CMS Perspective:

Medicare Advantage Value-Based Insurance Design (VBID) Evaluation of the First Three Years (2017-2019) of the Model

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For information on the model and to download the independent evaluation report discussed in this document, please visit https://innovation.cms.gov/innovation-models/vbid

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U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation
Research and Rapid Cycle Evaluation Group & Seamless Care Models Group
2810 Lord Baltimore Drive, Suite 130
Baltimore, MD 21244

CMS Perspective: Medicare Advantage Value-Based Insurance Design (VBID) Model Evaluation Report for the First Three Years of the Model (2017-2019)

The Value-Based Insurance Design (VBID) Model tests the impact of offering a broad array of flexibilities to Medicare Advantage (MA) Organizations (MAOs) on beneficiary health, quality of care and Medicare expenditures. In the first three years of the Model, participating MA plans could offer reduced cost sharing for high-value services and additional supplemental benefits to beneficiaries with certain conditions; plans could require participation in disease management or other activities as a condition of receiving the benefits. VBID is a voluntary model, with no changes to how payments are made to MAOs or extra direct financial incentives introduced. CMS made substantial changes to the Model beginning in 2020, including changes in response to the Bipartisan Budget Act of 2018 and additional flexibilities for participating MA plans based on early experiences from the Model and feedback from plans. These changes include introducing targeting of supplemental benefits by chronic condition and/or socioeconomic status, creating more meaningful Part C and D rewards and incentives, and promoting more adoption of advanced care planning in MAOs. Beginning in 2021 the Model is introducing a carve-in of the Medicare hospice benefit into MA, as well as adding additional flexibilities to MAOs per Executive Order 13890.

The Evaluation of the first three years (2017-2019) of the Medicare Advantage Value-Based Insurance Design Model presents findings for the first three years (2017-2019) of the VBID Model. However, due to variation in the completeness associated with MA data sources, this report covers most outcomes for the first two Model years (2017 and 2018), utilization for 2017 only, and enrollment for 2017, 2018, and 2019.

Between 2017 and 2019, 11 Parent Organizations (POs) from six states offered VBID in 51 plan benefit packages (PBPs) in the MA program, to beneficiaries with conditions of coronary artery disease (CAD), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, and/or hypertension. The evaluation shows that VBID participating plans experienced increased utilization of many high-value services that the plans selected to promote using the VBID flexibilities, such as primary care provider (PCP) visits, specialist visits for those select conditions, and 30-day drug refills; VBID participation was also associated with lower Part D bids. Plans' benefit designs varied widely, making it difficult to determine which design components had the largest impact on outcomes. VBID is not yet generating savings to Medicare, and it is also not costing Medicare additional money, as expected. There were no changes in MA program costs to Medicare (actual payments made by CMS to plans for benefits provided to MA and Part D enrollees after accounting for final risk scores and rebates) nor in plans' own realized spending (actual spending by plans on medical and drug benefits for enrollees).

Further, the report did not find significant changes in the first year of the Model in key beneficiary outcomes, such as quality and health outcomes, aside from slightly improved care coordination, as these outcomes usually take a longer time to materialize (and there was only a year of data available at the time of this Report for most of these quality and health outcomes). Further analysis using data from subsequent Model years will be required to assess whether favorable beneficiary outcomes emerge, as MA plans continue to innovate on their expanded VBID offerings for beneficiaries.

The VBID evaluation report draws conclusions that help us to understand what is happening in VBID. Based on program data, the evaluation report, and input from stakeholders, CMS has made adjustments to the Model mid-course. We also use these results to help to plan for any potential health plan models in the future.

Through the VBID Model, from 2017 to 2019, CMS tested the impact of providing MA Organizations with programmatic flexibility to target Part C mandatory supplemental benefits to specific beneficiaries based on those beneficiaries' underlying conditions. After the first year, CMS added states and allowable conditions for participating MA organizations to target over this time period. Additionally, through CMS-4182-F, CMS adopted a new interpretation that providing access to services (or specific cost sharing for services or items) that are tied to health status or disease state in a manner that ensures that similarly situated individuals are treated uniformly is consistent with the uniformity requirement in MA at § 422.100(d). Based on this reinterpretation of the uniformity requirements for the MA program, beginning in calendar year 2019, MA organizations could provide Part C mandatory supplemental benefits based on health status or disease state in the general MA program, similar to the VBID Model.

Starting with the 2020 calendar year, consistent with the Bipartisan Budget Act of 2018, eligible MA health plans in all 50 states and territories could apply to participate in the VBID Model (plan applications, reviews, and approvals for 2020 VBID participation took place in 2019 during the standard MA plan application cycle). Further, beginning with 2020, eligible plan types included all special needs plan types, including dual eligible special needs plans (D-SNPs) and institutional special needs plans (I-SNPs). In addition to continuing to test the impact on cost and quality of benefit design flexibility for Part C and Part D mandatory supplemental benefits by condition, CMS announced a complementary set of MA innovations that would be tested for 2020 and beyond in the general MA program. These innovations build off not only from the original VBID Model design, including the original evidence base and theory of change of the Model, but also from three years of evaluation findings and robust stakeholder input.

The first change was that MA organizations, through the VBID Model, could test providing mandatory supplemental benefits based on an enrollee's chronic health condition, socioeconomic status, or both. The second change was to test more meaningful Part C and novel Part D Rewards and Incentives programs and any impacts on beneficiary behavior and utilization. Further, CMS is testing ways that all participating MA organizations could increase the number of beneficiaries with advance care plans.

CMS also announced that it will test, starting in calendar year 2021, inclusion of the Medicare hospice benefit in MA through the VBID Model. In addition, and in response to President's Executive Order 13890 on Protecting and Improving Medicare for Our Nation's Seniors, the VBID Model will test permitting Medicare beneficiaries to share more directly in program savings by allowing participating MAOs to offer a mandatory supplemental MA benefit in the form of cash or monetary rebates to all enrollees in Model PBPs. Lastly, beginning in calendar year 2021 and in response to the President's Executive Order, CMS is encouraging participating MAOs to provide targeted coverage for: (i) FDA approved medical devices or new technologies that have a Medicare coverage determination where the MA plan seeks to cover it for an indication that differs from the Medicare coverage determination and the MA plan demonstrates the device is medically reasonable and necessary; and (ii) for new technologies that do not fit into an existing benefit category.

Overall, MA organization incentives to participate in this Model are clear: MA organizations need to believe that there is a specific deficit in care that they can better address through targeted programs and that those programs provide a positive return on investment overtime. Initial Model interventions were very focused on specific populations, as we would expect for a new Model where there is limited market knowledge of how competitors behave. As plans and CMS have built experience over time with the Model, along with the addition of new, meaningful complementary Model components, CMS has seen significant increases in Model adoption, especially focused on the ability to target mandatory supplemental benefits based on socioeconomic conditions.

CMS anticipates sustaining or continuing growth in participation and a focus on Model-unique components, including Part D cost sharing and Part D Rewards and Incentives, as MA organizations have time to understand how best to utilize and implement the Model's flexibilities.