

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

**Medicare Advantage Value-Based Insurance Design Model
Request for Applications for CY 2019**

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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 third year of the Medicare Advantage Value-Based Insurance Design (MA-VBID) Model.

This request for applications (RFA) is open to any Medicare Advantage Organization (MA organization) 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 Calendar Year (CY) 2019, an organization must respond to this RFA, even if that organization participated in CY 2017 and/or CY 2018.

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 2019

CMS is introducing changes to the Model test for CY 2019, including:

- Organizations that did not participate in CY 2017 and/or 2018 may apply for CY 2019 (see Section 0);
- Adding 15 new eligible states: California, Colorado, Florida, Georgia, Hawaii, Maine, Minnesota, Montana, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, Virginia, and West Virginia. (See Section 0);
- New Plan Benefit Package (PBP) type: Chronic Condition - Special Needs Plans (C-SNPs) (See Section 2.3.2);
- Flexibility for MA organizations to propose a methodology of how they will target VBID enrollees. (See Section 2.2.1)

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.

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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 continues to implement a five-year MA-VBID Model test. Participating organizations in the first year of the Model began offering benefits under the authority of the Model test on January 1, 2017.

The MA-VBID Model is testing 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 is exercising 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, 2019, CMS will test the MA-VBID Model in fifteen additional states beyond those approved for 2017 and 2018: Alabama, Arizona, Indiana, Iowa, Massachusetts, Michigan, Oregon, Pennsylvania, Tennessee, and Texas. The new states for 2019 are California, Colorado, Florida, Georgia, Hawaii, Maine, Minnesota, Montana, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, Virginia, and West Virginia. Eligible PBPs in the selected test states, upon approval from CMS, may offer varied plan benefit designs for enrollees that fall into certain clinical categories identified and defined by CMS. These nine 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.

For 2019, in addition to the current process of allowing applicants to select from a limited number of CMS-defined chronic conditions to target VBID enrollees, CMS will allow MA organizations the flexibility to propose their own methodology for targeting VBID beneficiaries using CMS data sources (e.g. ICD-10, encounter data, claims data or other data sources CMS has access to). This will allow MA organizations to propose a methodology that either: 1) identifies enrollees with different chronic conditions than those previously established by CMS; or 2) updates the existing approved CMS chronic condition category to target a broader or smaller subset of the existing chronic condition.

Organizations may design their own interventions for each targeted population, but plan benefit changes must fit into four 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 have access to 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 Patient Protection and 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

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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.

1.5 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.

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- 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 Targeting VBID Eligible Enrollees

For the purposes of the MA-VBID Model test, in the first two years of the Model, CMS identified a limited number of chronic conditions from which organizations may choose to target interventions. Participating organizations were responsible for applying the CMS-defined criteria

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to identify enrollees who fall within each of the clinical categories selected by an organization. For 2019, in addition to the existing process, CMS will allow MA organizations the flexibility to propose their own methodology for targeting VBID beneficiaries using CMS data sources.

Targeting Enrollees Using CMS Defined Chronic Conditions

Applicants may continue to target VBID eligible enrollees using the previously approved chronic conditions listed below.

The CMS approved 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
- Dementia

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 which are determined to not reach a large enough group 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 International Statistical Classification of Diseases and Related Health Problems, or hereinafter ICD-10 codes, formally define the targeted conditions. Appendix B provides tables listing the ICD-10 codes included in each category. CMS has approved the use of diagnoses using these codes as the only methodology for identifying VBID-eligible enrollees in a participating plan in Years 1 and 2 of the Model test.

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.

Flexibility for Applicants to Propose a Methodology to Target VBID Enrollees.

For 2019, in addition to the existing process of allowing applicants to select from a limited number of CMS defined chronic conditions and using only CMS-approved ICD-10 codes to identify and target VBID enrollees, CMS will allow MA organizations the flexibility to propose their own methodology for targeting VBID beneficiaries using CMS data sources (e.g. ICD-10, encounter

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data, claims data or other data sources CMS has access to). This will allow participants to propose a methodology that either 1) identifies enrollees with different chronic conditions than those previously established by CMS or 2) modifies the existing CMS-approved chronic condition category to target a broader or smaller subset of the existing chronic condition based on the use of new or different data sources to identify and target VBID-eligible enrollees with the CMS-approved chronic condition category. MA organizations may also combine both parts of the new flexibility being made available in designing the methodology and interventions for their applications.

This flexibility will provide the opportunity for participants to propose a methodology to target new chronic conditions to CMS, such as lower back pain, chronic kidney disease, obesity/pre-diabetes, asthma, tobacco use, hypercholesterolemia, ophthalmology issues, end-of-life conditions, frailty, and palliative care or to propose a methodology for targeting a subset of currently approved chronic conditions.

CMS has created a process to review and approve these methodology proposals that fits within the general MA application and bid timelines. Proposed methodologies should identify all CMS accessible data sources (e.g. ICD-10 codes, encounter data, claims data or other CMS accessible data) to be used and the algorithm used to define VBID eligible enrollees. CMS also requests research or studies to prove the success of the methodology and corresponding intervention to lower costs and improve quality be submitted with the proposal. CMS will review and approve or reject the applicant's methodology as part of the application process. If an applicant's methodology is rejected, applicants will still be allowed to apply to the VBID Model using the CMS pre-approved chronic condition categories described above. If such changes are necessary, applicants may work with CMS to adjust their application in a timely manner.

Note that it is critical for CMS to be able to replicate the proposed methodology for targeting VBID enrollees to ensure the methodology is not discriminatory against beneficiaries and to properly evaluate the impact on cost and quality and enrollee satisfaction. Thus, the further an applicant's methodology diverges from currently approved methodologies or the more challenging to replicate the methodology, the more likely CMS will not be able to approve it.

2.2.2 Permissible Interventions

For each of the target populations, participating organizations may select one or more of the permitted plan design modifications outlined in Section 2.1.

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

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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 approach 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

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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

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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.

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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

All Medicare Advantage 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. Organizations cannot cite their participation in this Model or specific benefits available under the Model in pre-enrollment marketing materials targeted at potential enrollees unless permitted in the guidelines set out in the language related to the marketing of MA Uniformity Flexibility in CMS's Medicare Advantage Final Call Letter or the Medicare Managed Care Manual.

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

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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 2018 Communications Guidelines (available at <https://innovation.cms.gov/initiatives/vbid>), which CMS may subsequently update for CY 2019.

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-approved¹ definitions of the target population, and are responsible for proactively identifying each enrollee with an eligible data source based on information known to the organization. Organizations must offer all VBID benefits specific to the condition category to all eligible enrollees within the chronic condition category identified in the VBID Model's chronic condition list or the targeted condition category as identified through the Plan's flexible methodology. 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 VBID eligible 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;

¹ This includes both target populations based on CMS-approved targeted conditions and on MA organization proposals approved by CMS that use other conditions as provided in section 2.2.1 above.

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- Randomized or targeted auditing to review compliance with CMS-approved 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 change 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 MA organization's agreement with CMS for participation in Medicare Advantage.

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

- Changing target conditions;
- Changing the permissible interventions;
- Changing 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 change 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.

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Any such Model design changes would be based on the experiences in 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 in advance of implementation.

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 (CY). The process for CY 2017 and/or CY 2018 Model test participants to request CMS approval for such changes for CY 2019 is detailed in Section 0 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 Application and Admission of New Organizations or PBPs in CY 2019 and Subsequent Model Years

All MA organizations looking to participate in CY 2019 in the VBID Model test must submit an application, including organizations that applied and were approved in prior years.

Organizations that did not participate in the Model test in CY 2017 or CY 2018 may apply to participate for CY 2019. Additionally, organizations that did participate in CY 2017 or CY 2018 may add PBPs that did not previously offer VBID benefits. CMS expects to similarly reopen the Model test to applications in future years.

2.2.8 Application and Admission of Existing Participants in CY 2019

All MA organizations currently participating in the VBID Model test must submit an application for CY 2019. If the participant is not changing its intervention, it may resubmit applicable information from previous applications.

2.3 Applicant Eligibility

2.3.1 Geographic Scope

Over the first two Model years, CMS selected ten states in which to test the model: Alabama; Arizona; Indiana; Iowa; Massachusetts; Michigan; Oregon; Pennsylvania; Tennessee; and Texas. 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.

Using a similar selection methodology, CMS has selected California, Colorado, Florida, Georgia, Hawaii, Maine, Minnesota, Montana, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, Virginia, and West Virginia to be added to the Model for 2019.

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

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counties or segments both inside and outside of a Model test state, the organization must offer Model interventions to all eligible plan enrollees in the service area, both inside and outside the Model test state. Organizations with multiple qualifying plans may enroll some of those plans (PBPs), 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, local PPO, or Chronic Condition Special Needs Plan (C-SNP);
- The PBP is not a regional PPO, Institutional or Dual Special Needs Plan (I-SNP or D-SNP), Medicare-Medicaid Plan (MMP); Employer Group Waiver Plan (EGWP) or other demonstration plan, cost plan, Medical Savings Account Plan (MSA), or Private Fee-For-Service Plan;
- 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 2019;
- 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 at the following link: <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 2019, 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

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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, 2019.

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.

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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 may 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 payers 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 VBIID 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' approved proposals and that the Model is not leading to any adverse beneficiary outcomes. This will include, but not necessarily be limited to, observing existing metrics of beneficiary access, outcomes, and satisfaction, and monitoring of increased beneficiary questions or complaints through 1-800-MEDICARE or the <https://www.medicare.gov> website. CMS will also monitor the impact the Model has on other CMS initiatives, such as the Part C and D Star Ratings.

CMS reserves the right to 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.

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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 November 17, 2017 on the VBID website (<https://innovation.cms.gov/initiatives/vbid/>). Interested participants should monitor the VBID website for a live link to be posted. Appendix A contains a template of the application questions to which organizations will be expected to respond through the online application portal. Organizations are encouraged to begin preparing responses prior to the opening of the portal. MA 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 26, 2018 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 and/or 2018 must submit a response to this RFA in order to participate in CY 2019.

The questions in Appendix A request that organizations participating in CY 2017 and/or 2018 focus their responses on proposed changes to their interventions, if any. If a current participant intends to switch their method for targeting VBID enrollees from their currently CMS approved chronic condition to proposing their own methodology for targeting VBID beneficiaries. The participant must submit their methodology to CMS as defined in section 2.2.1.

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Exceptions from Model test participation criteria issued by CMS to individual applicants for CY 2017 and/or 2018 are granted as to those same PBPs for CY 2019, 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 2020 and subsequent years.

6.5 Application Review and Model Contracting

6.5.1 Methodology to Target VBID Enrollees

If wishing to do something other than use CMS-approved ICD-10 codes listed in Appendix B to target enrollees eligible for VBID interventions, organizations must submit to CMS their proposed methodology for identifying VBID eligible beneficiaries as part of the VBID application period. Organizations must identify all CMS accessible data sources (e.g. ICD-10 codes, encounter data, claims data or other CMS accessible data) and the algorithm used to define VBID eligible enrollees. Organizations are recommended to submit any research or studies that support the success their proposed methodology and corresponding intervention to lower costs and improve quality. Alternatively, the applicant may instead choose to use one of the CMS pre-approved chronic conditions. If an applicant's methodology is rejected, applicants will still be allowed to apply to the VBID Model using the CMS pre-approved chronic condition categories. In such a case, applicants may work with CMS to adjust their application to reflect the changes in a timely manner. Please visit the VBID website at <https://innovation.cms.gov/initiatives/vbid> for additional guidance on submitting a proposed methodology 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 (and service areas) 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 interventions, 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;

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- 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 includes a proposed methodology for identifying and targeting beneficiaries that was not approved by CMS.
- 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

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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. 2019 VBID Model Participant Selection Tentative Timeline

Date	Milestone
November 17, 2017	Online Application Portal is opened
January 26, 2018	Model applications due to CMS
Late March 2018	Provisionally selected Model participants identified
June 4, 2018	2019 MA plan bids due (bids reflect negotiated agreement on VBID)
September 2018	Contract addenda for Model participation executed
January 1, 2019	Model Year 3 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 change 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

Contact Tab (Fields filled out during registration):

- Contract Number
 - Parent Organization (This is a picklist value, CMS loads the data into this field, the information is pulled from the HPMS)
 - Medicare Organization Name
 - Calendar Year (Picklist Value)
 - Primary and Secondary Contacts
 - Name
 - Phone number
 - Email
 - Address
-

General Information

- A. Provide a general overview of your proposed VBID interventions. Note: A more detailed response will be required later in the application. The overview here 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. Communication timeframe for notifying newly-eligible beneficiaries;
 7. If intervention requires participation in a disease management program, strategy for communication with beneficiaries who are not meeting the disease management participation requirements;
 8. How the plan will use existing data sources to identify eligible enrollees, including the time period in which a VBID diagnosis code must appear and any restrictions on the type of encounter on which the diagnoses must appear;
 9. Strategy for communication of VBID interventions to providers;
 10. Internal policies and procedures for protecting the interests of enrollees during the model test; and
 11. Suggested measures for evaluating 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

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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. Is your PBP a Chronic Care Special Needs Plan (C-SNP). If so, which type of chronic condition enrollees does it serve?
5. 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 (CAD)
 - vii. Mood Disorders
 - viii. Rheumatoid Arthritis
 - ix. Dementia
 - x. Other Flexible Targeting Methodology
6. Preliminary estimate of the number of PBP/Segment enrollees in the target population.

Flexibility for Applicants to Propose a Methodology to Target VBID Enrollees

C. Please describe the proposed methodology for identifying the target population. Please include the following information:

1. The data source that will be used to identify eligible beneficiaries (e.g. claims data, encounter data, CMS frailty scores);
2. The algorithm that will be applied to identify eligible beneficiaries;
For example, if the population is targeted through a chronic condition, include the following information:
 - i. The ICD-10 code(s) associated with the target condition(s);
 - ii. The time period in which the VBID-eligible diagnoses must appear in the plan's data (e.g. the calendar year prior to the current model year, or the current model year);
 - iii. The setting of care (e.g. IP, OP, or Physician) if applicable to targeting;
and

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- iv. Any additional requirements for beneficiary eligibility (e.g. participation in a care management program, provision of care from a High Value Provider, or utilization of certain services).
 3. The frequency that the algorithm will be applied to identify newly eligible beneficiaries;
 4. Provide a brief description of the specific benefits to be offered to this target population. This should be a general overview of the types of VBID benefits available to the target population, as well as any conditions on participation or receipt of VBID benefits; and
 5. Any additional information describing the methodology.
 - D. Provide a justification for the proposed VBID intervention. Describe the following:
 1. Why you are targeting this population;
 2. The clinical appropriateness of the intervention for the target population;
 3. Why the proposed VBID interventions for the target population would improve care quality or reduce costs; and
 4. Research or literature that supports your proposed intervention. Citations to published literature or internal research work may be included. Please list all documents here and attach them in the supplemental information section later in this application.
 - E. Describe how your organization will ensure non-discrimination for both VBID and non-VBID enrollees within the participating plan under this flexible methodology for targeting VBID enrollees. Note that MA organizations may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll on the basis of any factor that is related to health status.
 1. If the proposed target population is identified based on cost, explain how the methodology identifies high-cost enrollees without reference to receipt of health care.
 2. For conditional benefits, describe the link between the conditions and benefits, including the clinical justification for the link and how the conditions for receipt of benefits may be satisfied by all applicable targeted enrollees without regard to health status.
 - F. Describe how your organization will ensure the accessibility of the proposed VBID benefits and interventions under this flexible methodology for targeting VBID enrollees to all targeted enrollees.
 - G. 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.

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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, please include the narrative from the prior year's application. The response may incorporate the response from the prior application, and identify changes proposed, if any.

1. 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 for the target population.
2. Supplemental Benefits
 - i. Provide a clear description of which services are to be offered, and a justification for how the additional services will improve outcomes or lower costs for targeted enrollees. Identify how the supplemental benefits proposed conform to existing Medicare Advantage guidance for supplemental benefits.
3. 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.
4. 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 specifically do 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.

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

Applicant Suitability

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- I. 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. You may also upload research or literature supporting your methodology here. 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.

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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.

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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

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Chronic Condition: Diabetes	
ICD 10 Codes	ICD 10 Code Description
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

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Chronic Condition: Diabetes	
ICD 10 Codes	ICD 10 Code Description
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

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Chronic Condition: Diabetes	
ICD 10 Codes	ICD 10 Code Description
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

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Chronic Condition: Diabetes	
ICD 10 Codes	ICD 10 Code Description
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

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Chronic Condition: Diabetes	
ICD 10 Codes	ICD 10 Code Description
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

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Chronic Condition: Diabetes	
ICD 10 Codes	ICD 10 Code Description
E09.649	Drug or chemical induced diabetes mellitus with hypoglycemia without coma
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

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Chronic Condition: Diabetes	
ICD 10 Codes	ICD 10 Code Description
E10.359	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema
E10.36	Type 1 diabetes mellitus with diabetic cataract
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

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Chronic Condition: Diabetes	
ICD 10 Codes	ICD 10 Code Description
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
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

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Chronic Condition: Diabetes	
ICD 10 Codes	ICD 10 Code Description
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
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

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Chronic Condition: Diabetes	
ICD 10 Codes	ICD 10 Code Description
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
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

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Chronic Condition: Diabetes	
ICD 10 Codes	ICD 10 Code Description
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
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

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Chronic Condition: Diabetes	
ICD 10 Codes	ICD 10 Code Description
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
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

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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
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

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Chronic Condition: Congestive Heart Failure (CHF)	
ICD Codes	ICD 10 Code Description
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
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

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Chronic Condition: Congestive Heart Failure (CHF)	
ICD Codes	ICD 10 Code Description
150.43	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

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Chronic Condition: Patient with Past Stroke	
ICD 10 Codes	ICD 10 Code Description
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
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

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Chronic Condition: Patient with Past Stroke	
ICD 10 Codes	ICD 10 Code Description
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
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

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Chronic Condition: Patient with Past Stroke	
ICD 10 Codes	ICD 10 Code Description
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
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

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Chronic Condition: Patient with Past Stroke	
ICD 10 Codes	ICD 10 Code Description
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
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

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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
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

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Chronic Condition: Coronary Artery Disease	
ICD 10 Codes	ICD 10 Code Description
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
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

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Chronic Condition: Coronary Artery Disease	
ICD 10 Codes	ICD 10 Code Description
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
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

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Chronic Condition: Coronary Artery Disease	
ICD 10 Codes	ICD 10 Code Description
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
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

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Chronic Condition: Mood Disorders (see Section 0 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
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

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Chronic Condition: Mood Disorders (see Section 0 for additional flexibilities)	
ICD 10 Codes	ICD 10 Code Description
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
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

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Chronic Condition: Mood Disorders (see Section 0 for additional flexibilities)	
ICD 10 Codes	ICD 10 Code Description
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
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

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Chronic Condition: Mood Disorders (see Section 0 for additional flexibilities)	
ICD 10 Codes	ICD 10 Code Description
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.