CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model

Calendar Year 2021 Financial Projections

Background

The VBID Model tests a number of complementary health plan innovations designed to promote improved quality and reduced costs in the MA program. While applicants and certifying actuaries should refer to the VBID Model RFAs, located at https://innovation.cms.gov/Files/x/vbid-rfa2021.pdf for VBID flexibilities and https://innovation.cms.gov/files/x/vbid-hospice-rfa2021.pdf for the Hospice benefit component. For the Calendar Year (CY) 2021 VBID Model, eligible Medicare Advantage Organizations (MAOs) may participate in the VBID Model by proposing one or more of the following components:

VBID Flexibilities: Under this component, MAOs may targeted mandatory supplemental benefits to enrollees based on: (i) chronic condition(s); (ii) socioeconomic status, as defined by qualifying for the low-income subsidy; or (iii) a combination of both. MAOs may provide both primarily and non-primarily health related supplemental benefits, including a focus on new or existing technologies or FDA approved medical devices. MAOs may provide reduced Part D cost-sharing through VBID for specific covered Part D drugs for a specific population. MAOs may also share beneficiary rebate savings directly with all enrollees in a plan in the form of cash or monetary rebates (i.e., not targeted), including any necessary explicit notice of any tax consequences.

With the exception of the provision of cash or monetary rebates, MAOs may condition the other VBID flexibilities on the use of a high-value provider and/or participation in a care management or disease state management program.

Part C and Part D Rewards and Incentives Programs: MAOs that offer Part C and/or Part D Rewards and Incentives Programs through this VBID Model component must design programs that promote improved health, prevent injuries and illness, and promote the efficient use of health care resources. MAOs may offer Part C Rewards and Incentives with a value related to the benefit of the service. MAOs may also offer Part D Rewards and Incentives programs designed to improve the linkage between enrollees and the care team in understanding clinically-equivalent therapeutic options, prescription drug coverage, and the overall value to their health of adherence to prescribed drug therapy. Any Part C and Part D Rewards and Incentives Programs costs must be included as an administrative cost in the Bid Pricing Tool (BPT).

Hospice Benefit Component: While MAOs should refer to the full Medicare hospice benefit component RFA, through this component, CMS is testing the inclusion of the Medicare hospice benefit as part of MA.

Wellness and Health Care Planning: All Model participants must develop, and CMS must approve, a strategy to provide Wellness and Health Care Planning (WHP), including advance care planning (ACP), for enrollees in their Model-participating plan benefit packages (PBPs).

Financial Projection Requirements

Participating MAOs are required to submit to CMS: (i) projected costs for each VBID Model Component included in their application and (ii) projected net savings to Medicare over the course of the Model. In submitting these projections as part of the application, plans must clearly outline the projected costs of the VBID Model Components that the MAO is proposing to be implemented under the Model, as well as how the proposal will generate net savings to Medicare over the term of the Model. The financial supplemental document must reflect the MAO's best estimate of projected enrollee engagement, program implementation costs, utilization changes, including the expected timeframe of those utilization changes.

CMS requires that Model participants show net savings to CMS and no net increase in enrollee costs over the course of their participation in the Model. CMS will review these projections as part of reviewing the application for compliance with the terms of the Model test, including reviewing the reasonableness of assumptions, any potential detrimental impact to CMS, the Medicare program, or enrollees, and the sustainability of the proposal.

These projections must be prepared by an actuary and all final revenue and expense assumptions must be reflected in the MA or Part D bid by the certifying actuary. Any differences between these projections and the MA or Part D bid must be reconciled through submitting an updated version of this financial outline to CMS, via the VBID Model mailbox at VBID@cms.hhs.gov, **no later than the bid submission.** Based on the differences, including increase programmatic costs or an increase in enrollee costs, CMS may require a multi-year financial plan or other remedy as deemed necessary by CMS.

Instructions

CMS has provided the below form for applicants to outline their specific Model proposals.

i. Executive Summary - a summary in financial and actuarial terms of the Model strategy and expected PMPM changes. This should include any changes to an existing program if the MAO is current participating in the Model;
ii. Summary of Projected Costs by each VBID Model Component (a projected utilization, unit or PMPM costs and NBE costs together with an indication of what experience base, etc., was relied on in setting the assumption. A projection of the member months eligible for each component and/or targeted population and estimates of those that will participate or otherwise be engaged, if applicable);
iii. Summary of Projected Savings over the Course of the Model;
iv. Additional Quantitative Support, as needed, including past performance if returning MAO; and
v. Changes to Pricing (e.g., projected increase to risk scores, bid pricing tool changes).

The purpose for requesting the above supporting documentation is to assist CMS in assessing the reasonability of the pricing assumptions intended to be used when providing VBID benefits under this Model. Additionally, the supporting documentation should describe how the proposed VBID Model Components may be expected to meet the Model's financial goals of net savings to Medicare expenditures without any net increase in costs for plan enrollees attributable to the VBID elements over the life of the Model.

i. Executive Summary

Please list each VBID Model component that the MAO is proposing to include along with a summary of the proposed intervention(s). MAOs may also choose to submit a separate PDF of required information in the same format at this document.

As part of the executive summary, please provide the most recent count of enrollees in each contract and PBP included in the Model. MAOs may also provide this in a separate, attached document.

Contract_PBP_Segment	January 2020 Month's Enrollment	Model Component	Expected Enrollees to be Targeted	Expected Enrollees to Receive Intervention

ii. Summary Projected Costs from Model Participation

Please provide the expected increase in utilization, unit, per member per month (PMPM), or non-benefit expense increases by intervention. Where possible, please include baseline inpatient, professional, and other service categories that are relevant to the intervention and then projected changes due to Model participation. For MAOs including the hospice benefit component, please include any projected costs related to hospice-specific supplemental benefits.

iii. Summary of Projected Savings over the Course of the Model

Please provide the expected decrease in utilization, unit, per member per month (PMPM), or non-benefit expense by intervention over the timeframe of 2021 through 2024. Where possible, please include baseline inpatient, professional, and other service categories that are relevant to the intervention and then projected changes due to Model participation. To the extent there are savings to other health insurers, such as Medicaid, please include projected decreases in costs here (e.g., if you have D-SNP and costs for Medicaid are decreased as a result). For MAOs including the hospice benefit component, please include any projected savings related to hospice-specific supplemental benefits.

iv. Additional Quantitative Support

Please use this section only as necessary to outline any specific changes secondary to participation in the Model that are assumed and allow the MAO to meet the requirement of net savings to CMS over the course of the MAO's participation and no net increase in enrollee costs.

If an existing participant, please include previous year bid assumptions, any differences between the bid assumptions and actual performance, and net performance (costs and savings) over the MAO's participation.

v. Changes to Pricing

Please outline any changes to plan risk score or other pricing factors that may increase CMS or enrollee costs that the MAO assumes may result from participation in the Model. Please quantify the impact, where possible.

vii. Reflection in the BPT

Please explain how the above will be reflected in the BPT. If an existing Model participant, please provide an explanation of any BPT changes in terms of assumptions.