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Value Based Insurance Design Model FAQs

General Model Information

What is the Medicare Advantage Value-Based Insurance Design Model?

The Medicare Advantage Value-Based Insurance Design (VBID) Model is an opportunity for Medicare Advantage plans to offer supplemental benefits or reduced cost sharing to enrollees with the Centers for Medicare & Medicaid Services (CMS) specified chronic conditions, focused on the services that are of highest clinical value to them. The model tests whether this can improve health outcomes and lower expenditures for Medicare Advantage enrollees.

When did the VBID model begin and when will it end?

The VBID model began on January 1, 2017 and will run for 5 years, to conclude on December 31, 2021.

Where is CMS testing Value Based Insurance Design?

CMS is testing the VBID model in several states. In 2017, CMS allowed for MA plans in the following 7 states to apply to the model: Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee. For 2018, CMS opened the model test to Alabama, Michigan, and Texas. For 2019, CMS will include 15 more states in the model: California, Colorado, Florida, Georgia, Hawaii, Maine, Minnesota, Montana, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, Virginia, and West Virginia.

Who are the current participants in the model?

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.

The MA organizations and the years that they participated in the model are:

Medicare Advantage Organization	State	Years in the Model
Indiana University Health Plan	Indiana	2017 & 2018
BCBS of Massachusetts	Massachusetts	2017 & 2018
Fallon Community Health Plan	Massachusetts	2017 & 2018
Tufts Associated Health Plan	Massachusetts	2017 & 2018
BCBS of Michigan	Michigan	2018
Aetna	Pennsylvania	2017 & 2018
Geisinger Health Plan	Pennsylvania	2017 & 2018
Highmark	Pennsylvania	2017 & 2018
Independence Blue Cross	Pennsylvania	2017 & 2018
UPMC Health Plan	Pennsylvania	2017 & 2018

What are the approved disease categories in the VBID model?

For the purposes of the MA-VBID Model test, in the first two years of the Model, CMS has identified a limited number of chronic conditions from which organizations may 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 an organization.

Beginning in 2019, in addition to the existing process, CMS will allow MA organizations the flexibility to propose their own methodology for identifying VBID beneficiaries using CMS data sources. This process will be subject to CMS approval.

Applicants may continue to identify and include VBID eligible enrollees using the previously approved chronic conditions listed below.

The CMS approved targeted conditions are:

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

How were the chronic conditions identified for this model?

The chronic conditions included in this model in year one and two were selected based on several CMS selected conditions with relatively high incidence within the Medicare Advantage enrollee population so as to provide for greater potential overall impact on quality and cost, and to facilitate a robust evaluation of the effects of VBID. CMS also sought conditions where preliminary investigation suggested there were high-value services available to that population which a health plan could promote to improve beneficiary health outcomes. For 2019, participants will have the flexibility to propose additional chronic conditions to target for the model.

The model's announcement and other documents refer to "plans?" How is a plan defined in the VBID model?

Participants in the VBID model are Medicare Advantage Organizations (MAOs) that offer Plan Benefit Packages (PBPs) in the Medicare Advantage program. Formally, MAOs will apply to participate in the model and identify the specific PBP or PBPs within which they would like the flexibility to offer VBID benefits.

How does the VBID model differ from the regular Medicare Advantage (MA) plans?

In the VBID model, participants can offer lower cost-sharing or additional benefits to a specific group of MA enrollees with a defined clinical condition. The VBID model also allows plans to

lower cost sharing for Part D benefits. 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.

Are VBID benefits offered as a new product?

VBID benefits are offered as additions to existing MA benefit packages, and not as separate and new products.

How often will CMS make changes to the model design?

Acknowledging the difficulties inherent in mid-year changes, it is CMS's intention to endeavor to roll out changes on an annual basis with adequate notice. CMS retains the right to change any model policy or condition on an annual basis, or more frequently in accordance with the procedure and parameters to be agreed upon in the model's contractual addendum.

Model Participant Eligibility

How does a Medicare Advantage plan become a VBID model test participant?

Medicare Advantage Organizations (MAOs) that are located within one of the states that the VBID is being tested may apply by submitting an application. PBPs within these MAOs offered in these states may offer VBID benefits once accepted into the model test. To qualify to participate, among other requirements, a PBP must be offered in the test state and no more than one additional state. Furthermore, at least 50% of enrollees must reside in the model test state.

At what point does a selected Medicare Advantage Organization join the model test?

Selected organizations will formally join the model test by addendum to the MAO's contract with CMS for participation in Medicare Advantage for the applicable contract year(s). Organizations are required, at the time of application, to specify the PBPs they will enroll in the model test and the states (and service areas) in which those PBPs will participate. Organizations must submit a separate application for each Medicare Advantage contract held by that organization but one or more PBPs covered by that contract may be included in the application, even if the proposed VBID interventions vary from PBP to PBP.

Is there an opportunity for Medicare Advantage Organizations offering Plan Benefit Packages outside of the test states to voluntarily participate?

CMS is not testing the VBID model outside of the listed states at this time, except in the limited circumstances described in our guidance for plans with PBPs whose service areas fall inside and outside the test states.

Will CMS specify which Plan Benefit Packages are eligible to participate in the VBID model?

CMS will not specify the exact PBPs that are eligible to qualify. Interested organizations should consult the qualification criteria to determine which PBPs qualify, and whether an exception request is needed for a PBP.

How many VBID-eligible members does a PBP have to have included in the model to qualify?

The requirement is that the total enrollment of a PBP is at least 2,000 enrollees. Provided that an MA organization participates in the model test with at least one PBP with enrollment over 2,000 enrollees, the minimum enrollee requirement for each additional PBP from that MA organization (or other MA organizations with the same parent organization) to participate without an exception from CMS is 500 enrollees. Organizations still not meeting the enrollment requirement may contact CMS to discuss an exception request.

Are Special Needs Plans (SNPs) allowed to participate?

In 2019, Chronic Condition SNPs (C-SNPs) will be allowed to participate in VBID. At this time Dual Eligible SNPs (D-SNPs) and Institutional SNPs (I-SNPs) are not allowed to participate in the VBID model.

If a particular Plan Benefit Package does not strictly meet the eligibility criteria, may it still be approved by CMS to participate?

CMS will consider exception requests from organizations offering PBPs that do not meet the participation criteria, but for which good cause nevertheless exists for admission to the model test. For example, CMS could consider an exception for a PBP that has been offered for fewer than three years, where that plan is a successor to a previously offered plan, such that sufficient baseline data is available for evaluation.

CMS might also consider admitting a PBP with fewer than 2,000 enrollees where an organization has at least one other PBP that does qualify, and wishes to offer a uniform set of VBID benefits across all its PBPs in a test state.

These examples are illustrations of circumstances in which an MAO may wish to consider submitting an exception request. Note that CMS is not bound to issue exceptions in these cases or in response to any other exception request. To request an exception, send CMS a request in writing by e-mail to MAVBID@cms.hhs.gov and provide as much detail as possible, including the contract number, the plan benefit package number, projected enrollment, service area of that plan, and rationale for the requested exception.

How will CMS measure the star rating associated with a particular Plan Benefit Package to determine if it may participate in the VBID model?

CMS will look to the overall MA-PD rating of the contract under which the individual PBP is offered. Contracts without an overall rating are not eligible, but we will accept and consider exception requests from all interested participants regarding ineligible PBPs.

If an organization has a plan with multiple segments, must VBID benefits apply to all segments and not to a sub-set of segments?

If an organization has a plan with multiple segments, VBID benefits must apply to all segments and not to a sub-set of segments. Segmented plans can participate in the VBID model test; however, specific rules apply. Interventions pertaining to enhanced or additional supplemental benefits, any intervention consisting of a reduction of cost sharing for a Part D drug, or coverage of an excluded prescription drug must be applied uniformly across all segments of a segmented plan. This means that a plan that includes fewer than all associated segments in the VBID model may not offer these VBID interventions. These specific interventions are permissible as long as all associated segments are included in the VBID model and the same VBID interventions are offered across all associated segments. Consistent with existing MA segment requirements (in which there may be differential cost sharing across segments but not benefit design), only those VBID interventions that consist of reductions in cost sharing for Medicare Parts A and B covered services, whether as a specific intervention, for use of a high- value provider, or for participation in a disease management or similar program, may vary from segment to segment, or be offered in fewer than all plan segments.

Applicants to the model offering distinctive interventions by segment (e.g., reductions of cost sharing for Medicare Parts A and B covered services only) should upload a supplemental document describing which interventions apply to which segment as part of the application.

Did the current participants have to reapply for participation in 2019?

Current participants must reapply each year. If they are not making any changes, they may reuse information from previous applications.

Were the existing participants allowed to apply with new Plan Benefit Packages for 2019?

Existing participants were able to apply with new Plan Benefit Packages for 2019.

Eligible Enrollees

How will eligible enrollees be identified by VBID model participants?

For the first two years of the model (2017 and 2018), participating organizations will be responsible for applying the CMS defined criteria to identify enrollees who fall within each of the clinical categories selected by an organization in their VBID application. The VBID participating organization will identify eligible enrollees at the beginning of the year based on diagnosis data contained in claims submitted by network providers. Participants will then periodically review new data to identify enrollees newly eligible based on a diagnosis that may occur mid-year.

Starting in model year 3 (2019), CMS will allow participating organizations to propose their own methodology, subject to CMS approval, to identify eligible enrollees using CMS data sources (e.g., International Classification of Diseases (ICD) 10, encounter data, claims data, etc.)

Is someone who had an eligible condition prior to enrolling in the participating organization's plan eligible for VBID?

Yes, someone who had an eligible condition prior to enrolling in the participating organization's plan is eligible for VBID if their diagnosis falls within the targeted condition and the organization has identified them as eligible in accordance with the model test's requirements.

Can organizations ask enrollees to register for the VBID benefit?

Where the VBID benefit is a reduction in cost sharing or a reduction in cost sharing associated with visiting a high-value provider or a supplemental benefit, no registration requirement is permitted. Where the VBID benefit is a reduction in cost sharing associated with participation in a disease management or wellness program, the participating organization may require the enrollee to register for the program.

How are organizations required to validate or confirm qualifying diagnoses for new enrollees (e.g., those for whom they do not have encounters or claims data yet)? Is there a physician attestation form, or do they have to wait for a claim with a qualifying ICD-10 code?

Organizations may validate diagnoses from claims or provider encounters only. CMS will consider additional methods of identification and validation of enrollee eligibility; such proposals may be included in the organization's application. Additional methods should supplement, but not supplant, validation based on diagnosis.

Is there a limit to the lookback period for eligible VBID diagnosis codes?

No. Organizations wishing to limit the lookback period should propose a limit to CMS. Proposed lookback periods should have a clinical basis.

Some dual-eligible beneficiaries are enrolled in non-SNP MA plans. Would these beneficiaries be eligible to participate in the VBID program?

Yes. VBID benefits must be made available to Medicare-Medicaid beneficiaries that have one or more VBID specific conditions.

What flexibility will CMS offer on how the classes of eligible enrollees can be defined and how frequently plans may or need to identify beneficiaries with eligible target conditions? Could organizations define target conditions using other mechanisms such as by using the broader three digit ICD-10 code?

For Year 1 and 2 of the model, all categories of eligible enrollees are defined by ICD-10 codes. Beginning in Year 3 (2019), participating plans may use other CMS data to propose a methodology to identifying enrollees or continue using the CMS defined ICD-10 code.

As long as a participating organization offers VBID benefits to all members with a targeted condition in a plan, can that organization conduct outreach to specific high-risk members?

All enrollees eligible for VBID benefits must receive those benefits and must receive notice of those benefits in accordance with the VBID model test's minimum requirements. Participating organizations are permitted to conduct additional outreach to high-risk members as part of their ordinary care management efforts. However, participants doing so should take care to select enrollees for outreach in a non-discriminatory manner.

What happens if the enrollee falls into two clinical condition categories targeted by the participating organization (e.g., diabetes and CHF) and there are different benefits for each? Which benefit prevails?

The individual should receive both sets of VBID benefits. In the event that cost sharing varies depending on which targeted condition group for which the enrollee is eligible, the enrollee should receive the lower of the two amounts. In the event that there are additional supplemental benefits available to one targeted group, but not the other, the enrollee will be eligible for the additional benefits.

Can a participant offer interventions for enrollees with a combination of two targeted conditions, but not when the enrollee only presented with one condition?

Yes, applicants may propose multiple comorbidity categories.

May organizations design a VBID benefit that is only available to enrollees whom a case manager has determined should be eligible for the benefit, because the benefit eliminates an identified barrier to care?

No. VBID benefits are to be offered to all plan enrollees who meet the target clinical condition; benefits may not be offered on the basis of a case manager's discretion.

Understanding that VBID benefits must be "offered" to all enrollees within the CMS defined class selected by an organization, if an organization increases coverage of a service covered under Medicare Parts A or B as a VBID intervention, must all enrollees in the CMS defined class be able to access that benefit, including those who did not otherwise meet the medical necessity criteria for that benefit?

Increasing coverage of a benefit covered under Medicare Part A or B as a supplemental benefit does not eliminate the medical necessity criteria associated with that benefit.
Please reference the Medicare Managed Care Manual, Chapter 4, Section 30.2, regarding the impact of National Coverage Determinations on supplemental benefits extending original Medicare benefits

Marketing, Communications and Disclosures

Are VBID model materials subject to the marketing requirements in the Medicare Advantage program?

All marketing regulations and guidance remain applicable to materials and activities of the participating plan and other MA plans. See, for example, 42 C.F.R. parts 422 and 423, sub-part V. In addition to marketing and enrollee communication requirements outlined in the VBID model's request for application, CMS has issued further guidance on marketing and other communications. The model test's Communications Guidelines are available on the model test's website.

Can VBID participants market VBID benefits prior to enrollment?

Beginning in CY2019, organizations participating in the VBID model may be allowed to cite

their participation in the Model and the specific benefits available to potential enrollees during the enrollment period. Specific requirements and permissible actions will be set out in the language related to the marketing of MA Uniformity Flexibility in CMS's Medicare Advantage Final Call Letter or the Medicare Managed Care Manual.

The Communication Guidelines indicate that marketing code 31002 should be used for "Other VBID communications" and states that materials under this code are not subject to prospective review. Does that mean that these can be used upon filing?

The materials are not subject to prospective review and can be used upon filing. CMS will review the materials in the course of our regular monitoring and auditing processes, and reserves the right to prospectively disapprove them or may ask for prospective changes based on CMS findings.