



# Educational Webinar: Medicare Part C & D Proposed Rule for 2026

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# Housekeeping items

Everyone is welcome to join the conversation.



You can type questions in the Q & A box or raise your hand.



The slide deck will be sent to all registrants.



This webinar will be recorded and sent to all registrants.

## High-level takeaway

The 2026 Medicare Part C & D proposed rule was released November 26, 2024, with comments due January 27, 2025.

CMS's proposals – with one notable exception – largely focus on detailed housekeeping items to follow-up on policies finalized last year

# Agenda

1. Rulemaking during changes of Administration
2. Topics included in the Proposed Rule:
  - Benefits and providers
  - Enrollment, utilization management, & quality
  - Medical loss ratio
  - Dual eligibles and D-SNPs
3. Next steps

# Rulemaking



# Standard rulemaking

The Administrative Procedure Act (APA) establishes the procedures for rulemaking.

- APA has existing guardrails that constrain excessive rulemaking
- Section 553 requires the government to give interested parties the opportunity to comment
- “Good Cause” allows rules to be finalized immediately under certain circumstances

# The Presidential transition and rulemaking

Upon inauguration, the Trump administration will make the most immediate regulatory impact via:

- Congressional Review Act (CRA) and the Lookback Mechanism → Any regulation submitted 60 days before the previous Congress adjourns will be eligible
- August 1 projected lookback date
- Memo asking executive departments and agencies to halt progress all regulations in progress from the previous administration.
- What happens to policy changes within proposed rules that are not yet finalized?

# Benefits and Providers



# Coverage of anti-obesity medications

CMS proposes to cover anti-obesity medications by reinterpreting the statutory exclusion of weight-loss agents.

- Statutory exclusion dates back to the creation of Part D and 1990 for Medicaid
- CMS would effectively recognize obesity as a disease
- Proposal would expand coverage to Medicare Part D enrollees and Medicaid enrollees
- CMS estimates coverage would cost \$25B over 10 years for Part D and \$15B over 10 years for Medicaid

# Vaccine and insulin cost sharing limitations

- CMS proposes that the Part D deductible and cost-sharing would not apply to adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)
- CMS proposes that the Part D deductible would not apply to covered insulin products and copayments would be limited to \$35 for 2025 and for 2026 and later years the lesser of:
  - \$35
  - 25% of the established maximum fair price
  - 25% of the negotiated price
- Both implement policies included in the IRA of 2022

# Medicare prescription payment plan (MPPPP)

CMS proposes to codify several provisions of the IRA:

- MPPPP is available to all Part D enrollees, including low-income subsidy (LIS) enrollees
- Election-related materials must inform enrollees about LIS and other financial assistance programs
- Formalize requirements for election procedures, including multiple mechanisms for enrollment and a 24-hour effectuation timeframe for in-year election requests
- Feedback requested on requiring real-time election options facilitated by Part D sponsors for 2026 or later

# Special supplemental benefits for the chronically ill (SSBCI)

Last year, CMS required MAOs to provide evidence of the efficacy of services included as SSBCI, follow policies for determining enrollee eligibility, and document denials of eligibility.

This year, CMS proposes to:

- Codify a non-exhaustive list of non-primarily health related items or services that do not have a reasonable expectation of improving or maintaining the health of a chronically ill enrollee and therefore cannot be offered as SSBCI
- Specify that “a chronically ill enrollee” must meet all of the following:
  - Has  $\geq 1$  comorbid and medically complex chronic conditions that is life threatening or significantly limits overall health or function
  - Has a high risk of hospitalization or other adverse health outcomes
  - Requires intensive care coordination

# Improving access to behavioral health care

MA networks are required to include: 1) psychiatrists, 2) clinical psychologists, 3) clinical social workers, 4) inpatient psychiatric facilities, and as of 2025 5) Outpatient Behavioral Health specialty type

- For 2026, CMS proposes to limit in-network cost sharing for behavioral health services to no greater than TM
- CMS also proposes to apply for Cost Plans the longstanding determination that payment of less than 50% of total plan financial liability discriminates against enrollees who need these services
- CMS solicits comments on timing of new requirement, the application of a transition period, and potential impacts on actuarial equivalence

# Enrollment, Utilization Management, & Quality



# Promoting informed choice – expand agent/ broker requirements

Additions to topics brokers/agents must discuss with customers prior to enrolling in MA or MA-PD plan:

- Availability of low-income supports including Part D Low-income subsidy (Extra Help). Assists in premium, deductible, and prescription drug costs
- Medicare Savings Programs
- Medigap implications of switching to MA from traditional Medicare and a 12-month period to switch back to Medigap

# Prior authorization and health equity

- Previous:
  - Concerned about disparity in PA to underserved communities
  - In 2025, UM committee must have 1 member with health equity expertise
  - Conduct health equity study annually on the use of PA with specified social risk factors (SRF) like duals or disabilities in comparison to beneficiaries without SRF at the aggregate plan level
  - Post health equity study on website by July 2025 with approval of health equity UM committee member
- Proposed:
  - Standardized data required for report: For each separate covered item and service, percent of requests that were approved or denied before/after appeal, average/median time for decision. In addition, executive summary is required to assist public in understanding findings
  - CMS requests RFI on methods to group data in the study and adding mental health or substance use disorder diagnosis to collected data

# Quality rating changes

CMS continues to move to Universal Foundation measures to align quality measures across all programs (MA, FFS, ACO)

| Measure                                                       | Action                                                                                    | Purpose                                                                                                |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| Initiation/Engagement of substance use disorder treatment     | Adding in the 2028-star ratings (2026 measurement year)                                   | Encourage initiation of substance use disorder treatment options                                       |
| Initial opioid prescribing for long duration                  | Adding in the 2028-star ratings (2026 measurement year)                                   | Reduce risk for long term opioid prescription risk                                                     |
| Breast cancer screening                                       | Updating the screening age. Display page until 2029-star ratings                          | Increases size of population required for screening                                                    |
| Timely decisions about appeals and reviewing appeal decisions | Updating measure due to use of electronic submission. Display page until 2029-star rating | Align with movement to electronic submission like Eliminating grace periods for electronic submission. |

# Medical Loss Ratio



# Medical loss ratio (MLR)

CMS proposes to:

- Establish clinical and quality improvement standards for provider incentives and bonus arrangements included in the MA MLR numerator
- Prohibit administrative costs from being included in quality improvement activities in both the MA and Part D MLR numerator
- Codify additional requirements for the allocation of expenses in the MLR
- Establish new audit and appeals processes for MLR compliance
- Amend the regulations authorizing the release of MLR data
- Exclude Medicare Prescription Payment Plan unsettled balances from MLR
- Amend the reporting requirements for provider payment arrangements
- RFI for MLR and vertical integration

# Dual Eligibles & D-SNPs



# Dual-eligible beneficiaries

To improve the care experience for integrated plan enrollees, D-SNP plans that are acceptable integrated plans (AIP) must:

- Have integrated member ID cards that serve as ID cards for both Medicare and Medicaid plans the enrollee is in; and
- Have an integrated health risk assessment (HRA) for Medicare and Medicaid, rather than separate HRAs for each program

# Dual-eligible beneficiaries

CMS is also proposing:

- Changes to the definition of HIDE SNP plans
- Refinements for how the health equity index (HEI) reward is calculated for certain contracts
- That D-SNP only plans that received enrollees from legacy MA plans cannot qualify for HEI rewards if cannot have the rating-specific HEI score reliably calculated
- That I-SNP only contracts meet a certain threshold to have the rating-specific HEI calculated

# What's next?

- APG will submit a comment letter by January 27, 2025
- APG members are invited to participate in a focus group to share feedback, January 14 at 2:00pm ET
- APG members can also provide feedback by contacting Jennifer Podulka at [Jpodulka@apg.org](mailto:Jpodulka@apg.org) or Valinda Rutledge at [Vrutledge@apg.org](mailto:Vrutledge@apg.org)
- CMS is likely to release the 2026 MA Advance Notice by mid-February