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

MEMORANDUM

To: Current and New Medicare Advantage (MA) Organizations, Medicare Cost-based Plans, and Health Plan Demonstrations

From: Cynthia G. Tudor, Ph.D., Director, Medicare Drug Benefit Group /s/
David Lewis, Acting Director, Medicare Advantage Group /s/

Subject: Additions to the 2007 MA Model Evidences of Coverage (EOC)

Date: December 19, 2006

On November 20, 2006, CMS released the Final 2007 Model Evidences of Coverage (EOC). The model EOCs are intended for use by all MA Organizations and PDPs to explain covered benefits and related cost-sharing responsibilities.

CMS has identified additions to the 2007 EOC for HMO, PPO, 1876 Cost Plans and PFFS. Specifically, information in Section 3, "Getting care if you have a medical emergency or an urgent need for care," and Section 6, "Coverage for Outpatient Prescription Drugs," was omitted. CMS has created an errata sheet for these corrections. To ensure that organizations are able to issue the EOC to beneficiaries by the January 31, 2007, mailing deadline plans must utilize the errata sheets in the following manner:

For Organizations that Have Already Submitted Model/Non-Model EOC via the HPMS Marketing Module they should do the following:

- Submit MA Errata Sheet via HPMS using "EOC Errata" as part of the marketing material ID using ID Code 1002.
- Insert the MA Errata Sheet in the mailing with your approved EOC.
- If your approved EOC is already in the print/mail process, then the MA EOC Errata sheet can be mailed separately to beneficiaries by February 28, 2007.

For Organizations that Have Not Submitted Model/Non-Model EOC via the HPMS Marketing Module they should do the following:

- Insert information from the MA Errata Sheet directly into the sections that apply. Organizations must still mail the EOC documents to beneficiaries by January 31, 2007.

The MA EOC Errata Sheet will be posted on the CMS MA marketing website and in HPMS. The CMS MA marketing website is located at http://www.cms.hhs.gov/ManagedCareMarketing/.

Additionally, the following issues should be addressed if your organization EOC's have not been printed.

Dual Eligible SNPs:

- Dual eligible SNPs that have a Medicare contract with a state should include references to the Medicaid EOC in the following sections:
    - 'Welcome to [Name of Plan]' page
    - 4 – *Benefits*
    - 7 – *Hospital care, skilled nursing facility care, and other services*
    - 11 – *Information on how to make a complaint about Part C medical services and benefits*; and
    - 12 – *What to do if you have complaints about your Part D prescription drug benefits*.
- Section 4 – *Benefits*:

  Only those MA SNPs that have a contract with the state should include Medicaid benefits in the Medicare EOC. (i.e., if the MA is not providing the Medicaid benefits to the member, then it shouldn't be describing that member's Medicaid benefits.)

- Section 13 – *Leaving [Name of Plan] and your choices for continuing Medicare after you leave*:

  The loss of Medicaid status should be added to the list of involuntary disenrollment. Explain clearly, the length of the plan's "grace period" and how the process for disenrollment works.

- Section 13 – *Leaving [Name of Plan] and your choices for continuing Medicare after you leave*:

  The following statement should be added after enrollment lock-in. "In general, enrollment periods are limited however, as long as you remain entitled to both Medicare and Medicaid, you can make changes."

- Definition section – The following definition should be added for *Special Needs Plan*:

> "Exclusively enrolls Special Needs individuals as defined in 422.2 or enrolls a greater proportion of special needs individuals than occurs nationally in the Medicare population as defined by CMS."

All EOC's should include the following additions:

- Section 7 - *Hospice care for people who are terminally ill*:

  Delete the current paragraph in the Hospice care section and add the guidance below.

  > "Please inform us before you start a clinical trial so that we may track your health care services. Plans with a direct contracted network of providers add the following two sentences: You do not need to get a referral from a plan provider to join a clinical trial. Similarly, the clinical trial providers do not need to be plan providers."

Cost Plan EOC only

- Section 7 – *Participating in a clinical trail*

  The following paragraph should be changed to reflect that Original Medicare pays for costs related to clinical trails and not the plan. The correction is highlighted below.

  > "There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, Original Medicare (and not [name of plan]) pays the clinical trial doctors and other providers for the covered services you receive that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in [name of plan] and continue to get the rest of your care that is unrelated to the clinical trial through [name of plan]."

Checklists

- The section titled "Explain that premiums cannot be raised mid-year" should be deleted in all EOC checklists.

Questions regarding the 2007 model Evidences of Coverage should be referred to your CMS Regional Office.