



2026 Chronic Special Needs Plan (C-SNP) FAQs

C-SNP plans: What they are, what we offer, and more!

General

Who is eligible for a C-SNP plan?

- **Chronic Special Needs Plans** (C-SNP plans) are available for individuals who have a specific chronic condition, like diabetes, cardiovascular disorders, or chronic heart failure. C-SNP plans are tailored for individuals who need specialized care and benefits that focus on managing and treating their chronic health issues. They offer focused care coordination and access to specialized providers and treatments.

How are SNPs different from other plans?

- **They offer benefits tailored to the special healthcare needs of the population:** Compared to Devoted Health non-SNP plans, Devoted Health SNPs may offer lower cost shares for certain benefits (e.g., specialist visits for members on C-SNPs). Devoted Health SNPs may also offer more supplemental benefits (e.g., the Food & Home Card).
- **They provide additional care coordination and support:** Devoted Health works with SNP members to complete Health Risk Assessments (HRAs) and design Individual Care Plans (ICPs) based on member needs. For those who need it, Devoted Health also provides additional support in navigating Medicaid and Medicare benefits, care transitions, disease management, and/or care coordination.
- **They have special eligibility requirements and special election periods (SEPs).**
 - **Who qualifies:** Individuals with a CMS-approved severe or disabling chronic condition
 - **When it applies:** SEP remains open until the individual enrolls in a C-SNP for their condition
 - **Future changes:** Permitted during standard MA enrollment periods, special election periods, or if another C-SNP plan becomes available for another condition
 - **Provider verification:** Confirming the condition is required within 2 months of enrollment
 - Note: At the time of enrollment, the broker must clearly explain that the enrollment is conditional and the potential for disenrollment consequences if the provider verification is not received within 2 months of enrollment.
 - **If verification isn't received:** The member will be involuntarily disenrolled and will be eligible for a new SEP to join another plan (month of notice + 2 months)

What kinds of C-SNPs will Devoted Health offer in 2026?

- Starting in 2026, **all C-SNPs will be Group 4**, meaning that the member must have one of the following qualifying conditions to enroll:
 - Diabetes (any type)
 - Congestive heart failure
 - Cardiac arrhythmia
 - Coronary artery disease
 - Peripheral vascular disease
 - Chronic thromboembolic disorder
 - Valvular disease
- C-SNP plans will be offered in select markets in AL, AZ, AR, CO, DE, FL, GA, HI, IL, IN, IA, KS, KY, LA, MS, MO, NE, NM, NC, OH, OK, OR, PA, SC, TN, TX, UT, VA, and WA
 - *C-SNP plan eligibility varies by market*

- Devoted Health will be offering 3 types of C-SNP products in 2026:
 - **C-SNP Plus:** for high-need chronic beneficiaries
 - Will include tailored benefits for those with chronic conditions and supplemental benefits, including:
 - Generous Food & Home Card (for those who qualify)
 - OTC allowance for health essentials
 - Comprehensive dental and vision care
 - Members with LIS will have a \$0 premium
 - Primarily coinsurance-based medical benefits
 - Good fit for individuals with a qualifying chronic condition and who receive Medicaid cost share assistance for Medicare services (QMB-only, QMB+, SLMB+, FBDE)
 - May not be a good fit for partial duals (QI, QDWI, SLMB) and non-duals (higher-income individuals)
 - **Note: QDWI members are not automatically eligible for LIS.**
 - **C-SNP Premium:** for those receiving Extra Help
 - Will include tailored benefits for those with chronic conditions with robust supplemental benefits, including:
 - Food & Home Card for groceries and utilities and OTC allowance
 - Comprehensive dental and vision care
 - Members with low-income subsidy (LIS) will have a \$0 premium
 - Good fit for individuals with chronic conditions who typically get Extra Help but are not cost-share protected
 - May not be a good fit for members who do not have Extra Help
 - If there is a C-SNP Plus plan available in the market, that is a better fit for duals with Medicare cost-share protections (QMB-only, QMB+, SLMB+, FBDE)
 - **C-SNP Zero:** entry-point product for C-SNP-eligible members
 - Will include tailored benefits for members with chronic conditions, including:
 - Balanced medical and prescription drug costs
 - Supplemental dental and eyewear benefits
 - Good fit for individuals who want a standard \$0 plan with year-round enrollment flexibility
 - May not be a good fit for members who get Extra Help and would benefit from the extra benefits or support offered by a C-SNP Plus, C-SNP Premium, or D-SNP product that they qualify for

C-SNP Product	Member Fit (with condition)	Premium	Part C	Part D	Dental
Plus	Lowest-income members who receive cost-share assistance from Medicaid	LIPSA	Coinsurance	Max deductible + mostly coinsurances \$0 adherence tier	Network
Premium	Low income with Extra Help	LIPSA	Similar to Core/Choice - Copays	Max deductible + mostly coinsurances \$0 adherence tier	Network
Zero	Balanced \$0 option	\$0	Similar to Core	Similar to Core/Choice	Direct Member Reimbursement

C-SNP Eligibility and Enrollment: Process and Requirements

How can a member join a C-SNP?

1. **Qualify to enroll in an MA plan** — live in the plan’s service area, have a qualifying election period, be eligible for Part A and enrolled in Part B.
 - Note: At the time of enrollment, the broker must clearly explain that the enrollment is conditional and the potential for disenrollment consequences if the provider verification is not received within 2 months of enrollment.
2. **Submit a complete application for a C-SNP, including a completed member C-SNP attestation form.** To enroll in a Group 4 C-SNP, members must answer “yes” to at least one of the qualifying condition questions.
 - These questions can be found in the electronic application if completing an electronic enrollment when the plan is selected, or in the enrollment kit if completing a paper application.
 - The member attestation is built into the enrollment on the following platforms and becomes electronically available upon submission of the application so it can be completed at time of sale:
 - Agent Portal (agent.devoted.com)
 - Sunfire (for 2026)
 - Connecture (already there 2025 and on)
 - Paper enrollment kits (paper form)
 - **What if you are using another system?**
 - Once the application appears in the agent portal (1-2 days after submission to Devoted from your portal), you can complete the attestation in the agent portal with the member on the phone.
 - **There are a lot of questions on the attestation form; how do I know what actually qualifies an individual?**
 - **The member must only attest to having one of the conditions as listed on the form.**
 - There are questions on the form that can help you and the prospective member identify if they potentially have a qualifying condition.
 - **By checking yes** to any of these conditions, the form will be considered complete, but the provider still must verify that the individual has this actual condition (current diagnosis).
 - Prescription questions alone do not complete the form.
 - These questions are indicators only, not confirmation of a condition.
 - If only a prescription is selected, the form is incomplete, and the member will be notified that more information is needed. At that point, the member must call or attest electronically to Devoted Health before we can move forward with submitting the application to CMS for approval.
 - **Example:**
 - One of the qualifying conditions is “coronary artery disease (narrow or blocked heart arteries).” If a member does not know if they have this, asking some questions as listed on the form will help identify if the individual has the condition. These questions are listed as:
 - I have angina, atherosclerosis, arteriosclerosis, or another type of coronary artery disease
 - I have had a heart attack (myocardial infarction)
 - I have a stent in my heart arteries
 - I have had heart bypass surgery
 - By checking yes to any one of the above questions, this will complete the form and identify that the individual **may** have the condition. But, for example, if the individual had a heart attack many years ago and no longer has a heart condition or coronary artery disease, this should not be used as an enrollment option.
 - **Finally, provide as much provider contact information (e.g., fax, phone, address, etc.) as possible on attestation**

forms and encourage members to book a PCP appointment within their first month on the plan to ask their PCP to send in the attestation form.

Member Attestation Form Example:

Devoted Health C-SNP attestation and verification form

Check if you qualify for a C-SNP



About C-SNPs

If you have certain health conditions, a Chronic Condition Special Needs Plan (C-SNP) might be right for you. Depending on where you live, you may qualify for a Devoted Health C-SNP if you have either of these conditions:

- Diabetes
- Cardiovascular conditions (heart or blood flow problems)

How to join a C-SNP

Return this form with your plan application and we'll enroll you in our C-SNP. Within 30 days of your plan's start date, we'll use the form to verify your chronic condition with your doctor.

If we don't get a completed form from you — including a completed last page with your doctor's signature — we'll have to disenroll you and you'll need to join a new plan. Be sure to fill out this form completely and accurately so we have all the information we need.

PROVIDE YOUR PERSONAL INFORMATION

Full name:	Today's date:	
Phone number:	Medicare number:	Date of birth:

PROVIDE YOUR HEALTH DETAILS

Check ALL statements that are true for you.

Diabetes:

- ☐ I have diabetes (high blood sugar)

If you take medication to control your blood sugar, please check any medications you take (Optional):

- ☐ Insulin
☐ Metformin (Glucophage)
☐ Prandin or Repaglinide
☐ Acarbose
☐ Actos, Avandia, Pioglitazone, or Rosiglitazone
☐ Glipizide, Glimepiride, or Glyburide
☐ GLP1 medications: Byetta, Ozempic, Trulicity, Rybelsus, or Victoza
☐ SGLT2 medications: Invokana, Farxiga, or Jardiance
☐ DPP4 medications: Januvia or Tradjenta

Cardiovascular (heart or blood flow) conditions:

Congestive or chronic heart failure

- ☐ I have cardiomyopathy, pulmonary hypertension, or low heart function
☐ I have another type of congestive or chronic heart failure
☐ I have a defibrillator for low heart function
☐ I get swelling in my legs or fluid in my lungs due to a heart problem

Cardiac arrhythmias (irregular heartbeat)

- ☐ I have atrial fibrillation or AFib
☐ I have an abnormally slow or fast heart rate
☐ I have a defibrillator or pacemaker for cardiac arrhythmia

Coronary artery disease (narrow or blocked heart arteries)

- ☐ I have angina, atherosclerosis, arteriosclerosis, or another type of coronary artery disease
☐ I've had a heart attack (myocardial infarction)
☐ I have a stent in my heart arteries
☐ I have had heart bypass surgery

Valvular heart disease (problems with heart valves)

- ☐ I have aortic, tricuspid, or mitral regurgitation
☐ I have aortic or mitral stenosis
☐ I have narrowing of my heart valves or leaky heart valves
☐ I have another type of valvular heart disease
☐ I have had a valve replacement or valve procedure

Peripheral vascular disease or chronic thromboembolic disorder

- ☐ I have problems with blood flow in my legs
☐ I often get blood clots

Medications for heart conditions or for history of clots

- ☐ I take one or more of the following medications: (Optional)
☐ Plavix (Clopidogrel)
☐ Effient (Prasugrel)
☐ Brilinta (Ticagrelor)
☐ Coumadin (Warfarin)
☐ Pradaxa (Dabigatran)
☐ Xarelto (Rivaroxaban)
☐ Eliquis (Apixaban)
☐ Entresto (Sacubitril/Valsartan)

Need Help? Call 1-800-338-6833 (TTY 711) or text us at 866-85

(0526DHRV1) Y0142_25M54_C

CSNP-1



Need Help? Call 1-800-338-6833 (TTY 711) or text us at 866-85

(0526DHRV1) Y0142_25M54_C

CSNP-2



PROVIDE YOUR DOCTOR'S INFORMATION

Enter contact information for 1 doctor who can confirm your chronic condition. The second is optional. This should be a current doctor, whether or not they're in-network with Devoted Health.

Doctor 1 (required)

First name:	Last name:	Specialty:
Fax number:	Phone number:	☐ Primary care provider (PCP) ☐ Cardiologist (heart doctor) ☐ Endocrinologist (diabetes doctor)

Doctor 2 (optional)

First name:	Last name:	Specialty:
Fax number:	Phone number:	☐ Primary care provider (PCP) ☐ Cardiologist (heart doctor) ☐ Endocrinologist (diabetes doctor)

GIVE PERMISSION FOR YOUR PROVIDER TO SHARE HEALTH INFORMATION WITH US

I give permission to the providers listed above to share my health information with Devoted Health. This applies to all information the provider has about my medical history for the conditions listed above.

I understand that Devoted Health will use this information to confirm that I have a condition that qualifies for a C-SNP. They'll follow all applicable state and federal laws and requirements to keep my information private.

Signature:	Today's date:
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If you're signing for someone else: Please fill out the fields below and include proof that you can act for the member, such as a power of attorney, living will, or guardianship papers.

Your name:	Your relationship to the enrollee:
Your address:	Your phone number:

Please send your completed form to:

Mail: Devoted Health – Enrollment
PO Box 211127
Eagan, MN 55121
Fax: 1-877-264-3859

3. As soon as a CMS-approved application for enrollment is received, Devoted Health will both send (fax) the member’s provider(s) the member’s C-SNP attestation form and call to verify the member’s qualifying condition. The member’s attestation form **must be signed** by a current provider that is treating the member for that condition. Devoted Health must receive verification by the end of the second month of the member’s enrollment.

- If the provider verification is not received, Devoted Health will send the member a SMS and a letter at the end of the 1st month of enrollment. The letter explains that the provider verification is needed and the deadline date. It also explains that if the member is not eligible, they will have a SEP to make a plan switch.
 - Note: If eligible based on provider type, the member would also be encouraged to complete a D2Me visit.
- If Devoted Health is unable to verify the member’s condition, Devoted Health will send the member a notice of disenrollment within the first 7 days of the member’s second month of enrollment and will disenroll the member at the end of the second month of enrollment — unless Devoted Health receives verification from a provider. The member will have a special election period to select a new plan.
 - The enrollment period reason is “No Longer Qualifies for Special Needs Plan (SNP)”, and the special election period is “SEP: No Longer Meets SNP Status”.
 - The SEP will be valid the month the beneficiary is notified of the disenrollment by the plan and two months following.
- If the member doesn’t get a signed verification, we’ll need an approved application for a non-C-SNP plan.
 - If Devoted Health Telesales completes a plan change for the member before they disenroll, the original agent will remain the agent of record.

Provider Attestation Form Example:

For providers



The patient listed above has enrolled in a Devoted Health Chronic Condition Special Needs Plan (C-SNP). Based on CMS requirements, we need you to verify that this patient qualifies for a C-SNP.

Instructions
Fax this signed form to 1-877-264-3859, call us at 1-877-762-3515, or visit devoted.com/s/verifyCSNP for more options.

PATIENT PERSONAL INFORMATION		
Full name:		Today's date:
Phone number:	Medicare number:	Date of birth:

PATIENT CHRONIC CONDITIONS	
Check all conditions this patient has been diagnosed with:	
☐ Diabetes	☐ Valvular heart disease
☐ Congestive heart failure	☐ Peripheral vascular disease
☐ Cardiac arrhythmia	☐ Chronic thromboembolic disorder
☐ Coronary artery disease	☐ I don't have enough information to make a diagnosis
☐ None of the above	

SIGN THE FORM	
I hereby attest that I am the member's current provider and that the above information is correct.	
Printed name:	Title:
Signature:	Today's date:

Devoted Health is an HMO and/or PPO plan with a Medicare contract. Our D-SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.
To file a complaint with Devoted Health, call us at 1-800-338-6833 (TTY 711). To file a complaint with Medicare, call 1-800-MEDICARE (TTY 1-877-486-2048), 24 hours a day/7 days a week. If your complaint involves a broker or agent, be sure to include their name when you file your complaint.

Need Help? Call 1-800-338-6833 (TTY 711) or text us at 866-85 (0526DHRV1) Y0142_25M54_C CSNP-4

C-SNP FAQs

Q: Can dual-eligible members be automatically enrolled or moved out of their current SNP into a Medicare-Medicaid contract SNP without their consent?

A: No - states cannot force dual-eligible members into D-SNPs. CMS rules only allow passive enrollment if a special federal waiver is in place (like Ohio's MyCare demo before July 2025). Otherwise, duals always have a choice and the right to opt out. Bottom line: members can pick the plan that's best for them, and **if they choose our C-SNP, that choice sticks.**

- **More information:** Some states are moving toward aligned enrollment for integrated D-SNPs, and CMS guidance requires this in the coming years. MA Organizations with integrated D-SNPs and/or Medicaid MCOs must:
 - By 2027: limit new HIDE/FIDE enrollment to aligned members (same MA Org for Medicaid MCO + Medicare plan).
 - By 2030: disenroll non-aligned members in HIDE/FIDE SNPs.
 - This applies only to MA Orgs with integrated D-SNPs/Medicaid MCOs. Since Devoted Health operates as a HIDE SNP/MCO only in Florida, these changes affect us only in Florida. ([see FAQ #7](#) to learn more about how aligned enrollment changes do not affect Devoted Health outside of Florida.
 - Additionally please find this information directly from the [federal register](#): "We confirm there is no passive enrollment of individuals into MA plans—including D-SNPs—aside from what is described at §422.60(g). We did not propose (nor are we finalizing) changes to default enrollment provisions at §422.66(c) or any other passive provisions in conjunction with our proposals."
- Want to learn more about state specific requirements - [check out this Medicaid passive and default enrollment FAQ](#).

Q: Is a member technically enrolled after an application is processed? Will they have access to their Devoted Health benefits at that time? What happens if Devoted Health is not able to obtain verification from their provider?

A: Once an application is approved, a member is "conditionally enrolled." The member will have access to their Devoted Health benefits as of the plan's effective date printed on their enrollment letter. Devoted Health still needs to receive verification of a member's chronic condition within the first two months of their enrollment, or the member will be disenrolled from the plan after two months.

Q: When will Devoted Health send the provider verification form to the provider?

A: Starting in October, we will start faxing the provider as soon as we receive CMS approval for enrollment. We will send a fax weekly until the member is verified, or until the involuntary disenrollment happens. We also call provider offices (same timing).

Q: What requirements are there for completing the provider verification form?

A: Provider verification must be finished before the end of the second month of enrollment. If Devoted Health cannot confirm the member's condition, we will notify the member about disenrollment within the first 7 days of their second month. The member will be disenrolled at the end of the second month unless we receive the necessary verification from a provider.

Q: Does pre-diabetes qualify someone for a C-SNP for individuals with diabetes?

A: No. Individuals must have diabetes to qualify for a diabetes C-SNP.

Q: Why do some C-SNPs have a premium?

A: Devoted Health designed premium C-SNPs for individuals with chronic conditions who receive assistance from the federal government due to low or limited income. Devoted Health offers two premium C-SNPs (C-SNP Plus and C-SNP Premium) tailored to the unique needs of this population.

Q: What does LIPSA targeted mean?

A: LIPSA = Low Income Premium Subsidy Amount = the max Part D premium the government will cover for people who qualify for the low income subsidy (LIS)

- A **LIPSA targeted plan**, like our **D-SNPs, Premium C-SNPs, and Plus C-SNPs**, is designed so that its Part D premium is at or below the LIPSA for each state
- This means:
 - **LIS-eligible members can enroll without paying a Part D premium**
 - The plan becomes more attractive and accessible to low-income beneficiaries
 - It supports enrollment and retention in duals and Extra Help populations
- LIPSA targeting is a **strategic pricing approach** commonly used for dual-eligible and low-income plan offerings

Q: How does a member’s cost-share work with Medicaid?

A: For some services that the Devoted Health plan covers, the member will see 2 cost share amounts listed. The amount they pay depends on their level of Medicaid.

Agents should always encourage beneficiaries to confirm their specific Medicaid benefits and cost-share assistance directly with their state Medicaid agency, as these can vary.

- **QMB / QMB+:**
 - Federally protected from cost share for Medicare services. Medicare providers (INN or OON) cannot bill member cost shares for Medicare services, regardless of whether or not the provider accepts Medicaid.
- **FBDE / SLMB+ :**
 - **INN provider, in a state where Medicaid always covers cost share for Medicare services for Full Duals:** Member cannot be billed cost share for Medicare services
 - **INN provider, in a state where Medicaid only covers cost share for Medicare services if Medicaid also covers the benefit:** Typically, members cannot be billed cost share for Medicare services. However, if the member receives a service that Medicaid doesn't cover, the member could be billed for cost share.
 - **OON provider:** Members can be billed cost share for Medicare services. If a provider accepts Medicaid, the provider should bill Medicaid. Members can be held liable for cost shares if Medicaid doesn't cover the cost share.
 - Agents must explicitly communicate this risk to beneficiaries in these categories and strongly advise them to seek INN care or verify OON provider acceptance of Medicaid before services are rendered.

How cost shares works with Medicaid		
HMO - Full Medicaid Coverage State	FBDE or SLMB+	Members pay the lower amount.
HMO - Limited Medicaid Coverage State		Members pay the lower amount if Medicare and Medicaid both cover the service. Otherwise, members pay the higher amount.
PPO - Full Medicaid Coverage State		Members pay the lower amount if they see a provider who’s in the Devoted Health network or who accepts Medicaid. Otherwise, members pay the higher amount.

How cost shares works with Medicaid

PPO - Limited Medicaid Coverage State		Members pay the lower amount if both of these are true: - Members see a provider who's in the Devoted Health network or who accepts Medicaid. - Medicare and Medicaid both cover the service member is receiving. Otherwise, members pay the higher amount.
All States	QMB or QMB+	Members pay the lower amount.
	SLMB, QI, QDWI	Members always pay the higher amount.

Q: My member has a plan that manages their Medicaid benefits (sometimes called a Medicaid Managed Care Plan or MCO). How does that impact their cost share coverage?

A: For Medicare services with cost share, the provider will bill Devoted first. Devoted will pay the claim under Medicare coverage less any member cost share, and will direct the provider to either accept payment from Devoted as payment in full or to bill the member's Medicaid coverage as secondary for remaining cost share. Providers will then choose to accept Devoted's payment as payment in full, or submit a secondary claim to the member's Medicaid plan. When Medicaid is liable, the member's Medicaid plan will process as secondary coverage. Typically, the member's Medicaid plan will only pay claims as secondary if the provider is in the Medicaid plan's network.

- For services provided by Devoted's in-network (INN) providers: The member cannot be billed for Medicare cost share when Medicaid is liable. Even if the member's Medicaid plan doesn't cover the cost share, Devoted's INN providers are required by their contracts to accept any payment from Devoted (and any additional payment from the member's Medicaid coverage, if applicable) as payment in full, and are prohibited from billing the member for any cost shares when Medicaid is liable.
- For services provided by out-of-network (OON) providers: The member may be billed for Medicare cost share, even when Medicaid is liable, depending on their Medicaid level.
 - QMB/QMB+ members: Can never be billed for cost share for Medicare services. This is a federal requirement for all Medicare providers.
 - FBDE/SLMB+ members: Can be billed for cost shares for Medicare services. OON providers who are in-network with the member's Medicaid plan should bill the Medicaid plan as secondary and not bill the member. However, if the provider is not in-network with the member's Medicaid plan, they may bill the member for cost shares.

Q: Are dual eligible members eligible for Devoted Health's C-SNP plans?

A: Individuals can choose the Medicare plan that best suits their needs. If they decide to join our C-SNP plan as their MAPD plan and have a qualifying health condition, they can enroll during the designated election periods.

It's important to note that individuals who qualify for Qualified Medicare Beneficiary (QMB) only do not receive Medicaid benefits. As states transition to more coordinated enrollment for their D-SNPs, QMB-only individuals cannot enroll in Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) that offer this coordinated approach. However, they are federally protected from any out-of-pocket costs for Medicare services.

Our C-SNP PLUS plan may be a great choice for QMB-only members. Since they don't receive extra Medicaid benefits, all their healthcare coverage is included in their MAPD plan. They also enjoy cost protection, access to valuable supplemental benefits, and

additional disease management support through enrollment in our C-SNP.

Q: Are there any member abrasion points that you foresee with Devoted Health's 2026 CSNP's?

A: There are a few points that we want to educate our members on:

- **Showing both ID cards**-Members who receive cost share assistance from Medicaid will need to show their Medicaid card alongside their Devoted ID card to ensure providers know they have additional coverage under Medicaid, and to bill Medicaid as secondary for any cost share. This is the same approach they would use for any non-integrated MAPD plan and should not be new to most members.
- **Cost share protections for FBDE and SLMB+ members when OON**- As mentioned in many of our Broker education materials, our provider contracts require in-network (INN) providers to accept our payment as payment in full, or to bill Medicaid as secondary insurance to cover Medicare cost share for Full Duals and QMBs when Medicaid is liable. In a PPO SNP, we can't enforce similar requirements on out-of-network (OON) providers since we aren't contracted with them. As such, PPO members with FBDE or SLMB+ Medicaid levels may be held liable for full OON cost shares if they see OON providers who don't accept Medicaid. OON providers who accept Medicare can't bill QMB or QMB+ members any cost share for Medicare services given federal QMB cost share protections.
- **Coordinating with two payers:** If an individual receives Medicaid benefits (FBDE, SLMB+, QMB+), they will receive their Medicaid benefits through Medicaid Fee-for-Service or a Medicaid plan, and their Medicare benefits through their Devoted plan. Medicaid is the payer of last resort, so individuals will use their Devoted MAPD benefits before accessing any Medicaid benefits. In general, for most dual-eligibles, the vast majority of their care is covered under their MAPD plan benefits, but members may utilize additional Medicaid benefits not covered under their MAPD plan, such as non-emergency transportation, long-term care, or additional behavioral health benefits. For members who utilize a lot of Medicaid benefits, they may appreciate the simplicity of an integrated D-SNP (if one is available to them).

HRA FAQs

Q: What can a SNP member expect as a member of Devoted Health?

A: SNP members complete a Health Risk Assessment (HRA) when they join the plan. Based on the member's HRA responses and Individualized Care Plan (ICP) goals, Devoted Health staff may reach out to provide support coordinating healthcare and/or managing a chronic condition. Devoted Health sends an HRA to SNP members annually and updates the ICP (at least annually) based on changes in the member's HRA responses and health, such as instances of emergency inpatient admissions. Devoted Health care managers also help members navigate care transitions with pre- and post-discharge calls to support a safe discharge and recovery.

Q: What is an HRA? How and why do members complete an HRA?

A: An HRA is a series of questions that CMS requires all plans to ask SNP members. A member's HRA responses inform their care plan. Members can complete an HRA in-person with their broker, via a paper form they receive by mail, via the member portal, or over telephone. SNP members will receive a \$20 Devoted Dollars rewards card if they complete an HRA within 90 days of enrollment. They'll also be eligible for another reward every plan year when they complete their HRA. Reward cards are usually triggered within a few days of the time the member completes the HRA (or their SNP plan effective date — whichever is later), but the mail can take time. Brokers should let members know they can take between 60–90 days to arrive.

Additional Resources:

- [Medicare Savings Programs / Medicaid eligibility](#)
- [Spend down](#)
- Extra Help:
 - [Landing page](#)
 - [Application](#)
 - [More info on the Extra Help program](#)