Summary of Comments and Responses for 60-day PRA Integrated Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) Models

General Comments

Comment	Response
Gathering input about how to increase the linguistic and cultural relevance of the ANOC should begin with beneficiaries. To understand how consumers experience the ANOC, CMS should solicit feedback from diverse voices reflective of the demographic diversity of people dually eligible for Medicare and Medicaid. For example, listening sessions should be conducted in languages beyond English and Spanish. Including consumers in the ANOC development process can help CMS to deliver information in a more meaningful manner to people dually eligible for Medicare and Medicaid.	CMS appreciates the comment and agrees that consumer input is important. These model materials (henceforth models) were created based on models that were used for the Financial Alignment Initiative, which were informed by consumer input and testing. CMS will consider additional consumer input for future cycles.
The ANOC is an important document, as it informs plan members of key changes that may influence their decision to continue membership in the plan. To that end, the ANOC should be person-centered, provide information with specificity, and deliver information in a user-friendly manner. To achieve its purpose, highlighting the upcoming changes to the plan at the beginning of the document quickly alerts enrollees of changes that may directly impact them. In its current form, information about plan changes does not appear until page 8 of the document. To make it easier for enrollees to comprehend upcoming changes, we suggest adding a summary with highlights or bullet points on the first or second page of the ANOC. For example, the summary section could flag that the plan name or prescription drug co-payments are changing and then reference the page number and accompanying section where the change is discussed in more detail. Given that changes could influence a consumer's decision to remain in the plan, information about how to change plans can also be raised earlier in the document than in its current location on page 16. We also suggest that the document be	CMS appreciates the comment and agrees that the ANOC is an important document. However, CMS did not make any changes to the document because the model includes several pages of instructions to plans that will not be included in the actual document that enrollees receive. There is also a summary of changes in the introduction for the enrollees, and the detailed information on the changes are included a few pages into the document.

Comment	Response
personalized to the beneficiary. For example, on page 3, instead of giving Dual Eligible Special Needs Plans (D-SNPs) the option to address the document to the member by name, CMS should make using the individual's name a requirement.	
The ANOC and EOC should use plain language when possible. Plans must explain acronyms and less common terms in consumer-friendly language and provide relevant examples. Long-term services and supports are referenced multiple times in the EOC chapters; although this is a common term used by health care providers and health plans, the meaning may be obscure to the average consumer. Examples are helpful to illustrate services offered under long-term services and supports or an explanation of how care coordination would benefit a consumer. CMS should also consider developing standardized language to describe care coordination and care coordinators. While plans should continue to have the discretion to describe care coordination to some extent, developing standardized language or simple requirements, such as using examples, will ensure that all plans provide a basic description of care coordination that is meaningful.	CMS understands the need for simple language and to provide examples of terms. Over time, CMS has worked to increase the use of plain language in models, including spelling out acronyms the first time they are used. CMS will continue to review ways it can develop more standardized language for terms such as care coordination for future cycles.
Current regulations permit hard copies of the ANOC and EOC to be mailed or delivered electronically. Plans should be required to mail these documents by default unless the consumer affirmatively elects to receive these communications by electronic mail. Dually eligible individuals may not have ready access to technology, may not frequently check email communications, or may need assistance using technological devices. As a default, these materials should be delivered by mail while allowing consumers to elect electronic delivery. As previously indicated, people dually eligible for Medicare and Medicaid are more diverse than Medicare-only recipients. Therefore, analysis of the ANOC must consider how to improve the document's accessibility for subpopulations, including LEP enrollees. Information about alternative languages and	CMS has moved language regarding how to receive materials in alternate languages and formats to earlier in the introduction as well as included information on interpreter services. The current requirements for mailing materials are included in regulation at 42 CFR 422.2267(d), which include the ability to mail a notice informing enrollees how to access materials but also include the option for enrollees to request a copy of materials in writing. In addition, since these materials cover both Medicare and Medicaid services, the requirements for both programs apply to the materials. Finally, the CY 2024 Medicare Advantage/Part D proposed rule, if

Comment	Response
formats is not found in the ANOC until page 6, section B1. To increase the prominence of information about translated materials and alternative formats in the ANOC, we suggest that CMS provide this information as an insert or cover sheet. Consumers that receive the ANOC in English, but need translated materials or alternative formats, may not read to page 6 of the document to learn they can receive these materials in the language or format they need. An insert or cover sheet quickly alerts the consumer that translated and alternative format materials are available and provides critical information on how to request these materials. In addition to providing this information earlier in the document or as an insert, we encourage CMS to explore options to relay information about the plan's language and accessibility features in as many languages and formats as possible. For example, CMS should consider including an insert containing information about language assistance services and alternative document formats in the threshold languages in the plan's geographic area. In all respects, D-SNPs and Medicaid plans serving the same geographic area should be subject to the same language accessibility requirements, and should be whichever is most favorable to the beneficiary. It would be confusing for an enrollee to receive the ANOC and EOC in English and materials from their Medicaid plan in their preferred language. Additionally, information about language assistance services could be included at the bottom of every page of the document to improve access. The ANOC currently contains optional language for plans. This content, for example, on page 2, provides plans with the option of using "regionally appropriate terms or common dialects in translated models." Regionally appropriate language is more likely to resonate with specific communities, improving the document's usability for particular subpopulations. When regionally appropriate terminology is available, this content should be included in the document and, to	finalized, would require plans to provide materials to enrollees in alternate languages and/or formats as a standing request upon learning of the enrollee's preference. The proposed rule would also clarify that fully integrated dual eligible (FIDE) special needs plans (SNPs), highly integrated dual eligible (HIDE) SNPs, and applicable integrated plans (AIPs) must translate required materials, including the ANOC and EOC, into any languages required by the Medicare translation standard plus any additional languages required by their state's Medicaid translation standard.

Comment	Response
ensure relevance, be subject to beneficiary testing. As another example, plans currently have the option of providing translated materials in large print. Accessibility features should be available to all enrollees, regardless of the language of the materials they receive. Therefore, plans should be required to provide translated materials in large font, upon request, to consumers. We do not imagine that the requests for large print materials would be so great that they would cause a significant financial burden to health plans.	
We encourage CMS to explore options beyond text to relay information in the ANOC. To demonstrate this need, consider the consumers that do not recognize their enrollment in Medicare until they are shown a picture of a Medicare card. Simple visuals, such as a pill to denote medicine or an apple to signify preventative care, as found in The Medicare & You handbook, help orient readers to the subject matter outlined in the accompanying text. Additional formatting choices in the handbook, such as charts, text boxes, and arrows containing the word "Important," direct the reader to pay close attention to specific content while breaking up the dense text to make the document more visually accessible. While formatting suggestions gathered from consumers, such as plain language and bulleted lists, have been incorporated into the document, additional efforts could be taken to advance the document's accessibility. We encourage CMS to explore opportunities to use images and formatting alternatives to make the ANOC more user-friendly. Beneficiary outreach is yet another method to enhance members' understanding of their benefits. CMS might consider directing plans to discuss beneficiary-specific changes outlined in the ANOC with members as part of their ongoing case management duties. For example, the ANOC currently instructs members to contact Member Services to discuss changes related to their medication coverage. Instead of	CMS appreciates the feedback. These models were created based on models that were used for the Financial Alignment Initiative, which were informed by consumer input and testing. CMS will consider additional consumer input, as well as continue to review ways it can deliver information in a more meaningful manner, for future cycles.

Comment	Response
placing the sole responsibility of outreach on the beneficiary, we alternatively suggest that plans contact enrollees to discuss plan changes, answer questions, ensure access to accessibility features, and assist with benefits navigation. We believe that this additional support from plans will enhance members' understanding of their benefits, improve access to critical resources like medications, and ultimately improve their health outcomes. Precedence for this type of outreach already exists in California. Health plans participating in California's Financial Alignment Initiative (FAI) are conducting telephone calls to their members to alert them of the transition into exclusively aligned D-SNPs. Telephone calls are person centered, ensure enrollees are aware of critical changes, and offer an opportunity for enrollees to ask questions about their plan.	
Our analysis identified a few areas of the ANOC that likely fuel confusion. For example, cost-sharing references throughout the document may confuse Qualified Medicare Beneficiaries (QMBs) or those full-benefit dual eligible who do not have costs associated with their benefits. At the same time, removing cost-sharing references altogether may result in a need for more awareness amongst consumers of the savings related to their dual eligibility status. As this example demonstrates, beneficiary testing is needed to better understand how consumers interpret this information to improve messaging. As another example, when the document encourages readers to reference a section of the ANOC or EOC, a brief explanation should accompany the section name to help the reader understand its content. We urge CMS to utilize language beyond "Refer to Section E," as found on page 5, and instead use language like "Refer to Section E for information about changes to our drug coverage," as seen on page 7. This additional information helps to orient the reader to the section's content and makes the document easier to navigate.	CMS appreciates the comments about how and whether to describe cost-sharing. For example, it is possible for an AIP D-SNP to have Medicaid copays for Medicare Parts A and B as well as LIS cost-sharing for Part D. Therefore, CMS has included all cost-sharing language in the model as variable so it can be customized to the rules in a particular state and program. The language that the enrollee receives from the plan should be more specific to their coverage since plans are required to include the actual cost-sharing for the enrollee which can vary by state. CMS also appreciates the comments on references but did not make any changes at this point because the references are sufficiently clear. CMS will consider additional consumer input, as well as continue to review ways CMS can deliver information in a more meaningful manner, for future cycles.

Comment	Response
We would like to confirm if the option to use new EOC and ANOC models only applies to exclusively aligned HIDE SNPs and exclusively aligned FIDE SNPs or does it apply to other types of D-SNPs as well? When must the states declare that they opt to use the new models instead of the standard D-SNPs EOC/ANOC models? What is CMS's timeline in communicating to MA organizations the states that require the use of these integrated models and in releasing the final models for use?	These models are for use only by D-SNPs designated by CMS as AIPs in states that require them. CMS is reaching out to those states directly and the state will inform D-SNPs if they plan to require the use of these models. CMS and the states will work to finalize models and the states provide them to plans as soon as possible.
Change the word Ombudsman to Ombudsperson	CMS accepts this edit and will change the language throughout the document.
We urge extensive use of consumer testing to ensure the ANOC and EOC achieve the right balance of information and approachability. Too much information is overwhelming, too little is useless. Generally speaking, we found the drafts had a good balance, but we are also aware that many readers may be approaching the material without previous knowledge of or understanding of how Medicare Advantage works and what their rights and responsibilities are. We encourage testing around language, organization, and what information in the ANOC is necessary and what may be left to the EOC.	CMS appreciates the comment. These models were created based on models that were used for the Financial Alignment Initiative, which were informed by consumer input and testing. CMS will consider additional consumer input, as well as continue to review ways it can deliver information in a more meaningful manner, for future cycles.
We also urge personalization to the extent possible to ensure that people get information best tailored to their circumstances.	CMS appreciates the comment. The variable fields will allow state-specific customization of Medicaid information in the models. CMS will consider additional consumer input, as well as continue to review ways it can deliver information in a more meaningful manner, for future cycles.
A trade association supports the proposed changes to the ANOC and EOC for D-SNPs that are applicable integrated plans (AIPs). CMS properly notes there are advantages to receiving communications that integrate all the required Medicare and Medicaid content, including providing a more seamless description of health care coverage and enhancing the understanding of, and satisfaction with, the coverage both programs provide. The SNP Alliance has long advocated the integration of member materials as important for improving beneficiary experience	CMS appreciates the comments and support.

Comment	Response
and outcomes. We appreciate the actions taken here to advance integration.	
We request that final models be provided no later than early May, and final approvals from the State by 8/1, to allow sufficient time for development, quality review, translations, and print production to meet the 9/30 (ANOC mailing) and 10/15 (online posting) deliverables.	CMS appreciates the comment and will work to provide models as soon as possible.
Global comment for proposed integrated ANOC and EOC models: The content layout does not align with the current D-SNP model. UnitedHealthcare (UHC) recommends remaining consistent with the current models as creating a whole new format and content creates risk in developing the documents and increases time required to manage additional models.	CMS appreciates the comment. These models were created based on models that were used for the Financial Alignment Initiative, which were informed by consumer input. These models, similar to the Financial Alignment Initiative models, are formatted to provide all Medicare and Medicaid information to enrollees in one document to make it easier for these enrollees to understand the benefits that are available to them across both programs. CMS will consider additional consumer input, as well as continue to review ways it can deliver information in a more meaningful manner, for future cycles.

ANOC Comments

Comment	Response
The new ANOC in particular is a marked improvement over past versions, with more streamlined text and more visual appeal, including better use of white space and readable fonts.	CMS appreciates the comment and support.
Though it would extend the length of the document, we encourage the use of tested graphics to guide readers and flag important details.	CMS will consider additional consumer input, as well as continue to review ways it can deliver information in a more meaningful manner, for future cycles.
We urge clarifying what language help is available early on to ensure people see it immediately. The reference in the ANOC is not until B1. For comparison, in the Medicare & You Handbook, the information is on page two in the introduction.	CMS appreciates the comment, and has moved this language to an earlier location in the document.
Plans currently have the option of providing translated materials in large print. Accessibility features should be available to all enrollees, regardless of the language of the materials they receive.	CMS has deleted the ambiguous language in the ANOC and EOC related to accessibility. All MA organizations and Part D sponsors must comply with section 504 of the Rehabilitation Act of 1973, section 1557 of the Affordable Care Act, and implementing regulations at 45 CFR part 92. The regulations at 45 CFR 92.102(b) require plans to provide appropriate auxiliary aids and services, including interpreters and information in alternate formats, to individuals with impaired sensory, manual, or speaking skills, where necessary to afford such persons an equal opportunity to benefit from the service in question.
We suggest the use of cover sheets or early pages that list major or confusing changes with references pointing the reader to more information. The Medicare & You introduction (page two) could serve as a guide.	CMS appreciates the suggestion. CMS will consider additional consumer input, as well as continue to review ways it can deliver information in a more meaningful manner, for future cycles. CMS agrees that the Medicare & You Handbook is a good example for consideration.

Comment	Response
We suggest that some material may benefit from being introduced sooner in the ANOC: • Information about help in other languages • Information about plan changes, including plan name • Information about what happens if the enrollee does not choose another plan	CMS appreciates the suggestions and has moved the multi-language insert information to an earlier location in the document. The information about plan changes and what happens if the enrollee does not choose another plan is included within the first few pages of the actual document that the enrollee will receive. The current model includes several pages of instructions, which will not display in the version the enrollee receives. CMS will consider additional input, as well as continue to review ways it can deliver information in a more meaningful manner, for future cycles.
We encourage the use of state-specific names for Medicaid and also the use of "Medicaid" to ensure enrollees understand both.	CMS appreciates the comment, and has added the word "Medicaid" in parentheses to the header for section B. Plans should use the state-specific name for Medicaid throughout the document.
The ANOC does not include any information about Extra Help and similar low-income assistance programs, or identification of where to go to find information about such programs. We recommend adding this information to the introduction page, and throughout as appropriate.	CMS has not included this information because all enrollees that qualify for AIP D-SNPs (which are the only plans using these models) are deemed eligible for the low-income subsidy (LIS).
The ANOC uses "copay" instead of "cost-sharing." This may be confusing if plans employ and refer to coinsurance. References to all forms of cost-sharing should be clearly defined and used carefully, considering that Qualified Medicare Beneficiaries (QMBs) or some full-benefit dually eligible individuals may not have costs associated with their benefits and may be confused or dissuaded from seeking care if they believe they will incur costs.	CMS appreciates this comment and uses the term cost-sharing to encompass copays, co-insurance, and deductibles. Enrollees in AIP D-SNPs only includes enrollees who are full- benefit dually eligible (QMB+, SLMB+, other full benefit dual eligible). For all Medicare Part A and B services, cost-sharing is either $0 or the Medicaid copay applicable to that service (if the state charges such copays and the affiliated Medicaid plan does not waive such copays). For Part D, the copay is one of the Low-Income Subsidy (LIS) level copays for full LIS until catastrophic coverage, where there is no cost-sharing.

Comment	Response
	The language is variable since the cost-sharing can vary from state to state. Those states where there is no cost-sharing have the flexibility to modify any language related to cost-sharing or copays.
Instructions: We suggest adding direction to use state-specific compliant language block per guidance issued by the state.	CMS understands that some states have specific language requirements. Section A of the ANOC currently notes that plans must include all disclaimers included in state-specific guidance.
Page 3, Introduction: Members receive this document by September 30, but the Handbook and other member materials are not posted on the website until October 15. It would probably be helpful to make note of that here so they aren't looking for the materials before they are available.	CMS appreciates the comment but will maintain the current language. This is standard language that is used in all CMS models.
Page 4, Section B: This section appears to be redundant to section G2. If decide to keep recommend adding additional instructions. For example, "Plans may insert state-specific Medicaid enrollment options as applicable."	CMS rejects this suggestion as this is a general introduction section which refers the readers to enrollment options in section G2.
Page 5, Section B. Reviewing your Medicare and [Insert name of Medicaid program] coverage for next year. Regarding the sentence, "Refer to Section E for more information," a health plan commented: Does this mean more information about benefits or more information about how to leave the plan?	CMS agrees for the need for clarification. CMS has updated the language to read, "Refer to Section E for more information on changes to your benefits for next year."
Page 5, Section B, 2nd paragraph, first sentence: Plans should be able to edit this paragraph. This paragraph is not accurate for one of our plans and will need to be updated to reflect state guidelines regarding disenrollment.	CMS has updated the language to allow more flexibility for the Medicaid coverage end date.
Page 7, Section B.3: "Are they in a different cost-sharing tier?" The plan recommends removing the sentence.	While CMS declines to remove this sentence, it has modified the sentence to include instructions to insert if applicable and adjust the language as needed.

Comment	Response
Page 7, Section B.3 regarding the language, "Check if there are any changes to our benefits [insert if applicable: and costs] that may affect you". PrimeWest asks: If plans have no costs for medical services but only for Part D drugs, should the "costs" part be included here?	Since the ANOC includes medical and drug benefits, if there are changes to the cost of Part D drugs the language should be included.
Page 12, Section E2-E3: The plan recommends adding language from the D-SNP ANOC and EOC models to describe the Defined Standard benefit and cost-sharing if a member loses LIS.	CMS appreciates this edit but did not add the suggested language from the D-SNP ANOC and EOC models. The language in the AIP D-SNP ANOC and EOC models is tailored specifically for dually eligible enrollees who have the same plan for both Medicare and Medicaid. These enrollees may find language from the D-SNP ANOC and EOC models to be confusing. All dually eligible individuals are deemed or re-deemed eligible for LIS for the next plan year starting in July of the prior year. That means an individual who has lost Medicaid in the prior year and who is not re-deemed LIS-eligible for the coming plan year would have exhausted any period of deemed SNP LIS eligibility (maximum length is 180 days) by January 1 of the plan year. Since LIS eligibility lasts for the full plan year, even if the individual loses Medicaid during the plan year, all D-SNP enrollees will retain LIS eligibility for the full plan year (January-December).
Page 12, Section E.2: Changes to Prescription Drug Coverage: The model only allows for single and two payment stage charts. Will there be an option to include a four-stage chart like the standard Part D model? If not, where would we report changes to coverage gap?	Since this model is only for enrollees in D-SNPs that are AIPs, they will all be deemed for LIS and will not lose LIS coverage during the year. As a result, for the enrollee there are only two payment stages they encounter (unless the state pays the LIS cost-sharing which means there is only one payment stage.)
Page 12, Section E.2: For plans that file $0 RX on all tiers through VBID, would this be considered single stage?	Yes, this would be considered a single payment stage and the ANOC should reflect this as appropriate.

Comment	Response
Page 12, Section E.2: Changes to Prescription Drug Coverage. In the below chart in section E2 (page 12), for plans that file $0 RX on all tiers through VBID, would that be considered single stage?	CMS has added language that indicates only plans with multiple payment stages should include this information in this section. If there is $0 on all tiers, the plan would not include this section.
Page 12, Section E.2 regarding the language "[insert as applicable: $<initial coverage limit> or $<TrOOP amount >]". How should plans determine which of these to use?	CMS has modified the language to note that plans should insert the TrOOP amount.
Page 13, Section E.3 Regarding the language: "Refer to Chapter 6 of your Member Handbook for more information about how much you pay for prescription drugs." Is this sentence necessary? The chart above tells them how much they pay. The commenter also notes a word is missing in this sentence - "...more information about..."	CMS appreciates these comments. CMS rejects this comment since it believes it is helpful to let enrollees know where they can find general information about their prescription drug costs. CMS did update the language in Section E.3 to address the missing word.
Page 16, Section G.2, page 16, first bullet, Jan-March - As we also note in Chapter 10, at present we do not use these SEPs in any of our programs, so this one would be the first, and it would require reprogramming, testing, and extensive education and outreach about this change.	CMS rejects this edit. This is a required special enrollment period for dually eligible individuals per 42 CFR 438.38(c)(4).
Page 19, Section G.2 regarding the language "[insert name of program, phone number, days and hours of operation, and TTY number and website if applicable]. Is this the name of the Medicaid program?	CMS has updated the language to note that this is the name of the program as directed by the state.
Page 19, Section G.2, last paragraph: We anticipate directing members to our enrollment broker's call center which plays this role today.	CMS has updated the language to note that this is the name of the program as directed by the state.
Page 20, Section H.2 regarding the language ". [Insert name of program] HICAP " What is HICAP? Should this say SHIP?	CMS has edited the document to delete the word "HICAP" and instead changed this to the SHIP.
P 20, Section H2: Is the intent to have a Staff Member's Name?	CMS has deleted the word "staff." This should just be the name of the program.

Comment	Response
Page 20, Section H.2, heading: Our first referral after the plan would probably not be to the SHIP, which seems to play a more limited role in our state than others based on its prominence in these draft models. First, members should call our enrollment broker, which operates a call center and is trained on these topics. They are neither the SHIP nor the ombudsman. Can we please have the flexibility to include them before the SHIP?	CMS declines to make this edit. SHIPs can provide guidance to enrollees on all of their enrollment options. The model includes the flexibility to describe additional state resources later in the document.
Page 21, Section H.4 regarding the language "call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048." Should it be noted that the calls are free?	CMS appreciates the suggestion. However, this is the standard language used for all Medicare Advantage models and CMS plans to maintain it here for consistency.

EOC Comments

Chapter	Comment	Response
Chapter 1	Page 1, Section Header- Global comment for proposed integrated ANOC and EOC models: The content layout does not align with the current D-SNP model. A health plan sponsor recommended remaining consistent with the current models as creating a whole new format and content creates risk in developing the documents and increases time required to manage additional models.	CMS appreciates this comment but did not make any changes in response to it. The integrated ANOC and EOC models were created based on the models used for the Financial Alignment Initiative, which were informed by consumer input and testing. These models, similar to the Financial Alignment Initiative models, are formatted to provide all Medicare and Medicaid information to enrollees in one document to make it easier for these enrollees to understand the benefits that are available to them across both programs. While there are some differences with the current D-SNP ANOC and EOC models, CMS believes they are differences that make the models easier for beneficiaries to use. CMS will consider additional consumer input, as well as continue to review ways it can deliver information in a more meaningful manner, for future cycles.
Chapter 1	Page 1, Section member handbook: Would there be an approval process for state changes to the integrated plan materials?	The state will include state-specific information in the model prior to the state providing the models to plans. The models will be subject to review by the state.

Chapter	Comment	Response
Chapter 1	Page 1: Having the Handbook broken into chapters rather than combined into one document is problematic because it does not allow for searching the entire document at once unless the chapters are combined. For the sake of consistency when replacing terms or variables, it's important to be able to search the entire document. There are also issues with the TOCs for each chapter (noted later in this doc). When combining the chapters, the section letters often default to continuing the lettering from the previous chapter, forcing manual corrections for the section letters. These then need to be double checked several times to ensure that the formatting holds, because changes in one area of the document can cause reversions or updates in previous parts of the document. It would be preferable to receive this document in one piece rather than separate chapters, as we do for other member materials.	CMS understands the commenter's concern but has decided to keep the chapters separate since it allows CMS to finalize chapters with the state that are ready sooner than other chapters that take more time. CMS will consider ways to improve the process for future cycles. In addition, CMS is including some guidance to assist with updates to the chapter table of contents. • Combine documents in Word • Check formatting is still correct • For each TOC, select the content the plan wants to pull from and bookmark it • In each TOC, add the appropriate field code to pull from that bookmark • Select all (Control A) • Update Field (page number only or entire table depending on if changes were made to the sections) • Continue these steps until all TOC's have updated • Save as a PDF document
Chapter 1	Page 1, Section member handbook: Consistent with the global comment above, this is an example of an inconsistency between the proposed integrated model vs. the D-SNP model. In the D-SNP model, plans are instructed to include "(Medicaid)" when it is not part of the Medicaid agency name. Would plans be required to do the same for integrated plans?	AIP D-SNPs are not required to add "(Medicaid)" after the Medicaid agency name for this model because in section B2, CMS explains that the state-specific name of the Medicaid program is the name for the Medicaid program run by the state. This is how the state refers to the program, so CMS uses the actual name of the program to be more specific in this model and uses terms the enrollee will be familiar with based on interaction with Medicaid in a particular state. CMS will consider additional consumer input, as well as continue to review ways to deliver information in a more meaningful manner, for future cycles.

Chapter	Comment	Response
Chapter 1	Page 1: Suggest aligning model more closely to the CMS D-SNP EOC model in structure. Specifically, aligning the TOC section, chapter numbering, and names of the sections and chapters would help tremendously. Aligning the content to the greatest extent possible would be helpful as well.	CMS declines to make this edit. This model was created based on the models used for the Financial Alignment Initiative, which were informed by consumer input and testing. CMS will consider additional consumer input, as well as continue to review ways to deliver information in a more meaningful manner, for future cycles.
Chapter 1	Page 2, Section Your Health and Drug Coverage: Please clarify: When would integrated plans not provide both sets of benefits?	This statement allows some flexibility for benefit differences, such as when a benefit is carved out of the plan for Medicaid.
Chapter 1	Page 3: Section member handbook intro-recommends aligning with the D-SNP model which eliminated the need to include a table of contents (TOC) before every chapter.	CMS rejects this edit. This model was created based on the models used for the Financial Alignment Initiative, which were informed by consumer input and testing. CMS will consider additional consumer input, as well as continue to review ways to deliver information in a more meaningful manner, for future cycles.
Chapter 1	Page 3, Section Disclaimers: Are these disclaimers different than the disclaimers included in the D-SNP EOC model instructions?	The disclaimers included in the D-SNP EOC model instructions are the same as the disclaimers for MA plans that are required in regulation and the Medicare Communications and Marketing Guidelines plus additional disclaimers required by the state (including Medicaid regulations.)
Chapter 1	Page 5, TOC: The TOCs throughout the Handbook are problematic. Once the chapters are combined into one document (necessary to properly paginate) these TOCs can no longer be auto-updated because each one will list all of the headings for the entire document rather than the specific chapter. If you choose only to update the page numbers, it works sometimes—but other times it auto updates the entire table without asking if you want to only update the page numbers. Regardless, the chapter sections and headings in the TOCs must be updated manually, which increases the risk of error.	CMS appreciates the comment but is maintaining the format for the documents at this time. CMS will consider changing the formatting in a future cycle. In addition, CMS is including some guidance to assist with updates to the chapter table of contents. • Combine documents in Word • Check formatting is still correct • For each TOC, select the content the plan wants to pull from and bookmark it • In each TOC, add the appropriate field code to pull from that bookmark • Select all (Control A)

Chapter	Comment	Response
		• Update Field (page number only or entire table depending on if changes were made to the sections) • Continue these steps until all TOC's have updated • Save as a PDF document
Chapter 1	Page 5, Section Chapter 1 Intro: Can this be a single statement like "covers your Medicare and Medicaid services"?	This language should be included as directed by the state.
Chapter 1	Page 6: Should this be "covers"? "Includes" makes it sound as if the doctors and other provides are a part of our plan, rather than a part of our plan's network. i.e., the plan and the providers are separate entities.	CMS appreciates the comment and does not believe any edits are necessary. Plans have the flexibility to adjust this language as appropriate.
Chapter 1	Page 6: Could the word "over" be used here instead? Our members prefer not to be referred to as "older."	CMS appreciates the suggestion and has updated the model with this change.
Chapter 1	Page 7, Section B - 2nd bullet point: "Medicare and the State of …" The word "state" should be lowercase as it is not a proper noun. It would be capitalized if it said Illinois State (which is a proper noun).	CMS appreciates the suggestion and has accepted this edit.
Chapter 1	P7, Section A: Please consider combining the intro paragraph that is included before the TOC with Section A. The content for the intro paragraph and section A is similar and placing a short paragraph before the TOC could be missed by members.	CMS rejects this edit. Each chapter in the EOC contains an introduction section so this formatting is consistent throughout the document.
Chapter 1	P7, Section B2: recommends including standardized content/language rather than allowing input at a plan level.	The description may need to vary by state. CMS has updated the language to state that, "Plans may revise this section to best reflect the coverage of the plan in the state."
Chapter 1	P7, Section A: Please advise what information should go here?	This is an optional section if the plan wants to include additional information about the plan. It is not required.

Chapter	Comment	Response
Chapter 1	P8, Section C: Recommends including standardized content/language rather than allowing input at a plan level.	CMS declines to make this edit. For example, there may be some states where there are certain benefits that are carved out and the language should be adjusted to reflect this. CMS is revising this sentence to state, “Plans may revise this section to best reflect the coverage of the plan in the state”.
Chapter 1	D, page 8: “Approved ZIP codes that are excluded” is awkward; suggest deleting “approved.”	CMS accepts this change.
Chapter 1	P8, Section C: The plan recommends changing "all" to "most."	CMS accepts this change.
Chapter 1	P8, Section E: You are eligible for our plan as long as you: • Live in our service area (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.), and • Are age 21 and older at the time of enrollment, and • Have both Medicare Part A and Medicare Part B, and • Are currently eligible for Medicaid and [insert language as appropriate under terms of state contract], and • Are a United States citizen or are lawfully present in the United States.	CMS has added language regarding incarcerated individuals. The other eligible requirements such as age restrictions can be added as directed by the state.
Chapter 1	P9, Section E: Recommend deleting this bullet as it seems repetitive to the 3rd bullet which references eligibility under the state Medicaid program.	CMS declines to make this edit. This language is variable and can be adjusted as directed by the state.
Chapter 1	E, page 9, 4th bullet: We have a fairly detailed list of these in our current program, and being able to put this at the end of the list after citizenship requirements would be less confusing for members, so they don’t have to parse sub-bullets and then jump back to “citizen or lawfully present”.	CMS has made the suggested edit and moved the citizenship requirement up in the list.
Chapter 1	E, page 9, second paragraph: Presently, our state uses 60 days, which is similar to but not exactly two months. However, we do not want plans to choose a length; this needs to be determined by Medicaid policy and consistent across plans.	CMS has updated the language to allow more flexibility for the use of days or months for the deemed continuous eligibility period.

Chapter	Comment	Response
Chapter 1	Page 10: Can plans use health care provider or primary care provider instead? We have many mid-level providers (NPs, PAs, etc.) who are not doctors who provide services for our members.	The instructions specifically note, "Plans may change references to terms such as “member,” “customer,” “beneficiary, “member services,” “health risk assessment”, “care coordinator,” “primary care provider”, “prior authorization (PA)”, “nursing facility”, and “urgently needed care”, etc. as instructed by the state or based on plan preference and update them consistently throughout the Member Handbook."
Chapter 1	Page 10, Section F: This would be a change for us and we are curious how it works. What happens if a member ignores a mail health risk assessment (HRA)? Is there a penalty or a tracked performance measure for plans? Are they expected to follow up by other means?	This comment is outside of the scope of this process. Please contact MMCO to further discuss HRAs.
Chapter 1	P10, Section G2: Please clarify what constitutes “other services”.	CMS appreciates the request for clarification. “Other services” is intended to provide flexibility for services that can vary by state or plan.
Chapter 1	Page 11, Section H - misspelling: "If you already enrolled and are getting help form one of these programs" - should be "from, not "form"	CMS has made this update.
Chapter 1	P11, Section H: Please clarify the instruction here. If plan has no monthly premium, would plans delete the first bullet and all of the content under section H1. Plan Premium? Also, if plans delete, can plans renumber the sections?	CMS has updated this section to clarify the instructions as requested.
Chapter 1	Page 12: Is this the wrong section reference? This is H2.	CMS appreciates the comment and has updated the language to reference the appropriate section.
Chapter 1	Page 12: Can this section be deleted if plans don’t have optional supplemental benefits?	Yes, the instructions at the beginning of this section note that plans should only include the premium sections that apply for the member.
Chapter 1	Page 12: Should this say that the call is free? Also, should TTY number be included?	CMS rejects this edit.

Chapter	Comment	Response
Chapter 1	H3, page 12: At present, our plans can and do offer some supplemental benefits at no cost. We want to be sure the instructions are flexible for plans to indicate a no-cost option as well.	This section is describing optional supplemental benefits that plans can choose to offer under Medicare Advantage to members at an additional cost. This section is not describing supplemental benefits that are included at no additional cost to enrollees. These supplemental benefits should be included in the benefits chart in section D as described in the instructions to this section.
Chapter 1	P 12, Section I: Please clarify: Plans are usually effective from January 1 – December 31. Would there ever be a situation where plans would need to create non-calendar year materials?	The plan may choose to make this language member-specific if the member enrolls later in the year or may use the dates January 1 and December 31 as well.
Chapter 1	Page 13, Section J: Member ID Card is not a defined term so "card" should be lowercase.	CMS rejects this edit. Member ID Card should be capitalized throughout since CMS capitalizes the name of documents throughout the model.
Chapter 1	Page 13: Would it be possible to add an optional “most” in between get and services here? Re: the direction below for plans to include a separate description if there are Medicaid services members must use a different card for, it is possible and may confuse members if we state this here without the qualifier “most”.	CMS agrees with this update and have made the change in the text.
Chapter 2	Page 3, Section A. Bottom of page- Can these two sentences be combined? Example: To learn more about coverage decisions, refer to Chapter 9 of your member handbook or contact Member Services.	CMS declines to make this edit. We believe that Section A outlines two separate ways for enrollees to obtain more information: 1) calling the plan with questions about a coverage decision related to the enrollee’s health care and 2) referring to Chapter 9 of the Member Handbook for more information about coverage decisions in general. CMS believes it is helpful to keep the bullets listed separately for enrollees
Chapter 2	Page 3, Section A: Recommends remaining consistent with the current DSNP model as creating a whole new format and content creates risk in developing the documents and increases time required to manage additional models.	CMS declines to make this edit. This model was created based on the models used for the Financial Alignment Initiative, which were informed by consumer input and testing. These models, similar to the Financial Alignment Initiative models, are formatted to provide all Medicare and Medicaid information to enrollees in one

Chapter	Comment	Response
		document to make it easier for these enrollees to understand the benefits that are available to them across both programs. CMS will consider additional consumer input, as well as continue to review ways it can deliver information in a more meaningful manner, for future cycles.
Chapter 2	Page 4, 3rd hollow bullet last sentence: recommend changing "got to" to "received from".	Updated the language to state, "You can also make a complaint to us or to the Quality Improvement Organization about the quality of the care you received".
Chapter 2	Page 6, Section B.: Recommend allowing flexibility to modify this section.	The instructions to this section currently state that plans can modify this section as appropriate.
Chapter 2	Page 6, Section B: Recommend giving plans flexibility based on specific services and eligibility requirements if applicable.	CMS has adjusted this language to describe LTSS as applicable.
Chapter 2	Page 7, Section C: Our state currently offers contact information for additional resources before the SHIP, such as a nurse advice line and a behavioral health crisis line. While these could be moved to Section J instead, we believe the flow of the document and their relative importance warrant placement just after the care coordinator.	CMS appreciates the comment; however, CMS believes it is important to include the SHIP information early in this section so that enrollees have access to unbiased information on their health care options.
Chapter 2	Page 10, beginning of Section F: We would prefer to have the state-specific name written out in the first instance of the text as well as the title, if possible.	CMS has adjusted the language to note that the name of the Medicaid program should be included. Also, the instructions at the beginning of this section give states the ability to adjust this section to accurately describe the Medicaid program.
Chapter 2	Page 10: We believe this is a web link for Medi-Cal and should not be included here.	CMS has deleted the web link.
Chapter 2	Page 10, Section F, first sentence: We would prefer to have the state-specific name written out in the first instance of the text as well as the title, if possible	CMS has adjusted the language to note that the name of the Medicaid program should be included. Also, the instructions at the beginning of this section give states the ability to adjust this section to accurately describe the Medicaid program.

Chapter	Comment	Response
Chapter 2	Page 11, Section G: The D-SNP model EOC includes a placeholder for state-specific long-term care (LTC) ombudsmen program. Is this not applicable to integrated plans?	CMS has added the LTC Ombudsperson to this section.
Chapter 2	Page12, Section H1: The D-SNP EOC Model includes the following language: [Other plans should use this language: Most of our members qualify for and are already getting "Extra Help" from Medicare to pay for their prescription drug plan costs.] Is this not applicable?	All of the members enrolled in these integrated AIP D-SNPs will receive Extra Help, so this statement is not applicable. CMS appreciates this edit but did not add the suggested language from the D-SNP ANOC and EOC models because it is not applicable to dually eligible enrollees and these enrollees may find it confusing. In the AIP D-SNP ANOC and EOC models, CMS is working to better tailor language to dually eligible individuals.
Chapter 2	Page 13, Section H2: The D-SNP EOC model includes a table for the state pharmacy assistance program (SPAP) contact information. Is that not applicable here?	The SPAP section mirrors the language included in the D-SNP EOC. The instructions of this section do note that plans can modify this section to include contact information for resources.
Chapter 2	Page 14, Section I: The D-SNP EOC model includes a "How to contact the Railroad Retirement Board" and "Do you have "group insurance" or other health insurance form an employer?", do these sections not apply to integrated plans?	CMS has added this information.
Chapter 2	Page 15, Section J: Suggest using acronym for ESRD	CMS has added the acronym.
Chapter 2	Page 15, Section J, Other Resources: Are we no longer required to include information about the Rail Road board? That is currently part of the section in the non-integrated EOC	CMS has added this language.
Chapter 3	Page 4, Section A: We believe it would be clearer to introduce the acronym the first time the term is used….	CMS has made this update.
Chapter 3	Page 5, Section B: Suggest using "provided" instead of "furnished" in bullet point beginning with, "•You must get your care from network providers."	CMS has made this update.
Chapter 3	Page 10, Section F: Recommend adding new language to address the subject more completely and accurately.	CMS rejects this edit. Behavioral health services provided are very different from state to state. The state may provide model language for D-SNPs to use as appropriate.

Chapter	Comment	Response
Chapter 3	Page 13, Section I3: Lowercase governor and president as both are common nouns.	CMS has made this update.
Chapter 3	Page 15, Section J1: Last paragraph: Suggest change to 2nd sentence for clarity. Either: "If you go over the limit," Or "If you use services over the benefit limit,".	CMS has updated this language.
Chapter 3	Page 17: Would it be possible to add optional language here to indicate that it's the plan that rents the equipment for the member for plans that don't have member copays?	CMS has added flexibility for the state to modify this section.
Chapter 3	Page 17: If members do not make payments for DME under the plan because of Medicaid coverage, then all of this section can be modified to make it clear that the plan rather than the member is paying, correct?	CMS has added a sentence at the beginning of this section for the state to modify it based on member coverage.
Chapter 3	Page 18: 2024?	CMS has made this update.
Chapter 3	Page 17, Section M1: Recommend flexibility to describe DME coverage per State law.	CMS has added the flexibility for the state to modify this section.
Chapter 4	One commenter suggested including numbers instead of writing out numbers.	CMS rejects this edit as the standard formatting is to include writing out numbers.
Chapter 4	Page 1, TOC, Instructions: Should be updated to note that plans can update the content for the Table of Contents.	The instructions for the TOC do note that plans must update the TOC to accurately reflect the information is found on each page.
Chapter 4	Page 2, Section A - 2nd paragraph: Missing the word, "you". "For some services, are charged an out-of-pocket cost called a copay."	CMS has added the word "you" to Chapter 4.
Chapter 4	Page 2, Section A: Because some D-SNP members do have copays for Part D drugs (which are not described in this chapter), it might help to specify "covered medical services" here just to make it clear that we are not referring to absolutely everything. And maybe even add a sentence to this paragraph that tells them which chapter to go to for info about Part D drug costs.	There is language in the first paragraph that notes that information about drug benefits is found in Chapter 5. Some of these services may not be considered as "medical" services which is why this language is general.

Chapter	Comment	Response
Chapter 4	Page 3, Section C - bullet with apple icon: It reads better, "You will find this apple next to preventive services in the Benefits Chart."	CMs has made this update.
Chapter 4	Page 3: The wording here is problematic because it isn't a referral that's needed to see an out-of-network provider, it's an authorization. The plan (not the provider) can give a member an authorization to see an out-of-network provider. Referrals are different and some plans are direct access plans and do not require referrals to see specialists, etc.	CMS appreciates the comment but did not make a change as a result of it. This section of Chapter 4 separately addresses both referrals and prior authorization. Referrals are addressed two bullets above prior authorization.
Chapter 4	Page 3, Section A: It looks like coinsurance language (a % of costs rather than fixed copays) was removed. This does not affect our state at the moment, but we wonder whether it should be added back for program flexibility in other states. It is still mentioned in Chapter 8.	CMS removed cost-sharing language in Section A of Chapter 4 because AIP D-SNPs enroll only people who are full benefit dual eligible individuals (Qualified Medicare Beneficiary Plus, Specified Low-Income Medicare Beneficiary Plus and other full-benefit dually eligible individuals). For all Medicare Part A and B services, cost-sharing is either $0 or the Medicaid copay applicable to that service (if the state charges such copays and the affiliated Medicaid plan does not waive such copays). For Part D, the copay is one of the LIS level copays for full LIS until catastrophic coverage, where there is no cost-sharing. CMS has deleted the reference to coinsurance in Chapter 8 since it is not applicable.
Chapter 4	P.4, Section C: The instructions mention special supplemental benefits for the chronically ill (SSBCI) but do not mention value-based insurance design (VBID) benefits - recommend adding for D-SNPs that file VBID to include the required wellness and health care planning (WHP) language.	CMS has added language for VBID benefits.

Chapter	Comment	Response
Chapter 4	Page 4: Would it be possible to move the list of chronic conditions into the actual Benefits Chart? It seems odd to have that information here, and then in the chart, plans have to refer them back to this page to see what conditions are eligible.	CMS will consider this suggestion for a future cycle.
Chapter 4	Page 4, Section C, 4th bullet: Between this bullet and the next, our 2023 models include details about a continuity of care period and using existing providers. There was a brief instruction about it in Chapter 1, but we believe it needs further elaboration here, for states that have it. This is very important to our program at present and is likely to be carried forward into any successors. It will be important for members to be able to keep going to their existing providers for the first X days (presently 180) that they enroll in this program, and we need a space for plans to describe that.	CMS has added a variable field for states to add information on any continuity of care requirements.
Chapter 4	Page 5, 1st bullet: Currently plans are also able to write "prior authorization (PA) may be required" in this section. Is that still going to be allowed?	CMS rejects this update. Plans should clearly indicate any PA requirements.
Chapter 4	Page 6, Section D: Our Plan's Benefits Chart. In the Services That Our Plan Pays For chart beginning on page 6, there is some confusion about what a plan should do, and where the benefits should be listed, if the plan offers more services for a specific benefit, such as acupuncture, in the supplemental benefit, than it does in the Medicare-defined benefit. In short, if a supplemental benefit exceeds the Medicare-defined benefit, how and where should that be listed?	If the plan offers more services for a specific benefit, for example if they offer unlimited acupuncture benefits, then they should update the language in the benefits chart to reflect the actual benefits that are covered for the plan and note that the coverage is unlimited. If a plan offers additional benefits that are not listed, then they should add those benefits to the description.
Chapter 4	Page 6, Section C: This – and many other changes – are likely to be extensive. If states do not have the opportunity to modify these models before sharing them with our plans, how does CMS expect us to instruct or communicate these changes to plans and ensure consistency and accuracy in the handbooks?	The state will have the opportunity to work with CMS and modify language related to Medicaid prior to sharing the model with the D-SNPs in the state.

Chapter	Comment	Response
Chapter 4	Page 6, Section C: We anticipate directing plans to do this, assuming HCBS services continue to be included in 2024. We believe it was clearer to keep this as its own bullet, but we thank CMS for including it here.	CMS appreciates the comment.
Chapter 4	Page 6, Section D: The plan requests flexibility to modify the benefit chart appropriately to describe the integrated plans. The current structure does not allow flexibility for plans to fully integrate disclosures for supplemental Medicare benefits or for situations in which Medicare and Medicaid coverage may differ. For example, the benefits chart specifies visit limits for acupuncture and limits services to low back pain. California Medicaid, however, allows for coverage as medically necessary and does not limit services to treatment of low back pain. Members would benefit from flexibility by plans to integrate coverage descriptions to allow for a comprehensive description for enrollees.	CMS has included an instruction at the beginning of this section noting that plans should modify this section throughout to reflect Medicaid or plan-covered supplemental benefits.
Chapter 4	Page 7, Section D: If a plan's supplemental benefit is BETTER than the Medicare defined benefit (example Acupuncture) can plan remove the language and add the supplement benefit? Or should the supplement benefit be added to the same section, but under the Medicare benefit? We sometimes offer unlimited acupuncture and had questions on this benefit with the CA exclusively aligned enrollment (EAE) D-SNP.	If the plan offers more services for a specific benefit, for example if they offer unlimited acupuncture benefits, then they should update the language in the benefits chart to reflect the actual benefits that are covered for the plan and note that the coverage is unlimited. If a plan offers additional benefits that are not listed, then they should add those benefits to the description.
Chapter 4	Page 7: In other places, numerals have been used even for numbers below 10 (e.g., see highlighted use of 8 under Acupuncture above). Would it be possible to do that here (use 4) and throughout to be consistent? Numerals, from a health literacy standpoint, are easier to read and comprehend for many people.	Thank you for pointing out the inconsistency. CMS spells out numbers one through ten.
Chapter 4	Page 7, Acupuncture: Should probably say, "only if you have chronic lower back pain"	CMS rejects this change. This is standard language used for all Medicare models.

Chapter	Comment	Response
Chapter 4	Page 8, Ambulance: This paragraph should be the last paragraph as it sounds like it is for "non-emergent" transportation by ambulance.	CMS agrees that this language should be moved to the last paragraph and adopted the change.
Chapter 4	Page 8, Annual Wellness Visit: This is different than the current EOC. The current EOC has the caveat, "Note: the first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventative visit. However, you don't need to have a "Welcome to Medicare" visit to be covered by annual wellness visits after you've had Part B for 12 months. Is this caveat still going to apply?	CMS agrees and have made this update.
Chapter 4	Page 8, Cardiac (heart) rehabilitation services: Modify second sentence to read, "Members must meet certain conditions and have a doctor's...."	Thank you. CMS has updated this language.
Chapter 4	Page 8, Acupuncture: Our state is considering how pregnancy and pregnant members might interact with this program, and we believe that the care coordination services offered in this program would be beneficial. However, pregnancy-related services are barely mentioned in this model, perhaps because they are not thought of as a typical Medicare service. Prenatal care, delivery/childbirth, and post-natal care are just a few examples of the kind of detail we might need to add to this table in order to accurately describe “any Medicaid benefits” as directed above. We are flagging this so CMS can consider whether instructions in this draft are sufficient and flexible enough.	Yes, the state has the flexibility to add any Medicaid-covered benefits to this chart as described in the instructions for the chart.

Chapter	Comment	Response
Chapter 4	Page 10, Section D: Colorectal cancer screening: lowercase colonoscopy, Family planning services: lowercase contraception, Health and wellness education programs: misspelling of "fitness" , Hospice care: capitalize Member Services, Medicare Part B prescription drugs (continued) - remove the duplicate word "not" , Outpatient rehabilitation services: misspelling of Medicaid, Physician/provider services, including doctor's office visits (continued): suggest using acronyms.	Thank you for these comments. CMS has made several updates throughout this section.
Chapter 4	Page 11: The current recommendation is for people 45 and over. Can this be updated to be consistent with that?	Thanks for this comment. CMS updated Chapter 4 consistent with the recently revised policy recommendations by the U.S. Preventive Services Task Force that Medicare reduce the minimum age for colorectal cancer screening from 50 to 45 years.
Chapter 4	Page 11, Depression Screening: Is there a reason that "Can provide follow-up treatment and referrals" was removed? Many primary care settings do the screening and then make a referral for treatment. They don't always provide the treatment. Suggest adding "or" back in.	CMS has added the "or" back in the sentence.
Chapter 4	Page 12, Dental: We appreciate this. The interaction of this program with dental benefits in our state requires more explanation.	CMS appreciates the comment.
Chapter 4	Page 16, Family Planning Services: Should we clarify that this can either be a provider that is in network or out of network?	CMS appreciates the comment, but the existing language in Chapter 4, Family Planning Services makes this point as currently worded. However, CMS is revising the language further for clarity to state: "The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office."

Chapter	Comment	Response
Chapter 4	Page 21: Hospice provider/Original Medicare pays for this: Original Medicare will be billed for your hospice care, even if you're in a Medicare Advantage Plan. When you get hospice care, your Medicare Advantage Plan can still cover services that aren't a part of your terminal illness or any conditions related to your terminal illness. Chapter 4: An MA enrollee who elects hospice care, but chooses not to disenroll from the plan, is entitled to continue to receive through the plan any MA benefits other than those that are the responsibility of the hospice. Under such circumstances, the MA plan is paid a reduced capitation rate for that enrollee by CMS and the MA plan is responsible for continued coverage of supplemental benefits. CMS pays: (a) the hospice program for hospice care furnished to the enrollee and (b) the MA plan, providers, and suppliers for other Medicare-covered services furnished to the enrollee through the original Medicare program, subject to the usual rules of payment.	CMS has made a small adjustment to the language to note these are covered services.
Chapter 4	Page 21, Section Home health: Recommend removing or modifying the language in parenthesis to clarify as coverage is based on medical necessity: We pay for the following services, and maybe other services not listed here: • Part-time or intermittent skilled nursing and home health aide services. (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.)	CMS declines to make this edit as this section appropriately describes the benefit.
Chapter 4	Page 25, Inpatient stay, covered services in a hospital or skilled nursing facility (SNF): The previous language was clearer, "If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable or necessary, we will not cover your inpatient stay. However, in some cases we will cover	CMS has updated the language to clarify the inpatient stay benefit limitations.

Chapter	Comment	Response
	certain services you receive while you are in the hospital or the SNF.	
Chapter 4	Page 29, Nursing Facility (NF) Care: In our state, it is difficult to calculate copays because they depend on income. We would prefer to be able to refer members to their care coordinator or some other resource for help, or at least specify some standard language for our plans to use. Something like, "Please contact us at the number at the bottom of the page to learn if you will need to contribute toward your nursing home care."	The instructions at the beginning of section D of chapter 4 includes the following language which provides flexibility for the state to adjust the cost-sharing as needed, "*[Plans should modify this section throughout to reflect Medicaid or plan-covered supplemental benefits as appropriate as well as any copays that may differ for Medicaid.]"* CMS has left copay fields variable so the state should include the actual copay or possible range for copays and then can add additional instructions if needed.
Chapter 4	Page 29, NF Care: As allowed in Chapter 1, our state is likely to modify this to read, "Nursing home care," potentially without using the NF acronym.	This is an acceptable modification.
Chapter 4	Page 29, NF Care: It does not look like this acronym is used again, so should it be removed?	A plan can remove an acronym if a term is only used once in a document.
Chapter 4	Page 47, Section E: Supplemental Dental, vision, hearing - chart instructs plan to place supplemental benefit in Section E. But the title for Section E is "Supplemental benefits you can buy" and instructions do not say we can revise the title when supplement benefits have no extra premium. Should plans be adding free supp benefits to the medical chart, or Section E?	The dental instructions note that optional supplemental benefits should be included in Section E, "Extra "Optional Supplemental" benefits you can buy" rather than the included supplemental benefits section. CMS has further clarified this language. The plan should only include Section E if the plan offers extra optional supplemental benefits that you can buy as described in the instructions for section E.
Chapter 4	Page 48, Section E: As noted earlier, our state currently has plans offering some supplemental benefits at no cost. If possible, we would like to make sure the model is flexible to allow this in 2024 as well, potentially by modifying instructions to specifically address $0 copays or benefits at no cost.	Per the instructions, the plan should include supplemental benefits that are no cost in the table above. Section E is for optional supplemental benefits that are an additional cost. The plan should only include section E if the plan offers extra optional supplemental benefits that you can buy as described in the instructions for section E.

Chapter	Comment	Response
Chapter 4	Page 48, Section E: Example of above: If members do not have to pay an additional premium, should the title of the section be "...benefits you can get" instead of "…benefits you can buy"?	No, this section is for optional supplemental benefits that are an additional cost. If there are no supplemental benefits that are at an additional cost then plans should not include this section per the instructions.
Chapter 4	Page 49: The previous chart found in the CY 2023 D-SNP EOC which outlines what is not covered under any conditions or under any circumstances is more user friendly and easier to read. Suggest using the CY 2023 formatting in this section.	CMS rejects this edit but will consider it in a future cycle.
Chapter 4	Page 49, Section H: Missing word "pay".	CMS has made this edit.
Chapter 4	Page 49, Section G: We have some Medicaid-covered services we would like to include here, such as dental and non-emergency transportation. It looks like plans "should modify" this section to include them, but, similar to an earlier comment, how can we ensure consistent descriptions across plans?	Since this is a variable field, the state can modify this section as appropriate and provide the information to the plans in the state.
Chapter 4	Page 49, Section G1: The content here seems to be similar to the content written in the benefits chart. Would it be possible to combine this with the language in the benefits chart?	CMS rejects this edit. This section describes benefits covered outside of the plan.
Chapter 5	Page 4, Section A2: For consistency, Chapter 1 introduces this as Member ID card. Suggest changing for consistency.	CMS agrees and has made this update.
Chapter 5	Page 4, Section A.2.: This is a very high standard.	Thanks for the comment. CMS has not made any changes to the language.
Chapter 5	Page 10, Section B1. Drugs on our Drug List: The below statement in Section B1 will be an issue for some plans, as some plans operate in states where outpatient drugs are carved out of Medicaid plans and administered directly by the state or another entity. *Our Drug List includes drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under [Insert name of state Medicaid program]*.	CMS has added language to give states the flexibility to modify this language.

Chapter	Comment	Response
Chapter 5	Page 10: The drug list is not always mailed. The requirement is to send an electronic notice that tells members where they can access the document online. Could "we sent you in the mail" either be bracketed or removed?	CMS has made this language variable.
Chapter 5	Page 10, Section B.1: This statement will be an issue for D-SNPs in California, since outpatient drug benefits are carved-out of Medi-Cal (Medicaid) managed care organizations and administered directly by the State.	CMS has added language to give states the flexibility to modify this language.
Chapter 5	Page 11, Section B3, Drugs Not on our Drug List: It would not be feasible to list all excluded drugs (page 11). Is CMS expecting plans to list all excluded drugs? The below statement implies plans need to list all excluded drugs. *Our plan does not pay for the drugs listed in this section. These are called excluded drugs. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to Chapter 9 of your Member Handbook for more information about appeals.*	CMS does not expect D-SNPs to list all excluded drugs. CMS has modified the language to state, "Our plan does not pay for the kinds of drugs described in this section."

Chapter	Comment	Response
Chapter 5	Page 11, Section B3, Drugs Not on our Drug List. Plans have the ability to cover drugs outside of Part D, which some plans are doing. CMS has listed some drugs as examples of excluded drugs (page 11), which health plans may cover outside of Part D. Listing of drugs the health plans may cover outside of Part D, as done in the statement below, may lead to beneficiary confusion over what drugs the health plan covers. *Also, by law, Medicare or [Insert name of Medicaid program] cannot cover the types of drugs listed below.* • *Drugs used to promote fertility* • *Drugs used for cosmetic purposes or to promote hair growth* • *Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®* • *Outpatient drugs made by a company that says you must have tests or services done only by them*	CMS has updated the instructions for this section to note that plans can modify this section when the drugs are covered by Medicaid or as a supplemental benefit.
Chapter 5	Page 11, Section B.3: It is not feasible to list every excluded drug. Is that what CMS is expecting here?	CMS does not expect plans to list all excluded drugs and has modified the language to state, "Our plan does not pay for the kinds of drugs described in this section."
Chapter 5	Page 11, Section B.3: CMS should remove erectile dysfunction drugs from this list, since plans can cover these drugs outside of Part D. Keeping this would confuse beneficiaries who do have that coverage.	CMS has modified the instructions for this section to note that plans can modify this section when the drugs are covered by Medicaid or as a supplemental benefit.
Chapter 5	Page 11, Section B4: Recommend flexibility to remove Section B4 to align with the Part D Defined Standard benefit that is filed in the PBPs	CMS has updated the language to allow plans that do not use drug tiers to omit this section.
Chapter 5	Page 14, Section D1: Would like this to match the continuity of care period for new members if possible, and definitely not to vary across plans. In our state right now, it must be 180 days. While 180 is greater than 90, how can we communicate to our plans that it must be 180 and is not variable across plans?	CMS appreciates this comment. Please note that the state has the flexibility to modify the language based on state requirements since it is variable. The state will then send the EOC to the AIP D-SNPs in that state.

Chapter	Comment	Response
Chapter 5	Page 16: The term many plans use here is authorization rather than approval. Can that be an option here?	Yes, the instructions in Section 1 note that plans can modify these types of terms as applicable.
Chapter 5	Page 18, Section F2: Change pronoun to "its" refers to facility not people	CMS accepts this edit.
Chapter 6	Page 1: Perhaps this should this be optional text?	CMS has made this language variable.
Chapter 6	Page 1, Chapter Intro: Recommend flexibility to remove the bullet about tiers in the Introduction to align with the Part D Defined Standard benefit.	CMS has modified the instructions so that plans can omit if not applicable.
Chapter 6	Page 5, Section B: Recommend flexibility to remove the sentence about Catastrophic Coverage to align with the to align with the Part D Defined Standard benefit	The instructions already allow the ability to delete the last two sentences if there is no Part D cost-sharing.
Chapter 6	Page 5, Section B: For consistency, Chapter 1 introduces this as Member ID card.	CMS has modified this language.
Chapter 6	Pages 5-6: It seems that these two items should have been sub bullets of the previous item.	CMS has modified the formatting for this section.
Chapter 6	Page 6, Section C: Recommend flexibility to add language from the D-SNP ANOC and EOC models to describe the Defined Standard benefit and cost-sharing if a member loses LIS. This includes four drug stages, no drug tiers, and cost-sharing for Defined Standard coverage stages.	CMS declines to make this edit. This model is only for AIP D-SNPs. Dually eligible individuals are deemed or redeemed eligible for LIS for the next plan year starting in July of the prior year. That means an individual who has lost Medicaid in the prior year and who is not redeemed LIS-eligible for the coming plan year would have exhausted any period of deemed SNP LIS eligibility (maximum length is 180 days) by January 1 of the plan year. Since LIS eligibility lasts for the full plan year, even if the individual loses Medicaid during the plan year, all D-SNP enrollees will retain LIS eligibility for the full plan year (January-December).
Chapter 6	Page 7, Section C1: Plan instructions should include plans that have only 1 Tier with no Cost Share. Model should make allowances for those PBPs that would be filed as Defined Standard and would not having a tiering structure and remove all instances to tiering; to include would more than likely cause member confusion as their formulary will have no tiering information.	CMS has updated this language to allow this section to be deleted if there is no cost-sharing.

Chapter	Comment	Response
Chapter 6	Page 13: Can this be updated for 2024 copay amount?	Yes, the instructions allow the copay amounts to be updated.
Chapter 6	Page 14, Section G: We don't think any of our members will be eligible for ADAP because in our state, Medicaid eligibility seems to disqualify members from ADAP. Can we make this section optional? See this website: https://scdhec.gov/aids-drug-assistance-program. Our HIV/AIDS waiver does offer some additional covered prescriptions to members with HIV/AIDS, so if this section is not optional, could we modify it to include details about the waiver instead?	Yes, the instructions indicate that this section is optional.
Chapter 6	Page 14: Shouldn't this section be updated with the vaccine info from the September 6, 2022, HPMS memos "Updates to Part D Member Materials for Contract Year 2023" and "Additional Part D Updates to Contract Year 2023 Member Material Models for Medicare-Medicaid Plans and Minnesota Senior Health Options Plans?"	CMS has updated the section to reflect the Inflation Reduction Act requirements.
Chapter 6	Page 15: Aren't all Part D vaccines covered at no cost now?	CMS has updated the language to correctly reflect vaccine coverage.
Chapter 6	Page 16, Section H1: Change verb "work" to "works".	CMS has made this update.
Chapter 7	Page 2, Section A: Capitalize Member Services for consistency.	CMS has made this update.
Chapter 7	Page 2, Section A: For consistency, Chapter 1 introduces this as Member ID card.	CMS has updated the language to Member ID card.
Chapter 7	Page 2, Section A, 2nd sub bullet under 2nd bullet: Currently, our handbooks refer to member services or our program ombudsman. Understanding that the role of the ombudsman is still a bit TBD going forward, it would still be nice to include the option in the instructions	CMS has added this option.
Chapter 7	Page 3: Something seems to be missing here. This is a run-on sentence. Maybe just add "and" between the two clauses?	CMS has updated this sentence.

Chapter	Comment	Response
Chapter 7	Page 3, Section A, Bullet 1: We flagged this for discussion within our state. We hope that CMS will allow us the freedom to set retro enrollment policies that align with what we currently use in our Medicaid managed care program.	This is outside of the scope of the Federal Register notice. Please contact MMCO to further discuss these policies.
Chapter 7	Page 4, Section A, Bullet 2: Grammar item. "In only a few cases, we will" (with comma) or, "In only a few cases will we" (no comma).	CMS has updated this language.
Chapter 7	Page 4, Section A6: The D-SNP EOC model includes the following instruction: [Plans should insert additional circumstances under which they will accept a paper claim from a member.] Does this not apply to integrated plans?	CMS rejects this edit. The circumstances may vary by state in some situations so CMS is leaving this language more general.
Chapter 7	Page 5, Section B: Suggest adding the word "covered" to make clear only covered services will be reimbursed.	CMS rejects this edit because the section instructions include variability to add this information.
Chapter 7	Page 5, Section B: Missing the word "for" "you may also call us to ask for payment".	CMS has made this edit.
Chapter 7	Page 5, Section B: Suggest using "timeframe" instead of "days" as it could be years.	CMS has made this edit.
Chapter 8	Page 1, Section B: Please clarify what minimum access to care means?	This is the baseline for what plans are required to provide for access to care.
Chapter 8	Page 3: Would it make more sense to refer them to the number at the bottom of the page as we do in other places? They would also be able to access an interpreter or use the TTY numbers if we did that.	CMS has updated this to include Member Services but have also left the ability to write the plan.
Chapter 8	Page 4, Section B: Suggest using "You" instead of women for gender inclusive language.	CMS has edited this sentence.
Chapter 8	Page 5, Section C: Remove "to" from 3rd paragraph as not needed.	CMS has made this edit.
Chapter 8	Page 5, Section C1: Add bullet underneath here: Healthcare operations per HIPPA.	CMS rejects this edit.
Chapter 8	Page 6: Can we refer members to the number at the bottom of the page if that is the correct number?	CMS has changed this to read Member Services.
Chapter 8	Page 10, Section H1: Italicize "Member Handbook".	*Member Handbook* is italicized.

Chapter	Comment	Response
Chapter 8	Page 10, Section I: For consistency, Chapter 1 introduces this as Member ID card.	CMS has updated this language.
Chapter 8	Page 10: Refer them to the number at the bottom of the page?	CMS changed this to read Member Services.
Chapter 8	P.10, Section H1: Please clarify. Why wouldn't plans list their respective state agency here?	CMS has updated this language.
Chapter 8	P.10, Section H1: Please confirm what "if applicable" means here. Should this bullet be included if there is an Ombudsmen designated for this service area.	Yes, that is correct. The bullet should be included if there is an Ombudsperson designated for the service area.
Chapter 8	Page 11, Section I: There was a reference to coinsurance in Chapter 2 in 2023, but it was removed in this set of documents. Be sure these two chapters align.	CMS has removed this information in Chapter 2.
Chapter 8	Page 12: For 2023 and previous years, we have noted that members may face estate recovery in some circumstances, and we have included that information as a bullet before this one. Depending on program design, it is possible this might continue into 2024; is it OK for the handbook to be silent on the issue, or should the instructions be modified to allow states to insert it here if needed?	The instructions to this section specifically indicate, "Plans may add information about estate recovery and other requirements mandated by the state."
Chapter 9	Page 1: Should call out that this section can be used as a guide for how members can file an appeal.	CMS rejects this edit. The draft does note that it includes what to do if there is a disagreement with a decision.
Chapter 9	Page 1 - first instruction: Our state has always had a paragraph here referring people to our ombudsman as a resource for appeals. Assuming they remain in that role for 2024, should we add an instruction here or is this addressed adequately elsewhere?	The instructions give the state the flexibility to add information about the ombudsperson.
Chapter 9	Page 5: Could this say "the following chart" since it won't necessarily be "below" depending on page breaks?	CMS has made this update.
Chapter 9	Page 7, Section E2: Please confirm, should expedited and fast appeal be in quotation marks?	CMS has made this update.
Chapter 9	Page 7, Section E2: Suggest adding the following language as the last sentence as many services are covered by both Medicare	CMS has added this language.

Chapter	Comment	Response
	and Medicaid - "If your problem is about a coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 appeals."	
Chapter 9	Page 8: Because these parentheses are inside another set of parentheses, they should be changed to square brackets to avoid confusion for reader. Alternatively, the parentheses around the whole sentence could be removed.	CMS rejects this update.
Chapter 9	Page 10: "Refer" should be lowercase.	CMS has made this update.
Chapter 9	Page 11: I believe the bullet styles here should be swapped: this should be a first level bullet and the next two should be second level bullets.	CMS has made this update.
Chapter 9	Page 12: Do we need to have the phone number listed in both of these places, one right after the other? If the number is the same, can we make note of that instead?	The section includes variable language is for any additional contact information, as applicable.
Chapter 9	Page 12: I don't understand how this sentence works if you don't include the second optional part? It appears to be incomplete.	CMS has edited the language to make the whole bullet optional.
Chapter 9	Page 12: Does this item need to be bulleted? If so, shouldn't it be a first level bullet?	CMS has made this update.
Chapter 9	Page 12, Section F3: AIP plans require appointment of representative in this scenario. Suggest removing "insert as applicable."	CMS has removed this language.
Chapter 9	Page 12, Section F3: Under the Part D section, these 3 paragraphs are bulleted. Should they be bulleted here?	CMS has made this update.
Chapter 9	Page 12, Section F3: There is no guarantee that a member requesting an expedited appeal will receive one. While the second bullet states the process for a fast appeal is the same as for a fast coverage decision, the commenter believes it would be more member friendly to include similar language as coverage decision. We automatically give you a fast appeal if your doctor tells us your health requires it. If	CMS has updated the language in this section.

Chapter	Comment	Response
	you ask without your doctor's support, we decide if you get a fast appeal. If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you: • We automatically give you a fast appeal if your doctor asks for it. • How you can file a "fast complaint" about our decision to give you a standard appeal decision instead of a fast appeal decision. For more information about making a complaint, including a fast complaint, refer to Section K [insert reference, as applicable].	
Chapter 9	Page 13, Section F3: Suggest replacing "medication" with "item" to be consistent with previous bullets.	CMS agrees and has made this update.
Chapter 9	Page 19: Not italic	CMS has made this update.
Chapter 9	Page 19, Section F5: Italicize "Member Handbook"	CMS has made this update.
Chapter 9	Page 27, Section G5: Suggest changing this to "appeal".	CMS has made this update.
Chapter 9	Page 29, Section G5: Should these bullets be sub-bullets to bullet 1?	CMS has made this update.
Chapter 9	Page 29, Section G6: Grammatical correction: Should be "includes".	CMS has made this update.
Chapter 9	Page 31: Shouldn't this be a first level bullet? It doesn't follow from the one above it.	CMS has made this update.
Chapter 9	Page 38, Section I12: Suggest putting "Notice of Medicare Non-Coverage" in quotations.	CMS has made this update.
Chapter 9	Page 39, Section I.2: This should be changed to Quality Improvement Organization.	CMS has made this update.
Chapter 9	Page 41, section I4, Formatting: The bullets under if we say no to your fast appeal should be sub-bullets.	CMS has made this update.
Chapter 9	Page 41, Section I.5: Should hospital discharge be replaced with "termination, suspension, or reduction of previously authorized services:"?	CMS declines to make this edit and will leave the language as it currently stands. CMS notes that this section is not about the regular appeals process. Rather, it is about the quick review the Independent Review

Chapter	Comment	Response
		Organization does when someone is discharged from the hospital but the enrollee believes that it is too soon.
Chapter 9	Page 41, Section I.5: Under heading: Formatting or content may be missing here.	CMS has updated the formatting.
Chapter 9	Page 41, Section I.5: Should covered inpatient hospital services be replaced with "<termination, suspension, or reduction of previously authorized services:"	CMS rejects this edit and will leave the language as it currently stands.
Chapter 9	Page 43: This should be a first level bullet, not a second level.	CMS has made this update.
Chapter 9	Page 43, level 5 appeal: Suggest bolding the last sentence.	CMS appreciates the suggestion but declines to make this change.
Chapter 9	Page 43, Section J2: We will definitely want to have the plans include consistent language here.	The language is variable so that states can provide this direction to plans.
Chapter 9	Page 43, Section J3: Need to insert the word "may" as some states do not have other appeal rights after State Fair Hearing. You may also have other appeal rights if your appeal is about services or items that [insert name of state-specific Medicaid program] usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.	CMS has made this whole section variable to include information as directed by the state.
Chapter 9	Page 44: I don't think this item should be bulleted at all. Should mirror the "If Yes" statement above.	CMS has made this update.
Chapter 9	Page 44: This should be a first level bullet.	CMS has made this update.
Chapter 9	Page 45, Section K1: These added charts are very useful and member friendly.	CMS appreciates the comment.
Chapter 10	Page 3, Section A: Instructions here should state that plans have the ability to add additional reasons for disenrollment.	CMS reject this change. These are examples of when members are eligible to end their enrollment.

Chapter	Comment	Response
Chapter 10	Page 3, Section A, first sentence: We note that our current demonstration uses a continuous Special Enrollment Period (SEP), and members may change plans at any time. This program may be the only one in our state that eventually limits enrollment in this manner. Moving to this model rather than the “continuous Special Enrollment Period for dual eligible members (duals SEP)" will require extensive reprogramming and testing, as well as member and provider communication. We believe it is feasible, but it will be a big lift.	CMS appreciates the comment. It is outside the scope of updates to the EOC. Please contact MMCO to further discuss these policies. These SEPs are specified in Medicare regulations.
Chapter 10	Page 3, Section A, 3rd section bullet 1 of 3: At present, we have some passive enrollment into our demonstration. Would passively enrolled members have the same SEPs described above or do we need to modify instructions at all?	CMS rejects this change. These are examples of when members are eligible to end their enrollment.
Chapter 10	Page 3, Section A, last paragraph: We will add our enrollment broker here; how should we communicate changes like this to the plans?	The state can make updates prior to providing the models to the D-SNPs.
Chapter 10	Page 3, Section A, for paragraph beginning, "Your membership ends..." Instructions should state that plans can add information regarding state disenrollment timelines.	CMS has made this update.
Chapter 10	Page 8, 7th bullet: Change to, "If you lie about or withhold information about other insurance after you have prescription drugs.	CMS rejects this edit. The language is accurate as it is written.
Chapter 10	Page 8, Section E: For consistency, Ch 1 introduces this as Member ID card.	CMS has made this edit.
Chapter 12	Page 1, Section Header: There are different definitions used for the same term when comparing the Integrated model to the D-SNP model. Can we use the D-SNP model definitions for consistency and to alleviate any member confusion?	Plans must refer to the instructions here as to how terms can be modified. Plans should not replace terms used in this model with terms from other models.
Chapter 12	Page 2, Aid Paid Pending: This is an unfamiliar term. Is it optional?	CMS has deleted this term; however, plans should include it if directed by the state.
Chapter 12	Page 3, Cultural Competence Training: Will this be updated for the current 2024 copay amount?	The instructions indicate that the cost-sharing amount may be updated.

Chapter	Comment	Response
Chapter 12	Page 4, HRA: We note that the comprehensive assessment was removed from the 2024 models; we assume the HRA described here will play a similar role in the program going forward.	There may be different terminology used, but a health risk assessment is required for D-SNPs in Medicare regulations.
Chapter 12	Page 5, Section Term (LIS): During the Washington DC implementation, the District asked us not to use the term “state.” Is there an opportunity to use an alternative term in this section so that we do not have to version for DC?	These terms may be modified as directed by the state per the instructions.
Chapter 12	Page 6, Insert Name of Medicaid program: Formatting note: Be sure this is bold.	CMS has made this edit.
Chapter 12	Page 10, Service Area: Suggest changing verbiage to "enroll in our plan" instead of "get our plan".	CMS has made this update.
Chapter 12	Page 11: Our state and stakeholders all call these, “State Fair Hearings.” Can we modify this term accordingly?	Per the instructions the state may modify terminology.
Chapter 12	Page 12: Instructions should state that plans have the ability to add additional contact information.	CMS has made this update.