Frequently Asked Questions (FAQs)
Medicare Part C Policy Mailbox
Division of Policy, Analysis, and Planning (DPAP)
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Chronic Care Improvement Program (CCIP)

Q: Where are the CCIP requirements located?
A: The CCIP requirements are outlined in the MA CCIP Resource Document, which is located on the MA Quality website.

Q: Are plans with low membership (e.g., 200 enrollees or less) required to conduct a CCIP?
A: Yes. Regardless of the number of enrollees, all MA plans are required to conduct a CCIP as outlined at 42 CFR §422.152.

Q: Is there a separate point-of-contact for questions regarding CCIPs for Medicare-Medicaid Plans (MMPs)?
A: For questions regarding CCIPs for MMPs, please contact the Medicare-Medicaid Coordination Office (MMCO) mailbox at: MMCOcapsmodel@cms.hhs.gov.

Clinical Trials

Q: What costs are MAOs responsible for related to enrollee participation in clinical trials?
A: There are several kinds of clinical trials, and MAO responsibility varies based on the type of clinical trial. For more information, please refer to section 10.7 of chapter 4 of the Medicare Managed Care Manual.

Q: What are routine costs for enrollees participating in clinical trials?
A: Routine costs for enrollees participating in qualifying clinical trials include all items and services that are covered by the MA plan for all enrollees whether or not they are participating in the experimental or control arms of a Medicare-qualified clinical trial. For example, the cost of a visit to the enrollee's PCP for a service unrelated to the clinical trial in which the enrollee is participating, is a routine cost and the MA plan is responsible for the plan's share of the cost of that visit. See National Coverage Determination 310.1, Routine Costs in Clinical Trials, for additional information on routine costs.

Q: Are MA enrollees disenrolled from the MAO during the period they are in a CMS-approved clinical trial?
A: No. The MAO remains responsible for covering any condition or service that is not part of the clinical trial. CMS expects MAOs, as part of their coordinated care efforts, to help enrollees navigate issues related to participation in the CMS-approved clinical trial, including responsibility for coverage, claims payment, cost sharing, and outreach to clinical trial providers, as necessary.

Cost Plans

Q: Are cost plans MA plans?
A: No, cost plans are Medicare health plans authorized under section 1876 of title XVIII of the Social Security Act ("the Act"), a different authority than MA plans. The regulations governing cost plans can be found at 42 CFR Part 417.

Q: What are the primary differences between cost plans and MA plans?
A: Cost plans are paid based on actual costs for services provided to each enrollee, whereas MA plans are paid a capitated rate for enrollees. Also, cost plan enrollees may use the plan's network providers or may access care through providers outside of the network, through original Medicare, whereas MA enrollees generally receive care from providers in a plan's network.

Q: Can there be new cost contract plans?
A: No, section 1876(h)(5)(A) of the Act prohibits new cost plans; however, some existing cost plans may expand their service areas. Cost plan service area expansion applications can be found on the Medicare Cost Plans webpage.

Q: What are the cost plan competition requirements?
A: Section 1876(h)(5)(C) of the Act specifies that cost plans operating in the same service area, or portion of a service area, as two or more MA local or regional plans that meet specific enrollment requirements over the course of an entire year, may no longer offer health care services in the area. Because of statutory delays in implementation, contract year (CY) 2019 was the first year cost plans were affected by the competition requirements.

Q: Are the cost plan competition requirements affected by the recent legislation allowing cost plans to transition to MA?
A: The cost plan competition requirements remain law. However, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which provided cost plans affected by the competition requirements a two-year period (2017 and 2018) to continue to offer the plans and transition to the MA program by CY 2019, has sunset and is no longer in effect.

Explanation of Benefits (EOB)

Q: What claims must be included in the EOB?
A: MAOs must include all Part C claims processed during the reporting period, including all claims for Part A and Part B covered services, mandatory supplemental benefits, and optional supplemental benefits.

Q: Do claims for dental, vision, and Part B pharmacy drugs need to be included in the EOB?
A: Yes. Claims and enrollee out-of-pocket spending for Part B covered services and supplemental benefits, as applicable, must be included in the EOB.

Q: Should claims information for services furnished by delegated and/or capitated providers be included in the EOB?

A: Yes. All enrollee claims activity must be displayed in the EOB for that reporting period, including information from delegated and/or capitated providers.

Q: Should MAOs send EOBs to enrollees for whom there was no claims activity during the reporting period?
A: No. If there is no claims activity for the enrollee during the reporting period, the MAO is not required to send an EOB. However, if there is claims activity during the reporting period, the MAO must send an EOB, even if there is no associated enrollee liability.

Q: Does service/payment denial/appeal language need to be included in the EOB?
A: Any EOB that includes a denied claim(s) must include, in the same mailing, or within the EOB itself, information about the denial and the enrollee's appeal rights. That is, the service must be identified by: date, billing code, description, and provider; that the claim has been denied; and where information about the enrollees' appeal rights is included. The template instructions allow flexibility to either include the language provided in the EOB template itself or to include in the mailing the approved Integrated Notice of Denial of Payment (NDP) language (the Integrated Denial Notice, or IDN). When issuing payment denial notices, MAOs are required to use the IDN language (available at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MADenialNotices.html), which replaced the former NDP language. If there are multiple denied claims in one EOB, the language about appeals may be placed once at the end of the claims detail section. If the MAO opts to include the approved appeals language by including as a separate document the IDN instead of including the language in the CMS template, there should be a note within the EOB that directs the enrollee to that attachment or to that document included with the EOB rather than to "below," as in the CMS template.

Q: Does adjusted claims activity need to be included in the EOB?
A: Yes. The EOB must include any adjustments (e.g., for a reversed claim as a result of an appeal or wraparound payment) or corrections (e.g., a clerical error) that affect an enrollee's total out-of-pocket spending. Adjustments or corrections that do not affect an enrollee's out-of-pocket costs (e.g., for incorrect billing) do not have to be included in the EOB. Inclusion of such claims could be confusing and would not provide useful information to the enrollee.

Q: Does claim activity from a prior year need to be included in the EOB?
A: Yes. Any applicable prior year claims that are settled and ready for reporting are to be included in the EOB. The MAO may choose to either send a separate, updated EOB to reflect the prior year claim activity or may include the applicable information in the current EOB as long as the information, particularly the maximum out-of-pocket (MOOP) totals, are clearly differentiated by year. MOOP information must always be tracked on a contract year basis.

Q: When an enrollee disenrolls from an MAO, should the plan send an EOB(s) reflecting the claims processed after the disenrollment?
A: Yes. It is important that the plan send an EOB that reflects these claims, as it supports one of the most important purposes of the EOB, which is to include complete and meaningful out-of-pocket spending information for the enrollee. The enrollee is entitled to receive a full accounting of his/her out-of-pocket spending during enrollment in the plan and to receive a refund of any amount of out-of-pocket spending in excess of the plan's MOOP. In addition, in cases that the

disenrollment is mid-year and the enrollee enrolls in another plan of the same type offered by the MAO, that out-of-pocket spending should be credited toward the MOOP in the new plan.

Q: What are the requirements for the per-claim EOB?
A: MAOs that send per-claim EOBs must also send quarterly summaries that include all of the information reflected in the CMS quarterly template. Please note that the per-claim EOBs should be issued on a timely basis, and claims information must not be sent to enrollees less frequently than if the plan was using a monthly EOB cycle. That is, the plan may not hold claims and then issue a per-claim EOB less frequently than they would have issued a monthly EOB.

Q: Should claims for services that do not count toward the MOOP need to be included in the EOB?
A: Yes. Any services for which cost sharing does not count toward the MOOP are to be included in every monthly and quarterly summary EOB. See template instructions for additional information about depicting such services.

Q: Are MAOs permitted to change their election of sending EOBs either monthly or on a per-claim basis?
A: Yes; however, to avoid confusion, we recommend that if possible changes be made at the start of the calendar year.

Q: What plan types are required to send EOBs?
A: All MA plans, with the exception of section 1833 and 1876 cost contract plans, are required to provide EOBs to their enrollees.

Health Risk Assessment (HRA)

Q: Chapter 4 of the Medicare Managed Care Manual contains guidance about annual HRAs for non-SNP plans. Does this language mean that non-SNP coordinated care plans are required to complete an HRA and subsequent annual reassessment for each enrollee?
A: Per 42 CFR §422.112, all non-SNP coordinated care plans must make a best-effort attempt to conduct an initial HRA, including following up on unsuccessful attempts to contact an enrollee, within 90 days of the effective date of enrollment. Additionally, CMS expects, as a best practice, that non-SNP coordinated care plans will conduct annual assessments of enrollees. CMS believes that annual assessment of enrollees' health care needs is a well-established practice that is essential to the plans' effective care coordination. For more information, please refer to section 110.6 of chapter 4 of the Medicare Managed Care Manual.

MA Plan Treatment of Part A/B Services

Q; Do MA plans have to cover all Part A/B services? Do MA plans have to follow Part A/B billing rules? Do MA plans have to follow Part A/B reimbursement?
A: Coverage: MA plans must cover all services covered under Part A/B, including all national coverage determinations (NCDs), and local coverage determinations (LCDs) in a plan's service area, with a few exceptions:

- Billing: MA plans need not follow original Medicare billing rules. MA plans may create their own billing procedures as long as payments are (1) accurate, (2) timely, and (3) have an audit trail (i.e., backup documentation). This flexibility applies to both contracted and non-contracted providers.
- Cost Sharing: MA plans need not follow original Medicare cost sharing. That is, there may be individual service categories of benefits where MA plans are allowed to charge cost sharing that is different than the Part A/B cost sharing. There are specific service categories where MA plans are prohibited from charging more than original Medicare. Furthermore, MA plans have requirements on aggregate cost sharing and CMS must review and approve all bid submissions.
- Reimbursement:
    - Non-Contracted Provider: A non-contracted provider must be paid at least what they would have received had they furnished the service in an original Medicare setting.
    - Contracted Provider: MA plans may negotiate with their network of contracted providers for rates that are below the original Medicare rate. In such a case, the contract is governed by the laws of the state in which the MA plan is incorporated.

For information about NCDs and LCDs, please refer to the CMS National Coverage Database. When there is no written coverage decision (NCD/LCD) and in the absence of a "never covered" determination for a service, MA plans should use the coverage determination process described at section 90.5 of chapter 4 of the Medicare Managed Care Manual to determine if the item or service is coverable by the MA plan. For more information on provision of Part A/B services by MA plans, please refer to sections 10.2 and 50.1 of chapter 4. Section 10.7 of chapter 4 also contains information concerning Part A/B services furnished to an MA enrollee as they relate to clinical trials.

Medicare Diabetes Prevention Program (MDPP)

Q: Is the MDPP a basic benefit?
A: Yes, the MDPP is a basic benefit under Medicare Part B.

Q: Is there cost sharing for eligible Medicare beneficiaries who use MDPP services?
A: In-network MDPP services must be provided with zero cost sharing to eligible beneficiaries.

Medicare Outpatient Observation Notice (MOON) Act

Q: Are hospitals and critical access hospitals (CAHs) required to issue the MOON to MA enrollees?
A: Yes, hospitals and CAHs must issue the MOON to original Medicare beneficiaries and MA enrollees, in accordance with CMS guidance.

Q: What is the implementation date for the MOON?
A: When CMS posted the finalized MOON and form instructions on the CMS website on January 8, 2017, hospitals and CAHs were directed to begin using the MOON no later than March 8, 2017.

Model of Care (MOC)

Q: We want to revise our special needs plan's (SNP's) MOC. How do we submit the revised MOC?
A: SNPs should use the MOC Module in HPMS for submitting MOC revisions that are substantial for CMS approval. If you believe the revisions to your SNP's MOC should be submitted, please go into HPMS and click on *MOC Module*, then click on the *MOC Off-cycle Submission* section. The module also includes a checklist for users to ensure their changes are substantive and warrant an off-cycle submission. You can then upload your summary of revisions and the revised redlined MOC in the *MOC Matrix Upload Document.* Organizations sponsoring SNPs are permitted to submit off-cycle MOC revisions for CMS approval between June 1st and November 30th of any calendar year. Please note, CMS closes the window for SNP MOC off-cycle submissions between December 1st and May 31st of the following calendar year. SNPs may not implement any MOC changes until approved by CMS. Note that only I-SNPs and D-SNPs are allowed to submit off-cycle MOCs. C-SNPs are now required to submit MOCs annually for CMS review and approval, regardless of their score, and are therefore not permitted to submit a revised MOC through an off-cycle submission.

Q: Would you please confirm that only one MOC is needed for a new D-SNP that expects to enroll a significant number of nursing home eligible beneficiaries in addition to other dual-eligibles?
A: The MAO will address the entire population in its MOC. Completion of Element 1 (Population) of the MOC requires a full description of the SNP's most vulnerable populations and discussion of the health care and social needs of the entire population.

Q: As a large MAO with a SNP product that is offered in service areas across the country, can we describe our population at the national level in Element 1: Population?
A: No, that is not acceptable. CMS expects that the target population description is of the particular needs of the enrollees at the local service area and not a discussion on the overall national population.

Q: Where can we locate our MOC score and MOC detailed report?
A: The MOC detailed report with scores are located in HPMS under *Contract Management>Model of Care>Reports>Detailed Reports*. SNPs may also view their MOC scores at the public CMS/NCQA SNP MOC Approval website.

Q: Where can MAOs interested in offering SNPs locate information about the MOC?
A: MAOs can locate information about the MOC, resources, training materials, and MOC scoring guidelines at the public CMS/NCQA SNP MOC Approval website.

Network Adequacy

Q: How does CMS monitor network compliance?
A: CMS monitors network compliance by reviewing organizations' networks on a triennial basis (i.e., every three years). The triennial network adequacy review cycle helps to ensure a

consistent process for network oversight and monitoring. In addition to the triennial network adequacy review, CMS may perform a network review after specific triggering events. If an organization experiences a triggering event requiring a full network review, then the timing of that organization's subsequent triennial review may be reset. For more information, please refer to the Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance on the CMS website.

Q: What is a provider-specific plan (PSP)?
A: A PSP is an MA plan benefit package (PBP) that limits plan enrollees to a subset of contracted providers/facilities in a county or counties that are within the larger contract-level network approved by CMS. For example, a PSP has a network that is comprised of fewer providers/facilities than what CMS approved for that county during the organization's contract-level network review. As part of the bid submission process that begins in June, an organization offering a PSP must confirm and attest that the PSP's network meets current CMS network adequacy requirements. For more information, please refer to the Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance on the CMS website.

New Original Medicare Benefits

Q: Are MAOs responsible for providing new Medicare benefits resulting from legislative changes or national coverage determinations (NCDs)?
A: Yes. Unless the benefit is determined by CMS to be a significant cost, the MAO is required to cover the new benefit as soon as coverage becomes effective under original Medicare. If it is determined to be a significant cost, MAOs are not responsible for coverage until the costs can be included in the capitated payments to MAOs, usually in the following contract year.

Q: What are the thresholds for significant costs?
A: The formulas for determining whether or not a new benefit is a significant cost are specified at 42 CFR §422.109(a) and (b).

Q: Do MAOs have any responsibilities for coverage of a benefit that has been determined by CMS to be a significant cost before the cost is included in MAOs' capitated payments?
A: Yes. Although MAOs may not yet be responsible for the costs of a new benefit, 42 CFR §422.109(c)(2) requires that MAOs pay for:

- Services necessary to diagnose a condition for which the benefit may be covered;
- Most services furnished as follow-up care to the benefit;
- Any service that is already a Medicare-covered service and included in the annual MA capitation rate or previously adjusted payments; and
- Any services, including the costs of the new benefit, to the extent the MAO is already obligated to cover it as a supplemental benefit under 42 CFR §422.102.

Provider Directories

Q: Where is the current guidance on provider directories located?

A: There are currently two main guidance documents that address provider directory policy. The Medicare Communications and Marketing Guidelines (MCMG) contain guidance on provider directories in sections 70.1.2, 70.2, and 100.1-100.4 (located on the marketing guidelines website). In addition, the Medicare Advantage and Section 1876 Cost Plan Provider Directory Model is located on the marketing models website. Please note, CMS is currently in the process of updating chapter 4 of the Medicare Managed Care Manual; specifically, section 110.2 (provider directories) is outdated, and individuals should reference the MCMG and the model for the most up-to-date guidance on provider directories.

Q: Are organizations required to verify their provider directories on a quarterly basis?
A: Organizations may determine the best method to ensure up-to-date directories. CMS believes regular outreach to individual providers (e.g., quarterly) is one way to assist organizations in ensuring data is accurate. Note that facilities' (e.g., hospitals') information must be accurate but may not require as frequent outreach as individual providers. Whether updates are obtained by an organization's regular outreach or obtained through other sources (e.g., enrollee notification), CMS recognizes that there may be a delay between receipt of information from providers and the organization's ability to update its directory. Therefore, CMS allows organizations up to 30 days to update provider directories. CMS's measure of success is an accurate provider directory.

Q: Are plans required to submit their provider directories to CMS for review?
A: Plans are not required to submit their provider directories to CMS. However, CMS still reserves the right to request a plan's provider directory, for example, in instances of enrollee or provider complaints.

Q: The Provider Directory Model instructions state that plans may only list providers who *regularly* practice at the specified location (not on-call or substitute providers). The instructions also state that if a provider practices at multiple locations, the plan may only list the location(s) at which the provider *regularly* sees patients (not every location where the provider may practice only occasionally). How does CMS define "regularly" in these contexts?
A: Plans should list each individual provider at the location(s) where an enrollee may reasonably be expected to obtain services. If an enrollee calls to make an appointment with a provider, but is unable to obtain an appointment because that provider does not regularly practice at the location listed in the directory, then that provider should not be listed at that location because an enrollee cannot reasonably be expected to obtain services from that provider at the location listed.

Q: For non-physician practitioners—such as physician assistants (PAs) and nurse practitioners (NPs)—how do the requirements differ for provider directories versus HSD tables?
A: Organizations may include PAs/NPs on their provider HSD table for primary care **only if** the PAs/NPs meet certain specified requirements outlined in the Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance on the CMS website. In terms of provider directories, if an organization contracts with additional PAs/NPs that act as primary care providers and does not use them to satisfy the minimum network adequacy criteria for primary

care, then the organization may list those contracted PAs/NPs in the provider directory in order to provide more options for enrollees. Organizations may list non-physician practitioners (e.g., PAs/NPs) as primary care providers if an enrollee can make an appointment with that practitioner, but the organization must clearly identify that the provider is a non-physician practitioner.

Q: Should an organization's provider directory mirror its Health Service Delivery (HSD) tables for network adequacy reviews?
A: Changes in provider contracting/directories may affect access. Therefore, organizations must periodically reassess whether additional providers need to be added to the network to ensure that current CMS network adequacy standards are met. CMS expects that organizations complete the necessary steps to ensure that, when applicable, updates to provider directories are synced with updates to HSD tables. For example, if an organization finds that a provider has retired and then updates its provider directory, then the organization should also update its HSD tables and run the updated network through the Network Management Module in HPMS to see if the network still meets current standards.

Religious Non-Medical Health Care Institution (RNHCI) Coverage

Q: What is a RNHCI?
A: A RNHCI is a facility for non-medical treatment that provides coverage for MA enrollees who otherwise qualify for in-patient hospital or skilled nursing facility but, because of their religious beliefs, prefer to be treated in a RNHCI.

Q: Are MA plans responsible for coverage?
A: Yes, this is a benefit under the Medicare statute and must, therefore, be covered by MAOs.

Q: What are key conditions necessary for coverage from a RNHCI?
A: Key conditions include:

- The facility providing the care must be certified by Medicare.
- A plan's coverage of services is limited to *non-religious* aspects of care.
- This benefit is provided only for Part A inpatient services (non-medical health care services).

Q: What is the authorization process for an MA enrollee to enter a RNHCI?
A: A RNHCI will provide evidence of its determination that the Medicare coverage criteria are met and that the enrollee qualifies for a RNHCI. Plans may require approval in advance before an enrollee is admitted to the RNHCI.

Rewards and Incentives (RI) Programs

Q: Do RI programs have to be included in the annual bid?
A: Yes. All RI programs must be accounted for in the annual bid in the Bid Pricing Tool. However, because an RI program is not a benefit, it should be included in the bid as a non-benefit expense and should not be entered in the PBP. Per CMS Office of the Actuary Bidding

Guidance, "non-benefit expenses are all of the bid-level administrative and other non-medical costs incurred in the operation of the MAO." For more information, please refer to section 100 of chapter 4 of the Medicare Managed Care Manual and the Bid Pricing Instructions, located at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Bid-Pricing-Tools-and-Instructions-Items/BPT2017.html.

Q: Is it okay for an MAO to implement an RI program in the middle of a contract year?
A: MAOs may implement RI programs in the middle of the year; they do not necessarily have to begin on January 1 of a contract year. However, whatever program they implement must have been accounted for and included in the bid for that year. For more information, please refer to section 100 of chapter 4 of the Medicare Managed Care Manual and the Bid Pricing Instructions, located at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Bid-Pricing-Tools-and-Instructions-Items/BPT2017.html.

Q: We are considering an incentive program that would reward members for medication adherence and prescription fills. Would that be an acceptable incentive program per CMS guidelines?
A: No. At this time, RI program regulations are applicable only for Part C. Rewards and incentives may not be offered in exchange for any activities and services related to Part D prescription drug benefits. For more information, please refer to section 100 of chapter 4 of the Medicare Managed Care Manual.

Q: Would an RI program that offers chances or entries into a drawing as the reward or incentive be consistent with CMS policy for RI programs?
A: Rewards and incentives based on probability, including programs in which an enrollee may earn entries into a lottery or drawing in order to receive a reward or incentive of a significant value, are not permissible. CMS policy calls for all enrollees who participate in and complete the eligible services or activities to receive a tangible reward and incentive. The chance of winning a reward (depending on the pool of eligible enrollees) does not qualify as a tangible reward or incentive. Furthermore, CMS believes that RI programs structured in this manner are potentially vulnerable to fraud and abuse. For more information, please refer to section 100 of chapter 4 of the Medicare Managed Care Manual.

Q: Would it be permissible to design our RI program so that enrollees with a history of not participating in health promotional activities are given a different and/or larger reward for participation in a health-related service?
A: No. MAOs may give different rewards for different activities but may *not* give different rewards to different members for completing the same activity, regardless of the reason. MAOs must reward everyone equally for equal participation, regardless of whether that enrollee has previously missed appointments or has a 100 percent compliance record. For more information, please refer to section 100 of chapter 4 of the Medicare Managed Care Manual.

Q: Is there a maximum value allowed for a reward/incentive or any type of monetary cap?
A: Rewards and incentives for each RI program must have values that are expected to elicit intended enrollee behavior but may not exceed the value of the health related service or activity (See 42 CFR §422.134(C)(1)(iii)). At this time, CMS has established neither a limit for how

often rewards and/or incentives may be offered to enrollees nor a maximum monetary value for the rewards and/or incentives themselves. Instead, MAOs are to establish reasonable and appropriate values for rewards and incentives in accordance with CMS requirements. If necessary, in the future, we may exercise our authority to specify limits on the value of rewards and incentives through subregulatory guidance. For more information, please refer to section 100 of chapter 4 of the Medicare Managed Care Manual.

Special Needs Plans (SNPs)

Q: When does an MAO offering a SNP have to submit a MOC?
A: An MAO must submit a MOC if one of the following scenarios applies:

- The MAO seeks to offer a new SNP;
- The MAO's SNP's MOC approval period ends; or
- CMS deems it necessary to ensure compliance with the applicable regulation(s). Examples include:
  - During an audit, if it appears that the MOC is not meeting CMS standards, then CMS may ask the SNP to correct and resubmit the MOC; or
  - During a regulation change involving the MOC, CMS may ask SNPs to resubmit their MOCs to ensure that they meet the new regulatory requirements.

Please note, CMS approves I-SNP and D-SNP MOCs for one, two, or three year periods. C-SNPs must submit a MOC annually for evaluation and approval by NCQA. For more information on MOCs, please refer to chapters 16b and 5 of the Medicare Managed Care Manual, as well as the MOC FAQs above.

Q: What are the different types of chronic condition SNPs (C-SNPs)?
A: When completing the SNP application, MAOs may apply to offer a C-SNP that targets any one of the following:

1. A single CMS-approved chronic condition,
2. A CMS-approved group of commonly co-morbid and clinically-linked conditions, or
3. An MAO-customized group of multiple chronic conditions.

Please refer to chapter 16b of the Medicare Managed Care Manual for the 15 CMS-approved SNP-specific chronic conditions, as well as for details on the three options above.

Q: Are C-SNPs required to conduct a verification of an enrollee's chronic condition on an annual basis?
A: C-SNPs are not required to conduct a verification of an enrollee's chronic condition on an annual basis, only prior to enrollment. For more information, please refer to chapter 16b of the Medicare Managed Care Manual, as well as the Medicare Advantage Enrollment and Disenrollment Guidance, located on the Medicare Managed Care Eligibility and Enrollment webpage.

Q: How are coverage and cost sharing impacted when a dual-eligible enrollee loses Medicaid eligibility but the D-SNP deems continued eligibility?
A: During the period of deemed continued eligibility for a D-SNP specifically, the D-SNP must continue to provide all MA plan-covered Medicare benefits (i.e., all benefits included in the bid). During this period, the D-SNP is not responsible for continued coverage of Medicaid benefits

that are included under the applicable Medicaid State Plan, nor is the D-SNP responsible for Medicare premiums or cost sharing for which the state would be liable had the enrollee not lost his/her Medicaid eligibility. However, cost sharing amounts for Medicare basic and supplemental benefits do not change during this period.

During the period of deemed continued eligibility, SNPs are responsible for knowing:

- The benefits covered for the enrollee;
- The state requirements; and
- The enrollee notification requirements.

For more information, please refer to chapter 16b of the Medicare Managed Care Manual, as well as the Medicare Advantage Enrollment and Disenrollment Guidance, located on the Medicare Managed Care Eligibility and Enrollment webpage.