DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services 7500 Security Boulevard Baltimore, Maryland 21244-1850



CENTER FOR MEDICARE

DATE: May 04, 2022

TO: All Medicare Advantage Organizations, Prescription Drug Plans, and

Section 1876 Cost Plans

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SUBJECT: Issuance of Contract Year 2023 Model Materials

This memo announces the release of Contract Year (CY) 2023 Model Materials. These include the following: Annual Notice of Change (ANOC); Evidence of Coverage (EOC); ANOC Errata Notice; EOC Errata Notice; Provider Directory; Part D Explanation of Benefits (EOB); Excluded Provider Model, Formulary (Comprehensive and Abridged); Low Income Subsidy (LIS) Rider; Pharmacy Directory; LIS Premium Summary Table; Prescription Transfer Letter; Notice of Formulary Change; Transition Letter; and (optional) Member Request for Refusal notice.

For the first time in many years, CMS made structural changes (e.g., length, formatting) to the documents. The substance primarily remains the same. Changes that organizations will see include:

- Increased use of plain language
- Elimination of duplicative language
- Elimination of some tables
- Elimination of some Tables of Contents
- General reorganization
- Fewer pages

CMS would like to highlight the following changes in the ANOC and EOC models:

Annual Notice of Change (ANOC)

All models

- Removed "Summary of Important Costs for 2023" from the first line of the Table of Contents (TOC);
- Removed the "Enroll" section on the cover page;
- Removed benefit details under "inpatient hospital stays" in the Summary of Important Costs for CY2023 table;

- Added optional language about online disenrollment in Section 4;
- Streamlined and combined two paragraphs about Medicare resources (e.g., Medicare Plan Finder (MPF) into a single paragraph in Section 4.2; and
- Updated the language on the cover page and in Section 5 to note that an institutionalized individual in any Medicare Advantage (MA) plan can change their Medicare coverage at any time.

All Part D models

• Removed "The drugs included on our Drug List will be the same in 2023 as in 2022," from Section 2.5.

All models except PDP

• Removed "prior authorization" and added "Part B step therapy" in the population of Changes to Benefits and Costs for Medical Services table instructions in Section 2.4.

All models except Cost Plan, PFFS, MSA, and PDP

- Updated the language to reflect that Cash and Monetary Rebate benefits are ending for CY2023 for Value-Based Insurance Design (VBID) in Section 2.4; and
- Added instructional language for plans to communicate the removal of Cash or Monetary Rebates and replace with different supplemental benefits in Section 2.4.

Evidence of Coverage (EOC)

All models

- Removed the TOC from individual chapters;
- Updated the term "booklet" to "document";
- Updated language to describe Medicare Part A and Part B services in Chapter 1, Section 2.2;
- Updated how to get help and information from the Federal Medicare program, access State Health Insurance Assistance Program (SHIP) and other resources in Chapter 2, Sections 2 and 3;
- Updated language about Quality Improvement Organizations (QIOs) to avoid duplication and provide clarity on their role in Chapter 9, Section 8.3;
- Updated the Chapter 9, Section 10.2 header to read "How to make a complaint";
- Updated and added new language to the definitions for Chronic-Care Special Needs Plan (C-SNP) and Dual Eligible Special Needs Plans (D-SNP) in Chapter 12; and
- Updated the definition for Institutional Special Needs Plan (I-SNP) to reflect January 2021 final rule changes in Chapter 12.

All Part D models

- Added the phrase "at network pharmacies" in Chapter 4, Section 4.1 to clarify where the full cost of drugs may be lower;
- Updated the language to reflect that Cash and Monetary Rebate benefits are ending for CY2023 in the Value-Based Insurance Design (VBID) section of Chapter 4, Section 2;
- Added language to further describe brand name and generic drugs, and included optional language about biosimilars throughout Chapter 5;
- Added language referencing 2016 and 2020 Final Call Letters to the instructions about mail order services and automatic refills in Chapter 5, Section 2.3;
- Updated optional language regarding automatically processing new prescriptions from provider offices in Chapter 5, Section 2.3;
- Added language about refund eligibility after receiving a refill automatically by mail in Chapter 5, Section 2.3;
- Updated language about coverage restrictions on certain prescription drugs in Chapter 5, Section 4.1 and Section 4.2;
- Removed language in the drug restrictions bullet in Chapter 5, Section 5.1;
- Updated language to clarify the two options available to members when their temporary drug supply runs out in Chapter 5, Section 5.2;
- Updated the sub-heading and deleted duplicative introductory language about drug coverage changes in Chapter 5, Section 6.2;
- Added language explaining notifications about brand name drug coverage changes will include information on how to request an exception in Chapter 5, Section 6.2;
- Updated language to clarify what drugs hospice and the plan cover in Chapter 5, Section 9.4;
- Updated language to clarify the requirements for the Drug Management Program (DMP) and Medication Therapy Management (MTM) in Chapter 5, Sections 10.2 and 10.3;
- Removed optional instructions regarding adjusting for the number of days in a full month's supply of drugs in Chapter 6, Section 5.3;
- Removed the words "medication itself" and added bullets providing information about vaccines administered at pharmacies in Chapter 6, Section 9; and
- Removed "vaccine medication or the" in Chapter 6, Section 9.1.

All models except PDP

- Updated the criteria regarding who is eligible for plan membership in Chapter 1, Section 2.1;
- Added language informing beneficiaries that, in an emergency, they can get covered medical care (including pregnancy-related services) from any provider in Chapter 3, Section 3.1;
- Updated "Inpatient mental health care" to "Inpatient services in a psychiatric hospital" in the Medical Benefits Chart;

- Added language to telehealth services in the Medical Benefits Chart to elaborate on what telehealth services entail;
- Updated language regarding coverage decisions prior to receiving services, and provided instructions for what members should do if coverage is denied in Chapter 9, Section 4.1;
- Added language clarifying that plans must accept any written request for a coverage decision or appeal and that members should include certain details to assist the plan in processing the request in Chapter 9, Sections 6.4 and 6.5; and
- Added language to the Medicare Advantage Open Enrollment Period definition in Chapter 12 to inform beneficiaries that this period is also available for a 3-month period after they are first eligible for Medicare.

All models except MSA and PDP

• Updated the description of urgently needed services to include examples in Chapter 3, Sections 2.2 and 3.2.

All models except PFFS, MSA, and PDP

- Added language explaining how kidney dialysis services may be covered by the plan, particularly if the beneficiary is temporarily out of the service area or if the provider is temporarily unavailable, in Chapter 3, Section 1.2; and
- Removed the Special Supplemental Benefits for the Chronically III (SSBCI) language from the "optional supplemental" benefits section in Chapter 4, Section 2.2.

All models except Cost Plan, PFFS, MSA, and PDP

- Removed the instructional language around incentives for Wellness and Health Care Planning (WHP) under VBID benefits in Chapter 4, Section 2;
- Removed the Part D specific VBID language in Chapter 4, Section 2; and
- Updated language clarifying VBID enrollees are not always eligible for new and existing technologies or FDA approved Medical Devices in Chapter 4, Section 2.

All models except PFFS, MSA, Cost Plan, HMO MA, PPO MA, and PDP

• Updated the instructional language for plans that offer VBID to include reduced cost sharing for MA benefits and reduced or eliminated cost sharing for Part D drugs for members who qualify in Chapter 4, Section 2.

D-SNP Only

- Removed instruction that only non-Fully Integrated Dual Eligible (FIDE) and non-Highly Integrated Dual Eligible (HIDE) SNP plans must coordinate coverage with Medicaid in Chapter 3, Section 4.2;
- Added "or the Medicaid copay, if applicable" to the instructions describing all applicable types of cost sharing in Chapter 4, Section 1.1;

- Updated instructions in Chapter 4, Section 2.1 regarding the period of deemed continued eligibility to clarify that the cost of Medicare covered services may increase:
- Added language clarifying that members who receive "Extra Help" may qualify for a reduction or elimination of deductible and cost sharing for Part D drugs in Chapter 6, Section 4;
- Streamlined information about Level 2 and Level 3 Appeals in Chapters 9A and 9B; and
- Updated language regarding members who recently moved into, currently live in, or just moved out of an institution in Chapter 10, Section 2.4.

MSA Only

• Added clarifying language in Chapter 3, Section 2.1 that the deposit amount plans make into a member's medical savings account will be less than the member's deductible.

PFFS Only

• Added language informing beneficiaries that they can receive covered services from out-of-network providers as long as those providers accept the plan's terms and conditions of payment in Chapter 3, Section 1.2.

Formulary (Abridged and Comprehensive)

• Added regulatory citation to the instructions.

Part D Explanation of Benefits (EOB)

• Updated benefit parameters throughout all exhibits to reflect CY 2023 values.

Part D EOB, Exhibit B

- Added "inj." to prescription description in Part 1, Example 2 (Section 1, Chart 1) to clarify drug type; and
- Added "caps" to the prescription description in Part 2, Example 3, Chart 2 and Part 3, Example 4 (Section 1, Chart 1) to clarify drug type.

Low Income Subsidy (LIS) Rider

- Updated the benefit parameters to reflect CY 2023 values;
- Added instructional language for plans offering the VBID model; and
- Updated HPMS link for premiums for beneficiaries who receive Extra Help.

Model Transition Letter

• Added "your representative" and "and on your behalf" to language under "How do I request coverage determination, including an exception?";

- Replaced "his or her" with "their" under "How do I request coverage determination, including an exception?";
- Removed email address from instructional language under "What if my request for coverage is denied?";
- Deleted the last paragraph in the letter, as it was duplicative of a paragraph on page 1; and
- Moved the following sentence "You can also visit our website at <WEB ADDRESS>" from the last paragraph in the letter to the same paragraph on page 1, beginning with "If you need assistance in requesting a coverage determination..."

All models and standardized documents are located at:

http://www.cms.gov/Medicare/HealthPlans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html and https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Materials

Organizations and sponsors must ensure that their CY 2023 documents are compliant with CMS requirements. Questions should be directed to your CMS Account Manager or Marketing Reviewer.

^{*}Note: The location of changes may vary between the models referenced above.