Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Proposed Rule CMS-4208-F

On April 4, the Centers for Medicare & Medicaid Services released a final rule updating the Medicare Advantage (MA) Program, Medicare Prescription Drug Benefit Program (Part D), Medicare Cost Plan Program, Programs of All-Inclusive Care for the Elderly (PACE) for contract year CY 2026.

This rule is released annually to incorporate updates in program administration, payment methodologies, and policy refinements to these programs. Updates are often needed when legislation dictates a change in policy or payment, or economic factors require that payment rates be updated. A fact sheet accompanied the release of the final rule.

***Effective and Applicability Dates**:*
The effective date of the regulations is June 3, and the applicability date is January 1, 2026, unless otherwise noted. The applicable date for integrated member ID cards, i.e., a single enrollment card for dual eligibles is applicable beginning October 1, 2026, for contract year 2027. The health risk assessment (HRA) policy finalized in the rule is applicable October 1, 2026, for all HRAs conducted for effective dates of beneficiary enrollment on or after January 1, 2027.

Prior Authorization, Inpatient Stays, and Appeals
The final rule **did not address** several policies from the proposed rule related to the prior authorization process, including the following:

- Ensuring prior authorization policies are appropriately applied when using internal coverage criteria, as well as making those internal coverage criteria available to the public.
- Clarifying the definition of internal coverage policies; and clarifying that internal coverage criteria cannot be the basis to deny coverage for medically necessary care that is covered by traditional Medicare.
- Requiring MA plans to collect and make available prior authorization data at the service level, as opposed to collecting prior authorization data at the aggregate level.

The agency also avoided addressing policies proposed under the proposed rule heading "Enhancing Health Equity Analyses: Annual Health Equity Analysis of Utilization Management Policies."

However, the agency did finalize other policies meant to improve transparency for both beneficiaries and providers regarding health coverage decisions. Specifically, CMS will now limit MA plans from revisiting and altering, by changing or denying coverage of previously approved inpatient hospital admissions, except in cases involving clear error or fraud. Per the agency, this change will prevent retroactive denials based on newly surfaced information, thereby protecting continuity of patient care, and minimizing disruption to providers and their patients.

Additionally, CMS aims to strengthen and improve the integrity of the MA program, by closing gaps in the appeals process. This includes clarifying that all adverse coverage decisions, regardless of when those adverse decisions occur, are subject to appeal. CMS has also finalized the requirement that both providers and enrollees must be notified of coverage determinations, ensuring transparency in the delivery of health care services.

Guardrails for Use of Artificial Intelligence (AI)

The new administration has **decided to forgo** rulemaking on any of the proposed AI policies outlined in the proposed rule. While not surprising given that many of the proposals were drafted based on priorities of the Biden administration, many hoped that the current administration would support policy on the appropriate use of AI given the administration's interest in supporting innovation. Per the final rule "CMS, however, does want to acknowledge the broad interest in regulation of AI and will continue to consider the extent to which it may be appropriate to engage in future rulemaking in this area."

Improving Experiences for Dually Eligible Enrollees

The rule finalizes policies for improving care for dually eligible enrollees by allowing the use of a single ID card to serve as the ID card for both Medicare and Medicaid. Additionally, the rule finalizes policy that requires HRAs be integrated and performed for both Medicare and Medicaid so that dually eligible enrollees are not subject to duplicative HRAs; adjusting the timeframes for completing HRAs and care plans; and "prioritizing the involvement of the enrollee or the enrollee's representative, as applicable, in the development of the care plans."

Anti-Obesity Medications (AOMs)

The agency **did not finalize** coverage for anti-obesity medications, and there was no additional information or rationale provided for this decision. For program year 2026, CMS proposed to cover the use of AOMs. The change in coverage policy was related to the fact that the agency, and administration at the time the proposed rule was published, viewed obesity as a chronic disease and therefore believed that coverage for AOMs would be appropriate under Medicare Part D.