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TO: Medicare Advantage Organizations with a Dual Eligible Special Needs Plan

FROM: Lindsay P. Barnette
Director, Models, Demonstrations, and Analysis Group
Medicare-Medicaid Coordination Office (MMCO)

Kathryn A. Coleman, Director
Medicare Drug & Health Plan Contract Administration Group
Center for Medicare

SUBJECT: Updates to Medicare Managed Care Manual Chapter 16-B

The purpose of this memorandum is to share updates to Medicare Managed Care Manual Chapter 16-B.

Updates to Chapter 16-B of the Medicare Managed Care Manual

We have updated section 20.2.2 and created new sections 20.2.9 and 20.2.10 of Chapter 16-B of the Medicare Managed Care Manual. Updated section 20.2.2 titled “State Contract Requirements for D-SNPs” follows the regulation at § 422.2. New sections 20.2.9 and 20.2.10 titled “D-SNP Enrollee Advisory Committees” and “Additional Responsibilities for D-SNPs” follow regulations at §§ 422.107(f), and 422.562(a)(5), respectively. We have also made minor updates to sections 40.1, 50.2, 50.3, and 80.

The updated section 20.2.2 newly describes when and how MA organizations can submit a state Medicaid agency contract (SMAC) revision and under what circumstances a request for a redetermination of integration level directly through the D-SNP Management Module in HPMS is permissible.

The updated sections reflect current regulatory requirements. Where there are differences between statute or regulations and the manual, the statute or regulations control over the manual (and any other guidance). Therefore, interested parties should consult the applicable statutes, regulations, and final rules.

Chapter 16-B, incorporating the updated section, is available at the following link:
<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c16b.pdf>. The updates for this section are also in Attachment A.

Questions

Questions regarding updates to Chapter 16-B may be directed to MMCO_DSNPOperations@cms.hhs.gov. Please include your CMS Account Manager regarding any questions on Chapter 16-B.

Attachment A

20.2.2.1 Establishing Integration Status

(Issued: XX-XX-XX; Effective: XX-XX-XX; Implementation: XX-XX-XX)

The process outlined in section 20.2.2.1 relies on CMS regulation at 42 CFR 422.2, which was codified in the CY 2020 and 2021 MA and Part D Final Rule ([CMS-4185-F](#)), which was published on April 16, 2019.

CMS determines a D-SNP's status as CO, HIDE, FIDE, and/or AIP based on language in the SMAC. The matrices that D-SNPs complete inform (but do not dictate) the outcome of the CMS assessment. We notify MA organizations during the SMAC review of our determination of integration status for each D-SNP. MA organizations can request a review of that determination during the annual SMAC review process.

20.2.2.2 Changes in State Medicaid Agency Contracts

(Issued: XX-XX-XX; Effective: 01-01-2025; Implementation: 01-01-2025)

We recognize that states and MA organizations offering D-SNPs may amend the SMAC throughout the contract year. CMS seeks to maintain the most current version of the executed SMAC within HPMS as the system of record for MA organizations. While not all changes made in the SMAC impact provisions set forth in 42 CFR 422.2 and 422.107 specifically, we request the MA organization submit all amendments made to the SMAC through HPMS.

20.2.2.2.1 Changes in Integration Status

(Issued: XX-XX-XX; Effective: 01-01-2025; Implementation: 01-01-2025)

There are limited circumstances when revisions to the SMAC may affect the integration level of the D-SNP. These limited circumstances are typically a result of a Medicaid managed care program procurement or other state contracting process. In many instances the outcome of these procurements may be protested by losing organizations or disputed through the judicial system. In other instances, a state Medicaid program may start a new contract period in a month other than January. When there are changes to the state contracting with the Medicaid managed care plan that impacts the D-SNP's integration status, the MA organization should submit the revised SMAC to CMS for CMS to make a redetermination of the integration status. Examples of when CMS expects to review a revised SMAC and may make a redetermination of the integration level include when:

- The Medicaid managed care contract with the D-SNP, the D-SNP's parent organization, or another entity that is owned and controlled by the parent organization adds LTSS and/or behavioral health covered services that may change the D-SNP from coordination-only to FIDE or HIDE*
- The Medicaid managed care plan affiliated with the D-SNP, the D-SNP's parent organization or another entity that is owned and controlled by the parent organization loses its Medicaid managed care contract with the state mid-year, thus changing the D-SNP from FIDE or HIDE to coordination-only*

- *The state makes changes that create enrollment limitations*

MA organizations can submit a SMAC revision request directly through the D-SNP Management Module in HPMS. CMS requests the SMAC revision requests be submitted no later than 30 days prior to the proposed integration status change. This should allow CMS sufficient time to review the updated SMAC prior to implementation of the Medicaid managed care program change. We note, however, that in no instances will an off-cycle redetermination of D-SNP integration status allow for a mid-year crosswalk of enrollees between D-SNP benefit packages.

20.2.9 – D-SNP Enrollee Advisory Committees

(Rev. XXX; Issued: XX-XX-XX; Effective: XX-XX-XX; Implementation: XX-XX-XX)

The policies outlined in section 20.2.9 rely on CMS regulation at 42 CFR 422.107(f), which was codified in CY 2023 MA and Part D Final Rule (CMS-4192-F), which was published on May 9, 2022.

Enrollee advisory committees provide a means to engage enrollees in discussions and to provide information and viewpoints on ways to improve access to covered services and coordination of services. For dually eligible individuals, these considerations are especially important. By soliciting and responding to enrollee input, D-SNPs, like all managed care plans, can better ensure that policies and procedures are responsive to the needs, preferences, and values of enrollees and their families and caregivers. One of the ways D-SNPs can engage dually eligible individuals is by including enrollees in plan governance, such as establishing enrollee advisory committees and placing enrollees on governing boards. Engaging enrollees in these ways seeks to keep enrollee and caregiver voices front and center in plan operations and can help plans achieve high-quality, comprehensive, and coordinated care.¹

42 CFR 422.107(f) requires that an MA organization offering one or more D-SNPs in a state establish and maintain one or more enrollee advisory committees (EACs) that serve D-SNPs offered by the MA organization in that state. The EAC must:

- 1. Include at least a reasonably representative sample of the population enrolled in the D-SNP(s), or other individuals representing those enrollees; and*
- 2. Solicit input on, among other topics, ways to improve access to covered services, coordination of services, and health equity for underserved populations.*

Some D-SNPs, or their Medicaid managed care plans offered by the same parent organization as the MA organization offering the D-SNP, covering long term services and supports, may also operate similar advisory committees to meet state or federal Medicaid requirements. An MA organization that operates a D-SNP that is affiliated with a Medicaid managed care plan can use one EAC to meet both the requirement under 42 CFR 438.110 and 42 CFR 422.107(f), when all the criteria in both requirements are met.

20.2.9.1 – Flexibility in EAC Operations

(Rev. XXX; Issued: XX-XX-XX; Effective: XX-XX-XX; Implementation: XX-XX-XX)

We encourage MA organizations to work with D-SNP enrollees and their representatives to establish the most

¹ Resources for Integrated Care and Community Catalyst, “Listening to the Voices of Dually Eligible Beneficiaries: Successful Member Advisory Councils”, 2019. Retrieved from:

https://www.resourcesforintegratedcare.com/Member_Engagement/Video/Listening_to_Voices_of_Dually_Eligible_Beneficiaries

effective and efficient processes for enrollee engagement. The requirements at 42 CFR 422.107(f) are nonprescriptive on meeting frequency, location, format, enrollee recruitment and training methods, use and adoption of telecommunications technology, or other parameters for operation of the EACs.

This flexibility extends to the geographic scope of the EAC(s) within each state. For example, the EAC could include enrollees from a D-SNP offered in a single county, or it could consist of enrollees from D-SNPs offered in multiple counties. For instance, a MA organization that offers separate D-SNPs in Broward, Hillsborough, and Orange counties in Florida could establish one EAC that convenes enrollees representative of each of these distinct regions via virtual communication methods. Alternatively, the MA organization could establish separate EACs in each county or use a combination of these approaches. Similarly, an MA organization that offers separate D-SNPs serving full-benefit dually eligible individuals and partial-benefit dually eligible individuals in the same state could solicit enrollee input through one or more EACs where separate committees might represent specific eligibility groups.

20.2.9.2 – Other Information and Technical Assistance

(Rev. XX; Issued: XX-XX-XX; Effective: XX-XX-XX; Implementation: XX-XX-XX)

We sponsored technical assistance for MA organizations on establishing meaningful EACs through the Resources for Integrated Care.² Nothing in these technical assistance materials supersedes the applicable regulation or guidance in this manual. However, we encourage D-SNPs to consider those materials to maximize the success of the EAC.

We issued a Health Plan Management System (HPMS) memorandum on June 18, 2024, entitled “Lessons Learned from Dual Eligible Special Needs Plans Enrollee Advisory Committee Strategic Conversation.”³ The memorandum outlines lessons learned from a series of strategic conversations CMS held with MA organizations to understand first year implementation of D-SNP EACs. Lessons learned focus on EAC:

- *Participant recruitment and retention*
- *Participant preparation and engagement*
- *Meeting structure*
- *Follow up*

We also issued an HPMS memo on November 28, 2022, “Cash, Cash Equivalent, Voucher, Gift Card, and In-Kind Benefits for Enrollees Who Are Enrollee Advisory Committee Participants.”⁴ This memorandum describes

² Resources for Integrated Care, “Best Practices for Implementing Enrollee Advisory Committees”, video recording, webinar slides, and other resources retrieved from:

https://www.resourcesforintegratedcare.com/2022_ric_webinar_best_practices_for_implementing_enrollee_advisory_committees/. Resources for Integrated Care, “Launching an Enrollee Advisory Committee”, Tip Sheet https://www.resourcesforintegratedcare.com/wp-content/uploads/2024/01/TA-Duals_Tip-Sheet-Launching-an-EAC_final.pdf. Resources for Integrated Care, “Enrollee Advisory Committees: Navigating the Feedback Process”, Tip Sheet https://www.resourcesforintegratedcare.com/wp-content/uploads/2023/07/TA-Duals_-TipSheet-Feedback-for-Improvement_final.pdf.

³ CMS, Lessons Learned from Dual Eligible Special Needs Plans Enrollee Advisory Committee Strategic Conversation,” June 18, 2024 retrieved from: <https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-3-june-17-21>

⁴ CMS, “Cash, Cash Equivalent, Voucher, Gift Card, and In-Kind Benefits for Enrollees Who Are Enrollee Advisory Committee Participants,” November 28, 2022 retrieved from: <https://www.cms.gov/httpseditemsgovresearch-statistics-data-and-systemscomputer-data-and-systemshpms-hpms-memos-archive/hpms-memos-wk-5-november-28-30>

considerations for D-SNPs regarding cash, cash equivalent, voucher, gift card, and in-kind benefits for individuals who participate in enrollee advisory committees.

20.2.10 – Additional Responsibilities for D-SNPs

(Rev. XXX; Issued: XX-XX-XX; Effective: XX-XX-XX; Implementation: XX-XX-XX)

The policies outlined in section 20.2.10 rely on CMS regulation at 42 CFR 422.562(a)(5), which was codified in CY 2020 and 2021 MA and Part D Final Rule ([CMS-4185-F](#)), which was published on April 16, 2019.

20.2.10.1 – Responsibilities Related to Assisting with Access to Benefits, Appeals, and Grievances

(Rev. XXX; Issued: XX-XX-XX; Effective: XX-XX-XX; Implementation: XX-XX-XX)

Per 42 CFR 422.562(a)(5), D-SNPs must offer to assist an enrollee with obtaining Medicaid-covered services and resolving grievances, including requesting authorization of Medicaid services, as applicable, and navigating Medicaid appeals and grievances in connection with the enrollee's own Medicaid coverage, regardless of whether such coverage is in Medicaid fee-for-service or a Medicaid managed care plan, such as a Medicaid MCO, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), as defined in 42 CFR 438.2. If the enrollee accepts the offer of assistance, the plan must provide the assistance.

Examples of such assistance include the following:

- (A) Explaining to an enrollee how to make a request for Medicaid authorization of a service and how to file an appeal following an adverse benefit determination, such as—*
 - (1) Assisting the enrollee in identifying the enrollee's specific Medicaid managed care plan or fee-for-service point of contact;*
 - (2) Providing specific instructions for contacting the appropriate agency in a fee-for-service setting or for contacting the enrollee's Medicaid managed care plan, regardless of whether the Medicaid managed care plan is affiliated with the enrollee's D-SNP; and*
 - (3) Assisting the enrollee in making contact with the enrollee's fee-for-service contact or Medicaid managed care plan.*
- (B) Assisting a beneficiary in filing a Medicaid grievance or a Medicaid appeal.*
- (C) Assisting an enrollee in obtaining documentation to support a request for authorization of Medicaid services or a Medicaid appeal.*

D-SNPs can provide assistance in many ways, also including advising enrollees to call providers and questions to ask, identifying necessary forms to file, and referring enrollees to an organization with more expertise (such as a state ombudsman, State Health Insurance Assistance Programs, and other relevant assistance programs). We recognize that state Medicaid systems vary substantially, and that the specific forms of assistance will also vary from market to market. We do not seek to be overly prescriptive in the types of assistance a D-SNP must provide, and the examples provided above and in regulation are not intended to be exhaustive.

20.2.10.1.1 – When 42 CFR 422.562(a)(5) Requires D-SNPs to Provide Assistance

(Rev. XXX; Issued: XX-XX-XX; Effective: XX-XX-XX; Implementation: XX-XX-XX)

The D-SNP must offer to provide the assistance described above and in 42 CFR 422.562(a)(5)(i) whenever it becomes aware of an enrollee's need for a Medicaid-covered service. Offering such assistance is not dependent on an enrollee's specific request. There are a number of ways in which a D-SNP could become aware of the need for assistance. A non-exhaustive list includes: During a health risk assessment when an enrollee shows a need for

more LTSS than she currently receives through Medicaid; during a request for coverage of a Medicaid-covered service made to the D-SNP; and during a call to the D-SNP's customer service line.

Each D-SNP must offer to provide and actually provide assistance as required by 42 CFR 422.562(a)(5)(i) using multiple methods.

(A) When an enrollee accepts the offer of assistance described in 42 CFR 422.562(a)(5)(i), the D-SNP may coach the enrollee on how to self-advocate.

(B) The D-SNP must also provide an enrollee reasonable assistance in completing forms and taking procedural steps related to Medicaid grievances and appeals.

We expect that D-SNPs, as plans with expertise in serving dually eligible beneficiaries, should be able to identify a potential Medicaid coverage issue as part of their regular assessments and care management processes. For example, a D-SNP may become aware that an enrollee is unsatisfied with the personal care services she is receiving based on the work of a care coordinator or from a call or email from the enrollee or enrollee's family. We note that regulation text at 42 CFR 422.562(a)(5) does not explicitly require a D-SNP to use its care coordination or case management programs to identify this type of issue.

Not all enrollees would need assistance in the actual filing of grievances and appeals; for many enrollees, simply receiving information under 42 CFR 422.562(a)(5)(i) would be sufficient. However, it would not be acceptable for a D-SNP to tell an enrollee simply to contact "Medicaid" in general when the enrollee encounters a problem with his or her Medicaid coverage or is obviously in need of assistance in figuring out how to file an appeal of a denial of Medicaid-covered benefits.

20.2.10.1.2 – When 42 CFR 422.562(a)(5) Does Not Require D-SNPs to Provide Assistance

(Rev. XXX; Issued: XX-XX-XX; Effective: XX-XX-XX; Implementation: XX-XX-XX)

If an enrollee does not want the D-SNP's help in resolving an issue, then the D-SNP would not be obligated to provide assistance. The intention is not to create any affirmative obligation on the D-SNP to assist enrollees if they decline the offer of assistance. Enrollees are free to decide for themselves how to navigate their Medicaid coverage. The only obligation on D-SNPs is to offer assistance, and when a request is made or an offer of assistance is accepted, to provide it.

Further, partial-benefit dually eligible enrollees do not qualify for the full range of Medicaid services, and therefore, this requirement does not create any new obligation for D-SNPs to offer assistance for such enrollees to access Medicaid-covered services.

20.2.10.1.3 – Other Considerations

(Rev. XXX; Issued: XX-XX-XX; Effective: XX-XX-XX; Implementation: XX-XX-XX)

Each D-SNP must, upon request from CMS, provide documentation demonstrating its compliance with 42 CFR 422.562(a)(5).

The obligation to provide assistance under 42 CFR 422.562(a)(5)(i) does not create an obligation for a D-SNP to represent an enrollee in a Medicaid appeal. Further, it does not include a requirement to resolve the coverage issue.

40.1 – General

(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

As specified in section 1859(f) of the Act, SNPs may only enroll individuals who meet the plan's specific eligibility criteria and enrollment requirements. For example, a D-SNP that is approved to serve only *full-benefit* Medicaid *beneficiaries* may not enroll an individual who is not qualified for *full-benefit* Medicaid even though the individual may qualify for a different category of Medicaid.

Similarly, an individual who has no Medicaid entitlement may not enroll in a D-SNP of any type. A C-SNP approved to serve a population with diabetes may not enroll individuals who do not have the diabetic condition. However, enrollees who are dually eligible and who qualify for a C-SNP can choose to enroll in either a D-SNP or a C-SNP. An individual who loses eligibility and is disenrolled from a SNP may re-enroll in the same SNP if that individual once again meets the specific eligibility criteria of the SNP. In general, limits on enrollment, whether specific to persons with Medicare or for any individual eligible to enroll in the SNP, are not permissible. MA *organizations*, including those offering SNPs, must accept, without restriction, all eligible individuals whose enrollment elections are received during a valid election period, *except where a state limits or freezes enrollment through a D-SNP's SMAC*. See 42 CFR 422.52, 42 CFR 422.60 and section 1851(g)(1) of the Act.

42 CFR 422.52 *establishes eligibility rules for SNPs*. SNPs must include elements on the enrollment request that correspond to the special needs criteria of the particular SNP. Refer to policy regarding enrollment request mechanisms, including special guidance for C-SNPs, in the Medicare Advantage Enrollment and Disenrollment Guidance.

SNPs that choose whether to opt in to the Online Enrollment Center (OEC) are held to the same accountability as other MA *organizations*. MA *organizations* must accept enrollments through the OEC *except when limited by CMS or when a D-SNP is limited by provisions in its SMAC*. Additional guidance on enrollment processes is available in the Medicare Advantage Enrollment and Disenrollment Guidance. Refer to section 40.2.1 of this chapter and the Medicare Advantage Enrollment and Disenrollment Guidance for more information about C-SNP eligibility verification processes. The Medicare Advantage Enrollment and Disenrollment Guidance also includes information about special election periods (SEPs) for dually eligible enrollees or enrollees who lose their dual eligibility.

50.2 – D-SNP Terminations and Non-Renewals for lack of a State Medicaid Agency Contract

(Rev. *XXX*, Issued: *XX-XX-XX*, Effective: *XX-XX-XX*, Implementation: *XX-XX-XX*)

All MA *organizations* that offer D-SNPs must have contracts with *state* Medicaid *agencies* in the states in which they operate per section 1859(f)(3)(D) of the Act and 42 CFR 422.107. In the event that an MA *organization* is not able to secure such a contract (or subcontract) with the *state* Medicaid *agency(ies)* for one or more of its D-SNPs, the MA *organization* must *non-renew or* terminate those D-SNPs in accordance with 42 CFR 422.506 through 422.510. Enrollees in those plans will be disenrolled from their D-SNP and may elect to receive Part A and Part B benefits under original Medicare or another MA plan into which they wish to enroll.

Several SEPs are available to individuals affected by such an action, including:

- Enrollees have a SEP at 42 CFR 422.62(b)(1) available when an MA plan (including a D-SNP) is terminating.
- Enrollees who are dually eligible individuals *or LIS-eligible individuals* have a SEP at 42 CFR 423.38(c)(4) that may be used *in any month* to *enroll into original Medicare and a standalone Part D prescription drug plan*.

- *Full-benefit dually eligible individuals also have a SEP at 42 CFR 423.38(c)(35) that may be used in any month to enroll into a FIDE SNP, HIDE SNP, or AIP to facilitate aligned enrollment in the affiliated Medicaid MCO.*

In the event of a D-SNP *termination or* non-renewal, the D-SNP enrollees who do not make an enrollment request will be enrolled into original Medicare and automatically enrolled in a benchmark stand-alone PDP after the termination of the D-SNP. For more information about SEPs and enrollment periods available to dually eligible individuals, refer to Chapter 2 of the MMCM, which is also posted as the MA Enrollment and Disenrollment Guidance here: <https://www.cms.gov/medicare/eligibility-andenrollment/medicaremangcareeligenrol>.

50.3 – SNP Crosswalks

(Rev. **XXX**, Issued: **XX-XX-XX**, Effective: **XX-XX-XX**, Implementation: **XX-XX-XX**)

A crosswalk is the movement of enrollees from one plan (or plan benefit package (PBP)) to another plan (or PBP) under a contract between the MA *organization* and CMS. To crosswalk enrollee from one PBP to another is to change the enrollment from the first PBP to the second. Except as specified in 42 CFR 422.530(c)(2), (3), and (4)(ii), MA *organizations* may not crosswalk enrollees from one contract to another contract. MA *organizations* may not crosswalk enrollees from one SNP type to a different SNP type.

In addition, MA *organizations* must comply with renewal and nonrenewal rules in 42 CFR §§ 422.505 and 422.506 in order to complete plan or PBP crosswalks. Please refer to 42 CFR § 422.530 for the standard crosswalk rules applicable to all MA plans, including all SNPs. Please also refer to the annual End-of-Year Enrollment and Payment Systems Processing Information memo released each year for details related to the Medicare Advantage and Prescription Drug (MARx) System Transaction Processing and Rollover and Terminating Plan MARx Transaction Processing instructions. The tables below outline the crosswalk scenarios for D-SNPs, C-SNPs, and I-SNPs.

Table 7: D-SNP Crosswalk Scenarios

Activity	Regulatory Authority	Requires Crosswalk Exception	Allows Movement across Contracts	Guidelines	HPMS Plan Crosswalk
Renewing D-SNP with a multi-state service area that reduces its service area and moves enrollees who are no longer in the service area of the renewing D-SNP to one or more renewing D-SNPs (for which the enrollees are eligible) offered under the same parent organization.	42 CFR 422.530(c)(3)	Yes	Yes	Movement is permitted if the enrollees are eligible for the receiving D-SNPs and CMS determines the crosswalk is necessary to accommodate changes to the contracts between the state and D-SNP under 42 CFR 422.107.	During Crosswalk Exception Submission window, select Crosswalk Exception Request Type 2 – Renewing D-SNP with service area change, includes RPPO to LPPO
A D-SNP in a RPPO that non-renews to create state-specific local PPOs in its place to accommodate state contacting efforts in the service area and moves enrollees who are no longer in the service area to one or more renewing D-	42 CFR 422.530(c)(3)	Yes	Yes	Movement is permitted if the enrollees are eligible for the receiving D-SNPs and CMS determines the crosswalk is necessary to accommodate changes to the contracts between the state and D-SNP under 42 CFR 422.107.	During Crosswalk Exception Submission window, select Crosswalk Exception Request Type 2 – Renewing D-SNP with service area change, includes RPPO to LPPO

Activity	Regulatory Authority	Requires Crosswalk Exception	Allows Movement across Contracts	Guidelines	HPMS Plan Crosswalk
SNPs offered under the same parent organization.					
Renewing D-SNP has another new or renewing D-SNP and the two D-SNPs are offered to different populations, and moves enrollees who are no longer eligible for their current D-SNP into the	42 CFR 422.530(c)(4)(i)	Yes	No	Movement is permitted if the enrollees meet the eligibility criteria for the new or renewing D-SNP and CMS determines it is in the best interest of the enrollees to move to the new or renewing D-SNP in order to promote access and continuity of	During Crosswalk Exception Submission window, select Crosswalk Exception Request Type 3 – Change in D-SNP populations
other new or renewing D-SNP offered by the same MA <i>organization.</i>				care for enrollees relative to the absence of a crosswalk exception.	

Activity	Regulatory Authority	Requires Crosswalk Exception	Allows Movement across Contracts	Guidelines	HPMS Plan Crosswalk
MA <i>organization</i> creates a new D-SNP-only MA contract when required by a state as described in 42 CFR 422.107(e), eligible enrollees may be moved from the existing D-SNP (that is non-renewing or having its eligible population newly restricted by a state to achieve exclusively aligned enrollment) to a D-SNP offered under the D-SNP-only contract.	42 CFR 422.530(c)(4)(ii)	Yes	Yes	The new D-SNP-only contract is approved and permitted by CMS under § 422.107(e) and movement must be to the same plan type operated by the same parent organization.	During Crosswalk Exception Submission window, select Crosswalk Exception Request Type 9 – MA-PD with a D-SNP transition to D-SNP only contract

Activity	Regulatory Authority	Requires Crosswalk Exception	Allows Movement across Contracts	Guidelines	HPMS Plan Crosswalk
<i>When one or more MA organizations that share a parent organization seek to consolidate D-SNPs in the same service area down to a single PBP under one MA-PD contract to comply with the requirements at 42 CFR 422.514(h) and 422.504(a)(20).</i>	<i>42 CFR 422.530(c)(4)(iii)</i>	<i>Yes</i>	<i>Yes</i>	<i>Available beginning in 2026 for CY 2027. Movement must be to the same plan type and operated under by the same parent organization</i>	<i>During Crosswalk Exception Submission window, select relevant Crosswalk Exception Request</i>

80 – Quality Improvement

*(Rev. **XXX**, Issued: **XX-XX-XX**, Effective: **XX-XX-XX**, Implementation: **XX-XX-XX**)*

The quality improvement requirements applied to non-SNP MA plans are also applied to SNPs. Pursuant to 42 CFR 422.152(c), each SNP must conduct a Chronic Care Improvement Program (CCIP) targeting the special needs population that it serves. Refer to chapter 5 of the MMCM for further guidance on SNP quality improvement and reporting requirements.