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

Value-Based Insurance Design Model
Calendar Year 2024

Model Communications and Marketing Guidelines

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Background and General Information

Through the Value-Based Insurance Design (VBID) Model, CMS is testing a broad array of complementary Medicare Advantage (MA) health plan innovations designed to reduce Medicare program expenditures, enhance the quality of care for Medicare enrollees, including those who have low-income subsidy (LIS) status, and improve the coordination and efficiency of health care service delivery. The VBID Model for Calendar Year (CY) 2024 consists of the following Model components:

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

If approved by CMS, participating MA Organizations (MAOs) are required to offer WHP and permitted to offer enrollees any of the Model components listed as items 2 through 4 above. As used in this document, the term "Model Benefits" means the items, services, and reductions in cost sharing offered to enrollees (or to Targeted Enrollees[1] if there are limits on eligibility) in the Model components listed as items 1, 2, and 4 above.

This document outlines the 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 2024 agree to adhere to these guidelines through the CY 2024 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 2023 must adhere to these guidelines for any newly submitted CY 2023 VBID Model communications and marketing materials, effective July 1, 2023.[4]

[1] "Targeted Enrollee" means a Medicare beneficiary who is enrolled in one of the participating MAO's VBID participating PBPs and targeted to receive one or more VBID Components, except for WHP and the Hospice Benefit Component. While all enrollees in VBID PBPs participating in the Hospice Benefit Component are eligible for those Model Benefits, a participating MAO may also target enrollees for specific supplemental hospice benefits (Targeted Hospice Enrollees).

[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. Specifically, all MA communications and marketing regulations and guidance issued by CMS, as well as other applicable laws, continue to apply to materials and activities of participating MAOs, including the MA and Part D [for MA Prescription Drug (MA-PD) plans] regulations at 42 CFR §§ 422.2260 through 422.2276 and 423.2260 through 423.2276. In the event of a conflict between the requirements in the Underlying Contract and the Model Communications and Marketing Guidelines such that the MAO cannot comply with both, the MAO must comply with the Model Communications and Marketing Guidelines.

The marketing and engagement strategies discussed in these guidelines for Model Benefits and RI Programs are customizable so MAOs may use unique approaches to inform enrollees of Model Benefits and options to participate in RI Programs.

Below, CMS provides an overview of this document:

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

- Section 2 provides additional requirements that participating MAOs offering the Hospice Benefit Component must follow in communicating this Model Benefit to providers and in communicating and/or marketing this Model Benefit to enrollees, both current and prospective.

- Section 3 discusses additional requirements that participating MAOs offering RI Programs must follow in communicating and/or marketing the existence of RI Programs to enrollees. 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 RI Programs to enrollees, both current and prospective.

- Appendix 1 includes instructions and a template of the VBID Member Engagement Strategy (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 Model Benefits and RI Programs.

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

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 Model Benefits and/or RI Programs available to them (herein referred to as the "VBID Member Engagement Strategy").**

   One key to successfully offering Model Benefits and/or RI Programs is achieving enrollee awareness, engagement, and activation. As such, CMS is interested in learning, through the VBID Member Engagement Strategy, how participating MAOs will ensure enrollees have a clear understanding of the Model Benefits and RI Programs that they are eligible for (including how to access them), and the specific strategies and processes participating MAOs will use to engage and activate Eligible Enrollees[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] who may require different types of approaches and/or culturally competent communications and outreach in order to fully engage in the Model Benefits and/or RI Programs for which they are eligible.[8]

2. **Consistent with their VBID Member Engagement Strategy, participating MAOs shall only use the materials described below that have been approved by CMS to notify enrollees who are eligible for Model Benefits and/or RI Programs.**

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

      In the CY 2024 EOCs that are required as part of the MA program, participating MAOs must include all Model Benefits, including WHP Services, along with language that ensures enrollees are aware of any chronic conditions or targeting criteria for accessing Model Benefits.

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[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 Model Benefits under one or more VBID Components.

[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

Participating MAOs that are new or continuing in the Model and are adding VBID Model benefits to an existing plan for CY 2024, or participating MAOs that are continuing but have changes to VBID Model Benefits, must also include the VBID Model Benefits in the ANOC for existing enrollees. For all PBPs that will no longer include VBID Model benefits in CY 2024, a participating MAO must include the benefit changes in the ANOC. The CY 2024 ANOC must include these changes in eligibility for and scope of Model Benefits and be provided to enrollees in accordance with the MA Program ANOC deadline. CMS includes Model-specific language in the CY 2024 standardized models for the EOC and ANOC, which can be found here: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.[9]

For CY 2024, participating MAOs offering the Hospice Benefit Component must submit excerpts from their EOC(s) and ANOC(s) inclusive of this Model Benefit description 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. These Model-specific excerpts may be submitted on a rolling basis but must be submitted no later than **July 14, 2023** to the VBID Model Communications and Marketing Mailbox at MAVBIDhelpdesk@acumenllc.com, with the email subject heading "[PO] EOC/ANOC VBID Model Excerpt" where [PO] is the name of the Parent Organization. CMS will provide approval or feedback by **July 28, 2023**. Participating MAOs are required to incorporate these CMS-approved excerpts into their published EOC(s) and ANOC(s).

b. **Participating MAOs that offer the Hospice Benefit Component must provide additional communications about access to in-network and out-of-network Hospice Providers[10] for Hospice services:**

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

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

While RI Programs are not benefits and may not be listed in the EOC or ANOC, participating MAOs must communicate accurate and complete information about their

[9] 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 2024 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

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

Model RI Programs via other vehicles in order to ensure that enrollees have sufficient information to understand and access the available RI Programs (*see section 3 for additional, specific requirements*).

d. **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 Model Benefits; a notice of determination that an enrollee no longer qualifies for Model Benefits; and a notice of determination that an enrollee is not participating in a care management program, medication therapy management, or other service on which Model Benefits are conditioned.

Note: The aforementioned material notices are not applicable to the Hospice Benefit Component.

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 communication), 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 RI Programs through additional communications materials and approaches**.

Additional communications to enrollees regarding Model Benefits and 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 2024 relative to previously provided high-value provider directories, the participating MAO must provide written notice to all Targeted Enrollees of the updated high-value provider directory (*see section 2 for additional provider directory requirements for participating MAOs that offer the Hospice Benefit Component*). In addition, participating MAOs must comply with the new notice requirements at 42 CFR §§ 422.111(e) and 422.2267(e)(12) regarding provider terminations from the plan network.[11]

In the event eligibility of Targeted Enrollees for Model Benefits or RI Programs is not assured or cannot be determined before a Plan Year, the MAO shall provide a disclaimer on all materials describing the Model Benefits or RI Programs, e.g., during the Annual Enrollment Period (AEP). Such a disclaimer must clearly state that eligibility for the Model Benefit 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

[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).

management program). This requirement does not apply to communications materials related to the Hospice Benefit Component.

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

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

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

All communications and marketing of Model Benefits must be designed to both engage Eligible Enrollees for Model components and inform them of their additional rights and benefits based on the MAO's participation in the VBID Model. Participating MAOs may not mislead, confuse, or provide materially inaccurate information to current or prospective enrollees.[12] In addition to the requirements in 42 CFR Parts 422 and 423, 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 Model Benefits and RI Programs. This is especially important for individuals who have LEP and/or need auxiliary aids or services.

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

In addition to complying with the applicable program regulations, participating MAOs must adopt an approach for submitted materials that include information on Model Benefits that clearly outlines:

- the Model Benefits available to enrollees (or, in the case of WHP Services, to all enrollees as applicable);
- what must be done to qualify for and receive Model Benefits (as applicable); and
- where and how to ask questions or receive help with understanding Model Benefits (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 Process for Submission of Materials and 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 to the HPMS Marketing Review Module under the "VBID-Member Engagement Strategy" material type, which is within the "Required" submission type.

- **Hospice Benefit Component Communications and Marketing Materials Requiring Prospective Review:** Participating MAOs must submit for CMS pre-review and approval ***all*** Hospice Benefit Component communications and marketing materials related to the VBID Model (including excerpts of the relevant sections of the EOC and ANOC) to the VBID Model Communications and Marketing 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 approved, with the exception of the excerpts of the relevant sections of the EOC and ANOC related to the Hospice Benefit Component, participating MAOs must submit these materials to the HPMS Marketing Review Module. Communications that are not marketing must be submitted under the "Communications with VBID Content" material type, which is within the "Required" submission type. Marketing materials must be submitted under the "VBID" content type, which is within the "Plan Created" submission type. As a reminder, these materials are subject to prospective review, and participating MAOs may not use or distribute such materials to enrollees or potential enrollees until these materials have been 1) submitted to the VBID Model Communications and Marketing Mailbox for CMS pre-review, 2) approved by CMS via email, and 3) submitted to the HPMS Marketing Review Module for final approval.

- **Other Communications and Marketing Materials:** Participating MAOs must submit for CMS review and approval all other communications and marketing materials specific to Model Benefits (outside those materials noted above) and RI Programs (as defined and described in section 3 below), including all pre-enrollment materials and scripts to the HPMS Marketing

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 Model Benefits; a notice of determination that an enrollee no longer qualifies for Model Benefits; and a notice of determination that an enrollee is not participating in a care management program, medication therapy management, or other service on which Model Benefits are conditioned.

In accordance with 42 CFR §§ 422.2261(b)(3) and 423.2261(b)(3), materials submitted under these categories may be distributed five calendar days after submission to HPMS provided that CMS has not denied permission to use the material(s) within that five-day window or following the five-day window. When submitting, the participating MAO certifies 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 requires 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 and 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 the MA program, 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

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 Model Benefits.** EOBs for Model Benefits need not be distinct from those delivered by the participating MAO for covered benefits that are not VBID Model Benefits. EOBs must accurately reflect the Model Benefits provided to enrollees and the appropriate cost sharing if reduced or eliminated as part of the Model component, and must meet all applicable regulations and guidance for EOBs. See 42 CFR §§ 422.111(k) and 423.128(e) for requirements for EOBs, which include an exception at 42 CFR § 422.111(k)(5) that participating MAOs are not required to send MA EOBs to dual-Eligible Enrollees. Note: For participating MAOs with PBPs offering the

Hospice Benefit Component, sending an EOB for Hospice Services is only applicable if there is claims activity to report.

- **Notice of acknowledgment of an opt-out from Model Benefits.**[13]
  The notice must include an explanation of any changes in access, availability, cost sharing, and eligibility for Model Benefits that will occur as a result of the opt-out by the enrollee(s), including instructions for rescission of the opt-out. An example of when a notice of acknowledgment of an opt-out is needed would be for an enrollee who has requested to opt out of a VBID care management program. If a participating MAO offers Model Benefits that are offered or structured in a manner that opting-out is not necessary, and therefore, would have no reason to send an acknowledgement of an opt-out, the MAO may request an exception by submitting a request and explanation to the 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 provide a rationale specific to each Model Benefit where an exception is being requested. An example of when a notice of acknowledgment of an opt-out is not needed would be for certain supplemental benefits that are available to all enrollees, such as eyeglasses or meals where the enrollee may simply choose not to utilize the benefit. MAOs must submit exception requests annually, even if an exception request was approved in the previous contract year.

- **Notice of acknowledgment of a rescission of an opt-out from Model Benefits.**[14]
  The notice must include an explanation of any changes in access, availability, cost sharing, and eligibility for Model Benefits that will occur as a result of the rescission of the opt-out by the enrollee(s).

- **Notice of determination that an enrollee no longer qualifies for Model Benefits.**
  The notice must include the rationale underlying such a determination. This determination is considered a standard Organization Determination for Part C benefits or a Coverage Determination for Part D benefits, and must contain the information required for notices of such determinations (see 42 CFR §§ 422.560 through 422.634 and 423.558 through 423.638, and associated guidance available at: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG), including content requirements in 42 CFR §§ 422.568 and 423.568. For example, a notice of determination that an enrollee no longer qualifies for Model Benefits is not required if an enrollee disenrolls from the plan.

- **Notice of a determination that enrollees are not participating in case management and, therefore, are not eligible for Model Benefits, as applicable.**
  The notice must include information on how to resume participation in case management, if so desired. This determination is considered a standard Organization Determination for Part C benefits or a Coverage Determination for Part D benefits, and must contain the information required for notices of such determinations (see 42 CFR §§ 422.560 through 422.634 and

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

[14] Id.

423.558 through 423.638 and associated guidance available at: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG).

Except for standard EOBs for payment of claims for Model Benefits, each of the written communications listed in section 1.4 must contain the following disclaimer: "Medicare approved [participating MAO name/marketing name] to provide [these benefits and/or lower co-payments/co-insurance] as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans."

The mandated communications to enrollees detailed in this guidance represent the minimum required of participating MAOs. However, participating MAOs may go beyond this and communicate further with enrollees regarding Model Benefits and/or RI Programs so long as those communications are subject to CMS review and approval. 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 Model 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.

1.5 Provider/Pharmacy Directories and Network-Related Communications

Participating MAOs must satisfy all current program requirements, including in 42 CFR §§ 422.111, 423.128, 422.2267(e)(11) and 423.2267(e)(15) as applicable, with regard to provider and pharmacy directories.[15] Additionally, participating MAOs offering Model Benefits contingent on the use of a high-value provider network must identify those high-value providers and the benefits they may provide in the directory. Participating MAOs may use a full provider network directory in which the high-value providers are identified and distinguished from other providers or a distinct supplemental document (akin to a sub-network directory or specialty directory) listing only the high-value providers and their locations. Enrollees eligible for reduced cost sharing for using high-value providers[16] 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)

[15] CMS has revised the minimum content requirements for MA provider directories. 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, 22153 through 22158) regarding new provider directory requirements. See also 42 CFR § 422.120 regarding the Provider Directory API requirement. Additional guidance is also available in Chapter 4 of the Medicare Managed Care Manual and Chapter 5 of the Medicare Prescription Drug Benefit Manual.

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

once established. This includes, in particular, specialists essential to the specific Model Benefits offered and the primary care providers of enrollees. Providers identified as high-value under the Model should also be specifically made aware of this fact.

In accordance with the provider directory requirements in 42 CFR 422.111(e) and 422.2267(e)(12), participating MAOs must make a good faith effort to provide written notice of termination of a contracted provider at least 30 calendar days before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care professional or behavioral health provider, all enrollees who are patients of that primary care professional must be notified at least 45 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 Model Benefits and other information about Model participation accessible to enrollees, provided the requirements in this guidance and in the MA and Part D marketing and communication regulations (e.g., 42 CFR §§ 422.111, 422.2260 through 422.2276, 423.128 and 423.2260 through 423.2276) are met. Websites may supplement, but not replace, the written communications 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.

Websites should be clearly marked, with language easily understood by individuals who have LEP, on where to access materials in alternative languages for PBPs within a service area where 5% of the population speak an alternate language or if Eligible or Targeted Enrollees are directed to a website to retrieve translated materials.

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 Model Benefits and/or 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

Model Benefits, a notice of determination that an enrollee is not participating in case management, and a notice alerting enrollees how to access or receive a directory.[17]

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 MAOs are not required to submit alternate format versions of a previously submitted standard material.

Participating MAOs must take reasonable steps to provide meaningful access to each enrollee or potential enrollees, including those who have LEP who are eligible or potentially eligible for a Model Benefit and/or RI Program. This requirement means that participating MAOs may need to provide language assistance services, such as written translation and oral interpretation, in languages other than those that constitute at least five percent of the population within the participating MAO's service area in which Model Benefits or RI Programs are being offered. MAOs must notify enrollees and potential enrollees of the availability of materials.[18] 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 participating MAOs include a standardized multi-language insert describing availability of free interpreter services in all required materials. 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 exceptions include scripts and other non-enrollee facing materials, outdoor advertising and outdoor 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 Model Benefits and 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).[19] 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

[17] In addition, 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 paragraph (a)(2) of this section.

[18] See 42 CFR 422.2267(a)(3) and 423.2267(a)(3).

[19] See 42 CFR 422.2267(a)(3) and 423.2267(a)(3).

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).

The guidelines within this section are also applicable to communications and marketing materials used for and distributed at information sessions and events, as well as sales meetings by MAOs and agents 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 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 Model Benefits and 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 18 – October 20, 2023	Submit directly to HPMS under the "VBID-Member Engagement Strategy" material type which is within the "Required" submission type.
EOC/ANOC Excerpts of Hospice Benefit Component Language Only	**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 July 28, 2023.)*	Rolling basis but no later than July 14, 2023	Submit first to the (1) VBID Communications and Marketing Mailbox for CMS pre-review and approval with the subject heading "[PO]: EOC/ANOC VBID Model Excerpt", and once approved by CMS via email (2) include as part of the entire EOC and ANOC and follow appropriate MA guidelines for HPMS submission (*see row below*).
EOC/ANOC *(which includes VBID Model Benefits but cannot include RI Programs)*	**File & Use** if the conditions have been met under 42 CFR §§ 422.2261(b)(3) and 423.2261(b)(3), and the participating MAO certifies compliance *(5 Days)*	See CMS regulations and guidance on HPMS submission timing for additional instructions. Resubmission using the "VBID" content type in HPMS is not necessary.	
Model Benefit and RI Program Communications *(except for the EOC and communications materials related to the Hospice Benefit Component)*	**File & Use** if the conditions have been met under 42 CFR §§ 422.2261(b)(3) and 423.2261(b)(3), and the participating MAO certifies compliance* *(5 Days)*	Rolling Basis	Submit directly to HPMS under the "Communications with VBID Content" material type which is within the "Required" submission type.
Model Benefit and RI Program Marketing *(except for the ANOC and marketing materials related to the Hospice Benefit Component)*	**File & Use** if the conditions have been met under 42 CFR §§ 422.2261(b)(3) and 423.2261(b)(3) and the participating MAO certifies compliance* *(5 Days)*	Rolling Basis	Submit directly to HPMS under the "VBID" content type which is within the "Plan Created" submission type.
Hospice Benefit Component Communications *(outside of the EOC)*	**Prospective** CMS review & approval (42 CFR §§ 422.2261(b)(1) & (2) and 423.2261(b)(1) & (2)) *(Total 45 Days)*	Rolling Basis	Submit first to the (1) VBID Communications and Marketing Mailbox for CMS pre-review and approval with the subject heading "[PO]: Hospice communication submission for review and approval" and once approved by CMS via email (2) submit to HPMS under the "Communications with VBID Content" material type which is within the "Required" submission type.**
Hospice Benefit Component Marketing *(outside of the ANOC)*	**Prospective** CMS review & approval (42 CFR §§ 422.2261(b)(1) & (2) and 423.2261(b)(1) & (2)) *(Total 45 Days)*	Rolling Basis	Submit first to the (1) VBID Communications and Marketing Mailbox for CMS pre-review and approval with the subject heading "[PO]: Hospice communication submission for review and approval" and once approved by CMS via email (2) submit to HPMS under the "VBID" content type which is within the "Plan Created" submission type.**

* If the conditions of § 422.2261(b)(3) for file and use are not met (such as for content included in sales presentations) then the materials will require a 45-day prospective review. For CMS Model or standardized marketing materials as outlined in §§ 422.2267(e), 422.2261(b)(2) will apply and no prospective review is needed.

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

2. Additional Requirements for Communications Regarding the Hospice Benefit Component

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

2.1 Hospice Communications and Marketing Materials

Participating MAOs must ensure Hospice Benefit Component communications, including marketing materials, 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 to elect or revoke the enrollee's Hospice benefit;
- Describe eligibility and/or what must be done to receive Hospice benefits and/or Additional Hospice Benefits;
- Do not state or imply that there are prior authorization or utilization management requirements needed for hospice care;
- Specify the time period during which, and types of providers from whom Transitional Concurrent Care (TCC) will be provided, as applicable;
- Do not state or imply that TCC may be provided by an out-of-network provider;
- Do not state or imply that enrollees are required to be terminal ill, i.e., have a life expectancy of six months or less if the illness runs its normal course to receive palliative care (e.g., prior to hospice care) under the Hospice Benefit Component; and
- Specify if coverage of Additional Hospice Benefits is 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.

2.2 Communications with Network and Non-Network Providers

Participating MAOs and their contracted Hospice Providers have the flexibility to create contracting arrangements that work best for each entity and support the goals of the Hospice Benefit Component. Participating MAOs and Hospice Providers have the opportunity to work together in ways that require 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, CMS requires participating MAOs to reach out to local Hospice Providers to discuss the Model and billing processes to minimize confusion and maximize efficiencies, even if the parties do not ultimately contract with each other. Additionally, and as discussed later in this section, CMS strongly encourages participating MAOs to communicate with their network of non-hospice providers about participation in the Hospice Benefit Component of the VBID Model.

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

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

Consistent with MA program requirements in 42 CFR Part 422, Subpart E regarding participating MAOs relationships with providers, participating MAOs must be responsive to Hospice Providers' outreach with requests to participate in the MAO's hospice network or enter into a contracting process. In accordance with 42 CFR 422.202, participating MAOs are permitted to decline including a Hospice Provider or group of Hospice Providers in their networks, but must furnish written notice to the affected provider(s) with the reason for the decision. Even in situations where a participating MAO does not intend to contract with a Hospice Provider, in CY 2024, the Hospice Benefit Component requires participating MAOs to permit enrollees to choose any Hospice Provider, which may require a billing relationship between the non-contracted Hospice Provider and the participating MAO. Hospice Providers are encouraged to expect and respond to outreach from participating MAOs in order to ensure smooth working relationships under the Model, as maintenance of good coordination and communication can contribute significantly to ensuring high-quality enrollee care. Participating MAOs do not need to submit these communications materials to HPMS, but CMS may request copies of these communications as part of monitoring activities for the Model.

Note: CMS will make information for participating 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 Fall 2023. Participating MAOs are encouraged to ensure timely updates of this contact information as necessary by reaching out to the VBID mailbox at VBID@cms.hhs.gov with the new 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, participating MAOs must inform other members of their provider network about the MAO's VBID Model participation if notification could enhance or increase beneficiary engagement and care coordination in the VBID Model, such as around the availability of Transitional Concurrent Care through in-network hospice providers and other in-network providers. Participating MAOs must communicate, consistent with applicable law, specific enrollees' eligibility status (i.e., the participating MAO may identify Hospice Enrollees and/or Targeted Hospice Enrollees) once the provider network is established. Participating MAOs' communication with network providers includes, in particular, specialists essential to the specific Model Benefits offered (e.g., specialists involved in delivery of any Transitional Concurrent Care services as part of a participating MAO offering the Hospice Benefit Component) and the primary care and palliative care providers of enrollees with serious illness.

Furthermore, a participating MAO that chooses to discontinue its participation in the Hospice Benefit Component must notify certain hospice providers that it is discontinuing its participation. The hospice providers that must receive this notification are those that have submitted at least one hospice claim to the participating MAO in its most recent year of participation.[20] The notification must include the following:

- A statement that the MAO is still financially responsible, through discharge or revocation from Hospice Care, disenrollment from the VBID PBP, or death, for Hospice Care furnished to a Hospice Enrollee whose Hospice Election started during the time in which the Hospice Enrollee was in a Hospice Benefit Component VBID PBP;
- Information on how to continue to submit hospice claims after the MAO's exit from the Model Component for all Hospice Enrollees who elected Hospice 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 MAO's discontinuing participation in 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.

MAOs that discontinue their participation in the Hospice Component of the Model must send out this notification no later than one month before their last day of participation. This notification must be provided to CMS upon request.

[20] See Appendix 3(B)(5)(c) of the Addendum.

2.3 Provider Directories & Network-Related Communications

Participating MAOs must develop and deliver provider directories to enrollees that include and identify in-network Hospice Providers. This directory may be a full provider network directory in which the Hospice Providers are identified and distinguished from other providers, or a distinct supplemental document (akin to a sub-network directory or specialty directory) listing only the in-network Hospice Providers and their locations. Directories listing in-network Hospice Providers must include language stating that enrollees have the option to receive services from an out-of-network Medicare-participating Hospice Provider that is willing to provide treatment. The directory of hospice providers must also comply with the requirements for provider directories in §§ 422.111(b)(3) and 422.2267(e)(11), as amended by the April 2023 final rule.

Participating 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 the Hospice Benefit Component or for community resources for enrollees entering or considering hospice. Participating MAOs may request approval from CMS to use alternative means of satisfying this network directory requirement for Hospice Provider networks.

If a participating MAO makes any changes to its network of Hospice Providers in CY 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 in section 1.5 above and in §§ 422.111(e) and 422.2267(e)(12), as amended by the April 2023 final rule.

3. Requirements for Informing Enrollees about RI Programs

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

Continuing in CY 2024, participating MAOs may offer both Part C and Part D RI Programs consistent with the terms of the Model and the Addendum. RI Programs are not Medicare benefits or Model Benefits and thus, must not to be treated as benefits. Participating MAOs may use different approaches to communicating with enrollees and potential enrollees about RI Programs. First, while RI Programs are not benefits and may not be listed in the EOC or ANOC, participating MAOs that communicate the availability of these RI Programs to enrollees must describe the RI Program(s) completely and accurately in order to ensure that enrollees have sufficient information to understand the available RI Programs. Moreover, participating MAOs must answer questions about the RI Programs and must include information about the RI Programs in the educational information sent to enrollees and made available to potential enrollees.

Participating MAOs may market the existence of RI Programs to potential enrollees. Participating MAOs must comply with existing marketing requirements for Part C RI Programs in marketing materials for potential enrollees at 42 CFR §§ 422.134 and 422.2260 through 422.2272. These

standards must be met in conjunction with any communications or marketing of Model RI Programs, even if the RI Program is tied to a Part D benefit.

Marketing of all RI Programs must:

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

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

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

CMS will apply 42 CFR § 422.2260 to determine when and if these communication materials are marketing and subject to review as marketing materials. Participating MAOs must submit all RI Program marketing materials to HPMS for CMS review and approval under the "VBID" content type, which is within the "Plan Created" submission type. Similar to other materials submitted to HPMS under this category, RI Program marketing materials may be distributed five calendar days after submission to HPMS if the conditions in 42 CFR § 422.2261(b)(3) are met and unless and until CMS directs the participating MAO to stop using the material(s). Participating MAOs are encouraged to craft RI Program communications in a way that will effectively engage enrollees and potential enrollees and communicate consistent with the communications principles described in section 1 above, which must be designed to outline all of the RI Programs available to potential enrollees and enrollees.

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.[21] Importantly, reward and/or incentive "items" may not be offered to potential enrollees under any circumstances. Nominal gifts as part of promotional activities are separate and distinct from RI Programs. Participating MAOs must comply with §§ 422.2263(b)(2) and 423.2263(b)(2) and all other applicable authorities in connection with nominal gifts or promotional items.

[21] See Addendum, Article 3, sections E and G and Appendix 2, sections A, B, and C which require compliance with 42 CFR § 422.134 – except as specifically waived – for all RI Programs, including Part D RI Programs.

Appendix 1: VBID Member Engagement Strategy

INTRODUCTION

Your CY 2024 VBID application previewed approaches that your organization plans to use to engage and activate Eligible and/or Targeted Enrollees in Model Benefits, the Hospice Benefit Component and RI Programs. As CY 2024 enrollment approaches, the VBID Member Engagement Strategy 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 Model Benefits, the Hospice Benefit Program, and RI Programs, and fully engaged in them.

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

If you are offering multiple VBID Model Benefits or RI Programs through several Model Components, please group your responses by Component type (e.g., VBID-Flex, RI Programs, Hospice Benefit Component). Note: You do not need to include your WHP communications and engagement strategy since that information is collected elsewhere.

SECTION 1: MEMBER ENGAGEMENT STRATEGY FOR EACH VBID MODEL BENEFIT AND RI PROGRAM

For each VBID Model Benefit and RI Program you are offering in CY 2024 (e.g., Healthy Foods Card, transportation benefit, reward for participation in a care management activity, etc.), please respond to following questions. For MAOs offering the Hospice Benefit Component, please consider the elements of this Model Component in your responses (e.g., palliative care, Transitional Concurrent Care, Hospice care, Additional Hospice Benefits).

1. Benefit Awareness

- How will you ensure enrollees, including those targeted for Model Benefits or eligible for the Hospice Benefit Component and/or RI Programs, are aware of their eligibility for these Model Benefits and RI Programs(s)?
- How will you ensure that Eligible Enrollees understand how to access Model Benefits, hospice and other benefits available through the Hospice Benefit Component and/or RI Programs, and how the Model Benefits, hospice and other benefits available through the Hospice Benefit Component and/or RI Programs actually work (e.g., where the Healthy Foods Card can be used, when the card is re-loaded, whether funds carry over month to month, and other key information)?

2. Engagement

- How will you engage Eligible Enrollees, including those targeted to receive specific benefits, to fully use Model Benefits, leverage interventions within the Hospice Benefit Component, and/or participate in RI Programs (e.g., individual enrollee outreach, staff training on VBID benefits, network and provider training and communications)? Please describe the range of activities you intend to use.

3. Continuous Improvement

- How do you define successful engagement of your enrollees (e.g., meeting or exceeding engagement projections, full use of benefits or rewards by Eligible Enrollees, etc.)?
- What processes, measures, and data will you use to monitor and continually improve enrollee engagement (e.g., monthly review of beneficiary level benefit utilization, beneficiary experience, etc.)? Please specify the data sources [e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS)] to the extent possible.

4. Health Equity Plan (HEP)

- Please explain how you will ensure the engagement plan outlined in your HEP is applied to this Model Benefit or RI Program and maps to your HEP priority populations?
- Please describe the types of approaches and/or culturally competent communications and outreach that may be required to engage Targeted Enrollees that you plan to incorporate within your engagement strategy.

SECTION 2: OVERALL ENGAGEMENT

- How will you inform individuals who have LEP and/or need auxiliary aids or services of the availability of Model communication and marketing materials in their language of choice?
- Please describe any challenges you have encountered in implementing the VBID Member Engagement Strategy, and the steps taken to overcome them.

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 Model Benefits (including the Hospice Benefit Component), and RI Programs. These checklists are not complete summaries of all applicable legal requirements for the MA program that continue to apply to communication, including 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 Model Benefits and the Hospice Benefit Component in the EOC and ANOC, please see the CY 2024 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 Model Benefits and/or RI Programs:

- ☑ Accurately describes Model Benefits and 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 Model Benefits and RI Programs
- ☑ Provides accessibility for individuals with disabilities to ensure an equal opportunity to access Model Benefits and RI Programs
- ☑ Provides accessibility for individuals who have limited English proficiency (LEP) to ensure an equal opportunity to access Model Benefits and 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 or oral interpretation 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 Model 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 Model Benefits and/or RI Programs (as applicable)
- ☑ Includes the form, frequency, and amount of Model Benefits,[22] Additional Hospice Benefits, and RI Programs as applicable

[22] 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.

- ☑ Includes a disclaimer to specify that "Eligibility for the Model Benefit 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 Model Benefits or RI Programs is not assured or cannot be determined before a Plan Year, as applicable.[23]

Requirements that participating MAOs offering the Hospice Benefit Component must follow in communicating and/or marketing this Model Benefit:

- ☑ Does not state or imply that an entity other than the enrollee (or their designated representative) has the choice to elect or revoke the enrollee's Hospice Benefit
- ☑ Describes eligibility and/or what must be done to receive Hospice Benefits and/or Additional Hospice Benefits
- ☑ Does not state or imply that there are prior authorization or utilization management requirements needed for components of hospice care[24]
- ☑ Specifies the time period during which and types of providers from whom Transitional Concurrent Care will be provided, as applicable[25]
- ☑ Does not state or imply that TCC may be provided by an out-of-network provider
- ☑ Does not state or imply that enrollees are required to be terminally ill (i.e., have a life expectancy of six months or less if the illness runs its normal course) to receive palliative care (e.g., prior to hospice care) under the Hospice Benefit Component
- ☑ Specifies coverage of Additional Hospice Benefits is limited to in-network providers, as applicable[26]

Requirements that participating MAOs offering RI Programs must follow in communicating and/or marketing the existence of RI Programs:

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

[23] This disclaimer is not required for communications or marketing materials related to the Hospice Benefit Component.
[24] Prepayment or post-payment review for Hospice care and care unrelated to the terminal illness and related conditions is permissible.
[25] An exception to the time period specification requirement is for participating MAOs that do not have a fixed length of TCC.
[26] An exception to the coverage specification requirement is for participating MAOs that have not elected to limit coverage.

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

- ☑ Contain 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."[27]

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

- ☑ Includes an explanation of any changes in access, availability, cost sharing, and eligibility for Model 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 Model Benefits

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

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

- ☑ Includes the rationale[28] underlying such a determination
- ☑ Informs the enrollee affected by the initial determination of their right to a reconsideration (Part C) or redetermination (Part D) by the plan
- ☑ 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 case management, if so desired[29]

Requirements for all Explanations of Benefits (EOBs):[30]

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

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

[28] This must include a specific and detailed explanation of why the medical services, items or Part B drugs 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) and 422.568 regarding denials, including the content and timing of notices. A notice of determination that an enrollee no longer qualifies for Model Benefits is not required if an enrollee disenrolls from the plan.

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

[30] Participating MAOs with PBPs offering the Hospice Benefit Component are required to send an EOB only if there is claims activity to report.

Note: If any requirements are not met, please use the "Material Description" or "Plan Comments" sections in the HPMS Marketing Review Module to provide a justification. For materials subject to CMS pre-review and approval (i.e., materials related to the VBID Hospice Benefit Component), please use the space within the email body to provide a justification.