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

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

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SUBJECT: Model Notice Corrections and Re-issuance of Contract Year 2023 ANOC and EOC models

This memo provides corrections to the Contract Year (CY) 2023 Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) models and announces the re-issuance of all CY 2023 ANOC and EOC models (previously issued on May 4, 2022).
The re-issued models will reflect the following edits that are already incorporated:

- minor formatting (e.g. Table of Contents, Headers), typographical/grammatical corrections, and correct section references
- minor content changes
- correct content for applicable plan type
- elimination of duplicative language
- including instructional language

CMS encourages Medicare Advantage Organizations and Plan sponsors to reference the *2023 Annual Notice of Change and Evidence of Coverage Standardized Models Instructions*, for guidance on permissible alterations, and modifications or deletions of standardized language that may be applied when populating the models.

Below is a brief summary of the substantive corrections, their location within the documents, and the required updates:

1. **ANOC model for HMO MAPD**

   Summary of issue: The phrase "prior authorizations" needs to be added to the list of examples for new/changing limitations or restrictions in the section.

   Issue location: Section 2.4

Change Implemented: Updated language as shown below (changes noted in red text).

[The table must include: (1) all new benefits that will be added or 2022 benefits that will optional supplemental benefits are available for an extra premium); (2) new/changing limitations or restrictions, including referrals, prior authorizations, and Part B step therapy for CY2023 Part C benefits; and (3) all changes in cost sharing for 2023 for covered medical services, including any changes to service category out-of-pocket maximums and cost sharing for optional supplemental benefits (plans must indicate these optional supplemental benefits are available for an extra premium).]

2. **EOC models for HMO MAPD, PPO MAPD, D-SNP, Cost Plan, PFFS, MSA, HMO MA, and PPO MA**

Summary of issue: Optional language needs to be added to indicate that Section 4.3 does not apply to all plans.

Issue location: Chapter 1, Section 4.3

Change Implemented: Updated the language as shown below (changes noted in red text).

If you signed up for extra benefits, also called "optional supplemental benefits," then you pay an additional premium each month for these extra benefits. See Chapter 4, Section 2.2 for details. *[If the plan describes optional supplemental benefits within Chapter 4, then the plan must include the premium amounts for those benefits in this section.]*

[Delete Chapter 1, Section 4.3 if your plan doesn't offer optional supplemental benefits. Renumber remaining sections as appropriate.]

3. **EOC model for D-SNP**

Summary of issue: Language needs to be modified throughout the section to better address plans with and without premiums.

Issue location: Chapter 1, Section 5.1

Change Implemented: Updated the language as shown below (changes noted in red text).

What to do if you are having trouble paying ~~your~~ [*plans with a premium insert:* your plan premium]

[Plans that do not disenroll members for non-payment may modify this section as needed.]

~~*Your [plans*~~*[Plans that do not have a plan premium or a $0 premium may modify this section as needed.]*

[Plans with a premium insert: Your plan premium] payment is due in our office by the *[insert day of the month]*. *[Plans with no premium insert:* If you are required to pay a Part D late enrollment penalty that penalty is due in our office by the *[insert day of the month]*. If we have not received your payment by the *[insert day of the month]*, we will send you a notice telling you that your plan

membership will end if we do not receive your [*plans with a premium insert:* premium] payment within *[insert length of plan grace period]*.

If you are having trouble paying ~~your~~ [plans with a premium insert: your premium] on time, please contact Member Services to see if we can direct you to programs that will help ~~with your~~ [*plans with a premium insert:* with your plan premium].

If we end your membership because you did not pay ~~your~~ [*plans with a premium insert:* your plan premium], you will have health coverage under Original Medicare. As long as you are receiving "Extra Help" with your prescription drug costs, you will continue to have Part D drug coverage. Medicare will enroll you into a new prescription drug plan for your Part D coverage.

4. **EOC models for HMO MAPD, PPO MAPD, D-SNP, Cost Plan, PFFS, MSA, HMO MA, PPO MA, and PDP**

Summary of issue: The hours of availability for the Social Security Office need to be modified.
Issue location: Chapter 2, Sections 5 and 7
Change Implemented: Updated the language as shown below (changes are noted in red text).

- The Social Security Office at 1-800-772-1213, between ~~7~~8 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or

5. **EOC model for HMO MAPD, D-SNP, HMO MA**

Summary of issue: Language regarding prior authorization needs to be removed in the *How to get care from specialists and other network providers* section.

Issue location: Chapter 3, Section 2.3

Change Implemented: Updated language as shown below (changes noted in red text).

[Plans should describe how members access specialists and other network providers, including:

- *What is the role (if any) of the PCP in referring members to specialists and other providers?*

- *Include an explanation of the process for obtaining PA, including who makes the PA decision (e.g., the plan, PCP, another entity) and who is responsible for obtaining the PA (e.g., PCP, member). Refer members to Chapter 4, Section 2.1 for information about which services require PA.*

~~Prior authorization may be needed for certain services (please see Chapter 4 or information which services require prior authorization). Authorization can be obtained from the plan. You or your provider, including a non-contracted provider, can ask the plan before a service is furnished whether the plan will cover it. You or your provider can request that this determination be in writing. This process is called an advanced determination. If we say we will not cover your services, you, or your provider, have the right to appeal our decision not to cover your care.~~

~~Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made.~~

~~If you do not have an advanced determination, authorization can also be obtained from a network provider who refers an enrollee to a specialist outside the plan's network for a service; provided that service is not explicitly always excluded from plan coverage as discussed in Chapter 4.~~

- *Explain if the selection of a PCP results in being limited to specific specialists or hospitals to which that PCP refers (i.e., sub-network, referral circles).]*

6. EOC model for PPO MAPD

Summary of issue: The word "once" needs to be added to the description of the flu shot benefit.

Issue location: Chapter 4, Medical Benefits Chart, Immunizations section

Change Implemented: Updated the language as shown below (changes noted in red text).

Services that are covered for you	**What you must pay** when you get these services
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit. *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.

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

Summary of issue: Language regarding screening with a low dose computed tomography needs to be modified.

Issue location: Chapter 4, Medical Benefits Chart (Screening for lung cancer with low dose computed tomography (LDCT) section)

Change Implemented: Updated the language as shown below (changes are noted in red text).

Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged ~~55~~50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least ~~30~~20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision--making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision--making visit or for the LDCT.

8. **EOC model for PPO MAPD, MSA, PPO MA**

Summary of issue: The phrase "inpatient or outpatient" needs to be removed from the smoking and tobacco use cessation benefit.

Issue location: Chapter 4, Medical Benefits Chart, Smoking and tobacco use cessation section

Change Implemented: Updated language as shown below (changes noted in red text).

Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable ~~inpatient or outpatient~~ cost sharing. Each counseling attempt includes up to four face-to-face visits. *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

9. EOC model for HMO MA

Summary of issue: Language regarding moving on to the next level of appeal needs to be added to Step 3 of the section.

Issue location: Chapter 7, Section 7.4

Change Implemented: Updated language as shown below (changes noted in red text).
The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

10. EOC models for HMO MAPD, PPO MAPD, D-SNP, Cost Plan, PFFS, MSA, HMO MA, PPO MA, and PDP

Summary of issue: Language regarding making an appeal needs to be modified at the end of the section.

Issue location: HMO MAPD, PPO MAPD, Cost Plan, PFFS: Chapter 9, Section 4.1,
D-SNP: Chapter 9, Section 5.1,
MSA, HMO MA, PPO MA, PDP: Chapter 7, Section 4.1

Change Implemented: Updated language as shown below (changes noted in red text).

If we do not dismiss your case but say no to all or part of your Level 1 appeal, ~~your appeal will automatically~~ you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (~~You~~ Appeals for medical services and Part B drugs will be automatically sent to the independent review organization for a Level 2 appeal – you do not need to do anything ~~to start a Level 2 appeal. Medicare rules require we automatically send.~~ For Part D drug appeals, if we say no to all or part of your appeal ~~to~~ you will need to ask for a Level 2 ~~if we do not fully agree with your Level 1~~ appeal.~~)~~ Part D appeals are discussed further in Section 6 of this chapter). If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes).

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

Summary of issue: Language regarding asking for coverage decisions needs to be modified throughout the section.

Issue location: HMO MAPD, PPO MAPD, Cost Plan, PFFS: Chapter 9, Section 4.1,
D-SNP: Chapter 9, Section 5.1,
MSA, HMO MA, PPO MA, PDP: Chapter 7, Section 4.1

Change Implemented: Updated language as shown below (changes noted in red text).

Asking for coverage decisions prior to receiving services

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, ~~if~~ your plan network doctor ~~refers you to a medical specialist, this is~~ makes a (favorable) coverage decision.

~~If your doctor, whether the doctor is in our network or outside it, is unsure whether we will cover a medical service,~~ for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision ~~prior~~ if your doctor is unsure whether we will cover a particular medical service or refuses to ~~receiving the service. This is called an "advanced determination" or prior authorization. You or your doctor can also request~~ provide medical care you think that ~~the response be in writing if you would like a copy of the decision for your records~~ you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make ~~an initial coverage decision for you. If your plan denies the coverage asked about in the advanced determination, then your plan must issue a standardized denial notice informing you or your doctor of your right to appeal this decision.~~

~~If you do not have an advanced determination, authorization for services can also be obtained from a network provider who refers an enrollee to a specialist. This can also be a provider outside of the plan's network. However, the service cannot be a service that is explicitly excluded from plan coverage (that is, never covered by the plan) as discussed in Chapter 4. If the enrollee receives an authorization from the provider and the service is not~~

~~an excluded service, the enrollee only has to pay plan cost sharing. If the plan attempts to charge the enrollee more, the enrollee can formally request a review called an appeal. This is discussed in the next section.~~ a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal. ~~This review is a formal process called an appeal. Appeals are discussed in the next section.~~

We are making a coverage decision for your whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

12. EOC model for HMO MAPD

Summary of issue: The phrase "or within" needs to be removed from the bullet under "Step 2: The independent review organization gives you their answer."

Issue location: Chapter 9, Section 5.4

Change Implemented: Updated the language as shown below (changes noted in red text).

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 service,** 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. For expedited requests, we have ~~or within~~ 72 hours from the date we receive the decision from the review organization.
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The re-issued CY 2023 ANOC and EOC model documents are located at: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial

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