Value-Based Insurance Design Model Test

Center for Medicare and Medicaid Innovation

Division of Health Plan Innovation

Innovation.cms.hhs.gov/initiatives/VBID

MAVBID@cms.hhs.gov

Center for Medicare and Medicaid Innovation

- Center for Medicare and Medicaid Innovation (Innovation Center)
  - Created by the Affordable Care Act
  - Tasked with developing and testing "innovative payment and service delivery models to reduce program expenditures …while preserving or enhancing the quality of care" in Medicare, Medicaid, or CHIP
- Examples of Innovation Center models include:
  - Pioneer ACOs
  - Bundled Payments for Care Improvement
  - Partnership for Patients

Health Plan Innovation

- Innovation Center work on Health Plan Innovation:
  - November 2014 - Issued RFI requesting public feedback on potential model approaches
  - September 2015 – Announced first Health Plan Innovation model – Medicare Advantage Value-Based Insurance Design
- Additional potential models are currently under consideration and/or in development.

What is Value-Based Insurance Design?

- Insurance benefit and cost sharing design that encourages enrollees to use the services that have the greatest potential to positively impact their health.
- Clinically nuanced – the design can differ based on an enrollee's health: Each condition has different needs.
- Using VBID may improve quality of care and save costs.
- CMS will test VIBD in MA via limited waiver of the MA uniformity rules.
- Gives MA and MA-PD plans the flexibility to offer cost sharing reductions and extra non-covered benefits only to enrollees with CMS-specified conditions.

Snapshot of the MA-VBID Model

- 5 year model test, begins 1/1/2017.
- Tested in: Arizona, Indiana, Iowa, Massachusetts, Pennsylvania, Tennessee, and Oregon.
- Plan flexibility to design VBID benefit packages, for CMS-defined targeted clinical conditions, using CMS-allowed flexibilities.
- VBID benefits must be reduced cost-sharing or extra benefits only: a “carrot” not “stick” approach to VBID.

Clinical Conditions

1. Diabetes	**5. Hypertension**
2. Chronic Obstructive Pulmonary Disease (COPD)	**6. Coronary Artery Disease**
3. Congestive Heart Failure (CHF)	**7. Mood disorders**
4. Patient with Past Stroke	

- Plans select one or more CMS-defined groups to receive VBID benefits.
  - Groups defined by ICD-10 code. All eligible enrollees must receive that group's VBID benefit package.
- May pair conditions for multiple-comorbidity packages.

VBID Intervention Types and Examples

1. ***Reduced Cost Sharing for High-Value Services, Supplies, Part D Drugs***
   - $5 co-pays for eye exams for diabetics; $0 co-pays for ACE inhibitors for enrollees who have previously experienced an AMI.

2. ***Reduced Cost Sharing for High-Value Providers***
   - $0 co-pays for diabetics who visit PCP's with track record of controlling Hba1c levels; $0 co-pays for non-emergency surgeries at cardiac centers of excellence.

3. ***Reduced Cost Sharing for Disease Management Participation***
   - Elimination of primary care co-pays for diabetes patients who meet with a case manager.

4. ***Coverage of Extra Supplemental Non-Covered High-Value Benefits***
   - Extra coverage of smoking cessation for COPD patients.

Beneficiary Protection

- No reductions in targeted enrollee benefits or increases in targeted cost-sharing amounts as VBID interventions.
- Interventions may not discriminate against other populations.
- Strict adherence to definitions of eligible populations.
- All VBID benefits must be disclosed to eligible enrollees.
- No requirement for enrollee opt-in.

Marketing Communications & Disclosures

- Participation must not be included in pre-enrollment marketing materials.
- Plans may convey truthful and accurate information when asked directly by potential enrollees; CMS may require disclaimer language to accompany such information.
- After enrollment, all enrollees in target populations must receive written materials summarizing the VBID benefits available to them.
  - For eligible enrollees, this is the minimum. Participants encouraged to further communicate with eligible enrollees by multiple channels.

Monitoring & Evaluation

- Model evaluation will test effectiveness of VBID strategies on improving quality of care and reducing costs. Assistance with evaluation is requirement of participation.
- CMS intends to base evaluation on data sources already collected, such as HEDIS measures or encounter data.
  - Some additional data collection may be required.
  - Enrollee surveys may contain some additional questions.
- CMS will conduct compliance monitoring on a regular basis to track participant compliance. Audit activity may require additional data or site visits.
- Activities designed with concern of burden on participants in mind.

Model Learning and Diffusion

- Learning activity to provide CMS, participants and the community with insight into VBID principles.
- Regular collaborative calls.
- Periodic reports.
- Presentations from subject-matter experts on field work and proven practices.

Qualified Participants

- MA and MA-PD Plan Benefit Packages offered in test states.
- HMO, HMO-POS & Local PPO (no SNP, MMP, EGWP, PFFS, 1876, MSA, RPPO etc.).
- Three Star – Not consistently low performing.
- Not under sanction, no past performance outlier rating.
- 3 years of operation prior to CY 2017.
- Minimum of 2,000 enrollees (for evaluation).
- Offered in no more than two states w/ 50% of enrollees in test state.
- CMS will entertain written exception requests.

Application Process

- RFA released Sept. 2015; responses Dec. 2015.
- CMS will review qualification of applicant, acceptability of proposed VBID benefits.
  - Not competitive. No maximum number of qualified plans participating.
  - Actuarial projections required.
- Separate guidance to participants will follow on marketing, CY 2017 bid procedures, other topics.

Disclaimer

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

Value-Based Insurance Design Model Test

Center for Medicare and Medicaid Innovation

Division of Health Plan Innovation

Innovation.cms.hhs.gov/initiatives/VBID

MAVBID@cms.hhs.gov