RECENT REFORMS TO THE MEDICARE ADVANTAGE PROGRAM, BY POLICY AREA

2026 UPDATE

AS OF AUGUST 14, 2026

The Centers for Medicare & Medicaid Services (CMS) shapes the Medicare Advantage program through an annual rulemaking and rate-setting cycle, and through demonstrations, audits, and litigation that unfold on their own timelines. The table below tracks the status of recent reforms by policy area, noting which provisions are now in effect, which remain proposed or pending, and which have been terminated, reversed, or vacated by the courts.

POLICY AREA	RECENT ACTION	EFFECTIVE DATE	STATUS
Part C Risk Adjustment Model and Normalization	In the CY 2027 Final Rate Announcement, CMS stated it will continue to use the 2024 CMS-Hierarchical Condition Category (HCC) risk adjustment model, implemented in CY 2026, rather than the updated risk adjustment model proposed in the CY 2027 Advance Notice. CMS will continue to use a simple linear regression methodology to calculate the Part C normalization factor across all CMS-HCC models. CMS finalized the exclusion from risk score calculations of diagnoses from audio-only encounters and diagnoses submitted on unlinked chart review records (CRRs). CMS added an exception for unlinked CRRs from beneficiaries who switch from one MA organization. These changes would not prohibit MA organizations from submitting CRRs to the Encounter Data System.	2027	**Effective**
Interoperability and Prior Authorization	The CY 2027 Final Rate Announcement builds on the 2024 requirement that plans answer expedited prior authorization requests within 72 hours and standard requests within seven calendar days. The CY 2026 MA and Part D Final Rule (April 2025) restricts plans from reopening a previously approved inpatient hospital admission except for cases of error or fraud. CMS also clarified that coverage decisions made concurrently while an enrollee is receiving services are MA organization determinations subject to applicable appeal and notice requirements. In the CY 2026 MA and Part D Final Rule, CMS did not finalize a proposed definition of "internal coverage criteria" or AI guardrails for utilization management. In April 2026, CMS issued a proposed rule (CMS-0062-P), which would extend electronic prior authorization and interoperability requirements to Part D drugs. The comment period closed on June 15, 2026.	2026	**Effective** Drug PA extension proposed
Value-Based Insurance Design (VBID) Model	The CMS Innovation Center terminated the MA VBID Model at the end of CY 2025, citing unsustainable Trust Fund costs of $2.3 billion in CY 2021 and $2.2 billion in CY 2022. Beneficiaries in VBID plans selected a new MA plan or returned to Traditional Medicare during the 2026 Open Enrollment Period. Many VBID flexibilities (transportation, food and produce assistance) have been folded into standard supplemental benefit offerings.	Ended Dec. 31, 2025	**Terminated**
Supplemental Benefits	In the CY 2025 MA and Part D Final Rule, CMS implemented new requirements for the documentation and reporting of supplemental benefits. The SSBCI evidence-submission and unused-benefit notification requirements remain in effect for the annual bid cycle. In the CY 2027 MA and Part D Final Rule, CMS rescinded the Mid-Year Enrollee Notification of Unused Supplemental Benefits requirement and finalized additional SSBCI transparency requirements, including public posting of plan-developed eligibility criteria and requirements governing administration of supplemental benefits through debit cards.	Implemented CY 2025; updates CY 2027	**Implemented**

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Medicare Prescription Payment Plan (Part D OOP Cost Smoothing / M3P)	In the CY 2025 Rate Announcement, CMS finalized policies on true out-of-pocket (TrOOP) cost changes and their impacts on the Medicare Prescription Payment Plan (M3P). M3P allows Part D enrollees to spread their out-of-pocket prescription drug costs over the course of the plan year rather than paying the full amount at the pharmacy. The program has been operational since January 2025 for all Part D and MA-PD enrollees who opt in. The CY 2026 MA and Part D Final Rule codified program requirements for 2026 and future years, including automatic annual re-enrollment of participants unless they affirmatively opt out.	Implemented CY 2025; codified CY 2026	**Effective**
Marketing and Communication Practices	The CY 2025 MA and Part D Final Rule's $100 fixed-fee cap and related agent/broker contract-term restrictions were vacated in August 2025. A federal district court (Americans for Beneficiary Choice v. HHS) held CMS lacks statutory "ratemaking" authority over compensation and found the provisions arbitrary and capricious. The court upheld the beneficiary data-sharing consent requirement, which remains in effect. The CY 2027 MA and Part D Final Rule further revised MA and Part D marketing and broker requirements to provide greater flexibility in beneficiary outreach. CMS removed restrictions on the timing and manner of beneficiary outreach, eliminated the 48-hour waiting period between completion of a Scope of Appointment (SOA) and a personal marketing appointment, and eliminated the 12-hour waiting period between educational and marketing events. CMS also allows plans and agents to collect SOAs at educational events. For Third-Party Marketing Organizations (TPMOs), CMS requires the TPMO disclaimer to be provided before any discussion of plan benefits. The rule also provides greater flexibility in marketing content, including the use of superlatives. DOJ 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.	Vacated Aug. 2025 (compensation caps); consent requirement remains in effect; CY 2027 marketing changes	**Partially Vacated / In Litigation**
Special Needs Plans (SNPs)	In the CY 2026 MA and Part D Final Rule, CMS finalized timeframes for all SNPs to complete health risk assessments and individualized care plans, generally within 90 days. In the rule, CMS delayed the requirement for integrated Medicare-Medicaid ID cards and a single integrated HRA for D-SNPs that are Applicable Integrated Plans to January 1, 2027. Fully Integrated Dual Eligible SNPs (FIDE-SNPs) replaced the Medicare-Medicaid Plan (MMP) demonstration effective January 1, 2026. In the CY 2027 rulemaking cycle, CMS requested information on the significant growth in C-SNP enrollment among dually eligible individuals and potential policy approaches to address concerns that some beneficiaries may be enrolling in C-SNPs rather than more integrated D-SNPs. CMS did not finalize any policy changes in response to the RFI and indicated that feedback may inform future rulemaking.	Implemented CY 2026; ID card/HRA integration CY 2027	**Effective**
Phase-In of Direct Graduate Medical Education	CMS completed the three-year phase-in of the technical adjustment removing medical education costs from MA growth rate calculations, applying 100% of the adjustment beginning with the CY 2026 Rate Announcement.	CY 2026	**Effective** Phase-in complete
Network Adequacy	In the CY 2025 MA and Part D Final Rule, CMS added an "Outpatient Behavioral Health" facility-specialty type (marriage and family therapists, mental health counselors, opioid treatment programs, and related providers), which remains in effect. The CY 2027 MA and Part D Final Rule includes further network adequacy changes and requires plans to submit provider directory data for display on Medicare Plan Finder.	Implemented CY 2025; additional changes finalized for 2027	**Effective** Additional provisions
Utilization Management (UM) Committees	In the CY 2025 MA and Part D Final Rule, CMS finalized the requirement that UM committees include a member with health equity expertise and publish an annual health equity analysis of prior authorization use. CMS declined to require that this 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 CY 2026 rule. In the CY 2027 Final Rule, CMS eliminated all three of these health-equity-specific UM Committee requirements.	Implemented CY 2025; eliminated CY 2027	**Effective** AI guardrails not finalized

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Star Ratings	In the CY 2025 MA and Part D Rate Announcement, CMS continues aligning Star Ratings measures with the Universal Foundation measure set, including reducing the weight of patient experience/access measures and adding a substance use disorder treatment measure (2028 Star Ratings) and a depression screening measure (2029 Star Ratings). A June 2026 court ruling in litigation brought by Clover Health found 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. In the CY 2027 Final Rule, CMS finalized the removal of 11 measures from Star Ratings with the goal of aligning the program with the agency's Quality Strategy and the Universal Foundation. The CY 2027 Rate Announcement also removes three measures from the 2027 Star Ratings. In the CY 2027 Final Rule, CMS did not implement the Excellent Health Outcomes for All (EHO4all) reward, previously called the Health Equity Index (HEI) reward, for the 2027 Star Ratings and instead continued the historical reward factor.	Ongoing; 2028–2029 measure additions	**In Progress** Legal uncertainty
Transparency	In the CY 2027 MA and Part D Final Rule, CMS finalized requiring 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, addressing long-standing beneficiary access to plan network information.	TBD	**Effective**
Risk Adjustment Data Validation (RADV) Audits	In May 2025, CMS announced an expansion of RADV audits, including plans to audit all eligible MA contracts in newly initiated audit years — approximately 550 contracts — and review between 35 and 200 medical records per contract. CMS's announced goal of completing the PY 2018–2024 audit backlog by early 2026 was not completed on that timeline. CMS initiated PY 2020 audits on March 20, 2026 and PY 2021 audits on May 29, 2026, and RADV audit activity remains ongoing. 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. CMS has since restored a five-month medical record submission window and moved to quarterly audit initiation to ease plan burden.	Ongoing; extrapolation vacated Sept. 2025, on appeal	**In Progress / In Litigation**
Anti-Obesity Medication (GLP-1) Coverage	A proposal to reinterpret the statutory exclusion of weight-loss drugs, which would have allowed Part D/MA coverage based on an obesity diagnosis alone, was not finalized by CMS in April 2025. CMS instead created the Medicare GLP-1 Bridge Program, a temporary Section 402 demonstration covering certain GLP-1 drugs for beneficiaries with a BMI of 35 or higher, effective July 1, 2026 through December 31, 2027. A related CMMI demonstration, the BALANCE Model, was announced in December 2025. CMS has since stated that BALANCE will not launch in Medicare in 2027; the GLP-1 Bridge was extended through the end of 2027 ahead of potential future Part D implementation of BALANCE.	Bridge: July 1, 2026 – Dec. 31, 2027	**Demonstration Implemented** BALANCE Medicare implementation deferred
Medical Loss Ratio (MLR) Requirements	CMS sought comment in both the CY 2026 and CY 2027 rulemaking cycles on how MA and Part D MLR calculations should account for vertical integration, including payments plans make to their own affiliated providers, pharmacies, and PBMs. The CY 2027 MA and Part D Final Rule did not finalize a vertical-integration-specific change to the MLR methodology.	Under consideration; no final action	**Under Review**

Note: Status reflects publicly available CMS rulemaking, rate announcements, and litigation as of August 13, 2026.