ICRC | Integrated Care Resource Center

Helping states develop integrated programs for individuals who are dually eligible for Medicare and Medicaid

November 27, 2024

Integrated Care Updates

CMS Issues CY2026 Notice of Proposed Rulemaking

On November 26, 2024, the Centers for Medicare & Medicaid Services (CMS) issued a Notice of Proposed Rulemaking (NPRM) on the Medicare Advantage (MA) program, Medicare Prescription Drug Benefit Program (Part D), Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE).

CMS also issued a fact sheet summarizing the major provisions of the NPRM.

CMS will accept comments on the proposed rule received by 5 p.m. Eastern Time on January 27, 2025. To submit comments electronically, go to http://www.regulations.gov and follow the "Submit a comment" instructions. Reference file code **CMS-4208-P** in your comments. Instructions for submitting comments by mail are provided in the introduction to the NPRM.

The proposed rule includes several provisions related to dually eligible individuals, including proposals to establish new federal requirements for D-SNPs that are applicable integrated plans (AIPs) to 1) have integrated member identification (ID) cards that serve as the ID cards for both the Medicare and Medicaid plans in which an enrollee is enrolled; and 2) conduct an integrated health risk assessment (HRA) for Medicare and Medicaid, rather than separate HRAs for each program. (See pages 448 – 459 in the current version of the NPRM for information about these proposals.)

The NPRM also includes proposals to:

- Codify timeframes for special needs plans to conduct HRAs and individualized care plans (ICPs) and prioritize the involvement of the enrollee or the enrollee's representative, as applicable, in the development of the ICPs (pp. 459 – 468);
- No longer exclude anti-obesity medications from coverage under Medicare Part D and Medicaid for the treatment of obesity (pp. 109 – 122);
- Require agents and brokers to discuss with their customers, among other topics, the availability of low-income supports including the Medicare Savings Programs (pp. 258 – 269); and
- Improve the administration of supplemental benefits provided through debit cards by MA organizations (pp. 138 – 157); and
- Broadening the definition of marketing to expand CMS oversight of MA and Part D communications materials and activities and strengthen beneficiary protections against misleading and confusing advertising tactics (pp. 278 – 296).

The proposed rule also solicits comments on (1) public posting of state Medicaid agency contracts (SMACs) held between states and D-SNPs (pp. 469 – 470), and (2) whether conducting network adequacy evaluations at the MA plan benefit package (PBP) level would provide greater assurances regarding the adequacy of an MA organization's network than the current CMS practice of conducting network adequacy reviews of an MA organization's network at the contract level (pp. 255 – 257).

The current online version of the proposed rule is a double-spaced, unpublished PDF. **The page numbers shown above are from that version.** ICRC will issue an e-alert with the updated Federal Register page numbers once the published version is available.

State Medicaid Agency Contract Posted for Public Comment

On Friday, November 22nd, CMS posted in the Federal Register for 60-day comment the SMAC Application that will be available for use by MA organizations intending to offer D-SNPs in CY2027. The 60-day comment period closes January 21, 2025.

MA organizations intending to offer D-SNPs use the SMAC application to submit SMACs to CMS for review during the annual MA bid process. The updated SMAC Application provides several technical updates to make the attestations and matrices more user-friendly. For instance, CMS updated the titles of both matrices to clarify whether the matrix is required for all D-SNPs or for those organizations seeking Fully Integrated D-SNP or Highly Integrated D-SNP status and Applicable Integrated Plan status. Additionally, the updated SMAC Application includes new instructions for D-SNPs to upload Medicaid managed care contracts for the affiliated Medicaid managed care organizations where applicable to enable CMS to confirm compliance with the service area requirements described in 42 CFR 422.2. All of the updates are aimed at improving the D-SNP integration status determination process for MA organizations.

To submit comments electronically, click on "Submit a public comment" at the top of the Federal Register page for this information collection activity. The page also provides additional instructions to submit comments by mail.

CMS Reminds Plans of Billing Rules Related to Qualified Medicare Beneficiaries in Recent Memo

On October 31, the Centers for Medicare & Medicaid Services (CMS) and the Consumer Financial Protection Bureau (CFPB) released three new educational resources for Medicare plans, providers, and debt collectors to remind them of their responsibilities in protecting Qualified Medicare Beneficiaries (QMBs) from unlawful medical bills:

- A Health Plan Management System (HPMS) memo that (1) reminds Medicare plans of their obligation to educate their networked providers, suppliers, and pharmacies about, and ensure compliance with, QMB billing rules, and (2) explains how plans can identify QMB status;
- An updated Medicare Learning Network fact sheet for Medicare providers and suppliers that explains the QMB balance billing prohibition and how providers can ensure compliance with the law; and
- A joint statement summarizing previous CMS and CFPB efforts, highlighting the two new resources for plans and providers described above, and detailing how the Fair Debt Collection Practices Act (FDCPA) and Fair Credit Reporting Act (FCRA) prohibit debt collectors from misrepresenting whether QMB individuals owe debts and/or the amount owed.

Per 42 CFR 422.107(c)(4), states that contract with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) must also describe in their state Medicaid agency contracts (SMACs) with those plans the cost-sharing protections afforded to D-SNP enrollees. States can review this ICRC technical assistance tool for sample SMAC language, and states can also review the new resources above for information about the federal prohibition on billing QMB individuals for Medicare Part A or Part B cost sharing.

Now Available: 2022 Medicaid Managed Care Enrollment Report and State Tables

The 2022 CMS Medicaid managed care enrollment report and Medicaid managed care state tables are now available. The enrollment report summarizes the number of enrollees in Medicaid managed care programs at both the national and state levels as of July 1, 2022. The state tables provide overviews of each state's Medicaid managed care program features as of 2022. CMS collected the data and information presented in these reports from all states and territories authorized to provide Medicaid managed care benefits and services.

November 2024 Enrollment in Medicare-Medicaid Plans, Programs of All-Inclusive Care for the Elderly, and Applicable Integrated Plans

November data on enrollment in Medicare-Medicaid Plans (MMPs), Program of All-Inclusive Care for the Elderly (PACE) organizations, and AIPs are now available on the ICRC website at: Monthly Integrated Care Exclusively Aligned Enrollment Report: Dually Eligible Individuals Enrolled in MMPs, PACE, and AIPs. Table 1 in this document shows total monthly enrollment for all integrated care plans with exclusively aligned enrollment (MMPs, PACE, and AIPs). Between October and November 2024, total enrollment in integrated care plans with exclusively aligned enrollment held steady at about 1.3 million.

Point of Contact Update for the Resources on Integrated Care Website

As of November 15, 2024, the RIC@Lewin.com and ICCOP@Lewin.com inboxes will be decommissioned. Starting on November 15, 2024, please email RIC@cms.hhs.gov with any inquiries regarding the Resources for Integrated Care website. Please visit the Resources for Integrated Care Available for Health Plans and Providers page on the CMS website for more information.

Key Upcoming Dates

- **December 7, 2024**: End of the CY2025 annual election period for MA and Part D plans (began on October 15).
- **January 1, 2025**: Medicare Advantage (MA) and Part D plan contract year starts; enrollment effective date for plan enrollments processed during the Medicare Annual Enrollment Period (AEP) that took place between October 15 and December 7 and 2024.
- **January 1 – March 31, 2025:** Annual MA Open Enrollment Period, during which an individual who is already enrolled in an MA plan – including Dual Eligible Special Needs Plans (D-SNPs) and Medicare-Medicaid Plans (MMPs) – can switch to a different MA plan or disenroll from that MA plan to go to original, fee-for-service Medicare (with or without a Part D prescription drug plan).
- **Early January 2025:** Model of Care (MOC) renewal submission period begins for D-SNPs, Institutional Special Needs Plans (I-SNPs) and Chronic Condition Special Needs Plans (C-SNPs) with MOC approvals ending December 31, 2025.
- **January 8, 2025:** CY 2026 MA and Part D applications posted on CMS website
- **January 17, 2025:** Final day for MA organizations to submit NOIAs to CMS for CY2026. (CMS requires NOIAs from all MA organizations wishing to operate a new product type or expand the service areas of an existing contract in 2026.)
- **February 12, 2025:** CY 2026 Initial and Service Area Expansion Applications due to CMS from organizations wishing to operate a new MA plan (including D-SNPs) in 2026 or to expand the service area of an existing MA plan (including D-SNPs) for 2026; MOC initial and renewal submissions are due for D-SNPs, I-SNPs, and C-SNPs with MOC approvals ending December 31, 2025.
- **February 21, 2025:** CMS notifies MA organizations with CY 2025 D-SNP look-alike plans of their need to comply with the federal regulations described at 42 CFR 422.514(d) and (e) and options for transitioning members to other plans.