DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR MEDICARE

DATE: August 5, 2019

TO: Medicare Advantage Organizations, Prescription Drug Plans, and Section 1876 Cost Plans

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SUBJECT: Model Notice Corrections and Updates

This memorandum provides Medicare Advantage Organizations (MAOs), Section 1876 Cost Plans and Prescription Drug Plans with corrections to the following model templates: Contract Year (CY) 2020 Annual Notice of Change (ANOC); Evidence of Coverage (EOC); Part D Explanation of Benefits (EOB); and Low Income Subsidy (LIS) Rider.

On May 24, 2019, CMS issued a memorandum announcing the issuance of certain CY 2020 model marketing materials, which included the CY 2020 ANOC and EOC standardized models for all plan types, the Part D EOB, and the LIS Rider. This memorandum clarifies and corrects standardized language that MAOs and Part D sponsors must use for their CY 2020 ANOCs and EOCs, as appropriate for their plan type(s), the Part D EOB, and the LIS Rider. Below is a brief summary of each issue, a description of where the issue is located, and the required updates:

1. ANOC model for D-SNP

Summary of issue: First bullet does not include the optional crosswalk language and the third bullet was specific to 2019.

Issue location: 'What to do now' Section under ENROLL

Action required: Update the language as shown below (changes are noted in red text).

> 4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2019**
>   - If you don't join another plan by **December 7, 2019**, you will stay in *[insert 2019 plan name]*. [*If the plan is being crosswalked, replace previous sentence with:* If you don't join another plan by **December 7, 2019**, you will be enrolled in *[insert 2020 plan name]*.]
>   - If you join another plan between **October 15** and **December 7, 2019**, your new coverage will start on **January 1, 2020**.
>   - ~~Starting in 2019, there are new limits on how often you can change plans. Look in section *[insert section number]*, page *[insert page number]* *[plans may insert additional reference, as applicable]* to learn more.~~

2. ANOC model for D-SNP

Summary of issue: Enrollment timeframe and reference to 2019 plan changes need to be updated.

Issue location: Section 1

Action required: Update the language as shown below (changes are noted in red text).

> **If you do nothing to change your Medicare coverage in 2019, we will automatically enroll you in our *[insert 2020 plan name]*.** This means starting January 1, 2020, you will be getting your medical and prescription drug coverage through *[insert 2020 plan name]*. If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare and get your prescription drug coverage through a Prescription Drug Plan. If you want to change, you can do so between now and December ~~31~~7. The change will take effect on January 1, 2020. ~~Starting in 2020, there are limits on how often you can change plans. For more information, see Chapter 10, Section 2.1 of the *Evidence of Coverage*.~~

3. ANOC model for D-SNP

Summary of issue: Reference to coverage effective date needs to be removed.

Issue location: Section 4.2

Action required: Update the language as shown below (changes are noted in red text).

> **Section 4.2 – If you want to change plans**
>
> We hope to keep you as a member next year but if you want to change for 2020 follow these steps:
>
> **Step 1: Learn about and compare your choices**
>
> - You can join a different Medicare health plan,
> - -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.
>
> ~~Your new coverage will begin on the first day of the following month.~~ If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

4. ANOC model for D-SNP

Summary of issue: Enrollment timeframe and reference to 2019 plan changes need to be updated.

Issue location: Section 5

Action required: Update the language as shown below (changes are noted in red text).

SECTION 5 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from now until December ~~31~~7. The change will take effect on January 1, 2020.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. ~~Starting in 2020, there are limits on how often you can change plans. For more information, see Chapter 10, Section 2.1 of the *Evidence of Coverage*.~~

5. EOC models for HMO MA and PPO MA

Summary of issue: Federal Contracting Disclaimer should be removed.

Issue location: Cover Page

Action required: Update the language as shown below (changes are noted in red text).

~~*[Plan's/Part D Sponsor's legal or marketing name] is a [plan type] with a Medicare contract. Enrollment in [Plan's/Part D Sponsor's legal or marketing name] depends on contract renewal.]*~~

6. EOC models for HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, MSA, HMO MA, and PPO MA

Summary of issue: The current EOC documents do not include instructions for plans and Part D sponsors to disclose a complete list of Part B drugs that are subject to step therapy requirements; however, instructions will be provided for plans to direct enrollees to a list of Part B drugs for which Part B step therapy applies.

Issue location: Chapter 4, Medical Benefits Chart

Action required: Update the language as shown below (changes are noted in red text).

Medicare Part B prescription drugs	
[MA plans that will be or expect to use Part B step therapy should include the Part B drug categories below that may or will be subject to Part B step therapy as well as a link to a list of drugs that will be subject to Part B step therapy. The link may be updated throughout the year and any changes need to be added at least 30 days prior to implementation per 42 CFR 422.111(d)] These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs ~~[*insert if applicable:* that may be subject to step therapy]~~ include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents *[plans may delete any of the following drugs that are not covered under the plan]* (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases [*insert if applicable:* The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: *insert link*] Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	*[List copays / coinsurance / deductible]* *[Indicate whether drugs may be subject to step therapy]*

7. EOC models for HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, MSA, HMO MA, and PPO MA

Summary of issue: Language needed to clarify Part B drug requests.

Issue location: HMO MA-PD, PPO MA-PD, Cost Plan, and PFFS: Chapter 9, Section 5.1
D-SNP: Chapter 9, Section 6.1
MSA, HMO MA, PPO MA: Chapter 7, Section 5.1

Action required: Update the language as shown below (changes are noted in red text).

> This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay*). To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

8. EOC models for HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, MSA, HMO MA, and PPO MA

Summary of issue: Language needed to clarify Part B drug adjudication timeframes.

Issue location: HMO MA-PD, PPO MA-PD, Cost Plan, and PFFS: Chapter 9, Section 5.2
D-SNP: Chapter 9, Section 6.2
MSA, HMO MA, PPO MA: Chapter 7, Section 5.2

Action required: Update the language as shown below (changes are noted in red text).

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request **for a medical item or service**. If your request is for a **Medicare Part B prescription drug, we will give you an answer within 72 hours** after we receive your request.

- **However,** for a request **for a medical item or service** **we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

If your health requires it, ask us to give you a "fast coverage decision"

- **A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.**
  - **However,** for a request **for a medical item or service** **we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.) We will call you as soon as we make the decision.

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast coverage decision"

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours.**
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), or 24 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard coverage decision"

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request.** If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
    - For a request for a medical item or service, w~~W~~e can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
    - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or 72 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 14 calendar days, or 72 hours if your request is for a Part B prescription drug, after we received your request. If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

9. EOC models for HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, MSA, HMO MA, and PPO MA

Summary of issue: Language needed to clarify Part B drug adjudication timeframes.

Issue location: HMO MA-PD, PPO MA-PD, and PFFS: Chapter 9, Section 5.3
D-SNP: Chapter 9, Section 6.3
MSA, HMO MA, PPO MA: Chapter 7, Section 5.3

Action required: Update the language as shown below (changes are noted in red text).

Deadlines for a "fast appeal"

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug, we will give you our answer **within 7 calendar days** after we receive your appeal if your appeal is about coverage for a Part B prescription drug you have not yet received. -We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
  - If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 calendar days, **or within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we receive your appeal.

10. EOC model for Cost Plan

Summary of issue: Parenthetical language in Cost Plan model was omitted.

Issue location: Chapter 9, Section 5.3

Action required: Update the language as shown below (changes are noted in red text).

***Note:** Insertion of the word "applicable," as shown below, is duplicative of corrections edit provided in number 8 (see above).

> - If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

11. EOC models for HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, MSA, HMO MA, and PPO MA

Summary of issue: Language needed to clarify Part B drug adjudication timeframes.

Issue location: HMO MA-PD, PPO MA-PD, Cost Plan, and PFFS: Chapter 9, Section 5.4
D-SNP: Chapter 9, Section 6.4
MSA, HMO MA, PPO MA: Chapter 7, Section 5.4

Action required: Update the language as shown below (changes are noted in red text).

> - However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
>
> ***If you had a "standard appeal" at Level 1, you will also have a "standard appeal" at Level 2***
>
> - If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service, t~~T~~he review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.

- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of a request for a medical item or servicewhat you requested,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date the planwe receives the decision from the review organization for expedited requests.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug under dispute within **72 hours** after we receive the decision from the review organization for **standard requests** or within **24 hours** from the date we receive the decision from the review organization for **expedited requests**.

12. LIS Rider

Summary of issue: Deductible and cost sharing values need to be updated to reflect CY2020 values.

Issue location: Pages 1 and 2

Action required: Update the language as shown below (changes are noted in red text).

Your monthly plan premium is	Your yearly deductible is	Your cost sharing amount for generic/preferred multi-source drugs is no more than	Your cost sharing amount for all other drugs is no more than
<Insert applicable amount>*	<$0/$8589>	<$0/$1.30/ $3.60 /15%>(each prescription)	<$0/$3.90/ $8.95/15%> (each prescription)

[Sponsors: Please fill out the chart to reflect the deductible and cost sharing amounts applicable to the beneficiary who will receive this form. If you were notified that one of your members qualifies for the subsidy and has an $8589 deductible but the plan is a zero deductible plan, please insert a $0 in the chart above. In addition, if you were notified

that one of your members qualifies for a co-payment amount that is more than the co-payment amounts listed in the Evidence of Coverage, insert the co-payment amount listed in the Evidence of Coverage in the chart above. For example, if the member qualifies for a $3.~~30~~60 co-payment for generics, but your plan is a $0 generic plan, insert a $0 in the chart above. Sponsors must ensure that the premiums displayed in the table above are accurate and therefore reflect the premiums for beneficiaries who receive extra help as displayed on HPMS at Plan Bids/Bid Submission/Contract Year 2020 Manage Plans/Review Plan Data. The only exception is that sponsors have the option to modify the premium and copayment amounts to reflect any wraparound coverage provided by a State Pharmacy Assistance Program in which a member is enrolled. Premiums in this chart must reflect the total plan premium for Part C and Part D, including both the basic and supplemental premium for each if applicable]

13. Formulary (Abridged and Comprehensive)

Summary of issue: Language needed to clarify that MAOs and Part D sponsors are required to follow Medicare rules when making changes to the Drug List and a typographical error needed correction.

Issue location: Page 2

Action required: Update the language as shown below (changes are noted in red text).

Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but [~~"~~"we" or <plan name>] may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes.

14. Part D EOB

Summary of issue: Language does not include electronic delivery option for EOCs.

Issue location: Section 6

Action required: Update the language as shown below (changes are noted in red text).

We have sent you a copy of the *Evidence of Coverage* *[if EOB is for a member with LIS, insert:* and *LIS Rider]*. *[insert as applicable:* These documents are OR This document is] also available on our website: *[insert plan website URL]*. You may also elect to receive the *Evidence of Coverage* electronically, please contact us if you would like to change your method of delivery. If you need another copy *[if EOB is for a member with LIS, insert:* of either of these], please call us (phone numbers are on the cover of this summary).

15. Part D EOB – Exhibit E

Summary of issue: Language does not include electronic delivery option for EOCs.

Issue location: Section 4

Action required: Update the language as shown below (changes are noted in red text).

To learn what you must do to ask for an exception, see the *Evidence of Coverage* that we sent to you. This document is also available on our website: http://www.xyzhealth.com. You may also elect to receive the *Evidence of Coverage* electronically, please contact us if you would like to change your method of delivery. If you need another copy, please call us (phone numbers for XYZ Member Services are on the cover of this summary). Look for Chapter 7, *What to do if you have a problem or complaint*.

16. Part D EOB – Exhibit F

Summary of issue: Language does not include electronic delivery option for EOCs.

Issue location: Section 6

Action required: Update the language as shown below (changes are noted in red text).

We have sent you a copy of the *Evidence of Coverage* and *LIS Rider*. These documents are also available on our website: http://www.xyzhealth.com. You may also elect to receive the *Evidence of Coverage* electronically, please contact us if you would like to change your method of delivery. If you need another copy of either of these, please call us (phone numbers for XYZ Member Services are on the cover of this summary).

17. Part D EOB – Exhibit G

Summary of issue: Language does not include electronic delivery option for EOCs.

Issue location: Section 6

Action required: Update the language as shown below (changes are noted in red text).

We have sent you a copy of the *Evidence of Coverage*. This document is also available on our website: http://www.xyzhealth.com. You may also elect to receive the *Evidence of Coverage* electronically, please contact us if you would like to change your method of delivery. If you need another copy, please call us (phone numbers for XYZ Member Services are on the cover of this summary).

Plans and Part D sponsors should direct questions regarding this memorandum to their CMS Account Manager.