Attachment B: 30-day Federal Register Crosswalk: High Level Summary of Revisions

For the 2024 contract year, based on public comments for a 60-day Federal Register Paperwork Reduction Act (PRA) notice and feedback from CMS subject matter experts (SMEs), the Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) standardized documents have been revised to reflect policy changes and simplify information for plan members. The changes will not result in additional burden. The table below summarizes the edits.

General Updates
Throughout the document we have changed the word Ombudsman to Ombudsperson
We have made updates to ensure acronyms were spelled out for the first use.
We have made additional grammatical updates.

ANOC

Section	**Change/Reason**
Instructions to Health Plans	We have deleted the ambiguous language stating, "Consider producing translated models in large print." All MA organizations and Part D sponsors must comply with section 504 of the Rehabilitation Act of 1973, section 1557 of the Affordable Care Act, and implementing regulations at 45 CFR part 92. The regulations at 45 CFR § 92.102(b) require plans to provide appropriate auxiliary aids and services, including interpreters and information in alternate formats, to individuals with impaired sensory, manual, or speaking skills, where necessary to afford such persons an equal opportunity to benefit from the service in question.
Introduction	We have moved up language disclaimers, information regarding the availability of materials in alternate formats, how to request a preferred language, and the availability of interpreter services to the introduction prior to the table of contents in order to ensure that this information is easy to locate in the document.
Section B	We have added the word "Medicaid" in parentheses to the header for section B. Throughout the document plans should use the state-specific name for Medicaid.
Section B	We have updated language to read, "Refer to Section E for more information on changes to your benefits for next year."
Section B	We have updated the language regarding membership end dates to allow more flexibility for the Medicaid coverage end date.
Section B2	We have modified language regarding cost sharing tiers to include instructions to insert if applicable and adjust the language as needed.

Section E1 and E2	We have added instructions to plans offering value-based insurance design (VBID) model benefits.
Section E2	We have added additional instructions regarding information to include for plans with one payment stage vs. two payment stages.
Section E2	We have modified the last paragraph of this section as follows: "The Initial Coverage Stage ends when your total out-of-pocket costs for prescription drugs reaches [*insert as applicable:* **$<TrOOP amount>**]. At that point, the Catastrophic Coverage Stage begins. Our plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information on how much you will pay for prescription drugs."
Section E3	We have modified the last paragraph of this section as follows: "The Initial Coverage Stage ends when your total out-of-pocket costs reach [*insert as applicable:* ***$<TrOOP amount>***]. At that point the Catastrophic Coverage Stage begins. [*Insert as applicable:* The plan covers all of your drug costs from then until the end of the year. *If the plan covers excluded drugs under an enhanced benefit or Medicaid drugs with cost-sharing in this stage insert:* The plan covers all of your Part D drugs until the end of the year. You may have cost-sharing for excluded drugs that are covered under <*insert as applicable:* our enhanced benefit/Medicaid>]. Refer to **Chapter 6** of your *Member Handbook* for more information about how much you pay for prescription drugs."
Section E4	We have deleted instruction language regarding the initial coverage limit and modified instructions regarding excluded drugs.
Section G2	In the last paragraph, we have updated the language to note that this is the name of the program as directed by the State.
Section H2	In the first paragraph, we have deleted the word "staff". This should just be the name of the program.
Section H2	We have edited the document to delete the word "HICAP" and instead changed this to the SHIP.

EOC Comments

Chapter	Section	Change/ Reason
1	Instructions	We have deleted the ambiguous language stating, "Consider producing translated models in large print." All MA organizations and Part D sponsors must comply with section 504 of the Rehabilitation Act of 1973, section 1557 of the Affordable Care Act, and implementing regulations at 45 CFR part 92. The regulations at 45 CFR 92.102(b) require plans to provide appropriate auxiliary aids and services, including interpreters and information in alternate formats, to individuals with impaired sensory, manual, or speaking skills, where necessary to afford such persons an equal opportunity to benefit from the service in question.

1	Introduction	We have added the alternative language disclaimer and availability of interpreter disclaimer.
1	B1	We changed the word “older” to “over”.
1	B2 and C	We updated the instructions to note that plans may revise the section to best reflect the coverage in the State.
1	C	We changed the word “all” to “most”.
1	D	We deleted the word “approved” prior to zip codes.
1	E	We have added language regarding incarcerated individuals and moved up the citizenship requirement to the third bullet in the list.
1	E	We have updated the instructions to allow more flexibility for the use of days or months for the deemed continuous eligibility period and noted that states may specify required deeming period per the State Medicaid Agency Contract.
1	H	We have updated this section to clarify that plans should delete the portions of the section that are not applicable and update the numbering as appropriate.
1	H	We have changed the word “form” to “from”.
1	H2	We have updated the reference from H2 to E.
1	J1	We added the word “most” to the first sentence in the third paragraph.
2	A	On page 4, third hollow bullet, we updated the language to state, “You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received.”
2	B	We have revised the fourth bullet to make language regarding LTSS as applicable.
2	F	We have adjusted the language in the first sentence to note that the State-specific name of the Medicaid program should be included.
2	F	We have deleted the Medi-Cal specific web link and made the URL variable.
2	G	We have made the general ombudsperson section optional and made the web URL field variable.
2	H	We have added the option to include information regarding a long-term care ombudsperson.
2	K	We have added a Railroad Retirement Board section.
2	L	We have added a group insurance section.
3	B	For the bullet point beginning with, “You must get your care from network providers…” we have changed the word “furnished” to “provided”.

3	J1	In the last paragraph, second sentence, we have changed the word “use” to “go”.
3	M1	For the DME section we have moved up the instructions which allow the flexibility to modify this section as directed by the state to the beginning of the section.
3	M2	For the *Medicare and You* handbook we have made the year variable.
4	C	We have added a variable field for states to add information on any continuity of care requirements after the fourth bullet.
4	C	We have added instructions for plans offering VBID benefits.
4	C	We have updated the sentence, “You find this apple next to preventative services in the Benefits Chart” to read, “You will find this apple next to preventative services in the Benefits Chart.”
4	D	We have updated numbering to spell out all numbers one through ten.
4	D	For ambulance services, in the third paragraph we have clarified that this is for non-emergent cases.
4	D	For the annual wellness visit, we have added a note regarding the Welcome to Medicare visit.
4	D	For the breast cancer screening section, we have changed the word “older” to “over”.
4	D	For the Cardiac (heart) rehabilitative services we have modified the second sentence to read, “Members must meet certain conditions and have a doctor’s…”
4	D	For the colorectal cancer screening section, we have updated the screening eligibility from 50 to 45 and over.
4	D	For dental services in the last paragraph with instructions, we clarified that the optional supplemental benefits referred to those supplemental benefits with an additional cost.
4	D	For depression screening, we added back in the word “or” so it reads, “The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.”
4	D	For family planning services, we have updated the first sentence to read, “The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services.”
4	D	For hospice care, we have made an adjustment to the language to note these are covered services for the second paragraph.
4	D	For inpatient stay, we have updated the language to clarify the inpatient stay benefit limitations.

4	D	For Medicare Part B prescription drugs, we added a bullet to the Part B covered drugs stating, "Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)."
4	E	In the first paragraph instructions, second sentence we have deleted the phrase, "and must indicate if any of the optional supplemental benefits are covered by Medicaid."
5	A2	We have changed the term "plan ID card" to "Member ID Card" for consistency throughout the EOC.
5	B1	We have added language to give states the flexibility to modify the language in this section.
5	B2	We have made this language in the first bullet variable.
5	B3	We have modified the instructions after the first paragraph to note that plans can modify this section when the drugs are covered by Medicaid or as a supplemental benefit.
5	B3	We have modified the language in the second paragraph to state, "Our plan does not pay for the kinds of drugs described in this section."
5	B3	We modified the list of the types of drugs that Medicare cannot cover to state: • Drugs used to promote fertility • Drugs used for the relief of cough or cold symptoms • Drugs used for cosmetic purposes or to promote hair growth • Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations • Drugs used for the treatment of sexual or erectile dysfunction • Drugs used for the treatment of anorexia, weight loss or weight gain • Outpatient drugs made by a company that says you must have tests or services done only by them
5	B4	We have moved up the language which allows plans that do not use drug tiers to omit this section and deleted it from other locations in this section. We also added to the end of the first paragraph, "In general, the higher the cost-sharing tier, the higher your cost for the drug."
6	Introduction	We have made the language in the third bullet variable.
6	Introduction	In the second series of bullets, we have modified the sub-bullets under the first bullet to read as follows: o We call this the "Drug List." It tells you: • Which drugs we pay for • [*Plans that do not have cost sharing in any tier or do not have tiers may omit this bullet.*] Which of the <number of tiers> tiers each drug is in
6	B	For item four, we have modified the formatting of the bullets.
6	C	We have added instructions for plans participating in the VBID model.

6	C1	We have updated the instructions to allow the plans to modify the section depending on whether the plan includes tiers.
6	C2	We have added instructions allowing this section to be deleted if the plan does not have tiers.
6	C2	We have added an optional bullet to include if the plan benefits include mail-order pharmacy service.
6	C4	We have modified the instructions for the first paragraph to state, "[*Plans that have copays must include the following language. Other plans should delete this section.*]"
6	C4	In the fourth paragraph, we have deleted the reference to the CY 2016 Call Letter.
6	D	We have revised the first paragraph with instructions to state, "[*Plans must provide an explanation of tiers; refer to the examples below. Plans have flexibility to describe their tier model as appropriate. Plans may also edit or delete language regarding Medicaid based on Medicaid coverage.*]"
6	D3	In the fourth paragraph, we have deleted the reference to the CY 2016 Call Letter.
6	D3	We have revised the second paragraph of instructions as follows, "[*Plans should add or remove tiers as necessary. Plans should remove references to "cost sharing as appropriate. If mail-order is not available for certain tiers, plans should insert the following text in the cost-sharing cell: Mail-order is not available for drugs in [insert tier].*]"
6	D4	We have deleted "initial coverage limit" from the first and second paragraph.
6	F	We have clarified that the cost sharing example in the third bullet should be updated for the current year.
6	H	We have added the following paragraph to this section as a result of the Inflation Reduction Act, "**Important Message About What You Pay for Vaccines:** Some vaccines are considered medical benefits. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).* Our plan covers most Medicare Part D vaccines at no cost to you. Refer to your plan's *List of Covered Drugs (Formulary)* or contact Member Services for coverage and cost sharing details about specific vaccines."
7	A	We have modified the second hollow sub-bullet to read, "If you paid for services covered by [*insert name of state-specific Medicaid program*] we can't pay you back, but the provider will. Member Services or [*insert the term for your care coordinator and/or ombudsperson, if applicable.*] can help you contact the provider's office. Refer to the bottom of the page for the Member Services phone number."
7	A	We have modified the second bullet to state, "In only a few cases, we will…"
7	B	In the last paragraph of instructions, we have replaced "number of days" with "insert timeframe".

8	A	We have revised the second bullet to state, "Our plan can also give you materials *[insert if required to provide materials in any non-English languages: in languages other than English and]* in formats such as large print, braille, or audio. To obtain materials in one of these alternative formats, please call Member Services or write to [*Insert Plan name, address, and phone number*]. *[Plans specifically state which languages are offered. Plans also simply describe:"*.
8	B	In the first bullet, we changed the word "women" to "you".
8	C	We have removed the word "to" from the third paragraph.
8	D	We modified the first two sentences of the second paragraph to read, "If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Member Services."
8	H1	We changed the first bullet to read, "Member Services".
8	H1	We modified the last instruction to state, "[*Plans should insert additional contact information, such as for the state Medicaid agency.*]."
8	I	We deleted the reference to coinsurance in the seventh hollow bullet.
9	D	We have changed the first paragraph to read, "If you have a problem or concern, read the parts of this chapter that apply to your situation. The following chart helps you find the right section of this chapter for problems or complaints."
9	E1	We have modified the first paragraph to read, "A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs." We have also added the following sentence to the beginning of the last paragraph of the section, "We make a coverage decision whenever we decide what is covered for you and how much we pay."
9	E2	We added the following sentence to the end of the second to the last paragraph, "If your problem is about a coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 Appeals."
9	F3	We have removed the "if applicable" language in the first bullet. The sentence now states, "If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, you may need to name them as your representative to act on your behalf."

9	F3	We revised the language after the heading "If your health requires it, ask for a fast appeal" to state:
		
		• If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.
		
		We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.
		• If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
		  • We automatically give you a fast appeal if your doctor asks for it.
		  • How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K** [*insert reference, as applicable*].

9	F3	We replaced the word "medication" with "item".
9	G5	In the first bullet, we have changed the word "claim" to "appeal".
9	J2	We have added instructions at the beginning of this section to insert the language and adjust as necessary for the state Medicaid program.
12		We have deleted the term "Aid payed pending" since it is state-specific.
12		We have added the terms "administrative law judge", "AIDS drug assistance program", "drug management program", "independent review organization", "Medicare appeals council", and "Medicare diabetes prevention program" since they are used in the document.
12		For the term "service area" we changed "get our plan" to "enroll in our plan".
12		For the last page, we updated the instructions to allow for additional contacts to be added to the page.