



MEDICARE-MEDICAID COORDINATION OFFICE

DATE: June 6, 2018

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

FROM: Lindsay P. Barnette
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SUBJECT: Medicare-Medicaid Plan and Minnesota Senior Health Options Plan Member
Material Model Updates for Contract Year 2019

This month CMS will begin issuing state-specific Medicare-Medicaid Plan (MMP) and Minnesota Senior Health Options (MSHO) Plan model materials for use in Contract Year (CY) 2019. The purpose of this memorandum is to provide an overview of CY 2019 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, dually eligible beneficiaries, and other stakeholders when updating the national templates that serve as the basis for state-specific MMP and 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. The Member ID Card for MMP enrollees required no revisions for CY 2019.

The most substantive changes occurred as a result of the implementation of CMS-4182-F, Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE program, which may be found in the Final Rule published April 16, 2018 (see <https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare>). The following is a summary of general changes for CY 2019:

General

- Updated Contract Year (CY) references.

- Updated references to CMS guidance and uniform resource locators (URLs) for websites.
- Added a set of best practice formatting instructions to improve readability for English-speaking and non-English speaking enrollees in standalone models.
- Clarified language and added cross references where appropriate.
- Aimed to improve readability by:
 - Adding a Table of Contents and brief Introduction to each model
 - Separating text into shorter paragraphs or bulleted lists
 - Using consistent language across templates to define common terms (e.g., prior authorization, referral, Extra Help)
 - Incorporating current Section 508 best practices (e.g., activated hyperlinks, removed other underlining, removed double emphasis, limited use of italics, emphasized in bold)
 - Applied consistent style and formatting across models (organization, section and subsection numbering, line spacing, bullets, font size)

In addition to general revisions previously described, the following is a summary of updates where content changed in specific model materials:

Annual Notice of Changes

- Revised actual mail date (AMD) submission instructions.
- Modified disclaimer instructions.
- Added flexible instructions and language for continuation of the continuous Special Enrollment Period for dual eligible beneficiaries (duals SEP) or implementation of the new duals SEP effective CY 2019. (We note that demonstration states are currently in the process of making decisions about duals SEP policy and will communicate those policy decisions to MMPs.)
- Updated required availability of CY 2019 Member Handbook to October 15, 2018.

Member Handbook (Evidence of Coverage)

Chapter 1:

- Revised actual mail date (AMD) submission instructions.
- Modified disclaimer instructions.
- Added flexible language to accommodate receipt of hard copy or availability of electronic Member Handbook based on state-specific preference.

Chapter 2:

- Added language to include questions about substance use disorder services in the Behavioral Health Crisis Line section.

Chapter 3:

- Clarified language explaining rules for renting and owning DME.

Chapter 4:

- Included instructions and language about “Uniform Flexibility” supplemental benefits that may be included in section B-19 of the Plan Benefit Package submission and related “Help with certain chronic conditions” in the Benefits Chart.
- Added a simplified description for “Medicare Diabetes Prevention Program (MDPP)” in the Benefits Chart.

Chapter 5:

- Updated instructions for number of days in a temporary supply of drugs from “at least 30 days” to “the number of days in plan’s one-month supply.”
- Revised language about the timing, reasons, and communication related to changes in drug coverage.
- Added a section concerning drug management programs to help members safely use their opioid medications.

Chapter 8

- Updated language and added cross reference in the section related to the enrollee’s right to leave the plan.

Chapter 9

- Included “at risk determination” as another legal term example for “coverage decision.”
- Increased the adjudication timeframes to 14 days for Part D payment redeterminations and IRE reconsiderations.
- Added “attorney adjudicator” as a person who can make a decision in a Level 3 appeal.

Chapter 10

- Added flexible instructions and language for continuation of the continuous Special Enrollment Period for dual eligible beneficiaries (duals SEP) or implementation of the new duals SEP effective CY 2019. (We note that demonstration states are currently in the process of making decisions about duals SEP policy and will communicate those policy decisions to MMPs.)

Chapter 12

- Clarified definitions for cost sharing tier, drug tiers, Extra Help, Member Handbook and disclosure information, medically necessary, and ombudsman.
- Added definitions for cultural competence training, Medicare Advantage plans, over-the-counter (OTC) drugs, personal or protected health information (PHI), and referral.
- Removed definition for model of care.

Summary of Benefits

- Modified disclaimer instructions.

- Clarified FAQs for Medicare-Medicaid Plan, prior authorization, referral, and Extra Help.

List of Covered Drugs

- Modified disclaimer instructions.
- Updated and renumbered FAQs related to changes to the Drug List, such as additions and removals of drugs and changes to plan coverage rules and/or limits.
- Updated instructions for number of days in a temporary supply of drugs from “at least 30 days” to “the number of days in plan’s one-month supply.”

Provider and Pharmacy Directory

- Modified disclaimer instructions.
- Included flexibility for plans in fulfilling requirements satisfied by all network providers or facilities.
- Included flexibility for plans in fulfilling “as applicable” requirements.
- Included option for plans to include provider and pharmacy general information before provider and pharmacy listings begin.
- Added brief descriptions for mail-order, home infusion, and long-term care (LTC) pharmacies.
- Added instructions for including an Index.

Integrated Denial Notice

- Modified disclaimer instructions.

Exhibits 5a and 5b, Welcome Letters for Passively Enrolled Individuals and Individuals Who Opt In

- Modified disclaimer instructions.
- Updated instructions for number of days in a temporary supply of drugs from “at least 30 days” to “the number of days in plan’s one-month supply.”
- Added flexible language to accommodate receipt of hard copy or availability of electronic Member Handbook based on state-specific preference.
- Added flexible instructions and language for continuation of the continuous Special Enrollment Period for dual eligible beneficiaries (duals SEP) or implementation of the new duals SEP effective CY 2019. (We note that demonstration states are currently in the process of making decisions about duals SEP policy and will communicate those policy decisions to MMPs.)

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 dually eligible beneficiaries, 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 as required, we will work with states to release state-specific CY 2019 model materials as soon as possible. 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/MMPInformationandGuidance/MMPMarketingInformationandResources.html>, 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.