Summary of CMS Proposed Rule for Year 2026 Policy and Technical Chang to the MA Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and PAC Program (CMS-4208-P)

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The Centers for Medicare & Medicaid Services (CMS) recently unveiled an exten proposed rule under the designation CMS-4208-P, which aims to implement significant reforms across multiple Medicare programs. These include the Medi Advantage (MA) Program, the Medicare Prescription Drug Benefit Program (Par the Medicare Cost Plan Program, and the Programs of All-Inclusive Care for the Elderly (PACE). The proposed changes are designed to address several key priori including enhancing beneficiary access to critical services, promoting equitable coverage, improving program integrity, and ensuring that these programs meet t evolving needs of Medicare enrollees. The proposed rule targets the 2026 contra year, reflecting the agency's commitment to long-term, sustainable improvement the quality and accessibility of care.

Coverage of Anti-Obesity Medications

One of the most notable elements of the proposal is the re-evaluation of Part D coverage for anti-obesity medications. Historically, CMS has excluded weight-lo drugs from coverage unless prescribed for secondary conditions such as type 2 diabetes or cardiovascular risks. However, recognizing that obesity is now widel acknowledged as a chronic disease with significant health implications, CMS is reconsidering this exclusion.

The reinterpretation would authorize Part D coverage for medications explicitly indicated for weight reduction and long-term maintenance in individuals clinica diagnosed with obesity. This proposal aligns with the increasing medical consen that views obesity as a disease requiring targeted treatment. However, the exclus would continue to apply to individuals classified as overweight without meeting clinical criteria for obesity. The shift in coverage represents an alignment with o policies that cover medications for specific conditions such as AIDS-related was and cachexia. Furthermore, Medicaid programs would also be required to cover obesity medications for treating obesity under this proposal, broadening the sco access for vulnerable populations.

By expanding access to these medications, CMS aims to address the long-term h implications of obesity, such as its association with chronic diseases, hospitaliza and overall healthcare costs. This change could result in improved quality of life millions of beneficiaries while potentially reducing healthcare expenditures thro effective weight management and prevention of obesity-related conditions.

Enhancements to Medicare Advantage and Part D Programs

Addressing Prior Authorization and Utilization Management

Prior authorization practices within Medicare Advantage plans have long been a source of concern for beneficiaries and healthcare providers. Data suggests that significant portion of denials issued by MA plans are later overturned on appeal raising questions about the initial determination processes and the impact on pa care. In response, CMS is proposing several measures aimed at increasing transparency, consistency, and fairness in these processes.

Key changes include requiring MA plans to base their internal coverage criteria evidence-based guidelines in cases where Medicare statutes or regulations do no provide explicit guidance. This ensures that decisions are grounded in widely

accepted clinical standards, fostering consistency with Traditional Medicare cov
Additionally, MA plans would be required to involve healthcare professionals wi
relevant expertise before denying coverage for medical services, ensuring that
decisions are clinically sound and aligned with best practices.

To streamline prior authorization, CMS proposes limiting its use primarily to cc
diagnoses or validate medical necessity, rather than as a blanket barrier to acces
care. This reform includes a mandatory 90-day transition period for enrollees
undergoing treatment when switching MA plans, ensuring continuity of care.
Furthermore, MA plans would be required to establish Utilization Management
Committees tasked with annually reviewing prior authorization policies to ensu
alignment with Traditional Medicare guidelines and current clinical standards.

Strengthening Marketing and Consumer Protections

CMS is also targeting deceptive marketing practices within the Medicare Advan
and Part D programs. Beneficiaries have reported instances of misleading
advertisements and aggressive sales tactics, which can result in confusion and
suboptimal plan selection. To address this, CMS proposes banning advertisemer
that fail to specify plan names or that use misleading imagery or language, such
unauthorized references to Medicare.

In addition, CMS seeks to codify protections against high-pressure sales tactics.
example, agents would be prohibited from conducting sales presentations
immediately following educational events, which could otherwise blur the line
between education and marketing. Agents would also be required to disclose the
range of plans they sell and to conduct a standardized needs assessment for
beneficiaries. This assessment would ensure that plan recommendations conside
individual's healthcare needs, current providers, and prescriptions, ultimately h
beneficiaries make more informed choices.

Star Ratings and Quality Improvement

CMS has identified opportunities to refine the Medicare Star Ratings program t enhance its effectiveness as a quality measurement and improvement tool. Propc changes include eliminating restrictions on the movement of measure cut points non-CAHPS (Consumer Assessment of Healthcare Providers and Systems) measu which would allow more accurate reflection of plan performance. Additionally, C plans to modify the Improvement Measure hold harmless policy to incentivize meaningful quality enhancements.

Further, CMS is introducing stricter criteria for the removal of Star Ratings mea to maintain the program's integrity. The adjustments also address extreme circumstances, such as natural disasters, by removing rigid rules that could unfa penalize plans during uncontrollable events. These changes aim to ensure that tl Star Ratings system remains a fair and accurate tool for evaluating and incentivi high-quality care.

Improving Access to Behavioral Health Care Providers

Access to behavioral health services remains a critical area of focus for CMS, particularly in light of the growing recognition of mental health's role in overall being. In response to legislative changes, CMS proposes to update network adeq standards to include newly recognized behavioral health providers, such as marr and family therapists (MFTs) and mental health counselors (MHCs). By expandir range of providers included in network adequacy evaluations, CMS seeks to imp access to behavioral health services for Medicare enrollees.

In addition, the proposal incentivizes the inclusion of telehealth providers in MA networks. A 10% credit would be applied to plans that incorporate telehealth providers in the outpatient behavioral health specialty category, encouraging the of technology to overcome geographic and logistical barriers to care.

These measures aim to address longstanding disparities in access to mental heal care, ensuring that beneficiaries have timely access to a broad range of services, whether in-person or virtual. By broadening the scope of behavioral health provi

and promoting telehealth integration, CMS is prioritizing mental health as an essential component of comprehensive care.

Enhancing Utilization of Supplemental Benefits

Supplemental benefits offered by MA plans are often underutilized by beneficiar part due to a lack of awareness or understanding of the available options. CMS proposes a mid-year notification system to address this issue. Under this system, plans would be required to send personalized notifications to enrollees detailing unused supplemental benefits, such as dental, vision, or transportation services, the first six months of the plan year.

These notifications would provide comprehensive information on the scope of benefits, associated cost-sharing, access instructions, and relevant network detai equipping beneficiaries with clearer and more timely information, CMS aims to increase the utilization of these benefits, thereby improving enrollee satisfaction health outcomes.

Strengthening Oversight of Marketing Practices

Building on its efforts to address deceptive marketing, CMS proposes additional measures to enhance oversight of agents and brokers. Plans would be required t actively monitor agent activities and report non-compliance to CMS. Coordinati with state Departments of Insurance would also be emphasized to ensure that beneficiaries are protected from misleading or harmful practices.

This heightened oversight reflects CMS's commitment to safeguarding beneficia and ensuring that plan marketing and enrollment activities align with regulatory standards and ethical practices. By holding agents and brokers accountable, CM aims to restore trust in the Medicare Advantage and Part D programs.

Modernizing Consumer Tools

To further support beneficiaries in navigating the complex landscape of Medicar options, CMS plans to modernize consumer-facing tools on Medicare.gov. Enhancements to the Plan Finder tool would enable beneficiaries to more easily compare plans based on factors such as coverage, cost, and provider networks. B providing clearer, more user-friendly interfaces and resources, CMS aims to emp beneficiaries to make informed decisions that align with their healthcare needs a financial circumstances.

Program Integrity and Data Transparer

In addition to these beneficiary-focused changes, CMS is prioritizing program integrity and transparency. Proposed measures include stricter reporting requirements for plans, enhanced oversight of provider directories, and efforts t improve the accuracy and accessibility of data. By ensuring that plans meet rigor standards for transparency and accountability, CMS aims to strengthen trust in Medicare programs while preventing fraud, waste, and abuse.

Conclusion

CMS's proposed rule for the 2026 contract year represents a comprehensive effo enhance the Medicare Advantage, Part D, Medicare Cost Plan, and PACE progra By addressing issues such as coverage limitations, prior authorization, behaviora health access, and marketing practices, the rule seeks to improve the quality, accessibility, and equity of care for Medicare beneficiaries. These changes reflec broader commitment to modernizing Medicare to meet the evolving needs of its enrollees, ensuring that the program remains a cornerstone of health security fo millions of Americans.