December 12, 2024

Contract Year 2026 Medicare Advantage & Part D Proposed Rule

Potential areas for comment

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Overview

- CMS published a notice of proposed rulemaking on December 10, 2024 for Medicare Advantage (MA) and Part D for contract year 2026
- Areas for potential comment
  - Mandatory coverage of anti-obesity medications (AOMs)
  - Integrated care for dually eligible individuals
  - Access to cost-sharing tools
- Next steps

Mandatory Coverage of AOMs

- The definition of a Medicare Part D covered drug is tied to the definition of covered outpatient drugs under the Medicaid Drug Rebate Program
  - Excludes coverage of agents used for anorexia, weight loss, or weight gain
- AOMs are not covered under Medicare for weight loss, states may optionally cover them under Medicaid
- Centers for Medicare & Medicaid Services (CMS) proposes to reinterpret the statutory exclusion to allow coverage of AOMs for obesity
  - CMS previously reinterpreted this statute to allow coverage of weight gain drugs for certain diseases
- Potential for gap in applicability date between Medicare and Medicaid could result in Medicaid covering and paying for AOMs for dually eligible beneficiaries for a period of time
  - Statute prohibits significant changes to Medicare Part D except at the start of a calendar year while Medicaid has no such prohibition

Mandatory Coverage of AOMs, Cont'd

- Proposed rule estimates $11 billion in costs to federal Medicaid and $3.8 billion in costs to state Medicaid programs over a ten-year window
- It is unclear whether the cost estimate accounts for the amount states may have to pay for dually eligible beneficiaries due to a potential gap in applicability dates for Medicare and Medicaid
- CMS notes that states would still have access to cost-control tools, such as preferred drug lists and prior authorization (PA)
  - Nearly all states that currently cover these drugs for weight loss required PA or had body-mass index (BMI) requirements

Potential Comment

- Guidance on CMS expectations of states in terms of allowable PA criteria
  - CMS does not propose a definition of obesity, which could create uncertainty as to when a beneficiary seeking coverage is overweight (not covered) or obese (covered)
  - MACPAC's June 2019 report to Congress noted the challenges states face in developing drug coverage policies and what may be allowable PA criteria
- Linking Medicare and Medicaid effective dates for mandatory coverage would avoid the potential for cost shifting
  - If CMS moves forward with an earlier applicability date for Medicaid, CMS should issue guidance on expectations for Medicaid coverage of AOMs for dually eligible individuals
  - The Medicaid exclusion of coverage of Medicare Part D drugs or cost sharing is tied to the definition of a Part D eligible individual rather than the coverage of a Part D drug

Integrated Care for Dually Eligible Individuals

Proposes to

- Require applicable integrated plans (AIPs) to issue integrated member identification (ID) cards
  - Must meet existing ID requirements for Medicaid and Medicare
  - Most states with AIPs already require this
- Require AIPs to use a combined health risk assessment (HRA)
  - States may already require this to reduce duplication and burden on beneficiaries
- Codify timelines for conducting HRAs and developing integrated care plans (ICPs)
  - Puts into regulation that HRAs must be completed at least 90 days before or after enrollment
  - Adds that ICPs must be completed within 30 days of the HRA or effective date of enrollment, whichever is later
  - Adds specific requirements to conduct and document outreach to enrollees

Potential Comment

- Prior MACPAC work noted the opportunity to use exclusively aligned enrollment to increase integration, such as through integrated member materials
  - Recent CMS rulemaking will likely increase the number of AIPs by 2030
- The Commission's June 2024 report to Congress highlighted how states rely on HRAs and ICPs to provide dually eligible beneficiaries with integrated care
- CMS also requested comment on publicly posting state Medicaid agency contracts (SMACs) with MA dual eligible special needs plans (D-SNPs)
  - States face challenges in developing and retaining D-SNP expertise and have expressed interest in learning from peers
  - However, this question falls outside of the scope of our prior work

Access to Cost-Sharing Tools

- The proposed rule would require MA agents and brokers to discuss their potential eligibility for cost-sharing supports, such as the Medicare Part D Low-Income Subsidy, Medicare Savings Programs (MSPs), and supplemental Medigap insurance
  - Agents and brokers must offer to connect individuals with the state to learn more about state programs
- CMS also proposes to clarify the use of debit cards for supplemental benefits in MA
  - Concerns about tracking appropriate use of debit cards only for covered items and services as well as beneficiary confusion over how to use the cards
  - Proposes to codify requirements in the Medicare managed care manual and adds requirements that plans provide instructions and customer service for debit card use
  - Would prohibit plans from advertising the debit card as a benefit or its dollar amount

Potential Comment

- Prior MACPAC work identified issues in enrolling eligible individuals into MSPs and recommended changes, which CMS implemented in part
  - While the Commission's June 2024 report to Congress found enrollment in MSPs was improving, millions eligible for MSPs remain unenrolled
- Dually eligible individuals may be drawn away from integrated care models by MA plans advertising debit cards
  - Evaluations of the Medicare-Medicaid Plans (MMPs) under the Financial Alignment Initiative found state and plan officials noted competition from MA plans as a challenge for enrollment

Next Steps

- Comments are due by January 27, 2025
- If the Commission wants to comment, staff will incorporate feedback from the session to draft a letter for review

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