DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE-MEDICAID COORDINATION OFFICE

DATE: May 23, 2017

TO: Medicare-Medicaid Plans and Minnesota Senior Health Options Plans

FROM: Lindsay P. Barnette
Director, Models, Demonstrations, and Analysis Group

SUBJECT: Medicare-Medicaid Plan and Minnesota Senior Health Options Plan Member Material Model Updates for Contract Year 2018

Earlier this month, the Medicare-Medicaid Coordination Office began issuing state-specific Medicare-Medicaid Plan (MMP) model materials for use in Contract Year (CY) 2018. The purpose of this memorandum is to provide an overview of CY 2018 changes.

Each year we consider CMS guidance and revisions to Medicare Advantage and Part D model materials as well as input from state partners, advocacy organizations, Medicare-Medicaid enrollees, and other stakeholders when updating the national templates that serve as the basis for state-specific MMP and Minnesota Senior Health Options (MSHO) Plan models. We use the information to assess needed revisions to the Annual Notice of Change; Member Handbook (Evidence of Coverage); Summary of Benefits; Provider and Pharmacy Directory; List of Covered Drugs (Formulary); Member ID Card; Explanation of Benefits; Integrated Denial Notice; and plan-delegated enrollment notices, including Exhibits 5a and 5b, Welcome Letters for Passively Enrolled Individuals and Individuals Who Opt In. Because state-specific requirements vary, the content and number of each state's model materials may differ somewhat from the national templates mentioned above.

Some MMP and MSHO Plan model materials required no revisions for CY 2018. Overall, updates were relatively minor with the most significant changes occurring in state Medicaid appeals processes resulting from implementation of the Medicaid and CHIP Managed Care Final Rule published in May 2016 (see https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered). The following is a summary of changes for CY 2018:

General

- Updated Contract Year (CY) references.

- Made minor edits in grammar and content for clarity.
- Updated references to CMS guidance and uniform resource locators (URLs) for websites.
- Added commonly used acronyms as appropriate (for example, "DME" for durable medical equipment and "SNF" for skilled nursing facility).
- Added a reference to the Affordable Care Act's Section 1557 requirements and information located on the Office for Civil Rights' website.
- Revised the required non-English languages disclaimer consistent with changes to the CY 2018 Medicare Marketing Guidelines (MMG) and noted that the disclaimer is required only in materials that must be translated into non-English languages.
- Clarified that plans must include a description of how members can make a standing request for materials in non-English languages or in an alternate format only in materials required to be translated.

Annual Notice of Change

- Updated actual mail date (AMD) submission instructions.
- Moved the cover page to appear before the Table of Contents, consistent with findings from Medicare-Medicaid enrollee interviews.
- Clarified that plan members will remain enrolled in Medicare and Medicaid if they disenroll from the plan, provided they are still eligible for both programs.

Member Handbook (Evidence of Coverage)

Chapter 1:

- Updated AMD submission instructions.
- Added a disclaimer on minimum essential coverage to be consistent with the ANOC.
- Added language to heighten awareness about the prohibition of inappropriate or improper billing for Medicare-Medicaid enrollees.

Chapter 3:

- Updated language for the plan's notice to members when a provider leaves the plan.
- Simplified and updated the definition of "medical emergency" consistent with regulatory language.
- Clarified language about the responsibilities of clinical trial sponsors.
- Updated language about services in religious non-medical care institutions.
- Revised language explaining rules for renting and owning DME.

Chapter 4:

- Updated apple icons that identify preventive services in the Benefits Chart (removed from "Cardiac (heart) rehabilitation services," added to "Medical nutrition therapy," and included option for "Vision care" based on plan coverage).
- Updated service descriptions in the Benefits Chart for "Colorectal cancer screening," "Durable medical equipment (DME)," "Lung cancer screening," and "Partial hospitalization services."

- Clarified the definition of “medical emergency” under “Emergency care” in the Benefits Chart.
- Changed the title of “Inpatient services covered during a non-covered inpatient stay” to “Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered stay.”

Chapter 7

- Updated language to heighten awareness about the prohibition of inappropriate or improper billing for Medicare-Medicaid enrollees so that a plan member would know what to do if a network provider sends a bill.

Chapter 8

- Updated the list of reasons for which plans cannot discriminate against members.
- Clarified language for members who cannot stay in the plan if they move outside the plan’s service area.

Chapter 9

- Updated information on timeframes for filing appeals and grievances, in accordance with the new Medicaid and CHIP Managed Care Final Rule.
- Revised to state that enrollees must exhaust plan level appeals before requesting a state fair hearing, for states that previously allowed enrollees to skip plan level appeals, in accordance with the new Medicaid and CHIP Managed Care Final Rule.
- Removed language allowing plans to charge enrollees fees for copies of materials used in appeal decisions.
- Deleted reference to “balance billing” to align with changes to other chapters.

Chapter 10

- Clarified that plan members will remain enrolled in Medicare and Medicaid if they disenroll from the plan, provided they are still eligible for both programs.

Chapter 11

- Added the example of a nondiscrimination notice described in the Affordable Care Act’s Section 1557 requirements to the list of allowed legal notices.
- Included a reference to clarify that companies working with both Medicare and Medicaid must obey nondiscrimination laws.

Chapter 12

- Replaced the definition of “Balance billing” with the definition of “Improper/inappropriate billing.”
- Updated the definition of “Durable medical equipment (DME).”
- Revised the definition of “Service area” to clarify that members who move outside the plan’s service area cannot stay in the plan.

Summary of Benefits

- Updated the service description for "Durable medical equipment (DME)."
- Clarified that freedom from any form of physical restraint or seclusion is a plan member's right.

Provider and Pharmacy Directory

- Clarified instructions about the content required for online and print directories.
- Clarified instructions to give plans additional flexibility to indicate if some network pharmacies are not available to all members.
- Made including days and hours of operation optional for all pharmacy types, consistent with three-way contract requirements.
- Made indicating if a pharmacy is open 7 days per week and/or 24 hours a day optional for all pharmacy types, consistent with three-way contract requirements.
- Added references to Chapter 5 of the Member Handbook for more information about mail-order pharmacies and drug coverage in special cases for members using a long-term care pharmacy.

Member ID Card

- Added an option to include the federal and state contracting disclaimer and the Medicare logo.
- Added an option to add $0 cost sharing language to increase provider awareness of the prohibition of inappropriate or improper billing of Medicare-Medicaid enrollees.

Integrated Denial Notice

- Updated information on timeframes for filing appeals and grievances, in accordance with the new Medicaid and CHIP Managed Care Final Rule.
- Revised to state that enrollees must exhaust plan level appeals before requesting a state fair hearing, for states that previously allowed enrollees to skip plan level appeals, in accordance with the new Medicaid and CHIP Managed Care Final Rule.

As part of our ongoing initiative to improve MMP and MSHO Plan member materials, we continue to collaborate with state partners and other stakeholders, plan additional testing of model materials with Medicare-Medicaid members, and explore ways to provide accurate and timely information while reducing burden for members, plans, and states. To allow plans sufficient time to customize models and make materials available on their websites by September 30 as required, we anticipate releasing the remaining state-specific CY 2018 model materials as soon as possible, but no later than June 30, 2017. After release, we will post model materials to the Financial Alignment Initiative website at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html, approximately halfway down the page, grouped alphabetically by state under the "State-Specific Information" heading.

Please contact the Medicare-Medicaid Coordination Office at MMCOCapsModel@cms.hhs.gov if you have any questions about the contents of this memorandum.