Request for Information for the Value-Based Insurance Design Model

Innovating to Meet Person-Centered Needs

Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation

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I. Summary

This request for information seeks input regarding various aspects of the Value-Based Insurance Design (VBID) Model. Responses to this Request for Information (RFI) may be used to inform potential future Model policy development. We encourage input from a wide variety of voices on the questions below, including beneficiary advocates, plans, providers, community-based organizations, researchers, and all other interested parties.

II. Advancing Health Equity by Best Identifying and Meeting Needs

The VBID Model continues to look for opportunities to provide enrollees with more person-centered care and interventions. The introduction of Area Deprivation Index (ADI) as a targeting criterion is part of an ongoing strategy to allow for innovative person-centered benefit design and targeting sensitive to the important role location plays in health outcomes and lived experiences. In furtherance of this strategy, CMS will explore the possibility of additional flexibility to target enrollees in underserved areas by the presence of health-related social needs (HRSNs) in future Model years. Under such a flexibility, for example, Medicare Advantage Organizations (MAOs) could target housing benefits to enrollees experiencing housing instability in underserved areas.

CMS seeks comment from interested parties generally on flexibilities allowing MAOs to target VBID benefits based on HRSNs and ADI and specifically responding to the following questions:

1. CMS is considering the merits and feasibility of allowing plans to target VBID benefits based on certain HRSN screening responses for enrollees residing in the most underserved ADI areas. If permitted, would your organization consider leveraging an ADI targeting flexibility in combination with targeting based on enrollees' specific unmet HRSNs?
2. CMS is considering the merits and feasibility of allowing plans to target VBID benefits based on certain ICD-10 z-codes for enrollees residing in the most underserved ADI areas. Is using z-codes to target benefits feasible for your organization? What tools do you or could you leverage to encourage accurate and consistent use of z-codes across all enrollees?
3. What challenges, operational or otherwise, do you foresee with targeting by ADI, HRSN, and/or z-codes?
4. CMS is interested in ensuring screening is linked to actions to address identified needs such as benefits and referrals. Does your organization currently utilize a closed loop referral system to track if/when enrollees' identified HRSNs are resolved through a social service provider? If no, what do you see as next steps or enablers to building this capability?
5. What additional targeting flexibilities – geographic or otherwise – should CMS consider? What are any adjustments that could be made to ADI to better reflect enrollee need?
6. As some beneficiaries may not know the census block they live in, how should MAOs plan to communicate eligibility for ADI targeted benefits to enrollees? What could CMS provide to support MAOs in effectively communicating to enrollees regarding ADI targeting?

III. Expanding Access to Higher Quality Hospice Care

Beginning in 2026, CMS intends to permit participating MAOs more flexibility to require their enrollees to only receive hospice services from hospice providers in their network, as long as the MAOs meet CMS's qualitative and quantitative network adequacy requirements. This change is intended to help test whether model enrollees have greater care continuity and receive higher quality hospice care.

In preparation for Calendar Year (CY) 2026, CMS seeks comment from interested parties on how to structure the future access to hospice care policies, how to continue to encourage comprehensive, high-quality networks, and how to continue to implement Model-specific network adequacy standards. CMS is looking for feedback on these specific questions:

1. How can CMS implement network access policies for hospice providers in line with current MA program policies (e.g., the ability for health maintenance organizations (HMOs) to limit access to in-network providers) while minimizing confusion among enrollees/patients, caregivers, and hospice and non-hospice providers?
2. How should statutory protections ensuring access to covered benefits, even out of network, where services are "medically necessary and immediately required because of an unforeseen illness, injury, or condition, and it was not reasonable given the circumstances to obtain the services through the organization" be potentially applied in the context of the hospice benefit?[1] Additionally, how could such protections be operationalized by participating MAOs?
3. To what extent should CMS implement new or additional access safeguards specifically in the VBID Model Hospice Benefit Component to address situations when an enrollee may want to elect hospice in situations when hospice care is urgently needed?
4. To what extent should CMS modify the current Model-specific network adequacy standards, including the minimum number of providers requirement and the comprehensive network development strategy? For example, should CMS include any special consideration for states with certificate of need for hospice providers or use alternative datasets to set and implement the network adequacy standards?
5. To what extent should CMS maintain its Model-specific requirement to not allow any prior authorization requirements for hospice care? If CMS should change the policy, what would the alternative look like and how could it be operationalized?

IV. Comment Submission

Please submit written comments to the VBID Mailbox at VBID@cms.hhs.gov by February 16th, 2024.

[1] Existing regulatory requirements regarding this obligation include, but are not limited to, requirements under 422.100(b)(1) for an MAO to make timely and reasonable payment to providers or supplies that do not contract with the MAO for emergency and urgently needed services.