

**CENTER FOR MEDICARE**

---

**DATE:** August 8, 2023

**TO:** Medicare Advantage Organizations, Prescription Drug Plans, and Section 1876 Cost Plans

**FROM:** Kathryn A. Coleman  
Director, Medicare Drug & Health Plan Contract Administration Group

Vanessa S. Duran  
Acting Director, Medicare Drug Benefit and C & D Data Group

**SUBJECT:** Model Notice Corrections

This memo provides corrections to the Contract Year (CY) 2024 Annual Notice of Change (ANOC), Evidence of Coverage (EOC), Part D Explanation of Benefits (EOB), and Low-Income Subsidy (LIS) Rider models.

The re-issued models reflect the following edits that are already incorporated:

- minor formatting
- grammatical corrections
- correct section references

CMS encourages Medicare Advantage Organizations and Prescription Drug Plan sponsors to reference the *2024 Annual Notice of Change and Evidence of Coverage Standardized Models Instructions*, for guidance on alterations, modifications or deletions of standardized language that are permissible when populating the models.

Questions regarding this memorandum may be directed to your CMS Account Manager.

Below is a summary of the substantive and required corrections and their location within the documents:

**1. ANOC model for DSNP**

**Summary of Issue:** Information regarding LIS level 4 was not removed to conform with 2024 Inflation Reduction Act (IRA) changes to LIS.

**Issue location:** Section 2.5, Changes to the Deductible Stage Chart

**Change Implemented:** Deleted the following plan instruction (*change noted in red text*):

## Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
<p><b>Stage 1: Yearly Deductible Stage</b>            During this stage, you pay the <b>full cost</b> of your <i>[insert as applicable: Part D OR brand name OR [tier name(s)]]</i> drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.</p> <p><i>[Plans with no deductible, omit text above.]</i></p>	<p>The deductible is \$<i>[insert 2023 deductible]</i>.</p> <p><i>[Plans with no deductible replace the text above with: Because we have no deductible, this payment stage does not apply to you.]</i></p> <p><i>[Plans with tiers excluded from the deductible in 2023 and/or 2024 insert the following]</i> During this stage, you pay <i>[insert cost-sharing amount that a member would pay in a tier(s) that is exempted from the deductible]</i> cost sharing for drugs on <i>[insert name of tier(s) excluded from the deductible]</i> and the full cost of drugs on <i>[insert name of tier(s) where copayments apply]</i> until you have reached the yearly deductible.</p> <p><i>[Plans enrolling members who are LIS level 4, replace text above with: Your deductible amount is either \$0 or \$[insert 2023 parameter], depending on the level of "Extra Help" you receive. [If not applicable, omit information about the LIS Rider.] (Look at the separate insert, the LIS Rider, for your deductible amount.)]</i></p>	<p>The deductible is \$<i>[insert 2024 deductible]</i>.</p> <p><i>[Plans with no deductible replace the text above with: Because we have no deductible, this payment stage does not apply to you.]</i></p> <p><i>[Plans with tiers excluded from the deductible in 2023 and/or 2024 insert the following:]</i> During this stage, you pay <i>[insert cost-sharing amount that a member would pay in a tier(s) that is exempted from the deductible]</i> cost sharing for drugs on <i>[insert name of tier(s) excluded from the deductible]</i> and the full cost of drugs on <i>[insert name of tier(s) where copayments apply]</i> until you have reached the yearly deductible.</p> <p><del><i>[Plans enrolling members who are LIS level 4, replace text above with: Your deductible amount is either \$0 or \$[insert 2024 parameter], depending on the level of "Extra Help" you receive. [If not applicable, omit information about the LIS Rider.] (Look at the separate insert, the LIS Rider, for your deductible amount.)]</i></del></p>

~~[Plans enrolling members who are LIS level 4, replace text above with: Your deductible amount is either \$0 or \$[insert 2024 parameter], depending on the level of “Extra Help” you receive. [If not applicable, omit information about the LIS Rider.] (Look at the separate insert, the LIS Rider, for your deductible amount.)]~~

## 2. ANOC model for HMO MAPD, PPO MAPD, DSNP, PFFS, Cost, and PDP

**Summary of Issue:** Cost-sharing changes were not included for plans that cover excluded drugs under an enhanced benefit with the same cost sharing as covered Part D drugs.

**Issue location:** HMO MAPD, PPO MAPD, DSNP, PFFS, and Cost (Section 2.5, Changes to the Coverage Gap and Catastrophic Coverage Stages); PDP (Section 2.3, Changes to the Coverage Gap and Catastrophic Coverage Stages)

**Change Implemented:** Add the following text as shown below (change noted in red text):

*[Plans that do not cover excluded drugs under an enhanced benefit, OR plans that do cover excluded drugs under an enhanced benefit but with the same cost sharing as covered Part D drugs in this stage, insert the following: **Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs [insert if applicable: and for excluded drugs that are covered under our enhanced benefit].]***

## 3. EOC model for MSA

**Summary of issue:** Urgently needed services section needs to be added to the Medical Benefits Chart in its entirety.

**Issue location:** Chapter 4, Medical Benefits Chart, Urgently Needed Services

**Change Implemented:** Added language and placed in alphabetical order in the Medical Benefits Chart.

<b>Urgently needed services</b>	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.
Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require, medically needed immediate services for an unforeseen condition, and it is not a medical emergency, or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. In these examples,	After you meet your deductible, you pay \$0 for Medicare-covered services.

your plan will cover the urgently needed services from a provider out-of-network.

*[Include in-network benefits. Also identify whether this coverage is within the U.S. or s a supplemental world-wide emergency/urgent coverage.]*

#### **4. EOC models for HMO MAPD, PPO MAPD, DSNP, Cost, MSA, PFFS, HMO MA, PPO MA**

**Summary of issue:** Partial hospitalization services needs to be updated to include Intensive outpatient services.

**Issue location:** Chapter 4, Medical Benefits Chart, Partial hospitalization services

**Change Implemented:** *Updated the language by adding to the Partial hospitalization services definition in Medical Benefits Chart (changes noted in red text).*

#### **Partial hospitalization services and Intensive outpatient services**

*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.*

*Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.*

#### **5. EOC models for HMO MAPD, PPO MAPD, DSNP, Cost, PFFS, HMO MA, PPO MA**

**Summary of issue:** The plan instruction in the Dental services section of the Medical Benefits Chart needs to be updated.

**Issue location:** Chapter 4, Medical Benefits Chart, Dental services

**Change Implemented:** *Updated language below modifying the Medical Benefits Chart (changes noted in red text).*

*[Include row if applicable. If plan offers dental benefits as optional supplemental benefits, they should not be included in the chart. Plans may describe them in Section 2.2 instead.]*

## 6. EOC models for HMO MAPD, PPO MAPD, DSNP, Cost, PFFS, MSA, HMO MA, PPO MA

**Summary of issue:** Colorectal cancer screening needs to be updated in two places.

**Issue location:** Chapter 4, Medical Benefits Chart, Colorectal cancer screening

**Change Implemented:** Updated the language in two places below (*changes noted in red text*):

- **Services that are covered for you** column, add as final bullet to the current bulleted list of colorectal screening tests.
  - ~~As of January 1, 2023, e~~ Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.
- **What you must pay when you get these services** column, delete language as indicated per strikeout below:

There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam *[and subject to copays/coinsurance]. [THE PLAN SHOULD LIST APPLICABLE COPAYMENT AND COINSURANCE.]* ~~and you pay 15% of the Medicare approved amount for your doctors' services. In a hospital outpatient setting, you also pay the hospital a 15% coinsurance. The Part B deductible doesn't apply. [If applicable, list copayment and/or coinsurance charged for barium enema.]~~

## 7. EOC model for MSA

**Summary of issue:** Urgently needed services definition needs to be added to definitions chapter.

**Issue location:** Chapter 10, Definitions of important words

**Change Implemented:** Added the definition and placed in alphabetical order in definitions:

**Urgently needed services** - Covered services that are not emergency services, provided *[Network plans, insert: when the network providers are temporarily unavailable or inaccessible or]* when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

**8. EOC models for HMO MAPD, PPO MAPD, PFFS, Cost, MSA, DSNP, HMO MA, PPO MA, PDP**

**Summary of issue:** The instructions to “Click on Talk to Someone” followed by the bulleted options is inaccurate.

**Issue location:** Chapter 2, Section 3, METHOD TO ACCESS SHIP and OTHER RESOURCES text box

**Change Implemented:** Updated the language (*changes noted in red text*):

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit <https://www.shiphelp.org> (Click on SHIP LOCATOR in middle of page) ~~Click on Talk to Someone in the middle of the homepage-~~
- Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.
- ~~You now have the following options~~
  - ~~Option #1: You can have a live chat with a 1-800-MEDICARE representative~~
  - ~~Option #2: You can select your STATE from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.~~

**9. EOC models for HMO MAPD, PPO MAPD, DSNP, PFFS, Cost, and PDP**

**Summary of Issue:** IRA-related coverage changes for insulin and most adult Part D vaccines were not included.

**Issue location:** HMO MAPD, PPO MAPD, DSNP, PFFS, and Cost (Chapter 6); PDP (Chapter 4); Section 6, Costs in the Coverage Gap Stage

**Change Implemented:** Added the following text below (*changes noted in red text*):

**SECTION 6 Costs in the Coverage Gap Stage**

[Plans with no coverage gap replace Section 6 title with: There is no coverage gap for [insert 2024 plan name].]

[Plans with no coverage gap replace text below with: There is no coverage gap for [insert 2024 plan name]. Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage (see Section 7).]

*[Plans with some coverage in the gap, revise the text below as needed to describe the plan's coverage.]*

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay, and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 25% of the cost for generic drugs and the plan pays the rest. Only the amount you pay counts and moves you through the coverage gap.

You continue paying these costs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach this amount \$*[insert 2024 out-of-pocket threshold]*, you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage.

Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs (Section 1.3).

**Coverage Gap Stage coinsurance requirements do not apply to Part D covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.**

**You won't pay more than \$35 *[update the cost sharing amount, if lower than \$35]* for a one-month supply of each covered insulin product regardless of the cost-sharing tier *[modify as needed if plan offers multiple cost sharing amounts for insulins (e.g., preferred and non-preferred insulins)]*.**

**Please see Section 9 of this chapter for more information on Part D vaccines and cost sharing for Part D vaccines.**

## 10. EOC model for MSA

***Summary of issue:*** Plan instruction regarding monthly plan premium needs to be deleted.

***Issue location:*** Chapter 1, Section 4.2

***Change Implemented:*** Updated language below (*changes noted in red text*):

~~*[Plans with no monthly premium, omit: In addition to paying the monthly plan premium,]*~~  
**You must continue paying your Medicare premiums to remain a member of the plan.** This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

## 11. EOC model for Cost plan

***Summary of issue:*** Step therapy for Part B drugs language needs to be removed.

**Issue location:** Chapter 4, Section 2.1

**Change Implemented:** Deleted the following:

- [Insert if applying utilization management policies, such as step therapy for Part B drugs, to any Part B drug benefit:
- At minimum, add information that states if a plan utilizes step therapy for Part B drugs and explains what this means and how to access the benefit.]

## 12. LIS Rider

**Summary of issue:** The term “yearly deductible” was not removed to conform with 2024 IRA changes to LIS. The IRA eliminated the partial subsidy and enrollees who receive Extra Help will have no deductible.

**Issue location:** First paragraph

**Change Implemented:** Deleted the term “yearly deductible” from the following sentence (*changes noted in red text*):

“This means that you will help pay your monthly premium, ~~yearly deductible~~, and prescription drug cost sharing.”

## 13. Part D EOB Plan Instructions, matching the plan instructions to conform to Exhibit C

**Summary of issue:** Missing first bullet under the header “You’re in Stage 2: Initial Coverage.” Stage 1: Yearly Deductible is not applicable for members with LIS, thereby the first payment stage for these members is the Initial Coverage Stage.

**Issue location:** Chart 3 for members with LIS who are in the Initial Coverage Stage:

**Change Implemented:** Added the bullet for members with LIS in the Initial Coverage Stage (*changes noted in red text*):

The following language should be used for the first bullet under, “You’re in Stage 2: Initial Coverage.”

- You start in this payment stage when you fill your first prescription of the year.

## 14. Part D EOB Plan Instructions

**Summary of issue:** Bullets under “About Coverage Stages” need to be updated to reflect the accurate benefit stages for a member with LIS in the Initial Coverage Stage.

**Issue location:** Chart 3 for members with LIS who are in the Initial Coverage Stage.

**Change Implemented:** Stage 1 and Stage 3 updated to reflect that they are not applicable for members with LIS (changes noted in red text).

- **Stage 1: Yearly Deductible**

Because you get “Extra Help” from Medicare, Stage 1: Yearly Deductible doesn’t apply to you.

- **Stage 3: Coverage Gap**

Because you get “Extra Help” from Medicare, Stage 3: Coverage Gap doesn’t apply to you.

## 15. Part D EOB Plan Instructions

**Summary of issue:** Bullets under “About Coverage Stages” need to be updated to reflect the accurate benefit stages for a member with LIS in the Initial Coverage Stage.

**Issue location:** Chart 3 for members with LIS who are in the Initial Coverage Stage.

**Change Implemented:** Updated “Total Drug Costs” with the term “Out-of-Pocket Costs” for accuracy (changes noted in red text).

The bullet for **Stage 2: Initial Coverage** should read: “In this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date ~~Total Drug Costs~~ **Out-of-Pocket Costs** reach \$[insert initial coverage limit].”

## 16. Part D EOB Plan Instructions and Part D EOB Exhibit C, Example 3

**Summary of Issue:** IRA-related coverage changes for insulin and most adult Part D vaccines were not included.

**Issue location:** You’re in Stage 3: Coverage Gap

**Change Implemented:** Add the following text (changes noted in red text):

You’re in Stage 3: Coverage Gap

- During this payment stage, you (or others on your behalf) get a 70% manufacturer’s discount on covered brand name drugs and the plan will cover [insert if additional brand gap coverage: “at least”] another 5%, so you pay [insert if additional brand gap coverage: “less than”] 25% of the negotiated price on brand-name drugs. You pay [insert if additional generic gap coverage: “less than”] 25% of the costs of generic drugs.
- You generally stay in this stage **until your year-to-date Out-of-Pocket Costs reach \$[insert out-of-pocket threshold]**. As of [insert end date of month], your year-to-date Out-of-Pocket Costs were \$[insert year-to-date TrOOP].
- **During this payment stage, coinsurance requirements do not apply to Part D covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.**

## 17. Part D EOB Plan Instructions, Exhibit C, and Exhibit G

***Summary of Issue:*** IRA-related coverage changes for insulin and most adult Part D vaccines necessitated changes to the description of the Coverage Gap.

***Issue location:*** About Coverage Stages, Coverage Gap bullet

**Change Implemented:** Add the following text as shown below (*change noted in red text*):

- **Stage 3: Coverage Gap**

In this stage, you **generally** pay 25% of the cost of your brand-name drugs and 25% of the cost of your generic drugs. **You generally stay in this stage until your year-to-date out-of-pocket costs reach \$8,000.**