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

Vanessa S. Duran
Director, Medicare Drug Benefit and C & D Data Group

SUBJECT: Issuance of Contract Year 2025 Standardized and Model Materials

This memo announces the release of Contract Year (CY) 2025 standardized and model materials. These include the following: Annual Notice of Change (ANOC); Evidence of Coverage (EOC); ANOC Errata Notice; EOC Errata Notice; Provider Directory; 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. CMS made considerable revisions to the CY 2025 materials reflecting the Part D benefit redesign and other changes under the Inflation Reduction Act of 2022 (IRA) and multiple final regulations that take effect in CY 2025.

As a reminder, CMS releases the 2025 ANOC and EOC Standardized Materials Instructions along with the other materials listed above. CMS encourages plans to review and apply the instructions for permissible alterations whenever possible.

All CY 2025 materials 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 2025 materials are compliant with CMS requirements. Questions should be directed to your CMS Account Manager or Marketing Reviewer.

We've summarized the changes (not including grammar or formatting edits) to the materials in the list below. Note that the location of changes may vary between the referenced documents.

Annual Notice of Change (ANOC)

All models

- Deleted "(applications)" from Section 7, 3rd open bullet

All Part D models

- Deleted quotation marks around Drug List except for first instance
- Deleted all references to Coverage Gap Stage throughout models
- Added mail order cost-sharing language to each tier in both Initial Coverage Stage charts in Section 2.5
- Changed 2024 and 2025 columns 'Catastrophic Coverage' language in Summary of Important Costs, Part D prescription drug coverage section
- Added plan instruction *[insert URL]* in the Changes to the Provider and Pharmacy Networks section
- Added Medicare Prescription Payment Plan row (CY 2025 only) in Administrative Changes section
- Added bullet with Medicare Prescription Payment Plan language in Section 7
- Added 3rd bullet regarding the "Extra Help" program in the Ask section
- Added sentence to 5th paragraph and made edits throughout the Changes to Part D Prescription Drug Coverage section

HMO MAPD, HMO MA and MSA models only

- Added 3rd bullet in "About" section regarding Part D eligibility

All models except MSA and PDP

- Added plan instruction *[insert URL]* to Provider Directory

All models except PDP

- Deleted last sentence with plan instruction regarding cost sharing for insulin in Section 2.4, 3rd paragraph
- Modified language and added an additional sentence in Checklist #3 CHOOSE, 3rd bullet

All models except HMO MA, PPO MA, Cost, and PDP

- Added first paragraph and plan instruction related to pharmacy types in Section 2.3
- Edited Value-Based Insurance Design (VBID) instructions in Section 2.4, 5th paragraph

PDP model only

- Added 3rd paragraph in Section 5

DSNP model only

- Added language regarding translation for FIDE and HIDE D-SNPs in the Additional Resources section, first bullet
- Revised language illustrating enrollment options in another Medicare plan in Section 5, 3rd paragraph including bullets
- Added plan instruction for $0 cost sharing plans to remove Medicare Prescription Payment Plan information in two instances

Evidence of Coverage (EOC)

All models

- Replaced Medicare.gov link with https://www.medicare.gov/medicare-and-you in Chapter 1, Section 4
- Replaced "60" with "65" days in each instance referring to appeal request timeline requirements for enrollees

All Part D models

- Deleted quotation marks around Drug List except for first instance
- Deleted all references to Coverage Gap Stage throughout models
- Revised plan instruction to address self-administered drugs provided in an outpatient setting in the "When can you use a pharmacy that is not in the plan's network?" section under "Using the plan's coverage for Part D prescription drugs"
- Revised the last two bullets of the Making an Appeal section under "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" to explain Part B and Part D drugs
- Added information about the Medicare Prescription Payment Plan Amount under "Getting Started as a Member"
- Added plan instruction *[insert URL]* in the Changes to the Provider and Pharmacy Networks section
- Replaced "Coverage Determination" with "Redetermination" under "How to make a level 1 appeal: Step 2" in "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)"
- Revised Extra Help language related to SPAP and added Medicare Prescription Payment Plan paragraph under "Information about programs to help people pay for their prescription drugs" in the important phone numbers and resources chapter
- Made significant edits consistent with Part D benefit redesign under the IRA under "Using the plan's coverage for Part D prescription drugs" and "What you pay for your Part D prescription drugs"
- Added Manufacturer Discount Program, Interchangeable Biosimilar, and Original Biological Product definitions
- Revised definitions for Initial Coverage Stage and Prior Authorization
- Added plan instruction to the Catastrophic Coverage Stage definition

All models except PDP

- Changed all flu shots references to flu/influenza shots (or vaccines) in Immunizations row in Chapter 4, Section 2.1, Medical Benefits Chart (MBC)
- Revised Prosthetic devices and related supplies row to include orthotic devices and related supplies in Chapter 4, Section 2.1, MBC
- Replaced "written order" with "order" in Screening for lung cancer with low dose computed tomography (LDCT) row in Chapter 4, Section 2.1, MBC
- Clarified national coverage determinations requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies in Chapter 3, Section 5.1, 4th paragraph
- Changed Outpatient substance abuse services to Outpatient substance use disorder services in Chapter 4, Section 2.1, MBC
- Added bullet to section identifying circumstances where neither Medicare nor the plan will pay for a clinical research study in Chapter 3, Section 5.2
- Deleted plan instruction in 4th bullet of Vision care row, Chapter 4, Section 2.1, MBC
- Added licensed marriage and family therapists (LMFT) and licensed professional counselors to definitions of both structured programs in Partial hospitalization services and Intensive outpatient services row, Chapter 4, Section 2.1, MBC
- Updated eligibility for diabetes screenings in Diabetes screening row, Chapter 4, Section 2.1, MBC
- Updated Urgently needed services definition in four locations: Chapter 3, Section 2.2, Chapter 3, Section 3.2; Chapter 4, Section 2.1, MBC, Urgently Needed Services row; and Chapter 12, Definitions of important words
- Deleted Section 7.4 in Chapter 9
- Deleted Section 8.5 in Chapter 9
- Added terms diagnostic, preventive, and comprehensive to last plan instruction in Dental services row, Chapter 4, Section 2.1, MBC
- Added bullet regarding telehealth services that are provided by qualified occupational therapists (OTs), physical therapists (PTs), speech-language pathologists (SLPs), and audiologists in Chapter 4, MBC, Physician/Practitioner Services row
- Deleted language regarding making appeal requests directly to the plan

All models except Cost, MSA and PDP

- Added text related to the months of entitlement in Chapter 10, Section 2.2, 1st bullet

All models except HMO MA, PPO MA, DSNP and MSA

- Moved optional language in the 6th bullet to the 5th bullet in Chapter 6, Section 9 "Situation 3"

All models except HMO MA and PPO MA

- Replaced Department of Veterans Affairs with Veterans Health Administration (VA) in Chapter 1, Section 4.4, 3rd bullet

All models except MSA

- Added premium/penalty to describe payment options in Chapter 1, Section 5.1, Option 2, 1st plan instruction, 1st sentence

All models except MSA, and PDP

- Added plan instruction *[insert URL]* to Provider Directory in several instances

PFFS model only

- Replaced plan instruction *[Full and Partial Network plans insert this row]* in Urgently needed services row, Chapter 4, Section 2.1, MBC

D-SNP model only

- Added variable field to include the correct timeframe for Fair Hearing requests in Chapter 9B, Section 6.4, Step 1
- Added plan instruction for $0 cost sharing plans to remove Medicare Prescription Payment Plan information in three instances

Cost Plan model only

- Replaced language in Chapter 3, Section 1.2, first section, third bullet, first sub-bullet clarifying out-of-network cost sharing situations
- Included variable language in Chapter 3, Section 5.1

HMO MAPD, PPO MAPD and DSNP models only

- Changed language regarding appeals and Quality Improvement Organization reference in Chapter 9, Section 8.3, Step 1, 2nd bullet under "Act quickly"

Cost Plan and PFFS models only

- Added plan instruction addressing Part D LEP, IRMAA, and Medicare Prescription Payment Plan Amount for those plans not offering Part D, Chapter 1, Section 4
- Added text to plan instruction: "*and related sections below]*" to 2nd paragraph, Chapter 1, Section 4

PPO MAPD and PPO MA models only

- Modified language regarding emergency providers in each model to be identical, Chapter 7, Section 1 (PPO MAPD) and Chapter 5, Section 1, (PPO MA)

HMO MAPD, PPO MAPD, DSNP, HMO MA and PPO MA models only

- Edits made to all VBID plan instruction sections in Chapter 4, Section 2.1
- Added VBID row in Chapter 4, Section 2.1, MBC

HMO MAPD, Cost, PFFS, PDP models only

- Revised language related to the Appointment of Representative form in Chapter 7, Section 4.2, 4th bullet, 2nd sub-bullet

MSA model only

- Added plan instruction related to Part B step therapy to Medicare Part B prescription drugs row, Chapter 4, Section 2.1, MBC
- Added bullet with language, "If you no longer meet the MSA's eligibility criteria due to a mid-year change in eligibility. " in Chapter 8, Section 6.1

Formulary (Abridged and Comprehensive)

- Removed reference to the coverage gap and associated cost sharing references throughout
- Updated "doctor" to "prescriber" throughout
- In the instructions, updated the reference to "HPMS marketing name" to "HPMS Plan Name" to align with what is submitted in HPMS
- Added reference to 42 CFR Part 423 Subpart C (Benefits and Beneficiary Protections) in the instructions
- Added "Drug List" in the title of the document to align with the Part D EOC
- Clarified language for plans to provide the date the formulary was updated and available to enrollees; dates used in the front and back of the formulary covers should be the same as the date of the last update in the footer
- Removed the reference to formulary version number
- Updated "list of drugs" to "Drug List" to align with the EOC
- Updated the section "Can the formulary change? " to reflect regulatory changes in CMS-4205-F (89 FR 30448) regarding immediate substitutions and other formulary changes
- Added clarifying language to the definition of generic drugs
- Added a new paragraph, "What are original biological products and how are they related to biosimilars?"
- Added clarifying language to "How do I request an exception to the formulary?"
- Reordered language in the section, "How do I request an exception to the formulary?" so that the formulary exception bullets are listed together

Notice of Formulary Change

- Changed "member" to "enrollee" throughout
- Edits made throughout for clarity and to make language more beneficiary friendly
- Revised plan instructions and model language throughout to incorporate regulatory changes in CMS-4205-F (89 FR 30448)

Prescription Transfer Letter

- Changed "member" to "enrollee" throughout

Member Request for Refusal

- Changed "member" to "enrollee" throughout

Pharmacy Directory

- In the instructions, updated "HPMS marketing name" to "HPMS Plan Name" to align is with what is submitted in HPMS
- Changed "member" to "enrollee" throughout
- Updated the benefit year to reflect CY 2025 in the paragraph that plans insert for a "higher than normal number of pharmacies leaving its pharmacy network."

LIS Premium Summary

- No changes for CY 2025

Low Income Subsidy (LIS) Rider

- Updated annual benefit parameters for CY 2025
- Removed instructional language referencing cost sharing beyond the Initial Coverage Stage
- Removed "deductible" and "premium"

Transition Letter

- Changed "member" to "enrollee" throughout
- Added clarifying language for enrollee to contact their plan regarding prior authorization.
- Changed "limit" to "restriction"
- Removed the phrase "given your condition" in the section "How do I request a coverage determination, including an exception?"
- Removed the phrase "for coverage" from the section title and paragraph, "What if my request for coverage is denied?" The header should now read as "What if my request is denied?" And the sentence should begin with, "If your request is denied"