46 Comments & Responses to Federal Register Notice #1 (60-day)

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 changed the copay language for dispensing for brand drugs and wants to keep it the same until 2020 when it is a fixed amount.

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.

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, <u>if you cannot use a network provider</u> during a disaster, your plan will allow you to obtain care from out-of-network providers ….

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

<u>CMS Action</u>: 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.

<u>Comment 23</u>: 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).

<u>Response</u>: 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.

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

<u>Comment 24</u>: 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."

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

<u>CMS Action</u>: 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).

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.

33 Comments & Responses to Federal Register Notice #2 (30-day)

Comment 1: These sections (EOC: Medical Benefits Chart and Definitions: Grievance and Organization Determination) continue to require language that would indicate the plan has network providers. For clarity and to ensure consistency, we recommend that CMS review these sections and update them to include language and instructions for plans with no network.

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

CMS Action: CMS updated the EOC (applicable to all models except PDP) and removed the red text below from the following locations:

Benefits Chart: Getting your non-hospice care through our network providers will lower your share of the costs for the services.

Grievance definition: or one of our network providers

Organization Determination definition: The Medicare Advantage plan's network provider or facility has also made an organization determination when it provides you with an item or service, or refers you to an out-of-network provider for an item of service.

Comment 2: The cover page of each model EOC states "[*Remove terms as needed to reflect plan benefits]* Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2018."

Rationale: We understand this sentence is intended to caution that the benefits and other information in the EOC apply in calendar year 2018 and may change in 2019. Therefore, we believe the date referenced in the sentence above may be an error and recommend that CMS review these sections and revise to "January 1, 2019."

Response: CMS agrees with the suggestion to update the year.

CMS Action: In all ANOC models, CMS changed 2018 to 2019 in the following text (red text is new):

[Remove terms as needed to reflect plan benefits] Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, ~~2018~~ 2019.

Comment 3: We appreciate the addition of Section 4 to the ANOC titled "Changes to your Medicaid Benefits." Include a section in the ANOC that highlights changes to a member's Medicaid benefits as well as their Medicare.

Rationale: D-SNPs integrate both Medicare and Medicaid.

Response: CMS rejects the suggestion and will take this into consideration for calendar year (CY) 2019.

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

<u>Comment 4</u>: Additional language allowing the option to include examples of Medicaid specific providers was added to Chapter 1, Section 3.2 on page 11 to the EOC titled "What are 'network providers'?." Again, as mentioned in the comment above, integration of both Medicare and Medicaid is the goal of our D-SNPs.

Rationale: Giving health plans the option to add Medicaid specific provider examples to further demonstrate how SNBC combines both Medicare and Medicaid benefits is deemed as an appropriate change.

<u>Response</u>: CMS agrees with the suggestion and updated the text.

<u>CMS Action</u>: CMS updated the EOC and added the red text (only applicable to the D-SNP model) to the sentence below to read as follows:

Network providers are the doctors and other health care professionals, medical groups, [*insert if applicable*: durable medical equipment suppliers,] hospitals, [*insert other applicable provider types, including Medicare-specific and Medicaid-specific provider types,]* and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full.

<u>Comment 5</u>: Additional language has been added to Chapter 4, Section 2.1 of the EOC clarifying that health plans may address Medicaid cost-sharing and benefits as well as Medicare cost-sharing and benefits. Similar to the comments above, as this ANOC/EOC is for D-SNPs who cover both Medicare and Medicaid benefits, it would make sense for health plans to have the option to include this information in the EOC.

<u>Response</u>: CMS is concerned about the burden of this proposal and rejects this suggestion.

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

<u>Comment 6</u>: Our general understanding is that the significant majority of D-SNPs only enroll full benefit dual eligibles and, in some cases, also accept QMB-onlys. Although we have not undertaken a review of enrollment restrictions of all D-SNPs, we believe that very few also enroll SLMB-onlys, and QI-onlys, and fewer still have any QDWI-onlys as members. We therefore urge that, when considering modifications to the ANOC and the EOC, CMS design the documents –and particularly the ANOC-- around full benefit duals and QMBs, and then, as necessary, permit modification for any plans that, in fact, enroll other partial duals.

Rationale: Using this approach as a starting point could significantly simplify both documents.

<u>Response</u>: CMS rejects the suggestion and will take this into consideration for CY 2019.

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

<u>Comment 7</u>: Provide an ANOC that is specific to the individual as it relates to costs and cost sharing.

<u>Response</u>: CMS will take the comment under advisement, but is concerned about the burden of this proposal and rejects this suggestion.

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

Comment 8: In ANOC Section 2.1, we question the need for the three bullets. The Low Income Subsidy (LIS) extends all year except for changes in marital status or death of a spouse and, even with death of a spouse, the survivor has a grace period. The bullets are confusing and not very helpful.

Rationale: The bullets are not relevant to the purpose of the ANOC, which is highlighting changes in plan coverage.

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

CMS Action: CMS updated the ANOC (applicable to all models except MSA, HMO MA and PPO MA) to remove the three bulleted items below:

- Your monthly plan premium will be *more* if you are required to pay a monthly Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- 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 coverage for 63 days or more. If you have a higher income as reported on your last tax return ($*[insert amount]* or more), you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- *[Sponsors may remove this bullet if ALL members in a plan qualify such that the bullet would not apply to any individuals in the plan.]* Your monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs.

Comment 9: In ANOC Section 2.6, since every member of the D-SNP (except in the rare case where a plan has QDWI members) is either a full or partial dual eligible and thus qualifies for LIS, we urge changing all statements that talk about "if you get Extra Help". The statements should be more direct: "Because you receive Extra Help . . ." (the statement could be modified if the plan enrolls QDWIs.) Further, because all plan members receive the LIS, it also is confusing to include all the complexity of deductibles, coverage gap and the rest.

Rationale: While we recognize that there may be value in making all ANOCs similar across plan types, we believe that a more compelling consideration is clarity and brevity, particularly in the ANOC. If, however, CMS is committed to an apples-to-apples comparison of D-SNPs to other MA-PD plans, then we ask, at a minimum, that the agency limit that comparison to the EOC. The ANOC needs to be as simple as possible and only contain information that is directly relevant to members of the particular plan type.

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

CMS Action: CMS updated Section 2 of the ANOC (applicable to all models except the MSA, HMO MA and PPO MA) and revised the language below (red text is new):

Because ~~If~~ you receive ~~get~~ "Extra Help" and [*if plan sends LIS Rider with ANOC, insert:* didn't receive this insert with this packet,] [*if plan sends LIS Rider separately from the ANOC, insert: haven't received this insert by [insert date]*,] please call Member Services and ask for the "LIS Rider."

Comment 10: In ANOC Section 2.6, since every member of the D-SNP (except in the rare case where a plan has QDWI members) is either a full or partial dual eligible and thus qualifies for LIS, we urge changing all statements that say you "may" have different payments.

Rationale: While we recognize that there may be value in making all ANOCs similar across plan types, we believe that a more compelling consideration is clarity and brevity, particularly in the ANOC. If, however, CMS is committed to an apples-to-apples comparison of D-SNPs to other MA-PD plans, then we ask, at a minimum, that the agency limit that comparison to the EOC. The ANOC needs to be as simple as possible and only contain information that is directly relevant to members of the particular plan type.

Response: CMS rejects the suggestion and will take this into consideration for CY 2019.

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

Comment 11: In ANOC Section 5.2, unless the D-SNP enrolls SLMB-only, QI-only or QDWI-only members, we urge dropping any reference in Step 1 to joining a Medicare supplement (Medigap) policy.

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

CMS Action: CMS updated the ANOC (applicable to all models except the PDP) and removed the red text below:

Your new coverage will begin on the first day of the following month. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.. and whether to buy a Medicare supplement (Medigap) policy.

Comment 12: In EOC Section 6, change the heading to "No Deadline for Changing Plans."

Response: CMS rejects the suggestion and will take this into consideration for CY 2019.

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

Comment 13: In ANOC Section 8, the first bullet should be written to recognize that everyone receiving the ANOC already receives Extra Help (unless QDWIs are enrolled). We suggest the following rewrite: "'Extra Help' from Medicare. You are already enrolled in 'Extra Help,' also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty."

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

CMS Action: In all ANOC models, CMS updated the language and rewrote the following bullet, adding the red text below:

• *[Plans with Qualified Working and Disabled Individual (QDWI) members should modify this section as needed.]* **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in 'Extra

Help,' also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. ~~People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify~~ If you have questions about Extra Help, call:

Comment 14: In ANOC Section 7, we question whether referring consumers to their state Medicaid Office for LIS applications is appropriate.

Rationale: Our expectation is that many state Medicaid Offices would simply refer individuals over to SSA.

Response: CMS believes that contacting the State Medicaid Office may be of value to enrollees and rejects this suggestion.

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

Comment 15: In ANOC Section 9.3, if the individual is enrolled in a Medicaid managed care plan, we recommend also including the plan name and contact information.

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

CMS Action: CMS updated the text in the D-SNP ANOC to read as follows (red text is new):

[Plans may edit this section to use the state-specific name for the Medicaid program or the Medicaid managed care plan.]

To get information from *[*Medicaid OR your Medicaid managed care plan*]* you can call *[insert state-specific Medicaid agency OR Medicaid managed care plan name]* at *[insert Medicaid OR Medicaid managed care plan contact information]*. TTY users should call *[insert Medicaid OR Medicaid managed care TTY number]*.

~~To get information from Medicaid, you can call *[insert state-specific Medicaid agency]* at *[insert Medicaid contact information]*. TTY users should call *[insert Medicaid TTY number]*.~~

Comment 16: EOC, Chapter 1, Section 3.1. We suggest recommending that the beneficiary also always show the provider the individual's Medicaid card.

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

CMS Action: CMS updated the text in Chapter 1 of the EOC (applicable to all models) to read as follows (red text is new):

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card.

Comment 17: EOC, Chapter 1, Section 4.1. The sentence telling members that they must continue to pay Part B premiums unless it is paid by Medicaid should only be used if the plan enrolls QDWI members.

Response: CMS rejects the suggestion for CY 2018, but notes it will be incorporated in CY 2019.

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

Comment 18: EOC, Chapter 1, Section 5.1. The last paragraph of this section states that CMS will send a letter annually listing other medical or drug insurance. It would be helpful to identify the month in which the beneficiary can expect the letter.

Response: CMS rejects this suggestion, noting enrollments can occur at different times. Therefore, CMS cannot uniformly specify the month a beneficiary will receive this document.

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

Comment 19: EOC, Chapter 2. We note throughout that, except for Medicare complaints, there is no place for email addresses and no reference to secure portals where information may be sent.

Rationale: Since email is becoming an increasingly important means of communication in health care, we ask that CMS consider incorporating email addresses into the template.

Response: CMS rejects the suggestion and will take this into consideration for CY 2019.

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

Comment 20: Edit sentence in EOC, Chapter 2, Section 5 to read: U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare.

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

CMS Action: CMS updated the text in Chapter 2 of the EOC (applicable to all models) to read as follows (red text is new):

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare.

Comment 21: EOC, Chapter 3, Section 2.1. For plans that use sub-networks, we suggest requiring plans to add language explaining that changing PCP may mean that the member will also need to change other providers. We note that this is referenced in Section 2.3 but believe at least a cross-reference here would be helpful.

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

CMS Action: CMS updated the text in Chapter 3 of the EOC (applicable to all models except the PFFS, MSA, and PDP) to read as follows (red text is new):

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP. *[Explain if the member changes their PCP this may result in being limited to specific specialists or hospitals to which that PCP refers (i.e., sub-network, referral circles). Also noted in Section 2.3 below.]*

Comment 22: For all MA-PDs, we continue to urge CMS to provide an ANOC that is specific to the individual. This is particularly important for dual eligible and QMB members whose rights and payment responsibilities are significantly different from those of other plan members.

Response: CMS rejects the suggestion and will take this into consideration for CY 2019.

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

Comment 23: For all MA-PDs, we continue to urge CMS to provide an ANOC that is specific to the individual. This is particularly important for dual eligible and QMB members whose rights and payment responsibilities are significantly different from those of other plan members. Thus, for example, Section 1 should tell a member who is eligible for LIS that the individual can change plans at any time.

Response: CMS agrees with the suggestion to add information about Low Income Subsidies and updated the text.

CMS Action: In all ANOC models, CMS updated the text in Section 1 to read as follows (red text is new):

If you do nothing to change your Medicare coverage in 2017, we will automatically enroll you in our *[insert 2018 plan name]*. This means starting January 1, 2018, you will be getting your medical and prescription drug coverage through *[insert 2018 plan name]*. If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare and get your prescription drug coverage through a Prescription Drug Plan. If you are eligible for Low Income Subsidies, you can change plans at any time.

Comment 24: For all MA-PDs, we continue to urge CMS to provide an ANOC that is specific to the individual. This is particularly important for dual eligible and QMB members whose rights and payment responsibilities are significantly different from those of other plan members. Thus, for example, Sections 2.1 and 2.2 should tell Medicaid and QMB beneficiaries that they are not responsible for deductibles and co-payments.

Response: CMS agrees to add text clarifying cost sharing assistance means assistance with payment of deductibles and copays.

CMS Action: CMS updated the text in the below section of the D-SNP ANOC to read as follows (red text is new):

[Plans that include both members who pay Parts A and B service cost sharing and members who do not pay Parts A and B service cost sharing insert: If you are eligible for ~~Medicare~~ Medicaid assistance with Part A and Part B copays [*insert if plan has a deductible*: and deductibles] ~~cost-sharing assistance under Medicaid,~~ you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.]

Comment 25: For all MA-PDs, we continue to urge CMS to provide an ANOC that is specific to the individual. This is particularly important for dual eligible and QMB members whose rights and payment responsibilities are significantly different from those of other plan members. Thus, for example, Section 2.6, instead of merely referring to the LIS Rider, should explain drug costs right in the ANOC and should indicate the actual premium that the LIS individual must pay.

Response: CMS rejects the suggestion, but will incorporate this in CY 2019.

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

Comment 26: EOC, Chapter 4, Section 1.1. We suggest revising the references to Medicaid and Medicare Savings Programs. We suggest: "Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider. If you think that you are being asked to pay improperly, contact Member Services at XXX)." References to SLMB, QI and QDWI should be dropped since these programs only cover Medicare premiums, not out-of-pocket costs.

Rationale: We think the emphasis should be reversed, focusing more forcefully on the billing protection.

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

CMS Action: CMS updated the text in Chapter 4 of the EOC (applicable to all models except the D-SNP, MSA and PDP) to read as follows (red text is new):

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider. If you think that you are being asked to pay improperly, contact Member Services. ~~Some people qualify for State Medicaid programs to help them pay their out-of-pocket costs for Medicare. (These "Medicare Savings Programs" include the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled & Working Individuals (QDWI) programs.) If you are enrolled in one of these programs, you may still have to pay a copayment for the service, depending on the rules in your state.~~

Comment 27: EOC, Chapter 4, Section 1.6. This section discusses protections from billing above plan-approved amounts but does not address improper billing of QMBs and dual eligibles. We urge CMS to add a reference here to additional billing protections for individuals who receive cost-sharing from Medicaid.

Rationale: We think it is particularly important to add the reference here since many dual eligibles are accustomed to using the term "balance billing" to describe their protection against co-insurance charges.

Response: CMS rejects the suggestion and will take this into consideration for CY 2019.

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

Comment 28: The plan commented in August 2016 that when there are no changes to ANOC Sections 2.1, 2.2 and 2.6, it would be helpful to readers if plans could simply state there are no changes to premiums, MOOP, networks, and drug coverage. In response to the plan's comment, a new instruction has been added to Section 2.1 (premiums) that allows plans to state if there are no premium changes. For consistency and to avoid member confusion, the plan suggests adding the same instruction to Sections 2.2 and 2.6.

Response: CMS rejects the suggestion, but will incorporate this in CY 2019.

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

Comment 29: The plan provided a comment in August 2016 regarding the 2017 EOC copy "Certain screenings and preventive services" because the phrase is too general and potentially confusing to members. The plan is requesting clarification about the proposed new copy. Please advise if all preventive care cost sharing is supposed to be represented in this section considering that not all preventive care is provided without cost sharing (e.g., EKG following Welcome visits). Alternatively, to simplify the chart and for consistency, remove the item altogether from this section because it is inconsistent to list preventive care in this section but not any other similar sections where preventive care also applies (e.g., outpatient lab services).

Response: CMS agrees with the suggestion to remove the reference to preventative screenings and services listed throughout the chart.

CMS Action: CMS removed the below bullet in the Outpatient hospital services section of the Medical Benefits Chart (applicable to all models except the PDP):

- Preventive screenings and services listed throughout this chart

Comment 30: EOC, Medical Benefits Chart. The proposed language states a plan will "pay for" one glaucoma screening. However, this implies the plan pays 100% when the member may pay a portion (copay). The plan suggests changing the language from "pay for" to "cover." The sentence would read: "The plan will cover one glaucoma screening each year."

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

CMS Action: CMS updated the text in the Vision care section of the Medical Benefits Chart to read as follows (red text is new):

• For people who are at high risk of glaucoma, we will cover ~~pay for~~ one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older.

Comment 31: The bullets below were removed from the EOC, but may need to be added back in.

• If your drug is in [insert name of non-preferred/highest cost-sharing tier subject to the tiering exceptions process] you can ask us to cover it at the cost-sharing amount that applies to drugs in [insert name of preferred/lowest cost-sharing tier subject to the tiering exceptions process]. This would lower your share of the cost for the drug.

• [Plans with more than one tier subject to the tiering exceptions process may repeat the bullet above for each tier.]

Rationale: The deletion of the above assumes that the policy clarification to tiering exceptions suggested in the draft Call Letter (page 136) becomes the final rule. If the tiering exception guidance does not become the final rule, please reinstate the language above in Chapter 9, Section 6.2.

Response: CMS rejects the suggestion and will take this into consideration for CY 2019.

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

Comment 32: “That” has been added to the sentence below, which makes the sentence confusing (i.e., the construction of the sentence now reads: You must continue to pay coverage limitations that may apply). Please revise the sentence accordingly. The plan suggests removing “that.”

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

CMS Action: CMS updated the text in Chapter 9 of the EOC (applicable to all models except the PDP) to read as follows:

• You must continue to pay your share of the costs and coverage limitations ~~that~~ may apply.

Comment 33: The EOC uses the term “member,” which is defined in Chapter 12 as “a person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).” But, in some instances the term “enrollee” is used. Please change the few references in the EOC from “enrollee” to “member” for consistency.

Response: CMS agrees with the suggestion to use the term “member” for consistency.

CMS Action: CMS changed references (applicable to all models) from “enrollee(s)” to “member(s)” throughout the ANOC/EOC.