

Value-Based Insurance Design Model
CY 2020 Communications and Marketing Guidelines
Updated on November 15, 2019

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

Value-Based Insurance Design Model
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Table of Contents

1 Background and General Information.....	2
Model Benefits Communications Timeline	2
2 General Guidance.....	3
Applicability of Other Guidance.....	3
Naming of Model Benefits and Benefit Packages for Enrollees	3
Communication Principles.....	4
CMS Review of Materials.....	4
3 Marketing and Communications with Non-Eligible Enrollees	5
4 Mandated Model Benefits Communications with Eligible Enrollees	6
Strategy for Communicating Model Benefits	6
Timing of Notice of Model Benefits.....	8
Enrollee Communications.....	9
Contingent VBID Benefits.....	10
5 Provider Directories & Network-Related Communications	10
Electronic Communications and Websites	11
Accessibility for Individuals with Disabilities and Non-English Speaking Populations.....	11
6 Model Rewards	11
Types of Model Rewards	11
Model Rewards Requirements.....	12
Model Rewards Communications Timeline	13
7 Communications with Persons Other than Beneficiaries.....	13
Network Providers	13
Communication with the Public Regarding the VBID Model.....	13
Attachment.....	14

1 Background and General Information

This document provides guidance to Medicare Advantage Organizations (MAOs) participating in the Value-Based Insurance Design (VBID) Model on communications and marketing. MAOs participating in the model must adhere to this guidance pursuant to the Addendum to Medicare Managed Care Contract for Participation in the Medicare Advantage Value-Based Insurance Design Model (VBID).

Through the VBID Model, CMS is testing a broad array of complementary MA health plan innovations designed to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries (including those who have low-income subsidy (LIS) status), and improve the coordination and efficiency of health care service delivery. The service delivery model components selected for CY 2020 are:

1. Value-Based Insurance Design by Condition, Socioeconomic Status, or both
2. Rewards and Incentives Programs
3. Wellness and Health Care Planning (required for all VBID-participating plan benefit packages (PBP))

Overall, the VBID Model contributes to the modernization of Medicare Advantage and tests whether these model components improve health outcomes and lower expenditures for MA enrollees.

Capitalized terms not otherwise defined in these VBID Model Communications and Marketing Guidelines have the meaning provided in the current VBID Contract Addendum (Addendum) to Medicare Managed Care Contract for Participation in the Medicare Advantage Value Based Insurance Design Model.

Model Benefits Communications Timeline

All Model participants should review the Addendum and all applicable Medicare Communication and Marketing Guidelines (MCMG) found here: [Medicare Communications and Marketing Guidelines](#) and regulations. Outlined below are general timelines for informing enrollees, both current and new, of Model Benefits.

- August 6, 2019: MAOs submit the Notice of Model Benefits (NOB) or its different strategy for communicating information regarding Model Benefits, as described at Section 4.1, for CY 2020 to CMS (**Both CY 2019 and CY 2020 Participants**);
- September 16, 2019: CMS completes review of MAOs' submitted NOB or the MAO's different strategy for communicating Model Benefits for CY 2020;
- September 30, 2019: **CY 2019 Participants Only** - MAOs provide currently Targeted Enrollees with their NOB or their different strategy for communicating Model Benefits for CY 2020. All changes, including any change in benefits due to a PBP not being included in CY 2020, must be communicated to Targeted Enrollees by this date;

Value-Based Insurance Design Model
CY 2020 Communications and Marketing Guidelines
Updated on November 15, 2019

- By January 30, 2020: MAOs must provide all Targeted Enrollees, including new enrollees, for CY 2020 with the NOB or the MAO’s different strategy for communicating Model Benefits; and
- Throughout CY 2020: All newly identified Targeted Enrollees must be provided a NOB or the plan’s different strategy for communicating Model Benefits for CY 2020.

2 General Guidance

Applicability of Other Guidance

All MA communication and marketing regulations and guidance issued by CMS, as well as other applicable laws, continue to apply to materials and activities of participating organizations, including the MA regulations at 42 C.F.R. parts 422 and 423, Subparts V and the Medicare Communications and Marketing Guidelines (MCMG). In the event of a conflict between the marketing requirements in the Underlying Contract and the Model Communications and Marketing Guidelines such that the MAO cannot comply with both, the MAO must comply with the VBID Model Communications and Marketing Guidelines outlined here.

Naming of Model Benefits and Benefit Packages for Enrollees

For the purposes of these VBID Model Communication Guidelines, the term “Model Benefits” means the following:

- (1) Wellness and Health Care Planning (WHP) Services as defined in the Addendum; and
- (2) Any additional supplemental benefits offered by the MAO pursuant to Article 3 of the Addendum.

The term “Model Rewards” refers to rewards and incentives offered as part of implementing a VBID Model Approved Proposal. Model Rewards are not Model Benefits. Please see section 5 for a description of Model Rewards.

When naming and describing the Model Benefits the participating organization will offer under the Model to Targeted Enrollees, participating organizations should not refer to them as “Model” or Value Based Insurance Design” or “VBID” benefits or make specific reference to the VBID Model. Instead, a participating organization should adopt a communications approach, including all naming, that clearly outlines the Model Benefits available to Targeted Enrollees, what must be done to receive the Model Benefits, where and how to ask questions or receive help on understanding the Model Benefits that ultimately serves to engage Targeted Enrollees to utilize these specific benefits available under the Model. Additionally, participating organizations must use this approach consistently in communication materials so that Targeted Enrollees are able to understand the relationship between the NOB or the MAO’s different strategy for communicating benefits, and any subsequent communications or marketing.

Value-Based Insurance Design Model
CY 2020 Communications and Marketing Guidelines
Updated on November 15, 2019

Communication Principles

Generally, participating organizations' communication of Model Benefits must be designed to outline all of the benefits available to Targeted Enrollees. Such communications must be designed to minimize confusion where possible.

If a participating organization offers more than one distinct package of Model Benefits, distinct Notices of Model Benefits, or the MAO's different strategy for communicating Model Benefits, must be created. For example, if a participating organization offers a distinct Wellness and Health Care Planning (WHP) program for one set of Targeted Enrollees and also offers reduced cost-sharing based on low-income subsidy (LIS) status, the participating organization must have two separate Notices of Model Benefits or use a different strategy for communicating different Model Benefits, as described in Section 4.1, for each targeted population.

Additionally, as the NOB and any accompanying communications or marketing material is meant for the distinct Targeted Enrollee group(s), participating organizations should make all attempts to limit any potential confusion of non-eligible enrollees by targeting communications clearly to applicable groups of Targeted Enrollees and developing scripts for inquiries from both Targeted Enrollees and non-eligible enrollees. Participating organizations must not selectively identify subgroups of Targeted Enrollees for any marketing or communications related to Model Benefits in any way that discriminates among Targeted Enrollees based on impermissible criteria, such as race, national origin, limited English proficiency, gender, disability, chronic disease, whether a person resides or receives services in an institutional setting, frailty, or health status.

Further, other general plan information may accompany the NOB or the MAO's different strategy to communicate Model Benefits, provided that the information is complementary to the additional supplemental benefits and WHP Services being offered under the Model. For example, the NOB or plan's Model Benefits Communications strategy may be part of a larger communication describing Model Benefits, disease management programs, and general health information relevant to a particular population of Targeted Enrollees.

All communication of Model Benefits must be designed to both engage Targeted Enrollees and inform them of their additional rights and benefits based on the organization's participation in the VBID Model. As such, participating organizations should use plain language, clear and actionable communication formats, and methods that are accessible and easy to understand for the targeted population.

CMS Review of Materials

Participating organizations must submit the materials identified in this section to CMS for review prior to use or distribution to any enrollees or potential enrollee. CMS has the right, at any time, to require that a participating organization modify or cease use of VBID Model-related materials, including those previously approved.

To facilitate the review and approval of specific VBID Model-related materials, CMS has established two VBID Model-specific review codes in the HPMS marketing module:

- Code 31001: NOB and other VBID Model communications (e.g., scripts for telephonic outreach and written communications), including any VBID-specific communication to be

Value-Based Insurance Design Model
CY 2020 Communications and Marketing Guidelines
Updated on November 15, 2019

included as content in the Annual Notice of Change or Evidence of Coverage. Materials submitted under this code are subject to a 45-day prospective review. ***Note: if a plan benefit package is included in CY 2020 and the MAO choose to not include it in CY 2021, a communication plan and all draft communication(s) for that change, must be submitted to CMS by July 15, 2020 utilizing this code.***

- Code 31002: Other VBID Model-specific materials, such as: notice of acknowledgement of an opt-in or opt-out from Model Benefits; notice of determination that an enrollee no longer qualifies for Model Benefits; notice of determination that an enrollee is not participating in a care management program, medication therapy management, or other service that Model Benefits are conditioned on; and communications materials (see 42 C.F.R. § 422.2260) specific to Model Benefits or Model Rewards, as defined and described in Section 5 below, including all pre-enrollment or prospective material and scripts. Materials submitted under this code are not subject to prospective review and may be used immediately following submission unless and until CMS directs that the MAO stop use of the material(s).

All other CMS requirements relating to the review of marketing materials under 42 C.F.R. part 422, subpart V, continue to apply. Therefore, to the extent other materials contain VBID Model-related content, but are not specifically identified in this section, that material should be submitted to HPMS as required under the MA program, and coded using the existing code appropriate to the type of material submitted.

3 Marketing and Communications with Non-Eligible Enrollees

All MA, Part D marketing and communication regulations, and guidance and all other applicable laws, remain in place with respect 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, subpart V.

Participating organizations must follow all applicable laws that apply to the Medicare Communications and Marketing Guidelines (MCMG), including any updates to the MCMG, and other CMS guidance documents when communicating with potential enrollees. VBID Model participating organizations may choose to include Model Benefits in their Summary of Benefits (SB) available to potential enrollees, provided they follow the instructions for adding additional benefits to the SB as outlined in Appendix 5 of the MCMG.

Of note, any inclusion of, or discussion regarding Model Benefits, must indicate any and all qualifying benefit criteria as well as the fact that eligibility for interventions are not assured and will be determined by the participating organization after enrollment. Moreover, the information must be conveyed in accordance with all other CMS marketing and communication restrictions, particularly those prohibiting misleading information to enrollees.

4 Mandated Model Benefits Communications with Eligible Enrollees

Strategy for Communicating Model Benefits

MAOs must include all VBID Model Benefits, including Wellness and Health Care Planning (WHP), in the Evidence of Coverage (EOC), along with language that ensures beneficiaries are aware of any conditional or targeting criteria. MAOs that are new to the VBID Model for CY 2020 must also include the VBID Model Benefits in the Annual Notice of Changes (ANOC) for existing enrollees.

MAOs that are leaving the VBID Model but are offering the same supplemental benefits through CMS policies and authorities applicable to all MA plans (such as Uniformity Flexibility (UF) or Special Supplemental Benefits for the Chronically Ill (SSBCI)) are not required to include a change in the ANOC when there is not a change to the covered benefits that are available to enrollees in the MA plan. MAOs that are leaving the VBID model and are not continuing to offer benefits that are similar to the Model Benefits offered under the MAO's previous participation in the VBID Model must include the change in the Section 2.4, "Changes to Benefits and Costs for Medical Services" of the ANOC.

In light of the diverse approaches to providing Model Benefits, MAOs are best positioned to identify how they communicate Model Benefits to eligible enrollees. Note that for the 2020 Model Year, MAOs may utilize the NOBs that have been submitted for CMS review, as long as they include any changes required by CMS. Alternatively, MAOs may propose a different strategy for communicating information regarding Model Benefits. Such proposals would be subject to CMS review and approval. For example, while CMS recommends MAOs utilize a written NOB provided to all Targeted Enrollees, MAOs are also permitted to first engage verbally or telephonically and then provide written follow-up communication that augments enrollee understanding and participation. All MAOs must either submit their NOB or their alternative strategy for communicating Model Benefits to enrollees for CMS for review and approval.

CMS is not specifying a standard format for the NOB nor a CMS-standard notice to eligible enrollees. Instead, CMS is providing the following guidance. MAOs participating in the VBID model must utilize a strategy that does the following:

- Informs and engages Targeted Enrollees to receive their Model Benefits over the course of the year;
- Provides either a written NOB, or a verbal or telephonic NOB together with a written NOB through a care management program; and
- Wellness and Health Care Planning (WHP) may be included in the NOB, but MAOs are only required to include WHP in the EOC.

The EOC and/or the NOB, or MAO's different strategy for communicating Model Benefits and the ANOC must contain, at a minimum, the following information:

Value-Based Insurance Design Model
CY 2020 Communications and Marketing Guidelines
Updated on November 15, 2019

- A description of the Model Benefits available to the Targeted Enrollee, including what the additional benefits are, how to receive the benefits, restrictions or conditions placed on receipt of the benefits, and where to receive more information. If the Model Benefits are different than the Model Benefits offered to that enrollee in a previous model year, the description must include a clear explanation of those changes. Participating organizations are encouraged, but not required, to explain how these benefits differ from their MAO's generally available plan benefit package; and
- If the Targeted Enrollee's receipt of any Model Benefits is contingent on participation in care management or other like programs, a description of the participating organization's standards for measuring participation, how to enroll (if required), and how to seek an accommodation, if needed, due to health status, location, or disability.

In developing the NOB and/or different strategy for communicating Model Benefits, MAOs must include the following information for enrollees:

- Enrollees receiving any Model Benefit retain their rights to file appeals and grievances;
- For Targeted Enrollees who do not want the additional benefits, reduced cost sharing or VBID Model-related communications, they may contact the participating MAO to opt out;
- For Targeted Enrollees who do opt out or become ineligible for Model Benefits, due to non-engagement in required care management or similar program activities, they may be allowed to enter/re-enter and become re-eligible for Model Benefits, along with the process to become re-eligible;
- For participating organizations offering reduced cost-sharing for Targeted Enrollees participating in disease management programs, organizations cannot make cost-sharing reductions conditional on achieving any specific clinical goals or outcomes;
- For participating organizations offering Model Benefits contingent on enrollee participation in care management: That Targeted Enrollees are not required to participate in care management if they do not wish to do so, but that if they do not, they will not obtain the Model Benefits;
- For participating organizations offering Model Benefits requiring use of a high-value provider: That Targeted Enrollees in a plan are free to visit any provider in the organization's network, at the original cost sharing amount;
- How to contact the participating organization with questions regarding the Model Benefits, eligibility for Model Benefits, or to opt out of the Model Benefits;
- How to file a grievance, or an appeal of a determination relating to Model Benefits, including, if applicable, a determination that a Targeted Enrollee is not satisfying requirements for participation in care management or similar program. This must include the timely provision of an organizational/coverage determination, and grievance/appeal information required for enrollees eligible for Model Benefits;
- Contact information for 1-800 MEDICARE and the local State Health Insurance Assistance Program (SHIP) for assistance;
- How to obtain the information in alternative formats, as required by Section 4.6.; and

Value-Based Insurance Design Model
CY 2020 Communications and Marketing Guidelines
Updated on November 15, 2019

- A disclaimer noting that the Model Benefits may change on January 1 of each year and that annually the participating organization will provide information of any changes prior to enrollment for the following year as part of the following year NOB.

Timing of Notice of Model Benefits

Notice in Advance of Contract Year

In advance of each Contract Year, participating organizations must identify, based on information known to the participating organization and in accordance with implementing an Approved Bid, those current enrollees who are Targeted Enrollees. Current participating organizations must deliver the NOBs or use a different strategy to communicate Model Benefits to these enrollees by September 30, to coincide with the delivery of the Annual Notice of Change (ANOC) required pursuant to 42 CFR 422.111 and 423.128. See also Section 100.4 of the Medicare Communications and Marketing Guidelines (MCMG). The NOB or MAO's different strategy to communicate Model Benefits may accompany the ANOC, or be delivered separately.

Notice during Contract Year for New Enrollees

For Targeted Enrollees who did not receive a NOB or plan outreach to enrollees using a different strategy to communicate Model Benefits by September 30 prior to a contract year, participating organizations must mail a NOB or notify using the plan's strategy for communicating Model Benefits within 30 calendar days of the participating organization's identification of that enrollee as a Targeted Enrollee eligible for Model Benefits. This will apply in cases such as when a Targeted Enrollee is newly enrolled in an MA plan or the participating organization determined his or her eligibility as a Targeted Enrollee during the contract year based on newly available information.

Newly Participating MAOs for Contract Year 2020

In order to allow newly participating organizations to carry out an orderly implementation of the VBID Model in their first year, newly participating organizations must ensure all ANOCs and/or NOBs or plan strategy to communicate Model Benefits are provided to Targeted Enrollees by January 30, 2020. However, unless a particular Model Benefit is contingent upon participation in a care management or similar program that requires registration, Targeted Enrollees are eligible for Model Benefits beginning on January 1, 2020, on which date participating organizations must begin providing Model Benefits in accordance with the Addendum.

MAOs Not Participating in the VBID Model for Contract Year 2020

In order for VBID plan enrollees to have sufficient time to make other MA elections for Contract Year 2020, participating organizations that chose not to renew their VBID PBP offering(s) for 2020 or reduce their service areas for VBID enrollees must notify all affected VBID plan enrollees of the changes to their current plan as part of their ANOC. In addition, MAOs may also communicate this change in the NOB or plan outreach to enrollees where they use a different strategy to communicate Model Benefits than a NOB. This must be provided to affected VBID plan enrollees by September 30, 2019, consistent with MA program guidelines.

Value-Based Insurance Design Model
CY 2020 Communications and Marketing Guidelines
Updated on November 15, 2019

Participating organizations that are terminated from the MA program for the following year must notify their affected enrollees that their plan will not be available in the following contract year. They must follow all MA program rules regarding contract termination.

Enrollee Communications

In addition to the mandated annual EOC as well as ANOC or NOB, as applicable, VBID Model participating organizations must deliver the following written communications to Targeted Enrollees:

- An Explanation of Benefits (EOB) for payment of claims for Model Benefits. EOBs for Model Benefits need not be distinct from those delivered by the participating organization for non-VBID-Model Benefits, but EOBs must accurately reflect the Model Benefits provided to eligible enrollees and the appropriate cost sharing if reduced or eliminated as part of the model component and meet all applicable regulations and guidance for EOBs. Participating organizations approved to furnish Model Benefits to enrollees by retroactive reimbursement check may either issue an EOB for such benefits or propose alternative forms of notice to CMS. Such alternate forms of notice must be approved before the participating organization uses it.
- Notice of acknowledgment of an opt-out from Model Benefits. The notice must include an explanation of any changes in access, availability, cost sharing, and eligibility for Model Benefits that will occur as a result of the opt-out by the Targeted Enrollee, and instructions for rescission of the opt-out to the Targeted Enrollee;
- Notice of acknowledgment of a rescission of an opt-out from Model Benefits. The notice must include an explanation of any changes in access, availability, cost sharing, and eligibility for Model Benefits that will occur as a result of the rescission of the opt-out by the Targeted Enrollee;
- Notice of determination that an enrollee no longer qualifies for Model Benefits. The notice must include the rationale underlying such a determination. This determination is considered a standard Organization Determination for Part C benefits or a Coverage Determination for Part D benefits, and must contain the information required for notices of such determinations (see 42 C.F.R. Parts 422 & 423, subparts M and associated guidance available at: <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index>);
- Notice of a determination that a Targeted Enrollee is not participating in case management and, therefore, is not eligible for Model Benefits. The notice must include information on how to resume participation in case management if so desired. This determination is considered a standard Organization Determination for Part C benefits or a Coverage Determination for Part D benefits, and must contain the information required for notices of such determinations (see 42 C.F.R. Parts 422 & 423, subparts M and associated guidance).

Value-Based Insurance Design Model
CY 2020 Communications and Marketing Guidelines
Updated on November 15, 2019

Each of the written communications listed above, except for standard EOBs for payment of claims for Model Benefits, must contain the following disclaimer: “Medicare approved [participating organization name/marketing name] to provide [these benefits and/or lower co-payments/co-insurance] as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans.”

The mandated communications to Targeted Enrollees detailed in this guidance represent the minimum required of participating organizations – however, participating organizations can go beyond this and communicate further with Targeted Enrollees.

Examples of further communications with Targeted Enrollees that participating organizations might use include: (a) regular (quarterly or monthly) follow-up mailings, reminding Targeted Enrollees of the potential advantages available to them as the result of participating in Model Benefits, (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 Targeted Enrollee. For instance, a participating organization might remind a Targeted Enrollee, when granting that enrollee prior approval for a service that s/he is eligible for reduced cost-sharing for a surgical procedure if s/he uses a high-value provider.

Contingent VBID Benefits

Some Targeted Enrollees whose benefits are contingent on participation in disease or care management or like programs may have participation conditions that differ from those delivered in the NOB. For example, some enrollees may have an accommodation made to the program’s requirements for health status, location or disability. Others may have a plan of participation customized in cooperation with a case manager upon enrollment. In these and like cases, participating organizations must deliver a second written document to the Targeted Enrollee detailing the specific requirements of participation applicable to that enrollee.

5 Provider Directories & Network-Related Communications

Participating organizations must satisfy all current MA program requirements with regard to provider directories. Additionally, participating organizations offering Model Benefits contingent on the use of a high-value provider network must provide directory information identifying high-value providers to Targeted Enrollees eligible for those contingent benefits. This directory may be a full provider network directory in which the high-value providers are identified and distinguished from other providers, or a distinct supplemental document (akin to a sub-network directory or specialty directory) listing only the high-value providers and their locations. Participating organizations may request approval from CMMI to use alternative means of satisfying this network directory requirement for high-value provider networks.

If a participating organization makes any changes to its high-value provider list in CY 2020 relative to previously provided directories, the participating organization must provide written notice to all Targeted Enrollees of the updated high-value provider directory.

Electronic Communications and Websites

Participating organizations may use websites to make information about Model Benefits and other information about model participation accessible to Targeted Enrollees, provided the requirements in this guidance, in the MA and Part D marketing and communication regulations (e.g., 42 C.F.R. §§ 422.111, 422.2260 through 422.2276, 423.128 and 423.2260 through 423.2276), and in the Medicare Communications and Marketing Guidelines (MCMG) are met. Websites may supplement, but not replace, the written communications required to be provided by participating organizations in the model.

Accessibility for Individuals with Disabilities and Non-English Speaking Populations

Participating organizations must make the following documents available in any language that is the primary language of at least five percent of the organization's service area in which VBID benefits are offered: NOB, notice of determination that an enrollee no longer qualifies for Model Benefits; notice of determination that an enrollee is not participating in case management; notice alerting enrollees how to access or receive a directory.

Participating organizations must take reasonable steps to provide meaningful access to each individual with limited English proficiency (LEP) eligible to be served or likely to be encountered in the model as a Targeted Enrollee. This requirement means that participating organizations may need to provide language assistance services, such as written translation and oral interpretation, to individuals with LEP in languages other than those that constitute at least five percent of the organization's service area in which Model Benefits are being offered.

Participating organizations also must ensure effective communication with individuals with disabilities and provide auxiliary aids and services, such as alternate formats (e.g., braille, audio, large format), to individuals with disabilities to ensure an equal opportunity to access the benefits available in the VBID model.

6 Model Rewards

Types of Model Rewards

Currently, MAOs are authorized to offer Part C Rewards and Incentives Programs but not Part D Rewards and Incentives under 42 C.F.R. § 422.134. For CY 2020, VBID Model participants may offer both Part C and Part D Rewards and Incentives, collectively referred to as "Model Rewards." Model Rewards are not Medicare benefits and are not to be treated as benefits. MAOs may use two different approaches to communicating with Targeted Enrollees about Model Rewards. First, while Model Rewards are not benefits and may not be listed in the EOC or Annual Notice of Change, MAOs may communicate information about their Model Rewards in the same material as the NOB or in the plan's strategy to communicate Model Benefits in order to ensure that Targeted Enrollees have complete information and are given sufficient information to understand the

Value-Based Insurance Design Model
CY 2020 Communications and Marketing Guidelines
Updated on November 15, 2019

available Model Rewards. Second, and subject to CMS approval, MAOs may inform Target Enrollees about Model Rewards either together with, or separately from the NOB.

Model Rewards Requirements

MAOs may market Model Rewards to potential enrollees. MAOs must comply with existing marketing requirements for Part C Rewards and Incentives in marketing materials for potential enrollees at 42 C.F.R. §§ 422.134(c)(2)(ii) and 422.2268, as well as additional guidance in 40.8 of the MCMG and any updates. As noted in CMS Communications and Marketing Guidelines and updates, MAOs may include information about rewards and incentives programs in marketing materials for potential enrollees. Marketing of rewards and incentives programs must:

- not be used in exchange for enrollment; and
- be provided to all potential enrollees without discrimination.

Please see Section 100, Chapter 4 (Benefits and Beneficiary Protections) of the Medicare Managed Care Manual for additional information on rewards and incentives.

In addition to these requirements, participating organizations should adopt a communications strategy, that clearly outlines the Model Rewards, (i.e., Part C and/or Part D Rewards and Incentives) programs available to both Targeted Enrollees and prospective enrollees. These communications must include, at a minimum:

- the intended goal of the reward and incentive program(s);
- what must be done to receive the rewards and incentives;
- the per unit value of the reward and incentive;
- the total value that an enrollee can receive;
- where and how to ask questions or receive help on understanding the rewards and incentives program; and
- Sufficient information on how the rewards/incentives will be delivered (e.g., debit card, gift card or grocery card), and clear instructions on how to ask any model specific questions;

MAOs participating in the VBID Model must submit marketing material for Model Rewards to CMS for review. All Model Rewards marketing materials must be submitted in HPMS using Code 31002 for CMS review and approval. Like other materials submitted in HPMS using Code 31002, they are not subject to prospective review and may be used immediately following submission unless and until CMS directs that the MAO stop use of the material(s).

In light of the diverse approaches to providing Model Rewards, CMS is not specifying either a standard format for notifying Targeted Enrollees of their potential eligibility for Model Rewards, or a CMS-standard notice to eligible enrollees. Participating organizations are encouraged to craft Model Rewards communication in a way that will effectively engage Targeted Enrollees and communicate consistent with the communication principles described in Section 2.3 above, which

Value-Based Insurance Design Model
CY 2020 Communications and Marketing Guidelines
Updated on November 15, 2019

must be designed to outline all of the Model Rewards available to potential and Targeted Enrollees. Such communications must be designed to minimize confusion where possible. Again, such communications would require submission in HPMS using code 31002.

Model Rewards Communications Timeline

Outlined below are timelines for informing enrollees of any Model Rewards offered by the plan. These timelines are in concert with the start of the MA Annual Election Period (AEP) which begins on October 15, 2019 for the CY 2020 plan year.

- September 30, 2019: By this date, MAOs must submit to CMS via HPMS and using code 31002 Model Rewards marketing material for CY 2020; and
- October 1, 2019: MAOs may begin marketing, including Model Rewards to current and prospective VBID Model plan enrollees for 2020 using the Model Rewards marketing materials submitted no later than September 30, 2019. As noted in 2.4 above, Materials submitted under code 31002 are not subject to prospective review and may be used immediately following submission unless and until CMS directs that the MAO stop use of the material(s).

7 Communications with Persons Other than Beneficiaries

Network Providers

In addition to communications with enrollees, participating organizations should communicate their VBID Model participation to those members of their provider network for whom notification could enhance/increase beneficiary engagement in the VBID Model, and may communicate, consistent with applicable law, specific enrollees' eligibility status (i.e., identify Targeted Enrollees) once established. This includes, in particular, specialists essential to the specific Model Benefits offered and the primary care providers of Targeted Enrollees. Providers identified as high-value under the Model should also be specifically made aware of this fact.

Communication with the Public Regarding the VBID Model

Participating organizations must obtain prior approval from CMS during the VBID Model, and for six months thereafter, for the publication or release of any press release, external report, or statistical/analytical material that materially or substantially references the organization's participation in the Model, and include certain disclaimers on those materials if approved. Reference Article 3, Section H (Release of Information) of the Addendum to Medicare Managed Care Contract for Participation in the Medicare Advantage Value-Based Insurance Design Model for the specific requirement.

To obtain prior approval, provide a copy of the material proposed for publication by electronic mail to VBID@cms.hhs.gov.

Value-Based Insurance Design Model
CY 2020 Communications and Marketing Guidelines
Updated on November 15, 2019

Attachment – Suggested VBID Model Updates to EOC for CY 2020

What follows is suggested updated Evidence of Coverage (EOC) language for VBID Model participants to use that includes new Model components for CY 2020, including Wellness and Health Care Planning (WHP) and targeting VBID benefits to Low Income Subsidy (LIS) enrollees. The existing Model EOC for 2019, while it does include VBID plan participant information relating to Chronic Conditions, it does not include all VBID Model Components, but will be updated when the next Model EOC is updated in 2020.

[Insert if offering Value Based Insurance Design Model Test (VBID) benefits: Important Benefit Information for Enrollees Participating in Wellness and Health Care Planning Services

- Because [XX plan name] participates in VBID (*insert VBID program name*), you may be eligible for the following Wellness and Health Care Planning (WHP) services, including advance care planning (ACP) services:
 - *[Include a summary of WHP services that will be provided to the enrollee in CY 2020. If only a subset of enrollees will receive the services in 2021, consistent with WHP guidance updated on April 18, 2019, include a description of the eligible population. The description must include language that WHP and ACP are voluntary and enrollees are free to decline the offers of WHP and ACP*
 - *[Include information how and when the enrollee would be able to access WHP services]*
- *[Instructions to MAOs offering WHP benefits:*
- *MAOs must deliver to each VBID PBP's enrollee, or for plans targeting only a subset of enrollees in 2021 to the Targeted Enrollees, a written summary of WHP benefits so that such enrollees are notified of the benefits for which they are eligible. VBID plans should follow the VBID guidance on communications for delivering such Notice of Model Benefits when offering WHP benefits. (See Medicare Advantage Value-Based Insurance Design Model CY 2020 Communications Guidelines).*
- *If applicable, MAOs should mention that enrollees may qualify for cost-sharing or co-payment reductions as well as any rewards and incentives proposed to incentivize WHP].*

[Insert if offering Value-Based Insurance Design Flexibility benefits and/or targeted supplemental benefits to Low Income Subsidy (LIS) enrollees, as defined in the Plan Communication User Guide (PCUG): Important Benefit Information for Enrollees Who Qualify for Extra Help:

- If you receive Extra Help to pay your Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.

Value-Based Insurance Design Model
CY 2020 Communications and Marketing Guidelines
Updated on November 15, 2019

- *[If applicable, plans offering benefits under VBID that require participation in a health and wellness program, direct the enrollee to see the “Notice of VBID Benefits.” (See Medicare Advantage Value-Based Insurance Design Model CY 2020 Communications Guidelines).]*
- Please go to the Medical Benefits Chart in Chapter 4 for further detail].

[Instructions to plans offering VBID benefits for LIS Targeted Enrollees:

- *MAOs must deliver to each LIS-targeted enrollee a written summary of those benefits so that such enrollees are notified of VBID benefits for which they are eligible. VBID plans should follow the VBID guidance on communications for delivering such notice when offering targeted supplemental or VBID benefits. (See Medicare Advantage Value-Based Insurance Design Model CY 2020 Communications Guidelines).*
- *MAOs who choose to reduce cost-sharing for an item or service, including Part D drugs covered by MA-PD plan through member participation in a plan-sponsored disease management or similar program must include a summary of the additional supplemental benefits they would receive as well as the activities and/or programs the member must complete in order to receive the benefit.*
- *If applicable, MAOs must update the Medical Benefits Chart and include a supplemental benefits chart including a column that details the exact targeted reduced cost sharing amount for each specific service, and/or the additional supplemental benefits being offered. Specific services should include details as it relates to Part D benefits and VBID.*
- *If applicable, MAOs with VBID should mention that members may qualify for a reduction or elimination of their cost sharing for Part D drugs.]*