Regulatory Compliance in 2026 and Beyond

Updated as of 1/15/2026

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PRWORA

- **Effective Date: Effective immediately, starting July 10, 2025**
- **Summary of the rule: Health and Human Services (HHS) rescinded the 1998 interpretation of the Personal Responsibility and Work Opportunity Act (PRWORA), which had previously excluded 330 grantees and others from the definition of 'federal public benefits' when complying with restrictions of federal public benefits to "illegal aliens".**

- Specific provisions for implementation in 2026:
    - Prohibits 330 grantees from providing services under their grant or other federal funds to 'illegal aliens.'
    - At this time, federally qualified health centers do not need to verify immigration status
- *Preliminary injunction in 22 states that has paused implementation until further legal action: New York, Washington, Rhode Island, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Nevada, Minnesota, New Jersey, New Mexico, Oregon, Vermont, and Wisconsin.*

Marketplace Affordability and Integrity Rule

- **Effective Date: Various implementation dates starting August 25, 2025**
- **Summary of the rule: HHS changed Marketplace regulations to protect consumers from improper enrollment and adjustments to their health coverage while strengthening the integrity of the Marketplace (federal and state-based). Some changes only apply to the 2026 plan year.**
- Specific provisions for implementation in 2026:
    - Disqualified DACA recipients from enrollment in a qualified health plan (QHP), premium tax credit (PTC), advanced premium tax credit (APTC), cost-sharing reduction (CSR), or a basic health plan (BHP). *(Effective immediately)*
    - The Special Enrollment Period (SEP) for APTC-eligible individuals with household income at or below 150 percent of the federal poverty level (FPL) will no longer be available. This applies to Marketplace Exchanges and Group and Individual Health Insurance Markets *(Only for Plan Year 2026)*
- *The following provisions, originally scheduled to begin in 2026, are delayed due to a lawsuit:*
    - All Federal Marketplaces are now required to verify income before enrollment for at least 75% of new enrollments in SEPs. This does not apply to State-based Marketplaces.
    - All Exchanges must flag income differences if someone reports their annual household income as between 100% and 400% of the Federal Poverty Level (FPL), but official data shows it's below 100% of the FPL.
    - CMS will no longer accept self-attestation of income on all Exchanges without verification when the Internal Revenue Service (IRS) does not have the tax return data to verify.
    - Issuers can attribute payment of premium for new coverage to past-due premiums for prior coverage.

    - A required $5 premium responsibility to consumers who are automatically re-enrolled with no premium responsibility, following application of APTC, who do not affirm or update their information (only for Federal marketplaces, not State exchanges.)
- Additional NACHC resources:
    - NACHC blog, NACHC factsheet, NACHC comparison chart

CY2026 Medicare Advantage (MA) and Part D rule

- **Effective Date: Effective June 3, 2025 (applicable to coverage starting January 1, 2026, unless noted)**
- **Summary of the rule: The CY2026 MA and Part D final rule implements changes related to prescription drug coverage, the Medicare Prescription Payment Plan, dual eligible special needs plans (D-SNPs), Star Ratings, and other programmatic areas, including the Medicare Drug Price Negotiation Program (MDPNP).**
- Specific provisions for implementation in 2026 and 2027:
    - Finalizes a definition of "organization determination" to include when a Medicare Advantage (MA) plan makes a decision about whether something is covered while the patient is receiving care. Also makes official the requirement that MA plans must inform both the patient and the medical provider about what is covered. Additionally, it clarifies that a patient cannot be held responsible for payment until the MA plan has reviewed the provider's bill and made an official decision regarding payment.
    - New federal requirements for certain dual eligible special needs plans (D-SNPs) to, by 2027:
        - 1) have integrated member identification (ID) cards that serve as the ID cards for both the Medicare and Medicaid plans in which an enrollee is enrolled; and
        - 2) conduct an integrated health risk assessment (HRA) for Medicare and Medicaid, rather than separate HRAs for each program.
    - Codified statutory requirements that, effective for plan years beginning on or after January 1, 2023, the Medicare Part D deductible shall not apply to, and there is no cost sharing for, an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP) and covered under Part D AND the Medicare Part D deductible does not apply to covered insulin products, AND the Part D cost-sharing amount for a one-month

supply of each covered insulin product must not exceed the covered insulin product applicable cost-sharing amount

- Beginning in 2025, the Medicare Prescription Payment Plan requires all Medicare Prescription Drug Plans (Part D plans) to offer Part D enrollees the option to pay their out-of-pocket (OOP) prescription drug costs in the form of monthly payments over the course of the year instead of all at once at the pharmacy.
- Initial prescription drug events (PDE) records are due within 30 calendar days following the date the claim is received by the Part D sponsor.
- Adjustment and deletion of PDE records are due within 90 calendar days following discovery of the issue requiring a change to the PDE.
- Resolution of rejected PDE records is due within 90 calendar days following the receipt of the rejected record status from CMS.
- Established a distinct PDE submission timeliness requirement for selected drugs under the Medicare Drug Price Negotiation Program, in which Part D sponsors must submit initial PDE records within seven calendar days from the date the Part D sponsor (or its contracted first-tier, downstream, or related entity) receives the claim.
- Part D sponsors' network participation agreements with contracting pharmacies, including any contracts with first-tier, downstream, and related entities, must require such pharmacies to be enrolled in the MTF DM and that such pharmacies certify the accuracy and completeness of their enrollment information in the MTF DM.

CY26 Medicare Physician Fee Schedule (PFS) rule

- **Effective Date: Effective January 1, 2026**
- **Summary of the rule: The Physician Fee Schedule is the major Medicare annual payment rule that impacts payments for Community Health Centers and other Medicare providers.**
- Specific provisions for implementation in 2026:
  - In this final rule, for the first time in six years, CMS finalized an increase in physician payments. The CY 2026 PFS Conversion Factor is $33.5675 for clinicians who meet certain participation thresholds in Advanced Alternative Payment Models (APMs) and $33.4009 for other clinicians.
  - Beginning in 2026, most non-time-based services will get a 2.5% reduction in their work values. This means Medicare payment rates will be lowered to reflect that many medical procedures have become faster and more

efficient over time. However, time-based services, like office visits (evaluation/management), behavioral health, and telehealth, won't be affected, so primary care providers may benefit as their services become relatively more valued compared to procedures.

- Add-on codes for Behavioral Health Integration (BHI) and Psychiatric Collaborative Care Model (CoCM) services when CHCs are providing advanced primary care management (APCM) were finalized (HCPCS code G0568, G0569, and G0570. This moves to further integrate behavioral health services into primary care.
- CMS retained the Healthcare Common Procedure Coding System code (G0136) that describes social determinants of health risk assessment, but revised its descriptor to refer to "upstream drivers" of health rather than "social determinants."
- Six new RPM (Remote Patient Monitoring) & RTM (Remote Therapeutic Monitoring) CPT codes were finalized by CMS for 2026, adding flexibility for shorter monitoring periods (2-15 days for RPM/RTM devices like 99445, 98984) and shorter care management times (10-19 mins for RPM like 99470, 98979), allowing providers to bill for crucial short-term or transitional care that previously fell below minimum thresholds, especially for conditions like respiratory, musculoskeletal, and cognitive-behavioral issues. Some of those Medicare codes have lower valuations than expected.
- Permanent definition of direct supervision now allows provider supervision through real-time audio and visual interactive telecommunications (excluding audio-only).
- CHCs can furnish non-behavioral health visits furnished via telehealth, including audio-only, by reporting HCPCS code G2025 through December 31, 2026. However, Congress still needs to act and extend it beyond the January 30, 2026, deadline they established in their continuing resolution to reopen the federal government.
    - See also: CMS FAQ on Telehealth (11/14/25), NACHC FAQ on the government shutdown (11/6/25)
- Under the Medicare Prescription Drug Inflation Rebate Program, CMS established a claims-based methodology to remove 340B units from Part D rebate calculations and a voluntary Medicare Part D Claims Data 340B Repository for Part D claims with dates of service on or after starting on January 1, 2026.
- Starting January 1, 2027, the Medicare Shared Savings Program (MSSP) quality performance standards and reporting requirements were updated:
    - Maximum of 5 Program Years (PYs) for ACOs on the BASIC track (instead of 7 years) & requirement that ACOs have at least 5,000 assigned Medicare FFS beneficiaries. NACHC is concerned that this change could push CHCs into full risk before they are ready.

    - Allows an ACO that does not meet the 5,000 minimum assigned beneficiary threshold in one or more of its benchmark years to participate in the MSSP. This is a positive step forward and could increase CHC participation in ACOs.
- Additional NACHC resources:
    - NACHC December 2025 webinar slides

Medicare Drug Price Negotiation Program (MDPNP) as part of the Inflation Reduction Act (IRA)

- **Effective Date: January 1, 2026, with additional drugs added every year**
- **Summary of the rule: The Inflation Reduction Act (IRA), signed into law on August 16, 2022, introduced significant changes across multiple sectors, including health care. The IRA established the Medicare Drug Price Negotiation Program (MDPNP) to enable the federal government to negotiate the prices that Medicare pays for selected drugs. As part of the MDPNP, the Centers for Medicare and Medicaid Services (CMS) has negotiated 'maximum fair prices' (MFP) for 10 drugs beginning January 1, 2026.**
- Specific provisions for implementation in 2026:
    - The 2026 drugs are: Eliquis, Enbrel, Entresto, Farxiga, Imbruvica, Januvia, Jardiance, Novolog/FIASP, Stelara, Xarelto.
    - Pharmacies planning to dispense Medicare Part D drugs need to enroll in the Medicare Transaction Facilitator (MTF) so they can receive payment from drug manufacturers.
- Additional NACHC resources:
    - NACHC webpage

340B Rebate Model Pilot Program

- **Effective Date: January 1, 2026 (POSTPONED UNTIL FURTHER LEGAL ACTION)**
- **Summary of the rule: Beginning January 1, 2026, all covered entities, including community health centers (CHCs) must pay the full price upfront for selected drugs dispensed to 340B eligible patients under HRSA's 340B Rebate**

Model Pilot Program. This reverses the traditional 340B model in which discounts are applied upfront. The approved drugs are Eliquis, Enbrel, Entresto, Farxiga, Imbruvica, Januvia, Jardiance, Novolog/FIASP, Stelara, and Xarelto. Novartis's plan for Entresto was approved with a delayed implementation of April 1, 2026.

- Additional NACHC resources:
  - NACHC webpage

Notice of Benefit and Payment Parameters (NBPP) for 2026

- **Effective Date: January 15, 2025**
- **Summary of the Rule: This annual rule sets standards for the Health Insurance Marketplaces, both Federal and State, as well as for health insurance issuers, brokers, and agents who connect millions of consumers to ACA coverage.**
- Specific provisions for implementation in 2026:
  - CMS can take enforcement actions against insurance agents to hold them responsible for violations of Marketplace standards, such as suspending an agent or broker's ability to transact information with the Marketplace if they discover circumstances that pose an unacceptable risk to the accuracy of Marketplace eligibility determinations, operations, applicants, or enrollees, or Marketplace information technology systems.
  - The model consent form, a document created by CMS to help agents, brokers, and web-brokers document consent from consumers to assist with their Marketplace enrollments and submission of Marketplace eligibility applications, has been updated.
  - Application filers can now file appeals on behalf of applicants and enrollees on the application filer's Exchange application.
  - Health insurance issuers were granted flexibility to avoid terminating coverage when enrollees underpay their premiums by implementing a fixed-dollar premium payment threshold/, a net premium threshold, or a gross premium threshold. CMS increased the fixed-dollar threshold to $10, decreased the gross premium percentage-based threshold to 98% from 99%; and the final rule will allow issuers to select a fixed-dollar threshold in tandem with one of the two percentage-based thresholds.

- The approach for conducting Essential Community Provider (ECP) certification reviews of Qualified Health Plans (QHPs) in Federally Facilitated Marketplaces (FFMs) in states performing plan management functions has been updated to ensure issuers include in their provider networks enough and geographic distribution of ECPs.
- Issuers offering multiple standardized plan options within the same product network type, metal level, and service area must meaningfully differentiate between plans. Language was included to clarify that issuers may vary the inclusion of "adult dental benefit coverage, pediatric dental benefit coverage, **and** adult vision benefit coverage", instead of "adult dental benefit coverage, pediatric dental benefit coverage, **and/or** adult vision benefit coverage" to enhance clarity and minimize risk of confusion
- Marketplaces must notify enrollees or their tax filers who have failed to file their federal income taxes and reconcile their Advanced Premium Tax Credits (APTC) for two consecutive tax years that they are at risk of losing APTC. Failing to do so (often called Failure to File and Reconcile or "FTR") means a consumer will no longer be eligible for APTC.

Confidentiality of Substance Use Disorder Patient Records rule

- **Effective Date: The Rule went into effect on April 16, 2024, and Part 2 programs must come into full compliance by February 16, 2026.**
- **Summary of the rule: The Rule aims to better align Part 2 with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule while reducing the administrative and compliance burden on Part 2 programs, covered entities, and business associates.**
- Specific provisions for implementation in 2026:
  - Patients may now provide a single consent for all future uses and disclosures for treatment, payment, and health care operations.
  - Part 2 programs are permitted to create and maintain Substance Use Disorder (SUD) counseling notes. Patients must sign a separate consent form for the use and disclosure of their SUD counseling notes.

    - Part 2 programs are prohibited from disclosing Part 2 protected records in legal proceedings, unless the patient provides written consent or a court order authorizes the use or disclosure, and a subpoena compels the use or disclosure.
- Additional NACHC resources:
    - NACHC factsheet

Public Service Loan Forgiveness (PSLF) rule

- **Effective Date: July 1, 2026**
- **Summary of the rule: The Department of Education finalized a rule that changes the qualification standards for employers who participate in the Public Service Loan Forgiveness (PSLF) program to ensure federal funds are not used to support illegal activities.**
- Specific provisions for implementation in 2026:
    - No payment will be credited to a borrower who works for an employer engaging in activities of substantial illegal purpose after July 1, 2026.
    - "Substantial illegal purpose" is defined as:
        - aiding or abetting violations of 8 U.S.C. 1325 or other Federal immigration laws;
        - supporting terrorism, including by facilitating funding to, or the operations of, cartels designated as Foreign Terrorist Organizations consistent with 8 U.S.C. 1189, or by engaging in violence for the purpose of obstructing or influencing Federal Government policy;
        - engaging in the chemical and surgical castration or mutilation of children in violation of Federal or State law;
        - engaging in the trafficking of children to states for purposes of emancipation from their lawful parents in violation of Federal or State law,
        - engaging in a pattern of aiding and abetting illegal discrimination; or
        - engaging in a pattern of violating State laws as defined in paragraph (34) of this subsection.
- Multiple lawsuits have been filed attempting to stop the implementation of this rule, including one from 21 state attorneys general. No court has taken any action yet.

Medicaid Access rule

- **Effective Date: July 9, 2025, various implementation dates starting in 2026**
- **Summary of the rule: CMS finalized this rule in 2024 to improve access to care and services for the people enrolled in the Medicaid program. While the majority of provisions have already taken effect, new regulations aimed at improving transparency and rates will take effect in the summer of 2026.**
- Specific provisions for implementation in 2026:
    - Requires states to publish all FFS Medicaid fee schedule payment rates on a publicly available and accessible website. Does not extend to PPS, FQHCs' encounter rates (*July 1, 2026)*
    - Requires states to compare their FFS payment rates for primary care, OBGYN care, and outpatient mental health and substance use disorder services to Medicare rates. Does not include FQHC payment rates (*July 1, 2026)*

Managed Care Rule

- **Effective Date: effective date July 9, 2024, various provisions effective 2027 and 2028**
- **Summary of the Rule: CMS finalized this rule in 2024 to improve access to care, quality, and health outcomes, and better address health equity issues for Medicaid and Children's Health Insurance Program (CHIP) managed care enrollees. The final rule addresses standards for timely access to care and States' monitoring and enforcement efforts, reduces State burdens for implementing some State directed payments (SDPs) and certain quality reporting requirements, adds new standards that will apply when States use in lieu of services and settings (ILOSs) to promote effective utilization and that specify the scope and nature of ILOSs, specifies medical loss ratio (MLR) requirements, and establishes a quality rating system for Medicaid and CHIP managed care plans**
- Specific provisions for implementation in 2027 and 2028:
    - Establishes maximum appointment wait time standards in alignment with some Marketplace standards *(July 9, 2027)*

- Requires states to contract with an independent vendor to perform secret shopper surveys of plan compliance with appointment wait times and accuracy of provider directories and send directory inaccuracies to the State within three days of discovery. (*July 10, 2028)*
- Mandates states to conduct an annual enrollee experience survey for each managed care plan *(July 10, 2028)*

Interoperability and Prior Authorization rule

- **Effective Date: January 1, 2027**
- **Summary of the Rule: CMS finalized this rule in 2024 to improve the electronic exchange of health care data and streamline processes related to prior authorization through new requirements for Medicare Advantage (MA) organizations, state Medicaid fee-for-service (FFS) programs, state Children's Health Insurance Program (CHIP) FFS programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally-facilitated Exchanges (FFEs).**
- Specific provisions for implementation in 2027:
  - Impacted payers must add information about prior authorizations (excluding prescription drugs) and annual report metrics in aggregated, de-identified data about patient use of the Patience Access API
  - Impacted payers must implement and maintain a Provider Access API to share patient data with in-network providers with whom the patient relationship
  - Impacted payers must develop an attribution process to associate patients with their providers to ensure that a payer only sends data to providers for patients with whom they have a treatment relationship.
  - Impacted payers must ensure patients can opt out of having their health insurance available and shared on the API.
  - Impacted payers must implement and maintain a Prior Authorization API that is:
    - Populated with its list of covered items and services (excluding prescription drugs);
    - Can identify documentation requirements for prior authorization approval; and
    - supports a prior authorization request and response
    - Must also provide specific information about prior authorization denials

    - Impacted payers (excluding QHP issuers on the FFEs) must send prior authorization decisions within 72 hours for expedited requests and seven calendar days for standard requests.
        - Impacted payers must publicly report certain prior authorization metrics annually by posting them on their website – initial set of metrics must be reported by March 31, 2026
- Additional NACHC resources:
    - NACHC factsheet

Streamlining Medicaid and CHIP Eligibility Determination, Enrollment, and Renewal Processes rule

- **Effective Date: June 6, 2027**
- **Summary of the Rule: CMS finalized this rule in 2024 to simplify the eligibility and enrollment processes for Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP).**
- Provisions set for implementation in 2027:
    - Applies the primacy of electronic verification and a reasonable compatibility standard for resources and implements stronger recordkeeping practices in Medicaid and CHIP, including maintaining records for a minimum of three years and specifying record accessibility rules when authorized third parties request them.
    - Establishes CHIP application enrollment improvements, including eliminating CHIP and BHP lockout periods due to nonpayment of premiums, eliminating the CHIP waiting period, and improving transitions between Medicaid and CHIP.
    - Establishes a new optional eligibility group for reasonable classification of individuals under age 21 who meet criteria for another group and application of financial eligibility methodologies.
    - Removes the requirement to apply for all other benefits as a condition of eligibility.
- **Section 71102 of the One Big Beautiful Bill Act** (OB3 or H.R. 1) temporarily prohibits CMS from implementing, administering, or enforcing certain amendments made by the provisions of the Eligibility and Enrollment final rule that had a compliance date after July 4, 2025, the date OB3 was enacted. The temporary prohibition on these amendments ends on September 30, 2034:
    - Allows non-modified adjusted gross income (MAGI) applicants to provide applications and supplemental forms through all modes of submission allowed for MAGI applicants

    - Establishes a minimum timeframe (at least 15 days) to return information requested in connection with an initial application, and (at least 30 days) to provide documentation when needed to retain enrollment
    - Individuals must have at least 15 calendar days to respond to requests for additional information although individuals awaiting a Medicare Savings Program (MSP) determination have 30 calendar days to apply additional information
    - Simplifies verification of citizenship and identity by considering verification of birth with a state vital statistics agency or verification of citizenship with DHS SAVE as stand-alone evidence of citizenship (without requesting separate verification of identity)
    - Establishes a clear process to prevent termination of eligible individuals who should be transitioned between Medicaid and CHIP when their income changes or when their beneficiary appears to be eligible for the other program
    - Establishes specific guidelines for states to check available data before terminating eligibility when a beneficiary cannot be reached due to returned mail.
    - Requires states to use certain types of available information to update addresses when individuals move within the state.
- Section 71102 affects regulations applicable to all states, the District of Columbia, and the territories. Review the most up-to-date information on Medicaid Eligibility requirements here and updates on the blocked provisions of the 2024 final rule here.

Rules that were Proposed but not Finalized as of 1/15/26

- HIPAA Security Rule to Strengthen the Cybersecurity of Electronic Protected Health Information (RIN-0945-AA22)
- Special Registrations for Telemedicine and Limited State Telemedicine Registrations (Docket No. DEA-407)