Summary of Comments and Responses for 30-day PRA Integrated Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) Models

General Comments

Comment	Response
A plan stated that during the 60-day comment period, stakeholders inquired whether there would be an approval process for state changes to the integrated plan materials, and CMS replied that the state will include state-specific information in the model prior to providing the models to MA organizations and that models will be subject to review by the state. The plan recommends that CMS provide states with a deadline in providing the models to MA organizations so they can obtain timely state approvals and meet the CMS-required fulfillment deadlines. The plan requests that models be released in early May to give enough time for state review and approval. The plan also requests state approvals by July 1 to meet CMS-required fulfillment dates.	CMS appreciates the comments and will work with states to finalize models and provide them to plans as soon as possible.
For consistency, a plan recommends that CMS adopt definitions that can be used across both AIP plans and non-AIP plans when practicable. For example, adopt one definition for Ambulatory Surgical Center: Integrated Model Definition: Ambulatory Surgical Center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care. D-SNP EOC model Definition: Ambulatory Surgical Center: An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.	We decline 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. We will consider ways to promote consistency, and consider additional consumer input, for future cycles.

A beneficiary advocate applauds the changes made to the ANOC and EOC that reflect their previous concerns and edits, noting that the updates include better signaling of language access, references to state-specific names of Medicaid programs, and clarification that the materials must be available in large print. To further promote readability, the commenter continues to recommend extensive use of consumer testing to ensure the ANOC and EOC achieve the right balance of information and approachability. In addition, the commenter urges an exploration of tested graphics to guide readers and flag important details.	We appreciate the support. We agree 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. As we stated in response to the 60 day comments, will consider additional consumer input for future cycles.

ANOC Comments

Comment	Response
A plan suggests setting up the sections and section numbers in the same way as the other models (nonintegrated) to ease multiple set ups of sections.	We decline 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. We will consider ways to promote consistency, and consider additional consumer input, for future cycles.
A plan suggests that CMS clarify in instructions that plans that offer $0 RX on all stages skip sections E3 and E4.	We appreciate the request for clarification. The "Changes to prescription drug costs [option for plans with two drug payment stages]" currently states, "[Only plans with two payment stages (i.e., those charging LIS cost-shares in the initial coverage stage, etc.), include the following information in this section of the ANOC. Plans with one payment stage do not include the information in this section.]*"* Based on these instructions, we confirm that plans that offer $0 RX on all stages should skip sections E3 and E4. We believe the current language is sufficiently clear and are not making any further updates.
A plan encourages CMS to provide health plans with flexibility to include language in the ANOC for plans that currently include a Low-Income Subsidy (LIS) buy-down and for beneficiaries who have already paid $0 in the catastrophic phase of the Part D benefit in 2023. A plan also conveyed concern that the 2023 model language would not be appropriate for LIS Levels 1 to 3 beneficiaries without a buy-down because they do not pay anything in the catastrophic phase of the Part D benefit. The plan encourages CMS to provide model language for such circumstances.	We agree with the plan and updated this language since the 60-day version. The instructions in the Changes to Prescription Drug Costs sections include the following language: "[Plans with two payment stages (i.e., those charging LIS cost-shares in the initial coverage stage), should include the following information in the ANOC.] [Only plans with two payment stages (i.e., those charging LIS cost-shares in the initial coverage stage, etc.), include the following information in this section of the ANOC. Plans with one payment stage do not include the information in this section.]"
A plan suggests that CMS make the following changes to make the Value-Based Insurance Design (VBID) language clearer to beneficiaries: [Instructions to plans offering VBID Model benefits: VBID Model participating plans should update this section to reflect coverage for any new VBID Model benefits that will be added for CY 2024 benefits, and/or for previous CY 2023 VBID Model benefits that will end for	We agree with the plan and updated this language since the 60-day version. The instructions in the Changes to Benefits and Costs for Medical Services, section E1, now includes the following language: "[Instructions to plans offering Value-Based Insurance Design (VBID) Model benefits: VBID Model participating plans should update this section to reflect coverage for any new VBID Model benefits that will be added for CY 2024 benefits, and/or for previous CY 2023 VBID Model benefits that will end for CY 2024. Specific to the

CY 2024. Specific to the VBID Model benefits, the table must include: (1) all new VBID Model benefits that will be added for 2024, except for the hospice benefit component (which has separate ANOC instructions to VBID participating plans and Part D cost-sharing reduction or elimination which should be listed in Section 2.5), including mandatory supplemental benefits such as the flexibility to Cover New and Existing Technologies or FDA approved Medical Devices or 2023 benefits that will end for 2024 and (2) all changes in cost-sharing for all VBID Model benefits for 2024.]	VBID Model benefits, the table must include: (1) all new VBID Model benefits that will be added for 2024, except for the hospice benefit component (which has separate ANOC instructions to VBID participating plans and Part D cost-sharing reduction or elimination which should be listed in Section 2.5), including mandatory supplemental benefits such as the flexibility to cover new and existing technologies or Food and Drug Administration (FDA) approved medical devices or 2023 benefits that will end for 2024 such as cash or monetary rebates; and (2) all changes in cost-sharing for all VBID Model benefits for 2024.
A plan encourages CMS to make the following additions to make the language clearer to beneficiaries: VBID Model Part D cost-sharing reduction or elimination suggestion (to make instruction clearer): Changes to Prescription Drug Costs: [Plans that are VBID Model participants and offer $0 cost-sharing for all Part D drugs across all phases for all levels of LIS may delete the following sentence.] If you receive "Extra Help" to pay your Medicare prescription drugs, you may qualify for a reduction or elimination of your cost-sharing for Part D drugs. Some of the information described in this section may not apply to you. [Plans that enroll partially dual eligible beneficiaries should delete the following paragraph for QDWI beneficiaries.] Note: If you are in a program that helps pay for your drugs ("Extra Help"), the information about costs for Part D prescription drugs [insert as applicable: may OR does] not apply to you. [If not applicable, omit information about the LIS Rider.] We [insert as appropriate: have included OR sent you] a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the Low Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive "Extra Help" [if plan sends LIS Rider with ANOC, insert: and	We appreciate the suggestions. This model is only for AIP D-SNPs, and all AIP D-SNP enrollees qualify for Extra Help. Thus, we are not including language that refers to, "If you receive "Extra Help…". Also, AIP D-SNPs do not enroll Qualified Disabled Working Individuals (QDWI) beneficiaries. If the plan offers $0 cost-sharing for Part D drugs, then the plan should state in the document that there is $0 cost-sharing for Part D drugs (if there are no changes to prescription drug costs from one year to the next, this section should not be included).

didn't receive this insert with this packet,] [if plan sends LIS Rider separately from the ANOC, insert: and you haven't received this insert by [insert date],] please call Member Services and ask for the LIS Rider. -or separate sentences- [Plans that are VBID Model participants and offer $0 cost-sharing for all Part D drugs across all phases for all levels of LIS may delete the following sentences.] If you receive "Extra Help" to pay your Medicare prescription drugs, you may qualify for a reduction or elimination of your cost-sharing for Part D drugs. Some of the information described in this section may not apply to you. [Plans that enroll partially dual eligible beneficiaries should delete the following paragraph for QDWI beneficiaries.] Note: If you are in a program that helps pay for your drugs ("Extra Help"), the information about costs for Part D prescription drugs [insert as applicable: may OR does] not apply to you. [If not applicable, omit information about the LIS Rider.] We [insert as appropriate: have included OR sent you] a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the Low Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive "Extra Help" [if plan sends LIS Rider with ANOC, insert: and didn't receive this insert with this packet,] [if plan sends LIS Rider separately from the ANOC, insert: and you haven't received this insert by [insert date],] please call Member Services and ask for the LIS Rider.	
A plan recommends that CMS include instruction for plans that do not have cost-sharing changes, especially when there is no cost-sharing in the current year nor the next year, to delete the table. There are no costs so the inclusion of the table could cause confusion.	We clarify that this table is only for plans that have cost-sharing changes. The instructions in that section state, "[If there are no changes in prescription drug costs, insert: There are no changes to the amount you pay for prescription drugs in 2024. Read below for more information about your prescription drug coverage.]"

Costs are the same for a 30-, 60- or 90-day supply.	
A plan commented that it does not see any revisions made to the plan instructions added in the "Changes to Your Cost-Sharing in the Initial Coverage Stage" section but does identify these revisions applied in the chart instructions. Plan instructions added in the Changes to Your Cost-Sharing in the Initial Coverage Stage section updating CY2024 Initial Coverage Stage (Tier 1 and Tier 2) insulin cost-sharing differences from cost-sharing for other drugs on the same tier.	Per the section numbers and descriptions provided in the spreadsheet by the commenter, these comments appear to apply to other MA ANOC models rather than the AIP D-SNP model. As a result, we are not making any updates.
A plan is asking how they can show the current 2023 insulin cost-sharing in order to properly reflect a change between 2023 and 2024? Should the language they created for the 2023 ANOC Errata be used for the 2023 column or will CMS be providing standard copy to add to the 2023 column for this change? The current proposed 2024 ANOC Model does not address covered insulins in 2023 column, but does in 2024 which makes it appear as if covered insulins are new to 2024. Plan instructions added in the Changes to Your Cost-Sharing in the Initial Coverage Stage (chart with standard and preferred cost-sharing rates) section updating CY2023 and CY2024 Initial Coverage Stage (Tier 1 and Tier 2) insulin cost-sharing differences from cost-sharing for other drugs on the same tier. How should we show the current 2023 insulin cost-sharing in order to properly reflect a change between 2023 and 2024? Should the language we created for the 2023 ANOC Errata be used for the 2023 column or will CMS be providing standard copy to add to the 2023 column for this change? The current proposed 2024 ANOC Model does not address covered insulins in 2023 column, but does in	Per the section numbers and descriptions provided in the spreadsheet by the commenter, these comments appear to apply to other MA ANOC models rather than the AIP D-SNP model. As a result, we are not making any updates.

2024 which makes it appear as if covered insulins are new to 2024.	
Members receive the ANOC by September 30, but the Member Handbook and other member materials are not posted on the website until October 15. A plan believes it would probably be helpful to make note of that in the Introduction so enrollees are not looking for the materials before they are available. The plan submitted a similar comment as above for Instructions in E2: Should make note that the EOC (aka Member Handbook) is available as of October 15.	We believe the below language addresses these comments: Section H.1 of the ANOC includes the following instructions that address the timing of the Member Handbook: "[If the ANOC is sent or provided separately from the Member Handbook, include the following: The Member Handbook for 2024 will be available by October 15.] [Insert if applicable: You can also review the <attached **or** enclosed **or** separately mailed> Member Handbook to find out if other benefit [insert if applicable: or cost] changes affect you.]"
A plan would like CMS to clarify whether plans are supposed to translate the entire bullet 4 under Additional Resources in Introduction into all of the languages listed here and include all of them in the document regardless of whether they meet the 5% Medicare threshold for any languages? If so, the plan indicates that this may duplicate information in the multi-language insert. Would it make more sense to have CMS provide the approved translations so all plans use the same language? Also, plan notes that the first bullet in this list reads: [Plans that meet the 5% alternative language or Medicaid required language threshold insert: This document is available for free in [insert the languages that meet the threshold].] Does this instruction duplicate the above?	CMS appreciates the request for clarity. In a May 2022 final rule, we adopted a requirement at §§ 422.2267(e)(31) and 423.2267(e)(33) for the multi-language insert.[1] The disclaimer included in bullet 4 is the same multi-language insert disclaimer per the regulation and the Medicare Communications and Marketing Guidelines plus additional disclaimers required by the state (including Medicaid regulations). The plan is responsible for translating the multi-language insert into all of the required languages. The insert describes verbal interpretation services that are available. The 5 percent alternative language disclaimer pertains to those languages that are available for written translation and therefore is not duplicative of the multi-language insert.
Should this be [insert state-specific name of Medicaid program]?	The Instructions to Health Plans states that "*[Plans must use the state-specific name for Medicaid in references to "Medicaid" in any plan-customized language throughout the ANOC.]"* This means that plans can update this language.

[1] Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drugs Benefit Program; Policy and Regulatory Provisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Provisions in Response to the COVID-19 Public Health Emergency final rule, which appeared in the May 9, 2022 Federal Register (87 FR 27704) available at: www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf

Is this phone number specifically referencing the plan? What about in the case of third party references which may not have a toll-free phone number?	We agree that the phone number is specifically referencing the plan. As a result, we are updating the language in the model to read, "Where the model material instructs inclusion of a *plan* phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation." Plans must use toll-free phone numbers and TTY numbers.
A plan noted that CMS included duplicate instructions for section E.2 Changes to prescription drug costs.	We agree that this is a duplicate instruction, and we removed the following bullet from the model: "[Plans with two payment stages (i.e., those charging LIS cost-shares in the initial coverage stage), should include the following information in the ANOC.]"
A plan suggested that CMS add TrOOP definition in section E3.	We will consider this suggestion for a future cycle.

EOC Comments

Chapter 1	Instructions: Does this preclude the use of local area numbers, which are not toll-free for out-of-area enrollees?	This instruction is specifically for plan phone numbers. As a result, we are updating the language in the model to read, "Where the model material instructs inclusion of a plan phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation." Plans must use toll-free phone numbers and TTY numbers.
Chapter 1	Page 1: A plan suggests applying the same sections and section numbering as the nonintegrated models to ease production of multiple setups. Additionally, the commenter recommends providing one continuous document including all chapters in one document as opposed to a unique document for each chapter to align with the nonintegrated models and ease production.	We decline 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. For future cycles, we will consider additional consumer input, as well as continue to review ways to deliver information in a more meaningful manner.
Chapter 1	Page 3: A plan requests CMS to clarify whether plans should to translate this whole paragraph into all of the languages listed here and include all of them in the document regardless of whether they meet the 5% threshold for any languages? If so, the plan believes this may duplicate information in the multi-language insert. And questions whether would it make more sense to have CMS provide the approved translations so all plans use the same language. A plan also inquires whether the paragraph below, also on page 3, duplicates language on page 3 of Chapter 1 Member Handbook Introduction: "[Plans that meet the 5% alternative language or Medicaid required language threshold insert: This document is available for free in [insert the languages that meet the threshold].]"	CMS appreciates the request for clarity. The language on page 3 of Chapter 1 "Member Handbook Introduction" is the language consistent with the requirements we adopted in a May 2022 final rule at §§ 422.2267(e)(31) and 423.2267(e)(33) for the multi-language insert. The disclaimer included is the same multi-language insert disclaimer per the regulation and the Medicare Communications and Marketing Guidelines plus additional disclaimers required by the state (including Medicaid regulations). The plan is responsible for translating the multi-language insert into all of the required languages. The insert describes verbal interpretation services that are available. The 5 percent alternative language disclaimer pertains to those languages that are available for written translation and therefore is not duplicative of the multi-language insert.
Chapter 1	Page 3: A plan states that it no longer uses this term, Evidence of Coverage. The plan also notes that it might be confusing to enrollees who only know this document as the Member Handbook. Can it be optional to include or maybe use "previously known as"?	The Member Handbook instructions on page 1 of Chapter 1 offer plans the flexibility to use the term Evidence of Coverage or Member Handbook: "[States may choose to use the term Evidence of Coverage instead of Member Handbook and modify this term throughout all

		chapters.]" We are not making further updates to the language.
Chapter 1	Page 3: A plan questions whether instruction to include interpreter services information in other languages would duplicate information if the multi-language insert were added as part of the document and inquired whether this language could be optional if the MLI is included in the document. The plan also inquires if a plan translates a document, such as Chapter 1 of the EOC into one of the non-English languages, would the plan also include the other translated languages for this section, and then does English become one of the translated languages to be listed? The plan notes that, generally, it receives requests for a translated version of the document, so none of the other languages would be applicable as an aid for the requestor. Does this instruction only apply to the English version?	The language in the model regarding interpreter services is the MLI found at §§ 422.2267(e)(31) and 423.2267(e)(33), so this language is not duplicative of the MLI. We do not expect the MLI to accompany any translated material (beyond English). When one requests a translated document, we can safely assume that it is in the primary language spoken in that household (including alternate formats). Therefore, the MLI would not be applicable/necessary if the plan provides the material in other languages such as Spanish or Chinese.
Chapter 1	Page 8, Section C and subsequent sections and EOC Chapters: Should this be [insert state-specific name of Medicaid program]? CMS received this comment for several different sections in multiple chapters in the EOC.	There is an instruction at the beginning of the document so this can be modified per the state. "Plans must use the state-specific name for Medicaid in references to 'Medicaid' in any plan-customized language throughout the Member Handbook.]"
Chapter 1	Page 12, Section H3: A plan inquires, if it does not have Optional Supplemental Benefits, can this section be deleted. The plan also suggests making the language clearer here.	The title of Section H3 is "Optional Supplemental Benefit Premium". Only plans that include supplemental benefit premiums need to include this section. We believe the language is sufficiently clear and are not making further updates.
Chapter 1	Page 12, Section I: A plan requests that we change "the" in "the Member Handbook" to "your" to be consistent with references in other chapters.	The sentence reads, "You can also refer to the *Member Handbook* found on our website" We believe that the sentence reads better with "the" and the Section I title already uses the language "Your Member Handbook". Thus, we are not making further changes to the language.
Chapter 2	Page 7, Section C: A commenter noted that the model currently provided by New Jersey is populated with the state agency contact	We appreciate the question. The states provide the models with state-specific updates to the plans directly.

	information. How will the New Jersey-specific data updates be communicated? Will other states be providing state agency data?	
Chapter 2	Page 15, Section J: A plan notes that the crosswalk of changes for the 60-day ANOC and EOC PRA package mentions the addition of sections K and L for Railroad Retirement Board and group insurance, but those sections do not appear to be included here.	We added sections K and L to the Chapter 2 30-day model per the crosswalk provided with the 30-day models.
Chapter 2	Page 25, Section E: A plan inquires whether the word “looking” found in language next to “website” should be changed to something like "searching" in order to remove potentially ableist language?	We will consider this suggestion for a future cycle.
Chapter 3	A plan notes that language regarding prior authorization needs to be removed in the “Care from specialists and other network providers section”. The 2024 Proposed EOC Model copy for Chapter 3, Section 2.3 still includes instructional copy related to prior authorization and inquires whether this copy (see below) be disregarded? “Plans should describe how members access specialists and other network providers, including: Include an explanation of the process for obtaining PA, including who makes the PA decision (e.g., the plan, PCP, another entity) and who is responsible for obtaining the PA (e.g., PCP, member). Refer members to Chapter 4, Section 2.1 for information about which services require PA.”	We reviewed this comment and it appears to relate to the MA model. We are not making any updates to the language.
Chapter 3	Page 11, Section H: The plan suggests that CMS clarify if plans enter the Medicaid transportation AND the plan's supplemental transportation here, or if this is reserved only for the Medicaid transportation benefit.	Section H instructions indicate that the plan should provide applicable information about getting transportation services and not limit them to Medicaid services. The plan should therefore include information about getting all transportation services.
Chapter 3	Page 7, Section D1. A plan questions whether the phrase “look in” in this section should be changed to something like "refer	We will consider this suggestion for a future cycle.

	to" in order to remove potentially ableist language?	
Chapter 3	Page 17, Section M2. A plan notes that the crosswalk of changes for the 60-day ANOC and EOC PRA package, states that reference to the year of the Medicare & You Handbook had been made variable, but it does not appear to be.	We have made the language variable so that plans can update it to the applicable year.
Chapter 3	Page 6, Section D1. A plan notes that it encourages but does not require its members to choose a primary care provider, nor does it require referrals for them to see any provider. The plan inquires whether CMS can update the beginning of this section to be a bit more flexible to describe this current practice. The plan further noted that it understood it can change the terms used for primary care provider. As an example, the plan provided its previous wording for the beginning of this section: "You may choose a primary care clinic (PCC) to provide and manage your care. Definition of a 'PCC,' and what does the PCC do for you A primary care clinic (PCC) is the first place you normally go for care, and can provide most of the health care services you need. As a plan member, you choose your PCC or are assigned one if you do not choose one on enrollment. Using a PCC makes it easier for your care providers to know you and your family, and for you to know them."	We appreciate the comment and have updated the language to allow for more flexibility.
Chapter 4	A plan comments that the phrase "inpatient or outpatient" needs to be removed from the smoking and tobacco use cessation benefit. The commenter notes that the reissued 2023 and proposed 2024 model language does not have a phrase referencing inpatient or outpatient in this section and requests that CMS confirm if "Chapter 4, Medical Benefits Chart, Smoking and tobacco use cessation" section is the correct section that needs to be revised.	This comment appears to apply to other MA EOC models rather than the AIP D-SNP model. The description of the smoking and tobacco use cessation benefits in Chapter 4 does not reference "inpatient or outpatient". The description of these benefits are accurate as is, and we are not making any updates to the language.

Chapter 4	Section 5.4: A plan inquires whether if they could add plan instruction after the chart "Your share of the cost when you get a long-term supply of a covered Part D prescription drug" to state: [For plans that offer insulin cost-sharing different from the cost-sharing applicable to the other drugs on the same tier, insert the following: You won't pay more than [inset the applicable language: $70 [update the cost-sharing amount, if lower than $70] for up to a two-month supply or $105 [update the cost-sharing amount, if lower than $105] for up to a three-month supply] of each covered insulin product regardless of the cost-sharing tier [modify as needed if plan offers multiple cost-sharing amounts for insulins (e.g., preferred and non-preferred insulins)] [insert only if plan's benefits design includes a deductible: even if you haven't paid your deductible.] Plan wanted to know if in the Part D cost-sharing chart, they can apply the proposed copy to the end of the chart vs. on each individual tier to make the direction clearer and more concise to the member? This is how they addressed the change in their 2023 MAPD EOCs, since their insulin cost-sharing did not differ by tier, and was $35 across all covered insulins?	This comment appears to apply to other MA EOC models rather than the AIP D-SNP model. As a result, we have not made any changes.
Chapter 4	Page 4, Section C: A plan suggests that CMS add a section to define the VBID socioeconomic eligibility section to call out VBID-specific benefits.	In response to 60-day comments, we added the VBID language that was included in the MA model to Chapter 4.
Chapter 4	Page 23, Section C: A plan states that the use of the word "referral" in this section is problematic because it is not a *referral* that is needed to see an out-of-network provider; rather it is an *authorization*. The plan notes that the plan (not the provider) can give a member an authorization to see an out-of-network provider. The plan further notes that referrals are different and some plans are	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.

	direct access plans that do not require referrals to see specialists, etc.	
Chapter 4	Page 30, Section D: A plan states the crosswalk of changes for the 60-day ANOC and EOC PRA package notes that all numbers 1-10 have been spelled out, but that does not appear to be the case under the Acupuncture benefit where it says 8 sessions vs. eight. The plan also suggests that using numerals for all numbers, including those under 10, in communications to members is often considered a best practice from a health literacy standpoint. According to a US Department of Health and Human Services Style Guide published at https://health.gov/styleguide/content, "Numerals are more easily recognizable for readers" and users are directed to use numerals instead of words except at the beginning of sentences and a few other exceptions (see the "Numbers" entry under the Style and Usage section). So as a consistent alternative to spelling out numbers under 10, the commenter requests that CMS consider using numerals throughout the document for all numbers.	We appreciate pointing out the inconsistency; however, the CMS standard practice is to spell out numbers one through ten.
Chapter 4	Page 31, Section D: A plan inquires whether the phrase "look at" under Bone mass measurement benefit should be changed to something like "review" in order to remove potentially ableist language?	CMS appreciates the comment and will consider this suggestion for a future cycle.
Chapter 5	Page 4, Section A1: A plan questions whether the phrase "look in" should be changed to something like "refer to" in order to remove potentially ableist language? (This comment applies to all "look" references in chapter.)	CMS will consider this suggestion for a future cycle.
Chapter 5	Page 4, Section A2: A plan suggests that CMS clarify if plans should be calling out when to present their Medicaid card to pharmacies, for example, "MediCal covers Over the Counter (OTC) when MediCal Rx card is presented at the pharmacy."	In response to 60-day comments, we added this instruction so that states that have a separate card for carved out services such as OTC drugs, can add instructions for using the Medicaid card.

Chapter 5	Page 10, Section B1: A plan suggests that this sentence be optional or add clarification that some OTC drugs are covered by Medicaid and not under the plan's Part D formulary.	We appreciate the suggestion. However, per the first instruction, states are allowed to modify Section B1. It states, "[States should modify this section to accurately reflect the coverage in the state.]"
Chapter 5	Page 11, Section B3: A plan suggests providing instruction to allow plans to delete certain excluded drugs if the plan offers coverage of excluded drugs (i.e., ED drugs) since some Part D plans do include coverage for excluded drugs.	We do not expect D-SNPs to list all excluded drugs. In response to 60-day comments, we modified the language to state, "Our plan does not pay for the kinds of drugs described in this section."
Chapter 5	Page 12, Section B4: A plan raises concerns about how to explain only one tier of drugs when it has more than one tier. The plan believes that it can only explain that it has one tier, with both brand and generic options, which have differing copays—Tier 1 Generic and Tier 1 Brand. The plan inquires whether it could have flexibility to change this language to make it more accurate for plans? For example, the plan describes its wording from last year as: "Every drug on our plan's Drug List is in a cost-sharing tier level. What you pay for a drug on the Drug List depends on whether the drug is a generic or brand name drug. Tier 1 generic drugs have the lowest copay. Tier 1 brand name drugs have a higher copay. Over-the-counter drugs and products have a $0 copay."	We added an instruction in section B4 allowing plans to modify the description of the tier structure as appropriate. The revised instruction reads: "[Plans that do not use drug tiers should omit this section. Plans may modify this section to reflect the tiering structure]."
Chapter 6	Section 4: A commenter states that the draft EOC language in corresponding EOC 508CY2024_1_HMO_MAPD_ISNP_CSNP_EOC_12052022_CLEAN_PRA goes one step further with the language in Chapter 6, Section 4. The commenter notes that language there refers to both insulin and vaccines being exempt from the deductible: "[Plans with a deductible amount other than $0, add: The deductible does not apply to covered insulin products and most adult Part D vaccines.]" The commenter believes CMS would want to include the Part D vaccines reference in the ANOCs as well to minimize confusion/discrepancies between documents.	We do not agree with this suggestion since the vaccine change took effect in CY 2023, therefore the vaccine language should not be included in the ANOC.

Chapter 6	Section 5.2: A plan suggests that CMS insert plan instruction after chart: [Plans that offer cost-sharing for insulin that differs from the cost-sharing for other drugs on the same tier, insert the following footnote: You won't pay more than $35 [update the cost-sharing amount, if lower than $35] for a one-month supply of each covered insulin product regardless of the cost-sharing tier [modify as needed if plan offers multiple cost-sharing amounts for insulins (e.g., preferred and non-preferred insulins)] [insert only if plan's benefit design includes a deductible: even if you haven't paid your deductible.] In the Part D cost-sharing chart, the plan inquires whether it can apply the proposed copy to the end of the chart vs. on each individual tier to make the direction clearer and more concise to the member? The plan notes that this is how it addressed the change in our 2023 MA EOCs, since the insulin cost-sharing did not differ by tier, and was $35 across all covered insulins.	This comment appears to apply to other MA EOC models rather than the AIP D-SNP model based on the section numbers and spreadsheet information. We are not making any updates to the language in response to this comment.
Chapter 6	Page 1, Introduction: A plan questions whether the word "look" should be changed to something like the phrase "refer to the following" in order to remove potentially ableist language?	We will consider this suggestion for a future cycle.
Chapter 6	Page 8, Section C2: A plan recommends that CMS change "the" in "the Member Handbook" to "your" to be consistent with references in other chapters.	Since this section previously describes "your Member Handbook" we believe it is clear to enrollees that we are describing their Member Handbook here. However, will consider this suggestion for a future cycle.
Chapter 6	Page 12, Section D3, Table: A plan inquires whether CMS will have plans mention the removal of LIS Level 4 at all? Can plans that file $0 remove chart?	We have reviewed this comment and section D3 already includes instructions that allow adjustments to the chart as necessary. Those instructions state: "[Plans may delete columns and modify the table as necessary to reflect the plan's prescription drug coverage. Include all possible copay amounts (not just the high/low ranges) – i.e., all three possible copay amounts for a tier in which LIS cost sharing applies – in the chart, as well as a statement that the copays for prescription drugs may vary based on the level of Extra Help the member gets.]

		[Plans should add or remove tiers as necessary. Plans should remove references to “cost sharing as appropriate. If mail-order is not available for certain tiers, plans should insert the following text in the cost-sharing cell: Mail-order is not available for drugs in [insert tier].]”
Chapter 8	Page 3, Section A: Change "obtain" to “get” to improve readability?	We will consider this suggestion for a future cycle.
Chapter 8	Page 4, Section B: A plan inquires whether the word “look” should be changed to something like "refer to" in order to remove potentially ableist language? (This comment applies to all “look” references in chapter.)	We will consider this suggestion for a future cycle.
Chapter 8	Page 5, Section C: A plan suggests that CMS change “Practice” to plural form “Practices”.	While we are not updating this chapter, plans can make this grammatical update.
Chapter 8	Page 10, Section I: A plan requests that CMS change “the” in “the Member Handbook” to “your” to be consistent with references in other chapters.	We believe that it is clear to enrollees that we mean their Member Handbook. However, will consider this suggestion for a future cycle.
Chapter 9	Section 5.1: A plan notes that language regarding asking for coverage decisions needs to be modified throughout the section. The plan states that when this change was released in a memo on August 12, 2022, it included new gendered language but both CMS and NCQA recommendations were to remove gendered language moving forward. The plan indicates that it made the permissible change of replacing "him or her" with "them." However, in the proposed 2024 EOC Models, "him or her" are still present. Does CMS plan to update the model to remove the addition of new gendered language?	This comment appears to apply to other MA EOC models rather than the AIP D-SNP model based on the section numbers and spreadsheet information. We are not making any updates to the language.
Chapter 9	Page 1, Introduction: A plan inquires whether the word “look” should be changed to something like "searching" in order to remove potentially ableist language. (This comment applies to all “look” references in chapter.)	We will consider this suggestion for a future cycle.

Chapter 9	Page 12, Section F3: A plan recommends clarifying this since it seems to imply the member and doctor determine expedited treatment and not the plan.	We disagree with this update. The bold sentence above the last bullet referenced on page 12 specifically states, "If your health requires it, ask for a fast appeal." As a result, we believe that it is clear that the enrollee and/or doctor must request the fast appeal.
Chapter 11	Page 2, Section A: A plan inquires whether CMS could change "the" in "the Member Handbook" to "your" to be consistent with references in other chapters.	We will consider this suggestion for a future cycle.
Chapter 12	Page 1, Introduction: A plan inquires whether the word "looking" should be changed to something like "searching" in order to remove potentially ableist language.	We will consider this suggestion for a future cycle.