MEMORANDUM

To: PQA Members

From: PQA

Date: April 29, 2026

Re: **Medicare Program; Contract Year 2027 and Certain Contract Year 2026 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 and Certain Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program"

The final rule, CMS-4208-F3 and CMS-4212-F, was published in the Federal Register on April 6, 2026, and can be found here. An April 2, 2026, CMS press release and fact sheet provide additional information on the final rule.

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

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

VIII. Request for Information on Future Directions in Medicare Advantage (Risk Adjustment and Quality Bonus Payments)

Summary Explanation

The page numbers listed in the following summary correspond to the Federal Register document https://www.federalregister.gov/documents/2026/04/06/2026-06600/medicare-program-contract-year-2027-and-certain-contract-year-2026-policy-and-technical-changes-to. 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 4-19.

Our goal with this summary is to isolate for your convenience the most relevant sections within the 219-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 addressed comments, with a focus on comments relevant to PQA and its work. Not all comments and responses are included in the PQA summary.

PQA Executive Summary: CMS-4208-F3 and CMS-4212-F

V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings) [PP. 17495]

B. Adding, Updating, and Removing Measures [PP. 17496-17521]

CMS proposed to remove the 12 measures in Table 3 beginning with the Star Ratings year shown in the table for each measure. As stated in the Contract Year 2027 proposed rule, 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 final rule, would generally increase 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 Measures [PP. 17510-17514]

a. CMS is committed to continuing to improve the Part C and D Star Ratings system by focusing on improving clinical and other health outcomes. As CMS continues to align with the Universal Foundation, CMS proposed to add the Part C Depression Screening and Follow-Up (DSF) measure to the 2029 Star Ratings (measurement year 2027). CMS began reporting the DSF measure on the display page for the 2026 Star Ratings.

After considering the comments CMS received and for the reasons outlined in the Contract Year 2027 proposed rule and its responses to the comments, CMS is finalizing the addition of

the Depression Screening and Follow-Up measure to the Star Ratings beginning with the 2029 Star Ratings.

D. Health Equity Index Reward [PP. 17515-17519]

Since the Contract Year 2024 final rule, CMS has reviewed the Health Equity Index (HEI) reward consistent with the Executive Order, “Unleashing Prosperity Through Deregulation” and proposed to remove the HEI reward from the Star Ratings methodology. CMS proposed 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.

After considering the comments CMS received and for reasons outlined above and CMS responses to comments, CMS is finalizing language as proposed.

F. Impact of Proposed and Finalized Changes [PP. 17520-17521]

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 the Contract Year 2027 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.

After consideration of the public comments CMS received, and for the reasons outlined in the Contract Year 2027 proposed rule and their responses to comments, CMS is finalizing all Star Ratings proposals from the Contract Year 2027 proposed rule, except for the removal of the Diabetes Care—Eye Exam (Part C) measure.

PQA Summary: CMS-4208-F3 and CMS-4212-F

V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings) [P. 17495]

A. Introduction [PP. 17495-17496]

CMS has continued to identify enhancements to the Star Ratings program to ensure it is aligned with the CMS Quality Strategy as that Strategy evolves over time to increase the health and wellbeing of enrollees. In this final rule, CMS is finalizing most of the changes proposed to simplify and refocus the areas included in the Star Ratings, including changes to the measure set, with the exception of the proposal to remove the Diabetes Care – Eye Exam measure from the Star Ratings. CMS also is finalizing its proposal 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 is finalizing adding additional information about the data available to MA organizations and Part D sponsors during the plan preview periods before each Star Ratings release. CMS also solicited comments in the Contract Year 2027 proposed rule 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. In this rule CMS is also finalizing a technical clarification proposed in the 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 proposed rule, which appeared in the Federal Register on December 10, 2024, to provide details about how the enrollment-weighted measure score is calculated when a consumed or surviving contract is missing data for a measure. CMS also solicited additional feedback related to Star Ratings in the Request for Information on Future Directions in Medicare Advantage in the Contract Year 2027 proposed rule.

B. Adding, Updating, and Removing Measures [PP. 17496-17521]

1. Removing Measures [PP. 17497-17510]

As the Part C and 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 proposed 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 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 proposed 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 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 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 D Star Ratings program, and MA organization and Part D sponsor performance rates are consistently fairly high.

CMS also proposed 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. This is where there is more room for

improvement and measures where CMS sees MA organization and Part D sponsors need more incentives to perform well. 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. One purpose of providing quality and performance information is to highlight differences in performance across contracts that can impact the care and services provided by the 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 proposed to remove the 12 measures in Table 3 beginning with the Star Ratings year shown in the table for each measure. As stated in the Contract Year 2027 proposed rule, 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 final rule, would generally increase ratings.

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

TABLE 3: 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

CMS solicited feedback on all of the potential measure removals discussed in the Contract Year

2027 proposed rule, including feedback on the timing of measure removals and received many comments.

*The summarized comments and responses from CMS are found on **PP. 17498-17500**. Excerpts from the comments and CMS responses are below.*

- *Some commenters supported streamlining and refocusing the Star Ratings measure set. These commenters supported a focus on clinical care, outcomes, and patient experience.*
- *Some commenters were concerned that removing measures will reduce oversight and transparency of plan performance. Several commenters recommended that the measures continue to be reported on the display page. Some commenters were also concerned about the potential loss of quality gains if the measures are removed.*
- *Some commenters supported simplification of the Star Ratings, but cautioned against wholesale removal of measures without replacement. They recommended that if measures are removed from Star Ratings, CMS should consider beneficiary impacts and maintain robust, transparent compliance monitoring, enhanced CAHPS questions, or public reporting to preserve accountability. Many of these commenters emphasized that the removed measures should still be publicly reported, even if CMS restructures how they are measured or incentivized.*
  - CMS response: *CMS appreciates commenters' support for simplifying the Star Ratings program while maintaining accountability. CMS agrees that continued transparency and oversight are important when measures are removed from Star Ratings.* ***Thus, CMS will publicly report removed measures on the display page and will continue to monitor plan performance through its existing oversight and compliance activities. This approach preserves transparency for beneficiaries and other interested parties while allowing the Star Ratings program to focus on measures that more meaningfully differentiate performance across contracts.***
- *Some commenters raised concerns about Star Ratings volatility, destabilizing the Star Ratings system, and downstream impacts to QBPs if CMS removes multiple administrative measures at the same time. These commenters also raised concerns about making the remaining measure set smaller and more sensitive to single-measure changes. Some commenters were concerned about removing too many measures too fast and recommended a phased approach for removal of measures. Commenters also raised concerns about program disruption, which they believe will undermine the predictability and stability of the program and impact beneficiary experience.*
  - CMS response: *CMS does not agree that removal of measures destabilizes the Star Ratings program. The measures CMS proposed for removal have topped out (i.e., have very high performance across all contracts such that cut points for the measure are very close together and do not reflect meaningful differences in performance), are duplicative, or no longer provide meaningful*

differentiation across plans. Retaining such measures reduces the impact of measures that better distinguish differences in plan quality and performance. Removing these measures in a timely manner strengthens the Star Ratings program and supports informed beneficiary choice.

- *A couple of commenters recommended changing measure specifications or redesigning measures rather than removing measures. Other commenters proposed alternative approaches to deal with a "topped-out" measure apart from removing it from Star Ratings, including increasing the cut points, penalizing contracts if performance is not maintained, creating a composite measure of operational performance, and reassessing whether or how high scoring measures should impact payment.*
  - CMS response: *As discussed in the Contract Year 2027 proposed rule, the Part C and D Star Ratings program continues to evolve and align with the measures included in the Universal Foundation. As such, CMS proposed simplifying and refocusing the measure set to focus on measures of clinical care, outcomes, and patient experience 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 MAHA initiative. CMS's proposal aimed to strike a balance between streamlining the measure set and maintaining enough measures to assess performance across the range of health care quality.*
- *A commenter raised concerns that removing too many operational and administrative measures may weaken the program's ability to capture aspects of performance that are most relevant to beneficiaries, and that removing the measures may shift focus away from day-to-day experiences that shape beneficiary satisfaction and trust. Another commenter disagreed that the measures proposed for removal are not meaningful to beneficiaries.*
  - CMS response: *CMS will continue to closely monitor any measure removed from Star Ratings through existing oversight and compliance activities and will publicly report these measures on the display page. This approach preserves transparency for beneficiaries and other interested parties while allowing the Star Ratings program to focus on measures that more meaningfully differentiate performance across contracts.*

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

CMS proposed removing the Statin Therapy for Patients with Cardiovascular Disease (Part C) measure as part of its 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. In light of this substantive change, the Statin Therapy for Patients with Cardiovascular Disease measure was already set for removal to the 2028 display page, and any adoption of the updated measure would need to be proposed and finalized through future rulemaking. While CMS has the discretion to continue to use a legacy measure in Star Ratings while a substantively updated version is on the display page, use of the legacy measure was not feasible here due to the nature of the substantive changes. CMS will monitor changes in performance for this measure, as updated and included on the display page, since statin therapy is important in lowering cholesterol and reducing the risk of cardiovascular disease.

CMS solicited comment on removing the Statin Therapy for Patients with Cardiovascular Disease measure from the 2028 Star Ratings.

After considering the comments CMS received and for the reasons outlined in the Contract Year 2027 proposed rule and its responses to the comments, CMS is finalizing the removal of the Statin Therapy for Patients with Cardiovascular Disease beginning with the 2028 Star Ratings.

*The summarized comments and responses from CMS are found on **PP. 17508-17509**. Excerpts from the comments and CMS responses are below.*

- *Many commenters supported removing this measure due to minimal performance variation and the availability of similar measures already in Star Ratings, such as Medication Adherence for Cholesterol (Statins). Commenters highlighted significant clinical limitations with the measure, such as that it captures prescriptions but not adherence, inadequately accounts for statin intolerance, creates administrative burden, and encourages coding behaviors that conflict with clinical judgment. A commenter also emphasized that a single prescription is insufficient for cardioprotective benefits, with some commenters adding that the measure excludes alternative cholesterol-lowering treatments, such as diet, exercise, or alternative medications. Commenters also noted the measure would remain on the 2028 display page as another reason for their support.*
- *Some commenters opposed removing the measure, emphasizing its importance for the health and quality of life of patients with cardiovascular disease. Commenters noted that statin therapy is evidence-based for this population and linked to reduced mortality. Others urged CMS to delay removal until another validated outcome-based measure is introduced.*
  - CMS response: *This measure will be on the display page so it will still be publicly reported and used for monitoring. Given the substantive change for the 2026 measurement year for this measure, the measure has to be moved to the display page for at least two years. The updated measure would need to be proposed through rulemaking. CMS does not have data for the legacy measure to continue to include in the Star Ratings.*

- *Some commenters recommended replacing the Statin Therapy for Patients with Cardiovascular Disease process measure with a low-density lipoprotein cholesterol (LDL-C) control or LDL-C response outcome measure. These alternative measures would account for statin intolerance while expanding the denominator to include all patients who could benefit from cholesterol-lowering therapy. Additionally, rather than removing the measure, a commenter recommended considering a complimentary measure focused on medication access, affordability, and utilization since statins remain underused in peripheral arterial disease. Another commenter recommended that CMS eliminate the exclusion of individuals aged 66 and above to align with the Statin Use in Persons with Diabetes.*
  - CMS response: *CMS appreciates the suggestions and will take them into consideration as CMS considers future measure changes. If CMS were to introduce an alternative measure in the future, it would need to be proposed and finalized through the rulemaking process. It is important that providers and plans provide appropriate care for Medicare beneficiaries with cardiovascular disease whether the Star Ratings includes the Statin Therapy for Patients with Cardiovascular Disease measure or not.*
- *Some commenters noted that despite an apparent performance ceiling for this measure at the contract level, substantial disparities in statin initiation and adherence persist among older adults, women, and racial/ethnic minorities, populations disproportionately represented in MA organizations.*
  - CMS response: *This measure will be on the display page so performance on this measure will still be publicly available. While Part C and D Star Ratings cannot measure every aspect of care delivery, providers and plans should still deliver clinically appropriate care to all populations.*
- *Some commenters argued that removal of this measure is premature given NCQA's recent substantive specification changes expanding the eligible population. They urged CMS to evaluate the updated measure's performance before removal. Some commenters urged CMS to reintroduce the measure after the two-year display period, with one commenter arguing that the measure is more robust at identifying high risk patients than the Statin Use in Persons with Diabetes (Part D) measure and more methodologically sound as it includes clinically justified exclusions.*
  - CMS response: *The measure will be on the display page starting with the 2028 Star Ratings due to the substantive change made by NCQA discussed above. CMS is committed to continuing to monitor performance on the updated measure. If CMS were to bring back this measure into Part C Star Ratings, it would have to be proposed through future rulemaking.*

2. Adding Measures [PP. 17510-17514]

a. CMS is committed to continuing to improve the Part C and D Star Ratings system by focusing on improving clinical and other health outcomes. As CMS continues to align with the Universal

Foundation, CMS proposed to add the Part C Depression Screening and Follow-Up (DSF) measure to the 2029 Star Ratings (measurement year 2027). CMS began reporting the DSF measure on the display page for the 2026 Star Ratings.

Although this is a process measure, health outcomes can be improved by identifying individuals with depression and providing treatment. There are currently no measures specific to behavioral health care in the Part C and D Star Ratings, so adding this measure would fill an important gap.

CMS submitted the DSF measure through the 2024 Pre-rulemaking Review Process for review by the Measures Application Partnership, which is a multi-stakeholder partnership that provides recommendations to HHS on the selection of quality and efficiency measures for CMS programs, and the Measures Application Partnership provided support for this measure. Consensus was not reached on this measure. The committee recommended that the Merit-based Incentive Payment System (MIPS) program consider replacing their similar measure with this one to improve alignment across quality programs and to report the screening and follow-up rates separately. The HEDIS measure differs slightly from the MIPS measure since the specification is at the health plan level and also focuses on examining follow-up actions when positive screenings occur. CMS will display separate rates for screening and follow-up on the display page and take an average of the rates for the Star Ratings measure.

CMS solicited comment on adding the Depression Screening and Follow-Up measure to the 2029 Star Ratings.

After considering the comments CMS received and for the reasons outlined in the Contract Year 2027 proposed rule and its responses to the comments, CMS is finalizing the addition of the Depression Screening and Follow-Up measure to the Star Ratings beginning with the 2029 Star Ratings.

*The summarized comments and responses from CMS are found on **PP. 17511-17514**. Excerpts from the comments and CMS responses are below.*

- *Many commenters supported adding the DSF measure to the Star Ratings program. Commenters noted that this measure would encourage MA plans to screen for depression and follow up with appropriate care and to expand access to behavioral health services. Some commenters noted that the DSF measure would fill a gap in the Star Ratings.*
- *Some commenters were concerned about inadequate behavioral health resources in communities that already face significant behavioral health workforce and capacity shortages, potentially limiting their ability to provide follow-up care for those who screen positive for depression. These commenters requested that CMS monitor behavioral health network adequacy before implementing this measure.*

- CMS response: *CMS recognizes the health care workforce shortages facing many communities, particularly in the field of behavioral health. Measuring depression screening and follow-up care will increase focus on behavioral health and likely lead to MA plans expanding access to behavioral health care. In addition, the measure specifications allow for telehealth or virtual appointments so that enrollees with limited access to follow-up care in their local vicinity may be able to access services in a virtual setting.*

- *Some commenters recommended that CMS report the depression screening and follow-up rates separately because averaging the rates may discourage depression screening since plans that screen fewer people may more easily achieve high follow-up rates. A commenter also suggested a higher weight for the follow-up rate.*
  - CMS response: *There is incentive to do well on both rates. For the screening rate, performance will be worse if fewer individuals are screened since the measure focuses on screening among the general population. CMS will display the rates for screening and follow-up separately on the display page so this information is publicly available. For the Star Ratings program, CMS plans to take an average of the rates to minimize the number of measures displayed on Medicare Plan Finder. CMS will monitor the rates for both the screening and follow-up measures and may propose changes over time if it sees issues with combining the rates.*

C. Streamlining the Methodology, Further Incentivizing Quality Improvement, and Suggestions for New Measures [P. 17515]

CMS solicited 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 also solicited feedback on additional measures that could be removed in future years.

Commenters broadly supported CMS's goal to streamline the Part C and D Star Ratings program and shift towards more outcome-focused and prevention-oriented measures, but many commenters cautioned against rapid, large-scale changes that could destabilize plans, reduce competition, and disproportionately harm plans serving high-need, complex, or vulnerable populations (e.g., SNPs, dually eligible individuals, and ESRD beneficiaries). Commenters urged CMS to phase in changes slowly, preserve stability tools in the methodology (guardrails, hold harmless, predictable cut points), and ensure fair benchmarking through stratification by plan type, population, and geography. Many commenters recommended reducing reliance on process and survey-based measures that have small samples or high volatility, while expanding outcome measures tied to chronic disease management, functional status, behavioral health access, nutrition/food-as-medicine, primary care investment, provider experience, and care transitions. Across commenters, there are comments related to aligning measures across programs, reducing administrative burden, improving transparency, and ensuring that quality incentives reflect plan-driven actions that improve

beneficiary health, access, and well-being.

CMS will take all comments received into consideration as it considers ways to streamline and modify the Star Ratings methodology and continues to review the Star Ratings measure set.

D. Health Equity Index Reward [PP. 17515-17519]

Since the Contract Year 2024 final rule, CMS has reviewed the Health Equity Index (HEI) reward consistent with the Executive Order, "Unleashing Prosperity Through Deregulation" and proposed to remove the HEI reward from the Star Ratings methodology. CMS proposed 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.

CMS recognizes that some health plans may have already expended resources on performance improvement focused on the populations included in the HEI reward; however, any improvements in performance among these populations will still contribute to higher performance on the Star Ratings by increasing measure-level scores even without the implementation of the HEI reward. Higher measure-level scores benefit health plans by improving overall performance on the Star Ratings.

CMS invited public comment on this proposal and received several comments.

After considering the comments CMS received and for reasons outlined above and CMS responses to comments, CMS is finalizing language as proposed.

*The summarized comments and responses from CMS are found on **PP. 17515-17519**. Excerpts from the comments and CMS responses are below.*

- *Commenters appreciated CMS's responsiveness to previous stakeholder feedback recommending not implementing the HEI reward and retaining the historical reward factor.*
- *Some commenters encouraged CMS to continue to look for ways to evaluate health equity and address social risk factors, cultural competency, and complex care needs in the Star Ratings. Commenters expressed that it is important to ensure vulnerable populations do not have barriers to care and to hold MA plans accountable for improving the care of vulnerable populations.*
- *Several commenters encouraged CMS to implement a one-year or multiple year hold harmless policy starting with the 2027 Star Ratings where contracts would earn the better of the HEI reward and the historical reward factor, or a phased transition for removing the HEI reward.*
  - CMS response: *CMS does not agree that such a hold harmless or phased transition is necessary, because any improvements contracts made among the populations included in the HEI are consistent with existing program goals and expectations to provide high quality care to all enrollees, including those*

that are dually eligible (DE), receive a low-income subsidy (LIS), or are disabled. Improvements made for these populations are not isolated to the HEI reward and will only help contracts in their performance on the Star Ratings more broadly.

- *A couple of commenters supported removing the HEI reward but did not support adding back the historical reward factor. A few other commenters suggested changes to the historical reward factor methodology.*
  - CMS response: *CMS will consider whether the historical reward factor should continue to be part of the Star Ratings in the future.*
- *A number of commenters opposed removing the HEI reward and adding back the historical reward factor. Several commenters raised concerns about the timing of this proposal since it is not in advance of the measurement years for the HEI reward and historical reward factor for the 2027 Star Ratings. Commenters argued plans have made investments in improving care for populations included in the HEI reward. A couple of commenters noted negative financial implications for plans that invested in improving care as a result of the HEI reward. Other commenters raised concerns about removing incentives for plans to invest in care models, improved access, and high quality care for populations with high needs and social risk factors.*
  - CMS response: *CMS expects that plans will invest in improving care for all enrollees regardless of the Star Ratings and QBPs, including among enrollees that may have higher needs, such as the populations included in the HEI reward. While CMS recognizes that plans have made investments to improve care for populations included in the HEI reward, these investments should not be viewed as contingent on the continuation of a specific reward mechanism, as improvements in care delivery, access, and outcomes for these populations are foundational to the MA program and remain important regardless of the Star Ratings structure.*
- *A couple of commenters stated that removing the HEI reward from the 2027 Star Ratings is impermissibly retroactive or a retroactive policy change.*
  - CMS response: *CMS disagrees with the commenters' assertion that removing the HEI reward from the 2027 Star Ratings is retroactive. There are no retroactive effects on past Star Ratings. That is, all Star Ratings that have already been calculated stay exactly the same. This change only affects how Star Ratings will be calculated in the future, starting with the 2027 Star Ratings. Removing the HEI reward is a methodology change, not a measure specification change.*
- *A couple of commenters stated that removing the HEI and continuing the historical reward factor risks allowing plans to improve on average while not improving or potentially worsening disparities in performance among high-need and socially disadvantaged populations. One commenter stated if CMS does not move forward with the HEI it should replace it with stratified reporting or weighting for dual eligible/LIS enrollees so that plans can't improve on average while*

neglecting high-need populations.

- *A commenter stated their belief that removing the HEI would perpetuate D-SNPs being penalized by the Star Ratings as a result of the impact of non-medical risk factors on enrollees' health. The commenter supported continuing the HEI or making changes to the Categorial Adjustment Index (CAI) for D-SNPs. The commenter also stated the Star Ratings do not adjust for member mix effectively.*
  - CMS response: *CAHPS and HOS measures are adjusted for case mix, and the Part D medication adherence measures will be adjusted for case mix beginning with the 2028 Star Ratings.*
- *Several commenters stated that the historical reward factor embeds disparate quality standards that favor more resourced, healthier populations. A couple of commenters also stated that removing the HEI reward and adding back the historical reward factor would mask gaps in care and remove the focus on fixing such gaps.*
- *A couple of commenters stated that removing the HEI reward and adding back the reward factor is not consistent with the objective of shifting the Star Ratings toward outcome-based measures and away from operational incentives, because the reward factor is unrelated to improving clinical care, outcomes, or patient experience.*
  - CMS response: *CMS disagrees that the reward factor is unrelated to clinical care, outcomes, and patient experience. The reward factor incentivizes high, consistent performance across all measures included in the Star Ratings, including those focused on clinical care, outcomes, and patient experience.*
- *A commenter did not support adding back the historical reward factor, stating that it benefits a small subset of plans and does not recognize improvement because it is intended to only reward plans that have consistently high Star Ratings across multiple years.*
  - CMS response: *The reward factor is not based on multiple years of performance; it is based on consistent, high performance across measures in a single Star Ratings year.*
- *A commenter opposed CMS's proposal to not implement the HEI reward and add back the historical reward factor, stating that policies should support, not penalize, clinicians and plans serving high-risk populations and should encourage investment in primary care, care coordination, and community-based interventions.*
  - CMS response: *CMS appreciates these comments; however, the historical reward factor is an upside-only reward that encourages consistent, high performance across Star Ratings measures and does not penalize plans or clinicians. CMS expects that plans will invest in improving care for all enrollees regardless of the Star Ratings and QBPs, including among enrollees that may have higher needs, such as the populations included in the HEI reward*

E. Plan Preview of Star Ratings [PP. 17519-17520]

CMS proposed to add additional information about the data available to MA organizations and Part D sponsors during the plan preview periods before each Star Ratings release. During the first plan preview, CMS expects Part C and D sponsors to closely review the methodology and their posted numeric data for each measure in HPMS prior to display on MPF. The second plan preview provides an opportunity for Part C and D sponsors to review any updates from the first plan preview and preliminary Star Ratings for each measure, domain, summary rating, and overall rating. As the plan previews have continued to evolve, CMS has added de-identified contract-level sample data for one of each type of measure needed for MA organizations and Part D sponsors to replicate the calculation of the measure-level cut points (that is, one CAHPS measure, one measure for Part C and one for Part D that use clustering, and any measures requiring a different type of calculation such as Complaints about the Plan). These data allow MA organizations and Part D sponsors to validate CMS's cut point calculations. The same cut point programming is used for all other measures as the sample measures, so de-identified contract-level data for only the sample measures are displayed in HPMS during the second plan preview. CMS proposed to codify their current practice of providing sample data for one of each type of measure during the second plan preview.

After consideration of the public comments CMS received and for the reasons outlined in the Contract Year 2027 proposed rule and its responses to comments, CMS is finalizing to codify its current practice of providing sample data for one of each type of measure during the second plan preview as proposed and without modification.

*The summarized comments and responses from CMS are found on **PP. 17519-17520**. Excerpts from the comments and CMS responses are below.*

- *A majority of commenters expressed support for CMS's proposal to codify its current practice of providing sample data during the plan preview periods. Some commenters stated that increased transparency will help plans more accurately review, validate, and understand their Star Ratings calculations, ultimately improving the integrity of Star Ratings and leading to improved quality assurance and better outcomes for beneficiaries.*
- *Several commenters recommended CMS expand the current practice of providing sample data for one of each measure type by providing sample data for all measures. They stated that without full access to the underlying data for all measures, plans cannot fully validate CMS's methodologies and calculations. Another commenter noted that much of the data already exists and asked that CMS provide a list on the HPMS Star Ratings website of all data sets available to plans and where to obtain them.*
  - CMS response: *As stated in the Contract Year 2027 proposed rule, CMS provides de-identified contract-level sample data for one measure of each type so MA organizations and Part D sponsors can replicate calculation of the measure-level cut points. Because the same cut point programming is used for all measures of the same type, only de-identified contract-level data for the sample measures are needed to validate CMS's cut point methodology. Adding de-identified contract-level data for all*

measures would be burdensome to implement, and data provided during the plan preview are preliminary. The purpose of the plan preview is for Part C and D sponsors to closely review their own Star Ratings data, including preliminary Star Rating assignments. Contracts are not entitled to review other contracts' preliminary Star Ratings data before they are public. Adding a list of all data sets available to plans and where to obtain them may be easier to implement and CMS will take this suggestion under consideration as a future enhancement.

F. Impact of Proposed and Finalized Changes [PP. 17520-17521]

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 the Contract Year 2027 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.

After consideration of the public comments CMS received, and for the reasons outlined in the Contract Year 2027 proposed rule and their responses to comments, CMS is finalizing all Star Ratings proposals from the Contract Year 2027 proposed rule, except for the removal of the Diabetes Care—Eye Exam (Part C) measure. The impact of the finalized changes based on the simulations using data from the 2025 Star Ratings and accounting for changes implemented in the 2026 Star Ratings, as explained at the beginning of this section, show most contracts (63 percent) would have no change in their overall rating. The overall rating would increase by a half star for 13 percent of contracts, and would decrease by a half star for 24 percent of contracts. Four percent of contracts would gain QBPs, and three percent of contracts would lose QBPs.

*The summarized comments and responses from CMS are found on **PP. 458-459**. Excerpts from the comments and CMS responses are below.*

- *A commenter requested that CMS conduct an impact analysis that separates out SNP from non-SNP plans. The commenter also requested an analysis broken out by region and size of enrollment. The commenter stated that these analyses would ensure that the proposed changes do not inadvertently harm vulnerable populations.*
    - CMS response: *In the tables below, CMS broke out the impacts for MA contracts by SNP-only contracts, partial SNP contracts (those with both SNP and non-SNP plans), and non-SNP contracts and by contract enrollment size. These tables show the impacts of the changes finalized in this final rule (i.e., removing 11 measures as finalized in section V.B. of this final rule, removing the HEI reward, and keeping the historical reward factor). CMS does not provide a breakout of the impacts by region because some contracts have broad service areas.*

TABLE 4. CHANGE IN OVERALL RATING AND ELIGIBILITY FOR QBPS FOR SNP-ONLY, PARTIAL SNP, AND NON-SNP CONTRACTS

Overall Rating	*SNP-Only Contracts*	*Partial SNP Contracts*	*Non-SNP Contracts*
No Change	*65%*	*65%*	*60%*
Increase by half star	*4%*	*15%*	*15%*
Decrease by half star	*31%*	*20%*	*25%*
Gain QBPs	*0%*	*3%*	*7%*
Lose QBPs	*4%*	*4%*	*3%*

**Percentages out of contracts in the category receiving a numeric overall rating.*

TABLE 4. CHANGE IN OVERALL RATING AND ELIGIBILITY FOR QBPS BY CONTRACT ENROLLMENT

Overall Rating	*Less than 10,000 Enrollees*	*10,000 to less than 125,000 Enrollees*	*Greater than or Equal to 125,000 Enrollees*
No Change	*63%*	*63%*	*66%*
Increase by half star	*12%*	*13%*	*22%*
Decrease by half star	*25%*	*24%*	*12%*
Gain QBPs	*4%*	*4%*	*7%*
Lose QBPs	*1%*	*5%*	*2%*

**Percentages out of contracts in the category receiving a numeric overall rating. Enrollment as of October 2024.*

VIII. Request for Information on Future Directions in Medicare Advantage (Risk Adjustment and Quality Bonus Payments) [P. 17555]

C. Quality Bonus Payments in Medicare Advantage [PP. 17557-17558]

In this Request for Information (RFI), CMS solicited information from stakeholders and all interested parties to inform future policy development and potential refinement to the Quality Bonus Payment (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 prior to being finalized as Star Ratings measures used for payment. CMS, therefore, solicited 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 also solicited information on whether it 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. Specifically, CMS solicited 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?

*The summarized comments and responses from CMS are found on **P. 17558**. Excerpts from the comments and CMS responses are below.*

- *Commenters broadly supported updating MA risk adjustment and the Quality Bonus Payment/Star Ratings framework to better align payments and incentives with beneficiary needs and meaningful outcomes.*
- *For QBP/Star Ratings, commenters recommended refining measure selection, weighting, and program design to better reflect outcomes and beneficiary experience, improve alignment with other CMS quality programs, and reduce timing lags between measurement and payment. Some raised concerns about overall spending and whether QBP should be budget neutral, while others cautioned against abrupt changes that could disrupt plan benefits and supplemental offerings.*
    - CMS response: *CMS appreciates the feedback received and will consider comments as it evaluates future policy directions for the MA program.*