MEMORANDUM

To: PQA Members

From: PQA

Date: January 24, 2025

Re: Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

The Centers for Medicare & Medicaid Services (CMS) has issued "Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly."

The proposed rule, CMS-4208-P, was published in the Federal Register on December 10, 2024, and can be found here. A November 26, 2024, CMS press release and fact sheet provide additional information on the proposed rule.

CMS invites comments on the proposed rule, which can be submitted electronically via regulations.gov. To be considered, comments must be received by 5 p.m. Eastern Time on **January 27, 2025**. In commenting, please refer to file code CMS-4208-P.

PQA summarized points of interest in this proposed rule for our members, including proposed updates to the Star Ratings program.

Summary Explanation

The page numbers listed in the following summary correspond to the Federal Register document. An executive summary is provided on pages 2-3 and focuses narrowly on items most relevant to PQA's work. A broader summary of points of interest to PQA, its members and medication use is provided on pages 4-12.

Our goal with this summary is to isolate for your convenience the most relevant sections within the 240-page final rule. **In the broad summary, the language used is almost entirely verbatim from the proposed rule, so that we do not introduce interpretations of CMS's language. We recommend reviewing the original, full text for clarity and context as needed.**

The bold language in our summary is for emphasis to draw attention to specific items within the text. Finally, the text boxes indicate areas where CMS seeks comments, with a focus on comments relevant to PQA and its work.

III. Strengthening Current Medicare Advantage, Medicare Prescription Drug Benefit, and Medicaid Program Policies

A. Part D Coverage of Anti-Obesity Medications (AOMs) and Application to the Medicaid Program [P. 99375]

The statutory definition of a covered Part D drug excludes "[a]gents when used for anorexia, weight loss, or weight gain." All drugs used for weight loss have been excluded historically from the definition of covered Part D drug. Given the changes in how the medical community has come to regard obesity as a disease since the start of the Part D program in 2006, CMS believes that it would be more consistent with current medical views to propose to reinterpret the phrase "[a]gents when used for…weight loss" to exclude AOMs when used for the treatment of obesity.

As a result of this proposed reinterpretation, AOMs— when used for weight loss or chronic weight management for the treatment of obesity—would no longer be excluded from Part D coverage or from the definition of a Part D drug. CMS's proposal is not contingent on the underlying etiology of obesity (for example, due to unspecified causes or specified causes such as drug induced obesity or obesity due to specific genetic variants or syndromes) and would encompass any drugs that are indicated for weight loss or chronic weight management for the treatment of obesity.

Under current policy, AOMs are coverable under Part D for individuals with obesity or overweight only if the drug is being prescribed for another condition (other than weight loss or chronic weight management) for which the drug has an FDA-approved indication or its use is supported by CMS-approved compendia. Should CMS's proposed reinterpretation be finalized, Part D enrollees with obesity could receive coverage for AOMs even in cases where the AOM is prescribed for treatment of obesity and not prescribed for another condition that is an FDA-approved indication or that is supported by CMS-approved compendia.

- CMS solicits comment on the proposed reinterpretation, including CMS's underlying assumptions and the decision not to extend CMS's reinterpretation of the statutory exclusion to provide that individuals with overweight and at least one weight-related comorbidity could receive coverage of AOMs for weight loss or chronic weight management under Part D.

C. Part D Medication Therapy Management (MTM) Program Eligibility Criteria [P. 99381]

In response to the December 2022 proposed rule, some commenters suggested expanding the inclusion of Alzheimer's disease on the list of core chronic diseases to include other dementias such as Lewy Body disease or frontotemporal lobar degeneration. In CMS's responses to those comments in the April 2024 final rule, CMS stated that they would continue to analyze chronic diseases that are highly prevalent in the Part D population, align with common targeting practices across sponsors, and are commonly treated with covered Part D drugs, where MTM services could most impact therapeutic clinical outcomes, including those suggested by the commenters, and that CMS may consider proposing additional core chronic diseases in future rulemaking.

Consistent with this proposal, CMS proposes to modify the regulatory text identifying

"Alzheimer's disease" as a core chronic disease to include "Alzheimer's disease and dementia" effective January 1, 2026.

IV. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System

B. Adding, Updating, and Removing Measures [P. 99473]

1. Adding Measures

b. Initial Opioid Prescribing for Long Duration (IOP-LD) (Part D) [P. 99475]

CMS proposes to add the IOP-LD measure for the 2028 Star Ratings (2026 measurement year) because it is an important measure to promote safer prescription opioid use. The IOP-LD measure will be an additional tool for Part D sponsors to monitor initial opioid prescription exposure to reduce the risk for long-term opioid use and opioid use disorder. CMS began reporting the IOP-LD measure to Part D sponsors through the Patient Safety reports starting in measurement year 2020 and has publicly reported the measure on the Part D display page since 2023 (2021 performance data).

3. Summary of Measure Changes for the Part C and D Star Ratings [P. 99480]

TABLE 14: SUMMARY OF NEW AND REVISED INDIVIDUAL STAR RATING MEASURES FOR PERFORMANCE PERIODS BEGINNING ON OR AFTER JANUARY 1, 2026 *(Excerpt, PQA Measures)*

Measure	Measure Description	Domain	Category and Weight	Data Source	Measurement Period	Reporting Requirements (Contract Type)
Part D Measures						
Initial Opioid Prescribing for Long Duration	The percentage of beneficiaries, 18 years of age or older, with at least one initial opioid prescription for more than 7 cumulative days' supply.	Drug Safety and Accuracy of Drug Pricing	Process Measure Weight of 1	PDE	The calendar year 2 years prior to the Star Ratings year	MA-PD and PDP

- CMS currently plans to solicit comments through the 2026 Advance Notice and Rate Announcement process on ways to focus the measurement set to improve the impact of the Star Ratings program.
- CMS seeks comments from a broad range of interested parties on the proposal to add the IOP-LD measure to the Part D Star Ratings.

PQA Summary of the Proposed Rule by the Centers for Medicare & Medicaid Services

III. Strengthening Current Medicare Advantage, Medicare Prescription Drug Benefit, and Medicaid Program Policies

A. Part D Coverage of Anti-Obesity Medications (AOMs) and Application to the Medicaid Program [P. 99375]

The statutory definition of a covered Part D drug excludes "[a]gents when used for anorexia, weight loss, or weight gain." All drugs used for weight loss have been excluded historically from the definition of covered Part D drug. Given the changes in how the medical community has come to regard obesity as a disease since the start of the Part D program in 2006, CMS believes that it would be more consistent with current medical views to propose to reinterpret the phrase "[a]gents when used for…weight loss" to exclude AOMs when used for the treatment of obesity. Reinterpreting the statute to provide for coverage for AOMs for individuals who have obesity would build on the National Strategy by offering another tool that can support Medicare beneficiaries in addressing obesity and living healthier lives.

As a result of this proposed reinterpretation, AOMs— when used for weight loss or chronic weight management for the treatment of obesity—would no longer be excluded from Part D coverage or from the definition of a Part D drug. CMS's proposal is not contingent on the underlying etiology of obesity (for example, due to unspecified causes or specified causes such as drug induced obesity or obesity due to specific genetic variants or syndromes) and would encompass any drugs that are indicated for weight loss or chronic weight management for the treatment of obesity.

CMS believes that its longstanding interpretation of the phrase "[a]gents when used for…weight gain" to not include drugs used to treat acquired immunodeficiency syndrome (AIDS) wasting and cachexia is correct, and by adjusting its interpretation of "[a]gents when used for...weight loss," CMS would be bringing the interpretation of these two phrases into alignment.

CMS would permit Part D sponsors to define obesity for the purposes of their prior authorization (PA) criteria as long as the Part D sponsor's PA criteria are not more restrictive than the FDA labeling for the particular AOM which is consistent with other disease states. This approach is consistent with other disease states for which CMS does not specify diagnostic criteria, but reviews Part D plan-submitted PA criteria for clinical appropriateness.

Under current policy, AOMs are coverable under Part D for individuals with obesity or overweight only if the drug is being prescribed for another condition (other than weight loss or chronic weight management) for which the drug has an FDA-approved indication or its use is supported by CMS-approved compendia. Should CMS's proposed reinterpretation be finalized, Part D enrollees with obesity could receive coverage for AOMs even in cases where the AOM is prescribed for treatment of obesity and not prescribed for another condition that is an FDA-approved indication or that is supported by CMS-approved compendia.

In comparison, AOMs with FDA-approved indications for weight loss or chronic weight management in individuals with overweight, who do not have another condition that is a medically accepted indication (MAI) for the AOM, would continue to be excluded from the definition of a Part D drug and would not be coverable under Part D because, unlike obesity, overweight is not recognized as a disease. CMS acknowledges, however, that by limiting CMS's

proposed reinterpretation, CMS could create a perverse incentive for some individuals with overweight to gain additional weight in order to meet criteria for obesity.

- CMS solicits comment on the proposed reinterpretation, including CMS's underlying assumptions and the decision not to extend CMS's reinterpretation of the statutory exclusion to provide that individuals with overweight and at least one weight-related comorbidity could receive coverage of AOMs for weight loss or chronic weight management under Part D.

CMS's proposal to reinterpret the reference to "[a]gents when used for…weight loss" to allow for Medicare Part D coverage of drugs used for the treatment of obesity would also apply to the Medicaid program. Thus, if finalized, CMS's proposed reinterpretation would mean that AOMs, when used for weight loss or chronic weight management for the treatment of obesity, could not be excluded from Medicaid drug coverage. States would continue to have the discretion to utilize preferred drug lists and PA to establish certain limitations on the coverage of these drugs as long as such practices are consistent with the requirements to ensure appropriate utilization. This proposed policy is intended to facilitate access to these medications for individuals who meet the criteria for obesity whether they are enrolled in Medicaid, Medicare, or both.

C. Part D Medication Therapy Management (MTM) Program Eligibility Criteria [P. 99381]

Regulation specifies that to be targeted for MTM, beneficiaries must have multiple chronic diseases, with three chronic diseases being the maximum number a Part D sponsor may require for targeted enrollment. CMS established improved targeting criteria for the Part D MTM program to help ensure more consistent, equitable, and expanded access to MTM services, effective January 1, 2025, in the April 2024 final rule. Specifically, CMS finalized that Part D sponsors must include all core chronic diseases in their targeting criteria for identifying beneficiaries who have multiple chronic diseases. The 10 core chronic diseases are:

(1) Alzheimer's disease;
(2) Bone disease-arthritis (including osteoporosis, osteoarthritis, and rheumatoid arthritis);
(3) Chronic congestive heart failure (CHF);
(4) Diabetes;
(5) Dyslipidemia;
(6) End-stage renal disease (ESRD);
(7) Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS);
(8) Hypertension;
(9) Mental health (including depression, schizophrenia, bipolar disorder, and other chronic/disabling mental health conditions); and
(10) Respiratory disease (including asthma, chronic obstructive pulmonary disease (COPD), and other chronic lung disorders).

Sponsors retain the flexibility to target additional chronic diseases beyond those codified as core chronic diseases.

In response to the December 2022 proposed rule, some commenters suggested expanding the inclusion of Alzheimer's disease on the list of core chronic diseases to include other

dementias such as Lewy Body disease or frontotemporal lobar degeneration. In CMS's responses to those comments in the April 2024 final rule, CMS stated that they would continue to analyze chronic diseases that are highly prevalent in the Part D population, align with common targeting practices across sponsors, and are commonly treated with covered Part D drugs, where MTM services could most impact therapeutic clinical outcomes, including those suggested by the commenters, and that CMS may consider proposing additional core chronic diseases in future rulemaking.

Therefore, CMS has concluded that it would be appropriate to update the list of core chronic diseases used to identify Part D enrollees who have multiple chronic diseases for eligibility for MTM enrollment to include not only Alzheimer's disease but also all other causes of dementia to improve medication adherence and to reduce the risk of adverse events. **Consistent with this proposal, CMS proposes to modify the regulatory text identifying "Alzheimer's disease" as a core chronic disease to include "Alzheimer's disease and dementia" effective January 1, 2026.**

IV. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System

A. Introduction [P. 99472]

The policies and regulatory changes proposed here will apply to the quality ratings for MA plans, cost plans, and Part D plans. To support the CMS National Quality Strategy, CMS is moving towards a building-block approach to streamline quality measures across CMS quality and value-based care programs. Using the Universal Foundation of quality measures would focus provider attention, reduce burden, identify disparities in care, prioritize development of interoperable, digital quality measures, allow for cross-comparisons across programs, and help identify measurement gaps. The Universal Foundation is a building block to which programs would add additional aligned or program-specific measures. This core set of measures would evolve over time to meet the needs of individuals served across CMS programs. CMS currently plans to solicit comments through the 2026 Advance Notice and Rate Announcement process on ways to focus the measurement set to improve the impact of the Star Ratings program. **In this proposed rule CMS is proposing to add or update the following measures:**

- Initiation and Engagement of Substance Use Disorder Treatment (IET) (Part C)
- Initial Opioid Prescribing for Long Duration (IOP-LD) (Part D)
- Breast Cancer Screening (Part C)
- Plan Makes Timely Decisions about Appeals (Part C) and Reviewing Appeals Decisions (Part C)

B. Adding, Updating, and Removing Measures [P. 99473]

CMS lists the measures used for the Star Ratings each year in the Medicare Part C & D Star Ratings Technical Notes or similar guidance issued with publication of the Star Ratings. In this rule, CMS is proposing to add the Initial Opioid Prescribing for Long Duration (Part D) measure to the Star Ratings program for performance periods beginning on or after January 1, 2026. CMS continues to review measures that are nationally endorsed and in alignment with the private sector. For example, CMS regularly reviews measures developed by the National

Committee for Quality Assurance (NCQA) and Pharmacy Quality Alliance (PQA).

1. Adding Measures

b. Initial Opioid Prescribing for Long Duration (IOP-LD) (Part D) [P. 99475]

CMS proposes to add the IOP-LD measure for the 2028 Star Ratings (2026 measurement year) because it is an important measure to promote safer prescription opioid use. The IOP-LD measure will be an additional tool for Part D sponsors to monitor initial opioid prescription exposure to reduce the risk for long-term opioid use and opioid use disorder. CMS began reporting the IOP-LD measure to Part D sponsors through the Patient Safety reports starting in measurement year 2020 and has publicly reported the measure on the Part D display page since 2023 (2021 performance data). CMS announced in the Announcement of Calendar Year (CY) 2021 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, as well as in subsequent Rate Announcements, that the IOP-LD measure would be considered in the future for addition to the Star Ratings.

The IOP-LD measure underwent further review and evaluation during the 2023 Pre-rulemaking Measure Review (PRMR) process by the CBE to provide recommendations for selecting quality and efficiency measures for use in CMS programs. A consensus for inclusion in the Part D Star Ratings was not reached during the PRMR process for the IOP-LD measure. Approximately 36 percent (5 of the 14 voting members) did not recommend this measure, resulting in the committee not reaching the 75 percent consensus threshold as summarized in the PRMR 2023 Recommendations Report. As noted in the Report, committee members acknowledged the importance of having a measure that assesses opioid prescriptions as a method of harm reduction and that the measure may fill a gap in opioid safety in the Star Ratings program. Committee members sought clarification on the specifications and consideration of measure exclusions for patients with complex medical needs. Some members of the committee expressed concern for the adequacy of evidence and alignment with current clinical guidelines for opioid prescribing. The committee also discussed potential unintended consequences of measure implementation on prescriber hesitancy, the quality of pain management, and harm for patients who need long-term opioids. CMS discussed that the measure is not intended to guide clinical decision-making for individual patients and does not represent a prescribing limit.

Measure Specifications:

The measure specifications are designed to reduce unintended consequences and complement Medicare Part D opioid-related policies. The IOP-LD measure was endorsed by the PQA's membership and included a review by the PQA's Patient and Caregiver Advisory Panel in 2018, with 100% voting members in favor of the measure as important to patients and caregivers. The National Quality Forum (NQF) Patient Safety Standing Committee (NQF #3558) also endorsed the measure in 2019, demonstrating that it meets high standards of evidence to impact healthcare quality. The NQF Patient Safety Standing Committee unanimously deemed the IOP-LD measure to meet the importance criterion, with zero votes for "low" on any importance-related sub-criteria.

CMS will use the PQA Measure Manual specifications and Value Sets. The IOP-LD measure evaluates the percentage of Part D beneficiaries, 18 years or older with at least one initial opioid prescription for more than 7 cumulative days' supply. To prevent misapplication, the following beneficiaries are excluded: (i) those with cancer or sickle cell disease diagnoses and (ii) those who elected to receive hospice care or are in palliative care at any time during the measurement period or the 90 days prior to the index prescription start date, which is the earliest date of service (DOS) for an opioid medication during the measurement year. The IOP-LD period has a lookback period, which is 90 days prior to each opioid prescription claim.

The initial opioid prescription is the earliest DOS for an opioid prescription claim during the measurement year following a negative medication history. The opioid initiation period is the 3-day period when the numerator is assessed and ensures a comprehensive view of initial opioid prescribing and includes the date of the initial opioid prescription plus 2 days. All prescription claims during the opioid initiation period are counted cumulatively towards the days' supply total to avoid situations where a patient is prescribed a long duration of opioids following a very brief initial duration (that is, 1-3 days).

The IOP-LD measure is intended for retrospective population-level performance measurement of Part D plan sponsors (at the contract-level) and not to guide clinical decision making for individual patients. The measure does not address opioid dosage, only the duration of an initial opioid prescription. Medications used for opioid use disorder (MOUD) are not included in the IOP-LD measure; for methadone, only use for pain is included.

The measure is not intended to impact current long-term opioid use. Because this measure only captures initial opioid prescriptions in individuals with no opioid history in the preceding 90 days, it is not anticipated to result in unintended consequences related to discontinuation or abrupt tapering of opioid use in current, long-term users. CMS recognizes that some beneficiaries may require a longer duration for their initial opioid prescription based on the acute pain condition being treated (for example, major surgery or injury). Subsequent fills for opioids after the initial opioid prescription are not factored into the measure. However, by design, the measure does encourage re-evaluation of the benefits and risks for continued opioid therapy, which is a recommendation in the updated Centers for Disease Control and Prevention (CDC) Clinical Practice Guideline for Prescribing Opioids for Pain, 2022. These mechanisms should allow for timely reevaluation to confirm or revise the initial diagnosis and adjust pain management accordingly.

Evidence for Measure:

The duration of initial opioid exposure is associated with a higher likelihood of long-term opioid use. There is a consistent body of empirical evidence that a greater days' supply for initial opioid prescriptions is associated with significant risks, including increased risk of long-term opioid use, opioid misuse, and overdose. In the 2022 CDC Guideline, the CDC reaffirmed their recommendation on initial opioid prescription duration that "when opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids." In the

associated implementation consideration text, the updated CDC Guideline notes that "when the diagnosis and severity of acute pain warrant use of opioids, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids" and "for many common causes of nontraumatic, nonsurgical pain, when opioids are needed, a few days or less are often sufficient." In an April 2023 Drug Safety Communication, the Food and Drug Administration (FDA) stated "Data also suggest that many acute pain conditions treated in the outpatient setting require no more than a few days of an opioid pain medicine, although the dose and duration of treatment needed to adequately manage pain will vary based on the underlying cause and individual patient factors."

Existing evidence-based literature reinforces the CDC's recommendations regarding the duration of initial opioid prescriptions. A retrospective cohort study by Shah et al., found that the probability of long-term opioid use increased with each additional day supplied when initiating opioid therapy, following the third day supplied. A different retrospective study published by Shah et al., provided further evidence that a greater days' supply for initial opioid prescriptions was associated with a decreased likelihood of opioid discontinuation. Another study by Hadlandsmyth replicated Shah et al.'s methodology and the results corroborated Shah's study that an association exists between initial opioid exposure and the rate of long-term use. Additionally, a study by Mojtabai analyzed trends in prescription opioid use among adults in the United States from 1999-2000 to 2013-2014 and found a significant increase in the prevalence of prescription opioid use, driven by an increase in long-term use.

Medicare Part D Opioid-Related Policy Alignment:

To help prevent and combat prescription opioid overuse through improved concurrent DUR, sponsors are expected to implement real-time opioid safety edits at the POS, including an edit to limit initial opioid prescription fills for opioid naïve beneficiaries to no more than a 7 days' supply. Sponsors should not implement these edits so that beneficiaries' access to MOUD, such as buprenorphine, is impacted; sponsors should not include MOUD in this edit.

The IOP-LD measure complements the opioid naïve safety edit because it is similarly focused on the duration of initial opioid prescriptions to reduce risks, but the IOP-LD measure is retrospective. Sponsors are also required to establish a drug management program (DMP) for beneficiaries at-risk for misuse or abuse of frequently abused drugs, and beneficiaries with potential patterns of opioid misuse or with a history of opioid-related overdose are to be included in DMPs per the established retrospective criteria.

The IOP-LD measure is an additional tool for sponsors to assess the effectiveness of Medicare Part D opioid-related strategies to reduce the risk of long-term opioid use, opioid misuse, or overdose.

Data-Driven Need:

The IOP-LD rates for Part D contracts can be improved. The average IOP-LD rate across all contracts was about 16 percent for the 2021 measurement year (2023 display page) and 2022 measurement year (2024 display page). The average rates were 17 percent for

MA-PDs and 13 percent for PDPs in the 2021 measurement year and 17 percent and 14 percent for MA-PDs and PDPs, respectively, in 2022. There was a range of IOP-LD rates among contracts; some of the highest rates for this measure by contract are 43 percent, 53 percent, and 64 percent.

The PQA has developed other measures to address opioid misuse, including the Use of Opioids at High Dosage in Persons without Cancer (OHD), Use of Opioids from Multiple Providers in Persons without Cancer (OMP), and Use of Opioids at High Dosage and from Multiple Providers in Persons without Cancer (OHDMP) measures, which CMS has used for quality and performance oversight. In 2019, the PQA revised these three measures which CMS implemented in the Patient Safety reports to Part D sponsors for the 2019 measurement year. These three measures were added to the display page beginning in 2021 (then using 2019 data).

These three measures share the same denominator criteria, based on the number of member-years (MYs) of enrolled Part D beneficiaries with two or more prescription claims for opioids, filled on at least two unique dates of service, for at least 15 total cumulative opioid days' supply over a period of 90 days or longer during the measurement period. CMS currently adjusts Part D enrollment based on MYs to account for enrolled beneficiaries for only part of the contract year. There has been an increase in the number of MYs of enrolled beneficiaries from almost 35.6 million to about 42.7 million from 2017 to 2022 measurement years (respectively, from 2019 to 2024 display page) while the proportion of MYs of enrolled beneficiaries receiving at least two fills of prescription opioids and at least 15 days of supply of opioids over a period of 90 days or longer has decreased from 17 percent in 2017 to 9 percent in 2022. Even with this reduction, roughly four million MYs of enrolled beneficiaries still demonstrate long-term use of opioid prescriptions.

The disparities in opioid overdose rates underscore the urgency to address the widening gap in health outcomes. There is room for improvement and variations in IOP-LD rates among Part D sponsors. The IOP-LD measure is a preventative-focused quality measure that addresses initial prescription opioid exposure to reduce the likelihood of long-term opioid use and reduce the risk of opioid overdose. CMS proposes to add the Part D IOP-LD measure to the Star Ratings for the 2028 Star Ratings (2026 measurement year).

3. Summary of Measure Changes for the Part C and D Star Ratings [P. 99480]

Table 14 summarizes the additional and updated measures addressed in this proposed rule, beginning with the 2028 Star Ratings. The *Medicare Part C & D Star Ratings Technical Notes* provide detailed specifications for each measure including a measure's: (1) numerator, (2) denominator, (3) calculation, (4) timeframe, (5) case-mix adjustment, and (6) exclusions. The Technical Notes document is updated annually.

TABLE 14: SUMMARY OF NEW AND REVISED INDIVIDUAL STAR RATING MEASURES FOR PERFORMANCE PERIODS BEGINNING ON OR AFTER JANUARY 1, 2026 *(Excerpt, PQA Measures)*

Measure	Measure Description	Domain	Category and Weight	Data Source	Measurement Period	Reporting Requirements (Contract Type)
Part D Measures						
Initial Opioid Prescribing for Long Duration	The percentage of beneficiaries, 18 years of age or older, with at least one initial opioid prescription for more than 7 cumulative days' supply.	Drug Safety and Accuracy of Drug Pricing	Process Measure Weight of 1	PDE	The calendar year 2 years prior to the Star Ratings year	MA-PD and PDP

- CMS currently plans to solicit comments through the 2026 Advance Notice and Rate Announcement process on ways to focus the measurement set to improve the impact of the Star Ratings program.
- CMS seeks comments from a broad range of interested parties on the proposal to add the IOP-LD measure to the Part D Star Ratings.