National Rural Health Association

Contract Year (CY) 2026 Medicare Advantage and Part D Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) recently released its CY 2026 Medicare Advantage (MA) and Part D Policy and Technical Changes proposed rule. For more information, please see NRHA's summary below and CMS' fact sheet here.

Comments are due January 27, 2024, via regulations.gov. If you have any questions or comments that you would like addressed in NRHA's response, please contact NRHA's Government Affairs and Policy Director, Alexa McKinley Abel (amckinley@ruralhealth.us).

Prior authorization and internal coverage criteria reforms:

Building on requirements around prior authorization and medical necessity determinations finalized in an April 2023 rule, CMS is proposing new rules for MA organizations' (MAOs) use of internal coverage criteria and prior authorization:

- In response to provider concerns about MAOs **denying inpatient admissions or services**, CMS is clarifying that coverage decisions made contemporaneously with when an enrollee is receiving services (such as inpatient services) are subject to rules around timely notice and appeal rights for the beneficiary. This also applies to retrospective reviews, or denials of service after a beneficiary has been discharged but before a request for payment has been received.
    - This change is primarily for the benefit of beneficiaries who would otherwise likely face different cost sharing responsibilities based on whether inpatient or outpatient hospital services were provided.
- Additionally, CMS proposes to clarify that MAOs may not approve an inpatient admission during a concurrent review (as in review of a beneficiary's need for continued care) and **later deny services based on a lack of medical necessity**. This will help provide certainty for beneficiaries and providers that medically necessary services will continue to be covered and paid for by the MAO.
- CMS proposes to **define "internal coverage criteria"** as: any policies, measures, tools, or guidelines, whether developed by an MAO or a third party, that are not expressly stated in applicable statutes, regulations, national or local coverage determinations, or CMS manuals, and are adopted or relied upon by an MAO for purposes of making a medical necessity determination.
    - This includes any coverage criteria that restrict access to or payment for medically necessary Part A or Part B items or services based on the duration, setting or level of care, or clinical effectiveness.
- Generally, **MA plans must follow national and local coverage determinations established by Traditional Medicare** when determining whether an item or service is medically necessary for prior authorization purposes.
    - In this rule, CMS proposes to amend regulatory text to clarify that MAOs' internal coverage criteria may not be used to add new, unrelated coverage criteria for an item or service that already has existing, but not fully established, coverage policies under Traditional Medicare. Internal coverage criteria may only supplement or help interpret existing coverage policies.
- CMS proposes to remove the requirement that MAOs must demonstrate that their additional internal coverage criteria provide clinical benefits that outweigh any clinical harms, including

those from delayed or decreased access to services. Since this requirement has been effective, CMS found that MAOs provide little evidence as to the clinical benefit of their criteria.
    - CMS solicits comments on replacing this with the **requirement that the MAOs demonstrate through evidence that additional coverage criteria support patient safety.**
- CMS proposes to add **two requirements that would prohibit the use of all internal coverage criteria:**
    - When internal coverage criteria do not have any clinical benefit and only exist to reduce utilization of the item or service.
    - When internal coverage criteria are used to automatically deny coverage of basic benefits without the MAO making an individual medical necessary determination.
- **Regarding automated systems, including the use of AI,** to make decisions, CMS is clarifying that they must comply with existing regulations around discrimination against beneficiaries based on any factor related to their health status.
    - Additionally, internal coverage criteria must be made publicly available per existing regulations. CMS clarifies that this includes any internal coverage criteria are built into automated systems.

Increasing beneficiary access:

- Medicare Part D deductible and cost sharing waived for **adult vaccines** recommended by the Advisory Committee on Immunization Practices.
- For **covered insulin products** under a Part D or MA Prescription Drug Plan (MA-PD), the deductible is waived and cost sharing is the lesser of $35, 25% of the maximum fair price, or 25% of the negotiated price.
- Requiring that MA plans **in-network cost sharing for behavioral health care** are no greater than Traditional Medicare. This includes:
    - Zero cost sharing for opioid treatment program services.
    - 20% coinsurance for mental health specialty services, psychiatric services, partial hospitalization/intensive outpatient services, and outpatient substance abuse services.
    - 100% of estimated Medicare Fee-For-Service (FFS) cost sharing for inpatient hospital psychiatric services.
- **Permitting MA plans to cover anti-obesity medications** when such drugs are used to reduce excess body weight and maintain weight reduction long-term for individuals with obesity.

Beneficiary protection:

- CMS proposes broaden its definition of "marketing" in order to require MAOs to submit more advertisements to CMS for review before their use.
- MAO agents and brokers must discuss an individual's potential eligibility for the Low-Income Subsidy and Medicare Savings Programs
- MAO agents and brokers must discuss the potential impact of MA enrollment on future Medigap guaranteed issue rights and practical implications of switching from Traditional Medicare to an MA plan. This proposal should help beneficiaries understand that switching from MA to Traditional Medicare may make their Medigap plan unaffordable.