Overview of Calendar Year (CY) 2025 Request for Applications (RFA) Webinar Transcript

Thursday, February 15, 2024

Anna Rosenblatt:
Hello everyone. Welcome to today's webinar on the Medicare Advantage (MA) Value-Based Insurance Design, VBID, Model. My name is Anna Rosenblatt. I am the Communications Lead for VBID. In today's webinar, we will review the Calendar Year 2025 updates, VBID Request for Applications, the Hospice Benefit Component Payment Methodology, and briefly discuss the Application Process. But first, to kick us off, we are pleased to introduce Dr. Liz Fowler, CMS Deputy Administrator, and Director of the CMS Innovation Center for opening remarks. [00:00:55]

Liz Fowler:
Thanks so much, Anna, and good afternoon, everyone. I really want to welcome you warmly current and potential new participants in VBID. Thank you for joining us today. I'm excited to be here with you today as the VBID Team shares Calendar Year 2025 updates. The VBID Model, along with the rest of the CMMI portfolio, is aligned with the CMS Innovation Center's strategic objectives, and vision for a health system that achieves equitable outcomes through high-quality, affordable person-centered care. It's highlighted in our December blog post, *Charting a Path for the Medicare Advantage Value-Based Insurance Design Model: Innovating to Meet Person-Centered Needs*. The Growth in Enrollment in the Medicare Advantage VBID Model, means that the Model, and by extension all of you as MA organization participants, play an essential role in health system transformation, in CMS's efforts to ensure that Medicare Advantage beneficiaries' have access to high-quality affordable care. [00:01:50]

With VBID projected to reach 8.7 million beneficiaries in plan year 2024, I imagine you share our excitement for what we can accomplish together in 2025. Since 2017, the VBID Model has led CMMI's testing of Medicare Advantage innovations, such as targeting Part D cost-sharing reductions and supplemental benefits based on socioeconomic status. Through these interventions, plans are better able to address medical and non-medical drivers of health, particularly for underserved beneficiaries. We're encouraged by the progress we've seen so far on improved drug adherence and beneficiary experiences. At the same time, however, we've seen higher Medicare costs associates with VBID contracts and plans. [00:02:36]

VBID continues to evolve to be responsive to these findings. We look forward to what we can accomplish in the future. It's wonderful to see such great attendance for today's webinar, and I'm confident that together, we can use the tools at our disposal to make meaningful impact on care delivery and Medicare Advantage in measurable ways. Thanks for inviting me to join you today and for all your continued efforts in the VBID Model. With that I'm going to turn it over to Yixuan Song and the VBID Team. Thanks very much. [00:03:12]

Yixuan Song:
Thank you, Liz. As always, please note that the disclaimer, and this presentation is for educational purposes. Slides will be posted publicly on the VBID website in the coming weeks. *Next slide.*

Today's agenda includes an overview of the VBID Model, updates for 2025, an outline of the hospice benefits component payment methodology, application details, and finally a question-and-answer session. To kick us off, I'll start with introductions. Here are today's presenters. You have already heard from Anna and Liz. I'm Yixuan Song, Co-Lead of the VBID Model focusing on VBID General, and I will allow other presenters to introduce themselves.

Megan Coufal:
Hello, I'm Megan Coufal. I'm also the Co-Lead of the VBID Model. [00:04:00]

Michael de la Guardia:
Hi, I'm Michael de la Guardia. I'm Acting Deputy Director for the Division of Health Plan Innovation.

Anna Rosenblatt:
Julia will be joining for the question-and-answer session, and I will now pass it to Richard.

Richard Coyle:
And hi, I'm Richard Coyle. I work in the Office of the Actuary at CMS, and I'm part of the team that develops the VBID Hospice rates. Welcome! [00:04:45]

Yixuan Song:
All right., *next slide*.

Thank you, moving on, we want to provide a reminder of CMMI's mission. The CMS Innovation Center fosters healthcare transformation by finding new ways to pay for and deliver care that can lower costs and improve care. CMMI was established by statute to test innovative payment and service delivery models, to reduce costs and improve quality. Because models that demonstrate improved quality without increasing costs, reduce costs without negatively affecting quality, or that both improve quality and reduce costs can be extended into the overall MA program by the secretary, our work and measuring impact on cost, quality and enrollee experience is vital to having health-related social need benefits, and reduce cost-sharing for those who need it most, reach even more beneficiaries. *Next slide*. [00:05:52]

Before we begin, we want to make sure everyone knows how to submit questions during the presentation. Questions can be submitted by utilizing the Q&A section, and selecting all panelists, and will be responded to at the end of today's session. And now for an overview of the VBID Model. *Next slide*. [00:06:15]

CMS is testing through the voluntary VBID Model, a broad array of complementary MA health plan innovations designed to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries, and include the coordination and efficiency of healthcare service

delivery. Eligible Medicare Advantage Organizations, or MAOs, in all fifty states and territories may apply annually to participate in the Model. The Model began in 2017, and is currently set to run through 2030. [00:06:52]

For calendar year CY 2025, there are three components of the Model. This is a change from CY 2024, in which the Model had five components. Wellness and healthcare planning (WHP), and New and Existing Technologies, are no longer standalone components of VBID. Instead, WHP has been rolled into the mandatory health equity plan, and New and Existing Technologies component has been removed as the larger MA program now offers similar flexibilities. For CY 2025, the three components are: one, VBID Flexibilities, referred to as VBID-Flex; two, Part D Rewards and Incentives, or RI programs; and three, the Hospice Benefit Component. [00:07:44]

Under VBID Flex, MAOs may propose reduced cost-sharing and/or additional supplemental benefits for targeted enrollees. New in CY 2025 is the new additional option for MAOs to target based on a beneficiary's location in specific Area Deprivation Index, or ADI areas. MAOs may propose additional eligibility conditions, like participation in a disease management program, and benefits can include primarily health-related benefits, such as vision, dental, or hearing, or non-primarily health-related benefits, such as grocery assistance, or non-medical transportation. [00:08:28]

Under Part D-RI, MAOs have the flexibility to offer RI, where the value of the reward provided to the consumer is capped not by the cost of the service, as it is under the larger MA program, but rather by the cost of the benefit, up to $600. Like VBID Flex, RI programs can be targeted to a subset of enrollees. Lastly, the Hospice Benefit Component, sometimes called the Hospice Carve-In, includes the hospice benefit in the scope of MA coverage to facilitate care coordination across the care continuum. *Next slide*. [00:09:12]

The Hospice Benefit Component has seven main objectives. In CY 2025, we would like to call out the clarification of Concurrent Care. New in 2025, we have removed the descriptor "Transitional" from “Transitional Concurrent Care”, to better align with other CMMI models, and more accurately reflect the benefit. You can see that reflected in the element, “enables Concurrent Care for hospice enrollees.” These seven elements together 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. [00:09:58]

There has been significant growth in VBID Model participation. In 2024, VBID is projected to reach 8.7 million beneficiaries, a huge increase from the 96,000 beneficiaries in 2017. The most common intervention, Part D cost-sharing reduction or elimination, is projected to reach 7.6 million low-income beneficiaries. Meanwhile, food and nutrition-related supplemental benefits are on track to reach 7.3 million beneficiaries this year alone. *Next slide*. [00:10:37]

In September 2023, CMS released an early Model evaluation report with some initial 2020-2022 findings. Results suggest that one, VBID plans leverage the Model as a tool for the direct provision of supplemental benefits that address needs among underserved beneficiaries. Two, VBID plans are associated with modest increase in quality of care. Three, VBID's most common intervention, eliminating Part D prescription drug cost sharing, is associated with greater

adherence to treatment. Four, VBID plans have an increase in targeted enrollees' risk scores relative to not comparable non-VBID plans. Five, VBID contracts were associated with increased rebates from improved Star Ratings relative to comparable non-VBID contracts. And lastly, six, this increase in risk scores and rebates drove higher Medicare costs associated with VBID contracts and plans. [00:11:42]

Going forward, we're taking immediate action to revise certain aspects of the VBID Model's design to both strengthen our understanding of cost-drivers, and to ensure the Model has the right tools in place to be responsive to evaluation findings and statutory requirements. For example, we have, one, strengthened focus and prioritization on health equity. Two, incorporated participation eligibility requirements in support of program integrity and compliance. Three, updated our savings goals via Model financial requirements. And four, increased data transparency and oversight.

Now I'll turn it over to Megan to provide a deep dive on the new elements of the VBID Model in 2025. [00:12:33]

Megan Coufal:
Thank you, Yixuan.

Along with the December blog post that was published on Charting a Path Forward for the VBID Model that discussed the most recent evaluation findings that Yixuan just addressed, the VBID Team has also put together a two-part Request For Information or RFI. Please keep in mind that the extended response deadline is tomorrow, February 16th. We do thank those of you who have already submitted your responses. [00:12:58]

The two parts of the RFI are one, advancing health equity by best identifying and meeting needs. And two, expanding access to higher-quality hospice care. The VBID Model continues to look for opportunities to provide enrollees with more person-centered care and interventions. As part of this goal, we are seeking feedback on testing additional flexibilities to target enrollees in underserved areas by the presence of health-related social needs, or HRSNs, in the future. And as part of the Hospice Benefit Component, we are seeking comments on how to structure future access to hospice care, how to continue to encourage comprehensive high-quality networks, and how to continue to implement Model-specific network adequacy standards that better align with the traditional MA requirements. *Next slide*. [00:13:48]

Now we would like to dive into what's new for CY 2025. *Next slide*.

The VBID Model continues to prioritize health equity, in concert with the CMS Innovation Center Strategy Refresh. VBID is continuing to evolve with an expanded focus on health equity that leverages Model flexibilities. In order to achieve equitable outcomes through high-quality affordable and person-centered care, VBID requires a Health Equity Plan for all MAO participants, provides the Health Equity Incubation Program for shared learning among MAO participants, and has a continued focus on Part D Reduced Cost-Sharing to support drug affordability. We continue to explore HRSN screening data in MA, the new addition of targeting

flexibilities, including Area Deprivation Index, or ADI, and a new requirement for supplemental benefits to meet beneficiary needs. *Next slide*. [00:14:47]

For CY 2025, the VBID Model is introducing a new flexibility for MAOs to direct benefits to beneficiaries living in high-ADI areas. This will enable MAOs to focus on geographically-disadvantaged areas and address HRSNs, among the non-dual population through evidence-based benefits tailored to community-identified needs. Under this new targeting mechanism, MAOs may use national and/or state ADI for targeting enrollees residing in the most underserved ADI areas. The VBID RFA allows for state deciles seven through ten, or national percentiles 61 to 100. If utilizing this targeting flexibility, all qualifying ADI census blocks within the plan benefit package service area must be targeted. Please note that you can find an ADI data book on the VBID Model website. *Next slide*. [00:15:49]

Also new for CY 2025 is the requirement for applicants to address two out of three priority HRSNs. Requiring participating plans to offer benefits in the categories of food and nutrition, transportation, and/or housing and living environment will improve CMS's ability to text and evaluate the impact of these benefits on health and quality outcomes, including health equity and Medicare program costs. All applicants will be required to offer a minimum of two HRSN benefits selected from the categories of food and nutrition, transportation, and housing and living environment in each participating PBP. These benefits may be offered in combination with other benefits, such as those with a shared maximum benefit amount administered through a flex spending card. [00:16:36]

We do recognize that MAOs may be offering supplemental benefits that address priority HRSNs in the MA program. Medicare supplemental benefits outside of the Model can be used to satisfy this requirement for participating PBPs. However, we want to highlight that supplemental benefits used to satisfy this requirement are subject to summary level and beneficiary level data collection in reporting, as described in section 3.3 of the RFA, and must be identified within the VBID application. Of note, MAOs that are applying only to the Hospice Benefit Component are exempt from this requirement. *Next slide*. [00:17:15]

We also would like to highlight an adjustment outlined in the 2025 RFA on certain modifications to promote high-quality plan participation. There will be additional considerations of program integrity, quality, and financial requirements, namely that plans must show net savings to CMS due to Model participation over the course of the calendar year, and multi-year participation of the Model. There will be initial program integrity screens and requirements to align with the MA program and participating PBP contracts must have at least three-star overall quality rating for the most recently available year to qualify. *Next slide*. [00:17:55]

Some of the key updates and changes made to the Model for CY 2025, Wellness and Healthcare Planning, or WHP, has been discontinued as a discrete component, and instead will be integrated into each MAO's Health Equity Plan. The Part C RI program, as a VBID Model component, is being discontinued beginning in CY 2025, given the similar ability to offer Part C RI Programs authorized through flexibilities within the broader MA program outside of the Model. Additionally, the flexibility to cover new and existing technologies and FDA-approved medical

devices is discontinued beginning in CY 2025. And monitoring and data collection has been modified to better support evaluation and further understanding of drivers of important quality and cost reductions. We're also clarifying the term "transitional concurrent care" to "concurrent care" to clarify broader flexibility for MAOs in designing concurrent care programs under the hospice benefit component. *Next slide*. [00:18:56]

For this section, I will hand it over to Richard Coyle, the VBID Hospice Lead within the CMS Office of the Actuary (OACT).

Richard Coyle:
Thank you, Megan, and good afternoon.

We're going to briefly provide an outline of three aspects of the VBID Hospice payments. First, just an overview of how the payment structures work, and then talk briefly about some of the key payment parameters for 2024, and then, provide some insights into the proposed changes for 2025. *Next slide*. [00:19:36]

To a large extent, the structure of the rating for the VBID Hospice Model is similar to Medicare Advantage rates. Some of the key similarities are that we use multiple years of data to develop the base experience. There are also localized rates that are developed using the national average number applied with the geographic adjustment. And also, the base data which is, you know, obviously historical experience, has trended to the contract year. One of the key differences between the MA payments and VBID Hospice payments, is that while the VBID Hospice payments are not risk adjusted, they are adjusted by geography and the duration of the stay. We expect that the 2025 rates will be released in April of 2024. *Next slide, please*. [00:20:42]

This is an illustration of the payments that are made for participants in the VBID Hospice Model and non-participants in the VBID Hospice Model. The first two rows reflect the scenario when a beneficiary elects hospice after the first of the month. And the last two rows indicate when a beneficiary selects hospice or is in hospice as of the first of the month. The only difference between being in the Model and not in the Model for payments is the second column from the right, the hospice capitation. For the plans participating in the Model, they get a hospice capitation payment. In the case of a mid-month enrollment, that capitation payment comes after the enrollment, whereas for someone already in hospice as of the first of the month, that payment is made as of the first of the month, as reflected in the last row. *Next slide*. [00:21:49]

And a little background on year-one versus mature year. For those of you who are familiar with the hospice benefit, on a monthly basis, the costs tend to go down the longer the duration of the hospice election. That's because first of all the routine home care payments drop after 60 days and there tends to be less utilization of inpatient services the longer an enrollee is in hospice. So because of that, those last two columns indicate year-one versus mature year rates, and I'll talk about that briefly. [00:22:23]

Going back to the left column of this table, you can see that we have hospice payments for the first month of election, and then months two and later. In the first month of the election, it is

broken up into three tiers depending upon the length of the stay in the hospice, one to five, seven to 15, and 16-plus. Looking at the gross monthly rates from 2024, they are essentially the same for year-one and mature year they are different by a few pennies because of budget neutrality requirements, but essentially the same. And of course, the level of payment is, responds to the length of stay. When you get to the last month of the table for months two and later, the payments for year one of the Model is slightly higher, again, representing the higher intensity of services. *Next slide, please*. [00:23:23]

I'll talk more about the year-one and mature year in a moment to wrap up the special on 2024 rates. These are links to the materials that we posted last year to support the development of the hospice rates, and they are available on the VBID Hospice page on CMS.gov. *Next slide*. [00:23:48]

Okay, so now we're going to talk a little bit about the proposed changes for 2025, these changes are outlined in our preliminary actuarial memo which I believe was released yesterday, and is available on the VBID Model page. To start off with the experience period is going to be advanced as a three-year experience period. For 2024, we used data from 2019-2021, and we're going to advance that a year to 2020-2022. [00:24:22]

Next slide, I'm getting back to that year-one versus mature year rates. If a plan offered VBID Hospice coverage in 2024 in a particular county, then going into 2025, those rates are going to be mature year rates. Just because we're going to have carryover claims that again tend to have less intensity of services than first year. If the county was not offering VBID Hospice benefits in 2024, then it will continue to be the year-one rate in 2025. *Next slide*. [00:25:08]

And then of course, the predominant part of the rating is the Hospice benefits. Hospice claims represent about 92 percent of the capitation rate. And first, we will re-price the historical hospice claims to reflect the most recent hospice regulation, which is for fiscal year 2024. We will re-price the per diem rates, the five-level services, you know, routine home care, inpatient respite care, et cetera and that will also reflect the most recent wage index indices for fiscal year 2024. And then of course, we'll trend the 2024 rates to 2025, that actually go from fiscal year 2024 to Calendar Year 2025. And we'll talk more about that in a moment. [00:26:00]

And then the last four items on the slide, I'm not going to go into detail now, because I'm going to talk about them later. But these are some of the other assumptions and trends that are proposed be reflected in the rates. *Next slide*. [00:26:18]

You can see that we have two trend rates here for Hospice. One is fiscal year update for 2025, which is 2.8 percent and the fiscal year 2026 update of 2.9 percent. Claims in the experience period that were incurred between January 1st and September 30th, you know, that is during 2020, 2021, or 2022, we will trend those from fiscal year 2024 to fiscal year 2025. Because that's consistent with how they would be paid if the beneficiary wasn't in the Model. Whereas the claims that are paid between October 1 and December 31 in the base year, they get an additional year of trend. They'll be trended, you know, 2.8 percent and then another 2.9 percent on top of that to correspond again to what the payments would have been absent the Model. *Next slide*. [00:27:22]

And then, about eight percent of the base experience is for non-hospice benefits, and in this case, we will be trending the rates by, with the experience consistent with what we just published in the 2025 advance notice for the non-ESRD rate book. And so you can see in this table, for instance, the claims experienced in 2020 are going to get a trend of basically 32.67% in the last column there, so that's the trend rate from 2020 to 2025, as opposed to say, 2022 experience that will get a trend of 14.9%. *Next slide*. [00:28:09]

Another adjustment we apply is to reflect changes in the utilization and intensity of services from, in this case we're trending it from 2020 or 2021 to 2022. That is, we do not have enough information to apply these trends to the Calendar Year 2025, so we are just making sure that the experience period, the three years of experience period all reflect the same level utilization and distribution of services. So, effectively, this adjustment's applied by taking the average service days per month, multiply that times a weighted per diem amount and these are all calculated based on fiscal year 2024. The product of those two leads to this composite value in the third column of the table. And then the fourth column represents the difference between the 2022 composite rate and what is in the experience year. I know this is a lot of information, and I would suggest that you refer to our memorandum which has a lot more data on this calculation, if you care to, you know, understand some of the more details in this development. *Next slide*. [00:29:34]

Okay, so for those of you who are familiar with the hospice program, you are probably aware that there is a requirement to report quality information to CMS. Hospices that do not report this, or do not report it appropriately, receive a two percent less market basket update. At least, the two percent was the adjustment through 2023. Starting in fiscal year 2024, that reduction in payments is now increased to four percent. So, our experience period reflected the two percent, but the payment year 2025 is expected to represent a four percent. We are applying a national adjustment to account for this increase. [00:30:20]

The way we calculate this is first item A there is, from the fiscal year 2024 regulation, there is a table that shows that the expected impact on payment of this increased penalty, let's call it for noncompliance, is $41.2 million. Item B is the estimate national hospice spending for fiscal year 2024, which is $27.7 billion. And then if you divide A by B, you end up with 0.15 percent, and it's a negative adjustment, so that's why a negative 0.15 percent will be applied on the national level for our rates. *Next slide*. [00:31:09]

And then, in the last aspect of our rating I want to discuss is what's called the Aggregate Cap. As many of you are probably aware that there is a cap placed on basically a per-beneficiary cost for each hospice, and to the extent that a hospice exceeds the cap, money must be returned to the government, to bring it back down the cap. This cap, for instance in 2020, was about $30,700 That is the average per beneficiary. In fiscal year 2024, it is going to be $33,500. So what we're looking at here is experience from 2016 to 2022 on the caps. The column labeled Aggregate Cap is the national number of this cap or this is the claw back, we would say, that CMS is receiving from all the hospices. [00:32:09]

The next column over is the hospice spending in aggregate, and the last column, Cap Ratio, was the aggregate cap divided by hospice spending. When you look at these trends, you can see 2016 and 2017, it was around one percent, and then it jumped up starting in 2018, and has remained at an elevated level through 2021. You can see fiscal year 2022, or cap year 2022, is very low, and that's because the aggregate cap data is immature but we anticipate once the data is mature, we expect that it's going to be comparable to the more recent years. *Next slide*. [00:32:55]

Now, transitioning that table to the 2025 rates. The last four years, we've developed rates, and have applied it at CBSA (Core-Based Statistical Area) level. The last two years of rates for 2023 and 2024, we use cap experience from 2018 to 2020. For various reasons, we kept it the same both years but we are anticipating updating it for this year's rates we are proposing to use data for 2020 and 2021. As I just mentioned, the data for 2022 is immature, and would not be appropriate for said purpose. *Next slide*. [00:33:41]

Okay, so that concludes the discussion of the Hospice Actuarial, and turn it back to Yixuan.

Yixuan Song:
Thanks Rich. *Next slide*.

First we would like to emphasize that the VBID Model Team is hard at work to ensure ongoing communication with participants. Please reach out at any time to the VBID mailbox, VBID@cms.hhs.gov, for assistance.

The two highlighted dates are of particular importance, as they mark due dates to both the response to the Request For Information (RFI), and the CY 2025 applications. To reiterate by February 16th, tomorrow, 2024, the VBID RFIs are due to CMS and by April 12th, 2024, the CY 2025 VBID applications are due to CMS. *Next slide* [00:34:40]

Some tips for a seamless application submission: you can find all resources on the VBID Model website, including the Request for Applications, application link, and supplemental materials when available. Submit one application per parent organization. Each MAO needs to complete one application inclusive of all Model components, contracts, and PBPs that they are proposing to include in the VBID Model. Please reach out to the VBID team with questions. CMS is available for meetings throughout the application process to provide technical assistance. To request a meeting with the VBID Model team, please email VBID@cms.hhs.gov. To aid in expedited scheduling, please provide requested dates and times. I will now turn it over to Michael to start the Q&A portion of the webinar. [00:35:39]

Michael de la Guardia:
Great, thanks Yixuan. I want to thank everyone for joining us all today. We know we presented a lot of information, so we'd like to open the floor to questions submitted through the Webex chat feature. Our previous presenters will be joining us for the Q&A panel, as well as Julia Driessen, the Model's Evaluation Lead. I will go ahead and get started with some of the questions we've been receiving in the chat. I'll start off maybe with this easy one: "Could you please confirm the timeline for submission of the application?" And the answer here is that the deadline for the VBID RFA and Part D application is April 12th, 2024 at 11:59 p.m. Pacific Time. [00:36:41]

We also received a question here saying, “the RFA indicates that CMS may limit the maximum number of MAOs allowed to participate in the VBID program in 2025. Can you please talk more about this? Does CMS anticipate approving all qualifying applications?” This points out the possibility of a competitive application in the RFA. If the application for 2025 participation is competitive, we will release clear guidance on the criteria used to select Model participants well in advance of the application due date. VBID is at its core a model, but we're mindful of the potential impact on beneficiaries, and it will be top of mind in any action that we take. We value MAO's participation and partnership in the Model and will continue to take your feedback and comments into consideration. [00:37:47]

We also received a set of questions around the priority HRSN requirement and the requirement to offer two-out-of-three benefits in our HRSN focus areas. We have one question here, “to confirm, the required HRSN benefits can be offered through SSBCI, but will be added to the VBID application and included in reporting.” Yixuan, do you want to take that one? [00:38:19]

Yixuan Song:
Sure Michael. So that's correct; it's if an SSBCI benefit is being used to satisfy the health-related social needs, HRSN benefit requirement, it must be identified in the VBID application, along with the relevant financial information to provide CMS better insight into those benefits. Additionally, any benefits used to satisfy this requirement would be subject to summary-level and beneficiary-level data collecting and reporting, as described in section 3.3 of the RFA, the monitoring and data collection section. [00:39:03]

Michael de la Guardia:
Then, Yixuan, we also had a question around something similar related to HIDE and FIDE SNPs that integrate Medicare and Medicaid benefits, and whether benefits offered through the Medicaid side would qualify as an HRSN benefit. [00:39:27]

Yixuan Song:
Thanks, Michael. No, only benefits that are Medicare Benefits would be eligible to satisfy the HRSN requirement. [00:39:45]

Michael de la Guardia:
Let's see, other questions coming in. I see here a question, “will any exceptions be given for health plans who are small and haven't had a full year of Star Ratings yet?” We also have a similar question, “will you, or can you if not, plan to discuss the qualifications in waiver for Star Ratings if an applicant is too new for a Star Rating for 2023?” Here on this one, more information on the eligibility exception process is forthcoming. We also received a few other questions. There's one on the wellness and healthcare planning component, “just confirming that whether this part of the application is required this year or not.” Megan, would you like to take this one? [00:40:45]

Megan Coufal:
The Wellness and Healthcare Planning portion of the Model has been rolled in as a discrete component of the Model but is part of the Health Equity Plan for CY 2025. You will still see some questions about advance care planning in that portion of the application. [00:41:04]

Michael de la Guardia:
Thank you. Let's see, we have another question on, "can you please go over the VBID Model components that will be removed for CY 2025". Yixuan, would you like to take that, or should I take that one? [00:41:26]

Yixuan Song:
Sure, I can take that one. As we said during the webinar, there are three components of the Model that are in 2024 that will no longer be in the Model in 2025. As Megan had said, Wellness and Healthcare Planning will be rolled into the Health Equity Plan and the New and Existing Technologies have been removed because the larger MA program now offers a similar flexibility, as well as Part D RI. [00:42:00]

Michael de la Guardia:
Thank you, and continuing to scroll through some of these questions. "when will the application forms be available on HPMS?" The application materials will be posted on the CMS website. Please note that we have been working hard to update and streamline the application based on MAO feedback, and we thank everyone for the feedback that they have provided. Our goal is to make the application as user-friendly as possible, and we anticipate the application with these updates will be released around the end of February. We thank everyone for their patience as we make these updates to improve the user experience and lead to more seamless application process. [00:42:53]

Okay, let's see. We also had a question around the Health Equity Incubation Program and whether that is open to everyone. Yixuan, would you like to take this one? If not, I can jump in.

Yixuan Song:
Please take this one, Michael. [00:43:20]

Michael de la Guardia:
Great, so the quick answer here, the Health Equity Incubation Program will continue to be voluntary and open to all interested participating MAOs in 2025. The program will only be open to VBID MAOs and offer focused technical assistance in diffusing evidence and best practices related to the targeting and delivery of specific interventions and supplemental benefits in high-impact areas. And you'll notice a trend here in food and nutrition, transportation, and housing and living environment, in order to drive improvement in learning from the Model. [00:44:11]

Great, let's see, what other questions do we have coming in? Here, and maybe this one is for you, Yixuan. "In previous years, we have been limited to apply for five VBID packages within the components. Will this stay the same? If so, what variables can exist within each package?" [00:44:45]

Yixuan Song:
I believe we have increased the number of packages allowed, but you can find more information on what we are specifically requiring in the application when it is released. [00:45:04]

Michael de la Guardia:
I believe this year there will be no limits on the number of VBID packages, but MAOs can reach out to the VBID mailbox, VBID@cms.hhs.gov, for any technical assistance, or issues related to this.

All right, let's see what other questions we have coming in. So, here "regarding ADI, if the plan decides to service members in the 10 decile and the member moves within the plan year two, in the eighth decile census block, what happens to the beneficiary and their eligibility?" Megan, do you want to take this one? [00:45:58]

Megan Coufal:
Yes, happy to take this one. Enrollee eligibility for ADI-targeted benefits are determined at the beginning of the contract year, based on the enrollee place of residence. There is no redetermination throughout the year, so long as the enrollee remains enrolled in the plan and does not opt out of the benefit. We would like to note though that as new enrollees are identified to be eligible throughout the year, the plan is required to offer ADI-targeted VBID benefits to those newly-eligible enrollees. [00:46:33]

Michael de la Guardia:
Let's see what other questions we may have here. Yixuan or Megan, any other questions, or Megan, would you mind repeating what you just said? It looks like an attendee missed the response. [00:46:59]

Megan Coufal:
Yes, I can certainly repeat that. And I will note, there is more information on the ADI section of the RFA as well. The question was, "if the plan decides to service members in the 10th decile, and the member moves within the plan year to the eighth decile, what happens to those benefits?" And so we want to note that enrollee eligibility for ADI-targeted benefits are determined at the beginning of the contract year, and that should be based on the enrollee place of residence. There is no redetermination throughout the year, so long as the enrollee remains in the plan and does not opt out of the benefit. But as new enrollees are identified to be eligible throughout the year, the plan is required to offer that ADI-targeted VBID benefit to those newly eligible enrollees. [00:47:50]

And I see another question here asking if we said that the ADI-based targeting is only applicable to non-duals, and no, that is not the case. I've seen some other questions come in. Michael, do you want me to take one or two of these ones that I've seen here?

Michael de la Guardia:
Yes, sure. [00:48:09]

Megan Coufal:
Okay, so we did get a question, "for organizations that are participating in both VBID Flex and the Hospice Benefit Component, do the hospice PBPs have to satisfy the HRSN requirements?" No, for PBPs that are only participating in the Hospice Benefit Component, they do not have to meet that two-out-of-three HRSN requirement. But if a PBP is participating in both elements of the model, then yes, they do have to meet that requirement. [00:48:39]

Michael de la Guardia:
Then I have a few quick questions that came in. One is "following up on the topic of limited accepted applications, when is CMS planning to share more details on their approach for VBID participant selection, and the limitation of plans? Is the additional criteria targeted to be released at some point prior to the 4/12 application deadline?" Yes, any additional information here would be released well in advance of the 4/12 application deadline. "Does the application tool require you to complete the application in one sitting, or is the user able to save the work as you go along?" Yes, the user can save the work as they go along. And I know last year part of the feedback we received was that applicants wanted the ability to both save the work as they go along, and to have multiple collaborators on the application, so that's something that we've solved for this year and are excited to share. [00:49:50]

Then, "for organizations participating in both VBID Flex and the hospice components, will the hospice PBPs be required to satisfy the HRSN requirement?" So for this one, for those MAOs that, where hospices, so for these hospice-only PBPs, there would not be a requirement. There would not be a need to satisfy that requirement. But again, this is for the PBPs with only hospice. Megan or Yixuan, any other questions you're seeing in the chat currently? [00:50:43]

Megan Coufal:
Yeah, I see one here about "will there be additional training on completing the application in its new form?" And we will have information on the VBID Model website. We encourage interested MAOs to read the application instructions that will be posted along with the updated application, and review those instructions. And as always, the VBID Model Team is available to answer your questions if you come across any while you're completing the application. We highly encourage you to email us at VBID@cms.hhs.gov with any questions that come up. [00:51:20]

Yixuan Song:
I see a few questions, one about net savings template, and another about flex cards, and I can respond to the net savings template question first. The question was, "will there be a net savings Excel template similar to prior years?" Yes, there will be a net savings template. It will look largely the same as prior years, but we are requesting a few additional items on the template. We plan to release it at the same time we release the rest of the application materials. Another question concerned whether multiple benefits could be covered under one flex card, and the answer is yes. [00:52:18]

Michael de la Guardia:
Another flex card question here to tack on, "can an HRSN flex card purse be combined with other supplemental benefits, dental, vision, et cetera?" Yes, is the quick answer to that.

Then, we have a question, "is there a software that will tell us if a specific member's address qualifies for a particular decile, thus allowing additional flexible benefits? As an example, James Smith is potentially ready to enroll. He gives us his address. We will need to look this address up immediately to see if he qualifies for additional benefits." To this, we say, we love this idea and encourage plans to submit similar ideas on types of resources that would be helpful to MAOs in implementing VBID. We try to, in ways to use our Health Equity Incubation Program as an opportunity for this dialogue, but also encourage MAOs to respond to the RFI, and encourage MAOs to reach out to our VBID mailbox, VBID@cms.hhs.gov. [00:53:35]

I did see a question asking "whether a response to the RFI is required," and again RFI is Request For Information that we put out around the time of the RFA release. No, there's no requirement to answer the request for information. It is very helpful to us to get responses to that RFI, but there's absolutely no requirement related to the RFI. Just scanning through to see if there's any questions that we missed. We have one, "can you repeat the information about plans already offering supplemental benefits that address HRSNs and if they can be used for the VBID application?" Yixuan, do you want to take that one again? [00:54:56]

Yixuan Song:
Yeah, of course. So, any Medicare supplemental benefits that are being used to satisfy the VBID HRSN benefit requirement must be identified in the VBID application along with relevant financial information to provide CMS better insight into those benefits. As to what relevant financial information looks like, again, more information will be forthcoming in the release of the application, but we would direct you to take a look at last year's application to get a sense of what we have historically requested for VBID benefits. Additionally, any benefit used to satisfy this requirement would be subject to a summary-level and beneficiary-level data collection and reporting as described in section 3.3 of the RFA. [00:56:02]

Michael de la Guardia:
Then, Megan, we received a question clarifying transitional concurrent care in the Hospice Benefit Component. Particularly, "can you elaborate on the change from transitional concurrent care to concurrent care, what does that change mean, and what impact does CMS anticipate that will have?" [00:56:29]

Megan Coufal:
Yeah, that clarification is to ensure that MAOs understand the flexibility that has always been allowed in the transitional concurrent care, now concurrent care, to offer those services. It aligns better with how other models are referring to the same benefit. It doesn't change what the MAOs are able to offer. If you have other questions, we're happy to discuss that further. [00:57:08]

Michael de la Guardia:
And then there's a question, "does covering the LI copays count as one of the two required benefits, or one of the two-out-of-three HRSN benefits?" No, that does not count towards that. Definitely would recommend that you take a look at the RFA; the RFA lays out the three categories, food and nutrition, transportation, and then housing and living environment, and lists a noncomprehensive list of benefits that would fall under those buckets, and we'd also suggest that you look at the VBID Model Monitoring Guidelines that outlines benefits that fall under the food and nutrition, transportation, and housing and living environment buckets. More information will be provided when the application is released, but to the extent that you want to familiarize yourself with those areas before do look at these resources. [00:58:29]

Anything else before we end? We only have about a minute left. [pause] Okay, great. So, I want to again thank everyone for joining today's webinar and for your engagement and all the questions we received. I do want to note that we will be having an Application Office Hours on March 19th, and this will be to answer all of your questions regarding the application, any troubleshooting with the application, and another opportunity to answer many of the specific questions. Thank you again for joining and thank you so much for your time, bye.