Calendar Year (CY) 2025 Value-Based Insurance Design (VBID) Model
Frequently Asked Questions (FAQs) on Pricing and Financial Application Requirements

Overview: The CY 2025 Request for Applications (RFA) to participate in the VBID Model is available on the VBID Model Webpage at: https://www.cms.gov/priorities/innovation/innovation-models/vbid. CMS is providing this accompanying FAQ document to provide additional clarifications to the actuarial requirements for Medicare Advantage Organizations (MAOs) interested in applying to participate in the VBID Model that are outlined in the CY 2025 RFA. If you have additional questions about the pricing and financial application requirements after reviewing this FAQ document, please contact the VBID Model Team at VBID@cms.hhs.gov.

Q. To what extent must an actuary be involved in the preparation of application materials for the VBID Model?
A. Per section 3.4 of the CY 2025 VBID Model RFA, MAOs seeking to participate in the VBID Model must provide as part of their application "projections of the impact that their participation will have, for CY 2025 and over the course of the MAO's participation in the Model on plan medical and prescription drug utilization, cost, and premiums." These projections are expected to be prepared by, or have the preparation directed by, a qualified actuary who is a member of the American Academy of Actuaries (MAAA). This portion of the application is considered to be an Actuarial Communication in accordance with Actuarial Standard of Practice (ASOP) Number 41. Thus, the actuary must be clearly identified in the submission of application materials.

Q. With respect to the projections required as part of the application related to medical and prescription drug utilization, cost, and premiums, what are MAOs expected to show?
A. As noted under section 3.4 of the CY 2025 RFA, the projections are expected to "show net savings to CMS in CY 2025, net of risk score trends attributable to the Model, and over the course of the MAO's participation in the Model; and no net increase in enrollee cost in CY 2025 and over the life of the Model." It is sufficient for the actuary to demonstrate that the pricing assumptions being applied for the contract year will lead to reductions in CMS payments, with similar assumptions in future Model years (as opposed to a longitudinal projection). The decision of whether to model a single year and assume similar directional changes in future years or to prepare a longitudinal projection is left to the discretion of the actuary.

Continuing in CY2025, CMS has provided a ***required*** "Net Savings Template," which documents the various revenue streams projected as part of MA and Part D (PD) bidding, including MA payments, Part D direct subsidy payments, low-income cost sharing subsidies (LICS), Part D Federal Reinsurance, and projected risk scores. MAOs are expected to show a reduction in CMS payment in total across these streams. As noted above, these reductions can be shown in a single year with expectations for similar reductions in future years, or with a longitudinal projection over the participation period. The template has been provided to aid in the preparation of these materials; the underlying assumptions used to develop the estimates included in completed templates should be well-documented. Where possible, specific Bid Pricing Tool (BPT) line items should be identified.

Q. Is a "Net Savings Template" required for all PBPs included in the application?
A. Yes, each PBP is required to demonstrate net savings to CMS.

Q. Do projections need to be provided separately for each Model component?
A. MAOs must demonstrate net savings to CMS; MAOs may demonstrate this in aggregate across all Model components *or* separately for each Model component. Additionally, in the Financial Application Memorandum, the projected costs and project savings for each Model intervention must be provided.

For CY 2025, participating MAOs must offer a minimum of two Health-Related Social Needs (HRSN) benefits selected from the categories of food and nutrition, transportation, and housing and living environment in each participating PBP, regardless of whether the PBP uses one or more of the permissible targeting criteria. Recognizing that MAOs may already be offering supplemental benefits that address priority HRSNs in the MA Program those supplemental benefits can be used to satisfy this requirement for participating PBPs. Supplemental benefits used to satisfy this requirement must be identified in the VBID Application and submit the same financial information required of regular VBID interventions.

Q. If certain aspects of the overall VBID approach are already offered as part of the MA plan separate from participation in VBID, should only the incremental cost or savings of VBID Model participation be included in financial projections?
A. Please provide only the incremental cost/savings of the VBID Model intervention(s). E.g., if non-VBID supplemental benefits used to satisfy the minimum of two HRSN benefits requirement would have been offered even without the VBID Model's HRSN requirement, then it would not be an incremental cost/savings attributable to the VBID Model.

Q. How do I determine if a supplemental benefit meets the HRSN benefits requirement?
A. While the list is not exhaustive, the RFA points to examples of qualifying benefits. Please see Appendix 3 of the CY 2024 VBID Monitoring Guidelines for a more comprehensive list of benefits that would fall under the three HRSN categories.

Q. Are MAOs required to provide historical experience related to prior Model participation?
A. The VBID Financial Application specifically requests quantitative estimates related to Model participation.

Q. How should plans reducing Part D copayments price the benefit in bids?
A. As with all pricing elements, bid submission should comply with all relevant guidance promulgated by the Office of the Actuary including, but not limited to, the Part D Bid Instructions and Actuarial User Group Questions and Answers. Enhanced Alternative (EA) plans offering reduced cost sharing should include the value of the reduced or eliminated cost sharing as a supplemental benefit offering. Defined Standard (DS) plans waiving the low-income copayment amount should include the value of that reduced or eliminated cost sharing as a non-benefit expense. In the event that an EA plan is changing to a DS plan and offering reduced or eliminated low-income copayments, the financial projection should consider any additional low-income cost-sharing subsidies (LICS) revenue that may be received as a result of the benefit change.

Q: What are Part D pricing considerations for VBID as a result of the Inflation Reduction Act?
A: The IRA does not impact VBID uniquely or differently from the broader Part D program. Beginning in 2025, cost sharing reduction benefits through VBID, like many other supplemental benefits, will count towards the TrOOP. Effective 1/1/25, VBID benefits historically reported through PLRO will have to be reported through the Other TrOOP field. Similarly, all manufacturer discounts will be applied prior to any supplemental benefit. This is because in 2025, the provision concerning supplemental benefits and the application order of the discount no longer applies.

Q: What are the Part D targeting considerations for plans interested in Area Deprivation Index (ADI) targeting?
A: As noted in section 2.1.3 of the RFA, MAOs may not propose to limit eligibility for Part D RI Programs by ADI area. Furthermore, as noted in section 3.4.2 of the RFA, DS plans will not be permitted to offer a reduction or elimination of cost sharing targeted based on ADI, similar to the restriction for chronic health condition targeting.