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Center for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4208-P
By electronic submission at: http://www.regulations.gov

P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

To Whom It May Concern:

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal lawmakers. The Panel is pleased to offer comments in response to the proposed rules for Contract Year 2026. Our comments focus specifically on implications for rural healthcare delivery and access.

As context for our comments, we note the increasing importance of Medicare Advantage (MA) in rural America. Previous RUPRI analyses document that MA enrollment growth rates are higher in rural counties than in metropolitan counties. This rapid growth creates both opportunities and challenges that must be carefully considered in rulemaking.

Promoting Transparency for Pharmacies and Protecting Beneficiaries from Disruptions

The Panel supports the proposed requirements for Part D sponsors to notify network pharmacies of their plan participation status by October 1 and to allow reciprocal without-cause contract termination rights. These protections are particularly critical in rural communities where there may be only one pharmacy serving Medicare beneficiaries. A sole rural pharmacy provider's network status affects the ability to serve beneficiaries where they live, and reduction in beneficiary use may jeopardize the ability to remain in business, affecting access more broadly. We encourage CMS to monitor the implementation of these requirements with particular attention to impacts on rural independent pharmacies.

Request for Information on Access to Pharmacy Services and Prescription Drugs

We commend CMS's explicit recognition of concerns about pharmacy sustainability in rural and underserved areas. The Panel agrees that pharmacy closures pose particular risks in rural communities where alternative access points may be distant or nonexistent. We recommend CMS closely examine reimbursement rates and contracting terms through a rural lens to ensure Part D network adequacy standards to effectively safeguard beneficiary access. .

Promoting Community-Based Services and Enhancing Transparency of In-Home Service Contractors (§ 422.2, 422.111)

The Panel appreciates CMS's efforts to enhance transparency regarding community-based organizations (CBOs) providing MA benefits. We recommend expanding the proposed CBO definition to better reflect rural realities. Specifically:

- Faith-based organizations should be explicitly included, as churches often address health-related social needs in rural communities.
- Senior centers should be specifically named, as they commonly provide services in rural areas.
- The requirement that organizations "apply for grants or contract with health care entities" may inappropriately exclude small, volunteer-run rural programs that lack grant-writing capacity.

The Panel also recommends that provider directories be updated frequently given rural workforce dynamics.

Medicare Advantage Network Adequacy (§ 422.116)

The Panel supports CMS's consideration of conducting network adequacy reviews at the plan benefit package level rather than the contract level. A granular assessment would provide greater transparency regarding actual network availability in rural areas. Rural areas often have fewer MA plan choices, and contract-level assessment may mask important differences in network adequacy between urban and rural service areas within the same contract. A recent analysis from the Kaiser Family Foundation found that Medicare beneficiaries in metropolitan areas have access to an average of 46 MA plans, while those in micropolitan areas have 31 plans available, and rural beneficiaries have only 27 plans to choose from. Additionally, fewer MA organizations operate in rural areas, with an average of 6 firms offering plans compared to 10 firms in metropolitan areas. To illustrate the need for network adequacy standards at the plan level, consider this example from Iowa. Humana's contract H1651 has 8 plans available across 31 counties, but in 24 counties only 1 of those plans was available. Allowing adequacy to be met at the contract level across all plans may disguise access issues in some counties.

We recommend CMS carefully evaluate how plan-level assessment could affect MA organizations' decisions about rural market entry. Would MA organizations leave counties where they currently have only plan? What are the consequences for beneficiaries in those counties? We suggest prioritizing network adequacy standards, as plan availability without meeting these standards may ultimately disadvantage beneficiaries. At the same time, we recognize the need to balance network adequacy with ensuring beneficiaries have a range of choices.

Promoting Informed Choice—Expand Agent and Broker Requirements Regarding Medicare Savings Programs, Extra Help, and Medigap (§§ 422.2274 and 423.2274)

The Panel supports enhanced requirements for agents and brokers to discuss Medicare Savings Programs, Extra Help, and Medigap implications. These requirements are particularly important in rural areas where:

- Broker utilization may be proportionally higher.
- Recent enrollment growth could be driven by broker activity. For example, in the interest of generating fees by selling MA plans to beneficiaries, brokers may not provide an adequate balance of information regarding MA plans and Traditional Medicare.

- Beneficiaries could have fewer opportunities for in-person counseling.

We recommend CMS consider requiring disclosure of broker compensation arrangements to promote transparency and informed decision-making, although this may be beyond current statutory authority.

Strengthening Requirements Related to Notice to Providers (§§ 422.568, 422.572, and 422.631)

The Panel supports strengthening requirements for MA organizations to notify providers regarding network inclusion determinations. This notification is especially critical in rural areas experiencing rapid MA enrollment growth where providers may be less familiar with MA processes.

Thank you for considering these comments. The Panel welcomes the opportunity to provide additional rural health expertise as needed.

Respectfully submitted,

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