Part B Insider (Multispecialty) Coding Alert

Part B Payment: MA Reimbursement Could Change Dramatically Thanks to VBID Testing

Model focuses on treatment of most expensive and common chronic diseases.

As the Medicare program soars headlong into the value-based reimbursement paradigm, CMS is testing several models for transforming its payment system. And the latest experiment will target Medicare Advantage (MA) Plans.

On Sept. 1, CMS announced a new Value-Based Insurance Design (VBID) model for MA Plans and MA Organizations (MAOs). The model is part of the Health Plan Innovation Initiatives under the Center for Medicare and Medicaid Innovation (CMMI) and aims to reduce costs and improve care for MA enrollees with chronic conditions.

The VBID model begins on Jan. 1, 2017 and lasts for five years. CMS issued a Request for Applications, responses for which are due by Jan. 8, 2016. Applicants may respond using an online application portal, which CMS anticipates opening in November 2015.

What VBID Model Means for Medicare

Background: CMS has encouraged VBID approaches to structure health plan enrollee cost-sharing and other health plan design elements to boost enrollees' utilization of high-value clinical services those services that have the greatest potential to positively impact enrollee health.

"VBID approaches are increasingly used in the commercial market," CMS notes. "And evidence suggests that the inclusion of clinically-nuanced VBID elements in the health insurance benefit design may be an effective tool to improve the quality of care and reduce the cost for Medicare Advantage enrollees with chronic diseases."

VBID is an approach that can change how insurers pay for care and how they engage consumers to seek care, and MA plans are in a unique position to spur further changes in the value-based direction, because private health plans participating in MA have the flexibility to use care management techniques to promote evidence-based care.

Participation Criteria Limits Model's Scope

Only seven states are eligible to participate in the VBID model: Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee. CMS selected these states because collectively they represent an accurate cross-section of MA Plan populations nationally, Amodeo explains.

To participate in the VBID program, MA Plans must meet certain criteria, as follows:

- They must have at least 2,000 enrollees in one of the model states, and 50 percent of total enrollment must reside in one of the states;
- They must have been offered for at least three years prior to enrollment in the VBID program (CMS may be willing to waive this requirement in some cases, including when the MA Plan is a successor to another plan);
- They have to be an HMO, HMO-POS or local PPO plan type (other MAO plan types such as Special Needs Plans, Regional PPOs, Medical Savings Account Plans and others are not eligible to participate);
- They must have at least a 3-star overall quality rating; and
- They must have a target population cohort of sufficient size to generate an appreciable evaluation of proposed interventions.

Participating MA Plans must submit actuarial projections showing net savings to CMS at the end of five years. Also, MAOs

with multiple MA Plans may choose to enroll more than one of their Plans, but CMS won't require all of the MAO's MA Plans to participate in the program.

Initially, CMS will limit varied plan benefit designs or "interventions" for targeted enrollees in certain clinical categories patients with diagnoses of diseases such as diabetes, congestive heart failure, COPD, hypertension, past stroke, coronary artery disease, mood disorders or a combination of these.

MA Plans Must Adhere to 4 Intervention Categories

As for how MA Plans will design interventions for their targeted populations, CMS is allowing significant flexibility, including using different and/or multiple interventions for each population, but those interventions must fit into one of the following categories:

1. Reduced cost-sharing for high-value services Plans may choose to reduce or eliminate cost-sharing for "high-value" items or services under the targeted population's benefit plan. CMS will allow MA Plans broad discretion in choosing the specific items and services that are eligible for cost-sharing reductions.

2. Reduced cost-sharing for using high-value providers MA Plans may structure interventions that reduce cost shares for targeted populations when the beneficiary receives services from certain "high-value" providers that the Plan designates. Such providers can include any or all Medicare provider types, including hospitals, physicians, skilled nursing facilities, home health agencies, etc.

3. Reduced cost-sharing for participation in disease management programs MA Plans may also offer unique disease management programs to targeted populations, in addition to or in lieu of cost-share reductions.

4. Coverage of additional supplement benefits Otherwise prohibited under current MA benefit uniformity rules, MA Plans participating in the VBID program may selectively restrict coverage for certain supplemental benefits to targeted populations.

How Model Could Trigger Future Payment Changes

Impact: Depending on the outcomes, this VBID model could revolutionize MA Plans' benefit structure, particularly in light of CMS's recent aggressive initiatives in moving reimbursement from volume to value.

The MA VBID model "fills an immediate need for testing ways to improve care and reduce cost in MA Plans and offers the prospect of lower out-of-pocket costs and premiums along with better benefits for enrollees," said **Patrick Conway, MD, MSc,** CMS deputy administrator and chief medical officer, in a recent statement.

Resources: You can find more information about the VBID model program at http://innovation.cms.gov/initiatives/VBID . To access the RFA, go to http://innovation.cms.gov/Files/reports/VBID-RFA-10-9-15.pdf .