

# **VBID model - CY2020 Application Actuarial Guidance**

## **Centers for Medicare & Medicaid Services**

### **Center for Medicare and Medicaid Innovation**

#### **Value-Based Insurance Design Model**

#### **CY2020 Application Actuarial Guidance**

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## 1 Background and General Information

The Center for Medicare and Medicaid Innovation (CMMI) is announcing an array of health plan innovations that will be tested in the Value-Based Insurance Design (VBID) model for CY 2020. Designed to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries, including those with low incomes such as dual-eligibles, and improve the coordination and efficiency of health care service delivery, these new components of the VBID model test additional approaches to reduce costs and improve Medicare Advantage and Medicare Part D. This document provides guidance to both returning and new applicants for the Value-Based Insurance Design (VBID) model, including general pricing considerations and detailed instructions for completing the financial projections required of the applicants.

Calendar Year (CY) 2020 will be the fourth year of the CMS VBID model test that began on January 1, 2017. However, it will act as the first year of the expanded Model test that will now continue through 2024.

Sponsors of eligible Medicare Advantage and Medicare Advantage Prescription Drug (MA-PD) plans wishing to participate in the Model, including sponsors *already* participating in the Model, must submit applications in accordance with the instructions included in the Request for Applications (RFA). Applications will include a narrative description of the VBID elements plans propose to provide to eligible enrollees in CY2020. To support their proposals, in accordance with the instructions contained in this document, applicants will provide financial projections of the impact of their VBID components, which will quantify the expected impact of VBID on utilization and unit cost assumptions as well as on beneficiary premiums.

As part of a comprehensive review of applications for participation, CMS will review applicants' actuarial assumptions to ensure that they are valid and adequately supported, and to assess whether they are consistent with the proposed components and justifications. CMS will review that the Model's goals are being met by examining projections for support that demonstrates that plan enrollees will not be subject to net increased costs attributable to the VBID elements over the life of the Model. CMS will also examine the financial projections to determine that the introduction of VBID elements is expected to produce net savings with respect to Medicare expenditures over the life of the Model.

For current VBID model participants, note that as a result of the extensive changes made for the CY2020 application period, these instructions have undergone a thorough revision. In particular, Wellness and Health Care Planning (WHP) is now a required benefit for VBID participation and special considerations may apply for other selected components. Please review each section carefully.

### 1.1 Document Overview

Following are the contents of each section:

- Section 1, "Background and General Information," contains a general description of the objectives of the VBID model and provides sources of information that can be accessed for assistance in preparing the application.
- Section 2, "Components," contains a description of each of the components available for CY2020 under the expanded VBID model.
- Section 3, "What to File," contains a summary of the requirements for CY2020 applicants. Note that there are certain materials required of all applicants and additional materials required for some

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applicants depending on the types of components.

- Section 4, “Pricing Considerations,” contains guidance for presenting CMS with financial projections by revising the CY2019 MA (and if applicable Part D) BPT(s) to reflect the planned VBID components.
- Section 5, “Supporting Documentation,” contains requirements for Supporting Documentation.
- Appendix A, “MA BPT Data Entry and Formulas,” contains MA-specific pricing guidance.
- Appendix B, “Part D BPT Data Entry and Formulas,” contains Part D-specific pricing guidance.
- Appendix C, “Sample Cover Sheet,” contains a sample cover sheet for submission with the application.

### 1.2 Resources

- The Request For Applications and other CMS guidance for the VBID model found at <http://innovation.cms.gov/initiatives/vbid/>
- Instructions for Completing the Medicare Advantage and Prescription Drug Plan Bid Pricing Tools for Contract Year CY2019 found at <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Bid-Pricing-Tools-and-Instructions-Items/BPT2019.html>.
- For questions about the actuarial forms or documentation requirements, e-mail [vbid@cms.hhs.gov](mailto:vbid@cms.hhs.gov).

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### 2 Components

Given the significant expansion of the Model for CY2020 in terms of potential components, this section outlines each type of component and outlines the general requirements for actuarial submissions.

#### 2.1 Wellness and Health Care Planning (WHP)

Participating organizations, will be required to offer enrollees improved, timely access to Wellness and Health Care Planning (WHP), including advance care planning, for those enrollees that choose, by introducing a timeliness standard. Each MA organization applying for the VBID model must submit its proposed approach to WHP, including advance care planning, for their enrollees as part of the application. In order to promote timely wellness and health care planning, including advance care planning, for enrollees, MA plans participating in the Model will be required, working with their provider network, to offer health care planning to beneficiaries by the earlier of: i) the second visit with the patient that occurs during the applicable Model year or ii) the annual wellness visit or any health risk assessment.

Because this element will now be required for all VBID model applicants, each application will need to assess the actuarial impact of offering the required services. This will include a discussion of the costs associated with performing the required interventions and any projected changes to utilization or costs associated with these services.

#### 2.2 Value-Based Insurance Design Flexibilities by Condition and/or Socioeconomic Status

For CY 2020, MA plans may provide reduced cost-sharing and/or additional supplemental benefits to enrollees based on disease state(s), socioeconomic status (as defined by Low Income Subsidy (LIS) status), or a combination of both. Further, plans may offer enrollees additional “non-primarily health related” supplemental benefits based on disease state(s), socioeconomic status, or a combination of both.

The benefit flexibilities already offered under the VBID model are included in this component and refer to four specific items:

- Reducing cost-sharing for high-value services
- Reducing cost-sharing for enrollees participating in disease management or related programs
- Reducing cost-sharing for high-value providers
- Covering additional supplemental benefits

Per the RFA, these components can continue to be offered, either combined with additional components described below or on their own. However, the applicant will be required to add Wellness and Health Care Planning as a Model component. This change will need to be incorporated into the actuarial estimates supporting that, on a present value basis, the chosen components show net savings to Medicare and no net cost increases to enrollees over the course of the Model test, as explained further in Section 4.

In addition to the original benefit flexibilities provided as part of the Model test (discussed above), VBID model participants will now be offered the flexibility to offer expanded supplemental benefits, reduced cost-sharing, or additional services to any targeted subset of enrollees, including benefits that address specific social determinants of health for Low Income Subsidy (LIS) status enrollees.

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These flexibilities are intended to allow for tailored offerings of services and items, including those that are “non-primarily health related”, to a targeted group or groups of beneficiaries, including beneficiaries who qualify based on LIS eligibility. As with the original VBID options, applicants will be expected to show that the Model financial goals are met, i.e. that on a present value basis, net savings to Medicare and no net cost increases to enrollees over the course of the Model.

### 2.3 Rewards and Incentives Programs

Currently, the MA program allows MA plans to offer rewards and incentives (RI) programs, as regulated by 42 CFR §422.134 and as described in Chapter 4 of the Medicare Managed Care Manual. Under the regulation, the limit of the reward and incentive is that it may not exceed the value of the health-related services or activity itself.

In order to reduce barriers to greater MA plan uptake of RI programs, and to be able to offer rewards and incentives that effectively influence healthy behaviors, plans may propose RI programs with a value that reflects the benefit of the service, rather than just the cost of the service. All RI program proposals must promote improved health, prevent injuries and illness, and promote efficient use of health care resources. Specifically, plans may propose the following RI programs:

1. A reward or incentive value beyond the cost of the health-related service or activity itself, up to an annual limit of \$600.00<sup>1</sup>;
2. For MA-PDs, a reward and incentive associated with the Part D benefit;
3. A rewards and incentives program specific to participation in a disease management or transition of care program; and
4. Other rewards and incentives programs on a case-by-case basis.

As specified in the RFA and consistent with current bidding guidance, costs associated with R&I programs must be included as administrative costs. The actuarial evaluation to establish that the Model financial goals are met will be the same as for other components (on a present value basis there are savings to Medicare without increasing enrollee costs). Applicants will be required to explain the rationale and theory for the reward and incentive approach. Any proposed rewards and incentives programs must show a projected return on investment materially beyond the cost of the health-related service/activity and reward/incentive. In the application, organizations should describe the kind of RI program that they intend to offer, the value of the reward or incentive, the expected decrease in cost derived from utilizing the item or service, the number of enrollees it expects to target, and the number of enrollees that ultimately will receive the reward or incentive. The information provided should be sufficiently detailed to allow for an actuarial evaluation of the projected costs and savings impact of the proposed RI program.

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<sup>1</sup> Pre-VBID rewards and incentives are included in the \$600 annual limit per enrollee.

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### 2.4 Telehealth Networks

Through the VBID model, CMS is testing how different service delivery innovations in telehealth can be used to both augment and complement an MA plan's current network of providers, as well as how access to telehealth services may appropriately allow MA plans to expand their service area to underserved counties.

Under two different scenarios, MA plans may be able to use telehealth providers in lieu of in-person visits to meet network adequacy requirements, with the caveat that the enrollee has the option for an in-person visit if that is the enrollee's preference. First, for plans that meet all existing MA network adequacy requirements for their service area, and where they have three or more providers available to enrollees in their network by provider specialty type, CMS will allow plans to augment their current network with telehealth services, where these telehealth services would be considered by CMS to be clinically appropriate and evidence-based.

Second, for MA plans serving underserved areas, and where the Minimum Provider Calculation may be less than three providers per specialty type, (such as Counties with Extreme Access Considerations (CEAC), Rural, or Micro county types, etc.), CMS will allow plans to apply for a modified telehealth flexibility request. Under this second approach, MA plans will need to continue to provide access that is consistent with or better than the original Medicare pattern of care for a given county and specialty type, and they will need to show that the use of the proposed telehealth services will be clinically appropriate and evidence-based.

Section 50323 of the Bipartisan Budget Act of 2018 created section 1852(m) of the Social Security Act to allow MA plans to provide "additional telehealth benefits" to enrollees starting in CY2020. These additional telehealth benefits will be treated as basic benefits for purposes of bid submission and payment by CMS. The composition of "additional telehealth benefits" in the MA program will be provided when the proposed 2020 MA and Part D rule (CMS-4185-P) is finalized as well as any accompanying guidance. If the specialties and associated telehealth services proposed by an MA plan are not identified as "additional telehealth benefits" in the MA program for CY2020, they will continue to be treated as supplemental benefits as they currently are for the purpose of bidding and payment.

As with all other components listed above, access to telehealth will need to meet the Model goals of net savings to Medicare and no net cost increases to enrollees over the course of the Model. In contrast to the other components, however, impacts on bids related to the additional use of telehealth to achieve network adequacy in certain underserved areas have the potential to be much broader and more complicated than the other components. For this reason, the detailed pricing considerations and supplemental documentation required contain specific subsections related to this component (see below).

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### **3 What to File**

In prior years, the requirements for this application have differed depending on whether the applicant was already participating in the Model or was newly applying. This year, to incorporate the new components and to streamline the application process, the structure of this actuarial guidance has changed. Please carefully review the sections below. Note that there is a set of materials to be provided by all applicants, and that additional items are required depending on the nature of the application. There are also variations in detailed requirements depending on a sponsor's current status within the Model.

#### **3.1 Required Materials**

All applicants are required to submit the following elements described in Section 5: Supporting Documentation:

- Cover Sheet
- Revised CY2019 MA and, if applicable, Part D BPTs
- Narrative Summary
- Quantitative Support
- Wellness and Health Care Planning Summary
- Telehealth Networks (if selected)
- Five-year Projection (if required, see Section 5 for details)
- Summary of VBID Program Experience (if returning applicant)
- Description of Program Changes (if returning applicant)
- Changes to Pricing (if returning applicant)

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### 4 Pricing Considerations

#### 4.1 General Pricing Approach

To participate in the VBID model, in CY2020 and subsequent years, applicants must submit to CMS their final CY2019 Bid Pricing Tools (BPTs) and a revised version thereof, that includes the VBID plan design elements that they intend to include in their CY2020 BPT submissions in June 2019.

Revised BPT entries submitted with the application must follow the instructions for completing the MA and, if applicable, Part D BPTs and follow all existing requirements and guidance promulgated by CMS, except as explained otherwise in this document.

The revised BPT entries must reflect the applicant's best estimate of expected, plan-wide unit costs and utilization (i) for the entire plan population, including unit costs and utilization for all beneficiaries targeted for component(s) under the Model (VBID enrollees) and (ii) for those beneficiaries who are not targeted (non-VBID enrollees).

Under the initial VBID model, interventions or components were limited to benefit offerings – copay reductions and additional supplemental benefits. The framework for the actuarial submission was developed with these types of interventions or components in mind. Some of the new components represent fundamentally different types of changes that have potentially more complicated effects on plan bidding, and potentially a large measure of overlap between the effects of different components. Accordingly, applicants must show the expected effects of the following sets of components separately, e.g. by providing supporting documentation that shows the development of bid adjustments separately for each component as well as for all components combined.<sup>2</sup>

- Wellness and Health Care Planning (WHP),
- Value-Based Insurance Design by Condition and/or Socioeconomic Status (if selected),
- Rewards and Incentives Programs (if selected), and
- Telehealth Networks (if selected).

See Section 5: Supporting Documentation for details on the requirements for supporting documentation.

The Model goals of net Medicare savings with no increase in enrollee costs must be met on a present value basis either over the next five Model years or over the first five years of Model participation for each component separately. In general, however, these long-term projections are not required if the revised CY2019 BPT with VBID shows a decrease in Medicare expenditures and no change or a decrease in enrollee costs and there are no factors that would lead to an expectation that future experience would lead to a different outcome, absent any changes to any intervention or component.

Organizations applying to participate with multiple plan benefit packages may submit a single revised 2019 BPT as an exemplar, but only so long as the components and anticipated effects are consistent across the various plans.

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<sup>2</sup> This requirement could be met by submitting separate CY2019 BPTs for each component; however, applicants have the flexibility to provide sufficient documentation to meet this requirement using other approaches.

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### **4.2 Application Review & CY2020 Bid Procedures**

CMS will review the revised 2019 BPT with VBID changes as part of the overall application review for compliance with the terms of the Model (including net savings requirements), reasonableness of assumptions, potential detrimental impact to CMS or enrollees and the sustainability of the proposal. CMMI may request that organizations revise projections or update components in order to be approved for participation.

Once approved by CMS, organizations must complete their CY2020 bids reflecting VBID model impacts in a manner consistent with the assumptions and projections of VBID model impacts in their revised CY2019 BPT(s) with VBID.

Approval of Model applications merely qualifies plan sponsors to include these VBID elements in their CY2020 bid submissions; it does not guarantee that these elements will be approved during Bid Desk Review.

### **4.3 Actuarial Certification & Participant Attestation**

It is anticipated that VBID elements of the bids for CY2020 will be covered by the general Actuarial Certification submitted in accordance with 42 C.F.R. § 422.254(b)(5), and actuaries preparing applications should keep this requirement in mind. No certification is required for the applications; however, the actuarial information submitted in applications must be signed by a qualified actuary.

An authorized representative of the participating Medicare Advantage Organization must attest, in the Model test's contractual addendum, that the Model-participating plan's BPT has been completed in a manner consistent with the actuarial assumptions and projections of VBID-model impacts contained in the actuarial component of the plan's application for participation.

### **4.4 Wellness and Health Care Planning – Special Considerations**

All applicants are required to offer Wellness and Health Care Planning (WHP). Plans will address the inclusion of this benefit in the bids following the required bidding procedures. It is expected that some WHP costs are already incorporated into plan bids. To the extent that there may be additional costs, these may be factored into the bids per standard processes. It is also expected that plans will have opportunities to achieve net savings if the services result in reduced plan expenditures. It is further expected that these savings would accrue over the longer, extended period of performance for the Model. To the extent there are material assumptions related to either costs or savings from WHP, plans should address these separately, as is required for each selected component.

Organizations may propose, and CMS will also consider the appropriateness of, any enrollee rewards and incentives to promote WHP and/or the reducing of co-payments or cost-sharing for WHP outside the Annual Wellness Visit (AWV), including the appropriateness of groups or subsets of enrollees for whom co-payments may be proposed to be reduced. For plans that wish to propose reduced cost-sharing for WHP outside of the AWP, please outline in your application the specific targeted population.

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### **4.5 Telehealth Networks – Special Considerations**

Applicants choosing to participate in the telehealth network component of the VBID model, must show how the distribution of service utilization by provider will change as a result of providing a telehealth option, the potential for additional utilization by beneficiaries not previously seeking treatment, variations in provider reimbursement rates and other performance and/or bonus arrangements. Capitated arrangements with telehealth providers should be clearly explained. Impacts on global capitations of offering telehealth should also be described. These requirements apply to either of the two options where sponsor may offer telehealth benefits: 1) where the Minimum Provider Calculation is equal to or greater than three providers or 2) where the Minimum Provider Calculation is less than three providers.

In addition to these contractual issues, sponsors offering telehealth in underserved areas, where the Minimum Provider Calculation is less than three providers (such as Counties with Extreme Access Considerations (CEAC), Rural, or Micro county types, etc.), should carefully explain how the introduction of telehealth is changing the plan's service area. Further, revised BPTs are required to reflect any new areas in the calculation of the A/B Benchmark.

Sponsors should also consider and clearly explain the strategy for enrollment inherent in expansions of telehealth. If service area changes are expected to attract different enrollment cohorts, the impacts should be delineated.

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### 5 Supporting Documentation

The purpose for requesting the following 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 provide evidence that the proposed VBID 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.

Documentation submitted in support of VBID model applications must conform to the general requirements of supporting documentation submitted in support of MA and Part D bid submissions. (See Appendix B in the MA & Part D BPT Instructions for CY2019.)

Plan sponsors must upload all required documents and support files to the VBID model application portal, in the section designated for actuarial documents. Sponsors need not resubmit files that were uploaded in the CY2019 bid submission process and are not modified for this application. Please note that there is a maximum permitted total upload of 25 megabytes across all files.

#### 5.1 Supporting Documentation Requirements

The aim of the supporting documentation is to enable reviewers to view and understand the development of pricing for VBID elements in the BPT “with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary's work” (ASOP No. 41, Actuarial Communications, Section 3.2, “Actuarial Report”).

Plan sponsors must provide:

- **Cover Sheet** – A document that lists all of the supporting documentation that is provided with the application and any revisions requested during application review and:
  - A list of files that document and support the VBID entries in the BPT. These files can be newly created files and/or files that were previously uploaded to HPMS, but have been revised.
  - Detailed information for each support item—such as the filename and the location within the file, if applicable—and applicable contract number-plan IDs and whether the substantiation is related to MA, Part D or both.
- **Revised CY2019 MA and Part D BPTs**, where the revisions reflect the inclusion of VBID plan design elements that the plan intends to include in its CY2020 bid submission in June.
- **Narrative Summary** – A single, written document (Word or PDF format) that includes the following items:
  - A narrative describing the plan sponsor's overall approach to VBID and the expected actuarial effects for each component and/or targeted group.<sup>3</sup>
  - For each individual VBID component plans must provide:
    - A brief description of the component and the type of provider, if applicable. Information from the applicant's RFA response may be repeated here.
    - A list of the chronic condition and/or Low Income Subsidy (LIS) status populations eligible for benefits
    - A list of geographic areas in which the VBID component is being offered.
  - Commercial experience, internal studies, reports, and/or other sources considered in setting

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<sup>3</sup> Where the effects are expected to be the same for some or all targeted groups, a single description is sufficient along with an indication of which groups it refers to.

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- assumptions and/or estimating the expected impact of the VBID components. Due to the expected novel nature of some proposed components, it is possible that limited public experience or literature exists on which to base estimates of the impact of specific VBID components on utilization patterns or the cost of Part C and D services. In this case, it is sufficient for the justification of actuarial assumptions to be derived from the actuary's reasoning, judgment, or other factors. Documentation in this form is still required to be sufficiently clear that another actuary can appraise its reasonableness.
- A general description in actuarial terms of the strategy followed to estimate the effects on utilization and/or unit or PMPM costs for each component and/or targeted group in light of the sources considered.
  - A list of the changes made to utilization, unit or PMPM costs and NBE costs together with an indication of what experience base, etc., was relied on in setting the assumption.
  - Projection of the member months eligible for each component and/or targeted group and estimates of those that will participate or otherwise be engaged, if applicable.
  - For organizations submitting an exemplar plan, documentation explaining why the components and anticipated effects should be expected to be similar for the designated plans.
- **Quantitative Support** that documents and explains **ALL** the revised entries to the BPTs identified by comparing the final approved CY2019 BPT with the revised CY2019 BPT with VBID changes. For revised entries derived from multiple components, the quantitative support should show the development of each separately and include a composition into the final factors used for the revised BPT.
- Documentation showing for each type of medical service line in the MA BPT Worksheets 1 and 3 how entries are composited by component and/or targeted group and non-VBID enrollees.
  - Documentation that shows the impact on the following BPT entries for each component in isolation:
    - MA BPT:
      - Plan A/B Bid (MA Worksheet 5, Section II, Line 7)
      - Member Cost Sharing (MA Worksheet 3, Section III, Column o, Line s)
    - Total Estimated Plan Premium (MA Worksheet 6, Section III, Subsection C, Line 9)
      - PD BPT:
        - Standardized Part D Bid (PD Worksheet 7, Section III, Line 1)
        - Supplemental Premium, Unrounded (PD Worksheet 7, Section III, Line 7)
    - For other entries to the MA BPT, documentation showing relevant assumptions for the components and/or targeted groups, any changes to assumptions related to the non-VBID population, an indication of the reason for changes in other entries flowing from changed entries, and a demonstration that these assumptions tie to the BPT entries.
    - For Part D (if applicable), a quantitative mapping in a spreadsheet format of allowed costs, effective cost sharing and script counts from the formulary tiers to type-of-drug and point-of-sale (retail or mail order) categories used in pricing (Worksheets 2, 6 and 6A) that clearly indicates how cost sharing for the VBID population is incorporated and how the component impacts utilization and costs.
    - For other entries to the Part D BPT, relevant assumptions for the component and/or targeted groups, any changes to assumptions related to the non-VBID population and a demonstration that these assumptions tie to the BPT entries.
    - For non-benefit expenses (NBE), an expansion of the documentation provided as support for NBE entries for the CY2019 BPTs to show the cost estimate for any new administrative

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functions, as well as the revised entries reflecting NBE with VBID changes.

- **Wellness and Health Care Planning (WHP) Summary** – Plan sponsors should describe their approach to providing the required services for Wellness and Health Care Planning. Additionally, if not outlined specifically in the quantitative support section, plan sponsors should discuss how the costs and potential benefits associated with offering Wellness and Health Care Planning were developed and included in the revised CY2019 BPT.
- **Telehealth Networks** – As noted above in the pricing considerations, the offering of substitute telehealth benefits to meet provider network requirements represents a more complicated benefit to price than the other components. For this reason, plan sponsors are required to provide the following additional information:
  - Description of Service Area – Please provide a list of the counties/SSA codes in which the sponsor is offering substitute telehealth benefits in the circumstance: 1) where the Minimum Provider Calculation is equal to or greater than three providers or 2) where the Minimum Provider Calculation is less than three providers. Please specify whether the area is an existing service area or represents an expansion.
  - Description of Specialties – Please provide a list of the specialty codes for which telehealth will be offered as an option.
  - Network Adequacy – Please describe how the use of telehealth in lieu of an in-person health care delivery provider will complement current network adequacy standards and requirements.
  - Beneficiary Risk Profile – To the extent that plan sponsors believe offering telehealth may change the risk profile of plan enrollment, this should be described. For rural and small network areas, to the extent a service area expansion is expected to change the risk profile of the plan, this should also be described.
- **Five-year Projections** – If an increase to net enrollee or no decrease in Medicare costs is projected in the revised CY2019 BPT or for any particular component included as part of the application, provide a five-year, bid-specific, summary-level projection that demonstrates no net increases to the present value of enrollee costs and a decrease in Medicare costs over the next five Model years, associated with that component.
- **Summary of VBID Program Experience<sup>4</sup>**
  - For each of the types of components, description of Experience to Date – Summary of any and all relevant management, programmatic, or other reviews that have already been prepared. These summaries could include observations of how emerging experience from the VBID program offering compares with expectations. Topics may include, but are not limited to:
    - Proportion of enrollees who qualify for VBID benefits.
    - Participation rates in any covered services and/or additional supplemental services or other indications of enrollee participation take-up or opt-out.
    - Utilization of services with reduced copayments for the VBID-eligible population.
    - Utilization and unit costs of covered services and/or additional supplemental benefits offered to the VBID-eligible population.
    - Credibility of VBID experience.
    - Any effects on non-benefit costs.
  - Emerging Experience Data
    - Separately for VBID eligible and non-VBID enrollees, provide the following data items.

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<sup>4</sup> Applicants for which 2019 was the first model year are not required to complete this section.

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All values should be prepared consistently to how the BPT was prepared. For each item, provide CY 2018 and CY 2017 experience (on an equivalent basis) for utilization per 1,000 and unit costs for comparison purposes for the following:

- Services with reduced cost sharing,
    - MA: by service category.
    - PD: by tier.
  - Covered service or additional supplemental benefits.
  - Services for which significant reductions in allowed costs were expected to be obtained for VBID enrollees, e.g., inpatient hospital, emergency services, etc.
  - Provide the monthly enrollment of individuals eligible for VBID, individuals actively participating in VBID (if applicable), and individuals not eligible for VBID.
- **Description of Program Changes for Each Component** – Narrative listing any changes being made to the VBID program, including (if applicable):
    - List of changes being made to VBID copayments or coinsurance and rationale for the changes.
    - Summary of changes to covered services or additional supplemental benefit offerings for VBID eligible enrollees and rationale for the changes.
    - A list of new geographic areas and/or areas that are no longer included in the program.
      - If an exemplar plan was submitted with the initial application, an explanation of how the exemplar plan is appropriate for any new geographic areas.
    - Rationale for each proposed change, e.g.:
      - Based on emerging experience with Medicare VBID.
      - Based on other experience with VBID in commercial business.
      - Based on new literature or other sources including internal studies, reports and/or other items considered in setting assumptions and/or estimating the expected impact of the VBID components.

CMS will review applications and may request further documentation or explanation of the application. Responses to such inquiries must be made within 48 hours by inserting answers to questions in the Microsoft Word document used in the inquiries. For this purpose, applicants should designate the appropriate respondents along with email addresses and phone numbers if different from those listed on the revised BPTs submitted with the application.

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### 5.2 Documentation Checklist

<b>January MA-VBID Submission</b>
Cover Sheet
Revised CY2019 MA and, if applicable, Part D BPTs
Narrative Summary
Quantitative Support
Wellness and Health Care Planning Summary
Telehealth Networks (if selected)
Five-Year Projections
Summary of VBID Program Experience
Description of Program Changes
Changes to Pricing

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### Appendix A MA BPT Data Entry and Formulas

The following highlights the inputs in the CY2019 MA BPT, by relevant sections, that may be revised to incorporate VBID components.

The base period experience, projected enrollment along with risk assumptions, and benefits for the non-VBID enrollees should remain unchanged from the CY2019 BPT since these assumptions should not be impacted by VBID. If exceptions are found in preparing the revised CY2019 BPT, the need for modification as well as the specific entry should be explained.

#### MA Worksheet 1, Section IV – Projection Assumptions:

All VBID changes are expected to appear in the following columns:<sup>5</sup>

- Utilization Adjustment – Benefit Plan Change (column k). The effects of all VBID changes in utilization rates are expected to appear in this column, e.g., increased utilization of services with reduced cost sharing for targeted enrollees.
- Utilization Adjustment – Other Factor (column m). Indirect shifts in utilization rates due to VBID components are expected to appear in this column.
- Unit Cost Adjustment – Provider Payment Change (column n). An example is negotiated provider reimbursement changes for certain high-value providers.
- Unit Cost Adjustment – Other Factor (column o). All other VBID impacts to unit cost entries should appear in this column. Examples include changes in unit cost due to changes in the intensity of service trend as a result of VBID benefit changes.
- Projected Additive Adjustments (columns p and q). Examples include additional benefits due to VBID components as either Medicare covered or supplemental coverage depending on how the additional benefits would be classified.

In each case, VBID changes should appear in the appropriate service line as composited entries of the original entries for non-targeted enrollees and those that apply to enrollees with each targeted chronic condition.

#### Worksheet 2, Section II – Projected Allowed Costs:

There will be a number of changes that flow from those noted above. Note that the manual rate, if applicable, must be updated for the inclusion of the VBID components in the same way as for the experience rate, reflecting the same proportions of each VBID affected subpopulation.

#### Worksheet 3, Section III – Development of Contract Year Cost Sharing PMPM:

A number of changes will be needed to conform to changes noted above. In addition:

- In general, all VBID cost sharing changes should appear in the appropriate service lines as composited entries of the original entries for non-targeted enrollees and those that apply to enrollees with each targeted chronic condition and/or socioeconomic status (as defined by Low Income Subsidy (LIS) status).
- Service Category (column c). Blank rows may be used at the bottom of the worksheet to include additional non-Medicare covered VBID components that were in categories that were not

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<sup>5</sup> If exceptions are found, make the entries where they are needed but explain in the documentation the need for using these fields as well as the entries made.

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offered in the original bid submission.

### **Worksheet 4 Section II – Development of Projected Revenue Requirement:**

In addition to entries needed to conform to those directly affecting VBID utilization and costs, the revised entries for non-benefit expenses and gain/(loss) margin should reflect the same general assumptions that led to the original 2019 entries, i.e., revised from the final approved 2019 MA bid to reflect the direct effects of including the VBID related benefits.

### **Worksheet 5 Section VI – County Level Detail and Service Area Summary:**

Any changes to service area or population risk arising from offering VBID components should be reflected in the county level detail submitted on Worksheet 5.

### **Worksheet 6 – MA Bid Summary:**

- In general, Worksheet 6 entries should show how the bid would have been completed for CY2019 if the VBID entries had been included. Changes to the following items are expected. Any changes in strategy related to these elements should be explained in the supporting documentation.
  - Section II – B. Rebate Allocation for Part B Premium, C. Rebate Allocations – 1. Reduce A/B Cost Sharing, 2. Other A/B Mand Suppl Benefits
  - Section III – Plan A/B Bid Summary, Subsection C:
    - Part D Basic and Supplemental Premiums Prior to rebates (lines 7a and 8a).
    - A/B Rebates allocated to the Part D Basic Premium and allocated to Part D Supplemental Premium (lines 7b and 8b)

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### Appendix B Part D BPT Data Entry and Formulas

Similar to the VBID model CY2019 MA BPT, the CY2019 Part D BPT should be completed for participating MAPD plans by following applicable guidance for CY2019 bidding. It should be revised to reflect the impact of offering VBID and should reflect what a CY2019 Part D bid would have been – had VBID benefits been offered then. The Part D bid pricing tools must reflect the final National Average Monthly Bid Amount released in <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmarks2019.pdf>.

The following sections highlight the inputs that can be revised to incorporate VBID components. Support for changes to items not listed must include the rationale for the need for changes as well as documentation of the particular BPT element(s). Base Period Experience (Worksheet 1) and the Contract Period Projection for Defined Standard Coverage (Worksheet 3), projected enrollment and risk score, should remain the same as in the original bid submission without the VBID components. Reduced Part D cost sharing offered as a VBID component must be reflected as Enhanced Alternative (EA) benefits in the BPT, unless the entire prescription drug benefit (including VBID reductions in cost sharing) meets the applicable standards for Actuarially Equivalent or Basic Alternative coverage.

Worksheet 2, Section V – PMPM Non-Benefit Expenses:

- Non-Benefit Expenses should be updated to include the cost of providing VBID components.

Worksheet 3, Section IV – Non-Benefit Expenses and Gain/(Loss):

- The Total Gain/(Loss) (line 6, column d).

Worksheet 5, Section IV – Development of Bid Components:

- Line 6, columns f and g – Value of Defined Standard Deductible
- Line 7, columns f and g – Value of Proposed Deductible
- Line 11, columns f and g – Coinsurance Percentages
- Line 17, columns o and q – Minus Rebates for both covered and non-Part D covered drugs.
- Line 19, columns m, o and q – Plus Part D as Secondary for reinsurance-eligible Part D-covered drugs, Part D-covered drugs, and non-Part D covered drugs.

Worksheet 5, Section V – Development of Actuarial Equivalence Test:

- The projected average low-income cost-sharing PMPM subsidy (line 9, column o).

Worksheet 5, Section VIII – Development of Induced Utilization Adjustment:

- The projected Impact of Alternative Utilization on Standard (line 2, column f).

Worksheet 6, Section II – Projections for Equivalence Tests:

- Lines 1 through 8, 10 through 17, 19 through 26, and 28 through 35: The Number of Scripts (column i), Allowed (column j), and Cost Sharing (column k) should be modified for the Actuarially Equivalent or Alternative Benefits to reflect the utilization, cost, and cost sharing assumptions resulting from the VBID components. This should include adjustments in utilization and average allowed given the proposed benefits.
- In the event that changes to average discounts or dispensing fees are expected as a result of VBID components, the network pricing on line 37 should be updated.

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Worksheet 6A, Section II – Spending in the Coverage Gap:

- Lines 12 through 21 and 23 through 32: The Number of Scripts (column i), Allowed (column j), and Cost Sharing (column k) should be modified for the Actuarially Equivalent or Alternative Benefits to reflect the utilization, cost, and cost sharing assumptions for spending in the coverage gap resulting from the VBID components.

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**Appendix C Sample Cover Sheet**

**SAMPLE COVER SHEET – SUBMITTED WITH INITIAL VBID  
UPLOAD**

**Supporting Documentation Cover Sheet**

**CY2020 VBID Pricing Submission**

**Organization Name:** H Sponsor

**Contract(s):** H9999

**Date:** January xx, 2019

<b>Documentation Requirement</b>	<b>Applicable to MA, Part D or Both</b>	<b>File Name</b>	<b>Location within File (if Applicable)</b>
Cover Sheet	Both	Cover Sheet 1-11-19.pdf	Page 1
Revised 2019 MA BPT	MA	2019MABPTRevised.xlsx	
Revised 2019 Part D BPT	PD	2019PDBPTRevised.xlsx	
Narrative Summary	Both	Narrative1-11-19.pdf	Page 2
Quantitative Support	Both	Impacts 1-11-19.xlsx	Sheet 1- MA
Multi-year Projections	Both	FinancialPlan 1-11-19.xlsx	Sheet 1