Request for Applications for the Calendar Year 2023 Value-Based Insurance Design Model

Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation

Table of Contents

1. Background and General Information

The Centers for Medicare & Medicaid Services (CMS) is seeking applications from eligible Medicare Advantage Organizations (MAOs) to participate in the Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model for Calendar Year (CY) 2023. As described in detail in this Request for Applications (RFA), the VBID Model continues to test a number of complementary health plan innovations. CMS is conducting this Model test through the Center for Medicare and Medicaid Innovation (CMMI) under section 1115A of the Social Security Act (the Act).

The Model components that will be available to MAOs in CY 2023 are largely consistent with those available in CY 2022, with the exception of the updates outlined in section 1.2 and described in subsequent, applicable sections in greater detail. Likewise, the CY 2023 application process and timeline, which is discussed in more detail in section 5 below, is generally consistent with the CY 2022 application process and timeline.

CMS will provide separate application guidance for MAOs interested in offering the Hospice Benefit Component in CY 2023 through the CY 2023 VBID Hospice Benefit Component RFA. Although there are separate RFAs, there is only one application for participating in the Model in 2023 (see section 6 for additional detail).[1]

All eligible MAOs that wish to participate in the VBID Model for CY 2023, including MAOs that are participating in CY 2022, must apply for participation in the Model. The VBID Model RFA is **open** to MA-only and Medicare Advantage-Prescription Drug (MA-PD) plan offerings for the following plan types (1) Coordinated Care Plans (CCPs), including Health Maintenance Organizations (HMOs) (including those with a Point of Service (POS) option), Local Preferred Provider Organizations (PPOs), and Regional PPOs (RPPOs); and (2) all Special Needs Plans (SNPs), including Chronic Condition SNPs (C-SNPs), Dual Eligible SNPs (D-SNPs) and Institutional SNPs (I-SNPs). The following plan types are **not** eligible to participate in the VBID Model test: Private Fee-for-Service (PFFS) Plans, Employer Group Waiver Plans (EGWPs),[2] Medicare-Medicaid Plans (MMPs) or other demonstration plans, and MA Medical Savings Account (MSA) Plans. In addition, Cost Plans and Programs of All-Inclusive Care for the Elderly (PACE) organizations are not eligible to participate in the VBID Model.

1.1 Scope and General Approach

The VBID Model began in January 2017 with the goal of testing the impact of permitting MAOs to have the flexibility to use certain varied supplemental benefit designs (using service delivery and payment flexibilities) for certain chronic conditions to provide patient-centered care and

[1] For more detail on the Hospice Benefit Component of the VBID Model, please see the VBID Model Website for the CY 2023 VBID Hospice Benefit Component RFA: https://innovation.cms.gov/initiatives/vbid/.

[2] This exclusion applies to EGWPs that are offered exclusively to employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations and that exclusively enroll members of group health plans. An MA plan that is open to all beneficiaries in the service area and enrolls members of an employer (or union, labor organization, or fund) group health plan as well may be eligible to participate if the other eligibility criteria are met.

greater price transparency, increase enrollee choice and access to timely and clinically-appropriate care, improve quality, and reduce costs. For 2018 and 2019, the Model was broadened to all states and territories and to allow MAOs greater flexibility in designing their plan benefit packages (PBPs).

Beginning in CY 2020, CMS required participating MAOs to develop and implement Wellness and Health Care Planning (WHP) strategies to improve awareness and availability of advance care planning to test the inclusion of these strategies with benefit design. Additionally, beyond testing how MAOs could further target their benefit designs to enrollees based on chronic health conditions, CMS began testing additional targeted benefit designs by using certain socioeconomic characteristics in order to better address potential unmet social and medical needs. For 2020, the VBID Model also began testing higher-value Part C and Part D Rewards and Incentives (RI) Programs.

As announced in January 2019, CMS began testing a carve-in of the Medicare hospice benefit into the original Medicare benefits that MAOs coordinate and offer in CY 2021. Information on the Hospice Benefit Component of the Model is available on the VBID Model website at https://innovation.cms.gov/initiatives/vbid.

Additionally, in CY 2021, the VBID Model began testing the flexibility to share beneficiary rebates savings more directly with beneficiaries in the form of a supplemental benefit that is cash or monetary rebates and the ability of MAOs to use targeting for more coverage of technologies and FDA approved medical devices for targeted populations that would receive the highest value from the new technologies. The Cash or Monetary Rebates component of the VBID Model is not continued in CY 2023.

For CY 2023, the VBID Model will continue to test most of the same Model components (see Table 1), with some updates as described in the relevant pieces of section 2 of this RFA. MAOs that wish to participate in the Model must apply and receive approval from CMS for one or more of the optional components. As in CY 2020 through 2022, all participating MAOs must participate in the WHP component of the VBID Model in CY 2023.

Table 1: CY 2023 VBID Model Components

VBID Model Component	Scope	Mandatory / Optional Component
1. Wellness and Health Care Planning	All enrollees in all Model PBPs.	Mandatory
2. VBID Flexibilities: Targeted to Enrollees Based on Chronic Health Condition and/or Socioeconomic Status i. Primarily and non-primarily health related supplemental benefits,[3] which may include new and existing technologies or FDA approved medical devices ii. Use of high-value providers and/or participation in care management programs/disease management programs iii. Reductions in cost sharing for Part C items and services and covered Part D drugs	Participating MAOs may limit these to select Model PBPs as well as to Targeted Enrollees.	Optional
3. Part C and/or Part D RI Programs	Participating MAOs may limit the availability of the RI Program(s) to select Model PBPs; RI Programs may be available to all enrollees in the Model PBPs that participate in this Component or targeted to enrollees based on chronic health conditions or socioeconomic status.	Optional
4. Medicare Hospice Benefit Component (Separate RFA)	Participating MAOs may also limit these to select Model PBPs but hospice eligibility must be for all enrollees in the Model PBP(s) that participates in this Component. Additional supplemental benefits may be limited to enrollees that elect hospice.	Optional

[3] Note: These benefits that are not primarily health related are of the same type and scope as special supplemental benefits for the chronically ill (SSBCI), which are authorized under section 1853(a)(3)(D) of the Act and 42 CFR § 422.102(f) but are permitted under this Model, pursuant to the necessary waivers, to be furnished to a different population of MA enrollees **based on different eligibility criteria** than required for SSBCI. SSBCI are limited to only being provided to "chronically ill enrollees," as that term is defined in section 1853(a)3)(D) of the Act and 42 CFR § 422.102(f). We do not use the term "SSBCI" or "special supplemental benefits for the chronically ill" when referring to the benefits available in the VBID Model in order to avoid potential confusion about the broader eligibility criteria that may be used in the Model.

Model Geography and Model Performance Period
In accordance with section 50321 of the Bipartisan Budget Act of 2018, eligible MA plan types in all states and territories may apply to participate in the VBID Model. The overall Model performance period will be through CY 2024. MAOs must apply every year. However, CMS reserves the right to not open the application to new MAOs each year.

1.2 Important Updates for CY 2023

Removal of the Cash or Monetary Rebates Component from the VBID Model

Beginning in CY 2021, the VBID Model gave participating MAOs the option of offering enrollees a mandatory supplemental benefit in the form of cash or monetary rebates, available to all enrollees in a participating plan benefit package. After careful consideration, CMS is removing the Cash or Monetary Rebates component of the VBID Model for the CY 2023 Model year and future years. The agency's decision to end this Model component is due to potential negative impacts on enrollee eligibility for means-tested benefits based on receipt of cash benefits under the Model. While CMS is removing this Model component for 2023, CMS strongly encourages MAOs to address the medical and social needs of enrollees who receive LIS and/or other underserved populations. Through the value-based insurance design flexibilities under the Model, MAOs could offer a range or combination of primarily health related and non-primarily health related benefits that could include benefits such as healthy groceries, non-emergency medical transportation, transportation for non-medical needs and other innovative benefits outlined in section 2.2.3. CMS recommends MAOs (1) provide these benefits together as part of a holistic benefit design; and (2) seek input from enrollees in structuring such benefit designs, such as through enrollee advisory committees.[4] Overall, in removing the Cash or Monetary Rebates component, CMS's goal is to ensure that the Model is focused on encouraging Model participants to use targeted supplemental benefits, with a sound evidence base, to help address medical and social needs of underserved enrollees while advancing CMS health equity goals.

Voluntary Health Equity[5] Incubation Program
Through the VBID Model, CMS is testing a broad array of MA health plan innovations designed to enhance the quality of care for Medicare beneficiaries – including those with low incomes, such as dually eligible beneficiaries and those qualifying for Low-Income Subsidies (LIS) – as well as

[4] Please see additional information on enrollee advisory committees in the CY 2023 Medicare Advantage and Part D Proposed Rule (CMS-4192-P), available at: https://www.federalregister.gov/documents/2022/01/12/2022-00117/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and

[5] Health equity means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes. CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive.

to reduce costs for enrollees and the overall Medicare program. As part of the Model test, MA plans may offer additional supplemental benefits, reduced co-payments, and/or rewards and incentives to encourage enrollee participation in activities that are anticipated to improve health, prevent injuries and illness, and/or promote the efficient use of health care resources. The additional supplemental benefits available under the Model and the targeted activities to earn rewards and incentives used by participating MA plans may address health equity in part by meeting social needs that have been tied to poor health outcomes. Because MA plans enroll a disproportionately large share of more vulnerable and lower income beneficiaries, the flexibilities being tested in the VBID Model to address the health and non-primarily health related needs of lower income beneficiaries that may improve or maintain health or overall function are an important component of the CMS' commitment to achieve equitable health outcomes for all beneficiaries.[6]

In CY 2023, CMS will continue to focus on issues of quality, specifically health equity, in this Model, in alignment with CMMI's vision for a health system that achieves equitable outcomes through high-quality, affordable, and person-centered care.[7] The flexibilities provided in the VBID Model – including the ability of MAOs to target Model Benefits and RI Programs to populations with LIS and those with chronic illnesses – provide a unique and far-reaching opportunity to address issues of health equity. To this end, CMMI will implement learning activities around health equity in CY 2023 through a voluntary Health Equity Incubation Program. The goal of the Health Equity Incubation Program is to help drive a critical mass of interventions in the most promising focus areas (e.g., around addressing food and nutritional insecurity and other Health Related Social Needs (HRSN), and disease prevention and management such as diabetes and cardiovascular disease (CVD), which have well established intersections with social needs), optimizing design and implementation best practices for interventions focused on health equity, and building and sharing an evidence base for quality improvement and medical savings related to HRSN interventions. Please see section 4 of this RFA for more details.

Benefit and RI Program Designs Uniquely Authorized by the Model

Beginning in CY 2018, additional flexibilities for MAOs were enabled in the broader Part C Program, establishing additional paths, outside the VBID Model, for MAOs to offer additional benefits and incentives to the chronically ill. **Accordingly, CMS emphasizes that the VBID Model will test only those interventions within each Model component (with the exception of the WHP component) that are uniquely authorized by the VBID Model, and that are not authorized through flexibilities within the broader Part C Program outside the Model,** as discussed in greater detail in section 2. CMS invites MAOs to reach out to CMS with any questions and/or technical assistance on any interventions that an MAO may be considering for possible inclusion within the VBID Model or continuation in the Part C Program via the VBID mailbox at VBID@cms.hhs.gov.

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[6] Please note: Except as otherwise permitted by applicable law, MAOs may not propose actions that selectively target or discriminate against beneficiaries based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, geographic location, or income.

[7] See the Innovation Center's Strategy Refresh here: https://innovation.cms.gov/strategic-direction-whitepaper#:~:text=As%20part%20of%20its%20strategy,role%20in%20achieving%20these%20goals.

Guidance on Defining High-Value Providers

Under the VBID Model, participating MAOs may make the provision of additional supplemental benefits (including reductions in cost sharing) to targeted enrollees conditional on the use of high-value providers. **MAOs may propose to define "high-value" providers as those serving and treating low income, medically underserved individuals.** Examples include providers listed as Essential Community Providers (ECPs) under 45 CFR 156.235 (including safety net providers), providers serving a majority of enrollees living in areas identified by the CDC/ATSDR Social Vulnerability Index[8] or the Area Deprivation Index,[9] or providers serving predominantly dual-eligible enrollees. Please see section 2.2.5 for more details.

1.3 Statutory Authority

Section 1115A of the Act (42 U.S.C. § 1315a, added by section 3021 of the Patient Protection and Affordable Care Act) authorizes CMS to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and Children's Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care.

1.4 Waiver Authority

CMS will exercise its waiver authority under section 1115A of the Act to test this Model in the Medicare program.

Under section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) of the Act as may be necessary solely for purposes of carrying out section 1115A of the Act with respect to testing models described in section 1115A(b) of the Act. For this Model, and consistent with this standard, the Secretary may consider issuing waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act.

For this Model and consistent with the authority under section 1115A(d)(1), the Secretary issued waivers of the fraud and abuse provisions in section 1128A(a)(5) (relating to civil monetary penalties for beneficiary inducements) and sections 1128B(b)(1) and (2) of the Act (relating to the federal anti-kickback statute) for the following remuneration, provided that the conditions of the relevant waiver are satisfied: (i) certain rewards and incentives offered by the MAO to Targeted Enrollees; and (ii) Cash or Monetary Rebates offered by the MAO to all enrollees in a VBID plan benefit package approved by CMS. CMS has terminated the Cash or Monetary Rebates Component of the VBID Model for Plan Year 2023. Accordingly, the fraud and abuse waiver for the provision of Cash or Monetary Rebates will be inapplicable for Plan Year 2023.

Further, no new fraud and abuse waivers are being issued in this document; any new or revised fraud and abuse waiver would be set forth in separately issued documentation. Any such waiver would apply solely to this Model and could differ in scope or design from waivers granted for other programs or models, or those described below.

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[8] https://www.atsdr.cdc.gov/placeandhealth/svi/at-a-glance_svi.html

[9] https://www.neighborhoodatlas.medicine.wisc.edu/

Notwithstanding any other provision of this RFA, all parties must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued pursuant to section 1115A(d)(1) specifically for this Model.

1.5 Medicare Program and Payment Waivers

No waivers of program requirements or payment provisions are provided in this document. This RFA merely describes the waivers contemplated at this time for the Model; program or payment waivers, if any, would be set forth in Model documentation (such as an appendix to the contractual addendum for participation in the Model). In support of the Model, the Secretary intends to waive certain Title XVIII provisions and their implementing rules, to the extent described below and only as necessary to conduct the tests described in this RFA. Intended to be waived to the extent necessary to permit MAOs to participate in the Model are:

- **Uniformity and Accessibility of Benefits and Cost Sharing**: The following may be waived only to the extent necessary to permit MAOs to offer supplemental benefits and reduced or eliminated cost sharing to the targeted enrollee population, rather than to all enrollees, subject to the terms of the Model. The targeted enrollee population may be identified based on (i) one or more chronic health conditions, or (ii) Low-Income Subsidy (LIS) eligibility, or (iii) a combination of both chronic health conditions and socioeconomic statuses.
    - Sections 1852(d)(1)(A) and 1854(c) of the Act;
    - 42 CFR §§ 422.2 (definition of an MA plan), 422.100(d)(2), 422.102(a)(2), 422.254(b)(2), and 422.262(c)(1);
    - Section 1860D–2(a) of the Act; and
    - 42 CFR §§ 423.104(b)(2) and 423.265(c).

- **Provision of Non-Primarily Health Related Supplemental Benefits**: The following may be waived to the extent necessary to allow MAOs to offer to certain enrollees "non-primarily health related" supplemental benefits subject to the terms of the Model. Such supplemental benefits must have a reasonable expectation of improving or maintaining the health or overall function of the enrollee with regard to the chronic health condition or socioeconomic status of the targeted enrollee population. The targeted enrollee population may be identified based on (i) one or more chronic health conditions, or (ii) LIS eligibility, or (iii) a combination of these chronic health conditions and socioeconomic statuses. An MAO may propose (for CMS consideration and approval) to offer to certain Targeted Enrollees (who do not meet the definition "chronically ill enrollee" in section 1852(a)(3)(D) of the Act or 42 CFR 422.102(f)(1)(i)) additional non-primarily health related supplemental benefits subject to the terms of the Model:
    - Section 1852(a)(3)(D)(i), (ii)(I) and (iii) of the Act; and
    - 42 CFR 422.100(c)(2)(ii)(A) and 422.102(f)(2)(i), (ii) and (iii).

- **Increased Flexibility for RI**: The following may be waived to the extent necessary to allow a participating MAO to offer RI Programs, subject to the terms of the Model, that: are available only to Targeted Enrollees if not uniformly offered to all enrollees; are permitted in connection

with Part D benefits; are based on the anticipated benefit (rather than the value) of the associated healthcare item or service and subject to an annual limit of $600.00 per enrollee for all rewards received by the enrollee; and are available before the entire activity has been completed:

- 42 CFR §§ 422.134 as a whole and specifically §422.134(c)(1)(iv), (c)(1)(v), (c)(2)(i), and (d)(1)(i) to the extent the requirements for availability and eligibility for RI are broader than permitted in the Model;
- 42 CFR §§ 422.134(c)(2)(i) related to RI associated with Part D benefits;
- 42 CFR § 422.134(d)(2)(ii), related to the prohibition on offering a reward that has a value that exceeds the value of the target activity;
- 42 CFR 422.134(g)(1), related to anti-discrimination provisions implicated in the offering of RI to targeted enrollees.

- **Star Ratings for MAOs Participating in the VBID Model:** The following may be waived to the extent necessary to permit CMS to adjust the rules for calculating the Star Ratings for MAOs participating in the VBID Model to protect against a statistically significant negative impact to the Part C or Part D Star Ratings for MAOs that are not participating in the Model when the impact is directly attributable to participation in the Model:
  - 42 CFR 422.162 through 422.166 (Part C Star Ratings for participating MAOs); and
  - 42 CFR 423.182 through 423.186 (Part D Star Ratings for participating MA-PDs).

Note: *Please view the CY 2023 VBID Hospice Benefit Component RFA for information on programmatic waivers related to the Hospice Benefit Component of the VBID Model.*

CMS will not waive title XVIII's anti-discrimination provisions. Such a waiver is not necessary for the Model test because participating MAOs are required to implement Model interventions in a non-discriminatory manner. MAOs shall comply with section 1852(b)(1) of the Act concerning discrimination against enrollees in offering benefits and/or RI as part of participation in the Model.

Program waivers, once issued, are: (1) each contingent on compliance with the terms and conditions of the Model test, including the VBID Contract Addendum for participation in the Model test and documents incorporated therein; (2) granted **only to the extent necessary** for the Model test and to implement an MAO's approved proposal for participation; (3) granted only to MAOs for those PBPs for which CMS has approved a proposal; and (4) granted only for the term of the addendum for participation in the Model test. CMS reserves the right to revoke one or more of the Title XVIII waivers or to suspend Model testing (or both) at any point. Further, all other statutory and regulatory requirements (i.e., non-waived) will continue to apply and be enforced.

2. Model Design Elements

The VBID Model for CY 2023 consists of the components listed in Table 1 and detailed in sections 2.1 through 2.4; details on the Hospice Benefit Component can be found in the CY 2023 VBID Hospice Benefit Component RFA.

2.1 Wellness and Health Care Planning (WHP)

Currently, MAOs are required under 42 CFR 422.128 [10] to maintain written policies and procedures concerning advance directives for all adult enrollees. The regulation requires that MAOs provide, at the time of initial enrollment, their policies regarding advance directives and written information regarding an enrollee's rights under applicable state law to make health care decisions (including accepting or refusing treatment) and to formulate an advance directive. MAOs are similarly required to provide for community education regarding advance directives and to ensure documentation is maintained in a prominent part on an individual's current medical record as to whether or not the individual has executed an advance directive.

Building on these existing requirements regarding advance directives, CMS aims to better understand and encourage more systematic offerings of WHP, including advance care planning (ACP), using person-centered planning approaches.[11] Overall, WHP provides an opportunity for enrollees to discuss with their provider(s) preferences for the kind of care they would like to receive should they not have the capacity to do so at some time in the future, and if they so choose, to prepare ACP documents, including advance directives, explaining their wishes. Given the importance of enrollees receiving care consistent with their wishes, as a condition of receiving any program waiver granted in connection with this Model, MAOs must describe in their applications, receive approval for, and implement a **strategy** in CY 2023 that not only meets 42 CFR 422.128 but also furthers the delivery of WHP services and discussions, including ACP services and ACP completion.

Examples of potential WHP strategies include, but are not limited to, MAO infrastructure investments around WHP (e.g., digital platforms to support ACPs, improved access to ACP data), provider-focused initiatives around WHP education, and member focused initiatives (e.g. general outreach communications (such as providing information on how enrollees can access WHP services in the Evidence of Coverage and/or other materials provided to enrollees that describe their benefits), and individual outreach, and education opportunities). Additionally, MAOs participating in the Model may have a targeted strategy for subpopulations of their VBID enrollees to receive WHP, provided that a targeted strategy is combined with a strategy for all enrollees in all PBPs that participate in the Model. Because CMS seeks to support innovations in care delivery – in partnership with participating MAOs – that promote patient autonomy in health care and ACP decisions with the goal of improving the quality of care beneficiaries receive, WHP strategies may vary from MAO to MAO. Overall, CMS is interested in understanding Model participants' experience and successes in engaging enrollees and providers in WHP and ACP, consistent with

[10] See also sections 1852(i) and 1866(f) of the Act.
[11] See Secretary's Guidance on Implementing Section 2402(a) of the Affordable Care Act and The National Center on Advancing Person-Centered Practices and Systems.

CMS's test of how different approaches affect cost and quality of care. Additionally, CMS's objective is to extend WHP and ACP to more beneficiaries.

The broad scale of this WHP test, the engagement of health care provider practices within it, and the aligned efforts of private and public payers and integrated delivery systems are expected to lead to improvements in the delivery system infrastructure for accessing, maintaining, and updating advance directives. Better access to ACP documentation resulting from this test should improve its effectiveness and impact in avoiding unwanted and unnecessary care.

As part of their application, MAOs must include information such as:

- The mechanism(s) (e.g., Annual Wellness Visit, Health Risk Assessment, care/case management program, etc.) proposed to ensure the offering of WHP services to all enrollees;
- Any RI (as part an MAO's RI Program, as applicable) offered to enrollees for participating in WHP activities, as well as any RI offered to physicians or clinicians for offering WHP services to enrollees; and
- Ways that the MAO is leveraging technology (e.g., Electronic Health Record, Electronic Medical Record, provider/patient portal) to document and communicate WHP activities to its enrollees and/or enrollees' providers.

Each MAO must propose a robust approach and rationale towards supporting the effective implementation of WHP. MAOs must have a plan for capturing the data needed to monitor and track the provision of WHP, including specifics about ACP, and be prepared to report this information using the WHP Reporting Template to CMS at the conclusion of the calendar year. CMS may provide additional guidance to approved participants on WHP and/or ACP tracking and reporting and may request a review of an MAO's plan for tracking and reporting WHP and/or ACP if necessary. MAOs may propose, for CMS's consideration and potential approval, enrollee and/or provider RI to promote WHP, including proposals for subpopulations of enrollees.

CMS will review and consider the appropriateness of any proposed groups or targeted subpopulations of enrollees and the extent to which proposals demonstrate: that enrollees of similar circumstances will be approached similarly; that safeguards protect against fraud, waste and misuse are in place; and that monitoring of the appropriate receipt of RI occurs. CMS also reserves the right to terminate an accepted proposal based on a practice of inadequate enrollee protections.

2.2 VBID Flexibilities

In this section, CMS outlines how participating MAOs can target enrollees for value-based insurance design initiatives, such as additional primarily and non-primarily health related supplemental benefits and reduced or eliminated cost sharing, and safeguards for protecting enrollees.

All benefits described in this section 2.2 of the RFA and provided under the Model by participating MAOs must be mandatory supplemental benefits and must comply with all rules and requirements that apply to mandatory supplemental benefits, except for the specifically waived provisions where the conditions for the waiver are met (see section 1.5 of the RFA for the potential scope of waivers).

While certain benefits under the Model may be limited to certain targeted categories of enrollees, the benefit will be funded by rebates and/or premiums paid by all PBP enrollees, just like all mandatory supplemental benefits pursuant to 42 CFR 422.100(c)(2)(i)(A). In this respect, the Model's supplemental benefits would be similar to existing Special Supplemental Benefits for the Chronically Ill (SSBCI) supplemental benefits, Uniformity Flexibility (UF) supplemental benefits and enhanced disease management programs, which may be offered as a mandatory supplemental benefit but are only available to eligible, targeted enrollees.

2.2.1 Targeting by Condition and/or Socioeconomic Status or a Combination of Both

Participating MAOs may provide non-uniform supplemental benefits to targeted enrollees so long as they do so in a non-discriminatory manner and the targeting methodology is uniquely authorized by the VBID Model. The supplemental benefits that can be offered on a non-uniform and non-discriminatory basis include: (i) "non-primarily health related supplemental benefits" that have a reasonable expectation of improving or maintaining the health or overall function of the Targeted Enrollee; (ii) reductions in cost-sharing; and/or (iii) additional items and services that meet the criteria for supplemental benefits in § 422.100(c)(2)(ii). MAOs are also permitted to reduce or eliminate cost sharing for high-value providers.

MAOs may target enrollees for VBID benefits and services based on the following provided the resulting targeting methodology is not authorized within the overall Part C program:

1) Chronic health conditions(s);
2) Socioeconomic status (e.g., LIS eligibility);[12] or
3) A combination of both (e.g., enrollees who are LIS eligible and have COPD).

2.2.2 Allowable Targeting Criteria

Chronic Health Conditions: MAOs may choose both the chronic health condition(s) and a methodology to identify enrollees with the condition or combination of conditions. The methodology used to identify enrollees with the chronic health condition may be **broad** (using named diagnoses, such as congestive heart failure (CHF), or other means to identify enrollees with related diagnoses or conditions) or **narrow** (such as using a specific list of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes[13] or other data to identify enrollees with a specific level or intensity of a chronic health condition, such as frailty indicators).[14]

Overall, the targeting criteria, which are wider than when the Model was first implemented in 2017 for identifying chronic health conditions, will allow CMS to test the impact for a broad group of enrollees on cost and quality outcomes.

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[12] For information on LIS eligibility and for reports that contain LIS indicators, please refer to the Plan Communication User Guide at https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide.html

[13] ICD-10 Codes may be found at https://www.cdc.gov/nchs/icd/icd10cm.htm

[14] Kim DH, Schneeweiss S, Glynn RJ, Lipsitz LA, Rockwood K, Avorn J. Measuring Frailty in Medicare Data: Development and Validation of a Claims-Based Frailty Index. *J Gerontol A Biol Sci Med Sci*. 2018;73(7):980-987. doi:10.1093/gerona/glx229

As part of the application process, CMS will review and approve proposed targeting methodologies for use by the participating MAO. Targeting methodologies may be rejected if they do not reach a large enough cohort for meaningful evaluation of the intervention. While participating MAOs will have the opportunity to modify their benefit design for any or all of the targeted conditions, plan benefit design still must be uniform for enrollees within each condition category. This means that every enrollee who meets the criteria (using the approved methodology) established by the MAO and approved by CMS must be treated the same and have access to the intervention benefits. MAO determinations will be subject to retrospective, randomized audits by CMS to determine if all VBID-eligible enrollees actually received the VBID interventions.

Socioeconomic Status: MAOs may choose to target enrollees for VBID interventions based on socioeconomic status but may only use LIS status, as defined in the Plan Communication User Guide (PCUG) for MA-PDs, to identify those targeted enrollees. For the territories where the LIS status is not available, participating MAOs may identify targeted enrollees based on dual eligibility for both Medicare and Medicaid, using CMS identification of a dual-eligibility status in MARx. MAOs have the option of targeting enrollees eligible for LIS at any of the LIS subsidy levels. Within its application, an MAO must propose one or more of the four subsidy levels.

MAOs must identify how the HRSNs for targeted enrollees in this category will be addressed by the supplemental benefit identified in the MAO's proposal. Supplemental benefits targeted to enrollees based on socioeconomic status include disease management programs, reductions in cost sharing (tied to specific benefits or to high-value providers), and/or coverage of additional items and services, including an expanded list of non-primarily health related benefits allowed under the VBID Model (see section, Additional Non-Primarily Health Care Related Supplemental Benefits, for more information about non-primarily health related benefits).

In sections 2.2.3 through 2.2.6, CMS outlines the options under the VBID Flexibilities component that may be offered by participating MAOs to targeted enrollee populations. These include primarily and non-primarily health related supplemental items and services (including new and existing technologies or FDA approved medical devices), reduced cost sharing for Part C services and reduced cost sharing for covered Part D drugs (for participating MA-PDs), and use of high-value providers and/or participation in disease state management program.

2.2.3 Primarily and Non-Primarily Health Related Supplemental Benefits

Participating MAOs are permitted to make supplemental benefits under the Model available only for targeted enrollees. See section 2.2.2 for requirements for targeting enrollees. Unless waived and the conditions for the waiver are met, supplemental benefits offered by a participating MAO must comply with all MA program rules and requirements, as interpreted by CMS and consistent with CMS guidance (see e.g., 42 CFR 422.102; Medicare Managed Care Manual, Ch. 4, section 30).

Additionally, through the Model, participating MAOs have the ability to offer non-primarily health related supplemental benefits to targeted enrollees, beyond the statutorily-defined "chronically ill enrollee," provided that such benefits have a reasonable expectation of improving or maintaining

the health or overall function of the targeted enrollee. For purposes of this intervention, participating MAOs may use one of the following targeted populations:

(1) Enrollees who qualify for the LIS (or in the case of the Territories, enrollees who qualify for dual eligibility in Medicare and Medicaid);
(2) Enrollees who have one or more chronic or other health conditions, but that are not within the scope of the statutory definition of "chronically ill enrollee" in section 1852(a)(3)(D)(iii) of the Act and the implementing regulation at § 422.102(f)(1)(i). To be approved for this type of targeted population, the MAO must specify in its application what non-primarily health related benefits it will provide for this intervention and to which targeted enrollee group the benefits will be available.
(3) A combination of the factors identified in categories (1) – (3) above.

Primarily health related items or services must diagnose, prevent or treat an illness or injury; compensate for physical impairments; act to ameliorate the functional or psychological impact of injuries or health conditions; or reduce avoidable emergency and healthcare utilization.

For a non-primarily health related item or service, participating MAOs may – in a targeted way outlined above – address a specific deficit for a set of enrollees that results in deteriorated health and any resultant increase in the utilization of health care services or costs of care. Any non-primarily health related benefit offered under the Model must have a reasonable expectation of improving or maintaining the health or overall function of the targeted enrollee. MAOs that target supplemental benefits to targeted enrollees (see section 2.2.2) must offer and cover the benefit uniformly for all eligible enrollees targeted for intervention. Further, when offering non-primarily health related benefits under this Model, participating MAOs must comply with 42 CFR § 422.102(f), except for the provisions that have been explicitly waived under the Model (see section 1.5).

The non-primarily health related supplemental benefits that CMS will consider approving to be offered under the Model include, but are not limited to:

- food and produce;
- meals (beyond the current allowable limits);
- transportation for non-medical needs;
- indoor air quality equipment and services;
- access to community or plan-sponsored programs and events to address social needs (such as non-fitness club memberships, community or social clubs, park passes, family counseling, martial counseling, access to companion care, classes for enrollees with primary caregiving responsibilities, or events to address enrollee isolation and improve emotional and/or cognitive function, etc.);
- complementary therapies (offered alongside traditional medical treatment);
- services supporting self-direction;[15]

[15] These services allow enrollees to have the responsibility for managing all aspects of healthcare delivery in a person-centered planning process; while such services are a non-primarily health related benefit, they may have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee. Plans may provide services to assist in the establishment of decision-making authority for healthcare needs (e.g., power of attorney for health services) and/or may provide education such as financial literacy classes, technology education, and language classes. Plans may not include expenses for funerals as a covered benefit.

- structural home modifications;
- general supports for living, which may include plan-sponsored housing consultations; subsidies for rent or assisted living communities; and/or subsidies for utilities such as gas, electric, and water as part of the benefit; and
- pest control.

Aligned with the MA program, MAOs may propose to offer primarily and non-primarily health related supplemental benefits in aggregate as a "package" supplement benefit, that enrollees may choose from, as aligned with their medical and social needs and wishes.

Where appropriate, MAOs may also propose spousal sharing of non-primarily health related supplemental benefits when spouses are enrolled in the same participating plan and meet the eligibility requirements used by the MAO (for that specific VBID participating PBP) for the non-primarily health related supplemental benefit.

In providing VBID supplemental benefits that are not furnished or prescribed by a health care provider, MAOs must use the same processes as currently allowed for coverage of OTC supplemental benefits (see Chapter 4 of the Medicare Managed Care Manual, section 40), including, where appropriate, requiring documentation from an enrollee's provider or care team of the necessity of an item or service or that the item or service has a reasonable expectation of improving or maintaining the health or overall function of the targeted enrollee. MAOs must include safeguards that prevent fraud, waste, and abuse, including any misuse or inappropriate provision of these items or services and potential resale (see section 2.5, Enrollee Safeguards, for information on general enrollee safeguards).

MAOs must identify in their applications the items and services that they propose to offer under this flexibility, and must be prepared to provide the rationale for offering the non-primarily health related supplemental benefits, including expected improvements in health outcomes.

2.2.4 Reductions in Cost Sharing for Part C Items and Services and Covered Part D Drugs

Participating MAOs may reduce or eliminate cost sharing for items or services covered by the MA plan, including Part D benefits covered by a participating MA-PD plan. The covered benefits subject to the reductions in cost sharing must be identified by the MAO in its application with an explanation of how each benefit is high-value for the target population. Participating MAOs have broad flexibility to choose which items or services are eligible for cost sharing reductions (including for high-value services and services offered by high-value providers); however, these items or services must be clearly identified and defined in the application and in advance to the eligible target population. Reductions in cost sharing must be uniformly available to all enrollees within the target population and administered in a non-discriminatory fashion.

Reductions in cost sharing may include: (a) elimination or reduction of co-pays, (b) elimination or reduction of co-insurance, or (c) exemption of a given service from the plan deductible. These examples of modification to cost sharing are not exhaustive; MAOs can propose other approaches to reducing cost sharing.

Examples of cost sharing reductions within this category might include the elimination of co-pays for primary care or specialist visits for enrollees who qualify for LIS status; or the reduction of condition-specific covered Part D drug co-pays (e.g., all generic Angiotensin-converting enzyme (ACE) inhibitors, Angiotensin II Receptor Blockers (ARBs), calcium-channel blockers, beta-blockers, diuretics, and statins) for enrollees with CVD.
Participating MAOs cannot make cost sharing reductions conditional on achieving any specific clinical goals (e.g., an organization cannot condition cost sharing reductions on enrollees achieving certain thresholds in HbA1c levels or body-mass index). In general, this reduced cost sharing approach may not be structured in a discriminatory manner, and all applicable targeted enrollees must have the opportunity to participate in the activities in question (or an alternative), regardless of health status, location, or disability. The underlying disease management or similar program must comply with all otherwise applicable rules and regulations.

2.2.5 Use of High-Value Providers and/or Participation in Care Management/Disease State Management Programs

MAOs may also make the provision of additional supplemental benefits (including reductions in cost sharing) for targeted enrollees conditional on: (i) the use of high-value providers and/or (ii) participation in a care management/disease state management program.

For participating MAOs utilizing this approach, targeted enrollees must be clearly informed which providers are considered high-value, along with any supporting rationale to encourage uptake and enrollee engagement and understanding. In their applications, MAOs must provide the rationale and standards for how it will identify high-value providers for use in this intervention. CMS will only accept proposals where it agrees that the criteria used to select the providers are reasonably constructed to ensure that the providers identified are high-value for enrollees in the selected group (i.e., by chronic health condition, LIS eligibility or a combination of both).

High-value providers can include physicians and practices, hospitals, skilled-nursing facilities, home health agencies, ambulatory surgical centers, and others. High-value providers cannot include pharmacies. MAO determination of high-value providers cannot be solely based on cost or efficiency, and therefore must also include relevant quality considerations and/or criteria, such as those related to health equity. Identification of high-value providers must be prefaced on a sound evidence base, such as independent, external metrics when determining whether a provider is high-value. Examples of such metrics might include whether a primary care practice is a National Committee for Quality Assurance (NCQA) certified medical home, whether a hospital has American Heart Association advanced certification in heart failure, or whether a provider meets certain performance metrics on National Quality Forum (NQF) validated quality measures. However, more or locally specific approaches also may be proposed with accompanying clinical justification. In addition, organizations cannot identify high-value providers based on coding accuracy or intensity alone.

Other examples of high-value providers include providers that qualify as Essential Community Providers (ECPs) under 45 CFR 156.235[16] and other similar providers who predominantly serve underserved populations (e.g., providers serving a majority of enrollees living in areas identified by the CDC/ATSDR Social Vulnerability Index[17] or the Area Deprivation Index[18] or providers serving predominantly dual-eligible enrollees). High-value providers can also include those who provide care through an Area Agency on Aging, Aging and Disability Resource Center, or Center for Independent Living (statutorily defined in section 102 of the Older Americans Act of 1965 [42 U.S.C. 3002] and section 702 of the Rehabilitation Act of 1973 [29 U.S.C. 796a]).[19] These providers demonstrate high value in their potential to increase quality through culturally competent care, offering of both medical and social needs, such as language services that meet enrollee language preference(s), and increased continuity of care for enrollees in underserved areas.

MAOs do not need to meet any specific quantitative network adequacy or access standards for the subset of high-value providers selected. However, all VBID interventions – including high-value providers - must be available and accessible to applicable targeted enrollees. CMS may require an MAO to modify its intervention in cases where accessibility is inadequate and lack of accessibility impacts performance in a manner inconsistent with the goals of the Model. Certain patterns of inaccessibility of care may constitute prohibited discrimination or a failure of the MAO to make high-value providers accessible or to meet generally applicable MA access standards. Notwithstanding the Model intervention(s), MAOs must still meet all current MA network adequacy standards (see 42 CFR 422.112, 422.116 and CMS guidance). All plan enrollees, including those targeted by this Model, retain the right to see any provider in network at any time (at non-VBID levels of cost sharing), without penalty or restriction. Additionally, participating MAOs may not condition access to high-value providers or lower cost-sharing on the enrollee meeting specific health measurements (e.g., conditioning lower cost-sharing on maintaining specific blood pressure ranges).

Participating MAOs may not remove a provider from the roster of high-value providers during a contract year; unless the provider is terminated from the network, the provider requests exclusion from the high-value network or, with the concurrence of CMS, exclusion from the high-value network is warranted in the best interests of enrollees. All changes to the roster of high-value providers must be treated, with respect to VBID-eligible enrollees and notification to the Model administration team, in the same manner as if they were significant changes to networks under Chapter 4, section 110.1.2 of the Medicare Managed Care Manual and 42 CFR § 422.62(b)(23) regardless of whether such changes are considered "significant" with respect to the network-at-large.

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[16] ECPs include Federally Qualified Health Centers, entities receiving grants under 340A, Native Hawaiian Health Centers receiving funds under the Native Hawaiian Health Care Act of 1988, and many other entities (see section 340b340B of the Public Health Service Act for a full list of qualifying entities here: https://www.hrsa.gov/sites/default/files/opa/programrequirements/phsactsection340b.pdf.

[17] https://www.atsdr.cdc.gov/placeandhealth/svi/at-a-glance_svi.html

[18] https://www.neighborhoodatlas.medicine.wisc.edu/

[19] An Area Agency on Aging, Aging and Disability Resource Center, or Center for Independent Living that is Medicare-certified directly qualifies as a high-value provider.

Additionally, participating MAOs can condition reductions in cost sharing for an item or service, including Part D drugs covered by MA-PD plans, on participation in a plan-sponsored disease management or similar program. A plan-sponsored disease management or similar program could include an enhanced disease management program, offered by the plan as a supplemental benefit, or it could refer to specific activities that are offered or recommended as part of a plan's basic care coordination activities. Examples of interventions within this category might include elimination of primary care co-pays for diabetes patients who meet regularly with a case manager or reduction of prescription drug co-pays for patients with cardiovascular disease who regularly monitor their blood pressure and are part of a plan's disease state management program.

2.2.6 Flexibility to Cover New and Existing Technologies or FDA Approved Medical Devices

This VBID supplemental benefit flexibility allows MAOs to propose to cover new and existing technologies and medical devices that are FDA approved and that do not fit into an existing Medicare benefit category for targeted populations (chronic health conditions and/or LIS status) that would receive the highest value from the new technology. As an option available under the VBID supplemental benefit flexibility, this Model component allows MAOs to offer supplemental benefits on a non-uniform basis to determine whether these technologies will reduce program costs or improve the quality of care for enrollees targeted for these technologies.

Today, MAOs may elect to cover new and existing FDA approved technologies that are not covered by Original Medicare. Such additional healthcare items or services can be covered as a supplemental benefit paid using the rebate under section 1854 of the Act or supplemental premiums paid by enrollees. Currently, MAOs cover many additional healthcare items and services, including some newly developed or newly FDA approved technologies and medical devices, compared to Original Medicare coverage. The VBID flexibility for supplemental benefits may allow for more coverage of technologies for targeted populations that would receive the highest value from the new technologies.

Consistent with existing MA rules for supplemental benefits, participating MAOs would be permitted to provide coverage for: (i) an FDA approved medical device or new technology that has a Medicare coverage determination (either national or local) where the MA plan seeks to cover it for an indication that differs from the Medicare coverage determination and the MAO demonstrates the device can be medically reasonable and necessary for the other indication; and (ii) for new and existing technologies that do not fit into an existing Medicare benefit category. <u>These are benefits uniquely authorized by the Model to be offered to Targeted Enrollees.</u>

Under MA bidding requirements (e.g., § 422.254), MAOs must treat this coverage as a mandatory supplemental benefit that is paid for using rebates as part of bid development and must factor in any projected reduction in utilization of Part A or Part B benefits in the A/B bid.

In order to ensure at least budget neutrality of the VBID Model, as part of their application, MAOs must project or show, in year one or over the duration of the Model, the accounting of costs and utilization of the new or existing technology or device (covered as a supplemental benefit paid for using the rebates) and a resultant direct reduction in A/B utilization due to the use of the technology

or device. CMS will require MAOs to share negotiated costs and other information as necessary to inform Medicare coverage determination and pricing.

2.2.7 Benefits Uniquely Authorized by the Model

CMS is clarifying that the VBID Model will test only those interventions within each Model component (with the exception of the WHP component) that are uniquely authorized by the VBID Model, and that are not authorized through flexibilities within the broader Part C Program, outside the Model. Given this, it's important to be aware of flexibilities granted outside the VBID Model, including (1) expansion of the interpretation of what items and services are "primarily health related;" (2) the ability to offer benefits that are tied to disease state or health status in a manner that ensures that similarly situated individuals are treated uniformly and where there is a nexus between the health status or disease state and the specific benefit package designed for enrollees meeting that health status or disease state; and (3) the authorization for special supplemental benefits for the chronically ill (SSBCI) under section 1852(a)(3)(D) of the Act and 42 CFR § 422.102(f). The following provides detail on each of these and the differences with VBID Flexibilities.

CMS invites MAOs to reach out to CMS with any questions and/or if interested in a working discussion on any interventions that an MAO may be considering for possible inclusion within the VBID Model or continuation in the Part C Program via the VBID mailbox at VBID@cms.hhs.gov.

Expansion of "Primarily Health Related"
In the Final CY 2019 Call Letter,[20] CMS reinterpreted the criteria used to identify permissible supplemental benefits. Under longstanding guidance, which has recently been codified at 42 CFR § 422.100(c)(2),[21] CMS requires supplemental benefits to: (1) be not covered by Medicare Parts A, B or D; (2) be primarily health related; and (3) cause the MA plan to incur a non-zero medical cost. CMS reinterpreted the standard "primarily health related" to use a broader approach for approving MA plans' supplemental benefit offerings. Under the reinterpretation, plans may offer items and services as supplemental benefits if the items and services:

1. Diagnose, prevent, or treat an illness or injury;
2. Compensate for physical impairments;
3. Act to ameliorate the functional/psychological impact of injuries or health conditions; or
4. Reduce avoidable emergency and health care.

As stated in the CY 2019 Final Call Letter, items or services that are "solely or primarily used for cosmetic, comfort, general use, or social determinant purposes" do not meet its new definition. All supplemental benefits must be offered uniformly to all enrollees.

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[20] See Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information (cms.gov).
[21] See the final rule titled, Medicare and Medicaid Programs; Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All Inclusive Care for the Elderly (86 FR 5864). In that rule, CMS codified the longstanding guidance with the relatively new interpretation noted here.

In addition, section 1853(a)(3)(D) of the Act was amended in the Bipartisan Budget Act of 2018 to authorize MA plans to offer a new type of supplemental benefits, which can be non-primarily health related, to "chronically ill enrollees."[22] The statute specifically defines "chronically ill enrollee" as meaning an enrollee in an MA plan that the Secretary determines—

> (I) has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;
> (II) has a high risk of hospitalization or other adverse health outcomes; and
> (III) requires intensive care coordination.

This new type of supplemental benefits, termed "special supplemental benefits for the chronically ill" by CMS, are not required to be primarily health related so long as the item or service has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee. In addition, the statute authorizes CMS to waive uniformity requirements for MA plans to offer this new type of supplemental benefit.

Unique to the VBID Model, primarily health related supplemental benefits may be targeted to enrollees with LIS eligibility.

Uniformity Flexibility

In the CY 2019 Final Call Letter and an April 2018 final rule,[23] CMS also adopted a reinterpretation of the requirement that MA plans offer uniform benefits. CMS determined that providing access to services (or specific cost sharing for services or items) that are tied to health status or disease state in a manner that ensures that similarly situated individuals are treated uniformly is consistent with the uniformity requirement in the MA regulation at 42 CFR § 422.100(d). Under this interpretation, CMS permits MA plans to offer tailored supplemental benefits or cost sharing for similarly situated individuals based on disease state.[24] This uniformity flexibility is not applicable to Part D benefits.

Unique to the VBID Model, cost sharing reductions or eliminations may be targeted to enrollees based on LIS eligibility; or a combination of both chronic health condition and LIS eligibility. Also unique to the VBID Model, Part D cost sharing reductions or eliminations may be targeted to enrollees with chronic health condition(s); LIS eligibility; or a combination of both chronic health condition and LIS eligibility.

SSBCI

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[22] CMS has also recently codified a regulation regarding these new benefits. See the final rule entitled "Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program" (85 FR 22796) and 42 CFR § 422.102(f).

[23] See the final rule titled, "Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program" (83 FR 16440)

[24] CMS also discussed this and issued guidance about this policy in an HPMS memo. CMS Memorandum from Kathryn A. Coleman, Director: Reinterpretation of the Uniformity Flexibility. April 27, 2018. Retrieved from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Annual

The BBA of 2018 (Pub. L. 115-123) included new authorities concerning supplemental benefits that may be offered to chronically ill enrollees in MA plans, specifically amending section 1852(a)(3) of the Act to add a new subparagraph (D) authorizing a new category of supplemental benefits that may be offered by MA plans. Specifically, the BBA of 2018 amended section 1852(a)(3) of the Act to: (1) authorize MA plans to provide additional supplemental benefits that have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee to chronically ill enrollees; (2) permit those additional supplemental benefits to be not primarily health related; (3) define "chronically ill enrollee" to limit eligibility for these additional supplemental benefits; and (4) authorize CMS to waive uniformity requirements in connection with providing these benefits to eligible chronically ill enrollees. These benefits are referred to as SSBCI. Specifically, plans may offer supplemental benefits that are "non-primarily health-related" non-uniformly to eligible chronically ill enrollees.

As defined in Section 1852(a)(3)(D)(ii) of the Act, chronically ill enrollee is as an individual who:

- Has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;
- Has a high risk of hospitalization or other adverse health outcomes; and
- Requires intensive care coordination.

Additionally, SSBCI benefits must have a reasonable expectation to improve or maintain health or overall function related to chronic health condition or illness.

Unique to the VBID Model, non-primarily health related benefits and Part D cost sharing reductions or eliminations may be targeted to enrollees with chronic health conditions and/or LIS eligibility.

2.3 Part C and Part D Rewards and Incentives

Currently, MAOs are authorized to offer RI Programs under 42 CFR 422.134 in connection solely with MA (i.e., Part A, Part B, and Part C supplemental) benefits. Under the regulation, RI must not exceed the value of the health related services or activity for which the RI is provided nor be offered in the form of cash, cash equivalents, or other monetary rebates (including reduced cost sharing or premiums). Additionally, under 42 CFR 423.128, Part D sponsors may provide RI to enrollees who use the beneficiary real time benefit tool (RTBT) beginning in CY 2023, provided the RI complies with regulation, and the RI information is made available to CMS upon request. Otherwise, RI programs in connection with the Part D benefit are not permitted.

In order to test the cost and quality of care impact of a service delivery model that permits MAOs to provide higher-value RI and RI Programs in connection with Part D prescription drug benefits, MAOs participating in this Model for CY 2023 will be permitted flexibilities (which are not available outside of the Model) to design RI Programs as described in this section. These flexibilities include the below.

- MAOs may propose to use RI with a value that reflects the expected *benefit of the service or activity*, rather than just the cost of the health related service or activity, up to $600 annually per enrollee. Of note, an annual aggregate limit of $600 per enrollee applies to all RI provided by a single PBP across the VBID Model and the Part D Senior Savings (PDSS)

model.[25] An MA-PD that participates in both this Model and the PDSS model may offer RI Programs under each model, but the combined value of all RI provided to an enrollee in the PBP under the two models may not exceed $600 annually. Additionally, the MA-PD cannot provide a reward or incentive under any RI Program in this Model to a Targeted Enrollee in connection with the same healthcare activity or service that Targeted Enrollee completed to be eligible for any reward or incentive in the PDSS Model.

- MAOs offering MA-PD plans may propose to use an RI Program for the *Part D benefit* covered by a participating MA-PD plan.[26]
- MAOs may propose an RI Program specific to participation in a disease management or transition of care program;
- MAOs may propose to limit the RI Program to targeted enrollees (rather than all enrollees in the PBP) such that only targeted enrollees (who engage in the target service or activity) are eligible for the RI (meaning, other enrollees who engage in the same service or activity are not eligible for the RI);
- MAOs may propose multiple RI in a PBP as long as the activities/steps that an eligible enrollee must complete to receive the reward and incentive are specific and distinct between each reward and incentive offered; and
- MAOs may propose other RI Programs, approved by CMS on a case-by-case basis as supported by evidence and justified by MAOs, that use the programmatic waivers authorized under the VBID Model.

Unless waived or additionally authorized under this Model, participating MAOs must follow all of the RI requirements at 42 CFR 422.134; these standards will apply to Part D RI Programs offered under the Model as well. This includes limitations on the type of activity for which a reward may be provided and parameters on the development and administration of an RI program as well as limits on what may be used as a permissible reward. See section 1.4 above for a discussion of programmatic provisions in 42 CFR 422.134 that may be waived to provide participating MAOs additional flexibility in offering RI Programs in the Model. MAOs must implement Model RI Programs in a manner that complies with all fraud and abuse laws, including when applicable, the anti-kickback statute and civil monetary law prohibiting inducements to beneficiaries.

Model Part D RI Programs

Participating MAOs that offer MA-PD plans may propose Part D RI Programs under this Model that, in connection with medication use, focus on promoting improved health, medication adherence, or the efficient use of health care resources. All proposed Model Part D RI Programs must be designed to encourage enrollees to use Part D covered medications in ways that lead to improvement in at least one of these three areas (i.e., health outcomes, medication adherence, and the efficient use of health care resources).

Provided below are general rules governing the Part D RI Programs in this Model. Any Part D RI Program offered under this Model should aim to strengthen the linkage between enrollees and

[25] A Part C or Part D reward or incentive provided by a PBP outside of any Model is not subject to the aggregate cap.

[26] RI Programs may not incentivize avoidance of medically necessary care.

members of the care team, such as pharmacists and providers, to facilitate better understanding of clinically-equivalent therapeutic options, coverage provided by the MA-PD plan, and the overall value to their health of adherence to their prescribed drug therapy.

Permissible MA-PD Part D RI Program Designs Options Generally
Part D RI Programs under this Model must fit within one or more of the following designs of an RI Program:

1. Part D RI Programs may be designed for enrollees who have specific conditions or enrollees who would otherwise benefit from participation in disease state management programs.
2. Part D RI Programs may be designed to provide RI for participating in plan sponsor medication therapy management (MTM) programs.
3. Part D RI Programs may be designed to provide RI for enrollees who participate in preventive health services, such as receiving covered Part D vaccines.
4. Part D RI Programs may be designed to allow enrollees to better understand their Part D plan benefits, costs, and therapeutic-equivalent coverage alternatives, including biosimilars and generics.

Impermissible MA-PD RI Programs
MAOs approved to offer RI Programs under this Model **must not**:

1. Provide an RI to a Medicare beneficiary who is not enrolled in a Model PBP, except as permitted by 42 CFR § 423.128(d)(5);
2. Structure a Part D RI Program to:
    a. Use prescription fills or adherence as the sole basis for providing a RI;
    b. Incentivize enrollees to use mail service pharmacies, preferred pharmacies or any other specific network or contracted providers;
    c. Discourage clinically indicated medication use, or otherwise reward enrollees not taking any, or taking few, Part D covered drugs or vaccines;
3. Provide RI in the form of cash, cash equivalents, or other monetary rebates or in the form of decreased cost-sharing or plan premiums. For example, a gift card to a pharmacy or grocery store that can be used to pay cost-sharing on prescription drugs is prohibited. If an MAO wishes to provide RI in a form that beneficiaries can use to purchase products or services that may also be covered as an MA supplemental benefit, such as over-the-counter drugs, transportation, or groceries, the MAO must ensure that the RI cannot be used to decrease cost-sharing on those supplemental benefits. If a supplemental benefit is offered as a dollar amount without any cost-sharing obligation on the part of the beneficiary, then RI that can be used to cover the cost of the same or similar items after the supplemental benefit is applied is not prohibited. An MAO will need to ensure that communications to beneficiaries make clear the distinction between the RI and supplemental benefit;
4. Provide RI that can be used for the purchase of alcohol, tobacco, gambling or firearms;
5. Identify targeted enrollees based on the identity of their pharmacy provider;
6. Receive or use funding, in-kind resources, or any kind of remuneration provided directly or indirectly by a drug manufacturer. This includes, but is not limited to, the use of personnel affiliated with a drug manufacturer, manufacturer-financed coupons or discounts provided to a beneficiary, or manufacturer supplied education materials;
7. Receive or use funding, in-kind resources, or any kind of remuneration provided directly or indirectly by a pharmacy or entity that owns or operates pharmacies. This includes use of

personnel affiliated with a pharmacy, pharmacy-financed coupons or other discounts provided to a beneficiary, or pharmacy supplied education materials;

8. Provide RI to a targeted enrollee in a PBP participating in the VBID Model in connection with the same healthcare activity or service that the Targeted Enrollee completed to be eligible for a reward or incentive under the PDSS Model;
9. Use a RI Program largely to market a PBP or encourage beneficiaries to remain with a specific plan;
10. Use a RI Program to, in any way, choose or solicit healthier (or sicker) enrollees over enrollees who the MA Plan believes may be less healthy;
11. Create a RI Program that discriminates against enrollees based on race, national origin, limited English proficiency, gender, disability, chronic disease, whether a person resides or receives services in an institutional setting, frailty status, health status, or other prohibited basis; or
12. Use a RI Program that allows RI to be won based on probability or that do not meet the standards described in 42 CFR § 422.134(d), excluding § 422.134(d)(2)(ii).

Other Requirements for RI Programs

1. RI must be tangible items that align with the purpose of the RI Program and must directly benefit the Targeted Enrollee. For example, a plan's charitable contribution made on behalf of the Targeted Enrollee is not a permissible RI because the enrollee who earned the reward does not benefit directly from such a contribution by the MA-PD plan. However, the use of points (which are not themselves tangible) to purchase a tangible reward may be permissible because the points are used by each enrollee to obtain a tangible reward that is of value to the enrollee.
2. RI Programs must be completed by the end of a plan year. For MAOs using a gift card for a RI, any unspent value could carry over into the next plan year for enrollees' use but participating MAOs may not require additional actions by the enrollee in the next plan year to receive that reward or incentive.
3. Any RI offered under RI Programs must be:
   (i) limited to a value that may be expected to impact enrollee behavior;
   (ii) limited to the value of the expected benefit of the associated activity or service (but may exceed the cost of the activity or service); and
   (iii) subject to an annual limit of $600 per enrollee in the aggregate for all RI provided by a single PBP under this Model and under any Part D RI Programs under other the PDSS Model (as discussed above).
4. For Part D RI Programs, participating MA-PD plans must reasonably establish value for the successful medication adherence or formulary compliance for which they offer RI.
5. MAOs must implement Part D RI Programs in a manner that complies with all applicable fraud and abuse laws, including the anti-kickback statute and civil monetary law prohibiting inducements to beneficiaries.

RI Program Application

Applications must detail the RI Programs under the VBID Model that the participating MAO wishes to use, for CMS review and approval, including any changes in the design of the RI Program(s) for MAOs that previously participated in the VBID Model. In their RI proposal(s) within their applications, MAOs must include: information on the nature, frequency, delivery format (such as gift cards), and goals of the rewards; eligibility criteria the enrollee must satisfy

to receive the reward (including targeting criteria if applicable); and the target activity that must be completed in order to receive the reward.

More generally, CMS will review all proposed RI Programs based on the rationale and theory for the reward or incentive; the targeted population if the RI Program is targeted (otherwise, the criteria used for eligibility for the RI); how the plan defines the value of the reward to total cost of care; and the expected health outcomes and cost and savings effect of its proposed intervention. As part of the application process, CMS may offer guidance on what may or may not be acceptable in an MAO's specific proposal. The RI Program must be included in the participating plan's bid as a non-benefit expense for the applicable bid (i.e., in the MA or the Part D bid). CMS, in its sole discretion, reserves the right to accept or reject any RI Program proposal.

Model RI Program Monitoring
As part of monitoring VBID Model participation, CMS will require participating MAOs that have RI Programs to report and maintain records regarding the number and dollar amounts of RI earned regarding these RI Programs in a form and manner determined by CMS. If CMS determines that a RI Program is not in compliance with the Model, CMS may impose sanctions or civil monetary penalties on the MAO in accordance with 42 CFR 422.723 or § 423.752.

2.4 Enrollee Safeguards

MAOs must not propose reductions in targeted enrollee benefits or increases in targeted cost-sharing amounts as VBID interventions.

MAOs shall permit eligible enrollees to opt out of additional supplemental benefits provided under the Model at any time. Additionally, if after opting out of the benefits provided under the Model or a component of the Model, if an enrollee (who meets the criteria to be a Targeted Enrollee) wishes to regain eligibility for or access to the benefits (or the RI under a Model RI Program) provided under the Model or a Model component, MAOs must honor that request and begin or resume providing the Model Benefits (or Model RI) provided under the Model or eligibility for or access to a Component to the enrollee prospectively.

CMS reserves the right to reject proposals that may pose an undue risk of enrollee harm or confusion, have potential to impose excessive costs on the Medicare program, or are inconsistent with the implementation and evaluation objectives of the Model. CMS also reserves the right to reject proposals that discriminate against non-targeted populations, for example in cases where VBID interventions are coupled with changes made to the plan-at-large in ways that decrease the benefits available to enrollees with non-targeted clinical conditions.

CMS will carefully review proposals using VBID flexibilities for non-uniform benefit designs, including proposals for administering primarily and non-primarily health related benefits, for protections against misuse of the reduced cost sharing or supplemental benefits. CMS will review and consider the appropriateness of any targeted enrollees and the extent to which proposals demonstrate that enrollees in a subpopulation of similar circumstances are treated similarly. CMS will also review to ensure that safeguards protecting against fraud, waste and misuse are in place; and that monitoring of the appropriate receipt of RI occurs. Finally, CMS will review the plan's

projections and justification of expected cost savings and quality of care improvements for the targeted population(s) that are anticipated as a result of participation in the Model and the various benefits and RI Programs available under the Model.

CMS also reserves the right to reject proposals that, as determined solely through CMS' discretion, may result in beneficiary inducement, potential fraud, waste, and abuse, decreased beneficiary plan choice or mobility, or other negative impact to Medicare beneficiaries or CMS generally.

CMS reserves the right to terminate an MAO's participation in the Model or exercise other available remedies at any time for a number of reasons, including but not limited to the following: if the MAO has failed to comply with the terms of the Model; the MAO is subject to investigation or sanctions for program integrity issues; or if CMS determines that there are inadequate enrollee protections or that the organization's participation in the Model, or its performance of model activities, may compromise the integrity of the Model, including by resulting in lower quality care or adverse outcomes for enrollees or the Model.

3. Model Requirements

The VBID Model eligibility requirements are outlined below for interested MAOs. Participating MAOs must meet the requirements of the Model communication and marketing guidance, monitoring, bidding, and other general CMS oversight to ensure beneficiary protections while participating in the Model. CMS will reserve the right to impose a corrective action plan or take other remedial actions, including termination from the Model test to rectify or address a failure to adhere to Model requirements.

Further, an MAO's failure to adhere to the requirements of the Model test may result in rescission or invalidation of any program or payment waiver issued by CMS to that MAO, which could trigger enforcement action by CMS related to the waived requirements. All other regulatory and statutory requirements applicable to the MAO will remain in effect. Failure by an MAO to comply with those requirements could result in enforcement action consistent with the authority of the MA program, including intermediate sanctions or contract termination.

3.1 Eligibility Requirements

Participation in the VBID Model is voluntary. The Model is open for participation to MAOs at the individual plan benefit package (PBP) level. MAOs may propose one or multiple MA and MA-PD contracts and/or plans for participation. All MAOs applying to participate in the any Component of the Model in CY 2023, including existing participants, must submit an application to CMS by the application deadline. Refer to the CY 2023 VBID Hospice Benefit Component RFA for instructions for how to apply to participate in that Component of the Model in CY 2023.

Note that all segments[27] of PBPs that the MAO wishes to include in the Model must be included in the Model for participation. Additionally, consistent with current rules for MA plans with

[27] Segments are county-level portions of a plan's overall service area.

segments, MAOs may vary Model Benefits and Model Part C RI Programs by segment so long as the supplemental benefits, premium and cost-sharing are uniform within each segment of an MA plan's service area (See section 1854(h) of the Act; §§ 422.100(d)(2), 422.262(c)(2); 83 FR 16440). *However*, this does not apply to Model components related to Part D or the Hospice Benefit Component, which must be similarly provided across all segments within a PBP.

While exceptions may be granted by CMS as outlined below, eligible MA PBPs must meet the following criteria:

- **Plan Type:**
  - The following MA only and MA-PD plan offerings are eligible to apply:
    - CCPs, including HMOs, HMO-POS, PPOs, RPPOs; and
    - All SNPs, including C-SNPs, D-SNPs, and I-SNPs.

  - The following plan types are **not** eligible to participate in this Model:
    - PFFS Plans;
    - EGWPs;[28]
    - MMPs or other demonstration plans;
    - MA MSA Plans;
    - Cost Plans; and
    - PACE organizations.

- **Length of Plan Existence:**
  - At least one of the MAO's MA plans/PBPs listed in the application for the Model must have been offered in at least three annual coordinated elections (open enrollment) periods prior to the open enrollment period for CY 2023 (i.e., offered in open enrollment for 2020, 2021, and 2022).

- **Plan Performance and Compliance:**
  - In the last 12 months from the date of application submission, the MAO's contract offering the PBP is not and has not been under sanction by CMS, as described in 42 CFR 422.750 and 42 CFR 423.750.
  - CMS may deny an application on the basis of information obtained from a program integrity screening or patterns of consistent low performance.

In regards to plan type, although an individual market MA plan that is one of the eligible types outlined above may participate in the Model while contracting with an employer, labor organization, or the trustees of a fund established by one or more employers or labor organizations for the enrollment of members of a group health plan *into the individual MA plan*, benefit design waivers are prohibited in connection with Model Benefits (e.g., actuarial swapping or actuarial equivalence of Model Benefits). See Medicare Managed Care Manual, Chapter 9 sections 10 -

[28] This exclusion applies to EGWPs that are offered exclusively to employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations and that exclusively enroll members of group health plans.

10.2[29] and Appendix 2 for discussion of the differences between an individual MA plan that enrolls members of these group health plans and EGWPs. EGWPs that enroll only members of plans sponsored by an employer, labor organization, or the trustees of a fund established by one or more employers or labor organizations may not participate in the Model.

Outside of a CMS exception, which is outlined below, PBPs that fail to meet the eligibility criteria may not participate in the Model in CY 2023, although they may become eligible in subsequent years. Conversely, PBPs that meet these requirements initially, but fail to do so later (i.e., are later sanctioned by CMS) may be disqualified from participation in later years or terminated by CMS from the Model, upon consideration of the best interests of the plan's enrollees and needs of the Model.

In their applications, MAOs must disclose any present or past history of sanctions, investigations, probations, or corrective action plans for the MAO, affiliates, or other relevant persons and entities. Before execution of the VBID Contract Addenda, MAOs must also disclose any sanctions, investigations, probations, or corrective action plans for the MAO, affiliates, or other relevant persons and entities. CMS will conduct appropriate program integrity (PI) screens during the application process and prior to the beginning of the start of the Model, and may reject an application or terminate a contract addendum on the basis of the results of a PI screening regarding the applicant, its affiliates, and any other relevant individuals or entities. The PI screening may include, without limitation, the following:

- Identification of delinquent debt if applicable;
- Review of performance in, and compliance with the terms of, other CMS models, demonstration programs, and initiatives;
- Review of compliance with Medicare program requirements;
- Review of any administrative audits, investigations, or other activities conducted regarding suspicious billing or other potential program fraud and abuse; and
- Review of any civil or criminal actions related to participation in a federal health care program.

CMS will consider exception requests in limited circumstances and will reserve the right, in its sole judgment, to admit a PBP, an MA contract, or overall parent organization that does not strictly meet the eligibility criteria. For example, CMS may consider approving an exception request for an MAO's contract offering a PBP that is or has been under sanction in the past 12 months based on considerations that demonstrate improvement by the MAO and that the sanction and the conduct underlying the sanction are not related to the Model's purposes and Model performance requirements. In addition, CMS might admit an MAO with plans offered for fewer than three years, where that MAO is a successor to a previously offered MAO, such that sufficient baseline data is available for evaluation. However, CMS will only exercise that discretion when that admission is consistent with the administration and goals of the VBID Model. In circumstances where a plan fails to meet plan performance-related criteria, CMS will apply a high degree of scrutiny to the request, and is unlikely to approve such an exception without consideration of additional monitoring or other conditions to be imposed upon the excepted PBP. In addition, CMS will

[29] Please find Chapter 9 of the Medicare Managed Care Manual here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c09.pdf

consider applications for plans that do not meet the criteria at the time of application but are anticipated to qualify by January 1, 2023.

MAOs seeking an exception should do so in writing by submitting a request in their application, specifying the specific contract and plan numbers for which an exception is sought, and the grounds for the exception. MAOs are strongly encouraged to make requests well in advance of the due date for responses to this RFA via email to VBID@cms.hhs.gov.

The participant selection requirements listed in this section are in addition to any participation requirements generally applicable to the MA program. A condition of continuing participation in the VBID Model is that the participating PBP continues to be offered in the MA program.

3.2 Communication and Marketing Guidelines

All MA communications and marketing regulations remain applicable to materials and activities of the participating organization and other MA and MA-PD plans and should serve as the main reference for plans (see, e.g., 42 CFR parts 422 and 423, subparts V).[30] In addition to compliance with those existing requirements, participating MAOs must comply with marketing and communication standards in the Model. For reference, please see the CY 2022 VBID Model Communications and Marketing Guidelines, which will be updated for CY 2023: https://innovation.cms.gov/media/document/cy2022-vbid-communications-and-marketing-guidelines.

Participating MAOs may choose to cite their participation in most components of this Model or any or all specific benefits available under the Model in pre-enrollment marketing materials. For MAOs participating in the Hospice Benefit Component, they must seek and receive prior approval from CMS of marketing and communication materials related to this Component.

CMS will permit participating MAOs and their representatives to convey information about the benefits, including any approved VBID benefits, available as part of their plan offerings. That said, MAOs must submit to CMS, as part of their organization-specific communication materials, a description of how they will inform and engage enrollees about the Model Benefits and/or Model Rewards that will be available ("VBID Member Engagement Strategy"). One of the keys to successful interventions offered through Model Benefits and/or RI Programs is achieving enrollee awareness, engagement, and activation. As such, CMS is interested in understanding how participating MAOs will ensure enrollees have a clear understanding of Model Benefits and RI Programs they are eligible for (including how to access them), and the specific strategies and processes MAOs will use to engage and activate eligible enrollees and/or targeted enrollees. The goal of the VBID Member Engagement Strategy is to ensure each enrollee understands the Model Benefits and/or RI Programs that he or she may be eligible for and how to access them and for CMS to understand how Model Benefits and RI Programs are being communicated to enrollees. CMS is also particularly interested in any strategies that MAOs may be using to reach underserved populations with health equity concerns and who may require different types of approaches and/or

[30] For reference, please see standardized outreach and educational material for MA and MA-PD plans, available at: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial

culturally competent communications and outreach in order to fully engage in the Model Benefits and/or RI Programs for which they are eligible.

As required based on the MAO's approved model application, if eligibility for an intervention or flexibility available under the Model (e.g., a reward in the Model RI Program) is not assured or cannot be determined before a model year for a specific enrollee or enrollees, participating MAOs must use a disclaimer indicating that eligibility for interventions is not assured and will be determined by the organization after enrollment based on relevant criteria (e.g. clinical diagnoses, eligibility criteria, participation in a disease state management program). Moreover, the information must be conveyed in accordance with all other CMS communications and marketing guidelines, including those prohibiting misleading communications to enrollees.

CMS believes MAOs participating in the Model are aligned with CMS's implementation and evaluation goals, and the MAOs will create communication and marketing strategies that ensure beneficiaries are engaged and informed. CMS will provide guidance on Model communications and marketing requirements for CY 2023 in summer 2022. Unless specifically waived, requirements for marketing and communications for MA plans under 42 CFR Part 422 continue to apply to participating MAOs, including requirements for prior review and approval of all marketing materials.

In addition to communications with enrollees, participating MAOs are expected to communicate their model participation to network providers who may be providing services to enrollees as part of the Model, including specifically to any providers who have been identified as high-value. Additionally, MAOs may communicate enrollees' eligibility status to providers once established.

3.3 Monitoring and Data Collection

Participating MAOs will be subject to timely data collection and reporting that supports CMS's monitoring of the Model's implementation, and can also be used as part of the Model evaluation. CMS monitoring activities are designed to track model progress and implementation, ensure beneficiaries are not harmed or discriminated against, and provide assurance that MAOs are in compliance with the terms and conditions of participation in the Model.

CMS will provide participating MAOs with Model Monitoring Guidelines in fall/winter 2022 that will detail what reporting is necessary during and for Model participation in 2023, when data should be reported, how data is being collected and should be shared with CMS, and who CMS expects to receive reporting on (e.g., beneficiaries targeted and engaged in receiving wellness and health care planning (accepted or declined)). Both beneficiary-level and summary-level reporting will be required. Specific requirements will be detailed in the contract addendum and other CMS guidance. In addition, CMS will provide training and support to participating MAOs to assist with these requirements and is actively working on approaches to data sharing and reporting that minimize burden and improve transparency to both CMS and participating MAOs.

Participating MAO data collection and reporting might include:

- For the WHP Component, participating MAOs must report annually to CMS, using the WHP reporting template, the number enrollees who participated in a WHP discussion and

the number of enrollees who completed or updated an ACP (i.e., signed document indicating their wishes), and other qualitative data to track the MAO's WHP implementation experience. CMS will specify the details and timing of annual WHP reporting in Model monitoring guidelines. Annually, CMS will host a learning workgroup on WHP for interested participating MAOs to share successes, challenges, and best practices, such as WHP activities that are culturally sensitive and informed by data and other information that supports improved equity across underserved populations.

- For the VBID Flexibilities Component, participating MAOs must monitor and report to CMS on enrollees that have been targeted (or are eligible to receive) and that have received or used the VBID Flexibility being offered (e.g., reduced cost-sharing, additional supplemental benefits, etc.).

- For the Part C and D RI Model component, participating MAOs must monitor and report on enrollees who are targeted for RI and keep track of the frequency and dollar amount for each enrollee during the year.

- For MAOs participating in the voluntary Health Equity Incubation Program, CMS will work with MAOs to collect data and evidence regarding the effects of identified impactful benefits.

- Please see the CY 2023 VBID Hospice Benefit Component RFA and Hospice Benefit Component Monitoring Guidelines for information on data collection and reporting for the Hospice Benefit Component.

In addition to the information above, CMS will monitor and collect data about beneficiary opt-outs; complaints and grievances to the plan, 1-800-MEDICARE and the Medicare Complaint Tracking Module; enrollee appeals and grievances, including proportion of Independent Review Entity (IRE) appeals and the number overturned; increases in drug rebates or other remuneration or utilization measures related to an RI Program; and other items as deemed necessary to ensure compliance with all model terms, beneficiary protections, and program integrity.

This Model's approach to monitoring is designed to protect all beneficiaries and assure the MAOs' compliance with the terms of the Model test. CMS or its contractor will conduct compliance monitoring on a regular basis to track MAO compliance with the terms of the Model test. As with evaluation, while CMS or its contractor will monitor chiefly through existing data sources, participating MAOs will be required to provide additional data collected specifically for the Model test where no existing data are available. CMS or its contractor will also conduct specific audits of all participating organizations in identified risk areas, and may initiate audit activity that requires additional data or site visits, particularly in response to high levels of complaints or other indicators of poor performance.

Improving the standardization, completeness and accuracy of supplemental benefits data (related to costs, savings, and utilization by enrollees) has been identified as a top priority for the VBID Model. CMS will collaborate with MAOs participating in the voluntary Health Equity Incubation Program to identify the appropriate file layouts, assess feasibility of data collection, and test data

reporting and performance feedback metrics related to supplemental benefits data. Such data will help provide better insights into supplemental benefits utilization and their related outcomes by all enrollees, including underserved populations. By better understanding the value and impact of supplemental benefits in MA, CMS would like to understand which benefits have the most meaningful quality and other health equity outcomes and inform future Model design development (e.g., benefit engagement incentives or benefit enhancements in Fee-For-Service).

CMS intends to request additional reporting only when it determines existing data sources are limited or insufficient. Likewise, CMS and its contractors will monitor the Model primarily through leveraging existing data sources, such as VBID application data and CMS encounter, enrollment, payment, survey, complaint, and bid data. CMS may also ask for additional information if clarification is needed from participating MAOs.

CMS will work with participating MAOs and may conduct on-site visits to allow for the direct observation of the model implementation. Overall, CMS expects to learn from the Model implementation and reserves every right to make changes to the Model as necessary to ensure beneficiary safety, the integrity of the model test, and that CMS's aims are achieved.

3.4 Bidding and Projected Savings

Each Model component must be detailed in the application, and once approved, included as part of the MAO's PBP and Bid Pricing Tool (BPT) submission. WHP and Part C and D RI Model components must be priced in the BPT as an administrative cost. VBID Flexibility Model components must be priced and included in the bid as mandatory supplemental benefits. Depending on the type of Part D benefit offered, the costs of waiving LIS maximum Part D copays for LIS enrollees must either be priced and included as administrative costs or, if such reduced or $0 cost sharing applies to both LIS and non-LIS enrollees or otherwise qualifies as a Part D supplemental benefit, then the cost should be priced as Part D supplemental benefits.[31] (Premiums for Part D supplemental benefits may be paid using the MA beneficiary rebates per § 422.266 but Part D benefits and payment of Part D cost sharing are not MA supplemental benefits; Part D benefits – including reductions in cost sharing – cannot be included in MA bids.) See section 3.4.2 for more details. Bids must be prepared according to the bidding rules and bidding guidance for the Part C and Part D programs.

Benefits under the Model are subject to all existing funding rules and other regulations for supplemental benefits unless specifically waived.

Participating PBPs will be required to satisfy all existing CMS requirements, such as service category cost sharing standards, without consideration of the VBID interventions. VBID interventions must be documented within separate areas of the PBP submission for benefits review. MAOs must also provide in their applications projections of the impact that their participation will have, for CY 2023, on plan medical and prescription drug utilization, cost, and premiums.

[31] See also 42 CFR § 423.104(f).

These projections are to be prepared by an actuary who meets the requirements of 42 CFR § 422.254(b)(5) and, furthermore, the analysis is considered to be an Actuarial Communication in accordance with Actuarial Standards of Practice No. 41. Thus, a qualified actuary who is a member of the American Academy of Actuaries (MAAA) must prepare or direct the preparation of these materials, be clearly identified in the submission, and certify the actuarial valuation. Similar to instructions provided for completing the BPT, the objective of obtaining an actuarial certification is to place greater responsibility on the actuary's professional judgment and to hold him/her accountable for the reasonableness of the assumptions and projections.[32]

CMS will review these projections as part of reviewing the application for compliance with the terms of the Model test; reasonableness of assumptions; potential detrimental impact to CMS, the Medicare program, or beneficiaries; and the sustainability of the proposal. In order for the plan to be approved to participate in the Model, these projections must show net savings to CMS over the course of the MAO's participation in the Model and no net increase in enrollee cost over the life of the Model.

An MAO may be required to correct its projections or change its proposal, or establish a multi-year financial plan, in case of unacceptable submissions. Once approved by CMS for participation in the Model, MAOs must incorporate these assumptions into their annual bids in accordance with actuarial standards and CMS guidance. These instructions might require MAOs to supply additional plan-specific model information through the BPT in connection with their bids for each of the Model years, demonstrating the specific impact of the Model on that year's bid. CMS will require annual updates to the projections to include actual historical experience after a full year of participation. Outlined below is the information that plans are required to submit as part of their application to the Model.

3.4.1 What to Submit for Projected Costs and Savings as Part of the Application

Participating MAOs are required to submit to CMS projected costs and net savings to Medicare over the course of the Model for each VBID Model component included in their application. In submitting these projections as part of the application, plans must:

- Submit responses to the "CY 2023 VBID Financial Application Template" on the Model webpage. MAOs are strongly encouraged to include details in addition to the information and responses specifically requested by the template. The CY 2023 VBID Financial Application Template and associated materials must reflect the MAO's best estimate of projected enrollee engagement, program implementation costs, utilization changes, including the expected timeframe of those utilization changes.

In completing the CY 2023 VBID Financial Template and associated materials, MAOs must include the following:

- Executive Summary (i.e., a summary in financial and actuarial terms of the Model strategy and expected PMPM changes). This should include any changes to an existing VBID flexibility

[32] Please see HPMS for the latest contract year instructions for completing the BPT.

used by the MAO if the MAO is current participating in the Model;

- Summary of Projected Costs by each VBID Model component (a projected utilization, unit or Per-Member-Per-Month (PMPM) costs and Non-Benefit Expense (NBE) costs together with an indication of what experience base, etc., was relied on in setting the assumption. A projection of the member months eligible for each component and/or targeted population and estimates of those that will participate or otherwise be engaged, if applicable);
- Summary of Projected Savings over the Course of the Model, including considerations for net savings after accounting for projected costs over the same time period;
- Additional Quantitative Support, as needed, including historical data and past performance if the applying MAO has previously participated in the Model (if there is at least one full year of experience to review); and
- Changes to Pricing (e.g., projected increase to risk scores, bid pricing tool changes).

In addition to the memorandum discussing the bulleted items above, applying MAOs must complete the ***required*** "Net Savings Template" which provides a simple format for including costs, savings, and net savings for the MAO's proposed policies and benefits over the life of the Model.

The purpose for requesting the above supporting documentation is to assist CMS in assessing the reasonability of the pricing assumptions intended to be used when providing VBID benefits under this Model. Additionally, the supporting documentation should describe how the proposed VBID Model components may be expected to meet the Model's financial goals of net savings to Medicare expenditures without any net increase in costs for plan enrollees attributable to the VBID elements over the life of the Model.

Plan sponsors applying for the VBID Model must email documentation to VBID@cms.hhs.gov.

3.4.2 CY 2023 Bid Procedures and Special Considerations

VBID Model components of the bids for CY 2023 will be covered by the general actuarial certification submitted in accordance with 42 CFR 422.254(b)(5), and actuaries preparing applications should keep this requirement in mind. Approval of Model applications merely qualifies plan sponsors to include these VBID Model components in their CY 2023 bid submissions; it does not guarantee that these elements will be approved during Bid Desk Review.

An authorized representative of the participating MAO must attest, as part of the application, the bid, and via the contract addendum, that the model-participating plan application and bid, as applicable, have 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.

Wellness and Health Care Planning – Special Considerations

MAOs must address the inclusion of this Model component (to implement the WHP strategy approved by CMS as part of application review) in the bids following the required bidding procedures. It is expected that some WHP costs are already incorporated into plan bids because of the need to comply with 42 CFR 422.128. To the extent that there may be additional costs, these

may be factored into the bids per standard processes. It is also expected that plans will have opportunities to achieve net savings if the WHP services result in reduced plan expenditures. It is further expected that these savings would accrue over the longer, extended period of performance for the Model. To the extent there are material assumptions related to either costs or savings from WHP, plans should address these separately, as is required for each selected component.

Hospice Benefit Component – Special Considerations
Please refer to the CY 2023 VBID Hospice Benefit Component RFA for information on the inclusion of this benefit in the bids following the required bidding procedures.

Part D Reduced Cost Sharing – Special Considerations
The CY 2023 Part D BPT should be completed for participating MA-PD plans by following applicable guidance for CY 2023 bidding. The Part D BPT must reflect the VBID Part D benefits to be offered. Please consult the CY 2023 VBID Frequently Asked Questions document for additional information.

In general, if the MA-PD is reducing or eliminating cost-sharing for non-LIS enrollees, the bid must be filed as an Enhanced Alternative (EA) unless the entire prescription drug benefit (including VBID reductions in cost-sharing) meets the applicable standards for Actuarially Equivalent (AE) or Basic Alternative (BA) coverage. AE and BA plans will not be permitted to offer a reduction or elimination of cost-sharing targeted to LIS beneficiaries. However, if the MA-PD is a Defined Standard (DS) plan and is reducing or eliminating the LIS enrollees' portion of cost sharing (i.e., the LI copay) for their Part D drugs, the expected value of the LI copay must be reflected as a direct administrative cost in the BPT. DS plans will not be permitted to offer a reduction or elimination of cost-sharing targeted based on chronic health condition. Finally, the application must clearly label the bid type that will be filed for a plan proposing Part D reduced cost-sharing and how the benefit will be reflected in the BPT.

Regardless of drug benefit type, beginning CY 2023, some MAOs that are approved by CMS under the VBID Model to offer eliminated Part D cost-sharing will have this information displayed on the Medicare Plan Finder (MPF) tool. Display of these benefits will only be possible if an MAO's Approved Proposal for the VBID Model includes:

- All Part D drugs,
- All Part D benefit phases, and
- All LIS levels (or dual eligible status in territories only).

MPF will not display any other cost-sharing reductions or eliminations in CY 2023 under the VBID Model, including reductions or eliminations in Part D cost-sharing that are offered only on specific formulary tiers or targeted only to certain LIS levels. Additionally, reductions but not eliminations of LIS cost-sharing across all drugs and all benefit phases will not be displayed. Similarly, in territories, reductions but not eliminations of cost-sharing targeted to dual eligible enrollees across all drugs and all benefit phases will not be displayed.

3.5 General Model Oversight

CMS reserves the right to terminate an MAO's participation in the Model or exercise other available remedies at any time if the organization has failed to comply with the terms of the Model, is subject to investigation or sanctions for program integrity issues (e.g., if a participating MAO fails to provide a reward or incentive to an enrollee who meets the eligibility criteria, or a reward and incentive is offered for a purpose or on terms and conditions other than which is approved), or if CMS determines that the organization's participation in the Model, or its performance of model activities, may compromise the integrity of the Model, including by resulting in lower quality care or adverse outcomes for enrollees or the Model.

CMS will use a contractor to conduct regular monitoring to review compliance with the terms of the Model test. The contractor will monitor for compliance using existing data sources to the extent practicable, but may seek plan-provided data or conduct site visits, particularly in response to high levels of complaints or other indicators of poor performance. CMS will closely monitor model implementation, to ensure that plan performance is consistent with model rules and approved proposals and that the Model is not leading to any adverse beneficiary outcomes. This will include, but not necessarily be limited to, observing existing metrics of beneficiary access, outcomes, and satisfaction, and monitoring of increased beneficiary questions or complaints through 1-800-MEDICARE or the https://www.medicare.gov website. CMS will also monitor the impact the Model has on other CMS initiatives, such as the Part C and D Star Ratings.

CMS reserves the right to investigate an MAO if there is evidence that indicates that the MAO's participation in the Model is adversely impacting enrollee quality of care, and to exercise all available remedies in appropriate instances, including potential termination from the model test or termination of the MA contract.

CMS retains the right to change any Model policy on an annual basis or more frequently, in accordance with procedures and parameters that will be established in the Model's contractual addendum to the MAO's agreement with CMS for participation in the MA program.

CMS may consider more broad-reaching policy changes, including changes to the permissible interventions and Model components, setting additional financial requirements for participants, as well as adding or eliminating requirements for participation.

An MAO may withdraw a PBP from the Model test, or cease participating entirely, by providing advance notice to CMS in accordance with the timeframes stated in the contractual addendum for participation in the VBID Model. In each case of withdrawal from the Model, MAOs are required to provide adequate notice to participating enrollees, consistent with current requirements in the MA program for termination of the MA plan.

4. Health Equity Learning System

CMS will use a voluntary learning system approach to accelerate MAO VBID engagement in a targeted set of high impact areas, referred to as the Health Equity Incubation Program. The Health Equity Incubation Program aims to diffuse evidence and best practices related to the delivery of

specific interventions and supplemental benefits in these areas in order to drive improvement and learning from the Model. This learning system will use a variety of approaches including webinars, facilitated collaboratives of MAO participants organized by intervention type, and dissemination of lessons learned across CMS (Medicare FFS, MA and Medicaid), resources and tools to support MAOs considering participation in VBID as well as active VBID Model participants.[33] Specifically, in CY 2022, CMS will offer technical assistance and learning diffusion efforts leading up to the deadline for applications for CY 2023. Following the application deadline through CY 2023, CMS will continue learning and information sharing efforts to support implementation of the VBID Model.

CMS will focus on initiatives addressing health equity with a particular focus on building a critical mass of interventions that have well established intersections with social needs, such as in the areas of food and nutritional insecurity, transportation, housing and other HRSNs, and disease management (notably for diabetes and CVD). Focusing on specific high-impact areas will allow CMS to prioritize learning support to these areas through the Health Equity Incubation Program. In partnership with MAOs participating in the Health Equity Incubation Program, CMS' goal is to help develop best practices in the design, operations and measurement of interventions in these areas; optimize their impact on health equity; and build and share an evidence base for quality improvement and medical savings related to HRSNs.

This focused learning agenda allows CMS to address known barriers in the adoption and successful operation of supplemental benefit flexibilities that represent important opportunities to mediate health disparities. A January 2021 Health Management Associates Issues Brief entitled *Medicare Advantage Supplemental Benefit Flexibilities: An Early Assessment of Adoption and Policy Opportunities for Expanded Access* assessed the factors contributing to an MAO's decision to offer supplemental benefits as well as the challenges to adoption and implementation that present barriers to accelerating MAO innovation in these areas.[34] The assessment concluded that limited research and data on the impacts of offering additional benefits makes it difficult for MAOs to evaluate whether, and how, to provide them. MAOs interviewed for the assessment indicated their belief "that flexible benefits have the potential to improve outcomes, increase beneficiary satisfaction, and reduce overall cost of care for beneficiaries… All indicated, however, that limited data and evidence regarding the short-term and long-term effects of specific benefits and interventions impedes them from identifying and developing the most impactful benefits that can be adopted and made accessible on a wide scale."

The assessment recommended CMS develop and disseminate evidence on flexible benefits and encourage MAOs to offer innovative benefits by 1) providing guidance, based on evidence and data, on how best to plan and structure these benefits; 2) working with early adopter MAOs to collect data and information to support effective and efficient delivery of these benefits; and 3) convening a learning collaborative that engages MAOs and other stakeholders in generating

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[33] As aligned with the Innovation Center's Strategy Refresh here: https://innovation.cms.gov/strategic-direction-whitepaper#:~:text=As%20part%20of%20its%20strategy,role%20in%20achieving%20these%20goals.

[34] Ipakchi, N., Hsieh, M., Barth, S. and Blum, J. Medicare Advantage Supplemental Benefit Flexibilities: An Early Assessment of Adoption and Policy Opportunities for Expanded Access. Health Management Associates. January 2021. Retrieved from: https://www.healthmanagement.com/wp-content/uploads/HMA-MA-Supplemental-Benefit-Flexibilities-Brief-2_Interview-Findings_FINAL.pdf

additional evidence, sharing "non-competitive best practices, and identifying meaningful approaches to design, implementation, and evaluation."

CMS is implementing these recommendations and launching the voluntary Health Equity Incubation Program in light of CMS's focus on addressing health disparities and the increased MAO interest in offering additional supplemental benefits that address the social and health needs of underserved populations, and the informational barriers MAOs face regarding offering these benefits. CMS will support potential VBID participants in their decision making regarding offering innovative supplemental benefits under the Model by conducting "incubator sessions" that will disseminate information on the business, health and cost rationale for specific interventions and review relevant case studies. These sessions are designed to encourage MAOs to offer benefits and undertake interventions in the designated priority areas in order to facilitate the scale needed for further development of evidence and the dissemination of information supporting effective execution of interventions in these areas. CMS will also support learning and innovation across MAO participant organizations through facilitated forums in which participant MAOs can share their experiences and results in offering interventions in the priority areas, including their challenges and successes in the planning, operations, measurement and assessment of their respective programs.

5. Evaluation

In addition to timely submission of required reports, all Model participants are required to cooperate with efforts to conduct an independent, federally funded evaluation of the Model, which may include participation in surveys, interviews, site visits, and other activities that CMS determines necessary to conduct a comprehensive formative and summative evaluation. The evaluation will assess the impact of the Model in meeting intended goals and whether the flexibilities available in the Model reduce program expenditures (e.g., reducing bids) under the Medicare program while preserving or enhancing the quality of care (e.g., uptake of high-value care, plan quality performance measures) furnished to Medicare beneficiaries in order to inform policymakers about the effect of the model concepts relative to health care delivery. To do so, the evaluation will seek to understand the behaviors of plans, providers, suppliers, and beneficiaries, how each individual intervention is adopted and implemented (including WHP, VBID Flexibilities, RI, and Hospice), the impacts of increased financial risk, the effects of various payment arrangements and benefit enhancements, the impact of the Model on beneficiary engagement and experience, and other factors associated with patterns of results. In situations where the evaluation uses non-publicly available data, CMS will report results at an aggregate-level so as to avoid the disclosure of private and sensitive data of specific model participants.

6. Application Process and Selection

MAOs interested in applying to participate in the VBID Model for 2023 should submit their application no later than April 15, 2022 11:59 pm PT. The online application portal will be accessible by early March 2022 on the VBID Model website at: https://innovation.cms.gov/initiatives/vbid/.

Questions regarding the Model or application process may be sent by email to VBID@cms.hhs.gov. While CMS will not share the source of the question, CMS may publicly share questions and responses or compile them into a Frequently Asked Questions compendium to ensure that all MAOs have access to information regarding the VBID Model and the application process.

To participate in the Model, MAOs must follow the following process:

Step 1: CMS Feedback and Technical Assistance Early March – April 2022

In an effort to provide MAO support for the VBID Model, CMS will provide feedback and technical assistance on a rolling basis between the release of this RFA through April 15, 2022. CMS expects to engage with MAOs to ensure the success of the Model and to offer technical assistance where possible in regard to Model participation, Model requirements, and beneficiary protections.

Step 2: Application Due April 15, 2022, 11:59 PM PT

Using the Application provided by CMS through the VBID Model website, MAOs may apply to participate in the Model with one or multiple model-eligible PBPs under one or multiple MA contracts. MAOs must indicate to CMS the contract(s), PBP(s), and segment(s), if eligible, that they are proposing to include in the Model. (Although there are separate RFAs for (1) the VBID Model's Hospice Benefit Component and (2) other Model components, there is only one application for participating in the Model in 2023.)

CMS will use the application process to capture concise, complete applications from MAOs on all of their proposed VBID intervention(s) and Model components. MAOs are encouraged to provide specific, clear answers in their application that directly state what the plan proposes to do (or cover as a benefit), for whom, how, and when. The applications should also explain how the interventions being proposed are not authorized by other flexibilities available outside the VBID model within the overall MA program. Where applicable, a supplemental document or presentation that better defines the overall narrative and specifics of the program may be uploaded.

As part of the application, MAOs must submit all accounting and actuarial assumptions associated with their proposal and Model participation to CMS at VBID@cms.hhs.gov. This includes projected costs for each proposed intervention and participation in each component, including any changes in administrative costs, specific projected changes to utilization, and projected changes to the plan bid. MAOs offering the Hospice Benefit Component through the Model will be given additional bid instructions by the CMS Office of the Actuary and need to include any costs or projections for hospice-specific supplemental benefits as part of the application to participate in the Model in 2023.

CMS encourages MAOs to reach out to CMS using the VBID mailbox at VBID@cms.hhs.gov prior to submitting the application to ask questions or request additional information. After each application has been submitted, CMS will review applications and may contact MAOs for clarification, additional information, or to request changes.

After close review, CMS will provide MAOs with a provisional approval for model participation. Of note, model participant selection is not competitive. CMS does not intend to set a maximum number of qualified MAOs participating in the Model test. CMS also reserves the right to reject any organization, PBP, or proposal to preserve the integrity of the Medicare program, the welfare of beneficiaries, or the efficient and advantageous administration of the Model.

In accordance with authorities granted in section 1115A(d)(2) of the Act, CMS is exempt from administrative or judicial review of its selection of organizations, sites, or participants to test models. Responders are advised that the U.S. government will not pay for any information or administrative costs incurred in response to this RFA; all costs associated with responding to this RFA will be solely at the interested party's expense. There is no requirement to respond to this RFA, as participation in the VBID Model is voluntary.

Step 3: Bid Submission (Monday, June 6, 2022)

A provisionally approved MAO will include participation in the VBID Model and all VBID Model components it is participating in, as part of submitting its PBP(s) to CMS by June 6, 2022. MAOs must follow all bid guidance as provided by CMS. In addition, provisionally approved MAOs will be required to confirm their participation in the Model by the bid submission date of June 6, 2022, concurrent with and as part of their plan bid submission. In addition to the bid submission requirements, MAOs that were provisionally approved must notify CMS in writing by June 6, 2022, of any changes they seek to make from their provisionally approved application, including changes to participating PBP(s). MAOs should submit one Model application per parent organization.

6.1 Timeline

Below outlines the timeline for the application period for the VBID Model.

Date	Milestone
Early March 2022	CMS releases CY 2023 RFA for the VBID Model
Early March - April 2022	CMS provides feedback and technical assistance to MAOs
Early March 2022	CMS opens VBID Model Application Portal (inclusive of Hospice Benefit Component)
April 15, 2022	Completed Application due to CMS by 11:59 pm PT
Mid-May 2022	CMS completes review of applications and provides feedback to MAOs for inclusion in their CY 2023 PBP
June 6, 2022	CY 2023 MA and Part D Bids Complete by 11:59 pm PT
June 10, 2022	VBID Supplemental Formulary file submitted (only applicable to MA plans that have been preapproved for Part D VBID benefits) (11:59 am ET)
September 2022	Contract addenda for Model participation executed
January 1, 2023	CY 2023 performance period of the VBID Model begins

6.2 Withdrawal or Modification of Application

MAOs seeking to withdraw an entire application or requesting to modify a pending or preliminarily approved application should submit a written request on the MAO's letterhead that is signed by the primary point of contact named in the application submission. To submit a withdrawal request, MAOs must send the request in PDF format by e-mail to VBID@cms.hhs.gov.

After application submission (April 15, 2022) but prior to provisional approvals (mid-May), CMS may allow MAOs that have submitted an application to propose to add Model components. However, after provisional approvals (mid-May) and prior to bid submission (June 6, 2022), CMS will only allow incremental changes to provisionally approved interventions or Model components (such as adding or removing PBPs or increasing the amount of VBID Model Benefits; adding interventions within a provisionally approved Model Component), so that MAOs may incorporate feedback from CMS or otherwise improve the application to meet their goals for the Model.

After application and bid submission on June 6, 2022, CMS will only allow changes of a type typically allowed for MA and Part D benefits after bid submission, such as those required in response to CMS bid desk review findings or made during rebate reallocation. Allowance of changes to preliminarily approved interventions is a matter of CMS discretion, and CMS may require resubmission of application materials, such as the financial application, to account for proposed changes.

6.3 Amendment of RFA

CMS may change the terms of the Model or cancel it entirely in response to stakeholder comments or other factors. The terms set forth in this RFA may differ from the terms set forth in the final addendum for participation in the Model test.