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MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: August 7, 2012

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

FROM: Danielle R. Moon, J.D., M.P.A., Director
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SUBJECT: Annual Notice of Change/Evidence of Coverage Corrections

On May 31, 2012, CMS issued an HPMS memorandum announcing the issuance of certain contract year (CY) 2013 model marketing materials. Included in this release were the CY 2013 Annual Notice of Change/Evidence of Coverage (ANOC/EOC) standardized templates for all plan types. Since this release, we have identified errors in the standardized language in several areas. The purpose of this memorandum is to provide corrected standardized language that plan sponsors must use in their CY 2013 ANOC/EOCs, as appropriate for their plan type(s). Below, please find a brief summary of the issue, a description of where the issue is located, and the required action to address the identified error.

1. ANOC template for PFFS plans

Summary of issue: The ANOC states that beneficiaries wishing to change from their PFFS plan to Original Medicare can do so by enrolling in a prescription drug plan.

Issue location: PFFS ANOC - Section 4.2, Step 2

Action required: MA-only PFFS plans must update the language as instructed below. MA-PD PFFS plans should make no changes to the current language.

- The language currently reads as follows:
  "To change to Original Medicare with a prescription drug plan, enroll in the new drug plan. You will automatically be disenrolled from [insert 2013 plan name]."

- MA-only PFFS plans must replace the language cited above with the following standardized language:
  "To change to Original Medicare with a prescription drug plan you must:

  - Send us a written request to disenroll from [insert 2013 plan name] or contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call

1-877-486-2048. Contact Member Services if you need more information on how to disenroll.
- – *and* – Contact the Medicare prescription drug plan that you want to enroll in and ask to be enrolled."

2. ANOC template for Cost plans

Summary of issue: The ANOC currently requires maximum out-of-pocket (MOOP) language.

Issue location: Cost plan ANOC – *Summary of Important Costs* for 2013 AND Section 2.2, *Changes to your Maximum Out-of-Pocket Amount*

Action required: Cost plans not offering a MOOP must delete the MOOP row in the *Summary of Important Costs* section. Additionally, Cost plans not offering a MOOP must delete Section 2.2, *Changes to your Maximum Out-of-Pocket amount*. Cost plans with a MOOP must retain the original language in both areas.

3. EOC template for Cost plans

Summary of issue: the eligibility requirements in the EOC for Cost plan members are incorrect.

Issue location: EOC – Chapter 1, Section 2.1 AND Chapter 8, Section 2.1.

Action required: Plans must update the language as instructed below (note, two corrections).

- The language in Chapter 1, Section 2.1 currently reads as follows:
  "You are eligible for membership in our plan as long as:
  - You live in our geographic service area (section 2.3 below describes our service area)
  - --and—you have Medicare Part A or Medicare Part B (or you have both Part A and Part B)"

- Replace language cited above with the following standardized language:
  "You are eligible for membership in our plan as long as:
  - You live in our geographic service area (section 2.3 below describes our service area)
  - --and—you have Medicare Part B (or you have both Part A and Part B)"

- The language in Chapter 8, Section 2.1, *Pay what you owe* currently reads as follows:
  "In order to be eligible for our plan, you must have Medicare Part A or Medicare Part B (or both Part A and part B). For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan."

- Replace language cited above with the following standardized language:
  "In order to be eligible for our plan, you must have Medicare Part B (or both Part A and Part B). For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan."

4. EOC template for DE SNPs

Summary of Issue: the EOC does not provide sponsors the choice to insert one of two possible drug coverage stages.

Issue location: DE SNP EOC - Chapter 6, Section 5.4

Action required: Plans must update the language as instructed below.

- The language in Chapter 6, Section 5.4 currently reads as follows:
  "We will let you know if you reach this [*insert as applicable:* $[*insert initial coverage limit*] *OR* $[*insert TrOOP amount*] amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage."

- Replace language cited above with the following standardized language:
  "We will let you know if you reach this [*insert as applicable:* $[*insert initial coverage limit*] *OR* $[*insert TrOOP amount*] amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the *[insert as applicable:* Coverage Gap Stage *OR* Catastrophic Coverage Stage*]*."

5. EOC template for PDP, DE SNP, MA-PD (HMO and PPO), PFFS, and Cost plans

Summary of issue: the EOC displays the incorrect year in the Part D IRMAA table.

Issue location: - PDP EOC – Chapter 4, Section 11.2
- DE SNP EOC – Chapter 6, Section 11.3
- MA-PD (HMO and PPO), PFFS and, Cost EOC – Chapter 6, Section 11.2

Action required: Plans must replace the year 2010 with 2011 in all areas of the table.

6. EOC template for DE SNP, MA-PD (HMO and PPO), MA (HMO and PPO), PFFS, MSA, and Cost plans.

Summary of issue: the EOC incorrectly lists transportation as a home health benefit.

Issue location: EOC – Chapter 4, Medical Benefits Chart, Home Health Agency Care Row, 3rd bullet

Action required: Plans must update the language as instructed below.

- The language currently reads as follows:
  "Medical and social services or transportation service"

- Replace language cited above with the following standardized language:
  "Medical and social services"

7. EOC template for PDP, DE SNP, MA-PD (HMO and PPO), PFFS, and Cost plans

Summary of issue: the EOC lists the incorrect timeframe for a standard coverage decision about payment for a drug a beneficiary has purchased.

Issue location: - PDP EOC – Chapter 7, Section 5.4, Step 2
- DE SNP EOC – Chapter 9, Section 7.4, Step 2
- MA-PD (HMO and PPO), PFFS and Cost EOC – Chapter 9, Section 6.4, Step 2

Action required: Plans must update the language as instructed below.

- The language currently reads as follows:
  "If our answer is yes to part or all of what you requested, we are also required to make payment to you within 30 calendar days after we receive your request."

- Replace language cited above with the following standardized language:
  "If our answer is yes to part or all of what you requested, we are also required to make payment to you within 14 calendar days after we receive your request.

8. EOC template for MA (HMO and PPO), MA-PD (HMO and PPO), PFFS, DE SNP, MSA, and Cost plans

Summary of issue: The definition of organization determination needs to be clarified.

Issue location: - MA-PD (HMO and PPO), DE SNP, PFFS, and Cost EOC – Chapter 12, Definitions of Important Words
- MA (HMO and PPO), MSA, and PDP EOC – Chapter 10, Definitions of Important Words

Action required: Plans must update the language as instructed below.

- The language currently reads as follows:
  "Organization Determination - The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called "coverage decisions" in this booklet. Chapter [x] explains how to ask us for a coverage decision."

- Replace language cited above with the following standardized language:

"Organization Determination – The [*insert as applicable*: Medicare Advantage organization or Cost plan] has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. The [*insert as applicable*: Medicare Advantage organization's or Cost plan's] network provider or facility has also made an organization determination when it provides you with an item or service, or refers you to an out-of-network provider for an item or service. Organization determinations are called "coverage decisions" in this booklet. Chapter [x] explains how to ask us for a coverage decision."

9. EOC template for all plan types

Summary of issue: the EOC indicates the QI program is ending in 2012.

Issue location: EOC – Chapter 2, Section 6, *Medicaid*

Action required: Plans must update the language as instructed below.

- The language currently reads as follows:
  "Qualified Individual (QI): Helps pay Part B premiums. (The QI program is scheduled to end on December 31, 2012.)"

- Replace language cited above with the following standardized language:
  "Qualified Individual (QI): Helps pay Part B premiums."

10. EOC template for all plan types

Summary of issue: the EOC identifies incorrect resources to assist a beneficiary with a coverage decision or appeal.

Issue location: - MA-PD (HMO and PPO), PFFS, and Cost EOC – Chapter 9, Section 4.2
- MA (HMO and PPO), MSA, and PDP EOC – Chapter 7, Section 4.2
- DE SNP EOC – Chapter 9, Section 5.2

Action required: Plans must update the language as instructed below*.

- The language currently reads as follows:
  "Your doctor or other provider can make a request for you. Your doctor or other provider can request a coverage decision or a Level 1 Appeal on your behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative."

- * "Part D option" - PDPs replace language cited above with the following standardized language:
  "For Part D prescription drugs, your doctor or other prescriber can request a coverage determination or a Level 1 or 2 appeal on your behalf. To request any

appeal after Level 2, your doctor or other prescriber must be appointed as your representative."

- * "Part C option" - MA (HMO and PPO), MSA, PFFS plans not offering prescription drugs, and Cost plans not offering prescription drugs replace language cited above with the following standardized language:

  "For medical care, a doctor can make a request for you. Your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative."

- *MA-PD (HMO and PPO), DE SNP, PFFS plans offering prescription drugs, and Cost plans offering prescription drugs replace the original language with the two aforementioned coverage determination options (include language for both Part D and Part C options).

11. EOC template for all plan types

Summary of Issue: the EOC references an outdated annual mailing requirement for provider and pharmacy directories.

Issue location: - MA (HMO and PPO) and MSA EOC: Chapter 1, Section 3.2
- PDP EOC: Chapter 1, Section 3.2
- DE SNP, MA-PD (HMO and PPO), PFFS, and Cost plan EOC: Chapter 1, Section 3.2 AND Chapter 1, Section 3.3

Action required: Plans must update the language as instructed below.

- Plans should delete the following language in Chapter 1, Section 3.2 of the MA (HMO and PPO) and MSA EOC:

  "Every year that you are a member of our plan, we will send you either a new *Provider Directory* or an update to your *Provider Directory.* This directory lists our network providers."

- Plans should delete the following language in Chapter 1. Section 3.2 of the PDP EOC:

  "Every year that you are a member of our plan, we will send you either a new *Pharmacy Directory* or an update to your *Pharmacy Directory.* This directory lists our network pharmacies."

- Plans should delete the following language in Chapter 1, Section 3.2 of the DE SNP, MA-PD (HMO and PPO), PFFS, and Cost plan EOC:

"Every year that you are a member of our plan, we will send you either a new *Provider Directory* or an update to your *Provider Directory.* This directory lists our network providers."

AND

Plans should delete the following language in Chapter 1, Section 3.3 of the DE SNP, MA-PD (HMO and PPO), PFFS, and Cost plan EOC:

"Every year that you are a member of our plan, we will send you either a new *Pharmacy Directory* or an update to your *Pharmacy Directory.* This directory lists our network pharmacies."

12. ANOC template for PPO plans (MA and MA-PD)

Summary of issue: the ANOC omits out-of-network out-of-pocket maximum amounts.

Issue location: - PPO (MA and MA-PD) ANOC – Summary of Important Costs Section
- PPO (MA and MA-PD) ANOC – Section 2.2, Changes to Your Maximum Out-of-Pocket Amount

Action required: MA and MA-PD PPO plans must update the language as instructed below (note, two corrections).

- The language in the ANOC, Summary of Important Costs Section currently reads as follows:

Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section *[edit section number as needed:]* 2.2 for details.)	*[Insert 2012 MOOP]*	*[Insert 2013 MOOP]*

- Replace language cited above with the following standardized language:

Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section *[edit section number as needed:]* 2.2 for details.)	From in-network providers: *[Insert in-network 2012 MOOP]* From in-network and out-of-network providers combined: *[Insert combined 2012 MOOP]*	From in-network providers: *[Insert in-network 2013 MOOP]* From in-network and out-of-network providers combined: *[Insert combined 2013 MOOP]*

- The language in ANOC Section 2.2, Changes to Your Maximum Out-of-Pocket Amount currently reads as follows:

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

[Plans that include the costs of supplemental benefits in the MOOP limit may revise this information as needed.]

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach the maximum out-of-pocket amount, you generally pay nothing for covered [*insert if applicable:* Part A and Part B] services for the rest of the year.

	2012 (this year)	**2013 (next year)**
Maximum out-of-pocket amount Your costs for covered medical services (such as copays [*insert if plan has a deductible:* and deductibles]) count toward your maximum out-of-pocket amount. [*Plans with no premium delete the following sentence:]* Your plan premium does not count toward your maximum out-of-pocket amount.	*[insert 2012 MOOP amount]*	*[insert 2013 MOOP amount]* Once you have paid *[insert 2013 MOOP]* out-of-pocket for covered [*insert if applicable:* Part A and Part B] services, you will pay nothing for your covered [*insert if applicable:* Part A and Part B] services for the rest of the calendar year.

- Replace language cited above with the following standardized language:

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amounts

[Plans that include the costs of supplemental benefits in the MOOP limit may revise this information as needed.]

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach the maximum out-of-pocket amounts, you generally pay nothing for covered [*insert if applicable:* Part A and Part B] services for the rest of the year.

	2012 (this year)	**2013 (next year)**

	2012 (this year)	2013 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays [*insert if plan has a deductible:* and deductibles]) from in-network providers count toward your in-network maximum out-of-pocket amount. [*Plans with no premium delete the following sentence:]* Your plan premium does not count toward your maximum out-of-pocket amount.	*[insert 2012 in-network MOOP amount]*	*[insert 2013 in-network MOOP amount]* Once you have paid *[insert 2013 MOOP]* out-of-pocket for covered [*insert if applicable:* Part A and Part B] services from in-network providers, you will pay nothing for your covered [*insert if applicable:* Part A and Part B] services from in-network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays [*insert if plan has a deductible:* and deductibles]) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. [*Plans with no premium delete the following sentence:]* Your plan premium does not count toward your maximum out-of-pocket amount.	*[insert 2012 combined MOOP amount]*	*[insert 2013 combined MOOP amount]* Once you have paid *[insert 2013 MOOP]* out-of-pocket for covered [*insert if applicable:* Part A and Part B] services, you will pay nothing for your covered [*insert if applicable:* Part A and Part B] services from in-network or out-of-network providers for the rest of the calendar year.

The ANOC/EOC templates are available on the following link by clicking on the zip file titled *CY 2013 Model Marketing Materials:* http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html.

Plan sponsors should direct questions regarding these corrections to their CMS Account Manager.