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Medicare

CMS Seeks Input on Improvements To Medicare Advantage Design Model

The Medicare agency wants to know how to improve a new project that will allow Medicare Advantage plans to tailor their services to individuals with certain chronic conditions, such as diabetes and hypertension.

The five-year Medicare Advantage Value-Based Insurance Design (MA-VBID) model test begins Jan. 1, 2017, but the agency is already interested in feedback as to which conditions should be considered for future years.

The Centers for Medicare & Medicaid Services ''is requesting feedback to facilitate the improvement of the MA-VBID model test for model years two through five'' or 2018- 2021, according to a March 21 memo to MA organizations from the CMS's Center for Medicare & Medicaid Innovation.

Eligible plans may be offered in seven states: Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania and Tennessee.

Under Medicare Advantage, private managed care organizations contract with the federal government to coordinate care for Medicare beneficiaries who choose to enroll.

Recommendations Due Next Month. Suggestions are due by April 18 on the model that will test ''clinically-nuanced benefit packages'' to promote quality of care and cost reduction for MA enrollees. The program generally requires that plan benefits and cost sharing be the same for all enrollees.

The agency announced the model in September 2015 as a way to give MA plans the flexibility to offer benefits, such as extra coverage or reduced cost sharing for high value services, to enrollees with certain chronic conditions. Only some types of managed care plans, including health maintenance organizations, HMO point-of-service (HMO-POS) plans and local preferred provider organizations (PPOs), are eligible to participate, the agency said in 2015. Other plans, including special needs plans, regional PPOs and Medicare-Medicaid plans, will be ineligible (170 HCDR, 9/2/15).

Conditions Allowed. The chronic conditions are diabetes, congestive heart failure, chronic obstructive pulmonary disease, past stroke, hypertension, coronary artery disease, mood disorders, and combinations of these categories.

In addition to asking about additional conditions, the CMS wants feedback on the definition of these conditions and whether MA organizations should be permitted to propose new conditions as part of the annual application process.

Mark Fendrick, director of the University of Michigan's Center for Value-Based Insurance Design, told Bloomberg BNA that additional conditions worth considering are: epilepsy, schizophrenia, atrial fibrillation, deep venous thrombosis and chronic renal failure.

Short-Term Increased Spending. Fendrick said that he's concerned that the model may actually raise costs for plans in the beginning of the model when patients use more services to treat the chronic conditions.

''Expenses will likely rise in the early years,'' he said.

The model is intended to encourage enrollees to use high-value clinical services—those that have the greatest potential to positively impact enrollee health—but at the same time requires cost neutrality.

In response, participating plans might have to raise premiums as targeted enrollees can't receive fewer benefits or have to pay higher cost-sharing than other enrollees.

''I'm not sure how the plan bidding process might be altered to mitigate the potential negative market effects of higher costs in the early years,'' he said.

While the five-year duration of the model allows time for eventual ''spending offsets'' as a result of reduced emergency room visits and hospitalizations, he said that in the beginning, higher premiums could make the participants less competitive with other plans in the marketplace.

By Mindy Yochelson

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The CMS's March 21 memo is at http://src.bna.com/dzu. Additional information is at https://innovation.cms.gov/initiatives/vbid/.

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