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CENTER FOR MEDICARE AND MEDICAID INNOVATION

Medicare Advantage Value-Based Insurance Design Model Test

Responses to Stakeholder Inquiries

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This document provides guidance and clarification to stakeholders regarding implementation of the Medicare Advantage Value-Based Insurance Design (MA-VBID) model test. The MA-VBID model will test the utility of structuring patient cost-sharing and other health plan design elements to encourage patients to consume appropriate high-value clinical services, thereby improving quality and reducing costs. More information about the model test is available in the MA-VBID model's Request for Applications (RFA), published October 9, 2015, and other documents available at innovation.cms.gov/initiatives/VBID.

General Model Information

1. The model's Announcement and other documents refer to "plans?" How is a plan defined in the MA-VBID model?

Participants in the MA-VBID model are Medicare Advantage Organizations (MAOs), which are the offerors of Plan Benefit Packages (PBPs) in the Medicare Advantage program. Formally, MAOs will apply to participate in the model and identify the specific PBP or PBPs within which they would like the flexibility to offer VBID benefits.

2. Where is CMS testing Value Based Insurance Design?

CMS will test the Medicare Advantage Value-Based Insurance Design (MA-VBID) model in 7 states: Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee. Plans

offered in these states may offer VBID benefits once accepted into the model test. To qualify to participate, among other requirements, a Plan Benefit Package (PBP) must be offered in the test state and no more than one additional state. Furthermore, at least 50% of enrollees must reside in the model test state. If a qualifying plan does cover counties inside and outside of a model test state, the organization must offer VBID model interventions to all eligible plan enrollees, both inside and outside.

3. **Is there an opportunity for Medicare Advantage Organizations offering Plan Benefit Packages outside of the seven states to voluntarily participate?**

CMS is not testing the MA-VBID model outside of the listed states at this time, except in the limited circumstances described in our guidance for plans with PBPs whose service areas fall inside and outside the test states. See the response to Question 2 in this section above.

4. **If an organization participates in model Year 1 with a single disease condition, could that organization add a new clinical condition (from the approved list of conditions) in Year 2 either within the same Plan Benefit Package or in a package new to the model? Can organizations that did not participate at all in Year 1 participate in Year 2?**

Organizations can add new clinical condition groups from the 7 approved categories from year to year within PBPs already participating in the MA-VBID model, and change the interventions for existing condition groups from year to year. CMS hopes and intends to open the model in years 2 and later to new organizations, or to new PBPs from already-participating organizations, although given the dynamic nature of this model test CMS cannot provide absolute assurances. CMS will issue instructions on intervention changes and new applications for years 2 and later (if any) at a later date.

5. **Are VBID benefits offered as a new product?**

VBID benefits will be offered as additions to existing Medicare Advantage benefit packages, and not as separate and new products.

6. **How will VBID affect Medicare Part C and D star ratings?**

CMS is hopeful that the flexibilities offered in the MA-VBID model will improve the quality of care available to beneficiaries enrolled in Medicare Advantage. These improvements may manifest as improvements in the individual measures underlying the Medicare Part C and D star ratings. We recognize the concern that organizations not eligible to participate in the MA-VBID model will not have access to the same flexibilities and do not wish to be placed at a disadvantage relative to participating organizations. We also recognize that participants in the MA-VBID model do not want their improvements in individual measures discounted. We are considering several alternatives for potential MA-VBID model-related adjustments to the star ratings with the aim of accommodating each of these concerns, and welcome comments or suggestions for methods for doing so.

7. **What health plan system changes are required for reporting?**

CMS intends to focus its monitoring and evaluation activity on existing data sources. We recognize the potential burdens associated with data collection, and will make efforts to minimize the supplemental data collection associated specifically with this model, and where that data collection is needed, to do so in the least burdensome way. More information regarding data collection requirements will be forthcoming in future guidance to organizations selected to participate in the VBID model.

8. **How often will CMS make changes to the model design?**

Acknowledging the difficulties inherent in mid-year changes, it is CMS's intention to endeavor to roll out changes on an annual basis with adequate notice.

Eligible Enrollees

1. **How will eligible enrollees be identified by MA-VBID model participants?**

Participating organizations will be responsible for applying the CMS-defined criteria to identify enrollees who fall within each of the clinical categories selected by an organization in their MA-VBID application. The MA-VBID participating organization will identify eligible enrollees at the beginning of the year based on diagnosis data contained in claims submitted by network provides. Participants will then periodically review new data to identify enrollees newly eligible based on a diagnosis that may occur mid-year.

2. **Is someone who had an eligible condition prior to enrolling in the participating organization's plan eligible for VBID?**

Yes, someone who had an eligible condition prior to enrolling in the participating organization's plan is eligible for VBID if their diagnosis falls within the targeted condition and the organization has identified them as eligible in accordance with the model test's requirements.

3. **Would it be possible for plans to distinguish individuals eligible for VBID cost sharing reduction based on additional factors, for example beneficiaries with diabetes with specific cardiac risk factors? May the intervention vary by age of the member within the PBP?**

In the first year of the model, enrollee eligibility for VBID is defined exclusively based on ICD-10 codes. The intervention may not vary by age. For future years, CMS will consider alternative methodologies for defining eligible enrollees. Please send suggestions to the MA-VBID email box, MAVBID@cms.hhs.gov.

4. **How were the chronic conditions identified for this model selected?**

The chronic conditions included in this model in year one were selected based on a several factors. CMS selected conditions with relatively high incidence within the Medicare Advantage enrollee population so as to provide for greater potential overall impact on quality and cost, and to facilitate a robust evaluation of the effects of VBID. CMS also sought conditions where preliminary investigation suggested there were high-value services available to that population which a health plan could promote to improve beneficiary health outcomes.

5. **Will CMS consider additional targeted conditions?**

CMS may consider adding to the MA-VBID model new targeted clinical conditions or methodologies for identifying targeted enrollees after model year 1 (Contract Year 2017). Any suggestions for additional conditions, along with supporting rationale may be submitted to the MA-VBID email box, MAVBID@cms.hhs.gov.

6. **Can organizations ask enrollees to register for the VBID benefit?**

Where the VBID benefit is a reduction in cost sharing, or a reduction in cost sharing associated with visiting a high-value provider or a supplemental benefit, no registration requirement is permitted. Where the VBID benefit is a reduction in cost sharing associated with participation in a disease management or wellness program, the participating organization may require the enrollee to register for the program.

7. **How are organizations required to validate/confirm qualifying diagnoses for new enrollees, (i.e., those for whom they do not have encounters/claims data yet)? Is there a physician attestation form, or do they have to wait for a claim with a qualifying ICD-10 code?**

Organizations may validate diagnoses from claims or provider encounters only. CMS will consider additional methods of identification and validation of enrollee eligibility; such proposals may be included in the organization's application. Additional methods should supplement, but not supplant, validation based on diagnosis.

8. **Is there a limit to the lookback period for eligible VBID diagnosis codes?**

No. Organizations wishing to limit the lookback period should propose a limit to CMS. Proposed lookback periods should have a clinical basis.

9. **Some dual-eligibles are enrolled in non-SNP MA plans. Would these beneficiaries be eligible to participate in the VBID program?**

Yes. VBID benefits must be made available to Medicare-Medicaid eligibles enrolled in participating plans that are not SNPs, so long as they fit the clinical criteria for the specific benefit in question.

10. What flexibility will CMS offer on how the classes of eligible enrollees can be defined and how frequently plans may or need to identify beneficiaries with eligible target conditions? Could organizations define target conditions using other mechanisms such as by using the broader three digit ICD-10 code?

For Year 1 of the model, all categories of eligible enrollees are defined by ICD-10 code. CMS will detail in the model's contractual addendum its expectations for the minimum intervals at which participants must examine claims or encounter data to identify eligible enrollees. CMS anticipates that it will require participating organizations to examine data at least quarterly.

11. As long as a participating organization offers VBID benefits to all members with a targeted condition in a plan, can that organization conduct outreach to specific high-risk members?

All enrollees eligible for VBID benefits must receive those benefits and must receive notice of those benefits in accordance with the MA-VBID model test's minimum requirements. Participating organizations are permitted to conduct additional outreach to high-risk members as part of their ordinary care management efforts. However, participants doing so should take care to select enrollees for outreach in a non-discriminatory manner.

12. What happens if the enrollee falls into two clinical condition categories targeted by the participating organization (e.g., diabetes and CHF) and there are different benefits for each? Which benefit prevails?

The individual should receive both sets of VBID benefits. In the event that cost-sharing varies depending on which targeted condition group for which the enrollee is eligible, the enrollee should receive the lower of the two amounts. In the event that there are additional supplemental benefits available to one targeted group, but not the other, the enrollee will be eligible for the additional benefits.

13. Can a participant offer interventions for enrollees with a combination of two targeted conditions, but not when the enrollee only presented with one condition?

Yes. Applicants may propose multiple comorbidity categories, so long as those categories are constructed using combinations of only the seven CMS-selected conditions.

14. May organizations design a VBID benefit that is only available to enrollees whom a case manager has determined should be eligible for the benefit, because the benefit eliminates an identified barrier to care? (Added 12/21/2015)

No. VBID benefits are to be offered to all plan enrollees who meet the target clinical condition; benefits may not be offered on the basis of a case manager's discretion.

15. May an organization offer a VBID intervention to only a subset of enrollees from within the CMS-specified chronic condition groups? (Added 12/21/2015)

No. VBID interventions must be offered to all enrollees who have a diagnosis for one or more of the ICD-10 codes listed in the RFA for the chronic condition group selected by the organization. If an organization proposes a VBID benefit package for a group of enrollees with multiple comorbidities as described in 2.2.1 of the RFA, benefits must be offered to all enrollees who have a diagnosis from each of the categories comprising the group.

16. Understanding that VBID benefits must be "offered" to all enrollees within the CMS-defined class selected by an organization, if an organization increases coverage of a service covered under Medicare Parts A or B as a VBID intervention, must all enrollees in the CMS-defined class be able to access that benefit, including those who did not otherwise meet the medical necessity criteria for that benefit? (Added 12/21/2015)

Increasing coverage of a benefit covered under Medicare Part A or B as a supplemental benefit does not eliminate the medical necessity criteria associated with that benefit. Please reference the Medicare Managed Care Manual, Chapter 4, Section 30.2, regarding the impact of National Coverage Determinations on supplemental benefits extending original Medicare benefits.

VBID Benefit Design – General

1. **Could multiple interventions be proposed for the same condition?**

Yes. MA Organizations may design interventions for each targeted population selected in their application using one or more of the available flexibilities.

2. **Can organizations offer VBID across multiple Plan Benefit Packages? Can organizations vary the intervention by PBP within the same contract number? For instance, offer intervention A to PBP 001, 002, 003 and intervention B to PBP 001 and 004.**

Participants can offer the same or different VBID designs across multiple PBPs.

3. **If a participating organization offers a supplemental benefit for a VBID-eligible enrollee, must this supplemental benefit be offered to a non-VBID-eligible enrollee?**

A supplemental benefit designed for VBID eligible enrollees does not have to be offered to non-VBID members. Additionally, an organization can offer a supplemental benefit to all enrollees, but provide additional coverage or lower cost sharing under that benefit to VBID-eligible enrollees.

4. **If a participating organization offers reduced cost sharing for non-Medicare-covered dental services, is that considered a "reduced cost sharing" intervention, or an additional supplemental benefits intervention?**

This would be considered a form of an additional supplemental benefits intervention. Note that when benefits are entered and uploaded into HPMS for the CY 2017 bid cycle, this type of benefit may be grouped with cost sharing. Additional guidance on HPMS bid submissions will be released in future.

5. **Does an intervention need to be available statewide if a participating organization's PBP's service area is only in select counties?**

MA-VBID model participants must offer interventions that are available and accessible to eligible enrollees throughout the PBP's approved service area. If that service area is smaller than the entire state, the participating plan will offer it only in the defined service area, and not throughout the entire state.

6. **Are participating organizations allowed to change the drugs included on formularies as part of their VBID initiative? Can a plan offer excluded drugs as a part of the VBID model?**

For covered Part D drugs, the flexibility offered under the MA-VBID model is to offer specific enrollees with CMS-specified chronic conditions a cost sharing amount for a drug on a formulary that is lower than the cost sharing amount at which that same drug is available to the remainder of the plan's enrollees. As to the composition of formularies, CMS is not changing the current Medicare Part D formulary requirements for the MA-VBID model, and plans must comply with all formulary requirements. Model participating plans continue to have the ability to change their formularies to the extent they are permitted to do so under current rules.

For excluded drugs, an applicant may propose to offer coverage of an excluded drug to the VBID-eligible population even if that coverage is not offered to the entire plan membership. Or an applicant can propose to reduce the cost sharing of an otherwise covered excluded drug, but for the VBID-eligible population only. VBID interventions for drugs specifically excluded as Part D drugs under 42 CFR 423.100, and as described in section 20.1 of chapter 6 of the Prescription Drug Benefit Manual, are treated as supplemental drugs offered under the Part D benefit. VBID interventions for over-the-counter (OTC) drugs are considered a Part C supplemental benefit. Participating organizations retain existing flexibilities in accordance with current rules to offer OTC drugs as a component of step therapy or utilization management protocol and price them as part of their administrative cost structure, but not as a MA-VBID model test intervention.

7. **Can completion of a health risk assessment be required in order to qualify for VBID benefits?**

Yes. This is an example of "Reduced Cost Sharing for Enrollees Participating in Disease Management or Related Programs." However, receipt of the benefit must be contingent only upon completion of the HRA, and not on the results of the HRA.

8. **Could an organization offer telemonitoring or remote access technologies as a supplemental benefit in the VBID model?**

Yes.

9. **Could an organization offer optional supplemental benefits as a VBID intervention?**

No. Only mandatory supplemental benefits may be offered as part of the VBID design model.

10. **May a participating organization offer a free in-home blood pressure monitor as a VBID intervention? (Added 12/21/2015)**

Yes. This is a form of an Over-the-Counter supplemental benefit, and could therefore be proposed as an extra supplemental benefit available only to VBID-eligible enrollees. Please consult Chapter 4, Section 40 of the Medicare Managed Care Manual for more information on over-the-counter supplemental benefits in general.

11. **May organizations design VBID interventions to complement disease management or other like programs already offered by the organization, or intended to be offered by the organization? (Added 12/21/2015)**

Yes. CMS encourages all organizations to design VBID interventions with an eye towards integrating with existing disease management or other initiatives already in place or under development, as long as they comply with existing law.

12. **May participating organizations offer post discharge in-home medication reconciliation as a supplemental benefit in the VBID model? Could an organization conduct this via video or even telephonically? (Added 12/21/2015)**

Post-discharge in-home medication reconciliation is an eligible supplemental benefit described in Chapter 4, Section 30.3 of the Medicare Managed Care Manual, and is therefore a service that may be proposed to be offered as an extra supplemental benefit in the VBID model. It may be conducted in the VBID model via telephone or video.

13. May an organization reduce premiums as a reward or incentive for participation in a disease management program as a VBID intervention? (Added 12/21/2015)

No.

14. Must reductions in cost sharing for Part C services be administered at the point of care, or may an organization reimburse enrollees by check? (Added 12/21/2015)

If approved by CMS, an organization may reimburse enrollees by check for reductions in cost sharing to Medicare Part C services. Organizations are cautioned that there is no ability in the model to simply send a check or payment to a member to encourage participation in a disease management or other like program. Enrollees are entitled to reduced cost sharing for specific high-value services, or for use of a high value provider, and the checks sent are merely a means of effectuating that reduction. Therefore, the amount of the payment will vary based on the services utilized, and cannot be greater than the cost sharing amount associated with the service under the plan's regular benefit package and actually paid by the enrollee to the provider. All payments by check must be tracked and reported to CMS for purposes of evaluation and monitoring, and CMS will make arrangements with participating organizations for reporting to CMS the reimbursements for Part C services administered by check that do not appear in encounter data. In general, sponsors interested in pursuing this strategy should detail their proposed approach (and the rationale for that approach) in their model application. In reviewing the request, CMS will consider the rationale, as well as potential for beneficiary confusion associated with the reimbursement methodology. If not approved, organizations must reduce cost sharing according to methodologies applied to non-VBID benefits under the plan.

CMS may also consider requests to process reimbursements for reductions in Part D cost sharing by check. However, all Prescription Drug Event data must accurately reflect the actual enrollee out of pocket cost net of any VBID-model reimbursements paid to the enrollee by check.

15. May participating organizations offer gift cards to VBID-eligible enrollees as a reward for completing a wellness or similar program? (Added 12/21/2015)

Participating organizations may not offer, as a VBID-specific intervention, gift cards to VBID-eligible enrollees as a reward for completing a wellness or similar program. The MA-VBID model's permitted interventions consist of reductions of cost sharing or the provision of extra non-covered supplemental benefits, not the provision of gift cards. Organizations seeking to offer gift cards as a component of their VBID interventions may instead consider offering a

Rewards and Incentives (RI) program to enrollees with chronic conditions eligible for VBID benefits. Interested organizations should consult and comply with all relevant Medicare Advantage (MA) regulations and guidance concerning RI programs, including regulations at 42 CFR 422.134, Chapter 4 of the Medicare Managed Care Manual, and the December 4, 2014 HPMS Memorandum from Katherine A. Coleman entitled "Rewards and Incentives Program Guidance."

Note that any RI Program offered by an MAO must not discriminate against enrollees based on race, gender, chronic disease, institutionalization, frailty, health status or other impairments and must be designed so that all enrollees are able to earn rewards. However, the non-discrimination and equal access requirements do not preclude MAOs from offering rewards and incentives programs that target enrollees with a specific disease or chronic condition as long as the RI Program does not discriminate against any enrollee who would otherwise qualify for participation in that program. Importantly, a RI program would not be considered a VBID intervention but, rather, a component of the broader MA program, unaffected by the MA-VBID model test. Therefore, CMS's approval of the interventions proposed in the VBID application should not be construed as approval of any RI program that may be offered by the plan. However, applicants may provide information about any relevant RI program(s) directed to enrollees with chronic conditions eligible for VBID interventions in their applications, in response to Prompt A.4, in order to provide CMS appropriate context in evaluating the VBID-specific interventions.

High Value Providers

1. **How are "high-value providers" defined?**

CMS is providing the flexibility to organizations to offer their own definition of high-value providers in their proposals as part of the RFA process. 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 assure that the providers identified are high-value for enrollees in the selected clinical condition group. CMS encourages 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 an NCQA certified medical home, whether a hospital has American Heart Association advanced certification in heart failure, whether a provider meets certain performance metrics on NQF validated quality measures. However, more idiosyncratic or

locally-specific approaches also may be approved, 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.

2. **Will plans proposing the use of high-value providers be required to specifically identify those providers at the application stage?**

No. Organizations that propose to use high-value provider interventions need not submit lists of providers with their application, and there is no requirement in the application itself akin to the submission of "Health Services Delivery" tables for this model test. Organizations whose intervention focuses on a single provider or a group of providers (such as an ACO) are encouraged to identify that provider in the application narrative. CMS may request that directories of high-value providers be submitted at some time during the model test, so that CMS can audit conformity with the proposed definition of a high-value provider. Further, participating organizations must identify high-value providers to eligible enrollees during the model test.

3. **How will CMS determine that a high-value provider benefit is available and accessible to all eligible enrollees?**

In light of the multiple potential variants of high-value provider interventions that organizations might propose to CMS, and potentially uneven geographic distribution of high-value providers, CMS will not employ a fixed numerical adequacy standard when evaluating the availability of high-value providers. Instead, CMS has specifically solicited a description of the proposed network's accessibility throughout the service area and will holistically evaluate the accessibility of the proposed network as described in applications. In conducting its review, CMS will take into account the reasons for inaccessibility, accommodations or alternatives available to enrollees not able to access a high-value provider and the overall availability of the total VBID benefit package proposed for the eligible class of enrollees. In addition, CMS will monitor incoming data, including encounter data and beneficiary complaints, to assess the actual accessibility of particular interventions.

4. **Can organizations designate non-physician providers, such as nurse practitioners and optometrists, as high-value providers?**

Yes. The high value provider designation need not be limited to physicians.

Model Participant Eligibility

1. **Will CMS specify which Plan Benefit Packages are eligible to participate in the MA-VBID model?**

CMS will not specify the exact Plan Benefit Packages that are eligible to qualify. Interested organizations should consult the qualification criteria to determine which PBPs qualify, and whether an exception request is needed for a PBP.

2. **Does a PBP have to have 2,000 VBID-eligible members included in the model to qualify?**

The requirement is that the total enrollment of a PBP is at least 2,000 enrollees.

3. **If a particular PBP does not strictly meet the eligibility criteria, may it still be approved by CMS to participate?**

CMS will consider exception requests from organizations offering PBPs that do not meet the participation criteria, but for which good cause nevertheless exists for admission to the model test. For example, CMS could consider an exception for a PBP that has been 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. CMS might also consider admitting a PBP with fewer than 2,000 enrollees where an organization has at least one other PBP that does qualify, and wishes to offer a uniform set of VBID benefits across all its PBPs in a test state.

These examples are illustrations of circumstances in which an MAO may wish to consider submitting an exception request. Note that CMS is not bound to issue exceptions in these cases or in response to any other exception request. To request an exception, send CMS a request in writing by e-mail to MAVBID@cms.hhs.gov and provide as much detail as possible, including the contract number, the plan benefit package number, projected enrollment, service area of that plan, and rationale for the requested exception.

4. **How will CMS measure the star rating associated with a particular PBP to determine if that PBP may participate in the MA-VBID model?**

CMS will look to the overall MA-PD rating of the contract under which the individual PBP is offered. Contracts without an overall rating are not eligible, but we will accept and consider exception requests from all interested participants regarding ineligible PBPs.

5. **If an organization has a plan with multiple segments, must VBID benefits apply to all segments and not to a sub-set of segments?**

Segmented plans 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 an excluded prescription drug must be applied uniformly across all segments of a segmented plan. This means that 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 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.

Financial and Actuarial

1. **Will CMS be releasing an updated bid pricing tool form to address the demo? Will there be detailed documentation requirements in the 2017 bid instructions?**

The 2017 bid instructions will contain information on how to properly reflect the impact of the MA-VBID model.

2. **Are there financial penalties, shared savings as upside/downside or risk corridors for participants? Considering the assumption is VBID will save cost, which in turn will decrease the bid and increase the savings when compared to the benchmark, will any savings be subject to the same rebate percentage or will the plan retain 100% of the savings?**

There are no special supplemental payments or risk corridors available to participants in this model. The costs of the VBID model interventions, as well as the impact of improved enrollee health and changes in utilization are to be reflected in participants' annual bids. Please reference the MA-VBID model's Request for Application and Application Actuarial Guidance for more information.

3. **Can organizations offering standard or basic alternative prescription drug coverage participate in the model?**

If the organization offers Part D VBID benefits, that organization must offer enhanced alternative coverage, unless the entire prescription drug benefit (including VBID reductions in cost sharing) meets the applicable standards for actuarially equivalent or basic alternative coverage. Organizations offering defined standard coverage may not offer Part D VBID benefits.

4. **How would reductions in prescription drug cost sharing as part of a VBID intervention for a target chronic population be treated with respect to the TrOOP threshold? (Added 12/21/2015)**

Reductions in cost sharing for prescription drugs offered as part of a VBID intervention will not be counted as incurred costs that count toward the TrOOP threshold. As noted on page 13 of the RFA, "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."

5. **Is the five year projection requested in the model test's Actuarial Guidance meant to represent the effects of the interventions proposed for CY 2017, or can they include consideration for changes to the CY 2017 intervention anticipated for years 2 through 5 of the model? (Added 12/21/2015)**

The five year projection should include any potential changes expected to be made to the proposed intervention(s), particularly contingency plans or other considerations expected to be made as experience in providing the intervention(s) becomes available.

Marketing, Communications and Disclosures

1. **Are VBID model materials subject to the marketing requirements of the rest of the MA program?**

All marketing regulations and guidance remain applicable to materials and activities of the participating plan and other MA plans. See, e.g., 42 C.F.R. parts 422 and 423, subparts V. In addition to marketing and enrollee communication requirements outlined in the MA-VBID model's request for application, CMS will issue further guidance on the specific marketing, communication and disclosure requirements of the MA-VBID model test to organizations identified for participation at a later date.

CY 2017 Application Procedures

1. **Which individuals' contact information should be listed in a response to the Request for Applications? (Added 12/21/2015)**

Please enter the names of individuals CMS may directly contact with respect to the RFA and implementation of the MA-VBID model..

2. **When responding to the RFA, if an organization cites published literature, is there a specific format that should be used when citing references, i.e. MLA format? Should citations be placed in the response text, or may we upload a supplemental bibliography, with references to the bibliography in the text? (Added 12/21/2015)**

There is no specific format required for responses to the RFA that cite published literature. Applicants should use whatever format they feel suits the application and will be easily understandable to CMS reviewers.

3. **When responding to the RFA's "VBID Interventions" tab, section B, should applicants enter the PBP number, or the contract and PBP number? (Added 12/21/2015)**

Applicants should enter the PBP number only, in three-digit format using leading zeroes (e.g., "001").

4. **What information is CMS referring to in the RFA prompt requesting "Internal policies and procedures for protecting the interests of enrollees during the model test?" (Added 12/21/2015)**

CMS is referring to policies and procedures, whether general ones already existing or specific ones intended to be put in place for the VBID model, which would aid in the detection of adverse impacts of the model intervention on enrollees, or non-compliance with model rules designed to protect enrollees. As part of the application, a general description (and a reference to existing policies and procedures, as applicable) is all that is required, not submission of the policies or procedures themselves.

5. **How should an applicant proceed if the individual submitting an application on behalf of an organization is not authorized, for internal control reasons, to make the required attestations on the organization's behalf? (Added 12/21/2015)**

Applicants facing this issue should contact CMS at MAVBID@cms.hhs.gov to make alternate arrangements.

6. **May multiple employees of a single organization log in to the RFA response portal and have access to an application? (Added 12/21/2015)**

At this time, while many users from a single organization can create logins, only one person can create and have access to a single application under a single login.