

Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation
Medicare Advantage Value-Based Insurance Design Model
CY 2018 Communications Guidelines
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1 Background and General Information

This document provides guidance to Medicare Advantage Organizations participating in the Medicare Advantage Value-Based Insurance Design (MA-VBID) model test on marketing and other communications. Organizations participating in the model test must adhere to this guidance pursuant to Article II, Section D of the Addendum to Managed Care Contract for Participation in the Medicare Advantage Value-Based Insurance Design Model Test.

In the MA-VBID model test, CMS is testing the utility of structuring patient cost-sharing and other health plan design elements to encourage patients to consume appropriate high-value clinical services, thereby improving quality and reducing costs. CMS is implementing a five-year model test that began on January 1, 2017, and will continue through December 31, 2021. The MA-VBID model is testing whether the flexibility to offer clinically-nuanced VBID elements in Medicare Advantage plan benefit designs will lead to higher quality and more cost-efficient care for targeted enrollees. More information about the model test is available in the MA-VBID model's Request for Applications (RFA), published on October 25, 2016.

2 General Guidance

2.1 Applicability of Other Guidance

All MA marketing regulations and guidance remain applicable to materials and activities of participating organizations, including the Medicare Marketing Guidelines and regulations at 42 C.F.R. parts 422 and 423, subparts V. In the event of a conflict between those regulations and guidance, and the marketing requirements contained in these guidelines, such that participating organization cannot comply with both, the participating organization should comply with the MA-VBID Model Test Communications Guidelines. Whenever possible, the participating organization must comply with both.

2.2 Naming of VBID Benefits and Benefit Packages

When naming and describing VBID benefits, participating organizations need not refer to them as "Value Based Insurance Design" benefits or make specific reference to the MA-VBID model test. Instead, a participating organization may adopt an approach for naming VBID benefits that is most apt for the specific VBID benefits it offers and to whom it is offered, makes clear what the benefit is, and engages enrollees. Whatever approach is adopted, participating organizations must use the approach consistently in communication materials, so that enrollees are able to understand the relationship between the Notice of VBID Benefits and subsequent communications.

2.3 Communication Principles

If a participating organization offers distinct packages of VBID benefits to enrollees in more than one targeted clinical condition group, those enrollees must receive distinct communications describing the benefits specific to their condition.

VBID communications may present the VBID benefits in conjunction with other information, provided that the information is complementary to the VBID benefits offered. For example, the Notice of VBID Benefits may be constructed as a larger communication describing VBID benefits, disease management programs, and general health information relevant to a clinically-targeted enrollee population.

VBID communications with enrollees are intended to apprise enrollees of their rights and benefits under the MA-VBID model test, and also to engage them and promote individual participation. As such, they should be created in a manner designed to both facilitate enrollee understanding of VBID benefits and encourage participation in model test-related activities through use of plain-language and actionable communications that are easy to understand and use.

2.4 CMS Review of Materials

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

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

- Code 31001: Notice of VBID Benefits. For the Notice of VBID Benefits. Materials submitted under this code are subject to a 45 day prospective review.
- Code 31002: Other VBID-specific Communications. For model versions of: Notice of acknowledgement of an opt-in or opt-out from VBID benefits; notice of determination that an enrollee no longer qualifies for VBID benefits; notice of determination that an enrollee is not participating in case management; and scripts for responses to VBID-related inquiries from prospective enrollees. Materials submitted under this code are not subject to prospective review.

All other CMS requirements relating to the review of communication materials continue to apply. Therefore, to the extent other communication material contains VBID-related content, but is not specifically identified in this section, that material should be submitted to HPMS if otherwise ordinarily required, and coded using the existing code appropriate to the type of material submitted.

3 Marketing and Communications with Non-Eligible Enrollees

Participating organizations may not cite their participation in this model or specific benefits available under the model in any pre-enrollment marketing material targeted to potential enrollees. Similarly, participating organization sales representatives are not permitted to mention the plan's participation in the model test to prospective enrollees.

Communications from the participating organization that are intended for receipt by the organization's membership at large and not directed specifically at clinically targeted enrollees may not reference VBID benefits. Accordingly, the participating organization's Annual Notice of Change, Evidence of Coverage or Summary of Benefits may not reference VBID benefits.

Only when a beneficiary or another party acting on behalf of a beneficiary specifically enquires about them may participating organizations and their representatives convey information about VBID benefits to beneficiaries who are potential enrollees or current enrollees not eligible for VBID benefits. Such discussions must be accompanied by a disclaimer indicating that eligibility for VBID benefits is based on the enrollee having a specific chronic disease(s) as established by clinical diagnosis data following enrollment. The information must be conveyed in accordance with all other CMS marketing restrictions, particularly those prohibiting misleading communications to beneficiaries.

4 Mandated Communications with Eligible Enrollees

4.1 Notice of VBID Benefits

Participating organizations must deliver to each clinically-targeted enrollee a written summary of those benefits (the "Notice of VBID Benefits") so that such enrollees are notified of the VBID benefits for which they are eligible.

In light of the diverse approaches to VBID benefits anticipated in the model, CMS is not specifying either a standard format for the Notice of VBID Benefits or a CMS-standard notice to eligible enrollees. Participating organizations are encouraged to craft the Notice of VBID Benefits in a way that will effectively engage targeted enrollees and communicate the VBID benefits being offering, consistent with the communication principles described in Section 2 above.

Despite the flexibility offered in the construction of the Notice of VBID Benefits, it must contain, at a minimum, the following information, in language appropriate to the organization's Notice of VBID Benefits:

- A description of the VBID benefits available to the enrollee. If the VBID benefits are different than the VBID benefits offered to that enrollee in a previous model year, the description must include a clear explanation of those changes. Participating organizations are encouraged, but not required, to explain how these benefits differ from their plan's generally available benefit package;
- If the enrollee's receipt of any VBID benefits is contingent on participation in care management or other like programs, a description of the participating organization's

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standards for measuring participation, how to enroll (if required), and how to seek an accommodation if needed due to health status, location or disability;

- If a participating organization is reducing cost-sharing contingent on obtaining services from certain high-value providers, a directory of these providers. If high-value providers are explicitly identified as such in the organization’s general provider directory, a statement directing enrollees to that directory is sufficient. If provider directories are provided online, information on how to access the directory and request a hard copy. See Section 4.4 below for more information on directories;
- A clear explanation of the clinical value of the services and activities included in the participating organization’s package of VBID benefits and the reasons why certain providers are considered high-value. This description is intended to assist enrollees in making an informed choice to use identified high-value providers and participate in required VBID activities;
- An explanation of the following elements of the MA-VBID model test:
 - That the VBID benefits are offered as part of a CMS (or Medicare) initiative to increase the quality and decrease the cost of care for beneficiaries in the Medicare Advantage program. This explanation must contain (or consist of) the following verbatim statement: “Medicare approved [participating organization name/marketing name] to provide [these benefits and/or lower co-payments/co-insurance] as part of the Medicare Advantage Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans;”
 - That not all other MA organizations and Plan Benefit Packages are participating in this initiative;
 - That the participating organization may only offer VBID benefits that consist of additional benefits or reduced cost sharing to enrollees in the targeted clinical condition group, and may not offer a plan that reduces available benefits or increases cost sharing;
 - That enrollees receiving VBID benefits retain their rights to file appeals and grievances;
 - That enrollees who do not want the additional benefits, reduced cost sharing or VBID-related communications may contact the participating organization to opt out;
 - That enrollees who do opt out or become ineligible for VBID benefits, due to non-engagement in required care management or similar program activities, may be allowed to enter/reenter the model;
 - For participating organizations offering VBID benefits contingent on enrollee participation in care management: That enrollees are not required to participate in care management if they do not wish to do so. But if they do not, they will not obtain the VBID benefits;
 - For participating organizations offering VBID benefits requiring use of a high-value provider: That enrollees in a plan are free to visit any provider in the organization’s network, at the original cost sharing amount;

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- How to contact the participating organization with questions regarding the VBID benefits, or to opt out of the VBID benefits;
- How to file a grievance, or an appeal of a determination relating to VBID benefits, including, if applicable, a determination that an enrollee is not satisfying requirements for participation in care management or like program. This must include the timely provision of an organizational/coverage determination, and grievance/appeal information required under Section 100.2 of the Medicare Marketing Guidelines to enrollees eligible for VBID benefits;
- Contact information for 1-800 MEDICARE and the local State Health Insurance Assistance Program (SHIP) for assistance;
- How to obtain the information in alternative formats as described in 4.6 of these communications guidelines;
- A disclaimer noting that the VBID benefits may change on January 1 of each year;
- The CMS-standard Multi-Language Insert.

4.1.1 Timing of Notice of VBID Benefits

4.1.1.1 Notice in Advance of Contract Year

In advance of each Contract Year, participating organizations must identify, based on information known to the participating organization and in accordance with the rules of the MA-VBID model test, those current enrollees who are members of an MA plan's clinically-targeted enrollee population. The participating organization must deliver the Notice of VBID Benefits to these enrollees by September 30, to coincide with the delivery of the Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) required pursuant to 42 CFR 422.111 and 423.128. See also Section 60.7 of the Medicare Marketing Guidelines.

The Notice of VBID Benefits may accompany the ANOC/EOC, or be delivered separately.

4.1.1.2 Notice during Contract Year

For enrollees who did not receive a Notice of VBID Benefits by September 30 prior to a contract year, perhaps because they are newly enrolled in an MA plan or the participating organization determined their eligibility during a contract year based on newly available information, participating organizations must mail a Notice of VBID Benefits within 30 calendar days of the participating organization's identification of that enrollee as eligible for VBID benefits.

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4.1.1.3 Transitional Implementation for Contract Year 2018

In order to allow newly participating organizations to carry out an orderly implementation of the MA- VBID model test in their first year, newly participating organizations may delay delivery of Notices of VBID Benefits until as late as January 30, 2018. However, unless a particular VBID benefit is contingent upon participation in a care management or like program that requires registration, the clinically-targeted enrollee populations of participating organizations' plans are eligible for VBID benefits beginning on January 1, 2018, on which date participating organizations must begin providing the approved VBID benefits.

4.2 Follow-Up Communications

In addition to the mandated annual Notice of VBID Benefits, participating organizations must deliver the following written communications to enrollees:

- An Explanation of Benefits (EOB) for payment of claims for VBID benefits. EOBs need not be distinct from those delivered by the participating organization for non-VBID benefits but EOBs must accurately reflect the VBID benefits provided to eligible enrollees and the appropriate cost sharing if reduced or eliminated as part of the VBID intervention and meet all applicable regulations and guidance for EOBs. Organizations approved to pay VBID benefits to enrollees by retroactive reimbursement check may either issue an EOB for such benefits, or propose alternative forms of notice to CMS.
- Notice of acknowledgment of an opt-out from VBID benefits. The notice must include an explanation of any benefit changes that will occur as a result of the opt-out, and instructions for rescission of the opt-out;
- Notice of acknowledgment of a rescission of an opt-out from VBID benefits. The notice must include an explanation of any benefit changes that will occur as a result of the rescission of the opt-out
- Notice of determination that an enrollee no longer qualifies for VBID benefits. The notice must include the rationale behind such a determination. This determination is considered a Standard Organization Determination for Part C benefits or a Coverage Determination for Part D benefits, and must contain the information required for notices of such determinations (see 42 C.F.R. Parts 422 & 423, subparts M; Chapter 13, Section 40.2 of the Medicare Managed Care Manual; and Chapter 18, Section 40.3.4 of the Medicare Prescription Drug Benefit Manual);
- Notice of determination that an enrollee is not participating in case management, and therefore, is not eligible for VBID benefits. The notice must include information on how to resume participation in case management if so desired. This determination is considered a Standard Organization Determination for Part C benefits or a Coverage Determination for Part D benefits, and must contain the information required for notices of such determinations (see 42 C.F.R. Parts 422 & 423, subparts M; Chapter 13, Section 40.2 of the Medicare Managed Care Manual; and Chapter 18, Section 40.3.4 of the Medicare Prescription Drug Benefit Manual)

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

The mandated communications to eligible enrollees detailed in this guidance represent the minimum that is expected of participating organizations – however, participating organizations can go beyond this and communicate further with targeted enrollees.

Examples of further communications with participating enrollees might include: (a) regular (quarterly or monthly) follow-up mailings, reminding eligible enrollees of the potential advantages available to them as the result of VBID, (b) follow-up phone calls with eligible enrollees, and (c) targeted phone calls or mailings, based on specific clinical or treatment patterns of a given enrollee. For instance, a participating organization might remind an enrollee, when granting that enrollee prior approval for a service that s/he is eligible for reduced cost-sharing for a surgical procedure if s/he uses a high-value provider.

4.3 Contingent VBID Benefits

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

4.4 Provider Directories & Network-Related Communications

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

Participating organizations must provide enrollees written notice of a provider’s loss of high value network status at least 30 calendar days before the effective date of the loss of status, if the loss of status is known at least 60 days prior, or otherwise within 30 days of the organization becoming aware of the loss of status. Participating organizations must send the written notice to all enrollees in the clinically-targeted enrollee population who are patients seen on a regular basis by the provider.

4.5 Electronic Communications and Websites

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Participating organizations may use websites to make information about VBID benefits or other information about VBID accessible to eligible enrollees. Websites may supplement, but not replace, the written communications required in the model test.

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

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

Participating organizations must make the following documents available in any language that is the primary language of at least five percent of the organization's service area in which VBID benefits are offered: Notice of VBID Benefits, notice of determination that an enrollee no longer qualifies for VBID benefits; notice of determination that an enrollee is not participating in case management; notice alerting enrollees how to access or receive a directory. Participating organizations that meet this five percent threshold for language translation must place on all written materials an alternative language disclaimer provided in applicable law (see also Section 30.5 of the Medicare Marketing Guidelines). CMS strongly encourages all participating organizations to translate other written materials.

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

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

5 Communications with Persons Other than Beneficiaries

5.1 Network Providers

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

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5.2 Communication with the Public Regarding the MA-VBID Model

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

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