



MEMORANDUM

To: PQA Members

From: PQA

Date: December 11, 2025

Re: Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program

The Centers for Medicare & Medicaid Services (CMS) has issued “Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program.”

The proposed rule, CMS-4212-P, was published in the Federal Register on November 28, 2025, and can be found [here](#). A November 25, 2025 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 **January 26, 2026**. In commenting, please refer to file code CMS-4212-P.

PQA has summarized points of interest in this proposed rule for our members, including proposed updates to the Star Ratings program. Specifically, our summary is focused on two sections of the proposed rule:

- Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System
- Request for Information on Future Directions in Medicare Advantage (Risk Adjustment, Quality Bonus Payments, and Well-Being and Nutrition)

Summary Explanation

The sections and page numbers listed in the following summary correspond to the 137-page Federal Register [PDF document](#). An executive summary is provided on page 2 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 3-7.

Our goal with this summary is to isolate for your convenience the most relevant sections within the 137-page final rule. **In the broad summary, the language used is almost entirely verbatim from the final rule, so that we do not introduce interpretations of CMS’ 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 solicits comments.

PQA Executive Summary: CMS-4212-P

The sections and page numbers listed in this Executive Summary correspond to the 137-page Federal Register [PDF document](#).

V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings)

- B. Adding, Updating, and Removing Measures [P. 71-74]
 - 1. Removing Measures [P. 72-74]

CMS proposes to remove the twelve measures in Table 1 beginning with the Star Ratings year shown in the table for each measure.

TABLE 1: MEASURES PROPOSED TO BE REMOVED FROM THE STAR RATINGS

Part C or D	Measure Name	Star Ratings Year Proposed for Removal
C	Plan Makes Timely Decisions about Appeals	2029 Star Ratings
C	Reviewing Appeals Decisions	2029 Star Ratings
C	Special Needs Plan (SNP) Care Management	2029 Star Ratings
C	Call Center – Foreign Language Interpreter and TTY Availability	2028 Star Ratings
D	Call Center – Foreign Language Interpreter and TTY Availability	2028 Star Ratings
C and D	Complaints about the Health/Drug Plan	2029 Star Ratings
D	Medicare Plan Finder Price Accuracy	2029 Star Ratings
C	Diabetes Care – Eye Exam	2029 Star Ratings
C	Statin Therapy for Patients with Cardiovascular Disease	2028 Star Ratings
C and D	Members Choosing to Leave the Plan	2029 Star Ratings
C	Customer Service	2029 Star Ratings
C	Rating of Health Care Quality	2029 Star Ratings

- 2. Adding Measure [P. 74-75]
 - a. Depression Screening and Follow-Up (Part C)

As CMS continues to align with the Universal Foundation, **CMS also proposes to add the Part C Depression Screening and Follow-Up (DSF) measure to the 2029 Star Ratings** (measurement year 2027). CMS will begin reporting the DSF measure on the display page for the 2026 Star Ratings.

[PQA note for clarification: DSF measure reporting on the 2026 display page will use data from the 2024 measurement year.]

- D. Health Equity Index (HEI) Reward [P. 75-76]

Since the April 2023 final rule, CMS has reviewed the HEI reward consistent with the Executive Order 14192, “Unleashing Prosperity Through Deregulation” and **proposes to remove the HEI reward from the Star Ratings methodology. CMS proposes not to implement the HEI reward with the 2027 Star Ratings and instead continue the historical reward factor.**

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

V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings)

A. Introduction [P. 71]

In this proposed rule, CMS is proposing changes to simplify and refocus the areas included in the Star Ratings, including changes to the measure set. CMS also proposes to not move forward with the implementation of the Health Equity Index reward and to continue to include the historical reward factor in the Star Ratings methodology. CMS proposes to add additional information about the data available to Medicare Advantage (MA) organizations and Part D sponsors during the plan preview periods before each Star Ratings release. CMS also solicits comments on ways to further simplify and modify the Star Ratings program to further drive improved quality of care, and whether there are ways to streamline the timeline from measure development to implementation.

B. Adding, Updating, and Removing Measures [P. 71-74]

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.

1. Removing Measures [P. 71--74]

As the Part C and Part D Star Rating program continues to evolve and align with the measures included in the Universal Foundation, a strategy to align measures across the agency's quality and value-based care goals, CMS proposes to simplify and refocus the measure set on clinical care, outcomes, and patient experience of care measures where performance is not topped out and where there is more variation in performance across contracts.

Reducing the number of measures would increase the focus on the remaining measures, including those consistent with the Make America Healthy Again (MAHA) initiative, such as Reducing the Risk of Falling and Monitoring Physical Activity. Additionally, reducing the number of measures is consistent with recommendations from MedPAC and other interested parties that CMS consider having fewer measures in the Part C and Part D Star Ratings program. This is also consistent with the Universal Foundation which attempts, among other things, to focus attention on measures that are meaningful for the health of broad segments of the population and to reduce provider burden by streamlining and aligning measures—in other words, to focus the measure set on clinical care, outcomes, and patient experience of care measures.

CMS initially solicited feedback on simplifying and refocusing the measure set in the Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies ("2026 Rate Announcement"), as well as from the Star Ratings Technical Expert Panel (TEP) in October 2024.

Although the TEP recommended keeping the measure set as large as possible to avoid the ratings being influenced by a single measure, the TEP did support rethinking the measures included. Overall, the TEP supported measures from the current Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems

(CAHPS), Health Outcomes Survey (HOS), and some of the operational measures. Suggestions included the following: adding more evidence-based, clinical outcomes measures or redesigning current measures to assess patient outcomes (such as medication adherence); considering relevance, reliability, and the small denominator for some measures; considering “gameability,” attribution issues, provider burden, and the sensitivity of measures to small changes; and considering measures focused on trust enrollees have in the plan and network issues.

After taking into consideration feedback from the TEP and from interested parties that commented on the Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, **CMS is proposing to remove seven Star Ratings measures focused on operational and administrative performance, three additional measures focused on process of care, and two additional measures focused on patient experience of care.**

There are various measures currently in the Part C and Part D Star Ratings measure set that focus on operational performance or on completion of required administrative processes. While these measures have been invaluable to CMS’s efforts to monitor and improve plan performance and compliance in critical operational areas, many of these measures may be better suited as measures to monitor plan performance and compliance rather than as quality measures in the Part C and Part D Star Ratings program, especially since ratings for many of these measures are sensitive to small changes in performance because they have smaller denominators, such that small changes in the numerator can have a large impact on the measure Star Rating. Additionally, CMS has seen improvement on these measures since the inception of the Part C and Part D Star Ratings program, and MA organization and Part D sponsor performance rates are consistently fairly high.

CMS also proposes to remove three additional process measures (Diabetes Care – Eye Exam, Statin Therapy for Patients with Cardiovascular Disease, and Members Choosing to Leave the Plan) and two patient experience of care measures (Customer Service and Rating of Health Care Quality) to further streamline the Star Ratings measure set. CMS wants to focus more on clinical care, outcomes, and patient experience of care measures where performance is not topped out and where there is more variability in performance across contracts. Additionally, when there is little variation in performance across contracts for a measure, this does not provide meaningful information to beneficiaries or their caregivers when choosing a plan. Reducing the number of operational and administrative measures and removing some additional process and patient experience of care measures would also increase the relative weight of the outcome measures in the summary and overall ratings.

CMS proposes to remove the twelve measures in Table 1 beginning with the Star Ratings year shown in the table for each measure. CMS expects that removing these measures would result in an overall decrease in ratings since performance on many of these measures is very high; however, CMS also expects that the proposed removal of the Health Equity Index (HEI; also called Excellent Health Outcomes for All) reward along with keeping the historical reward factor, discussed in more detail in section V.D. of this proposed rule, would generally increase ratings.

CMS is also considering removing additional measures in the future as it continues to simplify and refocus the program. Removal of any additional measures would need to be proposed and finalized through rulemaking.

TABLE 1: MEASURES PROPOSED TO BE REMOVED FROM THE STAR RATINGS

Part C or D	Measure Name	Star Ratings Year Proposed for Removal
C	Plan Makes Timely Decisions about Appeals	2029 Star Ratings
C	Reviewing Appeals Decisions	2029 Star Ratings
C	Special Needs Plan (SNP) Care Management	2029 Star Ratings
C	Call Center – Foreign Language Interpreter and TTY Availability	2028 Star Ratings
D	Call Center – Foreign Language Interpreter and TTY Availability	2028 Star Ratings
C and D	Complaints about the Health/Drug Plan	2029 Star Ratings
D	Medicare Plan Finder Price Accuracy	2029 Star Ratings
C	Diabetes Care – Eye Exam	2029 Star Ratings
C	Statin Therapy for Patients with Cardiovascular Disease	2028 Star Ratings
C and D	Members Choosing to Leave the Plan	2029 Star Ratings
C	Customer Service	2029 Star Ratings
C	Rating of Health Care Quality	2029 Star Ratings

g. Statin Therapy for Patients with Cardiovascular Disease (Part C)

CMS proposes removing the Statin Therapy for Patients with Cardiovascular Disease (Part C) measure as part of their effort to streamline the Star Ratings measure set and increase the focus on patient experience and outcome measures. There is not a lot of variation in performance across contracts on this measure, and there are other measures, such as Medication Adherence for Cholesterol (Statins), currently in the Star Ratings that cover a similar topic area as this measure. As noted in the Announcement of Calendar Year (CY) 2026 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, the National Committee for Quality Assurance (NCQA) reevaluated the Statin Therapy for Patients with Cardiovascular Disease (Part C) measure for the 2026 measurement year. The changes finalized by NCQA expand the eligible population and are considered a substantive change to the measure. CMS will include the updated Statin Therapy for Patients with Cardiovascular Disease on the 2028 display page and monitor changes in performance for this measure since statin therapy is important in lowering cholesterol and reducing the risk of cardiovascular disease.

2. Adding Measure [P. 74-75]

a. Depression Screening and Follow-Up (Part C)

CMS is committed to continuing to improve the Part C and Part D Star Ratings system by focusing on improving clinical and other health outcomes. As CMS continues to align with the Universal Foundation, **CMS also proposes to add the Part C Depression Screening and Follow-Up (DSF) measure to the 2029 Star Ratings** (measurement year 2027). CMS will begin reporting the DSF measure on the display page for the 2026 Star Ratings. As new performance measures are developed and adopted they are initially posted on the display page for at least 2 years.

[PQA note for clarification: DSF measure reporting on the 2026 display page will use data from the 2024 measurement year.]

C. Streamlining the Methodology, Further Incentivizing Quality Improvement, and Suggestions for New Measures [P. 75]

- Finally, CMS is also soliciting feedback on ways to streamline and modify the Star Ratings methodology to further incentivize quality improvement and suggestions for new outcomes measures to promote prevention and wellness of health and drug plan enrollees to make the Star Ratings program more aligned with MAHA efforts related to healthy aging, such as nutrition and patient well-being.
- CMS is also soliciting feedback on additional measures that could be removed in future years.

D. Health Equity Index Reward [P. 75-76]

In the “Medicare Program; Contract Year 2024 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” final rule, CMS finalized the addition of the Health Equity Index (HEI) reward (also called the Excellent Health Outcomes for All (EHO4all) reward) along with the removal of the historical reward factor at the same time. The HEI reward was intended to further incentivize Part C and Part D contracts to focus on improving care for enrollees that are dually eligible, receive a low-income subsidy, or are disabled because these groups are at risk for poor health outcomes and Star Ratings data show gaps in the quality of care for these enrollees. This reward was finalized to be implemented beginning with the 2027 Star Ratings using data from the 2024 and 2025 measurement years. The historical reward factor, which incentivizes consistent high performance across Star Ratings measures, was finalized to be removed from the Star Ratings methodology with the implementation of the HEI reward in the 2027 Star Ratings using data from the 2025 measurement year.

Since the April 2023 final rule, CMS has reviewed the HEI reward consistent with the Executive Order 14192, “Unleashing Prosperity Through Deregulation” and **proposes to remove the HEI reward from the Star Ratings methodology. CMS proposes not to implement the HEI reward with the 2027 Star Ratings and instead continue the historical reward factor.** Rather than incentivizing improvement among certain populations like those included in the HEI, CMS would instead incentivize improvement efforts on clinical care, outcomes, and patient experience, in line with the proposal in section V.B. of this proposed rule to refocus the Star Ratings measure set.

F. Impact of Proposed Changes [P. 76-77]

Simulations of the impact of removing the HEI reward, keeping the historical reward factor, and removing the 12 measures as proposed in section V.B. of this proposed rule, using data from the 2025 Star Ratings (2022 and 2023 measurement years) but updating the measure set and measure weights for changes consistent with the 2026 Star Ratings (for example, reducing the weight of patient experience/complaints and access measures from 4 to 2) show most contracts (62 percent) would have no change in the overall rating. The overall rating would increase by a half star for 13 percent of contracts, would decrease by a half star for 25 percent of contracts, and would decrease by one star for one contract. Five percent of contracts would gain quality bonus payments (QBPs), and four percent of contracts would lose QBPs.

- CMS welcomes feedback on these proposed changes.

VIII. Request for Information on Future Directions in Medicare Advantage (Risk Adjustment, Quality Bonus Payments, and Well-Being and Nutrition)

C. Quality Bonus Payments in Medicare Advantage [P. 100-101]

In this Request for Information (RFI), CMS solicits information from stakeholders and all interested parties to inform future policy development and potential refinement to the QBP structure for MA plans and the impact of QBPs on rebates.

It takes several years to test, validate, propose, and add a new measure to the Part C and Part D Star Ratings. Separately, for measures that are already implemented, a 2-year lag exists between the end of the measurement period and actual payment to the MA plan. CMS would like to explore potential options to shorten the timeline for implementation of new measures, as well as the lag between measurement and payment for existing measures.

Regulations require CMS to announce potential new measures and solicit feedback through the Advance Notice and Rate Announcement process and subsequently propose and finalize new measures through rulemaking. In addition, measures are required to be on the display page on the CMS website for a minimum of 2 years while being finalized as Star Ratings measures used for payment. CMS, therefore, solicits comments on potential methods to condense the timeline to add a new measure to the Star Ratings, for example, by reducing the display period for new measures.

For existing measures, the lag between the Star Ratings measurement year and payment year is due to the statutory requirements, which link the MA bid process to QBP ratings. CMS is also soliciting information on whether CMS should test an Innovation Center model that would delink QBPs from MA bids, with the aim of further incentivizing health plans to improve quality and providing beneficiaries with more timely and actionable quality information.

- CMS is soliciting comments on the following questions:
 - What could an alternative policy look like, if one is needed at all?
 - What are the potential advantages and disadvantages of the suggested alternative?
 - When should bonus payments be finalized and disbursed? More broadly, how might CMS better incentivize cost containment within the MA program, while improving care quality?