RECENT REFORMS TO THE MEDICARE ADVANTAGE PROGRAM, BY POLICY VEHICLE

2026 UPDATE

AS OF JULY 30, 2026

The annual Medicare Advantage regulatory cycle consists of the Medicare Advantage (MA) and Medicare Part D Final Rule and the Rate Announcement, finalized by the Centers for Medicare & Medicaid Services (CMS) each spring for the applicable contract year. This document tracks key policies by the regulatory or administrative vehicle that produced them — the CY2025 and CY2026 Final Rules and Rate Announcements, subsequent litigation, CMS Innovation Center actions, and the pending CY2027 rulemaking cycle — and notes where implementation has changed since these policies were first finalized.

CY 2025 MEDICARE ADVANTAGE AND PART D FINAL RULE (FINALIZED APRIL 2024)

Strengthening Access to Behavioral Health

- Adds a new facility-specialty type, "Outpatient Behavioral Health," that includes marriage and family therapists, mental health counselors, opioid treatment programs, and other behavioral health and addiction medical specialists and facilities.

> **UPDATE** *This network adequacy standard remains in effect. The CY2027 proposed rule would add further network adequacy changes and require plans to submit provider directory data for display on Medicare Plan Finder (pending).*

Increasing Oversight of Marketing and Communications Practices

- Prohibits third-party marketing organizations (TPMOs) from collecting personal beneficiary data for marketing or enrollment purposes if that data would be shared with other TPMOs without the beneficiary's written consent.
- Finalizes a one-to-one consent structure requiring TPMOs to obtain written consent for each TPMO that would receive beneficiary data.
- Updates agent and broker compensation definitions, including a $100 fixed administrative fee and related contract-term restrictions.

> **UPDATE** *The $100 fixed-fee cap and related agent/broker contract-term restrictions above were vacated in August 2025, when a federal district court (Americans for Beneficiary Choice v. HHS) held that CMS lacks statutory "ratemaking" authority over compensation and found the provisions arbitrary and capricious. The one-to-one beneficiary consent requirement was upheld and remains in effect. CMS's CY2027 proposed rule would repeal or narrow additional 2024 marketing oversight provisions; the comment period closed January 26, 2026. Separately, the Department of Justice has an active kickback/steering enforcement action against several large MA plans and broker organizations; a motion-to-dismiss hearing was held in January 2026.*

Implementing New Requirements for the Documentation and Reporting of Supplemental Benefits

Requires Medicare Advantage Organizations (MAOs) to:

- Establish a bibliography of evidence that a Special Supplemental Benefit for the Chronically Ill (SSBCI) will improve or maintain the beneficiary's health (applicable beginning with the CY2025 bid process).
- Follow policies based on objective criteria to determine an enrollee's SSBCI eligibility.
- Document SSBCI denials and approvals.
- Notify beneficiaries midyear of any unused supplemental benefits available to them.
- List the chronic conditions an enrollee must have to be eligible for an SSBCI.
- Apply specific font and reading-pace parameters for SSBCI disclaimers in advertising.
- Include SSBCI disclaimers in all marketing and communications materials that mention the SSBCI.

> **UPDATE** *These SSBCI documentation and reporting requirements remain in effect. CMS did not finalize additional SSBCI utilization-data guardrails in the CY2026 final rule; further supplemental benefit reporting changes are among the items under consideration in the CY2027 rulemaking cycle.*

Updating Requirements for Utilization Management

Requires all MAOs that use utilization management (UM) to establish a UM Committee to:

- Review and approve all UM policies and procedures at least annually.
- Ensure consistency with fee-for-service national and local coverage determinations and with relevant Medicare statutes and regulations.

Updates the composition of and requirements for the UM Committee by requiring:

- A member of the UM Committee to have expertise in health equity.
- An annual health equity analysis of prior authorization policies and procedures used by Medicare Advantage plans.
- MAOs to make the analysis results available on their websites.

> **UPDATE** *These UM Committee requirements remain in effect. CMS declined to require that the annual health equity analysis be reported at the individual item/service level rather than in aggregate, and did not finalize proposed AI guardrails for UM decision-making in the CY2026 final rule.*

Enhancing Enrollees' Right to Appeal a Medicare Advantage Plan's Decision to Terminate Coverage for Non-Hospital Provider Services

- Aligns Medicare Advantage regulations with reviews available in Medicare fee-for-service and expands Medicare Advantage beneficiaries' ability to fast-track the appeals process connected to terminations at a home health agency, comprehensive outpatient rehabilitation facility, or skilled nursing facility.

> **UPDATE** *This appeals right remains in effect. The CY2026 final rule separately narrowed the definition of appealable organizational determinations and restricted retroactive denial of previously approved services (see CY 2026 Final Rule, below).*

Improving Managed Care for Enrollees in Dual Eligible Special Needs Plans (D-SNP)

- Limits out-of-network cost sharing for D-SNP Preferred Provider Organizations for specific services beginning in 2025.
- Lowers the D-SNP look-alike threshold from 80% of dual-eligible enrollment to 70% in 2025 and to 60% in 2026.
- Beginning in 2027, in states where a parent organization also holds a Medicaid contract covering full-benefit dual eligibles, limits new enrollment in that parent organization's D-SNP to individuals also enrolled in a Medicaid managed care organization with the same parent organization.

> **UPDATE** *The integrated Medicare-Medicaid ID card and single integrated health risk assessment requirements for D-SNPs that are Applicable Integrated Plans, referenced above as a 2027 milestone, were confirmed for January 1, 2027 in the CY2026 final rule. Fully Integrated Dual Eligible SNPs (FIDE-SNPs) replaced the Medicare-Medicaid Plan (MMP) demonstration effective January 1, 2026. The CY2027 proposed rule would further tighten the D-SNP look-alike threshold and address C-SNP enrollment growth that CMS believes may be circumventing D-SNP integration requirements.*

CY 2025 MEDICARE ADVANTAGE AND PART D RATE ANNOUNCEMENT (FINALIZED APRIL 2024)

Updating Medicare Advantage Payment Factors

- Projects that the FFS growth rate (the basis for Medicare Advantage benchmarks) will decrease 0.16% relative to 2024.
- Continues the three-year phase-in of the graduate medical education (GME) technical adjustment finalized in the CY2024 Rate Announcement, applying 52% of the adjustment in CY2025 rather than the 67% originally proposed.

> **UPDATE** *CMS completed the GME technical adjustment phase-in, applying 100% of the adjustment beginning with the CY2026 Rate Announcement.*

Continuing Phase-In of the HCC Risk Adjustment Model

- Continues phasing in the 2024 CMS-Hierarchical Condition Category (HCC) risk adjustment model. For CY2025, CMS blends 33% of risk scores using the 2020 model and 67% using the updated 2024 model. For 2026 and beyond, 100% of risk scores will be calculated using the updated 2024 model.

> **UPDATE** *This phase-in is complete: 100% of MA risk scores have been calculated using the 2024 CMS-HCC model since CY2026. For CY2027, CMS declined to adopt a newer encounter-data-only risk adjustment model it had proposed and instead retained the 2024 model.*

Updating Star Ratings Measures	• CMS is considering a "Universal Foundation," a subset of measures aligned with the agency's broader quality and value-based care strategy, and is working to incorporate Universal Foundation measures into the Star Ratings pending future rulemaking. **UPDATE** *CMS has continued aligning Star Ratings with the Universal Foundation, reducing the weight of patient experience/access measures beginning with the 2026 Star Ratings and adding a substance use disorder treatment measure (2028 Star Ratings) and a depression screening measure (2029 Star Ratings). Separately, CMS's CY2027 final rule declined to implement the Health Equity Index reward previously scheduled for the 2027 Star Ratings, continuing the prior historical reward factor instead. A June 2026 court ruling in litigation brought by Clover Health found that CMS used certain 2026 Star Ratings measures without proper notice-and-comment rulemaking, prompting recalculation of that plan's rating; broader industry implications are still developing.*
IRA Part D Redesign Program Instructions	• CMS released separate guidance on implementation of the Part D redesign for 2025, finalizing key policies on true out-of-pocket (TrOOP) cost changes, the impact of TrOOP changes on Medicare Prescription Payment Plan (MPPP) calculations, beneficiary progression through the deductible, and enhanced alternative plan designs and prescription drug plan (PDP) meaningful difference. **UPDATE** *The Medicare Prescription Payment Plan (renamed M3P) has been operational since January 2025 for all Part D and MA-PD enrollees who opt in. The CY2026 final rule codified M3P requirements for 2026 and future years, including automatic annual re-enrollment of participants unless they affirmatively opt out.*

CMS INNOVATION CENTER AND ADMINISTRATIVE ACTIONS (2024–2026)*

Termination of the MA Value-Based Insurance Design (VBID) Model	• In December 2024, CMS announced it would terminate the MA VBID Model at the end of CY2025, citing unsustainable Medicare Trust Fund costs ($2.2–4.5 billion in 2021–2022 alone). Beneficiaries in VBID plans selected a new MA plan or returned to Traditional Medicare during the 2026 Open Enrollment Period; many VBID flexibilities, such as transportation and food/produce assistance, have been folded into standard supplemental benefit offerings.
Expansion of RADV Audits	• In May 2025, CMS announced it would audit all roughly 550 eligible MA contracts annually (up from about 60), increase sampled records per contract to as many as 200, and complete the backlog of Payment Year 2018–2024 audits by early 2026. • A September 2025 federal court ruling (Humana v. Becerra) vacated the extrapolation and FFS Adjuster provisions of the 2023 RADV Final Rule on procedural grounds. CMS has appealed; pending that appeal, recoveries are limited to sampled enrollees rather than extrapolated across full contracts.
Medicare GLP-1 Bridge Program	• CMS did not finalize a proposed reinterpretation of the statutory exclusion of weight-loss drugs that would have permitted broader Part D/MA coverage based on an obesity diagnosis alone (announced April 2025). • CMS instead created the Medicare GLP-1 Bridge Program, a temporary demonstration providing coverage of certain GLP-1 drugs for beneficiaries with a body mass index of 35 or higher, effective July 1, 2026 through December 31, 2027, alongside a related CMS Innovation Center demonstration (the BALANCE Model) announced in December 2025.

CY 2026 MEDICARE ADVANTAGE AND PART D FINAL RULE (FINALIZED APRIL 2025)*

Prior Authorization and Appeals	• Requires plans to honor medical necessity decisions rendered through prior authorization. • Restricts retroactive denial of previously approved services, including inpatient admissions, absent evidence of fraud or a valid "good cause" reason. • Narrows and clarifies the definition of organizational determinations eligible for appeal. • Did not finalize a proposed definition of "internal coverage criteria" or proposed AI guardrails for utilization management decision-making.
Behavioral Health Cost-Sharing	• Aligns MA and cost plan in-network cost sharing for behavioral health services with Traditional Medicare, including capped coinsurance for outpatient services and zero cost sharing for opioid treatment program services.

Special Needs Plans	• Codifies timeframes (generally within 90 days) for all SNPs to complete health risk assessments and individualized care plans. • Sets January 1, 2027 as the effective date for integrated Medicare-Medicaid ID cards and a single integrated health risk assessment for D-SNPs that are Applicable Integrated Plans.

CY 2026 MEDICARE ADVANTAGE AND PART D RATE ANNOUNCEMENT (FINALIZED APRIL 2025)*

- Completed the three-year phase-in of the GME technical adjustment, applying 100% beginning with CY2026.
- Completed the three-year phase-in of the 2024 CMS-HCC risk adjustment model, with 100% of risk scores calculated using the updated model beginning with CY2026.

LITIGATION AND ENFORCEMENT DEVELOPMENTS (2025–2026)*

Americans for Beneficiary Choice v. HHS (August 2025)	• A federal district court vacated the CY2025 final rule's $100 fixed-fee cap and related agent/broker contract-term restrictions, holding that CMS lacks statutory "ratemaking" authority over compensation. The court upheld the beneficiary data-sharing consent requirement, which remains in effect.
Humana v. Becerra (September 2025)	• A federal district court vacated the extrapolation and FFS Adjuster provisions of the 2023 RADV Final Rule on procedural grounds. CMS has appealed; the outcome will determine whether CMS can extrapolate audit findings across full MA contracts.
DOJ Kickback/Steering Enforcement Action	• The Department of Justice has an active complaint against several of the largest MA plans and insurance broker organizations alleging kickbacks and discriminatory steering; a hearing on a joint motion to dismiss was held in January 2026.
Clover Health Star Ratings Litigation (June 2026)	• A federal court found CMS used certain measures to calculate Clover Health's 2026 Star Rating without the required notice-and-comment rulemaking, ordering recalculation of that plan's rating. Broader implications for the Star Ratings methodology industrywide are still developing.

CY 2027 MEDICARE ADVANTAGE AND PART D PROPOSED RULE (ISSUED NOVEMBER 2025 — PENDING)*

- Would further tighten D-SNP look-alike thresholds and address C-SNP enrollment growth that CMS believes may be circumventing D-SNP integration requirements.
- Seeks comment on streamlining medical loss ratio (MLR) and network adequacy reporting requirements, and on how MA and Part D MLR calculations should account for vertical integration between plans and their affiliated providers, pharmacies, and PBMs.
- Would require MA plans to submit provider directory data for display on Medicare Plan Finder and to attest to its accuracy and consistency with network adequacy filings.

> **UPDATE** *The comment period closed January 26, 2026. Final action is pending as of this update.*

CY 2027 MEDICARE ADVANTAGE AND PART D RATE ANNOUNCEMENT (FINALIZED APRIL 2026)*

- Finalized a net average MA payment increase of 2.48% (over $13 billion) for CY2027, up from the 0.09% projected in the January 2026 Advance Notice, reflecting more complete FFS spending data.
- Retained the 2024 CMS-HCC risk adjustment model rather than adopting a newer encounter-data-only model that had been proposed in the Advance Notice.
- Confirmed that the Health Equity Index reward previously scheduled for the 2027 Star Ratings will not be implemented; the prior historical reward factor continues in its place.

*** Denotes a regulatory vehicle or development not included in the 2024 edition of this document.**

Note: Status reflects publicly available CMS rulemaking, rate announcements, and litigation as of July 30, 2026, and is intended to be read alongside the companion document, Recent Reforms to the Medicare Advantage Program, by Policy Area (2026 Update). The CY2027 Medicare Advantage and Part D proposed rule remains pending final action and may further revise several items above.