RFA Webinar Transcript

Thursday, March 10, 2022

Martina Gill:
Welcome to the RFA Webinar. At this time, I'll turn the presentation over to Jason Petroski.

Jason Petroski:
Thanks a lot, Martina. And thanks, everybody, for joining us today. Today we're here to discuss the Medicare Advantage Value-Based Insurance Design, or VBID Model, and we'll be going through an overview of the Calendar Year 2023 Request for Applications, the Hospice Benefit Component payment methodology, and application process. Before we get going, I just wanted to provide our general disclaimer. Our goal here today is for educational purposes and general information sharing as noted on the slide. Also, we'll be posting slides and a recording of the presentation on the VBID Model website by mid-March. [00:01:02]

So, just to give everybody an overview of our agenda and topics for today, we'll start with some CMS introductions, very brief introductions. We'll walk through, then, an overview of the Medicare Advantage Value-Based Insurance Design, or VBID Model, what are some of its key components and some of the context of the Model. We'll then move to a focus on highlighting what's new for 2023, followed by some specific commentary from our colleague in the Actuary's Office on the CY 2023 Hospice Benefit Component Payment Methodology. [00:01:43]

We'll then look into some important information that all applicants need to know about the 2023 application timeline and process, followed by some information on CMS technical assistance and applicant resources. And then, last but not least, we are saving some time at the end of this presentation for a question-and-answer period. So, please feel free to put your questions into the Q&A, the chat, along the way and at the end we will reserve some time for that interactive period. [00:02:24]

So, to just quickly introduce who we have on the call today, these are our presenters. I won't go through everybody's names but just want to recognize that you have a great attendance here from not only the VBID Model team, the Centers for Medicare Innovation Leadership, like Laura McWright and myself, but we also have colleagues from the Office of the Actuary, Rich Coyle, as well, being on the call. So, today was just going to get started with the presentation, as I mentioned, by going through an overview of the VBID Model design. So, let's go ahead and dive in. [00:03:15]

Okay, so we thought we'd start with CMMI's mission. CMMI was established by statute to test innovative payments and service delivery models to reduce costs and improve quality. Models that improve quality without increasing costs, reduced cost without negatively affecting quality, or that both improved quality and reduced costs can be scaled by the secretary. So, this is kind of like the main directive that we operate by. Specifically, about the VBID Model, or what is an overview of this specific Model. So, through the voluntary VBID Model, CMS is testing a broad array of complementary MA health plan innovations designed to reduce Medicare program

expenditures, enhance the quality of care for Medicare beneficiaries, and improve the coordination and efficiency of healthcare service delivery. [00:04:15]

You'll hear more about how the Model can be used to focus on certain beneficiaries like those with low incomes, such as dual eligibles. Eligible Medicare Advantage Organizations (MAOs) can choose to apply with a plan benefit packages, or PBPs, in all 50 states and territories for the Model. And this Model started in 2017, and currently, is set to be tested through 2024. [00:04:45]

Now, little bit on the history and VBID Model growth. As you can see here, starting on the left-hand side of the slide, we've seen steady growth in participation in the VBID Model over time. In 2017, we started with 9 MAOs in three states. Moving forward to 2020, and consistent with the requirements of the Balanced Budget Act of 2018, VBID opened eligibility to Medicare Advantage Organizations in all 50 states. And with this, participation increased to 14 MAOs in 30 states, and one territory. And finally, in this year, Calendar Year 2022, we currently have 34 MAOs participating in 49 states, the District of Columbia, and Puerto Rico. [00:05:36]

This slide gives an overview of the VBID Model fit within the overall Innovation Center, or CMMI's portfolio. The CMS Innovation Center tests a number of innovative models, but we thought it would be helpful to highlight the unique and important role of VBID in the overall portfolio of models for this audience. VBID is only model directed at Part C Medicare Advantage, which is, as we know, an increasingly popular option for Medicare beneficiaries, and for beneficiaries who are dually eligible for Medicare and Medicaid. VBID is set up to provide a unique opportunity for CMS to learn about innovative approaches to structure and deliver high-value services and benefits, and with its unique targeting flexibility, VBID is well positioned to provide even greater insight into how high value services and benefits are offered to underserved populations. [00:06:36]

With that, I'll turn it over to Sibel Ozcelik, who is the co-lead of the VBID Model to provide a bit more information on the VBID Model. Sibel?

Sibel Ozcelik:
Thanks so much, Jason, and really great to be here with everyone on the call today. So, to begin with a quick overview of the VBID Model, there are now five components that are being offered through the VBID Model. One mandatory component called the Wellness and Health Care Planning (WHP) component, and four optional components. I'll go through the slide from left to right, and as I'm going through, please don't hesitate to put in any questions that might come to mind in the chat box so that we can answer them at the end. [00:07:19]

So, starting from the left, we have a component called VBID Flex. VBID Flex allows MAOs to propose reduced cost sharing and/or additional supplemental benefits, including non-primarily health-related supplemental benefits, for targeted enrollees. MAOs may target enrollees based on a chronic condition, and or by low-income subsidy status, or dual status in territories, or both. MAOs may propose additional eligibility conditions, like participation in a disease management program, or use of a high-value provider. Benefits can include primarily health-related benefits,

such as vision, dental, or hearing, or non-primarily health related benefits, such as grocery assistance, or non-medical emergency transportation. [00:08:05]

The second component of the VBID Model is Medicare Advantage, or Part C and Part D rewards and incentive [RI] programs. Now, as compared to the program, MAOs have the flexibility to offer higher value rewards or incentives. The value of the reward provided to beneficiaries is capped, not by the cost of the service, but rather, by its benefit. Rewards and incentives can be targeted to a subset of enrollees under the Model and they can be associated with the Part D benefit.

The third component of the Model is Wellness and Health Care Planning. This is the mandatory component of the Model. Participating MAOs must implement a strategy in 2023 regarding the delivery of WHP, or Wellness and Health Care Planning services, including Advanced Care Planning (ACPs) services to all of their enrollees, and all of the ACPs that are included in the Model. [00:08:55]Now, implementation of the strategy could include something much broader, like investing in WHP infrastructure such as digital platforms to support ACPs, or could be focused on member initiatives, like providing information on how enrollees can access advanced care planning services.

The fourth component of the Model is the Hospice Benefit Component. The Hospice Benefit Component is sometimes referred to as the hospice carve-in, and that includes carving in the hospice benefit into the scope of MA coverage to facilitate care coordination across the care continuum, improve access to palliative care, transitional concurrent care, and hospice-specific supplemental benefits. [00:09:38]And we'll talk a little bit more about the Hospice Benefit Component later in this presentation.

The last component is new and existing technologies. This allows MAOs to propose to cover new technologies that are updated or approved, but don't fit into an existing benefit category for targeted population, including targeted by chronic condition, and or by low-income subsidy status. And these are enrollees who would receive the highest value from such a new technology. [00:10:11]

So, what's new in 2023? So, in making update for the Model for 2023, we were guided by some of the themes in the Innovation Center's Strategy Refresh, including the focus on health equity. The five key updates of the Model in 2023 are one, the addition of the voluntary Health Equity Incubation Program that we're so excited about. Number two, focusing the VBID flexibilities within benefits and rewards and incentives to interventions that are uniquely authorized by the Model, and not permissible in the broader MA program. Number three, providing additional guidance on how we define high-value providers to include those providers who predominately serve underserved populations. [00:11:03]

Number four, removing the Cash or Monetary Rebates component of the Model. And number five, for the Hospice Benefit Component, incorporating a requirement around a health equity plan, and adding network adequacy standards that are both quantitative, and qualitative. I'll now turn to our legal work team lead, Aurelia Chaudhury, to share more about these five key updates. Aurelia?

Aurelia Chaudhury:

Thank you, Sibel. The goal of the voluntary Health Equity Incubation Program is to encourage innovation in key areas of focus, optimize design and implementation practices, build an evidence-base for quality improvement and medical savings related to social needs interventions, and guide future directions for innovation in the MA program. We've had great participation in our initial webinar sessions focused on the business case for investments in health equity. And throughout 2022, we'll be offering further sessions focused on technical assistance in the most promising areas, such as nutrition assistance, bringing in relevant partners and experts. And in the longer term, we aim to create a learning network, where plans could learn from each other and relevant experts about advancing health equity. [00:12:24]

As Sibel mentioned, one change in 2023 is focusing benefits in RI programs to those that are uniquely authorized by the VBID Model and not allowed in the broader Part C program. And this is with the exception of the Wellness and Health Care Planning component. With respect to benefit targeting, it's important for MAOs to be aware of the flexibilities that currently exist in the MA program, including the Special Supplemental Benefits for the Chronically Ill, or SSBCI, and Uniformity Flexibility, or UF. SSBCI allows MAOs to target both primarily and non-primarily health related supplemental benefits to chronically ill enrollees. Under the regulations, chronically ill enrollees are those with one or more comorbid and medically complex conditions that are life-threatening or significantly limit the overall health or function of the enrollee, which have a high risk of hospitalization, and require intensive care coordination. [00:13:14]

Targeting by LIS or dual status alone is not allowed in SSBCI, but MA plans can consider social determinants to identify chronically ill enrollees whose health or overall function could reasonably be expected to improve or be maintained with SSBCI. MA plans may not use social determinants of health as the sole basis for determining eligibility.

Uniform flexibility allows MAOs to target supplemental benefits that are primarily health related by health status, or disease state. Now, the VBID Model flexibilities, in terms of benefit targeting, allow interventions that are not possible under SSBCI or UF in a few ways, such as offering non-primarily health-related benefits to a broader set of enrollees than those who qualify as 'chronically ill' under the SSBCI definition., targeting by socioeconomic status, offering reduced cost-sharing in the Part D benefit, and new and existing technologies, or FDA-approved medical devices as a mandatory supplemental benefit. [00:14:13]

We recognize that there are probably going to be questions about what exactly is permitted through SSBCI or UF, versus what may be permitted in the VBID Model. We encourage you to ask questions and we'll be working closely with our colleagues in the Center for Medicare to answer any questions we receive. For RI programs, again, we're emphasizing that MAOs should focus on those RI programs that are uniquely authorized by the Model and not permitted in the broader Part C program. As Sibel mentioned, the MA program has a different cap on the value of the reward that an enrollee can receive. And in the broader MA program, the cap is tied to the cost of the health-related activity, rather than the benefit, which is the standard in the VBID Model. [00:14:54]

Also, in the broader MA program, RI intervention with the Part D benefit is not permitted, whereas that is permitted in the VBID Model. And finally, with the Hospice Benefit Component in Part C, MAOs do not cover any part of the hospice benefit, whereas they may in VBID. And so, we encourage you to think about what interventions may be permitted in the broader Part C program as you craft your VBID applications. [00:15:25]

The CY 2023 RFA also provides additional guidance on defining high-value providers in terms of crafting supplemental benefits, or reduced cost sharing, that may be associated with using those providers. Under the VBID Model, we provide additional guidance about who can be a high-value provider, including providers who predominately serve underserved populations, for example, providers who serve populations with a majority of enrollees living in areas identified under the CDC/ATSDR Social Vulnerability Index, or the Area Deprivation Index, providers who provide care through Area Agency on Aging, Aging or Disability Resource Centers, or Centers for Independent Living, or providers that qualify as a central community providers under the regulations, including federally qualified health centers. [00:16:19]

Also, as Sibel mentioned, in CY 2023, we are removing the Cash or Monetary Rebates component of the Model, due to potential negative impacts on enrollee eligibility for means-tested benefits based on the receipt of these cash benefits under the Model. While CMS is removing this Model for 2023, CMS strongly encourages MAOs to address the medical and social needs of enrollees who receive LIS, or other underserved populations, in designing and offering supplemental benefits under the Model that are paid for by using the MA Beneficiary Rebate dollars. [00:16:50]

Through the use of VBID flexibility under the Model, MAOs could offer a range or combination of primarily health-related and non-primarily health related benefits for targeted enrollees including healthy groceries, non-emergency medical transportation, transportation for non-medical needs, or other innovative benefits. CMS recommends that MAOs (1) provide these types of benefits as part of a holistic benefit design and (2) seek input from enrollees in structuring such benefit designs. Overall, by removing the cash or monetary rebates component, CMS's goal is to ensure that the Model is focused on encouraging Model participants to use targeted supplemental benefits with a sound evidence base to help address medical and social needs of underserved enrollees while advancing health equity goals. [00:17:38]

So, turning now to the Hospice Benefit Component. One of the changes in 2023 are updates to the network design standards. As you may know, the Hospice Benefit Component has a "phased-in" network adequacy policy to allow participating MAOs and hospice providers to develop administrative, clinical, and operational experience, where they may not have had it before due to the historical carve out of the hospice benefit. With that said, we are incorporating updates to our network design standards for 2023. All participating MAOs with PBPs that have participated in the Model component for at least one year, and are applying to participate for a second year, called in the RFA "mature-year PBPs," must meet two new network adequacy requirements. [00:18:23]

The first is a quantitative requirement for the participating MAOs with mature year PBPs to form a network of hospice providers, so the enrollees have access to a minimum number of hospice

providers in every county within the service area of their mature PBPs. The second, is a qualitative requirement for the participating MAOs with mature year PBPs to describe their comprehensive strategy for forming a network of Medicare hospice providers to ensure enrollees receive a set of timely, comprehensive, and high-quality services aligned with enrollee preferences in a culturally sensitive and equitable fashion. [00:18:59]

The quantitative and qualitative requirements are designed to complement one another and work together to help form and ensure a full review of network adequacy so that we can measure and track adequacy on more than just one dimension. Please note that we will be publishing additional technical and policy guidance on the minimum number of providers requirement in the late spring. Finally, I want to emphasize and highlight that we're continuing the policies that we've had in 2021, and have in 2022, to allow enrollees to access any hospice provider they wish, regardless of network status. [00:19:37]

The other change in the Hospice Benefit Component we'd like to highlight is the addition of the advancing health equity requirement for all participating MAOs. Building on our commitment to health equity that Sibel discussed earlier, each participating MAO must describe a detailed strategy for advancing health equity as part of its approach to the Hospice Benefit Component. This strategy must include, but is not limited to, identifying, addressing, and monitoring, any potential inequities in access, outcomes, or experience of care, as it relates to the participating MAOs' palliative care strategies, and to their coverage and coordination of the Medicare Hospice Benefit. [00:20:11]

Here, we want to emphasize and encourage the participating MAOs and their palliative care and hospice provider partners to continue to cultivate close relationships to create and implement successful health equity strategies. We also want to welcome Model participant and other stakeholder feedback on the role of the Hospice Benefit Component in advancing health equity. Now, I'll turn it over to Richard Coyle from the Office of the Actuary to discuss the CY 2023 Preliminary Actuarial Payment Methodology for the Hospice Benefit Component. [00:20:48]

Richard Coyle:
Good afternoon. As mentioned, I'm going to discuss the actuarial aspects of the Hospice Benefit Component. First item is just going to be a brief overview of the payment design, then discuss a little bit about the development of the rates and payments, and then get into a little bit of the changes being proposed for 2023, and just want to mention there, there's an appendix to this that includes various resources, including links to prior materials published in 2021 and 2022. [00:21:34]

So, the graphic at the top of this page illustrates the different potential payments that will be made to VBID hospice participants. It's worth noting that the payments are largely the same, or they are the same, except for those non-participating plans, except for the monthly hospice capitation rate. So, for example, if a member in a Medicare Advantage non-participating plan enters hospice status mid-month, that plan receives all the typical payments. They get the basic capitation rate, which is the first graphic on the left. They also get the beneficiary rebate amount, which is the second from the right. [00:22:23] And then, the prescription drug payment, if any. If that member was in a participating hospice plan, then they would also get the monthly hospice

capitation payment. Similarly for month two, if a hospice enrollee is in hospice status as of the first of the month, for non-participating plans, they would get just the two items on the right, the beneficiary rebate amount and the monthly prescription drug payment. But those plans that are participating in the Hospice Benefit Component will also get the monthly hospice capitation rate. [00:23:06]

Okay, so this is a little bit of a busy slide, but it has pretty good graphics of how the payment development works, or the rate development works. And this is for Calendar Year 2022. I will say, we proposed to have similar structure for 2023, but updated the parameters as I'll discuss throughout this discussion. So, the first row of this graphic, you can see there's really three components related to development of a rate. We start with the national capitation base rate, then we apply a monthly rating factor to that, and then we apply a geographic adjustment, a hospice geographic adjustment, which is similar to the Medicare Advantage geographic adjustment, but obviously applies to said Hospice Benefit Component. [00:24:00]

In the next row, there is more information on how the national hospice base rate is developed. First, we start with three years of experience. For the 2022 rates, we had CY 2017 to 2019 experience, and we aggregate that at a national level. We then reprice it to use the most recent per diem rates and wage index. So, for the 2022 rates, that's the fiscal year '21 per diem rates and wage index, for 2023, we're proposing to use 2022 fiscal year hospice parameters. And then, finally, we trend it to the payment year. So, again, last year, we trended it to calendar year 2022. [00:24:56]

Next row on this graphic is the monthly rating factor. And you can see, there are four different factors, three for month one, and a second one for months two and later. So, for month one, we break it out into the number of days of care during that first month, number of days in hospice status, one through six, seven through 15, or 16 or more. And I'll talk more about this in a moment. And then, finally, we have the geographic adjustment and there's a separate geographic adjustment for the month one payments and the month two plus. [00:25:35]

So, as this chart right here demonstrates, here are some of the parameters used to come up with the rates. Again, if you look at the first column, we have month one, and it's the three breakouts that I just mentioned. There's a composite month one, which is just here for illustration. And then, we have the two and later, and then just a total, which is a combination of the month one composite and month two. So, going over to the third column, you can see, this is the monthly service days and it correlates quite well with the range of days for the payment. So, for instance, one to six days, on average that that's 3.28 days of hospice coverage, whereas if you go down, the same month two and later, on average, there is 26.25 days of hospice coverage per month. [00:26:35]

The next column of distribution of stay, in months, it's just, again, a step used in the calculation, and it's just here for illustration. Then, the second column from the right, the monthly rating factor, this indicates a relative cost for each of those cohorts of days. So, for instance, the monthly rating factor for days one through six is 0.3400, it's 0.6400 for days having stays of seven to 15 days, and 1.0030 for stays of 16 days or longer. And then, for months two, the factor

was just 1.0000. And then, the last column on the right is what the monthly rate is, again, with each of the periods. [00:27:27]

So, again, if you get through the rates, if you go the formula on the rates, this will make a lot of sense, but just wanted to illustrate how these are developed. Now, this information is for 2022, and it's also for the year-one rates. That means for counties that were new in 2022, we did not account for any hospice claims that occurred in the prior year when we were developing the rates. This is the comparable chart to what I just showed. Again, it's for 2022, but it reflects year-two rates, that is, for counties that were in the VBID hospice program for both 2021 and 2022, their 2022 rates were based on what we're calling year-two rates, and in developing the rates, we included experience for hospice claims that began in each calendar year, and also, the prior calendar year. [00:28:33]

So, it's a subtle difference, but it is an important parameter so that the rates match what the actual experience is. If you look at the last two columns, monthly waiting factor, gross monthly base rate, for month one, they're very close to what's there in the prior slide for year-one rates. For month two, the first monthly base rate is slightly lower than for the year-one rates, just accounting for the fact that there's less intensity of services, in general. So, I mentioned the geographic adjustment. It actually is called the Hospice Average Geographic Adjustment (AGA). [00:29:25]

And the idea, again, similar to the Medicare Advantage Rate, for those of you who are familiar with it, it takes into account differences in spending by local geographic areas. Now, the Medicare Advantage rate is developed at a county level, whereas the hospice rates are at a core-based statistical area, also known as a CBSA. And the reason for that is, in many counties, there's just not sufficient hospice experience to develop a credible rate. So, we group the counties by CBSA and develop rates at that level. As I mentioned, we use three years' worth of historical data to develop the cost for each of the experience years, and we have separate geographic adjustments for the month one and month two plus rates, because there are differences in utilization that the index should take into account. [00:30:21]

For month one, we do an actuarial calibration of the hospice AGA to come back to what the actual distribution of claims are in each CBSA. This is actually a provision we adopted based on feedback from one of the participating plans. So, it's just an actuarial calibration exercise. And then, for month two, the hospice AGA is also reflected to account for the hospice caps. There is an inpatient cap and an aggregate cap that is reflected in the month two plus hospice average geographic adjustment. [00:31:07]

Just to help stakeholders visualize how the rates work, this is a snapshot from the 2022 capitation rates. You can see from the first three columns, these are rates for specific counties in Colorado, beginning with Delta, Denver, Dolores, etc. The next column indicates the CBSA that I mentioned that the rates are at a CBSA level. I know just looking at these it doesn't tell you much. I will say that the first CBSA, 99906, that represents all the rural counties in Colorado, whereas the next one, 19740, that represents the Denver and surrounding counties at CBSA. The next column indicates whether it's a year-one or year-two rate. [00:32:03]

So, as I just mentioned, those that show year-one rate, these are counties that did not participate in the Model in 2021, so any plans that participated and offered coverage in these counties would get the year-one rate, whereas for instance, in Denver, there were participating plans in 2021, and therefore, in 2022, the rates were for the year-two rates. And then, the last four columns on the right are the rates corresponding to the rating tiers I just mentioned. And if you follow this, you'll see, for instance, for each CBSA, the rates are consistent. So, for Delta and Dolores that are both rural areas, they have the same rates, same as Denver and Douglas, which are both in the Denver CBSA. [00:32:50]

Okay, so now I'm going to talk a little bit about changes we're proposing for Calendar Year 2023. And CMMI issued a memorandum back on March 1st, 2022, that outlined some of the changes we are proposing. And I'm going to highlight two of those right now. The first is, we're going to move forward the experience period to 2018 to 2020. So, the next bullet point points out that for the month two rates in the counties that didn't participate in 2022, they will basically be year one, similar to what I just showed you in the Denver example. So, if it's a new county, they will get the month one rate. If it's a county that participated in 2022, the rate will be what we call a mature rate. [00:33:53]

So, in the build-up of the rate, we will include experience not only for episodes that begin calendar year but begin in any preceding calendar year. So, hopefully that makes sense. Next item is, we will reprice claims based on the fiscal year 2022 per diem rates and the hospice wage index. In the appendix, we have the per diem rates listed along with what they were for fiscal year '21. If you're interested, the wage index can be found on the CMS website under our hospice payment rules. Next, also in the final regulation, there was a revision to the labor shares that is the proportion of the rate that is adjusted for wage index, and those were revised for 2022. [00:34:52]

And these new labor shares, are included in table one of the preliminary memo that I mentioned that was released on March 1st. Here are some additional changes for actuarial assumptions. We're going to update the claim trend for the most recent experience. Again, that's also included in the memorandum. And then, in non-hospice claims, those are claims for services other than hospice, such as inpatient and physician. We also included the preliminary trend rates in the memo. We're also going to update the hospice aggregate and inpatient caps to be based on most recent data. We're updating the administrative expense load, to replicate what we're putting in the Medicare Advantage rates. [00:35:49]

The claim completion factors will be revised to represent most recent program experience. And then, finally, we're going to update the hospice service mix adjustment and I'll talk more about that in a moment. And that's also in the memorandum. So, as I just mentioned, we were updating the labor shares based on what's in the latest fiscal year 2022 rule. They changed for all five levels of service, or types of service. So, for routine home care, the labor share was previously 68.71 percent, and that's being updated to 66 percent. [00:36:34]

Continuous home care, that labor share is going up from almost 69 percent to 75 percent. Inpatient respite care is also increasing from 54 percent to 61 percent. And finally, general inpatient care that labor share is decreasing slightly from 2021. And then, the last function I'm

going to talk about is what we call the service intensity trends. And what this is, if you look at the second column of this, this shows the average service days per stay month for each year. This is all hospice claims. And you can see, it actually went up from 2018 to 2019, but then went down from 2019 to 2020. I'll talk more about that in a moment. [00:37:35]

Same thing in this next column, the weighted per diem. That's essentially where we take a distribution of services by the five levels in the prior slide, and weigh those by with the most recent wage payment rates are, fiscal year 2022. And you can see how that went down somewhat from 2018 to 2019, basically indicating that there was lower intensity of services, for instance, fewer general inpatient days, going from '18 to '19. And then, we saw another drop from '19 to '20, but it was much more pronounced from '19 to '20. [00:38:19]

And then the next column is just multiplying the service days by the weighted per diem. But what we thought when we saw the 2022 experience, we thought possibly that it could have been affected by COVID. And so, what we did was to come up with adjusted 2020 values, which are in the last row of this table. So, for instance, instead of 23.0 service days per month, our trending indicated should be 23.27. Similar with the weighted per diem, instead of using $184.85, it was increased about a dollar extra. And so, the result is, the composite rate is somewhat higher than what the unadjusted data for 2020 would show. [00:39:12]

And then, the last column indicates that we're going to trend each years' experience for this measure to basically bring it up to the 2020 adjusted level. Again, if you're interested in this, I highly suggest that you refer to our memorandum table four. It has a lot more information and we're certainly interested in comments, as represented in the memorandum. So, that's it for the actuarial portion of this discussion. We'll turn it back to CMMI. [00:39:47]

Abigale Sanft:
Thank you, Rich. So, next, we'll go through the 2023 application process and corresponding timelines, including immediate next steps for the application process. As far as next steps for MAOs, first, if you have any questions or technical assistance needs as you're thinking through your VBID interventions and developing your application, the VBID team is happy to support you. Please reach out to us with any requests at VBID@cms.hhs.gov. And then, second, as we heard about earlier, the hospice specific county level rate book will be released in mid-April of 2022, and we encourage MAOs interested in participating in the Hospice Benefit Component to review that document. [00:40:40]

Third, MAO applicants will submit their applications to CMS via the Qualtrics application portal by April 15th, 2022. In terms of steps after application submission, fourth, CMMI plans to provide notification for MAOs with provisionally approved interventions for Model participation in mid to late May of this year. And those provisionally approved MAOs may include their VBID interventions in their MA bids, which are due on June 6th, 2022. As for step six, for organizations that are granted final approval for the Model for CY 2023, these MAOs will execute contract addenda for CY 2023 participation in the VBID Model in September of 2022. [00:41:35]

So, to aid in your submission, we've outlined a number of CY 2023 application materials and resources. And materials on this slide are available for download in a zip file of application materials on the VBID webpage, and also, within the Qualtrics application, which is also linked on the VBID Model webpage. Within the zip file, the PDF of application questions is available to aid MAOs in preparing their applications and understanding the specific question being asked within the Qualtrics application for each component. Similarly, the supplemental application instructions document provides helpful tips and applications materials, and the financial FAQ document answers some common questions about the actuarial requirements for VBID Model applications. [00:42:25]

The next three documents are required to be submitted. The application summary spreadsheet outlines the participating PBPs and interventions to be offered in the Model, along with plan information and enrollment projections. The net savings template is also required and identifies the per-member per-month cost with and without the VBID Model. The financial template requests the projected cost for each VBID Model component, along with projected savings to Medicare over the life of the VBID Model. Finally, the Part D supplemental file is required for MAOs proposing to offer reduced or eliminated cost-sharing on certain drugs. [00:43:05]

MAOs proposing to offer reduced or eliminated cost-sharing across drugs on specific formulary tiers, or across all Part D drugs do not need to submit a Part D supplemental file, but those offering reduced or limited cost-sharing on select drugs will be required to submit the Part D supplemental file. We also have a few tips on how to put together a seamless application submission. Firstly, you can, as we mentioned, find all the relevant materials on the VBID Model webpage, including the requests for applications, the link to the Qualtrics application, and the additional application materials. [00:43:49]

Your organization should submit a single application per parent organization, including all contract PBPs and segments, and Model components you're proposing to offer in the Model. With respect to the Qualtrics application, towards the beginning of the application, you'll be asked to select the Model components that you are proposing to implement for CY 2023. And these selections will impact the questions that are displayed to you throughout the application, so please make sure the correct Model components are selected. The last thing I'll mention is that CMS is available to help support your application development and submission. Please reach out to the VBID Model team, again, at VBID@cms.hhs.gov, with any questions, or if it would be helpful to schedule a meeting to discuss your application. [00:44:40]

And with that, I'll turn things over to Jason for a brief Q&A session. [00:44:48]

JP:
Thank you, Abigale. So, we are at that point of the webinar we are able to go through some question and answers here. I do see a number of questions that have come in throughout the webinar already for the Q&A aspect of the webinar. We also encourage you to still continue to send in questions. We're not going to have time to go through every single question, but we will try to field as many as we can in the remaining time here. So, I think what I'll do is, I might kick things off with just two basic questions. [00:45:30]

The first question, I think Abigale just spoke to, and it's confirmation of the timeline for submission of the RFA, and I'll just take this once since it's simple. The deadline for the VBID RFA, and Part D application, is April 15th, which is coming up. And it's at 11:59 p.m Pacific Time. We also have another general question that I'll just hit at the beginning here, and that's whether the slides will be made available and whether there will be a recording of this webinar. The answer is yes, we will make both slides and recording available, and we'll post that to our website as soon as possible, after we've completed the webinar. [00:46:18]

Okay, so those were the easy ones. Now, I'm going to get help from my CMS colleagues on some of the other more technical questions. And I do see that there's some questions on the Wellness and Health Care Planning [WHP] component of the Model. So, what I'm going to do is I'm going to ask Sibel if she can help us with some of these questions. The question is, what would be included in the Wellness and Health Care Planning piece of the Model? Is this something tangible, or a health survey, or something else? Sibel, can you take that one? [00:47:16]

SO:
That's such a great question. So, when we talk about wellness and health care planning, we really mean advanced care planning. And advanced care planning can take a number of different strategies, depending on your plan, the contracted network you have, the members you're serving, and we really leave it to the MAOs to propose to us within their application what types of WHP strategies they are looking to implement in 2023. And so, potential WHP strategies could include, as I mentioned earlier, it could mean investing in infrastructure, so creating digital platforms to support advanced care planning. It could look like provider-focused initiatives around WHP education. [00:48:03]

It could look like member-focused initiatives around advanced care planning. So, think about general outreach communications, providing information to enrollees about how they can access advanced care planning, or other occasional material to enrollees that describe what advanced care planning is, and the importance of it. And so, those are some of the mix of high-level advanced care planning strategies. Additional WHP plans can propose more targeted strategies for specific subpopulations, so some of what we've seen is plans proposing advanced care planning specifically for, in addition to a broader strategy for all enrollees, also proposing targeted strategies for enrollees who have serious illness. [00:48:48]

And at a high level, we seek to support innovation in care delivery. And so, in partnership with plans, we really want to promote patient autonomy in healthcare, and advanced care planning decisions, with the goal of overall improving the quality of care that beneficiaries are receiving, so recognize that WHP strategies may vary from plan to plan. And if it would be helpful, as Abigale shared, we're more than happy to set up a technical assistance session to walk through some additional examples. Jason, back to you. [00:49:20]

JP:
Thanks, Sibel. And while you were responding to that question, I found the other WHP question. Can you answer this one, as well, Sibel? The question is, am I required to do Wellness

and Health Care Planning, or WHP, as part of the Model if I'm looking to apply to do the hospice component only? [00:49:41]

SO:
That's such a good question. So, WHP, that component is a required component of the Model. So, if you are only participating in the hospice benefit component, you must also do the Wellness and Health Care Planning component. And they fit really nicely together as we're thinking about the importance of advanced care planning, alongside the importance of palliative care strategies, and carving in the hospice benefit, as well. [00:50:09]

JP:
Thanks, Sibel. I'm going to ask for your help on one more and I think this is a really great question to ask and answer. The question is, can CMS talk about the advantages to a health plan for participating in VBID versus simply creating additional benefits as part of their plan under the regular program? Can you take one, Sibel? [00:50:29]

SO:
Yeah, that's a good one. So, VBID, I like to think about it big picture. VBID offers plans the ability to test innovative flexibilities that wouldn't otherwise be flexible in the overall MA program that could help to increase your member engagement, retention, really improve quality, and member satisfaction. That's so important as we're thinking about putting beneficiaries at the center of our focus. It can also help to lower medical spending and utilization of low-value services, and most importantly, advance health equity. [00:51:08]

And I really want to focus in on that point around health equity. Plans that participate in VBID, I believe, are uniquely positioned to promote and lead on health equity. So for example, when I was going over that one slide with the five components, for plans that are, let's say, participating in VBID Flex, and targeting specific benefits, health-related social needs benefits like grocery cards, or housing subsidies, or rental assistance, or heating and utilities assistance, and targeting those supplemental benefits, by low-income subsidy or dual status, that really allows plans to address health-related social needs at their core rather than using proxy variables to identify needs. [00:51:54]

So, in short, that's how I would respond to that, Jason. [00:52:00]

JP:
Thanks, Sibel. Okay, so I think we have another question here that would be helpful to respond to. Let's see. The question is, will you be providing the required questions and documents that are needed for the application prior to going into the online application process? This would be beneficial to understand all that is required in greater detail, so we can determine if time will be needed to fill out the application. Abigale, can you respond to that question and just give some context on what would be helpful for the person or people raising this question? [00:52:40]

AS:
Yeah, thanks, Jason. This is a really important point. So, on the VBID Model webpage, there's a section under CY 2023 materials, and there, you can find a zip file, it's called "Additional

VBID Model Application Materials," and that's where you would find all of these resources and required files for the application. If you're interested in going through the actual application questions to understand what's being asked on the Qualtrics application itself, you can also find a PDF of the complete listing of all the application questions for all the Model components within that zip file, as well. [00:53:27]

JP:
Great, thank you so much, Abigale, for clarifying. Okay, so now I'm going to turn to Aurelia for a question about some of the estimate's projections that are asked for in the application. Aurelia, the question that we received was, do projections need to be provided separately for each Model component? Can you take that one? [00:53:51]

AC:
Sure. So, the answer is no. MAOs can choose whether they want to demonstrate savings in the aggregate across all of the Model components, or separately for each Model component. Additionally, the net savings of CMS can be over the course of participation in the Model performance period, or just during the applicable calendar year of participation. So, to the extent that aggregate projections are developed from component level cost and savings protections, they should be well-documented, and the component level of cost and savings projections should be shown. [00:54:25]

JP:
Thanks, Aurelia. Okay. We have a somewhat similar question that I'd like to throw back to our team to just clarify. So, we just talked about some of the supplemental materials, i.e., projections, which are required with the application. But there's also a question that was asked which says, what is the Qualtrics application? Is that in reference with specific software or the CY 2021 application materials? Abigale, can you take that question? Can you clarify what CMS means by the Qualtrics application versus some of these other materials? [00:55:05]

AS:
Yes, absolutely. So, the question is spot on. The Qualtrics application is actually the survey platform that's being used, but the Qualtrics application is where you'll go to find the actual list of application questions that relate to each Model component. So, on the VBID Model webpage, you'll find that the VBID Model application materials zip file that I just mentioned, and then, you'll also find a link to the CMS Qualtrics platform, where you can actually submit your answers to the questions. [00:55:43]

JP:
Okay, thanks a lot for clarifying that, Abigale. Okay, we're almost out of time here. I'm going to answer one question very quickly, and then, maybe just throw out one final question for a response from the team. There was a question that was asked. The question was, is there a document that you can provide that outlines or summarizes the differences in requirements for VBID, uniformity flexibility, and SSBCI? So, we did have a slide [slide 14] in our deck that specifically went through these differences or nuances, and so, again, we'll make sure that we make this presentation, including the slide deck and its contents, available on our VBID Model

webpage. And I would recommend that anyone interested in those differences, please see the slide that went through those nuances. [00:56:44]

Okay. And then, I think one final question. I thought this was a good question, and I think I'm going to ask this one of Sibel. The question is, when CMS refers to the life of a Model, and I think we referred to the life of a Model in the context of when plans are making savings projections and submitting their materials, can you clarify what we mean by life of the Model? [00:57:13]

SO:
Yeah, no. That's a good question. So, actuaries that are submitting the financial application component of the overall VBID application have the discretion to either show net savings to CMS over the applicable contract year that they're applying for, or what we say, over the life of the Model. So, when we say life of the Model that could include your past participation in VBID and future participation in VBID. So, if you're planning on participating in 2023 and 2024, you would show what your projections would look like. You have the discretion to show what your saving projections will look like over those two years, to prepare more of a longitudinal projection of savings, rather than just the upcoming contract year. [00:58:07]

JP:
Okay, thanks, Sibel. And I think with that, I think we're going to wrap things up here. Again, I just want to thank everybody for their time today, really appreciate our participants joining us for the hour. We covered a lot of material. I know there's probably questions that we didn't get a chance to answer, but again, hopefully, we have provided our contact information and other materials that are helpful. I also just want to say thanks to the VBID team and Rich Coyle, our colleague from OACT for helping us with the presentation. And thanks again, everyone, for your interest in the Value Based Insurance Design Model, and hope to talk soon.