Centers for Medicare & Medicaid Services

Center for Medicare and Medicaid Innovation

Value-Based Insurance Design Model

Calendar Year (CY) 2023 Monitoring Guidelines

Updated on December 4th , 2023

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1. Background and General Information

This document provides Medicare Advantage Organizations (MAOs) participating in the Value-Based Insurance Design (VBID) Model in Calendar Year (CY) 2023 with guidance pertaining to Model requirements that supports the Centers for Medicare and Medicaid Services (CMS) monitoring and evaluation activities for the VBID Model. These guidelines provide instructions about the required data and information that will be collected and reported in relation to the MAO's participation in the Model. MAOs participating in the VBID Model must adhere to this guidance pursuant to the CY 2023 Addendum to Medicare Managed Care Contract for Participation in the VBID Model (Addendum).[1]

Through the VBID Model, CMS is testing a broad array of complementary Medicare Advantage (MA) health plan innovations designed to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries (including those who have low-income subsidy (LIS) status), and improve the coordination and efficiency of health care service delivery. The additional flexibilities provided through the VBID Model, including the ability of MAOs to target benefits to LIS populations, provide a unique opportunity to address issues of health equity[2] in underserved communities.[3] Overall, the VBID Model tests a broad array of MA service delivery and/or payment approaches. Using these approaches may contribute to the modernization of MA through increasing choice, lowering cost, and improving the quality of care for Medicare beneficiaries.

These monitoring guidelines address the VBID Components of the VBID Model as follows:

1. Wellness and Health Care Planning (WHP) (required for all participating Model plan benefit packages (PBPs));
2. VBID Flexibilities (VBID Flex) for targeting primarily or non-primarily health-related supplemental benefits (by LIS and/or chronic condition); such supplemental benefits may include new and existing technologies or FDA-approved medical devices (New Tech); use of high-value providers and/or participation in care management programs/disease management programs; and reductions in cost sharing for Part C items and services and covered Part D drugs; and
3. Part C and Part D Rewards and Incentives Programs (RI Programs).

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[1] Capitalized terms not otherwise defined in these VBID Model Monitoring Guidelines have the meaning provided in the CY 2023 Addendum.

[2] CMS defines health equity as 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.

[3] Section 2(b) of Executive Order 13985 defines "underserved communities" as referring to populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by the communities listed in the definition of "equity" in section 2(a) of the Executive Order.

Monitoring requirements for the Hospice Benefit Component are addressed in the CY 2023 VBID Hospice Benefit Component Monitoring Guidelines.

1.1 VBID Monitoring and Evaluation Objectives

VBID monitoring and evaluation activities are critical to CMS' ability to test the VBID Components. In general, VBID *monitoring* objectives cover the following areas:

- Ongoing review and tracking of Model participants' efforts, progress, and potential issues in implementation;
- MAO compliance with approved VBID Components and terms of the Model;
- Identification of unintended consequences of operating the Model such as beneficiary harm or program integrity issues;
- Ensuring that beneficiaries are not harmed or discriminated against;
- Making sure that beneficiary choice is protected;
- MAO compliance with all Prescription Drug Event (PDE) reporting rules, such as the requirement that supplemental benefits be applied before the gap discount is calculated; and
- Tracking the reach of the Model in identifying and addressing MA enrollees' clinical needs and drivers of health, including those enrollees within underserved communities.

In addition to monitoring activities, all participating MAOs are required to cooperate with efforts to conduct an independent, federally funded evaluation of the VBID Model. In general, VBID *evaluation* objectives include:

- Rigorously assessing the impact of the Model on enrollee health outcomes, quality and experience of care, and spending;
- Evaluating data that is (1) submitted to CMS by participating MAOs as part of their monitoring activities, and (2) from administrative data sources already available to CMS; and
- Assessing the reach and impact of the Model on underserved communities.

CMS must collect monitoring data and information to allow for real-time Model monitoring. Delays in reporting impede CMS' efforts to monitor and evaluate the Model. CMS will work with participating MAOs to ensure these data are submitted to CMS accurately and timely. A guiding principle in CMS' approach toward data collection and reporting is to minimize burden for participating MAOs, consistent with the government's need to monitor and evaluate model tests. Therefore, CMS has developed guidelines for data collection and reporting with consideration of the data needed to support Model activities and what data are already available to CMS. CMS may also ask for additional information if clarification of submitted information is necessary.

Examples of existing CMS data and data sources that may be used in monitoring and evaluation of the Model include:

- MA Encounter Data;
- Medicare Claims;
- PDE Data;
- Beneficiary enrollment, eligibility, and payment data (Medicare Advantage Prescription Drug (MARx) System and the CMS Enrollment database);

- Plan data submitted for bids using the PBP software and available in the Health Plan Management System (HPMS);
- Quality data (e.g., Healthcare Effectiveness Data and Information Set (HEDIS), Health Outcome Survey, Consumer Assessment of Healthcare Providers & Systems (CAHPS)) submitted by MA plans; Medicare Complaint Tracking Module; and 1-800-Medicare);
- Data from the Center for Disease Control/Agency for Toxic Substances Disease Registry/ Social Vulnerability Index (CDC/ATSDR/SVI) and Area Deprivation Index (ADI);
- VBID annual application data; and
- Other items as deemed necessary to ensure compliance with all Model terms, beneficiary protections, and program integrity.

We reiterate that MAOs must submit complete and accurate risk adjustment data pursuant to 42 CFR § 422.310, which includes encounter data. Model participants must submit accurate and complete encounter data related to VBID Component-specific activities in their encounter data submissions so that this Model's monitoring and evaluation have the benefit of those data.[4]

2. General Reporting Guidance and Requirements

2.1 Applicability of Other Guidance and Requirements

All MA data collection and reporting regulations and guidance issued by CMS, as well as other applicable laws, continue to apply to data collection and reporting activities of participating MAOs.

2.2 Overview of Types of Monitoring Data

Under the Addendum, MAOs are required to report monitoring data as specified in these monitoring guidelines. These required monitoring data collected from participating MAOs will fall into one of four high-level categories: (a) Benefit Crosswalk, that includes Plan Characteristics and VBID Component Information; (b) Beneficiary-level Data Reporting; (c) WHP Summary Report; and (d) VBID Flex Supplemental Benefits Summary Report. Additionally, we request that MAOs *voluntarily* report their Beneficiary-level Data Reporting on VBID Flex Health Equity Incubation Program (HEIP) Supplemental Benefits. **Table 1** provides an overview of the types of required and voluntary monitoring data, the frequency for reporting, examples of data content included in the reporting, file format, and acceptable methods for transmission to CMS. Outside of the monitoring data described in this guidance, CMS reserves the right to require MAOs to collect and report data on an ad hoc basis to monitor, audit, and evaluate the VBID Model in order to gain more insight into how participating MAOs are implementing VBID Components. In addition to VBID Component reporting requirements, participating MAOs must also comply with the record retention and data submission requirements set forth in the CY 2023 Addendum.

[4] For reference, please see the most recent Encounter Data Submission and Processing Guide.

Table 1: Attributes of Different Types of Monitoring Data[a]

Type of Monitoring Data	Reporting Frequency	Data Content - Examples	File Format	Transmission Method
Benefit Crosswalk that Includes Plan Characteristics and VBID Component Information	Annual (MAOs will receive file for review on or around December 6, 2022)	Contract, Benefit Package, Segment IDs, Brief VBID Component Descriptions, Targeting Methodology, etc.	**Pre-populated by CMS**, participating MAOs will review and verify information; Fixed format Excel file	VBID Mailbox
Beneficiary-level Data Reporting on VBID Component Targeting[b]	Biannual	Targeting Date; Benefit Eligible Date; Medicare Beneficiary Identification # (MBI); RI Amount, etc.	Fixed format reporting; Delimited files (e.g., .txt)	*CMMI Portal only*
WHP Summary Report[c]	Annual	Summary information on WHP implementation efforts	Fixed format; Survey questionnaire	Qualtrics Application
VBID Flex Supplemental Benefits Summary Report[d]	Annual	Summary information on VBID Flex supplemental benefits excluding reduced cost sharing benefits for basic Part C and D services	Fixed format Excel file	VBID Mailbox
(VOLUNTARY) Beneficiary-level Data Reporting on VBID Flex HEIP Supplemental Benefits[e]	Biannual	Food Benefit Utilization; Non-Emergency Medical Transportation Utilization; General Supports for Living Utilization, etc.	Fixed format reporting; Delimited files (e.g., .txt)	*CMMI Portal only*

[a] CMS reserves the right to require MAOs to collect and report data on an ad hoc basis to monitor, audit, and evaluate the VBID Model, including to gain more insight into how participating MAOs are implementing VBID Components.

[b] This reporting applies to MAOs offering VBID Flex, New Tech and/or RI Programs.

[c] MAOs will submit an annual Qualtrics report to CMS on WHP implementation.

[d] MAOs offering VBID Flex are required to report annual summary-level VBID-Flex supplemental benefits information. This information is for VBID Flex primarily and non-primarily health related supplemental benefits only and should not include cost sharing reductions on Parts A or B benefits (Orginal Medicare), or Part D benefits.

[e] This voluntary reporting applies to MAOs offering VBID Flex and participating in the VBID Model's Health Equity Incubation Program (HEIP).

a. Benefit Crosswalk that Includes Plan Characteristics and VBID Component Information

Accurate information on plan characteristics and VBID Components offered by participating MAOs is fundamental to CMS monitoring and evaluation activities. CMS intends to capture the majority of this information through its application process and internal CMS data sources (e.g., HPMS information, etc.). However, because this information is the basis for accurate and efficient reporting under the VBID Model, CMS will prepopulate a "Benefit Crosswalk" file that will include the required parent organization-specific data fields. These data elements include a listing of all contracts, plan benefit packages, segments, and VBID Component characteristics/attributes. The Benefit Crosswalk file that includes plan characteristics and VBID Component information will be sent to plans in a fixed format Excel file for review. This verification file will contain a report of all approved CY 2023 contracts-PBPs-segments and associated VBID Components. Participating MAOs will receive specific instructions for review, submission, and reporting deadlines to CMS when they receive the pre-populated crosswalk file on (or around) December 6, 2022. Once confirmed, the Benefit Crosswalk file will serve as the basis for subsequent reporting and monitoring activities.

Appendix 1, "CY 2023 Benefit Crosswalk File Key," provides participating MAOs with a sample of the benefit crosswalk file layout and content. Note that for CY 2023, CMS added columns related to supplemental benefits. These columns will help inform new data collection for the mandatory VBID Flex Supplemental Benefits Summary Report and the voluntary Beneficiary-level Data Reporting on VBID Flex HEIP Supplemental Benefits.

b. Beneficiary-level Data Reporting

In accordance with the schedule presented in **Table 2**,[5] beneficiary-level data reporting for targeted enrollees will be required on a biannual basis in CY 2023 for the following VBID Components (as applicable to approved MAOs): VBID Flex, New Tech, and RI Programs. Participating MAOs offering these VBID Components must keep a record of each unique beneficiary in each VBID PBP throughout the year and use the biannual updates to provide the most current accounting of beneficiaries who were offered and engaged or did not engage on VBID-specific activities for all VBID Flex, New Tech, and RI Programs, as applicable.

CMS requires participating MAOs to report on all data elements for all VBID Components relevant to their respective VBID PBPs, according to data element and value definitions described in the appropriate file layout in **Appendix 2, "CY 2023 VBID Beneficiary Level File Layout."** Appendix 2 provides file layouts for biannual beneficiary-level reporting for MAOs participating in the VBID Flex, New Tech, and RI Programs components. The Benefit Crosswalk file will provide further details on how key data elements in these file layouts will map specifically to your MAO's VBID program characteristics. MAOs are required to ensure all required data elements are complete and accurate; MAOs must ensure all dates entered match definition formats (e.g., target start date, target end date, eligible start dates, etc.).

[5] "Performance Period," as referenced in **Table 2**, refers to the period of time where services were provided to the enrollee. "Report Submission Period," as referenced in **Table 2**, refers to the period of time that a participating MAO has to submit the required beneficiary-level data reporting to CMS.

MAOs that were not participating in any VBID Component in CY 2022 must submit beneficiary-level data via the CMMI Portal for the Test Data Submission; the Test Data Submission period occurs before the biannual report submission periods for CY 2023 (see **Figure 1**). For any MAO that participated in any VBID Component in CY 2022, submission of beneficiary-level data for the Test Data Submission is voluntary.

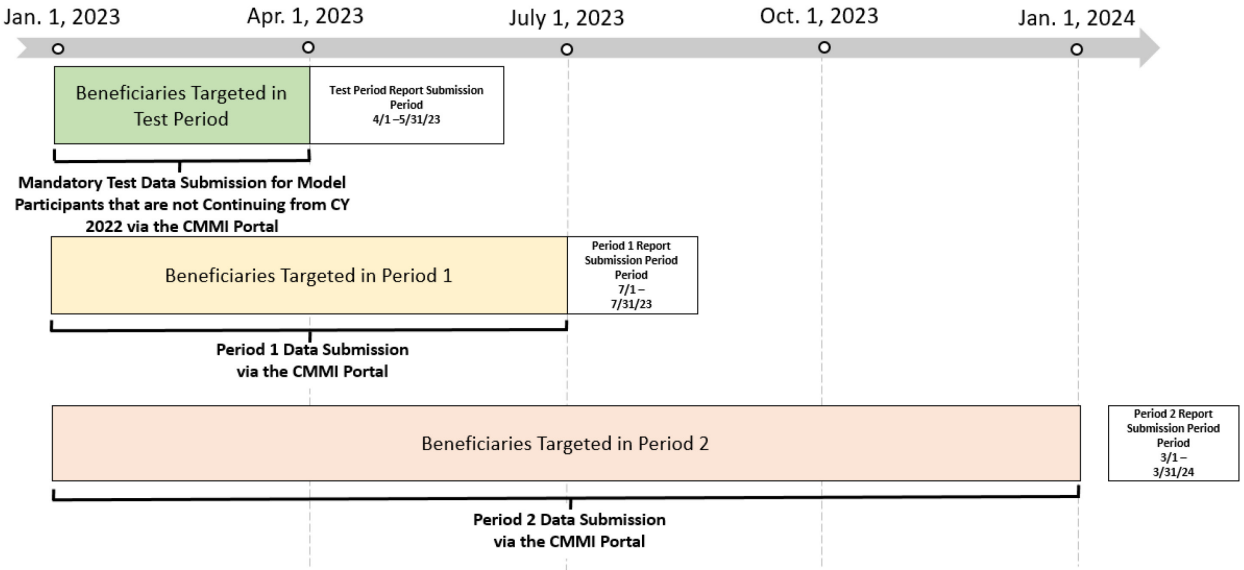
Both biannual submissions should serve as a cumulative "snapshot" of all beneficiary-specific activity in the Model year to date for the identified performance period. Submissions for the Period 2 Report Submission Period must include all information for CY 2023, regardless of what was reported for the Period 1 Report Submission Period. If a beneficiary's information was delayed or not reported accurately in the Period 1 Report Submission Period, the information must be updated by the participating MAO in the Period 2 Report Submission Period (see **Figure 1** and footnote 5). Additional instructions and training on beneficiary-level data reporting will be provided to plans prior to the Period 1, 2023 Submission.

Table 2: Beneficiary-level Data Reporting Schedule (CY 2023)

Biannual Submission	Cumulative Performance Period	Report Submission Period
2023 Test Data Submission[a]	1/1/23 – 3/31/23	4/1/23 – 5/31/23
Period 1, 2023 Submission (Q2-2023)	1/1/23 – 6/30/23	7/1/23 – 7/31/23
Period 2, 2023 Submission (Q4-2023)	1/1/23 – 12/31/23	3/1/24 – 3/31/24

[a] Test data submission is mandatory for any participating MAO that is not continuing from CY 2022; test data submission is voluntary for all other participating MAOs.

Figure 1: 2023 Cumulative Performance Period, Report Submission Period, and Ongoing Updates



MAOs should email questions about the data definitions to the CMS VBID Mailbox at VBID@cms.hhs.gov prior to report submission periods to prevent errors. Additionally, MAOs should pay close attention to the definition of the field, "Target End Date Reason Code," as detailed in the respective file layouts in Appendix 2 and ensure submitted data aligns exactly with these definitions as each code represents a distinct reason that a beneficiary is no longer targeted for VBID benefits and/or RI Programs. For further guidance on proper use of Target End Date Reason Codes, please contact the MA VBID Help Desk at MAVBIDhelpdesk@acumenllc.com.

With respect to submission mechanics, beneficiary-level data must be reported to CMS through the CMMI Portal, unless otherwise instructed by CMS. The CMMI Portal will only allow reporting during the applicable report submission period. Therefore, if a participating MAO is unable to report during the applicable report submission period, the MAO must inform CMS in writing before the close of the report submission period and request an extension to meet VBID Model monitoring requirements.

c. Summary Reports and Other Reporting

i. Annual WHP Summary Report

In CY 2023, participating MAOs are required to submit an annual summary report of activities undertaken to implement their WHP strategy and to assess the impact of these activities on the number of enrollees who engage in individualized one-on-one WHP discussions. WHP must include Advance Care Planning (ACP) services and report the number of enrollees who have participated in a WHP discussion or completed an ACP document, like an Advance Directive, during CY 2023. The summary report collects qualitative data, such as Model participants'

experience and successes in engaging enrollees and providers in WHP including ACP, consistent with CMS' objective to extend WHP and encourage more beneficiaries to complete ACP.[6]

Appendix 3, "CY 2023 WHP Reporting Template" provides a worksheet for this report that Model participants will complete and submit to CMS by March 31, 2024 via a Qualtrics survey, issued from the VBID mailbox. Participating MAOs must report their CY 2023 status of these activities in the format provided by CMS.

Additionally, in CY 2023, CMS may conduct outreach to some participating MAOs, individually or together as part of a learning and diffusion activity to discuss progress in implementing their WHP strategy and to gain a better understanding of WHP reporting capabilities.

ii. Summary Level Reporting on VBID Flex Supplemental Benefits Data

Consistent with the CY 2023 RFA for the VBID Model, CMS is interested in better understanding the value and impact of VBID Flex supplemental benefits, including which benefits have the most meaningful quality and health equity outcomes. CMS is committed to addressing health inequities and the underlying inequities within the health care system. Having more granular data about enrollees will allow for better understanding of these individuals' needs and how VBID Flex supplemental benefits may be tailored to eliminate barriers to health and health care access, quality, and outcomes among the individuals CMS serves.

Accordingly, for CY 2023, CMS will require annual summary level data reporting of VBID Flex supplemental benefits in a format detailed in **Appendix 4, "CY 2023 VBID Summary Level Flex Supplemental Benefit File Layout"** (see Table 3 for reporting schedule). This information is for VBID Flex primarily and non-primarily health related supplemental benefits only and should not include cost sharing reductions on Parts A or B benefits (Orginal Medicare), or Part D benefits. This information will be collected at the contract-PBP-segment level.

See **Appendix 6, titled, "CY 2023 VBID Technical Specifications for Summary Level Supplemental Benefits File Layouts"** for technical specifications for mandatory annual reporting of summary level supplemental benefits.

Table 3: Schedule for Summary Level Reporting on VBID Flex Supplemental Benefits Data (CY 2023)

Annual Submission	Cumulative Performance Period	Report Submission Period
Period 1, 2023 Submission	1/1/23 – 12/31/23	3/1/24 – 3/31/24

[6] For reference, consistent with their CY 2023 Approved Proposal, participating MAOs must implement a WHP strategy to inform all enrollees in all of the PBPs included in the Model regarding their opportunity for WHP/ACP and to engage them in these activities. In addition to outreach to all enrollees, participating MAOs may also have a more targeted strategy for their VBID enrollees or other subpopulations (e.g., enrollees living with serious illness) to receive WHP/ACP and to complete ACP documents.

Additionally, in CY 2023, CMS may conduct outreach to participating MAOs, individually or together as part of a learning and diffusion activity, to gain a better understanding of VBID Flex supplemental benefits reporting capabilities.

iii. Other Reporting

CMS reserves the right to require MAOs to collect and report data on an ad hoc basis to monitor, audit, and evaluate the VBID Model, including to gain more insight into how participating MAOs are implementing VBID Components. An example of this type of reporting, if specifically requested by CMS, might include more detailed information on a participating MAO's targeting methodology (e.g., ICD-10 codes, or a narrative on how this methodology is operationalized via plan data systems/sources, etc.) or additional information to demonstrate the evidence base and/or theory of action for a specific VBID Component. CMS is not prescribing a specific format for ad-hoc reports at this time. Other reporting will not be requested unless it is essential to CMS monitoring, auditing, or evaluation activities. To facilitate ad-hoc data exchange of PII/PHI between CMS and MAOs, CMS will use the Box application certified by CMS to allow sharing PII/PHI data. CMS' Box application is a secure, web-based, electronic file transfer (EFT) tool. In general, this tool provides the following functions: secure file transfer and file management. Data submitted is only visible to the individual MAO and CMS.

d. (VOLUNTARY) Beneficiary-level Data Reporting on VBID Flex HEIP Supplemental Benefits

As noted in the CY 2023 Request for Applications (RFA) for the VBID Model, for MAOs participating in the Health Equity Incubation Program (HEIP), CMS will, in collaboration with participating MAOs, collect data and evidence regarding the effects of identified impactful supplemental benefits. As part of these efforts, CMS encourages MAOs participating in the HEIP to voluntarily report beneficiary-level supplemental benefit data using the file layout detailed in **Appendix 5, "CY 2023 VBID Beneficiary Level HEIP Supplemental Benefit File Layout"** on a biannual basis (see Table 4 for reporting schedule). In contrast to the VBID Flex Supplemental Benefits Summary Report, the Beneficiary-level Data Reporting on VBID Flex HEIP Supplemental Benefits is specifically focused on priority areas for advancing heath equity, such as food, transportation, and general supports for living.

Table 4: Schedule for Voluntary Beneficiary-level Data Reporting on VBID Flex HEIP Supplemental Benefits (CY 2023)

Biannual Submission	Cumulative Performance Period	Report Submission Period
Period 1, 2023 Submission (Q2-2023)	1/1/23 – 6/30/23	7/1/23 – 7/31/23
Period 2, 2023 Submission (Q4-2023)	1/1/23 – 12/31/23	3/1/24 – 3/31/24

Additionally, in CY 2023, CMS may conduct outreach to participating MAOs, as part of a learning and diffusion activity in the HEIP, to gain a better understanding of each MAO's capability to report beneficiary-level data on VBID Flex HEIP supplemental benefits.

2.3 CMMI Portal

In CY 2020, CMS began to utilize its CMMI Portal to capture plan-reported information whenever possible and specifically for the collection of beneficiary-level data reporting. The CMMI Portal is a secure, web-based, electronic file transfer tool. In general, this tool provides the following functions: secure file transfer, file management, tracking and validation, and a framework for CMS to link beneficiary-level data reported by participating MAOs to internal CMS data. Files submitted via the CMMI Portal will be accessible in a secure manner to both CMS and its implementation contractor for review of quality of data reported, analysis for compliance with the CY 2023 Addendum, and preparation of monitoring reports. Data submitted by each MAO is only visible by the individual MAO, CMS and CMS' contractor.

Each participating MAO will be allowed one primary user in the CMMI Portal (at the parent organization level). After registering and being approved by CMS, this primary user in the CMMI Portal will be authorized to approve access for additional users affiliated with the participating MAO. If/When a participating MAO needs to change the primary user authorized for the CMMI Portal, the MAO must contact the VBID mailbox at VBID@cms.hhs.gov and CMS' implementation support contractor at MAVBIDHelpdesk@acumenllc.com. CMS will provide additional instructions and specific hyperlinks to the CMMI Portal separately. Participant training will also be provided during the year to assist participating MAOs with the mechanics and technical details associated with reporting via the CMMI Portal.

2.4 Prescription Drug Event Data – Technical Guidance for Reporting

For CY 2023, certain participating MAOs were approved by CMS (as part of the VBID Component, VBID Flex) to offer reduced or zero cost-sharing for covered Part D drugs offered in a participating MA-PD plan. Examples of this might include: (a) elimination or reduction of co-pays, (b) elimination or reduction of co-insurance, or (c) exemption of a given drug from the plan deductible. These plan flexibilities directly impact a beneficiary's out-of-pocket spending and must be reported by participating MAOs in prescription drug event (PDE) data submitted to CMS. Participating MAOs offering these plan flexibilities must report beneficiary/drug event-specific costs (associated with these changes in beneficiary cost sharing) in the appropriate PDE data fields.

The Patient Pay Amount on the PDE should contain the reduced cost sharing amount that the beneficiary actually paid. The difference between the original cost-sharing amount after the application of any supplemental coverage the plan offers outside of VBID Flex and the reduced cost sharing amount after the application of VBID Flex (i.e., the cost-sharing buy-down under the VBID Model) should be reported on the PDE in the Patient Liability Reduction due to Other Payer Amount (PLRO) field. Participating MAOs must comply with all other PDE reporting rules, such as the requirement that Enhanced Alternative (EA) supplemental benefits be applied before the gap discount and before LIS, as established by CMS for Part D plans not participating in the Model.

For more guidance on the treatment of reductions in Part D cost-sharing under the VBID Model, please refer to the memorandum, "VBID Model Guidance on Treatment of Reductions in Part D Cost-Sharing," available on the VBID Model website. The memorandum provides further details

and instructions to participating MAOs regarding low-income cost-sharing subsidy (LICS) applicability and calculations for the Manufacturer discount for the Coverage Gap Discount Program (CGDP), as it pertains to the Model flexibility to reduce or eliminate Part D cost-sharing. A further memorandum, "VBID Prescription Drug Event (PDE) Reporting Guidance for Contract Year (CY) 2023)," released on December 1, 2022 to the VBID Model website, provides additional detail and examples regarding the reporting of VBID Model benefits in PDE data.

Appendix 1: CY 2023 Benefit Crosswalk File Key

Parent Organization	Parent Organization Code	Target Population	Target Population Code	Benefit*	Benefit Code	Supplemental Benefit Category Name	Supplemental Benefit Category Code	Supplemental Benefit Category, as in bid	Model Component	Target Start Date Definition	Opt-in Date Definition	Eligible Start Date 1 Definition
World's Best HMO	V###	Patients with XYZ chronic health conditions	V###01	Reduced cost sharing for XYZ	V###0101	N/A	N/A	N/A	VBID	First date identified with XYZ condition.	First date opted-into the VBID program[7]	First date met care management requirements
World's Best HMO	V###	LIS members	V###02	Reduced cost sharing for ABC	V###0201	N/A	N/A	N/A	VBID	First date identified as LIS.	N/A	N/A
World's Best HMO	V###	Patients with ABC chronic conditions	V###03	OTC Card	V###0301	OTC Items	3	Categorized in bid as "OTC Item"	R&I	First date identified with ABC condition.	N/A	N/A
World's Best HMO	V###	Enrollees targeted to receive Medical Devices	V###04	Medical Device A	V###0401	N/A	N/A	N/A	Technology/ Medical Devices	First date eligible for Medical Device A.	N/A	N/A
World's Best HMO	V####	Enrollees targeted to receive a food benefit	V###05	Food Benefit A	V###0501	Meals (beyond limited basis)	19	Categorized in bid as "Food and Produce"	VBID	First date eligible for Food Benefit A.	N/A	N/A
World's Best HMO	V####	Enrollees targeted to receive Home Assistance	V###06	Home Assistance A	V###0601	Home and Community Based services	11	Categorized in bid as "Home and Community Based Services"	VBID	First date eligible to receive Home Assistance A.	N/A	N/A

*Note that use of "Benefit" here includes all VBID Components, including RI, which are not benefits.

[7] MAO's program design would influence including Opt-In and Eligible Start dates. Opt In and Eligible Start Date may not apply to all MAOs submitting Flex files.

Appendix 2: CY 2023 VBID Beneficiary Level File Layout

Appendix 2, titled, "**VBID FLEX - File Layout**" provides file layouts for quarterly beneficiary-level reporting associated with the VBID Flexibilities, Part C and D RI Programs, and New and Existing Technologies/Medical Devices.

Appendix 3: CY 2023 WHP Reporting Worksheet Template

Deadline for Reporting Date to CMS: March 31, 2024
Plan Reporting Period: January 1, 2023 – December 31, 2023
Reporting Platform: Qualtrics

ALL REPORTING IS AT THE PARENT ORGANIZATION LEVEL AND COVERS ALL PBPs PARTICIPATING IN VBID IN CY 2023

Please note that questions in Qualtrics are generated based on your answers to previous questions. Thus, in Qualtrics, you may not see all questions.

WHP OUTREACH

Q1. Please enter your Parent Organization name, your name, and your e-mail address:

Parent Organization name _____
Name of point of contact completing this report _____
E-mail address of point of contact _____

Q2. Did you inform **all enrollees** in each of your VBID Plan Benefit Packages (PBPs) of their opportunity to take part in Wellness and Health care Planning (WHP) activities?

Note that throughout this document and consistent with the Addendum, "WHP services" mean advance care planning (ACP) services and other services identified in the Approved Proposal for the WHP Services VBID Component. Such services may be in addition to the activities and performance required by 42 CFR § 422.128. In this WHP reporting template, we will be requesting information on ACPs, such as completion of an advance directive, to understand how WHP influences ACP outcomes.

[Yes/No]

Q3. In your VBID PBPs, in what ways did you promote awareness of WHP services, including ACP, and access to these services using both general outreach, such as print materials, and more individualized one-on-one outreach? (Select all that apply.)

Q3.a General Outreach	Q3.b One-on-One Outreach
General enrollee outreach by a Medicare Advantage Organization (MAO) that is one-way print or digital communications that are not personalized or other types of outreach that are not specific to a single enrollee.	*One-on-one outreach is individualized enrollee outreach by an MAO.*
☐ WHP information is included in enrollment materials (e.g., Evidence of Coverage (EOC))	☐ An outreach conversation with an enrollee by case management staff (conducted either in person, by phone, or virtually) that promotes awareness of WHP opportunities and access

Q3.a General Outreach	Q3.b One-on-One Outreach
☐ WHP information is included in other post enrollment written materials (e.g., letters, emails, portal posting)	☐ An outreach conversation with an enrollee by customer service or other MAO staff (conducted either in person, by phone, or virtually) that promotes awareness of WHP opportunities and access
☐ WHP specific print communications (e.g., WHP including ACP brochures, flyers, reminders sent to all enrollees or to targeted enrollees)	☐ Outreach to an enrollee's provider to encourage the provider to conduct a WHP conversation with the enrollee
☐ Annual Wellness Visits (AWV) reminders and promotions that mention WHP (including print or digital communications)	☐ Other one-on-one individualized outreach by an MAO to an enrollee that promotes awareness of WHP opportunities and access (Please specify)
☐ Other online or digital WHP postings or communications	
☐ Outreach or training to network providers to encourage WHP discussions	
☐ Other (Please specify)	

UNDERSTANDING YOUR WHP POPULATION

Q4. Do you track WHP discussions for all beneficiaries enrolled in each of your 2023 VBID Model-participating PBPs in 2023? If so, how did you track the WHP discussions for all enrollees in VBID PBPs? (Select all that apply). If not, please indicate that you do not track WHP discussions in the check box below.

☐ Claims ☐ Care Management System ☐ Electronic Health Record (EHR) ☐Registry ☐ Digital application (e.g., a digital advance directive platform or other online platform) ☐ Other (Please specify _____) ☐ We do not track WHP discussions.

Q5. Think about **all beneficiaries enrolled in each of your 2023 VBID Model-participating PBPs in CY 2023**. In Columns A through D, please report the following metrics at your parent organization level, taking into consideration your entire enrolled population.

Total number of enrollees in 2023 in VBID PBPs	Number of enrollees in VBID PBPs who participated in a WHP discussion* with a provider, care manager, or other qualified individual in 2023	Did you track the number of enrollees in VBID PBPs that completed ACP in or prior to 2023 (i.e., the number of enrollees for whom there is a preexisting signed document indicating their wishes)?	If in 2023 you tracked the number of enrollees in VBID PBPs who completed an ACP, what number completed or updated an ACP document in 2023?
Column A	*Column B*	*Column C*	*Column D*

Total number of enrollees in 2023 in VBID PBPs	**Number of enrollees in VBID PBPs who participated in a WHP discussion* with a provider, care manager, or other qualified individual in 2023**	**Did you track the number of enrollees in VBID PBPs that completed ACP in or prior to 2023 (i.e., the number of enrollees for whom there is a preexisting signed document indicating their wishes)?**	**If in 2023 you tracked the number of enrollees in VBID PBPs who completed an ACP, what number completed or updated an ACP document in 2023?**
Report the total number of beneficiaries enrolled in 2023 VBID-participating PBPs at any point (and for any length) between January 1, and December 31, 2023 regardless of current enrollment status .	*Report the number of enrollees who had a WHP discussion.** *This number should be **less than or equal** to the total number of enrollees.*	*Select "yes" or "no".*	*{If yes,} Report the specific number of enrollees that completed an ACP **in 2023**.* *This number should be **less than or equal** to the total number of enrollees.* ***NOTE: If you do not track ACP completions, enter "0".***
#	#	Yes/No	#

* A WHP discussion is a face-to-face, telephonic, or virtual conversation between a qualified health care professional and an enrollee that discusses the enrollee's health care wishes if he or she becomes unable to make decisions about their care. The discussion may talk about an ACP including advance directives, with or without completing legal forms.

[If Column C = "yes" indicating completion of an ACP was tracked for full enrollment, continue to Q5.a. Otherwise, skip to Q5.b.]

Q5.a. The regulation at 42 CFR § 422.128 requires MAOs to document in an enrollee's medical record whether the individual has a current advance care directive in place. In addition to such notations, you indicated that you track the number of completed ACPs for your full enrollment in VBID PBPs. How did you track the number of completed ACPs? (Select all that apply)

☐ Claims ☐ Care Management System ☐ Electronic Health Record (EHR) ☐Registry
☐ Digital application (e.g., a digital advance directive platform or other online platform) ☐ Other (Please specify _____)

_____
_____
_____

[Skip to Q6.a.]

Q5.b. You indicated that you did not track the number of ACPs completed in 2023 for your full enrollment in VBID PBPs. What are the barriers to the annual tracking of the number of completed ACPs under this Model?

_____
_____
_____

UNDERSTANDING YOUR WHP IMPLEMENTATION EXPERIENCE

Q6.a. Which of your CY 2023 WHP activities do you see as the most impactful in terms of leading to the largest number of enrollees engaging in a WHP discussion, including completing ACPs?

_____
_____
_____

Q6.b. Please review your response to Q6.b, and explain how you are determining what activities were the most impactful?

_____
_____
_____

Q7. CMS is interested in your experience and insights engaging enrollees in sensitive ACP conversations, including supporting ACP through WHP activities that are culturally sensitive and informed by data and other information that supports improved equity across underserved populations. Please tell us about your experiences to date including your planned activities.

_____
_____
_____

Q8. What additional support could CMS provide to help you best execute your WHP initiatives so that more enrollees complete ACPs? (Optional)

_____
_____
_____

Thank you for taking the time to complete this worksheet, and for the important work you do in implementing your WHP program. Your insights and feedback are an important part in helping us understand the impacts of the Model. Your WHP programs support this Model and work to ensure that beneficiaries receive the care they need and want.

Appendix 4: CY 2023 VBID Summary Level Flex Supplemental Benefit File Layout

Appendix 4, titled, "CY 2023 VBID Summary Level Flex Supplemental Benefit File Layout" provides file layouts for annual summary level data reporting of VBID Flex supplemental benefits.

Appendix 5: CY 2023 VBID Beneficiary Level HEIP Supplemental Benefit File Layout

Appendix 5, titled, "CY 2023 VBID Beneficiary Level HEIP Supplemental Benefit File Layout" provides file layouts for voluntary biannual reporting of beneficiary-level supplemental benefits focused on priority areas for advancing heath equity, such as those related to food, transportation, and general supports for living.

Appendix 6: CY 2023 VBID Technical Specifications for Summary Level Supplemental Benefit File Layout

See Appendix 6, titled, "CY 2023 VBID Technical Specifications for Summary Level Supplemental Benefits File Layouts" for technical specifications for mandatory annual reporting of summary level supplemental benefits.