



Value-Based Insurance Design Model Test: Model Year 2 (2018)



*Center for Medicare and
Medicaid Innovation*

*Division of Health Plan
Innovation*

[Innovation.cms.gov/initiatives/VBID](https://innovation.cms.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

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 is testing VBID in Medicare Advantage (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

- Participating Medicare Advantage Organizations have 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 a “stick” approach to VBID.
- 5-year model test, with benefits first offered January 1, 2017.
 - Applications for CY 2017 received January 2016.
 - CMS will announce CY 2017 participants in September 2016.
- More information and model documents at <http://www.innovation.cms.gov/initiatives/VBID> .

Summary of Changes for CY 2018

- Model open to new applications for 2018.
- Three new states: Alabama, Michigan, and Texas.
- Two new targeted clinical conditions:
 - Rheumatoid Arthritis
 - Dementia
- New flexibility to select specific conditions from within the Mood Disorders group.
- Minimum PBP enrollment size is now 500 enrollees for organizations participating, with another PBP over 2,000 enrollees.

Qualified Participants

- MA and MA-PD Plan Benefit Packages offered in test states.
 - 2017: Arizona, Indiana, Iowa, Massachusetts, Pennsylvania, Tennessee, and Oregon.
 - Beginning 2018: Alabama, Michigan, and Texas.
- 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.
- Three years of operation prior to the application year.
- Minimum of 2,000 enrollees.
 - New for 2018: For organizations participating with 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.
- Offered in no more than two states with 50% of enrollees in test state.
- CMS will entertain written exception requests.
 - Send requests by email to mavbid@cms.hhs.gov

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 | 8. Rheumatoid Arthritis (new for 2018) |
| | 9. Dementia (new for 2018) |

- Participants select one or more CMS-defined groups to receive VBID benefits.
- All eligible enrollees must receive that group's VBID benefit package.
- Groups defined by ICD-10 code.
 - Code sets for 2017 conditions are on model test website.
 - New for 2018: Rheumatoid Arthritis group is defined by ICD-10 codes in the HEDIS Rheumatoid Arthritis value set.
 - New for 2018: Dementia group codes in the CMS Chronic Conditions Warehouse include Alzheimer's Disease and Related Disorders or Senile Dementia algorithm.

Clinical Condition Flexibilities

- Multiple-comorbidity packages
 - Participants can combine two or more of the CMS-specified conditions and create a multiple-comorbidity group.
 - Benefits in these groups restricted to only enrollees with all specified conditions.
- Mood Disorders
 - Participants selecting Mood Disorders may choose one or more ICD-10 code categories from within the CMS code set.
 - Must select all ICD-10 codes from within a chosen code category that are on the CMS list. May instead choose to cover all codes from within the category.
 - Example: Participant chooses F32 (“Major Depressive Episodes”). May cover all F32 codes on CMS list. Or may cover all F32 codes, regardless of whether they are on the list. May not cover only F32.0.
- Rheumatoid Arthritis
 - HEDIS Rheumatoid Arthritis value set excludes enrollees with HIV and Pregnancy. Participants may add enrollees with co-occurring HIV or pregnancy, if clinically justified.
- Plans wishing to use methods additional to ICD-10 diagnoses appearing on claims to validate diagnosis or impose a look-back period, etc. may propose to do so in their application and provide clinical justification.

VBID Intervention Types and Examples

- 1. Reduced Cost Sharing for High-Value Services, Supplies, and 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.
- Participants 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.
 - Notice of VBID Benefits: participants craft their own initial communication to beneficiaries, subject to CMS guidelines.
- More information in the MA-VBID Communications Guidelines. Some materials subject to prospective review.

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 contemplated:
 - MARx Enrollment transaction: see August 2016 software release memorandum.
 - CAHPS: CMS may develop additional CAHPS questions.
 - Enrollee EHR data: CMS may also request the submission of enrollee-level electronic health record data for evaluation and monitoring purposes.
 - Ad hoc data requests.
- 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.

CY 2018 Application Process

- RFA expected to be released October 2016
 - Expected to look similar to CY 2017 RFA.
 - Due date released with RFA; expected to be in January 2016.
 - Application open to organizations not participating in 2018.
 - Current participants must reapply; can add/subtract PBPs; will have condensed application requirements.
- Separate actuarial guidance will specify financial projection requirements for RFA submission.
- CMS will review qualification of applicant, acceptability of proposed VBID benefits.
 - Not competitive. No maximum number of qualified PBPs participating.
- Participants receiving preliminary acceptance of applications must include VBID benefit details in June bid submission.
- Formal “acceptance” into the model test is upon signing of participation addendum during Medicare Advantage contracting (September).

Disclaimer

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