MEDICARE ADDICTION PARITY Project

**Calendar Year (CY) 2026 Medicare Advantage Final Rule:**
Substance Use Disorder and Mental Health Provisions

April 2025

The Centers for Medicare & Medicaid Services (CMS) released its CY 2026 Medicare Advantage (MA) final rule on April 15, 2025. Each year, CMS issues proposed regulations to make policy and technical changes to Medicare Part C (the Medicare Advantage Program) and Part D (the Prescription Drug Benefit Program) for the upcoming calendar year. The Legal Action Center (LAC) responded to the proposed rule with public comments on a number of provisions affecting access to substance use disorder (SUD) and mental health (MH) Care. Notably, CMS only finalized some of the proposed provisions, and indicated that other provisions from the proposed rule "may be finalized in subsequent rulemaking, as appropriate." The following chart summarizes CMS's proposals, LAC's comments, the final rule, and our next steps.

| CMS Proposal | LAC Comment | CMS Final Rule | Next Steps (if applicable) |
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| **Aligning MA Cost-Sharing for Behavioral Health with Traditional Medicare:** Require MA and Cost Plan in-network cost-sharing to be no more than the cost-sharing amounts in Traditional Medicare. This proposal would cap coinsurance at 20% for intensive outpatient (IOP), MH specialty services, outpatient SUD services, partial hospitalization (PHP), and psychiatric services; with zero cost-sharing for opioid treatment program (OTP) services. Cost-sharing would also be aligned for inpatient hospital psychiatric services. | LAC strongly supported this proposal. | CMS did not finalize this proposal, nor did it address the comments to this provision. It may be addressed in future rulemaking. | Continue advocacy to CMS, and Congress if appropriate, to highlight the impact of cost sharing on access to SUD and MH care and finalize this proposal, as well as reduce other financial barriers to SUD and MH care. |

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| **MA Network Adequacy:** Modify the definition of "county" to include "county equivalents" for network adequacy evaluation purposes, limit the network adequacy exception request rationales, and conduct network adequacy reviews at the plan benefit package level rather than the contract level. | LAC supported these proposals, and encouraged CMS to develop separate network adequacy standards for SUD facilities and providers. | CMS finalized the proposals to modify the definition of county at 42 C.F.R. § 422.116.<br><br>CMS did not finalize the other proposals or address the comments, and did not indicate whether they may be addressed in future rulemaking. | Continue advocacy with CMS, and Congress if appropriate, to improve network adequacy and oversight of SUD and MH providers and facilities. |
| **Format Provider Directories for Medicare Plan Finder:** Require MA organizations to make their provider directories available to CMS to add to the Medicare Plan Finder for easier comparison across plans, and attest that such information is accurate and consistent with network adequacy requirements, and update the information no later than 30 days after notified of a change in provider information. | LAC supported this proposal. | CMS did not finalize this proposal, nor did it address the comments to this provision. It may be addressed in future rulemaking. | Continue advocacy to CMS, and Congress if appropriate, to improve transparency and accuracy of provider directories. |
| **Enhancing Rules on Internal Coverage Criteria:** Define "internal coverage criteria,"[1] require such criteria only be used to supplement or interpret the plain language or Traditional Medicare | LAC supported these proposals, but encouraged CMS to continue to require plans to demonstrate that any | CMS did not finalize this proposal, nor did it address the comments to this provision. It may be addressed in future rulemaking. | Continue advocacy with CMS, and Congress if appropriate, to ensure MA organizations are using coverage criteria |

[1] In the CY24 final rule, CMS began requiring MA plans to align their coverage criteria with those for Traditional Medicare. When the criteria in Traditional Medicare not fully established in statute, regulations, or national or local coverage determinations, then MA plans may develop or use their own "internal coverage criteria" that must be based on current evidence in widely used treatment guidelines or clinical literature. § 422.101(b).

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| criteria, and establish policy guardrails. MA plans would also be required to publicly post their internal coverage criteria on their websites. | internal coverage criteria have clinical benefits that are highly likely to outweigh clinical harm. | | that align with clinical standards for SUD and MH care and do not limit or deter access. |
| **Clarifying MA Determinations to Enhance Enrollee Protections in Inpatient Settings:** Clarify notice and appeal rights and requirements for concurrent review (when plans have pre-approved coverage or payment, but then require a provider to demonstrate that ongoing care is still necessary). Prohibit MA plans from using after-the-fact clinical information to reopen a decision to cover inpatient care. | LAC supported this proposal. | CMS finalized the rules as proposed: Concurrent review decisions are subject to notice requirements and can be appealed at §§ 422.566(b)(3), 422.138(c). New clinical information obtained after the initial approval for an inpatient hospital admission cannot be used to reopen a previous approval. §§ 422.616, 422.138. | |
| **Annual Health Equity Analysis of Utilization Management**: Enhance the health equity analysis of MA organizations' utilization management policies and procedures by adding an executive summary and disaggregating metrics by covered item and service. Requested comment on whether having a MH or SUD diagnosis should be a social risk factor for this analysis. | LAC supported this proposal and encouraged CMS to add having a MH or SUD diagnosis as a social risk factor for the health equity analysis. | CMS did not, and does not intend to, finalize this proposal.<br><br>CMS indicated it "will continue to review regulations and policies in the Medicare program and make necessary and appropriate changes to ensure consistency with the Executive Order 14192." This includes the annual health equity analysis of utilization management policies and procedures, as well as other equity requirements. | Continue advocacy with CMS, and Congress if appropriate, to ensure utilization management is not being used to deny needed care or exacerbate health disparities. |

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| **Agent and Broker Requirements:** Require agents and brokers to discuss with current and potential enrollees information about the low-income subsidy eligibility, Medicare Savings Programs, and Medigap. | LAC supported this proposal. | CMS did not finalize this proposal or address the comments. It did not indicate whether it may be addressed in future rulemaking. | Continue advocacy with CMS to ensure current and potential enrollees have meaningful access to information about affordable enrollment options. |
| **Guardrails for Artificial Intelligence:** Clarify that any use of artificial intelligence (AI) and automated systems by MA plans must preserve equitable access to MA services. | LAC supported this proposal and recommended some additional, more specific guardrails. | CMS did not, and does not intend to, finalize this proposal. It does 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. | Continue advocacy with Congress, CMS, and other relevant agencies to highlight problematic uses of AI and to ensure AI is not being used to deny access to needed care or to exacerbate health disparities. |
| **Quality Reporting:** Add Initiation and Engagement of SUD Treatment (IET) measure to the MA Star Ratings. | LAC supported this proposal and encouraged CMS to consider additional measures of SUD quality for the MA Star Ratings. | CMS did not finalize this proposal or address the comments. It did not indicate whether it may be addressed in future rulemaking. | Continue advocacy with CMS to improve data collection, transparency, and accountability for quality SUD care in MA plans, as well as in Traditional Medicare.<br><br>Continue advocacy with Congress and CMS to reduce barriers to quality SUD care and close remaining gaps in coverage and access. |

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| **Dually Eligible Enrollees:** Require certain dual eligible special needs plans (D-SNPs) to have a single, integrated member ID card, conduct a comprehensive health risk assessment (HRA) within 90 days of enrollment, and develop an individualized care plan (ICP) within 30 days after the HRA for enrollees. Require these plans to solicit feedback from the Enrollee Advisory Committee (EAC) on the HRA, ICP, and Model of Care (MOC). Requested comment on making State Medicaid Agency Contracts (SMAC) publicly available online. | LAC supported these proposals and encouraged CMS to require SMACs to be publicly available. | CMS finalized the proposal for certain D-SNPs to have a single, integrated member ID card. § 422.2267(e)(32)(viii).<br><br>CMS finalized the proposal for certain D-SNPs to complete a single, integrated HRA, but delayed the effective date to January 2027. § 422.101(f)(1).<br><br>CMS finalized the proposal to require a single, integrated ICP, but extended the timeframe for it to be developed to 90 days after the HRA or enrollment, whichever is later. § 422.101(f)(1)(vii).<br><br>CMS did not address the proposal to require D-SNPs to solicit feedback from the EAC.<br><br>CMS received overwhelming support for making SMACs publicly available and will begin working through the operational process to make that possible. | Continue advocacy with CMS to improve access to care for dually eligible individuals and apply the Mental Health Parity and Addiction Equity Act to D-SNPs, and all Medicare plans, to ensure enrollees with SUD and MH conditions are not subject to discriminatory barriers to care. |