DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTERS for MEDICARE & MEDICAID SERVICES

CENTER FOR MEDICARE

DATE: August 11, 2010

TO: Medicare Advantage Organizations
Medicare Advantage-Prescription Drug Organizations
Cost-Based Contractors
Prescription Drug Plan Sponsors

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

On May 27, 2010, CMS sent an HPMS memorandum announcing the issuance of the final 2011 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. Below, we provide corrected standardized language that plan sponsors must use in their 2011 ANOC/EOCs as appropriate for their plan type(s). In addition, CMS has created a document of identified typographical errors for which plans should make any and all changes as appropriate. This document is located at: http://www.cms.gov/ManagedCareMarketing/.

- **PDP EOC Chapter 8, Section 5.1 (When must we end your membership in the plan?)** – This section references the timeframe in which a beneficiary can remain out of the service area and still be a member of the plan.

  The language currently reads as follows:

  "If you move out of our service area for more than 6 months."

  Plan sponsors of PDPs must replace the language cited above with the following standardized language (note that plan sponsors of MA-PD plans should not update this language in the MA-PD, PFFS or PPO EOC):

  "If you move out of our service area for more than 12 months."

- **PPO EOC Chapter 1, Section 3.2 (The Provider Directory: Your guide to all providers in the plan's network)**

  The language in this section currently reads as follows:

"It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you [*insert as appropriate:* must use *OR* may be required to use] network providers to get your medical care and services. The only exceptions are emergencies, urgently needed care when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which *[insert plan name]* authorizes use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage."

Plan sponsors of PPO plans must replace the language cited above with the following standardized language:

"As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information."

- **EOC Chapter 10, Section 4.1 (Until your membership ends you are still a member of our plan)**

  The language in this section currently reads as follows:

  "If you are hospitalized on the day that your membership ends, you will usually be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins)."

  Plan sponsors of PPO, MAPD, PFFS, MA, MSA, and cost plans must replace the language cited above with the following standardized language (Note: This language is contained in Chapter 8, Section 4.1 of the MA EOC and Chapter 8, Section 5.1 of the MSA EOC):

  "If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins)."

- **EOC Chapter 4, Section 2.1 (Your medical benefits and costs as a member of our plan)**

  The outpatient rehabilitation service row of the Medical Benefits Chart currently reads as follows:

  "Covered services include: physical therapy, occupational therapy, speech language therapy, cardiac rehabilitative therapy, and Comprehensive Outpatient Rehabilitation

Facility (CORF) services."

Plan sponsors of PPO, MA-PD, PFFS, MA, MSA, and cost plans must replace the language cited above with the following standardized language:

"Covered services include: physical therapy, occupational therapy, speech language therapy, cardiac rehabilitation services, intensive cardiac rehabilitation services, pulmonary rehabilitation services, and Comprehensive Outpatient Rehabilitation Facility (CORF) services."

Further, plan sponsors of PPO, MAPD, PFFS, MA, MSA, and cost plans must insert an additional row in the Outpatient Services Table to include a benefit for Kidney Disease Services. This information should be placed after the Medical Nutrition Therapy row and before the Outpatient Diagnostic Tests and Therapeutic Services and Supplies row. Plan sponsors should list the following under the column "Services that are covered for you":

"Kidney Disease Education Services – Education to teach kidney care and help members make informed decisions about their care. For people with stage IV chronic kidney disease when referred by their doctor. We cover up to six sessions of kidney disease education services."

Plan sponsors must list the following under the column "What you must pay when you get these services":

[List copays / coinsurance]

- **EOC Chapter 4, Section 2.1 (Your medical benefits and costs as a member of our plan) –**

  The Hospice care row of the Medical Benefits chart currently reads as follows:

  "You may receive care from any Medicare-certified hospice program. Original Medicare (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. Covered services include:

  - Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Original Medicare
  - Home care

  [Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.]"

Plan sponsors of PPO, MA-PD, PFFS, MA, and MSA plans should replace the language cited above with the following standardized language:

"You may receive care from any Medicare-certified hospice program. Original Medicare (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. However, Original Medicare will pay for all of your Part A and Part B services. Our plan will bill Original Medicare for these services while your hospice election is in force. Covered services include:

- Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Original Medicare
- Home care

[Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.]"

The second column under the Hospice care row currently reads as follows:

"When you enroll in a Medicare-certified hospice program, your hospice services are paid for by Original Medicare, not *[insert plan name]*.
[Include information about cost-sharing for hospice consultation services if applicable.]"

Plan sponsors of PPO, MA-PD, PFFS, MA, and MSA plans should replace the language cited above with the following standardized language:

"When you enroll in a Medicare-certified hospice program, your hospice services and your Original Medicare services are paid for by Original Medicare, not *[insert plan name]*.
[Include information about cost-sharing for hospice consultation services if applicable.]"