Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation
Medicare Advantage Value-Based Insurance Design Model
CY 2020 Model Communications and Marketing Guidelines
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Contents

1 Background and General Information

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

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 with low incomes such as dual-eligibles, and improve the coordination and efficiency of health care service delivery. The service delivery model components available for CY 2020 are:

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

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 Addendum to Medicare Managed Care Contract for Participation in the MA VBID Model.

1.1 Model Benefits Communications Timeline

All model participants should review the MA VBID Addendum and all applicable Medicare Communication 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 (see section 4.1) for CY2020 to CMS ***(Both CY 2019 and CY 2020 Participants)***;
- September 16, 2019: CMS completes review of MAOs' submitted Notices of Model Benefits for CY2020;
- September 30, 2019: ***CY 2019 Participants Only -*** MAOs provide currently Targeted Enrollees with their Notice of Model Benefits for CY2020. All changes, including any change in benefits due to a PBP not participating in CY2020, must be communicated to Targeted Enrollees by this date;

- By January 30, 2020: MAOs must provide all Targeted Enrollees, including new enrollees, for CY2020 with the Notice of Model Benefits for CY2020; and
- Throughout CY2020: All newly identified Targeted Enrollees must be provided a Notice of Model Benefits for CY2020.

2 General Guidance

2.1 Applicability of Other Guidance

All MA marketing regulations, and guidance issued by CMS regarding those regulations and other applicable laws continue to apply to materials and activities of participating organizations, including the 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.

2.2 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 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.

CMS will provide additional guidance (such as through an update or addendum to these CY 2020 Model Communications and Marketing Guidelines) for marketing and communicating information about 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 enrollees, what must be done to receive the Model Benefits, where and how to ask questions or receive help on understanding the Model Benefits, and that ultimately serves to engage Targeted Enrollees to utilize these specific benefits.

Additionally, participating organizations must use this approach consistently in communication materials so that enrollees are able to understand the relationship between the Notice of Model Benefits and any subsequent communications or marketing.

2.3 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 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, with or without overlap, also offers reduced cost-sharing based on low-income subsidy status, the participating organization must have two separate Notices of Model Benefits for each targeted population. Additionally, as the Notice of Model Benefits and any accompanying communications or marketing material is meant for the distinct target group(s), participating organizations should make all attempts to limit any potential confusion or dissatisfaction 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 Notice of Model Benefits, provided that the information is complementary to the additional supplemental benefits and WHP Services being offered under the model. For example, the Notice of Model Benefits 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 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.

2.4 CMS Review of Materials

Participating organizations must submit the Model-related 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: Notice of Model Benefits. Materials submitted under this code are subject to a 45-day prospective review. ***Note: if a plan benefit package is participating in CY 2020 and chooses to not participate in CY 2021, a communication plan and all draft communication(s) for that change, which must be sent either with or separately but at the same time as the Annual Notice of Change (ANOC) for Targeted Enrollees, 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, 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 CFR part 422, subpart V, continue to apply. Therefore, to the extent other materials contain VBID Model-related content, but is 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 Medicare Advantage, Part D marketing 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 the all applicable laws, the Medicare Communications and Marketing Guidelines and other CMS guidance documents in communicating all benefits to potential enrollees. VBID Model participating organizations may choose to include Model Benefits in their Summary of Benefits available to potential enrollees.

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 restrictions, particularly those prohibiting misleading communications to enrollees.

4 Mandated Communications with Eligible Enrollees

4.1 Notice of Model Benefits (NOB)

In addition to specific instructions related to the VBID Model Benefits included in the Evidence of Coverage (EOC)[1] and CMS-provided templates for materials issued by participating organizations, participating organizations must deliver to each Targeted Enrollee a "Notice of Model Benefits (NOB)." The NOB is a written summary of Model Benefits so that Targeted Enrollees are notified of the benefits available to them under the VBID Model (consistent with what is outlined in Section 2 above).

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

Despite the flexibility offered in the construction of the NOB, it must contain, at a minimum, the following information:

- 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 plan's generally available benefit package;

- 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;

- If a participating organization is reducing cost-sharing contingent on obtaining services from certain high-value providers, a directory of these providers must be made available to Targeted Enrollees. If high-value providers are explicitly identified as such in the organization's general provider directory, a statement directing Targeted Enrollees to that directory is sufficient. If provider directories are provided online, information on how to access the directory and request a hard copy must be provided. See Section 4.4 below for more information on directories. Further, if a provider has been deemed high-value, the specific clinical and service rationale must be provided, including any objective and verified outcomes measures, for why a provider or providers are high-value to assist enrollees in making decisions about the provider.

[1] Participating organizations are reminded that EOC documents do not contain information about rewards programs.

- An explanation of the following elements of the VBID model, including at a minimum:

    - That the Model Benefits are offered as part of a CMS (or Medicare) initiative to increase the quality and decrease the cost of care for beneficiaries in the MA program. This explanation must contain (or consist of) the following verbatim statement: "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;"
    - That not all other MAOs and Plan Benefit Packages (PBPs) are participating in this initiative;
    - That the participating organization may only offer Model Benefits that consist of additional benefits or reduced cost sharing and WHP Services and may not offer a plan that reduces available benefits or increases cost sharing;
    - That enrollees receiving any Model Benefit retain their rights to file appeals and grievances;
    - That Targeted Enrollees who do not want the additional benefits, reduced cost sharing or VBID Model-related communications may contact the participating MAO to opt out;
    - That Targeted Enrollees who do opt out or become ineligible for Model Benefits, due to non-engagement in required care management or similar program activities, may be allowed to enter/reenter 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;
    - Sufficient information on how the benefits will be delivered (e.g. debit card, gift card or grocery card), and clear instructions on how to ask any model-benefit specific questions;
    - 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
- 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.

4.1.1 Timing of Notice of Model Benefits

4.1.1.1 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 Proposal, those current enrollees who are Targeted Enrollees. Current participating organizations must deliver the NOBs 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 Notice of Model Benefits may accompany the ANOC, or be delivered separately. To meet the September 30 deadline, participating MAOs must submit their NOB material for review to HPMS by August 6, 2019. CMS will then review the NOB materials and provide approval no later than September 16, 2019.

4.1.1.2 Notice during Contract Year for New Enrollees

For Targeted Enrollees who did not receive a NOB by September 30 prior to a contract year, participating organizations must mail a NOB 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.

4.1.1.3 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 Notice(s) of 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.

Newly participating organizations for 2020 must submit their NOB material for review to HPMS by August 6, 2019. CMS will then review the NOB materials and provide approval no later than September 16, 2019.

4.1.1.4 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 plan benefit package 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 NOB. This must be provided to affected VBID plan enrollees by September 30, 2019. This policy is consistent with MA program guidelines.

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.

4.2 Enrollee Communications

In addition to the mandated annual NOBs, VBID Model participating organizations must deliver the following written communications to 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/.);

- 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).

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.

4.3 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.

4.4 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 CY2020 relative to previously provided directories, the participating organization must provide written notice to all Targeted Enrollees of the updated high-value provider directory.

4.5 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.

In order to reduce beneficiary confusion during the Annual Election Period (AEP), participating organizations may not post information about the VBID Model, Model Benefits or Model Rewards to the internet in a publicly-available manner prior to the conclusion of that AEP. Following the conclusion of the AEP, a participating organization may make information about VBID benefits accessible in a section of its website intended for viewing by current enrollees.

4.6 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 that meet this five percent threshold for language translation must place on all written materials an alternative language disclaimer provided in applicable law (see also Medicare Communications and Marketing Guidelines (MCMG). CMS strongly encourages all participating organizations to translate other written materials.

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.

5 Communications with Persons Other than Beneficiaries

5.1 Network Providers

In addition to communications with enrollees, participating organizations should communicate their 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.

5.2 Communication with the Public Regarding the VBID Model

Participating organizations are required to 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 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.