Kansas Hospital Association

Summary of the Contract Year 2026 Medicare Advantage and Part D Proposed Rule

The Centers for Medicare and Medicaid Services released the CY 2026 Medicare Advantage (MA) and Part D Policy and Technical Changes Proposed Rule on November 27, 2024. KHA has prepared the summary of major provisions below. Comments are due to CMS by January 27. If you have any concerns, thoughts, or other points of feedback, please send those to Jaron Caffrey and Shannan Flach by January 13.

Highlights:

1. Strengthens limitations on insurer use of internal coverage criteria and medical necessity determinations.
2. Increases transparency, including through making provider directory information more widely available.
3. Supports beneficiary protections with expanded oversight of MA marketing and agent and broker communications with enrollees.
4. Improves oversight of the usage of AI.
5. Updates reporting requirements regarding the Medical Loss Ratio (MLR) to address concerns about the vertical integration of insurers.
6. Enables Part D and Medicare Advantage plan coverage of anti-obesity medications for individuals diagnosed with obesity.

Summary of Major Proposed Provisions:

Strengthens rules on the definition of "internal coverage criteria" and of publicly posting internal coverage criteria content on MA websites.

CMS noted its concern that various Medicare Advantage plans have interpreted the meaning of 'internal coverage criteria' differently since the implementation of the CY 2024 MA final rule. Specifically, CMS has clarified in the following additional context:

- CMS proposes to broadly define internal coverage criteria as "any policies, measures, tools, or guidelines, whether developed by an MA organization or a third party, that are not expressly stated in applicable statutes, regulations, NCDs [National Coverage Determinations], LCDs [Local Coverage Determinations], or CMS manuals and are adopted or relied upon by an MA organization for purposes of making a medical necessity determination."
- Clarifies that internal coverage criteria may only be used to supplement or interpret already existing content with the Medicare coverage and benefit rules — not to add

new, unrelated coverage criteria for an item or service that has already existing, but not fully established, coverage policies.

- Requires MA plans to identify the plain language of the applicable Medicare coverage and benefit criteria they are interpreting or supplementing when it is permissible to adopt internal coverage criteria and make such plain language explanation available in publicly accessible materials.
- Prohibits using an MA plan internal criterion that does not provide clinical benefit to the patient and only exists to reduce utilization of the item or service.
- Prohibits using internal criteria to automatically deny coverage of Basic Benefits without the MA organization making an individual medical necessity determination based on the patient's individual circumstances and medical condition.
- Eliminates the current requirement that additional coverage criteria must "provide clinical benefits that are highly likely to outweigh any clinician harms, including from delayed or decreased access to items or services" due to difficulty in providing through evidence and enforce as a policy. CMS seeks input on potential alternatives.
- Requires MAOs prominently display all items or services covered under Medicare for which the organization uses internal coverage criteria when making medical necessity decisions, including specific information about how the criteria meet the CMS standards for high-quality evidence, clinical benefit, public accessibility and appropriate use.

Strengthens regulations on medical necessity determinations

- Clarifies that an enrollee's further liability to pay for services cannot be determined until an MA organization has made a determination on a request for payment.
- Modifies the definition of an organization determination to clarify that a coverage decision made by an MA organization contemporaneously to when an enrollee is receiving such services, including level of care decisions (such as inpatient or outpatient coverage), is an organization determination subject to appeal and other existing requirements.
- Proposes to strengthen the notice requirements to ensure that a provider who has made a standard organization determination request on an enrollee's behalf, or when it was otherwise appropriate, receives notice of the MA organization's decision.
- Proposes a change to the reopening rules to eliminate the discretion of an MA organization to reopen an approved authorization for an inpatient hospital admission.

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Revises the required metrics for the annual health equity analysis of the use of prior authorization to require the metrics be reported by each item or service, rather than aggregated for all items and services

Reforms Medical Loss Ratio (MLR) standards to improve reporting and oversight and better align MA and Part D MLR requirements with commercial and Medicaid MLR requirements.

- Proposes to establish clinical and quality improvement standards for provider incentives and bonus arrangements included in the MA MLR numerator in order to help align such bonus payments with care outcomes.
- Prohibits administrative costs from being included in quality improvement activities in both the MA and Part D MLR numerator.
- Adopts additional requirements for the allocation of expenses in the MLR.
- Establishes new audit and appeals processes for MLR compliance.
- Explicitly provides that the Medicare MLR reporting include detailed information regarding provider payment arrangements.

Increases transparency with provider directories

- Requires MA provider directory data be submitted for use to populate Medicare Plan Finder. Additionally, CMS proposes to require MA organizations to attest that this information is accurate and consistent with data submitted to comply with CMS's MA network adequacy requirements.

Expands agent and broker requirements regarding Medicare Savings Programs, Extra Help, and Medigap

- CMS is adding new topics to the existing list of requirements that agents and brokers must discuss with their customers:
  - The availability of low-income supports including the Part D Low-Income Subsidy (also known as "Extra Help") and Medicare Savings Programs;
  - For beneficiaries enrolling into MA when first eligible for Medicare or dropping a Medigap plan to enroll in an MA plan for the first time, general information on Medigap Federal guaranteed issue (GI) rights, the practical implications of switching from Medicare Advantage to Traditional Medicare, and, when applicable, provide information on state laws regarding Medigap GI rights for those states where the agent or broker is licensed and appointed to sell; and
  - Requiring that agents pause to address remaining questions the beneficiary may have related to enrollment in a plan prior to moving forward with an enrollment.

Enhances review of MA and Part D marketing and communications

- CMS proposes to broaden the marketing definition to expand CMS oversight of MA and Part D communications materials and activities, specifically CMS will eliminate the current content standard and rely solely on an intent standard to determine whether communications material and activities are considered marketing.
    - This will expand the scope of materials that plans must prospectively submit to CMS for review to ensure entities are not providing misleading, inaccurate, or confusing information to Medicare or potential Medicare beneficiaries.

Improves oversight of MA supplemental benefits administered by debit card

- CMS creates parameters to describe when, how, and in what manner debit cards can be used by an MA organization and enrollee
- Introduces additional disclosure requirements to increase transparency
- Requires MA organizations to allow an enrollee to receive covered benefits through an alternative process if there is an issue with a plan debit card
- Prohibits MA plans from marketing the dollar amount of a supplemental benefit or if an enrollee is provided with debit cards

Fully aligns MA cost-sharing of behavioral health services with Traditional Medicare

- In-network cost-sharing for behavioral health services cannot be greater than cost-sharing for those services in Traditional Medicare.

Establishes new federal requirements for Dual Special Need Plans that are applicable integrated plans to address care fragmentation amongst dually eligible individuals.

Part D coverage of anti-obesity medications

- Includes anti-obesity medications when used to treat obesity by reducing excess body weight or maintaining weight reduction long-term for individuals with obesity for Part D coverage and Medicaid coverage.

Vaccine cost-sharing changes

- Waives the deductible and cost-sharing for adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) covered under Part D.

Insulin cost-sharing changes

- Waives the deductible and requires the cost-sharing amount to be the lesser of $35, 25% of the maximum fair price, or 25% of the negotiated price for covered insulin products under Part D or MA plans.

Medicare Prescription Payment Plan cost-sharing

- Codifies agency guidance implementing a component of the Inflation Reduction Act which requires prescription drug plans to provide enrollees the option to elect to pay cost-sharing under the plan in monthly amounts that are capped instead of requiring a single upfront payment.

Promotes transparency for pharmacies and protects beneficiaries from disruptions

- Part D sponsors including PBMs, must notify network pharmacies which plans the pharmacies will be in-network for in a given plan year by October 1 of the year prior to that plan year, and to require sponsors to provide pharmacies a list of these plans to network pharmacies on request after October 1.
- CMS also proposes to require contracts with pharmacies for participation in Part D networks that allow the Part D sponsor or FDR to terminate the contract without cause to also allow pharmacies to terminate the contracts without cause after providing the same notice that the contract requires the sponsor or FDR to provide the pharmacy.

Updates Medicare transaction facilitator requirements for network pharmacy agreements

- CMS proposes to require that Part D sponsors' network contracts with pharmacies require such pharmacies to be enrolled in the Medicare Drug Price Negotiation Program's ("Negotiation Program") Medicare Transaction Facilitator Data Module ("MTF DM").

Implements guardrails for the use of Artificial Intelligence (AI) when it is being used to make decisions.

- Internal coverage criteria must be publicly available per existing regulations. This includes any internal coverage criteria that are built into automated systems.
- AI and other automated systems must comply with existing laws and regulations that prohibit discrimination against beneficiaries based on any factor that is related to health status or condition.

Conclusion:

KHA appreciates CMS' efforts to build upon prior MA rulemaking to strengthen limitations on the use of internal or proprietary coverage criteria that are more restrictive than Traditional Medicare. It is reassuring that CMS plans to increase oversight of prior authorizations and utilization management

tools. CMS expressed concern about barriers accessing care and high burden on the system. KHA appreciates Kansas hospitals taking the time to complete timely complaint forms to show CMS the delays in patient access to care, which adds cost and burden to the healthcare system.

CMS is seeking further comments related to mandatory coverage of anti-obesity medications, integrated care for dually eligible individuals, and access to cost-sharing tools.

Comments are due by January 27, 2025. KHA will incorporate feedback from hospital members to draft a letter for review. Please reach out to Jaron Caffrey at jcaffrey@kha-net.org for any questions.