Value-Based Insurance Design Model Test

Center for Medicare and Medicaid Innovation

Division of Health Plan Innovation

Innovation.cms.hhs.gov/initiatives/VBID

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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
Health Plan Innovation

• Innovation Center work on Health Plan Innovation:
  – November 2014 - Issued RFI requesting public feedback on potential model approaches
  – September 2015 – Announced first Health Plan Innovation model – Medicare Advantage Value-Based Insurance Design

• Additional potential models are currently under consideration and/or in development.
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 will test VIBD in 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

- 5 year model test, begins 1/1/2017.
- Tested in: Arizona, Indiana, Iowa, Massachusetts, Pennsylvania, Tennessee, and Oregon.
- Plan 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 “stick” approach to VBID.
Clinical Conditions

- Plans select one or more CMS-defined groups to receive VBID benefits.
  - Groups defined by ICD-10 code. All eligible enrollees must receive that group’s VBID benefit package.
- May pair conditions for multiple-comorbidity packages.

| 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 | |

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7. Mood disorders
1. **Reduced Cost Sharing for High-Value Services, Supplies, 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.

• Plans 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.
  – For eligible enrollees, this is the minimum. Participants encouraged to further communicate with eligible enrollees by multiple channels.
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 may be required.
  – Enrollee surveys may contain some additional questions.

• 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.
Model Learning and Diffusion

• Learning activity to provide CMS, participants and the community with insight into VBID principles.
• Regular collaborative calls.
• Periodic reports.
• Presentations from subject-matter experts on field work and proven practices.
Qualified Participants

- MA and MA-PD Plan Benefit Packages offered in test states.
- 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.
- 3 years of operation prior to CY 2017.
- Minimum of 2,000 enrollees (for evaluation).
- Offered in no more than two states w/ 50% of enrollees in test state.
- CMS will entertain written exception requests.
Application Process

• RFA released Sept. 2015; responses Dec. 2015.
• CMS will review qualification of applicant, acceptability of proposed VBID benefits.
  – Not competitive. No maximum number of qualified plans participating.
  – Actuarial projections required.
• Separate guidance to participants will follow on marketing, CY 2017 bid procedures, other topics.
Disclaimer

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