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Medicare Advantage Value-Based Insurance Design (VBID) Model to End after Calendar Year 2025: Excess Costs Associated with the Model Unable to be Addressed by Policy Changes

Medicare Part D

Share

The Centers for Medicare & Medicaid Services (CMS) is terminating the Medicare Advantage (MA) Value-Based Insurance Design (VBID) model at the end of 2025 due to the model's substantial and unmitigable costs to the Medicare Trust Funds. Excess costs to the Medicare Trust Funds of this magnitude — $2.3 billion in Calendar Year (CY) 2021 and $2.2 billion in CY 2022 associated with the VBID model, based on the prior and forthcoming evaluation reports, respectively — are unprecedented in CMS Innovation Center models. Additional analyses of model performance and policy options demonstrated that these substantial costs were driven in part by increased risk score growth and Part D expenditures and that no viable policy

modifications could address these excess costs. As such, the model must be terminated at the end of 2025 to meet the CMS Innovation Center's statutory requirements.

CMS is making this announcement more than a year before the termination effective date to provide ample time for MA plans and their partner organizations to prepare for CY 2026 in ways that best support their enrollees' needs. In particular, as many of the VBID model's interventions are now widely available in the MA program, model termination will not impact the ability of MA plans to continue to offer most of the interventions offered under the model. CMS will also continue to promote whole-person health, transparency, and affordability in the MA program and effectively manage MA program costs to protect beneficiaries and the Medicare Trust Funds.

VBID Model Background and Lessons Scaled

Since its launch in 2017,[1] the VBID model has tested an array of MA health plan interventions intended to lower Medicare spending and improve the quality of care for MA enrollees. It has also built on CMS' commitment to transparency and whole-person health in the MA program. Through the model, participating MA plans have had the added flexibility to target potentially high-value services and cost-sharing assistance for prescription drugs to chronically ill and underserved populations, with the goal of increasing access to and uptake of these services to improve health and decrease avoidable medical spending of these enrollees.

The VBID model has generated important lessons that have informed broader MA program policies, including strategies to:

- Improve population health outcomes, enabled by the model's requirements for MA plans to screen for health-related social needs (HRSNs), offer certain supplemental benefits that address HRSNs, and implement health equity plans. In particular, the Special Supplemental Benefits for the Chronically Ill (SSBCI), which can generally mirror VBID interventions, provides an opportunity for CMS to continue collaboration with plans and other partners on these important initiatives across the MA program.

- Improve transparency in MA through new reporting requirements, for example, regarding enrollees' use of supplemental benefits. These learnings have informed data collection efforts across the MA program, particularly regarding supplemental benefit policy.
- Increase medication adherence through reduced Part D cost sharing, some of which were enacted in the Inflation Reduction Act (IRA) for all qualifying beneficiaries, for example around the expansion of the Low-Income Subsidy program under Medicare Part D.

Evaluation Findings and Model Termination

Initial findings from the 2023 evaluation of the VBID model indicated that the model incurred substantial costs in part due to the fact that risk scores of enrollees in MA plans participating in VBID increased substantially more than those of similar enrollees in other MA plans not participating in the VBID model.[2],[3] MA plans participating in VBID were also associated with increased rebates and increased Part D expenditures, compared to MA plans that did not participate in VBID. Together, this increase in risk scores, combined with rebates to MA plans and higher Part D expenditures, drove significantly higher Medicare costs. Based on the 2023 evaluation report, the model's cost to the Medicare Trust Funds is estimated to be $2.3 billion in CY 2021. In a December 2023 blog post, CMS summarized these findings and indicated that the evaluation results would continue to be reviewed more closely and additional model changes or model termination might be possible in the future. To be responsive to initial concerns regarding costs associated with the model, CMS made changes to the VBID model for CY 2025.[4]

Since the release of the 2023 evaluation report, the CMS Innovation Center also continued to review the model, conducting additional analyses and examining new data from the forthcoming evaluation report covering performance years 2020 through 2023. In its additional analyses of the risk score findings, CMS found that although the magnitude of association varied, the increased enrollee risk scores associated with the VBID model were not isolated to subsets of the VBID model. Likewise, as noted in the

executive summary of the forthcoming evaluation report that will be released in early 2025, CMS found that MA plans participating in VBID continue to be associated with higher risk scores, again leading to higher payment above what CMS would have paid absent the model. In addition to the previously identified $2.3 billion in costs associated with the model in CY 2021, based on the forthcoming evaluation report, VBID is estimated to have resulted in a $2.2 billion cost to the Medicare Trust Funds in CY 2022 — an unprecedented cost trend in Innovation Center models.

The law authorizing CMS to test innovative payment and service delivery models requires CMS to either terminate or make changes to models that are expected to increase costs to the Medicare program. Consistent evaluation report findings of significantly increased costs associated with the VBID model, combined with unsuccessful efforts to consider policy options to mitigate losses, left CMS with no viable modifications that could address the substantial costs associated with the model. Therefore, the VBID model will terminate at the end of CY 2025 in accordance with the law.

Charting a Path Forward and Supporting a Stable Transition

CMS is committed to supporting a stable transition for all enrollees in MA plans participating in the VBID Model. Importantly, even with VBID's termination, enrollees may be able to remain in their MA plan based on their plan's decision in CY 2026 or will be able to choose a different MA plan or Traditional Medicare, depending on what best meets their needs during the 2026 Open Enrollment Period.

Additionally, enrollees who choose to remain in MA will likely be able to access many of the same benefits after VBID's termination (e.g., transportation to medical appointments, healthy food assistance), because many elements of the VBID model have become benefits that can be offered in the MA program. Since the model launched, Congress and CMS have made key legislative and regulatory changes related to supplemental benefits, such as CMS' reinterpretation of uniformity flexibility (i.e., who can be the target population(s) for certain benefits) and the Bipartisan Budget Act (BBA) of 2018 that created SSBCI. In particular, SSBCI

allows MA plans to offer similar interventions to those available under the VBID model. MA plans will be able to leverage similar pathways and help enrollees maintain access to supplemental benefits that meet their needs.

CMS recognizes some beneficiaries may experience disruption to Part D cost sharing in CY 2026 due to the end of the VBID model. CMS strives to make prescription drugs more affordable for millions of Americans by continuing the improvements to the Part D prescription drug program enacted in the IRA – including the expansion of the Low-Income Subsidy – and through continued development of the CMS Innovation Center's voluntary Medicare $2 Drug List model, which CMS aims to start in January 2027. CMS will also coordinate closely with beneficiary and consumer advocacy groups and the State Health Insurance Assistance Programs to assist beneficiaries in the 2026 Open Enrollment Season.

Ultimately, while the VBID model must be terminated due to its significant, unmitigable costs and the CMS Innovation Center's statutory requirements, lessons learned lay the groundwork for continued improvement within the MA and Part D programs. Informed by this model experience, CMS will explore innovations that not only advance whole-person health, enhance transparency, and promote drug affordability but also address rising costs and protect the Medicare Trust Funds.

Frequently Asked Questions

1. Why is CMS terminating the Value-Based Insurance Design (VBID) model?

The Centers for Medicare & Medicaid Services (CMS) is terminating the Medicare Advantage (MA) Value-Based Insurance Design (VBID) model at the end of 2025 due to the model's substantial and unmitigable costs to the Medicare Trust Funds. Excess costs to the Medicare Trust Funds of this magnitude — $2.3 billion in Calendar Year (CY) 2021 and $2.2 billion in CY 2022 associated with the VBID model, based on the prior and forthcoming evaluation reports, respectively — are unprecedented in CMS Innovation Center models. Additional

analyses of model performance and policy options demonstrated that these substantial costs were driven in part by increased risk score growth and Part D expenditures and that no viable policy modifications could address these excess costs. As such, the model must be terminated at the end of 2025 to meet the CMS Innovation Center's statutory requirements.

2. What were the findings of the forthcoming evaluation report and the additional analyses conducted by CMS?

Alongside this announcement, CMS published an executive summary of the forthcoming evaluation report, in advance of the release of the full report in early 2025. This forthcoming evaluation confirmed that the VBID model was associated with substantially increased costs to the Medicare Trust Funds, driven in part by increased risk scores in participating MA plans.[5] The model's cost to the Medicare Trust Funds is estimated to be $2.2 billion in CY 2022, on top of the estimated $2.3 billion in costs in CY 2021 based on the prior report, which is unprecedented for CMS Innovation Center models. CMS also released additional analyses of VBID risk score impact by intervention and plan type,[6] as well as the impact of various risk score factors. These analyses found that although the magnitude of association varied, the enrollee risk score increase associated with VBID was seen across VBID interventions and plan types. MA plan participation in VBID was also associated with an increase in the number of Hierarchical Condition Category (HCC) diagnoses for certain enrollees that are factored into risk scores, including conditions that were and were not targeted for VBID interventions. Notably, CMS found no evidence to conclude that the increased costs of the model were associated with the offering of interventions that address health-related social needs (HRSNs).

3. Why is CMS announcing the termination of the VBID model now instead of trying to make changes to the model or waiting for additional evaluation results?

In a December 2023 blog post, CMS summarized findings from the 2023 VBID evaluation report and indicated that the evaluation results would continue to be reviewed closely, and that additional model changes or model termination might be possible in the

future. To be responsive to initial cost concerns, CMS made changes to the VBID model for CY 2025 (e.g., using a competitive application process). Since the release of the 2023 evaluation report and the December 2023 blog post, the CMS Innovation Center continued to review the model, conducting additional analyses and examining new data from the forthcoming evaluation report covering performance years 2020 through 2023. In its review, CMS found that in addition to the previously estimated $2.3 billion in costs associated with the model for CY 2021, VBID was associated with a $2.2 billion cost to the Medicare Trust Funds in CY 2022 — an unprecedented cost trend in Innovation Center models.

The statute authorizing CMS to test innovative payment and service delivery models requires CMS to either terminate or make changes to models that are expected to increase costs to the Medicare program. Given consistent evaluation report findings of significantly increased costs associated with the VBID model, combined with unsuccessful efforts to consider policy options to mitigate losses, CMS sees no viable modifications that could address the substantial costs associated with the model. Therefore, the VBID model will terminate at the end of CY 2025, in accordance with the law.

4. How does CMS plan to support enrollees most impacted by the VBID model's termination?

CMS is committed to working with plans, enrollees, and others to support a stable transition for all those affected by the VBID model's termination. CMS announced termination at this time to provide ample notice to MA plans and other partners, allowing time for plans to prepare for CY 2026. Additionally, CMS will coordinate closely with beneficiary and consumer advocacy groups and the State Health Insurance Assistance Programs to assist beneficiaries in the 2026 Open Enrollment Season.

5. What is CMS' vision for the future of the MA program?

The VBID model's requirements regarding supplemental benefits, health equity plans, and reporting on HRSN screening outcomes enabled plans to prioritize addressing HRSNs and advancing

whole-person health. CMS looks forward to building on these achievements to continue to provide high-value benefits to beneficiaries. Additionally, CMS will continue to make drugs more affordable for millions of Americans, by continuing to implement improvements to the Part D benefit through provisions included in the Inflation Reduction Act and through the proposed Medicare $2 Drug List Model, which CMS aims to start in January 2027. Informed by the experience in the VBID model, CMS will also explore innovations that not only advance whole-person health, enhance transparency, and promote drug affordability but also address rising costs and protect the Medicare Trust Funds.

Other Evaluation-Related Frequently Asked Questions

1. Why is CMS releasing additional analyses and an executive summary of the forthcoming VBID model evaluation report?

CMS is releasing an executive summary of the forthcoming evaluation report for VBID and a report summarizing additional analyses of 2023 evaluation report findings. These materials offer additional detail on the evaluation findings that informed the termination of the VBID model at the end of 2025. CMS is working to release the forthcoming full evaluation report, which will mirror and expand upon the findings released in the executive summary as soon as possible in early 2025.

2. What do these materials say?

The executive summary of the forthcoming evaluation report indicates continued increased costs associated with the VBID model. Building on the 2023 evaluation report finding of increased costs associated with the VBID model in 2021 ($44.90 PMPM, for an estimated $2.3 billion in total), the latest evaluation indicates increased costs associated with the model in 2022 ($24.64 PMPM, for an estimated $2.2 billion in total). The executive summary of the forthcoming evaluation report also continues to find an association between the VBID model and higher risk scores among enrollees targeted by the model, which contributed to the total cost increase associated with the VBID model.

CMS' additional analyses of 2023 evaluation findings provide more

detail on the association between VBID participation and higher enrollee risk scores. These analyses conclude that the association between VBID plan participation and higher enrollee risk scores was seen across subsets of the model and that the increased prevalence of Hierarchical Condition Categories (HCCs) drove the risk score increase associated with the model.

3. Why is CMS releasing these additional analyses and a summary of the forthcoming evaluation now?

CMS aims to provide further context behind model termination to model participants and other interested parties in advance of the forthcoming evaluation report, slated to be released in early 2025. In particular, the additional analyses confirm the findings of the 2023 evaluation report. In addition, the executive summary of the forthcoming report previews the main findings of the next evaluation report, and specifically the continued finding of increased costs associated with the VBID model.

4. How did the evaluation findings contribute to the VBID model's termination?

Consecutive evaluation findings indicate that the VBID model was associated with increased costs in CYs 2021 and 2022. The law authorizing CMS to test innovative payment and service delivery models requires CMS to either terminate or make changes to models that are expected to increase costs to the Medicare program. Given the evaluation findings, combined with unsuccessful efforts to consider policy options to mitigate losses, there are no viable model modifications that can meet these requirements. Therefore, the VBID model will terminate at the end of 2025.

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[1] The Bipartisan Budget Act of 2018 (Public Law No. 115-123) (BBA 2018) required CMS to allow plans in all 50 states and territories to participate beginning in 2020 and, through the end of 2021, suspended the statutory requirement to modify or terminate the model if it is not expected to improve quality of care and/or reduce spending.

[2]MA payment is risk adjusted, meaning that higher risk scores led to higher payment for MA plans, above what CMS would have paid absent VBID.
[3]In 2022, CMS observed a 4.4% increase in VBID enrollee risk scores relative to what would have been expected in the absence of the model with a comparable population.
[4] For CY 2025, CMS made some modifications to the VBID model to both strengthen CMS' understanding of cost drivers and be responsive to initial evaluation findings (e.g., using a competitive application process).
[5]For example, a 4.4% increase in risk scores among enrollees who were the focus of VBID interventions in 2022 relative to what would have been expected in the absence of the model.
[6] Plan type refers to the type of coordinated care plan, such as a Dual Eligible Special Needs Plan (D-SNP).

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