DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE-MEDICAID COORDINATION OFFICE

DATE: July 30, 2025

TO: Applicable Integrated Plan (AIP) Dual-Eligible Special Needs Plans (D-SNPs) in States Using Integrated D-SNP models

FROM: Kerry Branick
Deputy Director, Medicare-Medicaid Coordination Office

SUBJECT: Revisions to Contract Year 2026 Models for AIP D-SNPs

The purpose of this memorandum is to provide updates to the Contract Year (CY) 2026 Member Handbook (Evidence of Coverage) and Annual Notice of Change (ANOC) for applicable integrated plan (AIP) dual eligible special needs plans (D-SNPs) in states using an integrated models. This includes AIP D-SNPs in California, the District of Columbia, Illinois, Massachusetts, Michigan, Minnesota, New Jersey, Ohio, Rhode Island, South Carolina, Tennessee, Texas, and Wisconsin. These changes are based on updates to the CY 2026 Medicare Advantage models that were released as described in the Health Plan Management System (HPMS) memorandum, "Contract Year 2026 Model Notice Corrections" on July 28, 2025.

MMCO will not issue revised CY 2026 state-specific model materials for changes included in this memorandum. We instruct AIP D-SNPs in the applicable states to update their CY 2026 model materials based on the information provided in this memorandum. The information below includes updates to the Member Handbook Chapters 1 and 4 and ANOC.

Hard copy Member Handbooks and ANOCs must include this information before they are mailed to enrollees whenever possible. If updates to the hard copy ANOC and Member Handbook are not practicable – for example, if they have already been printed – the model errata may be used to communicate the updated and accurate information until current stock of outdated materials is depleted.

We will post this memorandum to MMCO's D-SNPs: Integration & Unified Appeals & Grievance Requirements webpage at https://www.cms.gov/medicaid-chip/medicare-coordination/qualified-beneficiary-program/d-snps-integration-unified-appeals-grievance-requirements.

If you have any questions about the contents of this memorandum, please contact the Medicare-Medicaid Coordination Office at MMCO_DSNPOperations@cms.hhs.gov.

CY 2026 Model Updates

Member Handbook/EOC

Chapter 1

- Section C, insert the following paragraph as applicable after the last bullet in the section:

  [*Insert the following paragraph if the Medicaid coverage start date could be different than the Medicare coverage start date:* **New members to <plan name>:** In most instances you'll be enrolled in <plan name> for your Medicare benefits the 1st day of the month after you request to be enrolled in <plan name>. You may still receive your <insert Medicaid program name> from your previous <insert Medicaid program name> health plan for one additional month. After that, you'll receive your <Medicaid program name> services through <plan name>. There will be no gap in your <Medicaid program name> coverage. Please call us at the number at the bottom of the page if you have any questions.]

- Section H and the table of contents, change the section heading, "Your monthly costs for <plan name>" to "Summary of important costs".

Chapter 4

- Section D, Chronic pain management and treatment services row. Add the following language to the "What you pay" column.
  - Cost sharing for this service will vary depending on individual services provided under the course of treatment. [*List copays*.]

- Section D, Colorectal cancer screening row. Revise the language as follows:

  We pay for the following services:

  - Colonscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy.

  - Computed tomography colonography for patients 45 years and older who aren't at high risk of colorectal cancer is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed, or when 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonsocopy was performed.

  - Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48

months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography.

- Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.
- Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.
- Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.
- Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test resturns a positive result.
- Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

[*List any additional benefits offered*.]

- Section D, Smoking and tobacco use cessation row. Revise the language as follows:

  Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria:

  - use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease
  - are competent and alert during counseling
  - a qualified physician or other Medicare-recognized practitioner provides counseling

  We cover two cessation attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with up to eight sessions per year).

  [*List any additional benefits offered*.]

<u>Annual Notice of Change</u>

- Section B, insert the following paragraph as applicable after the first paragraph:

  [*Insert the following paragraph if the Medicaid coverage start date could be different than the Medicare coverage start date:* **New members to <plan name>:** In most instances you'll be enrolled in <plan name> for your Medicare benefits the 1st day of the month after you request to be enrolled in <plan name>. You may still receive your <insert Medicaid program name> from

your previous <insert Medicaid program name> health plan for one additional month. After that, you'll receive your <Medicaid program name> services through <plan name>. There will be no gap in your <Medicaid program name> coverage. Please call us at the number at the bottom of the page if you have any questions.]