# MED D - 2025 Open Enrollment Period (OEP) Health Plan Reminders

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**Description:** This document provides reminders for Med D OEP Health Plans.

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| Helping With Heart |

**Helping With Heart** is important in every beneficiary interaction. **Helping With Heart** is especially important when new members interact with us for the first time or when existing beneficiaries have a change in their plan.

Following the **Helping With Heart** actions below, with every beneficiary and on every interaction, will help us achieve our goal of bringing our **Heart** to every experience.

* **I provide** a friendly greeting and offer my help.
* **I ensure** the safety and well-being of others.
* **I listen** and make sure I understand before I act.
* **I remove** obstacles to make experiences easier.
* **I follow through,** working with others to find solutions.
* **I create** heartfelt, personalized moments.

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| Process Reminders |

**Health Plan CMS Test Calls:**



**Center for Medicare and Medicaid Services (CMS), Quality Assurance (QA) department, and clients routinely call Medicare Part D plan sponsors posing as a potential beneficiary, enrolled beneficiary, or someone calling on behalf of the beneficiary.**

* When CMS makes test calls, they do not have beneficiary information to provide.
* They are calling the client(s) beneficiary phone line or Pharmacy Help Desk to confirm that the CCRs can assist with questions regarding the plans Medicare Part D prescription benefits.
* General benefit questions that do not pertain to a specific beneficiary can be answered without authenticating the call.
* Regardless of what plan the caller references, the answer is ALWAYS “Yes I can help you”.
* It’s also critical you are **logging out of your phone properly**. Stepping away from your desk without logging out or using the correct AUX code allows CMS test calls to route to your line and be left unanswered, resulting in failure. Be sure to double-check your phone before walking away.
* For additional information review [MED D – Health Plan CMS Test Questions](file:///C:\Users\C337799\Downloads\TSRC-PROD-044629).

**Locating a Beneficiary’s Account:**

**Sometimes when a beneficiary contacts Customer Care, the CCR will have difficulty in locating the account.**

* Before telling the beneficiary, they do not have an active account, utilize ALL resources in researching the beneficiary’s eligibility.
* Remember to select “All” within the “Eligibility Filter” in Compass.
* If no account can be found, look for beneficiary by name and date of birth.
* It is possible that a prospective beneficiary may call in, remember to ask for the client’s name and attempt to locate the CIF (ask for the plan name to search for CIF) to assist the caller as much as possible.
* If nothing is found, have a Supervisor or Senior verify eligibility in RxClaim.

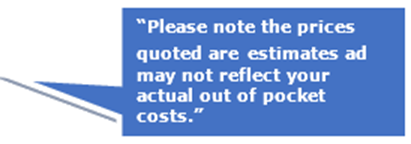
**General Reminders:**

**It is critical that you ALWAYs check the CIF on every call!**

**The CIF is a living document that can change at any time as needed.**

* Do not go from memory or past claim history to answer beneficiary questions.
* Always run a test claim, this includes for coverage/copays questions and order placement. Use all your resources & provide the disclaimer!
* **Year over year plan benefit changes are found in each client’s CIF.**
* For clients that handle their own plan design calls, refer beneficiaries to the

plan for questions about changes to their benefits.



**Health Plans are not affiliated with SilverScript.**

* NEVER reference SilverScript or refer to the SilverScript website on calls with Health Plan beneficiaries.
  + Check client’s CIF for the appropriate website and formulary for the client.

**Health Plan clients frequently monitor CVS Caremark Customer Care calls.**

* Remember to express empathy, use proper greeting and closing, and provide first call resolution. This also includes not utilizing CVS jargon and only using appropriate language. On call recordings, internal partners and clients can hear what you are saying while you are on hold as well.
* CVS Caremark is an extension of the Client and is not only for mail order, and we manage the prescription benefit.

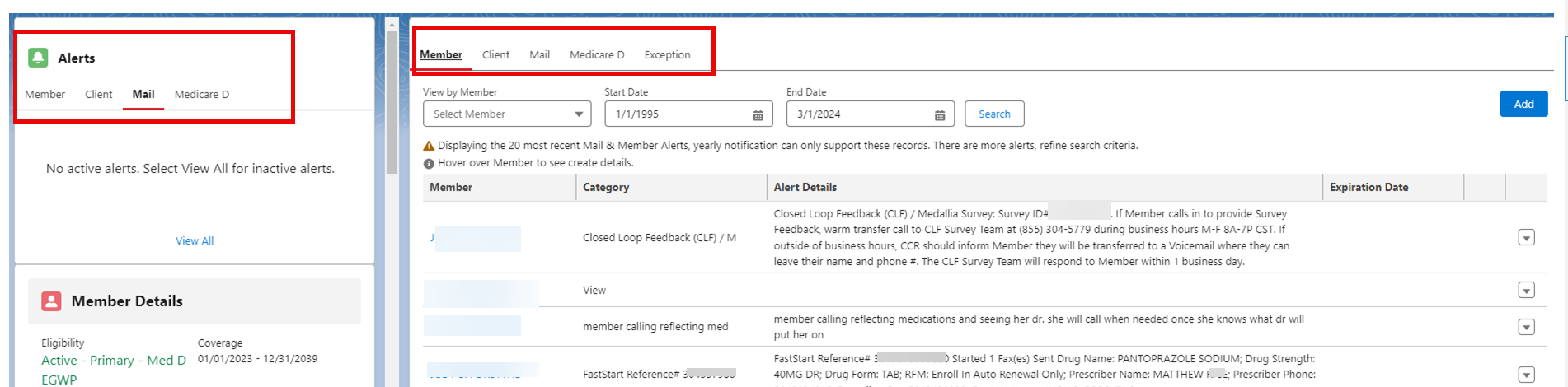
**After exhausting all your resources, when in doubt with ANYTHING, ASK for assistance.**



**Helping With Heart Reminders:**

Complete an Account Wellness Check on every call to proactively diagnose the call reason to make sure you understand why the beneficiary is calling and to achieve a first call resolution.

1. Complete the Account Wellness Check to proactively diagnose the call reason.
2. Review all messages within**Alerts**.



1. Ask probing questions to fully understand the caller’s inquiry.
2. Restate the caller’s need to ensure understanding and to provide **accurate** information.
3. Thank the caller for providing requested information.
4. Follow through on agreed items with the caller.
5. When returning from research or placing a beneficiary on hold, thank the caller for their patience.

**Remember to:**

* Demonstrate your ability to answer questions by showing **enthusiasm** and confidence throughout the call.
* Be aware of the caller’s needs and adjust your call flow, language, pace, and tone to match the caller’s.

**Note:**  To ensure **accuracy**, run a Test Claim and use other resources, such as theSource and Compass, to provide the caller with **helpful options and solutions**.

Refer to: [Universal Care - Consultative Call Flow (CCF) Process](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=c954b131-7884-494c-b4bb-dfc12fdc846f)

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| Annual Notice of Changes (ANOC) |

The mailing dates for the Annual Notice of Changes (ANOC) can vary by Health Plan clients. When the beneficiary calls in with questions regarding plan year 2025, the CCR should first determine if the beneficiary has received their ANOC.

* Refer to the CIF if additional information is required on the mailing date.

**Note:** You should **not** discuss 2025 plan information until **October 1, 2024**. The only exception is if a current beneficiary asks questions AFTER receiving the ANOC mailing prior to October 1st.

**Helping With Heart Reminders:**

**Medicare Phases**

A member’s plan has several phases and each phase charges members differently; depending on how much they pay overall is also a direct driver for moving them through each phase.

* **Deductible Phase:**  the member is responsible for 100% of the cost. As a note, not all plans have a Deductible and not all drug tiers may apply towards it.
* **Initial Coverage Limit:**  the member only pays a portion of the overall drug cost.
* **Coverage Gap:**  as a result of the Inflation Reduction Act, the coverage gap phase will be eliminated in 2025.
* **Catastrophic Phase:**  the beneficiary will have no cost share responsibility for covered Part D drugs through the end of the year.

**Effective 01/01/2025:** The new MDR TrOOP will be **$2,000.**

Starting in 2025, the Inflation Reduction Act has mandated that a beneficiary shall pay no more than $2,000 total out of pocket in any calendar year. For beneficiaries who have high cost or multiple prescriptions per month, this was designed to ease the drug costs for our Medicare beneficiaries.

**Refer to:**

* [Compass MED D – Inflation Reduction Act](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=f1ea65f5-0fb5-4457-b695-260bc18bb1b8)
* [MED D – ICL, Coverage Gap, TrOOP, Catastrophic Coverage](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=9a075697-260f-4edd-a78d-91cb5b52f73b)

**Medicare Payment Plan** – Effective 01/01/2025

The Medicare Prescription Payment Plan is a payment option that works with current drug coverage to help beneficiaries manage their out-of-pocket Medicare Part D drug costs by spreading them across the plan year.

Starting in 2025, anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan with drug coverage) can use this payment option for drugs covered by Part D. Beneficiaries may opt-in or opt-out of the program at any time during the plan year.

If beneficiaries select this payment option, each month they’ll continue to pay their plan premium (if they have one), and they’ll get a bill from their health or drug plan to pay for their prescription drugs (instead of paying the pharmacy). All plans offer this payment option and participation is voluntary. It doesn’t cost anything to participate in the Medicare Prescription Payment Plan, and beneficiaries won’t pay any interest or fees on the amount they owe, even if their payment is late.

**Refer to:**

* [Compass MED D – Medicare Prescription Payment Plan Guidelines](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=54f362a8-c10b-43c3-b4dd-124af1173532)

**What is a formulary?**

* A formulary is a list of approved or recommended drugs with additional information. These drugs are deemed to be the most effective and economical.
* A list of preferred brand drugs (grouped by therapeutic category) compiled by a group of our pharmacists and prescribers committee called P&T (Pharmacist and Therapeutics) consisting of medical directors and clinical pharmacists who review medications, making the decision. Formulary drugs are selected for their ability to meet a member’s therapeutic needs at a lower cost.
* Medications which the plan helps pay for or the plan covers, each year the formulary changes are communicated through the ANOC. Medications on a formulary may change due to medication availability in the market, less expensive but equally effective drugs are added, or medications are removed for safety reasons.

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| Grievances |

**Part D Grievances may be delegated to CVS Caremark or may be handled by the Health Plan.**

If a beneficiary shows **ANY** sign of dissatisfaction, you must follow the Grievance Process as outlined in the [Compass MED D - Grievances Index](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=70034f51-77df-49a4-ae97-7d3d63b216b3) work instruction. Reference the Grievance section of the CIF to determine which entity handles the Grievance type.



* It is **critical** that adequate and complete documentation is included in Compass call notes for **ALL** Grievance types whether they are delegated to CVS Caremark or the Health Plan.
* For First Call Resolution (FCR) Grievances, document with Reason, Action, Result specific to the Grievance, refer to [Med D - Compass Grievances: CCR - First Call Resolution Documentation Templates (Health Plans)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=0e126cf2-ca19-4e62-b84f-72733e77b8b9).
* For a new standard (not resolved) Grievance, use the standard verbiage provided in [MED D - Grievances in PeopleSafe for Health Plans, JE (formerly MHK Fusion)](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=731c1bac-3039-46da-85e1-0e49a8c9721d).

**Make sure Grievances are filed under the appropriate active line of eligibility.**

* Ensure that the termination date has not passed to ensure you are filing the Grievance under the active account. Refer to [Compass MED D - When to File a Grievance in Compass](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=8895dffc-cf45-44d4-b795-c4d95f7bd555)

**Client Handles Grievances:**

After informing the caller you are going to conference the beneficiary with the client, where applicable, you should use GRV CLIENT HANDLES if the transfer was a success. If the caller refuses to be conferenced, you should use GRV MEM REFUSE XFER TO CLIENT if you are for any reason unable to complete the warm transfer. Remember to provide the beneficiary with the client phone number if they would like to call on their own to file the Grievance.

Grievance Submitted 1319  
Grievance Client Handles 1320  
Grievance Caller Not Eligible 1323  
Grievance – Mem Refuse Xfer to Client 1325

**Helping With Heart Reminders:**

When a beneficiary expresses dissatisfaction and a grievance is filed, it is important to acknowledge the beneficiary and treat each person professionally, with respect and with **Empathy**.

**Why is Empathy important?**

**Empathy** is the ability to understand, be sensitive to, and vicariously experience the feelings and thoughts of others without having the same experience. In other words, empathy is the ability to put yourself in the caller’s shoes.

**Empathy** helps to**:**

* Create human connections and heartfelt moments.
* Make callers feel valued.
* Increase beneficiary satisfaction.

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| **Do…** | **Don’t…** |
| **Let the beneficiary explain the situation**   * Remain calm * Be patient * Actively listen * Acknowledge the situation at hand * Take ownership of the call | * Take it personally * Interrupt * Rush the beneficiary * Be sarcastic * Forget to breathe (Be sure not to ‘sigh’ in frustration.) * Get upset or angry * Go silent * Think you cannot assist |
| **Empathize**  **•** Sympathize with the beneficiary’s concern  Ask questions to clearly understand the situation Pay attention to non-verbal cues (long pauses) |  |

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| Call Documentation |

When documenting a MED D call, the details of the call must be noted on the beneficiary’s account. As per CMS guidance, detailed documentation is required for all MED D calls.



**Refer to:**

* [Compass MED D - Call Documentation Job Aid](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=433711aa-8fa6-447c-872b-bd69cd6cd7c0).
* [Automated Call Summarization](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=f28dbdf4-4355-45be-95c4-6bda1c08a521)

**User Tips:**

* Place the Cresta Agent Assist application so that it is visible to you when you receive and/or make a call within Five9.
* Assure key applications, such as Five9, PeopleSafe or Compass, are also visible on your screen.

Copy and Paste the Cresta generated call summary notes to PeopleSafe or Compass.

Do not revise the auto generated notes before copying and pasting them to PeopleSafe or Compass.

**Note:** After the Call Summarization Notes have been copied and pasted to the system, they can be edited to include any process-specific requirements.

**Medicare D Note:**  For grievances, cut and paste the summary notes generated from Cresta to PeopleSafe or Compass and follow the grievance process to add the note and associated grievance number to the Cresta generated notes.

**Dispositioning Your Call:**

* Log the root cause of the call using the Capture Activity and Log Activity screens.
* Call logging is crucial and is required each time a member’s account information is accessed for reporting and compliance purposes.
* Log with appropriate disposition
* Source of Contact and Form of Contact need to be selected based on who made the call.

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| Plan Benefit Overrides (PBO) |

 It is critical that you **always** check the CIF under “Overrides” and the specific Override scenario.



**Each client has a unique set of guidelines for their Plan Benefit Overrides.**

* Many clients have financial penalties (and/or reimbursement for claims) for CVS Caremark when overrides are entered that are not permitted per CIF or that are entered incorrectly.
* If you have ANY questions regarding the ability to enter or how to enter, use ALL resources available including reaching out for assistance as needed.
* Review if the medication is a controlled substance and if that is allowed to be overridden based on CIF.

**PBO Client Sensitivities:**

**Healthfirst -** **Check the CIF thoroughly**

* Proactively review any plan benefit Year over Year changes with the members
* Educate members whenever possible on plan benefit programs to assist them
* Check the cost of the medication as they have a limit on the amount they approve for overrides before it requires client approval
* Client does not allow overrides for controlled medications
* Override entry is required to be limited to one fill, please reach out to Sr CCR, guidelines provided in CIF

**Devoted Health - Check the CIF thoroughly**

* Client has very specific requirements and CIF provides guidance on what is approved vs what should go back to the Devoted
* Controlled substances are limited and should be warm transferred to Devoted

**NHPRI - Check the CIF thoroughly**

* Plan is an MMP benefit and has primary (x2322) and secondary coverage (x6441)
  + Review if the override needs to be place on primary, secondary, or both based on the plan coverage
  + Run test claim after override is entered to ensure the coverage/copay is accurate
* Educate members whenever possible on plan benefit programs to assist them

**Elderplan - Check the CIF thoroughly**

* Primary carrier X8585, Account 007 Group 007/Secondary Carrier X5525, Account 007, Group 007 is a STCOB plan
  + PBOs for this STCOB plan must be entered by the Senior Team
* There is a claim limit threshold of $5,000 for Lost/Stolen/Damaged and Vacation overrides
  + Any claim that exceeds a total approved cost of $5,000 or more, MUST be sent to account manager for approval

**MVP - Check the CIF thoroughly**

* CCR’s should reach out to the Senior Team and the Senior will follow their internal process to complete. Health Plan Client Support will require Seniors and Case Coordinators to initiate SFDC cases for all requests.

 When client specific override processes are not followed, CVS Caremark may have to pay financial penalties.

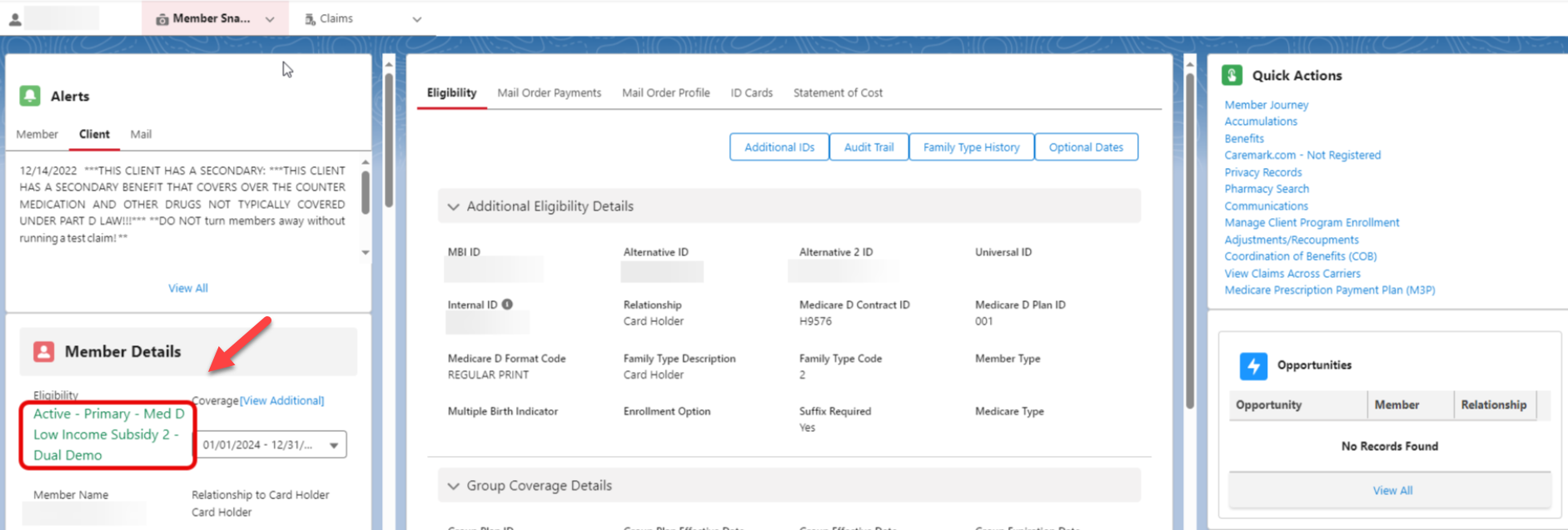
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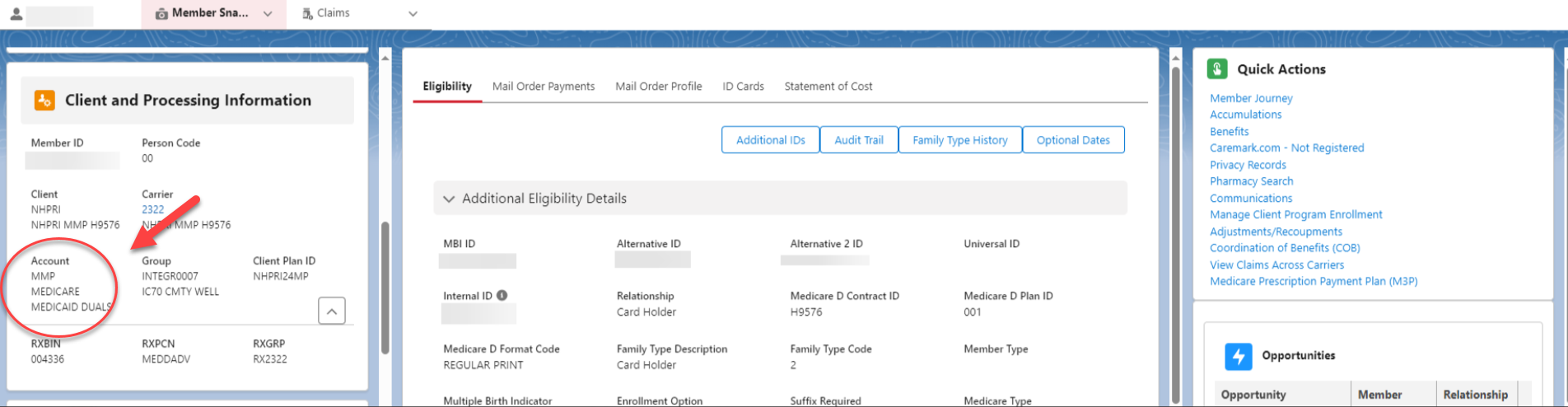
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| Dual Demo, MMP-Medicare Medicaid Plan, DSNP |

This program will use the STCOB process in place today, with MED D as primary and Medicaid as secondary. These Medicare plans have a secondary Medicaid benefit that will often cover drugs that are usually excluded by Part D law. Refer to [Compass MED D - Dual Demo/MMP/DSNP - Single Transaction Coordination of Benefits (STCOB) Tips and Reminders](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=cb68c123-27da-4028-8f01-7d32d5804c6d) on how to identify a Dual Demo Plan.

* NHPRI (Neighborhood Health Plan of Rhode Island) – an MMP Dual Demo plan. This client has a secondary benefit that covers some over the counter (OTC) medications and other drugs that are typically not covered under Part D Law. Review the CIF for coverage/copay details.
* CCA (Commonwealth Care Alliance)- is a new MMP Dual Demo plan for 2025. This client has a secondary benefit that covers some over the counter (OTC) medications and other drugs that are typically not covered under Part D Law. Utilize the universal IDs (UIDs) in the CIF to run test claims to determine coverage and copays for 2025. The UIDs should only be used when the members eligibility is not loaded.

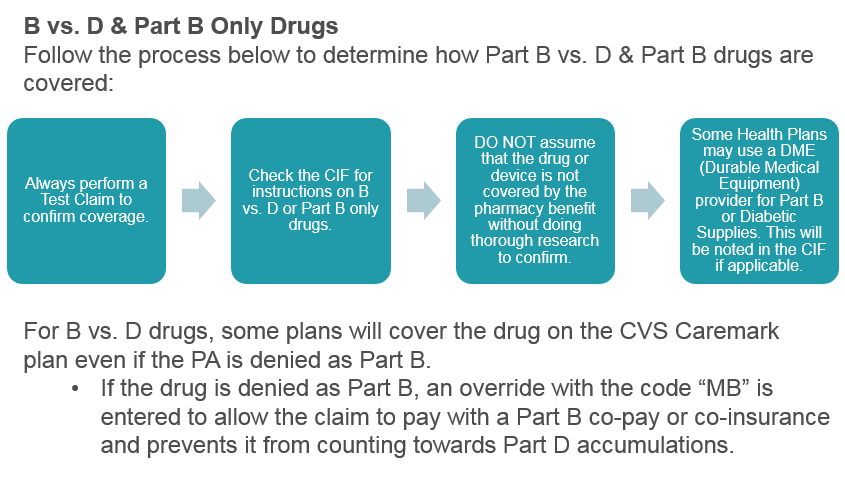
**Screen shots below show how you can identify if a plan is a Dual Demo/MMP plan:**





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| B vs. D Reminders |



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| **Over the Counter (OTCHS) Updates 2025** |

The CVS Over the Counter, OTCHS, department is adding some new additions to the benefits offered effective 01/01/2025.

OTC Health Solutions is a CVS Pharmacy program that provides over the counter (OTC) benefit administration. There are over 1,000 products and [a plan](https://thesource.cvshealth.com/nuxeo/nxfile/default/23106c01-cf42-4b22-8c20-6bb6d370659a/ncf:generated_pdf/045610%20Over%20the%20Counter%20(OTC)%20Health%20Solutions%20010324%20cg3.docx.html?changeToken=10633-0&inline=true#_List_of_Health) can choose to offer the full list of products or a subset of them.

**Note:** Do **NOT** proactively offer this program to beneficiaries or advise any beneficiary they are eligible for this benefit. Only certain beneficiaries of the plans listed below are eligible for an OTC benefit.

Warm transfer the beneficiary to OTC Health Solutions at **1-888-628-2770** to place an order, have questions regarding an existing order or about the OTC benefit.

* **OTC Health Solutions – Traditional Program:**
  + Beneficiaries receive an allowance from their health plan to spend on eligible OTC products.
    - Beneficiary cannot exceed the benefit when placing orders through home delivery (call center, online, or app).
    - Beneficiary can only exceed benefit in-store and pay difference out of pocket.
* **CVS Flexcard Offering:**
  + Participants receive a physical card to use as a credit card.
  + This card provides members access to their benefits through many “wallets” which may include OTC eligible categories in stores, Healthy Grocery / Food, utilities and more.
  + The Flexcard program varies by plan.
  + The Flexcard OTC program allows beneficiaries to select from a variety of categories in-store.

**Refer to:** [Over the Counter (OTC) Health Solutions](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=23106c01-cf42-4b22-8c20-6bb6d370659a)

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| Prospective Coverage Determination & Appeal (CD/A) Dates |

The prospective CD/A date is the effective date that beneficiaries and/or their physicians can request a CD/A for the upcoming plan year. These dates are pending until we have the beneficiary eligibility loaded in Compass. Transfer the caller to CD/A to initiate if requested.

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| **Client** | **Effective Date for Accepting CD/A Requests** |
| ArchCare  BCBS Arkansas  BCBS MA (DMP RD Only)  CareFirst  CCOK  Clover Health  Devoted Health  ElderPlan  FEP MPDP  Florida Complete Care (FC2)  GlobalHealth  Healthfirst  HMSA  Johns Hopkins  Martin’s Point  Mass General Brigham Health Plan  MetroPlus  Mount Carmel  NHPRI  NEJE  Paramount  Premera  Sharp  Wellmark | 11/1/2024 |
| Viva  **New Clients:**   * Community Care Alliance (CCA) * Zing Health | 12/1/2024 |

**Helping With Heart Reminders:**

**Understanding the types of Coverage Determinations**

* Prior Authorization examples are Step Therapy and Quantity Limits. In these situations, the drug is covered on the beneficiary’s formulary, however, they have to meet pre-qualifications before they can fill the initial prescription.
* Formulary Exception (FE) is requested when a drug that is not covered on the beneficiary’s formulary and they want to get it included/covered.
* Tiering Exception is requested when a drug is fully covered on the member’s formulary however the member is looking to lower the tier of the drug to make it more cost effective.

**FAQ:**

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| **Question** | **Answer** |
| Do I have to request a Coverage Determination every year or if I get approved, is it good for as long as I take my meds? | It must be renewed annually. The length of the approval may vary, it’s all based on the medication and the doctor’s approval. |
| Do I have to wait until 2025 to submit a Coverage Determination that will expire at the end of the year? | A Coverage Determination prospective review may be submitted after 11/1 for most plans. (see above chart)12/1/2024 |

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| 2025 Implementation Activities |

The chart below includes all the Medicare D Health Plan implementation activity for 2025. There are 2 brand new clients that will be joining us in 2025 and there are at least 4 existing clients adding new plans/carriers for 2025.



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| **New Clients** | **Client Code** | **Early Open Phone Lines** | **Additional Information** |
| FEP Medicare Prescription Drug Plan “MPDP” | X7117 (Primary), x7118 (Secondary) | 10/01/2024 for FAQ call types (utilizing existing phone line), OEP is 11/13-12/13/2024 | * New client to Medicare D * FEP “MPDP” will delegate CVS to handle their CD/A and Grievance process. |
| Triple S Salud | X5526 (Primary), X5527 (Secondary) | 10/01/2024 FAQ to be utilized for calls until eligibility is loaded. | * New client to Medicare D * Triple S Salud will delegate to handle their CD/A and Grievance process. * Membership is located in Puerto Rico and US Virgin Islands |
| Community Care Alliance (CCA) | X24BC (Primary), X24BD (Secondary), X24BE (Primary), X24BF (Secondary) | 10/1/2024  Utilize UIDs in the CIF to run test claims for 2025 | * New client to Medicare D * CCA will delegate CVS to handle their CD/A and Grievance processes. |
| Zing Health | X24BP, X24BQ, X24EG | 10/15/2024 | * Open phone lines will support Medicare Payment Plan (Enhanced). * CVS will be delegated for CD/A and Grievance processes. |
| **Existing Clients** | **Client Code** | **Early Open Phone Lines** | **Additional Information** |
| Devoted Health | X24CB, x24BV, x24BW, x24BX, x24BY, x24BZ, x24CA, x24CE, x24CC, x18AR, x18AC, x18AQ, x18AD, x18AB, x18AP, x18AA, x18AG, x18AF, x18AM | Utilizing existing phone lines | Adding new plans and new states to their benefit for 2025. Client Training will be provided separately for year-over-year changes. |
| Gateway Med D | X2342, X2343 | Utilizing existing phone lines | Adding new DE DSNP plan (X2343) to their benefit for 2025. |
| BCBSTN | X86CA | Utilizing Existing phone line | Adding X86CA to their membership |
| HPP/Jefferson Health | X4378 | Utilizing Existing Phone line | Adding Carrier X4378 to their plan |
| Molina HealthCare | X51Dk, X51Dm, X51DJ, X51DH | Utilizing Existing Phone lines | Converting X51DK, X51DM, and X51DJ to DSNP plans and X51M is Wisconsin’s carrier add. |
| Molina California | X51DG, X51CA | New phone line created | This was Molina Acquisition of Bright Health and implementing 100,000 lives. |

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| Sensitive Health Plan Client Reminders |

**These clients and your leaders expect CCRs to:**

* Be an extension of the plan.
* Provide accurate information.
* Be courteous, empathetic.
* Remember Hold Management - if the caller requests a check back, check in with the caller & thank them for holding.
* Follow Care Quality guidelines.
* Thoroughly educate beneficiaries regarding Mail Order and Plan Designs.
* Be proactive and offer to submit request to obtain New Rx.
* Make using Mail Order a hassle-free experience.
* Escalate concerns to a Senior CCR or Supervisor if you need assistance resolving an issue
* Senior CCR should accept and quickly take any call that is escalated from a CCR to ensure that all beneficiary concerns are addressed on the first call.
* Access the CIF and follow call handling expectations.
* Ask probing questions to identify the beneficiary’s hidden needs.
* Follow the grievance process as outlined in the CIF.
* DO NOT GIVE BENEFICIARIES HOMEWORK

**BCBSMA**

* Formulary Removals-Lantus, Revlimid, Vyvanse, Oral phosphate binders due to ESRD rule (Sevelamer Hydrochloride, Calcium Acetate, Lanthanum and Velphoro)
* Formulary Changes- Insulin supplies- alcohol swabs, Insulin pen needles, syringes, gauze will have a PA in 2025. Members with Insulin claims in history in the previous 6 months will not be impacted.
* Paxlovid – Tier increase and decrease in QL:
  + Changed from Tier 3 to Tier 5
  + Changed QL 40 or 60 tabs per 30 days to 40 or 60 tabs per 90 days
* DAW 5 will be removed for 2025
* Blue Cross Blue Shield MA MAPD has opted into Medicare Payment Plan Expanded coverage through Caremark. Please assist the member with ALL Medicare Payment Plan inquiries, opt in/opt out preferences, claim details, including maximum dollar amount etc.

**Healthfirst**

* Reminder to offer the After Call Survey

**Molina**

* Formulary Change of Novolog removal – this medication is no longer covered as of 01/01/24
* Every Plan will have a max day supply allowed at retail and mail of 100 days
* $0 cost share on DSNP plans (VBID) X5025, X 5001, X5002, X5003, X5019, X5022, X5024, X5056, X5059, X5004, X5026, X5038, X5014, X5039, X5253, X5063, X51BA, X0816, X51DB, X5059.
  + Only a LICS member will receive the VBID (Value Based Insurance Design) $0 cost share buy down. If they are not a LICS member at the time of claim adjudication it will be the standard cost share for Med D drugs only. Refer to [MED D - Value - Based Insurance Design (VBID)](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=238182b8-6a4f-4d1e-b65a-22c0e647e599).

**CareFirst**

* Reminder to offer post call survey

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| Terming Health Plan Client Reminders |

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| --- | --- | --- | --- |
| **Client** | **Client Code** | **Phone Lines Closing Date** | **Additional Information** |
| KelseyCare | X20AB, X20AA | 03/31/2025 | * Terming as of 12/31/24 * Moving to Optum |
| Blue Shield of California | X33MA, X33MB, X33MC, X33MD, X33ME, X33MF,  X33MJ, X33UH, X33UJ, X33MK | 03/01/2025 | * Terming as of 12/31/24 * Moving to AbarcaRX/Amazon |
| CareFirst | X8181 | Phone line is shared with other CareFirst lines of business, will remain active. | * Terming the Carrier and moving the lives to other CareFirst Plans. |

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