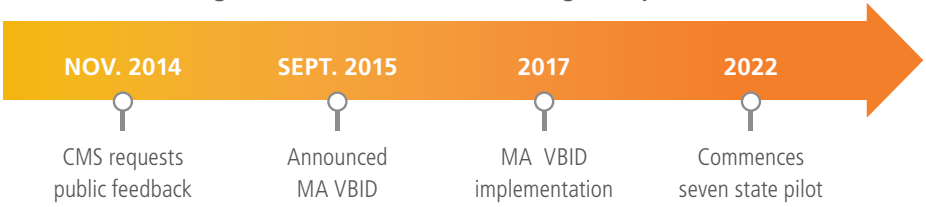
Medicare Advantage Value-Based Insurance Design: Considerations and implications

Health plans and providers are slowly moving away from traditional provider payment systems to a more innovative value-based model incentivizing providers on quality, outcomes and performance. On September 1, 2015, the Centers for Medicare & Medicaid Services (CMS) announced the Medicare Advantage Value-Based Insurance Design (MA VBID) Model as an entry into this new paradigm. Value-based design encourages enrollees to use the services that have the greatest potential to positively impact their health.[1] While VBID has been in existence for many years and continues to gain traction in the commercial market today, its clinically nuanced approach has been limited across Medicare programs due to various CMS regulations, including the uniform benefit, which requires that plans must offer the same benefits among all members enrolled in each plan.

With the release of a five-year MA VBID Model demonstration program, CMS attempts to provide an avenue through MA regulations by waiving the uniformity rules, thus allowing MA and MA-PD plans the flexibility to offer cost-sharing reductions and extra non-Medicare covered benefits to certain enrollee cohorts with CMS-specified medical conditions.

The following is a high-level summary of various VBID guidelines CMS published to date, including Optum® considerations for plans including the potential short- and long-term implications this model may have on the Medicare market if implemented uniformly.

Medicare Advantage Value-Based Insurance Design adoption timeline



Summary of MA VBID Model:

This five-year model demonstration will begin on January 1, 2017, in seven states: AZ, IN, IA, MA, PA, TN and OR. To be eligible to participate, plans must satisfy the following requirements:

- HMO, HMO-POS, or LPPO plan that offer benefits in the test states
- At minimum, a three-star quality rating for 2015 and not be a consistently low performing plan
- Not under sanction and have no past-performance outlier rating
- At minimum, three years of operations prior to CY2017
- A minimum of 2,000 enrollees (for evaluation)
- Offer no more than two states with 50% of enrollees in test states

A comprehensive combination of interventions, applicable to all Medicare Advantage services (Part C and/or Part D), affecting both member and physician, could lead to significantly improved outcomes compared to single focused interventions.

Plans participating in the MA VBID model demonstration are allowed to implement one or more interventions to enrollees with CMS-specified chronic disease conditions.

Clinical conditions	The permissible intervention options
• Diabetes • Chronic obstructive pulmonary disease (COPD) • Congestive heart failure • Coronary artery disease • Patient with past stroke • Mood disorders • Hypertension	1. Reduced cost sharing for high-value services 2. Reduced cost sharing for high-value providers 3. Reduced cost sharing for enrollees participating in disease management 4. Coverage of extra supplemental high-value benefits

MA plans declared their intention for intervention approach in the application process. In addition, along with various other requirements by CMS, plans must submit revised 2016 BPTs that reflect the utilization impact and cost savings of the proposed VBID intervention. Plans that are not expecting to achieve net cost savings from this model immediately will also be required to submit a five-year financial projection illustrating when such savings will occur.

Considerations

Why MA plans should choose to participate in MA VBID Model?

While participation in the MA VBID demonstration is optional, plans will face competitive pressure to participate due to the differentiating aspect of such a plan design. Plans will be drawn to the allure of capturing the long-term benefits of increased cost efficiency and improved quality of care anticipated by CMS. Considering the difficulty MA plans have had to maintain a low or $0 premium product in the market, this type of design could be a differentiator, as well as a way to possibly reduce costs with improved risk management for chronic subpopulation cohorts. Lastly, plans can use this model as incentives to re-contract with specific providers; potentially paving the way for value-based provider contracting leading to lower costs for those chronic conditions.

Ultimately, lower cost as a result of being more efficient needs to be a key objective for participating in such a program. CMS is not providing any additional adjustment to the benchmarks associated with this demonstration program. Thus, if costs cannot be lowered, the anticipated increase in benefits and services for the designated chronic conditions will only add, thus producing higher costs and ultimately a higher premium. In the long run a plan's benchmarks may change due to a higher star rating resulting from quality improvement. However, given the delay in the star rating influence to the benchmarks (i.e., 3 years), short term gains will be required in the interim. Thus the primary way a plan can generate more aggregate revenue and improve bottom-line performance is through an immediate reduction in costs via medical management and provider contracting, thus generating a lower premium to achieve higher enrollment.

What are the popular intervention options?

Each of the VBID interventions allowed by CMS has pros and cons. Some of the more common interventions being evaluated by plans include reduction of cost sharing for high-value services and coverage of additional supplemental high-value benefits associated with the various chronic conditions. These options are perceived to be the safest from the standpoint of potential confusions by members and political issues with providers. Since 2017 will be the first year of the MA VBID model, plans will not likely be ready to operationalize potential issues involving both providers and members stemmed from other intervention options, including potential provider disputes and litigation. Plans will also have the opportunity to change their VBID interventions in future years, as they are not locked into a preset list per the application process. For these interventions, plan communication to members will be the key. Eligible members must receive a clear communication to increase member awareness so high-value services can be fully utilized.

However, MA plans tend to stay away from the VBID intervention option allowing enrollees to pay reduced cost sharing for high-value providers due to contractual issues with the other providers. Providers not selected as one of the high-value providers for a particular chronic condition may challenge/ limit participation or attempt to escalate contractual proceeding against MA plans for excluding them from the high-value provider subnetwork. This situation would become difficult if these providers start to lose patients to competitors who receive a high-value designation. In addition, MA plans may also be challenged in the methodology, criteria and data used to for high-value providers. CMS had indicated it will review plans' methodologies, but will not provide specific guidelines on this issue. In the end, while this intervention option might serve as the springboard to value-based provider contract reimbursement, it would have to be on hold for now until MA plans can find satisfactory solutions to such issues.

A plan's participation in the MA VBID demonstration may have potential impact on several key departments within an organization.

Plans need to consider the potential operational elements as part of their assessment in order to ensure its participation in the demonstration is a success.

Implications: Assess and analyze plans

Risk assessment	Determine the number of individuals in each of the chronic conditions based on CMS definition of diagnosis. Determine their current claim cost and revenue, including risk score. Can the risk score be improved if greater focus is on their treatment (i.e., balance revenue with cost reduction)?
Claims	Do plans have the administrative capability to adjudicate two different plan designs under the same plan ID for both Part C and D?
Network	Do plans have a Center of Excellence for each of the chronic conditions or only for a select few? Can plans work with these providers to offer even better quality and cost effective care for selected chronic conditions? Are the providers willing to go at risk for chronic patients? Can plans work with these providers to develop the value-based benefits?
Quality	What star rating measures will be impacted and at what point in the future will they influence the bid star rating?
Prescription drugs	Can plans work with the PBM to develop a new prescription program to administer these conditional benefits?
Financial factors	How will this new program impact underlying claim cost based on number of patients and management programs? Is the cost reduction enough to materially lower premium and attract new members to this product?
Enrollment projection	How many members and new enrollees will participate?
Marketing	What communication strategy will be needed for the members and providers?
Success metrics	How will plans measure the effectiveness or success of this program including cost, trend, quality, provider relations, member relations, enrollment, etc.?

With the efficiency and quality of care a critical emphasis in today's U.S. health care industry, the shift from volume Fee For Service (FFS) to value-based provider contracting is gaining traction among various stakeholders. MA VBID Model by CMS provides MA plans a unique vehicle to accelerate the design of value-based benefits and innovative provider payment options. While plans may not take advantage of all the eligible VBID interventions, allowed by CMS initially, they should develop a long-term plan to phase in different interventions, considering the demonstration is for five years, and assuming the program achieves anticipated results.

About Optum

Optum® is a leading health services and innovation company dedicated to helping make the health system work better for everyone. With more than 85,000 people collaborating worldwide, Optum combines technology, data and expertise to improve the delivery, quality and efficiency of health care.

MA VBID Model by CMS provides MA plans a unique vehicle to accelerate the design of value-based benefits and innovative provider payment options.

To discuss MA VBID evaluation and assessment contact Optum today.

Call: 1-800-765-6807
Click: empower@optum.com
Visit: optum.com

optum.com

11000 Optum Circle, Eden Prairie, MN 55344

Optum® and its respective marks are trademarks of Optum, Inc. All other brand or product names are trademarks or registered marks of their respective owners. Because we are continuously improving our products and services, Optum reserves the right to change specifications without prior notice. Optum is an equal opportunity employer.

© 2017 Optum, Inc. All rights reserved. WF337767 3/17