Table of Key Provisions in AAHomecare's Comments in Response to the Contract Year 2026 Medicare Advantage and Part D Proposed Rule and CMS'S Responses in the Final Rule

Below is a summary of the key provisions that AAHomecare raised in its comment letter for CMS's Contract Year 2026 Medicare Advantage (MA) and Part D Proposed Rule and an update on CMS's responses in the Contract Year 2026 Final Rule, which CMS issued on April 15, 2025. The below table categorizes AAHomecare's comments under each of the seven topics included in the comment letter, with excerpts of AAHomecare's comments (as background) under each topic. Each topic has its own table comparing AAHomecare's specific requests in the comment letter and CMS's related determination in the Final Rule.

Notably, CMS in the Final Rule declines to finalize several key provisions from the Proposed Rule, though in some cases, CMS is deferring finalization to subsequent rulemaking. Additionally, CMS appears to be defining the "scope" of comments strictly, noting that it "received approximately 31,227 timely pieces of correspondence containing multiple comments on the proposed rule," but "some of the public comments were outside of the scope of the proposed rule," and the "out-of-scope public comments are not addressed in this final rule."

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I. Enhancing Rules on 'Internal Coverage Criteria'

AAHomecare comments: CMS … proposes to amend 42 C.F.R. § 422.101(b)(6)(i)(A) to "make it explicitly evident that internal coverage criteria may only be used to supplement or interpret already existing" Medicare coverage and benefit rules. CMS proposes to define "internal coverage criteria" to include "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, LCDs, or CMS manuals and are adopted or relied upon by an MA organization for purposes of making a medical necessity determination," noting that CMS manuals are not "internal coverage criteria" for MAOs. CMS proposes to replace the requirement that MA plans must "demonstrate that the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services" with policy guardrails for all internal coverage criteria, including prohibitions against: (1) criteria that do not have clinical benefit, and (2) criteria used to automatically deny coverage of "basic benefits without the MA organization making an individual medical necessity determination as required" by the regulations. Further, CMS proposes that, by January 1, 2026, MAOs must publicly display a list of all Part A and Part B items and services for which the MAO uses internal coverage criteria when making medical necessity decisions.

AAHomecare Comments (Proposed Rule)	CMS Determinations in the 2026 Final Rule
AAHomecare appreciates CMS's efforts to ensure that MA plans do not arbitrarily deny service based on internal coverage criteria, and we support CMS's proposal to require public disclosure of items and services for which internal coverage criteria are used … we recommend that CMS finalize these proposals.	CMS included "Enhancing Rules on Internal Coverage Criteria" (amendments to 42 C.F.R. §422.101) on its table of proposed provisions "that a decision to be finalized is deferred for subsequent rulemaking" (*see* Table 4—PRA-Related Provisions of Proposed Rule That a Decision To Be Finalized Is Deferred for Subsequent Rulemaking).
Additionally, we respectfully request that CMS ensure that MAOs comply with all internal coverage criteria requirements, including these enhanced protections, for DME.	
AAHomecare respectfully requests that CMS … explain that MA plans cannot interpret CMS coverage policies in a manner that limits beneficiary access to items and services available under FFS, including DME items.	
We respectfully request that CMS exercise its existing authority to limit MA plans' use of internal coverage criteria for DME items when criteria is more restrictive than … original (FFS) Medicare.	
MA plans also often deny beneficiary access to medically necessary accessories and associated electronics on Group 3 complex power wheelchairs. Despite clear coverage requirements, MA plans have not provided access in accordance with CMS policy: MA plans have denied the very items and services that DME MACs cover under the published LCD, associated policy articles, and a "Power Wheelchair Electronics Clarification" article. We therefore respectfully request that CMS use its existing authority to make clear that MA plans cannot reinterpret CMS's clear cover-age policies for DMEPOS items.	

II. Guardrails for Artificial Intelligence (AI).

AAHomecare comments: In response to the increase in utilization of AI technology in healthcare, and in alignment with key civil rights provisions in the *Executive Order on the Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence* (October 30, 2023), CMS in the 2026 Proposed Rule states that "it is necessary to ensure that the use of AI does not result in inequitable treatment, bias, or both, within the healthcare system..." As such, CMS proposes to revise existing regulations under § 422.112(a)(8) "to ensure services are provided equitably irrespective of delivery method or origin, whether from human or automated systems," and that, if a MA plan uses AI or an automated system, those technologies comply with the anti-discrimination requirements of § 1852(b) of the Social Security Act (the Act), and with 42 C.F.R. § 422.110(a), which prohibits MA organizations from "deny[ing], limit[ing], or condition[ing] the coverage or … benefits … on the basis of any factor that is related to health status," such as medical condition or history, genetic information, and disability, among others.

AAHomecare Comments (Proposed Rule)	CMS Determinations in the 2026 Final Rule
AAHomecare supports CMS's proposal, and we recommend that CMS finalize these provisions.	CMS declined to finalize this provision: "We also do not intend to finalize the following provisions from the proposed rule: Enhancing Health Equity Analyses: Annual Health Equity Analysis of Utilization Management Policies and Procedures, Part D Coverage of Anti-Obesity Medications (AOMs) and Application to the Medicaid Program, and Ensuring Equitable Access to Medicare Advantage Services— Guardrails for Artificial Intelligence (AI). 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."
…[W]e respectfully request that CMS take further steps to prevent discrimination against MA beneficiaries who rely on use of DME items to manage their health conditions…	

III. Network Adequacy Requirements for Medicare Advantage.

AAHomecare comments: Section 1852(d)(1)(A) of the Act authorizes MA organizations to "select the providers from which an enrollee may receive covered benefits," provided that the organizations make "such benefits available and accessible in the service area" in which the beneficiaries reside. CMS uses the "county level" to determine the amount and type or providers and facilities with which an MA organization must contract to ensure adequate access for beneficiaries in an area. To ensure consistency in the application of CMS's network adequacy standards throughout the U.S., CMS proposes to define "county," under 42 C.F.R. § 422.116, to include "county equivalents" (as recognized by the U.S. Census Bureau), and amend the regulatory definition of "service area," under § 422.2, in conformity with this change.

AAHomecare Comments (Proposed Rule)	CMS Determinations in the 2026 Final Rule
AAHomecare recommends that CMS finalize these provisions. By clearly defining an MAO's designated area, CMS can help ensure that MA plans adhere to network adequacy standards by ensuring an adequate number of providers for the area. Additionally, we respectfully request that CMS ensure that MAOs adhere to network adequacy standards regarding DMEPOS access.	CMS finalized the definitions for "service area" and "county": "… CMS currently uses counties and county-equivalents to establish network adequacy standards and to apply the network adequacy requirements. The changes herein serve to clarify, in our regulations, that CMS uses the Census Bureau's designation of county and county-equivalent in establishing network adequacy standards. Therefore, we agree with commenters that this clarification would promote

AAHomecare Comments (Proposed Rule)	CMS Determinations in the 2026 Final Rule
We again respectfully request that CMS establish metrics to determine when network adequacy has been met for each product category in the DMEPOS space. CMS currently has established time and distance requirements for many other provider types…	consistency. It does not impose any new requirements and therefore should not require additional guidance. Under the current rules, and the changes we are finalizing, organizations will continue to be able to use the exception request process outlined at § 422.116(f) in any service area, including in rural and underserved counties and county-equivalents, where they are unable to satisfy CMS network adequacy requirements. We agree that these proposals will allow us to continue to ensure consistency in CMS's application of network adequacy standards throughout MA organizations' existing and future service areas." "… CMS is finalizing its proposals to modify the definition of service area in § 422.2, and to add a definition of county in § 422.116 that includes county-equivalent for network adequacy purposes. The finalization of our proposals clarifies our longstanding policy and interpretation of the term 'county' for network adequacy determination purposes."
Moreover, we respectfully ask that CMS require MAOs to submit data demonstrating compliance with network-adequacy standards for DMEPOS, such as number of in-network suppliers, by product category and by geography, and beneficiary satisfaction data.	
Further, there should be a clear channel within CMS that DMEPOS suppliers can use to escalate concerns about patient access issues.	

IV. Annual Health Equity Analysis of Utilization Management Policies and Procedures.

AAHomecare comments: In the Contract Year 2024-2025 MA and Part D Final Rule … CMS enacted health equity regulations, under 42 C.F.R. § 422.137, which included requiring MAOs' utilization management committees to conduct annual health equity analyses on prior authorization (PA) use. In comments for the 2025 Final Rule, stakeholders recommended that CMS require disaggregation by item and service to help the agency better identify specific items or services that may be disproportionately denied. In response to these comments, CMS in the 2026 Proposed Rule proposes to amend §§ 422.137(d)(6)(iii)(A) – (H) to revise the required metrics for the annual health equity analysis to require metrics reporting for each item or service, rather than aggregated amounts. If finalized, starting in 2025, analyses must include the following metrics for each covered item or service: percentage of PA requests that were approved, denied, approved after appeal, had extended review timeframes and were approved, had expedited PA requests and were approved, had expedited PA requests and were denied, and average and median time elapsed between PA request submission and determination by the MA plan (standard and expedited).

AAHomecare Comments (Proposed Rule)	CMS Determinations in the 2026 Final Rule
AAHomecare appreciates CMS's consideration of comments requesting disaggregation by item and service, and we recommend that CMS finalize these proposed regulatory revisions.	CMS is declining to finalize these provisions. However, CMS retains the possibility of future changes through the Trump Administration's ongoing "deregulation" efforts:

AAHomecare Comments (Proposed Rule)	CMS Determinations in the 2026 Final Rule
AAHomecare respectfully proposes further policies to improve MA plans' PA processes, with the concomitant need for MA plans to provide public data demonstrating that they are not inappropriately denying PA requests or patient access to care, including for DMEPOS items: • MA plans should publish data on appeal processes for PA decisions for DMEPOS. • MA plans should be required to publicly disclose and report use of AI as part of the claims processing or PA processes, related to DMEPOS items. • MA plans should publicly disclose and report all PA statistics for DME items, by product category. • Affirmative PA decisions should not be subject to reversal based on medical need.	"CMS 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, 'Unleashing Prosperity Through Deregulation.' Such regulations and policies currently under review include but are not limited to … Annual health equity analysis of utilization management policies and procedures…" "We … do not intend to finalize … Enhancing Health Equity Analyses: Annual Health Equity Analysis of Utilization Management Policies and Procedures…"

V. Promoting Transparency for Pharmacies and Protecting Beneficiaries from Disruptions.

AAHomecare comments: CMS is proposing to require Part D plan sponsors and first tier, downstream, or related entities, such as pharmacy benefit managers (PBMs), to notify network pharmacies, by October 1 of the year preceding a plan year, about the plans for which the pharmacies will be "in-network." Pharmacies must be given lists of these plans upon request. CMS further proposes to require contracts with pharmacies for participation in Part D networks, which allow plan sponsors to terminate without cause, to also permit the pharmacies to terminate the contracts without cause.

AAHomecare Comments (Proposed Rule)	CMS Determinations in the 2026 Final Rule
AAHomecare appreciates CMS's efforts to protect beneficiaries from disruptions in care, due to changes in contracts between plan sponsors and pharmacies. We recommend that CMS finalize these proposals.	CMS does not appear to directly address this "in network" provision from the Proposed Rule. However, CMS does finalize the proposed modification to 42 C.F.R. § 423.505 to add the requirement that all Part D plan sponsor contracts with these entities contain a provision requiring the pharmacies to be enrolled in the Medicare Transaction Facilitator Data Module
AAHomecare respectfully asks that CMS use its existing authorities to enforce, and to ensure MAO compliance with, all applicable requirements for the MA program … we urge CMS to clarify that an MA plan cannot maintain in effect any medical necessity or medical review policy that is more restrictive than … the original (FFS) Medicare program.	

AAHomecare Comments (Proposed Rule)	CMS Determinations in the 2026 Final Rule
… AAHomecare is aware that some MA plans shifted coverage for CGMs and related supplies from the DME medical benefit to the Part D pharmacy benefit; similar to dispensing limitations, coverage shifts disrupt care for beneficiaries enrolled in these plans. AAHomecare respectfully asks that CMS expand its proposed transparency efforts and beneficiary protections by requiring MA plans to disclose which of the benefits the plans cover under Part D are also covered under Part B.	(MTF DM), which addresses the IRA's drug price negotiation provision: "We believe the inclusion of the requirement for Part D sponsors' network pharmacies to be enrolled in the MTF DM that will be added to Part D sponsors' network contracts with pharmacies will facilitate continued beneficiary access to selected drugs that are covered Part D drugs, promote access to negotiated MFPs under the Negotiation Program for both beneficiaries and dispensing entities, and help ensure accurate Part D claims information and payment."
…[W]e respectfully request that CMS issue rulemaking or guidance to clarify that CGMs, their related supplies, and other items covered by Medicare Part B within the DMEPOS benefit, are excluded from Part D. This is consistent with the Medicare Part D Manual definition of Part D covered drugs.	

VI. Formulary Inclusion and Placement of Generics and Biosimilars.

AAHomecare comments: CMS is seeking comments on "the prevalence of manufacturer rebates and the extent to which such rebates influence formulary decisions that reduce Part D beneficiaries' access to generics, biosimilars, and other lower cost drugs," and whether CMS should take further programmatic actions to prevent exclusions or disfavoring of generic, biosimilar, or lower-cost drugs.

AAHomecare Comments (Proposed Rule)	CMS Determinations in the 2026 Final Rule
…We recommend that CMS proceed with enacting protections in future rulemaking or guidance.	CMS is not finalizing the provision as proposed; according to the agency, there are already formulary review processes in place. CMS may "consider codifying additional requirements" if further oversight of formularies is needed: "With respect to the section of the proposed rule entitled 'Formulary Inclusion and Placement of Generics and Biosimilars,' CMS continues to encourage Part D sponsors to prioritize formulary placement for generics and biosimilars through favorable tier placement relative to branded and reference products. As we noted in the proposed rule, CMS currently conducts an extensive formulary review process to ensure Part D sponsors provide an adequate formulary consistent with § 423.120(b)(2)." "… we have been monitoring beneficiary access to generics and biosimilars, utilization of multi-source brand drugs when generics are available, and situations where the brand drug is situated more favorably in comparison to the generic with regard to tiering and [utilization management], and we will continue to do so. While we are not adding the additional step in our formulary review process described in the proposed rule, the policy reminders and clarifications with respect to Part D plan formularies providing broad access to generics and biosimilars as part of a cost-effective drug utilization program still apply. CMS may consider codifying additional requirements regarding formularies in future rulemaking if necessary."
…[W]e respectfully request that CMS address MA plan policies to exclude certain providers from dispensing DMEPOS...	

VII. Promoting Informed Choice—Expand Agent and Broker Requirements

AAHomecare comments: CMS is proposing to expand the list of requirements that agents and brokers must discuss with customers to include low-income supports (e.g., the Part D Low-Income Subsidy, Medicare Savings Programs, etc.), information on Medigap Federal guaranteed issue (GI) rights, implications of switching from MA to FFS Medicare, and requiring agents to answer questions before proceeding with enrollment...

AAHomecare Comments (Proposed Rule)	CMS Determinations in the 2026 Final Rule
AAHomecare supports these proposals and encourages CMS to finalize these policies … brokers should discuss Medigap coverage and ensure that beneficiaries are aware of potential restrictions on their ability to access Medigap in the future.	CMS included "Promoting Informed Choice—Enhancing Review of Marketing & Communications" (amendments to 42 C.F.R. § 422.2260 and 42 C.F.R. § 423.2260) on its table of proposed provisions "that a decision to be finalized is deferred for subsequent rulemaking" (*see* Table 4—PRA-Related Provisions of Proposed Rule That a Decision To Be Finalized Is Deferred for Subsequent Rulemaking).