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Contract Year (CY) 2026 Medicare Advantage Final Rule
ACR Detailed Summary

On April 4th 2025, Centers for Medicare and Medicaid Services (CMS) released the [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]. The regulations outlined in the rule are effective June 3, 2025, and the provisions are applicable to coverage beginning January 1, 2026 (except as otherwise noted within the rule).

Improving Experiences for Dually Eligible Enrollees – Pg. 270
Member ID Cards, Health Risk Assessments, and Individualized Care Plans (§§ 422.101, 422.2267, 423.2267)
In this rule, CMS addressed the fragmentation of care experienced by dually eligible Medicare and Medicaid enrollees by seeking approaches for better care integration. When a dually eligible individual is enrolled in both an MA plan and a Medicaid managed care plan, the plans usually issue the enrollee separate member ID cards, which CMS states is administratively confusing for both providers and enrollees.

To address this issue, CMS finalized new federal requirements for certain integrated Dual Special Needs Plans (D-SNPs) to have integrated member identification cards that serve as ID cards for both the Medicare and Medicaid plans in which the enrollee is enrolled. CMS did not make substantive changes to the Medicare or Medicaid requirements for the content of the ID cards. An integrated member ID card also does not limit an enrollee's ability to change Medicaid managed care plans as allowable in 42 CFR part 438.

Integrating Health Risk Assessments (HRAs) for Dually Eligible Enrollees in Certain Integrated DSNPs
Medicare requirements at § 422.101(f)(1) require D-SNPs to conduct a comprehensive Health Risk Assessment (HRA) for each enrollee, both at the time of enrollment and annually thereafter. Separately, Medicaid managed care regulations at § 438.208(b)(3) require Medicaid managed care plans to make a best effort to conduct an initial screening of enrollee needs within 90 days of a new enrollee's effective enrollment date, with some states having respective additional HRA requirements.

CMS states within the rule that completing two separate, but potentially overlapping, assessments creates an unnecessary burden for enrollees. CMS finalized the proposal to require integrated HRAs for applicable integrated plan D-SNPs with a modification to delay the implementation date of this provision to January 1, 2027 (with an applicability date of October 1, 2026, since HRAs may be conducted within 90 days before or after the effective

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date of enrollment. This provision does not change any specific Medicare or Medicaid requirements for the timing of or elements included in an HRA.

Financial Impact
The integrated HRA provisions may cause a small number of applicable integrated plans (AIPs) to incur some upfront costs to make administrative updates. CMS does not expect the provisions regarding integrated member ID cards and ICPs to have any financial impact.

Clarifying MA Organization Determinations to Enhance Enrollee Protections in Inpatient Settings (§§ 422.138, 422.562, 422.566, 422.568, and 422.616) – Pg. 160
Clarifying When a Determination Results in No Further Financial Liability for the Enrollee (§ 422.562)
Section 1852(g)(1)(A) of the Act requires an MA organization to have a procedure for making determinations regarding whether an enrollee is entitled to receive a health service and the amount (if any) that the individual is required to pay with respect to such service. Under section 1852(g)(2) of the Act, an MA organization must provide for reconsideration of an adverse determination upon an enrollee's request. The existing regulations at part 422, subpart M, set forth the administrative appeals process available to enrollees who wish to dispute an organization determination made by an MA organization. These regulations broadly distinguish between coverage decisions (whether the MA organization will furnish, authorize, or arrange for services) and payment decisions (whether to pay or deny payment for services).

In this rule, CMS finalized § 422.562(c)(2) to state that if a contract provider's request for payment has been adjudicated and the enrollee is determined to have no further liability to pay for the services furnished by the MA organization, the claim payment determination is not subject to the appeal process in this subpart.

Clarifying the Definition of an Organization Determination to Enhance Enrollee Protections in Inpatient Settings (§§ 422.138 and 422.566)
In accordance with § 422.568(d)(1), an MA organization must give the enrollee written notice when denying payment in whole or in part. Through routine audits, feedback from the provider community, and discussions with MA organizations, CMS identified circumstances where some MA organizations have misinterpreted the organization determination provisions to exclude decisions that rescind a previously authorized inpatient admission, deny coverage for inpatient services, or downgrade an enrollee's hospital coverage from inpatient to outpatient, when the decision is made concurrently to the enrollee receiving services.

To address this, CMS finalized the revisions to § 422.566(b)(3) and the corresponding change at § 422.138 on what constitutes an organization determination to include an MA

organization's refusal, pre- or post-service or in connection with a decision made concurrently with an enrollee's receipt of services, to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the MA organization.

Strengthening Requirements Related to Notice to Providers (§§ 422.568, 422.572, and 422.631)
The existing notice requirements for standard organization determinations at § 422.568(b)(1) only specify that MA organizations must provide the enrollee with notice of its decisions. However, existing CMS guidance instructs MA organizations to notify the provider, as well as the enrollee, whenever a provider submits an organization determination on behalf of the enrollee.

CMS finalized the proposal to codify existing guidance that requires plans to give providers notice of a coverage decision, in addition to the enrollee, whenever the provider submits a request on behalf of an enrollee. CMS stated within the rule that they believe an enrollee's provider is often in the best position to receive, explain, and timely act upon the MA organization decision for an enrollee.

Modifying Reopening Rules Related to Decisions on an Approved Hospital Inpatient Admission (§§ 422.138 and 422.616)
The reopening rules at § 422.616 permit an organization or reconsidered determination made by an MA organization that is otherwise final and binding to be reopened and revised by the MA organization under the applicable rules in part 405, subpart I, at §§ 405.980 through 405.986. CMS stated in the rule that they are aware that some MA organizations are reopening and revising or otherwise rescinding a prior approval for an inpatient hospital admission based on a medical necessity determination during the enrollee's receipt of the previously authorized services or during the adjudication of the subsequent inpatient claim for payment. Some MA organizations are not consistently providing notice or appeal rights to the enrollee for these decisions.

Due to the ongoing issues CMS has seen with previously approved inpatient hospital admissions later being inappropriately revised or rescinded, CMS finalized their proposal to restrict plans' ability to use information gathered after the inpatient admission has taken place when reviewing the appropriateness of the admission itself.

Financial Impact
CMS anticipates that these changes could decrease the number of inpatient downgrades which could, in turn, create a non-quantified cost to MA organizations that could be passed on to the Medicare Hospital Insurance Trust Fund.

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Risk Adjustment Data Updates – Pg. 259

Update the Definition of Hierarchical Condition Categories (HCC) (§ 422.2)

The first finalized provision involves a technical change to the definition of Hierarchical Condition Categories (HCCs) to remove the reference to a specific version of the ICD, as newer versions of the ICD become available and are adopted by the Secretary, to keep the HCC definition in § 422.2 current. Also included is the substitution of the terms "disease codes'' with "diagnosis codes'' and "disease groupings'' with "diagnosis groupings'' to be consistent with ICD terminology.

Clarifying the Obligation of PACE Organizations to Submit Risk Adjustment Data (§ 460.180(b))

In this final rule, CMS codified the longstanding practice of requiring the collection and mandatory submission of risk adjustment data by PACE (Program of All-Inclusive Care for the Elderly) organizations (§ 460.180(b)) and Cost plans (§ 417.486(a)). This does not change existing reporting requirements set forth and approved under OMB 0938-1152 (CMS-10340) and OMB 0938-0878 (CMS-10062), nor does it make any changes to payment for PACE organizations.

Clarifying the Obligation of Cost Plans to Submit Risk Adjustment Data (§ 417.486(a))

CMS also finalized the proposal to amend § 417.486(a) to add a new § 417.486(a)(3) to codify the longstanding practice of requiring the collection and mandatory submission of risk adjustment data as specified in 42 CFR 422.310 by 1876 Cost plans. This change codifies the longstanding requirement of the submission of risk adjustment data from organizations that operate Cost plans under section 1876 of the Act in the same manner as MA organizations.

Financial Impact

CMS does not expect these regulatory changes to have an impact on the Medicare Trust Funds.

Proposal for Use of Guardrails in AI

In the CY2026 Medicare Advantage proposed rule, CMS stated that it is necessary to ensure the use of AI does not result in inequitable treatment, bias, or both, within the healthcare system, and instead is used to promote equitable access to care and culturally competent care for all enrollees. As such, CMS proposed to revise § 422.112(a)(8) to ensure services are provided equitably irrespective of delivery method or origin, whether from human or automated systems. The rule also clarified that if an MA plan uses AI or automated systems, it must comply with section 1852(b) of the Act and § 422.110(a) and other applicable regulations and requirements and provide equitable access to services and not discriminate based on any factor that is related to the enrollee's health status.

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CMS **did not finalize** these proposals to establish new guardrails on artificial intelligence in the MA program. CMS stated within the rule that they "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."

CMS also announced that it is not finalizing two other provisions from the proposed rule (Enhancing Health Equity Analyses: Annual Health Equity Analysis of Utilization Management Policies, and Part D Coverage of Anti-Obesity Medications (AOMs) and Application to the Medicaid Program).

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