Comment Number	Source of Comment: (Company Name)	2013 MA Application Version #__ (60 day or 30 day)	Application Part	Application Section *(Number/ Header)*	Application Page Number	Description of the Issue or Question
1	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Some recruitment efforts struggle with meeting both of CMS' time and distance requirements.
2	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Because of contracting issues (providers not willing to accept MA rates), we typically do not recruit free standing radiology centers to provide Diagnostic Radiology or Mammography. Instead these services are directed to Acute Inpatient Hospitals or received at PCP or Specialist.
3	United Healthcare	60day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Medicare.gov is our main source of truth in terms of comparison of our networks.
4	United Healthcare	60 dau	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Medicare.gov lists services available at an Acute Inpatient Hospital, yet the hospital operating certificate is not approved by DOH to provide those services, or the hospital confirms they do not provide those services.
5	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	CMS requires information that is not readily or easily available for use in an automated fashion. For instance, the number of Medicare certified beds for hospitals, SNFs, ICUs and IP Psych facilities is not readily available to MCOs. This is also true of Medicare certification numbers.

6	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Release of HSD Tables Prior to Final Release of Application in Early January.
7	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Not all document revisions are dated in the naming convention to know that those downloaded from HPMS are the same as those posted on CMS website.
8	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	For Large Metro and Metro counties that in addition to one or more urban centers also contain large rural areas where physicians are not available (forests, reservations, military bases, etc) and the number of Medicare beneficiaires is low or non-existent in these areas.
9	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Medicare.gov does not provide downloadable files of providers performing these services: Cardiac Surgery, Cardiac Catheterization, Outpatient Infusion Chemo, Mammography, and Outpatient Dialysis.
10	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	CMS Exception form required for 2014 - DISTANCE FROM BENEFICIARIES IN THE COUNTY field.
11	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Certification number: The lists of certified providers that we receive from CMS' (downloadable files from their website) does not always show all locations of a contracted provider. Ex: Walgreens - CMS's lists show some Walgreens' locations, but not all of the locations that we have contracted.
12	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	It is redundant/duplicative to require health plans to repeat listing the contracted providers/facilities "that will ensure access" on the Exception form when they are already listed on the HSD table.

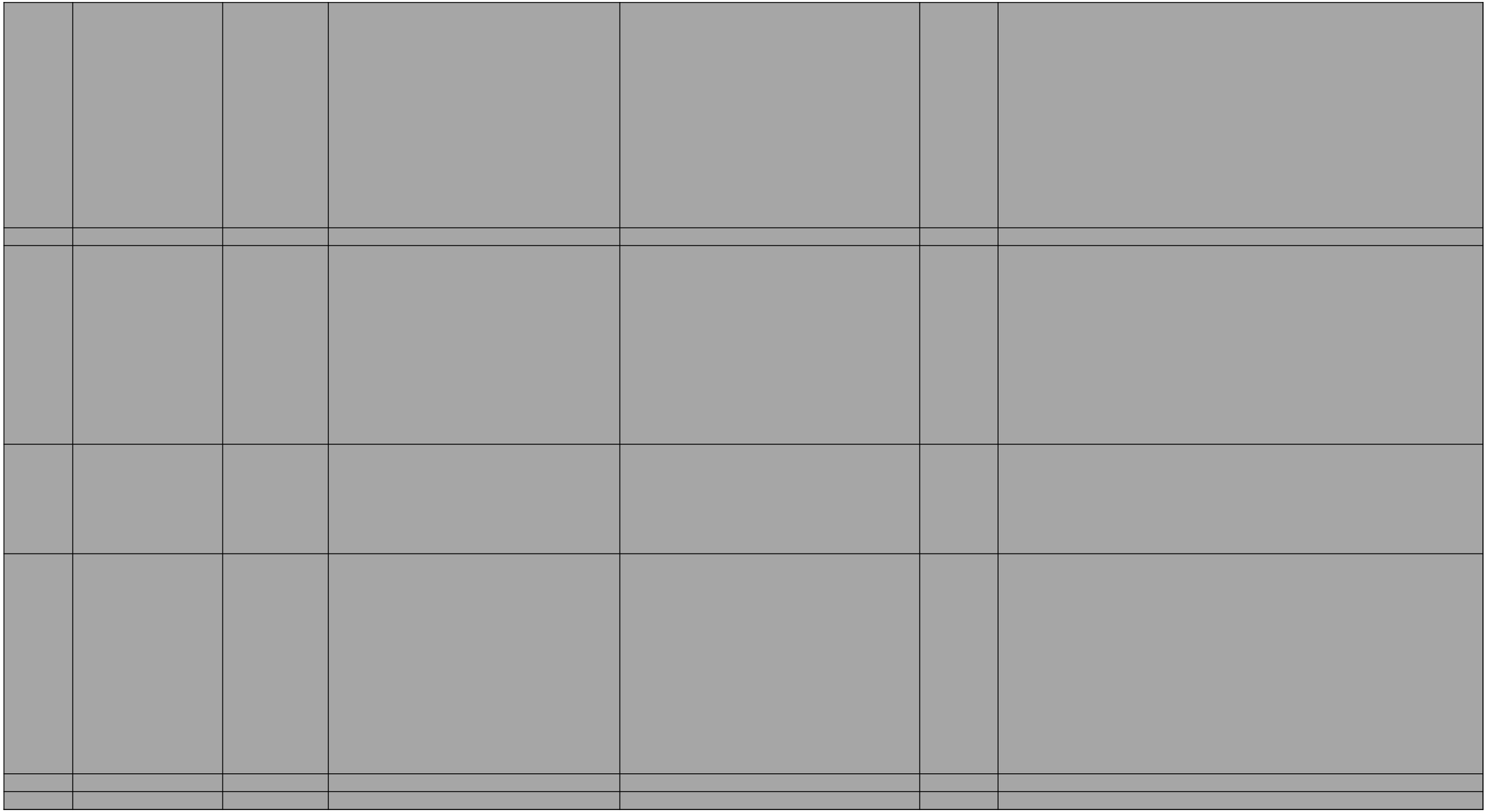
13	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	With the suggested change in requiring complete copies of executed Medicare contracts and any applicable downstream agreements, the standard previous turnaround time may be too short.
14	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	CY 2014 HSD Application Instructions reference column Q (Model Contract Amendment - Indicate if contract uses CMS Model MA Contract Amendment by entering Yes or No) in the MA Provider Table section.
15	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	The CMS downloadable certified Transplant facilities list is in PDF format requiring considerable manual manipulation to convert to Excel or Access so that it can be used in an automated reporting
16	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Certain Orthotic & Prosthetic providers can serve a county without necessarily being located in the county, e.g. a mail order vendor supplying directly to the home. In addition, we've noticed that CMS is including retail vendors such as Walmart, CVS, etc. in the O&P category when MA plans may focus on more typical orthotic suppliers who can customize the orthotics/prosthetics, etc. or provide them through hospitals or physician offices.
17	United Healthcare	60 day	Attestations	3.7 Fiscal Soundness	28	3.7(A)(2) is duplicative of 3.3(A)(1); that is we attest to state licensing twice.
18	United Healthcare	60 day	Attestations	3.9 CMS Provider Participation Contracts & Agreements (Section B)	30	As part of the application review process, Applicants will need to provide fully executed contracts for physicians/providers that CMS reviewers select based upon the CMS Provider and Facility tables that are part of the initial application submission. CMS reviewers will list the providers/facilities and specific instructions in CMS' first deficiency notice. 4.3 CMS Provider Contract Matrix Instructions for CMS Provider Contract Matrix This matrix must be completed by MA Applicants and should be used to indicate the location of the Medicare requirements in each contract / agreement for the Applicant's first tier, downstream and related entity providers that CMS has identified in the contract sample.

19	Ucare	60 day	Attestations	3.10 Contracts for Administrative & Management Services	30	Regarding attestation #15 under section 3.10.A, is this the time period for the previous two calendar years when a plan may have received an automatic renewal? Or is this the previous two times that a plan has completed an application, either as a service area expansion or a new application regardless of the time between such applications?
20	United Healthcare	60 day	Attestations	3.13 Marketing (Section A.4.)	37	Applicant agrees to provide general coverage information, as well as information concerning utilization, grievances, appeals, exceptions, quality assurance, and financial information to any beneficiary upon request.
21	United Healthcare	60 day	Attestations	3.16 Claims (Section A.4.)	42-43	We think that the addition of the word “complete” in this attestation will more closely align with the CMS requirements and with United’s claims processing policies. For example, United does not “develop” all claims that are incomplete, such as certain claims that are missing information or have invalid coding. These claims typically involve only provider liability, so they would not affect the member. This slight change in the attestation wording would allow United to answer this attestation with a “yes” without having to qualify our response.

22	United Healthcare	60 day	Attestations	3.16 Claims (Section A.3.)	42	Applicant agrees to give beneficiary prompt notice of acceptance or denial of a claim's payment in a format consistent with the appeals and notice requirements stated in 42 CFR Part 422 Subpart M.
23	United Healthcare	60 day	Attestations	3.28 Tiering of Medical Benefits (Section A.1.)	58	All beneficiaries have equal access to the various tiers proposed. Note: this is new for 2014
24	UCare	60 day	Attestations	3.28 Tiering of Medical Benefits (Section A.1.)	58	If a plan does not tier benefits, would they answer the attestation (“equal access to the various tiers proposed”) as yes or no if no tiers are proposed? A not applicable option would be more accurate.
25	United Healthcare	60 day	Document Upload Templates	4.3 CMS Provider Contract Matrix (Number 3)	67	Designate if the contract uses the CMS Model Medicare Advantage contract amendment with a "(M)" next to the provider/facility name.
26	Ucare	60 day	Document Upload Templates	4.13 Tiering of Medical Benefits Request Document	86	Not provided
27	United Healthcare	60 day	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	Specific Requirements for Dual-Eligible SNPs (State Medicaid Agency Contracts)	89	We encourage CMS to provide flexibility with the deadlines for completing State Medicaid Agency contracts. There may be cases where state legislative activity or the start of Financial Alignment Demonstration plans may make it difficult to complete the contract by July 1st.

28	United Healthcare	60 day	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	Definitions	92-93	Can clarification be provided on when the "Dual Eligible Subset - Zero Dollar Cost Share" designation or the "Dual Eligible Subset" designation should be used?
29	United Healthcare	60 day	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	4. D-SNP Proposal Application	97	Not provided
30	Ucare	60 day	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	6. D-SNP State Medicaid Agency(ies) Contract(s) (Attestations #2 and #8)	98	None provided
31	United Healthcare	60 day	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	11. Model of Care Attestations (Provider Network and Use of Clinical Practice Guidelines)	104	Under the "Provider Network and Use of Clinical Practice Guidelines" category, item #59 states, "Applicant conducts periodic surveillance of employed and contracted providers to assure that nationally recognized clinical protocols and guidelines are used when available and maintains monitoring data for review during CMS monitoring visits), the term "contracted providers". This statement implies that the Applicant will need to conduct surveillance of all providers, Therefore, this raises concerns about this applicability to the broader provider network that can be several thousand providers.
32	United Healthcare	60 day	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	14. D-SNP Upload Document (Number 3)	115	Under the 2011 D-SNP State Medicaid Agency Contract Upload Document, item #3, bullet #3 states, "Third party liability and coordination of benefits". We believe that clarify is needed with regard to the meaning of "third party liability."

33	United Healthcare	60 day	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	14. D-SNP Upload Document (Number 5)	115	a. There is a significant amount of confusion for both D-SNPs and State Medicaid Agencies as to whether the State Medicaid Agency contract requires the D-SNP to provide Medicaid services. Please clarify that the provision of Medicaid benefits is not always required and that increased levels of agreed-upon coordination of Medicaid benefits is also acceptable. b. Specifically, the NOTE comment only makes reference to Medicaid services "that the organization is obligated to provide under its State contract," which is confusing without a reference to coordination of services as another alternative.
34	United Healthcare	60 day	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	15. D-SNP State Medic aid Agency Contract Matrix (Element #3)	117	The third element of the Dual SNP contract matrix provides that: Medicaid benefits covered under the SNP These are the Medicaid medical services that the organization is obligated to provide under its State contract, not the non-Medicare mandatory Part C services covered under the MA contract. There is confusion about what should be documented for this element. Further the above description makes it sound like the D-SNP is required to provide Medicaid benefits, when in fact most D-SNPs do not provide/cover Medicaid benefits, but rather help members to coordinate the services available through Medicare and Medicaid.
35	UnitedHealthcare	60 day	APPENDIX II: Employer/Union-Only Group Waiver Plans (EGWPs) MAO "800 Series"	6.4 Attestations ; 2 Certification (Number 9)	135	Applicant understands that dissemination/disclosure materials for its EGWPs are not subject to the requirements contained in 42 CFR 422.80 or 42 CFR 423.50 to be submitted for review and approval by CMS prior to use.



Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion Deletion, or Revision)*	CMS Decision *(Accept, Accept with Modification, Reject, Clarify)*		
Will CMS reconsider health plans as meeting criteria if at least one (time OR distance) is met? Example geographical terrain in rural areas impedes meeting criteria requirements.	Revision	Reject: Recruitment is a plan issue as to timing, effort, flexibility on payment arrangements, use of commercially-contracted network, leverage, etc. If terrain in a rural area is a barrier to transportation and access for health care and other services, the particular circumstances should be explained during the application process for the county in question via the exception process after the initial deficiency letter is received.		
Will CMS reconsider Diagnostic Radiology/Mammography as a required Facility specialty type?	Revision	Clarify: This needs to be clarified. A PCP or Specialist who operates his or her own state and federally approved radiology and/or mammography equipment in the office could be used as could a hospital's OP radiology department.		
Will there ever be an opportunity to review providers based on specialty type in excess of a 25 mile range? Will CMS update their web site to offer searching criteria beyond 25 mile range?	Revision	Accept: CMS is looking into expanding the search radius early next year. It has not been implemented due to technical database issues.		
How do we address a service or provider that is posted to Medicare.gov as being Medicare participating and those providers are used to judge our network adequacy/accessibility, but we find out through provider verification that they do not perform the services or are not participating? (ie outpatient cardiac catherization v. cardiac surgery)	Revision	Clarify: Medicare.gov information should not be the sole source of information about the Medicare status of individual services or components operated by a hospital. Due dilligence with regard to this issues is the responsibility of the plan bulding a Medicare Advantage network and the specifics of what the facility says about these services needs to be confirmed by documents and written assurances, not taken over the phone from one individual.		
We believe that CMS's requirements for this data is administratively burdensome. Therefore, we request that CMS provide certain information downloadable in excel or other data files that will assist plans in their automated production of HSD tables and population of these fields with accurate CMS information. For example, CMS should provide a resource from which MCOs can obtain Medicare Certification #s, bed counts, etc so that this information is consistent across all health plans.	Insertion	Reject: This type of information is well known in multiple departments aand offices of these facilities and often maintained on their website or in other public relations and business documents for external users to request. No government data base is going to be as current and up to date as the facility's own official record in the CEO or CFO's office.		

Release of HSD Tables Prior to Final Release of Application in Early January: While it is recognized and appreciated that CMS provides draft applications earlier iin the year, we request that the final HSD Tables be made available by November or December rather than with the release of the Final Application in early January. This would allow organizations with a high volume of submissions additional time to train network personnel and sufficient time to upgrade HSD tools, excel formulas, etc. on any changes made to the tables.	Revision	Accept with Modification: We will look into the possibility of an earlier release of the final format of the HSD Tables prior to the release of the final version of the application in January.		
All documents posted to this site should be dated in the naming convention: http://www.cms.gov/MedicareAdvantageApps/	Revision	Accept with Modification: We will look into this with HPMS and our contractors for possible improvement.		
We recommend CMS consider adjusting the criteria either by using a lower level county classification or by lengthening the distance standards for certain specialists in those geographically challenged counties to better compensate for these geographical differences within a county? How do we approach this with CMS?	Revision	Reject: This example is one of the reasons why we offer the applicant the exception process. We are aware of differences across single counties, especially large counties, and have looked very carefully at how competing applicants and existing applicants have been able to structure their delivery networks in these counties or in more rural or other unique characteristics of parts of these counties.		
How does CMS determine availability of services? What are CMS' definitions of these services?	N/A	Reject: Definitions of these services are available from Medicare. We determine availiabilty of these services from private and public data and FFS claims file information as well as the provider networks of other managed care organizations operating in the same area.		
We recommend that CMS provide clarity & direction on how they want health plans to use the Sample Beneficiary file, HSD Beneficiary Coverage by Zip Code Report, and the Part D Eligibility File, and more detailed instructions on how CMS is calculating distances.	Revision	Accept with Modification: We will share this with the staff working to improve guidance and instructions and the automated fields for active consideration.		
We need clarification from CMS if not all locations are certified or if we are to assume our national and multi-location contracts are covered under the main provider's certification number.	Revision	Accept with Modfication: We will research this topic in CMS and clarify in instructions whether or not an application can assume national and multi-location contracted provider sites are covered under a "main provider" certification number.		
It is suggested that the exception form only require the health plan to identify the "closest contracted provider".	N/A	Reject: The exception template information is reviewed on its own merits with reference to HSD Tables by an exception team reviewer and others on the national team. These staff need to understand and the plan needs to affirmatively state the choices that will be available to Medicare enrollees to get the service in the most timely manner, not just one choice.		

We would like CMS to consider lengthening the time frame in which health plans have to provide complete executed Medicare agreements (including any applicable downstream agreements). The suggested timeframe would be 15 days.	Revision	Clarify: We will refer this suggestion to the workgroup revising the entire contract review approach.		
Will CMS be adding a column Q to the Provider Table? Column Q appears in CY 2014 Instructions but not in Provider Table sample or the CMS summary of changes. Our HSD table needs to be built to include this or be subject to HPMS upload fail. We would also need a copy of the Model Contract Amendment to know what CMS is referencing. Where is it available?	Revision	Accept: CMS will add column Q to the Provider Table and plans to release the CMS Medicare Advantage Contract Amendments for both provider and administrative contracts in the early fall of 2012.		
Request that CMS produce certified transplant list in a .txt or Excel/Access, similar to the other website posted downloadable files of CMS certified providers (Hospital, Home Health, DME, etc)	Revision	Accept with Modification: We are willing to look into making this list available in another format for a manipulable file capacity.		
Could CMS reconsider Orthotics & Prosthetics differently, for example, similar to home health?	Revision	Accept: We are making changes of this nature for 2014 application.		
United suggests that Section 3.7(A)(2) be deleted as it appears it is duplicative of 3.3(A)(1).	Deletion	Accept: The second reference to state licensure in attestation 3.7 (A)(2) will be removed from the Fiscal Soundness section.		
The new requirement requires more uploading since entire contracts are requested rather than just signature pages. It also requires provider matrices produced for each selected sample during the shorter deficiency period rather than with the initial application filing. Can CMS provide the sample size per application they expect to request, expected length of the window for uploading requested contracts and matrices, and the zip file size maximum that HPMS will accept?	Revision	Accept with Modification: Because CMS is no longer asking for provider contract templates, the agency anticipates a reduced burden for applicants in the initial application submission. CMS will identify the provider contract sample based upon the contracted network. As it has in the past with the signature page sample, the number of contracts included in that sample will depend upon the size of the requested service area and number of contracted providers serving the pending area. Thus, we cannot provide a set contract size that will apply to every applicant. CMS does not anticipate lengthening the period of time during which applicants will respond to the initial deficiency notice. The previous time frames have been adequate for applicants to locate and upload signature pages; CMS anticipates the same time frames will be adequate for the full contract upload. The upload file size remains unchanged from last year at 500 MB.		

Please verify what is meant by “at least one of the past two Medicare Advantage application review cycles.”	N/A	Clarify: CMS is asking for applicants to attest YES or NO as to whether the applicant has submitted an initial or SAE Medicare Advantage application during one (or both) of the previous two application review cycles (i.e., February 2012 or February 2011 submissions) and been approved for one (or both) of those applications. If the applicant attests YES, then the applicant does NOT need to upload executed administrative contracts with the application filing in Feburary 2013 (for contract year 2014). CMS does not consider an automatic renewal of a Medicare Advantage contract from one year to the next without an application submission to meet this criteria.		
We request clarification of specifically which materials are to be made available "upon request" as this language is not reflected in 42 CFR 422.2260 through 42 CFR 422.2276, referenced in the first paragraph of Section 3.13 of the Part C - Medicare Advantage and 1876 Cost Plan Expansion Application.	N/A	Clarify: Per 42 CFR 422.111 (c), an MA organization must disclose specific information upon request. This information includes, but is not limited to, the following: the procedures the organization uses to control utilization of services and expenditures; grievance information according to 422.564; and appeals information according to 422.578. CMS clarifies that the applicant could fulfill a request for the aforementioned information by providing the Evidence of Coverage document. Additionally, 42 CFR 422.111 (c) (5) requires the MA organization to fulfill requests for the financial condition of the MA organization, including the most recently audited information regarding, at least, a description of the financial condition of the MA organization offering the plan. MA organizations have flexibility in creating materials to fulfill a request for information on their financial condition. At a minimum, the material would need to include the elements noted in 42 CFR 422.111 (c) (5).		
We believe that the addition of the word “complete” in this attestation will more closely align with CMS requirements to process complete claims promptly. We recommend that the attestation be revised by inserting the word “complete,” as follows: "Applicant will comply with all applicable standards, requirements and establish meaningful procedures for the development and processing of all complete claims including having an effective system for receiving, controlling, and processing claims actions promptly and correctly."	Revision	Disagree: The requirement in 42 CFR 422.520 is that “clean” claims be paid promptly (within 30 days) and that all other claims be paid or denied within 60 days.		

CMS rules do not require that plans provide notice of claim acceptance when there is no cost share involved (except for PFFS claims). There is also no requirement to notify beneficiaries of claim denials when the claim only involves provider reimbursement (such notices would be confusing to beneficiaries). Rather, the requirement is that when a claim is denied resulting in member liability, plans must provide the member with his or her appeals rights. We suggest an addition to the attestation that explains that the notice is required in all cases where there is cost-sharing or member liability. We request that the attestation be revised as follows: Applicant agrees to give beneficiary prompt notice of acceptance or denial of a claim's payment in a format consistent with the appeals and notice requirements stated in 42 CFR Part 422 Subpart M, *in all cases where there is a member cost-sharing or member liability.*	Insertion	Accept with the following modifications: Applicant agrees to give beneficiary prompt notice of acceptance or denial of a claim's payment in a format consistent with the appeals and notice requirements stated in 42 CFR Part 422 Subpart M and in accordance with CMS guidance, in all cases where there is a member cost-sharing or member liability.		
We request clarification of "various tiers" as this term is not reflected in 42 CFR 422.112.	Revision	Clarify/Accept: Please note tiering will be deleted from the CY 2014 Part C MA application. For further clarification, tiering is not a requirement by CMS. Tieiring is optional for organizations that want to offering tiered networks in their medical benefits. Various tiers refers to the amount of tiers an organization chooses to offer within their plan. A plan may not offer more than three tiers withiin a service category. For ex. A plan may offer a three tier hopsital network, where the cost sharing would vary accoording to each tier.		
For section 3.28, tiering of medical benefits, we suggest adding a column for not applicable.	Revision	Clarify/Accept: Please note tiering will be deleted from the CY 2014 Part C MA application. For further clarification, tiering is not a requirement by CMS. Tieiring is optional for organizations that want to offering tiered networks in their medical benefits. Not all organizations offer tiering of their medical benefits, therefore, this column could be added to clarify this information.		
We believe the "CMS Model Medicare Advantage contract amendment" document has not been released and we would like to know when it will be released.	N/A	Clarify: CMS plans to release Medicare Advantage Contract Amendments for both provider and administrative contracts in the fall of 2012.		
For section 4.13, we suggest including instructions that this is optional if tiering of benefits is not offered.	Revision	Clarify/Accept: Please note tiering will be deleted from the CY 2014 Part C MA application. For further clarification, tiering is not a requirement by CMS. Tieiring is optional for organizations that want to offering tiered networks in their medical benefits. CMS will ensure that it is explained more clearly in our instructions or other material that this type of benefit offering is optional.		
We recommend removal of the reference to a July 1 deadline for submitting State Medicaid Agency contracts.	Deletion	Reject: We believe the July 1 deadline for submitting State Medicaid Agency contracts is flexible, and has been in place over the past 2 years.		

We request an example of when these designations should be used.	N/A	Clarify: The Dual eligible subset type allows for enrollment of - any (or all) categories of eligibility provided there is State agreement. It is the most flexible classification of D-SNP. The DE Subset D-SNP type can be further designated as a zero dollar cost share when the Subset enrolled includes the Medicaid categories with 0 dollar Medicare cost share, that is, QMB and QMB + , and/or any other Medicaid category, e.g., FBDE, when the State has agreed to cover the Medicare cost share for that Medicaid eligibility group in its State plan.		
Please clarify what material needs to be submitted for an existing D-SNP that is changing its subtype. Is the entire SNP proposal needed when changing D-SNP subtypes?		Clarify: An existing D-SNP will need to submit a new SNP proposal in the next year if it is changing its D-SNP type. Because this past year was the first year where a State contract was required for all D-SNPs, and there was confusion on the part of States and D-SNPs, we underwent a one time D-SNP type mismatch correction process.		
Questions #2 and #8 are duplicative.	Deletion	Reject: Questions two and eight are different because question two is asking the applicant if they want the contract with the State Medicaid Agency(ies) to be reviewed to determine fully integrated dual eligible (FIDE) status. Question eight specifies the period in which the contract should be reviewed, i.e., do they wish to have the contract reviewed for FIDE for the same period(s) as indicated for MIPPA compliance as answered to questions 6 and 7. This question seeks to determine that if the contract is a multi-year contract or an evergreen contract, whether it is the MAOs intention that FIDE determination be made for the same period(s).		
We recommend that this section be modified so that a sampling can be used in monitoring surveillance.	Revision	Reject: We do not believe this modification is necessary because sampling is an acceptable method of surveillance.		
We recommend that reference to "third party liability" be removed because CMS has not provided clear direction as to what is meant be this. As an alternative, CMS needs to clarify or provide background on "third party liability" in this context.	Deletion	Accept with Modification: This comment is referencing an old form that is no longer in use. A new Upload form will be inserted into the application document.		

We are assuming that this section would only be included if the State Medicaid Agency contract requires the D-SNP to provide Medicaid services. Broadly, if State Medicaid Agencies and MAOs determine that increased coordination will best serve dually-eligible members, the requirements should be clarified to allow this. Specifically, in item #5 and elsewhere that references providing Medicaid benefits, clarify in these areas that agreed-upon coordination is acceptable.	Revision	Accept with Modification: This comment is referencing an old form that is no longer in use. A new Upload form will be inserted into the application document. The language in the "Note" should read "provide or arrange". The old form says "provide and arrange". CMS does not feel that additional changes other than this needs to be made as the guidance in Chapter 16-B and all trainings cover this area in detail.		
Flexibility should be provided to allow the Medicaid benefits to be documented in a variety of ways that will accommodate each state's unique negotiated approach. For example, due to the overlap of benefits covered by both Medicare (primary) and Medicaid (secondary), if a state wants a combined list of Medicaid and Medicare benefits outlining each program's responsibility for a category of service, that should be sufficient to meet this element and will help MAO's create a better Section IV of the Summary of Benefits.	N/A	Reject: Submission of combined lists results in CMS not being able to determine the level of actual coordination and integration.		
We believes that the correct citations are 42 CFR 422.2262 and 42 CFR 423.2262, respectively.	Revision	Accept: However, we should note that while CMS does not currently require submission of marketing materials for pre-approval it resereves the right to review EGWP related marketing material at any time.