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

Value-Based Insurance Design Model
Calendar Year 2025

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, chronic health conditions, and/or live in the most underserved area deprivation index (ADI) areas, in order to improve the coordination and efficiency of health care service delivery. The VBID Model for Calendar Year (CY) 2025 consists of the following Model components:

1. VBID flexibilities, for enrollees targeted by chronic health condition, socioeconomic status, place of residence in the most underserved ADI areas or a combination of chronic health conditions, socioeconomic status, and/or place of residence in the most underserved ADI areas, offering:
    a. Primarily and/or non-primarily health related supplemental benefits;
    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.
2. Part D Rewards and Incentives (RI) Programs (herein referred to as "Part D RI Programs").

If approved by CMS, participating MA Organizations (MAOs) are permitted to offer enrollees any of the Model components listed above. As used in this document, the term "Additional Benefits" refers to the items, services, and reductions in cost sharing offered to enrollees (or to Targeted Enrollees if there are limits on eligibility) in Model component 1 listed above.[1]

This document outlines the requirements for communications (including marketing)[2] activities and materials used by MAOs participating in the VBID Model. MAOs that participate in the Model in CY 2025 agree to adhere to these guidelines through the CY 2025 Addendum to the Medicare Managed Care Contract for Participation in the MA VBID Model (Addendum).[3] MAOs that participate(d) in the Model in CY 2024 must adhere to these guidelines for any newly submitted CY 2024 VBID Model communications and marketing materials, effective July 1, 2024.[4]

[1] "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 interventions as permitted under one or more VBID Components. The standards and criteria used by the MAO to identify Targeted Enrollees may vary depending on the VBID Component and must be identified in the Approved Proposal and approved by CMS. Per the Addendum, "Additional Benefits" means extra MA and Part D benefits (in addition to MA and, as applicable, Part D benefits required to be offered by the terms of the Underlying Agreement (including basic benefits, standard prescription drug coverage, and supplemental benefits)) offered by the MAO under the Model and may be in the form of additional items and services and reductions in cost sharing. Additional Benefits includes reductions in Part D cost sharing targeted to LIS beneficiaries, which are referred to as "Part D Cost Sharing Reductions Based on SES."

[2] Per 42 CFR §§ 422.2260 and 423.2260, the term "communications" means "activities and use of materials created or administered by the MA organization or any downstream entity to provide information to current and prospective enrollees. Marketing is a subset of communications."

[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.

In addition to the requirements in this document, participating MAOs should review the Addendum and applicable regulations. 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 [regarding the Part D benefit coverage by 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 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.

Below, CMS provides an overview of this document:

- Section 1 discusses the requirements that participating MAOs must follow in communicating and/or marketing Additional Benefits to enrollees and provides general timelines for informing enrollees, both current and prospective, of those Additional Benefits.

- Section 2 discusses additional requirements that participating MAOs offering Part D RI Programs must follow in communicating and/or marketing the existence of Part D RI Programs to enrollees. Part D RI Programs refer to those offered as part of implementing a VBID Model approved proposal. Note: The principles outlined in section 1 are also applicable to communicating and/or marketing Part D RI Programs to enrollees, both current and prospective.

- Appendix 1 includes instructions for, and a template of, the VBID Member Engagement Strategy[5] (which all participating MAOs are required to submit), first described in section 1.1.

- Appendix 2 contains requirement checklists to guide participating MAOs in the development of communications and marketing materials that include information on Additional Benefits and Part D RI Programs.

- Appendix 3 contains communications requirements for MAOs that offered the Hospice Benefit Component in CY 2024.

1. Communications Requirements & Timeline

1.1 Summary of Model Communications and Marketing Requirements

1. **Participating MAOs must submit to CMS a description of how they will inform and engage enrollees about the Additional Benefits and/or Part D RI Programs available to them (herein referred to as the "VBID Member Engagement Strategy").**

[5] As per section 3.2 of the Request for Applications for the Calendar Year 2025 VBID Model, prior to the start of CY 2025, MAOs approved for participation in the Model must submit to CMS, as part of their organization-specific communication materials, a description of how they will inform and engage enrollees about the Model Benefits and/or Model Rewards that will be available ("VBID Member Engagement Strategy").

A key to successfully offering Additional Benefits and/or Part D RI Programs is achieving enrollee awareness and engagement. 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 Additional Benefits and Part D 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[6] and/or Targeted Enrollees.

Note: CMS is also particularly interested in any strategies that participating MAOs may be using to advance health equity and reach underserved communities[7] that may require different types of approaches and/or culturally competent communications and outreach to fully engage in the Additional Benefits and/or Part D RI Programs for which they are eligible.[8]

2. **Participating MAOs shall only use the materials described in section 1.1.2 below that have been approved by CMS to notify enrollees who are eligible for Additional Benefits and/or Part D RI Programs.**

   a. **An Evidence of Coverage (EOC) and an Annual Notice of Change (ANOC) must include the Additional Benefits that will be offered to enrollees:**

   In the CY 2025 EOCs that are required as part of the MA program,[9] participating MAOs must include all Additional Benefits along with language that ensures enrollees are aware of any targeting criteria for accessing Additional Benefits.

   Participating MAOs that are new or continuing in the Model and are adding VBID Additional Benefits to a CY 2024 plan for CY 2025, or participating MAOs that are continuing but have changes to VBID Additional Benefits, must also include the VBID Additional Benefits in the ANOC for existing enrollees. For all Plan Benefit Packages (PBPs) that will no longer include VBID Additional Benefits in CY 2025, a participating MAO must include the benefit changes in the ANOC. The CY 2025 ANOC must include these changes in eligibility for and scope of Additional Benefits and be provided to enrollees in accordance with the MA Program ANOC deadline. CMS includes Model-

[6] "Eligible Enrollee" means a Medicare beneficiary who is not yet enrolled in one of the participating MAO's VBID participating PBPs, but if enrolled, would be eligible to receive Additional Benefits under one or more VBID Components; or a beneficiary who is enrolled in the MAO's VBID participating PBP who is potentially eligible but has not yet been determined eligible or not yet started to receive the Model Benefits.

[7] 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.

[8] 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

[9] See 42 CFR §§ 422.111 and 422.2267(e)(1)

specific language in the CY 2025 standardized models for the EOC and ANOC, which can be found here: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.[10]

b. **Participating MAOs that offer Part D RI Programs must communicate information about the Part D RI Programs to enrollees:**

While Part D RI Programs are not Medicare or Model benefits and may not be listed in the EOC or ANOC, participating MAOs must communicate accurate and complete information about the Part D RI Programs via other vehicles in order to ensure that enrollees have sufficient information to understand and access the available Part D RI Programs (*see section 2 for additional, specific requirements*).

c. **Participating MAOs must provide additional communications to enrollees related to other VBID Model-specific materials, as applicable:**

These materials include: a notice of acknowledgement of an opt-in or opt-out from Additional Benefits; a notice of determination that an enrollee no longer qualifies for Additional 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 Additional Benefits are conditioned.

Participating MAOs may also tailor other communication materials required by the MA program and, for participating MAOs that offer Part D benefits, the Part D program (see 42 CFR §§ 422.2267(e) and 423.2267(e) for regulations governing other required communications), including all pre-enrollment materials and scripts, for use in the Model.

3. In addition to the requirements listed above, participating MAOs have the option, and are encouraged, to engage enrollees and inform them about Model Benefits and/or Part D RI Programs through additional communications materials and approaches.

Additional communications to enrollees regarding Model Benefits and Part D RI Programs must also be submitted to CMS for review and approval, as reflected in Table 1 of section 1.9 of this document. Further, if a participating MAO makes any changes to its high-value provider list in CY 2025 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. In addition, participating MAOs must comply with the notice

[10] 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 2025 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

requirements at 42 CFR §§ 422.111(e) and 422.2267(e)(12) regarding provider terminations from the plan network.[11]

4. **In the event eligibility of Targeted Enrollees for potential Additional Benefits or Part D RI Programs is not assured or cannot be determined before a Plan Year, the MAO shall provide a disclaimer on all relevant materials describing the Additional Benefits or Part D RI Programs.**

   Such a disclaimer must clearly state that eligibility for the potential Additional Benefit or Part D RI Programs under the VBID Model is not assured and will be determined by the MAO after enrollment, based on relevant criteria (e.g., clinical diagnoses, eligibility criteria, participation in a disease state management program). Additionally, the VBID disclaimer must align with all parameters of the SSBCI disclaimer as described in the April 2024 Final Rule.[12] Participation in the VBID Model does not waive applicable MAOs' requirements for the SSBCI disclaimer as described in the April 2024 Final Rule that requires all marketing and communications materials that mention SSBCI must include an SSBCI disclaimer that lists the relevant chronic condition(s) the enrollee must have to be eligible for the SSBCI offered by the MAO.

1.2 Communications and Marketing Material Principles and Naming of Model Benefit Packages for Enrollees

Generally, participating MAOs' communications, including marketing materials of Additional Benefits and Part D RI Programs, must be designed to outline all Additional Benefits and Part D RI Programs available to enrollees and Targeted Enrollees. Consistent with 42 CFR §§ 422.2262(a)(1)(iii) and 423.2262(a)(1)(iii), which prohibit 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 Additional 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 enrollees who are not Targeted 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 Additional Benefits and/or Part D RI Programs that in any way discriminates among enrollees based on race, ethnicity, national origin, religion, sex, or gender.

[11] See final rule titled, "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of all-Inclusive Care for the Elderly," which appeared in the Federal Register on April 12, 2023 (88 FR 22120, 22179 through 22185).

[12] https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescription-drug-benefit

Further, other general plan information may accompany communications and marketing of Additional Benefits and/or Part D RI Programs, provided the information is complementary to all the Additional Benefits and/or Part D RI Programs being offered. For example, the MAO's strategy to communicate Additional Benefits may be part of a larger communication describing Additional Benefits, disease management programs, and general health information, as relevant to a particular population of enrollees.

All communications and marketing of Additional Benefits and Part D RI Programs must be designed to both engage Eligible Enrollees and inform them of their additional rights and benefits based on the MAO's participation in the VBID Model. Participating MAOs must not mislead, confuse, or provide materially inaccurate information.[13] In addition to the requirements in 42 CFR Parts 422 and 423, and Subpart V, participating MAOs must use plain, concise, and well-organized language, clear and actionable communication formats, and methods that are accessible and easy for both Eligible and Targeted Enrollees to clearly understand the scope of Additional Benefits and Part D RI Programs. This is especially important for individuals who have Limited English Proficiency (LEP) and/or need auxiliary aids or services.

In addition to complying with the applicable program regulations, participating MAOs must adopt an approach for submitted materials that include information on Additional Benefits and/or Part D RI Programs that clearly outlines:

- the Additional Benefits and/or Part D RI Programs available to Eligible and Targeted Enrollees;
- what must be done to qualify for and receive Additional Benefits and/or Part D RI Programs (as applicable); and
- where and how to ask questions or receive help with understanding Additional Benefits and/or Part D RI Programs (by providing a toll-free phone number, at a minimum).

The activities in carrying out this approach must comply with applicable laws for MA and Part D plans, such as those that require provision of interpreter services. The approach should ultimately serve to engage enrollees eligible for Model component(s) to utilize these specific benefits available under the Model as well as include language that is easily understood by enrollees and potential enrollees, especially individuals who have LEP.

1.3 Submission Process of Materials for CMS Review

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

- **VBID Member Engagement Strategy:** Participating MAOs must submit the VBID Member Engagement Strategy via a Qualtrics survey, issued from the VBID mailbox at a later date.

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

- **Other Communications and Marketing Materials:** Participating MAOs must submit for CMS review and approval all other communications and marketing materials specific to Additional Benefits (outside those materials noted above) and Part D RI Programs (as defined and described in section 2 below), including all pre-enrollment materials and scripts to the HPMS Marketing Review Module. Marketing materials must be submitted under the "VBID" content type, which is within the "Plan Created" submission type. Communications that are not marketing must be submitted under the "Communications with VBID Content" material type, which is within the "Required" submission type. These other communications include VBID Model-specific materials, such as: a notice of acknowledgement of an opt-in or opt-out from Additional Benefits; a notice of determination that an enrollee no longer qualifies for Additional 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 Additional Benefits are conditioned, as defined in section 1.4 below.

  In accordance with 42 CFR §§ 422.2261(b)(3) and 423.2261(b)(3), CMS designated materials may be distributed five calendar days (File and Use) after submission to HPMS provided that CMS has not denied permission to use the material(s) within that five-day window. If CMS determines a material is non-compliant, the MAO may no longer use that material even though it was submitted using the File & Use process. When submitting, the participating MAO must certify 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 materials 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.

All other CMS requirements relating to the review of marketing materials under 42 CFR Part 422, Subpart V, and Part 423, Subpart V (for MA-PD Part D materials), continue to apply to participating MAOs for all communications and marketing materials, including VBID-related communications and marketing materials. Therefore, to the extent that other CMS-required materials contain VBID Model-related content but are not specifically identified in this section, the materials must be submitted to HPMS as required by CMS, under categories appropriate to the type of material submitted. For example, the EOC must be submitted 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

1. In addition to the mandated annual EOC and ANOC (as applicable), participating MAOs must deliver the following written communications to enrollees:

- **An Explanation of Benefits (EOB) for payment of claims for Additional Benefits.**

EOBs for Additional Benefits need not be distinct from those delivered by the participating MAO for covered benefits that are not VBID Additional Benefits. EOBs must accurately reflect the Additional 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.

- **Notice of acknowledgment of an opt-out from Additional Benefits.**[14]
  The notice must include an explanation of any changes in access, availability, cost sharing, and eligibility for Additional Benefits that will occur as a result of the opt-out by the enrollee(s), including instructions for rescission of the opt-out. 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 Additional 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, the MAO may request an exception by submitting a request and explanation to the CMS VBID mailbox at VBID@cms.hhs.gov for CMS review and approval. Exception requests must be received prior to the start of the contract year and must clearly provide the specific Additional Benefit for which the exception is requested, in addition to a rationale specific to each Additional Benefit where an exception is being requested.

  A non-exhaustive list of Additional Benefits where an exception of this requirement (i.e., the requirement for a notice of acknowledgment of an opt-out) may be granted include certain supplemental benefits that are available to all enrollees where the enrollee may simply choose not to utilize the benefit such as reductions in cost sharing (Part C or Part D) or primarily and non-primarily health related supplemental benefits that do not condition receipt of the benefit on the use of high-value providers and/or participation in care management program(s)/ disease state management program(s) and are structured in such a way so that enrollees are clearly not compelled to utilize the benefit or otherwise burdened by the benefit.

- **Notice of acknowledgment of a rescission of an opt-out from Additional Benefits.**[15]
  The notice must include an explanation of any changes in access, availability, cost sharing, and eligibility for Additional 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 Additional 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-

[14] 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.
[15] Id.

Grievances/MMCAG). For example, the notice must also inform the enrollee affected by the initial determination of their right to a reconsideration and must include instructions on how to request a reconsideration. A notice of determination that an enrollee no longer qualifies for Additional Benefits is not required if an enrollee disenrolls from the plan.

- **Notice of a determination that enrollees are not eligible for Additional Benefits due to lack of participation in disease management or similar programs, as applicable.**
  If the participating MAO has been approved to condition receipt of Additional Benefits using additional factors, such as participation in a disease management or care management program, a notice of a determination that the enrollee is not eligible must include information on how to resume participation in the disease management or care management program, if so desired, or how to regain eligibility for the Additional Benefit. This determination is considered a standard Organization Determination for Part C benefits or a Coverage Determination for Part D benefits when it is about Additional 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).

2. Additional Requirements for Materials

Except for standard EOBs for payment of claims for Additional Benefits, each of the written communications listed in section 1.4.1 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 requirements for participating MAOs. However, participating MAOs may go beyond this and communicate further with enrollees regarding Additional Benefits and/or Part D RI Programs so long as those communications are submitted to CMS for review and approval as stated in table 1 below. Examples include: (a) regular (quarterly or monthly) follow-up mailings, reminding enrollees of the potential advantages available to them as the result of participating in Additional Benefits; (b) follow-up phone calls with enrollees; and (c) targeted phone calls or mailings, based on specific clinical or treatment patterns for 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 reduced cost-sharing for that service if they use a high-value provider.

New for the VBID Model in CY 2025 is the use of residence in an area based on the ADI as a basis for targeting Additional Benefits to enrollees. All written communications and requirements described in this section are applicable to Additional Benefits targeted to enrollees living in the most underserved ADI areas just as they are for other Additional Benefits. As outlined in Article 3(C)(6), plans may additionally engage their VBID Enrollee Advisory Committee[16] to identify effective strategies and interventions for raising enrollee awareness and engagement with Additional Benefits.

1.5 Provider/Pharmacy Directories and Network-Related Communications

Participating MAOs must satisfy all current program requirements, including in 42 CFR §§ 422.111, 422.2267(e)(11), 423.128, and 423.2267(e)(15) as applicable, with regard to provider and pharmacy directories.[17] Additionally, participating MAOs offering Additional Benefits contingent on the use of a high-value provider 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 eligible for reduced cost sharing for using high-value providers[18] 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 Additional Benefits offered and the primary care providers of enrollees. Providers identified as high-value under the Model should also be specifically made aware they are listed as a high-value provider.

The requirements in 42 CFR 422.111(e) and 422.2267(e)(12) regarding changes to the provider network and notices of termination of a provider from the network are not waived and apply to

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[16] Per the CY 2025 VBID Request for Applications (RFA), in alignment with the existing D-SNP requirement described in § 422.107, participating MAOs targeting by ADI must incorporate input from one or more Enrollee Advisory Committees (EACs) in each state in which the MAO offers VBID participating plans proposing to include ADI targeting. An MAO may satisfy this requirement through its existing EAC(s), as applicable and feasible. For MAOs that propose to offer plans that include ADI targeting and do not have an EAC in place in those plans' state(s), the MAOs must establish one. EACs established and maintained to satisfy ADI targeting flexibility requirements remain subject to MA rules governing EACs in § 422.107, including that membership size and meeting frequency be at the MAO's discretion.

[17] CMS issues instructions and models for the provider and pharmacy directories required of MA and Part D plans. The provider directory model and instructions are posted at https://www.cms.gov/medicare/health-drug-plans/managed-care-marketing/models-standard-documents-educational-materials (see zipped file of model materials for the year) and the pharmacy directory model and instructions are posted at https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/part-d-model-materials (see zipped file of model materials for the year).

[18] See Addendum, Article 3(C)(3).

participating MAOs. MAOs must provide enrollees notice of a termination of a contracted provider, irrespective of whether the termination was for cause or without cause, in accordance with § 422.2267(e)(12). For network terminations that involve a primary care or behavioral health provider, all enrollees who are patients or have been patients within the past three years of that primary care professional or behavioral health provider must be notified at least 45 calendar days in advance of the termination, both in writing and by at least one attempted telephone contact.

1.6 Electronic Communications and Websites

Participating MAOs may use websites to make information about Additional 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 that 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) and 423.2267(d).

Electronic communications and websites should serve the intended audience, be person centered, and follow the guidelines provided within this document. More specifically, websites and their contents should be easily accessible and navigable by Eligible Enrollees and Targeted Enrollees, including those who have LEP or need auxiliary aids or services.

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

Participating MAOs must make VBID Model communications, including marketing materials, 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 Additional Benefits and/or Part D RI Programs are offered. Per 42 CFR 422.2267(a)(3) and 423.2267(a)(3), as amended in the April 2023 Final Rule, MAOs must provide required materials to enrollees on a standing basis in a non-English language or accessible format upon receiving a request or when otherwise learning of the enrollee's primary language or need for accessible format. This language accessibility requirement also applies to other communications such as a notice of determination that an enrollee no longer qualifies for Additional Benefits, a notice of determination that an enrollee is not participating in disease or case management, and a notice alerting enrollees how to access or receive a directory.[19]

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 for non-English translations. For plan-created materials that will only be used in a non-English language, participating MAOs must submit an English translation via a zip file containing both the material and the translation(s) to HPMS. Participating

[19] In addition, CMS's regulations at §§ 422.2267(a)(4) and 423.2267(a)(4)0 provide that for any fully integrated dual eligible special needs plan or highly integrated dual eligible special needs plan, as defined at § 422.2, or applicable integrated plan, as defined at § 422.561, all required materials be translated into the language(s) required by the Medicaid translation standard as specified through their capitated Medicaid managed care contract in addition to the language(s) required by the Medicare translation standard in §§ 422.2267(a)(2) and 423.2267(a)(2).

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 Targeted Enrollee, including those who have LEP who are eligible or potentially eligible for an Additional Benefit and/or Part D RI Program. This requirement means that participating MAOs may need to provide language assistance services, such as written translation and oral interpretation, in languages other than those that constitute at least five percent of the population within the participating MAO's service area in which Additional Benefits or Part D RI Programs are being offered. MAOs must notify enrollees and Targeted Enrollees of the availability of materials.[20] For example, VBID Model materials should clearly state language assistance services are available or describe how readers can request a translated version of the material. In addition, §§ 422.2267(e)(31) and 423.2267(e)(33), requires that all MAOs include a standardized multi-language insert (MLI) describing availability of free interpreter services in all required materials.[21] 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). Other examples not requiring an MLI are scripts and other non-enrollee facing materials, outdoor advertising and bus advertising, radio advertisements, radio sponsorships, and websites/social media posts which may automatically translate.

Participating MAOs also must ensure effective communication with individuals with disabilities and provide auxiliary aids and services, such as alternate formats (e.g., braille, large print, data/audio files, relay services, and TTY communications), to ensure an equal opportunity to access Additional Benefits and Part D RI Programs. In addition, per 42 CFR §§ 422.2267(a)(3) and 423.2267(a)(3) (see April 2023 Final Rule, 88 FR at 22232), participating MAOs are responsible for providing materials to enrollees in an accessible format on a standing basis upon request, such as alternative formats and/or using auxiliary aids and services when needed (e.g., Spanish braille).[22] Participating MAOs must provide a toll-free TTY number in conjunction with the customer service number in the same font size as the other toll-free 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), plans are not required to include a toll-free TTY number on outdoor advertising (ODA), banners or banner-like ads, radio advertisements, and radio sponsorships (e.g., sponsoring an hour of public radio).

[20] See 42 CFR 422.2267(a)(3) and 423.2267(a)(3).
[21] CMS updated its MLI requirements as part of the CY 2025 C/D final rule. These changes will apply starting with marketing for the CY 2026 plan year in the fall of 2025. The required notice will be referred to as the "Notice of availability of language assistance services and auxiliary aids and services (Notice of Availability)". The notice will be a required "model" communications material (whereas the MLI is a required "standardized" communications material), and thus will be subject to the requirements for "model" required materials at §§ 422,2267(c) and 423.2267(c).
[22] See 42 CFR 422.2267(a)(3) and 423.2267(a)(3).

The guidelines within this section are also applicable to communications, including marketing materials used for and distributed at marketing and education events, as well as sales meetings by MAOs and/or their agents and/or brokers.

1.8 Communication with the Public Regarding the VBID Model

Participating MAOs must obtain prior approval from CMS both during participation in the VBID Model, and for six months thereafter, for the publication or release of any press release, external report, and/or statistical and analytical material that substantially references the MAO's participation in the Model. If approved, these materials must also include certain disclaimers. Reference Article 3, section I (Release of Information) of the Addendum for specific requirements. To obtain prior approval, please email a copy of the material proposed for publication to the CMS VBID mailbox at VBID@cms.hhs.gov.

1.9 Communications Timeline

Table 1 below outlines general timelines for informing enrollees, both current and prospective, of Additional Benefits and Part D RI Programs. It distinguishes between VBID Model communications and marketing materials that are subject to prospective review or five calendar day File & Use, and also 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)*	Submission Timeline	Submission Mechanism
VBID Member Engagement Strategy	**Prospective** CMS review & approval *(45 Days)*	September 16 – October 18, 2024	Submit via a Qualtrics survey, issued from the VBID mailbox at a later date.
EOC/ANOC *(which includes VBID Additional Benefits but must not include Part D RI Programs)*	**File & Use*** if the material has been designated as File & Use under 42 CFR §§ 422.2261(b)(3) and 423.2261(b)(3), and the participating MAO certifies compliance	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 Part D RI Program Communications *(except for the EOC)*	**File & Use*** if the material has been designated as File & Use 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.

Material	Type of Review *(Calendar Days)*	Submission Timeline	Submission Mechanism
Model Benefit and Part D RI Program Marketing *(except for the ANOC)*	**File & Use*** if the material has been designated as File & Use 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.

* If CMS has not designated the material as File & Use, as permitted by §§ 422.2261(b)(3) and 423.2261(b)(3) then the materials will require a 45-day prospective review.

2. Requirements for Informing Enrollees about Part D RI Programs

This section sets out additional requirements that participating MAOs offering Part D RI Programs must comply with in communicating and marketing the existence of Part D RI Programs to enrollees and Targeted Enrollees. For CY 2025, the VBID Model will not include Part C RI Programs (as part of the model test) but participating MAOs may offer Part D RI Programs as approved by CMS.[23]

Participating MAOs may offer Part D RI Programs consistent with the terms of the Model and the Addendum. Part D RI Programs are not Medicare benefits or Additional Benefits and thus, must not to be treated as benefits. Participating MAOs may use different approaches for communicating with enrollees and potential enrollees about Part D RI Programs while keeping the following guidance in mind. First, while Part D RI Programs are not benefits and may not be listed in the EOC or ANOC, participating MAOs that communicate the availability of these Part D RI Programs to enrollees must describe the Part D RI Program(s) completely and accurately in order to ensure that enrollees have sufficient information to understand the available Part D RI Programs. Second, participating MAOs must answer questions about the Part D RI Programs and include information about the Part D RI Programs in the educational information sent to enrollees and made available to potential enrollees.

Participating MAOs may market the existence of Part D RI Programs to potential enrollees and must comply with the standards and requirements for RI Programs in 42 CFR §§ 422.134, 422.2260 through 422.2272 and 423.2260 through 422.2272 as if those requirements applied to the Part D RI Program offered as part of the Model and except as those standards are not made applicable to the Part D RI Programs in the Addendum.

Marketing of all Part D RI Programs must:

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

[23] Participating MAOs may offer Part C RI Programs pursuant to 42 CFR § 422.134.

In addition to these requirements, participating MAOs must adopt a communications strategy for clearly describing to both enrollees and prospective enrollees the Part D RI Program(s) available. These communications must include, at a minimum:

- the intended goal of the Part D RI Program(s);
- what must be done to receive the RI;
- the per unit value of the RI;
- the total annual value of the RI that an enrollee can receive;
- sufficient information on how the RI will be delivered; and
- where and how to ask questions or receive help with understanding the Part D RI Program(s) (by providing a toll-free phone number, at a minimum).

CMS will apply 42 CFR §§ 422.2260 and 423.2260 to determine if these communication materials are marketing and subject to review as marketing materials. Participating MAOs must submit all Part D 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, Part D RI Program marketing materials may be distributed five calendar days after submission to HPMS if CMS has designated the material as File & Use under 42 CFR § 422.2261(b)(3) unless and until CMS directs the participating MAO to stop using the material(s). Participating MAOs are encouraged to craft Part D RI Program materials in a way that will effectively engage enrollees and potential enrollees and is consistent with the communications principles described in section 1 above, which must be designed to outline all of the Part D RI Programs available to enrollees and potential enrollees.

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.[24] Importantly, RI "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.

[24] See Addendum, Article 3, sections D, E and Appendix 2, which require compliance with the standards in 42 CFR § 422.134, except as specifically made non-applicable, for Part D RI Programs.

Appendix 1: VBID Member Engagement Strategy

Deadline for Reporting the VBID Member Engagement Strategy to CMS: October 18, 2024
Reporting Platform: Qualtrics

INTRODUCTION

Your CY 2025 VBID application previewed approaches that your organization plans to use to engage and activate Eligible and/or Targeted Enrollees in Additional Benefits and/or Part D RI Programs. As CY 2025 enrollment approaches, the VBID Member Engagement Strategy (MES) is an opportunity to provide a more thorough review and explanation of the approach and actions you will take to ensure enrollees are aware of their Additional Benefits and/or Part D RI Programs and are fully engaged in them.

SECTION 1: MEMBER ENGAGEMENT STRATEGY FOR EACH VBID ADDITIONAL BENEFIT AND PART D RI PROGRAM

For each VBID Additional Benefit (e.g., food and produce; transportation for non-medical needs) and Part D RI program (e.g., reward for participation in a medication therapy management program) you are offering in CY 2025, please respond to the following questions.

1. Please select which Model Components you intend to offer in CY 2025**.**
   - □ VBID Additional Benefit(s) ONLY
   - □ VBID Additional Benefits(s) and Part D RI

2. Please select which methods you plan to use to ensure that enrollees are aware of key information regarding Additional Benefits and Part D RI Programs (e.g., eligibility, how to access Additional Benefits/Part D RI Programs, where Additional Benefits/Rewards and Incentives can be used). **(select all that apply)**
   - □ Evidence of Coverage (EOC) (for Additional Benefits only)
   - □ Annual Notice of Change (ANOC) (for Additional Benefits only)
   - □ Summary of Benefits (SB)
   - □ Explanation of Benefits (EOB)
   - □ Brochures
   - □ Welcome back kits
   - □ Welcome back texts/calls
   - □ Member orientation (in-person)
   - □ Member orientation (online)
   - □ Care management program
   - □ Face-to-Face interactions at retail locations
   - □ Sales and broker communication/marketing
   - □ Other (please describe)

3. In addition to complying with the requirement to include the Multi-language Insert with all required materials listed in § 422.2267(e), and to provide required materials in a non-English

language or accessible format on a standing basis where required as provided in § 422.2267(a)(3), how will you inform individuals who have Limited English Proficiency (LEP) and/or need auxiliary aids or services of the availability of Model communications and marketing materials in their language of choice? **(select all that apply)**

- ☐ Indicate in print materials that alternative formats are available
- ☐ Distribute notices of available aids and services
- ☐ Proactive translation of materials based on known populations
- ☐ Proactive translation of materials based on individual's stated preferences
- ☐ 508 remediation of online materials
- ☐ Other (please describe)

4. Please describe your organization's other planned engagement efforts (those not already discussed). **(500 characters)**

SECTION 2: MES GOAL TRACKER

Please describe your CY 2025 goals related to member awareness of, and engagement with, VBID Additional Benefits and RI Programs. **Your organization should define and select its own performance measures for CMS review and approval. The placeholder text in the following table is provided solely as an example and not as a definitive or exhaustive list of acceptable performance measures.** Through the VBID Model's monitoring efforts, your organization will be required to submit as a follow-up, in March 2026, an updated version of your MES Goal Tracker via Qualtrics that includes the CY 2025 Outcome for each goal.

Responses should be specific to each Additional Benefit and Part D RI Program that you are offering under the VBID Model.

If you are offering multiple VBID Additional Benefits and/or Part D RI Programs through several Model Components, please group your responses by Component type (e.g., VBID Additional Benefits, Part D RI Programs).

Performance Measure	Description	Rationale for Inclusion	Baseline (N/A if new MAO)	CY 2025 Goal	CY 2025 Outcome (to be filled out in update submitted in March 2026)
Benefit Awareness					
Example: Personalized Face-to-Face discussions of VBID benefit eligibility	**Placeholder text**	**Placeholder text**	**Example:** 30% of VBID enrollees	**Example:** 50% of VBID enrollees	
Benefit Engagement					
Example: Providers trained on VBID benefits and eligibility requirements	**Placeholder text**	**Placeholder text**	**Example:** 80% of in-network providers	**Example:** 100% of in-network providers	
Accessibility					
Example: Number of beneficiary requests for non-English VBID documents	**Placeholder text**	**Placeholder text**	**Example:** 5 (of 35 LEP enrollees in service area)	**Example:** 20 (of 35 LEP enrollees in service area)	

Appendix 2: VBID Model Communications and Marketing Checklists

The checklists below are intended to guide participating MAOs in the development of VBID materials that include information on Additional Benefits and/or Part D RI Programs. These checklists are not complete summaries of all applicable legal requirements for the MA program that continue to apply to communication and marketing activities and materials used by the MAO. Participating MAOs must take the necessary steps to ensure that they comply with all unwaived requirements regarding communication, including marketing.

For requirements related to inclusion of Additional Benefits in the EOC and ANOC, please see the CY 2025 Marketing Models here: https://www.cms.gov/medicare/health-plans/managedcaremarketing/marketngmodelsstandarddocumentsandeducationalmaterial.

Requirements that participating MAOs must follow in communicating and/or marketing any VBID Additional Benefits and/or Part D RI Programs:

- ☑ Accurately describes Additional Benefits and/or Part D RI Programs as approved by CMS
- ☑ Uses plain, concise, and well-organized language; clear and actionable communication formats; and methods that are accessible and easy for both Eligible Enrollees and Targeted Enrollees to clearly understand the scope of Additional Benefits and/or Part D RI Programs
- ☑ Provides accessibility for individuals with disabilities to ensure an equal opportunity to access Additional Benefits and/or Part D RI Programs
- ☑ Provides accessibility for individuals who have LEP to ensure an equal opportunity to access Additional Benefits and/or Part D RI Programs
- ☑ Provides information on how to request materials in alternate languages and/or formats as applicable and communicates that requests can be made on a standing basis
- ☑ Provides materials that are easily accessible and navigable by both Eligible and Targeted Enrollees, including individuals who have or need written translation services for PBPs within a service area where 5% of the population speak an alternate language
- ☑ Includes where and how to ask questions or receive help with understanding Additional Benefits (by providing a toll-free phone number, at a minimum, which includes interpreter services)
- ☑ Describes what must be done to qualify for and receive Additional Benefits and/or Part D RI Programs, as applicable
- ☑ Includes the form, frequency, and amount of Additional Benefits[25] and/or Part D RI Programs, as applicable
- ☑ Includes a disclaimer to specify that "Eligibility for the Additional Benefits or RI Programs under the VBID Model is not assured and will be determined by the MAO after enrollment, based on relevant criteria (e.g., clinical diagnoses, eligibility criteria, participation in a disease state management program)" in the event eligibility of Targeted Enrollees for Additional Benefits or Part D RI Programs is not assured or cannot be determined before a Plan Year, as applicable.

[25] Participating MAOs offering a Healthy Foods Card (HFC) to Targeted Enrollees for example must include the frequency and amount of the HFC. An exception to this amount requirement is if materials are intended for multiple PBPs and the associated amounts vary by PBP.

Requirements that participating MAOs offering Part D RI Programs must follow in communicating and/or marketing the existence of the Part D RI Program(s):

- ☑ Does not offer RI in exchange for enrollment
- ☑ Provides an accurate description of the intended goal(s) of the Part D RI Program(s)
- ☑ Describes what must be done to receive the RI
- ☑ Specifies the per unit value of the RI
- ☑ Specifies the total annual value of the RI that an enrollee can receive
- ☑ Includes where and how to ask questions or receive help with understanding the Part D RI Program(s)
- ☑ Includes sufficient information on how the RI will be delivered (e.g., gift card or grocery card)
- ☑ Does not conflate VBID/Medicare benefits with Model RI

Requirements that participating MAOs must follow in developing additional required enrollee communications:

- ☑ Contains the following disclaimer: "Medicare approved [participating MAO name/marketing name] to provide [these benefits and/or lower copayments/co-insurance] as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans."[26]

Additional Requirements for all Notices of Acknowledgement of an Opt-Out from Additional Benefits

- ☑ Includes an explanation of any changes in access, availability, cost sharing, and eligibility for Additional Benefits that will occur as a result of opt-out by the enrollee
- ☑ Includes instructions for rescission of opt-out, as applicable

Additional Requirements for all Notices of Acknowledgement of a Recession of an Opt-Out from Additional Benefits

- ☑ Includes an explanation of any changes in access, availability, cost sharing, and eligibility for Additional Benefits that will occur as a result of rescission of opt-out by the enrollee

Additional Requirements for all Notices of Determination that an Enrollee No Longer Qualifies for Additional Benefits

- ☑ Includes the rationale[27] underlying such a determination and complies with requirements in Part 422, Subpart M for organization determinations that are denials

[26] This disclaimer is required for all Notices of Acknowledgement of an Opt-Out from Additional Benefits, Notices of Acknowledgement of a Recession of an Opt-Out from Additional Benefits, and Notices of Determination that an Enrollee No Longer Qualifies for Additional Benefits.

[27] This must include a specific and detailed explanation of why the Additional Benefit (which could be medical services, items or Part B drugs or other items and services) were denied, including a description of the applicable coverage rule or plan policy (e.g., Evidence of Coverage provision) upon which the action was based. An explanation about what information is needed to approve coverage must be included, if applicable. See §§ 422.566(d), 422.568, 422.572, and 422.631 regarding denials, including the content and timing of notices. A notice of determination that an enrollee no longer qualifies for Additional Benefits is not required if an enrollee disenrolls from the plan.

- ☑ Informs the enrollee affected by the initial determination of their right to a reconsideration (Part C) or redetermination (Part D) by the plan.
- ☑ Includes instructions on how to request a reconsideration.
- ☑ Informs the enrollee affected by the initial determination of their right to submit additional evidence in writing or in person
- ☑ Includes instructions on how to resume participation in the disease management or case management program, if so desired[28]

Requirements for all Explanations of Benefits (EOBs):

- ☑ Accurately reflects Additional Benefits provided to enrollees and the appropriate cost sharing if reduced or eliminated as part of the Model component

Note: If any of the aforementioned requirements are not met, please use the "Plan Comments" section in the HPMS Marketing Review Module to provide a justification or any additional information to facilitate CMS review of Model communications and marketing materials.

[28] This is specifically for Notices that enrollees are not participating in case management and therefore are not eligible for Additional Benefits, as applicable.

Appendix 3: Additional Requirements for Communications Regarding the Hospice Benefit Component for MAOs who participated in the Hospice Benefit Component during CY 2024

For CY 2025, the Hospice Benefit Component will no longer be available through the VBID Model. These Model Communications and Marketing Guidelines address communications and marketing requirements related to participation in the Hospice Benefit Component for the remainder of CY 2024 and for certain CY 2025 materials that address benefit coverage.

MAOs that participated in the Hospice Benefit Component in CY 2024 (herein referred to as "transitioning MAOs") must submit excerpts from their CY 2025 EOC(s) and ANOC(s) for separate CMS-pre-review and approval prior to submission of the entire EOC(s) and ANOC(s) to the Health Plan Management System (HPMS) in accordance with § 422.2261. The overall goal of CMS's review for CY 2025 ANOCs and EOCs will be to ensure that CY 2024 MAO participants clearly and accurately describe to enrollees the transition from the PBP's participation in the Hospice Benefit Component to no longer participate as of January 1, 2025, and what this might mean for an enrollee's coverage and experience of care.

These Model-specific excerpts may be submitted on a rolling basis but must be submitted no later than **July 19, 2024** to the CMS VBID mailbox (VBID@cms.hhs.gov) and Acumen VBID Model Communications and Marketing Mailbox (MAVBIDhelpdesk@acumenllc.com), with the email subject heading "[PO] EOC/ANOC VBID Model Excerpt" where [PO] is the name of the Parent Organization. For timely submissions, CMS will provide approval or feedback by **August 2, 2024**. Participating MAOs are required to incorporate these CMS-approved excerpts into their published EOC(s) and ANOC(s).

Standards for Review of Enrollee-facing Hospice Communications

Transitioning MAOs must ensure enrollee-facing related communications meet the following requirements, as applicable:

- Do not state or imply that an entity other than the enrollee (or their designated representative) has the choice or authority to revoke the enrollee's hospice election;
- Describe the process by which the MAO will maintain continuity of care during the transition from the MAO's coverage of hospice services to Traditional Medicare (i.e., the Medicare Fee-for-Service program) coverage of hospice services;
- Do not state or imply that Transitional Concurrent Care[29] (TCC) may be provided by an out-of-network provider;
- Specify the time period during which, and types of providers from whom TCC may continue to be provided, as applicable, during CY 2024; and,

[29] Transitional Concurrent Care" means clinically appropriate continuing care needs related to the treatment of Hospice Enrollees' terminal conditions.

- Specify if coverage of Additional Hospice Benefits[30] during CY 2024 will be limited to in-network providers, as applicable.

Note: Materials that remain solely for use by and with clinical staff do not require CMS review and approval and do not need to be submitted to the HPMS Marketing Review module.

Enrollee-facing Hospice Communications Related to the Conclusion of the Hospice Benefit Component

Consistent with policies and requirements in past years, the primary method by which transitioning MAOs will communicate changes in benefits and cost-sharing structures will be through the ANOC. Given that all services and items uniquely authorized by the Hospice Benefit Component of the VBID Model will not be available to enrollees who elect hospice in 2025, transitioning MAOs must remove any wording uniquely associated with the VBID Hospice Benefit Component from their EOC(s) and use the CMS CY 2025 EOC model templates.

With respect to the ANOC, the following instructions and requirements apply to transitioning MAOs. References are made to relevant sections that require updates from the CY 2025 HMO-MAPD-ISNP-CSNP ANOC model template.

Section 2.3 of the ANOC
Section 2.3 of the ANOC ("Changes to the Provider and Pharmacy Networks") shall note changes to its network of providers and ensure that the participating plan's CY 2025 Provider Directory (in print and/or online) is updated, as applicable.

Section 2.4 of the ANOC
In Section 2.4 of the ANOC ("Changes to Benefits and Costs for Medical Services"), plans shall update this section, including the table, to indicate the following: 1) Traditional Medicare will cover hospice care in CY 2025; 2) TCC will no longer be covered in CY 2025; 3) **(if applicable)** hospice supplemental benefits will no longer be covered in CY 2025; and 4) **(if applicable)** all changes in cost-sharing for CY 2025 for covered services, including any differences in cost-sharing between the plan's cost-sharing structure for hospice care in CY 2024 and Traditional Medicare. With respect to the conditional fourth item, participating MAOs must highlight that, when applicable, enrollees may face changes in cost-sharing associated with Traditional Medicare coverage of the hospice benefit compared to any potential reductions in cost-sharing associated with hospice care that an enrollee may have experienced in CY 2024. This may not be applicable to all participating plans, as reductions in cost sharing for hospice services is not a requirement of the Model. Member cost-sharing amounts must not be left blank.

Section 8.1 of the ANOC
In Section 8.1 of the ANOC ("Getting Help from *[insert 2025 plan name]*"), plans shall remove any mention of programs/services associated with the VBID Hospice Benefit Component that will no longer be available to enrollees in CY 2025. Plans may retain the contact information if they

[30] Additional Hospice Benefits are defined per the CY 2024 Addendum Appendix 3(B)(9).

intend to include in their CY 2025 supplemental benefits or administrative services, any care manager programs formerly associated with just the Hospice Benefit Component.

Submission of Materials for CMS Review

Hospice Benefit Component Communications Requiring Prospective Review:
MAOs that participate in the Hospice Benefit Component in CY 2024 must submit for CMS pre-review and approval ***all*** Hospice Benefit Component communications (except those solely for use by and with clinical staff) related to the VBID Model (including excerpts of the relevant sections of the CY 2025 EOC and ANOC) to the CMS VBID mailbox (VBID@cms.hhs.gov) and Acumen VBID mailbox at MAVBIDhelpdesk@acumenllc.com, with the email subject heading "[PO] Hospice Communication/Marketing submission for review" where [PO] is the name of the Parent Organization.

Once the materials are approved by the Model team, with the exception of the excerpts of the relevant sections of the EOC and ANOC related to the Hospice Benefit Component, participating MAOs must then submit these materials to the HPMS Marketing Review Module. Communications must be submitted under the "Communications with VBID Content" material type, which is within the "Required" submission type. All materials regarding or including content about the Hospice Benefit Component are subject to prospective review, and participating MAOs may not use or distribute such materials to enrollees until these materials have been 1) submitted to the CMS and Acumen VBID mailboxes for CMS pre-review, 2) approved by CMS via email, and 3) submitted to the HPMS Marketing Review Module for final approval.

Table 2: VBID Model Hospice Benefit Component Communications Timeline

Material	Type of Review *(Calendar Days)*	Submission Timeline	Submission Mechanism
EOC/ANOC Excerpts of Hospice Benefit Component Language Only	**Prospective** CMS review & approval prior to submission of the entire EOC/ANOC in HPMS *(CMS intends to complete its review of these specific materials within a 10-day timeframe but no later than August 2, 2024.)*	Rolling basis but no later than July 19, 2024	Submit first to the (1) VBID@cms.hhs.gov and MAVBIDhelpdesk@acumenllc.com mailboxes 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
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@cms.hhs.gov and MAVBIDhelpdesk@acumenllc.com mailboxes 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.

Communications with Network and Non-Network Providers

Transitioning MAOs and their contracted Hospice Providers have had the flexibility to create contracting arrangements that work best for each entity and support the goals of the Hospice Benefit Component. Transitioning MAOs and Hospice Providers have worked together in ways that required up front collaboration and coordination to ensure efficient billing arrangements.

Where there are no existing contractual arrangements between a participating MAO and a Hospice Provider in its service area, transitioning MAOs must reach out to local Hospice Providers that have billed the MAOs at least once to discuss their transition out of the Model and billing processes to minimize confusion. Transitioning MAOs must notify such Hospice Providers of the termination of the Hospice Benefit Component and inform the provider(s) that care delivered in CY 2025 under a hospice election will be the responsibility of Medicare Part A for any Medicare beneficiary. More requirements on the form and content of the notice are below.

Note: CMS will make information for transitioning MAOs' hospice network administrative contact(s) and hospice clinical and patient support contact(s) available on the VBID Model Hospice Benefit Component webpage as a resource for Hospice Providers in the Fall of 2024. Transitioning MAOs must ensure timely updates of this contact information, as necessary for billing and other operational processes that may continue into 2025, by reaching out to the CMS VBID mailbox at VBID@cms.hhs.gov with the new contact 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, transitioning MAOs must inform other members of their provider network about the MAO's transition out of the Hospice Benefit Component VBID Model participation if notification could enhance or increase beneficiary engagement and care coordination transitions, such as around the availability of continuity of care for a period of time. Transitioning MAOs' communication with network providers includes, in particular, specialists essential to the specific Additional Benefits offered (e.g., specialists involved in delivery of any TCC 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. CMS strongly encourages transitioning MAOs to communicate with their network of non-hospice providers about participation in the Hospice Benefit Component of the VBID Model even more broadly for transparency.

The notice to Hospice Providers as described above must include at least the following:

- A statement that the MAO will no longer be financially responsible for hospice care that occurs after December 31, 2024, for all hospice elections previously covered by the MAO. Instructions to submit claims for hospice care furnished on and after January 1, 2025, to a Medicare beneficiary, including Hospice Enrollees in the MAO's participating plans in CY 2024, to the Medicare FFS program.
- Information on how to continue to submit hospice claims after the conclusion of the Hospice Model Component for service furnished before January 1, 2025, for all Hospice Enrollees who elected Hospice prior to or during CY 2024 and during the time that the MAO participated in the Hospice Benefit Component;
- Contact information for the individual or group of individuals at the participating MAO who will be able to answer any ongoing questions related to the conclusion of the Hospice Benefit Component; and
- Any other information necessary to describe how the MAO plans to logistically unwind its participation in the Hospice Benefit Component.

Transitioning MAOs must send out this notification no later than November 30, 2024. This notification must be provided to CMS upon request.

Provider Directories & Network-Related Communications

Transitioning MAOs developed and delivered provider directories to enrollees who started hospice prior to or during CY 2024 that include and identify in-network Hospice Providers. This directory may have been 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.

For CY 2025, transitioning MAOs 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 care manager program associated with transitioning out of the Hospice Benefit Component or for community resources for enrollees in hospice.

If a transitioning MAO makes any changes to its network of Hospice Providers in CY 2024, 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 and consistent with 42 CFR § 422.2267(e)(11)(iv). In addition, when a provider terminates from the participating MAO's network of Hospice Providers, the MAO must issue the notices described above and in §§ 422.111(e) and 422.2267(e)(12), as amended by the April 2023 Final Rule.

Transitioning MAOs must continue to abide by § 422.111 disclosure requirements. As per § 422.111(b)(2)(iv), for the content of plan description, MAOs must include the availability of the Medicare hospice option and any approved hospices in the service area, including those the MA organization owns, controls, or has a financial interest in.