Medicare Advantage Value-Based Insurance Design Model (VBID) Fact Sheet

Overview

In January 2017 the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) began a Medicare Advantage model test called the Medicare Advantage Value-Based Insurance Design (VBID) model. The VBID model is an opportunity for Medicare Advantage plans (MA plans), including Medicare Advantage plans offering Part D benefits (MA-PD plans), to offer clinically nuanced benefit packages aimed at improving quality of care while also reducing costs. This model test will run for five years and will end on December 31, 2021.

Value-Based Insurance Design (VBID) generally refers to health insurers' efforts to structure enrollee cost sharing and other health plan design elements to encourage enrollees to use high-value clinical services – those that have the greatest potential to positively impact enrollee health. VBID approaches are increasingly used in the commercial market, and evidence suggests that the inclusion of clinically-nuanced VBID elements in health insurance benefit design may be an effective tool to improve the quality of care while reducing its cost for Medicare Advantage enrollees with chronic diseases. CMS tests VBID in Medicare Advantage and measures whether structuring patient cost sharing and other health plan design elements encourages enrollees to use health care services in a way that improves their health and reduces costs.

In its first year, 2017, CMS tested the model in seven states: Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee. On January 1, 2018, CMS opened the model to Alabama, Michigan, and Texas. In the third year of the model, beginning January 1, 2019, CMS will open the model to 15 additional states – California, Colorado, Florida, Georgia, Hawaii, Maine, Minnesota, Montana, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, Virginia, and West Virginia.

These states have been selected in order to be generally representative of the national Medicare Advantage market, including urban and rural areas, areas with both high and low average Medicare expenditures, areas with high and low prevalence of low-income subsidies, and areas with varying levels of penetration of and competition within Medicare Advantage. Test states have also been selected based on the availability of appropriate paired comparison areas for the purposes of evaluation.

In the first two years of the Model, CMS identified a limited number of chronic conditions from which organizations could choose to target interventions. Participating organizations were responsible for applying the CMS-defined criteria to identify enrollees who fall within each of the clinical categories selected by the organization and offer varied plan benefit designs to these enrollees. For 2019, eligible MA plans, upon CMS approval, may offer varied plan benefit designs for enrollees who fall into clinical categories proposed by

participating organizations using their own methodology for identifying eligible enrollees using CMS accessible data sources (e.g., International Classification of Diseases (ICD) 10, encounter data, claims data, etc.) or into the clinical categories identified and defined by CMS.

Benefit design changes made through this model may reduce cost sharing and/or offer additional services to enrollees with targeted conditions; however, enrollees can never receive fewer benefits or be charged higher cost sharing than other MA enrollees in their plan as a result of the model.

Background

The model tests the hypothesis that giving MA plans flexibility to offer supplemental benefits or reduced cost sharing to groups of enrollees with CMS-specified chronic conditions in order to encourage the use of services that are of highest value to them, will lead to higher-quality and more cost-efficient care. The increase in high-quality, cost-efficient care is expected to improve beneficiary health, reduce utilization of avoidable high-cost care, and reduce overall costs for plans, beneficiaries, and the Medicare program. The model is also intended to improve outcomes and reduce costs by encouraging enrollees to obtain care from high-value providers and by providing new supplemental benefits specifically tailored to enrollees' clinical needs.

The VBID model is authorized under Section 1115A of the Social Security Act, which authorizes the Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce Medicare, Medicaid, and Children's Health Insurance Program expenditures while preserving or enhancing the quality of beneficiaries' care. CMS is testing this model in the Medicare program through a limited waiver of the Medicare Advantage and Part D uniformity requirements. The proposed rule for Medicare Advantage and the Prescription Drug Benefit Program for Contract Year 2019 (CMS-4182-P) released on November 16, 2017 set forth flexibilities to Part C benefits under the Medicare Advantage program that are similar to the Part C flexibilities offered under the VBID model. There are features of the VBID model that are different from the proposed rule, such as allowing flexibility for Part D benefits in the VBID model. We expect the VBID model to provide CMS with insights into future innovations for the MA program.

CMS will provide further details on how VBID flexibilities will be operationalized in the draft and final call letters, and sponsors applying for VBID can decide whether they want to stay in that process after the call letter is finalized.

Description

The VBID model supports improved health outcomes and health care cost savings or cost neutrality through the use of structured patient cost sharing and other health plan design elements that encourage enrollees to

use high-value clinical services. The VBID model provides flexibility for MA and MA-PD plans to develop clinically-nuanced benefit designs for enrollee populations. Participating organizations may, with CMS approval, develop benefit designs for enrollees who fall into clinical categories proposed by the organization using their own methodology, or for enrollees that fall within the clinical categories listed below.

The CMS pre-approved conditions are:

- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Patient with Past Stroke
- Hypertension
- Coronary Artery Disease
- Mood disorders
- Rheumatoid Arthritis
- Dementia

In addition to developing interventions aimed at all enrollees in one or more of the above categories, participating MA plans have the flexibility to identify specific combinations of the listed chronic conditions for one or more "multiple co-morbidities" groups and establish tailored VBID interventions for each group. Participating MA plans are required to provide VBID benefits to all VBID-eligible enrollees in the selected group. Participating MA plans selecting the Mood Disorders group have additional flexibility to focus on specific conditions within that group.

For each of the selected enrollee groups, participating plans may select one or more plan design modifications from a menu of four general approaches. Within each approach, plans have flexibility on how (and to what extent) to implement that approach. Plans may vary their proposed interventions from one population to another, and from one participating plan to another. CMS will also consider proposals for related variants of these interventions offered to included groups of enrollees, such as supplemental benefits conditional on participation in a disease management program.

The four approaches are:

1. Reduced Cost Sharing for High-Value Services

Plans can choose to reduce or eliminate cost sharing for items or services, including covered Part D drugs, that have been identified as high-value for a given population. Participating plans have flexibility to choose which items or services are eligible for cost-sharing reductions; however, these services must be clearly identified and defined in advance, and cost-sharing reductions must be available to all enrollees within the population.

Examples of interventions within this category include eliminating co-pays for eye exams for diabetics and eliminating co-pays for angiotensin converting enzyme inhibitors for enrollees who have previously experienced an acute myocardial infarction.

2. Reduced Cost Sharing for High-Value Providers

Plans can choose to reduce or eliminate cost sharing for providers that the plan has identified as high-value providers to included enrollees. Plans may identify high-value providers based on their quality and not solely based on cost, across all Medicare provider types, including physicians/practices, hospitals, skilled-nursing facilities, home health agencies, ambulatory surgical centers, etc.

Examples of interventions within this category include reducing cost sharing for diabetics who see a physician who has historically achieved strong results in controlling patients' HbA1c levels and eliminating cost sharing for heart disease patients who elect to receive non-emergency surgeries at high-performing cardiac centers.

3. Reduced Cost Sharing for Enrollees Participating in Disease Management or Related Programs

Participating plans can reduce cost sharing for an item or service, including covered Part D drugs, for enrollees who choose to participate in a plan-sponsored disease management or similar program. This could include an enhanced disease management program, offered by the plan as a supplemental benefit, or it could refer to specific activities that are offered or recommended as part of a plan's basic care coordination activities. Plans using this approach can condition enrollee eligibility for cost-sharing reductions on meeting certain participation milestones. For instance, a plan may require that enrollees meet with a case manager at regular intervals in order to qualify. However, plans cannot make cost-sharing reductions conditional on achieving any specific clinical goals (e.g., a plan cannot condition cost-sharing reductions on enrollees achieving certain thresholds in HbA1c levels or body-mass index).

Examples of interventions within this category include elimination of primary care co-pays for diabetes patients who meet regularly with a case manager and reduction of drug co-pays for patients with heart disease who regularly monitor and report their blood pressure.

4. Coverage of Additional Supplemental Benefits

Under this approach, participating plans can make coverage for specific supplemental benefits available only to included populations. Such benefits may include any service currently permitted under existing Medicare Advantage rules for supplemental benefits.

Examples of interventions within this category include physician consultations via real-time interactive audio and video technologies for diabetics, or supplemental tobacco cessation assistance for enrollees with COPD.

Value-Based Insurance Design Participants for 2018

Medicare Advantage Organization	State
Indiana University Health Plan	Indiana
BCBS of Massachusetts	Massachusetts
Fallon Community Health Plan	Massachusetts
Tufts Associated Health Plan	Massachusetts
BCBS of Michigan	Michigan
Aetna	Pennsylvania
Geisinger Health Plan	Pennsylvania
Highmark	Pennsylvania
Independence Blue Cross	Pennsylvania
UPMC Health Plan	Pennsylvania

Thirteen MA organizations from ten parent organizations in Indiana, Massachusetts, Michigan and Pennsylvania are participating in the model test in CY 2018. BCBS of Michigan is the only new participant for 2018, where the rest of the organizations participated in the model in 2017.

Eligible Applicants and Application Process for 2019

The Request for Applications (RFA) for CY2019 closed on January 31, 2018. For 2019, the VBID model was opened to all qualifying MA and MA-PD plans in the 25 test states that submitted acceptable programmatic proposals to CMS. Only certain MA and MA-PD plan types were eligible and certain restrictions apply to multi-state plans. For 2019, CMS also allowed Chronic Condition Special Needs Plans (C-SNPs) PBPs to participate in the model.

CMS will generally restrict the model test to plans with a minimum enrollment in the test states of 2,000 enrollees. However, a MA organization participating in the model test with at least one plan with enrollment over 2,000 enrollees may have additional PBPs participate with a minimum enrollee requirement of 500 enrollees. An additional PBP that participates using this lower enrollment requirement may be from that MA organization or another MA organization with the same parent company. CMS may also grant an exception to this requirement upon request.

Additionally, plans must meet minimum quality thresholds, including: being rated by CMS at three stars or higher in the previous year, not consistently low-performing, not an outlier in the CMS past performance analysis, not under sanction, and able to pass a program integrity screening.

The plan must have been offered in at least three annual coordinated election (open enrollment) periods prior to the open enrollment period for the year for which the plan is applying to participate. There is no cap on the total number of participating plans.

Organizations interested in joining the model in 2020 should visit the VBID website at https://innovation.cms.gov/initiatives/vbid/ regularly for any announcements about the VBID model.

More information

More information about the VBID model test is available at http://innovation.cms.gov/initiatives/vbid/.