

MISSISSIPPI MEDICAID

**GOP Drops Some Medicaid Cuts From Budget Plan: 5 Things To Know. Alan Condon. Beckers Hospital Review. May 7, 2025.**

“House Republicans have dropped two proposals to cut [Medicaid funding](#) from the reconciliation plan as Speaker Mike Johnson aims to broker a deal that can pass a divided caucus, [The Hill](#) reported May 6.”

[https://www.beckershospitalreview.com/finance/gop-drops-some-medicaid-cuts-from-budget-plan-6-things-to-know/?origin=CEO&utm\\_source=CEO&utm\\_medium=email&utm\\_content=newsletter&oly\\_enc\\_id=5767J8016534I8J](https://www.beckershospitalreview.com/finance/gop-drops-some-medicaid-cuts-from-budget-plan-6-things-to-know/?origin=CEO&utm_source=CEO&utm_medium=email&utm_content=newsletter&oly_enc_id=5767J8016534I8J)

The Hill: <https://thehill.com/policy/healthcare/5286567-house-republicans-medicaid-proposal-trump-agenda/>

**Special enrollment period underway for managed care members until June 1, 2025. Mississippi Medicaid Bulletin. May 2, 2025**

**RHW: This is a long bulletin and providers should read in its entirety. But here are some excerpts:**

“...Beginning July 1, 2025, Molina Healthcare, Magnolia Health, and TrueCare will provide managed care coverage for both the MississippiCAN program and CHIP.

What happens to UnitedHealthcare members? UnitedHealthcare will remain with the plan until June 30, 2025. Letters will be mailed to all managed care members, each of whom will have the choice to select one of the coordinated care organizations (CCOs). UnitedHealthcare members who do not return their enrollment form by June 1, 2025, will be auto-assigned among the three CCOs (Magnolia, Molina, or TrueCare). Members may only switch once, and after this period closes, members will not be able to switch plans again until the next Open Enrollment which will occur in October 2025...”

**Managed Care CCOs Effective July 1, 2025**

Mississippi Coordinated Access Network (MississippiCAN)	Children’s Health Insurance Program (CHIP)
Magnolia Health	Magnolia Health
Molina Healthcare	Molina Healthcare
TrueCare	TrueCare

<https://medicaid.ms.gov/wp-content/uploads/2025/05/April-2025-Provider-Bulletin.pdf>

**Medicaid Provider Enrollment and Data Maintenance: Requirements and Process Overview. Mississippi Medicaid Bulletin. May 2, 2025**

“As we have passed the two-year anniversary of the Division of Medicaid's implementation of its new Medicaid Management Information System (MMIS), MESA, we continue to prioritize the enrollment of providers into the Medicaid program for the State of Mississippi. MESA streamlines the enrollment process and enhances the integrity of claims management, ensuring that both billing and non-billing providers can deliver services efficiently and in compliance with federal and state regulations. ...

**CMS Application Fees:** Under federal regulations, CMS requires that certain providers pay an application fee when enrolling in Medicaid. This fee helps cover the costs associated with the provider screening process. The application fee is reviewed and updated annually by CMS.

- Who Must Pay the Fee: Institutional providers (e.g., hospitals, skilled nursing facilities, and home health agencies) are typically subject to this fee. However, individual practitioners and small physician group practices are generally exempt. ...

**Key Requirements for Billing Providers:** ◇ Must enroll with Medicaid for each service location where services are rendered. ◇ Must submit claims with the NPI and appropriate service location details in accordance with the

published Mississippi Division of Medicaid (DOM) guidance, including but not limited to Companion Guides, Job Aids, Paper Billing Manual, Late Breaking News articles, etc.

◇ Billing providers must also ensure that any individual practitioners included on a claim are properly enrolled and affiliated, if applicable.

◇ Billing providers are subject to comprehensive screening as they have direct financial interactions with Medicaid, which may include moderate to high-risk screenings, depending on the provider's taxonomy. ...

**Federal and State Exclusion Screening** Providers must pass exclusion screening to ensure they are not barred from participating in Medicaid. This includes checking the Office of Inspector General (OIG)'s List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) database. ...

**Enrolling in Mississippi Medicaid** requires careful attention to federal and state regulations. By ensuring compliance with the key requirements outlined above, both billing and non-billing performing providers can maintain their eligibility to participate in Medicaid and continue delivering services to beneficiaries. Providers should stay informed about changes to Medicaid policies and work closely with DOM to ensure their continued participation in the program.

<https://medicaid.ms.gov/wp-content/uploads/2025/05/April-2025-Provider-Bulletin.pdf>

### **Provider Recredentialing Mississippi Medicaid Managed Care Programs. Mississippi Medicaid Bulletin. May 2, 2025**

"All providers participating in MississippiCAN or the Children's Health Insurance Program (CHIP) are required to be credentialed by the Mississippi Division of Medicaid. Failure to complete credentialing/recredentialing will result in termination from these programs and will require reenrollment. There are a significant number of providers currently due for recredentialing that need to complete the process. Providers terminated for failing to recredential may reenroll for Medicaid's managed care programs (MSCAN/CHIP) through the MESA Provider Portal. ...

Beginning October 1, 2022, providers seeking participation in MississippiCAN and/or CHIP are now required to be enrolled, credentialed, and screened by DOM, and subsequently contract with their CCO of choice....

The CVO will perform recredentialing for both current providers and new providers every three (3) years unless the provider is credentialed by a DOM-approved Delegated Credentialing Entity."

<https://medicaid.ms.gov/wp-content/uploads/2025/05/April-2025-Provider-Bulletin.pdf>

### **Provider Revalidation. Mississippi Medicaid Bulletin. May 2, 2025**

"...Mississippi Division of Medicaid reinstated the revalidation process starting October 1, 2023. This requires all Mississippi Medicaid providers to verify the information in their provider files. According to 42 C.F.R. § 455.414 of the Affordable Care Act (ACA), all state Medicaid agencies must revalidate provider enrollments at least every five years. ..."

<https://medicaid.ms.gov/wp-content/uploads/2025/05/April-2025-Provider-Bulletin.pdf>

### **MSCAN Claim Dispute Process. Magnolia Health Weekly Updates. May 1, 2025**

- The First Time Claim claims must be submitted within 180 days of the member's service date.
- The Reconsideration is optional in the claim dispute process. Reconsiderations must be submitted within 90 days of the Explanation of Payment or Denial.
- Corrected Claims must be received within 90 calendar days from the notification of payment or denial.
- Claim Appeal must be received within 30 days from the date of notification of payment or denial.

**Corrected Claims and Reconsiderations** can be submitted through the Magnolia Secure Provider Portal, your preferred clearinghouse, or by mail.

Medical Corrected Claims - Magnolia Health Attn: Corrected Claim PO Box 3090 Farmington, MO 63640-3800

- The corrected claim should include the appropriate resubmission code, and the original claim number or EOP must be included with the resubmission.

- Failure to include the appropriate resubmission code and original claim number (or include the EOP) may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit.

**Request for Claim Reconsideration** can be submitted by logging into your Magnolia Secure Provider Portal or by mail.

Medical- Magnolia Health Attn: Reconsideration, PO Box 3090 Farmington, MO 63640-3800

Magnolia encourages providers to utilize the Secure Web portal, or the [Reconsideration Dispute form](#) located at [www.magnoliahealthplan.com](http://www.magnoliahealthplan.com) when submitting a reconsideration request via mail.

- A request for reconsideration is a written communication from the provider about a disagreement of a processed claim.
- Request must include sufficient identifying information which includes, at minimum, the patient's name, ID number, date of service, total charges, and provider name.
- Documentation must also include a detailed description of the reason for the request

\*Please note, a request for reconsideration cannot be filed after a request for a claim appeal or exhausting the claim dispute process.

If the corrected claim or the request for reconsideration results in an adjusted claim, you will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and the next step in the claim dispute process.

**Request for Claim Appeal** must be submitted by mail.

Medical Appeal - Magnolia Health Attn: Dispute PO Box 3090 Farmington, MO 63640-3800

To ensure timely processing, please utilize the [Claim Appeal form](#) located at [www.magnoliahealthplan.com](http://www.magnoliahealthplan.com) or the request must be marked as "ClaimAppeal" at the top of your documentation.

Request must include detailed and sufficient information, which includes the reason for the claims appeal request, the patient's name, patient ID number, date of service, total charges, and provider name.

If the request for a claim appeal is upheld or overturned, you will receive a letter detailing the decision.

\*Please note, a reconsideration cannot be filed after an appeal.

If you have questions about this process or want to receive education on the Claim Dispute Process, don't hesitate to contact Provider Services at 1.866.912.6285 or your Provider Engagement Representative.

<https://mailchi.mp/521016581da3/pooscgsvfh-38574?e=6d63e1c4a4>

## **Magnolia MSCAN and CHIP Provider Network Webinar Series. Magnolia Health. May 7, 2025**

Magnolia is excited to announce a Provider Network Webinar Series designed to share updates related to our July 1, 2025, MSCAN and CHIP programs.

### **Webinar Details:**

- **Audience:** Medical and Behavioral Health providers, clinical and non-clinical staff, and office administrators.
- **Purpose:** Share updates related to MSCAN and CHIP programs effective July 1, 2025.
- **Registration:** Please register by clicking on the name of the training topic beside the date and time of the training session you'd like to attend.

### **TRAINING**

**June 18th @ 9am -10am:** [Provider Orientation](#); **TOPIC:** MSCAN & CHIP Overview, Claims, Authorizations, Incentives, Provider Resources, HEDIS, EPSDT, and other topics. **Audience:** Medical Providers

[https://centene.zoom.us/meeting/register/RdX89IVhRPagPzMQz9Uv\\_Q?\\_x\\_zm\\_rtaid=rTZ6WHOHQviiHTBM8Da\\_gg.1746048081289.37c81109290fe4d851b12a0c06622d19&\\_x\\_zm\\_rtaid=379#/registration](https://centene.zoom.us/meeting/register/RdX89IVhRPagPzMQz9Uv_Q?_x_zm_rtaid=rTZ6WHOHQviiHTBM8Da_gg.1746048081289.37c81109290fe4d851b12a0c06622d19&_x_zm_rtaid=379#/registration)

## **CMS, NOVITAS, RAILROAD MEDICARE**

### **Extension of Medicare Provisions. CMS. March 27, 2025**

"The [Full-Year Continuing Appropriations and Extensions Act, 2025](#) extended certain Medicare provisions through September 30, 2025 including but not limited to:

- Increased inpatient hospital payment adjustment for certain low-volume hospitals
- Medicare-dependent hospital program
- Certain telehealth flexibilities

See the complete list of provision extensions in the Act.”

<https://www.cms.gov/training-education/medicare-learning-network/newsletter/2025-03-27-mlnc#extension>

### **Overpayment Appeals Module. Palmetto GBA. May 2, 2025**

“This module discusses what is an overpayment and what causes an overpayment. It also discusses a provider's appeal rights and options; the overpayment appeal process; how to submit an appeal and what occurs after submitting an appeal. Please review this information and share it with your staff.”

- [Railroad Medicare](#)

<https://www.palmettogba.com/internet/eLearn6.nsf/OverpaymentAppealsWeb/story.html>

### **Suspension of Eight Improvement Activities for the Merit-based Incentive Payment System (MIPS). CMS Quality Payment Program. May 6, 2025**

The Centers for Medicare & Medicaid Services (CMS) is suspending eight improvement activities for the 2025 performance year (PY) in accordance with the Merit-based Incentive Payment System (MIPS) Improvement Activities Suspension Policy finalized in the CY2021 Physician Fee Schedule (PFS) final rule (86 FR 65465). We intend to propose removing these improvement activities in future rulemaking.

Clinicians should select other improvement activities to complete. However, if any of the suspended improvement activities have already been completed or were in the process of being completed, clinicians will still be able to attest to completing them and receive credit. Please review the [2025 Improvement Activities Inventory](#) for available improvement activities.

Visit the [QPP website](#) for more information.

**Please Note:** CMS is in the process of updating all related resources (i.e. guides, factsheets, webpages, etc.), including the Explore Measures and Activities tool, to indicate these improvement activities have been suspended for PY 2025.

**Table 1: MIPS Improvement Activities Suspended for PY 2025**

Activity ID	Activity Name
IA_AHE_5	MIPS Eligible Clinician Leadership in Clinical Trials or CBPR
IA_AHE_8	Create and Implement an Anti-Racism Plan
IA_AHE_9	Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols
IA_AHE_11	Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients
IA_AHE_12	Practice Improvements that Engage Community Resources to Address Drivers of Health
IA_PM_6	Use of Toolsets or Other Resources to Close Health and Health Care Inequities Across Communities (Use of toolset or other resources to close healthcare disparities across communities)
IA_ERP_3	COVID-19 Clinical Data Reporting with or without Clinical Trial
IA_PM_26	Vaccine Achievement for Practice Staff: COVID-19, Influenza, and Hepatitis B

<https://qpp.cms.gov/mips/improvement-activities>

## **What to Know and Where to Go: A Beeline to Understanding Railroad Medicare! Railroad Medicare-Palmetto GBA. May 12, 2025**

### **Recorded Webinar Link below**

“Have questions about the Railroad Medicare program? We can help! Whether you are a new provider just getting started with Railroad Medicare, or a current provider who would like more information on the Railroad Medicare program, this webcast is for you. Join us as we address frequently asked questions about Railroad Medicare. In this webinar we will discuss many of our top telephone inquiries and answer common questions about Railroad Medicare enrollment, claims submission, appeals, eServices and more, with emphasis on the website resources and self-service tools that can help you succeed with Railroad Medicare.”

<https://web.cvent.com/hub/events/ae4ac603-9cb0-43f5-93f3-9a1b36b344dc/sessions/29500238-c939-4085-9087-258f6127c417>

## **Remote Patient Monitoring: Use & Bill Correctly. CMS MLN Connects. May 15, 2025**

“In a report, the Office of the Inspector General recommended additional oversight of remote patient monitoring in Medicare. About 43% of enrollees who received remote patient monitoring didn’t receive all 3 components, raising questions about whether it’s being used as intended.

Learn how to correctly use and bill for remote patient monitoring:

- [Remote Patient Monitoring](#) webpage
- [Telehealth & Remote Patient Monitoring \(PDF\)](#) booklet”

OIG Report: <https://oig.hhs.gov/documents/evaluation/10001/OEI-02-23-00260.pdf>

## **Medicare Information in Other Languages. Railroad Medicare-Palmetto GBA. May 21, 2025**

Ways to Improve Your Medicare Patients' Understanding of Medicare!

Your patients can get information in other languages on [Medicare.gov](#).

- Search for [publications](#) in their language
- Switch to Spanish using the "Cambiar a español" link at the top right of any web page
- The Centers for Medicare & Medicaid Services (CMS) web-based training course: [Introduction to Language Access Plans](#)

## **2023 Doctors and Clinicians Preview Period Is Coming [MIPS]. CMS. May 21, 2025**

“The Doctors and Clinicians Preview Period will open officially on Tuesday, May 27, 2025. You can preview your 2023 Quality Payment Program (QPP) performance information before it appears on the profile pages of clinicians and groups on the Medicare.gov [compare tool](#) and in the [Provider Data Catalog \(PDC\)](#). You’ll be able to access the secure preview on the [QPP website](#).

- For more help accessing the QPP website or getting your Health Care Quality Improvement Systems (HCQIS) Access Roles and Profile (HARP) user role, email the QPP Service Center at [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov). To learn how to [sign up for a HARP account](#), review the [QPP Access User Guide \(ZIP, 4MB\)](#).
- When the Preview Period opens, resources about the 2023 QPP performance information available for preview will be on the [Care Compare: Doctors and Clinicians Initiative webpage](#) and the [QPP Resource Library](#).
- Note that Accountable Care Organization (ACO) data isn’t available on the QPP website during the Preview Period. Merit-based Incentive Payment System (MIPS) eligible clinicians who participate in Medicare Shared Savings Program ACOs can preview their performance information in their 2023 MIPS Performance Feedback.
- Medicare Shared Savings Program ACOs can also review quality performance information in their previously provided 2023 Quality Performance Reports. When the Preview Period opens, the list of ACO performance information planned for public reporting will be available on the [Care Compare: Doctors and Clinicians webpage](#) and the [QPP Resource Library](#).
- The 2023 Preview Period will close Wednesday, June 25, 2025, at 8 p.m. ET (5 p.m. PT).
- Note that the 2023 QPP performance information planned for public reporting in 2025 will be added to the profile pages of clinicians and groups on the compare tool on Medicare.gov and in the PDC.

- If you have any questions about public reporting of clinicians and groups on the compare tool on Medicare.gov, contact the QPP Service Center by emailing [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov), submitting a [QPP Service Center ticket](#), or calling at 1-866-288-8292 (Monday–Friday, 8 a.m.–8 p.m. ET).
- People who are deaf or hard of hearing can call 711 to connect with a Telecommunications Relay Services (TRS) Communications Assistant.”

### **Electronic Comparative Billing Report (eCBR). Railroad Medicare-Palmetto GBA. May 29, 2025**

“Palmetto GBA uses Comparative Billing Reports (CBRs) as an educational tool for providers to use in order to provide insight into your billing patterns and utilization of services in comparison to your peers. eCBR will provide you with the ability to view and download your individual CBR online. The eCBR displayed will include links to additional education material and the associated Medicare guidelines. Providers can then use this information to conduct a self-audit to ensure they are in compliance with the Medicare regulations and prevent improper claims submission in order to avoid possible pre or post-pay medical review.”

<https://palmettogba.com/rr/did/ap8h9s0171#ls>

## **OTHER**

### **Aetna to Exit Individual Market. Rylee Wilson. Becker’s Payer Issues. May 1, 2025**

“Aetna will [exit](#) the individual ACA exchange market in 2026, citing continued underperformance.

CVS Health reported its first quarter earnings May 1. On a call with investors, CEO David Joyner said the company determined there is “not a near or long-term pathway for Aetna to materially improve its position in the market.”

“We must recognize what is and is not working, and will focus on the areas we have a clear right to win,” Mr. Joyner said. “This was not a decision we made lightly, as we recognize the importance of this product to millions of members.”

Here are three things to know:

1. CVS established a \$448 million premium deficiency reserve for its individual exchange business related to anticipated losses for 2025. The company is projecting it will lose between \$350 and \$400 million in its individual business in 2025, CFO Tom Cowhey told investors.
2. Aetna has around 1 million individual members in 17 states, according to [Forbes](#). Its individual membership is a small fraction of CVS Health’s 27.1 million members.
3. CVS Health’s decision to exit the individual market comes amid uncertainty for the program. Enhanced subsidies have spurred record enrollment in the program, but these subsidies will [expire](#) at the end of 2025 unless Congress votes to extend them.

“We are committed to supporting our individual exchange members for as long as we have the privilege to serve them, and we’ll also work closely with our partners to ensure a smooth transition and that these members continue to have access to quality, affordable care,” Mr. Joyner said.”

[https://www.beckerspayer.com/payer/aetna-to-exit-individual-market/?origin=PayerE&utm\\_source=PayerE&utm\\_medium=email&utm\\_content=newsletter&oly\\_enc\\_id=5767J801653418J](https://www.beckerspayer.com/payer/aetna-to-exit-individual-market/?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=5767J801653418J)

### **Total Vision Reaches Agreement To End Antitrust Case Against Vision Service Plan. AOA First Look. May 16, 2025**

“[Law360](#) (5/14, Subscription Publication) reports, “Optometry practice owner Total Vision has reached an agreement to end its antitrust case accusing eye care insurance giant Vision Service Plan of requiring anticompetitive terms in its contracts before trying to force Total Vision to sell at a dramatically reduced price.” Both “sides reached the agreement a day after U.S. District Judge Wesley L. Hsu denied VSP’s request to file multiple summary judgment motions.” The lawsuit “contends that VSP entered the independent optometry practice market itself around this time and eventually purchased Visionworks,” and “the situation allegedly worsened in 2020...when VSP began threatening Total Vision’s coverage unless it allowed the insurance giant to

acquire a stake and ultimately extracted even more anticompetitive terms out of Total Vision.” However, “in 2022, VSP expressed an interest in buying Total Vision, but the suit contends it became clear the insurer planned to use Total Vision’s need to stay in-network to force a sale at a ‘de minimis price.’” In February 2024, “U.S. District Judge Cormac J. Carney refused to toss the case...finding a release that would bar the suit, allegedly signed under duress, was part of the scheme that Total Vision claims violated antitrust law. The judge did cut some business interference claims and claims against some of VSP’s affiliates, as well as claims for ‘tying.’”

## **DOJ Accuses Insurers of Paying Kickbacks to Brokers to Push Medicare Advantage Plans. AOA First Look. May 20, 2025**

“[KFF Health News](#) (5/19, Appleby) reports the Department of Justice filed a “blockbuster lawsuit” on May 1 that alleges large insurers paid “hundreds of millions of dollars in kickbacks” to large insurance brokerages to “steer patients into the [insurers’] Medicare Advantage plans...while also discouraging enrollment of potentially more costly disabled beneficiaries.” In one example cited, the lawsuit claims Anthem paid broker GoHealth ‘more than \$230 million in kickbacks’ from 2017 to at least 2021 in exchange for GoHealth to hit specified sales targets in payments often referred to as ‘marketing development funds.’ Policy experts argue that “the lawsuit will add fuel to long-running concerns about whether Medicare enrollees are being encouraged to select the coverage that is best for them – or the one that makes the most money for the broker.”

Original article: <https://kffhealthnews.org/news/article/justice-department-accuses-medicare-advantage-insurers-kickbacks-top-customers/>

## **New Tool from AOA Coding and Reimbursement Committee**

[Understanding the Difference Between Vision Exams and Medical Eye Exams](#)

Vision plans and medical insurance are very different in terms of the services they cover, and it is important for patients to understand these differences. This patient facing resource can be used to help educate your patients.

## **How Uninsured Rates Could Change Under Current Medicaid, ACA Proposals, State By State. Rylee Wilson Becker’s Payer Issues. May 21st, 2025.**

“Lawmakers are [considering](#) a reconciliation package that would implement Medicaid work requirements. The provisions in the bill are evolving, but the Congressional Budget Office estimates 8.6 million more people will be uninsured by 2034.

In an analysis published May 21, KFF estimated how the increase in uninsured individuals would be distributed across states. ...

### **Mississippi**

Uninsured increase: 150,000

Percentage point increase: 5% ...”

[https://www.beckerspayer.com/payer/how-uninsured-rates-could-change-under-current-medicare-aca-proposals-state-by-state/?origin=PayerE&utm\\_source=PayerE&utm\\_medium=email&utm\\_content=newsletter&oly\\_enc\\_id=5767J801653418J](https://www.beckerspayer.com/payer/how-uninsured-rates-could-change-under-current-medicare-aca-proposals-state-by-state/?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=5767J801653418J)

## **United Health Care Commercial and Individual Exchange Plans: Ocular Photoscreening Policy Number: 2025T0660D Effective Date: June 1, 2025**

**Benefit Considerations** Added language to clarify most UnitedHealthcare Commercial and Individual Exchange plans cover instrument-based screenings (CPT codes 99174 and 99177) as a preventive care services benefit in certain circumstances

**Supporting Information** Updated Clinical Evidence section to reflect the most current information Archived previous policy version 2025T0660C

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/ocular-photoscreening.pdf>

## **UHC Oxford Policy Number: DIAGNOSTIC 112.2:**

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/oxford/ocular-photoscreening-ohp.pdf>

## **UHC-Complete Verification Form for C-SNP Enrolled Patients. UHC. May 20, 2025**

“When a Medicare beneficiary applies to enroll in a UnitedHealthcare Chronic Special Needs Plan (C-SNP), the Centers for Medicare & Medicaid Services (CMS) requires verification from a treating provider that the applicant has 1 or more of the plan’s 3 specific qualifying chronic conditions:

- Diabetes mellitus (pre-diabetes does not qualify)
- Cardiovascular disorders (cardiac arrhythmia, coronary artery disease, peripheral vascular disease and/or chronic venous thromboembolic disorder)
- Chronic heart failure

CMS rules do not allow a Medicare Advantage plan to use a diagnosis on a previously submitted claim, or any other previous proof of diagnosis, to support a C-SNP enrollment.

After the application is processed, UnitedHealthcare starts the verification process, and may begin verifying conditions before the member’s effective date with the plan. The plan has 60 days after the effective date to complete the verification of the qualifying chronic condition. Our verification team will reach out to the member’s provider (either a primary care provider [PCP] or specialist) to obtain the verification.

How to verify a patient’s qualifying condition

Providers need to complete the [Chronic Condition Verification Form](#) [open in new](#) and submit to us in one of the following ways:

- Call the number on the form; a doctor or nurse can leave a message
- Email the completed form to [mandrenrollment@uhc.com](mailto:mandrenrollment@uhc.com)
- Fax the completed form to the number on the form

If a member’s qualifying condition is not verified within 60 days of enrollment, CMS requires that the member be disenrolled from the C-SNP. If you receive a request from UnitedHealthcare to verify a qualifying chronic condition for one of your UnitedHealthcare patients, please respond as soon as possible using one of the methods listed above.

### **About C-SNP plans**

C-SNP plans offer tailored benefits and services to support qualifying conditions, including lower copays and prescription drug costs, care management and ancillary benefits, such as over the counter (OTC) and healthy food credits.

### **Questions?**

Connect with us through chat 24/7 in the [UnitedHealthcare Provider Portal.](#)”

<https://www.uhcprovider.com/en/resource-library/news/2025/complete-verification-c-snp-patients.html?cid=em-provider-news-2025nnb2-June25>

## **UHC: The AARP Healthcare Options Provider Website Has Moved. UHC. May 30, 2025**

**“Begin using the UnitedHealthcare Provider Portal to check AARP Medicare Supplement insured member data today**

Effective **June 30, 2025**, the AARP Healthcare Options Provider website will be decommissioned. Register with the UnitedHealthcare Provider portal before June 30 to avoid interruptions with administrative and patient care tasks.

### **What this means for you**

You can now access AARP® Medicare Supplement insured member data on the [UnitedHealthcare Provider Portal](#) by signing in with your One Healthcare ID and selecting the AARP Medicare Supplement Payer ID (36273). The portal’s convenient digital tools enable you to quickly access eligibility and claims and payment information for AARP Medicare Supplement insured members.

### **What’s new**

You can now use the UnitedHealthcare Provider Portal to:

- View and print insured member ID card images

- Access enhanced benefit details
- View remaining Medicare supplement plan deductible amounts, when applicable
- View ACH payment numbers
- View claims acknowledged (claims received but not yet processed) and pending (in process but adjudication not yet complete)
- Print benefit and claim summaries
- Get to know [AARP Medicare Supplement plans](#)”

<https://www.uhcprovider.com/en/resource-library/news/2025/aarp-healthcare-options-provider-move.html?cid=em-providernews-2025nnb2-June25>

### **UHC: Get SDOH Screening Aids and Resources In One Place. UHC. May 16, 2025**

“When you recognize a need in a member’s social drivers of health (SDOH), you’ve taken the first step in improving their situation. The second step? Sharing your assessment and screening results to get the ball rolling. We can help.

#### **Making the connection**

Visit our newly updated Social Drivers of Health webpage to find everything you need:

- How to share SDOH screening results
  - Directly in Epic (a leading electronic health record system)
  - Through [electronic data interchange](#) or the [UnitedHealthcare Provider Portal](#)
  - By uploading standard flat files
- Resources for members with social needs
- Free CME credit courses and an interactive guide
- Reference guides, opportunity reports and disparity rankings

[See SDOH resources](#)”

<https://www.uhcprovider.com/en/resource-library/news/2025/sdoh-screening-aids-resources.html?cid=em-providernews-2025nnb2-June25>