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Area Deprivation Index introduced to the Medicare Advantage Value-Based Insurance Design Model for CY 2025

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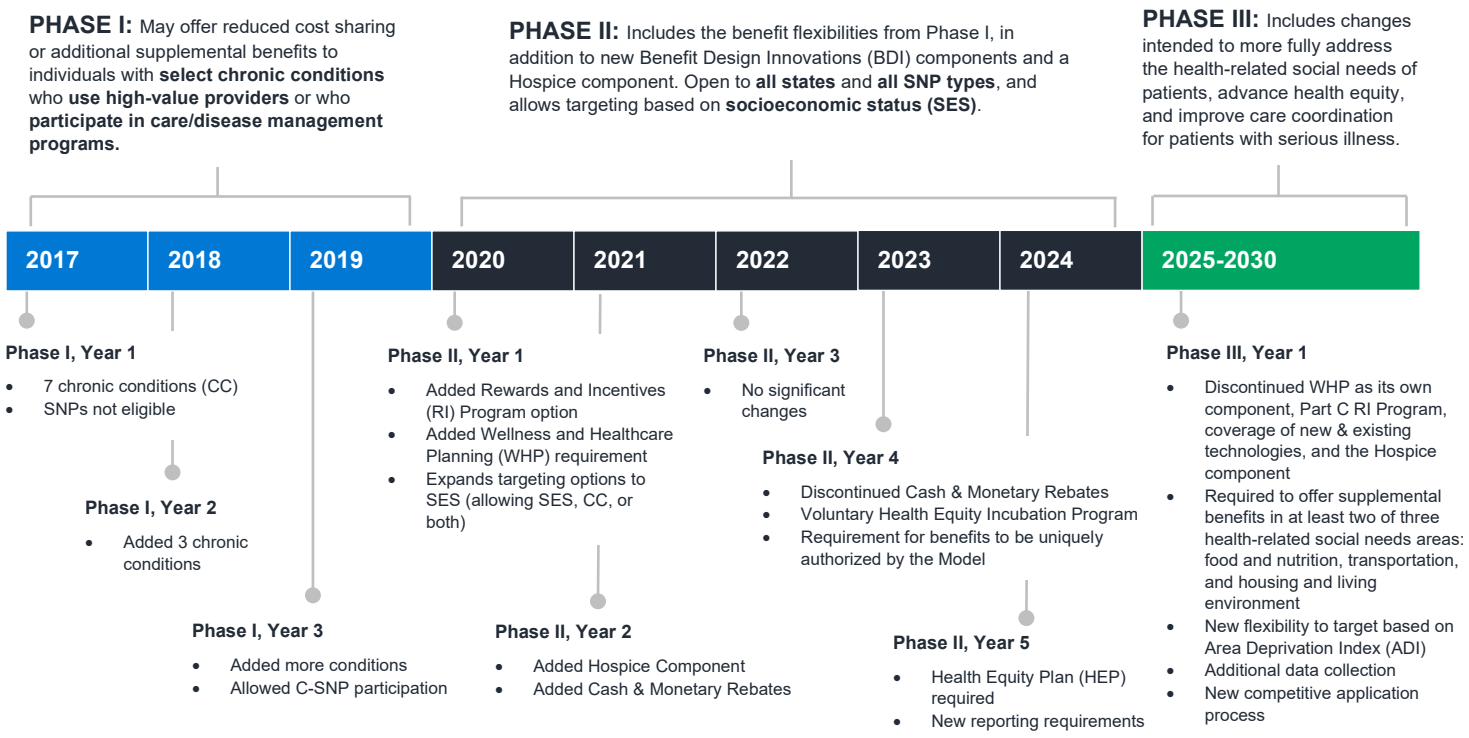
The Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model is one way the Centers for Medicare and Medicaid Services (CMS) aims to address concerns related to rising healthcare costs and the quality of care. New for the 2025 benefit year, CMS has expanded flexibility under VBID and is now allowing Medicare Advantage organizations (MAOs) to offer supplemental benefits, reductions in cost sharing, and/or rewards and incentives non-uniformly to members who reside in underserved areas, as defined by the Area Deprivation Index (ADI). This new targeting criteria has the potential to reach a whole new cohort of enrollees who have not historically met the eligibility criteria under other targeting options.

History of the VBID program

The VBID Model was first implemented in 2017 and has evolved through three phases, each aiming to address the emerging healthcare needs of Medicare beneficiaries. In Phase III of the VBID Model, the most recent phase beginning in the 2025 benefit year, CMS is placing greater emphasis on addressing health-related social needs (HRSNs), advancing health equity, and improving the coordination and quality of care for Medicare beneficiaries. Figure 1 outlines key milestones and known changes to the VBID Model from its inception through 2025.

FIGURE 1: VBID MODEL TIMELINE [1,2]



[1] Khodyakov, D. et al. (October 2022). Evaluation of Phase II of the Medicare Advantage Value-Based Insurance Design Model Test: First Two Years of Implementation (2020-2021). RAND Health Care. Retrieved March 20, 2024, from https://innovation.cms.gov/data-and-reports/2022/vbid-1st-report-2022.

[2] CMS (December 13, 2023). Request for Applications for the Calendar Year 2025 Value-Based Insurance Design Model. Retrieved March 20, 2024, from https://www.cms.gov/files/document/vbid-cy25-rfa.pdf.

Amid the changes introduced in Phase III is new flexibility for MAOs to offer non-uniform supplemental benefits to target enrollees who reside in underserved areas, as measured using the ADI.[3]

ADI landscape

CMS released an Area Deprivation Index Data Book (ADI Data Book) with the calendar year (CY) 2025 VBID materials.[4] The ADI Data Book shows that approximately 52% of Medicare Advantage beneficiaries in July 2023, or 13.6 million, lived in neighborhoods that would meet the minimum requirement for targeting under VBID.

Figure 2 compares the Medicare Advantage population meeting the minimum ADI targeting requirement to the population in plans offering VBID, Special Supplemental Benefits for the Chronically Ill (SSBCI), or Uniformity Flexibility (UF) benefits targeted using socioeconomic status[5] and/or chronic condition.

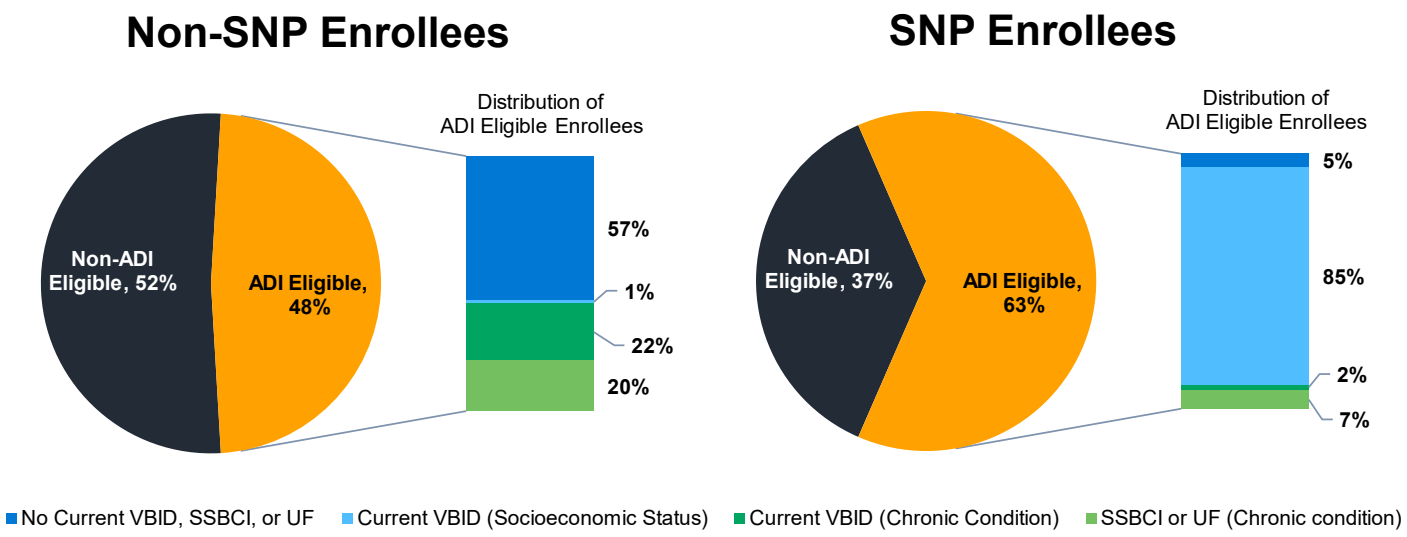
WHAT IS THE AREA DEPRIVATION INDEX?

ADI was established with the purpose of evaluating social disadvantage across neighborhoods. Neighborhoods are determined based on census block groups (formed by streets, roads, railroads, and other features). The ADI ranks neighborhoods' socioeconomic disadvantages based on 17 variables including income, education, employment, and house quality.

The ADI is provided as a relative measure at the state or national level. Larger ADI values represent a greater socioeconomically disadvantaged neighborhood.

The ADI was originally developed by the Health Resources and Services Administration and refined by Amy Kind, MD, PhD and her research team at the University of Wisconsin-Madison.

FIGURE 2: MA ENROLLEES IN JULY 2023 MEETING MINIMUM ELIGIBILITY UNDER ADI AND ENROLLED IN A PLAN THAT COVERS VBID, SSBCI, AND/OR UF IN 2024



Notes:

- ADI eligibility was determined using the ADI Data Book published by CMS. A beneficiary is assumed to meet minimum eligibility if the county where they reside is in the 7th through 10th nationwide or state ADI decile. An average of 5.5 enrollees are assumed to reside in cells where data is masked due to low volume (fewer than 10 enrollees).
- VBID, SSBCI, and UF coverage was incorporated by mapping 2024 plan details onto the ADI Data Book using the 2024 Milliman MACVAT[6]®.
- Enrollees were grouped sequentially into the categories: (1) no current VBID, SSBCI, or UF; (2) current VBID (socioeconomic status); (3) current VBID (chronic condition); and (4) SSBCI or UF (chronic condition). Enrollees were only counted once in the first category applicable to them.
- Current VBID (chronic condition) also includes beneficiaries who are targeted based on both socioeconomic status and chronic condition.

[3] Center for Health Disparities Research. About the Neighborhood Atlas. Retrieved March 20, 2024, from https://www.neighborhoodatlas.medicine.wisc.edu/.

[4] CMS (July 2023). State, County, Contract, Plan, Segment, ADI National and State Decile Enrollment Data for Medicare Advantage. Retrieved March 20, 2024, from https://www.cms.gov/files/document/vbid-adi-enroll-public.xlsx (Excel spreadsheet download). This resource includes the number of July 2023 MA enrollees by contract, state, county, and national/state ADI decile reported as of October 2023 (data is masked when there are fewer than 10 enrollees in an ADI decile split by county and plan).

[5] Defined as being eligible for the Low-Income Subsidy (LIS) or, in the U.S. territories, being dually eligible for Medicare and Medicaid.

[6] Learn more about MACVAT here: Milliman MACVAT (Medicare Advantage Competitive Value Added Tool) | Milliman | US

As shown in Figure 2, approximately 48% of non-special needs plan (non-SNP) enrollees and 63% of special needs plan (SNP) enrollees meet the minimum ADI-targeting criteria as of July 2023. However, 85% of SNP enrollees who meet the minimum ADI targeting criteria are already enrolled in a SNP plan offering VBID based on socioeconomic status, and another 9% are enrolled in a plan offering VBID, SSBCI, or UF based on chronic condition.

Within the non-SNP population, approximately 57% of beneficiaries who would meet the minimum ADI-targeting criteria are not enrolled in plans that currently offer non-uniform benefits under VBID, SSBCI, or UF.

ADI targeting under VBID has the potential to reach a large portion of the non-SNP population living in underserved areas who may not currently have access to VBID benefits, but this targeting option does not offer significant VBID expansion opportunities to the SNP population, who in large part already have VBID access.

ADI as a new VBID targeting option

Medicare regulations prior to 2019 required MAOs to offer all benefits uniformly to all members enrolled in a plan. Further, benefits were to be medical in nature. Since 2019, CMS has introduced a number of benefit flexibility options for MAOs to provide benefit enhancements (including non-primarily health-related benefits) in a non-uniform fashion to Medicare beneficiaries. There are three general avenues that MAOs can use, each with its own set of options and requirements: UF, SSBCI, and VBID.[7] These options are outlined in Figure 3.

FIGURE 3: MEDICARE ADVANTAGE NON-UNIFORM BENEFIT FLEXIBILITY OPTIONS

Option characteristic	UF	SSBCI	VBID
May offer non-primarily health-related benefits		■	■
May target benefits by disease state (chronic condition)	■	■	■
May target benefits by socioeconomic status			■
May target benefits by ADI (new in 2025)			■
Flexibility for Part C benefits	■	■	■
Flexibility for Part D benefits			■
Subject to a CMS application process			■

Non-uniform benefits

are supplemental benefits or reductions in cost sharing offered to a subset of enrollees based on their needs.

Non-primarily health-related benefits

are supplemental benefits that do not meet the definition of primarily health related, but have a reasonable expectation of improving the health or overall function of the enrollee.

Note: Includes financial projections showing overall savings to the Medicare program, among other requirements.

As shown in Figure 3, VBID offers the most flexibility in terms of targeting criteria and benefit type, but requires benefit offerings to be uniquely authorized under the model. That is, benefits that could be offered under another flexibility option may not be applied for under VBID (for example, offering non-primarily health-related supplemental benefits targeted to enrollees who have certain chronic conditions would need to be offered under SSBCI).

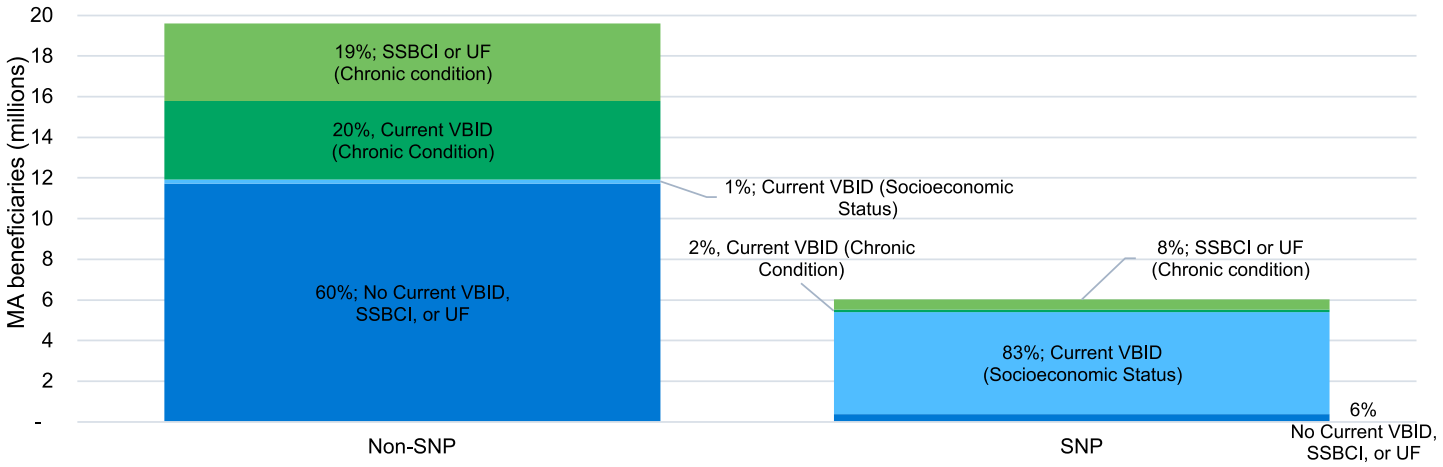
The vast majority of plans participating in the VBID model as of 2024 are dual-eligible special needs plans (DSNPs) targeting enrollees based on socioeconomic status.[8] Because socioeconomic status is highly correlated with DSNP eligibility requirements, most if not all enrollees in DSNPs meet the targeting criteria and are already eligible for non-uniform benefits. VBID benefits are

[7] Johnson, N. & Polakowski, M. (February 2019). Medicare Advantage: Changes and Updates to Enhanced Benefits. Health Watch via Society of Actuaries. Retrieved March 20, 2024, from https://www.soa.org/globalassets/assets/library/newsletters/health-watch-newsletter/2019/february/hsn-2019-iss88-johnson.pdf.

[8] Laktas, J. et al. (March 2024). 2024 VBID benefit MA market landscape and 2025 VBID Model application considerations. Milliman Insight. Retrieved March 26, 2024, from https://www.milliman.com/en/insight/2024-vbid-benefit-ma-market-2025-vbid-model-application.

less prevalent on non-dual plans, where a much smaller fraction of enrollees meet the targeting criteria under current 2024 options. Figure 4 outlines the 2024 VBID, SSBCI, and UF landscape for non-SNPs compared to SNPs.

FIGURE 4: SUMMARY OF MEDICARE ADVANTAGE BENEFICIARIES IN PLANS OFFERING NON-UNIFORM BENEFITS



Note: Percentages reflect the percentage of the total non-SNP or SNP populations. The methodology used to group beneficiaries into benefit categories is consistent with the methodology described in the notes section below Figure 2.

Targeting by ADI is uniquely authorized under VBID and is intended to target Medicare beneficiaries who reside in disadvantaged neighborhoods but may not have a qualifying chronic condition or meet the socioeconomic status requirements under VBID or SSBCI. By expanding non-uniform benefit flexibilities to enrollees who reside in underserved ADI areas, MAOs may be able to reach more non-dual eligible enrollees.

Enrollee eligibility under ADI targeting

Using ADI targeting allows plans to offer VBID benefits under state ADI deciles 7 through 10 and/or national percentiles 61 to 100. Plans may target enrollees based on a subset of the defined decile/percentile range as long as the highest deciles or percentiles are included. For instance, a plan may not target enrollees in ADI decile 7 without including deciles 8 through 10 as well.[9]

Enrollee eligibility under the ADI targeting option is determined by the MAO at the beginning of the contract year (or at the time of enrollment) based on the enrollee's place of residence. Redetermination does not occur throughout the year, so an enrollee who moves out of an ADI-eligible area during the year without changing plans will remain eligible for the remainder of the year, as long as they do not voluntarily opt out of the benefit.

Not all enrollees enrolled in a plan offering VBID, SSBCI, or UF benefits are eligible to receive those benefits

However, many plans use targeting criteria that covers a large portion of membership.

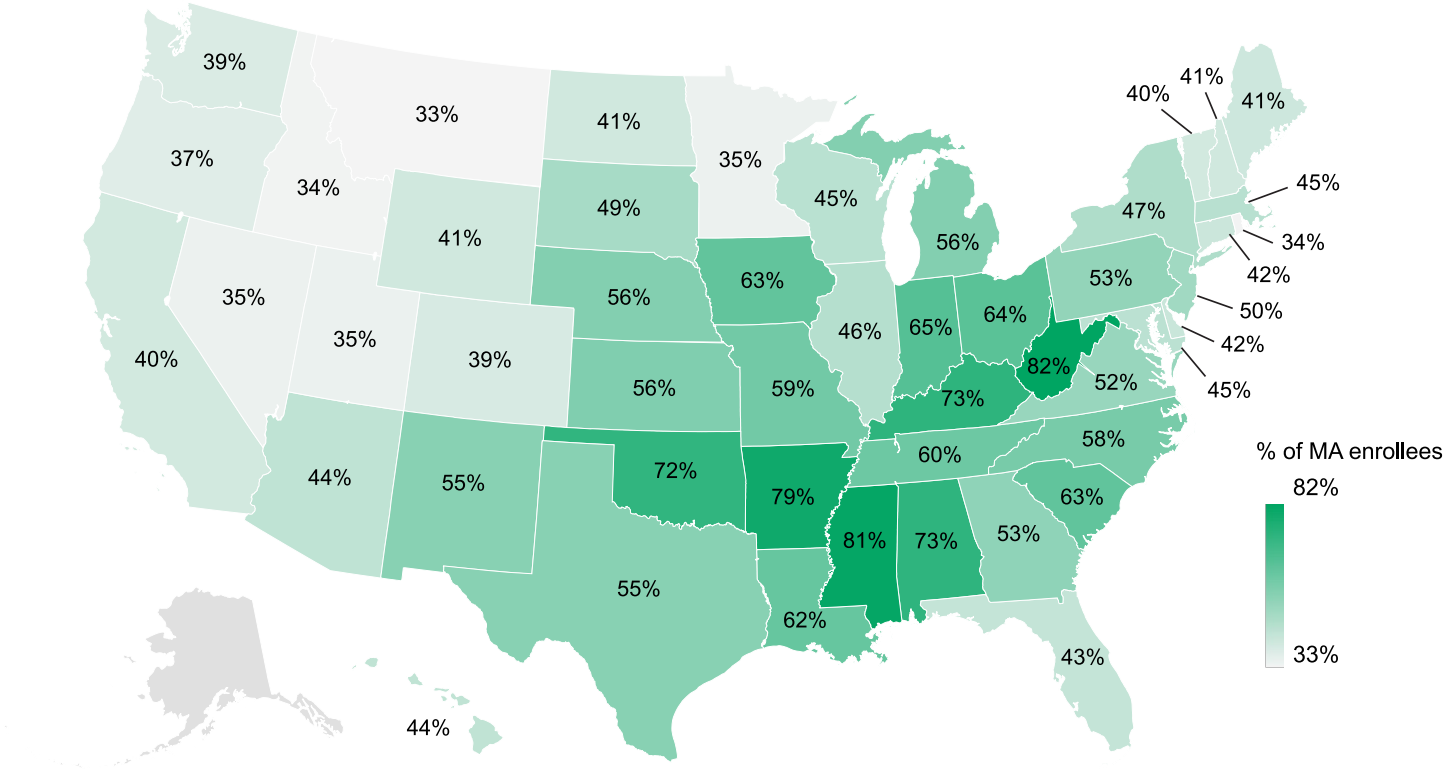
For DSNPs, low-income status is often a requirement for enrollment. Therefore, DSNPs targeting based on socioeconomic status are usually able to offer non-uniform benefits to most if not all members in the plan.

Eligibility for plans targeting based on chronic condition varies based on the conditions targeted and the prevalence of those conditions. Overall, chronic condition prevalence in the Medicare Advantage population is high, with many beneficiaries having more than one chronic condition.

[9] CMS, Request for Applications, op cit.

Figure 5 shows the percentage of Medicare Advantage enrollees by state as of July 2023 who would meet the minimum ADI eligibility requirement.

FIGURE 5: PERCENTAGE OF ENROLLEES RESIDING IN MINIMUM-QUALIFYING ADI NEIGHBORHOODS



Note: Minimum-qualifying ADI neighborhoods are in state ADI deciles 7 to 10 or national percentiles 61 to 100, as reported in the ADI Data Book. An average of 5.5 enrollees are assumed to reside in cells where data is masked due to low volume (fewer than 10 enrollees).

Figure 5 shows that there is a relatively moderate density of enrollees who meet minimum ADI-targeting criteria in all states and a very high density of enrollees in select states, primarily in the Midwest and Southeast states. MAOs in states with a high density of enrollees living in underserved communities may have a unique opportunity to offer VBID benefits to a large portion of enrollees.

MAO requirements for VBID participation

Organizations that choose to offer benefits targeted based on ADI must meet the requirements of VBID participation, including but not limited to developing a health equity plan, offering at least two benefits in health-related social needs areas, and providing an actuarial projection and certification showing that VBID benefits are expected to result in savings to Medicare over the life of the program. An MAO choosing to target using ADI must also solicit input on program design and implementation from one or more Enrollee Advisory Committees (EACs) from each state where it proposes to employ ADI targeting.

On March 13, 2024, CMS introduced new guidance through the Health Plan Management System (HPMS) outlining a substantial shift in the administration of the program.[10] With this new guidance, CMS is implementing a competitive application process whereby MAOs will be subject to an application screening and scoring rubric used to compare applications and select participants. Prior to this guidance, CMS has not used a competitive scoring rubric to determine acceptance.

[10] CMS (March 13, 2024). Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model Application Screening and Scoring Process for Calendar Year (CY) 2025. Retrieved March 20, 2024, from https://www.cms.gov/files/document/vbid-cy225-application-screening-scoring.pdf.

The application screening process checks to ensure the MAO's application includes all required documentation and that the MAO is eligible to participate under VBID eligibility requirements. For MAOs that make it through the application screening process, the scoring rubric includes points for the following categories:

- **Application content**: This component includes points for permissibility of application proposals, support for quality improvement, the health equity plan, and innovation. There are 10 points available for each of these criteria, with a total of 40 points in this category. MAOs that do not score at least 24 points under this component are automatically denied participation.
- **Potential for savings***:* This component includes points for the value of VBID benefit offerings (including rewards and incentives), the expectation of medical cost savings (excluding savings driven by bid margin), and support for savings estimates. There are 20 points available for each of these categories, with a total of 60 points available under this component. MAOs that do not score at least 36 points under this component are automatically denied participation.

The guidance includes some information on how CMS intends to award points for these categories, but there are many details that are not yet known. Nonetheless, this new competitive process will require MAOs to think strategically about how their VBID benefits meet these new criteria and align with CMS's goals for the program.[11]

MAOs choosing to include ADI targeting in their VBID application may receive points for doing so under the new scoring rubric, as CMS indicated in its guidance that using the new ADI targeting mechanism will influence scoring in the innovation category.

Risks and opportunities for MAOs considering the new ADI targeting criteria

MAOs interested in targeting enrollees using ADI have a number of risks and opportunities to consider, including but not limited to the following.

- **Selection considerations**. MAOs targeting based on ADI may enroll more members in underserved ADI areas. Members living in these areas may have unique healthcare needs that influence the average risk profile of the population as a whole. These factors will need to be considered in the bidding process and in the implementation of care management programs or other initiatives aimed at serving these members.
- **Competition.** MAOs that use VBID to offer non-primarily health-related benefits to non-dual eligible enrollees using ADI may have a unique competitive advantage, given that these benefit offerings have been less prevalent in the non-dual market to date.
- **Enrollee abrasion.** ADI eligibility can vary from neighborhood to neighborhood. Enrollees who are not eligible for VBID benefit enhancements may be unhappy if they become aware of neighbors who are eligible. Further, if an enrollee moves out of an ADI-eligible neighborhood to a neighborhood that is not eligible, they may be dissatisfied when they lose the benefit in the following year.
- **Future benefit reductions and take-aways.** There is revenue pressure on Medicare Advantage plans in 2025 relative to recent history,[12] and it is possible that revenue headwinds will continue to be a factor into the future. If VBID benefits need to be reduced in response, member disruption could initiate churn, especially if other MAOs in the enrollee's region offer similar benefits. This dynamic may also be influenced by the fact that the VBID program is now competitive. MAOs may be required to remove VBID benefits if they are selected for VBID participation one year but not the next.
- **Implementation and administrative requirements.** There are numerous requirements applicable to MAOs that choose to apply and participate in VBID. MAOs must complete an application that includes documentation of adherence to CMS requirements and includes a financial projection of savings to the Medicare program (including savings in medical expenditures, not just bid margin) over the life of the model. There are also requirements related to marketing and enrollee communication, implementing a health equity plan, and collecting, monitoring, and reporting data on the VBID Model back to CMS. MAOs will need to consider the benefits of participating in VBID in conjunction with the resources required to adhere to these requirements. This is especially true in a competitive environment where applications may be denied.

[11] Kotecki, L. & Polakowski, M. (March 2024). CMS introduces competitive bidding into the Value-Based Insurance Design program for 2025. Milliman Insight. Retrieved March 26, 2024, from https://www.milliman.com/en/insight/cms-introduces-competitive-bidding-into-the-vbid-program-2025.

[12] AHIP (February 9, 2024). What They Are Saying: 2025 Medicare Advantage and Part D Proposed Rate Notice Analysis. Press release. Retrieved March 20, 2024, from https://www.ahip.org/news/press-releases/what-they-are-saying-2025-medicare-advantage-and-part-d-proposed-rate-notice-analysis.

Caveats, limitations, and qualifications

In performing this analysis, we relied on publicly available information from CMS and the 2024 Milliman MACVAT. The Milliman MACVAT uses publicly available data released by CMS, which is then compiled, sorted, and summarized into a user-friendly format. We accepted the CMS public information without audit. However, we did review it for general reasonableness.

Milliman tools have been used to produce these results. We have reviewed the tools, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

Estimates in this analysis use published data on MA enrollment in July 2023 and benefits offered in calendar year 2024 plans. Future experience will differ from the estimates shown here to the extent future plan enrollment and offerings differ from those underlying this analysis.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in actuarial communications. Lindsy Kotecki and Tanisha Benjamin are members of the American Academy of Actuaries, and meet its qualification standards to perform the analysis and render any actuarial opinions contained herein.

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