Part C Explanation of Benefits (EOB)

Frequently Asked Questions

1. **When does the Part C EOB requirement become effective?**

   The Part C EOB requirement is effective April 1, 2014. This means that the first monthly EOBs would be mailed no later than May 31, 2014 (to reflect claims activity in April 2014) and the first quarterly EOBs would be mailed no later than July 31, 2014, for the second quarter of 2014 (to reflect claims activity in April-June).

2. **When will the final EOB templates be available?**

   The EOB templates and instructions issued on January 31, 2014, are final. MAOs are free to revise the format of the information in the CMS-developed templates as long as they provide the required information in at least 12 point font.

3. **What claims must be included in the EOB?**

   MAOs must include all Part C claims processed during the reporting period, including all claims for Part A and Part B covered services, mandatory supplemental benefits, and optional supplemental benefits.

4. **Do claims for dental, vision and Part B pharmacy drugs need to be included in the EOB?**

   Yes. Claims and enrollee out-of-pocket spending for Part B covered services and supplemental benefits, as applicable, must be included in the EOB.

5. **Does claims information for services furnished by delegated and/or capitated providers need to be included in the EOB?**

   Yes. All enrollee claims activity must be displayed in the EOB for that reporting period, including information from delegated and/or capitated providers. To accommodate MAOs that need to develop processes for obtaining cost information from capitated providers and delegated entities, we are delaying, until January 1, 2015, implementation of the requirement to report cost information in the "Total cost" and "Plan's share" columns. In the interim period, in lieu of dollar amounts, MAOs may insert language in each of those columns to indicate that the rate has been pre-negotiated and who the enrollee may contact to obtain that information. See the template instructions for additional information. The templates are posted on the same website as these Qs & As.

6. **Do MAOs need to send EOBs to enrollees for whom there is no claims activity for the reporting period?**

   No. If there is no claims activity for the enrollee during a reporting period, the MAO is not required to send an EOB. However, if there is claims activity during the reporting period, the MAO must send an EOB, even if there is no associated enrollee liability.

7. **Does service/payment denial/appeal language need to be included in the EOB?**

   Any EOB that includes a denied claim(s) must include, in the same mailing, or within the EOB itself, information about the denial and the enrollee's appeal rights. That is, the service must be identified by: date, billing code, description and provider; that the claim has been denied; and where information about the enrollees' appeal rights is included.

   The template instructions allow flexibility to either include the language provided in the EOB template itself or to include in the mailing the approved Integrated NDP language (the IDN). When issuing payment denial notices, MAOs are required to use the new Integrated Denial Notice (IDN) language (available at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MADenialNotices.html), which has replaced the former Notice of Denial of Payment (NDP) language. If there are multiple denied claims in one EOB, the language about appeals may be placed once, at the end of the claims detail section.

   If the plan opts to include the approved appeals language by including as a separate document the IDN instead of including the language in the CMS template, there should be a note within the EOB that directs the enrollee to that attachment or to that document included with the EOB rather than to "below," as in the CMS template.

8. **Does adjusted claims activity need to be included in the EOB?**

   Yes. The EOB must include any adjustments (e.g., for a reversed claim as a result of an appeal or wraparound payment) or corrections (e.g., a clerical error) that affect a enrollee's total out-of-pocket spending. Adjustments or corrections that do not affect the enrollee's out-of-pocket costs (e.g., for incorrect billing) do not have to be included in the EOB. Inclusion of such claims could be confusing and would not provide useful information to the enrollee.

9. **Does prior year claims activity need to be included in the EOB?**

   Yes, any applicable prior year claims that are settled and ready for reporting are to be included in the EOB. The MAO may choose to either send a separate, updated EOB to reflect the prior year claim activity or may include the applicable information in the current EOB as long as the information, particularly the maximum out-of-pocket (MOOP) totals, are clearly differentiated by year. MOOP information must always be tracked on a contract year basis.

10. In cases where a beneficiary disenrolls from a MA plan, does the plan need to send an EOB(s) that reflects claims that are processed after disenrollment?

Yes. It is important that the plan send an EOB that reflects these claims, as it supports one of the most important purposes of the EOB, which is to include complete and meaningful out-of-pocket spending information for the beneficiary. The enrollee is entitled to receive a full accounting of his/her out-of-pocket spending during enrollment in the plan and to receive a refund of any amount of out-of-pocket spending in excess of the plan's MOOP. In addition, in cases that the disenrollment is mid-year and the beneficiary enrolls in another plan of the same type offered by the MAO, that out-of-pocket spending should be credited toward the MOOP in the new plan.

11. What are the requirements for the per claim EOB?

MAOs that send per claim EOBs must also send quarterly summaries that include all of the information reflected in the CMS Quarterly template.

Please note that the per claim EOBs should be issued on a timely basis and claims information must not be sent to plan enrollees less frequently than if the plan was using a monthly EOB cycle. That is, the plan may not hold claims and then issue a per claim EOB less frequently than they would have issued a monthly EOB.

12. Do claims for services that do not count toward the MOOP need to be included in the EOB?

Yes. Any services for which cost sharing does not count toward the MOOP are to be included in every monthly and quarterly summary EOB. See template instructions for additional information about depicting such services.

13. Are MAOs permitted to change their election of sending EOBs either monthly or on a per claim basis?

Yes; however to avoid confusion, we highly recommend that such changes only be made at the start of the calendar year. Any changes to the composition of the EOB should be fully explained to enrollees.

14. Are MAOs required to submit their EOBs to HPMS for CMS review?

Part C EOBs are viewed as ad-hoc enrollee communication materials and are not subject to CMS review and approval prior to use. However, CMS reserves the right to request, for review, ad-hoc enrollee communication materials (per 42 CFR 422.2262(d)). In the future, we may require that MAOs submit their EOBs to HPMS and, therefore, request that material IDs be included on the EOBs.

15. What plan types are required to send EOBs?

Only section 1833 and 1876 cost contract plans are excluded from the requirement to provide EOBs to enrollees.

16. What are the penalties for non-compliance with the EOB?

CMS will determine the appropriate corrective action when MAOs are found to be non-compliant with EOB requirements.

17. Since the implementation date does not align with the start of a contract year, would the final EOB to be issued in CY 2014 need to represent all claims adjudicated for the entire year or just those claims settled beginning April 2014?

The final EOB issued in calendar year 2014 does not need to capture claims settled prior to April 1, 2014, but we encourage MAOs to include all claims for 2014 if possible.