DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR MEDICARE

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

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SUBJECT: Annual Notice of Change/Evidence of Coverage Corrections/Policy updates

This memorandum provides Medicare Advantage Organizations and Section 1876 Cost Plans (plans) and Prescription Drug Plans (Part D Sponsors) with the following:

I. Corrections and policy updates to the Contract Year (CY) 2015 Annual Notice of Change/Evidence of Coverage (ANOC/EOC)
II. Update to 2015 Provider Directory Model

I. Corrections and policy updates to the Contract Year (CY) 2015 Annual Notice of Change/Evidence of Coverage (ANOC/EOC)

On April 23, 2014, CMS issued an HPMS memorandum announcing the issuance of certain CY 2015 model marketing materials, which included the CY 2015 ANOC/EOC standardized models for all plan types. This memorandum clarifies and corrects standardized language that plans must use in their CY 2015 ANOC/EOCs, as appropriate for their plan type(s). Below, please find a brief summary of the issue, a description of where in the models the issue is located, and the required action to address the identified error/policy update.

1. ANOC model for PPO MA-PD plans

Summary of issue: The information about the combined out-of-pocket maximum in the ANOC incorrectly includes a reference to receiving services from "in-network providers."

Issue location: PPO MA-PD ANOC – Section 2.2, Changes to Your Maximum Out-of-Pocket Amount

Action required: PPO MA-PD plans must update the language as instructed below (changes are noted in red text).

Cost	2014 (this year)	2015 (next 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 2014 combined MOOP amount]*	*[insert 2015 combined MOOP amount]* Once you have paid *[insert 2015 combined MOOP amount]* 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 or out-of-network providers for the rest of the calendar year.

2. ANOC and EOC models for Cost plan, D-SNP, HMO MA-PD, PDP, PFFS, PPO MA-PD

Summary of issue: The Part D ANOC and EOC models do not reflect 42 CFR §423.120(c)(6)(ii) finalized in 79 Federal Register (May 23, 2014) which specifies that Part D Sponsors cannot cover prescriptions written by prescribers who have neither enrolled in Medicare nor filed a valid opt-out affidavit with CMS proving they are qualified prescribers.

Issue location: PDP ANOC, Section 2.3
Cost plan, D-SNP, HMO MA-PD, PFFS, PPO MA-PD ANOCs: Section 2.6
PDP EOC: Chapter 3, Section 1.2
Cost plan, D-SNP, HMO MA-PD, PFFS, PPO MA-PD EOCs: Chapter 5, Section 1.2

Action required: Part D Sponsors must update the language in the ANOC as instructed below.

- Insert the following at the start of the section:

"Changes to basic rules for the plan's Part D drug coverage

Effective June 1, 2015, before your drugs can be covered under the Part D benefit, CMS will require your doctors and other prescribers to either accept Medicare or to file documentation with CMS showing that they are qualified to write prescriptions."

Action required: All organizations offering Part D benefits must update the language in the EOC as instructed below.

- Insert the following bullet to follow the first bullet:

  "Effective June 1, 2015, your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions. You should ask your prescribers the next time you call or visit if they meet this condition."

3. EOC model for D-SNP, HMO-MA, HMO MA-PD, MSA, PDP, PFFS, PPO-MA, and PPO MA-PD plans

Summary of issue: The EOC models contain a disclaimer on the title page that incorrectly references 2015.

Issue location: Title Page

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

> "*[Remove terms as needed to reflect plan benefits]* Benefits, formulary, pharmacy network, premium, deductible, and/or copayments/coinsurance may change on January 1, ~~2015~~ 2016."

4. EOC model for Cost plan, D-SNP, and PDP

Summary of issue: The description of the *Part D Explanation of Benefits* in the EOC models include a typo.

Issue location: Cost plan and D-SNP EOCs: Chapter 1, Section 3.5
PDP EOC: Chapter 1, Section 3.4

Action required: Cost plans and D-SNPs must update the language as instructed below (changes are noted in red text).

> "The *Part D Explanation of Benefits* tells you~~, or others on your behalf,~~ the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month."

Action required: PDPs must update the language as instructed below (changes are noted in red text).

"The *Part D Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month."

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

Summary of issue: CMS issued guidance in the HPMS memo dated March 21, 2014 providing clarification of the mail order policy. All organizations offering Part D benefits are required to replace language and instructions as indicated below.

Issue location: PDP EOC, Chapter 3, Section 2.3
Cost plan, D-SNP, HMO MA-PD, PFFS, PPO MA-PD EOCs: Chapter 5, Section 2.3

Action required: All organizations offering Part D benefits must follow the updated instructions as follows.

- The instructions and text that begin with the following sentence through the end of Section 2.3 are no longer applicable: "*[Each plan a sponsor offers would fall within one of three categories:*"

- The instructions and text below should be followed instead:

  "*[Sponsors that provide automatic delivery should provide the information below from the following options, based on i) whether the sponsor requested the exception for new prescriptions described in the December 12, 2013 HPMS memo; and ii) whether the sponsor offers an optional automatic refill program. Sponsors who provide automatic delivery through retail or other non-mail order means have the option to either add or replace the word "ship" with "deliver" as appropriate.]*

  [For new prescriptions received directly from health care providers, insert one of the following two options.]

  *[**Option 1:** Sponsors that **did not** request the exception to the auto fill policy (all new prescriptions from provider offices must be verified with the beneficiary before filled), insert the following:]*

  New prescriptions the pharmacy receives directly from your doctor's office.
  After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before you are billed and it is shipped. It is important that you respond each time you are

contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

*[**Option 2:** Plans that **did** request the exception to the auto fill policy (new prescriptions from provider offices can be filled without beneficiary verification), insert the following:]*

New prescriptions the pharmacy receives directly from your doctor's office.

The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions now or at any time by [*insert instructions*].

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by [*insert instructions*].

If you never have never used our mail order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact us by [*insert instructions*].

[For refill prescriptions, insert one of the following two options.]

*[**Option 1:** Sponsors that **do not** offer a program that automatically processes refills, insert the following:]*

Refills on mail order prescriptions. For refills, please contact your pharmacy *[insert recommended number of days]* days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

*[**Option 2:** Sponsors that **do** offer a program that automatically processes refills, insert the following:]*

Refills on mail order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program [*optional:* "called *insert name of auto refill program"*]. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our auto refill program, please contact your pharmacy [*insert recommended number of days*] days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

To opt out of our program [*optional: insert name of auto refill program instead of* "our program"] that automatically prepares mail order refills, please contact us by [*insert instructions*].

[All plans offering mail order services, insert the following:]

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. *[Insert instructions on how enrollees should provide their communication preferences.]*"

6. EOC models for Cost plan, D-SNP, HMO MA-PD, PDP, PFFS, PPO MA-PD

Summary of issue: The EOC models incorrectly state that, for current enrollees, the transition supply will be provided starting from their first days as plan members-rather than from the start of the calendar year.

Issue location: PDP EOC: Chapter 3, Section 5.2, 2, third bullet
Cost plan, D-SNP, HMO MA-PD, PFFS, PPO MA-PD EOCs: Chapter 5, Section 5.2, 2, third bullet

Action required: All organizations offering Part D benefits must update the language as instructed below (changes are noted in red text).

"**For those members who were in the plan last year and reside in a long-term care (LTC) facility:**

We will cover a temporary supply of your drug **during the first *[insert time period (must be at least 90 days)]* of ~~your membership~~ ~~in the plan~~ the calendar year**. The total supply will be for a maximum of *[insert supply limit (must be at least a 91-day supply and may be up to a 98-day supply depending on the dispensing increment)]*. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of *[insert time period (must be at least a 91-day supply)]* of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)"

7. EOC models for HMO-MA, PPO-MA, Cost plan, D-SNP, HMO MA-PD, PFFS, PPO MA-PD

Summary of issue: The models do not reflect current policy for allowable cost-sharing for some preventive services.

Issue location: MA and MA-PD EOCs: Chapter 4, Section 2.1

Action required: MA and MA-PD plans must update the language as instructed below.

- Plans should delete the following bullet in Chapter 4, Section 2.1:

  "We do not charge office visit cost-sharing if the sole purpose of the visit is to obtain preventive services. [*Insert as applicable:* However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.]"

- Replace language above with the following:

  "For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. [*Insert as applicable:* However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.]"

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

Summary of issue: CMS is adding plan instruction on completing the Medical Benefits Chart found in MA, MA-PD and MSA plan EOC models.

Issue location: MA, MA-PD, and MSA plan EOCs: Chapter 4, Section 2.1

Action required: MA, MA-PD and MSA plans must follow the instructions below when completing benefits chart.

"*Plans that have tiered cost-sharing based on provider and/or benefit should clearly indicate for each service the cost-sharing for each tier, in addition to defining what each tier means and how it corresponds to the characters or footnotes indicating such in the provider directory (when one reads the provider directory, it is clear what the symbol or footnote means when reading this section of the EOC).*"

9. EOC models for HMO-MA, PPO-MA, Cost plan, D-SNP, HMO MA-PD, PFFS, PPO MA-PD, and MSA plans

Summary of issue: The MA, MA-PD, and MSA EOC models do not reflect current policy for allowable cost-sharing for some preventive services.

Issue location: MA, MA-PD, and MSA EOCs: Chapter 4, Section 2.1, Medical Benefits Chart, "Diabetes self-management training, diabetic services and supplies"

Action required: MA, MA-PD, and MSA plans must update the language as instructed below (changes are noted in red text).

Diabetes self-management training, diabetic services and supplies

[Plans may put items listed under a single bullet in separate bullets if the plan charges different copays. However, all items in the bullets must be included.] For all people who have diabetes (insulin and non-insulin users). Covered services include:

- Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.
- For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.
- Diabetes self-management training is covered under certain conditions.

[Also list any additional benefits offered.]

~~There is no coinsurance, copayment, or deductible for beneficiaries eligible for the diabetes self-management training preventive benefit~~.

[List copays / coinsurance / deductible]

10. EOC models for Cost plan, D-SNP, HMO MA-PD, PDP, PFFS, PPO MA-PD

Summary of issue: Several changes are required to incorporate guidance issued on July 18, 2014 regarding Part D payment for beneficiaries receiving the Medicare hospice benefit.

Issue location 1: Cost plan, D-SNP, HMO MA-PD, PFFS, PPO MA-PD): Chapter 4, Section 2.1, Medical Benefits Chart, "Hospice care"

Action required: All organizations offering Part D benefits must update the language as instructed below.

- Insert the following after the paragraph that begins "For services that are covered by *[insert 2015 plan name]* but are not covered by Medicare Part A or B" and before the paragraph that begins "**Note**: If you need non-hospice care…."

  "For drugs that may be covered by the plan's Part D benefit:
  Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*)."

Issue location 2: Cost plan, HMO MA-PD, PFFS, PPO MA-PD EOCs: Chapter 5, Section 1.1

Action required: All organizations offering Part D benefits must update the language as instructed below.

- Delete the following paragraph:

  "The two examples of drugs described above are covered by the plan's medical benefits. The rest of your prescription drugs are covered under the plan's Part D benefits."

- Replace the deleted paragraph with the following:

  "In addition to the plan's Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please see Section 9.4 *(What if you're in Medicare-certified hospice).*"

Issue location 3: D-SNP EOC, Chapter 5, Section 1.1

Action required: All organizations offering Part D benefits must update the language as instructed below.

- Add new paragraph below after the paragraph that starts, "Medicare Part B also provides benefits for some drugs…" and before the paragraph that begins, "In

addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits."

"In addition to the plan's Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please see Section 9.4 (*What if you're in Medicare-certified hospice*)."

Issue location 4: PDP EOC, Chapter 3, Section 9.3

Action required: All organizations offering Part D benefits must update the language as instructed below.

- Add new paragraphs after the paragraph that reads "Some drugs may be covered under Medicare Part B in some situations and through *[insert 2015 plan name]*" to read as follows:

"Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D. Chapter 4 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay."

Issue location 5: Cost plan, D-SNP, HMO MA-PD, PFFS, PPO MA-PD EOCs: Chapter 5, Section 9

Action required: All organizations offering Part D benefits must update the language as instructed below.

- Insert the following new section 9.4 "What if you're in Medicare-certified hospice?" after section 9.3 to read as follows:

"Section 9.4 What if you're in Medicare-certified hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay."

11. EOC model for Cost plan, D-SNP, HMO MA-PD, PDP, PFFS, PPO MA-PD

Summary of issue: The EOC models omitted the mention that plan payment for brand drugs while in coverage gap are not included in the out-of-pocket costs.

Issue location: PDP EOC: Chapter 4, Section 6.2, ninth bullet under "These payments are not included in your out-of-pocket costs"
Cost plan, D-SNP, HMO MA-PD, PFFS, PPO MA-PD EOCs: Chapter 6, Section 6.2, ninth bullet under "These payments are not included in your out-of-pocket costs"

Action required: All organizations offering Part D benefits must update the language as instructed below (change noted in red text)

"Payments made by the plan for your brand or generic drugs while in the Coverage Gap."

12. EOC model for HMO-MA, PPO-MA, Cost plan, D-SNP, HMO MA-PD, PFFS, PPO MA-PD

Summary of issue: The MA and MA-PD EOC models do not reflect current medical care coverage appeal policies.

Issue location: HMO-MA and PPO-MA EOCs: Chapter 7, Section 5.3
Cost plan, D-SNP, HMO MA-PD, PFFS, PPO MA-PD EOCs: Chapter 9, Section 5.3

Action required: MA and MA-PD plans must update the language as instructed below.

"If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf [*plans may also insert:* or on our website at *[insert website or link to form]*].) While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask ~~sent to~~ the Independent Review Organization to review our decision ~~for dismissal~~."

The ANOC/EOC models are available through the following link by clicking on the zip file titled *2015 Model Materials:* http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html

II. Update to 2015 Provider Directory Model

If cost-sharing varies based on provider and/or benefit tiering, plans should clearly denote the tier of a provider and/or facility using special characters and/or footnotes. Plans should refer enrollees to their EOC for more information on the cost-sharing for each tier. Note that plans are not required to use the word "tier" if that is not how they refer to it in the marketplace.
The document can still be submitted to HPMS as a model with the above changes.

Plans and Part D Sponsors should direct questions regarding the above to their CMS Account Manager.