Medicare Advantage (MA)
Value-Based Insurance Design (VBID) Model
Calendar Year 2024 Financial Projections

BACKGROUND

The VBID Model tests a number of complementary health plan innovations designed to promote improved quality and reduced costs in the MA program. Applicants and certifying actuaries should refer to the VBID Model RFAs, located at https://innovation.cms.gov/innovation-models/vbid. For the Calendar Year (CY) 2024 VBID Model, eligible MA Organizations (MAOs) may participate in the VBID Model by proposing one or more of the following components:

VBID Flexibilities: Under this component, MAOs may target mandatory supplemental benefits to enrollees based on: (i) chronic condition(s); (ii) socioeconomic status, as defined by qualifying for the low- income subsidy; or (iii) a combination of both. MAOs may provide both primarily and non-primarily health related supplemental benefits, including a focus on new or existing technologies or FDA approved medical devices. MAOs may provide reduced Part D cost-sharing through VBID for specific covered Part D drugs for a specific population. MAOs may condition VBID flexibilities on the use of a high-value provider and/or participation in a care management or disease state management program.

Part C and Part D Rewards and Incentives Programs: MAOs that offer Part C and/or Part D Rewards and Incentives Programs through this VBID Model component must design programs that promote improved health, prevent injuries and illness, and promote the efficient use of health care resources. MAOs may offer Part C Rewards and Incentives with a value related to the benefit of the service. MAOs may also offer Part D Rewards and Incentives programs designed to improve the linkage between enrollees and the care team in understanding clinically-equivalent therapeutic options, prescription drug coverage, and the overall value to their health of adherence to prescribed drug therapy. Any Part C and Part D Rewards and Incentives Programs costs must be included as a non-benefit expense cost in the Bid Pricing Tool (BPT).

Hospice Benefit Component: While MAOs should refer to CY2024 RFA for the Hospice Benefit Component for full details, through this component, CMS is testing the inclusion of the Part A Hospice Benefit within the MA benefits package through the Hospice Benefit Component of the VBID Model. By including the Medicare hospice benefit in the MA benefits package, CMS will test the impact on service delivery and quality of MA plans providing all original Parts A and B Medicare items and services required by statute. Additionally, CMS is testing how the Hospice Benefit Component can improve beneficiary care through greater care coordination,

reduced fragmentation, and transparency in line with recommendations by the Office of Inspector General (OIG), the Medicare Payment Advisory Commission (MedPAC) and others. CMS will require that MAOs provide beneficiaries with broad access to the complete original Medicare hospice benefit. MAOs participating in the Hospice Benefit Component will be required to outline how they will provide palliative care to eligible enrollees, irrespective of the election of hospice, and may make transitional, concurrent care services as well as hospice-specific supplemental benefits available to enrollees who elect hospice through network hospice providers.

Wellness and Health Care Planning: All Model participants must develop, and CMS must approve, a strategy to provide Wellness and Health Care Planning (WHP), including advance care planning (ACP), for enrollees in their Model-participating plan benefit packages (PBPs).

FINANCIAL PROJECTION REQUIREMENTS

Participating MA Organizations (MAOs) are required to submit to CMS: (i) projected costs[1] for each VBID Model component included in their application broken down by intervention and (ii) projected net savings to Medicare over the course of the Model. In submitting these projections as part of the financial application, plans must clearly outline the projected costs of each VBID Model component the MAO is proposing to implement under the Model, as well as how the proposed interventions will generate net savings to Medicare over the term of the MAO's expected participation in the Model.

The financial projection must be supported by three specific documents – 1) VBID Model Financial Application (this document or similar memorandum), 2) Net Savings Template(s), and 3) VBID Model Application Spreadsheet.

The MAO's VBID Model Financial Application must reflect the MAO's best estimate of projected enrollee engagement, program implementation costs, utilization changes, including the expected timeframe of those utilization changes.

The Net Savings Template(s) show specific projections illustrating net savings for each plan benefit package (PBP)-segment. **CMS requires that Model participants show net savings to CMS and no net increase in enrollee costs (e.g., copays, premium changes directly attributable to the intervention) over the course of their participation in the Model.** CMS will review these projections as part of reviewing the application for compliance with the terms of the Model test, including reviewing the reasonableness of assumptions, any potential detrimental impact to enrollees, CMS, or the Medicare program, and the sustainability of the proposal.

The VBID Model Application Spreadsheet summarizes the proposed interventions by the MAO, by plan and component, and includes enrollment, targeting, and engagement estimates. The interventions listed in the VBID Model Application Spreadsheet must be consistent with those reflected in the VBID Model Financial Application and Net Savings Template.

The projections in the VBID Model Financial Application and Net Savings Template must be prepared by an actuary and all final revenue and expense assumptions must be reflected in the MA or Part D bid by the certifying actuary. Any differences between these projections

[1] See section ii for definition of costs

and the MA or Part D bid must be reconciled through submitting an updated version of this Financial Application to CMS, via the VBID Model mailbox at VBID@cms.hhs.gov, **no later than the bid submission.**

Based on CMS's review of submitted financial information, CMS may seek additional information and/or modifications in the Financial Application prior to approval of the overall application for participation in the Model.

INSTRUCTIONS

CMS has provided the below form for applicants to outline their specific Model Financial Application proposals. Please include a single Financial Application proposal for your participation overall. The financial proposal must include information specific to each VBID Model component and each associated intervention(s) that the MAO is proposing to include.

i. Executive Summary: a summary in financial and actuarial terms of the Model strategy and expected PMPM changes. This should include any changes to an existing program if the MAO is currently participating in the Model. Of particular relevance to the financial application are changes in component offerings, anticipated targeting or engagement rates, or the value of supplemental benefits;

ii. Summary of Projected Costs by each VBID Model component broken down by intervention: a projected utilization, unit or Per Member Per Month (PMPM) costs and Non-Benefit Expense (NBE) costs together with an indication of what experience base, etc., was relied on in setting the assumption. Through the VBID Model Application Spreadsheet, CMS will collect a projection of the member months eligible for each component and/or targeted population and estimates of those that will participate or otherwise be engaged, if applicable;

iii. Summary of Projected Annual Savings over the Course of the Model (including the ***required*** CY2024 VBID Net Savings Template Excel workbook, separate file);

iv. Additional Quantitative Support and Past Performance;

v. Changes to Pricing (e.g., projected increase to risk scores); and

vi. Reflection in the Bid Pricing Tool (BPT) (bid pricing tool changes).

The purpose for requesting the above supporting documentation is to assist CMS in assessing the reasonability of the pricing assumptions intended to be used when providing VBID benefits under this Model. Additionally, the supporting documentation should describe how the proposed VBID Model components may be expected to meet the Model's financial goals of net savings to Medicare expenditures without any net increase in costs for plan enrollees directly attributable to the VBID elements over the life of the Model.

i. Executive Summary

Please list each VBID Model component that the MAO is proposing to include along with a summary of the proposed intervention(s) in financial and actuarial terms and expected PMPM changes. This should include any changes to an existing VBID intervention if the MAO is currently participating in the Model. Please also include the incremental costs or anticipated savings associated with VBID that are attributable to Wellness and Health Care Planning (WHP). MAOs may also choose to submit a separate PDF of required information in the same format as this document.

ii. Summary Projected Costs from Model Participation

Please provide the expected increase in utilization, unit, per member per month (PMPM), or non-benefit expense increases by intervention (including WHP). For each relevant Service Category presented in column (c) of MA Worksheet2 – MA Projected Allowed Costs PMPM, please provide an estimate of the impact on projected Annual Util/1000, Avg Cost per Unit, and Allowed PMPM in columns (m) through (o). If the impacts are differential for Non-DE (Dual eligible) # and DE# Allowed PMPMs in columns (p) and (q), please specify. These impacts should be reported both for the costs directly associated with the intervention, including incurred claims, provider incentive payments, and capitation payments but also indirect costs such as induced demand for other covered or non-covered services or non-benefit expenses. Accordingly, please specify the impact on projected Non-Benefit Expenses as estimated on MA Worksheet 4 – MA Projected Revenue Requirement PMPM, column (h), row v.

MAOs implementing the Hospice Benefit Component must include any projected costs related to this component (including any palliative care, transitional concurrent care, hospice and hospice supplemental benefits) as part of this financial application.[2] In particular, MAOs should address potential costs associated with palliative care that may fall under the current MA benefit prior to election of hospice in addition to those related to transitional concurrent care, hospice care, and any hospice supplemental benefits. In the event that any of these costs are expected to be priced in MA bids, please include an estimate.

CMS may follow-up with MAOs following bid submission to better understand projected costs associated with the VBID Model.

[2] Per the MA BPT instructions, certifying actuaries have the option of including or excluding projected costs of supplemental benefits offered exclusively to enrollees in hospice status and that this flexibility extends to plans participating in the Hospice Benefit Component of the VBID Model. Thus, once the beneficiary is in hospice status the choice to include those mandatory supplemental costs in the BPT is at the discretion of the certifying actuary. If the certifying actuary is excluding projected costs of hospice supplemental benefits in the BPT, please indicate as so in the CY 2024 Financial Application.

iii. Summary of Projected Savings over the Course of the Model

Please provide the expected decrease in utilization, unit, per member per month (PMPM), or non-benefit expense by intervention over the timeframe of 2024 through 2025. Where possible, please include baseline inpatient, professional, and other service categories that are relevant to the intervention and then projected changes due to Model participation. To the extent there are savings to other health insurers, such as Medicaid, please include projected decreases in costs here (e.g., if your participation includes D-SNPs and costs for Medicaid are decreased as a result).[3]

In addressing potential savings to Medicare, CMS has provided a ***required*** "Net Savings Template," which documents the various revenue streams projected as part of MA and PD bidding, including MA payments, Part D direct subsidy payments, low-income cost sharing subsidies, and Part D Federal Reinsurance. Net savings to CMS may occur over the course of participation in the Model performance period or during the applicable calendar year of participation. In the event that multiple years are required in order to show net savings, please submit one "Net Savings Template" for each year. A “Net Savings Template” is required for each participating PBP-segment.

MAOs implementing the Hospice Benefit Component must include any projected savings related to this component (including any palliative care, transitional concurrent care, hospice and hospice supplemental benefits) as part of this financial application. In particular, MAOs should address potential savings associated with the MA benefit as a result of participation. The net impact on MA bids should also be addressed.

[3] Please align to BPT guidance on projecting savings to other health insurers

iv. Additional Quantitative Support and Past Performance Prior to 2024

Please use this section as necessary to outline any specific changes secondary to participation in the Model that are assumed and allow the MAO to meet the requirement of net savings to CMS over the course of the MAO's participation and no net increase in enrollee costs. This could include literature reviews, estimated reductions in medical expenditures, or other assumptions and quantitative support related to savings.

If a Model Participant prior to 2023, please provide the following:

- Historical benefit utilization per 1,000 and allowed cost PMPMs for VBID interventions offered in the Model in prior years. For CY2022, please provide the most recent available values, even if not complete – at the most granular level of detail available. For 2022 data that represents a partial year please indicate the time period for the data you provide.
- Historical non-benefit expenses for providing VBID interventions,
- Estimates of reductions in medical expenditures, either on a PMPM or other reasonable basis, resulting from or correlating with interventions. These estimates may be provided in the format the MAO currently uses to calculate return on investment from participation in the Model.
    - If no such estimates are available, please describe the MAO's approach for estimating them in the future.
- If not described in sections ii. and iii. above, please provide a discussion of how the above experience is being used for bidding purposes in CY2024.

v. Changes to Pricing

Please outline any changes to plan risk score or other pricing factors at the PBP-segment level that may increase CMS or enrollee costs that the MAO assumes may result from participation in the Model. Please quantify the impact, where possible. This section is intended to encompass expected pricing changes made as a direct result of participation in the Model that are not directly related to the pricing of either costs (section ii.) or savings (section iii.) associated with the offered Model components.

vi. Reflection in the BPT

Please explain how the above changes to plan risk scores or other pricing factors will be reflected in the 2024 BPT. If you have participated in the Model prior to 2024, please provide an explanation of any changes in the BPT and/or BPT assumptions resulting from prior Model experience. For the cost and savings projections supplied above, please identify specifically where these will be applied in the BPT.