Centers for Medicare & Medicaid Services

Center for Medicare and Medicaid Innovation

Medicare Advantage Value-Based Insurance Design Model

CY 2017 Application Actuarial Guidance

October 27, 2015

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1 Background and General Information

This document provides guidance to potential applicants for the Medicare Advantage Value-Based Insurance Design (MA-VBID) model on general pricing considerations and detailed instructions for completing the financial projections required of those applicants.

The MA-VBID model will test the utility of structuring patient cost-sharing and other health plan design elements to encourage patients to consume appropriate high-value clinical services, thereby improving quality and reducing costs.

The phrase Value-Based Insurance Design (VBID) generally refers to health insurers' efforts to structure enrollee cost-sharing and other health plan benefit design elements to encourage enrollees to consume high-value clinical services—i.e., those that have the greatest potential to positively impact enrollee health relative to cost. In particular, VBID approaches often recognize that the relative value of a given service can vary significantly depending on the enrollee's underlying health status, and that plan design should therefore vary accordingly—i.e., be "clinically nuanced."

VBID approaches have increasingly been used in the commercial market, and the inclusion of clinically nuanced VBID elements in health insurance benefit design may be an effective tool to improve the quality of care and reduce the cost of care for Medicare Advantage enrollees with chronic diseases. However, VBID approaches have generally not been incorporated into Medicare Advantage due to existing regulations. A key barrier to implementation of clinically nuanced VBID approaches is the uniformity requirement, which precludes varying benefit design within a plan based on health status or other enrollee characteristics.

CMS will implement a five-year MA-VBID model test that will begin on January 1, 2017, and continue through December 31, 2021. The MA-VBID model will test whether the flexibility to offer clinically-nuanced VBID elements in Medicare Advantage plan benefit designs will lead to higher quality and more cost-efficient care for targeted enrollees. To test this hypothesis, CMS will exercise its Section 1115A authority to grant a limited waiver of Medicare Advantage and Part D plan uniformity requirements (in addition to certain other waivers), in order to permit organizations to include VBID approaches in MA and MA-PD plan benefit designs.

More information about the model test is available in the MA-VBID model's Request for Applications (RFA), published October 9, 2015.

Offerors of eligible Medicare Advantage and Medicare Advantage Prescription Drug (MA-PD) plans wishing to participate in the MA-VBID model will submit applications in accordance with the instructions included in the RFA. These applications will include a narrative description of the VBID elements they propose to provide to eligible enrollees in CY 2017.

In support of that application, and in accordance with the instructions contained in this document, applicants will also provide financial projections of the impact of the VBID elements. These financial projections will quantify the expected impact of VBID on utilization and unit cost assumptions as well as beneficiary premiums.

CMS will review actuarial assumptions to ensure that they are valid, adequately supported, and to assess whether they are consistent with the proposed interventions and justifications. CMS will specifically examine the projections for support that demonstrates that plan enrollees will not be subject to net increased costs attributable to the VBID elements over the life of the model. CMS

will also examine the financial projections to determine that the introduction of VBID elements will produce net savings with respect to Medicare expenditures over the life of the model.

1.1 Document Overview

Following are the contents of each section:

- Section 1, "Introduction" contains a general description of the objectives of the MA-VBID model and provides sources of information that can be accessed for assistance in preparing the application.
- Section 2, "Pricing Considerations" contains guidance for presenting CMS with financial projections by revising the CY2016 MA and PD BPTs to reflect the planned VBID interventions and presenting pricing results.
- Section 3, "MA BPT Data Entry and Formulas" contains MA-specific pricing guidance.
- Section 4, "Part D BPT Data Entry and Formulas" contains Part D-specific pricing guidance.
- Section 5, Appendix A contains requirements for Supporting Documentation.

1.2 Resources

- The Request For Applications and other CMS guidance for the MA-VBID model found at http://innovation.cms.gov/initiatives/vbid/
- Instructions for Completing the Medicare Advantage and Prescription Drug Plan Bid Pricing Tools for Contract Year CY2016 found at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Bid-Pricing-Tools-and-Instructions-Items/BPT2016.html.
- For questions about the actuarial forms or documentation requirements, e-mail mavbid@cms.hhs.gov .

2 Pricing Considerations

2.1 Pricing Approach

To participate in the MA-VBID Model, applicants must submit with their application to CMS revised versions of their final CY2016 BPTs, to reflect and illustrate effects of the VBID plan design elements they intend to include in their CY2017 BPTs bid submissions, in June 2016.

Revised BPT entries submitted with the application must follow the instructions for completing the MA and Part D BPTs and follow all existing requirements and guidance promulgated by CMS, except as explained otherwise in this document.

The revised BPT entries must reflect the applicant's best estimate of expected, plan-wide unit costs and utilization for the entire plan population, based on expected unit costs and utilization for each of the targeted VBID populations (e.g. each targeted chronic condition group that would have had reduced cost sharing for specific covered services) and the non-VBID sub-population (that would have the same cost sharing as in the actual 2016 bid).[1] Support must include the unit cost and utilization assumptions for each VBID subpopulation, and for each intervention offered

[1] For VBID elements that provide additional supplemental benefits, the non-VBID sub-population will be zero.

to that population, how these are composited with the actual 2016 assumptions for the non-VBID sub-population to form the entries into the revised BPT reflecting VBID changes. For bids with multiple VBID elements, BPT entries should reflect the net effect of all interventions; however, applicants should be prepared to quantify the impact of each intervention on a stand-alone basis. See Appendix A for details.

Organizations applying to participate with multiple PBP's may submit a single revised 2016 BPT as an exemplar, but only so long as the interventions and anticipated effects are consistent across the various plans.

2.2 Medicare & Enrollee Costs

Applicants must provide documentation on a present value basis, showing net savings to Medicare and no net cost increases to enrollees over the course of the model test. Accordingly, applicants submitting a revised 2016 BPT with VBID changes that predicts an increase in Medicare or enrollee cost or a lack of savings to Medicare must also provide documentation projecting the five-year financial impact to enrollees and Medicare in compliance with these requirements, as outlined in Appendix A. Five-year projections are not required if the revised 2016 BPT with VBID shows a decrease in Medicare and no change or a decrease in enrollee costs.

2.3 Application Review & CY 2017 Bid Procedures

CMS will review the revised 2016 BPT with VBID changes as a component of the overall application review for compliance with the terms of the model test (including net savings requirements), reasonableness of assumptions, potential detrimental impact to CMS or enrollees and the sustainability of the proposal. Organizations may be required to correct projections or interventions.

Once approved by CMS to participate in the model test, organizations must complete their CY 2017 bids, and reflect VBID model impacts in a manner consistent with the assumptions and projections of VBID model impacts in their revised 2016 BPT with VBID.

Approval of model applications merely qualifies plan sponsors to include these VBID elements in their CY2017 bid submissions; it does not guarantee that these elements will be approved during Bid Desk review.

2.4 Actuarial Certification & Participant Attestation

It is anticipated that VBID entries to the bids for CY2017 will be covered by the general Actuarial Certification submitted in accordance with 42 C.F.R. § 422.254(b)(5), and actuaries preparing applications should keep this requirement in mind. No certification is required for the applications; however, the actuarial information submitted in applications must be signed by a qualified actuary.

An authorized representative of the participating Medicare Advantage Organization must attest, in the model test's contractual addendum, that the model-participating plan's BPT has been completed in a manner consistent with the actuarial assumptions and projections of VBID-model impacts contained in the actuarial component of the plan's application for participation.

3 MA BPT Data Entry and Formulas

The following highlights the inputs in the CY2016 MA BPT, by relevant sections, that may be revised to incorporate VBID interventions.

The base period experience, projected enrollment along with risk assumptions, and benefits for the non-VBID enrollees should remain unchanged from the CY2016 BPT since these assumptions should not be impacted by VBID. If exceptions are found in preparing the revised CY2016 BPT, the need for modification as well as the specific entry should be explained.

MA Worksheet 1, Section IV – Projection Assumptions:

All VBID changes are expected to appear in the following columns:[2]

- Utilization Adjustment – Benefit Plan Change (column j). The effects of all VBID changes in utilization rates are expected to appear in this column, e.g., increased utilization of services with reduced cost sharing for targeted enrollees.
- Utilization Adjustment – Other Factor (column m). Indirect shifts in utilization rates due to VBID interventions are expected to appear in this column.
- Unit Cost Adjustment – Provider Payment Change (column n). An example is negotiated provider reimbursement changes for certain high-value providers.
- Unit Cost Adjustment – Other Factor (column o). All other VBID impacts to unit cost entries should appear in this column. Example includes: changes in unit cost due to changes in the intensity of service trend as a result of VBID benefit changes.
- Projected Additive Adjustments (column p and q). Examples include additional benefits due to VBID interventions as either Medicare covered or as supplemental coverage depending on how the additional benefits would be classified.

In each case, VBID changes should appear in the appropriate service line as composited entries of the original entries for non-targeted enrollees and those that apply to enrollees with each targeted chronic condition.

Worksheet 2, Section II – Projected Allowed Costs:

- Utilization Type (column e). An update may be needed to the utilization type due to incorporating the VBID interventions into the service category line.
- Manual Rate (columns i and k). If applicable, the manual rate must be updated for the inclusion of the VBID interventions in the same way as for the experience rate.
- Non-DE# and DE# Allowed PMPMs (columns p and q). Because VBID interventions impact overall costs, the separate allowed PMPM costs for non-DE# and DE# enrollees will need to be recalculated.
- There may also be changes in:
  - % of Svc OON (column r). The VBID interventions may influence OON usage.
  - COB/Subrogation (outside claim system) (line r).

[2] If exceptions are found, make the entries where they are needed but explain in documentation the need for using these fields as well as the entries made.

Worksheet 3, Section III – Cost Sharing:

- In general all VBID cost sharing changes should appear in the appropriate service line as composited entries of the original entries for non-targeted enrollees and those that apply to enrollees with each targeted chronic condition.
- Service Category (column c). Blank rows may be used at the bottom of the worksheet to include additional non-Medicare covered VBID interventions that were in categories that were not offered in the original bid submission.
- Changes may also appear in the following columns reflecting the VBID changes entered:
  - Measurement Unit Code (column e), updated to include the VBID interventions using the valid utilization types that are listed in the BPT instructions.
  - In-Network Effective Plan-Level Deductible PMPM (column f).
  - In-Network Cost Sharing After Plan-Level Deductible: In-Network Util/1000 or PMPM (column g), Effective Copay/Coinsurance Before OOP Max (column i), or In-Network Effective Copay/Coinsurance after OOP Max (column j).
  - Out-of-Network Cost Sharing PMPM (column n)
  - PMPM Impact of MOOP (line v).

Worksheet 4 Section II – Development of Projected Revenue Requirement:

- SUBSECTION A – There may be changes to items such as the % for Cov. Services and similar changes following from those in earlier Worksheets.
- SUBSECTION B – Dual-Eligible Beneficiaries without Full Medicare Cost-Sharing Liability (DE#) - Plan Cost Sharing for Total Benefits and Plan Reimbursement for Total Benefits (columns f and h) may need to be changed to reflect VBID changes to cost sharing.
- SUBSECTION C – All Beneficiaries (Total of Subsections A and B). Non-Benefit Expenses (lines v2 and v3) and Gain/(Loss) Margin (line w).

Worksheet 4 Section III – Development of Projected Contract Year ESRD "Subsidy"

There may be changes to the ESRD Subsidy amounts to reflect VBID interventions since there may be cases where target populations are also ESRD enrollees.

Worksheet 6 – MA Bid Summary:

- In general, Worksheet 6 entries should show how the bid would have been completed for CY2016 if the VBID entries had been included. Any expected changes in strategy from that followed in the CY2016 bid in the following should be explained in documentation. Changes to the following are expected:
  - Section II - Rebate Allocations for Part B Premium, Reduce A/B Cost Sharing, Other A/B Mandatory Supplemental Benefits
  - Section III – Plan A/B Bid Summary, Subsection C:
    - Part D Basic and Supplemental Premiums Prior to rebates (lines 7a and 8a).
    - A/B Rebates Allocated to the Part D Basic Premium to Part D Supplemental Premium (lines 7b and 8b).

4 Part D BPT Data Entry and Formulas

Similar to the VBID Model CY2016 MA BPT, the CY2016 Part D BPT should be completed by following applicable guidance for CY2016 bidding. It should be revised to reflect the impact of offering VBID and should reflect what a CY2016 Part D bid would have been had VBID benefits been offered then. The Part D bid pricing tools must reflect the final National Average Monthly Bid Amount released in https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmarks2016.pdf.

The following sections highlight the inputs that can be revised to incorporate VBID interventions. Support for changes to items not listed must include the rationale for the need for changes as well as documentation of the particular BPT element(s). Base Period Experience (Worksheet 1) and the Contract Period Projection for Defined Standard Coverage (Worksheet 3)[3], projected enrollment and risk score should remain the same as in the original bid submission without the VBID interventions. Reduced Part D cost sharing offered as a VBID intervention must be reflected as Enhanced Alternative (EA) benefits in the BPT, unless the entire prescription drug benefit (including VBID reductions in cost sharing) meets the applicable standards for Actuarially Equivalent or Basic Alternative coverage.

Worksheet 2, Section V – PMPM Non-Benefit Expenses:

- Non-Benefit Expenses should be updated to include the cost of providing VBID interventions. Update either the trend (column f) or manual rate expenses (column h).

Worksheet 3, Section IV – Non-Benefit Expenses and Gain/(Loss):

- The Total Gain/(Loss) (line 6, column d).

Worksheet 5, Section IV – Development of Bid Components:

- Line 6, column d – Proposed Deductible.
- Line 18, columns o and q – Minus Rebates for both covered and non-Part D covered drugs.
- Line 20, columns m, o and q – Minus Other Insurance for reinsurance-eligible Part D Covered drugs, Part D-covered drugs, and non-Part D covered drugs.
- Line 22, columns m, o and q – Plus Part D as secondary for reinsurance-eligible Part D-covered drugs. Part D-covered drugs, and non-Part D covered drugs.

Worksheet 5, Section V – Development of Actuarial Equivalence Test:

- The projected average low-income cost-sharing pmpm subsidy (line 9, column o).

Worksheet 5, Section VIII – Development of Induced Utilization Adjustment:

- The projected Impact of Alternative Utilization on Standard (line 2, column f).

Worksheet 6, Section II – Projections for Equivalence Tests:

- Lines 1 through 8, 10 through 17, 19 through 26, and 28 through 35: The Number of Scripts (column i), Allowed (column j), and Cost Sharing (column k) should be modified

[3] The exception is Section IV, line 6, column d, Total Gain/(Loss.

for the Actuarially Equivalent or Alternative Benefits to reflect the utilization, cost, and cost sharing assumptions resulting from the VBID interventions. This should include adjustments in utilization and average allowed given the proposed benefits.

- In the event that changes to average discounts or dispensing fees are expected as a result of VBID interventions, the network pricing on line 37 should be updated.

Worksheet 6A, Section II – Spending in the Coverage Gap:

- Lines 12 through 21 and 23 through 32: The Number of Scripts (column i), Allowed (column j), and Cost Sharing (column k) should be modified for the Actuarially Equivalent or Alternative Benefits to reflect the utilization, cost, and cost sharing assumptions for spending in the coverage gap resulting from the VBID interventions.

5 Supporting Documentation

5.1 Supporting Documentation for MA-VBID Model Applications

Documentation submitted in support of MA-VBID Model applications must conform to the general requirements of supporting documentation submitted in support of MA and Part D bid submissions. (See Appendix B in the MA & Part D BPT Instructions for CY2016.)

The aim of the supporting documentation is to enable reviewers to view and understand the development of pricing for VBID elements in the BPT "with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary's work" (ASOP No. 41, Actuarial Communications, Section 3.2, "Actuarial Report").

Plan sponsors must upload all required documents and support files to the MA-VBID model application portal, in the section designated for actuarial documents. Sponsors need not resubmit files that were uploaded in the CY2016 bid submission process and are not modified for this application. Please note that there is a maximum permitted total upload of 25 megabytes across all files. Plan sponsors must provide:

- Cover Sheet – A document that lists all of the supporting documentation that is provided with the application and any revisions requested during application review and:
    - A list of files that document and support the VBID entries in the BPT. These files can be newly created files and/or files that were previously uploaded to HPMS but have been revised.
    - Detailed information for each support item–such as the filename and the location within the file, if applicable–and applicable contract number-plan IDs and whether the substantiation is related to MA, Part D or both.
    - Revised files should contain the word "Revised" in the filename, and revisions should be clearly delineated (e.g., in color).

- **Revised CY2016 MA** and **Part D BPTs**, where the revisions reflect the inclusion of VBID plan design elements that the plan intends to include in its CY2017 bid submission in June.
- **Narrative Summary –** A single, written document (Word or PDF format) that includes the following items:
    - A narrative describing the plan sponsor's overall approach to VBID and the expected actuarial effects for each targeted chronic condition group.[4]
    - For each individual VBID intervention, plans must provide:
        - A brief description of the intervention and the type of provider, if applicable. Information from the applicant's RFA response may be repeated here.
        - A summary of commercial experience, internal studies, reports, and/or other sources considered in setting assumptions and/or estimating the expected impact of the VBID interventions. Due to the expected novel nature of some proposed interventions, it is possible that limited public experience or literature exists on which to base estimates of the impact of specific VBID interventions on utilization patterns or the cost of Part C and D services. In this case, it is sufficient for the justification of actuarial assumptions to be derived from the actuary's reasoning, judgment, or other factors. Documentation in this form is still required to be sufficiently clear that another actuary can appraise its reasonableness.
        - A general description in actuarial terms of the strategy followed to estimate the effects on utilization and/or unit or PMPM costs for each targeted chronic condition group in light of the sources considered.
        - A list of the changes made to utilization, unit or PMPM costs and NBE costs together with an indication of what experience base, etc. was relied on in setting the assumption.
        - Projection of the member months eligible for each targeted chronic condition group and estimates of those that will participate or otherwise be engaged, if applicable.
        - For organizations submitting an exemplar plan, documentation explaining why the interventions and anticipated effects should be expected to be similar for the designated plans.
- **Quantitative Support** that documents and explains **ALL** the revised entries to the BPTs identified by comparing the final approved 2016 BPT with the revised 2016 BPT with VBID changes, to include—
    - A spreadsheet showing the changes.
    - For each type of service line in MA Worksheets 1 and 3 changed by VBID entries, a spreadsheet that shows:
        (1) Disaggregated type of service lines for each targeted chronic condition group affected differently by VBID changes
        (2) The projected member month weights for each target group
        (3) How the entries in each line are combined to form the line in the revised CY2016 BPT.[5]

[4] Where the effects are expected to be the same for some or all targeted chronic condition groups, a single description is sufficient along with an indication of which groups it refers to.

[5] A general description of changes to MOOP or impacts of plan level deductibles in and out of network will suffice.

  - For other entries to the MA BPT, relevant assumptions for the targeted chronic condition groups, any changes to assumptions related to the non-VBID population, an indication of the reason for changes in other entries flowing from changed entries, and a demonstration that these assumptions tie to the BPT entries.
  - For Part D, a quantitative mapping in a spreadsheet format of allowed costs, effective cost sharing and script counts from the formulary tiers to type-of-drug and point-of-sale (retail or mail order) categories used in pricing (Worksheets 2, 6 and 6A) that clearly indicates how cost sharing for the VBID population is incorporated and how the intervention impacts utilization and costs.
  - For other entries to the Part D BPT, relevant assumptions for the targeted chronic condition groups, any changes to assumptions related to the non-VBID population and a demonstration that these assumptions tie to the BPT entries.
  - For NBE, an expansion of the documentation provided as support for NBE entries for the 2016 BPTs to show the cost estimate for any new administrative functions, as well as the revised entries reflecting NBE with VBID changes.
- **Five-year Projections –** If an increase to net enrollee or no decrease in Medicare costs is projected in the revised CY2016 BPT, provide a five-year, bid-specific, summary-level projection that demonstrates no net increases to the present value of enrollee costs and a decrease in Medicare costs over the five-year life of the model.

CMS will review applications and may request further documentation or explanation of the application. Responses to such inquiries must be made within 48 hours by inserting answers to questions in the Microsoft Word document used in the inquiries. For this purpose, applicants should designate the appropriate respondents along with email addresses and phone numbers if different from those listed on the revised BPTs submitted with the application.

5.2 Documentation Checklist

Initial January MA-VBID Submission – Required for all Applications
Cover Sheet
Revised 2016 MA BPT
Revised 2016 Part D BPT
Narrative Summary
Quantitative Support
Five-year projections

Appendix A – Sample Cover Sheet

SAMPLE COVER SHEET – SUBMITTED WITH INITIAL VBID UPLOAD

Supporting Documentation Cover Sheet

CY2017 VBID Pricing Submission

Organization Name: H Sponsor

Contract(s): H9999

Date: January 8, 2016

Documentation Requirement	Applicable to MA, Part D or Both	File Name	Location within File (if Applicable)
Cover Sheet	Both	Cover Sheet 1-4-16.pdf	Page 1
Revised 2016 MA BPT	MA	2016MABPTRevised.xlsx	
Revised 2016 Part D BPT	PD	2016PDBPTRevised.xlsx	
Narrative Summary	Both	Narrative1-4-16.pdf	Page 2
Quantitative Support	Both	Impacts 1-4-16.xlsx	Sheet 1- MA Sheet 2- PD
Five-year Projections	Both	FinancialPlan 1-4-16.xlsx	Sheet 1