Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation **Medicare Advantage Value-Based Insurance Design Model CY2018 Application Actuarial Guidance**
October 25, 2016

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1 Background and General Information

This document provides guidance to both returning and new 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 in their applications.

The MA-VBID model is testing 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 has implemented a five-year MA-VBID model test that will begin on January 1, 2017, and will continue through December 31, 2021. The MA-VBID model is testing 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 has exercised 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 apply to the MA-VBID model, either for the first time or as a returning CY 2017 participant 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 CY2018. To support them, applicants will provide financial projections of the impact of the VBID elements, following the instructions contained in this document, which will quantify the expected impact of VBID on utilization and unit cost assumptions as well as on 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, "Background and General Information" 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, "What to File" contains a brief summary of the requirements for new applicants and for sponsors who are returning to the MA-VBID Model.
- Section 3, "Pricing Considerations" contains guidance for presenting CMS with financial projections by revising the CY2017 MA and Part D BPTs to reflect the planned VBID interventions and presenting pricing results.
- Section 4, "MA BPT Data Entry and Formulas" contains MA-specific pricing guidance.
- Section 5, "Part D BPT Data Entry and Formulas" contains Part D-specific pricing guidance.
- Section 6, "Supporting Documentation" contains requirements for Supporting Documentation.
- Appendix A, "Sample Cover Sheet" contains a sample cover sheet for submission with the application.

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 CY2017 found at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Bid-Pricing-Tools-and-Instructions-Items/BPT2017.html.
- For questions about the actuarial forms or documentation requirements, e-mail mavbid@cms.hhs.gov.

2 What to File

The actuarial application requirements differ depending on whether the applicant is participating in the model for CY2017 or is a new applicant for CY2018. If the submission is for a returning applicant, see section 2.1 Returning Applicants. If the submission is for a new applicant, see section 2.2 New Applicants.

2.1 Returning Applicants

In general, returning applicants are required to provide less documentation than is requested from new applicants. Specifically, returning applicants are expected to submit only the supporting documentation outlined in section 6.1 Supporting Documentation for Returning MA-VBID Model Applicants for interventions that are continuing substantially unchanged from CY2017.

The application should be completed as if the program of VBID interventions is completely new in

the event that the applicant is proposing major changes to its program such as:

- Providing a VBID benefit package to a new chronic condition group,
- Offering substantially larger cost sharing reductions than offered in the previous year, except where those changes are needed to conform to changes in the cost sharing levels offered to all enrollees in the plan benefit package,
- Adding new types of extra supplemental benefits to VBID-eligible enrollees, or substantial increases to coverage of the supplemental benefits previously offered to VBID-eligible enrollees.

If you are unsure whether the changes you are proposing fall into these categories, please contact CMMI to discuss your particular case.

All applicants, including returning applicants, are required to 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, returning applicants whose proposals do not meet this criterion for CY2018, regardless of whether their VBID proposals contain major changes, must submit the multi-year financial projections described in Section 3.2.

Finally, for returning applicants that are offering VBID benefitsin new regions, include an explanation describing how the exemplar plan applies to the new area.

2.2 New Applicants

New applicants for CY2018 or currently participating applicants making major revisions to their program of VBID interventions should review sections 3 through 5 of these Instructions and submit all of the supporting documentation requested in section 6.2 Supporting Documentation for New MA-VBID Model Applicants.

3 Pricing Considerations

3.1 Pricing Approach

To participate in the MA-VBID Model, an applicant must submit with its application to CMS the final CY2017 Bid Pricing Tools (BPTs) and a revised version thereof, that includes the VBID plan design elements the applicant intends to include in its CY2018 BPTs bid submissions in June 2017.

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 will have reduced cost sharing for specific covered services and/or additional supplemental benefits) and the non-VBID sub-population (that will have the same cost sharing and benefits as in the actual 2017 bid). Support must include the unit cost and utilization assumptions for each VBID subpopulation reflecting each intervention offered to that population and how these assumptions are composited with the actual 2017 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 plan benefit packages may submit a single revised 2017 BPT as an exemplar, but only so long as the interventions and anticipated effects are consistent across the various plans.

3.2 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 2017 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 multi-year financial impact to enrollees and Medicare in compliance with these requirements, as outlined in Appendix A. Multi-year projections are not required if the revised 2017 BPT with VBID shows a decrease in Medicare expenditures and no change or a decrease in enrollee costs.

3.3 Application Review & CY2018 Bid Procedures

CMS will review the revised 2017 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 update interventions.

Once approved by CMS to participate in the model test, organizations must complete their CY 2018 bids and reflect VBID model impacts in a manner consistent with the assumptions and projections of VBID model impacts in their revised 2017 BPT with VBID.

Approval of model applications merely qualifies plan sponsors to include these VBID elements in their CY2018 bid submissions; it does not guarantee that these elements will be approved during Bid Desk Review.

3.4 Actuarial Certification & Participant Attestation

It is anticipated that VBID entries to the bids for CY2018 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.

4 MA BPT Data Entry and Formulas

The following highlights the inputs in the CY2017 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 CY2017 BPT since these assumptions should not be impacted by VBID. If exceptions are found in preparing the revised CY2017 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:[1]

- Utilization Adjustment – Benefit Plan Change (column k). 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. Examples include changes in unit cost due to changes in the intensity of service trend as a result of VBID benefit changes.
- Projected Additive Adjustments (columns p and q). Examples include additional benefits due to VBID interventions as either Medicare covered or 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:

There will be a number of changes that flow from those noted above. Note that the manual rate, if applicable, must be updated for the inclusion of the VBID interventions in the same way as for the experience rate, reflecting the same proportions of each VBID affected subpopulation.

Worksheet 3, Section III – Development of Contract Year Cost Sharing PMPM:

A number of changes will be needed to conform to changes noted above. In addition:

- In general all VBID cost sharing changes should appear in the appropriate service lines 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

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

include additional non-Medicare covered VBID interventions that were in categories that were not offered in the original bid submission.

Worksheet 4 Section II – Development of Projected Revenue Requirement:

In addition to entries needed to conform to those directly affecting VBID utilization and costs, the revised entries for non-benefit expenses and gain/(loss) margin should reflect the same general assumptions that led to the original 2017 entries, i.e., revised from the final approved 2017 MA bid to reflect the direct effects of including the VBID related benefits.

Worksheet 6 – MA Bid Summary:

- In general, Worksheet 6 entries should show how the bid would have been completed for CY2017 if the VBID entries had been included. Any expected changes in strategy from that followed in the CY2017 bid in the following should be explained in documentation. Changes to the following are expected:
    - Section II – B. Rebate Allocation for Part B Premium, C. Rebate Allocations – 1. Reduce A/B Cost Sharing, 2. Other A/B Mand Suppl 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 and allocated to Part D Supplemental Premium (lines 7b and 8b).

5 Part D BPT Data Entry and Formulas

Similar to the VBID Model CY2017 MA BPT, the CY2017 Part D BPT should be completed by following applicable guidance for CY2017 bidding. It should be revised to reflect the impact of offering VBID and should reflect what a CY2017 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/PartDandMABenchmarks2017.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), 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 administrative and non-benefit cost of providing VBID interventions.

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 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.

6 Supporting Documentation

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 CY2017.)

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 CY2017 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.

6.1 Supporting Documentation for Returning MA-VBID Model Applicants

The aim of the supporting documentation for returning applicants without major changes is to provide a general overview of the proposed changes to the applicant's program of VBID interventions and a description of the impacts these changes are expected to have on CY2018 MA bids.[2]

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 the proposed changes to the MA-VBID program and the anticipated impacts on CY2018 pricing.
- **Description of Program Changes –** Narrative listing the changes being made to the applicant's program of VBID interventions, including (if applicable):
    - List of changes being made to VBID copayments or coinsurance and rationale for the changes
    - Summary of changes to mandatory supplemental benefit offerings for VBID eligible enrollees and rationale for the changes
    - A list of new geographic areas and/or areas that are no longer included in the program of VBID interventions.
        - If an exemplar plan was submitted with the initial application, an explanation of how the exemplar plan is appropriate for any new geographic areas.
- **Description of CY2018 Bid Impacts –** Narrative description of the impacts to the following CY2018 bid pricing assumptions resulting from changes to interventions**:**
    - Utilization and unit cost
    - Eligible and participation percentages
    - Any changes to savings assumptions based on new studies or data
    - Gain/loss
    - Non-benefit expenses

[2] If upon examination, it is determined that the effects of proposed additional or altered VBID benefits cannot be extrapolated from those currently in place, information similar to that required of new participants may be requested for the new elements. If there is doubt as to whether changes should be regarded as major or minor, please contact CMMI. See section 2.1 Returning Applicants, above.

  - Impact on Medicare savings
  - Impact on 5 year projection, if any.
- **Additional documentation –** CMS may request that individual returning applicants provide specific additional documentation with their applications. CMS will communicate such requests directly to the applicant.

6.2 Supporting Documentation for New MA-VBID Model Applicants

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 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 CY2017 MA** and **Part D BPTs**, where the revisions reflect the inclusion of VBID plan design elements that the plan intends to include in its CY2018 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.[3]
  - 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.
    - For re-applicants with major changes, a narrative listing the changes being made to the applicant's program of VBID interventions, including (if applicable):
      - A list of additional chronic conditions eligible for benefits
      - An itemization of changes being made to copayments or coinsurance and the rationale for them
      - A description of new mandatory supplemental benefit offerings and the rationale for them
      - A list of new geographic areas or areas that are no longer included in the program of VBID interventions.
    - 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

[3] 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.

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 2017 BPT with the revised 2017 BPT with VBID changes.
  - Documentation showing for each type of medical service line in the MA BPT Worksheets 1 and 3 how entries are composited between non-VBID enrollees and those in each targeted chronic condition group.
  - For other entries to the MA BPT, documentation showing 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 2017 BPTs to show the cost estimate for any new administrative functions, as well as the revised entries reflecting NBE with VBID changes.
- **Multi-year Projections –** If an increase to net enrollee or no decrease in Medicare costs is projected in the revised CY2017 BPT, provide a multi-year, bid-specific, summary-level projection that demonstrates no net increases to the present value of enrollee costs and a decrease in Medicare costs. Multi-year projections may account for up to five years of projected VBID intervention impacts.

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.

6.3 Documentation Checklist for Returning Applicants

Initial January MA-VBID Submission – Required for Returning Applicants
Cover Sheet
Description of Program Changes
Description of Impacts

6.4 Documentation Checklist for New Applicants

Initial January MA-VBID Submission – Required for New Applicants
Cover Sheet
Revised 2017 MA BPT
Revised 2017 Part D BPT
Narrative Summary
Quantitative Support
Multi-year projections

Appendix A – Sample Cover Sheet

SAMPLE COVER SHEET – SUBMITTED WITH INITIAL VBID UPLOAD

Supporting Documentation Cover Sheet

CY2018 VBID Pricing Submission

Organization Name: H Sponsor

Contract(s): H9999

Date: January 8, 2017

Documentation Requirement	Applicable to MA, Part D or Both	File Name	Location within File (if Applicable)
Cover Sheet	Both	Cover Sheet 1-8-17.pdf	Page 1
Revised 2017 MA BPT	MA	2017MABPTRevised.xlsx	
Revised 2017 Part D BPT	PD	2017PDBPTRevised.xlsx	
Narrative Summary	Both	Narrative1-8-17.pdf	Page 2
Quantitative Support	Both	Impacts 1-8-17.xlsx	Sheet 1- MA Sheet 2- PD
Multi-year Projections	Both	FinancialPlan 1-4-17.xlsx	Sheet 1