RECENT REFORMS TO THE MEDICARE ADVANTAGE PROGRAM, BY POLICY AREA

2026

Update – as of July 30, 2026

POLICY AREA	RECENT ACTION	EFFECTIVE DATE	STATUS
Interoperability and Prior Authorization	▪ Builds on the 2024 requirement that plans answer expedited prior authorization requests within 72 hours and standard requests within seven calendar days. ▪ The CY2026 MA and Part D Final Rule (April 2025) requires plans to honor medical necessity decisions rendered through prior authorization and restricts retroactive denial of previously approved services, including inpatient admissions, absent fraud or good cause. CMS also narrowed the definition of appealable organizational determinations. ▪ CMS did not finalize a proposed definition of "internal coverage criteria" or AI guardrails for utilization management. ▪ A 2026 proposed rule (CMS-0062-P) would extend electronic prior authorization requirements to Part D drugs.	2026	**Implemented / Effective; drug PA extension Proposed**
Value-Based Insurance Design (VBID) Model	▪ CMS terminated the MA VBID Model at the end of CY2025, citing unsustainable 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 (transportation, food and produce assistance) have been folded into standard supplemental benefit offerings.	Ended Dec. 31, 2025	**Terminated**
Supplemental Benefits	▪ SSBCI evidence-submission and unused-benefit notification requirements remain in effect for the annual bid cycle. ▪ The CY2026 Final Rule did not finalize additional guardrails on SSBCI utilization data reporting; further supplemental benefit transparency measures remain under consideration in the CY2027 rulemaking cycle.	2025 Implemented; ongoing	**Implemented / Effective; additional guardrails Pending**

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Medicare Prescription Payment Plan (Part D OOP Cost Smoothing / M3P)	▪ M3P has been operational since January 2025 for all Part D and MA-PD enrollees who opt in. ▪ The CY2026 Final Rule codified program requirements for 2026 and future years, including automatic annual re-enrollment of participants unless they affirmatively opt out.	2025 Implemented; 2026 codified	**Implemented / Effective**
Marketing and Communication Practices	▪ The CY2025 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. ▪ CMS has since proposed rolling back additional marketing oversight provisions in the CY2027 proposed rule; the comment period closed January 26, 2026. ▪ 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	**Partially Vacated / In Litigation**
Special Needs Plans (SNPs)	▪ CMS finalized timeframes for all SNPs to complete health risk assessments and individualized care plans, generally within 90 days. ▪ The requirement for integrated Medicare-Medicaid ID cards and a single integrated HRA for D-SNPs that are Applicable Integrated Plans was delayed to January 1, 2027. ▪ Fully Integrated Dual Eligible SNPs (FIDE-SNPs) replaced the Medicare-Medicaid Plan (MMP) demonstration effective January 1, 2026. ▪ The CY2027 proposed rule would tighten D-SNP look-alike thresholds and address C-SNP enrollment growth that CMS believes may be circumventing D-SNP integration requirements.	2026 Implemented; 2027 (ID card/HRA integration)	**Implemented / Effective; additional provisions Proposed**

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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 CY2026 Rate Announcement. ▪ The related three-year phase-in of MA risk adjustment model improvements is also complete as of CY2026.	2026	**Implemented / Effective — phase-in complete**
Network Adequacy	▪ The 2025 expansion adding an "Outpatient Behavioral Health" facility-specialty type (marriage and family therapists, mental health counselors, opioid treatment programs, and related providers) remains in effect. ▪ The CY2027 proposed rule includes further network adequacy changes and would require plans to submit provider directory data for display on Medicare Plan Finder.	2025 Implemented; additional changes Proposed for 2027	**Implemented / Effective; additional provisions Pending**
Utilization Management (UM) Committees	▪ The requirement that UM committees include a member with health equity expertise and publish an annual health equity analysis of prior authorization use remains in effect. ▪ 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 CY2026 rule.	2025 Implemented	**Implemented / Effective; AI guardrails Not Finalized**

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Universal Foundation	▪ 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.	Ongoing; 2028–2029 measure additions	**In Progress; Legal Uncertainty**
Transparency	▪ CMS has proposed 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	**Preparation / In Progress**
Risk Adjustment Data Validation (RADV) Audits*	▪ In May 2025, CMS announced an aggressive expansion of RADV audits: all roughly 550 eligible MA contracts will be audited annually (up from about 60), sampled records per contract will grow to as many as 200, and CMS will 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. ▪ CMS has since restored a five-month medical record submission window and moved to quarterly audit initiation to ease plan burden. PY2018 findings are expected in mid-2026; PY2020 audits were slated to begin as early as February 2026.	Ongoing; extrapolation vacated Sept. 2025, on appeal	**In Progress / In Litigation**

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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.	Statutory reinterpretation not finalized (2025); Bridge Program effective July 1, 2026	**Demonstration Implemented; Broader Coverage Not Finalized**
Medical Loss Ratio (MLR) Requirements*	▪ CMS sought comment in both the CY2026 and CY2027 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 CY2027 proposed rule separately solicited feedback on streamlining MLR and network adequacy reporting to reduce administrative burden. ▪ No changes to MLR methodology addressing vertical integration have been finalized as of this update.	Under consideration; no final action	**Proposed / Under Review**
Health Equity Index (HEI) Reward*	▪ CMS finalized in the CY2027 rule that it will not implement the previously adopted Health Equity Index reward that had been scheduled to begin with the 2027 Star Ratings, and will instead continue the prior historical reward factor it was set to replace.	2027 Star Ratings	**Reversed / Not Implemented**

* Denotes a policy area 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. The CY2027 Medicare Advantage and Part D proposed rule (issued November 2025; comment period closed January 26, 2026) remains pending final action and may further revise several policy areas above.