

Comment 1: In the Stage 3 Coverage Gap, the models state what the member pays for the portion of brand drugs plus a portion of the dispensing fee. The language should be clarified to read that the **member pays 40%, with no separate reference to the dispensing fee.** (Suggested text is bold)

Rationale: The language update/clarification would be in alignment with requirements introduced several years ago in relation to PBP requirements.

Benefit: As the EOC and EOB models read today, the current language for dispensing fees for brand drugs is inconsistent and could be confusing to the enrollee.

Response: CMS will take this into consideration.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 2: The plan requests CMS consideration to allow plans to post the Agency Appendix information in the EOC for national plans online with printed copy to be provided on request.

Rationale: This would allow the plan the flexibility to post the state agency contact information referenced in Chapter 2 of the EOC on the plan's website instead of in an appendix that can be as large as 30-pages when all regions are included.

Response: CMS will keep the language in an Appendix as web lookup is inconvenient.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 3: The plan requests CMS consideration to allow plans to post the Agency Appendix information in the EOC for national plans online with printed copy to be provided on request.

Rationale: Chapter 2 of the EOC would direct the beneficiary to the website instead of the appendix. This would also allow updates to be made to the content if needed throughout the year. The contact information/appendix could be mailed to a beneficiary upon request.

Response: Service areas should not change that much within the contract year.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 4: The plan recommends simplifying the language in the EOC (e.g., including more generic language that would apply to both LIS and non-LIS enrollees).

Rationale: Updating the language in relation to both subsidized and non-subsidized enrollees would improve beneficiary understanding of the document as well as improve operational production efficiencies.

Benefit: Removing a large section of the document from the printed model that applies to a small percentage of membership will increase the relevancy of the remaining document and improve our members' ability to digest the plan information. The agency index information would be readily available on the plan website.

Response: There are no changes to the models as written, but CMS will discuss potential changes in the future.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 5: The plan recommends modification to the HPMS reporting for AMD (Actual Mail Date) for the ANOC/EOC mailing periods. Plan requests CMS consideration of changing the HPMS reporting process to have one final report of all the waves loaded into HPMS at the end of the mailing season vs. the weekly reporting that is required today.

Rationale and Benefit: Reduce plan administrative burden.

Response: CMS will take this into consideration.

CMS Action: No action being taken at this time.

Comment 6: The plan requests consideration of CMS issuing all marketing and non-marketing models and associated corrections by no later than 7/15 annually. Receiving updates after this timeframe critically impacts the production for the ANOC/EOC model. Further, should CMS publish corrections after the 7/15 date for the ANOC/EOC, plans would be allowed to implement those changes on a go-forward basis after the 9/30 mailing process is complete.

Rationale: Based on the current deadline to produce and mail the ANOC/EOC, the 7/15 deadline would ensure timeliness and accuracy of this important document and allow plans 60 days prior to mailing to compile and produce materials.

Benefit: Allow plan sufficient time to produce these important materials without introducing additional changes that would be required to be incorporated for the 9/30 delivery date.

Response: CMS will take this into consideration.

CMS Action: No action being taken at this time.

Comment 7: There is language in the EOC, Chapter 5, Section 5.3, regarding tiering exceptions that is not pertinent to a 5 tier plan with a straight 25% coinsurance across all tiers. Language in the EOC about the ability to request a tiering exception has no value for these members and could be misleading.

Response: CMS does not recommend striking the entire section as a cheaper drug at the same coinsurance still provides an alternative option.

CMS Action: CMS removed the following optional text in all Part D models: *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions: omit this section.]*

CMS edited the header to read: What can you do if your drug is in a cost-sharing tier you think is too high? *[Plans with a formulary structure (e.g., no tiers or defined standard coinsurance across all tiers) that does not allow for tiering exceptions: omit Section 5.3]*

Comment 8: There are redundancies between chapters (EOC Chapter 5: Using the Plans coverage for your Part D prescription drugs, Chapter 6: What you pay for your Part D prescription drugs, and Chapter 8: Appeals and Grievances). We recommend combining the chapters to avoid member confusion.

Response: CMS recommends doing this next year as this is a large request to ensure that all duplication is removed and nothing is erroneously omitted.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 9: Reformat tables (EOC, Chapter 2) where redundant numbers are combined and where list of references for necessary resources is duplicative. There are instances where the same phone numbers are provided for different call reasons.

Response: This seems more of an instruction to plans rather than for CMS to make a change to the template. If the plan is using the exact same set of numbers for two separate services, CMS can give them the option of combining two sections, but do not think the way the tables are formatted currently would cause beneficiary confusion about which numbers to call.

Beneficiaries are looking for their specific issues and will not pay attention to whether the phone number is duplicated elsewhere in the document. If they turn to the section that pertains to them, and the phone number is a duplicate somewhere else, they may miss the number. CMS treats this as a sort of reference book for beneficiaries.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 10: Request CMS leave websites and emails as “optional”: [Optional: website and e-mail addresses]

Reason/Impact: This is not part of the standardized data set that most providers share with the health plan.

Response: CMS disagrees with the commenter and thinks this is an appropriate listing as is. The information needs to be on the website.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 11: The exceptions tiering language in Chapters 6 and 9 is limiting and doesn’t quite suit our plans’ needs.

Response: Without additional information discussing what language is problematic, CMS is unable to make suggested changes based on this anonymous comment.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 12: Regarding the ANDA/NDA process and language, Drug manufacturers complete paperwork which identifies drugs as either a brand or a generic. The current EOC outlines ‘a drug that is treated like a generic’ and in some cases charges members a brand copay. Members get confused and

sometimes upset that we are charging them a brand copay in some cases when the formulary lists the drug as a generic drug – so they are expecting to pay a generic copay.

Response: CMS does not see a compelling reason to change this. Brand/generic status is based on FDA application status, not drug manufacturer reporting.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 13: Members have reported that they were not aware of benefit changes included in the ANOC because they assumed the purpose of the benefit chart at the beginning of the ANOC was to report all of the changes and some members haven't looked past the first chart to read about the rest of the plan's changes. It also makes it difficult and time-consuming to revise the documents quickly in response to benchmark changes. Remove the benefit summary chart at the beginning of the ANOC so that members will look inside the ANOC for all of the benefit changes and improve the QA process for plans.

Response: CMS disagrees, noting at the beginning of the section that this is ONLY a summary of changes. CMS feels that this is important so that beneficiaries can see what the most important changes are to their benefits, so they can go through the document more thoroughly as appropriate for them. CMS believes the disclaimer stating “it is important to read the rest of this Annual Notice of Changes” provides adequate notice to beneficiaries.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 14: ANOC, Section 2.2: Changes to Your Maximum Out-of-Pocket Amount.

Far left column: Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount. Far right column: Once you reach this amount, you generally pay nothing for covered [insert if applicable: Part A and Part B] services for the rest of the year. The plan notes its issues with this below.

Left column: Statement implies that Part B drugs do not apply to MOOP. Right column: Plans do not apply all supplemental benefits to MOOP. However, the language in the ANOC states that either all covered services apply to MOOP or only those covered by Parts A&B.

Plan suggestion: Far left column: Add "Part D" (...your costs for Part D prescriptions drugs do not count...). Far right column: Allow plans to revise for accuracy. Here's an example: Once you reach this amount, you generally pay nothing for covered Part A and Part B services [(and other health care services not covered by Medicare as described in Chapter 4 of the Evidence of Coverage)] for the rest of the year.

Response: CMS believes the chart reads as desired with no updates to the instructions.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 15: Preferred and Standard cost sharing. Issue: For PBPs that do not have different cost sharing for preferred and standard retail pharmacies (preferred and standard; aka nonpreferred pharmacies and preferred pharmacies), the preferred and standard cost sharing terminology is confusing, especially if a plan has preferred generic and brand cost sharing. The definition of “standard” as an adjective is

“regularly and widely used, available, or supplied,” which would lead a beneficiary to assume that it is the cost-sharing experienced most by members, when in fact, the most common is “preferred.” The adjective “standard” is not the opposite of “preferred” either, so the terms don’t logically connect the same way that the prior terms (nonpreferred and preferred pharmacies) did, which also adds to the confusion. Using a term in a way that is different from the way it is commonly used, and then listing those “standard” costs first, increases beneficiary confusion. Only use preferred and standard cost sharing if there is different network cost sharing depending upon the retail pharmacy. Alternatively, the meaning of the prior terminology, “nonpreferred” retail pharmacies, was clearer than “standard” cost sharing.

Response: CMS has used the term “preferred cost-sharing pharmacies” and “standard cost-sharing pharmacies” to describe the experience beneficiaries will have at POS, depending on which pharmacies they attend. CMS no longer uses the term ‘nonpreferred’ as it is offensive to pharmacies. CMS recommends keeping the term “standard” as CMS has been moving away from using the term “nonpreferred.”

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 16: The ANOC model requires certain benefits in Section 2 even if there are no changes. "2.1 Changes to the monthly premium" "2.2 Changes to your maximum out of pocket amount" "2.3 Changes to the provider network" "2.4 Changes to the pharmacy network" "2.6 Changes to Part D prescription drug coverage" In addition, Section 2 doesn't allow for the addition of all noteworthy changes. When there are no changes: "Section 2.5 – Changes to Benefits and Costs for Medical Services" provides instructions to state whether the plan has made no changes to benefits or to list only those benefits that are changing. In contrast, the five sections listed require that the plan provide a comparison of one year to the next even when there are no changes. For example, Section 2.6 states: "The information below shows the changes for next year to the first two stages" when there may not be any changes at all. The beneficiary is forced to evaluate two columns of information to determine that there are no changes for the upcoming. When there are changes but not permitted to state according to the model: Section 2, does not address changes to benefits that are unrelated to cost sharing or formulary changes. Plans should describe benefit changes; for example, if a plan has revised drug coverage during the gap, or a benefit description has changed, e.g., revised limitations but the cost sharing hasn't changed.

When there are no changes: To avoid confusing beneficiaries and for consistency, the plan suggests that premium, MOOP, network, and drug changes be presented the same as medical benefit changes. If there are no changes, plans could be allowed to simply state there are no changes. If there are changes, plans could state what is changing so that members do not have to compare two columns to determine if a drug tier, for example, has changed or not. Further if the drug deductible stage doesn't apply to a plan, the subject should be removed from the ANOC. In addition, since ICL and TROOP threshold amounts change every year, those should be included as standing changes. Also, if a plan has only made normal staffing changes (e.g., providers who leave and other are hired); the ANOC should be rewritten so beneficiaries understand that the Provider Directory is updated throughout the year in response to normal staffing changes instead of implying that the member should look at the directory to see if their provider will be available. When there are changes: Add an instruction allowing plans to describe other types of coverage changes unrelated to cost sharing, e.g., a new exclusion.

Response: CMS recommends it may be helpful to indicate if there are no changes to the deductible.

Attachment B: Comments and Response to Federal Register Notice #1

CMS Action: In all models of the ANOC, Section 2.1 'Monthly premium' table, CMS added the below text in red:

[Plans that include a Part B premium reduction benefit may modify this row to describe the change in the benefit. If there are no changes from year to year, plans may indicate in the column that there is no change for the upcoming benefit year.]

Comment 17: This sentence is confusing: In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary drug in the first 90 days of coverage of the plan year or coverage.

Suggestion: Revise for clarity, here's an example: In some situations, we are required to cover a one-time, temporary supply of a non-formulary drug in the first 90 days of the plan year or membership.

Response: CMS agrees with the suggestion and updated the text.

CMS Action: CMS updated the ANOC text in all Part D models to read as follows (red text is new): In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary drug in the first 90 days of the plan year or **the first 90 days of membership to avoid a gap in therapy**.

Comment 18: The Table of Contents approach in the EOC is overly complicated even for persons who are Word experts. The EOC should use a common approach to the Table of Contents consistent with beneficiaries' general experience with publications.

Suggestion: Instead of individual Table of Contents before each chapter, have one main Table of Contents at the beginning of the document.

Response: CMS rejects this suggestion as enrollees use the EOC as a reference book. They are more likely to look for specific provisions in one chapter, making the chapter TOCs as or more important than the main TOC.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 19: The chapter cover pages adds additional length to an already very long document without adding any value.

Suggestion: Remove the chapter cover pages or clarify that they are optional.

Response: This is not a relevant request at this time. CMS will revisit this for calendar year (CY) 2019 to see if the change is warranted and would improve the beneficiary experience.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 20: The eligibility section does not mention that grandfathered members either who live outside the service before 1/1/1999, can remain members. Suggest revising the eligibility section so that existing members understand they are not ineligible simply because they remain outside the service. Suggested revision is underlined: -- and -- you live in our geographic service area (section 2.3 below

describes our service area). [Plans with grandfathered members who were outside of area prior to January 1999, insert: If you have been a member of our plan continuously since before January 1999 and you were living outside of our service area before January 1999, you are still eligible as long as you do not move.]

Response: It is clear that the member would be disenrolled if they move, which is noted in the last sentence.

CMS Action: CMS updated related text (in all models) to read as follows: *[Plans with grandfathered members who were outside of area prior to January 1999, insert: If you have been a member of our plan continuously since before January 1999 and you were living outside of our service area before January 1999, you are still eligible as long as you have not moved since before January 1999.]*

Comment 21: The last sentence below is out of context considering the broad nature of the paragraph: Network providers are the doctors and other health care professionals, medical groups, [insert if applicable: durable medical equipment suppliers,] hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. [Insert as applicable: We included a copy of our durable medical equipment supplier directory in the envelope with this booklet.] The most recent list of suppliers is [insert as applicable: also] available on our website at [insert URL].]

Suggestion: Remove the last sentence as the provider listings area addressed in this section already. Alternatively, revise the reference so it is clear which suppliers are being referred to: The most recent list of durable medical equipment suppliers is [insert as applicable: also] available on our website at [insert URL].]

Response: CMS agrees with the suggestion and will update the language, as appropriate.

CMS Action: CMS updated EOC Chapter 1, Section 3.2 text to read as follows (new text is in red and is applicable to all models except the MSA and PDP): **Network providers** are the doctors and other health care professionals, medical groups, *[insert if applicable: durable medical equipment suppliers,]* hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. *[Insert as applicable: We included a copy of our Provider Directory in the envelope with this booklet.] [Insert as applicable: We [insert as applicable: also] included a copy of our Durable Medical Equipment Supplier Directory in the envelope with this booklet.]* The most recent list of providers *[insert as applicable: and suppliers]* is *[insert as applicable: also]* available on our website at *[insert URL].]*

Comment 22: For consistency and accuracy, the plan suggests qualifying the first sentence below for consistency with the second sentence regarding pharmacies.

Generally, during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

Suggestion for additional language is underlined: Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers

Response: CMS accepts the plan's addition of 'if you cannot use a network provider.'

CMS Action: CMS updated the text (applicable to all models except MSA and PDP) to read as follows: Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

Comment 23: Members enrolled in optional supplemental benefits should be able to locate their premium easily and quickly in the premium section of Chapter 1 without having to refer to another chapter.

Suggestion: Remove the text (in Chapter 1, Section 4.1) about optional supplemental premiums and instead require plans to display premiums for all members with and without optional supplemental benefits in the premium section (Chapter 1, Section 4.1).

Response: CMS disagrees with this suggestion. This may be even more confusing for beneficiaries, as their premium may vary depending on which optional supplementals they are choosing.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 24: If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay all or part of the member's monthly plan premium. **If Medicare pays only a portion of this premium, we will bill you for the amount Medicare doesn't cover.**

Issue: The text that is bolded above is confusing. The LIS program only pays for a portion of the Part D premium and would not pay any of the member's Part C premium. Note: The plan does not recommend clarifying that it is the Part D portion of the premium that is paid by LIS because MA-PD members are only familiar with the entire premium for both Part C and Part D.

Suggestion: If plans have a Part C premium, we suggest removing the last sentence in bold and "all or" in the first sentence: "If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium."

Response: CMS accepts this suggestion to remove the above sentence in bold and 'all or.'

CMS Action: CMS removed the above sentence in bold as well as 'all or.' CMS updated related text in all Part D models to read as follows: If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium.

Comment 25: Medicare coverage gap discount program. The underlined text below is new for 2017 EOCs. Two comments about this new text: (1) the term "branded drugs" should be "brand name drugs" consistent with the term used in the EOC; and (2) in the last sentence in the first paragraph, it is not clear how much members will pay. The implication is that members only pay the dispensing fee on a portion of the cost. The plan notes that generic cost sharing, in the same section, is explained clearly as follows: "If you reach the coverage gap, our plan pays 49% of the price for generic drugs and you pay the remaining 51% of the price."

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not receiving “Extra Help.” For branded drugs, the 50% discount provided by manufacturers excludes any dispensing fee for costs in the gap. The enrollee would pay the dispensing fee on the portion of the cost, which is paid by the plan (10% in 2017).

Suggestions: 1. Revise "branded" drugs" to "brand name drugs." 2. Revise the sentence consistent with other references in the EOC, for example, Chapter 6, Section 6.1: "Enrollees pay 40% of the negotiated price and a portion of the dispensing fee for brand name drugs."

Response: CMS agrees with these suggestions and will update the language, as appropriate.

CMS Action: CMS edited the above text in all Part D models (except the D-SNP where this section was removed) to read as follows (new text is red): The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not receiving “Extra Help.” For **brand name** drugs, the 50% discount provided by manufacturers excludes any dispensing fee for costs in the gap. **Enrollees pay 35% of the negotiated price and a portion of the dispensing fee for brand name drugs.**

Comment 26: As a Medicare health plan, *[insert 2015 plan name]* must cover all services covered by Original Medicare and must follow Original Medicare’s coverage rules.

Issue: Plans do not cover all services covered by Original Medicare, namely hospice care. Note: "for these services" is included in the DE-SNP model and should be added to all models because Medicare's coverage rules do not apply to supplemental benefits the plan covers that are not covered by Original Medicare.

Suggested revisions are underlined: As a Medicare health plan, *[insert 2015 plan name]* must cover all services and items covered by Original Medicare (except for hospice care, which is covered directly by Original Medicare) and must follow Original Medicare’s coverage rules for these services.

Response: CMS rejects the suggested revisions and believes specifically mentioning Hospice here will be more confusing to members. The commenter is confusing payment and coverage. Original Medicare pays for hospice. But the plan must assist the member in locating a hospice; also the plan must still provide all supplemental benefits if the member elects to stay in the MA plan. Finally (very important protection), if the plan arranges for the hospice to provide a benefit then the enrollee only pays plan cost sharing.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 27: Clinical Research Study. Although you do not need to get our plan’s permission to be in a clinical research study, you do need to tell us before you start participating in a clinical research study. Here is why you need to tell us: 1. We can let you know whether the clinical research study is Medicare-approved. 2. We can tell you what services you will get from clinical research study providers instead of from our plan.

Issue: The plan is unable to provide information in response to #1 and #2. Only the trial sponsor can provide such details. The plan suggests removing the text about #1 and #2 and explaining why the member should tell the plan about their participation in the study.

Response: CMS agrees with this suggestion to delete #1 and #2. CMS will add clarifying language to the end of this section to explain why a member should let the plan know they will be participating in a clinical research study (to find out more specific details about what the plan will pay).

CMS Action: CMS clarified language related to Clinical Research Studies (applicable to all models except PDP) to read as follows (new text is red): Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet) **to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.**

Comment 28: Throughout the EOC, the term "member" is used. The Medical Benefit Chart uses the term "beneficiaries" in five preventive care benefits when discussing "There is no coinsurance, copayment, or deductible for beneficiaries eligible for..."

Suggestion: Change references to "beneficiaries" to "members."

Response: CMS accepts this suggestion to change references from "beneficiaries" to "members" in the Medical Benefit Chart.

CMS Action: CMS changed references (applicable to all models except MSA and PDP) from "beneficiaries" to "members" within the Medical Benefits Chart.

Comment 29: Medical Benefits Chart - Inpatient services covered during a non-covered inpatient stay.

Issue: The benefit as written is confusing and counter-intuitive. Also, it is not a "benefit," instead, it is a situation when Part B covered services are provided and Part B covered services are already addressed in the benefit chart. Plans must repeat cost sharing, which makes the EOC longer and more complicated. It also isn't a complete list of covered services; for example, Medicare Part B drugs are covered but are not listed.

Suggestion: Remove the category from the benefit chart or revise so it is clearer (for example, the title is confusing for members and sounds like a contradiction).

Response: CMS agrees to revise the title of the benefit.

CMS Action: CMS edited the Medical Benefit Chart header (applicable to all models except PDP) from "Inpatient services covered during a non-covered inpatient stay" to read as follows "Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay."

Comment 30: Medical Benefits Chart – Outpatient hospital services.

Issue: The phrase "certain screenings" is general and potentially confusing to members, so the Plan respectfully requests that CMS define or list the specific screenings that this bullet is referring to so plans can list appropriate cost sharing. It also is not listed consistently throughout the benefit chart. For example, it isn't listed in outpatient diagnostic labs.

Suggestion: State which screenings are contemplated or remove from the section because it may be addressed elsewhere in the chart.

Response: CMS will remove the word ‘certain’ and update the phrase accordingly.

CMS Action: CMS updated the associated text (applicable to all models except PDP) in the Outpatient hospital services portion of the Medical Benefits Chart to read as follows: Preventive screenings and services listed throughout this chart.

Comment 31: Medical Benefits Chart – Partial hospitalization.

Plans should state accurate information about the settings where partial hospitalization is provided so that members are clear about the settings where members will receive the care. Not all plans provide care in a "community mental health center." The second paragraph allows the plan to correct the first paragraph reference to community health centers, but is unnecessarily complicated for the average reader to understand in this final sentence, when used.

Paragraph 1: “Partial hospitalization” is a structured program of active psychiatric treatment provided **in a hospital outpatient setting or by a community mental health center**, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.

Paragraph 2: *[Plans that do not have an in-network community mental health center may add: Note: Because there are no community mental health centers in our network, we cover partial hospitalization only in a hospital outpatient setting.]*

Suggestion: Make the settings variable in the first paragraph so that plans can state the settings where the care is provided. Remove the variable text in the second paragraph.

Response: CMS will clarify text related to the Partial hospitalization services benefit.

CMS Action: CMS updated text for Partial hospitalization services in the Medical Benefits Chart (applicable to all models except PDP) to read as follows (updated text is red):

“Partial hospitalization” is a structured program of active psychiatric treatment provided **as a hospital outpatient service** or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.

*[Plans that do not have an in-network community mental health center may add: Note: Because there are no community mental health centers in our network, we cover partial hospitalization only **as a hospital outpatient service.**]*

Comment 32: Medical Benefits Chart – Vision Care.

Issue: The description of the benefit underlined below has been removed from the EOC. Our understanding is that Original Medicare covers eyewear for life for persons without a lens implant. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.

Suggestion: Please add the underlined language back into the EOC.

Response: CMS rejects this suggestion. The current description of the Vision Care benefit is correct.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 33: The exclusions list isn't in any particular order.

Suggestion: Allow plans to alphabetize the list to assist beneficiaries who are looking for particular subjects.

Response: CMS accepts this suggestion.

CMS Action: CMS added the underlined sentence below (applicable to all models except PDP), which precedes the exclusions table in Chapter 4 of the EOC: *[The services listed in the chart below are excluded from Original Medicare's benefit package. If any services below are covered supplemental benefits, delete them from this list. When plans partially exclude services excluded by Medicare, they need not delete the item completely from the list of excluded services but may revise the text accordingly to describe the extent of the exclusion. Plans may add parenthetical references to the Benefits Chart for descriptions of covered services/items as appropriate. Plans may reorder the below excluded services alphabetically, if they wish. Plans may also add exclusions as needed.]*

Comment 34: Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network. [Plans may insert additional information about I/T/U pharmacy services in the plan's network.]

Issue: Inaccurate statement when plans do not have any such pharmacies in their network.

Suggestion: Make the text variable so plans can remove when it isn't a true statement.

Response: The policy in Chapter 5 states that to the extent that I/T/U pharmacies are present in their service areas, sponsors must demonstrate their contracted pharmacy networks provide convenient access to I/T/U pharmacies. Suggest that this remains in the list of specialized pharmacies. This will remain in for CY 2018, may make variable for the next year. This section is discussing specialized pharmacies, and I/T/U is a type of specialized pharmacy so it makes sense to keep in here as one of the bullets. CMS will reconsider this for CY 2019.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 35: "You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy."

Issue: The language is inaccurate. The member will pay 100% of the out-of-network pharmacy's total cost. The member can get reimbursed for some of the expense. The member will pay the copay and may pay the difference between the plan's total cost of the drug and the nonplan pharmacy's total cost. Example: Member pays nonplan pharmacy \$150 (the pharmacy's total cost). The plan's total cost is \$120 and the member copay is \$20. The member liability is \$50, which is the \$20 copay and the \$30 difference in the nonplan and plan's total cost for the drug (\$150-\$120 = \$30).

Attachment B: Comments and Response to Federal Register Notice #1

The following is a suggested revision: In addition to paying your normal cost-sharing, you may be required to pay the difference between our plan's total cost for the drug versus the out-of-network pharmacy's total cost.

Response: CMS agrees with the current language in the ANOC and does not accept this suggested revision.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 36: The "deductible" is the amount you must pay for drugs before our plan begins to pay its share. Issue: The deductible is stated as a cost sharing option even when the plan doesn't include a deductible, which is confusing for beneficiaries and inconsistent with how deductibles are treated throughout the EOC (i.e., it is only added if applicable).

Suggestion: Make the text variable so plans can remove when it isn't a true statement.

Response: CMS rejects this suggestion. "Deductible" is part of a bulleted list of terms and definitions, which needs to be included.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 37: EOC, Chapter 6, Section 9: What you pay for vaccinations covered by Part D depends on how and where you get them.

Issue: The section is overly complicated and long. Much of the information in the vaccination section is not applicable or incorrect for some plans like ours.

Suggestion: Remove the language from the model and insert an instruction for plans to explain the rules associated with vaccines to accurately describe the plan's benefits and what members will pay when they obtain vaccines covered under Part D.

Response: For CY 2018, CMS will be leaving this section as is. CMS will look to amend this for CY 2019.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 38: EOC, Chapter 6, Sections 10 and 11.

These two sections provide additional details about the Part D late enrollment penalty and Part D IRMAA that can increase a member's plan premium. The plan suggests that a more logical location is the premium section, (Chapter 1, Section 4.1) under "In some situations, your plan premium could be more." It is preferable in this situation to have all plan premium information in one location so that members can find all the relevant information easily. Note: This subject is partially addressed in Chapter 1, Section 4.1, and the text should be integrated to avoid redundancy.

Suggestion: Move the two sections to Chapter 1, Section 4, so that members have all information about premiums in the premium section.

Response: CMS accepts this suggestion to move Part D late enrollment penalty and income information to the premium section in Chapter 1, Section 4.1.

CMS Action: CMS moved Chapter 6, Sections 10 and 11 to Chapter 1, Section 4.1 (applicable to all models except D-SNP, MSA, and MA). The previous Chapter 6, Section 10 (Do you have to pay the Part D “late enrollment penalty”?) is now Chapter 1, Section 5. The previous Chapter 6, Section 11 (Do you have to pay an extra Part D amount because of your income?) is now Chapter 1, Section 6.

Comment 39: If you ever lose your low income subsidy (“Extra Help”), you must maintain your Part D coverage or you could be subject to a late enrollment penalty if you ever chose to enroll in Part D in the future. This language appears seven times and the language is misleading because the late enrollment penalty could apply to the enrollee when they lose Extra Help if they have gone without creditable coverage in the past when they didn't have Extra Help.

Suggestion: Remove or revise text so text so it is clear that the penalty may apply when they lost Extra Help, and is not limited to the “future.” If you ever lose your low income subsidy (“Extra Help”), you would be subject to the late enrollment penalty if you have ever gone without creditable coverage for 63 days or more.

Response: CMS agrees with the suggestion to revise text related to “Extra Help.”

CMS Action: CMS updated EOC, Chapter 1 text (applicable to all models except MSA, MA, and PDP) to read as follows: [If you ever lose your low income subsidy \(“Extra Help”\), you would be subject to the monthly Part D late enrollment penalty if you have ever gone without creditable prescription drug coverage for 63 days or more.](#)

Comment 40: EOC, Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints).

Issue: The grievance and appeal section spans 50+ pages. The length of the section makes finding information difficult and increases the overall complexity of the EOC (and increases cost for plans to produce). The models are not the same in chapter 9 where they should be the same. When you compare this chapter between the different models, there are differences that aren't related to plan type differences.

Suggestion: Please consider simplifying the section so it is more succinct and hopefully reduced in size by 50-75%. Please compare the different model versions of Chapter 9 and revise the models as needed to align the chapter accordingly where the text should be the same.

Response: CMS appreciates the commenter’s suggestion on this chapter of the ANOC/EOC. After having a contractor note where the models differ and careful review of each model, we believe the current format of the chapter “What to do if you have a problem or complaint (coverage decision, appeals, complaints)” is the most appropriate for beneficiaries to locate the applicable information based on their situation, and simplifying the Chapter by 50-75% would make locating pertinent information more difficult. Because this Chapter covers a complex variety of situations, to remain consistent, we provide similar information throughout to reduce confusion for the beneficiary and minimize the need to reference certain details elsewhere in the Chapter. In regards to this chapter differing among the various models, we feel the changes are necessary and appropriate based on the plan type each model is referring to.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 41: Given the length and complexity of these documents, we believe it is critically important for CMS to explore ways to improve the structure and readability of these documents. To that end, we recommend that CMS engage in discussions with plans and other key stakeholders to identify future improvements, potentially including eliminating redundancies and simplifying language, that would improve clarity and more effectively convey coverage information.

Response: CMS has determined that the format and/or structure will remain.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 42: Four overall strategies were recommended to improve model templates for members: 1) lower reading level, 2) use simpler terms (with a list including using Doctor instead of Provider), 3) avoid duplication, and 4) stay focused on each document's main purpose.

Use simpler terms: This commenter conducted proprietary research with more than 1,600 members, including nearly 700 Medicare members, and found that Medicare members preferred these simpler insurance terms:

Instead of Provider, use Doctor.

Instead of Network, use Doctors in your plan

Instead of Coinsurance, use Your percentage of the costs

Instead of Grievance, use Complaint

Instead of Formulary, use Medication list

Instead of Preauthorization, use Preapproval

Response: CMS has determined that the format and/or structure will remain. The terms are in accordance with the terminology used on Medicare.gov.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 43: The formatting and style sheets provided in the model documents can be difficult. Cleaner documents would be very helpful.

Response: CMS has determined that the format and/or structure will remain.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 44: We applaud CMS's approach this year to the Summary of Benefits. It has made creating accurate SBs much easier. We are asking if a similar approach could be developed for the ANOC and EOC.

Response: CMS has determined that the format and/or structure will remain.

CMS Action: CMS will keep the current text in the ANOC/EOC model.

Comment 45: Improving Medicare Markets Initiative (IMMI) and the National Council on Aging (NCOA) submitted a suggested revised version of the PDP ANOC model to CMS. The objective was to create a clearer, shorter, more consumer-friendly, and helpful document to those who choose to shop their coverage during the Annual Election Period. The following summarizes IMMI's suggested edits throughout the proposed PDP ANOC model: condensing text and benefit information into a lengthy "Summary of Changes" table, streamlining and shortening text where possible, reorganizing text so beneficiaries read the most crucial information first, creating a personalized cover letter, and creating a checklist that beneficiaries should use to understand the key elements that should be considered when reviewing changes to their plan. IMMI's proposed "What to do now" checklist (would replace the previously used list entitled "Important Things to Do") to the front page of the ANOC.

Rationale: IMMI's objective was to create a PDP ANOC model that improved formatting and readability, prioritized important information first, and increased personalized nature in order to help beneficiaries understand the key elements that should be considered when reviewing changes to their plan.

Response: CMS is largely keeping the existing PDP ANOC model language as many of the suggested edits will cause the document to be lengthier than it is currently due to 508 Compliance standards. CMS agrees with the suggestion to revise the "Important Things to Do" checklist by creating the "What to do Now" checklist and will update as appropriate. The "What to do Now" checklist will be incorporated in all nine ANOC models.

CMS Action: CMS revised the "Important Things to Do" checklist and replaced it with the "What to do Now" checklist, language and format, as appropriate, in all nine ANOC models.

Comment 46: Remove "Provider institutional affiliation" as a data requirement, as requested in Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. As an alternate, add a note to the top of the "Hospital" Section in the model to say "Be sure to work with your doctor to schedule hospital care. Before you visit, check if the hospital is listed below, or call us. This will ensure your care is covered."

Response: Not relevant to the ANOC/EOC model documents.

CMS Action: No action being taken at this time.