

**2026 National Conference on Special Needs Planning and
Special Needs Trusts**

**Stetson Law
October 23, 2026**

MEDICARE UPDATES

**David A. Lipschutz
Co-Director/Attorney, Center for Medicare Advocacy**

I. Federal Update

A. Reconciliation Bill – Overview

On July 4, 2025, President Trump signed into law H.R. 1 – One Big Beautiful Bill Act (OBBB).¹ Narrowly passing Congress using the reconciliation process in the Senate (which requires a simple majority rather than 60 votes), the bill extends the 2017 tax cuts and funds other administration priorities. In order to offset some of the costs of these policies, the bill makes unprecedented and wide-ranging cuts to a number of safety-net programs, including over \$1 trillion in cuts to health programs, which will result in an estimated 10 million people losing insurance coverage, along with cuts to food assistance provided to low-income individuals through the federal SNAP program, among other changes.² With respect to health care, the bulk of cuts, which will be implemented over a number of years, are directed at the Medicaid program and aimed at reducing the number people covered. These changes include: new “community engagement” (work requirements) for certain individuals to maintain coverage; more frequent eligibility redeterminations; rescission of eligibility for certain groups of lawfully present immigrants (similar to the Medicare-specific provision described below); and reduced ability for states to raise additional Medicaid funds through provider taxes. There are also significant changes for Affordable Care Act marketplace enrollees, including non-renewal of financial assistance for qualifying individuals.

¹ Pub. Law No: 119-21.

² Congressional Budget Office (CBO), “Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to the Budget Enforcement Baseline for Consideration in the Senate” (July 21, 2025), available at: <https://www.cbo.gov/publication/61569>.

Many of the cuts to Medicaid will impact people who have both Medicare and Medicaid (dual eligibles). As outlined in joint publications by the Center for Medicare Advocacy, Justice in Aging, Medicare Rights Center and Community Catalyst,³

- One in five Medicare enrollees relies on Medicaid to help pay Medicare premiums and cost sharing
- Nearly 30% of Medicaid funding goes to people with Medicare
- Medicaid is the primary payer for 63% of nursing facility residents
- Without Medicaid, over 12 million Medicare enrollees would experience gaps in care that jeopardize their health and well-being.

There are also provisions of the OBBB that will directly impact Medicare beneficiaries, including:

- *Ending implementation of a rule streamlining eligibility and enrollment in Medicare Savings Programs (MSPs)* – §71101 prohibits the Secretary of Health & Human Services from implementing (for 9 years) certain provisions of the final rule published by CMS on September 21, 2023 (88 Fed. Reg. 65230), which was aimed at making it easier for Medicare beneficiaries to enroll in and qualify for MSPs, which can cover some Medicare premiums and costs for lower income beneficiaries. The Congressional Budget Office (CBO) estimates that this will save over \$66 billion over 10 years due to fewer people enrolling in MSPs; more than 1.3 million dually

³ Center for Medicare Advocacy, Justice in Aging, Medicare Rights Center and Community Catalyst, “A Cut to Medicaid is a Cut to Medicare” (March 2025) – Fact Sheet: <https://medicareadvocacy.org/wp-content/uploads/2025/03/A-Cut-to-Medicaid-is-a-Cut-to-Medicare-fact-sheet.pdf>; Issue Brief: <https://medicareadvocacy.org/wp-content/uploads/2025/03/A-Cut-to-Medicaid-is-a-Cut-to-Medicare-Issue-Brief.pdf>.

eligible individuals are expected to lose assistance through MSPs. Note that while H.R.1 postponed certain federal requirements concerning MSPs, states still have the authority to enhance MSP access for their residents.⁴

- *Prohibiting implementation of a final staffing rule for nursing facilities* - §71111 prohibits CMS from implementing a final rule issued in 2024 (89 Fed Reg 408706) which established national minimum staffing requirements for nursing facilities to promote quality care (note that CMS subsequently rescinded the rule).
- *Restricting the Medicare program's ability to negotiate the price of certain drugs* – the Inflation Reduction Act of 2022 (Pub. Law No: 117-169) gave the Secretary authority to negotiate the prices for certain high-cost drugs for Medicare beneficiaries, with negotiated prices first effective in 2026. Section 71203 of the OBBB carves out certain “orphan drugs” (medications developed to treat rare diseases) from Medicare drug price negotiation.
- *Limiting eligibility and terminating coverage of certain lawfully present non-citizens* – See below.

⁴ See, e.g., Center for Medicare Advocacy and Aging & Disability Health Policy Lab, “Spotlight on Medicare Savings Programs (MSPs)” at: <https://medicareadvocacy.org/spotlight-on-msps/>.

B. Implementation of H.R. 1 Immigration Provisions

Before H.R.1, lawfully present non-citizens could qualify for Medicare by meeting work history requirements, or if they lacked the required work credits, by meeting length of residency requirements. Qualified non-citizens who worked and contributed payroll taxes for the required number of years were eligible for Medicare coverage on the same basis as U.S. citizens. H.R.1 strips away Medicare eligibility from specific categories of lawfully present non-citizen groups. Now, starting immediately upon passage of the bill, §71201 (now Section 1899C of the Social Security Act, 42 U.S.C. §1395mmm) restricts Medicare eligibility to:

- U.S. citizens
- And the following “eligible noncitizens”:
 - Lawful permanent residents (green card holders);
 - Cuban and Haitian Entrants; and
 - Individuals from certain Pacific Island nations with special agreements with the U.S. “COFA” migrants).

This eliminates Medicare eligibility for all other lawfully present immigrants, regardless of how long they have worked and paid into the system, including:

- Refugees and people granted asylum;
- People with Temporary Protected Status;
- Survivors of human trafficking;

- Survivors of domestic violence; and
- Individuals granted humanitarian parole.

Not later than one year after enactment (July 4, 2026), the Commissioner of the Social Security Administration (SSA) is directed to identify individuals with Medicare coverage who do not meet the new criteria, and notify such individuals “as soon as practicable after such identification and in a manner designed to ensure such individual’s comprehension of such notification” that their coverage will be terminated as of 18 months after enactment (at the end of January 2027). Note: Undocumented individuals have never been eligible for Medicare coverage, but, until enactment of the OBBB, lawfully present individuals who meet the requisite work history requirements through SSA have been eligible for Medicare coverage.

On July 16, 2026, the Centers for Medicare & Medicaid Services (CMS) issued a **proposed rule** that includes provisions implementing new Section 1899C of the Social Security Act (section 71201 of H.R.1, which CMS refers to in the proposed rule as the “Working Families Tax Cut” (WFTC) legislation) at 91 Federal Register 43842 (July 16, 2026) (CMS-1848-P). These rules incorporate definitions of newly specified groups of individuals who may be eligible for Medicare, procedures for termination and applicable appeal rights for those found ineligible, and enrollment options for individuals who later gain or regain eligibility. *Note that the provisions of this rule as described below are in proposed form and may be changed prior to being finalized before January 2027.*

The Center for Medicare Advocacy (CMA) issued an Explainer of the provisions in this proposed rule in August 2026.⁵ CMA also submitted comments to the proposed rule, expressing concerns about insufficient due process.⁶ In short, the proposed rule outlines the following procedures:

- **Notice & Termination Timeline:**

- ***Grace Period Population:*** for individuals who are identified by SSA as not or potentially not meeting the new criteria during an 18-month window following passage of H.R.1 (roughly through 2026 – identified as the “grace period”), SSA will issue:
 - Preliminary Notices will be sent some time in “Late Fall” 2026 informing them that SSA records indicate that they do not meet the new criteria and their entitlement will end if they cannot provide evidence proving eligibility; the notice will instruct them to contact SSA if they believe the information is incorrect.
 - Formal Termination Notices will be issued in late December 2026 to all identified individuals determined to be ineligible based on available data informing them that their Medicare coverage will be terminating effective **February 1, 2027**; the notice will inform individuals of their appeal rights under existing appeals regulations

⁵ CMA, “Explainer: Changes to Medicare Eligibility Based on Immigration Status” (Aug. 20, 2026), available at: <https://medicareadvocacy.org/explainer-changes-to-medicare-eligibility-based-on-immigration-status/>.

⁶ CMA, Comments to CY 2027 Proposed Physician Fee Schedule Rule (Sept. 14, 2026), available at: <https://medicareadvocacy.org/wp-content/uploads/2026/09/CMA-Comments-PFS-2027.pdf>.

for initial determinations delineated in 42 CFR part 405, subpart 1. (Appeals would be sent to SSA - see 42 CFR 405.900(b)(1) "... in accordance with SSA regs governing reconsiderations at 20 CFR, part 404, subpart J".)⁷

- **Outside Grace Period Population:** For individuals identified after the grace period, including individuals who may have been improperly enrolled, overlooked, or whose immigration status may have changed during the grace period, or who in the future may be properly enrolled in Medicare but then lose their eligible non-citizen status; only one Termination Notice will be sent explaining that they do not satisfy the new criteria and that their Medicare coverage will terminate at the end of the month following the month in which the notice is dated; the notice will also include information about appeal rights (same as above).
- **Plan Disenrollment:** CMS will automatically handle prospective disenrollment from Medicare Advantage, Part D, and Cost plans once SSA updates entitlement records. The plans are **not** required to send separate disenrollment notices.
- **Special Enrollment Periods (SEPs):** The proposed rule creates a 6-month SEP for individuals who gain or regain eligible status. Coverage for premium Parts A and B is prospective-only, while premium-free Part A can offer up to 6 months of retroactive coverage. There is an SEP for enrollment into a Medicare Advantage plan available the month the person is entitled to Part A and enrolled in Part B and lasts for 2 more

⁷ 91 Fed. Reg. 43842 (July 16, 2026), at 43999.

months; there is also a 2-month SEP for Part D after either the individual's Part A or B entitlement date, whichever is earlier.

II. Medicare Advantage and Part D Updates

The Medicare Advantage program (MA, also known as “Part C”) – the private plan option in Medicare in addition to traditional Medicare (sometimes called “Original” or Fee-for-Service) – now covers more than half of all Medicare beneficiaries, and is growing. According to KFF, MA “enrollment has more than doubled since 2010 and is projected to grow from 54% of the eligible population in 2024 to 60% by the end of this decade.”⁸

It is well established that MA plans are significantly overpaid relative to what traditional Medicare spends on a given beneficiary due to a variety of factors, including manipulation of the risk-adjusted payment system. According to the Medicare Payment Advisory Commission (MedPAC), for 2026, MA payments are projected to be \$76 billion – or 14% more – above what spending would be in traditional Medicare for the same beneficiaries. According to MedPAC, as outlined in a press release,⁹ this is largely due to two factors: 1) favorable selection of beneficiaries into MA plans – the tendency of beneficiaries with lower spending to enroll in MA; and 2) coding intensity – the tendency for MA plans to

⁸KFF, “10 Reasons Why Medicare Advantage Enrollment is Growing and Why It Matters” (Jan. 2024), available at: <https://www.kff.org/medicare/issue-brief/10-reasons-why-medicare-advantage-enrollment-is-growing-and-why-it-matters/>.

⁹ Medicare Payment Advisory Commission (MedPAC), “MEDICARE PAYMENT ADVISORY COMMISSION RELEASES REPORT TO CONGRESS ON MEDICARE PAYMENT POLICY” (March 12, 2026), available at: https://www.medpac.gov/wp-content/uploads/2026/03/March_2026_MedPAC_Report_Press_Release_SEC.pdf.

record more diagnoses codes for their enrollees, which increases risk adjusted payment to plans.

In addition to overpayments which add pressure to Medicare’s fiscal solvency, there have been some recent reductions in consumer protections (discussed below) coupled with ongoing problems with accessing care due to excessive prior authorization and denials and delays in care.

A. New Rules for 2027

CMS issues annual updated rules to the Medicare Advantage (Part C) and Part D programs for the following calendar year, first in proposed form, with opportunity for public comment, followed by a final rule. In November 2025, CMS issued a proposed Part C & D rule for CY2027.¹⁰ On April 2, 2026, CMS issued a final rule for 2027.¹¹

Summary of Selected Provisions of Final Rule¹²

- **Special Enrollment Period (SEP) re: Medicare Advantage Provider Terminations**

One of the only new consumer protections proposed by CMS was to expand current SEP rights to change MA plans following provider terminations, but CMS did not finalize

¹⁰ See *CMA Alert* “CMA Comments to Proposed CY 2027 Rule re: Medicare Advantage and Part D” (Jan. 29, 2026), available here: <https://medicareadvocacy.org/comments-on-2027-cd-rules/>; for the Center for Medicare Advocacy’s full comments on the proposed rule, see <https://medicareadvocacy.org/wp-content/uploads/2026/01/CMA-comments-CD-2027.pdf>.

¹¹ 91 Fed. Reg. 17384 (April 6, 2026)). CMS also released related press releases on April 2, 2026, available here: <https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-final-rule> and here: <https://www.cms.gov/newsroom/press-releases/medicare-beneficiaries-see-simpler-more-flexible-plan-choices-better-drug-coverage-higher-quality>.

¹² Note that this section is adapted from a CMA Alert titled “CMS Caves to Medicare Advantage Industry” (April 9, 2026), available at: <https://medicareadvocacy.org/cms-caves-to-medicare-advantage-industry/>.

it. Without further explanation, CMS stated: “In this final rule, CMS is not finalizing the proposal to establish a special enrollment period for provider terminations and are not addressing comments received on this proposal” (p. 17387).

- **MA Supplemental Benefits**

CMS finalized a number of changes relating to supplemental benefits offered by MA plans, including:

- Rescind Mid-Year Supplemental Benefits Notice – due to concerns with underutilization of supplemental benefits, in 2024 CMS proposed to require MA plans to issue mid-year personalized notices to plan enrollees that would include details about unused benefits. CMS first suspended, and now rescinds this requirement.
- Administration of Supplemental Benefits Through Debit Cards – MA plans using debit cards to administer supplemental benefits must electronically link cards to plan-covered items and services through a real-time point-of-sale verification mechanism. Further, card use is limited to a specific plan year. CMS is not finalizing a proposed prohibition on marketing the dollar value of supplemental benefits
- Special Supplemental Benefits for the Chronically Ill (SSBCI) – CMS is codifying a requirement for MA plans to post their objective SSBCI eligibility requirements on their public-facing website.

- **Updating Third-Party Marketing Organizations (TPMO) Disclaimer Requirements**
 - **Removal of Reference to SHIPs**

CMS finalized their proposal that TPMOs no longer need to reference State Health Insurance Assistance Programs (SHIPs) in their disclaimers. CMS provides no additional justification for this change beyond the thin reasoning in the proposed rule, which, as noted in comments filed by CMA, completely ignored a number of relevant issues. These include: 1) ongoing marketing misconduct and financial incentives of agents and brokers, including the fact that TPMOs don't have to sell all available plans in a given area; and 2) the value of SHIPs and their unbiased counseling compared to both agents/brokers and the shortcomings of 1-800-MEDICARE.

- **Removing Rules on Time and Manner of Beneficiary Outreach**

CMS finalized a number of changes to rules that restricted agent/broker activities; CMS characterized these changes in the above-referenced press release as being “designed to improve the enrollment decision-making process by creating a more convenient, beneficiary-friendly outreach experience and to reduce the burden on beneficiaries, plans, and agents/brokers.” To the contrary, as discussed at length in CMA's comments to the proposed rule, these changes are far more advantageous to insurers, agents and brokers and remove important consumer protections meant to address marketing misconduct.

- Marketing Events Following Educational Events in Same Location – the Medicare statute requires “educational” vs. “marketing” events to be

distinct. CMS has now removed the previous 12-hour delay requirement between educational and marketing events. Agents/brokers can now hold such events back-to-back, increasing the risk that individuals merely seeking information will be subject to high-pressure sales tactics. In response to concerns about marketing abuses raised in the comments, and in contrast to previous statements, the agency implausibly asserts that “CMS believes that such instances of plan marketing violations and negative beneficiary enrollment experiences that commenters describe are rare, as CMS does not often receive reports or complaints in this area” (p. 17453).

- Timing of Personal Marketing Appointment After Scope of Appointment (SOA) Form Completion (p. 17454) – CMS eliminates the 48-hour waiting period between collection of an SOA form and a subsequent marketing appointment (“cooling off” period). Among CMS’ provided rationale is that “[t]here is often a built-in layer of added protection from any potential undue pressure, as evidenced by the tendency for vulnerable beneficiaries to have other people help them with plan options and making decisions” which does not account for individuals who do not have other people to help them.
- Scope of Appointment (SOA) Forms at Educational Events (p. 17459) – CMS has lifted the prohibition on collecting SOAs at educational events, which contradicts the agency’s own prior rationale for reinstating this prohibition, including that educational events are “meant to provide generic information

about the different options, rather than to persuade beneficiaries to enroll in any type of plan” (see, e.g., 2024 proposed rule).

B. Part D Updates

i. End of Part D Premium Stabilization Demonstration

Among other things, the IRA made significant changes to Part D’s standard benefit design, which shift additional costs to Part D plan sponsors while reducing beneficiary out-of-pocket expenses. Out of concern about how these shifting costs could impact plan sponsors’ offerings, including premiums that they charge, in July 2024 CMS announced a voluntary Part D Premium Stabilization Demonstration “designed to test whether additional policy changes stabilize year-over-year changes in premiums for participating standalone PDPs, leading to more predictable options for beneficiaries during the initial implementation of the Inflation Reduction Act of 2022’s (IRA’s) benefit improvements [...].”¹³ This demonstration limited premium increases for participating Part D plan sponsors to no more than \$35 a month for 2025.

On July 28, 2025, CMS issued a memorandum¹⁴ announcing that the Part D Premium Stabilization Demonstration would continue for another year for CY 2026, but was scaled back. The monthly premium subsidy to plan sponsors was reduced from \$15 to \$10, and the limit on the monthly PDP premium increase was increased from \$35 in 2025 up to \$50

¹³ CMS, Memorandum: “Annual Release of Part D National Average Monthly Bid Amount and Other Part C & D Bid Information” (July 29, 2024), available at: <https://www.cms.gov/files/document/july-29-2024-parts-c-d-announcement.pdf>.

¹⁴ CMS Memo: “Annual Release of Part D National Average Bid Monthly Bid Amount and Other Part C & D Bid Information” (July 28, 2025), available at: <http://www.cms.gov/files/document/july-28-2025-parts-c-d-announcement.pdf>.

in 2026. The component of the demonstration that further mitigated costs to plan sponsors relating to risk corridors was eliminated.

As noted by KFF¹⁵ after CMS' announcement about a scaled back demo for 2026, "In announcing these changes, CMS states that it is 'facilitating the [Part D] program's return to operating under regular market conditions.' Increasingly, however, these regular conditions appear unfavorable to the ongoing stability of the stand-alone prescription drug plan market, further tilting the playing field for coverage towards Medicare Advantage."

Despite plans to continue the demo for at least 3 years, in July 2026, CMS announced that the demonstration is ending early and will not continue for the 2027 plan year. This will likely result in even more favorable conditions for the Medicare Advantage industry, and will likely push more people seeking to reduce their premium costs to enroll in Medicare Advantage plans, further diminishing the PDP market and original/traditional Medicare as a whole.¹⁶

ii. GLP-1 Coverage

The Medicare statute excludes coverage of drugs for weight loss but in 2024 CMS started to allow Part D coverage of anti-obesity medication when such drugs receive FDA approval for an additionally medically accepted indication that is not specifically excluded from

¹⁵ KFF *Quick Take*: "The Trump Administration is Reducing Enhanced Support for the Part D Stand-Alone Drug Plan Market" by Juliette Cubanski (July 28, 2025), available at: <https://www.kff.org/quick-take/the-trump-administration-is-reducing-enhanced-support-for-the-part-d-stand-alone-drug-plan-market/>.

¹⁶ See CMA Alert "Administration Ends Part D Premium Stabilization Demonstration" (Aug. 6, 2026), available at: <https://medicareadvocacy.org/administration-ends-part-d-premium-stabilization-demonstration/>.

Medicare coverage.¹⁷ In 2026, CMS announced a Medicare GLP-1 Bridge short-term demonstration that is providing eligible Medicare Part D beneficiaries with access to certain GLP-1 drugs for weight management between July 1, 2026, and December 31, 2027. Eligible beneficiaries will have a \$50 copay. This demonstration operates outside of the Medicare Part D benefit coverage structure, meaning that the Part D deductible will not apply, copays do not count toward the beneficiary's true out-of-pocket costs (TrOOP), and the low-income subsidy (LIS or Extra Help) does not apply.¹⁸

III. Miscellaneous Updates

A. Oversight of Nursing Facilities – New Risk Based Survey (RBS)

The Centers for Medicare & Medicaid Services (CMS) implemented a new risk-based survey (RBS) protocol for nursing facilities on September 8, 2026.¹⁹ The new survey protocol is available for 12% of nursing homes nationwide (more than 1,000 facilities) that CMS describes as “higher quality facilities.” A risk-based survey has fewer surveyors, includes fewer residents whose care is reviewed by surveyors, and looks at only a single regulatory requirement, infection control. Nine other requirements for care, including staffing, resident assessment, environment, medication administration, and personal

¹⁷ See, e.g., Dept. of Health & Human Services, Assistant Secretary for Planning and Evaluation, “Medicare Coverage of Anti-Obesity Medications” (Nov. 2024), available at: <https://aspe.hhs.gov/sites/default/files/documents/127bd5b3347b34be31ac5c6b5ed30e6a/medicare-coverage-anti-obesity-meds.pdf>.

¹⁸ For more information, see the CMS website at: <https://www.cms.gov/medicare/coverage/prescription-drug-coverage/medicare-glp-1-bridge>.

¹⁹ CMS, “Nursing Home Risk-Based Survey National Implementation,” QSO-26-14-NH (Jul. 16, 2026), available at: <https://www.cms.gov/files/document/qso-26-14-nh-original-release-2026-07-16.pdf>.

funds, are reviewed only if “triggered” by (1) a complaint or facility-reported incident, (2) identification of the issue by an ombudsman, or (3) identification of the issue during the survey (by a resident or surveyor observation). CMS links a nursing home’s eligibility for an RBS to meeting 11 criteria. Advocates are concerned about the new survey process, in part, because it reduces and streamlines longstanding survey requirements, places residents at a heightened risk of harm and undermines accountability.²⁰

B. Improper Coverage Changes by SNFs

CMA has received recent reports that nursing homes have disenrolled residents without their knowledge or consent from their Medicare Advantage plans they had selected to original Medicare, which pays higher reimbursement rates and does not require prior authorization.²¹ This practice is illegal. CMS issued memos in 2015 and 2021 telling long-term care facilities not to disenroll beneficiaries from MA without beneficiary’s “request, consent, knowledge, and/or complete understanding”.²² There has also been litigation filed surrounding this issue.²³

²⁰ See, e.g., Consumer Voice, “CMS Announces Plans to Reduce Oversight of Some Nursing Homes through ‘Risk-based Survey’ System” (July 2026) available at: <https://theconsumervoice.org/wp-content/uploads/2026/07/CV-Statement-CMS-RBS.pdf>; Long Term Care Community Coalition, “LTCCC Alert: CMS’s New Risk-Based Survey Policy for Nursing Homes Puts Vulnerable Residents at Risk” (July 2026) available at: <https://nursinghome411.org/wp-content/uploads/2026/07/LTCCC-Alert-on-CMS-Risk-Based-Survey-Policy-July-2026.pdf>; and CMA Press Release “The Risk-Based Survey Endangers Nursing Home Residents” (July 28, 2026), available at: <https://medicareadvocacy.org/risk-based-survey-endangers-nursing-home-residents/>.

²¹ See *CMA Alert* “Skilled Nursing Facilities Cannot Disenroll Residents from Medicare Advantage Plans” (Sept. 24, 2026), available at: <https://medicareadvocacy.org/nursing-homes-cant-disenroll-you/>.

²² CMS, “Memo to Long Term Care Facilities on Medicare Health Plan Enrollment” (October 2021) available at: <https://www.cms.gov/files/document/lctcdisenrollmentmemo.pdf>; this 2021 memo reiterates a prior CMS “Memo to Long Term Care Facilities on Disenrollment Issues” (May 25, 2015) available at: <https://www.cms.gov/sites/default/files/repo-new/35/LTCFDisenrollmentMemo052615.pdf>.

²³ See U.S. Attorney, S.D.N.Y. Press Release “U.S. Attorney Announces \$7.85 Million Settlement With Citadel Skilled Nursing Facility in Bronx For Fraudulently Switching Residents’ Healthcare Coverage To Boost

CMA has also encountered SNFs switching residents without consent to Medicare Advantage Special Needs Plans for Institutionalized individuals (I-SNPs) with which the facility has a contract or affiliation. Special Needs Plans (SNPs) were created by federal law in 2003. I-SNPs are a type of MA plan for people who, for 90 days or more, need the level of care provided in a long-term care facility. There is a small, but growing number of I-SNPs, which are increasingly owned by nursing home providers.²⁴ A growing number of nursing home residents are enrolled in I-SNPs; 8% of nursing home residents were in I-SNPs in 2018, compared with 12% in 2024 (more than 100,000).²⁵ For more information about I-SNPs, see, e.g., CMA materials.²⁶

C. Observation Status Appeals Misclassified

i. Overview

On October 4, 2024, CMS issued a rule implementing the Court’s order in the nationwide class action, *Alexander v. Azar*, 613 F. Supp. 3d 339 (D. Conn. 2020), *aff’d sub nom. Barrows*

Medicare Payments” (June 29, 2022), available at: <https://www.justice.gov/usao-sdny/pr/us-attorney-announces-785-million-settlement-citadel-skilled-nursing-facility-bronx>.

²⁴ In 2015, there were 57 I-SNPs, including 5 (9%) led by nursing home providers; in 2020, there were 150 I-SNPs, including 50 (33%) led by nursing home providers. See ATI Advisory, “An Idea That’s Growing: Long-Term Care Providers Taking Charge in Managed Care” (April 2020) available at: https://atiadvisory.com/wp-content/uploads/2020/04/An-Idea-Thats-Growing_ATI-Advisory.pdf.

²⁵ Medicare Payment Advisory Commission (MedPAC), “Institutional special needs plans: Provision of services, network adequacy requirements, and star ratings” (April 2026), available at: <https://www.medpac.gov/wp-content/uploads/2025/08/Tab-I-I-SNPs-April-2026.pdf>.

²⁶ Center for Medicare Advocacy, Issue Brief: “The Premise and Reality of Institutional Special Needs Plans (I-SNPs)” (Apr. 15, 2026), available at: <https://medicareadvocacy.org/wp-content/uploads/2026/04/I-SNP-Issue-Brief-PDF-for-Posting-00800881xC6348.pdf>; also see Center for Medicare Advocacy, *CMA Alert* “Nursing Homes Operate Managed Care Programs for Their Residents – A Conflict of Interest” (Mar. 23, 2023), available at: <https://medicareadvocacy.org/isnps-a-conflict-of-interest/>.

v. Becerra, 24 F.4th 116 (2d Cir. 2022).²⁷ In March 2020, the U.S. District Court in Hartford, Connecticut issued a decision concluding that Medicare beneficiaries whose hospital classification is changed from inpatient to outpatient receiving observation services have the right to appeal that decision to Medicare and a chance to receive certain types of coverage, or to receive reimbursement for certain noncovered services resulting from that change. Although the actual hospital services received are typically indistinguishable to beneficiaries under either classification, the distinction between designation as an inpatient (Part A coverage) versus outpatient (Part B coverage) can and has resulted in devastating financial consequences for Medicare beneficiaries. For example, many Medicare beneficiaries who were reclassified as outpatient have had to either pay thousands of dollars out of pocket for required skilled nursing facility (SNF) care or forgo it altogether.

The Center for Medicare Advocacy, Justice in Aging, and *pro bono* partner Wilson Sonsini Goodrich & Rosati represented the plaintiffs in this lengthy litigation. See the Center for Medicare Advocacy's Frequently Asked Questions webpage for more information about the case and outpatient observation status.²⁸

The regulations address two types of appeals: retrospective and prospective. The retrospective appeals process, which was for class members who were denied the right to appeal in the past, expired at the end of 2025. Prospective appeals became operational on

²⁷ 89 Fed. Reg. 83240 (Oct. 4, 2024).

²⁸ Center for Medicare Advocacy website at:

<https://link.edgepilot.com/s/092767ca/Jwg95muhu0qkp9o7qV9smQ?u=https://medicareadvocacy.org/frequently-asked-questions-about-the-observation-status-court-decision/>

February 14, 2025 and are available on an ongoing basis for eligible beneficiaries who are still in the hospital.²⁹ If a hospital changes someone’s status from inpatient to outpatient receiving observation services, and the individual is either not enrolled in Part B or has stayed in the hospital for 3 or more consecutive days but were an inpatient for fewer than 3 days, the hospital is required to issue a written notice called the Medicare Change in Status Notice (MCSN). Medicare contractors known as Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIO, or QIO) – currently Acentra Health (formerly Kepro) and Commence Health (formerly Livanta) depending on the jurisdiction,³⁰ are tasked with providing both the first level of review (expedited determination) and the second level of review (expedited reconsideration).³¹

ii. Misclassified Appeals

CMA has encountered (and heard additional reports of) Medicare contractors misclassifying observation status appeals as hospital discharge appeals.³² This includes when a hospital has changed an individual’s status from inpatient to outpatient but has not issued an MCSN. For example, an advocate assisting a client with such an appeal was recently told by one QIO staff member that they “had not heard of this type of appeal” and when contacted by another QIO representative who was familiar with such appeals, was

²⁹ See 42 C.F.R. §§405.1210 – .1212; also see Center for Medicare Advocacy website at: <https://medicareadvocacy.org/observation-status-appeal-resources/>.

³⁰ See CMS website at: <https://www.cms.gov/medicare/quality/quality-improvement-organizations/family-centered-care>.

³¹ For a flowchart outlining this appeals process, see CMA “Medicare Expedited Appeals for Changes to Patient Status” available at: <https://medicareadvocacy.org/wp-content/uploads/2025/03/Prospective-Appeals-Flowchart.pdf>.

³² See, e.g., CMA Alert “Case Study: Observation Status Appeal Results in Nursing Home Coverage” (Aug. 7, 2025), available at: <https://medicareadvocacy.org/case-study-observation-status-appeal-results-in-nursing-home-coverage/>.

told that there was no MCSN in the record so the appeal would be rejected and could not go forward.

Under the law, patients have a right to appeal a change in status regardless of whether or not they have received an MCSN. If you encounter this scenario, please contact the Center for Medicare Advocacy.

David A. Lipschutz
Co-Director/Attorney
Center for Medicare Advocacy
(202) 293-5760
dlipschutz@medicareadvocacy.org