DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

MEDICARE-MEDICAID COORDINATION OFFICE

DATE: September 7, 2023

TO: Medicare-Medicaid Plans

FROM: Lindsay P. Barnette
Director, Models, Demonstrations & Analysis Group

SUBJECT: Additional Revisions to Contract Year 2024 Member Handbook for Medicare-Medicaid Plans (MMPs)

The purpose of this memorandum is to provide additional updates to the Contract Year (CY) 2024 Member Handbook for all Medicare-Medicaid Plans (MMPs) based on updates to the CY 2024 Medicare Advantage models that were released as described in the Health Plan Management System (HPMS) memorandum, "Model Notice Corrections" on August 8, 2023.

MMCO will not issue revised CY 2024 state-specific model materials for changes included in this memorandum. We instruct MMPs to update their CY 2024 model materials based on the information provided in this memorandum. The information below includes updates to the Member Handbook (Evidence of Coverage) Chapters 4 and 5.

Hard copy Member Handbooks must include this information before they are mailed to enrollees by October 15th whenever possible. If updates to the hard copy Member Handbook are not practicable – for example, if they have already been printed – the model errata may be used to communicate the updated and accurate information until current stock of outdated Member Handbook documents is depleted.

We will post this memorandum to MMCO's Information and Guidance for Plans webpage at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.

If you have any questions about the contents of this memorandum, please contact the Medicare-Medicaid Coordination Office at MMCOCapsModel@cms.hhs.gov.

CY 2024 Model Updates

EOC

Chapter 4

- Section D, for Colorectal cancer screening, update the eighth bullet with the following:

  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.

- Section D, Partial hospitalization services, update this section as follows to add information regarding intensive outpatient services:

  [*Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.*]

  Partial hospitalization services and intensive outpatient services

  Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital.

  Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, 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.

  [*Network 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.]

Chapter 5

- Section C1, update the last bullet as follows:

  [*Plans that offer all drugs at $0 cost sharing, delete the following sentence:*] Your copay may be greater for the brand name drug [*insert as applicable: or original biological product*] than for the generic drug [*insert as applicable: or* interchangeable biosimilar].

- Section E, after the eighth bullet replace the language with the following up until the bullet that begins, "**A drug is taken off the market**. If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we will take it off the Drug List.":

[*Plans that otherwise meet all requirements and want the option to immediately replace brand name drugs with their generic equivalents must provide the following advance general notice of changes:*

Some changes to the Drug List will happen **immediately**. For example:

- **A new generic drug becomes available.** Sometimes, a new generic drug comes on the market that works as well as a brand name drug on the Drug List now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same [*insert if applicable, for example, if the plan's Drug List has differential cost-sharing for some generics: or will be lower.*]

  When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

  - We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.
  - You or your provider can ask for an "exception" from these changes. We will send you a notice with the steps you can take to ask for an exception. Please refer to Chapter 9 of this handbook [*plans may insert reference, as applicable]* for more information on exceptions.]

[*Plans that will not be making any immediate substitutions of new generic drugs should insert the following:*

Some changes to the Drug List may include:

- **A new generic drug** *[insert as applicable: or interchangeable biosimilar]* **becomes available.** Sometimes, a new generic drug [*insert as applicable: or an interchangeable biosimilar version of the same biological product*] comes on the market that works as well as a brand name drug [*insert as applicable: or original biological product*] on the Drug List now. When that happens, we may remove the brand name drug [*insert as applicable: or original biological product*] and add the new generic drug [*insert as applicable: or an interchangeable biosimilar version of the same biological product*], but your cost for the new drug [*insert as applicable: or an interchangeable biosimilar*] will stay the same [*insert if applicable, for example, if the plan's Drug List has differential cost-sharing for some generics: or will be lower.*]

  When we add the new generic drug, we may also decide to keep the brand name drug [*insert as applicable: or original biological product*] on the list but change its coverage rules or limits.

  When these changes happen, we will:

  - Tell you at least 30 days before we make the change to the Drug List **or**

- Let you know and give you a [*insert supply limit (must be at least the number of days in the plan's one-month supply)*]-day supply of the brand name drug [*insert as applicable: or original biological product*] after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. They can help you decide:

- If you should switch to the generic [*insert as applicable: or interchangeable biosimilar*] or if there is a similar drug on the Drug List you can take instead **or**
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, refer to Chapter 9 [*plans may insert reference, as applicable*].