Medicare Advantage Compliance Calendar 2026

Key dates and deadlines for MA providers

Q1 2026 (January - March)

January 1: New CPT code updates effective (review fee schedule)
January 10: CMS publishes final MA plan ratings (impacts network status)
January 31: Deadline to submit corrected 2025 claims (timely filing cutoff for most MA plans)
February 15: Medicare Advantage Open Enrollment ends (last day for beneficiaries to switch plans)
March 1: UHC prior auth expansion effective (72-hour turnaround requirement begins)
March 31: Q1 risk adjustment deadline (HCC coding submissions due)

Q2 2026 (April - June)

April 1: Annual Wellness Visit (AWV) campaign begins (target 80% completion by Q3)
April 15: Submit HEDIS/Stars measures for 2025 performance year
May 1: Provider revalidation window opens (every 3 years per CMS-855)
June 30: Mid-year compliance audit (internal review of prior auth, coding, documentation)

Q3 2026 (July - September)

July 1: New MA policies effective (review updated coverage criteria)
August 1: Annual Wellness Visit push (target stragglers before Q4)
September 15: Open Enrollment training begins (prepare staff for AEP)
September 30: Q3 risk adjustment deadline (final HCC submissions for 2026)

Q4 2026 (October - December)

October 1: ICD-10 code updates effective (new codes for 2027)
October 15: Annual Enrollment Period (AEP) begins (prepare for plan changes)
November 15: Open Enrollment closes (verify new plan assignments for Jan 1)
December 7: Medicare Advantage Open Enrollment begins (Jan 1 - March 31)
December 31: Year-end close (reconcile revenue, finalize risk adjustment, prepare for audit)

Ongoing Monthly Tasks:

- Submit prior authorizations within required timelines
- Review denial reports and appeal high-value denials
- Monitor days in AR (target: <30 days for MA claims)
- Track HEDIS/Stars quality measures
- Update fee schedules as plans release new rates

Critical Compliance Areas:

1. Risk Adjustment (HCC Coding)

• Document ALL chronic conditions at every visit
• Use highest specificity ICD-10 codes
• Submit diagnoses quarterly (don't wait until year-end)
• Track HCC capture rate (goal: 95%+)

2. HEDIS/Stars Measures
• Breast cancer screening (women 50-74)
• Colorectal cancer screening (adults 50-75)
• Diabetes HbA1c control (<8%)
• Blood pressure control (<140/90)
• Medication adherence (statins, diabetes meds, RASA)

3. Prior Authorization Compliance
• Verify auth requirements before service
• Track auth expiration dates
• Document medical necessity clearly
• Appeal denials within 60 days

4. Timely Filing
• MA plans: 90-180 days (varies by plan)
• Submit claims within 30 days of service
• Track submission dates vs DOS
• Set up automated alerts at 60-day mark

Red Flag Audit Triggers:

• Billing only 99213s and 99214s (undercoding or upcoding pattern)
• HCC codes with no supporting documentation
• Prior auth bypasses (billing without required auth)
• Consistent use of unspecified ICD-10 codes
• Appeal rate >15% (suggests systemic issues)

Pro Tip: Create a monthly compliance scorecard. Track HCC capture rate, Stars measures, prior auth compliance, and denial rate. Review with clinical and billing staff quarterly.