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CMS Unveils Value-Based Insurance Design Model for Medicare Advantage

Under the Affordable Care Act (ACA) authority to test innovative payment and service delivery models, CMS is launching a Value-Based Insurance Design (VBID) model test. CMS recently provided guidance to Medicare Advantage (MA) plans interested in participating in the test.[1] The VBID model will allow plans to vary their benefit design for specific populations with chronic conditions with the goal of improving quality of care and reducing costs for those groups. Plans will be allowed to reduce cost sharing or provide supplemental benefits to these groups without having to provide the same benefits to other MA beneficiaries. No other variations in benefit design are allowed.

The model is scheduled to begin on January 1, 2017 and last for five years. CMS currently anticipates that plans interested in participating will have to respond to a Request for Applications (RFA) sometime in November. The guidance that CMS has provided is only preliminary, and CMS is seeking comments on the proposal. Comments are due on Sept. 15.

Eligible Beneficiaries and Permissible Interventions

Only beneficiaries with certain chronic conditions will be able to receive the reduced cost sharing or additional supplemental benefits offered under the VBID model. The eligible groups are beneficiaries with diabetes, chronic obstructive pulmonary disease, congestive heart failure, a history of stroke, hypertension, coronary artery disease, or a mood disorder. CMS selected these conditions based on their high prevalence in the MA population, the potential for high-cost complications, and the existence of low-cost, high-value interventions that could improve care for individuals with these conditions. Plans do not need to vary benefit design for all of these targeted conditions, but instead are allowed to select certain conditions.

CMS outlined three different ways that plans could reduce cost sharing for these groups under the VBID model:

- *High Value Services*: Plans may reduce or eliminate cost sharing for items and services, including Part D drugs, that are thought to reduce costs and improve quality for a target population. For example, plans may reduce or eliminate cost sharing for eye exams for diabetics or for ACE inhibitors for those who have suffered from a heart attack.
- *High Value Providers*: Plans may also reduce or eliminate cost sharing when targeted enrollees are treated by providers that the plan identifies as being high value. Plans can either provide the reduced cost sharing to the targeted populations whenever a targeted enrollee is treated by the high-value provider, or they can provide this reduction only when the high-value provider treats the enrollee with a high value service. Plans will need a methodology for identifying which providers are high value, and CMS encourages plans to use a methodology that relies on independent metrics. For example, plans could reduce or eliminate cost sharing for diabetics who see a physician with a history of controlling patients' Hba1c levels or do so for heart disease patients who receive non-emergency services at a cardiac center of excellence.
- *Disease Management Programs*: Plans also have the option of reducing or eliminating cost sharing for targeted enrollees who participate in a disease management program. For example,

[1] CMS, Announcement of Medicare Advantage Value-Based Insurance Design Model Test (Sept. 1, 2015), *available at* http://innovation.cms.gov/Files/x/mavbid-announcement.pdf.

plans can reduce or eliminate primary care co-pays for diabetes patients who regularly meet with a care manager, or they can reduce or eliminate drug co-pays for patients with heart disease who regularly monitor and report their blood pressure.

In addition to reduced cost sharing, plans can also provide supplemental benefits to the targeted groups that would not be available to the general MA population. Plans, for example, might provide physician consultations via real-time video to patients with diabetes, or they could provide tobacco cessation assistance to patients with chronic obstructive pulmonary disease.

With these interventions, plans will provide a more favorable benefit design to beneficiaries with these chronic conditions than to other MA beneficiaries. In order to allow plans to do this, CMS anticipates waiving statutory and regulatory provisions that require uniformity of benefits and uniformity of cost sharing; CMS also intends to waive certain restrictions related to beneficiary communications and marketing. Section 1115A of the Social Security, which was adopted as part of the ACA, grants CMS the authority to provide these waivers. Despite these waivers, plans will not be allowed to vary the design within a chronic condition. For example, if a plan selects diabetes as one of its targeted conditions, then the reduced cost sharing and/or supplemental benefits would need to be available to all plan enrollees with diabetes.

Eligible Plans

Not all MA plans can participate in the VBID model. There are only seven model test states: Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee. In order to participate, all or part of a plan's service area must be within one of these states, at least 2,000 of the plan's enrollees must be in a model test state, and at least 50% of the plan's enrollment must be in the model test states. The plan must be an HMO or a local PPO, it must have been offered in at least three open enrollment periods prior to the open enrollment period for 2017, and it must be offered in no more than two states in total. Special Needs Plans, demonstration plans, regional PPOs, cost plans, Private Fee-for-Service plans, Medical Savings Account plans, and Employer Group Waiver Plans are excluded from the model. Low performing plans are also excluded; this exclusion applies to plans under sanction, plans identified as an outlier in a CMS Past Performance Review, plans with less than a three star overall quality rating in 2015, and plans designated as "consistently low performing." Nevertheless, CMS indicated that it might waive some of these criteria on a case-by-case basis.

Marketing and Enrollee Communication

CMS does not want the VBID model to influence the decision of potential enrollees to enroll in a particular plan. As a result, plans will be prohibited from citing their participation in the VBID model in any of their marketing materials. Similarly, a plan's sales representatives will not be allowed to mention the plan's participation in the model to potential enrollees, although they will be able to discuss the model with potential enrollees who specifically inquire about the VBID model.

Plans, however, are expected to communicate with their enrollees in the targeted populations about the VBID model. Plans should provide these populations with materials summarizing the reduced cost-sharing and/or additional benefits available to them. If a plan is reducing cost sharing for high value providers, the plan should provide these groups with a list of those providers. CMS also encourages plans to engage in more intensive communication, such as by calling targeted enrollees to discuss their treatment patterns and the potential advantages of their participation in the VBID model.

Model Evaluation

The VBID model is an experiment, and CMS intends to evaluate the model to determine if it is succeeding in its goals of reducing costs and improving quality. As part of that effort, CMS will analyze various data

sources, including enrollment and disenrollment files, encounter data, star ratings, HEDIS data, and disenrollment data. CMS may require plans to provide additional data.

Comment Period and Application Process

CMS is currently seeking comments on its proposed implementation of the VBID model test. Comments are due on Sept. 15, and should be emailed to HealthPlanInnovation@cms.hhs.gov.

After receiving the comments, CMS anticipates releasing the RFA in the second half of September and requiring RFA responses sometime in November. In their applications, plans must identify which plans they are seeking to enroll in the model test. Plans must include a list of the chronic disease categories selected, descriptions of their planned interventions, and descriptions of their assumptions concerning outcomes. Importantly, plans must include projections of the impact their participation in the VBID model will have on utilization, cost, and premiums. Those projections must show anticipated cost savings over the five-year period of the VBID, and they must be actuarially certified.

Plan selection is not competitive, so that all qualified applicants with acceptable proposals within a geographic area will be accepted.

CMS anticipates negotiating with plans about their proposals at the end of 2015 and in the first quarter of 2016. 2017 plan bids, due in June 2016, must incorporate information about a plan's participation in the VBID model. CMS anticipates that plans will sign a VBID addendum to their MA contracts in Sept. 2016.

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