Calendar Year 2023 Medicare Advantage (MA) Value-Based Insurance Design (VBID) Application Reference Template

NOTE: This .PDF includes the entire set of VBID RFA questions, and in most cases an applicant will not respond to every question based on the Model Components selected and specifics of your program. This .PDF is for reference only and applicants may not use this document to respond to the VBID application.

Contents

1 Introduction and Orientation

NOTE: This document should only be used for reference purposes. All applicants must fill out and submit their application in Qualtrics. Additionally, some embedded links may only be available on Qualtrics.

Thank you for your interest in applying to participate in the Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model for CY 2023. For CY 2023, CMS has streamlined the VBID Model application process to better align with the CY 2023 bid submission. Specifically, the questions in this application are similar to the questions your organization will need to complete in Health Plan Management System (HPMS) as part of the June 6, 2022 bid submission, if your organization is approved by CMS for participation in the Model.

Please note that application questions in Qualtrics are generated based on the different VBID Model Components that you select to implement in the application. Thus, in Qualtrics, you will only see questions for Model Components that you choose for your application.

Submission of VBID Financial Template
Applicants are also required to submit to CMS: (i) projected costs for each VBID Model Component included in their application and (ii) projected net savings to Medicare over the course of the Model. Please complete and upload as part of this application the CY 2023 VBID Model Financial Application Template and the CY 2023 VBID Model Net Savings Template by **11:59 PM PT on April 15, 2022**. You will be asked to upload the CY 2023 VBID Financial Application Template and CY 2023 VBID Model Net Savings Template toward the end of this application. You may also email your completed templates to VBID@cms.hhs.gov.

Submission of VBID Summary Template
Applicants are also required to submit to CMS the CY 2023 VBID Model Application Spreadsheet, which in conjunction with this survey, includes all contracts, plan benefit packages (PBPs), Model components, and interventions, and targeting and engagement estimates consistent with your Qualtrics application submission. Please complete and upload as part of this application the CY 2023 VBID Model Application Spreadsheet by **11:59 PM PT on April 15, 2022**. You may also email your completed template to VBID@cms.hhs.gov.

Applicants must be a representative, officer, chief executive officer, or general partner of the business organization that is applying to participate in this Model test, and authorized to submit this application on the organization's behalf.

The RFAs are located on the VBID Model webpage at the following link: https://innovation.cms.gov/initiatives/vbid/.

Additional information regarding the Hospice Benefit Component can be accessed at the following link: https://innovation.cms.gov/innovation-models/vbid-hospice-benefit-overview.

This application, including all files requested in this application must be submitted by **11:59 PM PT on April 15, 2022**.

2 Model Eligibility Requirements

Model Eligibility Requirements and Applicant (MAO) Attestation
This section outlines the eligibility requirements for an MAO to apply for participation in the VBID Model.

Plan Type
The following MA only and Medicare Advantage-Prescription Drug (MA-PD) plan offerings are eligible to apply:

- Coordinated Care Plans
  - Health Maintenance Organizations (HMOs), including those with a Point of Service (POS) option
  - Local Preferred Provider Organizations (PPOs) or Regional PPOs (RPPOs)
- All Special Needs Plans
  - Chronic Condition Special Needs Plans (C-SNPs)
  - Dual Eligible Special Needs Plans (D-SNPs)
  - Institutional Special Needs Plans (I-SNPs)

The following plan types are not eligible to participate in the VBID Model:

- Private Fee-For-Service (PFFS) Plans
- Employer Group Waiver Plans (EGWPs) *
- Medicare-Medicaid Plans (MMPs) or other demonstration plans
- MA Medical Savings Account (MSA) Plans
- Cost Plans
- Programs of All-Inclusive Care for the Elderly (PACE) organizations

* 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.

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 election (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

- 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 423.750.
- CMS may deny an application on the basis of information obtained from a program integrity screening or patterns of consistent low performance.

Disclosure of Present or Past History of Sanctions, Investigations, Probations, or Corrective Action Plans
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. CMS will conduct appropriate program integrity screens during the application process and may choose to not select otherwise qualified MAOs based on information found during a program integrity screen.

This information must be submitted along with your VBID Model Application for CY 2023.

3 Model Eligibility Exceptions

How to Request an Exception to a Model Eligibility Requirement
CMS will consider exception requests in limited circumstances and will reserve the right, in its sole judgment, to admit a PBP that does not strictly meet the criteria. However, CMS will only exercise that discretion when that admission is consistent with the administration and goals of the VBID Model. In addition, CMS will consider applications for plans that do not meet the criteria at the time of application but are anticipated to qualify by January 1, 2023.

- Is your organization requesting an exception to any of the Model Eligibility requirements?
  - Yes
  - No
- Since you selected "Yes", please indicate the type of exception that your organization is requesting
  - Length of Plan Existence
  - Plan Performance and Compliance
- Please provide the grounds for your exception request.
- Please provide the contract(s) and PBP(s) for which an exception is sought in following format (H1234-000).

4 Applicant Organization Information

- Parent Organization Name (Consistent with HPMS)
- Medicare Advantage Organization (Consistent with HPMS)
- States where VBID PBP(s) will be available.

Question on Existing Participation
- Does your organization currently participate in the VBID Model (i.e., are you participating in CY 2022)?
  - ❒ Yes
  - ❒ No
- Since you selected "Yes", please summarize any changes and/or updates (as applicable) to Model Components that you are proposing to offer for CY 2023.

5 Mandatory Submission of VBID Application Summary in Excel

Please note: you are required to submit an Excel file (VBID Application Summary Excel File) with the applicable VBID contracts, PBPs, and plan types in addition to answering the questions included in this application. The Excel File can be downloaded from the Model webpage and from the Qualtrics application.

6 Applicant Contact Information
- Applicant First and Last Name (e.g., John Doe)
- Title
- Street Address 1
- Street Address 2 **(Optional)**
- City
- State or Territory
- Zip code
- Business Phone # (and extension, if applicable)

- Alternative Phone # **(Optional)**
- Email Address
- Secondary Contact. First and Last Name (e.g., John Doe) **(Optional)**
- Secondary Contact. Business Phone # (and extension, if applicable) **(Optional)**
- Secondary Contact. Email Address **(Optional)**

Additional Contact(s). You may also designate an additional contact for specific model components (e.g., marketing materials, Part D) if applicable. Hospice contacts will be requested in a subsequent section of this application.

- Additional Contact. First and Last Name (e.g., John Doe) **(Optional)**
- Additional Contact. Business Phone # (and extension, if applicable) **(Optional)**
- Additional Contact. Email Address **(Optional)**
- Additional Contact. Model component **(Optional)**

7 VBID Application Summary

In addition to the required Wellness and Health Care Planning (WHP) Strategy which you will answer questions about at a later point in this application, please select the VBID Model Component(s) that your organization will offer in CY 2023. You may select more than one option, but you must select at least one of the Model components listed below.

NOTE: Please select all of the VBID Model Components that are applicable to your application before proceeding. Specific questions regarding each of these components will only be available if you select the relevant Components in this section.

- ❒ Hospice Benefit Component
- ❒ Value-Based Insurance Design by Condition and/or Socioeconomic Status (LIS)
- ❒ Part C Rewards and Incentives (RI)
- ❒ Part D RI
- ❒ New and Innovative Technologies

- **Total 2023 Model Contract & Plan Benefit Package (PBP) Enrollment.** Please provide a projection of the total number of unique enrollees across all of your MAO's contracts and PBPs in the Model for CY 2023. *(Please note that PBP-level estimates requested in the VBID Summary Spreadsheet are not required here.)*

- **2023 Projected VBID Target Population.** Please provide a projection of the total number of unique enrollees across all of your MAO's contracts and PBPs to be *targeted* for VBID components other than WHP (i.e., the number of enrollees that are expected to meet the targeting criteria for the services, benefits, RI, etc.). This projection should not exceed the projected total Model enrollment described above. *(Please note that PBP-level estimates requested in the VBID Summary Spreadsheet are not required here.)*

- **2023 Projected VBID Population to be Engaged.** Please provide a projection of the total unique number of enrollees across all contracts and PBPs to be *engaged* for VBID components other than WHP (the number of enrollees that are expected to be engaged in the intervention or receive the service, benefits, RI, etc.). In most cases, this will be a subset of the targeted population. Please describe the definition of engagement used for this projection. *(Please note that PBP-level estimates requested in the VBID Summary Spreadsheet are not required here.)*

- **Voluntary Health Equity Incubation Program.** How does participation in the VBID Model align

with your organization's overall health equity strategy? Are there particular areas of interest that you would request additional information on from CMS?

8 Wellness and Health Care Planning (WHP)

Participating MAOs must implement a WHP strategy to reach all enrollees in all of the PBPs included in the Model, not just those members targeted for VBID and not just in select PBPs. 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.
Note: Responses to applicable questions in the WHP Section should correspond directly to the responses submitted in the PBP.

- **WHP Program Type.** How will your organization offer WHP Services, including Advance Care Planning? Please check all boxes that apply. You may check more than one box.
  - ❒ Annual Wellness Visit
  - ❒ Medicare Health Risk Assessment
  - ❒ Care Management Program
  - ❒ In-Home Assessment
  - ❒ Other
- Since you selected "Other", please use this space below to describe the WHP Program Type.

- **WHP Model of Engagement.** What mode(s) will your organization use to engage enrollees? Please check all that apply. You may check more than one box.
  - ❒ Telephonic
  - ❒ In-Person (e.g., doctor's office, in-home, etc.)
  - ❒ Web-Based (e.g., web-based portal, telehealth, email, etc.)

- **WHP Strategy for All Enrollees.** Please describe the specific WHP activities, leveraging the program types you indicated, that your organization will offer to engage *all enrollees in VBID Model PBPs* in timely opportunities to access WHP activities/services. Please specifically discuss how your WHP activities will support ACP completion.

- **WHP for Subpopulations.** Will you specifically target and outreach to one or more defined subpopulations of your enrollees for WHP, including ACP, such as enrollees with specific health conditions as defined by a specific diagnosis, enrollees taking part in a specific care management program, or enrollees receiving specific types of services?
  - □ Yes
  - □ No

- Since you selected "Yes", please use the space below to describe the subpopulations that will receive tailored outreach or any additional WHP services, including ACP. Please describe how the subpopulations are identified and the outreach and services they will receive.

- **WHP RI for Enrollees.** Will your organization offer RI to enrollees for participating in WHP

activities?
- ❒ Yes
- ❒ No

- If you answered yes to the question above, is this WHP RI offered outside the VBID Model?
  - ❒ Yes
  - ❒ No

- If you answered yes to the question about offering WHP RI in the VBID Model , please check the type of Reward or Incentive that will be offered to enrollees as part of your WHP Strategy in the VBID Model
  - ❒ Gift Card
  - ❒ Item
  - ❒ Other

- Since you selected "Gift Card", please use this space below to describe the WHP Reward or Incentive
- Since you selected "Other", please use this space below to describe the WHP Reward or Incentive
- Since you selected "Item", please use this space below to describe the WHP Reward or Incentive

- **WHP Reward or Incentive Amount.** Please provide the total dollar amount of RI that the enrollee can receive under the WHP reward or incentive program.

- **WHP Reward or Incentive Frequency.** Please provide the general frequency of the offering of the Reward or Incentive
  - ❒ Every year
  - ❒ Every 6 months
  - ❒ Every 3 months
  - ❒ Every month
  - ❒ One-time
  - ❒ Other

- Since you selected "Other", please use this space below to describe the frequency of the offering of the Reward or Incentive

- **WHP RI Enrollee Eligibility Criteria.** Please use this space to describe the eligibility criteria for an enrollee to receive the Reward or Incentive

- **WHP RI for Providers.** Will your organization offer incentives to providers for engaging enrollees in WHP activities?
  - ❒ Yes
  - ❒ No

- If you answered yes to the question above, is this WHP RI for providers engaging enrollees in WHP activities offered outside the VBID Model?
  - ❒ Yes
  - ❒ No

- **WHP RI Amount for Providers.** If you answered yes to RI for providers in the VBID Model, please provide the total dollar amount of RI that the provider can receive for WHP in the VBID Model.

- **Additional Information regarding your organization's WHP Strategy.** Please use the space below if you would like to clarify or provide additional information regarding your WHP Strategy. **(Optional)**

9 VBID Targeting Methodology, Reduced Cost Sharing, and/or Supplemental Benefits

Participating MAOs may provide non-uniform supplemental benefits (including "non-primarily health-related supplemental benefits"), such as reduced cost sharing and/or additional benefits, to targeted enrollees. MAOs are also permitted to reduce cost sharing for High-Value Providers. MAOs may target enrollees for VBID benefits and services based on the following: (1) Chronic Conditions; (2) Socioeconomic Status (LIS) or Dual Eligibility; or (3) A Combination of Both (e.g., enrollees who are LIS eligible and have COPD).

Part D Reduced Cost Sharing
Plans may include reduced cost sharing or additional supplemental benefits for medical services and reduced cost sharing for one or more classes of covered Part D drugs for targeted enrollees. Is your organization offering reduced cost sharing for Part D drugs?

- ❒ Yes
- ❒ No

If your organization is offering reduced cost sharing for Part D drugs that does not include all Part D covered drugs, or Part D drugs on a given formulary tier, please complete and upload the VBID Part D Supplemental File, which can be accessed here: CY 2023 VBID Model Part D Supplemental File. You may also email this file to VBID@cms.hhs.gov

Note: If you are waiving cost sharing for all Part D drugs for LIS enrollees, you do not need to submit the CY 2023 VBID Model Part D Supplemental File as part of your application.

Please check how many Part D Reduced Cost Sharing targeting methodology packages your organization will implement under the Model. **NOTE: If your organization will implement multiple targeting methodologies (packages), you must select a box below for each targeting methodology (e.g., if you will use 3 targeting methodologies you must select 1, 2, and 3 below). Specific questions regarding each targeting methodology will only be visible in this application if you select one box for each targeting methodology that is applicable in this section.**

- ❒ 1
- ❒ 2
- ❒ 3

- **Part D Reduced Cost Sharing Targeting Methodology #1:** Please choose whether your organization will target enrollees based on chronic conditions, socioeconomic status, or both. Please select all that apply.
  - ❒ Chronic Condition(s)
  - ❒ Socioeconomic Status (LIS Level, or dual-eligible status for MAOs in U.S. territories)

- **Part D Reduced Cost Sharing Targeting Methodology #1:** Please list the conditions that will be targeted.

- **Part D Reduced Cost Sharing Targeting Methodology #1.** Please indicate whether the receipt of reduced or eliminated Part D cost sharing is conditional upon the receipt of one, or both, of the following
  - ❒ Participation in a disease state management program

- ❒ Use of a high-value provider(s) in the network
- ❒ Not Applicable

- **Part D Reduced Cost Sharing Targeting Methodology #1– Benefits Conditioned on Use of High-Value Provider or Program Participation.** Please explain the components of the disease state management program and/or the proposed methodology for identifying high-value providers.
  - For benefits conditioned on program participation, provide a description of how the organization intends to link disease state management or related programs to the conditional benefits, including what an enrollee must do to qualify and a justification of how this is clinically reasonable, non-discriminatory, and not likely to have adverse impacts on enrollees.
  - For benefits conditioned on high-value providers, please describe extent to which you anticipate that high-value providers will be accessible throughout the PBPs' service area, or confined to a specific geographic area, and any accommodations or alternatives available to eligible/targeted enrollees unable to access a high-value provider.

- **Part D Reduced Cost Sharing Targeting Methodology #1:** Please select the applicable LIS Levels
  - ❒ Level 1
  - ❒ Level 2
  - ❒ Level 3
  - ❒ Level 4
  - ❒ Dual-Eligible (only for MAOs in U.S. territories)

- **Part D Reduced Cost Sharing #1.** Which phase(s) of the benefit will have reduced cost- sharing? Please select all that apply.
  - ❒ Pre-ICL
  - ❒ Coverage Gap
  - ❒ Post-OOP Threshold/Catastrophic

- **Part D Reduced Cost Sharing #1.** Are you modifying the deductible amount?
  - ❒ Yes
  - ❒ No

- **Part D Reduced Cost Sharing #1.** Please provide the modified deductible amount.
- **Part D Reduced Cost Sharing #1.** Is the reduction or waiver of cost sharing for Part D drugs for LIS enrollees applicable to all drugs, or select drugs?
  - ❒ All Part D drugs for LIS enrollees
  - ❒ Select Part D drugs for LIS enrollees (to be included in the Part D Supplemental Excel File)

- **Part D Reduced Cost Sharing Targeting Methodology #2:** Please choose whether your organization will target enrollees based on chronic conditions, socioeconomic status, or both. Please select all that apply.
  - ❒ Chronic Condition(s)
  - ❒ Socioeconomic Status (LIS Level, or dual-eligible status for MAOs in U.S. territories)

- **Part D Reduced Cost Sharing Targeting Methodology #2:** Please list the conditions that will be targeted.
- **Part D Reduced Cost Sharing Targeting Methodology #2.** Please indicate whether the receipt of reduced or eliminated Part D cost sharing is conditional upon the receipt of one, or both, of the following

- ❒ Participation in a disease state management program
- ❒ Use of a high-value provider(s) in the network
- ❒ Not Applicable

- **Part D Reduced Cost Sharing Targeting Methodology #2– Benefits Conditioned on Use of High-Value Provider or Program Participation.** Please explain the components of the disease state management program and/or the proposed methodology for identifying high-value providers.
  - For benefits conditioned on program participation, provide a description of how the organization intends to link disease state management or related programs to the conditional benefits, including what an enrollee must do to qualify and a justification of how this is clinically reasonable, non-discriminatory, and not likely to have adverse impacts on enrollees.
  - For benefits conditioned on high-value providers, please describe extent to which you anticipate that high-value providers will be accessible throughout the PBPs' service area, or confined to a specific geographic area, and any accommodations or alternatives available to eligible/targeted enrollees unable to access a high-value provider.

- **Part D Reduced Cost Sharing Targeting Methodology #2:** Please select the applicable LIS Levels
  - ❒ Level 1
  - ❒ Level 2
  - ❒ Level 3
  - ❒ Level 4
  - ❒ Dual-Eligible (only for MAOs in U.S. territories)

- **Part D Reduced Cost Sharing #2.** Which phase(s) of the benefit will have reduced cost- sharing? Please select all that apply.
  - ❒ Pre-ICL
  - ❒ Coverage Gap
  - ❒ Post-OOP Threshold/Catastrophic

- **Part D Reduced Cost Sharing #2.** Are you modifying the deductible amount?
  - ❒ Yes
  - ❒ No

- **Part D Reduced Cost Sharing #2.** Please provide the modified deductible amount.
- **Part D Reduced Cost Sharing #2.** Is the reduction or waiver of cost sharing for Part D drugs for LIS enrollees applicable to all drugs, or select drugs?
  - ❒ All Part D drugs for LIS enrollees
  - ❒ Select Part D drugs for LIS enrollees (to be included in the Part D Supplemental Excel File)

- **Part D Reduced Cost Sharing Targeting Methodology #3:** Please choose whether your organization will target enrollees based on chronic conditions, socioeconomic status, or both. Please select all that apply.
  - ❒ Chronic Condition(s)
  - ❒ Socioeconomic Status (LIS Level, or dual-eligible status for MAOs in U.S. territories)

- **Part D Reduced Cost Sharing Targeting Methodology #3:** Please list the conditions that will be targeted.
- **Part D Reduced Cost Sharing Targeting Methodology #3.** Please indicate whether the receipt of reduced or eliminated Part D cost sharing is conditional upon the receipt of one, or both, of the

following
- ❒ Participation in a disease state management program
- ❒ Use of a high-value provider(s) in the network
- ❒ Not Applicable

- **Part D Reduced Cost Sharing Targeting Methodology #3– Benefits Conditioned on Use of High-Value Provider or Program Participation.** Please explain the components of the disease state management program and/or the proposed methodology for identifying high-value providers.
  - For benefits conditioned on program participation, provide a description of how the organization intends to link disease state management or related programs to the conditional benefits, including what an enrollee must do to qualify and a justification of how this is clinically reasonable, non-discriminatory, and not likely to have adverse impacts on enrollees.
  - For benefits conditioned on high-value providers, please describe extent to which you anticipate that high-value providers will be accessible throughout the PBPs' service area, or confined to a specific geographic area, and any accommodations or alternatives available to eligible/targeted enrollees unable to access a high-value provider.

- **Part D Reduced Cost Sharing Targeting Methodology #3:** Please select the applicable LIS Levels
  - ❒ Level 1
  - ❒ Level 2
  - ❒ Level 3
  - ❒ Level 4
  - ❒ Dual-Eligible (only for MAOs in U.S. territories)

- **Part D Reduced Cost Sharing #3.** Which phase(s) of the benefit will have reduced cost- sharing? Please select all that apply.
  - ❒ Pre-ICL
  - ❒ Coverage Gap
  - ❒ Post-OOP Threshold/Catastrophic

- **Part D Reduced Cost Sharing #3.** Are you modifying the deductible amount?
  - ❒ Yes
  - ❒ No

- **Part D Reduced Cost Sharing #3.** Please provide the modified deductible amount.

- **Part D Reduced Cost Sharing #3.** Is the reduction or waiver of cost sharing for Part D drugs for LIS enrollees applicable to all drugs, or select drugs?
  - ❒ All Part D drugs for LIS enrollees
  - ❒ Select Part D drugs for LIS enrollees (to be included in the Part D Supplemental Excel File)

- **Please check how many other VBID targeting methodology packages (not including any Part D Reducing Cost Sharing packages described above) your organization will implement under the Model.**
  NOTE: If your organization will implement multiple targeting methodologies (packages), you must select a box below for each targeting methodology (e.g., if you will use 5 targeting methodologies you must select 1, 2, 3, 4, and 5 below). Specific questions regarding each targeting methodology will only be visible in this application if you select one box for each targeting methodology that is applicable to your VBID program in this section.

- ❒ 1
- ❒ 2
- ❒ 3
- ❒ 4
- ❒ 5

- **Targeting Methodology #1.** Please provide the applicable contracts, PBPs, and segments.
  NOTE: (Please enter the data in the following format: Contract-PBP-Segment)

- **Targeting Methodology #1.** Please choose whether your organization will target enrollees based on chronic conditions, socioeconomic status, or both. Please select all that apply.
  - ❒ Chronic Conditions(s)
  - ❒ Socioeconomic Status (LIS Level, or dual-eligible status for MAOs in U.S. territories)

- **Chronic Conditions #1.** Please list the conditions that will be targeted and indicate if an enrollee must have one, multiple, or all of the conditions listed to be targeted. If available, please provide the data sources (e.g., ICD codes) and note any other qualifying criteria (e.g., lookback period, types of claims considered) used to identify and target enrollees. CMS may follow-up for more information.

- **Targeting Methodology #1 – Benefits Conditioned on Use of High-Value Provider or Program Participation.** Please indicate whether the receipt of supplemental benefits or reduced Cost sharing is conditional upon the receipt of one, or both, of the following
  - ❒ Participation in a disease state management program
  - ❒ Use of a high-value provider(s) in the network
  - ❒ Not Applicable

- **Targeting Methodology #1 – Benefits Conditioned on Use of High-Value Provider or Program Participation.** Please explain the components of the disease state management program and/or the proposed methodology for identifying high-value providers.
  - For benefits conditioned on program participation, provide a description of how the organization intends to link disease state management or related programs to the conditional benefits, including what an enrollee must do to qualify and a justification of how this is clinically reasonable, non-discriminatory, and not likely to have adverse impacts on enrollees.
  - For benefits conditioned on high-value providers, please describe extent to which you anticipate that high-value providers will be accessible throughout the PBPs' service area, or confined to a specific geographic area, and any accommodations or alternatives available to eligible/targeted enrollees unable to access a high-value provider.

- **LIS Level or Dual-Eligible Status #1**
  - ❒ Level 1
  - ❒ Level 2
  - ❒ Level 3
  - ❒ Level 4
  - ❒ Dual-Eligible (only for MAOs in U.S. territories)

- **Targeting Methodology #1.** Type of Supplemental Benefits and/or Reduced Cost Sharing. Please provide the type(s) and amounts (per enrollee) of supplemental benefits (including "non-primarily health-related supplemental benefits") and or/reduced cost sharing to be provided.

- **Targeting Methodology #2.** Please provide the applicable contracts, PBPs, and segments.
  NOTE: (Please enter the data in the following format: Contract-PBP-Segment)

- **Targeting Methodology #2.** Please choose whether your organization will target enrollees based on chronic conditions, socioeconomic status, or both. Please select all that apply.
  - ❒ Chronic Conditions(s)
  - ❒ Socioeconomic Status (LIS Level)

- **Chronic Conditions #2.** Please list the conditions that will be targeted and indicate if an enrollee must have one, multiple, or all of the conditions listed to be targeted. If available, please provide the data sources (e.g., ICD codes) and note any other qualifying criteria (e.g., lookback period, types of claims considered) used to identify and target enrollees. CMS may follow-up for more information.

- **Targeting Methodology #2– Benefits Conditioned on Use of High-Value Provider or Program Participation.** Please indicate whether the receipt of supplemental benefits or reduced cost sharing is conditional upon the receipt of one, or both, of the following
  - ❒ Participation in a disease state management program
  - ❒ Use of a high-value provider(s) in the network
  - ❒ Not Applicable

- **Targeting Methodology #2 – Benefits Conditioned on Use of High-Value Provider or Program Participation.** Please explain the components of the disease state management program and/or the proposed methodology for identifying high-value providers.
  - For benefits conditioned on program participation, provide a description of how the organization intends to link disease state management or related programs to the conditional benefits, including what an enrollee must do to qualify and a justification of how this is clinically reasonable, non-discriminatory, and not likely to have adverse impacts on enrollees.
  - For benefits conditioned on high-value providers, please describe extent to which you anticipate that high-value providers will be accessible throughout the PBPs' service area, or confined to a specific geographic area, and any accommodations or alternatives available to eligible/targeted enrollees unable to access a high-value provider.

- **LIS Level or Dual-Eligible Status #2**
  - ❒ Level 1
  - ❒ Level 2
  - ❒ Level 3
  - ❒ Level 4
  - ❒ Dual-Eligible (only for MAOs in U.S. territories)

- **Targeting Methodology #2.** Type of Supplemental Benefits and/or Reduced Cost- Sharing. Please provide the type(s) and amounts (per enrollee) of supplemental benefits (including "non-primarily health-related supplemental benefits") and or/reduced cost sharing to be provided

- **Targeting Methodology #3.** Please provide the applicable contracts, PBPs, and segments.
  NOTE: (Please enter the data in the following format: Contract-PBP-Segment)

- **Targeting Methodology #3.** Please choose whether your organization will target enrollees based on chronic conditions, socioeconomic status, or both. Please select all that apply.
  - ❒ Chronic Condition(s)
  - ❒ Socioeconomic Status (LIS Level)

- **Chronic Conditions #3.** Please list the conditions that will be targeted and indicate if an enrollee must have one, multiple, or all of the conditions listed to be targeted. If available, please provide the data sources (e.g., ICD codes) and note any other qualifying criteria (e.g., lookback period, types of claims considered) used to identify and target enrollees. CMS may follow-up for more information.

- **Targeting Methodology #3– Benefits Conditioned on Use of High-Value Provider or Program Participation.** Please indicate whether the receipt of supplemental benefits or reduced cost sharing is conditional upon the receipt of one, or both, of the following
  - ❒ Participation in a disease state management program
  - ❒ Use of a high-value provider(s) in the network
  - ❒ Not Applicable

- **Targeting Methodology #3 – Benefits Conditioned on Use of High-Value Provider or Program Participation.** Please explain the components of the disease state management program and/or the proposed methodology for identifying high-value providers.
  - For benefits conditioned on program participation, provide a description of how the organization intends to link disease state management or related programs to the conditional benefits, including what an enrollee must do to qualify and a justification of how this is clinically reasonable, non-discriminatory, and not likely to have adverse impacts on enrollees.
  - For benefits conditioned on high-value providers, please describe extent to which you anticipate that high-value providers will be accessible throughout the PBPs' service area, or confined to a specific geographic area, and any accommodations or alternatives available to eligible/targeted enrollees unable to access a high-value provider.

- **LIS Level or Dual-Eligible Status #3**
  - ❒ Level 1
  - ❒ Level 2
  - ❒ Level 3
  - ❒ Level 4
  - ❒ Dual-Eligible (only for MAOs in U.S. territories)

- **Targeting Methodology #3.** Type of Supplemental Benefits and/or Reduced Cost Sharing. Please provide the type(s) and amounts (per enrollee) of supplemental benefits (including "non-primarily health-related supplemental benefits") and or/reduced cost sharing to be provided

- **Targeting Methodology #4.** Please provide the applicable contracts, PBPs, and segments.
  NOTE: (Please enter the data in the following format: Contract-PBP-Segment)

- **Targeting Methodology #4.** Please choose whether your organization will target enrollees based on chronic conditions, socioeconomic status, or both. Please select all that apply.
  - ❒ Chronic Conditions(s)
  - ❒ Socioeconomic Status (LIS Level, or dual-eligible status for MAOs in U.S. territories)

- **Chronic Conditions #4.** Please list the conditions that will be targeted and indicate if an enrollee must have one, multiple, or all of the conditions listed to be targeted. If available, please provide the data sources (e.g., ICD codes) and note any other qualifying criteria (e.g., lookback period, types of claims considered) used to identify and target enrollees. CMS may follow-up for more information.

- **Targeting Methodology #4 – Benefits Conditioned on Use of High-Value Provider or Program**

Participation. Please indicate whether the receipt of supplemental benefits or reduced Cost sharing is conditional upon the receipt of one, or both, of the following
- ❒ Participation in a disease state management program
- ❒ Use of a high-value provider(s) in the network
- ❒ Not Applicable

- **Targeting Methodology #4 – Benefits Conditioned on Use of High-Value Provider or Program Participation.** Please explain the components of the disease state management program and/or the proposed methodology for identifying high-value providers.
  - For benefits conditioned on program participation, provide a description of how the organization intends to link disease state management or related programs to the conditional benefits, including what an enrollee must do to qualify and a justification of how this is clinically reasonable, non-discriminatory, and not likely to have adverse impacts on enrollees.
  - For benefits conditioned on high-value providers, please describe extent to which you anticipate that high-value providers will be accessible throughout the PBPs' service area, or confined to a specific geographic area, and any accommodations or alternatives available to eligible/targeted enrollees unable to access a high-value provider.

- **LIS Level or Dual-Eligible Status #4**
  - ❒ Level 1
  - ❒ Level 2
  - ❒ Level 3
  - ❒ Level 4
  - ❒ Dual-Eligible (only for MAOs in U.S. territories)

- **Targeting Methodology #4.** Type of Supplemental Benefits and/or Reduced Cost Sharing. Please provide the type(s) and amounts (per enrollee) of supplemental benefits (including "non-primarily health-related supplemental benefits") and or/reduced cost sharing to be provided.

- **Targeting Methodology #5.** Please provide the applicable contracts, PBPs, and segments. **NOTE:** (Please enter the data in the following format: Contract-PBP-Segment)

- **Targeting Methodology #5.** Please choose whether your organization will target enrollees based on chronic conditions, socioeconomic status, or both. Please select all that apply.
  - ❒ Chronic Conditions(s)
  - ❒ Socioeconomic Status (LIS Level, or dual-eligible status for MAOs in U.S. territories)

- **Chronic Conditions #5.** Please list the conditions that will be targeted and indicate if an enrollee must have one, multiple, or all of the conditions listed to be targeted. If available, please provide the data sources (e.g., ICD codes) and note any other qualifying criteria (e.g., lookback period, types of claims considered) used to identify and target enrollees. CMS may follow-up for more information.

- **Targeting Methodology #5 – Benefits Conditioned on Use of High-Value Provider or Program Participation.** Please indicate whether the receipt of supplemental benefits or reduced Cost sharing is conditional upon the receipt of one, or both, of the following
  - ❒ Participation in a disease state management program
  - ❒ Use of a high-value provider(s) in the network
  - ❒ Not Applicable

- **Targeting Methodology #5 – Benefits Conditioned on Use of High-Value Provider or Program**

Participation. Please explain the components of the disease state management program and/or the proposed methodology for identifying high-value providers.

- For benefits conditioned on program participation, provide a description of how the organization intends to link disease state management or related programs to the conditional benefits, including what an enrollee must do to qualify and a justification of how this is clinically reasonable, non-discriminatory, and not likely to have adverse impacts on enrollees.
- For benefits conditioned on high-value providers, please describe extent to which you anticipate that high-value providers will be accessible throughout the PBPs' service area, or confined to a specific geographic area, and any accommodations or alternatives available to eligible/targeted enrollees unable to access a high-value provider.

- **LIS Level or Dual-Eligible Status #5**
  - ❒ Level 1
  - ❒ Level 2
  - ❒ Level 3
  - ❒ Level 4
  - ❒ Dual-Eligible (only for MAOs in U.S. territories)

- **Targeting Methodology #5.** Type of Supplemental Benefits and/or Reduced Cost Sharing. Please provide the type(s) and amounts (per enrollee) of supplemental benefits (including "non-primarily health-related supplemental benefits") and or/reduced cost sharing to be provided.

10 Part C and Part D Rewards and Incentives (RI) Programs

In the VBID Model, plans are permitted to offer Model Part C RI, as well as RI in connection with the Part D benefit (Part D RI). The total RI amount per enrollee cannot exceed $600 per calendar year. Additional details on RI proposals can be found below:

- **Gift Card Types:** If you are proposing to offer a gift card, please identify what the specific gift card, or choice of gift cards, that you will provide to your eligible enrollees are. As a reminder, the gift card must not be redeemable for cash and your response should clearly identify where the gift card can be used, the amount of the gift card, how the enrollee will qualify to receive the gift card, the frequency with which the enrollee can earn the gift card, and other descriptions or limitations around the gift card.
- **Cash Equivalents:** Please note that we cannot approve an RI Program that includes a cash equivalent reward. See the below for more guidance on cash equivalents.
  - The 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 Final Rule (86 FR 5864), which specifies in part that "gas cards or restaurant gift cards" are not cash equivalents, but an item that can be converted to cash or used like cash, such as "a general purpose debit card" or "a VISA or Amazon gift card" is a cash equivalent.
  - The Medicare and State Health Care Programs: Fraud and Abuse; Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements Final Rule (85 FR 77684), which includes the guidance that "gift cards that can only be redeemed for certain categories of items (such as fuel-only gift cards redeemable at gas stations)" may not be cash equivalents, but that "gift cards offered by large retailers or online vendors that sell a wide variety of items (e.g., big-box stores)" are cash equivalents.

For more information, please consult the VBID RFA.

10.1 Part C RI

- **Number of Part C RI programs to be offered.** Please indicate the number of Part C RI programs that will be offered. If you are offering multiple Part C RI programs, please select multiple boxes as applicable.

NOTE: If you are offering multiple Part C RI programs, you must select a box for each program below (e.g., if you are offering 3 Part C RI programs you must select 1, 2, and 3 below). Specific questions regarding each Part C RI program will only be visible in this application if you select one box for each of your VBID Part C RI programs

- ❒ 1
- ❒ 2
- ❒ 3

- **Part C RI #1.** Please provide the applicable contracts, PBPs, and segments.
  NOTE: (Please enter the data in the following format: Contract-PBP-Segment)
- Type of Part C Reward or Incentive #1
  - ❒ Gift Card
  - ❒ Item
  - ❒ Other
- Since you selected "Gift Card", please use this space below to describe the Part C Reward or Incentive
- Since you selected "Item", please use this space below to describe the item
- Since you selected "Other", please use this space below to describe the Part C RI type

- Please provide the frequency of the Part C Reward or Incentive
  - ❒ Every year
  - ❒ Every 6 months
  - ❒ Every 3 months
  - ❒ Every month
  - ❒ One-time
  - ❒ Other
- Since you selected "Other", please specify the frequency of the Part C Reward or Incentive

- **Part C RI #1.** Please provide the per unit and total dollar amount of Part C RI that the enrollee can receive during the plan year
- **Part C RI #1.** Please use this space to describe the enrollee eligibility criteria for receiving the Part C RI

- **Part C RI #2.** Please provide the applicable contracts, PBPs, and segments.
  NOTE: (Please enter the data in the following format: Contract-PBP-Segment)
- **Part C RI #2.** Type of Part C Reward or Incentive #2
  - ❒ Gift Card
  - ❒ Item
  - ❒ Other
- Since you selected "Gift Card", please use this space below to describe the Part C Reward or Incentive
- Since you selected "Item", please use this space below to describe the item
- Since you selected "Other", please use this space below to describe the Part C RI type

- **Part C RI #2.** Please provide the frequency of the Part C Reward or Incentive
  - ❒ Every year
  - ❒ Every 6 months
  - ❒ Every 3 months
  - ❒ Every month
  - ❒ One-time
  - ❒ Other
- Since you selected "Other", please specify the frequency of the Part C Reward or Incentive

- **Part C RI #2.** Please provide the per unit and total dollar amount of Part C RI that the enrollee can receive during the plan year.

- **Part C RI #2.** Please use this space to describe the enrollee eligibility criteria for receiving the Part C RI

- **Part C RI #3.** Please provide the applicable contracts, PBPs, and segments.
  NOTE: (Please enter the data in the following format: Contract-PBP-Segment)

- **Part C RI #3.** Type of Part C Reward or Incentive #3.
  - ❒ Gift Card
  - ❒ Item
  - ❒ Other
- Since you selected "Gift Card", please use this space below to describe the Part C Reward or Incentive
- Since you selected "Item", please use this space below to describe the item
- Since you selected "Other", please use this space below to describe the Part C RI type

- **Part C RI #3.** Please provide the frequency of the Part C Reward or Incentive
  - ❒ Every year
  - ❒ Every 6 months
  - ❒ Every 3 months
  - ❒ Every month
  - ❒ One-time
  - ❒ Other
- Since you selected "Other", please specify the frequency of the Part C Reward or Incentive
- **Part C RI #3.** Please provide the per unit and total dollar amount of Part C RI that the enrollee can receive during the plan year
- **Part C RI #3.** Please use this space to describe the enrollee eligibility criteria for receiving the Part C RI

Additional Information regarding your organization's Part C RI Programs (Optional)

- Please provide information about how you intend to monitor and provide safeguards against misuse of Model rewards. Please also use the space below if you would like to clarify or provide additional information regarding your Part C RI programs.

10.2 Part D RI

- **Number of Part D RI programs to be offered.** Please indicate the number of Part D RI programs that will be offered.

NOTE: If you are offering multiple Part D RI programs, you must select a box for each program below (e.g., if you are offering 3 Part D RI programs you must select 1, 2, and 3 below). Specific questions regarding each Part D RI program will only be visible in this application if you select one box for each of your VBID Part D RI programs

❒ 1
❒ 2
❒ 3

- **Part D RI #1.** Please provide the applicable contracts, PBPs, and segments.
  NOTE: (Please enter the data in the following format: Contract-PBP-Segment)
- Type of Part D Reward or Incentive #1
  ❒ Gift Card
  ❒ Item
  ❒ Other
- Since you selected "Gift Card", please use this space below to describe the Part D Reward or Incentive
- Since you selected "Item,", please use this space below to describe the item
- Since you selected "Other", please use this space below to describe the Part D RI type

- Please provide the frequency of the Part D Reward or Incentive
  ❒ Every year
  ❒ Every 6 months
  ❒ Every 3 months
  ❒ Every month
  ❒ One-time
  ❒ Other

Since you selected "Other", please specify the frequency of the Part D Reward or Incentive

- **Part D RI #1.** Please provide the per unit and total dollar amount of Part D RI that the enrollee can receive during the plan year
- **Part D RI #1.** Please use this space to describe the enrollee eligibility criteria for receiving the Part D RI.

- **Part D RI #2.** Please provide the applicable contracts, PBPs, and segments.
  NOTE: (Please enter the data in the following format: Contract-PBP-Segment)
- **Part D RI #2.** Type of Part D Reward or Incentive #2
  ❒ Gift Card
  ❒ Item
  ❒ Other
- Since you selected "Gift Card", please use this space below to describe the Part D Reward or Incentive
- Since you selected "Item", please use this space below to describe the item
- Since you selected "Other", please use this space below to describe the Part D RI type

- **Part D RI #2.** Please provide the frequency of the Part D Reward or Incentive
  ❒ Every year
  ❒ Every 6 months
  ❒ Every 3 months
  ❒ Every month
  ❒ One-time

- ❒ Other
- Since you selected "Other", please specify the frequency of the Part D Reward or Incentive
- **Part D RI #2.** Please provide the per unit and total dollar amount of Part D RI that the enrollee can receive during the plan year.
- **Part D RI #2.** Please use this space to describe the enrollee eligibility criteria for receiving the Part D RI

- **Part D RI #3.** Please provide the applicable contracts, PBPs, and segments.
  NOTE: (Please enter the data in the following format: Contract-PBP-Segment)
- **Part D RI #3.** Type of Part D Reward or Incentive #3.
  - ❒ Gift Card
  - ❒ Item
  - ❒ Other
- Since you selected "Gift Card", please use this space below to describe the Part D Reward or Incentive
- Since you selected "Item", please use this space below to describe the item
- Since you selected "Other", please use this space below to describe the Part D RI type

- **Part D RI #3.** Please provide the frequency of the Part D reward or incentive
  - ❒ Every year
  - ❒ Every 6 months
  - ❒ Every 3 months
  - ❒ Every month
  - ❒ One-time
  - ❒ Other
- If you selected "Other", please specify the frequency of the Part D Reward or Incentive
- **Part D RI #3.** Please provide the per unit and total dollar amount of Part D RI that the enrollee can receive during the plan year
- **Part D RI #3.** Please use this space to describe the enrollee eligibility criteria for receiving the Part D RI

Additional Information regarding your organization's Part D RI Program(s)

- Please provide information about how you intend to monitor and provide safeguards against misuse of Model rewards. Please also use the space below if you would like to clarify or provide additional information regarding your Part D RI programs.

11 Medical Devices & New Technologies

Flexibility to Cover New and Existing Technologies or FDA Approved Medical Devices Consistent with existing MA rules for supplemental benefits, participating MAOs are permitted to provide coverage for:
(i) an FDA approved medical device or new technology that has a Medicare coverage determination (both national and local) where the MA plan seeks to cover it for an indication that differs from the Medicare coverage determination and the MA plan demonstrates the device is medically reasonable and necessary; and (ii) for new technologies that do not fit into an existing benefit category.

- Please provide the applicable contracts, PBPs, and segments.
  NOTE: (Please enter the data in the following format: Contract-PBP-Segment)
- Please describe the FDA approved medical device(s) or new technologies

- Will the FDA approved medical device(s) or new technologies be used to cover an indication that differs from the Medicare coverage determination? If yes, please explain
- Do the new technologies fit into an existing benefit category? If yes, please describe
- Please explain how the FDA approved medical device(s) or new technologies are reasonable and necessary for the targeted enrollee population.

Additional Information regarding your organization's offering of new devices or technologies for enrollees (Optional)

- Please use the space below if you would like to clarify or provide additional information regarding your offering of new devices or technologies

12 Hospice Benefit Component

Through the Hospice Benefit Component, CMS is testing the impact on payment and service delivery of incorporating the Medicare Part A hospice benefit with the goal of creating a seamless care continuum in the MA program for Part A and Part B services.

- Are you an existing VBID Model participant for CY 2021 and/or CY 2022 that is currently implementing the Hospice Benefit Component?
  - ❒ Yes
  - ❒ No

MAO Hospice Contacts

- Please provide the below contact information for your organization's Hospice Network Administrative Contact
  - First and Last Name (e.g., John Doe)
  - Email address
  - Business Phone #
  - Other Phone # **(Optional)**

- Please provide the below contact information for your organization's Clinical and Patient Support Contact. This can be the same contact as the Hospice Network Administrative Contact. **(Optional)**
  - First and Last Name (e.g., John Doe)
  - Email address **(Optional)**
  - Business Phone # **(Optional)**
  - Other Phone # **(Optional)**

Advancing Health Equity

The following questions ask about the efforts you plan to undertake to address potential inequities and disparities in access, outcomes, and/or enrollee experience of care as it relates to your participation in the Hospice Benefit Component as a whole. For illustrative examples of inequities in palliative and/or hospice care that may be applicable to your enrollee populations (e.g., across race, ethnicity, cultural or religious beliefs, disability, sexual orientation, gender, etc.), please see section 1.3 of the CY 2023 RFA for the Hospice Benefit Component.

As a resource to aid in completing this section of the application, please see the Office of Minority Health (OMH) Disparities Impact Statement, a planning tool that can be used to learn how to identify, prioritize, and take action on disparities that impact health outcomes for racial and ethnic minorities, people with disabilities, sexual and gender minorities, individuals with limited English proficiency, and rural populations: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-

Impact-Statement-508-rev102018.pdf. Additional technical assistance will be provided by CMS upon request.

Please note: Except as otherwise permitted by applicable law, a health equity plan 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.

1. Describe how you will identify, address and monitor any potential inequities in access, outcomes, and/or enrollee experience of care as it relates to palliative care, transitional concurrent care, and hospice. This can include, but is not limited to, the use of internal or external data sources, patient or caregiver feedback, provider feedback, and patient/caregiver/community needs assessments. Similarly, what are some potential metrics of success you may use to track your efforts?

2. Describe how you will engage enrollees, caregivers, and providers in your strategy to address any potential inequities.

Hospice Benefit Component - Approach to and Delivery of Palliative Care

The following questions are about your MAO's approach to providing access to timely, appropriate, and palliative care services for enrollees who can benefit from these services.

- Which of the following does or will your palliative care program include? Please select all that apply.
  - ❒ Palliative care assessment and consultation services
  - ❒ Care coordination by an interdisciplinary care team
  - ❒ Care planning and goals of care discussions
  - ❒ Advance care planning (ACP)
  - ❒ Access to social services and community resources
  - ❒ Access to mental health and medical social services
  - ❒ 24/7 telephonic palliative care support
  - ❒ Psychosocial and spiritual support
  - ❒ Pain and symptom management
  - ❒ Medication reconciliation
  - ❒ Caregiver support
  - ❒ Other
- Since you selected "Other" please describe the services that your palliative care program will provide

- Please use this section to provide any additional narrative on the above identified palliative care program and the role of an interdisciplinary care team in providing palliative care services. Please include both clinical/medical and social support aspects (e.g., community-based model, telephonic case management, case management, inpatient, outpatient, etc.). (Optional)

- What is your patient identification process (e.g., based on clinical interaction, claims data algorithm, etc.) and what are the patient population characteristics associated with that process (e.g., identified by diagnoses and utilization of specific services)?

- Describe your approach to align or introduce different care options, including hospice for those beneficiaries that elect the hospice benefit, through offering upstream palliative care services in CY 2023.

- Describe the providers you expect to engage with to provide palliative care (e.g., in-network hospice providers, primary care providers, or other specialists).

- Since you are an existing participant implementing the Hospice Benefit Component for CY 2021 and/or CY 2022, please describe any changes to your palliative care program from CY 2021 and/or CY 2022 to CY 2023, if applicable. Include description of how CY 2021 and/or CY 2022 experience (including the Public Health Emergency) informed these changes. (Optional)

Hospice Benefit Component - Transitional Concurrent Care

The following questions are about your MAO's approach to transitional concurrent care.

- Please describe the approach to working with in-network hospice providers to identify the services that will be offered, based on a beneficiary's plan of care, on a transitional concurrent basis.

- Please describe the expected items or services, based on the beneficiary's plan of care, that would be offered on a transitional basis in addition to the items or services offered as part of the hospice benefit.

- Since you are an existing participant implementing the hospice benefit for CY 2021 and/or CY 2022, please describe any changes to your transitional concurrent care program from CY 2021 and/or CY2022 to CY 2023, if applicable. Include description of how CY 2021 and/or CY 2022 experience (including the Public Health Emergency) informed these changes. **(Optional)**

- Please verify the following by selecting Yes to the check box below:
  1) Concurrent care will be appropriate, reflective of patients' and caregivers' needs as identified in the plan and goals of care;
  2) Concurrent care is transitional and will not duplicate the services covered in the Medicare hospice
     benefit;
  3) Concurrent care will be coordinated among in-network hospices, MAOs and other treating providers, as applicable; and
  4) Concurrent care guidelines or policies will be maintained by the MAO to ensure appropriate enrollee access to concurrent care.

  ❒ Yes

Hospice Benefit Component – Hospice Supplemental Benefits

- Are you offering any hospice supplemental benefits that are targeted to or for which eligibility is limited to enrollees who have elected hospice?
  - ❒ Yes
  - ❒ No

- What is the maximum plan benefit amount?

- Please indicate the types of supplemental benefits that will be offered. Please select all that apply. You may select more than one.
  - ❒ Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization

  - ❒ Temporary coverage (as a not primarily health related benefit) of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to which to discharge
  - ❒ Reduced cost sharing for unrelated medical care services received during hospice election
  - ❒ Reduced cost sharing for services under the hospice benefit, including hospice drugs and biologicals or inpatient respite care
  - ❒ Other mandatory supplemental benefits
- Since you selected "Other" please describe the type(s) of supplemental benefit(s)

- Since you selected "Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization," please select all that apply from the list below.
  - ❒ Home and bathroom safety devices/modifications
  - ❒ Over-the-counter (OTC) benefits
  - ❒ Support for caregivers of enrollees
  - ❒ Meals
  - ❒ Transportation
  - ❒ Other
- Since you selected "Other" please describe

- Please detail any use of care managers or other approaches that allow for the provision of hospice supplemental benefits for enrollees that have elected hospice. **(Optional)**

- Please identify any hospice supplemental benefits that are limited to enrollees who choose in-network providers. For MAOs offering PPO plans, please include an explanation for why the coverage of hospice supplemental benefits need to be limited to in-network providers only. **(Optional)**

Hospice Benefit Component – Beneficiary Access to Hospice Care and Network Requirements
The following questions are about your enrollees' access to hospice care, including questions about the hospice provider network structure.

- Describe the identification and selection criteria and processes (including credentialing for in-network providers) supporting the creation of your organization's hospice provider network and how that process complies with MA regulations on provider networks (see 42 CFR §§ 422.200 through 422.224).

- Describe how you will monitor and evaluate quality of care provided by in-network providers. Include the types of data or processes you expect to use in monitoring and evaluating quality for the purposes of network selection and on an ongoing basis and any training or quality improvement initiatives you plan to offer.

- Describe any planned innovative programs or payment arrangements. **(Optional)**

- Please describe how you plan to work with out-of-network hospice providers to ensure access for your enrollees and coordination of care throughout the Hospice Benefit Component.

- Will you be using a voluntary consultation process?
  - ❒ Voluntary Consultation Process
  - ❒ No Consultation Process

- If you use a voluntary consultation process, please list which PBPs will use one.

- If you answered that you have a voluntary consultation process, please describe any consultation process aimed at engaging enrollees prior to their accessing an out-of-network hospice.

Additional Network Requirements for Participating MAOs with Mature-Year PBPs ONLY

- Do you attest that all counties in your service area(s) will meet the hospice MNP requirements set forth by CMS prior to January 1, 2023, and that you will maintain compliance with the hospice MNP requirements all throughout 2023?
  ❒ Yes

- Please describe how you will ensure that each in-network hospice is able to deliver care in a timely manner across all four levels of hospice care. Please include separate considerations for in-home or in-community care (i.e., routine home care and continuous home care) and for inpatient care (i.e., general inpatient care and respite care).

- Please describe, beyond meeting the MNP requirement, how you will ensure that your network of hospice providers have adequate capacity (e.g., average daily census, staffing, access to facilities, etc.) to meet the needs of projected demand for hospice across your service area(s) and how your organization intends to ensure compliance with 42 CFR § 422.112 for hospice benefits.

- Please describe any efforts to engage and incorporate hospice providers into your network who have a history of serving underserved populations, provide additional value-add services to patients and families, have strong relationships with their local communities, and/or actively collaborate with organizations that may help meet the social needs of patients.

- Please describe how you will ensure cultural competency throughout your hospice network. This may include a description of cultural competency programs and/or trainings; if/how you engage local organizations to develop and inform relevant trainings, and which organizations you will engage; etc.

13 Financial Submission

Financials Supporting your VBID Application

***Applicants are also required to submit to CMS: (i) projected costs for each VBID Model Component included in their application and (ii) projected net savings to Medicare over the course of the Model. Please complete and upload the CY 2023 VBID Model Financial Application Template using the upload button below. If you have trouble uploading your completed Financial Application for CY 2023, please email it to VBID@cms.hhs.gov

*****When submitting this information please use the following naming convention for your materials, as well as in the subject of the email: "Parent Org Name_CY 2023 VBID Model Financial Application"**

14 Applicant Attestation

Applicant Information and Attestation

The applicant must attest that he or she is a representative, officer, chief executive officer, or general partner of the business organization that is applying to participate in this Model test, and authorized to submit this application on applicant's behalf. If the applicant becomes aware that any information in

this application is not true, correct, or complete, the applicant must notify the Centers for Medicare & Medicaid Services (CMS) immediately and in writing. CMS reserves the right to inspect and verify the information submitted in this application.

By clicking the "Yes" button below, you are attesting that the information provided in this application is true, correct, and complete as of the date it is submitted to CMS.

❒ Yes

15 Reminder to Submit Supplemental Files

****IMPORTANT REMINDERS****

VBID Financial Application: If you have not already done so, please download and submit the CY 2023 VBID Model Financial Application Template and the **required** CY 2023 VBID Model Net Savings Template at the button below by 11:59 PM PT on April 15, 2022. If you have trouble uploading your completed Financial Application for CY 2023, please email your completed to VBID@cms.hhs.gov.

CY 2023 VBID Model Application Spreadsheet: If you have not already done so, please download and submit the CY 2023 VBID Model Application Spreadsheet at the button below by 11:59 PM PT on April 15, 2022. If you have trouble uploading your completed CY 2023 VBID Model Application Spreadsheet, please email it to VBID@cms.hhs.gov.

VBID Part D Supplementary File: If you are reducing cost-sharing for Part D drugs for targeted enrollees, and you have not already done so, please download and submit a completed CY 2023 VBID Model Part D Supplemental File Template at the button below by 11:59 PM PT on April 15, 2022. If you have trouble uploading your completed Part D Supplemental File for CY 2023, please email your completed to VBID@cms.hhs.gov.