

## **2010 Standardized Combined ANOC/EOC**

### **Instructions for Plans:**

The 2010 Standardized Combined ANOC/EOC must be used by all Medicare Advantage Plans (MAs), Medicare Advantage Prescription Drug Plans (MA-PDs), Medicare Prescription Drug Plans (PDPs), and Medicare Cost plans. All sections of the standardized ANOC/EOC must be sent together in the same envelope, along with the plan formulary, for arrival no later than October 31. Text in this document is standardized and must be used exactly as provided, unless indicated otherwise. All instructions to plans should be deleted from the member document.

- 1) The ANOC/EOC must be submitted through File & Use Certification. Plans must submit an attestation checklist with the document to confirm no standardized language has been altered.
  - a. CMS will conduct retrospective reviews to ensure clarity and accuracy of the materials.
  - b. Premium and cost-sharing information must be reflected in the ANOC/EOC that is submitted. Plans should not submit a template with brackets.
  - c. If reproduced in separate sections (see plan instruction 3), all sections must be submitted in one file (such as a .zip file) as one complete document.
- 2) Plans will not be permitted a global or ad-hoc process for customizing standard language. Plans must use standard language as given in the document.
  - a. Plans may make minor edits (grammatical or punctuation changes, updates/corrections of phone numbers, etc) as necessary and submit as standardized.
  - b. Standardized text must be used and must remain in the exact order given in the standardized document. The document can be formatted as desired (i.e. font style, margins), so long as all changes meet CMS Marketing Guidelines and other CMS guidance.
  - c. Plans may recreate the graphics and/or tables in the document in the style and format desired. However, the standardized text must be used and must remain in the order given in the standardized document and the revised graphics and/or tables must meet the CMS Marketing Guidelines and other CMS guidance.
- 3) All sections of the standardized ANOC/EOC must be sent together in the same envelope, along with the plan formulary, for arrival no later than October 31 with the exception of fully-integrated SNPs (see instruction (3e)).
  - a. Plans may reproduce sections of the ANOC/EOC separately; however, the number of sections should be as limited as possible. If printed separately, the documents should still be packaged in the order this model provides.
  - b. The LIS Rider may be mailed with the ANOC/EOC, or may be mailed in a separate envelope. It must be received by members by October 31. Plans sending the LIS rider separately may edit the LIS Rider references within the standardized ANOC/EOC text to indicate that the LIS Rider was mailed separately.

- c. Plans may send the SB with the ANOC/EOC mailing if they so choose, but the SB is not required to be sent to all current members with the combined ANOC/EOC. However, the SB must be available upon request for current members and, per the CMS Marketing Guidelines, it remains a required pre-enrollment material and must be included in pre-enrollment material packages.
- d. Cost Plans offering Part D must send the combined standardized ANOC/EOC for receipt by Oct 31. Cost plans not offering Part D must send the combined ANOC/EOC for receipt by Dec 1.

Cost plans offering Part D as a separate and distinct optional supplemental benefit (that does not include other optional supplemental benefits in a package) may list the Part D premium amount separately within the ANOC/EOC. In other words, before a Cost plan can list a distinct Part D premium, members must be able to select the Cost plan either with or without only the Part D benefit.

- e. Fully integrated Medicare/Medicaid SNPs are not required to use the standardized combined ANOC/EOC document. Fully-integrated SNPs should send an ANOC with an SB and formulary for receipt by Oct 31 and the state-integrated EOC and LIS rider for receipt by Dec 31. Fully integrated SNPs should submit the ANOC through file and use certification. The fully integrated EOC will receive a 45-day review. As with the 2009 EOC submissions, fully-integrated Medicare/Medicaid SNP plans may submit the EOC as a template under the expedited review process. The plan sponsor would be responsible for populating the appropriate cost sharing and benefit information once the bid is approved. Fully-integrated Medicare/Medicaid SNP plans do not need to re-submit populated materials.

With respect to the ANOC/EOC, a “fully integrated Medicare/Medicaid SNP” is a CMS approved MA-PD SNP that:

- i. Provides dually eligible beneficiaries access to Medicare and Medicaid benefits under a single managed care organization (MCO);
  - ii. Has a contract with a state Medicaid agency that includes coverage of specified primary, acute and, long-term care benefits and services, consistent with State policy, under risk-based financing;
  - iii. Coordinates the delivery of covered Medicare and Medicaid health and long-term care services, using aligned care management and specialty care network methods for high-risk beneficiaries; and
  - iv. Employs policies and procedures approved by CMS and the state to coordinate or integrate member materials, including enrollment, communications, grievance and appeals, and/or quality assurance.
- 4) Plans can modify or delete standardized language in situations described below.
- a. Plans should modify or delete, as necessary for your plan, all references under “all Plan Types” not relevant to your plan.
  - b. Plans using an open access model: modify or delete, as necessary for your plan, all references to PCP, referrals, etc.

- c. Plans not offering a Part D benefit package: modify or delete, as necessary for your plan, all references to Part D benefits.
  - d. HMO-POS plans can modify language related to network providers when necessary to clarify when a POS benefit may furnish coverage.
  - e. All references to Member Services, Pharmacy Directory, Provider Directory, Membership Identification (ID) card, can be changed to the appropriate name your plan uses.
  - f. All references to TTY may be changed to TDD or TTY/TDD, if necessary, to reflect the communication technology provided by the plan.
  - g. Where the document indicates “[insert plan name],” plans may choose to insert their MAO name instead or to use “we,” “our,” “us,” “the plan,” “our plan,” or “your plan.” In addition, where the document already uses one of the terms, “we,” “our,” “us,” “the plan,” “our plan,” or “your plan,” plans may choose to substitute one of these terms for the term suggested in the model.
  - h. Throughout the document, plans may replace references to broad organization names (SHIPs, QIOs, SPAPs, etc) with the state-specific name in the areas where the product is being offered. Plans may choose to use the broad organization name throughout the document, but if doing so must refer the beneficiary to Chapter 2 for information on their state program.
  - i. Plans may include multiple benefit packages within one ANOC/EOC, however if doing so the plans must be clearly differentiated. The EOC can be edited to ensure that members easily understand exactly the plan in which they are enrolled. All benefit packages included in one document must be the same plan type and all either offer, or not offer, Part D coverage. For example, plans could include all MA-only HMOs, or all MA-PD HMOs, but could not include an MA-only HMO with an MA-PD HMO, or an MA-only HMO with an MA-only or MA-PD PPO.
  - j. Plans offering Part D benefits that do not include step therapy on any of their formulary drugs may delete all references to step therapy.
- 5) The 2010 combined ANOC/EOC document must be sent to all new members who enroll in a plan with an effective date of November 1, 2009, or December 1, 2009. Plans sending stand-alone EOCs to new enrollees with effective dates of 1/1/10 and later, may edit document to remove all references to ANOC (even if not bracketed) and send EOC portion only. Plans doing so do not need to resubmit the stand-alone EOC under a new code for CMS approval.
- a. The document must be provided to all new enrollees no later than 10 calendar days of the receipt of CMS confirmation of enrollment, or by the last day of the 1<sup>st</sup> enrollment month, whichever occurs first.
- 6) Please note that entities offering employer sponsored group plans (these include employer/union-only group waiver plans (EGWPs) or individual plans sponsored by employer/union groups) are subject to all applicable Medicare dissemination and disclosure requirements (including any requirements related to the timing of these

materials) unless specifically waived or modified. Please note the following important employer group waivers/modifications as they relate to the requirements in these combined ANOC/EOC instructions:

- a. Current CMS guidance does not require entities to submit employer group plan dissemination materials for prior review and approval; although this material must be made available to CMS upon request;
- b. CMS has waived any requirements that would otherwise prohibit entities offering employer group plans from modifying required standardized model combined ANOC/EOC language to allow these entities to customize these materials to the extent those customized materials will more clearly and accurately describe the benefits available to employer/union group plan members;
- c. With regard to premium amounts that are required to be accurately reflected on these standardized model materials, entities should ensure these materials accurately reflect the actual premium amount the beneficiary pays when the supplemental coverage, if any, and any corresponding employer/union premium subsidization is taken into account. If accurate premium information concerning the amount the beneficiary actually pays is not available, the entity may use the standardized model language in lieu of providing actual premium amounts (e.g., contact your employer group plan benefit administrator); and
- d. CMS has waived/modified applicable timing requirements in certain circumstances such as where a particular employer/union group plan sponsor has an open enrollment period that differs from Medicare's open enrollment period. In these situations, the combined ANOC/EOC must be received no later than 15 days before the particular employer/union sponsor's open enrollment period begins.

See Medicare Managed Care Manual (Chapter 9) and Prescription Drug Manual (Chapter 12) for more detailed information concerning employer group plans and applicable CMS waivers/modifications.