DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

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

FROM: Kathryn A. Coleman
Director, Medicare Drug & Health Plan Contract Administration Group

Amy Larrick Chavez-Valdez
Director, Medicare Drug Benefit and C & D Data Group

SUBJECT: Issuance of Contract Year 2024 Model Materials

This memo announces the release of Contract Year (CY) 2024 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.

The CY2024 Model Materials include a considerable number of edits due to the Inflation Reduction Act, multiple finalized regulations, and the Paperwork Reduction Act (PRA) process. Plans may notice grammar and formatting edits in the models that are not listed below. As a reminder, CMS releases the CY2024 Annual Notice of Change and Evidence of Coverage Standardized Models Instructions along with the other model documents listed above. CMS encourages plans to review and apply the instructions for permissible alterations whenever possible.

CMS would like to highlight the following changes in the models:

Annual Notice of Change (ANOC)
All models

- Updated SMID naming convention
- Added language in Additional Resources section that telephone calls to Member Services are free
- Updated plan instruction in first sentence in Section 7 to include reference to ADAPs

All Part D models

- Added third and fourth plan instruction paragraphs in Section 2.5 for consistency and added Part D to qualify covered drugs

- Added text in Section 2.5, Stage 2: Initial Coverage Stage Chart, in two instances indicating that most adult Part D vaccines are covered at no cost
- Added plan instructions in Summary of Important Costs Table - Part D prescription drug coverage for deductible and insulin cost-sharing changes during the Deductible, Initial and Catastrophic Coverage Stages
- Added plan instruction in Summary of Important Costs for 2024 under 2024 deductible amount indicating that if a deductible amount other than $0 is included, plans must add the following text: except for insulin furnished through an item of durable medical equipment
- Added language in Changes to the Deductible Stage Chart under Yearly Deductible Stage in Section 2.5 to clarify the deductible does not apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines
- Added plan instruction in Changes to Your Cost Sharing, Initial Coverage Stage (Tier 1 and Tier 2) section updating insulin cost-sharing differences from other drugs cost-sharing in the same tier
- Replaced generic drug with generic version in sixth paragraph of Section 2.5
- Added plan instructions in multiple instances in the Changes to Your Cost Sharing in the Initial Coverage Stage chart, Section 2.5, regarding insulin cost sharing differences from the cost sharing for other drugs in the same tier
- Added plan instructions in the Changes to the Coverage Gap and Catastrophic Coverage Stages section for plans that do and do not cover excluded drugs under an enhanced benefit, Section 2.5

All models except MSA and PDP

- Updated plan instruction and text in first paragraph of Section 2.3 to clarify current Provider and/or Pharmacy Directory and timeframe for mailing directories when requested from plan
- Deleted second sentence of last plan instruction in first column of Maximum-out-of-pocket amount chart, Section 2.2

All models except PDP

- Added sentence to the end of third paragraph plan instruction in Section 2.4: Note that beginning July 2023 cost-sharing for insulin furnished through an item of DME is subject to a coinsurance cap of $35 for one-month's supply of insulin

All models except Cost, MSA and PDP

- Added plan instruction under 2024 deductible amount in Summary of Important Costs for 2024 - Deductible Row regarding insulin furnished through an item of durable medical equipment

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

- Deleted Cash or Monetary Rebates language from the 5th paragraph and deleted the entire 6th paragraph in Section 2.4

HMO MAPD model only

- Added the phrase, prior authorizations, to the list of examples for new/changing limitations or restrictions in Section 2.4

DSNP model only

- Added Special Enrollment Period specific timeframes in Section 5
- Changed long-term care (LTS) to long-term services and supports (LTSS) in first page plan instruction

Evidence of Coverage (EOC)
All models

- Updated SMID naming convention
- Changed long-term care (LTS) to long-term services and supports (LTSS) in PACE definition, Chapter 12
- Replaced each instance with of the term spouse with domestic partner
- Added language in Additional Resources section that telephone calls to Member Services are free
- Replaced the term services with benefits with respect to coverage decisions
- Updated Social Security Office hours in Chapter 2, Sections 5 and 7
- Modified language regarding making an appeal for consistency at the end of Chapter 9, Section 4.1
- Modified language regarding asking for coverage decisions throughout Chapter 9, Section 4.1
- Changed Chronic-Care Special Needs Plan definition in Chapter 12

All Part D models

- Deleted plan instruction in Chapter 5, Section 5.2, related to omitting scenario if all current members would be transitioned in advance for the following year
- Added language to Chapter 5, Section 10.2, in first paragraph related to medications, and added language in second paragraph related to a letter regarding limiting coverage of drugs and changed "determination" to "decision"
- Added "Real-Time Benefit Tool" language and plan instruction in Chapter 5, Section 3.3
- Added two sentences in Chapter 6, Section 1.1 describing the purpose of the "Real-Time Benefit Tool" and that additional information can be obtained by calling Member Services
- Added phrase, "If you qualify for the program," to the second sentence in the second paragraph of Chapter 5, Section 10.3

- Deleted Options 1, 2, and 3 (in D-SNP only) in Chapter 6, Section 7 and added instructions for plans that do and do not cover excluded drugs under an enhanced benefit
- Added "Real-Time Benefit Tool" definition in Chapter 12
- Deleted plan instruction in Chapter 5, Section 5.2, directing sponsors to omit scenario if all current members will be transitioned in advance for the following year
- Updated definition of Catastrophic Stage in Chapter 12
- Changed Chapter 6, Section 7, section header and corresponding Table of Contents title
- Added instruction in third paragraph of Chapter 6, Section 4, for plans with a deductible amount other than $0 to add: "The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines."
- Added second bullet with plan instruction regarding insulin cost sharing differences from the cost sharing for other drugs on the same tier during all drug stages in Chapter 6, Section 5.1
- Added plan instruction regarding cost-sharing for insulin that differs from the cost sharing for other drugs on the same tier in Chapter 6, Section 5.2, after table and added the following text: "Please see Section 9 of this chapter for more information on Part D vaccines cost sharing for Part D vaccines."
- Added plan instruction in Chapter 6, Section 5.4, after the *Your share of the cost when you get a long-term supply of a covered Part D prescription drug* chart for plans that offer insulin cost sharing different from the cost sharing applicable to the other drugs on the same tier
- Made updates throughout Chapter 6, Section 9*,* **Part D Vaccines. What you pay for depends on how and where you get them**, to reflect vaccination benefits, costs, and where to receive a vaccine
- Added plan instruction with optional language in the penultimate paragraph of Chapter 5, Section 7.1, to address plans that offer coverage for any drugs excluded under Part D and added plan instruction for plans that do not offer coverage for any drugs excluded under Part D to the last paragraph
- Deleted instruction and added language related to biosimilar alternatives in the generic drug paragraph in Chapter 5, Section 3.1
- Added several plan instructions related to original biological products and interchangeable biosimilar products in Chapter 5, Section 4.2 and Section 6.2
- Added generic version to fourth bullet and added plan instruction regarding replacing an original biological product with an interchangeable biosimilar version of the biological product in Chapter 5, Section 6.1
- Updated first sentence in Chapter 5, Section 8.2, to be consistent with language in Chapter 7, Section 1
- Updated first sentence of Chapter 9, Section 5.4, to include the word "drug" following the term "anti-nausea"
- Added the language, in your out-of-pocket costs, in two instances in Chapter 6, Section 1.3
- Added "Biological Product" and "Biosimilar" definitions in Chapter 12

All models except PDP

- Corrected language in the Urgently Needed Services row of the Medical Benefits Chart
- Deleted coverage decision and replaced with Level 1 appeal, Chapter 9, Section 4.1
- Change made to the 6th bullet containing a plan instruction for completing the Medical Benefits Chart, Chapter 4
- Added language related to national coverage determinations (NCDs) and investigational device trials (IDE) and clinical research studies in Chapter 3, Section 5.1
- Updated language in Chapter 9, Section 4.1, Making an appeal subsection, to match the same section in DSNP, Chapter 9A
- Added plan instruction regarding optional supplemental benefits in Chapter 1, Section 4.3
- Added language to include the Part B drug timeframe in Chapter 9, Section 5.3, Step 1
- Corrected language describing favorable coverage decisions in Chapter 9, Section 4.1 under header **Asking for coverage decisions prior to receiving benefits**
- Optional language needs to be added to indicate that Section 4.3 does not apply to all plans, Chapter 1, Section 4.3
- Language regarding screening with a low dose computed tomography needs to be modified. Chapter 4, Medical Benefits Chart (Screening for lung cancer with low dose computed tomography (LDCT) section)
- Updated Outpatient mental health care row in Chapter 4, Section 2, Medical Benefits Chart to include licensed marriage and family therapist (LMFT) and licensed Professional Counsellor in accordance with the Consolidated Appropriations Act of 2023
- Replaced entire Colorectal cancer screening section in Chapter 4, Section 2, Medical Benefits Chart
- Updated Ambulance services to include clarity on emergency and non-emergency situations in Medical Benefits Chart, Chapter 4, Section 2
- Added qualifying language for medical care, (medical items, services and/or Part B prescription drugs), in second paragraph of Chapter 9, Section 3
- Moved second sentence in first paragraph of Chapter 9, Section 5.1 regarding medical care references to the second sentence in paragraph one in Chapter 9, Section 4.1
- Changed language in Chapter 9, Section 5.2, Step 1, first bullet related to medical items and/or services
- Updated Chapter 9, Section 7 section title heading and corresponding Table of Contents
- Changed section header, first paragraph and Table of Contents, Chapter 10, Section 4
- Replaced two instances of the term services with medical care in Level 3 Appeal section and one instance in Level 4 Appeal, Chapter 9, Section 9.1
- Added second bullet and edited third bullet in Chapter 4, Medical Benefits Chart, Medicare Part B Prescription Drugs

All models except PPO MAPD, MSA, PPO MA, PDP, DSNP

- Deleted Outside the service area from the first sub-bullet in Chapter 7, Section 1

All models except MSA

- Added the phrase, the option by which, in the first sentence of the **Changing the way you pay your premium** section in Chapter 1, Section 5.1
- Added the ship.help.org URL in the METHOD TO ACCESS SHIP and OTHER RESOURCES text box in Chapter 2, Section 3

All models except Cost Plan, MSA, and PDP

- Added plan instruction regarding whether drugs may be subject to step therapy and an instruction related to insulin cost sharing coinsurance cap, service category, and plan level deductibles in Chapter 4, Medical Benefits Chart, Medicare Part B Prescription Drugs
- Changed Chapter 9, Section 7.4 heading to include language regarding changing hospital discharge date

PFFS model only

- Added plan instruction regarding lower cost-sharing for network providers and deleted sub-network language and sentences related to prior authorization and exceptions in Chapter 1, Section 3.2
- Implemented several edits throughout, Chapter 3, Section 2.1

D-SNP model only

- Modified language throughout Chapter 1, Section 5.1 to better address plans with and without premiums
- Deleted language and plan instructions regarding Part D late enrollment penalty and related premium in Chapter 1, Section 4.4 and Section 5.1
- Added plan instruction in Chapter 6, Section 5.4 after the *Your share of the cost when you get a long-term supply of a covered Part D prescription drug* chart for plans that offer insulin cost sharing different from the cost sharing applicable to the other drugs on the same tier if these cost sharing levels are applicable
- Deleted plan instruction and bullets related to Low-Income Subsidy (LIS) Level 4 in Chapter 6, Section 4

Cost Plan model only

- Added plan instruction for Cost plans that do not offer Part D in Chapter 1, Section 4.4
- Deleted plan instructions related to optional supplemental benefits and Cost plans that do not offer Part D in Chapter 1, Section 4.5

PPO MAPD model only

- Added the word, once, to the description of the flu shot benefit in Chapter 4, Medical Benefits Chart, Immunizations section

PPO MA model only

- Deleted last sentence under *What is covered if you have a medical emergency*, in Chapter 3, Section 3.1

HMO MA model only

- Added language regarding moving on to the next level of appeal to Step 3 in Chapter 7, Section 7.4

HMO MAPD model only

- Removed the phrase, or within, from the bullet under **Step 2: The independent review organization gives you their answer,** in Chapter 9, Section 5.4

HMO MAPD and HMO MA models only

- Updated language for consistency and clarity in Chapters 5 and 7, Section 1 - When you've received emergency or urgently needed medical care from a provider who is not in our plan's network

Cost Plan and PFFS models only

- Deleted Point-of-Service (POS) plan instruction, Chapter 1, Section 3.2

All models except MSA and PDP

- Added plan instruction in Chapter 4, Section 1.2 related to services not subject to the plan deductible
- Updated plan instruction and added text regarding electronic and hard copy Provider and/or Pharmacy Directories and timeframes in Chapter 1, Section 3.2
- Added and edited language throughout Chapter 3, Section 2.3 related to providers leaving the plan
- Added language related to plan payment for dental services in a limited number of circumstances in Chapter 4, Medical Benefits Chart - Dental Services

All models except PPO MAPD, MSA, PPO MA, PDP

- Added sentence to plan instruction in third paragraph of Chapter 1, Section 3.2 referencing the current Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance for guidance on sub-network

All models except HMO MAPD, PPO MA, DSNP, Cost, PFFS, MSA

- Added the term, penalty, to the first sentence in plan instruction for Option 1 of Chapter 1, Section 5.1

PDP model only

- Added paragraph to address the limited circumstances in which a request for a coverage decision will be dismissed, Chapter 7, Section 4.1
- Deleted variable field in Medicare's "Extra Help" program section, Chapter 2, Section 7

MSA model only

- Removed third bullet in fourth paragraph of the Making an appeal section that contains Part D content, Chapter 7, Section 4.1
- Added the phrase, and within, for clarity in the first paragraph in Step 1 of Chapter 7, Section 5.2

Formulary (Abridged and Comprehensive)

- Replaced "his or her" and "he and she" with "their or they," as applicable

Excluded Provider Letter

- Replaced "his or her" and "he and she" with "their or they," as applicable

Member Request for Refusal

- Replaced "his or her" and "he and she" with "their or they," as applicable

Prescription Transfer

- Replaced "his or her" and "he and she" with "their or they," as applicable

LIS Premium Summary

- Incorporated IRA changes (full LIS status)
    - Instructions: Deleted second bullet referencing 4 different premium amounts, due to the enactment of the Inflation Reduction Act. There will not be different premium levels beginning in 2024.
    - First paragraph: Deleted the last sentence "The amount of extra help you get will determine your total monthly plan premium as a member of our Plan."
    - Deleted the plan premium chart and replaced with a list. Language preceding the list now reads: "If you get extra help, your monthly plan premium will be $0 for any of the plan(s) below. (This does not include any Medicare Part B premium

you may have to pay.)" *[Plan sponsors should list all applicable $0 premium plans available for enrollees]*

- <Plan Name A>
- <Plan Name B>

- References to the table have been deleted throughout the model

Low Income Subsidy (LIS) Rider

- Incorporated IRA changes (full LIS status)
  - Benefit parameters updated throughout for 2024. This includes the deletion of references to the cost sharing for partial LIS, as the partial subsidy has been eliminated under the implementation of the IRA. Those who would have been eligible under the partial LIS benefit are now eligible for the full LIS benefit.
  - First paragraph: All enrollees receiving Extra Help from Medicare in 2024 will receive the full LIS benefit and have no deductible, deleted "insert when applicable <yearly deductible>." The sentence now reads: "This means that you will get help paying your monthly premium, yearly deductible, and prescription drug cost sharing."
  - Cost Sharing Chart: Benefit parameters updated for 2024, including the reference to the 15% cost sharing due to the elimination of the partial subsidy for the low income subsidy (LIS) program under Medicare Part D
  - Instructional language for the cost sharing chart: deleted the deductible sentence, as all LIS beneficiaries have a zero dollar deductible beginning in 2024
  - Throughout: Deleted the statement for LIS members who qualify for 15% coinsurance

- Added the phrase "in a year" to the sentence: "Once the amount both you and Medicare pay (as the extra help) reaches $8,000 in a year, your copayment amount(s) will go down to <$0 per prescription/ $4.50 for generic and preferred brand drugs that are multi-source, or $11.20 for all others >."
- Instructional language added to conform with the Medicare Communications and Marketing Guidelines, stating that D-SNPs that have $0 cost sharing for all Part D drugs are exempt from sending the LIS Rider

Part D Explanation of Benefits (EOB) All Exhibits and Plan Instructions

- Annual updates to reflect the year and benefit parameters
- Replaced "his or her" and "he and she" with "their or they," as applicable
- Throughout: Capitalized the terms Out-of-Pocket Costs and Total Drug Costs
- Throughout: Removed decimal points and cents when dollar amounts ended in ".00"
- Throughout: Changed curly brackets to square brackets for clarity and consistency

Part D EOB Exhibit B

- Other Payment Definition has been updated for clarity. Added a note for beneficiary transparency indicating that some other payments may not count toward your Out-of-Pocket Costs
- Chart 1A: Removed explanations of Out-of-Pocket Costs, Total Drug Costs, and Other Payments, as the chart does not include any amounts that count toward TrOOP or total drug costs
- Revised Example 5 to reflect an enrollee without LIS
- Revised Example 6 to reflect an enrollee with LIS and removed Worker's Compensation from example

Part D EOB Exhibit C

- Revised the examples to reflect the expanded LIS benefit for enrollees. Examples now only include non-LIS and LIS status in the Part D benefit phases. Examples 7, 8, and 9 have been deleted from the exhibit and the remaining examples have been renumbered
- Throughout: Revised the language in Stage 4: Catastrophic Coverage from "In this stage, the plan pays most of the cost for your covered Part D drugs." The sentence now reads: "In this stage, the plan pays all of the cost for your covered Part D drugs."
- Throughout: Added the language in Stage 1: Deductible Stage: "The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines"
- Added new Example 8: LIS, in the Catastrophic Coverage Stage

Part D EOB Exhibit D

- Replaced "consumer" with "enrollee"

Part D EOB Exhibit E

- Revised the language within the instructional brackets from "name" to "drug" for clarity and consistency

Part D EOB Exhibit G

- Added cover sheet with instructions
- Incorporates all changes to individual exhibits

Part D EOB Plan Instructions

- Drug Pricing Information: revised the instructions to remove "appropriate" and included that "plans should use their clinical expertise when deciding which alternative drugs to list."
- Drug Pricing Information: Revised "gross drug spend or TrOOP" as "gross covered prescription drug costs or true out of pocket (TrOOP) amounts."

- In "Other things to know" section, the following revisions were made:
    - Revised the title to "Important things to know"
    - Redefined "Extra Help" to refer to the low-income subsidy (LIS) described in Subpart P of the Part D regulations
    - Redefined "Out-of-Pocket Costs" and "TrOOP" to refer to the enrollee's incurred costs, as defined at 1860D-2(b)(4)(C)
    - Redefined "Total Drug Costs" to refer to gross covered prescription drug costs, as defined at 1860D-15(b)(3)
- Added: Added to Instructions – Important things to know: "Do not provide information in the Part D EOB about drugs or supplies that would be covered for a beneficiary in original Medicare under Parts A and/or B; for an enrollee in a Part C plan under the plan's Part A/B coverage."
- Added: "In charts 1, 1A, and 2, the amounts to be used for 'you paid' are the final amounts after 'other payments' (those made by programs, organizations, or other plans; 'other payments' may include TrOOP and non-TrOOP amounts)."
- Added instructions to plans to display the amount of an enrollee's TrOOP limit instead of the enrollee's out-of-pocket costs

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

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 2024 documents are compliant with CMS requirements. Questions should be directed to your CMS Account Manager or Marketing Reviewer.