RECENT REFORMS TO THE MEDICARE ADVANTAGE PROGRAM, BY POLICY VEHICLE

2026 UPDATE

AS OF AUGUST 14, 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 CY 2024 through CY 2027 Final Rules and Rate Announcements, subsequent litigation, and CMS Innovation Center actions — and notes where implementation has changed since these policies were first finalized.

CY 2024 MEDICARE ADVANTAGE AND PART D RATE NOTICE (FINALIZED MARCH 31, 2023)

Beginning the V28 Risk Adjustment Transition

For CY 2024, CMS:

- Finalized the 2024 CMS-HCC risk adjustment model (V28) and began a three-year phase-in, calculating risk scores using 33% V28 and 67% of the 2020 CMS-HCC model.

> **UPDATE** *CMS continued the phase-in of the 2024 CMS-HCC model in CY 2025 and completed the phase-in in CY 2026, when 100% of MA risk scores were calculated using the 2024 model. In the CY 2027 Rate Announcement, CMS retained the 2024 CMS-HCC model for CY 2027 rather than implementing the updated risk-adjustment model proposed in the CY 2027 Advance Notice.*

Beginning the Graduate Medical Education (GME) Technical Adjustment

For CY 2024, CMS:

- Finalized a three-year phase-in of a technical adjustment removing direct and indirect graduate medical education costs from the Fee-for-Service (FFS) per-capita costs used to calculate MA payment rates, applying 33% of the adjustment in CY 2024.

> **UPDATE** *CMS continued the phase-in in CY 2025, applying 52% of the technical adjustment, and completed the phase-in in CY 2026 by applying 100% of the adjustment.*

CY 2024 MEDICARE ADVANTAGE AND PART D FINAL RULE (FINALIZED APRIL 5, 2023)

Advancing Health Equity

- For CY 2024, CMS requires plans to list language capabilities in their provider directories, assess digital health literacy of beneficiaries, and add at least one activity in their quality improvement programs aimed at reducing health disparities.

> **UPDATE** *In the CY 2027 MA and Part D Final Rule, CMS eliminated the requirement for plans to add at least one quality improvement activity addressing health disparities, citing regulatory burden and concluding that existing MA quality improvement requirements are sufficient; plans may continue such activities voluntarily.*

Strengthening Access to Behavioral Health Care

Beginning in CY 2024, CMS:

- Subjects Clinical Psychologists and Licensed Clinical Social Workers to MA network adequacy standards and allows these specialties to be eligible for the telehealth network adequacy credit.
- Clarifies that emergency behavioral health services must not be subject to prior authorization.
- Codifies appointment wait-time standards for primary care and behavioral health services, establishing clearer requirements for timely access to care. The requirements remain in effect and were supplemented by additional network adequacy requirements finalized for CY 2025.

Strengthening Enrollee Notification Requirements

Beginning in CY 2024, CMS:

- Requires specific enrollee notifications for no-cause and for-cause provider contract terminations, with more strict notification requirements for the termination of primary care and behavioral health providers. This provides beneficiaries more time to identify alternative providers and reduce care disruptions.
- Removes the "good faith effort" timing for no-cause terminations, limiting use to for-cause terminations, to strengthen plan accountability for timely beneficiary notification.

Limiting Use of Utilization Management (UM)	Beginning in CY 2024, CMS: • Requires plans to comply with general coverage and benefit conditions required in Medicare Fee-for-Service (FFS). Plans must make medical necessity determinations based on criteria specified in Medicare FFS regulation and cannot deny coverage on criteria that are not specified. • Limits plans' prior authorization (PA) use to confirm the presence of a diagnosis or other medical criteria needed to ensure that the basic benefit is medically necessary or that the supplemental benefit is clinically appropriate. • Requires plans to keep approved prior authorization requests valid for a course of treatment for as long as medically reasonable and necessary. Plans must also provide at least a 90-day transition period for beneficiaries receiving an active course of treatment who switch MA plans to reduce authorization requirements and potential care disruptions. • Requires plans to establish a UM committee to review policies and rationale at least once per year.
Updating the Star Ratings Program	• CMS finalized a reduction in the weight of patient experience and access measures from 4 to 2 beginning with the 2026 Star Ratings, reducing the impact of these measures on plan ratings and quality bonus payments. • CMS finalized removal of the 60% rule beginning with the 2026 Star Ratings, changing how CMS adjusts scores for contracts affected by extreme and uncontrollable circumstances.
Establishing the Health Equity Index (HEI) Reward	• CMS finalized an HEI reward beginning with the 2027 Star Ratings to replace the historical reward factor and reward contracts with high performance for beneficiaries with specified social risk factors. **UPDATE** *In the CY 2027 MA and Part D Final Rule, CMS reverses its decision to implement the HEI for 2027 Star Ratings. CMS said the change would provide greater stability while it considers broader simplification of the Star Ratings methodology and would refocus incentives on clinical care, outcomes, and patient experience.*

CY 2025 MEDICARE ADVANTAGE AND PART D FINAL RULE (FINALIZED APRIL 4, 2024)

Strengthening Access to Behavioral Health	For CY 2025, CMS: • 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 CY 2027 final rule adds further network adequacy changes and requires plans to submit provider directory data for display on Medicare Plan Finder.*
Increasing Oversight of Marketing and Communications Practices	Beginning in CY 2025, CMS: • 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. • Finalizes an expansion of the definition of agent/broker compensation and a $100 increase in the national fixed compensation amount for initial enrollments, as well as related contract restrictions for CY 2025 enrollments. **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 CY 2027 final rule narrows additional 2024 marketing oversight provisions. 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

Beginning with the CY 2025 bid process, CMS 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.
- Follow policies based on objective criteria to determine an enrollee's SSBCI eligibility.
- Document SSBCI denials and approvals.
- 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 CY 2026 final rule. Additionally, in the CY 2027 MA and Part D Final Rule, CMS rescinded the requirement for MA plans to send the Mid-Year Enrollee Notification of Unused Supplemental Benefits.*

Updating Requirements for Utilization Management

Beginning in CY 2025, CMS 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.

CMS also 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 CY 2026 final rule.*

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

Beginning in CY 2025, CMS:

- Aligns Medicare Advantage regulations with reviews available in Medicare FFS 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 CY 2026 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)

- CMS limits out-of-network cost sharing for D-SNP Preferred Provider Organizations for specific services beginning in 2025 to improve beneficiaries' access to providers.
- CMS lowers the D-SNP look-alike threshold from 80% of dual-eligible enrollment to 70% in 2025 and to 60% in 2026, reducing the ability of non-D-SNP MA plans to enroll high amounts of dual-eligible beneficiaries without meeting D-SNP integration requirements.
- Beginning in 2027, in states where a parent organization also holds a Medicaid contract covering full-benefit dual eligibles, CMS 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 CY 2026 final rule. Fully Integrated Dual Eligible SNPs (FIDE-SNPs) replaced the Medicare-Medicaid Plan (MMP) demonstration effective January 1, 2026. The CY 2027 final rule further tightens the D-SNP look-alike threshold and addresses C-SNP enrollment growth that CMS believes may be circumventing D-SNP integration requirements.*

Standardizing Risk Adjustment Data Validation (RADV) Appeals

- CMS finalizes revisions to the RADV appeal process requiring MA organizations to complete a medical-record review determination appeal before requesting a payment-error calculation appeal.

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

Updating Medicare Advantage Payment Factors

For CY 2025, CMS:

- Projects that Medicare Advantage revenue (prior to adjusting for risk score trend) will decrease by 0.16% relative to 2024.
- Continues the three-year phase-in of the graduate medical education (GME) technical adjustment finalized in the CY 2024 Rate Announcement, applying 52% of the adjustment in CY 2025 rather than the 67% originally proposed.

> **UPDATE** *CMS completed the GME technical adjustment phase-in, applying 100% of the adjustment beginning with the CY 2026 Rate Announcement.*

Continuing Phase-In of the HCC Risk Adjustment Model

- CMS continues phasing in the 2024 CMS-Hierarchical Condition Category (HCC) risk adjustment model. For CY 2025, 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 CY 2026.*

Updating Star Ratings Measures

- Beginning in CY 2025, 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 depression screening measure (2029 Star Ratings). Separately, CMS's CY 2027 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.*

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 CY 2025, citing unsustainable Medicare Trust Fund costs ($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, 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.

> **UPDATE** *RADV audit activity remains ongoing. CMS initiated PY 2020 audits in March 2026 and PY 2021 audits in May 2026 and has published an updated schedule for additional payment years.*

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 subsequently launched 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.
- 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.

CY 2026 MEDICARE ADVANTAGE AND PART D FINAL RULE (FINALIZED APRIL 4, 2025)	
Strengthening Prior Authorization and Appeals Protections	Beginning in CY 2026, CMS: • 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.
Implementing IRA Part D Redesign Program Modifications	• For CY 2026, CMS finalizes automatic re-enrollment requirements in the Medicare Prescription Payment Plan for 2025 enrollees beginning in the CY 2026 plan year. • The rule does not finalize requirements for plan sponsors to process enrollment requests during the plan year in real time or requirements for pharmacies to provide information on out-of-pocket costs for MPPP at the point-of-sale.
Behavioral Health Cost-Sharing	• Beginning in CY 2026, CMS 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.
Establishing Additional SSBCI Limits	• Beginning in CY 2026, CMS codifies categories of items and services that cannot qualify as SSBCI, including cosmetic products, non-healthy food, alcohol, tobacco, cannabis products, funeral expenses, and life insurance.
Special Needs Plans	• Beginning in CY 2026, CMS codifies timeframes (generally within 90 days) for all SNPs to complete health risk assessments and individualized care plans. • CMS 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 7, 2025)	
Full Implementation of CY 2024 Phase-In Adjustments	• CMS completes the three-year phase-in of the GME technical adjustment, applying 100% beginning with CY 2026. • CMS completes 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 CY 2026.

LITIGATION AND ENFORCEMENT DEVELOPMENTS (2025–2026)	
Americans for Beneficiary Choice v. HHS (August 2025)	• A federal district court vacates the CY 2025 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 vacates 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 finds 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 FINAL RULE (FINALIZED APRIL 6, 2026)

Removing Star Ratings Measures	• CMS finalizes 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. Some measures will be removed starting in 2028 Star Ratings, whereas other measures will be removed starting with 2029 Star Ratings. CMS does not finalize removal of "Diabetes Care — Eye Exam," as proposed.
Reversing the Health Equity Index (HEI) Reward Implementation	• CMS confirms that the Health Equity Index reward will not be implemented for CY 2027 Star Ratings; the prior historical reward factor continues in its place.
Finalizing Medicare Plan Finder Rule	• CMS will 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.
Improvements to Special Needs Plans	CMS finalizes several changes to SNP policies for CY 2027, including: • Simplifying passive enrollment for dual-eligible beneficiaries when their current integrated D-SNP is non-renewing or being terminated. • Replacing the "substantially similar" network requirement with a requirement that receiving plans provide a minimum 120-day continuity-of-care period. • Permitting certain coordination-only D-SNPs and Highly Integrated Dual-Eligible SNPs to continue enrolling dual-eligible beneficiaries in states that do not require mandatory Medicaid managed care.

CY 2027 MEDICARE ADVANTAGE AND PART D RATE ANNOUNCEMENT (FINALIZED APRIL 6, 2026)

Beginning in CY 2027, CMS:

- Finalized a net average MA payment increase of 2.48% (over $13 billion) for CY 2027, 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 the proposed recalibration using more recent underlying data.
- Finalized the exclusion from risk score calculations of diagnoses from audio-only encounters and diagnoses submitted on unlinked chart review records (CRRs). CMS also added an exception for unlinked CRRs from beneficiaries who switch from one MA organization in 2026 to another in 2027.
- Removed three measures from the 2027 Star Ratings, including "Care for Older Adults — Pain Assessment," "Medication Reconciliation Post-Discharge," and "Medication Therapy Management Program Completion Rate for Comprehensive Medication Review."
- 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.

Note: Status reflects publicly available CMS rulemaking, rate announcements, and litigation as of August 13, 2026, and is intended to be read alongside the companion document, Recent Reforms to the Medicare Advantage Program, by Policy Area (2026 Update).