EXHIBIT A

Coverage Decision Letter CMS-10716

CHANGE CROSSWALK

Form	Change to Form	Explanation
Throughout form	Changed all instances of <health plan name> to <plan name>	Changed for consistency with the form instructions.
Throughout form	Changed font from Times New Roman 12 to Arial 11	Changed to more closely align with other CMS model notices developed for Medicare-Medicaid Plans under the Financial Alignment Initiative capitated model demonstrations.
Page 1 in 1st paragraph. Original language: <Plan name> is called "our plan" or "we" in this letter. Our plan is your health insurance company. We combine: • your Medicare and Medicaid [*Insert state-specific term for Medicaid, if applicable*] services. • your doctors, hospitals, pharmacies, and other health care providers into one coordinated system.	Updated language: <Plan name> is a health plan that contracts with Medicare and Medicaid [*Replace with state-specific term for Medicaid, if applicable*] to provide coverage for both programs. Our plan coordinates your Medicare and Medicaid [*Replace with state-specific term for Medicaid, if applicable*] services and your doctors, hospitals, pharmacies, and other health care providers.	Edited to ensure the language was appropriate for both FIDE SNPs and HIDE SNPs.
Page 1 in 2nd paragraph.	Added language to 2nd paragraph: **Our plan <denied *or* partially denied *or* reduced *or* stopped *or* suspended> [*Insert if***	Added "partially denied" as an option to correct an omission.

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	***applicable*: payment for]** **the <service *or* item> listed below:**	
Page 1 in 2nd paragraph plan instruction.	Added language to 2nd paragraph plan instruction: [*Insert description of service or item being denied, partially denied, reduced, stopped, or suspended, and include doctor or provider's name if a particular doctor or provider requested the service or item.*]	Added "partially denied" as an option to correct an omission.
Page 1 in third paragraph	Edited 3rd paragraph plan instructions: Our plan made this decision because [*Provide a specific denial reason and a concise explanation of why the service/item was denied and include state or federal law and/or Evidence of Coverage/Member or Enrollee Handbook provisions to support the decision. Write rationale in plain language – see instructions for more information*].	Edited for consistency with the form instructions and to include terminology more appropriate for Medicaid managed care plans.
Page 1 under section titled **You have the right to appeal our decision**	Added second paragraph using language previously under the section titled "How to appeal": You can also call <Plan phone number for appeal requests> (TTY: <TTY number>) and ask us for a free copy of the information we used to make our decision. This may include health records, guidelines, and other documents. You should show this information to your <doctor *or* health care	Changed to improve readability.

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	provider> to help you decide if you should appeal.	
Page 2 under section titled **There are two kinds of appeals** Original plan instruction: <**30 calendar days** *or for a Part B drug* **7 calendar days**>	Changed all instances of the plan instruction throughout this section to: [*for a Part B drug, insert:* **7 calendar days** *or for any other service or item, insert:* **30 calendar days** *or a shorter timeframe if required by the state*]	Changed to clarify the different amounts of days plans must add for Part B drug and/or a state-specific timeline.
Page 2 under section titled "**There are two kinds of appeals**"	Changed 1st sentence under #2 of this section to: If you ask for a **fast appeal**, our plan will give you a decision within [**72 hours** *or a shorter timeframe if required by the state*] **after we get your appeal**."	Changed to provide flexibility for a plan to insert a state-specific timeline when required under the state Medicaid agency contract.
Page 2 under section titled "**There are two kinds of appeals**"	Added sentence to the end of the first paragraph under #2 of this section: "**Note:** You can't get a fast appeal if our plan denied payment for a service you already got."	Added language to note an exception to the ability to receive a fast appeal.
Page 2 under section titled "**There are two kinds of appeals**"	Reformatted the original last paragraph of this section to be the 2nd paragraph of #2 of this section. Moved language from the original last sentence of #1 to be the new last paragraph of this section	Changed language to clarify that a plan may delay a decision for both a standard and fast appeal.
Page 2 under section titled "**How to appeal"**	Added language to first sentence of this section: You, someone you have named in writing as your representative to act on your behalf (such as a	Added language to note the member must name a representative in writing.

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	relative, friend, or lawyer), or your <doctor *or* health care provider> can appeal.	
Page 2 under section titled "**How to appeal"**	Added language to 3rd sentence of this section: • **Mail:** Mail it to <plan mailing address for appeal requests>	Edited to clarify plan instruction regarding mailing address.
Page 3 under section titled "**How to appeal"**	Deleted second to last paragraph of this section.	Moved information in this paragraph to improve readability of the form.
Page 3 under section titled "**How to appeal"**	Added language to the plan instruction in the last paragraph's second sentence: You can also find more information in our plan's [*insert Evidence of Coverage, Member or Enrollee Handbook, or other term plan uses*], [*plans may insert chapter and/or section reference, as applicable*]. An up-to-date copy of the [*insert Evidence of Coverage, Member or Enrollee Handbook, or other term plan uses*] is always available on our website at <web address> or by calling our plan.	Added flexibility for an alternate name for Evidence of Coverage that may be used by some plans as well as for referencing the specific chapter and/or section that includes the additional information.
Page 3 under section titled "**How to keep getting your <service or item> during your appeal"**	Added language to plan instruction in the 1st bullet: [***Insert continuation of benefits request filing date in month, date, year format. Date will be the later of the following: (1) 10 calendar days from date of letter (or later than 10 calendar days, if required by the state),***	Changed to provide flexibility for a plan to insert a state-specific timeline when required under the state Medicaid agency contract.

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	or (2) date the decision takes effect]	
Under section titled "**How to keep getting your <service or item> during your appeal"**	Added 4th bullet: • If your <doctor *or* health care provider> is filing the appeal for you and you want your <service *or* item> to continue, then your <doctor *or* health care provider> must include your written consent.	Changed to note the need for consent when a provider is requesting a continuation of benefits.
Page 4 under section titled "**What happens next**"	Changed last sentence of this section to: If our plan still denies [*Insert if applicable*: payment for] the <service *or* item> listed on the first page of this Coverage Decision Letter, the Appeal Decision Letter will tell you what happens next, such as information about a Medicare Level 2 appeal or how to ask <state name> for a Fair Hearing.	Added a reference to Level 2 appeals and processes for getting a Fair Hearing from the state.
Page 4 under section titled "**What to do if you need help with your appeal**"	Changed 1st sentence in 1st paragraph to: You must first name them in writing as your "representative" by following the steps below.	Added language to note the member must name a representative in writing.

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Page 4 under section titled "**What to do if you need help with your appeal**"	Edited the 1st bullet of this section: • Call our plan at <plan phone number for representative requests> (TTY: <TTY number>) to learn how to name that person as your representative. Or, you can visit Medicare.gov/claims-appeals/file-an-appeal/can-someone-file-an-appeal-for-me. [*Plans may replace with a plan-specific web address that explains how members can appoint a representative.*]	Added flexibility for plans to include a plan-specific web address to the personal representative form.
Page 5 under section titled "**Get help and more information**"	Corrected Medicare Rights Center phone number and added a website under 6th bullet	Corrected an error and omission.
Page 5 under section titled "**Get help and more information**"	Corrected "Elder Care" to "Eldercare" and updated the web address under 7th bullet	Corrected an error.
Spanish Translation	Included a Spanish translation version of the coverage decision letter in this 30 day notice	Translated the revised coverage decision letter for Spanish speaking beneficiaries
Spanish Translation Page 5 under "**Obtenga ayuda y más información"**	Added additional instruction to **"**Centro de Derechos de Medicare" bullet not included in the English version	Included an instruction on how to directly access Spanish assistance when calling the Medicare Rights Center

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Throughout instructions	Changed "form" to "letter"	Corrected terminology.
Throughout instructions	Added Medicare before Part B drug	Added to improve clarity.

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Throughout instructions	Changed all instances of <health plan name> to <plan name>	Corrected for consistency throughout form and instructions.
Page 1 under section titled "**When should the plan use this letter?**"	Added the last sentence to the first paragraph of this section: "This letter must be used in place of the Notice of Denial of Medical Coverage (or Payment) (NDMCP) form (CMS10003)."	Added clarification on use of the form.
Page 1 under section titled "**When should the plan use this letter?**"	Added the second paragraph to this section.	Added clarification on the use of the form.
Page 1 under section titled "**Formatting and language requirements**"	Inserted as 1st bullet language previously under section "**When should the plan use this letter?**": • The letter contains text in pointed brackets < > when a particular piece of data must be inserted into the document and the data are either: 1. Based on the specific situation involved – for example, the appropriate term to be inserted depends on the situation, or 2. Specific to the individual letter – for example, an effective date or deadline date.	Changed to improve the organization and readability of the form instructions.
Page 1 under section titled "**Formatting and language requirements**"	Inserted as 2nd bullet language previously under section "**When should the plan use this letter?**":	Changed to improve the organization of and explain the plan instructions in the form.

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	• Instructions to plans appear in blue italicized text and brackets [ ] and are only for plan use. And added to the 2nd bullet the following sentence: Plans must ensure that no blue text remains in the Coverage Decision Letters that plans send to members.	
Page 2 under section titled "**Formatting and language requirements**"	Inserted the 6th bullet: • When the letter gives the plan specific choices about word usage (e.g., <service *or* item> <doctor *or* health care provider>), the plan should choose the term that fits the circumstances and use it consistently throughout the notice.	Changed to explain the plan instructions in the form.
Page 2 under section titled "**Required timeframes in this letter**"	Add this section and language: Plans operating in states that have established shorter timelines for a plan to make a decision on an appeal must replace any relevant timeframes with those set by the state. These timeframes must be documented in the plan's state Medicaid agency contract as provided under 42 CFR 422.629(c). This letter includes instructions for timeframes where such replacements are possible.	Changed to clarify when plans should change timeframes listed in the form.
Page 2 under section titled "**Heading instructions"**	Edited the 4th bullet: • **Service/item this letter is about:** Insert, ~~in plain language,~~ the name and/or brief ~~description~~ descriptor of the	Edited to improve readability.

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	service or item that was requested and for which authorization and/or payment is being denied	
Page 3 under section titled "**Heading instructions"**	Edited the 5th bullet: • [***Insert Additional Field(s) as needed, when plan is required by state to include specific information in the letter***]: The plan is permitted to insert additional fields of information in the header section of the letter if needed, consistent with applicable state requirements, such as the name of the provider making the request or the member's Medicaid number. If the plan operates in a state that requires contracted plans to include additional fields in this table, add those fields.	Changed to clarify when plans should insert additional information.
Page 3 under section titled "**First paragraph of letter**"	Edited the 2nd bullet: • In the first sentence and first bullet point of this paragraph, ~~insert~~ replace "Medicaid" with the state-specific term for Medicaid, if applicable.	Edited to conform with changes to the form.
Page 3 under section titled "**Second paragraph of letter**"	Added *partially denied* as a plan choice in the first paragraph and first bullet.	Edited to conform with changes to the form.
Page 3 under section titled "**Third paragraph of letter**"	Edited 1st paragraph: In the sentence that begins, "Our plan made this decision because," the plan should provide a specific denial reason and ~~detailed~~ a	Edited to improve readability and conform to plan instruction language in the form.

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	concise explanation of why the service/item was denied~~, including a description of the applicable Medicare (~~and include state or ~~Medicaid) coverage rule~~ federal law and/or ~~applicable plan policy (for example,~~ *Evidence of Coverage* ~~provision) upon which the action was based~~/*Member* or *Enrollee Handbook* provisions to support the decision.	
Page 4 under section titled "**Third paragraph of letter**"	Inserted the following sentence to the 2nd bullet: If the plan considered both Medicare and Medicaid coverage rules in making its decision, the description should include both sets of rules.	Added language based on comments regarding the importance of information on Medicare and Medicaid coverage rules for beneficiaries when making an appeal.
Page 4 under section titled "**Third paragraph of letter**"	Inserted the following sentence into the 3rd bullet: If the plan considered both Medicare and Medicaid coverage rules, the explanation should describe how both coverage rules were applied in this case.	Added language based on comments regarding the importance of information on Medicare and Medicaid coverage rules for beneficiaries when making an appeal.
Page 4 under section titled "**Section titled: You have the right to appeal our decision**"	Inserted the second paragraph: In the second paragraph, the plan should insert the most appropriate plan phone and TTY numbers for appeal requests. The plan may insert the toll-free Member Services phone number and toll-free TTY number if the plan doesn't have a specific phone number for appeal requests.	Added language to clarify that plans should insert the most appropriate phone number for appeal requests.

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Page 5 under section titled "**Section titled: There are two kinds of appeals**"	Inserted the following sentence into the 1st paragraph: Plans operating in states with shorter timelines to make a decision on an appeal must replace any relevant timeframes with those established by the state and documented in the state Medicaid agency contract.	Changed to clarify when plans should change timeframes listed in the form.
Page 5 under section titled "**Section titled: How to appeal**"	Edited 1st paragraph: The plan should insert ~~its toll-free~~ the most appropriate plan phone and TTY numbers, fax number, mailing address, and, if appropriate, the in-person delivery address that members may use to file an appeal. The plan may insert the toll-free Member Services phone number and toll-free TTY number if the plan doesn't have a specific phone number for appeal requests.	Added language to clarify that plans should insert the most appropriate phone number for appeal requests.
Page 5 under section titled "**Section titled: How to appeal**"	Deleted paragraph: In the paragraph that starts "On the first page of this Coverage Decision Letter," the plan should insert the appropriate term to describe the action taken in this letter. If the denial involves a payment request, insert the "*payment for…"* text.	Edited to conform with changes to the form.
Page 5 under section titled "**Section titled: How to appeal**"	Edited 3rd paragraph: In the paragraph that starts, "To get more information on how to appeal", the plan must insert the plan's toll-free Member Services	Added flexibility to allow an alternate name for the Evidence of Coverage that may be used by some plans as well as a reference to the specific

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	phone number in the <~~health~~ plan Member Services phone number> field and toll-free TTY number in the <TTY number> field. In the second sentence, the plan may also include additional chapter and/or section reference information, as applicable. The plan should also insert the ~~appeals chapter and section number of the plan's *Evidence of Coverage* (EOC) in the <chapter number, section number> field and the~~ website where members can access the most current version of the plan's ~~EOC~~ *Evidence of Coverage*/*Member* or *Enrollee Handbook* document in the <web address> field.	chapter and/or section that includes the additional information.
Page 6 under section titled "**Section titled: How to keep getting your <service or item> during your appeal**"	Inserted language into the 1st bullet: • 10 calendar days from the date of the letter (or later than 10 calendar days, if required by the state)	Changed to provide flexibility for a plan to insert a state-specific timeframe when required under the state Medicaid agency contract.
Page 6 under section titled "**Section titled: What happens next**"	Inserted the following sentence at the end of the 1st paragraph: The plan should insert the state name as indicated in the fields with pointed brackets.	Added instruction based on additional language added to the form regarding a Fair Hearing from the state.
Page 6 under section titled "**Section titled: What to do if you need help with your appeal**"	Modified first paragraph in this section: In the ~~field indicated by pointed brackets~~ first bullet in this section, the plan should insert the ~~toll-free~~ most appropriate plan phone and TTY numbers in the fields with	Changed to clarify information plans can provide to assist members in how to name an authorized representative.

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	pointed brackets to be used if the member needs information on how to name an authorized representative for the purposes of the appeal. The plan ~~should also~~ may insert~~, in~~ the ~~appropriate fields, the address and fax~~ toll-free Member Services phone number ~~that may be used to submit authorized~~ and toll-free TTY number if the plan doesn't have a specific phone number for representative requests. The plan may also replace the Medicare.gov web address with a plan-specific web address that explains how members can appoint a representative.	
Page 6 under section titled "**Section titled: What to do if you need help with your appeal**"	Inserted a 2nd paragraph to this section reading: In the third bullet in this section, the plan should insert, in the appropriate fields, the mailing address and fax number that may be used to submit authorized representative requests.	Added instruction based on additional language added to the form.