Request for Applications for the Calendar Year 2025 Value-Based Insurance Design Model

Innovating to Meet Person-Centered Needs

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

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1. Background and General Information

The Centers for Medicare & Medicaid Services (CMS) is seeking applications from eligible Medicare Advantage Organizations (MAOs) to participate in the Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model for Calendar Year (CY) 2025. As described in detail in this Request for Applications (RFA), the VBID Model continues to test several complementary health plan innovations, but with even greater focus on interventions promoting health equity, including new flexibilities and requirements in CY 2025. CMS is conducting this Model test through the Center for Medicare and Medicaid Innovation (CMMI) under section 1115A of the Social Security Act (the Act).

While most Model components available to MAOs in CY 2024 continue into CY 2025, there are several notable changes. These changes are outlined in section 1.2 and described in subsequent, applicable sections in greater detail. The CY 2025 application process, which is discussed in section 6 below, includes modifications to eligibility and financial requirements. The CY 2025 timeline, also discussed in section 6, remains generally consistent with the CY 2024 timeline. CMS will provide separate application guidance for MAOs interested in offering the Hospice Benefit Component in CY 2025 through the CY 2025 VBID Hospice Benefit Component RFA. Although there are separate RFAs, there is only a single application for participating in the Model in 2025 (see section 6 for additional detail).[1]

1.1 Scope and Model Background

The VBID Model began in January 2017 with the goal of testing the impact of permitting MAOs the flexibility to use certain varied supplemental benefit designs (using service delivery and payment flexibilities) for certain chronic conditions in order to better support patient-centered care and greater price transparency, increase enrollee choice and access to timely and clinically appropriate care, improve quality, and reduce costs.

Beginning in CY 2020, the Model expanded to all states and territories to allow participating MAOs greater flexibility in designing their plan benefit packages (PBPs). Beyond testing how MAOs could further target their benefit designs to enrollees based on chronic health conditions, CMS began testing the flexibility to offer benefit designs targeted by certain socioeconomic characteristics in order to better address potential unmet health-related social and medical needs. For 2020, the VBID Model also began testing higher-value Part C and Part D Rewards and Incentives (RI) Programs. As detailed in section 1.2 below, in CY 2025, the Model Part C RI Program will be discontinued, while the Model Part D RI Program will continue. Also, in CY 2020, CMS required participating MAOs to develop and implement Wellness and Health Care Planning (WHP) strategies to improve awareness and availability of Advance Care Planning (ACP) for all VBID enrollees. This component was introduced to test the impact of including WHP strategies as a condition of receiving VBID benefit design flexibilities. Improving equitable access to ACP remains a key CMS objective. However, in CY 2025, WHP will be restructured

[1] For more detail on the Hospice Benefit Component of the VBID Model, please see the VBID Model Website for the CY 2024 VBID Hospice Benefit Component RFA: https://www.cms.gov/priorities/innovation/innovation-models/vbid.

and discontinued as a discrete Model component and instead will be incorporated in each MAO's Health Equity Plan (HEP) as part of overall MAO activities aimed at improving equitable access to ACP.

As announced in January 2019, CMS began testing a carve-in of the Medicare hospice benefit into the Original Medicare benefits that MAOs coordinate and offer in CY 2021 (known as the "Hospice Benefit Component"). Information on the Hospice Benefit Component of the Model is available on the VBID Model website at https://www.cms.gov/priorities/innovation/innovation-models/vbid/vbid-hospice-benefit-overview.

Additionally, in CY 2021, the VBID Model began testing the flexibility to share MA beneficiary rebates savings more directly with beneficiaries as a supplemental benefit in the form of Cash or Monetary Rebates, and the ability of MAOs to provide coverage of new and existing technologies, and FDA-approved medical devices that do not fit into an existing benefit category as a supplemental benefit for targeted populations that would receive the highest value from the technologies. The Cash or Monetary Rebates component of the VBID Model was discontinued starting in CY 2023. The flexibility to provide additional coverage for new and existing technologies and FDA-approved medical devices will be discontinued starting in CY 2025 (see section 1.2 for additional details).

In CY 2023, the VBID Model also imposed the additional requirement that, with respect to all Model components, except for WHP, Model interventions must be uniquely authorized by the Model – that is, not authorized through flexibilities within the broader Part C Program outside the Model. CMS also provided additional guidance regarding the definition of "high-value providers" as used in the VBID Model and began the Health Equity Incubation Program (HEIP) in the VBID Model, described in more detail in section 4 of this RFA.

In alignment with the VBID Model extension announcement (see announcement at https://www.cms.gov/priorities/innovation/vbid-extension-fs)[2] for CY 2025, the VBID Model will include several updates to the flexibilities being tested including discontinuing selected components and adding new flexibilities and requirements (see section 1.2 for important updates and section 2 for details on components and flexibilities). Additionally, CMS will continue to test several of the same Model components as in CY 2024. MAOs that wish to participate in the Model must apply and receive approval from CMS for each Model component. In accordance with section 50321 of the Bipartisan Budget Act of 2018, eligible MA plan types in all states and territories may apply to participate in the VBID Model (see section 3.1 of this RFA).

In CY 2025, the VBID Model will be comprised of the following components:

1. VBID Flexibilities: Targeted to enrollees based on chronic health condition, socioeconomic status, and/or place of residence in the most underserved area deprivation index (ADI) areas;

[2] Medicare Advantage Value-Based Insurance Design Model Extension Fact Sheet. April 2023. https://www.cms.gov/priorities/innovation/vbid-extension-fs

   i. Primarily and non-primarily health related supplemental benefits[3]
   ii. Use of high-value providers and/or participation in care management programs/disease management programs
   iii. Reductions in cost sharing for Part C items and services and covered Part D drugs
2. Part D RI Programs; and
3. Hospice Benefit Component (Separate RFA).

1.2 Important Updates for CY 2025

Updates to the CY 2025 VBID RFA include three discontinued components, an additional new targeting flexibility, and several new or modified participation requirements, as outlined below:

Discontinuances

- Given the broad implementation by MAOs of WHP activities, and the more limited reach and engagement of ACP across historically underserved communities, beginning in CY 2025, WHP is discontinued as a discrete component and instead will be integrated within each MAO's HEP. This integration provides an opportunity to understand MAOs' overall health equity approach inclusive of VBID and ACP. See Appendix A for details.
- The Part C RI Program, as a VBID Model component, is discontinued beginning in CY 2025, given the similar ability to offer Part C RI Programs authorized through flexibilities within the broader MA Program outside the Model, which diminishes the opportunity for a robust test of the VBID Model (note: Part D RI will continue in CY 2025).
- Given limited participation by MAOs that does not allow for meaningful evaluation of the intervention, the flexibility to cover new and existing technologies and FDA-approved medical devices is discontinued beginning in CY 2025.

Additional Flexibilities

- To reach additional beneficiaries with significant Health-Related Social Needs (HRSNs) beyond Low-Income Subsidy (LIS) status (or dual status in the territories), CMS is adding a new flexibility to target supplemental benefits and reduced or eliminated cost sharing to enrollees living in the most underserved areas based on ADI. See section 2.1.3 for details.

Additional Requirements

- To better support the evaluation of targeted supplemental benefits, each VBID participant (except those participating only in the Hospice Benefit Component) must offer a minimum of two supplemental benefits to address priority HRSNs from among the categories of food and nutrition, transportation, and housing and living environment. See section 2.1.4.1 for details.

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

- CMS is modifying monitoring and data collection requirements to support evaluation and generate additional insights related to health equity and operational effectiveness. See section 3.3 for details.
- CMS is modifying eligibility requirements to better account for quality and align to the overall Program. See section 3.1 for details.
- CMS is modifying a financial requirement in the Model: Beginning CY 2025, plans must show net savings to CMS over the course of the calendar year of its participation and over the course of the Model, net of risk score trends attributable to the Model. See section 3.4 for details.
- CMS may choose to limit the total number of accepted applications. See section 6 for details.

For technical assistance related to any of the above changes, such as transitioning an existing VBID Part C RI Program to a Part C RI Program authorized through flexibilities within the MA Program outside the Model, please email the VBID Model team at VBID@cms.hhs.gov.

1.3 Advancing Health Equity[4]

Executive Order 13985 *Advancing Racial Equity and Support for Underserved Communities*[5] *Through the Federal Government* directs the Federal Government to pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Executive Order 13988 *Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation* builds upon this commitment by directing the Federal Government "to prevent and combat discrimination on the basis of gender identity or sexual orientation" and "to address overlapping forms of discrimination."[6] Stemming from these Executive Orders, CMS's vision for the next decade's innovation prioritizes achieving the goal of attaining the highest level of health for all people and eliminating health disparities.[7] CMS

[4] 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. See https://www.cms.gov/pillar/health-equity for additional information.

[5] 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 list in the preceding definition of "equity" that is in the Executive Order.

[6] See https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-preventing-and-combating-discrimination-on-basis-of-gender-identity-or-sexual-orientation/ for additional details.

[7] Innovation at The Centers for Medicare And Medicaid Services: A Vision for The Next 10 Years. August 12, 2021. https://www.healthaffairs.org/content/forefront/innovation-centers-medicare-and-medicaid-services-vision-next-10-years. See also Innovation Center Strategy Refresh, available at https://innovation.cms.gov/strategic-direction-whitepaper.

recognizes that achieving this goal requires that equity be embedded in all models and associated stages of model design, operation, and evaluation, including the VBID Model.[8]

In the VBID Model, CMS is testing interventions with the goal of improving quality of care and achieving equitable health outcomes for all VBID Model beneficiaries and recognizes the role the VBID Model can play in identifying opportunities to advance health equity for MA enrollees more broadly. Enrollment in MA now represents approximately 50% of Medicare beneficiaries.[9] A growing proportion of enrollees in MA represent beneficiaries from underserved communities,[10] such as those who are not only low-income or dually eligible for both Medicare and Medicaid, but also have unmet social risk factors.[11] While enrollment in MA continues to grow in size and diversity, recent CMS research has highlighted some health disparities in MA such as rates of flu vaccination for Black, Hispanic, and Multiracial MA enrollees are below the national average and a substantial proportion of clinical care scores below the national average for American Indian/Alaska Native, Black, and Hispanic MA enrollees.[12] Given increased enrollment in MA, increased representation of underserved communities in MA, and the presence of health disparities in MA, the VBID Model will both continue testing previous strategies to address health inequities and incorporate additional strategies to address health inequities in CY 2025.

The VBID Model tests potential improvements in quality of care and reductions in costs by addressing health inequities in MA through the additional flexibilities allowing participating MAOs to offer and target supplemental benefits to underserved enrollees. Since CY 2020, the VBID Model has tested the ability of MAOs to target supplemental benefits and/or reduced cost sharing by chronic condition and/or socioeconomic status, specifically, by Part D LIS status in the continental U.S. and by dual status in the territories, allowing MAOs to target those most in need. In CY 2025, the VBID Model will build on its well-established foundation of testing strategies addressing health equity and therefore improving quality and reducing costs by enhancing and focusing current approaches and by adding new requirements. These include the following:

- Leveraging the Health Equity Incubation program (HEIP) to provide operational assistance in health equity areas, and further refining the collection of data on VBID benefits addressing HRSNs in areas with a substantial evidence base, such as 1) food and nutrition, 2) transportation, and 3) housing and living environments (e.g., housing, utilities support). These focus areas were selected based on high prevalence in the MA population, existing

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[8] See https://innovation.cms.gov/strategic-direction-whitepaper for additional details.

[9] See https://www.cms.gov/newsroom/press-releases/medicare-advantage-and-medicare-prescription-drug-programs-remain-stable-2024 for additional details on CY 2024 MA enrollment.

[10] Contract Year 2024 Policy and Technical Changes to Medicare Advantage and Medicare Prescription Drug Programs Final Rule, available at https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf, noted an increasing number of beneficiaries who are dually eligible for both Medicare and Medicaid are enrolled in MA plans, Medicaid managed care, or both. About 4.1 million dually eligible beneficiaries currently receive their Medicare services through MA dual eligible special needs plans (D-SNPs).

[11] Teigland, C., Pulungan, Z., Shah, T., Schneider, E., & Bishop, S. (2020). As It Grows, Medicare Advantage Is Enrolling More Low-Income and Medically Complex Beneficiaries. The Commonwealth Fund. https://www.commonwealthfund.org/sites/default/files/2020-05/Teigland_Medicare_Advantage_beneficiary_trends_ib.pdf

[12] https://www.cms.gov/files/document/disparities-health-care-medicare-advantage-race-ethnicity-and-sex.pdf

evidence on their effect on costs and health outcomes, and alignment to existing CMS efforts. [13, 14, 15, 16] By focusing on these areas, CMS is testing whether making such additional benefits available to the targeted populations decreases costs or improves quality of care without increasing costs;

- Continuing to require MAOs to submit, within their application, and receive approval for, a single Health Equity Plan (HEP) encompassing the Hospice Benefit Component for those MAOs applying for the Hospice Benefit Component. Each MAO's HEP will provide a detailed strategy for advancing health equity within the Model. The HEP application questions and review criteria are further described in Appendices A and B. As in CY 2024, CMS will use a survey, referred to as the VBID HEP Progress Report, to collect information about and monitor the implementation of the VBID HEPs by participating MAOs (see section 3.3 for more details);
- Adding a new flexibility allowing MAOs to target benefits to enrollees living in the most underserved ADI areas to be tested alongside other Model flexibilities; and
- In order to better support the evaluation of targeted supplemental benefits, establishing a new requirement that each participant (except those participating only in the Hospice Benefit Component) must offer a minimum of two supplemental benefits to address priority HRSNs from among the categories of food and nutrition, transportation, and/or housing and living environment.

Through its partnerships with MAOs, CMS seeks to add to the evidence on primarily and non-primarily health related supplemental benefits and their impact on health equity in the Model. Current evidence supports that individuals with high or unmet HRSNs have worse healthcare outcomes and disproportionately drive cost.[17,18] A recently published study examining acute care utilization among MA beneficiaries found that HRSNs were associated with higher rates of acute care utilization.[19] Some primarily health related and non-primarily health related supplemental benefits can address HRSNs (e.g., meal delivery to address food insecurity, or non-emergency medical and non-medical transportation to address transportation barriers and social isolation). Hence, understanding the impact of the utilization of these supplemental benefits on costs and quality of care could help determine future directions in the MA program.

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[13] Madden JM, Shetty PS, Zhang F, et al. Risk Factors Associated With Food Insecurity in the Medicare Population. *JAMA Intern Med.* 2020;180(1):144–147. doi:10.1001/jamainternmed.2019.3900

[14] Tsega M, Lewis C, McCarthy D, Shah T, Coutts K. Review of Evidence for Health-Related Social Needs Interventions. The Commonwealth Fund. (2019).

[15] Wolfe MK, McDonald NC, Holmes GM. Transportation Barriers to Health Care in the United States: Findings From the National Health Interview Survey, 1997-2017. Am J Public Health. 2020 Jun;110(6):815-822. doi: 10.2105/AJPH.2020.305579. Epub 2020 Apr 16. PMID: 32298170; PMCID: PMC7204444.

[16] Ibid.

[17] Berkowitz SA, Baggett TP, Edwards ST. Addressing Health-Related Social Needs: Value-Based Care or Values-Based Care? J Gen Intern Med. 2019 Sep;34(9):1916-1918. doi: 10.1007/s11606-019-05087-3. Epub 2019 Jun 10. PMID: 31183686; PMCID: PMC6712198.

[18] Moy E, Chang E, Barrett M; Centers for Disease Control and Prevention (CDC). Potentially preventable hospitalizations - United States, 2001-2009. MMWR Suppl. 2013 Nov 22;62(3):139-43. PMID: 24264504.

[19] Canterberry M, Figueroa JF, Long CL, et al. Association Between Self-reported Health-Related Social Needs and Acute Care Utilization Among Older Adults Enrolled in Medicare Advantage. *JAMA Health Forum.* 2022;3(7):e221874. doi:10.1001/jamahealthforum.2022.1874

In the future, CMS anticipates further expansion of efforts to address health equity issues. For example, CMS is exploring initiatives such as providing participating MAOs with additional data and/or information to facilitate use of interventions that can advance health equity. CMS continues to explore new ideas to gain input from the public regarding various aspects of the MA program, including ways CMS can enhance health equity for all enrollees through MA. Please see the Request for Information (RFI) released concurrently with this RFA for an opportunity to provide input on the Model.

1.4 Statutory Authority

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

1.5 Waiver Authority

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

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

For this Model and consistent with the authority under section 1115A(d)(1), the Secretary issued waivers of the fraud and abuse provisions in section 1128A(a)(5) (relating to civil monetary penalties for beneficiary inducements) and sections 1128B(b)(1) and (2) of the Act (relating to the federal anti-kickback statute) for the following remunerations, provided that the conditions of the relevant waiver are satisfied: (i) certain Part D rewards and incentives offered by the MAO to targeted enrollees; and (ii) certain supplemental benefits provided by the MAO to all enrollees in a VBID PBP that has been approved by CMS to provide Cash or Monetary Rebates. CMS terminated the Cash or Monetary Rebates Component of the VBID Model for CY 2023 and going forward. Accordingly, the fraud and abuse waiver for the provision of Cash or Monetary Rebates will continue to be inapplicable for CY 2023 and future years.

Further, no new fraud and abuse waivers are being issued in this document; any new or revised fraud and abuse waiver would be set forth in separately issued documentation. Any such waiver would apply solely to this Model and could differ in scope or design from waivers granted for other programs or models, or those described below. Notwithstanding any other provision of this RFA, all parties must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued pursuant to section 1115A(d)(1) specifically for this Model.

1.6 Medicare Program and Payment Waivers

No waivers of program requirements or payment provisions are provided in this document. This RFA merely describes the waivers contemplated at this time for the Model; program or payment waivers, if any, would be set forth in Model documentation (such as in the contractual addendum to the MAO's agreement with CMS for participation in the MA program governing participation in the Model, also referred to as the VBID Contract Addendum). In support of the Model, the Secretary intends to waive certain title XVIII provisions and their implementing rules, to the extent described below and only as necessary to conduct the tests described in this RFA. The waivers contemplated here may be updated or revised as necessary, such as to take into account any new rulemaking that is applicable for CY 2025. Intended to be waived to the extent necessary to permit MAOs to participate in the Model are:

- **Uniformity and Accessibility of Benefits and Cost Sharing**: The following may be waived only to the extent necessary to permit MAOs to offer supplemental benefits and reduced or eliminated cost sharing (for MA and/or Part D benefits) to the targeted enrollee population, rather than to all enrollees, subject to the terms of the Model. The targeted enrollee population may be identified based on (i) one or more chronic health conditions, or (ii) Low-Income Subsidy (LIS) eligibility (or, in the territories, dual eligibility for both Medicare and Medicaid), (iii) place of residence in the most underserved ADI areas, or (iv) a combination of chronic health conditions, socioeconomic status, and/or ADI area residence.
    - Sections 1852(d)(1)(A) and 1854(c) of the Act [42 U.S.C. §§ 1395w-22(d)(1)(A) and 1395w-24(c)];
    - 42 CFR §§ 422.2 (uniformity requirement in the definition of an MA plan), 422.100(d)(2), 422.102(a)(2), 422.254(b)(2), 422.262(c)(1);
    - Section 1860D–2(a) of the Act [42 U.S.C. § 1395w-102(a)]; and
    - 42 CFR §§ 423.104(b)(2), 423.265(c).

- **Provision of Non-Primarily Health Related Supplemental Benefits**: The following may be waived to the extent necessary to allow MAOs to offer to certain enrollees "non-primarily health related" supplemental benefits subject to the terms of the Model. Such supplemental benefits must have a reasonable expectation of improving or maintaining the health or overall function of the enrollee in the targeted enrollee population. The targeted enrollee population may be identified based on (i) one or more chronic health conditions, or (ii) Low-Income Subsidy (LIS) eligibility (dual eligibility for both Medicare and Medicaid in the territories), (iii) place of residence in the most underserved ADI areas, or (iv) a combination of chronic health conditions, socioeconomic status, and/or ADI area residence. An MAO may propose (for CMS consideration and approval) to offer to certain targeted enrollees (who do not meet the definition "chronically ill enrollee" in section 1852(a)(3)(D) of the Act or 42 CFR § 422.102(f)(1)(i)) additional non-primarily health related supplemental benefits subject to the terms of the Model:
    - Section 1852(a)(3)(D)(i), (ii)(I), and (iii) of the Act [42 U.S.C. § 1395w–22(a)(3)(D)(i), (ii)(I), and (iii)];
    - 42 CFR §§ 422.100(c)(2)(ii)(A) and 422.102(f)(2)(i), (ii), and (iii).

- **Increased Flexibility for Part D RI**: The following may be waived to the extent necessary to allow a participating MAO to offer Part D RI Programs, subject to the terms of the Model, that: are available only to targeted enrollees if not uniformly offered to all enrollees; are permitted in connection with Part D benefits; are based on the anticipated benefit (rather than the value) of the associated healthcare item or service and subject to an annual limit of $600.00 per enrollee for all rewards received by the enrollee; and are available before the entire activity has been completed:
    - 42 CFR §§ 422.134(b) as a whole, and 422.134(c)(1)(iv), (c)(1)(v), and (d)(1)(i) to the extent the availability and eligibility for rewards and incentives is broader than permitted in the Model; and
    - 42 CFR § 422.134(c)(2)(i), related to RI associated with Part D benefits;
    - 42 CFR § 422.134(d)(2)(ii), related to the prohibition on offering a reward that has a value that exceeds the value of the target activity; and
    - 42 CFR § 422.134(g)(1), related to the offering of RI to Targeted Enrollees.

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

- **Part D Waivers**: The following are waived to the extent necessary for participating MA organizations that are not otherwise authorized to offer Part D supplemental benefits to offer cost sharing reductions consistent with the terms of the Model, and for participating MA organizations to include as administrative costs in the Part D portion of their bids the value of the reduction in the statutory maximum cost sharing for a Targeted Enrollee and to report such amounts on PDE data consistent with CMS instructions in VBID Model Technical and Operational Guidance:
    - 42 CFR § 423.104; and
    - Part 423, Subparts F and G.

Note: *Please view the CY 2025 VBID Hospice Benefit Component RFA for information on programmatic waivers related to the Hospice Benefit Component of the VBID Model.*

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

Program waivers, once issued, are: (1) each contingent on compliance with the terms and conditions of the Model test, including the VBID Contract Addendum for participation in the Model test and documents incorporated therein; (2) granted **only to the extent necessary** for the

Model test and to implement an MAO's approved proposal for participation; (3) granted only to MAOs for those PBPs for which CMS has approved a proposal; and (4) granted only for the term of the VBID Contract Addendum. CMS reserves the right to revoke one or more of the title XVIII waivers or to suspend Model testing (or both) at any point. Further, all other statutory and regulatory requirements (i.e., non-waived) will continue to apply and be enforced.

2. Model Design Elements

The VBID Model for CY 2025 consists of the Model components listed in Table 1 and detailed in sections 2.1 through 2.3; details on the Hospice Benefit Component can be found in the CY 2025 VBID Hospice Benefit Component RFA.

2.1 VBID Flexibilities

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

All benefits described in this section 2.1 and provided under the Model by participating MAOs must be mandatory supplemental benefits and must comply with all rules and requirements that apply to mandatory supplemental benefits, except for the specifically waived provisions where the conditions for the waiver are met (see section 1.5 of this RFA for the potential scope of waivers). While certain benefits under the Model may be limited to certain targeted categories of enrollees, the benefit will be funded by rebates and/or premiums paid by all PBP enrollees, just like all mandatory supplemental benefits pursuant to 42 CFR § 422.100(c)(2)(i)(A). In this respect, the Model's supplemental benefits would be similar to existing SSBCI, Uniformity Flexibility (UF) supplemental benefits, and Enhanced Disease Management (EDM) programs, which may be offered as a mandatory supplemental benefit but are only available to eligible, targeted enrollees.

2.1.1 Targeting by Condition, Socioeconomic Status, and/or Place of Residence in Most Underserved ADI Areas, or a Combination of These Methodologies

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

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

1) Chronic health conditions(s);
2) Socioeconomic status (e.g., LIS eligibility);[20]
3) Residence in most underserved ADI areas; or

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

4) A combination of the above criteria (e.g., enrollees who are LIS eligible and have COPD; or enrollees who have COPD and reside in the most underserved ADI areas as defined in section 2.1.3).

2.1.2 Allowable Targeting Criteria

Chronic Health Conditions: MAOs may choose both the chronic health condition(s) and another methodology to identify enrollees with the condition or combination of conditions. The methodology used to identify enrollees with the chronic health condition may be **broad** (using named diagnoses, such as congestive heart failure (CHF), or other means to identify enrollees with related diagnoses or conditions) or **narrow** (such as using a specific list of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes[21] or other data to identify enrollees with a specific level or intensity of a chronic health condition, such as frailty indicators).[22]

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

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

Socioeconomic Status: MAOs may choose to target enrollees for VBID interventions based on socioeconomic status but may only use LIS status, as modified by the Inflation Reduction Act (IRA, P.L. 117-169), and as defined in the Plan Communication User Guide (PCUG) for MA-PDs, to identify those targeted enrollees. For territories where the LIS status is not available, participating MAOs may identify targeted enrollees based on dual eligibility for both Medicare and Medicaid, using CMS identification of a dual-eligibility status in the MA Prescription Drug (MARx) System. MAOs have the option of targeting enrollees eligible for LIS at any of the four LIS subsidy levels. Within its application, an MAO must propose one or more of the four subsidy levels.

Most Underserved ADI Areas: Additionally, beginning in CY 2025, MAOs are permitted to target enrollees for supplemental benefits and reduced or eliminated cost sharing by residence in the most underserved ADI areas. ADI is a measure of neighborhood-level disadvantage based on

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

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

income, education, employment, and housing quality. See section 2.1.3 for details on ADI targeting, including a definition of "most underserved."

In sections 2.1.4 through 2.1.6 of this RFA, CMS outlines the options under the VBID Flexibilities component that may be offered by participating MAOs to targeted enrollee populations. These include primarily and non-primarily health related supplemental items and services, reduced cost sharing for Part C services, and reduced cost sharing for covered Part D drugs (for participating MA-PDs), and use of high-value providers and/or participation in disease state management program.

2.1.3 Most Underserved ADI Area Targeting

Most Underserved ADI Area Targeting Background and Purpose
Beginning CY 2025, MAOs will be permitted to target enrollees to offer supplemental benefits and reduced or eliminated cost sharing based on ADI, under specified conditions further described in this section. This flexibility may be used in addition to targeting flexibilities already available to VBID participating MAOs or as a standalone targeting flexibility. Through this new ADI flexibility, CMS will test the impact of MAOs leveraging place-based targeting to offer innovative benefits that best meet the HRSNs and medical needs of the most underserved beneficiaries.

ADI was defined by a National Institutes of Health (NIH) team and first published in 2003, with the goal of quantifying and comparing social disadvantage across geographic neighborhoods. It is a validated, area-level composite measure that captures local socioeconomic factors correlated with medical disparities and underservice. ADI is derived through a combination of 17 input variables[23] from census data, which are now estimated annually at the "census block group" level through the US Census Bureau's American Community Survey and reported publicly through the Neighborhood Atlas. ADI is a relative measure, typically reported by percentile (1-100) when comparing census block group across states or decile (1-10) when comparing census block groups within a state, with a higher ADI value representing relatively greater socioeconomic deprivation.

While existing VBID Model flexibilities have allowed for focus on unmet medical needs and HRSNs, current targeting criteria (namely LIS and dual-eligible status, in territories where LIS is unavailable) are based on income, and therefore, miss beneficiaries with unmet medical needs and HRSNs who still may be relatively disadvantaged, but do not qualify for these benefits. The introduction of the ADI targeting flexibility will test the impact of increasing the reach of supplemental benefits and reductions or eliminations in cost sharing to non-LIS eligible and non-dually eligible beneficiaries who may still have significant unmet medical needs and HRSNs.

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[23] Information on the variables considered in the calculation of ADI (e.g., percentage of households without a telephone) is available through the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at https://aspe.hhs.gov/reports/area-level-measures-account-sdoh.

CMS is testing the ADI targeting flexibility in recognition of the growing body of research linking neighborhood disadvantage to health disparities in total cost of care,[24] readmissions,[25] hospitalization rates,[26] prevalence of certain chronic conditions,[27] and other health outcomes.[28] As this research highlights, MA enrollees residing in socioeconomically disadvantaged areas may face place-based barriers, such as lack of access to transportation, grocery stores and healthy foods, or reliable internet infrastructure, and require additional support to fully utilize benefit offerings. For example, an enrollee lacking reliable internet may face difficulties accessing telehealth services covered by their plan, or an enrollee living in a food desert and lacking reliable transportation to the nearest grocery store may face difficulties accessing a grocery benefit offered by their plan. Additionally, particularly in geographies with high cost-of-living, some beneficiaries may reside in a relatively disadvantaged area and face unmet medical and social needs, but not meet eligibility criteria for income-based targeting. The ADI targeting flexibility allows CMS to test the impact of targeted support to address these barriers and challenges facing residents of underserved communities, including those in rural areas.

Most Underserved ADI Area Targeting Scope

In CY 2025, participating MAOs will be permitted to target supplemental benefits and reduced or eliminated cost sharing to enrollees residing in census block groups in state ADI deciles seven through ten, and/or in national ADI percentiles 61-100 (hereafter referred to as "the most underserved ADI areas"). Participating MAOs will be permitted to target VBID benefits to a subset of such deciles / percentiles, so long as enrollees of relatively greater need are still served. For example, an MAO could target only census block groups in state ADI decile ten, or nine and ten, or eight through ten, or seven through ten. The MAO would not be permitted to target census block groups in ADI decile seven without including the higher deciles as well. Allowing participating MAOs the flexibility to direct supplemental benefits and reductions or eliminations in cost sharing to the most underserved ADI areas will allow CMS to test the impact on reducing Medicare program costs and improving health and quality outcomes, including advancing health equity.

As noted above, in sections 2.1.4 through 2.1.6 of this RFA, CMS outlines the options under the VBID Flexibilities component (including ADI targeting) that may be offered by participating

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[24] Sapra KJ, Yang W, Walczak NB, Cha SS. Identifying High-Cost Medicare Beneficiaries: Impact of Neighborhood Socioeconomic Disadvantage. Popul Health Manag. 2020 Feb;23(1):12-19. doi: 10.1089/pop.2019.0016. Epub 2019 Jun 17. PMID: 31207198.

[25] Fahrenbach, John PhD; Chin, Marshall H. MD, MPH; Huang, Elbert S. MD, MPH; Springman, Mary K. MHA; Weber, Stephen G. MD, MPH; Tung, Elizabeth L. MD, MS. Neighborhood Disadvantage and Hospital Quality Ratings in the Medicare Hospital Compare Program. Medical Care 58(4):p 376-383, April 2020. | DOI: 10.1097/MLR.0000000000001283

[26] Maroko AR, Doan TM, Arno PS, Hubel M, Yi S, Viola D. Integrating Social Determinants of Health With Treatment and Prevention: A New Tool to Assess Local Area Deprivation. Prev Chronic Dis 2016;13:160221. DOI: http://dx.doi.org/10.5888/pcd13.160221

[27] Kind AJ, Jencks S, Brock J, Yu M, Bartels C, Ehlenbach W, Greenberg C, Smith M. Neighborhood socioeconomic disadvantage and 30-day rehospitalization: a retrospective cohort study. Ann Intern Med. 2014 Dec 2;161(11):765-74. doi: 10.7326/M13-2946. PMID: 25437404; PMCID: PMC4251560.

[28] Substance Abuse and Mental Health Services Administration (SAMSHA). Digital Access: A super Determinant of Health. March 2023. https://www.samhsa.gov/blog/digital-access-super-determinant-health

MAOs to targeted enrollee populations. MAOs may not propose to limit eligibility for Part D RI Programs by ADI area.

Most Underserved ADI Area Targeting Requirements

CMS seeks to ensure that participating MAOs that choose to target supplemental benefits and reductions or eliminations in cost sharing based on ADI understand the unique challenges faced by enrollees residing in the most underserved ADI areas and consider ways to address these challenges through ADI-targeted benefits. **As such, participating MAOs that target supplemental benefits and reductions or eliminations in cost sharing based on ADI must incorporate Enrollee Advisory Committee (EAC) input into the design and/or implementation of ADI-targeted benefits.**

In alignment with the existing D-SNP requirement described in § 422.107, participating MAOs targeting by ADI must incorporate input from one or more EACs in each state in which the MAO offers VBID participating plans proposing to include ADI targeting. An MAO may satisfy this requirement through its existing EAC(s), as applicable and feasible. For MAOs that propose to offer plans that include ADI targeting and do not have an EAC in place in those plans' state(s), the MAOs must establish one in alignment with the requirements in this section. EACs established and maintained to satisfy ADI targeting flexibility requirements remain subject to MA rules governing EACs, including that membership size and meeting frequency be at the MAO's discretion.

Building on the D-SNP EAC requirements described in § 422.107, EACs must include a reasonably representative sample of individuals enrolled in VBID plans. This may include enrollees and individuals representing enrollee interests such as family caregivers; community-based organizations; community health workers; and/or representatives of state, local, and/or tribal government agencies, as applicable. Participating MAOs should also ensure EAC membership reflects the diversity of populations within the participating PBPs' service area(s), with specific emphasis on individuals who reside in the most underserved ADI areas, including those in rural areas.

MAOs' ADI-targeted VBID benefits may be informed by EAC members' experiences, including attempts to access care and services such as primarily and non-primarily health-related supplemental benefits. An MAO may satisfy the EAC requirement by engaging its EAC in the benefit delivery and/or implementation process (e.g., by soliciting EAC input on the delivery of benefits).

Additionally, to promote informed decision-making by EACs, CMS encourages MAOs to provide relevant information to each EAC for its consideration when providing input on ADI-targeted VBID benefits. Such information might include, but is not limited to, the following:

- Community health needs assessments led by Public Health Accreditation Board (PHAB)-accredited state and/or local health departments, hospital facilities subject to the requirements under 26 CFR § 1.501(r)-3, or other such similar entities (e.g., Health Equity Zones). If provided to EACs, assessments could include the needs of all the most underserved ADI areas in the state relevant to the MAO's service area, as available;
- De-identified, summary results from HRSN screenings of individuals residing in the most underserved ADI areas within the MAO's service areas, based on the MAO's existing data from relevant screening tools;

- Opportunities to deliver VBID benefits in ways that consider the potential resource strengths and gaps of the most underserved ADI areas (e.g., food deserts, limited public transportation), possibly in partnership with community-based organizations (CBOs); and
- Publicly available ADI data, including the ADI mapping tool published by the Center for Health Disparities Research[29] and/or any relevant information published by CMS.

Enrollee eligibility for ADI-targeted benefits shall be determined at the beginning of the contract year based on enrollee place of residence, with no redetermination throughout the year so long as the enrollee remains enrolled in the plan and does not opt out of the benefit. As new enrollees are identified to be eligible throughout the year, the plan is also required to offer ADI-targeted VBID benefits to those newly eligible enrollees.

Through these ADI targeting flexibility requirements, CMS seeks to spur innovative person-centered benefits, ensure that MAO's ADI-targeted benefits consider and address the HRSNs and medical needs of beneficiaries in the most underserved ADI areas, support opportunities for future MAO and CBO collaboration and strategic alignment, and promote forums for trust building between MAOs and underserved communities.

Most Underserved ADI Area Application
In their ADI proposal(s) within their applications, MAOs must include: the eligibility criteria the enrollee must satisfy to receive ADI targeted benefits (i.e., which ADI deciles/ percentiles will be targeted), information on the nature of targeted benefits, details on the planned makeup of their EACs (e.g., including the names of any CBOs represented), and the MAO's plan to meaningfully engage EACs in ADI-targeted benefit design and/or implementation.

More generally, CMS will review all proposed ADI-targeted benefits based on the rationale and theory for the benefits; the targeted population; the responsiveness of benefits to identified needs within the most underserved ADI areas; the expected health outcomes, cost, and savings effects of the MAO's proposed intervention; and the applicable research and evidence submitted to support the intervention for the proposed population. As part of the application process, CMS may offer guidance on what may or may not be acceptable in an MAO's specific proposal. CMS, in its sole discretion, reserves the right to accept or reject any ADI targeting proposal.

ADI application questions will be included as part of the broader application described in section 6. As this is a new targeting flexibility for CY 2025, CMS encourages MAOs to engage CMS early and send questions to VBID@cms.hhs.gov.

Accompanying this RFA, CMS is releasing an ADI Databook. The ADI Databook is a useful resource for MAOs considering targeting enrollees by place of residence in the most underserved ADI areas. The ADI Databook is intended to be a static reference file showing the overlap between each MAO's service areas and ADI in CY 2023.

[29] The Neighborhood Atlas® ADI mapping tool is available at https://www.neighborhoodatlas.medicine.wisc.edu/

2.1.4 Primarily and Non-Primarily Health Related Supplemental Benefits

Participating MAOs are permitted to make primarily and non-primarily health related supplemental benefits under the Model available for only targeted enrollees.

Primarily Health Related Supplemental Benefits

Through the Model, participating MAOs have the ability to offer primarily health related supplemental benefits to targeted enrollees. Such primarily health related items or services must diagnose, prevent, or treat an illness or injury; compensate for physical impairments; act to ameliorate the functional or psychological impact of injuries or health conditions; or reduce avoidable emergency and healthcare utilization. MAOs may refer to additional guidance on the definition of "primarily health related" for supplemental benefits.[30]

Non-Primarily Health Related Supplemental Benefits

Through the Model, participating MAOs have the ability to offer non-primarily health related supplemental benefits to targeted enrollees, beyond the statutorily-defined "chronically ill enrollee," provided that such benefits have a reasonable expectation of improving or maintaining the health or overall function of the targeted enrollee. In reviewing applications, CMS will determine whether each MAO has sufficiently demonstrated that any non-primarily health related supplemental benefits it proposes to offer meet this standard with respect to the targeted population.

For a non-primarily health related item or service, participating MAOs may – for a specific population of targeted enrollees, as described in section 2.1.2 of this RFA – address a specific deficit that results in deteriorated health and any resultant increase in the utilization of health care services or costs of care. MAOs offering non-primarily health related supplemental benefits to targeted enrollees must offer and cover such benefits uniformly for all eligible enrollees targeted for intervention. Further, when offering non-primarily health related benefits under this Model, participating MAOs must comply with 42 CFR § 422.102(f) and all MA program rules and requirements, as interpreted by CMS and consistent with CMS guidance, except for the provisions that have been explicitly waived under the Model[31] (see section 1.5).

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

- food and produce;
- meals (beyond the current allowable limits);
- transportation for non-medical needs;
- indoor air quality equipment and services;
- access to community or plan-sponsored programs and events to address social needs (such as non-fitness club memberships, community or social clubs, park passes, family counseling, marital counseling, access to companion care, classes for enrollees with

[30] https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/hpms%2520memo%2520primarily%2520health%2520related%25204-27-18.pdf

[31] See the HPMS memorandum titled, "Implementing Supplemental Benefits for Chronically Ill Enrollees."

primary caregiving responsibilities, or events to address enrollee isolation and improve emotional and/or cognitive function, etc.);
- complementary therapies (offered alongside traditional medical treatment);
- services supporting self-direction;[32]
- structural home modifications;
- general supports for living, which may include plan-sponsored housing consultations; subsidies for rent or assisted living communities; and/or subsidies for utilities such as gas, electric, and water as part of the benefit; and
- pest control.

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

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

In providing VBID supplemental benefits that are not furnished or prescribed by a health care provider, MAOs must use the same processes as currently allowed for coverage of OTC supplemental benefits (see Chapter 4 of the Medicare Managed Care Manual, section 40), including, where appropriate, requiring documentation from an enrollee's provider or care team of the necessity of an item or service or that the item or service has a reasonable expectation of improving or maintaining the health or overall function of the targeted enrollee. MAOs must include safeguards that prevent fraud, waste, and abuse, including any misuse or inappropriate provision of these items or services and potential resale (see section 2.3, Enrollee Safeguards, for information on general enrollee safeguards).

MAOs must identify in their applications the items and services that they propose to offer under this flexibility and must be prepared to provide the rationale for offering the non-primarily health related supplemental benefits, including expected improvements in health outcomes. Applicants should also note proposals in the CY 2025 MA-PD Proposed Rule, which includes proposals related to how MAOs offer SSBCI.[33] Because additional primarily health-related and non-primarily health related supplemental benefits offered under the Model must comply with all non-waived requirements for such benefits, any requirements adopted in a final rule applicable to CY

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

[33] Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications. (November 6, 2023)

2025 for additional primarily health-related and non-primarily health related supplemental benefits will apply to Model coverage of these benefits unless waived.

2.1.4.1 Mandatory Supplemental Benefits to Address Priority HRSNs

To date, participating MAOs have offered a variety of targeted supplemental benefits through SSBCI, UF, and VBID flexibilities. Building off the impact and significance of those benefits in earlier years, the Model will require all applicants, except for those who are only applying for participation in the Hospice Benefit Component of the VBID Model, to offer a minimum of two HRSN benefits selected from the categories of food and nutrition, transportation, and housing and living environment in each participating PBP, regardless whether the PBP uses one or more of the permissible targeting criteria.[34] Requiring participating plans to offer benefits in these categories will improve CMS's ability to test and evaluate the impact of these benefits on health and quality outcomes, including health equity, and Medicare program costs. This requirement will also serve to complement the VBID Model's ongoing focus on better understanding, testing, and evaluating these benefit categories through model learning, benefit utilization data reporting, and HRSN screening data collection. Together these initiatives will strengthen CMS's ability to evaluate these benefits based on targeting, utilization, health outcomes, quality, and cost data. The list below provides examples of primarily and non-primarily health-related benefits that satisfy this requirement. This list is not exhaustive:

- **Food and Nutrition:** Qualifying benefits include primarily and non-primarily health-related supplemental benefits, such as meals (both primarily and non-primarily health-related) and food and produce (e.g., frozen foods, canned goods, and produce to assist enrollees in meeting nutritional needs).
- **Transportation:** Qualifying benefits include primarily and non-primarily health-related supplemental benefits, such as non-emergent medical transportation and transportation for non-medical needs (e.g., to a grocery store or to a bank).
- **Housing and Living Environment:** Qualifying benefits include primarily and non-primarily health-related supplemental benefits, such as home and bathroom safety devices and modifications (e.g., permanent mobility ramps or widening of hallways) and general supports for living (e.g., utility assistance).[35] CMS also recognizes that increased instances of extreme heat, extreme cold, air pollution, and other climate-related health hazards brought on by climate change are affecting enrollee living environments. As such, the housing and living environment category presents an opportunity for participating MAOs to provide benefits in additional PBP categories such as indoor air quality equipment and services to support greater enrollee resilience to climate-related health hazards through better adapted and resilient living environments.

Recognizing that MAOs may be offering supplemental benefits that address priority HRSNs in the MA Program those supplemental benefits can be used to satisfy this requirement for participating PBPs. Supplemental benefits used to satisfy this requirement are subject to summary-level and

[34] MAOs can offer additional supplemental benefits beyond this requirement.

[35] See HPMS Memo: Implementing Supplemental Benefits for Chronically Ill Enrollees for details on general supports for living: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf

beneficiary-level data collection and reporting as described in section 3.3 (Monitoring and Data Collection) and must be identified in the VBID Application along with relevant financial information to provide the VBID Model better insight into these benefits. All benefits remain subject to the regular bid desk review process, rules, and requirements.

In addition, benefits addressing the priority HRSNs may be offered in combination with other benefits, such as benefits with a shared maximum benefit amount administered through a flexible spending (debit) card.

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

Participating MAOs may reduce or eliminate cost sharing for items or services covered by the MA plan, including Part D benefits covered by a participating MA-PD plan. Drugs that are excluded from being covered Part D drugs would not be eligible for reduced cost-sharing in the VBID Model. The covered benefits subject to the reductions in cost sharing must be identified by the MAO in its application with an explanation of how each benefit is high value for the target population. Participating MAOs have broad flexibility to choose which items or services are eligible for cost sharing reductions (including for high-value services and services offered by high-value providers); however, these items or services must be clearly identified and defined in the application and in advance to the eligible target population through marketing materials and member communications, including the Annual Notice of Change (ANOC) and EOC. Reductions in cost sharing must be uniformly available to all enrollees within the target population and administered in a non-discriminatory fashion.

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

Examples of cost sharing reductions within this category might include the elimination of co-pays for primary care or specialist visits for enrollees who qualify for LIS status; or the reduction of condition-specific covered Part D drug co-pays (e.g., all generic Angiotensin-converting enzyme (ACE) inhibitors, Angiotensin II Receptor Blockers (ARBs), calcium-channel blockers, beta-blockers, diuretics, and statins) for enrollees with CVD.

Participating MAOs cannot make cost sharing reductions conditional on achieving any specific clinical goals (e.g., an MAO cannot condition cost sharing reductions on enrollees achieving certain thresholds in HbA1c levels or body-mass index).

In general, this reduced cost sharing approach may not be structured in a discriminatory manner, and all applicable targeted enrollees must have the opportunity to participate in the activities in question (or an alternative), regardless of health status, location, or disability.

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

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

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

High-value providers can include physicians and practices, hospitals, skilled-nursing facilities, home health agencies, ambulatory surgical centers, and others that provide safe, timely, efficient, effective, equitable, and patient-centered care. High-value providers cannot include pharmacies. MAO determination of high-value providers cannot be solely based on cost, efficiency, or affiliation to the MAO, and therefore, must also include relevant quality considerations and/or criteria, such as those related to health equity. Within its application, when explaining the methodology for identifying high-value providers, an MAO must disclose which, if any, of the identified high-value providers are related parties to the MAO. A related party is an entity that has a different tax identification number than that of the MAO but is associated with the MAO by any form of common, privately held ownership, control, or investment, including any arrangement in which the MAO does business with a related party through one or more unrelated parties.[36]

Identification of high-value providers must be prefaced on a sound evidence base, such as independent, external metrics when determining whether a provider is high-value. Examples of such metrics might include whether a primary care practice is a National Committee for Quality Assurance (NCQA) certified medical home, whether a hospital has American Heart Association advanced certification in heart failure, or whether a provider meets certain CMS consensus-based entity endorsed quality measures. However, locally specific approaches also may be proposed with accompanying clinical justification. When applicable within their applications, MAOs are encouraged to provide the specific quality measures used to identify high-value providers, and the provider's ratings for these measures. In addition, organizations cannot identify high-value providers based on coding accuracy or intensity alone.

[36] See Instructions for Completing the Medicare Advantage Bid Pricing Tool for Contract Year 2024 (OMB # 0938-0944) and 42 CFR 422.2

Other examples of high-value providers include providers that qualify as Essential Community Providers (ECPs) under 45 CFR § 156.235[37] and other similar providers who predominantly serve underserved communities (e.g., providers serving a majority of enrollees living in areas identified by the CDC/ATSDR Social Vulnerability Index [38] or the ADI [39] or providers serving predominantly dual-eligible enrollees). High-value providers can also include those who provide care through an Area Agency on Aging, Aging and Disability Resource Center, or Center for Independent Living (statutorily defined in section 102 of the Older Americans Act of 1965 [42 U.S.C. 3002] and section 702 of the Rehabilitation Act of 1973 [29 U.S.C. 796a]).[40] These providers demonstrate high value in their potential to increase quality through culturally competent care, offering of both medical and social needs, such as language services that meet enrollee language preference(s), and increased continuity of care for enrollees in underserved areas.

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

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

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[37] ECPs include Federally Qualified Health Centers, entities receiving grants under 340A, Native Hawaiian Health Centers receiving funds under the Native Hawaiian Health Care Act of 1988, and many other entities (see section 340b340B of the Public Health Service Act for a full list of qualifying entities here: https://www.hrsa.gov/sites/default/files/hrsa/rural-health/phs-act-section-340b.pdf and CMS' regularly updated list of ECPs here: https://data.healthcare.gov/dataset/dwyq-rebe

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

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

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

regardless of whether such changes are considered "significant" with respect to the network-at-large.[41]

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

2.1.7 Benefits Uniquely Authorized by the Model

The VBID Model will test only those interventions within each Model component that are uniquely authorized by the VBID Model, and that are not authorized through flexibilities within the broader Part C Program, outside the Model. Given this, it is important to be aware of flexibilities granted outside the VBID Model, including (1) expansion of the interpretation of what items and services are "primarily health related" (42 CFR § 422.100(c)(2)); (2) the ability to offer benefits that are tied to disease state or health status in a manner that ensures that similarly situated individuals are treated uniformly and where there is a nexus between the health status or disease state and the specific benefit package designed for enrollees meeting that health status or disease state (42 CFR § 422.100(d)(2)); and (3) the authorization for SSBCI under section 1852(a)(3)(D) of the Act and 42 CFR § 422.102(f). The following provides detail on each of these and the differences with VBID Flexibilities.

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

Expansion of the Definition of "Primarily Health Related"
In the Final CY 2019 Call Letter,[42] CMS reinterpreted the criteria used to identify permissible supplemental benefits. Under longstanding guidance, which has recently been codified at 42 CFR § 422.100(c)(2),[43] CMS requires supplemental benefits to: (1) be not covered by Medicare Parts A, B or D; (2) be primarily health related; and (3) cause the MA plan to incur a non-zero medical

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[41] CMS considers significant changes to provider networks to be those that go beyond individual or limited provider terminations that occur during the routine course of plan operations; affect, or have the potential to affect, a large number of the MAO's targeted enrollees; or would affect the participating MAO's ability to meet current MA network adequacy standards for their service area(s).
[42] See Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information (cms.gov).
[43] See the final rule titled, "Medicare and Medicaid Programs; Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All Inclusive Care for the Elderly (86 FR 5864)". In that rule, CMS codified the longstanding guidance with the relatively new interpretation noted here.

cost. CMS reinterpreted the standard "primarily health related" to use a broader approach for approving MA plans' supplemental benefit offerings. Under the reinterpretation, plans may offer items and services as supplemental benefits if the items and services:

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

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

Unique to the VBID Model, primarily health related supplemental benefits may be targeted to enrollees with LIS eligibility (or with dual eligible status in the territories) and/or to enrollees who reside in the most underserved ADI areas.

Uniformity Flexibility

In the CY 2019 Final Call Letter and an April 2018 final rule,[44] CMS also adopted a reinterpretation of the requirement that MA plans offer uniform benefits. CMS determined that providing access to services (or specific cost sharing for services or items) that are tied to health status or disease state in a manner that ensures that similarly situated individuals are treated uniformly is consistent with the uniformity requirement in the MA statute. CMS codified this reinterpretation at 42 CFR § 422.100(d). Under this interpretation, CMS permits MA plans to offer tailored supplemental benefits or cost sharing for similarly situated individuals based on disease state.[45] This uniformity flexibility is not applicable to Part D benefits.

Unique to the VBID Model, A/B cost sharing reductions or eliminations may be targeted to enrollees based on LIS eligibility, enrollees residing in the most underserved ADI areas, or a combination of these targeting mechanisms.[46] Also unique to the VBID Model, Part D cost sharing reductions or eliminations may be targeted to enrollees with chronic health condition(s), LIS eligibility, enrollees residing in the most underserved ADI areas, or a combination of these targeting mechanisms.[47]

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

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

[46] In the case of the territories, unique to the VBID Model, A/B cost sharing reductions or eliminations may be targeted to enrollees based dual eligibility in Medicare and Medicaid or a combination of both chronic health condition and dual eligibility in Medicare and Medicaid.

[47] In the case of the territories, unique to the VBID Model, Part D cost sharing reductions or eliminations may be targeted to enrollees with chronic health condition(s), who qualify for dual eligibility in Medicare and Medicaid, or a combination of both chronic health condition and dual eligibility in Medicare and Medicaid.

SSBCI

In addition, section 1853(a)(3)(D) of the Act was amended by the Bipartisan Budget Act of 2018 (Pub. L. 115-123) to authorize MA plans to offer a new type of supplemental benefits, which can be non-primarily health related, to "chronically ill enrollees."[48] The statute specifically defines "chronically ill enrollee" as meaning an enrollee in an MA plan that the Secretary determines—

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

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

Unique to the VBID Model, non-primarily health related supplemental benefits may be targeted to enrollees with chronic health condition(s) (that are not limited to those enrollees who meet the definition of "chronically ill enrollee" in section 1853(a)(3)(D) of the Act), socioeconomic status (e.g., LIS eligibility), enrollees residing in the most underserved ADI areas or a combination of these targeting mechanisms (see sections 2.1.1-2.1.3 for additional details).

2.2 Part D Rewards and Incentives (RI Programs)

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

In order to test the cost and quality of care impact of a service delivery model that permits MAOs to provide RI Programs in connection with Part D prescription drug benefits, MAOs participating in this Model for CY 2025 will be permitted flexibilities (which are not available outside of the Model) to design RI Programs as described in this section. RI Programs under the VBID Model must be uniquely authorized by the Model and not available through flexibilities in the broader MA program. That is, RI Programs under the VBID Model must use the flexibilities that are unique to the VBID Model. These flexibilities include the below.

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[48] CMS has also recently codified a regulation regarding these new benefits. See the final rule entitled "Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program" (85 FR 33796) and 42 CFR § 422.102(f).

- MAOs may propose to use RI with a value that reflects the expected *benefit of the service or activity* up to $600 annually per enrollee.
- MAOs offering MA-PD plans may propose to use an RI Program for the *Part D benefit* covered by a participating MA-PD plan.[49]
- MAOs may propose an RI Program specific to participation in a disease management or transition of care program.
- MAOs may propose to limit the RI Program to targeted enrollees (rather than all enrollees in the PBP) such that only targeted enrollees (who engage in the target service or activity) are eligible for the RI (meaning, other enrollees who engage in the same service or activity are not eligible for the RI).
- MAOs may propose multiple RI Programs in a PBP as long as the activities/steps that an eligible enrollee must complete to receive the reward and incentive are specific and distinct between each reward and incentive offered.
- MAOs may propose other RI Programs, approved by CMS on a case-by-case basis as supported by evidence and justified by MAOs, that use the programmatic waivers authorized under the VBID Model.

General Requirements for Model Part D RI Programs
Unless waived or additionally authorized under this Model, participating MAOs must follow all of the RI requirements at 42 CFR § 422.134; these standards apply to Part D RI Programs offered under the Model. This includes limitations on the type of activity for which an RI may be provided and parameters on the development and administration of an RI Program as well as limits on what may be used as a permissible RI.[50]

Additionally, any RI offered under RI Programs must be:

(i) limited to the value of the expected benefit of the associated activity or service (but may exceed the cost of the activity or service); and
(ii) subject to an annual limit of $600 per enrollee in the aggregate for all RI provided by a single PBP under this Model (as discussed above).

As reflected in § 422.134(g), MAOs must implement Model RI Programs in a manner that complies with all fraud and abuse laws, including when applicable, the anti-kickback statute and civil monetary law prohibiting inducements to beneficiaries.

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

1. health outcomes;
2. medication adherence; or
3. the efficient use of health care resources.

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[49] RI Programs may not incentivize avoidance of medically necessary care.
[50] See section 1.6 for a discussion of programmatic provisions in 42 CFR § 422.134 that may be waived to provide participating MAOs additional flexibility in offering RI Programs in the Model.

For Part D RI Programs, participating MA-PD plans must reasonably establish value for the successful medication adherence or formulary compliance for which they offer RI. Additionally, MAOs must implement Part D RI Programs in a manner that complies with all applicable fraud and abuse laws, including the anti-kickback statute and civil monetary law prohibiting inducements to beneficiaries.

Although such RI programs are not required in the VBID Model, CMS encourages participating MAOs that offer MA-PD plans to propose Part D RI Programs under this Model that aim to strengthen the linkage between enrollees and members of the care team, such as pharmacists and providers, to facilitate better understanding of clinically-equivalent therapeutic options, coverage provided by the MA-PD plan, and the overall value to their health of adherence to their prescribed drug therapy.

Provided below are general rules governing the Part D RI Programs in the VBID Model.

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

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

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

1. Provide an RI to a Medicare beneficiary who is not enrolled in a Model PBP, except as permitted by 42 CFR § 423.128(d)(5);
2. Structure a Part D RI Program to:
    a. Use prescription fills or adherence as the sole basis for providing a RI within the entire Part D RI Program;
    b. Incentivize enrollees to use mail service pharmacies, preferred pharmacies or any other specific network or contracted providers;
    c. Discourage clinically indicated medication use, or otherwise reward enrollees not taking any, or taking few, Part D covered drugs or vaccines;
3. Provide RI in the form of cash, cash equivalents, or other monetary rebates or in the form of decreased cost sharing or plan premiums. For example, a gift card to a pharmacy or grocery store that can be used to pay cost sharing on prescription drugs is prohibited. If an MAO wishes to provide RI in a form that beneficiaries can use to purchase products or services that may also be covered as an MA supplemental benefit, such as over-the-counter drugs, transportation, or groceries, the MAO must ensure that the RI cannot be used to decrease cost sharing on those

supplemental benefits. If a supplemental benefit is offered as a dollar amount without any cost sharing obligation on the part of the beneficiary, then RI that can be used to cover the cost of the same or similar items after the supplemental benefit is applied is not prohibited. An MAO will need to ensure that communications to beneficiaries make clear the distinction between the RI and supplemental benefit;

4. Provide RI that can be used for the purchase of alcohol, tobacco, gambling or firearms;
5. Identify targeted enrollees based on the identity of their pharmacy provider;
6. Receive or use funding, in-kind resources, or any kind of remuneration provided directly or indirectly by a drug manufacturer. This includes, but is not limited to, the use of personnel affiliated with a drug manufacturer, manufacturer-financed coupons or discounts provided to a beneficiary, or manufacturer supplied education materials;
7. Receive or use funding, in-kind resources, or any kind of remuneration provided directly or indirectly by a pharmacy or entity that owns or operates pharmacies. This includes use of personnel affiliated with a pharmacy, pharmacy-financed coupons or other discounts provided to a beneficiary, or pharmacy supplied education materials;
8. Use a RI Program largely to market a PBP or encourage beneficiaries to remain with a specific plan;
9. Use a RI Program to, in any way, choose or solicit healthier (or sicker) enrollees over enrollees who the MA Plan believes may be less healthy;
10. Create a RI Program that discriminates against enrollees based on race, national origin, limited English proficiency, gender, disability, chronic disease, whether a person resides or receives services in an institutional setting, frailty status, health status, or other prohibited basis; or
11. Use a RI Program that allows RI to be won based on probability or that do not meet the standards described in 42 CFR § 422.134(d), excluding § 422.134(d)(2)(ii).

RI Program Application

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

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

2.3 Enrollee and Medicare Program Safeguards

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

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

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

CMS will carefully review proposals using VBID flexibilities for non-uniform benefit designs, including proposals for administering primarily and non-primarily health related benefits, for protections against misuse of the reduced cost sharing or supplemental benefits. CMS will review and consider the appropriateness of any targeting criteria for enrollees eligible for Model benefits and the extent to which proposals demonstrate that enrollees in a subpopulation of similar circumstances are treated similarly and consistent with the underlying theory and evidence for the intervention. CMS will also review to ensure that safeguards protecting against fraud, waste and misuse are in place; and that monitoring of the appropriate receipt of RI occurs. Finally, CMS will review the plan's projections and justification of expected cost savings, as described in section 3.4.1, and quality of care improvements for the targeted population(s) that are anticipated as a result of participation in the Model and the various benefits and RI Programs available under the Model.

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

CMS reserves the right to terminate an MAO's participation in the Model or exercise other available remedies in the MA program at any time for a number of reasons, including but not limited to the following: if the MAO has failed to comply with the terms of the Model or any non-waived program requirement; the MAO is subject to investigation or sanctions for program integrity issues; or if CMS determines that there are inadequate enrollee protections or that the organization's participation in the Model, or its performance of Model activities, may compromise the integrity of the Model, including by resulting in lower quality care or adverse outcomes for enrollees or the Model. For example, if CMS determines that an RI Program is not in compliance with the Model, CMS may impose sanctions or civil monetary penalties on the MAO in accordance with 42 CFR §§ 422.723 or 423.752.

3. Model Requirements

The VBID Model eligibility requirements are outlined below for interested MAOs. Participating MAOs must meet the requirements of Model technical and operational guidance and other general CMS oversight to ensure beneficiary protections while participating in the Model. CMS will reserve the right to impose a corrective action plan or take other remedial actions, including termination from the Model test, to rectify or address a failure to adhere to Model requirements. Further, an MAO's failure to adhere to the requirements of the Model test may result in rescission or invalidation of any program or payment waiver issued by CMS to that MAO, which could trigger enforcement action by CMS related to the waived requirements. All other regulatory and statutory requirements applicable to the MAO will remain in effect unless waived under the terms of the Model; failure by an MAO to comply with those requirements could result in enforcement action consistent with the authority of the MA program, including intermediate sanctions or contract termination, or termination from the Model.

3.1 Eligibility Requirements

Participation in the VBID Model is voluntary. The Model is open for participation to MAOs at the individual plan benefit package (PBP) level. MAOs may propose one or multiple MA and MA-PD contracts and/or plans for participation. All MAOs applying to participate in any Component of the Model in CY 2025, including existing participants, must submit an application to CMS by the application deadline.

Note that all segments[51] of any PBPs that the MAO wishes to include in the Model must be included in the Model for participation. Additionally, consistent with current rules for MA plans with segments, MAOs may vary Model Benefits by segment as long as the supplemental benefits, premium and cost sharing are uniform within each segment of an MA plan's service area (see section 1854(h) of the Act; §§ 422.100(d)(2), 422.262(c)(2); 83 FR 16440). *However*, this does not apply to Model components related to any Part D coverage or the Hospice Benefit Component, which must be uniformly provided across all segments within a PBP.

Eligibility Requirements
While exceptions may be requested by MAOs and granted on a case-by-case basis by CMS as outlined below, eligible MA PBPs must meet the following criteria to participate in the Model:

- **Plan Type:**
  - The following MA only and 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 and Regional Preferred Provider Organizations (PPOs)
    - ✓ All Special Needs Plans (SNPs)

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

- ✓ Chronic Condition Special Needs Plans (C-SNPs)
- ✓ Dual Eligible Special Needs Plans (D-SNPs)
- ✓ Institutional Special Needs Plans (I-SNPs)

- The following types of Medicare health plan are **not** eligible to participate in the VBID Model:
  - Private Fee-for-Service Plans (PFFS)
  - Employer Group Waiver Plans (EGWPs)[52]
  - Medicare-Medicaid Plans (MMPs) or other demonstration plans
  - Medicare Advantage Medical Savings Account Plans (MSA)
  - Cost Plans (CP)
  - PACE organizations (PACE)

- **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 2025 (i.e., offered in open enrollment for 2022, 2023, and 2024).
  - For plans that have been operating as Medicare-Medicaid Plans (MMPs) under CMS's Financial Alignment Initiative, any annual coordinated election (open enrollment) period during 2022, 2023, or 2024 counts towards meeting the above requirement. Thus, an MAO may meet the length of plan existence requirement on the basis of a plan that has been offered, for example, for two open enrollment periods as an MMP and for one open enrollment period as an MA plan.

- **Plan Performance:**
  - In the 12 months prior to 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(a) and 423.750(a).
  - CMS may deny an application on the basis of information obtained from a program integrity screening or patterns of consistent low performance, including compliance history.
  - In the 12 months prior to the date of application submission, the MAO's contract offering the PBP has not met or exceeded 13 points for compliance actions for any one contract as outlined in 42 CFR §§ 422.502(b)(1) and 423.502(b)(1).
  - The PBP's contract has at least a three-star overall quality rating for the most recently available year. A PBP's contract that is not rated, due to newness or low enrollment, may participate in the Model if other contracts listed in the application for the Model from the same parent organization meet these requirements.

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

In regards to plan type, although an individual market MA plan that is one of the eligible types outlined above may participate in the Model while contracting with an employer, labor organization, or the trustees of a fund established by one or more employers or labor organizations for the enrollment of members of a group health plan *into the individual MA plan*, benefit design waivers for employer/union plans are prohibited in connection with Model Benefits (e.g., actuarial swapping or actuarial equivalence of Model Benefits). See Chapter 9 sections 10 - 10.2 and Appendix 2 of the Medicare Managed Care Manual[53] for discussion of the differences between an individual MA plan that enrolls members of these group health plans and EGWPs. EGWPs (that is, MA plans that enroll only members of plans sponsored by an employer, labor organization, or the trustees of a fund established by one or more employers or labor organizations) may not participate in the Model.

Outside of a CMS exception, which is outlined below, PBPs that fail to meet the eligibility criteria may not participate in the Model in CY 2025.

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

Plan Compliance: Disclosure of Present or Past History of Sanctions, Investigations, Probations or Corrective Action Plans

CMS may deny an application on the basis of information obtained from a program integrity screening or patterns of consistent low performance, including compliance history.

In their applications, MAOs must disclose any and all present or past history of sanctions, investigations, probations, or corrective action plans for the MAO, affiliates, or other relevant persons and entities, over the 12 months prior to the submission of the application. Before execution of the VBID Contract Addenda, MAOs must also disclose any additional sanctions, investigations, probations, or corrective action plans for the MAO, affiliates, or other relevant persons and entities that were not disclosed in the application that occurred between the time of the application and before execution of the VBID Contract Addenda.

CMS will conduct appropriate program integrity (PI) screens during the application process and prior to the beginning of the start of the Model and may reject an application or terminate a VBID Contract Addendum on the basis of the results of a PI screening regarding the applicant, its affiliates, and any other relevant individuals or entities.

The PI screening may include, without limitation, a review to determine if the applicant:

- Was under an intermediate sanction by CMS to prohibit the enrollment of new enrollees in accordance with either Part 422 subpart O or § 422.2410(c);
- Failed to maintain a fiscally sound operation consistent with the requirements of § 422.504(a)(14);

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

- Filed for or is currently in federal or state bankruptcy proceedings;
- Received any combination of Part C or D summary ratings of 2.5 or less in both of the two most recent Star Rating periods, as identified in § 422.166;
- Met or exceeded 13 points for compliance actions for any one contract as outlined in 42 CFR §§ 422.502(b)(1) and 423.502(b)(1).

CMS will also conduct the following:

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

Generally, CMS will conduct these PI reviews as well as review an MAO's ability to deliver on the goals of the Model (e.g., ability to generate cost savings to CMS and quality of care improvements for targeted population(s)) and meet Model requirements.

Exception Requests Related to the Eligibility Requirements

CMS will consider exception requests in limited circumstances and will reserve the right, in its sole judgment, to admit a PBP, an MA contract, or overall parent organization that does not strictly meet the eligibility criteria.

MAOs seeking an exception should do so in writing by submitting a request in their application, specifying the specific contract and plan numbers for which an exception is sought, and the grounds for the exception.

3.2 Communication and Marketing Guidelines

All MA communications and marketing regulations remain applicable to materials and activities of the participating organization and other MA and MA-PD plans and should serve as the main reference for plans (see, e.g., 42 CFR § parts 422 and 423, subparts V).[54] In addition to compliance with those existing requirements, participating MAOs must comply with marketing and communication standards in the Model. For reference, please see the CY 2024 VBID Model Communications and Marketing Guidelines, which will be updated for CY 2025: https://www.cms.gov/priorities/innovation/media/document/cy2024-vbid-communications-and-marketing-guidelines.

Overall, CMS encourages participating MAOs and their representatives to convey information about Model Benefits and/or RI Programs, available as part of their plan offerings. One of the keys to successful interventions offered through Model Benefits and/or RI Programs is achieving enrollee awareness, engagement, and activation. As such, prior to the start of CY 2025, MAOs

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

approved for participation in the Model must submit to CMS, as part of their organization-specific communication materials, a description of how they will inform and engage enrollees about the Model Benefits and/or Model Rewards that will be available ("VBID Member Engagement Strategy"). CMS is interested in understanding how participating MAOs will ensure enrollees have a clear understanding of Model Benefits and RI Programs they are eligible for (including how to access them), and the specific strategies and processes MAOs will use to engage and activate eligible enrollees and/or targeted enrollees. The goal of the VBID Member Engagement Strategy is to ensure each enrollee understands the Model Benefits and/or RI Programs that he/she/they may be eligible for and how to access them and for CMS to understand how Model Benefits and any Part D RI Programs are being communicated to enrollees. CMS is also particularly interested in any strategies that MAOs may be using to reach underserved communities and which enrollee groups may require different types of approaches, such as culturally competent communications and outreach, in order to fully engage in the Model Benefits and/or RI Programs for which they are eligible.

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

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

CMS believes MAOs participating in the Model are aligned with CMS's implementation and evaluation goals, and the MAOs will create communication and marketing strategies that ensure beneficiaries (and providers as applicable) are engaged and informed. CMS intends to provide guidance on Model communications and marketing requirements for CY 2025 in summer 2024.

3.3 Monitoring and Data Collection

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

CMS intends to provide participating MAOs with Model Monitoring Guidelines in Fall 2024 that will detail what reporting is required per the VBID Contract Addendum during and for Model participation in 2025, when data should be reported, how data are being collected and should be

shared with CMS, and who CMS expects to receive reporting on (e.g., beneficiaries receiving advance care planning). Both beneficiary-level and summary-level reporting may be required for specific data elements. Specific requirements will be detailed in the VBID Contract Addendum and Model technical and operational guidance. In addition, CMS will provide training and support to participating MAOs to assist with these requirements and is actively working on approaches to data sharing and reporting that minimize burden and improve transparency to both CMS and participating MAOs.

Participating MAO data collection and reporting will include the following:

- Participating MAOs that are offering reductions in cost sharing for covered Part D drugs are required to comply with all Prescription Drug Event (PDE) reporting rules in accordance with CMS guidance, including reporting the beneficiary/drug event-specific costs associated with these changes in beneficiary cost sharing in the appropriate PDE data fields.[55]

- For the VBID Flexibilities Component, participating MAOs must monitor and report to CMS on enrollees who have been targeted (or are eligible to receive) and who have received or used the VBID Flexibility being offered (e.g., reduced cost sharing, additional supplemental benefits, etc.). Participating MAOs must also report annually to CMS the summary-level data on supplemental benefits offered under the VBID Flexibilities Component. This data on these benefits include, but are not limited to, utilization and cost. MAOs must also report annually to CMS the beneficiary-level utilization data for certain supplemental benefits.

  Overall, improving the standardization, completeness and accuracy of supplemental benefits data (related to costs, associated quality outcomes and savings, and utilization by enrollees) has been identified as a top priority for the VBID Model. CMS will collaborate with MAOs to finetune the appropriate file layouts and continuously assess feasibility of data collection and development of performance feedback metrics related to supplemental benefits data. Such data will help provide better insights into supplemental benefits utilization and their related outcomes by all enrollees, including underserved communities. By better understanding the value and impact of supplemental benefits in MA, CMS would like to understand which benefits have the most meaningful quality and other health equity outcomes and inform future Model design development (e.g., benefit engagement incentives or benefit enhancements in Fee-For-Service).

- To better understand and monitor drivers of risk score trends associated with the VBID Model, CMS may require participating MAOs to report additional data and may conduct audits focused on excessive risk score trends.

- To better understand the HRSN of enrollees in VBID participating plans, MAOs must submit beneficiary-level HRSN screening data using a set of standardized screening tools.

[55] Additional information on PDE reporting guidance is available at https://www.cms.gov/priorities/innovation/media/document/vbid-partd-buydown-guidance.

The required HRSN screening data will focus on food security, access to transportation and housing stability.

- For the Model Part D RI component, as part of monitoring VBID Model participation, CMS will require participating MAOs that have Part D RI Programs to report and maintain records regarding the number and dollar amounts of RI earned regarding these Part D RI Programs in a form and manner determined by CMS.

- With respect to the VBID HEP, CMS will use a survey to collect information about and monitor the implementation of the VBID HEPs by participating MAOs. Participating MAOs will complete and submit an annual progress report through a survey. The VBID HEP Progress Report may ask questions on inequities in access, outcomes, and/or enrollee experience among identified underserved communities; development and implementation of targeted interventions to address said inequities; engagement of enrollees, caregivers, and providers to understand needs and craft potential interventions; and advancements in equitable access and delivery of supplemental benefits. Beginning in CY 2025, the HEP Progress Report will incorporate ACP, such as data on existing disparities in ACP discussions and ACP completion rates.

- Please see the CY 2025 VBID Hospice Benefit Component RFA and Hospice Benefit Component Monitoring Guidelines for information on data collection and reporting for the Hospice Benefit Component.

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

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

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

Overall, CMS expects to learn from the Model implementation, and reserves every right to make changes to the Model as necessary to ensure beneficiary safety, the integrity of the model test, and that CMS's aims are achieved.

3.4 VBID Bidding and Projected Savings

Each proposed Model component must be detailed in the Model application, and once approved, included as part of the MAO's PBP and Bid Pricing Tool (BPT) submission. As in all bids, related Medicare-covered or A/B mandatory supplemental benefits must be included as benefit expenses. Model RI components must be priced in the BPT as an administrative cost. VBID Flexibility Model components must be priced and included in the bid as mandatory supplemental benefits that are paid for using rebates and must factor in any projected reduction in utilization of Part A or Part B benefits in the A/B bid, as well as projected changes in risk scores attributable to the Model.

Also, depending on the type of Part D benefit offered under the VBID Flexibility Model component, the costs of waiving LIS maximum Part D copays for LIS enrollees must either be priced and included as administrative costs, or if such reduced or $0 cost sharing applies to both LIS and non-LIS enrollees or otherwise qualifies as a Part D supplemental benefit, then the cost should be priced as Part D supplemental benefits.[56] Premiums for Part D supplemental benefits may be paid using the MA beneficiary rebates per § 422.266, but Part D benefits and payment of Part D cost sharing are not MA supplemental benefits; Part D benefits – including reductions in cost sharing – cannot be included in MA bids. See section 3.4.2 for more details. Bids must be prepared according to the bidding rules and guidance for the Part C and Part D programs.

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

Participating PBPs will be required to satisfy all existing CMS requirements, such as service category cost sharing standards, without consideration of the VBID interventions. VBID interventions must be documented within separate areas of the PBP submission for benefits review.

MAOs must also provide in their applications projections of the impact that their participation will have for CY 2025 **and** over the course of the MAO's participation in the Model and over the life of the Model on plan medical and prescription drug utilization, cost, premiums, and risk scores.

These projections must be prepared by an actuary who meets the requirements of 42 CFR § 422.254(b)(5) and, furthermore, the analysis is considered to be an Actuarial Communication in accordance with Actuarial Standards of Practice No. 41. Thus, a qualified actuary who is a member of the American Academy of Actuaries (MAAA) must prepare or direct the preparation of these materials, be clearly identified in the submission, and certify the actuarial valuation. Similar to instructions provided for completing the BPT, the objective of obtaining an actuarial certification

[56] See also 42 CFR § 423.104(f).

is to place greater responsibility on the actuary's professional judgment and to hold them accountable for the reasonableness of the assumptions and projections.[57]

CMS will review these projections as part of reviewing the application for compliance with the terms of the Model test; reasonableness of assumptions; potential detrimental impact to CMS, the Medicare program, or beneficiaries; and the sustainability of the proposal. In order for the plan to be approved to participate in the Model, these projections must show net savings to CMS in CY 2025, net of risk score trends attributable to the Model, and over the course of the MAO's participation in the Model; and no net increase in enrollee cost in CY 2025 and over the life of the Model.

An MAO may be required to correct its projections or change its proposal in case of unacceptable submissions. Once approved by CMS for participation in the Model, MAOs must incorporate these assumptions into their annual bids in accordance with actuarial standards and CMS guidance. These instructions might require MAOs to supply additional plan-specific Model information through the BPT in connection with their bids for each of the Model years, demonstrating the specific impact of the Model on that year's bid. Prior to bid approval, MAOs may, at the discretion of CMS, be required to submit updated financial information to align with any proposed changes to the benefit or RI values after the initial approval is issued. CMS will require annual updates to the projections to include actual historical experience after a full year of participation.

3.4.1 Outlined below is the information that MAOs are required to submit as part of their application to the Model for each PBP (and segment as applicable) proposed to participate in the Model. What to Submit for Projected Costs and Savings as Part of the VBID Financial Application

Participating MAOs are required to submit to CMS projections of the costs and net savings to Medicare in CY 2025 and over the course of the Model for each Model component and plan benefit package included in their application. In submitting these projections as part of the application, MAOs must:

- Submit responses to the "CY 2025 VBID Financial Application Template" on the Model website. MAOs are strongly encouraged to include details in addition to the information and responses specifically requested by the template. The CY 2025 VBID Financial Application Template and associated materials must reflect the MAO's best estimate of projected enrollee engagement, program implementation costs, utilization changes, including the expected timeframe of those utilization changes, and risk score trends.

In completing the CY 2025 VBID Financial Template and associated materials, MAOs must include the following:

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

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

- Summary of Projected Costs by each Model component (a projected utilization, unit or Per-Member-Per-Month (PMPM) costs and Non-Benefit Expense (NBE) costs together with an indication of what experience base, etc., was relied on in setting the assumption. A projection of the member months eligible for each component and/or targeted population and estimates of those that will participate or otherwise be engaged, if applicable);
- Summary of Projected Savings in CY 2025 and over the course of the Model, including considerations for net savings after accounting for projected costs over the same time period;
- Additional Qualitative and Quantitative Support, as needed, including literature reviews showing the potential clinical significance of the benefit, historical data and past performance if the applying MAO has previously participated in the Model (if there is at least one full year of experience to review); and
- Changes to Pricing (e.g., projected changes to risk scores, bid pricing tool changes).

In addition to the memorandum discussing the bulleted items above, applying MAOs must complete the ***required*** "Net Savings Template," which provides a simple format for including costs, savings, and net savings for the MAO's proposed policies and benefits in CY 2025 and over the life of the Model.

This supporting documentation will assist CMS in assessing the reasonability of the pricing assumptions intended to be used when providing VBID benefits under this Model. Additionally, the supporting documentation should describe how the proposed VBID Model components can be expected to meet the Model's financial goal of net savings to Medicare expenditures without any net increase in costs for plan enrollees attributable to the VBID elements in CY 2025 and over the life of the Model.

Plan sponsors applying for the VBID Model must email documentation to VBID@cms.hhs.gov by the application deadline, April 12, 2024.

3.4.2 CY 2025 VBID Bid Procedures and Special Considerations

VBID Model components of the bids for CY 2025 must be covered by the general actuarial certification submitted in accordance with 42 CFR § 422.254(b)(5), and actuaries preparing applications should keep this requirement in mind. Approval of Model applications merely qualifies plan sponsors to include these VBID Model components in their CY 2025 bid submissions; it does not guarantee that these elements will be approved during Bid Desk Review.

An authorized representative of the participating MAO must attest, as part of the application, the bid, and via the VBID Contract Addendum, that the Model participation application and bid, as applicable, have been completed in a manner consistent with the actuarial assumptions and projections of VBID Model impacts contained in the actuarial component of the plan's application for participation.

Hospice Benefit Component – Special Considerations

MAOs participating in the Hospice Benefit Component of the Model are expected to address any potential costs or savings associated with palliative care that may fall under the current MA benefit prior to the election of hospice in addition to those related to concurrent care, hospice care and any

hospice supplemental benefits. In other words, MAOs should address whether participation in the Hospice Benefit Component has the potential to change MA bids and revenue, in addition to answering the question of whether the costs of providing the hospice benefit will outweigh the hospice capitation payment being made to Model participants. Please note that CMS expects that the A/B bid amount should not be increased due to the offer of concurrent care services or palliative care services. Please refer to the CY 2025 VBID Hospice Benefit Component RFA for additional information on the inclusion of this benefit in the bids following the required bidding procedures.

Model Part D RI Programs – Special Considerations
The Model Part D RI Program must be included in the participating plan's bid as a non-benefit expense for the applicable Part D bid. See also 42 CFR § 422.134(g)(3).

Part D Reduced Cost Sharing – Special Considerations
The CY 2025 Part D BPT should be completed for participating MA-PD plans by following applicable guidance for CY 2025 bidding. The Part D BPT must reflect the VBID Part D benefits to be offered. Please consult the CY 2025 VBID Frequently Asked Questions document for additional information.

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

Regardless of drug benefit type, in CY 2025, some MAOs that are approved by CMS under the VBID Model to offer elimination of Part D cost sharing will have this information displayed on the Medicare Plan Finder (MPF) tool. Display of these benefits will only be possible if an MAO's Approved Proposal for the VBID Model includes:

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

MPF will not display any other cost sharing reductions or eliminations in CY 2025 under the VBID Model, including reductions or eliminations in Part D cost sharing that are offered only on specific formulary tiers, targeted only to certain LIS levels, targeted by chronic condition, or targeted by ADI. Additionally, reductions but not eliminations of LIS cost sharing across all drugs and all benefit phases will not be displayed. Similarly, in the territories, reductions but not eliminations of cost sharing targeted to dual eligible enrollees across all drugs and all benefit phases will not be displayed.

3.5 General Model Oversight

CMS reserves the right to terminate an MAO's participation in the Model or exercise other available remedies at any time if the organization has failed to comply with the terms of the Model, is subject to investigation or sanctions for program integrity issues, or if CMS determines that the organization's participation in the Model, or its performance of model activities, may compromise the integrity of the Model, including by resulting in lower quality care or adverse outcomes for enrollees or the Model.

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

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

CMS retains the right to change any Model policy on an annual basis or more frequently, in accordance with procedures and parameters in the VBID Contract Addendum.

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

An MAO may withdraw a PBP from the Model test, or cease participating entirely, by providing advance notice to CMS in accordance with the timeframes stated in the VBID Contract Addendum for participation in the VBID Model. In each case of withdrawal from the Model, organizations are required to provide CMS, by the MA Program bid deadline, which is the first Monday in June of each year, prior to the upcoming Calendar Year, with a Model termination plan that includes how, what, and when the MAO will provide adequate notice to participating enrollees who are impacted by the change. If an MAO chooses not to participate in a future year, the MAO will propose to CMS a way to ensure beneficiaries eligible for VBID Benefits are made aware of any changes to their benefits, including but not limited to the ANOC.

4. Health Equity Learning System

CMS will continue its voluntary learning system approach to accelerate MAO VBID engagement referred to as the Health Equity Incubation Program, or HEIP in the targeted set of three high impact areas (food and nutrition, transportation and housing and living environment), and to support the development of best practices in the use of the ADI as a targeting mechanism. The HEIP aims to diffuse evidence and best practices related to the targeting and delivery of specific interventions and supplemental benefits in these focus areas in order to drive improvement and learning from the Model.

Overall, CMS will build upon its recent health equity initiatives that have well-established intersections with social needs, such as food and nutritional insecurity, transportation barriers, and housing insecurity and unhealthy/unsafe living environments. CMS aims to support development of best practices in the design, operations and measurement of interventions in these areas; optimize their impact on health equity; and build and share an evidence base for quality improvement and medical savings related to HRSNs.

As is planned for CY 2024, in CY 2025, CMS will continue learning and information sharing efforts with CY 2025 participating MAOs to support implementation and effectiveness of the VBID Model. This phase of the learning system will leverage facilitated forums in which participant MAOs can share their experiences and results in offering interventions in the priority areas, including their challenges and successes in the planning, operations, measurement, and assessment of their respective programs. Additionally, CMS will disseminate lessons learned across CMS (Medicare FFS, MA and Medicaid) and share resources and tools to support MAOs participating in the Model.

5. Evaluation

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

6. Application Process and Selection

MAOs interested in applying to participate in the VBID Model for CY 2025 should submit their application no later than April 12, 2024, 11:59 pm PT. The online application will be accessible by February 2024 on the VBID Model website at: https://www.cms.gov/priorities/innovation/innovation-models/vbid.

Questions regarding the Model or application process may be sent to VBID@cms.hhs.gov. While CMS will not identify the source of the question regarding the Model or application process, CMS may publicly share questions and responses or compile them into a Frequently Asked Questions compendium to ensure that all MAOs have access to information regarding the VBID Model and the application process. For CY 2025, CMS is undertaking efforts to streamline and simplify the application based on lessons learned from previous years.

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

Step 1: CMS Feedback and Technical Assistance, December 2023– April 2024

In an effort to provide MAOs with support for the VBID Model, CMS will provide feedback and technical assistance on a rolling basis between the release of this RFA through April 12, 2024. CMS expects to engage with MAOs to ensure the success of the Model and to offer technical assistance where possible in regard to Model participation, Model requirements, and enrollee protections.

Step 2: Application Due April 12, 2024, 11:59 PM PT

Using the Application provided by CMS through the VBID Model website, MAOs may apply to participate in the Model with one or multiple model-eligible PBPs under one or multiple MA contracts. MAOs must indicate to CMS the contract(s), PBP(s), and segment(s), if eligible, that they are proposing to include in the Model. (Although there are separate RFAs for (1) the VBID Model's Hospice Benefit Component and (2) other Model components, there is only one application for participating in the Model in 2025.)

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

As part of the application, MAOs must submit all accounting and actuarial assumptions associated with their proposal and Model participation. This includes projected costs and savings for each proposed intervention and participation in each component, including any changes in administrative costs, specific projected changes to utilization, projected changes to risk scores, and projected changes to the plan bid. MAOs offering the Hospice Benefit Component through the

Model will be given additional bid instructions by the CMS Office of the Actuary and need to include any costs or projections for hospice-specific supplemental benefits as part of the application to participate in the Model in CY 2025.

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

After close review, CMS will provide MAOs with a provisional approval for Model participation. CMS may collect additional information on proposals throughout the application process.

Of note, Model participant selection may be competitive. CMS reserves the right to set a maximum number of qualified MAOs, PBPs, enrollee population, or other limits on participating in the Model test. CMS also reserves the right to reject any organization, PBP, or proposal in order to preserve the integrity of the Medicare program, the welfare of beneficiaries, or the efficient and advantageous administration of the Model, including considerations related to costs to the Medicare Program.

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

Step 3: Bid Submission (Monday, June 3, 2024)

A provisionally approved MAO will include participation in the VBID Model and all VBID Model components it is participating in, as part of submitting its PBP(s) to CMS by June 3, 2024 (11:59 pm PT). MAOs must follow all bid guidance as provided by CMS.

In addition, provisionally approved MAOs will be required to confirm their participation in the Model by the bid submission date of June 3, 2024, concurrent with and as part of their plan bid submission. In addition to the bid submission requirements, MAOs that were provisionally approved must notify CMS in writing by June 3, 2024 (11:59 pm PT), of any changes they seek to make from their provisionally approved application, including changes to participating PBP(s). MAOs must submit one Model application per parent organization.

6.1 Timeline

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

Date	Milestone
December 2023	CMS releases CY 2025 RFA for the VBID Model

Date	Milestone
December 2023 – April 2024	CMS provides feedback and technical assistance to MAOs
February 2024	CMS releases VBID Model Application (inclusive of Hospice Benefit Component)
April 12, 2024	Completed Application due to CMS by 11:59 pm PT
Mid-May 2024	CMS completes review of applications and provides feedback to MAOs for inclusion in their CY 2025 PBP
June 3, 2024	CY 2025 MA and Part D Bids Complete by 11:59 pm PT
June 7, 2024	VBID Supplemental Formulary file submitted (only applicable to MA plans that have been preapproved for Part D VBID benefits) (11:59 am ET)
Mid-September 2024	VBID Contract Addenda for Model participation executed
Late September 2024	CY 2025 participating MAOs announced
January 1, 2025	CY 2025 performance period of the VBID Model begins

6.2 Withdrawal or Modification of Application

MAOs seeking to withdraw an entire application or requesting to modify a pending or preliminarily approved application should submit a written request on the MAO's letterhead that is signed by the primary point of contact named in the application submission. Requests for withdrawal will not be accepted after the MAO has submitted its bid. To submit a withdrawal request, MAOs must send the request in PDF format by e-mail to VBID@cms.hhs.gov.

After application submission (April 12, 2024) but prior to provisional approvals (mid-May), CMS may allow MAOs that have submitted an application to propose to add Model components. However, after provisional approvals (mid-May) and prior to bid submission (June 3, 2024), CMS will only allow incremental changes to provisionally approved interventions or Model components (such as adding or removing PBPs or increasing the amount of VBID Model Benefits; adding interventions within a provisionally approved Model Component), so that MAOs may incorporate feedback from CMS or otherwise improve the application to meet their goals for the Model.

Following the bid submission on June 3, 2024, CMS will only allow changes of a type typically allowed for MA and Part D benefits after bid submission, such as those required in response to CMS bid desk review findings or permitted during rebate reallocation.

Allowance of changes to preliminarily approved interventions is a matter of CMS discretion, and CMS may require resubmission of application materials, such as the financial application, to account for proposed changes. Any proposed changes to preliminarily approved interventions must be submitted to CMS for approval via the VBID Mailbox, VBID@cms.hhs.gov. Please note that updates to certain financial materials, including the financial application, may not be required for nominal changes in benefit value that are made after bid submission as part of rebate reallocation.

6.3 Amendment of RFA

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

Appendix A: VBID Health Equity Plan (HEP) Application Questions

Per section 1.3 of the CY 2025 VBID Model RFA, MAOs applying to participate in the VBID Model must provide, as part of their application, a VBID HEP. In order to assist potential Model applicants in drafting their responses to the application, CMS is providing here the core set of questions that MAOs must address in their submission of their VBID HEP. The application will be accessible on the VBID Model website at: https://www.cms.gov/priorities/innovation/innovation-models/vbid in February 2024.

CMS is available for technical assistance by emailing VBID@cms.hhs.gov. Please answer each application question as carefully and accurately as possible to avoid a delay in CMS review. CMS will review submitted applications and reach out to applicants with clarifying questions, requests for additional information, or to request necessary changes.

As part of the VBID Model's commitment to health equity and transparency, certain information in the HEP may be made publicly available. Similar to information that will be released through the CY 2024 benefits data (available at https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/benefits-data), such information could include what data sources are being utilized by MAOs to identify disparities, what HRSN domains are being addressed through the VBID Model, or other information.

Please note: A HEP may not propose or use activities that selectively target beneficiaries based on race, ethnicity, national origin, religion, sex, or gender. In addition, a HEP must comply with all applicable non-discrimination laws, including section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act, and the MA-program specific provisions in section 1852(b) of the Act and 42 CFR § 422.110.

Advancing Health Equity

The VBID HEP submitted by applicants must address the following questions, and those responses will help form each MAO's VBID HEP. These questions ask about the efforts you (i.e., the applying MAO) 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 VBID Model.** As applicable, MAOs should answer these questions with respect to Model Benefits, the Hospice Benefit Component and/or Part D Rewards and Incentives Programs and with respect to other benefits used to satisfy the requirements in section 2.1.4.1. For illustrative examples of inequities that may be applicable to your enrollee populations please see section 1.3 of the CY 2025 VBID Model RFA and section 1.3 in the CY 2025 Hospice Benefit Component RFA. Additional technical assistance will be provided by CMS upon request.

Advance Care Planning (ACP), formerly Wellness and Health Care Planning (WHP)
As described in section 1.2 above, in CY 2025 CMS is making changes in its approach to ACP within the VBID Model. CMS remains fully committed to its partnership with MAOs to ensure that all enrollees have an equitable opportunity to complete an advance care plan. Beginning in CY 2025, CMS will streamline and restructure this relationship by discontinuing WHP as a stand-alone VBID component. Instead, given that MAOs currently engage in multiple ACP activities across their enrollment, including complying with 42 CFR § 422.128,[58] maintaining written policies and procedures related to ACP, informing enrollees of their ACP rights and benefits, and conducting community education in addition to many other initiatives, in CY 2025 the VBID Model will heighten its focus on improving equitable access to ACP. Given the recognized disparities in ACP, participating MAOs will be asked to address ACP within the context of their overall HEP (see Appendices A and B for more detail).

Participating MAOs will also be required to report progress on advancing health equity in this area by reporting ACP completion data, including data on existing disparities in ACP discussions and ACP completion rates in its enrollee population, within the HEP progress report. As part of their application, MAOs must confirm they have the capability to capture the data needed to monitor and track the provision of ACP across enrollees in their VBID participating PBPs or have a plan to do so that enables the capture of ACP data for CY 2025. CMS may provide additional guidance to approved participants regarding ACP tracking and reporting and may request a review of an MAO's plan for tracking and reporting ACP if necessary.

The integration of ACP within the HEP will increase focus on health equity as it relates to ACP, as well as allow CMS to understand the MAO's approach to improving equity in ACP in the context of both the MAO's health equity efforts within VBID, and across its broader MA enrollment.

Hospice Benefit Component HEP Considerations
MAOs participating in the Hospice Benefit Component of the VBID Model must include in their VBID HEP information on how the MAO plans to address potential inequities and disparities in access, outcomes, and/or enrollee experience of care as it relates to their participation in the Hospice Benefit Component as a whole. This includes any inequities in access, outcomes, and/or enrollee experience of care as it relates to palliative care, concurrent care, and hospice. MAOs participating in the Hospice Benefit Component of the VBID Model and another Model Component must submit one VBID HEP, inclusive of the Hospice Benefit Component and any other Model interventions.

VBID Health Equity Plan (HEP) Application Questions

Identify Disparities

1. What data sources do you plan to use to identify disparities among your enrollees? (select all that apply)
    - ☐ Claims data

[58] See also sections 1852(i) and 1866(f) of the Act.

- ☐ Health care utilization data (e.g., Healthcare Cost and Utilization Project (HCUP), proprietary database)
- ☐ Health risk assessment (HRA)
- ☐ Healthcare Effectiveness Data and Information Set (HEDIS)
- ☐ Health Related Social Needs (HRSN) Screening (e.g., questions from AHC HRSN tool)
- ☐ MA Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey
- ☐ Publicly available data (e.g., US Census/state sociodemographic data)
- ☐ Enrollee Advisory Committees (or other group patient forums)
- ☐ Caregiver feedback (e.g., patient/family advisory councils)
- ☐ Provider feedback
- ☐ Patient/caregiver/community needs assessments
- ☐ CMS Health Equity Summary Score (HESS) Dashboard
- ☐ Other (please specify)

2. Provide any additional details on the data sources you selected in response to Question 1 regarding your plan to identify disparities. For example, if you are using MA CAHPS data, which MA CAHPS survey questions and responses are you analyzing?

3. Describe any identified disparities in access, outcomes, and/or enrollee experience of care. Include the populations experiencing these disparities.

Address Disparities

4. Use the table below to outline your planned VBID HEP intervention addressing the identified disparities in access, outcomes, and/or enrollee experience of care related to the VBID Model. This should include your quantitative goals and the key activities that will help you achieve these goals. The table below has been populated with examples for illustrative purposes.

Population Experiencing Identified Disparity	Performance Measure (PM)	Key Activity	PM Baseline Among Priority Population	CY 2025 Goal
LIS enrollees with an HRSN related to transportation	ED utilization	Providing non-emergency medical transportation for primary and specialty care visits	4.0%	3.0%

Population Experiencing Identified Disparity	Performance Measure (PM)	Key Activity	PM Baseline Among Priority Population	CY 2025 Goal
Enrollees with Limited English Proficiency	Annual Wellness Visit completion rates	Conducting targeted outreach in the member's language	8.5%	10.0%

5. Provide any additional details relevant to your intervention/plan to address the identified disparities in access, outcomes, and/or enrollee experience of care as it relates to the VBID Model, including your rationale for pursuing the intervention.

6. Which HRSN domain(s) will you be addressing through your VBID HEP intervention? (select all that apply)
   - ☐ Food and nutritional insecurity
   - ☐ Transportation problems
   - ☐ Housing instability/living environment (e.g., rent assistance, utilities support, air filtration devices for smoke/ wildfires)
   - ☐ Interpersonal safety
   - ☐ Family and community support
   - ☐ Education
   - ☐ Physical activity
   - ☐ Other HRSN domain (please describe)
   - ☐ We are not addressing additional HRSNs at this time

7. Please describe your referral strategy to address the HRSNs selected in Question 6, including how you plan to track resolution of unmet HRSNs and if you plan to leverage closed loop referrals.

8. As applicable, across which other government or community programs do you plan to coordinate benefits? (select all that apply)
   - ☐ Supplemental Nutrition Assistance Program (SNAP)
   - ☐ Low Income Home Energy Assistance Program (LIHEAP)
   - ☐ Sections 811 and 202 (HUD programs)
   - ☐ Housing Choice Vouchers (HCV)
   - ☐ State-based services and programs
   - ☐ None
   - ☐ Other (please describe)

9. Please describe how your VBID HEP aligns with your organization's broader health equity strategy or goals, as applicable.

Engagement

10. Please describe how you incorporated enrollee and/or caregiver input into:
    - The development of your goals
    - The design of your VBID intervention/ key activities
    - Your VBID application

11. Describe your planned efforts to deliver culturally competent care (beyond what is already required by § 422.112 outside of the Model) and engage[59] and incorporate providers, community-based organizations (CBOs), and/or vendors into your VBID interventions who have a history of serving underserved communities,[60] have strong relationships with their local communities, and/or actively collaborate with organizations that may help meet the social needs of patients.

12. (Optional) If applicable, describe the nature of any value-based contracting efforts related to VBID interventions and health equity.

13. Please cite any anticipated challenges or barriers to implementation of your VBID HEP.
    - ☐ Data collection
    - ☐ Data analytic capacity
    - ☐ Member awareness/ engagement
    - ☐ Provider practices
    - ☐ Cultural/language barriers
    - ☐ Staffing availability
    - ☐ Need for staff training
    - ☐ Other (please describe)

14. Please provide the full name(s) and title(s) of your organization's "HEP Champion(s)" (i.e., the highest-level individual(s) with oversight responsibility for the achievement of the HEP.

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[59] When approaching enrollee and caregiver engagement, consider committing to providing culturally responsive and linguistically appropriate care based on the CMS Guide to Developing a Language Access Plan: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan.pdf

[60] The term "underserved communities" refers to populations with shared characteristics and geographic communities that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, such as Black, Latino and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. In referencing members of rural communities, we are inclusive of individuals in frontier areas, tribal lands, and those residing in the U.S. territories.

Advanced Care Planning (ACP)

15. Have you identified existing disparities in ACP discussions and ACP completion rates in your member population? (yes/no)

    a) (if yes) Please select all population(s) for whom you have identified ACP disparities (select all that apply):
       - ☐ Enrollees with specific health conditions as defined by a specific diagnosis
       - ☐ Enrollees participating in a specific care management program
       - ☐ Enrollees eligible for Part D LIS Subsidy/ Medicaid, where LIS is unavailable (i.e., "duals")
       - ☐ Enrollees with unmet HRSNs
       - ☐ Enrollees residing in the most underserved Area Deprivation Index census block groups
       - ☐ Other (please describe)

    b) (if yes) Please describe the population(s) selected in 15a in further detail (e.g., which conditions, which HRSNs) and cite the data used to identify these disparities.

    c) (if yes) What specific activities do you plan to engage in to address these disparities? As part of your response, describe any enhanced outreach and/or services enrollees in these populations will receive, beyond what all enrollees in your VBID participating PBPs may receive or what enrollees may receive through the broader MA program (e.g., targeted strategies to account for limited health literacy, medical mistrust, cognitive and emotional barriers to discussion, etc.). Please provide a timeline for planned activities and describe how you plan to track your progress in addressing disparities in ACP discussion/ ACP completion rates.

    d) (if no) Please describe your plans for identifying existing disparities in ACP discussions and ACP completion rates for participation in the Model.

    e) (if no) Please describe how you ensure each enrollee in VBID Model PBPs has a timely opportunity to access ACP services. This could include describing how you engage enrollees, how you outreach to any subsets of your enrollees to promote ACP discussions and ACP completion, or other strategies to implement an ACP strategy.

Appendix B: VBID HEP Evaluation Checklist

Each MAO should draft its HEP with the understanding that the HEP is a tool to develop evidence-based strategies to advance health equity in their member population for purposes of quality improvement. MAOs' VBID HEPs will be reviewed in this regard by CMS using various means, including the use of the VBID HEP Evaluation Checklist provided in this Appendix B. For MAOs participating in the Hospice Benefit Component of the VBID Model, consideration of palliative care, concurrent care, and hospice in the VBID HEPs will also be evaluated. The MAO must support its VBID HEP with specific data or other information demonstrating a need for the identified strategy and a relationship between disparities and the action the MAO intends to take. We ask MAOs to demonstrate a close fit between the specific problem identified and the solution proposed to address the identified concern, citing data or other information about the cause of the disparity, and/or information indicating that other solutions will not address the problem.

Please note: A HEP may not propose or use activities that selectively target beneficiaries based on race, ethnicity, national origin, religion, sex, or gender. In addition, a HEP must comply with all applicable non-discrimination laws, including section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act, and the MA-program specific provisions in section 1852(b) of the Act and 42 CFR § 422.110.

VBID HEP Evaluation Checklist		
I. Identify Disparities		
Intent: The MAO uses a data-driven approach to identify disparities in access, outcomes, and/or enrollee experience.		
Checklist Elements	**Yes**	**No**
MAO identified multiple data sources it plans to use to identify disparities in access, outcomes and/or enrollee experience.	☐	☐
• Claims data	☐	☐
• Health care utilization data	☐	☐
• Health risk assessment	☐	☐
• Healthcare Effectiveness Data and Information Set (HEDIS)	☐	☐
• Health Related Social Needs (HRSN) Screening tools/ questions	☐	☐
• Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey	☐	☐
• Publicly available data	☐	☐
• Enrollee Advisory Committees (or other group patient forums)	☐	☐

VBID HEP Evaluation Checklist		
• Caregiver feedback	☐	☐
• Provider feedback	☐	☐
• Patient/caregiver/community health needs assessment	☐	☐
• Other:	☐	☐
MAO clearly described its plans to use data from the specified data sources to identify and analyze gaps in access, outcomes and/or enrollee experience. Please select all the MAO included:	☐	☐
• How MAO stratified measures and outcomes to compare and contrast populations and health disparities within its broader enrollee population.	☐	☐
• Clearly identified population(s) experiencing disparities. *(For example, how many individuals will be impacted and the disparities that will be addressed.)*	☐	☐
• (If applicable) Clearly identified screening tool(s) (e.g., Accountable Health Communities (AHC) Screening Tool) and specific HRSNs for which beneficiaries will be screened.	☐	☐
MAO will ensure that providers, vendors and/or community-based organizations (CBOs) use a standardized method of collecting accurate patient sociodemographic data, including social determinants of health, to help identify and address disparities.	☐	☐
II. Address Disparities		
Intent: The MAO is specific, clear and realistic about the activities it will engage in to address the identified disparities.		
Checklist Elements	**Yes**	**No**
MAO defined goals to drive improvements for the identified population(s) within the Model performance year.	☐	☐
MAO defined the specific actions it will take to achieve its identified goals.	☐	☐
MAO defined the specific performance measure it will use to evaluate progress towards its health equity goals.	☐	☐
MAO identified a baseline against which it will measure its disparities reduction efforts.	☐	☐
MAO provided the rationale behind its planned health equity intervention and key activities.	☐	☐
MAO has developed a plan to refer enrollees to appropriate government programs (e.g., SNAP), community supports, and other resources for HRSNs identified in screenings, in addition to linkages to relevant benefits.	☐	☐
III. Engagement		
Intent: The MAO has a plan for engaging enrollees, caregivers, providers and communities in its health equity efforts.		
Checklist Elements	**Yes**	**No**
MAO described how it incorporated enrollee and/or caregiver input into the development of its health equity goals, design of its VBID intervention/ key activities, and VBID application.	☐	☐
MAO presented a clearly defined engagement plan that:		
• Ensures that services are delivered in a culturally responsive manner to enrollees, including those with limited English proficiency, limited reading skills, or those with diverse cultural and ethnic backgrounds.	☐	☐

VBID HEP Evaluation Checklist		
• Increases enrollee and caregiver health literacy, empowerment, and engagement by implementing education strategies.	☐	☐
• Offers provider education on cultural humility and implicit bias, as well as ways to have challenging conversations with patients about end-of-life care.	☐	☐
• Encourages providers to offer advance care planning as a standard practice for all enrollees.	☐	☐
MAO considered the potential barriers to implementation of its HEP.	☐	☐
IV. Advance Care Planning (ACP)		
Intent: The MAO has a strategy to identify and address disparities in ACP discussion and completion rates, combined with a strategy that reaches all enrollees in all Model-participating PBPs.		
Checklist Elements	**Yes**	**No**
MAO has identified (or has developed a plan to identify) disparities in ACP discussion/ completion rates.	☐	☐
MAO described potential activities it will pursue as part of its ACP disparities reduction efforts.	☐	☐
MAO described potential strategies to reach all enrollees as part of its ACP disparities reduction efforts.	☐	☐