Centers for Medicare & Medicaid Services

Center for Medicare and Medicaid Innovation

Value-Based Insurance Design Model

Calendar Year 2021

Model Communications and Marketing Guidelines

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Disclaimer: The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

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 the Medicare Managed Care Contract for Participation in the Medicare Advantage (MA) VBID Model (Addendum). Additional communications and marketing requirements specific to Cash or Monetary Rebates, the Hospice Benefit Component, and Rewards and Incentives Programs are described in Sections 2, 3, and 4 of this document, respectively.

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 enrollees (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 for Calendar Year (CY) 2021 are:

1. Wellness and Health Care Planning (WHP)
2. VBID for MA and Part D Mandatory Supplemental Benefits:
    a. Targeting Benefits by Chronic Condition(s) and/or Socioeconomic Status, including new and existing technologies or FDA-approved Medical devices
    b. Cash or Monetary Rebates (all enrollees in the PBP)[1]
3. Part C and Part D Rewards and Incentives Programs (herein referred to as "Model Rewards")
4. Hospice Benefit Component

If approved by CMS, MAOs participating in the VBID Model are permitted to offer any of the Model components listed above to Eligible Enrollees. Eligible Enrollee(s) therefore refers to any enrollee that is eligible for one or more of the four Model components listed above.

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

Section 1 discusses the requirements and general timelines that MAOs must follow in communicating Model Benefits to Eligible Enrollees. Model Benefits means any or each of the following: (i) Wellness and Health Care Planning (WHP) Services as defined in the Addendum; (ii) Any additional supplemental benefits offered by the MAO pursuant to Article 3 of the Addendum;[2] and the (iii) Hospice Benefit Component pursuant to Appendix 3 of the Addendum.

Section 2 outlines requirements in addition to those in Section 1 that MAOs offering Cash or Monetary Rebates must follow in communicating this benefit to enrollees and marketing this benefit to enrollees and potential enrollees. Section 3 follows with additional requirements that

[1] Cash or Monetary Rebates is addressed specifically in Section 6 of this document.
[2] See Addendum, Article 3.D and 3.F.

MAOs offering the Hospice Benefit Component must follow in communicating and/or marketing this benefit to enrollees. Section 4 concludes by discussing additional requirements that MAOs offering the Model Rewards must follow in communicating Model Rewards to enrollees and marketing the existence of Model Rewards and RI Programs. Model Rewards refers to rewards and incentives offered as part of implementing a VBID Model Approved Proposal; Model Rewards are not Model Benefits. Lastly, Appendix 1 provides a template for the VBID Member Engagement Strategy, and Appendix 2 includes the 2021 EOC/ANOC Model Corrections for the VBID Model (including Corrections to the Instructions for CY 2021 EOC and ANOC for MAOs Participating in the Hospice Benefit Component of the VBID Model).

Capitalized terms not otherwise defined in these VBID Model Communications and Marketing Guidelines have the meaning provided in the current Addendum.

1 Communications Requirements & Timeline

1.1 General

This Section discusses the specific communications principles and requirements that MAOs must adhere to when communicating Model Benefits to Eligible Enrollees and provides general timelines for informing enrollees, both current and new, of those Model Benefits. The principles outlined in this Section are also applicable to communicating Model Rewards to Eligible Enrollees and potential enrollees, however additional requirements specific to Model Rewards are discussed in Section 4. Subject to specific instructions and guidance in Section 3, the principles outlined in this Section are also applicable to communicating about the Cash or Monetary Rebates Component to Eligible Enrollees and potential enrollees.

In addition to the requirements in this document, participating MAOs should review the Addendum, applicable regulations, and all applicable Medicare Communication and Marketing Guidelines (MCMG) found here: Medicare Communications and Marketing Guidelines. Specifically, 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 MAOs, including the MA regulations at 42 C.F.R. parts 422 and 423, Subparts V and the MCMG. In the event of a conflict between the marketing requirements in the Underlying Contract and the VBID 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. The marketing and engagement strategies for the Model Benefits and Model Rewards are customizable so that the MAO may have unique approaches to informing enrollees of the options to participate in the Model and the potential to receive different benefits and rewards.

MAOs must submit to CMS a description of how they will inform and engage enrollees about the Model Benefits and/or Rewards and Incentives Programs that will be available (herein referred to as the "VBID Member Engagement Strategy"). This description (in half of a page or less, or 400-500 words) must include how the Model Benefits to be offered to Eligible Enrollees, as well as any Rewards and Incentives Programs, will be communicated to Eligible Enrollees by the MAO.

The goal of the VBID Member Engagement Strategy is to ensure each enrollee understands the Model Benefits and/or Rewards and Incentives Programs that he or she may be eligible for and how to access them (see Appendix 1 for the VBID Member Engagement Strategy Form), and for CMS to understand how Model Benefits and Model Rewards are being communicated to Eligible Enrollees.

After each VBID Member Engagement Strategy has been submitted, CMS will review and may reach out to MAOs for clarity, additional information, or to request changes prior to approval.

Consistent with their VBID Member Engagement Strategy, MAOs shall only use the materials described below that have been reviewed and approved by CMS for notifying their enrollees who are eligible for Model Benefits or Model Rewards:

1. **An Evidence of Coverage (EOC) and an Annual Notice of Change (ANOC) that include the Model Benefits that will be offered to enrollees:** In their 2021 EOCs that are required as part of the MA program requirements, MAOs must include all Model Benefits, including WHP Services, along with language that ensures enrollees are aware of any conditions or targeting criteria for access to the Model Benefits. MAOs that are new to the VBID Model for CY 2021 must also include the Model Benefits in the ANOC for existing enrollees.

2. **MAOs offering Cash or Monetary Rebates must provide additional communications regarding the Cash or Monetary Rebates Model Benefit to Eligible Enrollees:** In addition to the EOC and ANOC, MAOs must inform and engage all Eligible Enrollees in the applicable PBP (all enrollees in such PBPs are Eligible Enrollees) about the Cash or Monetary Rebates. The required information includes: how the MAO will distribute the Cash or Monetary Rebates, availability of any other applicable Model Benefits over the course of the year, where to go if they have questions, and any potential tax implications (*See Section 2 for additional, specific requirements*).

3. **MAOs must communicate Rewards and Incentives Programs to Eligible Enrollees:** While Model Rewards are not benefits and may not be listed in the EOC or ANOC, MAOs must communicate information about their Model Rewards via other vehicles in order to ensure that Eligible Enrollees have complete and sufficient information to understand the available Model Rewards (*See Section 4 for additional, specific requirements*).

4. **Additional Required VBID Model-Specific Materials *(as applicable)*:** These materials include: a 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 all other communications materials required by the MA program (see 42 C.F.R. § 422.2260), including all pre-enrollment or prospective material and scripts, that are tailored for use in the Model.

In addition to the requirements above, an MAO has the option to engage Eligible Enrollees and to inform them about Model Benefits and/or Rewards and Incentives Programs through additional communications materials. These additional communications to Eligible Enrollees regarding Model Benefits and Rewards and Incentives Programs must be submitted to CMS for review and approval.

Further, if a participating MAO makes any changes to its high-value provider list in CY 2021 relative to previously provided high-value provider directories, the participating MAO must provide written notice to all Eligible Enrollees of the updated high-value provider directory (*See Section 3 for provider directory requirements for MAOs participating in the Hospice Benefit Component of the Model*).

Per 42 CFR §§ 422.2260, 423.2260, "Communications" means activities and use of materials to provide information to current and prospective enrollees, and "marketing" materials are a subset of communications and includes activities and use of materials that are conducted by the Plan/Part D sponsor with the intent to draw a beneficiary's attention to a MA plan or plans and to influence a beneficiary's decision-making process when selecting a MA plan for enrollment or deciding to stay enrolled in a plan (that is, retention-based marketing). Therefore, Table 1 on page 10 below distinguishes between VBID Model communications materials that are subject to prospective or retrospective review, and provides timelines for submission.

1.2 Communications Principles and Naming of Model Benefit Packages for Enrollees

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

In instances in which the communications or marketing material is meant for distinct Eligible Enrollees, and the MAO chooses to communicate these to Eligible Enrollees through materials in addition to the EOC and ANOC, participating MAOs should make all attempts to limit any potential confusion of non-Eligible Enrollees by targeting communications clearly to applicable groups of Eligible Enrollees and developing scripts for inquiries to address confusion of any enrollee. Participating MAOs must not selectively identify subgroups of Eligible Enrollees for any marketing or communications related to Model Benefits in any way that discriminates among Eligible Enrollees or other enrollees based on impermissible criteria, such as race, national origin, limited English proficiency, gender, disability, whether a person resides or receives services in an institutional setting, frailty, or health status (other than the chronic condition used to identify Eligible Enrollees, where applicable).

Further, other general plan information may accompany communications about Model Benefits, provided that the information is complementary to all the Model Benefits being offered under the Model. For example, the MAO's strategy to communicate Model Benefits may be part of a larger

communication describing Model Benefits, disease management programs, and general health information as they are relevant to a particular population of Eligible Enrollees.

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

When naming and describing the Model Benefits that the participating MAO will offer under the Model to enrollees, participating MAOs 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 MAO should adopt a communications approach, including all naming, that clearly outlines the Model Benefits available to Eligible Enrollees (or, in the case of WHP Services and the Hospice Benefit Component, to all enrollees as applicable) and the scope of Model Benefits for each VBID Component in which the MAO is participating for that VBID PBP, 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 enrollees eligible for VBID Component(s) to utilize these specific benefits available under the Model. Additionally, participating MAOs must use this approach consistently in communication materials so that enrollees eligible for VBID Components are able to understand the relationship between the EOC and ANOC and any subsequent communications or marketing.

1.3 Process for MAO Submission of Materials and CMS Review

Materials requiring prospective review must be submitted in HPMS under Code 31001 for CMS review and approval prior to use or distribution to any enrollees (Eligible Enrollees or other enrollees) or potential enrollees. Materials submitted in HPMS under Code 31002 are not subject to prospective review prior to use, but may be subject to retrospective review. Both prospective and retrospective materials are identified in Table 1 on page 10 below. CMS has the right, at any time, to require that a participating MAO 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 Health Plan Management System (HPMS) Marketing Module:

- **Code 31001:** Plans submit for CMS review and approval their VBID Member Engagement Strategy, communications materials specific to Model Benefits (except those identified under Code 31002 below) and, as applicable, communications (including marketing) materials related to the Cash or Monetary Rebates, and communications materials related to Model Rewards. Materials submitted under this code are subject to prospective review.[3]

[3] Note: All materials relating to Cash or Monetary Rebates are also subject to a prospective review and must be submitted under 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; as well as marketing materials related to 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 CFR. part 422, subpart V, continue to apply to the MAO and apply to the VBID-related communications. 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. For example, the EOC must be submitted to HPMS using Code 1150 File and Use, and the ANOC must be submitted to HPMS using Code 1140 File and Use. These should not be submitted under VBID Model-specific review codes in the HPMS module.

1.4 Additional Required Enrollee Communications

In addition to the mandated annual EOC, as well as ANOC, as applicable, participating MAOs must deliver the following written communications to enrollees eligible for Model Benefits:

- 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 MAO 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 VBID Component and meet all applicable regulations and guidance for EOBs. Participating MAOs 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 to be communicated by the plan to enrollees. Such alternate forms of notice must be approved before the participating MAO uses it. Note: For MAOs with participating PBPs offering the Hospice Benefit Component, this is only applicable if there is claims activity to report.
- Notice of acknowledgment of an opt-out from Model Benefits.[4] 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 Eligible Enrollees, including instructions for rescission of the opt-out to the Eligible Enrollees. An example of when a notice of acknowledgment of an opt-out is needed would be for an enrollee that has requested to opt out of a VBID care management program. If your organization offers Model Benefits that are offered or structured in a manner that opting-out is not necessary, and therefore would have no

[4] As described in the Addendum, Article 3.B.3 and 3.F.8, MAOs shall provide a mechanism for Eligible Enrollees to opt out of any benefits provided under the VBID Model (**except for the Hospice Benefit Component**).

reason to send an acknowledgement of opt out, your organization may a request an exception from this requirement by submitting your request and explanation for exception to the VBID mailbox, for CMS approval. Requests for exceptions to this requirement must be received prior to the start of the contract year and must provide a rationale specific to each Model Benefit where an exception is being requested. An example of when a notice of acknowledgment of an opt out is not needed would be for certain supplemental benefits that are available to all enrollees, such as eyeglasses or meals where the enrollee may simply choose not utilize the benefit;

- Notice of acknowledgment of a rescission of an opt-out from Model Benefits.[5] 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 Eligible Enrollees;
- Notice of determination that an enrollee no longer qualifies for Model Benefits. The notice must include the rationale underlying such a determination.[6] 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); and
- Notice of a determination that Eligible Enrollees are not participating in case management and, therefore, are not eligible for Model Benefits, as applicable.[7] 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 in Section 1.4, except for standard EOBs for payment of claims for Model Benefits, must contain the following disclaimer: "Medicare approved [participating MAO 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 Eligible Enrollees detailed in this guidance represent the minimum required of participating MAOs – however, participating MAOs can go beyond this and communicate further with Eligible Enrollees so long as those communications are subject to CMS review and approval.

Examples of further communications with Eligible Enrollees that participating MAOs might use include: (a) regular (quarterly or monthly) follow-up mailings, reminding Eligible Enrollees of the potential advantages available to them as the result of participating in Model Benefits, (b) follow-

[5] id.
[6] id.
[7] id.

up phone calls with Eligible Enrollees, and (c) targeted phone calls or mailings, based on specific clinical or treatment patterns of a given Eligible Enrollees. For instance, a participating MAO might remind Eligible Enrollees, 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.

1.5 Provider Directories and Network-Related Communications

Participating MAOs must satisfy all current MA program requirements in the Managed Care Manual, Chapter 4 with regard to provider directories. Additionally, participating MAOs offering Model Benefits contingent on the use of a high-value provider network must provide directory information identifying high-value providers to those eligible for a set of 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 MAOs may request approval from CMMI to use alternative means of satisfying this network directory requirement for high-value provider networks.

In addition to communications with enrollees, participating MAOs 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 those eligible) once established. This includes, in particular, specialists essential to the specific Model Benefits offered and the primary care providers of Eligible Enrollees. Providers identified as high-value under the Model should also be specifically made aware of this fact.

In accordance with the provider directory requirements in 42 CFR § 422.111(e), if a participating MAO makes any changes to its high-value provider list in CY 2021 relative to previously provided directories, the participating MAO must provide written notice to all Eligible Enrollees of the updated high-value provider directory.

1.6 Electronic Communications and Websites

Participating MAOs may use websites to make information about Model Benefits and other information about model participation accessible to Eligible 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 MCMG are met. Websites may supplement, but not replace, the written communications required to be provided by participating MAOs in the Model.

1.7 Accessibility for Individuals with Disabilities and Non-English Speaking Populations

Participating MAOs must make VBID Model enrollee materials, including those in the MAO's Member Engagement Strategy, available in any language that is the primary language of at least five percent of the population in the MAO's service area in which Model benefits are offered: Model Benefits (if applicable), Model Rewards (if applicable). This language accessibility

requirement also applies to other materials such as a notice of determination that an enrollee no longer qualifies for Model Benefits, notice of determination that an enrollee is not participating in case management, and notice alerting enrollees how to access or receive a directory.

Participating MAOs must take reasonable steps to provide meaningful access to each individual with limited English proficiency (LEP) eligible to be served by a Model benefit or reward or likely to be encountered in the Model as Eligible Enrollees. This requirement means that participating MAOs 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 population MAO's service area in which Model Benefits are being offered.

Participating MAOs 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 Model Benefits available in the VBID Model.

1.8 Communication with the Public Regarding the VBID Model

Participating MAOs 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 MAO'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 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.

1.9 Communications Timeline

Outlined below in Table 1 are general timelines for informing enrollees, both current and new, of Model Benefits and Model Rewards.

All changes in benefits, including, any change in benefits due to a PBP not being offered in CY 2021 or not participating in the Model in CY 2021, must be communicated to eligible enrollees in the Annual Notice of Change (ANOC) in accordance with the Medicare Advantage Program ANOC deadline.

Table 1: Model Communications & Marketing Timeline

Material	Prospective or Retrospective Review	Timeline to Submit to CMS via HPMS
EOC/ANOC (which includes VBID Model Benefits)*	Retrospective	See CMS Medicare Communications and Marketing Guidance (MCMG) on HPMS Submission Timing
VBID Member Engagement Strategy	Prospective (45 Days)	September 21 - October 19, 2020
Model Benefit Communications *(outside of EOC)***	Prospective (45 Days)	September 21 - October 19, 2020
Model Rewards Communications	Prospective (45 Days)	September 21 - October 19, 2020
Cash or Monetary Rebates Communications *(outside of EOC)*	Prospective (45 Days)	September 21 - October 19, 2020
Cash or Monetary Rebates Marketing *(outside of ANOC)*	Prospective (10 Days)***	No later than September 1, 2020 for MAOs seeking to have materials ready by Annual Enrollment Period (AEP) *And* On a Rolling Basis for MAOs seeking approval for other Marketing Materials not for use by October 1, 2020
With the exception of Cash or Monetary Rebates, all VBID Marketing Materials, including Model Rewards are subject to retrospective review	Retrospective	Rolling Basis

**For the EOC and ANOC, follow the most recent CMS MCMG on HPMS timing and submission codes. Resubmission using VBID Model-specific HPMS codes is not necessary.*

*** Note: Materials identified for prospective review in the above table must be submitted to HPMS under code 31001, except those identified under Code 31002 in Section 1.3.*

****Effective for Plan Year 2021, CMS will shorten its review period of Cash or Monetary Rebates Marketing Materials to allow MAOs sufficient time to market during AEP.*

2 Additional Requirements for Communicating Cash or Monetary Rebates in the Form of Supplemental Benefits

This Section outlines additional requirements that MAOs offering Cash or Monetary Rebates must comply with in communicating this to all enrollees in the applicable PBP(s).

Beginning in CY 2021, MAOs participating in the VBID Model have the additional flexibility to choose to share the beneficiary rebates under Section 1854 of the Social Security Act with all of their enrollees in Model PBPs through a new mandatory supplemental benefit, in the form of Cash or Monetary Rebates. Marketing and communication materials for the Cash or Monetary Rebates component of the Model must comply with the requirements set forth in the Addendum, these Communications Guidelines, and all applicable laws.

In addition, participating MAOs are prohibited from selectively advertising or offering cash or monetary rebates based on the enrollees' health status or risk profile or in a discriminatory manner. Cash or Monetary Rebates must not be offered in exchange for enrollment but should describe the Cash or Monetary Rebates as a form of a benefit under the plan. For example, in describing Cash or Monetary to enrollees, this description could include the following statements: The Cash or Monetary Rebates represent "savings the plan achieves compared to Original/FFS Medicare" or "an alternative benefit instead of coverage of additional healthcare services and items that are not covered under Medicare, like vision and dental."

Participating MAOs must have a protocol in place to monitor and track all cash or monetary rebates issued to guard against potential abuse. CMS will review and approve marketing materials and monitor implementation of this benefit to ensure the appropriate marketing and provision of the cash or monetary rebates to enrollees.

MAOs participating in the Cash or Monetary Rebates Component of the Model are required to communicate the availability of this benefit to all enrollees in the applicable PBPs. Therefore, prior to their use, MAOs must submit to CMS for review and approval all marketing materials regarding Cash or Monetary Rebates to enrollees consistent with the requirements discussed in Sections 1 and 2 of these VBID Model Communications and Marketing Guidelines. Communications regarding the Cash or Monetary Rebates Component to all enrollees in the PBP must include, at a minimum, information about the following:

- the form (e.g., check, debit card, etc.), amount, and frequency of the Cash or Monetary Rebates available to enrollees;
- the process for enrollees to opt-out of receiving the Cash or Monetary Rebates, which must be consistent with Article 3.F.8 of the Addendum; and
- a notice of the potential tax consequences associated with the provision of Cash or Monetary Rebates. This notice must be provided to the enrollee prior to the provision of the actual Cash or Monetary Rebate and no later than the January 1, 2021.

In addition, during the Plan Year, the participating MAOs in the Cash or Monetary Rebates Component of the Model must provide timely updated income reporting (e.g., 1099-MISC) for enrollees receiving Cash or Monetary Rebate consistent with applicable local, state, and federal law.

3 Additional Requirements for Communications Regarding the Hospice Benefit Component

This Section discusses additional requirements that MAOs offering the Hospice Benefit Component must comply with in communicating about this benefit to providers.

3.1 Communications with Network and Non-Network Providers

In addition to communications with enrollees, participating MAOs should inform members of their provider network about the MAO's VBID Model participation if notification could enhance/ increase beneficiary engagement in the VBID Model, and may communicate, consistent with applicable law, specific enrollees' eligibility status (i.e., the MAO may identify Targeted Enrollees) once the provider network is established. This MAO communication with network providers includes, in particular, specialists essential to the specific Model Benefits offered (e.g., specialists involved in delivery of any transitional concurrent care services as part of a participating MAO offering the Hospice Benefit Component) and the primary care providers and palliative care providers of enrollees with serious illness.

In addition to communications with network providers, participating MAOs may also inform out-of-network hospice providers within their service area of the MAO's participation in the Hospice Benefit Component of the VBID Model and CMS strongly encourages participating MAOs to do so. Participating MAOs may also inform other providers if such notification of the MAO's participation could enhance/increase beneficiary engagement and/or improve care coordination.

3.2 Provider Directories & Network-Related Communications

Participating MAOs offering the Hospice Benefit Component must provide directory information identifying in-network hospice providers. This directory may be a full provider network directory in which the hospice 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 in-network hospice providers and their locations. Directories should include hospice provider information in accordance with the Medicare Managed Care Manual, Chapter 4, Section 110.2, as well as applicable year Model Materials, including provider addresses and phone numbers.

Directories listing in-network hospice providers must include language stating that enrollees have the option to receive services from an out-of-network hospice provider that is willing to provide treatment. Limitations on coverage of services from out-of-network hospice providers, as proposed by the participating MAO and approved by CMS as described in 2.E. of Appendix 3 of the

Addendum, should be listed as well, if applicable.[8] Participating MAOs offering the Hospice Benefit Component may consider adding contact information in such directories for resources assisting enrollees with serious illness or their caregivers; for example, this may include contact information for the participating MAO's high-touch care manager program associated with the Hospice Benefit Component. Participating MAOs may request approval from CMS to use alternative means of satisfying this network directory requirement for hospice provider networks.

If a participating MAO makes any changes to its network of hospice providers in CY 2021, such changes must be reflected in the provider directory or distinct supplemental document (akin to a sub-network directory or specialty directory) within 30 days of that change. For additional guidance regarding enrollee notification of network changes, please see the Medicare Managed Care Manual Chapter 4, Section 110.1.2.3.

4 Requirements for Informing Enrollees about Model Rewards

This Section sets out additional requirements that MAOs offering Model Rewards must comply with in communicating information about Model rewards to Eligible Enrollees and potential enrollees, and marketing the existence of Model Rewards and RI Programs to potential enrollees.

Beginning in CY 2020, and continuing in CY 2021, participating MAOs may offer both Part C and Part D Rewards and Incentives, collectively referred to as "Model Rewards," consistent with the terms of the Model and the Addendum. Model Rewards are not Medicare benefits and are not to be treated as benefits. MAOs may use different approaches to communicating with Eligible Enrollees and potential enrollees about Model Rewards. First, while Model Rewards are not benefits and may not be listed in the EOC or ANOC, MAOs must communicate the availability of these Model Rewards and Incentives to Eligible Enrollees in order to ensure that Eligible Enrollees have complete information and are given sufficient information to understand the available Model Rewards. Moreover, MAOs must answer questions about the rewards program and must include information about the Model Reward Program in the educational information sent to enrollees and made available to potential enrollees.

MAOs may market the existence of Model Rewards and RI Programs 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's MCMG and updates, MAOs may include information about Model Rewards in marketing materials for potential enrollees. Marketing of Model Rewards and RI Programs must:

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

[8] This should be aligned with the network language included in the enrollee's CY 2021 ANOC, as described in section II of the CY 2021 VBID Hospice Benefit Component EOC and ANOC Instructions.

Refer to Section 100, Chapter 4 (Benefits and Beneficiary Protections) of the Medicare Managed Care Manual for additional guidance on rewards and incentives. Importantly, reward and/or incentive "items" may not be offered to potential enrollees under any circumstances. Nominal gifts as part of promotional activities are separate and distinct from Model Rewards.

In addition to these requirements, participating MAOs should adopt a communications strategy, that clearly describes to both Eligible Enrollees and prospective enrollees the Model Rewards and programs available. 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 Model Rewards marketing material to CMS for CMS review and approval. 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, Model Rewards 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).

Participating MAOs are encouraged to craft Model Rewards communication in a way that will effectively engage Eligible Enrollees and communicate consistent with the communication principles described in Section 2 above, which must be designed to outline all of the Model Rewards available to potential and Eligible Enrollees. Such communications must be designed to minimize confusion where possible, including emphasizing that Model Rewards are not benefits.

Appendix 1: Member Engagement Strategy Template

1. Please outline how you will implement a communications strategy in CY 2021 to promote enrollee understanding of Model Benefits and/or Model Rewards. Please specify the mechanisms and materials you will use to engage enrollees who are eligible for Model Benefits and/or Model Rewards.

Appendix 2: Corrections to the Instructions for CY 2021 EOC and ANOC for MAOs Participating in the Hospice Benefit Component and CY 2021 VBID Model EOC

What follows are July 2020 corrections to the Instructions for CY 2021 EOC and ANOC for MAOs Participating in the Hospice Benefit Component of the VBID Model and CY 2021 VBID Model EOC that were posted in June 2020 and are located here:
https://www.cms.gov/files/zip/2021modelmaterials.zip

Corrections to the Instructions for CY 2021 EOC and ANOC for MAOs Participating in the Hospice Benefit Component of the VBID Model:

Issue Summary: Clarification for model language related to the Hospice Section of the Medical Benefit Chart
Issue location: Instructions for the Calendar Year 2021 Evidence of Coverage and Annual Notice of Change for Medicare Advantage Organizations Participating in the Hospice Benefit Component of the Value-Based Insurance Design Model, Section 1. Instructions to Participating Plans Regarding the EOC
Action required: Within Section 2.1 of Chapter 4 of the EOC, participating plans should update the section on hospice care within the Medical Benefits Chart to make clear that hospice services and Part A and Part B services related to terminal prognosis are paid by the participating plan. If CMS has reviewed and approved any network provider limitations to ensure beneficiary safety, please indicate in the Medical Benefits Chart as indicated in the below example.

You may receive care from any Medicare-certified hospice program, except providers limited from plan payment to ensure beneficiary safety. These providers are listed in your plan's provider directory.

Issue Summary: Incorrect model language in Table 1 under "Hospice Care (continued)"
Issue location: Instructions for the Calendar Year 2021 Evidence of Coverage and Annual Notice of Change for Medicare Advantage Organizations Participating in the Hospice Benefit Component of the Value-Based Insurance Design Model, Section 1, Table 1
Action required: Add or delete text in navy to the section under "Hospice Care" in the Table indicated below.

For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network:
If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services
If you obtain the covered services from an out-of-network provider, you pay ~~the~~ cost-sharing ~~under Fee-for-Service Medicare (Original Medicare)~~ according to the plan's rules described in Chapter 3, Section 1.2, "Basic rules for getting your medical care covered by the plan."

Issue Summary: Incorrect guidance regarding Provider Directory for plans participating in the Hospice Benefit Component
Issue location: Instructions for the Calendar Year 2021 Evidence of Coverage and Annual Notice of Change for Medicare Advantage Organizations Participating in the Hospice Benefit Component of the Value-Based Insurance Design Model, Section 2, "Section 2.3 of the ANOC"
Action required: Add or delete text in navy as indicated below.

Additionally, ~~either~~ within ~~its provider directory or~~ its ANOC, participating plans may include which hospice providers, if any, that the participating plan has limitations on, from exclusion in-network or out-of-network. These provider limitations must also be listed in the Provider Directory. These hospice network provider limitations to ensure beneficiary safety must be approved by the CMS Innovation Center.

CY 2021 VBID Model EOC Corrections:

Issue Summary: Incorrect model language in Value Based Insurance Design (VBID) Model benefits language instructions for all plan types except for PFFS, Cost, MSAs and PDPs.
Issue location: Instructions for the Calendar Year 2021 Evidence of Coverage Chapter 4, Section 2.1, Participating Plans for the benefits instructions listed below:
Action required: Within Section 2.1 of Chapter 4 of the EOC, participating plans should update the instructions in the sections where they are offering VBID benefits. Add or delete text as indicated in navy font below.

[Instructions to plans offering MA Uniformity Flexibility benefits or Value-Based Insurance Design (VBID) Model benefits:

> *Plans ~~must~~ may deliver to each clinically-targeted enrollee a written summary of those ~~benefits~~ or its different strategy for communicating information regarding Model benefits so that such enrollees are notified of the ~~MA Uniformity Flexibility or~~ VBID benefits for which they are eligible. VBID plans should follow the VBID Addendum and this guidance for delivering ~~such notice~~ a written summary when offering targeted supplemental or VBID benefits. (See CY 2021 Value-Based Insurance Design Communications and Marketing Guidelines).*

[Instructions to plans offering WHP benefits:

> *In addition to offering advance care planning as a covered benefit, plans participating in the VBID Model ~~must~~ may deliver to each VBID PBP enrollee a written summary of WHP benefits ~~or its different strategy for communicating information regarding Model 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 or its different strategy for communicating information regarding Model Benefits~~ a written summary when offering WHP benefits (See CY 2021 Value-Based Insurance Design Communications and Marketing Guidelines).*

[*Insert if offering VBID flexibility benefits and 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.
- *[If applicable, plans offering benefits under VBID that require participation in a health and wellness program, must direct the enrollee to see the ~~"Notice of VBID Benefits," or the plan's different strategy for communicating information~~ written summary regarding Model Benefits (See CY 2021 Value-Based Insurance Design Communications and Marketing Guidelines).]*
- Please go to the Medical Benefits Chart in Chapter 4 for further detail.

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

Plans ~~must~~ may deliver to each LIS-targeted enrollee a written summary of those benefits ~~or its different strategy for communicating information regarding Model Benefits~~ so that such enrollees are notified of VBID benefits for which they are eligible. VBID plans must follow the VBID guidance on communications for delivering such ~~notice~~ a written summary when offering targeted supplemental or VBID benefits. (See CY 2021 Value-Based Insurance Design Communications and Marketing Guidelines).

[Instructions to plans offering Cash or Monetary Rebates as a mandatory supplemental benefit:

Plans must deliver to each VBID PBP's enrollee a written summary of cash or monetary rebate benefits ~~or its different strategy for communicating information regarding Model Benefits~~ so that such enrollees are notified of the benefits for which they are eligible. Plans must also include an explicit notice that addresses any potential tax implications for the enrollee, including the combined impact or consequences of the Cash or Monetary Rebate and any Rewards and Incentives (if applicable). VBID plans must follow the Addendum and this guidance for delivering ~~such Notice of Model Benefits or its different strategy for communicating information regarding Model Benefits~~ a written summary when offering Cash or Monetary Rebate benefits. (See CY 2021 Value-Based Insurance Design Communications and Marketing Guidelines).]

[Instructions to plans offering Coverage of New and Existing Technologies or FDA approved Medical Devices as a mandatory supplemental benefit:

Plans ~~must~~ may deliver to each VBID PBP's enrollee a written summary of coverage of new and existing technologies or FDA-approved medical devices ~~through its notice of benefits or its different strategy for communicating information regarding Model 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 or its different strategy for communicating information regarding Model Benefits~~ a written summary when offering coverage of new and existing technologies or FDA-approved medical devices (See CY 2021 Value-Based Insurance Design Communications and Marketing Guidelines).]