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

Value-Based Insurance Design Model
Calendar Year 2022

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.

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Background and General Information

Through the Value-Based Insurance Design (VBID) Model, CMS is testing a broad array of complementary Medicare Advantage (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 VBID Model for Calendar Year (CY) 2022 consists of the following Model components:

1. Wellness and Health Care Planning (WHP) (required for all participating Model plan benefit packages (PBPs));
2. VBID flexibilities, for Model PBPs' select enrollees targeted by condition, socioeconomic status or a combination of both, for offering:
   a. Primarily and non-primarily health related supplemental benefits, which may include new and existing technologies or FDA-approved medical devices as a mandatory supplemental benefit;
   b. Use of high-value providers and/or participation in care management program(s)/ disease state management program(s); or
   c. Reductions in cost-sharing for Part C items and services and covered Part D drugs;
3. Flexibility to share beneficiary rebates savings more directly with enrollees in the form of cash or monetary rebates (herein referred to as "Cash or Monetary Rebates")[1]
4. Part C and Part D Rewards and Incentives (RI) Programs (herein referred to as "Model Rewards"); and the
5. Hospice Benefit Component.

Overall, the VBID Model tests whether these Model components improve health outcomes and lower expenditures. If approved by CMS, participating MA Organizations (MAOs) are required to offer WHP and permitted to offer any of the Model components listed as items 2 through 5 above to enrollees. As used in this document, the term "Model Benefits" means the items and services offered to enrollees (or to Targeted Enrollees[2] if there are limits on eligibility) in the Model components listed as items 1 through 3 and 5 above.

This document outlines the communications and marketing requirements for MAOs participating in the VBID Model. Participating MAOs must adhere to these guidelines pursuant to the CY 2022 Addendum to the Medicare Managed Care Contract for Participation in the MA VBID Model

[1] Cash or Monetary Rebates is addressed specifically in Section 6 of this document.
[2] "Targeted Enrollee" means a Medicare beneficiary who is enrolled in one of the MAO's VBID PBPs participating in the Model and targeted by the MAO to receive one or more VBID Components, except for the Cash or Monetary Rebates Component, WHP, and the Hospice Benefit Component. All enrollees in the VBID PBP participating in the Cash or Monetary Rebates Component and the Hospice Benefit Component are eligible for those Model Benefits but the participating MAO may also target enrollees for specific supplemental hospice benefits (Targeted Hospice Enrollees).

(Addendum).[3] MAOs that participate(d) in the Model in CY 2021 must adhere to these guidelines for any newly submitted 2021 Model communications and marketing materials, effective July 1, 2021.[4] In addition to the requirements in this document, participating MAOs should review the Addendum and applicable regulations. Specifically, all MA communications 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 and Part D (for MA Prescription Drug (MA-PD) plans) regulations at 42 CFR Parts 422 and 423 and Subparts V. 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 Model Communications and Marketing Guidelines. The marketing and engagement strategies discussed in these guidelines for 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 Model Benefits and Model Rewards.

Below, CMS provides an overview of this document:

- Section 1 discusses the requirements that MAOs must follow in communicating Model Benefits to enrollees and provides general timelines for informing enrollees, both current and new, of those Model Benefits. Model Benefits mean any or each of the following: (i) WHP Services as defined in the Addendum; (ii) Any additional supplemental benefits offered by the MAO pursuant to Article 3 of the Addendum;[5] and the (iii) Hospice Benefit Component pursuant to Appendix 3 of the Addendum.

- Section 2 outlines additional requirements for MAOs offering Cash or Monetary Rebates in communicating and marketing this Model Benefit to enrollees and potential enrollees.

- Section 3 follows with additional requirements that MAOs offering the Hospice Benefit Component must follow in communicating this benefit to providers and in communicating and/or marketing this benefit to enrollees and potential enrollees.

- Section 4 discusses additional requirements that MAOs offering Model Rewards must follow in communicating RI Programs to enrollees and marketing the existence of Model Rewards and RI Programs. Model Rewards refers to Model Rewards offered as part of implementing a VBID Model Approved Proposal; Model Rewards are not Model Benefits. Of note, the principles outlined in Section 1 are also applicable to communicating Model Rewards to enrollees and potential enrollees.

[3] Capitalized terms not otherwise defined in these Model Communications and Marketing Guidelines have the meaning provided in the current Addendum.
[4] Operational updates, i.e., HPMS submission mechanisms, are effective immediately.
[5] See Addendum, Article 3.D and 3.F.

- Appendix 1 includes instructions, a template and an illustrative example for the VBID Member Engagement Strategy (required by all participating MAOs), first described in Section 1.1.

- Appendix 2 concludes with corrections to the CY 2022 Model Materials (specifically, the standardized models for the Evidence of Coverage (EOC) and an Annual Notice of Change (ANOC)) that CMS released in June 2021, which can be found: https://www.cms.gov/files/zip/cy-2022-model-materials.zip.

1 Communications Requirements & Timeline

1.1 Summary of Requirements in the Model Communications and Marketing Guidelines Requirements

In Section 1.1, CMS outlines the requirements detailed in subsequent sections of the Model Communications and Marketing Guidelines.

1. **MAOs must submit to CMS a description of how they will inform and engage enrollees about the Model Benefits and/or Model Rewards that will be available (herein referred to as the "VBID Member Engagement Strategy").** One of the keys to successful interventions offered through Model Benefits and/or using Model Rewards is achieving enrollee awareness, engagement, and activation. As such, CMS is interested in understanding how participating MAOs will ensure enrollees have a clear understanding of Model Benefits and Model Rewards they are eligible for (including how to access them), and the specific strategies and processes MAOs will use to engage and activate eligible enrollees and/or Targeted Enrollees. The goal of the VBID Member Engagement Strategy is to ensure each enrollee understands the Model Benefits and/or Model Rewards that he or she may be eligible for and how to access them and for CMS to understand how Model Benefits and Model Rewards are being communicated to enrollees.

   Please see Appendix 1 for further instructions, a template, and an illustrative example of the VBID Member Engagement Strategy. 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.

   Note: CMS is also particularly interested in any strategies that MAOs may be using to reach underserved populations with health equity concerns and who may require different types of approaches and/or culturally competent communications and outreach in order to fully engage in the Model Benefits and/or Model Rewards for which they are eligible.

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

   a. **An EOC and an ANOC must include the Model Benefits that will be offered to enrollees:**
   In their 2022 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 2022 or MAOs that are continuing, but have changes to VBID Model Benefits must also include the VBID Model Benefits in the ANOC for existing enrollees. This includes changes in benefits due to a PBP not

being offered in CY 2022 or not participating in the Model in CY 2022. These changes must be communicated to eligible enrollees in the ANOC in accordance with the MA Program ANOC deadline. CMS includes Model-specific language in the CY 2022 standardized models for the EOC and ANOC, which can be found here: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.

For CY 2022, MAOs offering the Hospice Benefit Component and/or Cash or Monetary Rebates must submit excerpts from their EOC and ANOC inclusive of these Model Benefit descriptions for CMS pre-review and approval prior to submission of the entire EOC and ANOC in HPMS. These drafts may be submitted on a rolling basis but must be submitted by no later than **July 16, 2021** to the VBID Model Communications and Marketing Mailbox at MAVBIDhelpdesk@acumenllc.com, with the email subject heading "[PO] EOC/ANOC VBID Model Excerpt" where [PO] is the name of the parent organization. CMS will provide approval or feedback by July 31, 2021.

b. MAOs offering Cash or Monetary Rebates must provide additional communications regarding Cash or Monetary Rebates to enrollees in both communications and marketing materials for CMS approval and review:
In addition to the ANOC (if there are changes from 2021 to 2022) and EOC, MAOs must inform and engage all enrollees in the applicable VBID PBP about Cash or Monetary Rebates. The required information includes: how the MAO will distribute the Cash or Monetary Rebates; amount of the rebate; availability of any other applicable Model Benefits over the course of the year; how remaining balances at the end of the Plan Year will be handled; the expiration date clearly indicated on either the check or debit card; who enrollees should contact if they have questions; and a notice of potential tax implications and a notice of impacts on beneficiary income and resource determinations that includes a plan phone number (*see Section 2 for additional, specific requirements*). The notice of impacts on beneficiary income and resource determinations may, at CMS' direction, be sent to only a subset of enrollees receiving Cash or Monetary Rebates. The Addendum, at At. III.F.7, provides that a notice of potential tax implications is not required subject to CMS approval if a tax authority has ruled, prior to October 1, 2021, that there is no tax liability for enrollees eligible to receive Cash or Monetary Rebates from the MAO but that a phone number must still be provided for enrollees to obtain additional information on tax consequences. For MAOs that are not required to provide a notice of potential tax consequences, the notice of impacts on beneficiary income and resource determinations is still required.

c. MAOs participating in the Hospice Benefit Component must provide additional communications about this Model Benefit to both in-network and out-of-network

Hospice Providers. [6] Additionally, participating MAOs must provide directory information identifying in-network Hospice Providers to their enrollees *(see Section 3 for additional, specific requirements*).

d. MAOs offering Model Rewards must communicate information about Model Rewards to 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 enrollees have complete and sufficient information to understand the available Model Rewards (*see Section 4 for additional, specific requirements*).

e. As applicable, MAOs must provide additional communications related to other VBID Model-specific materials:
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; and a 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; please note that the aforementioned materials are not applicable to the Hospice Benefit Component.

MAOs may also tailor other communications materials required by the MA program (see 42 CFR 422.2260), including all pre-enrollment material and scripts, for use in the Model.

3. **In addition to the requirements above, an MAO has the option to engage enrollees and to inform them about Model Benefits and/or Model Rewards through additional communications materials**. These additional communications to enrollees regarding Model Benefits and Model Rewards 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 2022 relative to previously provided high-value provider directories, the participating MAO must provide written notice to all Targeted Enrollees of the updated high-value provider directory (*see Section 3 for provider directory requirements for MAOs participating in the Hospice Benefit Component*).

1.2 Communications Principles and Naming of Model Benefit Packages for Enrollees

Generally, participating MAOs' communications of Model Benefits and Model Rewards must be designed to outline all of the benefits available to enrollees and Targeted Enrollees. Consistent with language in § 422.2262(a)(1)(iii), which prohibits MAOs from engaging in activities that

[6] "Hospice Provider" means a public agency or private organization or subdivision of either of these that is primarily engaged in providing Hospice Care in accordance with 42 CFR 418.3; the MAO may only provide hospice services through a Hospice Provider that has a participation agreement with Medicare and meets the applicable requirements of title XVIII and part A of title XI of the Social Security Act, in accordance with 42 CFR 422.204(b)(3).

could mislead or confuse Medicare beneficiaries, or misrepresent the MAO, VBID Model participants must minimize confusion and promote clarity where possible in their materials.

In instances in which the communications or marketing material is meant for distinct enrollees (e.g., materials about Model Benefits that are limited to Targeted Enrollees), and the MAO chooses to communicate these to enrollees through materials in addition to the EOC and ANOC, participating MAOs should limit any potential confusion of non-enrollees by targeting communications clearly to applicable groups of enrollees and developing scripts for inquiries to address confusion of any enrollee. Participating MAOs must not selectively identify subgroups of enrollees for any marketing or communications related to Model Benefits in any way that discriminates among 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 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 enrollees.

All communications 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.[7]

A participating MAO should adopt a communications approach, including all naming, that clearly outlines:

- the Model Benefits available to enrollees (or, in the case of WHP Services to all enrollees as applicable);
- the scope of Model Benefits for each Model component in which the MAO is participating for that VBID PBP;
- what must be done to receive the Model Benefits (as applicable); and
- where and how to ask questions or receive help on understanding the Model Benefits.

A participating MAO's communications approach should ultimately serve to engage enrollees eligible for Model 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 Model components are able to understand the relationship between the EOC and ANOC and any subsequent communications and/or marketing.

[7] *See also* 42 CFR §§ 422.2262(a)(1) and 423.2262(a)(1) (prohibiting MAOs from providing inaccurate or misleading information, engaging in activities that could mislead or confuse beneficiaries, misrepresenting the MAO, and making unsubstantiated statements).

1.3 Process for MAO Submission of Materials and CMS Review

As summarized in Table 1 in Section 1.9, to facilitate the review and approval of specific VBID Model-related materials, participating MAOs must submit their materials as follows:

- **VBID Member Engagement Strategy:** Plans must submit the VBID Member Engagement Strategy in the Health Plan Management System (HPMS) Marketing Module under the material type, "VBID-Member Engagement Strategy," which is a "Required" submission type.

- **Certain Communications and Marketing Materials Requiring Prospective Review:** Plans must submit for CMS review and approval ***all*** communications and marketing materials (including excerpts of the relevant sections of the EOC and ANOC) related to Cash or Monetary Rebates and the Hospice Benefit Component to the VBID Model Communications and Marketing Mailbox at MAVBIDhelpdesk@acumenllc.com, with subject heading "[PO] [Cash/Rebate or Hospice] communication submission for review." Once approved, with the exception of the excerpt of the relevant sections of the EOC and ANOC related to Cash or Monetary Rebates and the Hospice Benefit Component, plans must submit these materials within the HPMS Marketing Module. Communication materials must be submitted as a "Communications with VBID Content" material type, which is within the "Required" submission type. Marketing materials must be submitted as "VBID" content type, which is within the "Plan Created" submission type. Again, these materials are subject to prospective review, and participating MAOs may not use or distribute such materials to enrollees or potential enrollees until these materials have been submitted to first, the VBID Model Communications and Marketing Mailbox for a CMS review for compliance with the Model requirements, approval, and then, HPMS for final approval.

- **Other Communication and Marketing Materials:** Plans must submit through the HPMS Marketing Module for CMS review and approval all other communications and marketing materials specific to Model Benefits (outside those materials noted above) and Model Rewards (as defined and described in Section 5 below), including all pre-enrollment materials and scripts. Communication materials must be submitted as a "Communications with VBID Content" material type, which is within the "Required" submission type. Marketing materials should be submitted as "VBID" content type, which is within the "Plan Created" submission type. These materials also include 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; and 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.

  In accordance with 42 CFR §§ 422.2261(b)(3) and 423.2261(b)(3), materials submitted under this category may be distributed at least five (5) calendar days after submission to CMS for review and certification to CMS that the materials comply with all applicable standards in applicable regulations and these Model Communications and Marketing Guidelines, provided that CMS has not denied permission to use the material(s) in that 5-day window. If the requirements of § 422.2261(b)(3) are not met (including if CMS specifically identifies the

specific material or category of material as requiring additional review), the MAO may only use and distribute the material in accordance with § 422.2261(b)(1) and (b)(2). Further, an MAO must cease use of materials if CMS directs that the MAO stop use of the material(s) at a later point in time.

All other CMS requirements relating to the review of marketing materials under 42 CFR Part 422 and Part 423 (for Part D materials for MA-PDs), subparts V, continue to apply to the MAO and apply to the VBID-related communications (including marketing). Therefore, to the extent other CMS-required materials contain VBID Model-related content but are not specifically identified in this Section, that material must be submitted to HPMS as required under the MA program, and use categories appropriate to the type of material submitted. For example, the EOC must be selected as the material type and submitted to HPMS under "Required" submission type, and the ANOC must be selected as the material type and submitted to HPMS under the "Required" submission type.

CMS may, at any time, require that a participating MAO modify or cease use of VBID Model-related materials, including those previously approved.

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 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 covered benefits that are not VBID Model Benefits, but EOBs must accurately reflect the Model Benefits provided to 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. See 42 CFR 422.111(k) for requirements for EOBs.

  Note: For MAOs with participating PBPs offering Cash or Monetary Rebates or 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.**[8]
  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 enrollees, including instructions for rescission of the opt-out to the 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 a participating MAO offers Model Benefits that are offered or structured in a manner that opting-out is not necessary, and therefore would have no reason to send an acknowledgement of an opt-out, that participating MAO may a request an exception from this requirement by submitting a request and explanation for exception to the VBID mailbox at VBID@cms.hhs.gov, for CMS approval. Requests for

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

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 to utilize the benefit;

- **Notice of acknowledgment of a rescission of an opt-out from Model Benefits.**[9] 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 enrollees;

- **Notice of determination that an enrollee no longer qualifies for Model Benefits.** The notice must include the rationale underlying such a determination. A notice of determination that an enrollee no longer qualifies for Model Benefits is not required if an enrollee disenrolls from the plan. 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 CFR Parts 422 & 423, subparts M and associated guidance available at: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG), including content requirements in 42 CFR §§ 422.568 and 423.568; and

- **Notice of a determination that enrollees are not participating in case management and, therefore, are not eligible for Model Benefits, as applicable.** 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 CFR Parts 422 & 423, subparts M and associated guidance), including content requirements in 42 CFR 422.568.

Each of the written communications listed here 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 enrollees detailed in this guidance represent the minimum required of participating MAOs. However, participating MAOs may go beyond this and communicate further with enrollees regarding Model Benefits and Model Rewards so long as those communications are subject to CMS review and approval. Examples of further communications with enrollees that participating MAOs might use include: (a) regular (quarterly or monthly) follow-up mailings, reminding enrollees of the potential advantages available to them as the result of participating in Model Benefits; (b) follow-up phone calls with enrollees; and (c) targeted phone calls or mailings, based on specific clinical or treatment patterns of a given enrollees. For instance,

[9] id.

a participating MAO might remind enrollees when granting that enrollee prior approval for a service that s/he is eligible for reduced cost-sharing 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, including in 42 CFR §§ 422.111 and 423.128, with regard to provider and pharmacy directories;[10] additional guidance is also available in the Medicare Managed Care Manual, Chapter 4. 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. Participating MAOs may use 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. Enrollees who are eligible for reduced cost sharing for using high-value providers[11] must be provided the supplemental directory if that is how the participation MAO identifies high-value providers. Participating MAOs may request approval from CMS 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 or 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 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 2022 relative to previously provided directories, the participating MAO must provide written notice to all 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 enrollees, provided the requirements in this guidance and in the MA and Part D marketing and communication regulations (e.g., 42 CFR §§ 422.111, 422.2260 through 422.2276, 423.128 and 423.2260 through 423.2276) are met. Websites may supplement, but not replace, the written communications required to be provided by participating MAOs in the Model except where the MAO is permitted to use website information as a form of electronic delivery of required materials by 42 CFR 422.2267(d).

[10] See also 42 CFR 422.120 regarding the Provider Directory API requirement.
[11] See Addendum, Article 3.D.3.

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

Participating MAOs must make VBID Model communications and marketing materials, including those identified in the MAO's VBID 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 and/or Model Rewards are offered. 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 enrollee or potential enrollee with limited English proficiency (LEP) who is eligible or potentially eligible for a Model Benefit or Model Reward. 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 or Model Rewards 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 and Model Rewards. Participating MAOs must use a toll-free TTY number that must appear in conjunction with the customer service number in the same font size as the other phone numbers, except as outlined below. Plans/Part D sponsors may use their own TTY number, 711 for Telecommunications Relay Service, or state relay services, as long as the number is accessible from TTY equipment.

Exceptions to this TTY requirement include the following materials in accordance with 42 CFR § 422.2262(c)(2):

- Outdoor advertising (ODA) or banner/banner-like ads; and
- Radio advertisements and radio sponsorships (e.g., sponsoring an hour of public radio).

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 in Table 1 are general timelines for informing enrollees, both current and new, of Model Benefits and Model Rewards. Table 1 distinguishes between VBID Model communications materials that are subject to prospective or 5 (five) Calendar Day File & Use review and provides timelines for submission. See 42 CFR § 422.2261 for requirements related to CMS review and approval of materials.

Table 1: VBID Model Communications & Marketing Timeline

Material	Type of Review *(Calendar Days)*	Timeline to Submit to CMS	Submission Mechanism
VBID Member Engagement Strategy	**Prospective** CMS review & approval *(45 Days)*	September 21 – October 19, 2021	Submit directly to HPMS via "VBID-Member Engagement Strategy" material type under "Required" submission type
EOC/ANOC Excerpts of Hospice Benefit Component and/or Cash or Monetary Rebates Language Only	**Pre-review by CMS before HPMS Submission of the EOC/ANOC** *(CMS intends to complete its review of these specific materials within a 10-day timeframe but no later than July 31, 2021.)*	By no later than July 16, 2021	Submit to (1) VBID Communications and Marketing Mailbox for CMMI review and approval with the subject heading "[PO]: EOC/ANOC VBID Model Excerpt" *then* (2) *once approved by CMMI,* include as part of EOC and ANOC HPMS submission (*see row below*)
EOC/ANOC *(which includes VBID Model Benefits but cannot include Model Rewards)*	**File & Use** (if the conditions have been met under 42 CFR § 422.2261(b)(3)) and the MAO certifies compliance *(5 Days)*	See CMS regulations and guidance on HPMS submission timing for additional instructions. Resubmission using the VBID HPMS subcategories is not necessary.	
Model Benefit and Model Reward Communications *(except for EOC and communications materials related to Cash or Monetary Rebates and the Hospice Benefit Component)*	**File & Use** if the conditions have been met under 42 CFR § 422.2261(b)(3) and the MAO certifies compliance* *(5 Days)*	Rolling Basis	Submit directly within HPMS via "Communications with VBID Content" material type under "Required" submission type
Model Benefit and Model Reward Marketing *(except for ANOC and marketing materials related to Cash or Monetary Rebates and the Hospice Benefit Component)*	**File & Use** if the conditions have been met under 42 CFR § 422.2261(b)(3) and the MAO certifies compliance* *(5 Days)*	Rolling Basis	Submit directly within HPMS via "VBID" content type under "Plan Created" submission type
Hospice Benefit Component Communications *(outside of EOC)*	**Prospective** CMS review & approval *(42 CFR § 422.2261(b)(1) & (2)) (Total 45 Days)*	Rolling Basis	Submit to (1) VBID Communications and Marketing Mailbox for CMMI review and approval with the subject heading "[PO]: [Cash/Rebate or Hospice] communication submission for review and approval" *then* (2) *once approved by CMMI,* submit within HPMS via "Communications with VBID Content" material type under "Required" submission type***
Hospice Benefit Component Marketing *(outside of ANOC)*	**Prospective** CMS review & approval *(42 CFR § 422.2261(b)(1) & (2)) (Total 45 Days)*	Rolling Basis	Submit to (1) VBID Communications and Marketing Mailbox for CMMI review and approval with the subject heading "[PO]: [Cash/Rebate or Hospice] communication submission for review and approval" *then* (2) *once approved by CMMI,* submit within HPMS via "VBID" content type under "Plan Created" submission type***

Material	Type of Review *(Calendar Days)*	Timeline to Submit to CMS	Submission Mechanism
Cash or Monetary Rebates Communications *(outside of EOC)***	**Prospective** CMS review & approval *(42 CFR § 422.2261(b)(1) & (2)) (Total 45 Days)*	Rolling Basis	Submit to (1) VBID Communications and Marketing Mailbox for CMMI review and approval with the subject heading "[PO]: [Cash/Rebate or Hospice] communication submission for review and approval" *then* (2) *once approved by CMMI,* submit within HPMS via "Communications with VBID Content" material type under "Required" submission type***
Cash or Monetary Rebates Marketing *(outside of ANOC)***	**Prospective** CMS review & approval *(42 CFR § 422.2261(b)(1)) (Total 45 Days)*	Rolling Basis	Submit to (1) VBID Communications and Marketing Mailbox for CMMI review and approval with the subject heading "[PO]: [Cash/Rebate or Hospice] communication submission for review and approval" *then* (2) *once approved by CMMI,* submit within HPMS via "VBID" content type under "Plan Created" submission type***
Cash or Monetary Rebates Notice of Potential Impacts on Beneficiary Income and Resource Determinations *(note: CMS may direct that this notice shall only be sent to a subset of enrollees)*	**Prospective** CMS review & approval (CMS intends to complete its review of these materials within a 5 business day timeframe)	No later than 5 days after CMS sends the required text of the notice to the Participating MAOs; or, for beneficiaries who subsequently enroll, within five days of enrollment	Submit to (1) VBID Communications and Marketing Mailbox for CMMI review and approval with the subject heading "[PO]: Cash or Monetary Rebate Notice of Potential Impacts on Beneficiary Income and Resource Determinations" *then* (2) *once approved by CMMI,* submit within HPMS via "Communications with VBID Content" material type under "Required" submission type ***
Cash or Monetary Rebates Updated Information Regarding Potential Tax Consequences *(note: CMS may direct that this notice shall only be sent to a subset of enrollees)*	**Prospective** CMS review & approval (CMS intends to complete its review of these materials within a 5 business day timeframe)	No later than 5 days after the MAO receives updated information regarding potential tax consequences	Submit to (1) VBID Communications and Marketing Mailbox for CMMI review and approval with the subject heading "[PO]: Cash or Monetary Rebate Notice of Updated Information Regarding Potential Tax Consequences" *then* (2) *once approved by CMMI,* submit within HPMS via "Communications with VBID Content" material type under "Required" submission type ***

* If the conditions of § 422.2261(b)(3) are not met (such as for content included in sales presentations), 45-day prospective review will apply, except for CMS model or standardized marketing materials as outlined in §422.2267(e). For CMS model or standardized marketing materials as outlined in §422.2267(e), § 422.2261(b)(2) will apply.

** For Cash or Monetary Rebates Communications and Marketing, CMS intends to complete its review within twenty days of MAOs submitting these materials to the VBID Communications and Marketing Mailbox for MAOs seeking to have materials ready by or during Annual Enrollment Period (AEP) and on a 45-day prospective

basis for MAOs seeking approval for other materials (regarding the Cash and Monetary Rebates) for use after AEP ends on December 7, 2021. MAOs are encouraged to submit materials as soon as possible as delays may occur.
*** If submitting a sales presentation containing content on Cash or Monetary Rebates or the Hospice Benefit Component, please submit concurrently to HPMS and the VBID Communications and Marketing Mailbox for CMMI review and approval.

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 and marketing this Model Benefit to all enrollees in applicable PBP(s). Beginning in CY 2021, MAOs participating in the VBID Model have had the additional flexibility to choose to furnish, in the form of Cash or Monetary Rebates, the beneficiary rebates required under Section 1854 of the Social Security Act with all of their enrollees in an approved Model PBP through a new mandatory supplemental benefit. Marketing and communication materials for Cash or Monetary Rebates 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 any discriminatory manner. The MAO must provide and market Cash or Monetary Rebates in accordance with the anti-discrimination provisions of Section 1852(b)(1) of the Act, 42 CFR § 422.110, all other applicable federal and state anti-discrimination laws, Article 3 of the Contract Addendum, and these Model Communications and Marketing Guidelines. Cash or Monetary Rebates must not be offered in exchange for enrollment but should describe the Cash or Monetary Rebates as a form of benefits under the plan. For example, in describing Cash or Monetary Rebates to enrollees and potential 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 that is not furnished under Original/FFS Medicare."

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 communications and marketing materials prospectively, in accordance with the schedule in Table 1, and monitor implementation of this Model Benefit to ensure the appropriate communications, marketing and provision of Cash or Monetary Rebates to enrollees.

MAOs participating in Cash or Monetary Rebates are required to communicate the availability of this Model Benefit to all enrollees in the applicable PBPs, and indicate in the VBID Member Engagement Strategy (see Section 1.1 and Appendix 1) how the MAO plans to ensure member understanding of and activation in connection with Cash or Monetary Rebates. Therefore, prior to their use, MAOs must submit to CMS for review and approval all marketing and communications materials regarding Cash or Monetary Rebates to enrollees and potential enrollees consistent with the requirements discussed in Sections 1 and 2 of these 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 expiration date clearly indicated on both checks, debit cards, or other mechanisms used to deliver Cash or Monetary Rebates;
- 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;

- a notice of the potential tax consequences associated with the provision of Cash or Monetary Rebates or an explanation of the conditions under which the Cash or Monetary Rebates do not have any tax consequences for the enrollee. This notice must be provided to the enrollee prior to the provision of the actual Cash or Monetary Rebate and no later than January 1, 2022, or the first of the month following enrollment for those who enroll later in the year, and must include a plan phone number for more information on potential tax liability. In cases in which a tax authority has ruled in a year that the Cash or Monetary Rebates is not taxable income for enrollees (without conditions), then participating MAOs may make a request to CMS annually via the VBID mailbox at VBID@cms.hhs.gov for an exception to requiring this notice. If an MAO receives a ruling or advisory opinion from the applicable tax authority or receives additional instructions from CMS regarding the content of the required notice after the start of CY 2022 (or after issuance of the required notice of potential tax consequences), then participating MAOs shall notify enrollees regarding the updated information, along the timeline specified in Table 1; and
- a notice of the potential impacts on beneficiary income and resource determinations associated with the provision of Cash or Monetary Rebates. CMS will send the required text of the notice to participating MAOs. Participating MAOs must submit a final version of the notice and transmit the notice to enrollees along the timeline specified in Table 1 and in the correspondence from CMS. CMS may require related subsequent notices to be transmitted. CMS may specify that such notices must be sent to only a subset of the enrollees receiving Cash or Monetary Rebates.

This notice may be provided through email to the enrollee if the requirements in 42 CFR § 422.2267(d) are met with regard to use of electronic delivery of required notices. The MAO may provide a duplicate notice electronically as well if the MAO has not met the requirements of 42 CFR § 422.2267(d)(2)(ii) for providing required notices electronically. In the event delivery through electronic means of required notices has not been established for an enrollee, the participating MAO must provide this notice by conventional mail or through providers or case managers, who may make available, distribute, and display this notice, including in areas where care is being delivered. Please note that a notice stating the notice is posted on a website is not sufficient.

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, as applicable.

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 Model Benefit to providers and enrollees.

3.1 Communications with Network and Non-Network Providers

Participating MAOs and their contracted Hospice Providers have the flexibility to create contracting arrangements that work best for each entity and support the goals of the Hospice Benefit Component. In the initial years of the Hospice Benefit Component, participating MAOs and Hospice Providers have the opportunity to work together in new ways which will require up front collaboration and coordination to maximize efficient billing arrangements. Where there are no existing contractual arrangements between a participating MAO and a Hospice Provider in its service area, CMS requires that participating MAOs to reach out to local Hospice Providers to discuss the Model and billing processes to minimize confusion and maximize efficiencies, even if the parties do not ultimately contract with each other.

Participating MAOs must communicate actively with all Hospice Providers in their service areas to inform them of the following:

- the participating MAO is a CMS Innovation Center Model participant;
- the MAO's participation in the Hospice Benefit Component of the VBID Model;
- the structure of the Hospice Benefit Component of the VBID Model;
- the Hospice Provider's contract status with the participating MAO (including if it is non-contracted, out-of-network);
- the participating MAO's contracting and credentialing process for network providers;
- any information needed by the participating MAO to ensure the Hospice Provider is able to offer services to the participating MAO's enrollees;
- information on how to identify a Medicare beneficiary as an enrollee of the participating MA plan;
- details on the participating MAO's network structure (i.e., PPO, HMO-POS, HMO), enrollees' ability to seek non-hospice care out-of-network, how to help an enrollee coordinate receiving unrelated care if needed (e.g., prior authorization process for non-hospice care if applicable, finding a provider), and information on how to find providers that are in-network with the participating MAO;
- timeline for claims and notice submission and participating MAO payment to the Hospice Provider;
- contact information for CMS at VBID@cms.hhs.gov for questions about the Model, including questions on how to get in touch with the Beneficiary Liaison for Innovation Models, who provides Medicare Beneficiary Ombudsman supports; and
- importantly, contact information for the participating MAO.

Consistent with MA program requirements in 42 CFR Part 422, subpart E regarding MAO relationships with providers, participating MAOs must be responsive to Hospice Providers' outreach to them with requests to participate in the participating MAO's hospice network or to enter into a contracting process with the participating MAO. Participating MAOs are permitted to decline to include a Hospice Provider or group of Hospice Providers in its networks, but must furnish written notice to the affected provider(s) of the reason for the decision. Even in situations where a participating MAO does not intend to contract with a Hospice Provider, in CY 2022, the Hospice Benefit Component requires participating MAOs to permit enrollees to choose any Hospice Provider, which may require a billing relationship between the non-contracted Hospice

Provider and participating MAO. Hospice Providers are encouraged to expect and respond to outreach from participating MAOs in order to ensure smooth working relationships under the Model as maintenance of good coordination and communication can contribute significantly to ensuring high levels of enrollee care. Participating MAOs do not need to submit these communications materials to HPMS, but CMS may request copies of these communications to support monitoring activities.

Please note, CMS will make available MAO contact information for the MAO's hospice network administrative contact and hospice clinical and patient support contact available on the VBID Model Hospice Benefit Component webpage as a resource for Hospice Providers in fall 2021. MAOs are encouraged to ensure timely updates of this contact information as necessary and to share any web resources or materials with CMS as resources for Hospice Providers.

In addition to communications with enrollees and Hospice Providers, participating MAOs should inform other 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 Hospice Enrollees and/or Targeted Hospice 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.

3.2 Provider Directories & Network-Related Communications

Participating MAOs offering the Hospice Benefit Component must develop and deliver provider directories that include and identify 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 listing in-network Hospice Providers must include language stating that enrollees have the option to receive services from an out-of-network Medicare-participating Hospice Provider that is willing to provide treatment. Participating MAOs offering the Hospice Benefit Component may consider adding contact information in such directories for resources that assist 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 or for community resources for enrollees entering or considering hospice. 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 2022, 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 enrollees and potential enrollees, and marketing the existence of Model Rewards and RI Programs to enrollees and potential enrollees.

Continuing in CY 2022, participating MAOs may offer both Part C and Part D Model Rewards consistent with the terms of the Model and the Addendum. Model Rewards are not Medicare benefits and thus, must not to be treated as benefits. MAOs may use different approaches to communicating with 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 to enrollees in order to ensure that enrollees have complete information to understand the available Model Rewards. Moreover, MAOs must answer questions about the Model Rewards Program and must include information about the Model Rewards 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 Model Rewards in marketing materials for potential enrollees at 42 CFR §§ 422.134 and 422.2260 through 422.2272. 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.

CMS recently adopted a reorganization and several clarifications to the regulation governing MA reward programs at 42 CFR § 422.134; MAOs are encouraged to review that final rule (86 FR 5864, 5974-5981), which appeared in the Federal Register on January 19, 2021 and to review the revised regulation text.[12] 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 must adopt a communications strategy for clearly describing to both 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 Model Rewards;
- the per unit value of the reward and incentive;

[12] See Addendum Article 3, Section H and Appendix 2, Sections B(5), C, and D which require compliance with § 422.134 – excepted as specific waived – for both Part C and Part D RI Programs in the Model.

- the total value that an enrollee can receive;
- where and how to ask questions or receive help on understanding the Model Rewards 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.

CMS will apply 42 CFR § 422.2260 to determine when and whether these communication materials are marketing and subject to review as marketing materials. 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 within HPMS via "VBID" content type under "Plan Created" submission type for CMS review and approval. Like other materials submitted in HPMS using this category, Model Rewards may be used beginning 5 days following submission if the conditions in 42 CFR § 422.2261(b)(3) are met and unless and until CMS directs that the MAO stop use of the material(s). Participating MAOs are encouraged to craft Model Rewards communications in a way that will effectively engage enrollees and potential enrollees and communicate consistent with the communications principles described in Section 1 above, which must be designed to outline all of the Model Rewards available to potential enrollees and enrollees.

Appendix 1: VBID Member Engagement Strategy

As part of your VBID Member Engagement Strategy, please outline the communications mechanisms and materials, outreach approaches and related strategies you will use in CY 2022 to drive enrollee awareness, engagement and activation using the table on the next page (Appendix Table 1).

Instructions for Appendix Table 1:

1. Please outline the strategy for each Model Component you are offering (e.g. Supplemental benefits and/or reduced cost sharing; Part C rewards and incentives; Part D rewards and incentives; cash rebates; new technology; and hospice).

2. If you are offering several Model Components, please group your strategy by component type.

3. Where appropriate to your Model Component, please include details on the frequency (e.g., quarterly), content, timing (e.g., beginning of the year), target of communications or outreach.

4. Where appropriate to your Model Component, please include details on how enrollees who are eligible to receive the benefit will be informed of the logistics of how to access the benefit and the point of contact for questions regarding the benefit.

5. Examples of possible elements that could be included in describing your engagement strategy are provided in the sample table below, for illustrative purposes only. Please note that you do not need to include your WHP communications and engagement strategy since that information is collected elsewhere on or in detailed descriptions of your routine annual marketing or retention campaigns.

Appendix Table 1

Intervention [A]	**How will you ensure enrollees know they are eligible for this VBID Model Benefit and/or Model Reward?**	**How will you engage targeted members to participate in this Model Component?**	**How will you activate and sustain ongoing member engagement to improve outcomes, adherence or other objectives as appropriate?**

[A] E.g., Clinically-defined Model Components, Part D Reduced Cost-sharing, Hospice Benefit, VBID Flex - Healthy Food Card, Part D Rewards & Incentive Program, Cash or Monetary Rebates

In addition to populating Table 1, please detail below any innovative approaches you are using to target and improve engagement and activation in **clinical interventions targeted to sub-populations**, including the possible application of **behavioral economics** where appropriate. Please highlight any strategies you may be using to reach **underserved populations with health equity concerns** and populations who may require different types of approaches and/or **culturally competent** communications and outreach in order to fully engage in the Model Benefits and/or Model Rewards for which they are eligible.

In the sample table below, CMS illustrates an example of a VBID Member Engagement Strategy.

Sample Table

Intervention [A]	**How will you ensure members know they are eligible for this VBID Model Benefit or Reward, and how to access it?**	**How will you engage targeted members to participate in this intervention?**	**How will you activate and sustain ongoing member engagement to improve outcomes, adherence or other objectives as appropriate?**
Example VBID Flexibility: Healthy Food Card (HFC)	Standard print marketing and enrollment communications (ANOC, EOC, Notice of Benefits (NOB) and renewal communications) describe the HFC, who is eligible, how the card will be provided, how and where the card can be used to purchase healthy food and a point of contact for questions Welcome Kits for enrolled members include information on how and where the HFC may be used and a phone contact for questions. Website updated with HFC benefit information.	Following enrollment, eligible members are mailed an outreach letter describing the benefit and telling them to anticipate the HFC in the mail, followed by a card mailer. The outreach and card mailer include a contact for questions or issues and explain where, how and for what the HFC can be used. These communications clearly explain when the monthly amount is loaded or reloaded (e.g. at the start of the last week of the month to coordinate with possible other food benefit programs that may run out towards month end). Welcome calls by customer service in the first 60 days include information on the HFC benefit and logistics. Provider network staff and providers are trained on HFC. Training highlights which plan members are eligible and which are not to avoid member confusion. Eligible enrollees are mailed a reminder flyer on the HFC at mid-year including logistics on use and a HFC refrigerator magnet with number to call if there are issues with the card.	Utilization of the card is tracked monthly and non-users are mailed a HFC flyer describing how to use the benefit to purchase healthy food. Customer service is trained on the HFC benefit and CS scripts and case managers ask if information on HFC benefit will be helpful and if there are issues in using the card. Non-user and declined card data are analyzed to identify opportunities to improve uptake and possible geographies where vendor education may be helpful.

Intervention [A]	**How will you ensure members know they are eligible for this VBID Model Benefit or Reward, and how to access it?**	**How will you engage targeted members to participate in this intervention?**	**How will you activate and sustain ongoing member engagement to improve outcomes, adherence or other objectives as appropriate?**
Example Part D RI Program: Reward for participation and completion of disease specific medication therapy management (MTM) program	Standard print communications materials that describe the MTM rewards program; who is eligible; the rewards offered; how they are earned and distributed; and a point of contact for questions.	Targeted members receive three communications: an invitation to participate letter describing the program and rewards, followed by an outreach phone call from care managers and a program welcome kit detailing the program, what is required of the member, how and when quarterly and program completion rewards are earned and distributed, and how the program works with Part D benefits in the coverage gap. Members are also given a point of contact for questions. Network providers in relevant specialties and care managers are trained on the program and support participation.	Targeted Enrollees not participating in the program receive an additional outreach invitation call after 60 days. Participants completing the required activities receive a reward letter and gift card 15 days after the close of each quarter. Participating members not completing program requirements for a quarter receive a "back on track" letter outlining how the reward can be earned in the subsequent quarter and care managers receive information on participants falling off. Members completing all quarters receive a bonus award letter and the reward (a gift card) at year-end.

[A] E.g., Clinically-defined Model Components, Part D Reduced Cost-sharing, Hospice Benefit, VBID Flex - Healthy Food Card, Part D Rewards & Incentive Program, Cash or Monetary Rebates

Appendix 2: Corrections to the CY 2022 VBID Model EOC and the CY 2022 VBID Model ANOC

What follows are July 2021 corrections to the CY 2022 VBID Model EOC and CY 2022 VBID Model ANOC that were posted in June 2021 and are located here: https://www.cms.gov/files/zip/cy-2022-model-materials.zip

CY 2022 VBID Model EOC Corrections:
Issue Summary: Clarification for model language related to participating plans offering reduction or elimination of their cost-sharing for Part D drugs through the VBID Model based on chronic condition and/or LIS; Applicable for all MA-PD plan types except for PFFS, Cost, MSAs and PDPs.
Issue Location: Instructions for the Calendar Year 2022 Evidence of Coverage Chapter 6
Action required: Prior to Section 1 of Chapter 6 of the EOC, participating plans should update the instructions in the sections where they are offering VBID Benefits, as applicable. Add or delete text as indicated in navy font below.

[Instructions to plans offering reduction or elimination of their cost sharing for Part D drugs through the VBID Model based on chronic condition and/or LIS

- *Plans may provide a written summary of benefit of reduction or elimination of their cost sharing for Part D drugs through VBID based on chronic condition and/or LIS.*
- *Plans who choose to reduce cost sharing for 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.]*

[Insert if offering reduction or elimination of cost sharing for Part D drugs through the VBID Model based on LIS:]

If you are in a program that helps pay for your drugs, some information in this *Evidence of Coverage* about the costs for Part D prescription drugs [*insert as applicable: (including if offering reduction or elimination of cost sharing for Part D drugs through the VBID Model based on LIS status)* may *OR* does] not apply to you. *[If not applicable, omit information about the LIS Rider]* We [*insert as appropriate:* have included *OR* sent you] a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "LIS Rider."

Issue Summary: Clarification for model language related to participating plans offering reduction or elimination of their cost-sharing for Part D drugs through the VBID Model based on chronic condition and/or LIS; Applicable for all MA-PD plan types except for PFFS, Cost, MSAs and PDPs.

Issue Location: Instructions for the Calendar Year 2022 Evidence of Coverage, Chapter 6, Section 2.1
Action required: Plans participating in the VBID Model and approved to offer VBID reduced or eliminated Part D cost-sharing should update the table in Section 2.1 of Chapter 6 to reflect the approved Model Benefit(s), as appropriate.

Issue Summary: Clarification for model language related to WHP RI programs
Issue Location: Instructions for the Calendar Year 2022 Evidence of Coverage, Chapter 4, Section 2.1
Action required: Plans participating in the VBID Model and approved to offer WHP RI must not mention WHP RI programs in the EOC.

CY 2022 VBID Model ANOC Corrections:

Issue Summary: Clarification for model language related to participating plans offering reduction or elimination of their cost-sharing for Part D drugs through the VBID Model based on chronic condition and/or LIS; Applicable for all MA-PD plan types except for PFFS, Cost, MSAs and PDPs.
Issue Location: Instructions for the Calendar Year 2022 ANOC, Section 2.5
Action required: Add text in navy as indicated below.

> *[Instructions to plans offering VBID Model benefits: VBID Model participating plans should update this section to reflect coverage for any new VBID Model benefits that will be added for CY 2022 benefits, and/or for previous CY 2021 VBID Model benefits that will end for CY 2022. Specific to the VBID Model benefits, the table must include: (1) all new VBID Model benefits that will be added for 2022, except for the hospice benefit component (which has separate ANOC instructions to VBID participating plans and Part D cost sharing reduction or elimination which should be included under Section 2.6), including mandatory supplemental benefits such as the flexibility to Cover New and Existing Technologies or FDA approved Medical Devices and the Cash or Monetary Rebates, or 2021 benefits that will end for 2022; and (2) all changes in cost sharing for all VBID Model benefits for 2022.]*

Issue Summary: Clarification for model language related to participating plans offering reduction or elimination of their cost-sharing for Part D drugs through the VBID Model based on chronic condition and/or LIS; Applicable for all MA-PD plan types except for PFFS, Cost, MSAs and PDPs.
Issue Location: Instructions for the Calendar Year 2022 ANOC, Section 2.6
Action required: Add text in navy as indicated below.

> *[VBID Model participating plans approved to offer Part D reduced or eliminated cost sharing should update Section 2.6 to reflect any changes as a result of CY 2022 VBID Model participation.]*