



**CENTER FOR MEDICARE**

---

**DATE:** August 8, 2016

**TO:** Medicare Advantage Organizations, Prescription Drug Plans, and Section 1876 Cost Plans

**FROM:** Kathryn A. Coleman  
Director, Medicare Drug & Health Plan Contract Administration Group

Amy Larrick Chavez-Valdez  
Director, Medicare Drug Benefit and C & D Data Group

**SUBJECT:** Model Notice Corrections/Policy Updates

This memorandum provides Medicare Advantage Organizations (MAOs), Section 1876 Cost Plans and Prescription Drug Plans with corrections to the Contract Year (CY) 2017 model notices, including the Annual Notice of Change/Evidence of Coverage (ANOC/EOC) and the Part D EOB.

On May 10, 2016, CMS issued a memorandum announcing the issuance of certain CY 2017 model marketing materials, which included the CY 2017 ANOC/EOC standardized models for all plan types. This memorandum clarifies and corrects standardized language that MAOs and Part D Sponsors must use in their CY 2017 ANOCs/EOCs, as appropriate for their plan type(s), and the Part D EOB. Below is a brief summary of each issue, a description of where in the models the issue is located, and the required updates:

**ANOC/EOC Updates**

**1. ANOC models for HMO MA-PD, PPO MA-PD, D-SNP, PFFS, MSA, HMO MA, and PPO MA**

***Summary of issue:*** An updated link was not included in the models for Minimum Essential Coverage (MEC) language.

***Issue location:*** HMO MA-PD, PPO MA-PD, D-SNP, PFFS, MSA, HMO MA, and PPO MA: ANOC, Additional Resources

**Action required:** Plans must update this section with the updated link as shown below:

- Minimum essential coverage (MEC): Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at:

<https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families> for more information on the individual requirement for MEC.

**2. ANOC models for HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, MSA, HMO MA, PPO MA, and PDP**

**Summary of issue:** The instruction and language related to enrollment consolidation notice does not reflect current policy.

**Issue location:** HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, MSA, HMO MA, PPO MA, and PDP: ANOC section 1

**Action required:** Plans must remove the language as shown below:

~~[Plans that have previously notified members about the enrollment consolidation may insert the following paragraph, editing as necessary: [Insert MAO name] mailed you a letter called “[insert name of letter].” This letter tells you more about this change. If you have any questions, or if you did not receive the letter, please call Member Services (phone numbers are in Section [edit section number as needed] 8.1 of this booklet).]~~

**3. ANOC models for HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, and PDP**

**Summary of issue:** The language implies that the late enrollment penalty (LEP) will only apply if the member enrolls in a Part D plan in the future. However, the LEP may already apply to the member. Removing this language eliminates any obscurity with having to pay the Part D LEP.

**Issue location:** HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, and PDP: Section 2.1

**Action required:** Plans must remove the highlighted sentence as shown below (changes are noted in red text).

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as “creditable coverage”) for 63 days or more.  
~~, if you enroll in Medicare prescription drug coverage in the future.~~

**4. EOC models for HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, HMO MA, PPO MA, and PDP**

**Summary of issue:** The contact information related to membership termination does not reflect current policy.

**Issue location:** HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, HMO MA, PPO MA, and PDP: Chapter 1, Section 4.2

**Action required:** Plans must update the contact information as shown below (changes are noted in red text).

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 9, Section 10 of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can ask **us to reconsider this decision by calling <phone number> between <hours of operation>. TTY users should call <TTY number>. You must make your request no later than 60 days after the date your membership ends. Medicare to reconsider this decision calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048."**

## 5. EOC models for HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, and PDP

**Summary of issue:** Added language to clarify Extra Help assistance.

**Issue location:** HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, and PDP: Chapter 1, Section 4.3

**Action required:** Plans must update the language as shown below (changes are noted in red text).

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the “Extra Help” program or if you lose your eligibility for the “Extra Help” program during the year. If a member qualifies for “Extra Help” with their prescription drug costs, the “Extra Help” program will pay all or part of the member’s monthly plan premium. **If Medicare pays only a portion of this premium, we will bill you for the amount Medicare doesn’t cover.** A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the “Extra Help” program in Chapter 2, Section 7.

## 6. EOC models for HMO MA-PD, PPO MA-PD, D-SNP, PFFS, MSA, HMO MA, PPO MA

**Summary of issue:** An updated link was not included for MEC language.

**Issue location:** HMO MA-PD, PPO MA-PD, D-SNP, PFFS, MSA, HMO MA, and PPO MA: Chapter 2, Section 2

**Action required:** Plans must update this section with the updated link as shown below:

- **Minimum essential coverage (MEC):** Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: <https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families> for more information on the individual requirement for MEC.

**7. EOC models for HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, and PDP**

*Summary of issue:* The value for the coverage gap was not updated with the 2017 value.

*Issue location:* HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, and PDP: Chapter 2, Section 7

*Action required:* Plans must update the “amount paid by the plan” in the coverage gap to reflect the 2017 amount of 10% (changes are noted in red text).

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Part D Explanation of Benefits (Part D EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap. The amount paid by the plan (10%) ~~(5%)~~ does not count toward your out-of-pocket costs.

**8. EOC models for HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, MSA, HMO MA, and PPO MA**

*Summary of issue:* The language shown below related to religious non-medical health care does not reflect the current policy.

*Issue location:* HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, HMO MA, and PPO MA: Chapter 3, Section 6.2, MSA: Chapter 3, Section 7.2

*Action required:* Plans must remove the item shown below:

- ~~If you get services from this institution that are provided to you in your home, our plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.~~

**9. EOC Models for HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, MSA, HMO MA, and PPO MA**

*Summary of issue:* The colorectal cancer screening benefit does not reflect the current policy.

**Issue location:** HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, MSA, HMO MA, and PPO MA: Chapter 4, Section 2.1

**Action required:** Plans must update the language as shown below for colorectal cancer screening (changes are noted in red text).



### Colorectal cancer screening

For people 50 and older, the following are covered:

- Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months
- ~~Fecal occult blood test, every 12 months~~

One of the following every 12 months:

- Guaiac-based fecal occult blood test (gFOBT)
- Fecal immunochemical test (FIT)

DNA based colorectal screening every 3 years

For people at high risk of colorectal cancer, we cover:

- Screening colonoscopy (or screening barium enema as an alternative) every 24 months

For people not at high risk of colorectal cancer, we cover:

- Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy

*[Also list any additional benefits offered.]*

There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening.

*[If applicable, list copayment and/or coinsurance charged for barium enema.]*

## 10. EOC models for HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, MSA, HMO MA, and PPO MA

**Summary of issue:** The lung cancer screening with low dose computed tomography (LDCT) was not included in the models.

**Issue location:** HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, MSA, HMO MA, and PPO MA: Chapter 4, Section 2.1

**Action required:** Plans must include the lung cancer screening benefit in the benefits table after, “Screening and counseling to reduce alcohol misuse” (in alphabetical order).

### **Screening for lung cancer with low dose computed tomography (LDCT)**

For qualified individuals, a LDCT is covered every 12 months.

**Eligible enrollees are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.

There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.

*For LDCT lung cancer screenings after the initial LDCT screening:* the enrollee must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.

## **11. EOC models for HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, and PDP**

**Summary of issue:** Revised the language related to tiering exceptions to clarify and more accurately reflect current policy.

**Issue location:** EOC models for HMO MA-PD, PPO MA-PD, Cost Plan, and PFFS: Chapter 9, Section 6.1  
D-SNP Chapter 9, Section 7.1  
PDP: Chapter 7, Section 5.1

**Action required:** Plans must update the following bullet as shown below (changes are noted in red text).

- *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions: omit this bullet]* Asking to pay a lower cost-sharing amount for a covered ~~non-preferred~~ drug on a higher cost-sharing tier

## **12. EOC models for HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, and PDP**

**Summary of issue:** Revised the language related to tiering exceptions to clarify and more accurately reflect current policy.

**Issue location:** EOC models for HMO MA-PD, PPO MA-PD, Cost Plan,  
and PFFS: Chapter 9, Section 6.2  
D-SNP Chapter 9, Section 7.2  
PDP: Chapter 7, Section 5.2

**Action required:** Plans must update the following bullet as shown below (changes are noted in red text).

- If your drug is in *[insert name of ~~non-preferred~~/highest cost-sharing tier subject to the tiering exceptions process]* you can ask us to cover it at ~~the a~~ **lower** cost-sharing amount that applies to drugs in *[insert name of ~~preferred/lowest-lower~~ cost-sharing tier(s) subject to the tiering exceptions process]*. This would lower your share of the cost for the drug.

### **13. EOC models for HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, and PDP**

**Summary of issue:** Revised the language related to tiering exceptions to clarify and more accurately reflect current policy.

**Issue location:** EOC models for HMO MA-PD, PPO MA-PD, Cost Plan,  
and PFFS: Chapter 9, Section 6.3  
D-SNP Chapter 9, Section 7.3  
PDP: Chapter 7, Section 5.3

**Action required:** Plans must update the following language as shown below (changes are noted in red text).

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. **If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won’t work as well for you.**

### **14. EOC models for HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan, PFFS, MSA, HMO MA, PPO MA, PDP**

**Summary of issue:** Language updated to include Section 1557, of the Affordable Care Act.

**Issue location:** HMO MA-PD, PPO MA-PD, D-SNP, Cost Plan,  
and PFFS: Chapter 11, Section 2  
MSA, HMO MA, PPO MA, PDP: Chapter 9, Section 2

**Action required:** Plans must update the language as shown below (changes noted in red text).

~~We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin.~~ We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare Advantage Pplans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, **Section 1557 of the Affordable Care Act**, and all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

## **Part D Explanation of Benefits Updates**

### **Page 1: Table of Contents**

***Summary of issue:*** The title of the model displays as 2016

**Action required:** Plans note this is the 2017 Model Part D Explanation of Benefits

**Page 14:** Section 2 [Use this version of Section 2 for members without LIS who are in the deductible stage]:

***Summary of issue:*** A bullet was added in the Initial Coverage benefit phase for CY 2017 that may be misleading and confusing for beneficiaries.

**Action required:** Plans should update the language to accurately reflect the language below.

*[If the plan has a brand-name/tier level deductible, insert the following bullet.]*

- As of *[insert end date for the month]* **your year-to-date “total drug costs” were \$*[insert year-to-date Total Drug Costs]*. (See definitions in Section3.)**

**Page 15-16:** Section 2 [Use the following version of Section 2 for members without LIS who are in the initial coverage stage]:

***Summary of issue:*** A bullet contains improper grammar.

**Action required:** Plans should update the language to accurately reflect the language below.

- You generally stay in this stage until the amount of your year-to-date “total drug costs” reaches  $[\textit{insert initial coverage limit}]$ . As of  $[\textit{insert end date of month}]$ , your year-to-date “total drug costs” were  $[\textit{insert year-to-date Total Drug Costs}]$ . (See definitions in Section 3.)

**Page 17-18:** Section 2 [Use the following version of Section 2 for members without LIS who are in the coverage gap]:

**Summary of issue:** A bullet contains improper grammar.

**Action required:** Plans should update the language to accurately reflect the language below.

- You generally stay in this stage until the amount of your year-to-date “out-of-pocket costs” reaches \$4950. As of  $[\textit{insert end date of month}]$  your year-to-date “out-of-pocket costs” were  $[\textit{insert year-to-date TrOOP}]$  (see Section 3).

**Page 22:** Section 2 [Use the following version of Section 2 for members with partial LIS who are in the yearly deductible stage]:

**Summary of issue:** Under stage 1, the yearly deductible stage, if the plan has a brand-name/tier level deductible, the model chart references three bullets for plans to add, but only lists two bullets.

**Action required:** Plans should insert the following third bullet if the plan has a brand-name/tier level deductible:

- As of  $[\textit{insert end date for the month}]$  you have paid  $[\textit{insert year-to-date Deductible Drug Costs}]$  for your drugs in the deductible.

**Page 22:** Section 2 [Use the following for members with partial LIS who are in the yearly deductible stage]:

**Summary of issue:** A bullet was added in the initial coverage benefit phase for CY 2017 that may be misleading for beneficiaries.

**Action required:** Plans should update the language to accurately reflect the language below.

*[If the plan has a brand-name/tier level deductible, insert the following bullet.]*

- As of  $[\textit{insert end date of month}]$  your year-to-date “out-of-pocket costs” were  $[\textit{insert year-to-date TrOOP}]$ . (See definitions in Section 3)

**Page 23:** Section 2 [Use the following version of Section 2 for members with LIS who are in the initial coverage stage]:

**Summary of issue:** The header at the top of the page currently references the “initial payment stage.”

**Action required:** Plans should note this language should correctly reference the “initial coverage stage”.

**Page 23-24:** Section 2 [Use the following version of Section 2 for members with LIS who are in the initial coverage stage]:

**Summary of issue:** A bullet contains improper grammar.

**Action required:** Plans should update the language to accurately reflect the language below.

- You generally stay in this stage until the amount of your year-to-date “out-of-pocket costs” reaches \$4950. As of [insert end date of month] your year-to-date “out-of-pocket costs” were \$[insert year-to-date TrOOP] (see definitions in Section 3).

Plans and Part D Sponsors should direct questions regarding this memorandum to their CMS Account Manager.