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Participating States and Plans

CMS will test the VBID model in seven states: Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee. These states were selected by CMS because they collectively represent an accurate cross-section of MA Plan populations nationally. The VBID program will be open to all eligible MA Plans in participating states, and there will be no limit on the number of Plans that can participate.

Program Eligibility Criteria

In order to be eligible to participate in the VBID program an MA Plan must meet the following criteria:

- The MA Plan must have at least 2,000 enrollees in one of the model states, and 50 percent of the Plan's total enrollment must reside in one of the states.
- The MA Plan must have been offered for at least three years prior to enrollment in the Program; however, CMS indicated that it may be willing to waive this requirement in certain instances, including where the MA Plan is a successor to another Plan.
- MA Organizations (MAOs) with multiple MA Plans may choose to enroll one or more of their MA Plans, but CMS is not requiring all MA Plans offered by the MAO to participate in the program.
- Only HMO, HMO-POS and local PPO plan types are eligible. Other MAO plan types such as Special Needs Plans, Regional PPOs, Medical Savings Account Plans and others are excluded.
- The MA Plan must have at least a three-star overall quality rating.
- The MA Plan's target population cohort must be of sufficient size to generate an appreciable evaluation of proposed interventions.
- The MA Plan must submit actuarial projections showing net savings to CMS at the end of five (5) years.

Targeted Conditions

Under the VBID program MA Plans will be permitted to offer varied plan benefit designs (interventions) for targeted enrollees who fall into certain clinical categories defined by CMS. Initially, the interventions will be limited to patients with the following chronic disease diagnoses: diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), past stroke, hypertension, coronary artery disease, mood disorders or any combination of these. CMS indicated that it may expand these categories in the future.

Permissible Interventions

Participating MA Plans will have significant flexibility in designing interventions for their targeted populations, including using different and/or multiple interventions for each population. However, interventions must fall within one of the four categories listed below. If an MAO offers multiple MA Plans, it may have different interventions for targeted populations within those Plans. Permissible interventions for targeted populations are as follows:

1. Reduced Cost-Sharing for High-Value Services
MA Plans can choose to reduce or eliminate cost-sharing for "high value" items or services covered under the targeted population's benefit plan. MA Plans will have broad discretion in choosing which items and services are eligible for cost sharing reductions, but the services must be clearly identified for enrollees, and all enrollees in the target population must be eligible for the cost-sharing reductions/elimination.

CMS's announcement does not specify what constitutes a "high value" service, but presumably Plans would include services that have a demonstrated history of producing quality outcomes at lower cost. Plans are free to propose different approaches to cost-sharing reduction models, but typical ones would include elimination/reduction of co-pays, co-insurance, or carve-outs from MA Plan deductible amounts for certain services. One example provided by CMS is the elimination of co-pays for eye exams for diabetics.

2. Reduced Cost-Sharing for Using "High-Value" Providers
Under this intervention MA Plans may structure interventions that reduce cost shares for targeted populations when the member receives services from certain "high-value" providers designated by the Plan. High-value providers can include any or all Medicare provider types, e.g., hospitals, physicians, SNFs, home health agencies, etc. To qualify as a "high-value provider," MA Plans must demonstrate that the provider has a record of providing high-quality services at lower cost. MA Plans must provide CMS with the criteria and clinical rationale for its selection of high-value providers. Criteria cannot depend on cost alone; they must include a quality component as well. In its guidance CMS encourages MA Plans to rely on independent industry metrics such as those for National Committee for Quality Assurance, certified medical homes, American Heart Association certification, or other regionally specific approaches that can be clinically justified.

While CMS will not apply any network adequacy standard to a Plan's proposed high-value providers, they must be "available and accessible" to the targeted population enrollees. Targeted populations cannot be required to use high-value providers, and Plans cannot remove providers from their roster during a contract year, unless the provider is terminated from the MA Plan's entire network, or the provider requests exclusion

from the high-value network. All modifications to a Plan's roster of high-value providers must be communicated to CMS and enrollees in accordance with all other applicable Medicare Advantage policies and procedures, including those pertaining to Significant Changes to an MA Plan's network. Examples given by CMS of high-value provider interventions are reducing cost-sharing for diabetics who see a physician with a strong track record of controlling patients' HbA1c levels, and eliminating cost-sharing for heart disease patients who receive treatment at Plan-designated cardiac centers of excellence.

3. Reduced Cost-Sharing for Participation in Disease Management Programs
In lieu of or in addition to cost-share reductions, MA Plans can also offer unique disease management programs to targeted populations. Disease management programs can include both those offered as additional supplemental Plan benefits, or those that are part of the Plan's standard care coordination activities for chronically ill patients. This option is distinguishable from the flexibility offered by current MA Plan Rewards and Incentives programs in that the latter does not permit reduced cost-sharing for member participation. Like the Rewards and Incentives Program, however, eligibility for cost share reductions under this intervention cannot be tied to the enrollee's health status or to achieving certain health milestones. For example, a requirement that the enrollee meet with his/her case manager at certain intervals to qualify for reduced cost shares will be permitted, but conditioning the cost share reduction on the member achieving a certain body mass index or HbA1c level reduction will be prohibited. A permissible example highlighted by CMS is a reduced drug co-payment if a cardiac patient reports his/her blood pressure on a periodic basis.

4. Coverage of Additional Supplement Benefits
Participating VBID Plans can also selectively restrict coverage for certain supplemental benefits to targeted populations, a practice that is otherwise prohibited under current MA benefit uniformity rules. MA Plans choosing this option must provide CMS with the clinical rationale behind why the additional services will be projected to improve outcomes or lower costs for the targeted population. Supplemental benefits could include, by way of example, transportation to/from primary care visits for patients with multiple co-morbidities, nutritional services, or additional rehabilitation or other post-acute care service coverage. In CMS' informational session held on September 24, 2015, CMS indicated that coverage for telehealth and telemonitoring programs, such as virtual physician visits and remote monitoring of patients' health status indicators would qualify as supplemental benefits.

Additional Key Provisions

Marketing/Enrollee Communications:
MA Plans participating in the VBID Program will be bound by all existing MA marketing and enrollee communication rules and restrictions. In particular, MA Plans may not reference their participation in the VBID model or specific benefits available under the model in any pre-enrollment marketing materials targeted at potential enrollees. VBID Plans are, however, permitted to mention the Plan's participation in the program to potential enrollees, but only if specifically asked. Participating VBID Plans will be required to send informational materials to targeted enrollee populations at the beginning of each program year. The materials must be mailed as part of the same package as the annual Notice of Coverage and Explanation of Coverage, and include a listing of any high-value providers if the Plan has chosen to include this intervention as part of its VBID program.

CMS is encouraging Plans to engage in further communications with enrollees regarding the benefits of the VBID program, including follow-up mailings, enrollee reminders of potential advantages available to them, follow-up phone calls, and targeted phone calls regarding a member's specific treatment patterns and clinical needs.

Member Protections:
There are multiple enrollee protections built into the VBID model design. CMS indicated that one of the most important protections is the prohibition on reducing targeted enrollee benefits, or increasing costs sharing amounts as a means to incentivize enrollees to participate in VBID interventions. For example, VBID Plans cannot condition or limit a member's coverage for benefits to which the member would otherwise entitled on participation in the program, or impose higher cost shares for such benefits if the member chooses not to participate in the program.

Other protections include the use of "secret shoppers" to ensure that plan marketing and sales representatives are in compliance with marketing rules, random and targeted audits, an enrollee opt-out right, and ongoing monitoring of plan data concerning enrollee outcomes and member satisfaction.

For additional information regarding the VBID model, please contact:

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