.

TG:
Thank you, Aurelia. Another question: "Will there be additional training on application spreadsheets?" For this one, we highly encourage you to fully read through both the application instructions posted in the zip file available on the VBID Model website. And, additionally, carefully review the instructions included in the application spreadsheet itself. [00:54:50]

But, as always, the VBID Model team is available to answer any questions that you might have, so we highly encourage you to email us at VBID@cms.hhs.gov with any questions that you might have about completing your application. And, along that same line, we highly encourage you all to reach out sooner in the process so we can help resolve any issues as quickly as possible. All right, looking for additional questions.

AC:
I'm happy to take the question that just appeared in the chat: "With the new PBP platform, will MA plans be allowed to submit packages just the same as with SSBCI or are we required to create separate benefit packages per VBID flex benefit?" [00:56:00]

In the new PBP platform, there will be a separate set of pages related to VBID Model interventions. In that separate set of pages, you'll have the option of designing VBID packages. A VBID package can include different types of benefits in a single package subject to a single targeting criterion which is a similar structure to the way the SSBCI pages are built, but you'll be using the pages in the VBID area of the application rather than the SSBCI area of the application, if that answers your question.

TG:
And I see one question in the chat: "I'm assuming plans are going to receive the first month's payment on a quarterly basis as posted in the plan payment report. Is there an opportunity to obtain the detail of this computation to support the MA plan's reconciliation?" I believe this is referring to the hospice capitation payment that the participating MAOs receive. So, yes, the month one payments are indeed received in a lump sum basis on a quarterly cycle. We do provide the participating MAOs with additional technical and operational guidance on these types of payments during the calendar year, so current participating MAOs have access to that additional technical guidance right now. [00:57:28]

And then the question around the detail of the computation to support the MA plan's reconciliation. As Rich mentioned earlier in the presentation, we will be posting the final rates for 2024 in April. So please be on the lookout for that. And we encourage plans to use those finalized rates to support any reconciliation efforts that you may want to stand up internally. And I now see we're right on the hour which takes us to end of this presentation, so I will pass things over to Sibel to close this out.

SO:
Thank you. Thank you, Aurelia, Tzvetomir, and Michael for that wonderful Q&A session and all of our attendees for asking such thoughtful questions. Please continue to send us questions via VBID Model mailbox at VBID@cms.hhs.gov. We hope that the earlier release of our application materials affords plans who have joined us today with additional time to prepare their applications and to reach out to us with any technical assistance needs well in advance of the April 14 deadline. We look forward to working with you all during this exciting application process and season. Take care.