Calendar Year 2022 Medicare Advantage
Value-Based Insurance Design Model

January 2021
Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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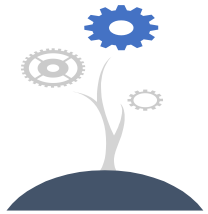
Agenda

- CMS Introductions
- Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model Overview
- Calendar Year (CY) 2022 Application Timeline & Process
- CMS Technical Assistance and Applicant Resources
- Question and Answer Session

Presenters

- Laura McWright, Deputy Director of the Seamless Care Models Group
- Jason Petroski, Director of Division of Delivery System Demonstrations
- Hunter Coohill, Co-Lead of the VBID Model
- Sibel Ozcelik, Co-Lead of the VBID Model

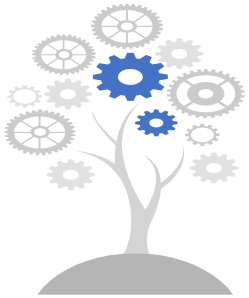
Model Growth



2017

First Health Plan Innovation Models Begin

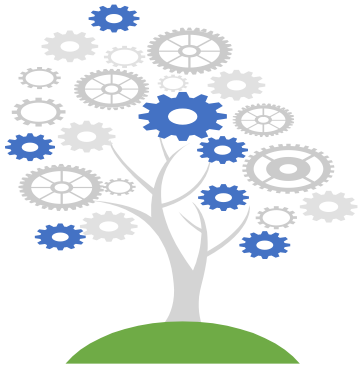
- MA VBID Model
- Enhanced Medication Therapy Management (MTM)



2020

Transformative Updates and New Model

- Significant VBID Model Additions
- Added Part D Payment Modernization Model



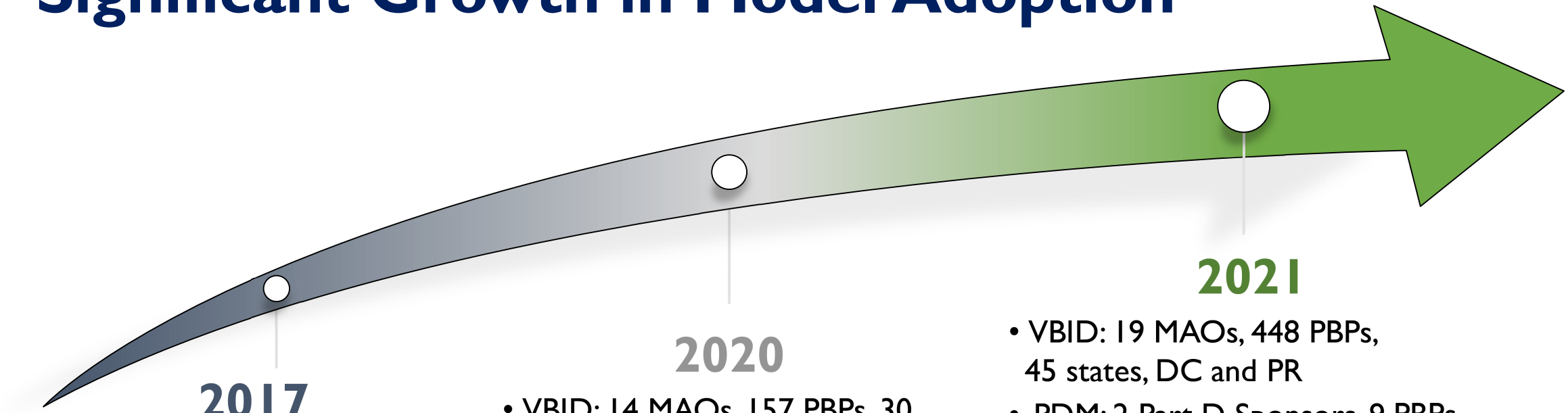
2021

Begin Hospice Carve-in

- Added Part D Senior Savings Model, a ground-breaking model to lower out-of-pocket expenses for insulin

Innovation & Model Adoption Increasing Over Time

Significant Growth in Model Adoption



2017

- VBID: 9 MA Organizations (MAOs), 45 PBPs, 3 states
- Enhanced MTM: 6 Part D sponsors; 22 standalone basic PDPs *(Only application cycle)*

2020

- VBID: 14 MAOs, 157 PBPs, 30 states and 1 territory
- Part D Payment Modernization (PDM): 2 Part D sponsors, 8 PBPs, 4 states

2021

- VBID: 19 MAOs, 448 PBPs, 45 states, DC and PR
- PDM: 2 Part D Sponsors, 9 PBPs, 4 states
- Part D Senior Savings Model: 1600+ PBPs, 50 states, DC, and PR

CY2022 VBID Model

CY2022 VBID Model Components

New for 2021

Tests Complementary MA Health Plan Innovations

Benefits by Condition, SES, or both	MA and Part D R&I Programs	Wellness and Health Care Planning (WHP)	Hospice Benefit Component	Cash or Monetary Rebates	New and Existing Technologies
Tests the impact of targeted reduced cost-sharing (including for Part D drugs) or additional supplemental benefits based on enrollees: a. Chronic Condition(s) b. SES c. Both (a) and (b)	Tests how R&I programs that more closely reflect the expected benefit of the health related service or activity, within an annual limit, may impact enrollee decision-making about their health in more meaningful ways	Tests the impact of timely, coordinated approaches to wellness and health care planning, including advance care planning	Tests how including the Medicare hospice benefit in an enrollee's MA coverage impacts financial accountability and care coordination across the care continuum	Tests the impact of sharing rebates directly with enrollees, in the form of cash or cash equivalents	Tests the impact of allowing MAOs to cover new and existing FDA-approved technology not currently covered by the Medicare program

Value-Based Insurance Design – Chronic Condition and/or Socioeconomic Status

- To test the impact of value-based insurance design, MAOs may propose reduced cost-sharing and/or additional supplemental benefits, including non-primarily health-related supplemental benefits, for targeted enrollees
- MAOs may propose reducing cost-sharing for Part C items and services and covered Part D drugs
  - For example, based on chronic condition(s) and/or low-income subsidy status (LIS), MAOs may propose generic drug(s) with $0 cost-sharing or elimination of co-pays for primary and specialty care visits
- MAOs may propose additional conditions for eligibility
  - For example, a conditional requirement may be participation in a disease state management program or seeing a high-value provider

Value-Based Insurance Design – Chronic Condition and/or Socioeconomic Status (cont.)

- MAOs may also propose providing additional "non-primarily health-related" supplemental benefits
- MAOs must provide an evidence base that justifies the use of additional "non-primarily health-related" supplemental benefits in the targeted population
- MAOs may choose how narrowly to provide these "non-primarily health related" supplemental benefits, including to all enrollees with a chronic condition or to a more defined subset of targeted enrollees (e.g., enrollees who qualify for LIS)

Rewards and Incentives (RI) Programs

Provides higher-value MA RI Programs than currently available under MA and tests how MAOs may improve uptake and utilization of RI through flexibilities to:

- Set a value that reflects the benefit of the service, rather than just the cost of the service;
- Provide a higher allowed annual aggregate amount per enrollee (up to $600);
- Provide the RI Program to targeted enrollees (e.g., specific to participation in a disease management or transition of care program); and
- Have a RI program associated with the Part D benefit

Part D RI Programs

- Permits MAOs to propose Part D RI programs that, in connection with medication use, focus on promoting improved health, medication adherence, and the efficient use of health care resources
- Goal is to reward and incentivize enrollees' medication adherence to their drug therapy regimen. RI programs may promote:
  - Participation in a disease state management program
  - Engagement in medication therapy management with pharmacists and/or providers
  - Receipt of preventive health services, such as vaccines
  - Active engagement with their plans in understanding their medications, including clinically-equivalent alternatives that may be more cost-accessible

Wellness and Health Care Planning (WHP)

- As a condition of receiving any program waiver granted in connection with this Model, MAOs must implement a strategy in 2022 regarding the delivery of timely WHP services, including advance care planning (ACP) services, to all enrollees in all of the PBPs included in the Model
- Broader strategies include, but are not limited to:
  - MAO WHP infrastructure investments (e.g., digital platforms to support ACPs);
  - Provider initiatives around WHP education; and
  - Member focused initiatives (e.g., providing information on how enrollees can access WHP services in the Evidence of Coverage)
- In addition to a broad strategy, MAOs participating in the Model may also have a targeted strategy for their VBID enrollees to receive WHP

Hospice Benefit Component Design

Aims to enable a seamless care continuum that improves quality and timely access to palliative and hospice care in a way that fully respects beneficiaries and caregivers

1. Maintains the full scope of the current Medicare hospice benefit

2. Focuses on improved access to palliative care

3. Enables transitional concurrent care for enrollees

4. Introduces additional hospice-specific supplemental benefits

5. Promotes care transparency and quality through actionable, meaningful measures

6. Maintains broad choice and improves access to hospice

7. Utilizes a budget neutral payment approach to facilitate all of the above aims

Reference:
CY2021 Hospice Base Capitation Payment

Basic Benefit Capitation Rate* *("A/B capitation rate")* + **Monthly Hospice Capitation Rate** + **MA Rebate Amount** + **Monthly Prescription Drug Payment** *(if any)*

*Risk-adjusted and consistent with current law; for only the month in which an enrollee elects hospice (Month 1), unless status is under hospice election as of the first of the month

- For enrollees who elect hospice, participating MAOs will receive a monthly hospice capitation rate, adjusted by a hospice-specific average geographic adjustment and a monthly rating factor
- For the first month of hospice coverage, MAOs will receive the risk-adjusted A/B capitation payment, the MA rebate amount, monthly prescription drug payment, (if offering prescription drug coverage), and a hospice capitation rate tied to the number of Month 1 days of hospice enrollment a beneficiary has:

Days in Month 1	Base Rate
1 – 6	$1,784
7 – 15	$3,359
16+	$5,353

- For hospice stays that occur in a second calendar month and on (Months 2+), MAOs will receive a monthly hospice capitation payment, the MA rebate amount, and monthly prescription drug payment, if offering prescription drug coverage

Month 2 and Later	Base Rate
Monthly Capitation	$5,248

Hospice Benefit Component Network Design

CMS seeks comment on network design and definition of network adequacy standards for Phase 3, including feedback on the following topics:

a) if a minimum hospice provider ratio is the appropriate metric or if there is a more appropriate access metric;
b) how to develop minimum hospice provider ratios in each county or service area;
c) how the quality and types of care a hospice provider traditionally has provided should apply in setting network adequacy requirements; and
d) considerations for continuing to allow for broad access.

Please submit comments to VBID@cms.hhs.gov.

Cash or Monetary Rebates

- Provides participating MAOs additional flexibility to choose to share rebates under section 1854 of the Act with all of their enrollees in Model PBPs through a new mandatory supplemental benefit in the form of cash or monetary rebates
- Tests different ways that sharing the beneficiary rebates:
  - (a) incentivize Medicare beneficiaries to choose MA plans with lower costs and/or higher quality (per Quality Star Ratings);
  - (b) incentivize MAOs to offer lower bids and/or earn higher Star Ratings
- Participating MAOs must notify beneficiaries, via an explicit notice, of potential tax consequences associated with the provision of the cash or monetary rebate
- Not subject to an annual limit of $600 per enrollee

New & Existing Technologies

- Allows MAOs to propose to cover new technologies that are FDA approved and that do not fit into an existing benefit category for **targeted populations** (chronic conditions and/or LIS status) that would receive the highest value from the new technology
- MAOs permitted to provide coverage for:
  - (a) FDA approved medical device or new technology that has a Medicare coverage determination (either national or local) where the MA plan seeks to cover it for an indication that differs from the Medicare coverage determination and the MA plan demonstrates the device can be medically reasonable and necessary for the other indication; and
  - (b) For new technologies that do not fit into an existing benefit category.

CY2022 Application Timeline & Process

CY2022 VBID Application Timeline

February 1, 2021

- Application portal-go live and associated materials released

April 16, 2021

- Completed Application due to CMS by 11:59 pm PT

Mid-May 2021

- CMS completes review of applications and provides feedback to MAOs for inclusion in their CY2022 PBP

June 7, 2021

- CY2022 MA and Part D Bids Complete; formulary submission deadline

September 2021

- Contract addenda for Model participation executed and Model participants announced

CY2022 Application Process and Resources

- VBID Requests for Applications outlines additional specifics on each of these components, plan eligibility, and the application process
- Main source of information is the VBID Model website: https://innovation.cms.gov/initiatives/vbid
  - Application link and materials will be available **on February 1st**
- VBID Model Team can be reached at VBID@cms.hhs.gov
- CMS is available for meetings throughout the application process. To request a meeting with the VBID Model Team, please email VBID@cms.hhs.gov. To aid in expedited scheduling, please provide requested times.

Thank you for joining us.

Please email us with any questions at:
VBID@cms.hhs.gov