Centers for Medicare & Medicaid Services

Center for Medicare and Medicaid Innovation

# Medicare Advantage Value-Based Insurance Design Model Request for Applications for CY 2018

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# 1 Background and General Information

The Centers for Medicare & Medicaid Services (CMS) is seeking applications from Medicare Advantage Organizations to participate in the second year of the Medicare Advantage Value-Based Insurance Design (MA-VBID) model.

This request for applications (RFA) is open to any Medicare Advantage Organization (MAO) approved by CMS to offer a Medicare Advantage (MA) plan or Medicare Advantage-Prescription Drug (MA-PD) plan that meets the criteria of this RFA. In order to participate in the model test in CY 2018, an organization must respond to this RFA, even if that organization participated in CY 2017.

CMS is conducting this model test through the Center for Medicare and Medicaid Innovation (Innovation Center) under Section 1115A of the Social Security Act.

## 1.1 Model Test Changes for CY 2018

CMS is introducing changes to the model test for CY 2018, including:

- Organizations that did not participate in CY 2017 may apply in CY 2018 (see Section 2.2.7);
- New, additional states: Texas, Alabama and Michigan (see Section 2.3.1);
- New and modified targeted clinical conditions (see Section 2.2.1):
  - Rheumatoid Arthritis;
  - Dementia; and
  - Additional flexibility for Mood Disorders; and
- New minimum plan benefit package (PBP) size of 500 enrollees for organizations participating in the model test with at least one other PBP with over 2,000 enrollees (see Section 2.3.2).

These changes are more fully described in the indicated sections. This list of changes to the model test is not exhaustive, and all interested organizations should review the RFA in its entirety.

## 1.2 Scope and General Approach

The phrase Value-Based Insurance Design (VBID) generally refers to health insurers' efforts to structure enrollee cost-sharing and other plan design elements to encourage enrollees to consume high-value clinical services, those that have the greatest potential to positively impact enrollee health relative to cost. In particular, VBID approaches often recognize that the relative value of a given service can vary significantly depending on the enrollee's underlying health status, and that plan design should therefore vary accordingly and be clinically-nuanced.

VBID approaches are in use in the commercial market. The inclusion of clinically-nuanced VBID elements in health insurance benefit design may be an effective tool to improve the quality of care and reduce the cost of care for Medicare Advantage enrollees with chronic diseases. However, VBID approaches generally are not used in Medicare Advantage due to existing regulations. A key barrier to implementation of clinically-nuanced VBID approaches is the

Medicare uniformity requirement, which precludes varying benefit design within a Medicare Advantage or Part D plan based on health status or other enrollee characteristics.

The MA-VBID model tests the impact of providing Medicare Advantage Organizations regulatory flexibility to integrate clinically-nuanced VBID approaches into their benefit design.

CMS is implementing a five-year MA-VBID model test. Participating organizations in the first year of the model will begin offering benefits under the authority of the model test on January 1, 2017.

The MA-VBID model will test whether the flexibility to offer clinically-nuanced VBID elements in Medicare Advantage plan benefit designs will lead to higher quality and more cost-efficient care for targeted enrollees. To test this hypothesis, CMS will exercise its Section 1115A authority to grant a limited waiver of Medicare Advantage and Part D plan uniformity requirements, in order to permit organizations to include VBID approaches in MA and MA-PD plan benefit designs.

Beginning January 1, 2018, CMS will test the MA-VBID model in ten states: Alabama, Arizona, Indiana, Iowa, Massachusetts, Michigan, Oregon, Pennsylvania, Tennessee, and Texas. Eligible PBPs in the selected test states, on approval from CMS, may offer varied plan benefit design for enrollees that fall into certain clinical categories identified and defined by CMS. These categories are diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), past stroke, hypertension, coronary artery disease, mood disorders, dementia, rheumatoid arthritis and combinations of these categories. CMS may approve other chronic conditions that might benefit from a clinically-nuanced VBID benefit design in subsequent model years.

Organizations may design their own interventions for each targeted population, but plan benefit changes must fit into four broad categories: (1) reduced cost-sharing for high-value services, (2) reduced cost-sharing for high-value providers, (3) reduced cost-sharing for enrollees participating in disease management or related programs, and (4) clinically targeted additional supplemental benefits. Changes to benefit design made through this model may only reduce cost-sharing and/or offer additional services; targeted enrollees can never receive fewer benefits or have to pay higher cost-sharing than other enrollees because of the model.

## 1.3 Statutory Authority

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

## 1.4 Waiver Authority

Section 1115A of the Social Security Act (the Act) (42 U.S.C. § 1315a, added by Section 3021 of the Affordable Care Act) authorizes CMS to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and CHIP spending while maintaining or improving the quality of beneficiaries' care. CMS will exercise this authority here 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) as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b). 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.

No fraud and abuse waivers are being issued in this document, fraud and abuse waivers, if any, would be set forth in separately issued documentation. Thus, notwithstanding any other provision of this Request for Applications, 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 the Value-Based Insurance Design Model. Any such waiver would apply solely to the Value-Based Insurance Design Model and could differ in scope or design from waivers granted for other programs or models, or those described below.

### 1.4.1 Medicare Program and Payment Waivers

In support of the model intervention, the Secretary intends to waive certain Title XVIII statutes and their implementing rules, to the extent described below. No program or payment waivers of any kind are being issued in this document, which merely describes the waivers contemplated at this time for the model; waivers, if any, would be set forth in separately issued documentation as an appendix to the contractual addendum for participation in the model test.

- **Uniformity and Accessibility of Benefits:** To be waived to the extent necessary to permit organizations to offer supplemental benefits to the clinically-targeted enrollee population, rather than to the entire membership.
  - Section 1852(d)(1)(A) of the Act [42 USC §§ 1395w-22(d)(1)(A)];
  - 42 C.F.R. §§ 422.2 (definition of an MA plan), 422.100(d)(2) & 422.254(b)(2);
  - Section 1860D–2(a) of the Act [42 USC § 1395w-102(a)]; and
  - 42 C.F.R. §§ 423.104(b)(2), 423.265(c).

- **Uniform Cost Sharing**: To be waived to the extent necessary to offer reductions in cost-sharing to the clinically-targeted enrollee population, but not to the entire membership.
  - 42 C.F.R. §§ 422.2 (definition of an MA plan), 422.100(d)(2), 422.254(b)(2) 422.262(c)(1);
  - Section 1860D–2(a) of the Act [42 USC § 1395w-102(a)]; and
  - 42 C.F.R. §§ 423.104(b)(2) & 423.265(c).

- **Communications, Disclosures and Marketing**: To be waived to the extent necessary for organizations to comply with model-specific guidance on communications, including disclosures and marketing, with enrollees or potential enrollees.
  - Section 1852(c)(1)(B) & (F) of the Act [42 USC §§ 1395w-22(c)(1)(B) & (F)];
  - 42 C.F.R. § 422.111(a) & (b);
  - Section 1860D–4(a)(1)(A) of the Act [42 USC § 1395w-102(a)]; and
  - 42 C.F.R. § 423.128(a) & (b)(2).

CMS is not proposing to waive Title XVIII's anti-discrimination provisions and does not believe such waiver is necessary for the model test. Participating organizations are required to implement model interventions in a non-discriminatory manner.

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

# 2 Description of the Model

## 2.1 Purpose and Concept

The MA-VBID model is testing the impact of providing Medicare Advantage Organizations regulatory flexibility to integrate clinically-nuanced VBID approaches into their benefit design. The model will test the hypothesis that VBID approaches will increase enrollee satisfaction, improve enrollee clinical outcomes, reduce overall plan expenditures, and result in lower plan bids, leading to savings for both Medicare and beneficiaries.

In general, organizations may choose to integrate one or more of the following VBID approaches into participating plan benefit designs:

1. Reduced cost-sharing for high-value services
2. Reduced cost-sharing for high-value providers
3. Reduced cost-sharing for enrollees participating in disease management or related programs
4. Coverage of additional supplemental benefits

This model will be evaluated to answer key research questions, including: (a) does the model improve enrollee outcomes, satisfaction, and out-of-pocket costs, (b) does the model result in lower expenditures for participating health plans, and if so, (c) do these lower costs translate into lower plan bids over time, resulting in savings for Medicare and/or enrollees.

## 2.2 Model Design Elements

### 2.2.1 Targeted Conditions

For the purposes of the MA-VBID model test, CMS has identified a limited number of chronic conditions from which organizations may choose to target interventions. Participating organizations will be responsible for applying the CMS-defined criteria to identify enrollees who fall within each of the clinical categories selected by an organization.

In addition to selecting specific chronic conditions, organizations have the flexibility to identify specific combinations of the listed chronic conditions for one or more "multiple co-morbidities"

groups and establish tailored VBID interventions for each group. CMS will review all groups selected for estimated cohort size and may reject those proposals not calculated to extend to a group large enough for meaningful evaluation of the intervention.

While participating organizations will have the opportunity to modify their benefit design for any or all of the targeted conditions, plan benefit design still must be uniform among enrollees within each condition category. Organization determinations will be subject to retrospective, randomized audits by CMS to determine if all VBID-eligible enrollees actually received the VBID interventions.

The targeted conditions are:

- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Patient with Past Stroke
- Hypertension
- Coronary Artery Disease
- Mood Disorders
- Rheumatoid Arthritis (starting in 2018)
- Dementia (starting in 2018)

ICD-10 codes formally define the targeted conditions. Appendix B provides tables listing the ICD-10 codes included in each category.

Organizations selecting the Mood Disorders category will have an additional flexibility starting in 2018. Those organizations may select from amongst the ICD-10 codes listed in Appendix B to create a smaller group suitable to the proposed intervention. Organizations exercising this option must select all ICD-10 codes from within a chosen code category. For example, an organization wishing to focus on Depressive Episodes (F32) may not select only F32.0 (“Major depressive disorder, single episode, mild”), but must provide benefits to all F32 codes in the CMS MA-VBID Mood Disorder code set. Organizations selecting F32 or F34 may also propose to include all codes from within those categories, instead of just those included in the CMS MA-VBID Mood Disorder code set.

When conducting clinical review of proposals submitted by organizations for the dementia population, CMS will specifically consider whether the proposal exposes this population to increased risk of unnecessary drugs, particularly the use of atypical antipsychotics, or other risk of harm.

CMS selected these conditions based on (1) their relatively high prevalence within the Medicare Advantage population, (2) their potential for high-cost complications, and (3) the existence of known low-cost, high-value interventions that may improve the disease course and/or reduce complications.

Participating organizations may not modify benefit design for enrollees with conditions not on this list or for any other subgroup of enrollees. However, based on organization feedback and the initial observations of the model’s implementation, CMS may consider adding additional

conditions to the list in later model years. Organizations may vary their selected conditions from one participating PBP to another.

### 2.2.2 Permissible Interventions

For each of the target populations, participating organizations may select one or more of the permitted plan design modifications.

Within each approach, organizations have significant flexibility on how (and to what extent) to implement the approach. An organization may vary its proposed interventions from one target population to another and from one participating PBP to another. CMS will also consider proposals for related variants of these interventions, such as additional supplemental benefits conditional on participation in a disease management program.

Only interventions consisting of additional benefits or lower cost-sharing are acceptable. Organizations may not propose reductions in targeted enrollee benefits or increases in targeted cost-sharing amounts as VBID interventions.

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

The plan design modifications permitted for this model test are listed below.

**1. Reduced Cost-Sharing for High-Value Services**

Organizations can choose to reduce or eliminate cost-sharing for items or services, including covered Part D drugs, they have identified as high-value for a given target population. Participating organizations have broad flexibility to choose which items or services are eligible for cost-sharing reductions; however, these items or services must be clearly identified and defined in advance, and reductions in cost-sharing must be available to all enrollees within the target population.

Reductions in cost-sharing could 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; organizations can propose other approaches to reducing cost-sharing.

Examples of interventions within this category might include the elimination of co-pays for eye exams for enrollees with diabetes or the reduction of co-pays for ACE inhibitors for enrollees who have previously experienced an acute myocardial infarction.

**2. Reduced Cost-Sharing for High-Value Providers**

Organizations can choose to reduce or eliminate cost-sharing when providers that the organization has identified as high-value treat targeted enrollees. Within this approach, there may be several potential variants, but all parameters must be described in the application and administered in a non-discriminatory fashion. One variant is simply to reduce or eliminate cost-sharing for a given provider, regardless of the specific service provided to a targeted enrollee. Another is to reduce or eliminate cost-sharing only when a high-value provider delivers a

specific high-value service, or one of several high-value services, to targeted enrollees. Both approaches are permissible and organizations can vary their approach by target population, provider type, or service type.

Organizations may identify high-value providers across all Medicare provider types. This can include physicians and practices, hospitals, skilled-nursing facilities, home health agencies, ambulatory surgical centers, etc.

As part of the application and approval process, organizations must propose their methodology for identifying high-value providers for each target population. CMS will review and approve each proposal individually, with particular emphasis on the clinical rationale behind each proposal. 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 clinical condition group. Providers not individually considered high-value might be enrolled as such by a plan when affiliated with high-value providers through a multi-specialty provider group or other clinically integrated arrangement.

CMS will encourage organizations to rely on independent, external metrics when determining whether a provider is high-value. Examples of such metrics might include whether a primary care practice is a National Committee for Quality Assurance (NCQA) certified medical home, whether a hospital has American Heart Association advanced certification in heart failure, or whether a provider meets certain performance metrics on National Quality Forum (NQF) validated quality measures. However, more idiosyncratic or locally specific approaches also may be proposed, so long as they can be clinically justified. Cost or efficiency can be part of organizations' criteria for identifying high-value providers, but must be combined with relevant quality measures; in other words, organizations cannot identify high-value providers based on cost alone. Organizations also cannot identify high-value providers based on coding accuracy or intensity.

Proposals will also be reviewed for potential adverse consequences, including enrollee confusion. When an organization offers cost-sharing elimination for a specific high-value service only, that service should be an easily discernable episode of care not subject to variable or unanticipated cost to the enrollee based on the provider's choice of coding, facility fees, or non-discounted services from other providers. For example, selected high-value providers should not be associated with higher or unexpected cost-sharing for enrollees for related services (e.g., if a high-value hospital's physicians were typically out-of-network, leading to higher co-pays for the physician services received at the hospital).

Organizations do not need to meet any specific network adequacy or access standards for the subset of high-value providers selected as part of this approach. However, all VBID interventions must be available and accessible to applicable targeted enrollees. CMS may require an organization to modify its intervention in cases where accessibility is inadequate and impacts performance in a manner inconsistent with the goals of the model. Certain patterns of inaccessibility may constitute discrimination. Notwithstanding the intervention, organizations must still meet all standard Medicare Advantage network adequacy requirements (see 42 C.F.R. 422.112 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.

Participating organizations 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 for the best interest 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 (See: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html) regardless of whether such changes are considered "significant" with respect to the network-at-large.

Examples of interventions within this category might include reducing cost-sharing for diabetics who see a physician who historically has achieved strong results in controlling her patients' Hba1c levels, or eliminating cost-sharing for heart disease patients who elect to receive non-emergency surgeries at cardiac centers of excellence (potentially including centers geographically remote from the PBP's service area, for which intervention CMS may establish additional safeguards, such as travel and accommodation requirements).

### 3. Reduced Cost-Sharing for Enrollees Participating in Disease Management or Related Programs

Participating organizations can reduce cost-sharing for an item or service, including covered Part D drugs, for enrollees who choose to participate in a plan-sponsored disease management or similar program. A plan-sponsored disease management or similar program could include an enhanced disease management program, offered by the organization 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.

This intervention is intended to complement the newly established flexibility within the Medicare Advantage program to offer Rewards and Incentives, under 42 C.F.R. § 422.134. However, the model goes beyond this existing flexibility in that participating organizations may offer reduced cost-sharing for participation.

Organizations using this approach can condition cost-sharing reductions on enrollees meeting certain participation milestones. For instance, an organization may require that enrollees meet with a case manager at some regular interval in order to qualify. However, organizations cannot make cost-sharing reductions conditional on achieving any specific clinical goals – e.g., an organization cannot condition cost-sharing reductions on enrollees achieving certain thresholds in Hba1c levels or body-mass index. In general, this intervention 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.

As part of the application and approval process, organizations must submit specific proposals for how they intend to link disease management or related programs to cost-sharing reductions or eliminations. CMS will review these proposals to determine that they are clinically reasonable, to ensure they are not discriminatory, and to ensure there is no other likely adverse impact on enrollees. The underlying disease management or similar program must comply with all existing CMS rules and regulations.

Examples of interventions within this category might include elimination of primary care co-pays for diabetes patients who meet regularly with a case manager or reduction of drug co-pays for patients with heart disease who regularly monitor and report their blood pressure.

**4. Coverage of Additional Supplemental Benefits**

Under this approach, participating organizations can make coverage for supplemental benefits available only to targeted populations. Such benefits may include any service consistent with existing Medicare Advantage rules for supplemental benefits—examples might include non-emergency transportation to primary care visits for enrollees with multiple co-morbidities, meals or other nutritional services, additional counseling or other covered services, and additional rehabilitation or other post-acute care. *See* 42 C.F.R. § 422.102; Managed Care Manual, Ch. 4, § 30.

These benefits will be treated as mandatory supplemental benefits and (excepting the points outlined above) would be subject to the same rules as any other benefit in that category. Note that while these benefits are available only to certain clinically-targeted categories of enrollees, they would be funded by rebate and/or premium dollars from all PBP enrollees. In this respect, the benefits would be similar to existing enhanced disease management programs, which may be offered as mandatory supplemental benefits, but are only available to enrollees with a targeted disease.

Organizations proposing interventions in this category must provide a rationale relating the additional services provided to improved outcomes or lower costs for targeted enrollees. CMS will review the clinical justification for this rationale. In addition, supplemental benefits offered as part of this intervention may not be structured in a discriminatory way, and must be available to all enrollees within the clinically-targeted category.

Examples of interventions within this category might include physician consultations via real-time interactive audio and video technologies for diabetics, or supplemental tobacco cessation assistance for enrollees with COPD.

### 2.2.3 Marketing and Enrollee Communications

Organizations cannot cite their participation in this model or specific benefits available under the model in pre-enrollment marketing materials targeted at potential enrollees. Similarly, organization sales representatives are not permitted to mention the organization's participation to potential enrollees who are not yet enrolled. All marketing regulations and guidance remain applicable to materials and activities of the participating organization and other MA and MA-PD plans. See, e.g., 42 C.F.R. parts 422 and 423, subparts V.

CMS will permit participating organizations and their representatives to convey information about the benefits available through VBID interventions, but only when a potential enrollee specifically enquires about them. Such discussions must be accompanied by a disclaimer indicating that eligibility for interventions is not assured, and will be determined by an organization after enrollment based on clinical diagnosis data. Moreover, the information must be conveyed in accordance with all other CMS marketing restrictions, particularly those prohibiting misleading communications to enrollees. These policies reflect the general goals of this model, which is intended to test the impact of offering organizations additional flexibilities in order to improve care for existing enrollees. The model is not intended to encourage or discourage enrollment either in Medicare Advantage generally or any specific participating organization or PBP.

At the beginning of each model year, organizations will be required to send all enrollees in target populations written materials summarizing the reduced cost-sharing and/or additional benefits

available to them as a result of the organization's participation in the MA VBID model, in a "Notice of VBID Benefits." If an organization is reducing cost sharing for certain high-value providers, a list of these providers must be included in the materials provided to VBID-eligible enrollees. The Notice of VBID Benefits should be mailed with the ANOC/EOC for existing enrollees and the EOC for new enrollees, or contemporaneously with the mailing of those documents. In addition, the Notice of VBID Benefits for VBID-eligible enrollees must include language with basic information on the VBID model, including enrollee protections. Enrollees who become eligible for participation in the VBID model in the middle of the year (those who are newly diagnosed with a targeted condition or the organization first learns of a diagnosis in the middle of a year) must receive this same information once they are identified by their organization.

These mandated communications to eligible enrollees represent the minimum that is expected of organizations; however, organizations can go beyond this and communicate further with targeted enrollees. Indeed, CMS believes that further and more intensive communications will likely be a prerequisite for the model's success. Examples of further communications with participating enrollees might include (a) regular (quarterly or monthly) follow-up mailings, reminding enrollees of the potential advantages available to them as the result of VBID, (b) follow-up phone calls with targeted enrollees, and (c) targeted phone calls or mailings, based on specific clinical or treatment patterns of a given enrollee. (For instance, an organization might remind an enrollee, when granting that enrollee prior approval for a service that she is eligible for reduced cost-sharing for a surgical procedure if she uses a high-value provider.) CMS will consider which of these materials and/or scripts for these follow-up communications, along with a general plan for distributing these materials, must be reviewed and approved by CMS if such review is not already required under existing requirements. CMS will specifically review those materials selected to ensure that all communications are factually accurate and are not discriminatory. Regardless of whether selected for review, all marketing materials communications must comply with the prevailing requirements for MA and MA-PD plans. See, e.g., 42 C.F.R. parts 422 and 423, subparts V.

In addition to communications with enrollees, participating organizations will also be expected to communicate their participation in the model with all members of their provider network, and may communicate enrollees' eligibility status once established. Providers who have been identified as high-value under the VBID model should also be specifically made aware of this fact.

More detail on the communication requirements for the MA-VBID model test can be found in the model test's CY 2017 Communications Guidelines (available at https://innovation.cms.gov/initiatives/vbid), which CMS may subsequently update for CY 2018.

### 2.2.4 Enrollee Protections

Organizations may not propose reductions in targeted enrollee benefits or increases in targeted cost-sharing amounts as VBID interventions. Furthermore, organizations may not discriminate against non-targeted populations, for example, in cases where VBID interventions are coupled with changes made to the PBP-at-large in ways that decrease the benefits available to enrollees with non-targeted clinical conditions. Organizations must strictly adhere to CMS definitions of the target population, and are responsible for proactively identifying each enrollee with an eligible diagnosis code based on information known to the organization. Organizations may not advertise their participation in the model except as permitted by CMS. CMS will review the

clinical justification of organizations' proposed interventions and screen to ensure that they are not discriminatory. Organizations are required to communicate the benefits of the model to all targeted enrollees, and CMS will review and approve specific communications.

In addition, CMS will layer several additional enrollee protections on top of those embedded in plan design. These include:

- Use of secret shoppers to ensure that marketing/sales representatives are not inappropriately citing participation in the VBID model;
- Randomized or targeted auditing to review compliance with CMS definitions of eligible target populations
- Construction of a customized script for any calls to 1-800-MEDICARE related to the VBID model and standardized process for following-up on any enrollee complaints;
- Enrollee right to opt-out of the model, if they so request;
- Standardized process for receiving and reviewing any provider complaints related to the model;
- Ongoing monitoring of incoming data, to ensure that there is no evidence of significant deterioration in enrollee outcomes or in enrollee satisfaction or other adverse enrollee impacts (e.g., limited access to high-value providers); and
- Ongoing monitoring of incoming data, to ensure there is no significant increase in coding intensity associated with participation in this model.

The model's monitoring plan is designed to protect all beneficiaries and assure organizations' compliance with the terms of the model test. As a component of this plan, CMS will use a contractor to conduct compliance monitoring on a regular basis that tracks compliance with the terms of the model test. As with evaluation, the contractor will monitor chiefly through existing data sources and not on additional data collected specifically for the model test. CMS's 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 reserves the right to terminate an organization's participation in the model or exercise other available remedies at any time if there is evidence to suggest that the organization's participation in the model is resulting in lower quality care or any other adverse outcomes for enrollees.

### 2.2.5 Changes to Model Design in Subsequent Model Years

CMS retains the right to modify any model policy or condition on an annual basis, or more frequently, in accordance with procedures and parameters that will be agreed upon in the model's contractual addendum to the organization's agreement with CMS for participation in Medicare Advantage. However, CMS's general intention is to limit changes to model design in the first three model years to minor modifications to correct any unexpected technical or operational problems, to address program integrity issues, or to address any observed unintended adverse consequences of the model. CMS also retains the right to add targeted conditions to the model in the initial three-year period, based on feedback from organizations and other stakeholders.

CMS may consider more broad-reaching policy changes in the later model years (i.e., Years 4 and 5). Such changes might include:

- Modifying target conditions;
- Modifying the permissible interventions;
- Modifying the restrictions on marketing or communications;
- Setting more stringent financial requirements for participants – e.g., requiring organizations to accept a lower benchmark in return for the flexibility offered by the VBID model (this modification might be appropriate if initial evaluation results showed savings that were not being reflected in lower plan bids); and
- Adding or eliminating requirements for participation.

Any such model design changes would be based on the experience of the first two-to-three years of the model, including both qualitative feedback from model participants and interim evaluation results. Any changes to the model would be announced well in advance of implementation.

CMS will retain the right to modify any model policy or parameter on an annual basis, or more frequently in accordance with procedures described in the model's contractual addendum.

### 2.2.6 Changes to an Organization's Interventions in Subsequent Model Years

Organizations may make changes to their interventions to be effective at the beginning of each calendar year. The process for CY 2017 model test participants to request CMS approval for such changes for CY 2018 is detailed in Section 6.4 of this RFA.

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

### 2.2.7 Admission of New Organizations or PBPs in CY 2018 and Subsequent Model Years

Organizations that did not participate in the model test in CY 2017 may apply to participate for CY 2018. Additionally, organizations that did participate in CY 2017 may apply to add PBPs that did not previously offer VBID benefits. CMS expects to similarly reopen the model test to applications in future years.

## 2.3 Applicant Eligibility

### 2.3.1 Geographic Scope

CMS has selected ten states in which to test the model. CMS will conduct the model test in Alabama (starting in 2018), Arizona, Indiana, Iowa, Massachusetts, Michigan (2018), Oregon, Pennsylvania, Tennessee, and Texas (2018). These states were selected in order to generally represent the national Medicare Advantage market. Collectively, they include urban and rural areas, areas with both high and low average Medicare expenditures, high and low prevalence of low-income subsidies and areas with varying levels of penetration of and competition within

Medicare Advantage. Test states were also selected based on the availability of appropriate paired comparison areas for the purpose of evaluation.

Organizations may only enter PBPs into the model when all or a portion of that PBP's service area is located within a test state. A PBP's service area need not cover the entire state, but all of a PBP's approved counties and segments must participate in the model test. If a PBP covers counties or segments both inside and outside of a model test state, the organization must offer model interventions to all eligible plan enrollees, both inside and outside. Organizations with multiple qualifying plans may enroll some of those plans, but not others, at their discretion.

### 2.3.2 Participant Eligibility

Participation in the model is voluntary. The model is open for participation to MA organizations at the individual PBP or segment level. Medicare Advantage organizations may propose one or multiple MA and MA-PD plans for participation, so long as each PBP individually meets the criteria specified below.

In order to participate in this model a Medicare Advantage PBP must meet the following criteria:

- The PBP is an HMO, HMO-POS or local PPO plan type;
- The PBP is not a regional PPO, Special Needs Plan (SNP), Medicare-Medicaid Plan (MMP) or other demonstration plan, cost plan, Medical Savings Account Plan (MSA), Private Fee-For-Service Plan or Employer Group Waiver Plan (EGWP);
- All or part of its service area lies within one of the model test states identified above;
- The PBP has at least 2,000 enrollees in a model test state.
  - Provided that an MA organization participates in the model test with at least one PBP with enrollment over 2,000 enrollees, the minimum enrollee requirement for each additional PBP from that MA organization (or other MA organizations with the same parent organization) to participate without an exception from CMS is 500 enrollees
- The PBP is offered in no more than two states total;
- At least 50% of the total PBP enrollment is within target states;
- The PBP must have been offered in at least three annual coordinated election (open enrollment) periods prior to the open enrollment period for CY 2018;
- The organization offering the PBP is not under sanction by CMS as described in 42 C.F.R. 422.750 and 42 C.F.R. 423.750;
- The organization offering the plan is not an outlier in CMS's Past Performance Review (more information about this review is available here: http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDComplianceActions.html);
- The PBP's contract has at least a three-star overall quality rating (plans that are not rated, due to newness or low enrollment, do not qualify);
- The PBP does not have a "consistently low performing" icon on the Medicare Plan Finder.

PBPs that fail to meet these criteria may not participate in the model in CY 2018, although they may become eligible in subsequent years. Conversely, PBPs that meet these requirements

initially, but fail to do so in subsequent years (i.e., are sanctioned by CMS) may be terminated by CMS from the model, upon consideration of the best interests of the plan's enrollees and needs of the model test.

Segmented PBPs can participate in the MA-VBID model test; however, specific rules apply. Interventions pertaining to enhanced or additional supplemental benefits, any intervention consisting of a reduction of cost sharing for a Part D drug, or coverage of a Part D excluded prescription drug must be applied uniformly across all segments of a segmented plan. As such, a plan that includes fewer than all associated segments in the VBID model may not offer these VBID interventions. These specific interventions are permissible as long as all associated segments are included in the VBID model and the same VBID interventions are offered across all associated segments. Consistent with existing Medicare Advantage segment requirements (in which there may be differential cost sharing across segments but not benefit design), only those VBID interventions that consist of reductions in cost sharing for Medicare Parts A and B covered services, whether as a specific intervention, for use of a high-value provider, or for participation in a disease management or similar program, may vary from segment to segment, or be offered in fewer than all plan segments.

Applicants must disclose any present or past history of sanctions, investigations, probations or corrective action plans for the applicant, affiliates or other relevant persons and entities. CMS will conduct appropriate program integrity screens during the application process, and will exercise its existing rights to not select otherwise qualified applicants on the basis of information found during a program integrity screen.

CMS will consider exception requests in limited circumstances and will reserve the right, in its sole judgment, to admit a PBP that does not strictly meet the criteria. For example, CMS might admit a plan offered for fewer than three years, where that plan is a successor to a previously offered plan, such that sufficient baseline data is available for evaluation. However, CMS will only exercise that discretion when that admission is consistent with the administration and goals of the MA-VBID model. In circumstances where a plan fails to meet quality-related criteria, CMS will apply a high degree of scrutiny to the request, and is unlikely to approve such an exception without consideration of additional monitoring or other conditions to be imposed upon the excepted PBP. In addition, CMS will consider applications for plans that do not meet the criteria at the time of application but are anticipated to qualify by January 1, 2018.

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

The participant selection requirements are in addition to any participation requirements generally applicable to the Medicare Advantage program. A condition of continuing participation in the MA-VBID model is that the participating PBP continues to be offered in the Medicare Advantage program.

## 2.4 Bidding and Projected Savings

The VBID interventions offered by an organization will be treated for bid purposes as mandatory supplemental benefits. Cost-sharing reductions made and supplemental benefits offered as part of a plan's participation in this model must be accounted for in the bid according to the rules

generally prevailing under Parts C and D. The benefits are subject to existing actuarial equivalence requirements, funding rules and other regulations for supplemental benefits.

Participating PBPs will be required to satisfy all existing CMS requirements, such as service category cost-sharing standards, Total Beneficiary Cost (TBC), and meaningful difference without consideration of the VBID interventions. VBID interventions will be documented within separate areas of the PBP submission such as a supplemental notes field so as not to influence the evaluation of cost-sharing standards, meaningful difference and TBC.

Organizations must also provide CMS with projections of the impact that their participation will have, for the coming year, on plan medical and prescription drug utilization, cost, and premiums. These projections need not be accompanied by the certification of a qualified actuary, but will be considered an actuarial communication. CMS will review these projections at the application stage for compliance with the terms of the model test, reasonableness of assumptions, potential detrimental impact to CMS or enrollees and the sustainability of the proposal. In order for the plan to be approved to participate in the model, these projections must show net savings to CMS over the course of five years, and no net increase in enrollee cost over the life of the model. CMS may require the submission of financial projections to demonstrate compliance with this requirement.

Organizations may be required to correct projections or interventions, or establish a multi-year financial plan, in case of unacceptable submissions. Once approved by CMS, organizations must incorporate these assumptions into their annual bids in accordance with instructions to be provided at a later date. These instructions might require organizations to supply additional plan-specific model information through the Health Plan Management System (HPMS) Bid Pricing Tool in connection with their bids for each of the model years, demonstrating the specific impact of the model on that year's bid. CMS will require annual updates to the projections, to include actual historical experience when available. Failure to adhere to these requirements may constitute grounds for dismissal from the model test, imposition of a corrective action plan or other available remedy.

CMS will separately publish further information on the financial and actuarial components of the application.

# 3 Learning and Diffusion Resources

CMS will support participating organizations in accelerating their progress by providing them with opportunities to both learn about VBID and evidence-based clinical practices. This will be accomplished through a "learning system" for the organizations. CMS expects organizations to actively participate in the learning system.

The MA-VBID Model is intended to provide CMS, participating organizations and the health insurance benefit design community at large with valuable insights into effective implementation of VBID principles. To this end, CMS will facilitate learning activities related to the implementation and outcomes of VBID so that organizations can improve their designs over the course of the model test. CMS may also engage in efforts to study the various VBID interventions in the model and diffuse findings about VBID implementation to payors and other stakeholders nationwide. Cooperation with these efforts will be a condition of participation in the model. In designing any learning activities, CMS will take into consideration that model participants exist in a competitive marketplace, and that some participants may consider some

elements of their interventions proprietary. CMS will work closely with participating organizations to develop learning and diffusion strategies that attempt to accommodate this limitation.

# 4 Quality and Performance Monitoring

## 4.1 Data Collection and Quality Indicators

Data collection is central to the success of the model evaluation. This evaluation will use several existing data sources to measure quality of care and impacts to cost, including enrollment and disenrollment files, plan bids, MA encounter data, Prescription Drug Event (PDE) data, Healthcare Effectiveness Data and Information Set (HEDIS), CMS Star Ratings, and MA & PDP CAHPS and Disenrollment Survey. The use of existing data sources is intended to reduce the administrative burden imposed on participants and to provide historical baseline.

However, CMS may also require organizations to report additional data, but only where that data is of significant importance to the evaluation so as to justify the additional burden. Organizations' submission of this data is a condition of participation for the model.

Participating organizations are required to report their determination of enrollee eligibility for VBID benefits to CMS via new MARx input transaction, transaction type 91. More information on this transaction is available in the June 29, 2016 Health Plan Management System Memorandum entitled "Announcement of the August 2016 Software Release." CMS is developing two additional CAHPS questions for insertion into the survey's "Your Health Plan" section participating organizations. CMS may also request the submission of enrollee-level health record data for evaluation and monitoring purposes.

Additional data collected may include, but is not necessarily limited to, measures of numbers of enrollees served, demographic information, participation in programs, the numbers and types of interventions in which enrollees participated, and other pertinent information to determine the reach of the project, when not available from existing reporting sources.

## 4.2 Monitoring and Oversight

CMS will use a contractor to conduct compliance monitoring on a regular basis that tracks compliance with the terms of the model test. The contractor will perform monitoring chiefly through existing data sources including measures of processes, outcomes, and enrollee satisfaction and not on additional data collected specifically for the model test. However, the CMS Innovation Center 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 will closely monitor model implementation, to ensure that model interventions are consistent with model rules and applicants' proposals and that the model is not leading to any adverse beneficiary outcomes. This will include, but not necessarily be limited to, observing existing metrics of beneficiary access, outcomes, and satisfaction, and monitoring of increased beneficiary questions or complaints through 1-800-MEDICARE or the 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 further investigate an organization if there is evidence that indicates that the organization's participation in the model is adversely impacting enrollee quality of care, and exercise all available remedies in appropriate instances, including potential termination from the model test.

# 5 Evaluation

All model participants are required to cooperate with efforts to conduct an independent, federally funded evaluation of the model, which may include participation in surveys, interviews, site visits, and other activities that CMS determines necessary to conduct a comprehensive formative and summative evaluation, as well as the timely submission of accurate encounter data to CMS. The evaluation will assess the impact of the model in meeting intended goals in order to inform policy makers about the effect of the model concepts relative to health care delivery. To do so, the evaluation will seek to understand the behaviors of providers, suppliers, and beneficiaries, the impacts of increased financial risk, the effects of various payment arrangements and benefit enhancements, the impact of the model on beneficiary engagement and experience, and other factors associated with patterns of results.

# 6 Application Process and Selection

## 6.1 Questions

Questions regarding the MA-VBID model or application process may be sent by email to MAVBID@cms.hhs.gov. CMS may publicly share questions and responses or compile them into a compendium to ensure that all applicants have access to information regarding the model and the application process.

## 6.2 Accessing the Online Application Portal

Interested organizations must apply to participate by responding to this RFA through an online application portal. CMS will only accept applications via the online application portal. CMS expects the online portal to be available shortly, and interested participants should monitor innovation.cms.gov/initiatives/vbid for a live link to be posted. Appendix A contains a template of the application questions to which organizations will respond through the online application portal. Organizations are encouraged to begin preparing responses prior to the opening of the portal.

Organizations should submit one application per contract.

## 6.3 Deadline for Applications

The deadline for receipt of applications in response to this RFA is 4:00 PM EST on January 20, 2017 for all applicants. Proposals in response to this RFA must be complete and submitted using the online portal before the deadline.

## 6.4 Applications from Current Participants

Organizations that applied to participate in the model test in CY 2017 must submit a response to this RFA in order to participate in CY 2018.

The questions in Appendix A request that organizations participating in CY 2017 focus their responses on proposed changes to their interventions, if any.

Exceptions from model test participation criteria issued by CMS to individual applicants for CY 2017 are granted as to those same PBPs for CY 2018, without need for a renewal request by the organization. The conditions of such exceptions also continue to apply. CMS will determine at a later date whether a renewal request will be required for CY 2019 and subsequent years.

## 6.5 Application Review and Model Contracting

### 6.5.1 Application Review

Model participant selection is not competitive. CMS does not intend to set a maximum number of qualified organizations participating in the model test.

Organizations are required, at the time of application, to specify the PBPs they will enroll in the model test and the states in which those PBPs will participate. Organizations must submit a separate application for each Medicare Advantage contract held by that organization but one or more PBPs covered by that contract may be included in the application, even if the proposed VBID interventions vary from PBP to PBP.

Organizations must respond to the RFA with sufficient detail for CMS to evaluate and understand the proposed VBID intervention. CMS may negotiate with applicants and request application modifications as part of its review of VBID intervention, though it may also choose to reject unacceptable proposals outright. Applicants to the model offering distinctive interventions by segment (i.e., reductions of cost sharing for Medicare Parts A and B covered services only) should upload a supplemental document describing which interventions apply to which segment as part of the application.

CMS reserves the right to reject any organization, PBP, or proposal to preserve the integrity of the Medicare program, the welfare of beneficiaries, or the efficient and advantageous administration of the MA-VBID Model. Without limitation, CMS might reject an application where:

- The applicant organization or a specific PBP does not meet the criteria for participation in the model test;
- The proposed VBID benefits do not meet the specific criteria for acceptable VBID interventions described in this RFA;
- The proposed VBID benefits cannot be reasonably considered, based on available clinical evidence, to be of high value to the targeted class of enrollees;
- The proposal poses an undue risk of enrollee harm, such as discrimination, or confusion;
- The proposal has potential to impose excessive costs on the Medicare program;
- The proposal is otherwise inconsistent with the implementation and evaluation objectives of the model test.

During the model selection process, CMS will conduct program integrity screening and will exercise its existing rights to not select otherwise qualified applicants on the basis of information found during a program integrity screen.

In accordance with authorities granted in Section 1115A(d)(2) of the Social Security 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 MA-VBID model test is voluntary.

### 6.5.2 Conduct Pending Acceptance and Contracting

Applicant organizations not already bound to a contractual addendum for participation in the model test do agree, by submission of an application, to adhere to the terms of this RFA pending their formal acceptance into the MA-VBID model test and execution of the contract addendum.

### 6.5.3 Contracting

Selected organizations will formally join the model test by addendum to the organization's contract with CMS for participation in Medicare Advantage for the applicable year(s), anticipated to be signed in September, 2017. This addendum is intended to reflect the requirements of this RFA, but may reflect changes to the MA-VBID model test made after the RFA's publication, or address matters not discussed in this RFA.

Participation in the model may be conditioned on criteria to be specified at a later date, such as a successful readiness review, approval of policies, review of communication materials, requirements for participation in CMS Innovation Center learning and diffusion activities, sharing of quality and performance monitoring data, and cooperating with CMS monitoring and evaluation activities.

Once contracted to participate in the model, each organization will be bound to adhere to its response to this RFA and to fully implement its proposal. Modifications to the proposal will be permitted only with express written approval of CMS.

CMS will reserve the right to impose a corrective action plan as a condition of continued participation or to terminate a participating organization from the model test to rectify or address a failure to adhere to model requirements. Further, an organization's failure to adhere to the requirements of the model test may result in rescission or invalidation of a waiver issued by CMS to that organization, which could trigger enforcement action by CMS related to the waived requirements. All other regulatory and statutory requirements applicable to the organization's MA plan will remain in effect. Failure by an organization to comply with those requirements could result in enforcement action consistent with the authority of the MA program, including intermediate sanctions or contract termination.

## 6.6 Timeline

Table 1 contains a tentative timeline for MA-VBID model participant selection.

Table 1. 2018 VBID Model Participant Selection Tentative Timeline

| Date | Milestone |
|---|---|
| January 20, 2017 | Model applications due to CMS |
| March – April 2017 | Provisionally selected model participants identified |
| June 2017 | 2018 MA plan bids due (bids reflect negotiated agreement on VBID) |
| September 2017 | Contract addenda for model participation executed |
| January 2018 | Model Year 2 implementation begins |

## 6.7 Withdrawal or Modification of Application

Applicant organizations seeking to withdraw an entire application or requesting to modify a pending or preliminarily approved application should submit a written request on the organization's letterhead that is signed by the primary point of contact named in the application submission. To submit a withdrawal request, applicants must send the request in a PDF format by email to MAVBID@cms.hhs.gov. Prior to bid submission, CMS will allow incremental changes to preliminarily approved interventions, but only where good cause is shown. After bid submission, CMS will only allow changes of a type typically allowed for Medicare Advantage and Part D benefits after bid submission, such as those required in response to CMS bid desk review findings, or made during rebate reallocation. Allowance of changes to preliminarily approved interventions is a matter of CMS discretion, and CMS may require resubmission of actuarial documentation to account for proposed changes.

## 6.8 Amendment of RFA

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

# Appendix A – Application Template

This Appendix details the information and certifications applicants must provide to CMS through the online application portal. Applicants will also be required to provide contact information and other like information. The application portal will be accessible from the MA-VBID model's home page, innovation.cms.gov/initiatives/VBID, and should be available shortly after publication of this RFA. CMS may revise the information below.

## General Information

A. Provide a narrative introduction to your proposed VBID interventions. The response need not describe each VBID proposal. Rather, this is an opportunity for a general overview of your proposals, which you will detail later in this application. The description should address:

1. Principles guiding your approach to VBID;
2. Anticipated overall effects of VBID;
3. Organizational experience with VBID in other lines of business;
4. Integration of VBID into other current or anticipated disease management and enrollee health improvement programs;
5. Strategy for communication of VBID interventions to eligible enrollees, including those with barriers to participation;
6. Strategy for communication of VBID interventions to providers;
7. Internal policies and procedures for protecting the interests of enrollees during the model test; and
8. Suggested measures for tracking the success or failure of the proposed interventions.

Organizations already participating in the model test may refer to a prior year's application, incorporate that response by reference, and provide a narrative description of any material changes to the proposed approach for the coming year, if any.

## VBID Interventions

In this section, applicants must detail the specific VBID benefits to be made available to a group of enrollees. Each combination of PBP and enrollee group must be separately identified and described. If information is repeated from one plan or enrollee group to another, do not refer back to the first PBP or enrollee group. Rather, information should be restated in the correct location, even if verbatim.

B. For your selected combination of PBP and target population specify:

1. PBP number
2. PBP Segment
3. PBP State
4. Target Population
    i. Diabetes
    ii. Chronic Obstructive Pulmonary Disease (COPD)

iii. Congestive Heart Failure (CHF)
iv. Patient with Past Stroke
v. Hypertension
vi. Coronary Artery Disease
vii. Mood disorders
viii. Rheumatoid Arthritis
ix. Dementia

5. Preliminary estimate of the number of PBP/Segment enrollees in the target population

C. Provide a succinct statement of the specific benefits to be offered to this target population. If the Mood Disorder category is selected, identify the specific code categories or additional codes selected.

D. Detailed descriptions of VBID benefits available to the target population.

1. Which of the following benefit types will be offered to the target population (check all that apply):

i. Reduction or Elimination of Cost Sharing
ii. Supplemental Non-Covered Benefits
iii. Benefits Conditioned on Use of High Value Provider
iv. Benefits Conditioned on Participation

Provide the requested detail for those benefit types that will be offered to the target population. Do not provide information for benefit types that will not be provided.

If this PBP or another under this contract is currently offering a VBID intervention for the selected targeted condition group, it is not necessary to repeat information from a prior year's application. The response may incorporate the response from the prior application, and identify changes proposed, if any.

2. Reduction or Elimination of Cost Sharing:

i. Provide a clear description of which services are eligible for cost-sharing reductions, the reductions offered and a justification of their clinical appropriateness in the target population.

3. Supplemental Benefits

i. Provide a clear description of which services are to be offered, and a justification relating the additional services provided to improved outcomes or lower costs for targeted enrollees. Identify how the supplemental benefits proposed conform with existing Medicare Advantage guidance for supplemental benefits.

4. Benefits Conditioned on Use of High Value Providers:

i. Identify the benefits conditioned on the use of a high value provider.

ii. Provide the proposed methodology for identifying high-value providers for

this target population from which services must be obtained in order to qualify for the proposed cost sharing reduction, and a justification for the methodology.

iii. Detail the means of communicating to enrollees the identities of providers in the proposed high-value network.

iv. Describe the extent you anticipate that high-value providers will be accessible throughout the PBP's service area, or confined to a specific geographic area, and any accommodations or alternatives available to eligible/targeted enrollees unable to access a high-value provider.

5. Benefits Conditioned on Participation

i. Identify the benefits conditioned on participation in a care management, wellness or other like program.

ii. Provide a description of how the organization intends to link disease management or related programs to the conditional benefits, including what an enrollee must do specifically to qualify for the reduction and a justification of how this link is clinically reasonable, non-discriminatory, and not likely to have adverse impacts on enrollees.

iii. Identify alternatives available to enrollees in the targeted population who cannot meet these criteria due to health status, location or disability.

E. Do you wish to enter another PBP/enrollee group combination?

## Applicant Suitability

F. Applicant must identify any investigations, probations, sanctions, penalties, or corrective action plans against the Medicare Advantage Organization offering the PBPs identified in this application, its owners or managers, and/or other participating organizations, entities, or individuals, including any sanctions or corrective actions imposed while participating in prior CMS demonstrations and programs (if applicable). Applicants must identify the foregoing information dating from five years prior to the date of the submission of this application.

Does applicant have any information to identify (y/n)?

If so, identify the information with an appropriate description.

## Actuarial/Financial Documentation

Upload all required actuarial or financial documentation here. For a description of the required materials, reference the MA-VBID Model Test Actuarial Guidance for the applicable Calendar Year. Do not upload other materials. Other materials can be uploaded on the following screen.

## Supplemental Information

Upload any additional materials such as supplemental statements if more space is needed to complete a question, or graphic items like charts and tables. Do not upload actuarial or financial documentation here.

## Applicant's Certification

By clicking below <<Name of user>> agrees on behalf of the applicant Medicare Advantage Organization that:

1. The information contained in the application is true, correct, and complete as of the date it is submitted to CMS. If applicant becomes aware that any information in this application is not true, correct, or complete, applicant will notify the Centers for Medicare & Medicaid Services (CMS) immediately and in writing.

2. Applicant authorizes CMS to verify the information contained herein, including inspecting of the premises of the applicant's organization or plan to ensure compliance. Applicant shall notify CMS in writing of any changes that may jeopardize applicant's ability to meet the qualifications for the MA-VBID model test prior to such change or within 30 days of the effective date of such change. Applicant acknowledges that such a change may result in revocation of any approval of any element of this application issued by CMS, or termination from the MA-VBID model test.

3. Applicant and <<name of user>>, submitting the application on applicant's behalf, understand that in accordance with 18 U.S.C. §1001, any omission, misrepresentation or falsification of any information contained in this application or contained in any communication supplying information to CMS to complete or clarify this application may be punishable by criminal, civil, or other administrative actions including revocation of approval, fines, and/or imprisonment under Federal law.

4. Applicant acknowledges that operational policy guidance relevant to this application is or may be posted on the CMS website, and that it is continually updated. Applicant will comply with such guidance, as applicable, should applicant be approved to participate.

5. Applicant agrees that until such time as it is admitted to the MA-VBID model test and bound by the terms of a model-test-specific addendum to its contract for participation in Medicare Advantage, it shall abide by the terms of the MA-VBID model test's Request for Application, and act only in a manner consistent with its terms. In particular:
    a. Applicant will not advertise its participation in the MA-VBID model test or market VBID benefits to Medicare beneficiaries without the authorization of CMS, and only then in accordance with CMS-issued guidance.
    b. In submitting bids, PBPs, formularies and other similar annual benefit-related items to CMS for the Calendar Year for which this application is submitted, applicant shall:
        i. Comply with any supplemental instructions issued by CMS for applicants to the MA-VBID model test;

ii. Submit a bid consistent with actuarial and financial documentation provided with this application, as directed by CMS;

iii. Not structure the benefit package, formulary or other feature of any PBP so as to discriminate against any Medicare beneficiary.

6. <<name of user>> is a representative, officer, chief executive officer, or general partner of the business organization that is applying to participate in this model test, and is authorized to submit this application on applicant's behalf.

**[check box]** I agree to the above on behalf of the applicant Medicare Advantage Organization.

# Appendix B – Targeted Clinical Conditions Defined by ICD-10 Code

| **Chronic Condition: Diabetes** | |
|---|---|
| **ICD 10 Codes** | **ICD 10 Code Description** |
| E08.9 | Diabetes mellitus due to underlying condition without complications |
| E09.9 | Drug or chemical induced diabetes mellitus without complications |
| E10.9 | Type 1 diabetes mellitus without complications |
| E11.9 | Type 2 diabetes mellitus without complications |
| E13.9 | Other specified diabetes mellitus without complications |
| Z79.4 | Long term (current) use of insulin |
| E08.00 | Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC) |
| E08.01 | Diabetes mellitus due to underlying condition with hyperosmolarity with coma |
| E08.10 | Diabetes mellitus due to underlying condition with ketoacidosis without coma |
| E08.11 | Diabetes mellitus due to underlying condition with ketoacidosis with coma |
| E08.21 | Diabetes mellitus due to underlying condition with diabetic nephropathy |
| E08.22 | Diabetes mellitus due to underlying condition with diabetic chronic kidney disease |
| E08.29 | Diabetes mellitus due to underlying condition with other diabetic kidney complication |
| E08.311 | Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema |

| **Chronic Condition: Diabetes** | |
|---|---|
| E08.319 | Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy without macular edema |
| E08.321 | Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema |
| E08.329 | Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema |
| E08.331 | Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema |
| E08.339 | Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema |
| E08.341 | Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema |
| E08.349 | Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema |
| E08.351 | Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema |
| E08.359 | Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema |
| E08.36 | Diabetes mellitus due to underlying condition with diabetic cataract |
| E08.39 | Diabetes mellitus due to underlying condition with other diabetic ophthalmic complication |
| E08.40 | Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified |
| E08.41 | Diabetes mellitus due to underlying condition with diabetic mononeuropathy |
| E08.42 | Diabetes mellitus due to underlying condition with diabetic polyneuropathy |
| E08.43 | Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy |

| **Chronic Condition: Diabetes** | |
|---|---|
| E08.44 | Diabetes mellitus due to underlying condition with diabetic amyotrophy |
| E08.641 | Diabetes mellitus due to underlying condition with hypoglycemia with coma |
| E09.00 | Drug or chemical induced diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC) |
| E09.01 | Drug or chemical induced diabetes mellitus with hyperosmolarity with coma |
| E09.10 | Drug or chemical induced diabetes mellitus with ketoacidosis without coma |
| E09.11 | Drug or chemical induced diabetes mellitus with ketoacidosis with coma |
| E09.641 | Drug or chemical induced diabetes mellitus with hypoglycemia with coma |
| E10.10 | Type 1 diabetes mellitus with ketoacidosis without coma |
| E10.11 | Type 1 diabetes mellitus with ketoacidosis with coma |
| E10.641 | Type 1 diabetes mellitus with hypoglycemia with coma |
| E11.00 | Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC) |
| E11.01 | Type 2 diabetes mellitus with hyperosmolarity with coma |
| E11.641 | Type 2 diabetes mellitus with hypoglycemia with coma |
| E13.00 | Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC) |
| E13.01 | Other specified diabetes mellitus with hyperosmolarity with coma |
| E13.10 | Other specified diabetes mellitus with ketoacidosis without coma |
| E13.11 | Other specified diabetes mellitus with ketoacidosis with coma |
| E13.641 | Other specified diabetes mellitus with hypoglycemia with coma |

| **Chronic Condition: Diabetes** | |
|---|---|
| E08.49 | Diabetes mellitus due to underlying condition with other diabetic neurological complication |
| E08.51 | Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy without gangrene |
| E08.52 | Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene |
| E08.59 | Diabetes mellitus due to underlying condition with other circulatory complications |
| E08.610 | Diabetes mellitus due to underlying condition with diabetic neuropathic arthropathy |
| E08.618 | Diabetes mellitus due to underlying condition with other diabetic arthropathy |
| E08.620 | Diabetes mellitus due to underlying condition with diabetic dermatitis |
| E08.621 | Diabetes mellitus due to underlying condition with foot ulcer |
| E08.622 | Diabetes mellitus due to underlying condition with other skin ulcer |
| E08.628 | Diabetes mellitus due to underlying condition with other skin complications |
| E08.630 | Diabetes mellitus due to underlying condition with periodontal disease |
| E08.638 | Diabetes mellitus due to underlying condition with other oral complications |
| E08.649 | Diabetes mellitus due to underlying condition with hypoglycemia without coma |
| E08.65 | Diabetes mellitus due to underlying condition with hyperglycemia |
| E08.69 | Diabetes mellitus due to underlying condition with other specified complication |
| E08.8 | Diabetes mellitus due to underlying condition with unspecified complications |
| E09.21 | Drug or chemical induced diabetes mellitus with diabetic nephropathy |

| **Chronic Condition: Diabetes** | |
|---|---|
| E09.22 | Drug or chemical induced diabetes mellitus with diabetic chronic kidney disease |
| E09.29 | Drug or chemical induced diabetes mellitus with other diabetic kidney complication |
| E09.311 | Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy with macular edema |
| E09.319 | Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy without macular edema |
| E09.321 | Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema |
| E09.329 | Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema |
| E09.331 | Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema |
| E09.339 | Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema |
| E09.341 | Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema |
| E09.349 | Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema |
| E09.351 | Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema |
| E09.359 | Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema |
| E09.36 | Drug or chemical induced diabetes mellitus with diabetic cataract |
| E09.39 | Drug or chemical induced diabetes mellitus with other diabetic ophthalmic complication |
| E09.40 | Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified |

| **Chronic Condition: Diabetes** | |
|---|---|
| E09.41 | Drug or chemical induced diabetes mellitus with neurological complications with diabetic mononeuropathy |
| E09.42 | Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy |
| E09.43 | Drug or chemical induced diabetes mellitus with neurological complications with diabetic autonomic (poly)neuropathy |
| E09.44 | Drug or chemical induced diabetes mellitus with neurological complications with diabetic amyotrophy |
| E09.49 | Drug or chemical induced diabetes mellitus with neurological complications with other diabetic neurological complication |
| E09.51 | Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy without gangrene |
| E09.52 | Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene |
| E09.59 | Drug or chemical induced diabetes mellitus with other circulatory complications |
| E09.610 | Drug or chemical induced diabetes mellitus with diabetic neuropathic arthropathy |
| E09.618 | Drug or chemical induced diabetes mellitus with other diabetic arthropathy |
| E09.620 | Drug or chemical induced diabetes mellitus with diabetic dermatitis |
| E09.621 | Drug or chemical induced diabetes mellitus with foot ulcer |
| E09.622 | Drug or chemical induced diabetes mellitus with other skin ulcer |
| E09.628 | Drug or chemical induced diabetes mellitus with other skin complications |
| E09.630 | Drug or chemical induced diabetes mellitus with periodontal disease |
| E09.638 | Drug or chemical induced diabetes mellitus with other oral complications |
| E09.649 | Drug or chemical induced diabetes mellitus with hypoglycemia without coma |

| **Chronic Condition: Diabetes** | |
|---|---|
| E09.65 | Drug or chemical induced diabetes mellitus with hyperglycemia |
| E09.69 | Drug or chemical induced diabetes mellitus with other specified complication |
| E09.8 | Drug or chemical induced diabetes mellitus with unspecified complications |
| E10.21 | Type 1 diabetes mellitus with diabetic nephropathy |
| E10.22 | Type 1 diabetes mellitus with diabetic chronic kidney disease |
| E10.29 | Type 1 diabetes mellitus with other diabetic kidney complication |
| E10.311 | Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema |
| E10.319 | Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema |
| E10.321 | Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema |
| E10.329 | Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema |
| E10.331 | Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema |
| E10.339 | Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema |
| E10.341 | Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema |
| E10.349 | Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema |
| E10.351 | Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema |
| E10.359 | Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema |
| E10.36 | Type 1 diabetes mellitus with diabetic cataract |

| **Chronic Condition: Diabetes** | |
|---|---|
| E10.39 | Type 1 diabetes mellitus with other diabetic ophthalmic complication |
| E10.40 | Type 1 diabetes mellitus with diabetic neuropathy, unspecified |
| E10.41 | Type 1 diabetes mellitus with diabetic mononeuropathy |
| E10.42 | Type 1 diabetes mellitus with diabetic polyneuropathy |
| E10.43 | Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy |
| E10.44 | Type 1 diabetes mellitus with diabetic amyotrophy |
| E10.49 | Type 1 diabetes mellitus with other diabetic neurological complication |
| E10.51 | Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene |
| E10.52 | Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene |
| E10.59 | Type 1 diabetes mellitus with other circulatory complications |
| E10.610 | Type 1 diabetes mellitus with diabetic neuropathic arthropathy |
| E10.618 | Type 1 diabetes mellitus with other diabetic arthropathy |
| E10.620 | Type 1 diabetes mellitus with diabetic dermatitis |
| E10.621 | Type 1 diabetes mellitus with foot ulcer |
| E10.622 | Type 1 diabetes mellitus with other skin ulcer |
| E10.628 | Type 1 diabetes mellitus with other skin complications |
| E10.630 | Type 1 diabetes mellitus with periodontal disease |
| E10.638 | Type 1 diabetes mellitus with other oral complications |
| E10.649 | Type 1 diabetes mellitus with hypoglycemia without coma |
| E10.65 | Type 1 diabetes mellitus with hyperglycemia |
| E10.69 | Type 1 diabetes mellitus with other specified complication |
| E10.8 | Type 1 diabetes mellitus with unspecified complications |

| **Chronic Condition: Diabetes** | |
|---|---|
| E11.21 | Type 2 diabetes mellitus with diabetic nephropathy |
| E11.22 | Type 2 diabetes mellitus with diabetic chronic kidney disease |
| E11.29 | Type 2 diabetes mellitus with other diabetic kidney complication |
| E11.311 | Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema |
| E11.319 | Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema |
| E11.321 | Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema |
| E11.329 | Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema |
| E11.331 | Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema |
| E11.339 | Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema |
| E11.341 | Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema |
| E11.349 | Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema |
| E11.351 | Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema |
| E11.359 | Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema |
| E11.36 | Type 2 diabetes mellitus with diabetic cataract |
| E11.39 | Type 2 diabetes mellitus with other diabetic ophthalmic complication |
| E11.40 | Type 2 diabetes mellitus with diabetic neuropathy, unspecified |
| E11.41 | Type 2 diabetes mellitus with diabetic mononeuropathy |
| E11.42 | Type 2 diabetes mellitus with diabetic polyneuropathy |

| **Chronic Condition: Diabetes** | |
|---|---|
| E11.43 | Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy |
| E11.44 | Type 2 diabetes mellitus with diabetic amyotrophy |
| E11.49 | Type 2 diabetes mellitus with other diabetic neurological complication |
| E11.51 | Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene |
| E11.52 | Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene |
| E11.59 | Type 2 diabetes mellitus with other circulatory complications |
| E11.610 | Type 2 diabetes mellitus with diabetic neuropathic arthropathy |
| E11.618 | Type 2 diabetes mellitus with other diabetic arthropathy |
| E11.620 | Type 2 diabetes mellitus with diabetic dermatitis |
| E11.621 | Type 2 diabetes mellitus with foot ulcer |
| E11.622 | Type 2 diabetes mellitus with other skin ulcer |
| E11.628 | Type 2 diabetes mellitus with other skin complications |
| E11.630 | Type 2 diabetes mellitus with periodontal disease |
| E11.638 | Type 2 diabetes mellitus with other oral complications |
| E11.649 | Type 2 diabetes mellitus with hypoglycemia without coma |
| E11.65 | Type 2 diabetes mellitus with hyperglycemia |
| E11.69 | Type 2 diabetes mellitus with other specified complication |
| E11.8 | Type 2 diabetes mellitus with unspecified complications |
| E13.21 | Other specified diabetes mellitus with diabetic nephropathy |
| E13.22 | Other specified diabetes mellitus with diabetic chronic kidney disease |
| E13.29 | Other specified diabetes mellitus with other diabetic kidney complication |

| **Chronic Condition: Diabetes** | |
|---|---|
| E13.311 | Other specified diabetes mellitus with unspecified diabetic retinopathy with macular edema |
| E13.319 | Other specified diabetes mellitus with unspecified diabetic retinopathy without macular edema |
| E13.321 | Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema |
| E13.329 | Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema |
| E13.331 | Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema |
| E13.339 | Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema |
| E13.341 | Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema |
| E13.349 | Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema |
| E13.351 | Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema |
| E13.359 | Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema |
| E13.36 | Other specified diabetes mellitus with diabetic cataract |
| E13.39 | Other specified diabetes mellitus with other diabetic ophthalmic complication |
| E13.40 | Other specified diabetes mellitus with diabetic neuropathy, unspecified |
| E13.41 | Other specified diabetes mellitus with diabetic mononeuropathy |
| E13.42 | Other specified diabetes mellitus with diabetic polyneuropathy |
| E13.43 | Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy |
| E13.44 | Other specified diabetes mellitus with diabetic amyotrophy |

| **Chronic Condition: Diabetes** | |
|---|---|
| E13.49 | Other specified diabetes mellitus with other diabetic neurological complication |
| E13.51 | Other specified diabetes mellitus with diabetic peripheral angiopathy without gangrene |
| E13.52 | Other specified diabetes mellitus with diabetic peripheral angiopathy with gangrene |
| E13.59 | Other specified diabetes mellitus with other circulatory complications |
| E13.610 | Other specified diabetes mellitus with diabetic neuropathic arthropathy |
| E13.618 | Other specified diabetes mellitus with other diabetic arthropathy |
| E13.620 | Other specified diabetes mellitus with diabetic dermatitis |
| E13.621 | Other specified diabetes mellitus with foot ulcer |
| E13.622 | Other specified diabetes mellitus with other skin ulcer |
| E13.628 | Other specified diabetes mellitus with other skin complications |
| E13.630 | Other specified diabetes mellitus with periodontal disease |
| E13.638 | Other specified diabetes mellitus with other oral complications |
| E13.649 | Other specified diabetes mellitus with hypoglycemia without coma |
| E13.65 | Other specified diabetes mellitus with hyperglycemia |
| E13.69 | Other specified diabetes mellitus with other specified complication |
| E13.8 | Other specified diabetes mellitus with unspecified complications |

| **Chronic Condition: Chronic Obstructive Pulmonary Disease (COPD)** | |
|---|---|
| **ICD 10 Codes** | **ICD 10 Code Description** |
| J41.0 | Simple chronic bronchitis |

| **Chronic Condition: Chronic Obstructive Pulmonary Disease (COPD)** | |
|---|---|
| J41.1 | Mucopurulent chronic bronchitis |
| J41.8 | Mixed simple and mucopurulent chronic bronchitis |
| J42 | Unspecified chronic bronchitis |
| J43.0 | Unilateral pulmonary emphysema [MacLeod's syndrome] |
| J43.1 | Panlobular emphysema |
| J43.2 | Centrilobular emphysema |
| J43.8 | Other emphysema |
| J43.9 | Emphysema, unspecified |
| J44.0 | Chronic obstructive pulmonary disease with acute lower respiratory infection |
| J44.1 | Chronic obstructive pulmonary disease with (acute) exacerbation |
| J44.9 | Chronic obstructive pulmonary disease, unspecified |
| J98.2 | Interstitial emphysema |
| J98.3 | Compensatory emphysema |

| **Chronic Condition: Congestive Heart Failure (CHF)** | |
|---|---|
| **ICD Codes** | **ICD 10 Code Description** |
| I09.81 | Rheumatic heart failure |
| I11.0 | Hypertensive heart disease with heart failure |
| I13.0 | Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease |

| **Chronic Condition: Congestive Heart Failure (CHF)** | |
|---|---|
| I13.2 | Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease |
| I26.01 | Septic pulmonary embolism with acute cor pulmonale |
| I26.02 | Saddle embolus of pulmonary artery with acute cor pulmonale |
| I26.09 | Other pulmonary embolism with acute cor pulmonale |
| I27.0 | Primary pulmonary hypertension |
| I27.1 | Kyphoscoliotic heart disease |
| I27.2 | Other secondary pulmonary hypertension |
| I27.81 | Cor pulmonale (chronic) |
| I27.89 | Other specified pulmonary heart diseases |
| I27.9 | Pulmonary heart disease, unspecified |
| I28.0 | Arteriovenous fistula of pulmonary vessels |
| I28.1 | Aneurysm of pulmonary artery |
| I28.8 | Other diseases of pulmonary vessels |
| I28.9 | Disease of pulmonary vessels, unspecified |
| I42.0 | Dilated cardiomyopathy |
| I42.1 | Obstructive hypertrophic cardiomyopathy |
| I42.2 | Other hypertrophic cardiomyopathy |
| I42.3 | Endomyocardial (eosinophilic) disease |
| I42.4 | Endocardial fibroelastosis |
| I42.5 | Other restrictive cardiomyopathy |
| I42.6 | Alcoholic cardiomyopathy |
| I42.7 | Cardiomyopathy due to drug and external agent |

| **Chronic Condition: Congestive Heart Failure (CHF)** | |
|---|---|
| I42.8 | Other cardiomyopathies |
| I42.9 | Cardiomyopathy, unspecified |
| I43 | Cardiomyopathy in diseases classified elsewhere |
| I50.1 | Left ventricular failure |
| I50.20 | Unspecified systolic (congestive) heart failure |
| I50.21 | Acute systolic (congestive) heart failure |
| I50.22 | Chronic systolic (congestive) heart failure |
| I50.23 | Acute on chronic systolic (congestive) heart failure |
| I50.30 | Unspecified diastolic (congestive) heart failure |
| I50.31 | Acute diastolic (congestive) heart failure |
| I50.32 | Chronic diastolic (congestive) heart failure |
| I50.33 | Acute on chronic diastolic (congestive) heart failure |
| I50.40 | Unspecified combined systolic (congestive) and diastolic (congestive) heart failure |
| I50.41 | Acute combined systolic (congestive) and diastolic (congestive) heart failure |
| I50.42 | Chronic combined systolic (congestive) and diastolic (congestive) heart failure |
| I50.43 | Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure |
| I50.9 | Heart failure, unspecified |
| I51.4 | Myocarditis, unspecified |
| I51.5 | Myocardial degeneration |

| **Chronic Condition: Patient with Past Stroke** | |
|---|---|
| **ICD 10 Codes** | **ICD 10 Code Description** |
| Z86.73 | Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits |
| I63.00 | Cerebral infarction due to thrombosis of unspecified precerebral artery |
| I63.011 | Cerebral infarction due to thrombosis of right vertebral artery |
| I63.012 | Cerebral infarction due to thrombosis of left vertebral artery |
| I63.019 | Cerebral infarction due to thrombosis of unspecified vertebral artery |
| I63.02 | Cerebral infarction due to thrombosis of basilar artery |
| I63.031 | Cerebral infarction due to thrombosis of right carotid artery |
| I63.032 | Cerebral infarction due to thrombosis of left carotid artery |
| I63.039 | Cerebral infarction due to thrombosis of unspecified carotid artery |
| I63.09 | Cerebral infarction due to thrombosis of other precerebral artery |
| I63.10 | Cerebral infarction due to embolism of unspecified precerebral artery |
| I63.111 | Cerebral infarction due to embolism of right vertebral artery |
| I63.112 | Cerebral infarction due to embolism of left vertebral artery |
| I63.119 | Cerebral infarction due to embolism of unspecified vertebral artery |
| I63.12 | Cerebral infarction due to embolism of basilar artery |
| I63.131 | Cerebral infarction due to embolism of right carotid artery |
| I63.132 | Cerebral infarction due to embolism of left carotid artery |
| I63.139 | Cerebral infarction due to embolism of unspecified carotid artery |
| I63.19 | Cerebral infarction due to embolism of other precerebral artery |
| I63.20 | Cerebral infarction due to unspecified occlusion or stenosis of unspecified precerebral arteries |

| **Chronic Condition: Patient with Past Stroke** | |
|---|---|
| I63.211 | Cerebral infarction due to unspecified occlusion or stenosis of right vertebral arteries |
| I63.212 | Cerebral infarction due to unspecified occlusion or stenosis of left vertebral arteries |
| I63.219 | Cerebral infarction due to unspecified occlusion or stenosis of unspecified vertebral arteries |
| I63.22 | Cerebral infarction due to unspecified occlusion or stenosis of basilar arteries |
| I63.231 | Cerebral infarction due to unspecified occlusion or stenosis of right carotid arteries |
| I63.232 | Cerebral infarction due to unspecified occlusion or stenosis of left carotid arteries |
| I63.239 | Cerebral infarction due to unspecified occlusion or stenosis of unspecified carotid arteries |
| I63.29 | Cerebral infarction due to unspecified occlusion or stenosis of other precerebral arteries |
| I63.30 | Cerebral infarction due to thrombosis of unspecified cerebral artery |
| I63.311 | Cerebral infarction due to thrombosis of right middle cerebral artery |
| I63.312 | Cerebral infarction due to thrombosis of left middle cerebral artery |
| I63.319 | Cerebral infarction due to thrombosis of unspecified middle cerebral artery |
| I63.321 | Cerebral infarction due to thrombosis of right anterior cerebral artery |
| I63.322 | Cerebral infarction due to thrombosis of left anterior cerebral artery |
| I63.329 | Cerebral infarction due to thrombosis of unspecified anterior cerebral artery |
| I63.331 | Cerebral infarction due to thrombosis of right posterior cerebral artery |
| I63.332 | Cerebral infarction due to thrombosis of left posterior cerebral artery |

| **Chronic Condition: Patient with Past Stroke** | |
|---|---|
| I63.339 | Cerebral infarction due to thrombosis of unspecified posterior cerebral artery |
| I63.341 | Cerebral infarction due to thrombosis of right cerebellar artery |
| I63.342 | Cerebral infarction due to thrombosis of left cerebellar artery |
| I63.349 | Cerebral infarction due to thrombosis of unspecified cerebellar artery |
| I63.39 | Cerebral infarction due to thrombosis of other cerebral artery |
| I63.40 | Cerebral infarction due to embolism of unspecified cerebral artery |
| I63.411 | Cerebral infarction due to embolism of right middle cerebral artery |
| I63.412 | Cerebral infarction due to embolism of left middle cerebral artery |
| I63.419 | Cerebral infarction due to embolism of unspecified middle cerebral artery |
| I63.421 | Cerebral infarction due to embolism of right anterior cerebral artery |
| I63.422 | Cerebral infarction due to embolism of left anterior cerebral artery |
| I63.429 | Cerebral infarction due to embolism of unspecified anterior cerebral artery |
| I63.431 | Cerebral infarction due to embolism of right posterior cerebral artery |
| I63.432 | Cerebral infarction due to embolism of left posterior cerebral artery |
| I63.439 | Cerebral infarction due to embolism of unspecified posterior cerebral artery |
| I63.441 | Cerebral infarction due to embolism of right cerebellar artery |
| I63.442 | Cerebral infarction due to embolism of left cerebellar artery |
| I63.449 | Cerebral infarction due to embolism of unspecified cerebellar artery |
| I63.49 | Cerebral infarction due to embolism of other cerebral artery |
| I63.50 | Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery |

| **Chronic Condition: Patient with Past Stroke** | |
|---|---|
| I63.511 | Cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery |
| I63.512 | Cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery |
| I63.519 | Cerebral infarction due to unspecified occlusion or stenosis of unspecified middle cerebral artery |
| I63.521 | Cerebral infarction due to unspecified occlusion or stenosis of right anterior cerebral artery |
| I63.522 | Cerebral infarction due to unspecified occlusion or stenosis of left anterior cerebral artery |
| I63.529 | Cerebral infarction due to unspecified occlusion or stenosis of unspecified anterior cerebral artery |
| I63.531 | Cerebral infarction due to unspecified occlusion or stenosis of right posterior cerebral artery |
| I63.532 | Cerebral infarction due to unspecified occlusion or stenosis of left posterior cerebral artery |
| I63.539 | Cerebral infarction due to unspecified occlusion or stenosis of unspecified posterior cerebral artery |
| I63.541 | Cerebral infarction due to unspecified occlusion or stenosis of right cerebellar artery |
| I63.542 | Cerebral infarction due to unspecified occlusion or stenosis of left cerebellar artery |
| I63.549 | Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebellar artery |
| I63.59 | Cerebral infarction due to unspecified occlusion or stenosis of other cerebral artery |
| I63.6 | Cerebral infarction due to cerebral venous thrombosis, nonpyogenic |
| I63.8 | Other cerebral infarction |
| I63.9 | Cerebral infarction, unspecified |

| **Chronic Condition: Patient with Past Stroke** | |
|---|---|
| I97.810 | Intraoperative cerebrovascular infarction during cardiac surgery |
| I97.811 | Intraoperative cerebrovascular infarction during other surgery |
| I97.820 | Post-procedural cerebrovascular infarction during cardiac surgery |
| I97.821 | Post-procedural cerebrovascular infarction during other surgery |

| **Chronic Condition: Hypertension** | |
|---|---|
| **ICD 10 Codes** | **ICD 10 Code Description** |
| I10 | Essential (primary) hypertension |

| **Chronic Condition: Coronary Artery Disease** | |
|---|---|
| **ICD 10 Codes** | **ICD 10 Code Description** |
| I25.2 | Old myocardial infarction |
| I21.01 | ST elevation (STEMI) myocardial infarction involving left main coronary artery |
| I21.02 | ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery |
| I21.09 | ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall |
| I21.11 | ST elevation (STEMI) myocardial infarction involving right coronary artery |
| I21.19 | ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall |
| I21.21 | ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery |
| I21.29 | ST elevation (STEMI) myocardial infarction involving other sites |

| **Chronic Condition: Coronary Artery Disease** | |
|---|---|
| I21.3 | ST elevation (STEMI) myocardial infarction of unspecified site |
| I21.4 | Non-ST elevation (NSTEMI) myocardial infarction |
| I22.0 | Subsequent ST elevation (STEMI) myocardial infarction of anterior wall |
| I22.1 | Subsequent ST elevation (STEMI) myocardial infarction of inferior wall |
| I22.2 | Subsequent non-ST elevation (NSTEMI) myocardial infarction |
| I22.8 | Subsequent ST elevation (STEMI) myocardial infarction of other sites |
| I22.9 | Subsequent ST elevation (STEMI) myocardial infarction of unspecified site |
| I23.4 | Rupture of chordae tendineae as current complication following acute myocardial infarction |
| I23.5 | Rupture of papillary muscle as current complication following acute myocardial infarction |
| I51.1 | Rupture of chordae tendineae, not elsewhere classified |
| I51.2 | Rupture of papillary muscle, not elsewhere classified |
| I20.0 | Unstable angina |
| I24.0 | Acute coronary thrombosis not resulting in myocardial infarction |
| I24.1 | Dressler's syndrome |
| I24.8 | Other forms of acute ischemic heart disease |
| I24.9 | Acute ischemic heart disease, unspecified |
| I25.110 | Atherosclerotic heart disease of native coronary artery with unstable angina pectoris |
| I25.700 | Atherosclerosis of coronary artery bypass graft(s), unspecified, with unstable angina pectoris |

| **Chronic Condition: Coronary Artery Disease** | |
|---|---|
| I25.710 | Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris |
| I25.720 | Atherosclerosis of autologous artery coronary artery bypass graft(s) with unstable angina pectoris |
| I25.730 | Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris |
| I25.750 | Atherosclerosis of native coronary artery of transplanted heart with unstable angina |
| I25.760 | Atherosclerosis of bypass graft of coronary artery of transplanted heart with unstable angina |
| I25.790 | Atherosclerosis of other coronary artery bypass graft(s) with unstable angina pectoris |
| I20.1 | Angina pectoris with documented spasm |
| I20.8 | Other forms of angina pectoris |
| I20.9 | Angina pectoris, unspecified |
| I25.111 | Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm |
| I25.118 | Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris |
| I25.119 | Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris |
| I25.701 | Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm |
| I25.708 | Atherosclerosis of coronary artery bypass graft(s), unspecified, with other forms of angina pectoris |
| I25.709 | Atherosclerosis of coronary artery bypass graft(s), unspecified, with unspecified angina pectoris |

| **Chronic Condition: Coronary Artery Disease** | |
|---|---|
| I25.711 | Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm |
| I25.718 | Atherosclerosis of autologous vein coronary artery bypass graft(s) with other forms of angina pectoris |
| I25.719 | Atherosclerosis of autologous vein coronary artery bypass graft(s) with unspecified angina pectoris |
| I25.721 | Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with documented spasm |
| I25.728 | Atherosclerosis of autologous artery coronary artery bypass graft(s) with other forms of angina pectoris |
| I25.729 | Atherosclerosis of autologous artery coronary artery bypass graft(s) with unspecified angina pectoris |
| I25.731 | Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris with documented spasm |
| I25.738 | Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with other forms of angina pectoris |
| I25.739 | Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unspecified angina pectoris |
| I25.751 | Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with documented spasm |
| I25.758 | Atherosclerosis of native coronary artery of transplanted heart with other forms of angina pectoris |
| I25.759 | Atherosclerosis of native coronary artery of transplanted heart with unspecified angina pectoris |
| I25.761 | Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris with documented spasm |
| I25.768 | Atherosclerosis of bypass graft of coronary artery of transplanted heart with other forms of angina pectoris |

| **Chronic Condition: Coronary Artery Disease** | |
|---|---|
| I25.769 | Atherosclerosis of bypass graft of coronary artery of transplanted heart with unspecified angina pectoris |
| I25.791 | Atherosclerosis of other coronary artery bypass graft(s) with angina pectoris with documented spasm |
| I25.798 | Atherosclerosis of other coronary artery bypass graft(s) with other forms of angina pectoris |
| I25.799 | Atherosclerosis of other coronary artery bypass graft(s) with unspecified angina pectoris |

| **Chronic Condition: Mood Disorders (see Section 2.2.1 for additional flexibilities)** | |
|---|---|
| **ICD 10 Codes** | **ICD 10 Code Description** |
| F22 | Delusional disorders |
| F24 | Shared psychotic disorder |
| F30.10 | Manic episode without psychotic symptoms, unspecified |
| F30.11 | Manic episode without psychotic symptoms, mild |
| F30.12 | Manic episode without psychotic symptoms, moderate |
| F30.13 | Manic episode, severe, without psychotic symptoms |
| F30.2 | Manic episode, severe with psychotic symptoms |
| F30.3 | Manic episode in partial remission |
| F30.4 | Manic episode in full remission |
| F30.8 | Other manic episodes |
| F30.9 | Manic episode, unspecified |

| **Chronic Condition: Mood Disorders (see Section 2.2.1 for additional flexibilities)** | |
|---|---|
| F31.0 | Bipolar disorder, current episode hypomanic |
| F31.10 | Bipolar disorder, current episode manic without psychotic features, unspecified |
| F31.11 | Bipolar disorder, current episode manic without psychotic features, mild |
| F31.12 | Bipolar disorder, current episode manic without psychotic features, moderate |
| F31.13 | Bipolar disorder, current episode manic without psychotic features, severe |
| F31.2 | Bipolar disorder, current episode manic severe with psychotic features |
| F31.30 | Bipolar disorder, current episode depressed, mild or moderate severity, unspecified |
| F31.31 | Bipolar disorder, current episode depressed, mild |
| F31.32 | Bipolar disorder, current episode depressed, moderate |
| F31.4 | Bipolar disorder, current episode depressed, severe, without psychotic features |
| F31.5 | Bipolar disorder, current episode depressed, severe, with psychotic features |
| F31.60 | Bipolar disorder, current episode mixed, unspecified |
| F31.61 | Bipolar disorder, current episode mixed, mild |
| F31.62 | Bipolar disorder, current episode mixed, moderate |
| F31.63 | Bipolar disorder, current episode mixed, severe, without psychotic features |
| F31.64 | Bipolar disorder, current episode mixed, severe, with psychotic features |
| F31.70 | Bipolar disorder, currently in remission, most recent episode unspecified |

| **Chronic Condition: Mood Disorders (see Section 2.2.1 for additional flexibilities)** | |
|---|---|
| F31.71 | Bipolar disorder, in partial remission, most recent episode hypomanic |
| F31.72 | Bipolar disorder, in full remission, most recent episode hypomanic |
| F31.73 | Bipolar disorder, in partial remission, most recent episode manic |
| F31.74 | Bipolar disorder, in full remission, most recent episode manic |
| F31.75 | Bipolar disorder, in partial remission, most recent episode depressed |
| F31.76 | Bipolar disorder, in full remission, most recent episode depressed |
| F31.77 | Bipolar disorder, in partial remission, most recent episode mixed |
| F31.78 | Bipolar disorder, in full remission, most recent episode mixed |
| F31.81 | Bipolar II disorder |
| F31.89 | Other bipolar disorder |
| F31.9 | Bipolar disorder, unspecified |
| F32.0 | Major depressive disorder, single episode, mild |
| F32.1 | Major depressive disorder, single episode, moderate |
| F32.2 | Major depressive disorder, single episode, severe without psychotic features |
| F32.3 | Major depressive disorder, single episode, severe with psychotic features |
| F32.4 | Major depressive disorder, single episode, in partial remission |
| F32.5 | Major depressive disorder, single episode, in full remission |
| F33.0 | Major depressive disorder, recurrent, mild |
| F33.1 | Major depressive disorder, recurrent, moderate |
| F33.2 | Major depressive disorder, recurrent severe without psychotic features |

| **Chronic Condition: Mood Disorders (see Section 2.2.1 for additional flexibilities)** | |
|---|---|
| F33.3 | Major depressive disorder, recurrent, severe with psychotic symptoms |
| F33.40 | Major depressive disorder, recurrent, in remission, unspecified |
| F33.41 | Major depressive disorder, recurrent, in partial remission |
| F33.42 | Major depressive disorder, recurrent, in full remission |
| F33.8 | Other recurrent depressive disorders |
| F33.9 | Major depressive disorder, recurrent, unspecified |
| F34.8 | Other persistent mood [affective] disorders |
| F34.9 | Persistent mood [affective] disorder, unspecified |
| F39 | Unspecified mood [affective] disorder |
| F41.0 | Panic disorder [episodic paroxysmal anxiety] without agoraphobia |
| F41.1 | Generalized anxiety disorder |
| F41.3 | Other mixed anxiety disorders |
| F41.8 | Other specified anxiety disorders |
| F41.9 | Anxiety disorder, unspecified |
| F43.22 | Adjustment disorder with anxiety |
| F43.23 | Adjustment disorder with mixed anxiety and depressed mood |

| **Chronic Condition: Dementia** |
|---|
| All enrollees with ICD 10 diagnoses included in the CMS Chronic Conditions Warehouse Alzheimer's Disease and Related Disorders or Senile Dementia algorithm (9/2015 revision), available at https://www.ccwdata.org/web/guest/condition-categories. |

| **Chronic Condition: Rheumatoid Arthritis** |
| --- |
| All enrollees with ICD 10 diagnoses included in the NCQA HEDIS 2016 Technical Specifications Rheumatoid Arthritis Value Set. Organizations may include enrollees otherwise excluded from that value set due to HIV and/or pregnancy, if clinically appropriate. |