MEMORANDUM

TO: Coalition to Preserve Rehabilitation

FROM: Peter Thomas and Michael Barnett

DATE: April 16, 2025

SUBJECT: CY 2026 Medicare Advantage and Medicare Part D Final Rule

On April 4, 2025, the Centers for Medicare and Medicaid Services ("CMS") released the Contract Year ("CY") 2026 Medicare Advantage ("MA") and Medicare Prescription Drug Benefit Program Final Rule (CMS-4298-P) (hereinafter referred to as the "final rule") and corresponding Fact Sheet for public inspection. The final rule is much narrower than the proposed rule, which was issued in the waning days of the Biden Administration. Several important issues in the proposed rule were either entirely not addressed or deferred for subsequent rulemaking by the new Trump Administration.

Overall, the CY 2026 final rule implements several changes related to prescription drug coverage, the Medicare Prescription Payment Plan, dual eligible special needs plans ("D-SNPs"), and other pragmatic areas, including the Medicare Drug Price Negotiation Program. The final rule also finalizes changes to close loopholes under the MA appeals process and codifies existing sub-regulatory guidance in the MA and Part D programs. Importantly, CMS is not finalizing three provisions from the proposed rule, including provisions related to enhancing health equity analyses of utilization management policies, proposed procedures and guardrails for artificial intelligence ("AI"), and the proposed coverage expansion of anti-obesity medications ("AOMs") under the Medicare and Medicaid programs.

A more detailed summary of the relevant provisions included in the final rule follows.

Updates to the Medicare Advantage Appeals Process

CMS is finalizing several proposals to clarify existing regulatory requirements under the MA appeals process to close a number of loopholes that adversely affect both providers and enrollees. These finalized policies include clarification of the timeline for enrollee's liability to pay for services; modification to the definition of "organization determination;" strengthened provider and enrollee notification requirements for coverage decisions; and changes to the reopening rules to curtail a MA plan's authority to reopen and modify an approved authorization for an inpatient hospital admission.

A summary of each of these finalized proposals is provided below:

Clarifying the Timeline for Enrollee's Liability to Pay for Services

CMS is finalizing its proposal to clarify the existing regulatory provision that states that when an enrollee receives plan-directed care from a contracted (in-network) provider, the enrollee cannot be financially liable for more than the applicable cost-sharing for that service, rendering that decision not subject to appeal. Historically, CMS has interpreted this appeal limitation as applying solely to payment determinations, not to coverage decisions. However, some MA plans have misinterpreted this limitation and improperly label coverage decisions as "contractual denials" or "payment decisions" even when a claim has not yet been submitted or services are still being rendered at the time of the MA plan's decision. Consequently, these enrollees are left without an avenue to appeal coverage decisions that directly affect their immediate medical care and may also alter the amount of their applicable cost-sharing if the enrollee's level of care is changed from inpatient status to outpatient status during the hospital stay.

Under this final rule, MA plans are now prevented from using this strategy as an end-run around actually denying care by clarifying that this limitation is only applicable to contracted provider payment disputes arising from a claim payment decision in which the enrollee has no additional financial liability. CMS notes in the final rule that this practice is inappropriate because the enrollee may still be potentially liable to pay for a service until the MA plan makes a determination following the submission of a provider's claim for the furnished service. Therefore, CMS is clarifying that an enrollee's liability to pay for services cannot be determined until a MA plan has made a formal determination on a request for payment, as opposed to a request for coverage (e.g., prior authorization). We believe this is a beneficial change from the enrollee perspective and are pleased that CMS has finalized this proposed clarification as it will result in improved transparency and oversight over MA plans' abusive practice to deny enrollees' appeal rights.

Definition of "Organization Determination"

CMS is finalizing its proposal to modify the definition of an "organization determination" to clarify that a coverage decision made by a MA plan contemporaneously to when an enrollee is receiving such services is an organization determination subject to appeal and other notification requirements. These types of decisions most often occur while enrollees are receiving inpatient services in an in-network hospital and are often referred to as "concurrent review decisions." According to CMS, some MA plans have asserted that these concurrent reviews are outside the definition of an organization determination because the decision is made *during* an ongoing course of treatment. Some MA plans have even attempted to use the provider's admission of the patient as a way to avoid offering a determination or claiming the provider gave up appeal rights by starting the care right away.

Given the often-mistaken interpretation of these rules, CMS proposed to clarify that decisions made on the review of the enrollee's need for continued care (i.e. concurrent review decisions)

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are, in fact, organization determinations that require timely notice and applicable appeal rights. We are pleased that CMS is finalizing this proposal as proposed and we believe this should curtail some of this troubling behavior from MA plans and ensure that MA appeal rules apply to adverse plan decisions, regardless of whether the decision is made before, after, or during the receipt of services.

Provider and Enrollee Notification of Coverage Decision

CMS is also finalizing its proposal to strengthen notification requirements by codifying existing guidance to require MA plans to provide a provider with notice of a coverage decision, in addition to notifying the enrollee, whenever the provider submits a request on behalf of an enrollee. Under this now-finalized policy, if MA plans fail to provide the enrollee, physician, or provider, with timely notice of a coverage decision, this failure now constitutes an appealable adverse organization determination. This positive change will improve the appeals process, reduce unnecessary delays in access to care, and close yet another avenue by which MA plans use delay tactics to circumvent appeal rights.

Timeline for Reopening Rules

CMS is finalizing its proposal to amend the reopening rules to curtail a MA plan's authority to reopen and modify an approved authorization for an inpatient hospital admission. Under Medicare, an inpatient hospital admission will be covered if the admitting physician expects the patient to require hospital care that spans two midnights based on the physician's knowledge at the time of admission. This is known as the "Two-Midnight Rule."

Current regulations state that a MA plan may reopen and revise an organization determination or reconsidered determination that is otherwise final and binding if there is "good cause," which is established when there is new and material evidence that was not available or known at the time of the determination. CMS noted in the proposed rule that it had become aware of instances where MA plans would reopen a prior authorization decision on an inpatient admission during the receipt of services or after services have been rendered based on "new and material evidence." This practice is not appropriate and runs counter to the Two-Midnight Rule, which is based on the clinical information known by the physician at the time of admission as well as the documented medical record at that time. To address this inappropriate conduct by MA plans, CMS is finalizing its proposal to amend the reopening rules to clarify that any additional clinical information obtained after the initial organization determination cannot be used as "new and material evidence" to establish good cause for reopening the determination.

Unfortunately, CMS declined to expand this limitation, as several IRF stakeholders requested, to reopenings of favorable determinations for inpatient rehabilitation hospital care. Several commenters had made this recommendation, but CMS is not finalizing this proposal stating that it would be a departure from corresponding Traditional Medicare reopening policies.

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