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

Value-Based Insurance Design Model
Calendar Year 2023

Model Communications and Marketing Guidelines

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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) 2023 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 chronic health 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. Part C and Part D Rewards and Incentives (RI) Programs (herein referred to as "RI Programs"); and
4. Hospice Benefit Component.

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 4 above to enrollees. As used in this document, the term "Model Benefits" means the items, services, and reductions in cost sharing offered to enrollees (or to Targeted Enrollees[1] if there are limits on eligibility) in the Model components listed as items 1, 2 and 4 above.

This document outlines the communications and marketing requirements for MAOs participating in the VBID Model. MAOs that participate in the Model in CY 2023 have agreed to adhere to these guidelines pursuant to execution of the CY 2023 Addendum to the Medicare Managed Care Contract for Participation in the MA VBID Model (Addendum).[2] MAOs that participate(d) in the Model in CY 2022 must adhere to these guidelines for any newly submitted 2022 Model communications and marketing materials, effective July 1, 2022, with the exception of Model communications and marketing materials related to CY 2022 Cash or Monetary Rebates.[3]

[1] "Targeted Enrollee" means a Medicare beneficiary who is enrolled in one of the participating MAO's VBID participating PBPs and targeted to receive one or more VBID Components, except for WHP and the Hospice Benefit Component. All enrollees in VBID PBPs participating in 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).

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

[3] Operational updates, i.e., HPMS submission mechanisms, are effective immediately.

Because CMS is terminating the Cash or Monetary Rebates Model component of the VBID Model beginning in CY 2023, participating MAOs offering Cash or Monetary Rebates in CY 2022 must continue to follow the CY 2022 VBID Model Communications and Marketing Guidelines for that Model Benefit only for 2022 Model communications and marketing materials. Additionally, participating MAOs offering Cash or Monetary Rebates in CY 2022 must include language in their CY 2023 Annual Notice of Change (ANOC) that clearly states the removal of this Model Benefit for CY 2023. For CY 2023, participating MAOs wishing to communicate the removal of Cash or Monetary Rebates and its replacement with supplemental benefits of equal or greater value to their enrollees may do so but must use the following language, "CMS removed the Cash Benefit for 2023. Instead, you'll get *[please identify and insert in these brackets supplemental benefits that your organization is offering in lieu of Cash or Monetary Rebates]* in place of the Cash Benefit you got in 2022. Review your Evidence of Coverage (EOC) for more information about available supplemental benefits." Any communications or marketing materials that include language on the previously offered Cash or Monetary Rebates Component must be submitted to CMS for 45-day prospective review and approval.

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 §§ 422.2260 through 422.2276 and 423.2260 through 423.2276. 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 RI Programs 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 RI Programs.

Below, CMS provides an overview of this document:

- Section 1 discusses the requirements that participating 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;[4] and (iii) the Hospice Benefit Component pursuant to Appendix 3 of the Addendum.

- Section 2 provides additional requirements that participating 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.

[4] See Addendum, Article 3(D).

- Section 3 discusses additional requirements that participating MAOs offering RI Programs must follow in communicating and marketing the existence of RI Programs to enrollees. RI Programs refer to those offered as part of implementing a VBID Model Approved Proposal; RI Programs are not Model Benefits. Of note, the principles outlined in section 1 are also applicable to communicating RI Programs to enrollees and potential enrollees.

- 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.

1 Communications Requirements & Timeline

1.1 Summary of Model Communications and Marketing Guidelines Requirements

1. **Participating MAOs must submit to CMS a description of how they will inform and engage enrollees about the Model Benefits and/or RI Programs 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 RI Programs is achieving enrollee awareness, engagement, and activation. As such, CMS is interested in learning through the VBID Member Engagement Strategy how participating MAOs will ensure enrollees have a clear understanding of the Model Benefits and RI Programs that they are eligible for (including how to access them), and the specific strategies and processes participating MAOs will use to engage and activate eligible enrollees and/or Targeted Enrollees.

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

   Note: CMS is also particularly interested in any strategies that participating MAOs may be using to advance health equity and reach underserved communities[5] 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 RI Programs for which they are eligible.[6] As CMMI gains greater insights into beneficiary perspectives around model testing, implementation and

[5] Section 2(b) of Executive Order 13985 defines "underserved communities" as referring to populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by the list in the preceding definition of "equity" that is in the Executive Order.

[6] CMS defines health equity as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes. CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive. Reference: https://www.cms.gov/pillar/health-equity

evaluation as one of the Center's new strategy objectives, CMMI would also like to understand our VBID participants' responsiveness to and inclusion of their enrollees' perspectives on their benefits, priorities and needs as a part of their Member Engagement Strategy.

2. **Consistent with their VBID Member Engagement Strategy, participating 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 RI Programs.**

   a. **An EOC and an ANOC must include the Model Benefits that will be offered to enrollees:**

   In their CY 2023 EOCs that are required as part of the MA program requirements, participating MAOs must include all Model Benefits, including WHP Services, along with language that ensures enrollees are aware of any chronic conditions or targeting criteria for access to the Model Benefits.

   Participating MAOs that are new or continuing in the Model and are adding VBID Model benefits to an existing plan for CY 2023 or participating MAOs that are continuing, but have changes to VBID Model Benefits, must also include the VBID Model Benefits in the ANOC for existing enrollees. For all PBPs that will no longer include Model benefits in 2023, a participating MAO must include the benefit changes in the ANOC. These changes must be communicated to eligible enrollees in the CY 2023 ANOC in accordance with the MA Program ANOC deadline. CMS includes Model-specific language in the CY 2023 standardized models for the EOC and ANOC, which can be found here: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.[7]

   For CY 2023, participating MAOs offering the Hospice Benefit Component must submit excerpts from their EOC and ANOC inclusive of the Model Benefit description for separate CMS-pre-review and approval prior to submission of the entire EOC and ANOC in HPMS in accordance with § 422.2261. These Model-specific drafts may be submitted on a rolling basis but must be submitted by no later than **July 15, 2022** 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 29, 2022. Participating MAOs are required to incorporate these CMS-approved excerpts into their published EOC/ANOC.

[7] Note: Participating MAOs that offer Part D reduced cost sharing for LIS enrollees may modify the LIS Rider Model language using the VBID instructions in the CY 2023 LIS Rider Model to adjust cost sharing amounts, so that the cost sharing in the LIS Rider does not conflict with the cost sharing amounts provided in the EOC. Reference: https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/part-d-model-materials

b. **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:**[8]

Additionally, participating MAOs must provide directory information identifying in-network Hospice Providers to their enrollees *(see section 2 for additional, specific requirements*).

c. **Participating MAOs offering RI Programs must communicate information about the RI Programs to enrollees:**

While RI Programs are not benefits and may not be listed in the EOC or ANOC, participating MAOs must communicate accurate and complete information about their RI Programs via other vehicles in order to ensure that enrollees have complete and sufficient information to understand the available RI Programs (*see section 3 for additional, specific requirements*).

d. **As applicable, participating MAOs must provide additional communications to enrollees 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.

Participating MAOs may also tailor other communications materials required by the MA program and, for participating MAOs that offer Part D benefits, the Part D program (see 42 CFR §§ 422.2260 and 423.2260), including all pre-enrollment material and scripts, for use in the Model.

3. In addition to the requirements above, a participating MAO has the option to engage enrollees and to inform them about Model Benefits and/or RI Programs through additional communications materials.

These additional communications to enrollees regarding Model Benefits and RI Programs must be submitted to CMS for review and approval, as reflected in Table 1 in section 1.9 of this document. Further, if a participating MAO makes any changes to its high-value provider list in CY 2023 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

[8] "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 participating 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).

directory (*see section 2 for additional 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 RI Programs must be designed to outline all of the benefits and rewards and incentives available to enrollees and Targeted Enrollees. Consistent with language in 42 CFR §§ 422.2262(a)(1)(iii) and 423.2262(a)(1)(iii), which prohibits MAOs from engaging in activities that could mislead or confuse Medicare beneficiaries, or misrepresent the MAO, participating MAOs must minimize confusion and promote clarity where possible in their materials.

For 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 participating MAO chooses to communicate these to enrollees through materials in addition to the EOC and ANOC, participating MAOs should limit any potential confusion for 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 that in any way that discriminates among 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 health 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 both the targeted and non-targeted VBID populations.[9]

A participating MAO must adopt a communications approach that clearly outlines:

- the Model Benefits available to enrollees (or, in the case of WHP Services to all enrollees as applicable), including the scope of the benefits'
- what must be done to qualify for and receive the Model Benefits (as applicable); and

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

- where and how to ask questions or receive help on understanding the Model Benefits (by providing a phone number, at a minimum).

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.

1.3 Process for Participating MAO Submission of Materials and CMS Review

As summarized in Table 1 in section 1.9, participating MAOs must submit their materials as follows:

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

- **Hospice Benefit Component Communications and Marketing Materials Requiring Prospective Review:** Participating MAOs must submit for CMS pre-review and approval ***all*** communications and marketing materials (including excerpts of the relevant sections of the EOC and ANOC) related to the Hospice Benefit Component to the VBID Model Communications and Marketing Mailbox at MAVBIDhelpdesk@acumenllc.com, with subject heading "[PO] Hospice communication submission for review." Once approved, with the exception of the excerpt of the relevant sections of the EOC and ANOC related to the Hospice Benefit Component, participating MAOs must submit these materials to the HPMS Marketing Module. Communication materials must be submitted under the "Communications with VBID Content" material type, which is within the "Required" submission type. Marketing materials must be submitted under the "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 1) submitted to the VBID Model Communications and Marketing Mailbox for CMS review, 2) approved by CMS via email, and 3) submitted to HPMS for final approval.

- **Other Communication and Marketing Materials:** Participating MAOs must submit for CMS review and approval all other communications and marketing materials specific to Model Benefits (outside those materials noted above) and RI Programs (as defined and described in section 3 below), including all pre-enrollment materials and scripts to the HPMS Marketing Module. Marketing materials must be submitted under the "VBID" content type, which is within the "Plan Created" submission type. Communication materials must be submitted under the "Communications with VBID Content" material type, which is within the "Required" submission type. These other communications materials include VBID Model-specific materials, such as: a notice of acknowledgement of an opt-in or opt-out from Model Benefits; a 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 on which Model Benefits are conditioned.

In accordance with 42 CFR §§ 422.2261(b)(3) and 423.2261(b)(3), materials submitted under this category may be distributed five calendar days after submission to HPMS provided that CMS has not denied permission to use the material(s) in that five-day window or following the five-day window. When submitting, the participating MAO is certifying that the materials comply with all applicable regulations and these Model Communications and Marketing Guidelines. If the requirements of 42 CFR §§ 422.2261(b)(3) and 423.2261(b)(3) are not met, or if CMS identifies the specific material or category of material as requiring additional review, the participating MAO may only use and distribute the material if it is approved or deemed approved by CMS in accordance with 42 CFR §§ 422.2261(b)(1) and 423.2261(b)(1) or §§ 422.2261(b)(2) and 423.2261(b)(2), respectively. Further, a participating MAO must cease use of materials if so directed by CMS at a later point in time.

All other CMS requirements relating to the review of marketing materials under 42 CFR Part 422, Subpart V, and Part 423, Subpart V (for Part D materials for MA-PDs), continue to apply to participating MAOs and 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 by the MA program, under categories appropriate to the type of material submitted. For example, the EOC must be submitted to HPMS under the "EOC" material type, which is within the "Required" submission type, and the ANOC must be submitted under the "ANOC" material type, which is within 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 and ANOC (as applicable), participating MAOs must deliver the below 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. 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 must meet all applicable regulations and guidance for EOBs. See 42 CFR §§ 422.111(k) and 423.128(e) for requirements for EOBs, which include an exception at 42 §§ CFR § 422.111(k)(5) that participating MAOs are not required to send MA EOBs to dual-eligible enrollees. *Please note that for participating MAOs with participating PBPs offering the Hospice Benefit Component, sending an EOB is only applicable if there is claims activity to report.*

- **Notice of acknowledgment of an opt-out from Model Benefits.**[10]

[10] As described in the Addendum, Article 3(B), participating MAOs shall provide a mechanism for enrollees to opt out of any benefits provided under the VBID Model. This requirement does not apply to the Hospice Benefit Component.

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 enrollee(s), including instructions for rescission of the opt-out to the enrollee(s). An example of when a notice of acknowledgment of an opt-out is needed would be for an enrollee who 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 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 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.**[11]
  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 enrollee(s).

- **Notice of determination that an enrollee no longer qualifies for Model Benefits.**
  The notice must include the rationale underlying such a determination. This determination is considered a standard Organization Determination for Part C benefits or a Coverage Determination for Part D benefits, and must contain the information required for notices of such determinations (see 42 CFR §§ 422.560 through 422.634 and 423.558 through 423.638, 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. A notice of determination that an enrollee no longer qualifies for Model Benefits is not required if an enrollee disenrolls from the plan.

- **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 §§ 422.560 through 422.634 and 423.558 through 423.638 and associated guidance).

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."

[11] Id.

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 RI Programs so long as those communications are subject to CMS review and approval. Examples may 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 enrollee. For instance, a participating MAO might remind an enrollee when granting them prior approval for a service that they are eligible for such a reduced cost-sharing if they use a high-value provider.

1.5 Provider/Pharmacy Directories and Network-Related Communications

Participating MAOs must satisfy all current program requirements, including in 42 CFR §§ 422.111 and 423.128 as applicable, with regard to provider and pharmacy directories.[12] Additional guidance is also available in the Medicare Managed Care Manual, Chapter 4 and the Medicare Prescription Drug Benefit Manual, Chapter 5. Additionally, participating MAOs offering Model Benefits contingent on the use of a high-value provider network must identify those high-value providers and the benefits they may provide in the directory. 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[13] must be provided the supplemental directory if that is how the participating 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 2023 relative to previously provided directories, the participating MAO must provide written notice to all enrollees who are patients seen on a regular basis by the high-value provider identified in the directory, whose contract is terminating.

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

[12] See also 42 CFR § 422.120 regarding the Provider Directory API requirement.
[13] See Addendum, Article 3(D)(3).

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 Model participating MAOs are required to provide, except where the participating MAO is permitted to use website information as a form of electronic delivery of required materials by 42 CFR § 422.2267(d).

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 participating 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 participating MAO's service area in which Model Benefits and/or RI Programs 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, a notice of determination that an enrollee is not participating in case management, and a notice alerting enrollees how to access or receive a directory.

Participating MAOs are not required to submit non-English language materials that are translations of a previously submitted English version. The English version of the Standardized material identification (SMID) may be used on non-English translations. For plan-created materials that will be used only in a non-English language, participating MAOs must submit an English translation to HPMS via a zip file containing both the material and the translation(s). Participating MAOs are not required to submit alternate format versions of a previously submitted standard material.

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 and/or RI Program. 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 within the participating MAO's service area in which Model Benefits or RI Programs are being offered. For example, Model materials might state language assistance services are available or describe how readers can request a translated version of the material. An exception to this translation requirement is ID cards, in accordance with 42 CFR §§ 422.2267(e)(30)(vi) and 423.2267(e)(32)(vi).

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 ensure an equal opportunity to access the Model Benefits and RI Programs. Participating MAOs must provide a toll-free TTY number in conjunction with the customer service number in the same font size as the other phone numbers, except as outlined below. Participating MAOs/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.

In accordance with 42 CFR §§ 422.2262(c)(2) and 423.2262(c)(2), exceptions to this TTY requirement include outdoor advertising (ODA), banners or banner-like ads, 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. If approved, the participating MAO must also include certain disclaimers on those materials. Reference Article 3, section I (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 the VBID mailbox at 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 RI Programs. Table 1 distinguishes between VBID Model communications materials that are subject to prospective review or five Calendar Day File & Use and provides timelines for submission. See 42 CFR §§ 422.2261 and 423.2261 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 19 – October 21, 2022	Submit directly to HPMS under the "VBID-Member Engagement Strategy" material type which is within the "Required" submission type.
EOC/ANOC Excerpts of Hospice Benefit Component 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 29, 2022.)*	Rolling basis but no later than July 15, 2022	Submit first to the (1) VBID Communications and Marketing Mailbox for CMS pre-review and approval with the subject heading "[PO]: EOC/ANOC VBID Model Excerpt", and once approved by CMS via email (2) include as part of the entire EOC and ANOC and follow appropriate MA guidelines for HPMS submission (*see row below*).
EOC/ANOC *(which includes VBID Model Benefits but cannot include RI Programs)*	**File & Use** if the conditions have been met under 42 CFR §§ 422.2261(b)(3) and 423.2261(b)(3) and the participating MAO certifies compliance *(5 Days)*	See CMS regulations and guidance on HPMS submission timing for additional instructions. Resubmission using the "VBID" content type in HPMS is not necessary.	
Model Benefit and RI Program Communications *(except for the EOC and communications materials related to the Hospice Benefit Component)*	**File & Use** if the conditions have been met under 42 CFR §§ 422.2261(b)(3) and 423.2261(b)(3) and the participating MAO certifies compliance* *(5 Days)*	Rolling Basis	Submit directly to HPMS under the "Communications with VBID Content" material type which is within the "Required" submission type.
Model Benefit and RI Program Marketing *(except for the ANOC and marketing materials related to the Hospice Benefit Component)*	**File & Use** if the conditions have been met under 42 CFR §§ 422.2261(b)(3) and 423.2261(b)(3) and the participating MAO certifies compliance* *(5 Days)*	Rolling Basis	Submit directly to HPMS under the "VBID" content type which is within the "Plan Created" submission type.
Hospice Benefit Component Communications *(outside of the EOC)*	**Prospective** CMS review & approval (42 CFR §§ 422.2261(b)(1) & (2) and 423.2261(b)(1) & (2)) *(Total 45 Days)*	Rolling Basis	Submit first to the (1) VBID Communications and Marketing Mailbox for CMS pre-review and approval with the subject heading "[PO]: Hospice communication submission for review and approval" and once approved by CMS via email (2) submit to HPMS under the "Communications with VBID Content" material type which is within the "Required" submission type.**
Hospice Benefit Component Marketing *(outside of the ANOC)*	**Prospective** CMS review & approval (42 CFR §§ 422.2261(b)(1) & (2) and 423.2261(b)(1) & (2)) *(Total 45 Days)*	Rolling Basis	Submit first to the (1) VBID Communications and Marketing Mailbox for CMS pre-review and approval with the subject heading "[PO]: Hospice communication submission for review and approval" and once approved by CMS via email (2) submit to HPMS under the "VBID" content type which is within the "Plan Created" submission type.**

Material	Type of Review *(Calendar Days)*	Timeline to Submit to CMS	Submission Mechanism
Communications including Limited Mention of Cash or Monetary Rebates *(as no longer being available in CY 2023 and to explain replacement benefits for Cash or Monetary Rebates)*	**Prospective** CMS review & approval *(42 CFR § 422.2261(b)(1) & (2)) (Total 45 Days)*	Rolling Basis	Submit first to the (1) VBID Communications and Marketing Mailbox for CMS pre-review and approval with the subject heading "[PO]: [Cash/Rebate communication submission for review and approval" and once approved by CMS via email (2) submit to HPMS under "Communications with VBID Content" material type which is within the "Required" submission type.**
Marketing including Limited Mention of Cash or Monetary Rebates Marketing *(as no longer being available in CY 2023 and to explain replacement benefits for Cash or Monetary Rebates (outside of ANOC))*	**Prospective** CMS review & approval *(42 CFR § 422.2261(b)(1)) (Total 45 Days)*	Rolling Basis	Submit first to the (1) VBID Communications and Marketing Mailbox for CMS pre-review and approval with the subject heading "[PO]: [Cash/Rebate communication submission for review and approval" and once approved by CMS via email (2) submit to HPMS under "VBID" content type which is within "Plan Created" 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.

** If submitting a sales presentation containing content on the Hospice Benefit Component, please submit concurrently to HPMS and the VBID Communications and Marketing Mailbox for CMS review and approval.

2 Additional Requirements for Communications Regarding the Hospice Benefit Component

This section discusses additional requirements that participating MAOs offering the Hospice Benefit Component must comply with in communicating about this Model Benefit to providers and enrollees.

2.1 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 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. Additionally, as discussed later in this section, CMS strongly encourages participating MAOs to communicate with their network of non-hospice providers about participation in the Hospice Benefit Component in the VBID Model.

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 support; and
- contact information for the participating MAO.

Consistent with MA program requirements in 42 CFR Part 422, Subpart E regarding participating 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 their networks, but must furnish written notice to the affected provider(s) with the reason for the decision. Even in situations where a participating MAO does not intend to contract with a Hospice Provider, in CY 2023, 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-quality enrollee care. Participating MAOs do not need to submit these communications materials to HPMS, but CMS may request copies of these communications as part of monitoring activities.

Please note, CMS will make contact information for the participating 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 2022. Participating MAOs are encouraged to ensure timely updates of this contact information as necessary by reaching out to the VBID mailbox at VBID@cms.hhs.gov with the new information 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 or increase beneficiary engagement in the VBID Model. Participating MAOs may communicate, consistent with applicable law, specific enrollees' eligibility status (i.e., the participating MAO may identify Hospice Enrollees and/or Targeted Hospice Enrollees) once the provider network is established. Participating 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 and palliative care providers of enrollees with serious illness.

2.2 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 2023, 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.

3 Requirements for Informing Enrollees about RI Programs

This section sets out additional requirements that participating MAOs offering RI Programs must comply with in communicating information about RI Programs to enrollees and potential enrollees, and marketing the existence of RI Programs to enrollees and potential enrollees.

Continuing in CY 2023, participating MAOs may offer both Part C and Part D RI Programs consistent with the terms of the Model and the Addendum. RI Programs are not Medicare benefits and thus, must not to be treated as benefits. Participating MAOs may use different approaches to communicating with enrollees and potential enrollees about RI Programs. First, while RI Programs are not benefits and may not be listed in the EOC or ANOC, participating MAOs must communicate the availability of these RI Programs to enrollees in order to ensure that enrollees have complete information to understand the available RI Programs. Moreover, participating MAOs must answer questions about the RI Programs and must include information about the RI Programs in the educational information sent to enrollees and made available to potential enrollees.

Participating MAOs may market the existence of RI Programs to potential enrollees. Participating MAOs must comply with existing marketing requirements for Part C RI Programs in marketing materials for potential enrollees at 42 CFR §§ 422.134 and 422.2260 through 422.2272. These standards must be met in conjunction with any communications or marketing of Model RI Programs, even if the RI Program is tied to a Part D benefit.

Marketing of all RI Programs must:
- not offer rewards in exchange for enrollment; and
- be offered to all potential enrollees without discrimination.

In addition to these requirements, participating MAOs must adopt a communications strategy for clearly describing to both enrollees and prospective enrollees the RI 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 reward or incentive;
- the per unit value of the reward or incentive;
- the total annual value that an enrollee can receive;
- where and how to ask questions or receive help in understanding the RI Program(s); and

- sufficient information on how the rewards/incentives will be delivered (e.g., gift card or grocery card), and clear instructions on where and 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. Participating MAOs must submit all RI Program marketing materials to HPMS for CMS review and approval under the "VBID" content type, which is within the "Plan Created" submission type. Similar to other materials submitted to HPMS under this category, RI Program marketing materials may be distributed five calendar days after submission to HPMS if the conditions in 42 CFR § 422.2261(b)(3) are met and unless and until CMS directs the participating MAO to stop using the material(s). Participating MAOs are encouraged to craft RI Program 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 RI Programs available to potential enrollees and enrollees.

CMS adopted a reorganization and several clarifications to the regulation governing MA reward programs at 42 CFR. 422.134. Participating MAOs are encouraged to review the final rule (86 FR 5864, 5974-5981) that appeared in the Federal Register on January 19, 2021, and in particular the revisions to the regulation text finalized therein. Per the Addendum and Appendix 2, the standards in § 422.134, unless specifically waived in the Addendum, apply to all RI Programs offered in the Model.[14] 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 RI Programs. Participating MAOs must comply with §§ 422.2263(b)(2) and 423.2263(b)(2) and all other applicable authorities in connection with nominal gifts or promotional items.

[14] See Addendum, Article 3, section H and Appendix 2, sections B(5), C, and D which require compliance with 42 CFR § 422.134 – excepted as specific waived – for all RI Programs, including Part D RI Programs.

Appendix 1: VBID Member Engagement Strategy

As part of your VBID Member Engagement Strategy, please outline your communications mechanisms and materials, outreach approaches and related strategies you will use in CY 2023 related to Model Components, outside of WHP, 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.

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), and target audience 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 your engagement strategy provided in the sample table below are 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 1, Table 1

Intervention [A]	**How will you ensure enrollees know they are eligible for this VBID Model Benefit and/or RI Program?**	**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 Component, VBID Flex - Healthy Food Card, Part D RI Program

In addition to populating Appendix Table 1 above, 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 communities** 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 RI Programs for which they are eligible and advance health equity. Additionally, please include information on how your organization is responding to and including beneficiary perspectives on their Model Benefits and/or RI Programs, priorities and needs in your Member Engagement Strategy.

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

Sample Table

Intervention	**How will you ensure members know they are eligible for this VBID Model Benefit or RI Program, 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 i.e., 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. The health care 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	How will you ensure members know they are eligible for this VBID Model Benefit or RI Program, 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. 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 letter describing the reward (a gift card) at year-end.