## Attachment C: 48 Comments & Responses to Federal Register Notice #1 (60-day)

**Comment 1**: The plan recommends allowing plans to discuss government programs that can assist with Part B premiums, such as MyAdvocate.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 2**: The plan recommends allowing plans to describe all methods for contacting members regarding coordination of benefit information (including using multiple methods).

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 3**: In the EOC, Chapter 1, Section 2, allow plans to include optional Behavioral Health and 24/7 Nurse Line contact information.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 4**: Medical Benefits Chart - Medicare Part B prescription drugs

The "Immunizations" benefit category of the benefits chart includes model language that reads "We also cover some vaccines under our Part D prescription drug benefit." We suggest allowing plans to include similar language under the Medicare Part B prescription drugs benefit category.

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

CMS Action: CMS updated the EOC text in the HMO MAPD, PPO MAPD, D-SNP and PFFS models, in the "Medicare Part B prescription drugs" section of the Medical Benefits Chart, to read as follows (red text is new): "We also cover some vaccines under our Part B and Part D prescription drug benefit."

CMS updated the EOC text in the HMO MA and PPO MA models, in the "Medicare Part B prescription drugs" section of the Medical Benefits Chart, to read as follows (red text is new): "We also cover some vaccines under our Part B prescription drug benefit."

**Comment 5**: In the HMO MAPD ISNP CSNP EOC, Chapter 9, Section 8.2, under the Legal Terms, the correct section reference is 8.3, not 7.3.

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

CMS Action: CMS updated the EOC text in HMO MAPD ISNP CSNP model to read as follows (red text is new): "(Section 8.3 below tells how you can request a fast-track appeal.)"

**Comment 6**: In the ANOC, Section 4.2, allow plans to include optional language/instructions for members regarding how and when to enroll and disenroll in optional supplemental benefits.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 7**: In the MA HMO ANOC document, under Section 4.2, CMS references a search function on CMS' website labeled "Review and Compare Your Coverage Options." However, this search function is no longer available. CMS should revise this section of the ANOC to reference the updated title for this search function, "Find health & drug plans."

Response: CMS rejects this suggestion, but additional changes were made to address the comment.

CMS Action: CMS revised the language in all ANOC models to read as follows (red text is new): Go to ~~https://~~www.medicare.gov/plan-compare. ~~and click "Find health & drug plans."~~

**Comment 8**: Recommend that CMS include language in the ANOC introduction, under the Summary of Important Costs section, that makes it clear to the beneficiary that the summary included in this section of the ANOC highlights some but not all the benefit changes. Language should be included in this section that encourages beneficiaries to review the entire ANOC document to learn about all the benefit changes the plan is making for the next year.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 9**: Terminologies Provider Directory & Pharmacy Directory need to be kept as a variable data field (in carets or brackets) in model documents because they're modifiable term per CMS model instruction, page 2: "References to Member Services, the Pharmacy Directory, the Provider Directory, …..may be changed to the term used by the MAO, PDP, or Cost Plan."

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 10**: In the HMO MA ANOC model, Section 4.2, Step 1, 4th paragraph, that begins with "You can also find information…": this paragraph references the option for members to access the provided website https://www.medicare.gov and click on "Review and Compare Your Coverage Options" but this option doesn't exist or it's not visible on the webpage.

Response: CMS rejects this suggestion, but additional changes were made to address the comment.

CMS Action: CMS revised the language in all ANOC models to read as follows (red text is new): Go to ~~https://~~www.medicare.gov/plan-compare. ~~and click "Find health & drug plans."~~

**Comment 11**: In ANOC models, under Additional Resources, [insert phone number] is vague and inconsistent. Should be changed to [insert member services phone number] as it is labeled in section 8.1

Response: CMS agrees with this change.

CMS Action: CMS has updated the language in all ANOC models to read as follows (red text is new): "Please contact our Member Services number at *[insert member services phone number]* for additional information."

**Comment 12**: In PPO MAPD and PPO MA models, Chapter 4, Section 2.1, change PPO deductible list instructions to allow plans to enter either what applies to the deductible or what doesn't apply to the deductible (like is instructed in the DSNP models).

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 13**: In all EOC models, Chapter 1, Section 5 and 7, the plan recommends that the IRMAA info and the LEP example payments are removed from the EOCs. This is standard Medicare info, so it's easily accessible on cms.gov. If it needs to stay in the EOCs, the plan would like to be able to use the prior year's information so that these data points do not delay the EOCs.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 14**: In all EOC models, plans are permitted to use "our plan" instead of [insert 2021 plan name]. The plan requests that the model be updated to remove [insert 2021 plan name] and replaced with "our plan" throughout.

Response: CMS rejects the suggestion to permit plans to use “our plan” throughout the model instead of *[insert 2021 plan name]*, as this is already explained in the introduction. CMS will consider for CY2022.

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

**Comment 15**: In all ANOC models, Section 2.6, the plan recommends that CMS allow more flexibility to the plan within this section to include more specific changes being made to coverage in the Coverage Gap. For example, current allowable model language is not ideal or clear for a beneficiary if a plan is making a change from having no additional coverage in the gap to including additional coverage in the gap.

Response: CMS rejects the suggestion at this time and will retain the current language. CMS will consider for CY2022.

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

**Comment 16**: Medical Benefits Chart - Opioid Treatment Program Services

The plan recommends CMS clarify this benefit and split out Opioid Use Disorder (OUD) treatment services provided by a Medicare OTP versus OUD treatment services not furnished by an OTP.

Neither the PBP nor EOC have a separate benefit category for OUD treatment services not furnished by an OTP. Since individual and group psychotherapy services in the office setting for an OUD diagnosis would now be billed under specific codes that are billed monthly rather than per visit, any applicable cost sharing would not be applied per visit as it would be when previously billed under the outpatient substance abuse benefit category. The plan believes it would make sense for both the PBP and EOCs be updated to accurately reflect a benefit category for OUD treatment services not furnished by an OTP.

CMS should also clarify that the cost sharing (if any) would be weekly for OUD treatment services furnished by an OTP and monthly for OUD treatment services not furnished by an OTP. Current language does not make this clear to plan beneficiaries.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 17**: Medical Benefits Chart - Outpatient substance abuse services

The plan recommends CMS add model language clarifying that this benefit is separate from the OUD treatment services provided by an OTP and OUD treatment services not furnished by an OTP.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 18**: Medical Benefits Chart - Physician/Practitioner services, including doctor's office visits

Additional Telehealth Services – The plan recommends CMS require a more general description of covered additional telehealth benefits. In addition, the plan recommends CMS remove the requirement to list the specific Part B services that the plan has identified as being clinically appropriate. Plan sponsors could then detail in a medical coverage policy the information on clinically appropriate services furnished via an electronic exchange that are covered by the plan. Based on the plan's experience, clinical appropriateness of telehealth services for a beneficiary should happen with the provider, and too much information in the EOC can be confusing for some beneficiaries and caregivers.

In addition, CMS should allow plan sponsors flexibility to revise the below paragraph if plan benefits include out-of-network coverage of additional telehealth services as mandatory supplemental benefits. The language as written is very confusing and misleading to members who are able to receive these services out-of-network. You have the option of receiving these services either through an in-person visit or via telehealth. If you choose to receive one of these services via telehealth, then you must use a network provider that currently offers the service via telehealth.

Most beneficiaries likely do not understand the difference between the Original Medicare telehealth benefit language and the additional telehealth language in this section. The plan recommends CMS allow plan sponsors flexibility to revise the Original Medicare telehealth language as needed if the plan includes overlapping additional telehealth coverage.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 19**: Medical Benefits Chart - Physician/Practitioner services, including doctor's office visits

CMS should revise the benefit language for the below services because it is confusing for beneficiaries. It appears CMS basically took the HCPC description which is not necessarily easily understandable for the layperson.

- o Brief virtual check-in
- o Remote evaluation of pre-recorded video and/or images sent to your doctor

The plan recommends CMS remove language referencing allowable timeframes for the visits because health care providers are responsible for making sure appropriate medical practices and coding guidelines are followed.

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

CMS Action: CMS updated the EOC text in the HMO MAPD, PPO MAPD, D-SNP, PFFS HMO MA, and PPO MA models, in the "Physician/Practitioner services, including doctor's office visits" section of the Medical Benefits Chart, to read as follows (red text is new):

- Brief virtual check-ins~~(for example, via telephone or video chat) 5-10 minute check-ins with your doctor—if you are an established patient and the virtual check-in is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment~~
- Remote evaluation of pre-recorded video and/or images ~~you~~ sen~~t~~d to your doctor~~,~~ ~~including your doctor's interpretation and follow-up within 24 hours—if you are an established patient and the remote evaluation is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment~~

**Comment 20**: In EOC models, Chapter 6, recommends that CMS add model language within this chapter explaining the coverage and process for self-administered drugs (SADs) received in a hospital outpatient setting. The SADs process is confusing and a dissatisfier to beneficiaries and it would be at least a little helpful to address in EOCs, similar to information that is included for vaccines. In addition, CMS should allow flexibility for plan sponsors to include language regarding specific plan processes related to SADs.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 21**: Cost Plan Only - Medical Benefits Chart - Opioid Treatment Program Services

The plan recommends CMS clarify this benefit and split out Opioid Use Disorder (OUD) treatment services provided by a Medicare OTP versus OUD treatment services not furnished by an OTP.

Neither the PBP nor EOC have a separate benefit category for OUD treatment services not furnished by an OTP. Since individual and group psychotherapy services in the office setting for an OUD diagnosis would now be billed under specific codes that are billed monthly rather than per visit, any applicable cost sharing would not be applied per visit as it would be when previously billed under the outpatient substance abuse benefit category. Commenter believes it would make sense for both the PBP and EOCs be updated to accurately reflect a benefit category for OUD treatment services not furnished by an OTP.

CMS should also clarify that the cost sharing (if any) would be weekly for OUD treatment services furnished by an OTP and monthly for OUD treatment services not furnished by an OTP. Current language does not make this clear to plan beneficiaries.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 22**: Cost Plan Only - Medical Benefits Chart - Outpatient substance abuse services

We recommend CMS add model language clarifying that this benefit is separate from the OUD treatment services provided by an OTP and OUD treatment services not furnished by an OTP.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 23**: Cost Plan Only - Medical Benefits Chart - Physician/Practitioner services, including doctor's office visits

CMS should revise the benefit language for the below services because it is confusing for beneficiaries. It appears CMS basically took the HCPC description which is not necessarily easily understandable for the layperson.

- o Brief virtual check-in
- o Remote evaluation of pre-recorded video and/or images sent to your doctor

We recommend CMS remove language referencing allowable timeframes for the visits because health care providers are responsible for making sure appropriate medical practices and coding guidelines are followed.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 24**: In the ANOC, What to do now Section, 3. Choose, Decide whether you want to change your plan, commenter recommends that CMS revise the second bullet to align with the first bullet in this section: If you decide to change plans, you can do so between October 15 and December 7.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 25**: In the ANOC, What to do now Section, 4. Enroll, To change plans, join a plan between October 15 and December 7, 2020, commenter recommends that CMS add information to this sentence clarifying that the member will be automatically disenrolled from the plan if they join another plan during open enrollment. Commenter recommends the following: "If you join another plan by December 7, 2020, your new coverage will start on January 1, 2021. You will be automatically disenrolled from your current plan."

Response: CMS accepts the plans addition of "You will be automatically disenrolled from your current plan."

CMS Action: CMS updated the text in all ANOC models to read as follows (red text is new): "If you join another plan by **December 7, 2020**, your new coverage will start on **January 1, 2021**. You will be automatically disenrolled from your current plan."

**Comment 26**: In the ANOC, Section 2.1, commenter recommends that CMS add additional language to this bullet directing members to Section 7 for more information on "Extra Help", as this is the first mention of this program in the ANOC document.

Your monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs. Please see Section 7 regarding "Extra Help" from Medicare.

Response: CMS accepts the plans addition of "Please see Section 7 regarding "Extra Help" from Medicare."

CMS Action: CMS updated the text in the ANOC HMO MAPD, PPO MAPD, Cost Plan, PFFS, and PDP models to read as follows (red text is new): "Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 7 regarding "Extra Help" from Medicare."

**Comment 27**: In the PPO MAPD ANOC, Section 2.1, commenter recommends that CMS update this section to include additional language indicating that prescription drugs do not count towards the Maximum Out-of-Pocket amount. Commenter proposes the following language:

Your costs for covered medical services (such as copays [insert if plan has a deductible: and deductibles]) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your [insert if plan has a premium: plan premium and] costs for prescription drugs do not count toward your maximum out-of-pocket amount.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 28**: In the ANOC, section 2.6, commenter recommends that CMS delete the word "we" from the following sentence to make the sentence clearer:

The Drug List ~~we~~ [insert: in this envelope] OR [insert: provided electronically] includes many – but not all – of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered.

Response: CMS accepts the plan's suggestions to remove "we" from the sentence.

CMS Action: CMS updated the text in all ANOC Part D models to read as follows: "The Drug List *[insert: in this envelope]* OR *[insert: provided electronically]* includes many – but not all – of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered."

**Comment 29**: In the ANOC, section 2.6, commenter recommends that CMS revise this sentence as follows to reduce member confusion:

For 2021, members in long term care (LTC) facilities will now receive the same ~~a~~ temporary supply that is ~~the same amount of temporary days supply~~ provided in all other cases: [insert supply limit (must be at least the number of days in the plan's one month)] ~~of medication rather than the amount provided in 2020~~ (in 2020 it was ~~(~~[insert 2020 LTC maximum supply limit] ~~of medication)~~.

Response: CMS rejects this suggestion, but additional changes were made to address the comment.

CMS Action: CMS revised the language to read as follows: *[Plans may omit this if all current members will be transitioned in advance for the following year.]* In some situations, we are required to cover a 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~~. *[Plans changing the LTC supply (for instance, from a minimum of 90 days to a month's supply, should insert the following:* For 2021, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: *[insert supply limit (must be at least the number of days in the plan's one month)]* of medication rather than the amount provided in 2020 (*[insert 2020 LTC maximum supply limit]* of medication).~~ (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the Evidence of Coverage.)

**Comment 30**: In the ANOC, section 2.6, commenter recommends that CMS simplify this sentence as follows:

"Changes to ~~Most of the changes in~~ the Drug List usually occur at ~~are new for~~ the beginning of each year. However, we may make changes during the year, ~~we might make other changes that~~ as long as they are allowed by Medicare rules."

Response: CMS rejects the plan's suggestion at this time, noting the need for consistency across models. CMS will consider for CY2022.

CMS Action: CMS will keep the current text in the ANOC.

**Comment 31**: In the ANOC, section 2.6, commenter recommends that CMS separate the following paragraph into two separate paragraphs:

[*Plan sponsors implementing for the first time in 2021 the option to immediately replace brand name drugs with their new generic equivalents, that otherwise meet the requirements, should insert the following:* Starting in 2021, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.]

Response: CMS accepts this suggestion to create two separate paragraphs.

CMS Action: CMS has revised the text in all ANOC Part D models as follows:

*[Plan sponsors implementing for the first time in 2021 the option to immediately replace brand name drugs with their new generic equivalents, that otherwise meet the requirements, should insert the following:* Starting in 2021, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.]

**Comment 32**: In the ANOC, section 2.6, commenter recommends that CMS delete directions on where to locate the Member Services phone number since directions for how to contact Member Services are not listed in any other section of the ANOC. Thus, delete the last sentence, "Phone numbers for Members Services are in Section [edit section number as needed] 8.1 of this booklet."

If you receive "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." ~~Phone numbers for Member Services are in Section [edit section number as needed] 8.1 of this booklet.~~

Response: CMS accepts the plan's suggestion to delete the last sentence of the paragraph.

CMS Action: CMS updated this section in all ANOC Part D models and removed the red text below to read as follows:

"If you receive "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." ~~Phone numbers for Member Services are in Section *[edit section number as needed]* 8.1 of this booklet~~"

**Comment 33**: In the ANOC, section 4.2, Step 2: Change your coverage, commenter recommends that CMS make the boldface font in this section consistent with other boldface bullets in this section.

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from *[insert 2021 plan name]*.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from *[insert 2021 plan name]*.
- To **change to Original Medicare without a prescription drug plan**, you must either:

Response: CMS accepts this suggestion to bold text for consistency.

CMS Action: CMS updated the text in all ANOC models to the following:

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from *[insert 2021 plan name]*.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from *[insert 2021 plan name]*.
- To **change to Original Medicare without a prescription drug plan**, you must either:

**Comment 34**: In the ANOC, section 8.1, commenter recommends that CMS direct members to the plan website before directing them to read their EOC. Commenter recommends the following:

Questions? We're here to help.

Call us at [insert member phone number] We are available [insert days and hours of operation]. TTY users can call [tty number]. [insert if applicable: Calls to these numbers are free.]

Visit [insert url] Our website has the most has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Read your 2021 Evidence of Coverage

This Annual Notice of Changes gives you a summary of your 2021 benefits and costs changes.

For details, look in the 2021 Evidence of Coverage for [insert 2021 plan name]. The Evidence of Coverage is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the Evidence of Coverage is located on our website at [insert URL]. [Insert as applicable: You can also review the attached OR enclosed OR separately mailed Evidence of Coverage to see if other benefit or cost changes affect you.] You may also call Member Services to ask us to mail you an Evidence of Coverage.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 35**: In the EOC, Chapter 1, Section 3.1, commenter recommends the following revisions to simplify readability:

Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan.

If you use your Medicare card instead of your [insert 2021 plan name] membership card, you may have to pay the full cost of medical services yourself.

Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in routine research studies.

Response: CMS accepts this suggestion.

CMS Action: CMS updated the EOC text in the HMO MAPD, PPO MAPD, D-SNP, PFFS, MSA, HMO MA, and PPO MA models, to read as follows (red text is new):

~~As long as you are a member of our plan, in most cases, you must not use your red, white, and blue Medicare card to get covered medical services (with the exception of routine clinical research studies and hospice services). You may be asked to show your Medicare card if you need hospital services. Keep your red, white, and blue Medicare card in a safe place in case you need it later.~~

Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your [insert 2021 plan name] membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in routine research studies.

**Comment 36**: In the EOC, Chapter 1, Section 7.1, commenter recommends that CMS update the following language to be consistent with the other paragraphs in this section and refer to either the premium or Part D late enrollment penalty (LEP) dollar amount values while continuing to include the generic IRMAA language in the EOC:

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. <Chapter 9, Section 10> of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your [plans with a premium insert: plan premium] [plans without a premium insert: Part D late enrollment penalty] within our grace period, you can ask us to reconsider this decision by calling [insert phone number] between [insert hours of operation]. TTY users should call [insert TTY number]. You must make your request no later than 60 days after the date your membership ends.

Response: CMS accepts this suggestion to include optional text.

CMS Action: CMS revised this language in all ANOC Part D models to read as follows (red text is new):

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 9, Section 10 of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your [*plans with a premium insert:* plan premium] [*plans without a premium insert:* Part D late enrollment penalty] within our grace period, you can ask us to reconsider this decision by calling *[insert phone number]* between *[insert hours of operation]*.

**Comment 37**: In the EOC, Chapter 1, Section 8.1, commenter recommends that CMS update references to “spouse” throughout the EOC to state “spouse or domestic partner”.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 38**: In the EOC, Chapter 2, Sections 3, 4, 6, 7, commenter strongly urges that CMS consider pre-populating State Health Insurance Assistance Program (SHIP)/Quality Improvement Organization (QIO)/Medicaid/State Pharmaceutical Assistance Programs (SPAPs)/AIDS Drug Assistance Programs (ADAPs) contact information in the EOC Model, and request that States notify CMS of any changes to this contact information. This approach would ensure that beneficiaries are receiving consistent information from MA plans and Part D sponsors. Commenter also recommends that CMS allow MA plans and Part D sponsors to update this information in their EOCs throughout the year, and publish them online, but not require that plans send errata sheets. The majority of our members access their EOCs online, where the information will be up-to-date, and if they contact our customer service department, the representative will be able to refer to the updated EOC. Until there is a central source of truth, there is no guarantee that the information plans publish in errata sheets will be accurate.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 39**: In the EOC, Chapter 3, Section 6.2, commenter recommends that CMS rename the section from "What Care From a Religious Non-Medical Health Care Institution is Covered by our Plan?" to "Receiving Care From a Religious Non-Medical Health Care Institution" as this section does not describe what actual care is provided by these institutions.

Response: CMS accepts this suggestion to rename the section.

CMS Action: CMS revised this section header (applicable to all EOC models except PDP) to read as follows (red text is new): "Receiving Care From a Religious Non-Medical Health Care Institution"

**Comment 40**: In the EOC, Chapter 4, Section 2.1, commenter recommends that CMS no longer require MA plans to describe which benefits require prior authorization in instances where it is the provider's responsibility to obtain prior authorization from the MA plan. Since beneficiaries are 'held harmless' in cases where the provider fails to obtain prior authorization (i.e., denial notices are not mailed to beneficiaries), the inclusion of provider prior authorization requirement language is confusing to beneficiaries and should not be described. We believe this requirement is better suited as a contractual obligation between the MA plan and provider, rather than information that must be presented in the EOC.

Response: CMS rejects the suggestion at this time but will consider this during future rulemaking. CMS will consider for CY2022.

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

**Comment 41**: In the EOC, Chapter 4, Section 2.1, commenter recommends that CMS delete the footnote for "Custodial Care" that appears at the end of the Exclusions Chart, and instead integrate this information into the existing Custodial Care line item of the Exclusions Chart.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 42**: In the EOC, Chapter 4, Section 2.1 and Medical Benefits Chart, commenter recommends that CMS create a new "Virtual Visits" section in the Chapter 4 Benefit Chart for telehealth-related benefits that are currently described in the Benefit Chart section “Physician/Practitioner services, including doctor’s office visits”. We have received beneficiary feedback indicating that the current placement is confusing and would be better suited as a separate plan benefit.

Response: CMS rejects the suggestion at this time but will look at amending for a future year. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 43**: In the EOC, Chapter 5, Section 3.1, commenter recommends that CMS add Lexi-Drugs to the list of reference books used to support a medically accepted indication.

Response: CMS accepts the plan’s addition of “Lexi-Drugs” to the list of reference books.

CMS Action: CMS updated the text in all EOC Part D models to read as follows (red text is new): (These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; Lexi-Drugs; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

**Comment 44**: In the EOC, Chapter 5, Section 4.2, commenter recommends that subheadings referencing drug restrictions are consistently described as “Getting plan approval in advance” for Prior Authorization, and “Trying different drug first” for Step Therapy to ensure that these subheadings align with the Quantity Limits subheading.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 45**: In the EOC, Chapter 9, commenter recommends that CMS center or left justify all legal terms that display in text boxes to help reduce beneficiary confusion.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.

**Comment 46**: In the EOC, Chapter 9, Section 4.2, commenter recommends that CMS structure all statements within a bulleted list using the same general format. As an example, commenter recommends that the bulleted list in Chapter 9, Section 4.2 be revised as follows:

- You can call us at Member Services (phone numbers are printed on the back cover of this booklet).
- You can get free help from your State Health Insurance Assistance Program (see Section 2 of this chapter).
- Your doctor can make a request for you.

Other examples of bulleted lists that should be revised include Chapter 6, Section 1.2 and Chapter 8, Sections 1.7 and 1.8.

Response: CMS accepts this suggestion to revise the bulleted lists referenced above.

CMS Action: CMS is changing the text according to the suggestion for Chapter 9, Section 4.2. CMS updated the EOC text in the HMO MAPD, PPO MAPD, D-SNP, PFFS, MSA, HMO MA, and PPO MA models, to read as follows (red text is new):

- You can call us at Member Services (phone numbers are printed on the back cover of this booklet).
- You can get free help from ~~To get free help from an independent organization that is not connected with our plan, contact~~ your State Health Insurance Assistance Program (see Section 2 of this chapter).
- Your doctor can make a request for you.

**Comment 47**: In the EOC, Chapter 9, Section 5.1 and 6.1, commenter recommends that CMS revise the language in the table subheadings as below. Commenter also recommends that language in the chart read as statements rather than questions.

| If ~~you are in this situation~~: | ~~This is what y~~You can ~~do~~: |
|---|---|
| | |

Response: CMS suggests leaving the heading as-is and revising the language in the chart to read as statements rather than questions.

CMS Action: CMS revised the language in all EOC models in the charts to read as follows (red text is new):

| **If you are in this situation:** | **This is what you can do:** |
|---|---|
| ~~Do you want t~~To find out whether we will cover the medical care ~~or services~~ you want.~~?~~ | You can ask us to make a coverage decision for you.<br>Go to the next section of this chapter, **Section 5.2**. |
| If ~~Have~~ we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for.~~?~~ | You can make an **appeal**. (This means you are asking us to reconsider.)<br>Skip ahead to **Section 5.3** of this chapter. |
| If ~~Do~~ you want to ask us to pay you back for medical care you have already received and paid for.~~?~~ | You can send us the bill.<br>Skip ahead to **Section 5.5** of this chapter. |

| **If you are in this situation:** | **This is what you can do:** |
|---|---|
| If ~~Do~~ you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover.~~?~~ | You can ask us to make an exception. (This is a type of coverage decision.)<br>Start with **Section 6.2** of this chapter. |
| If ~~Do~~ you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need.~~?~~ | You can ask us for a coverage decision.<br>Skip ahead to **Section 6.4** of this chapter. |
| If ~~Do~~ you want to ask us to pay you back for a drug you have already received and paid for.~~?~~ | You can ask us to pay you back. (This is a type of coverage decision.)<br>Skip ahead to **Section 6.4** of this chapter. |
| If ~~Have~~ we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for.~~?~~ | You can make an appeal. (This means you are asking us to reconsider.)<br>Skip ahead to **Section 6.5** of this chapter. |

**Comment 48**: In the EOC, Chapter 5, Section 5.1, commenter recommends that CMS revise all "formulary" references to "drug list (formulary)" to help reduce beneficiary confusion.

Response: CMS will take this into consideration. CMS will consider for CY2022.

CMS Action: No action being taken at this time.