



PQA-Prepared Summary Points of Interest April 2026

Announcement of Calendar Year (CY) 2027 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

The Centers for Medicare & Medicaid Services (CMS) released the [Announcement of Calendar Year \(CY\) 2027 Medicare Advantage \(MA\) Capitation Rates and Part C and Part D Payment Policies](#) on April 6, 2026.

PQA distributed a [summary of points of interest](#) from the CMS Advance Notice of Methodological Changes for Calendar Year (CY) 2027 for Medicare Advantage (MA) Capitation Rates and Part C and D Payment Policies to membership in February 2026. This follow-up communication highlights key points noted in the CY2027 Announcement. Excerpts of comments submitted to CMS are included in shaded boxes.

For further details on any of the points below, we have included page numbers and encourage you to refer to the document's full language, which can be found here: <https://www.cms.gov/files/document/2027-announcement.pdf>.

PQA will review all public comments submitted to CMS on its measures and, where appropriate, will engage the PQA Measure Update Panel and Quality Metrics Expert Panel as part of the review and maintenance process to determine any necessary measure revisions.

This document does not include a summary of the Part C and D final rule (CMS-4208-F3 and CMS-4212-F), published on April 2, 2026. PQA published a separate summary of the final rule in tandem with this summary. That summary is linked [here](#).

Attachment IV. Updates for Part C and D Star Ratings

Section B. Reminders for 2027 Star Ratings and Beyond [P. 101]

The Star Ratings plan previews are an opportunity for Part C and D sponsors to preview their Star Ratings data in HPMS and raise any questions prior to display on the Medicare Plan Finder. The two plan preview periods allow for any necessary corrections to be made prior to the Star Ratings data being public. During the first plan preview in August, CMS expects Part C and D sponsors to closely review the Star Ratings methodology and their posted numeric data for each measure. The second plan preview in September includes any revisions made as a result of the first plan preview and provides a preview of the preliminary Star Ratings for each measure, domain, summary score, and overall score. During the second plan preview, CMS expects Part C and D sponsors to again closely review the methodology and their posted data for each measure, as well as their preliminary Star Rating assignments.

As a reminder, there are four new or updated measures being added beginning with the 2027 Star Ratings

- Colorectal Cancer Screening
- Care for Older Adults – Functional Status Assessment
- Concurrent Use of Opioids and Benzodiazepines (COB)
- Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)

The Colorectal Cancer Screening measure is being replaced by a respecified version and is treated as a new measure. The other three measures are process measures developed from evidence-based clinical treatment guidelines, each with a weight of one. These three clinical process measures are critical for measuring health care and medication use quality, ensuring that care is delivered effectively, and preventing long-term health consequences by addressing potential health concerns early in the beneficiary's care. Care for Older Adults – Functional Status Assessment is returning to the Star Ratings after a substantive specification change and is treated as a new measure.

There are three measures being removed beginning with the 2027 Star Ratings:

- Care for Older Adults – Pain Assessment
- Medication Reconciliation Post-Discharge
- Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR)

As noted in the Announcement of Calendar Year (CY) 2026 MA Capitation Rates and Part C and Part D Payment Policies, NCQA reevaluated the Statin Therapy for Patients with Cardiovascular Disease (Part C) measure for the 2026 measurement year. As a result of this reevaluation, NCQA updated the measure specifications to expand the eligible population, which is considered a substantive change to the measure. As a result, CMS will include the updated version of the Statin Therapy for Patients with Cardiovascular Disease measure on the 2028 display page. Though this measure is already set to be moved to the 2028 display page in

light of the substantive changes, CMS has finalized the removal of this measure from the Star Ratings. The updated measure will remain on the display page. **The MTM Program Completion Rate for CMR measure will be on the display page for measurement years 2025 and 2026 and will return to the Star Ratings as a new measure beginning with the 2029 Star Ratings (measurement year 2027).**

Additionally, starting with the 2027 Star Ratings, CMS will implement a change in how it calculates the Categorical Adjustment Index when there is a contract consolidation. CMS will determine the percentage of low income subsidy (LIS)/Dual Eligible (DE) enrollees and the percentage of disabled enrollees for the surviving contract for the first two years following a consolidation by combining the enrollment data for the month of December for the measurement period of the Star Ratings year across all contracts in the consolidation.

Section C. Measure Updates for 2027 Star Ratings [P. 104]

The measures that will be used to calculate the 2027 Star Ratings are listed in Table VI-1 with information about the measure type, weight, and measurement year. Table VI-1 no longer includes the measures considered for inclusion in the Excellent Health Outcomes for All (EHO4all) reward (also known as the Health Equity Index reward), because CMS will not implement the EHO4all reward and will keep the historical reward factor in the Star Ratings methodology, consistent with policies finalized in the “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” final rule.

[PQA note for clarity for Table VI-1, and Sections D & E in this PQA summary: We have only included Part D Star Ratings measures in Table VI-1, below. PQA measures are bolded in the table. See the Rate Announcement for all Part C and D measures included in Table VI-1.]

Table VI-1. 2027 Part D Star Ratings Measures

Measure	Measure Type	Weight	Measurement Year	Improve-ment Measure	Included in the 2027 CAI Values
Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2	2/2026 – 5/2026	Yes	No
Complaints about the Drug Plan	Patients’ Experience and Complaints Measure	2	1/1/2025 – 12/31/2025	Yes	No

Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2	1/1/2025 – 12/31/2025	Yes	No
Drug Plan Quality Improvement	Improvement Measure	5	NA	No	No
Rating of Drug Plan	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	Yes	No
Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	Yes	No
MPF Price Accuracy	Process Measure	1	1/1/2025 – 9/30/2025	Yes	No
Medication Adherence for Diabetes Medications	Intermediate Outcome Measure	3	1/1/2025 – 12/31/2025	Yes	Yes
Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measure	3	1/1/2025 – 12/31/2025	Yes	Yes
Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measure	3	1/1/2025 – 12/31/2025	Yes	Yes
Statin Use in Persons with Diabetes	Process Measure	1	1/1/2025 – 12/31/2025	Yes	Yes
Concurrent Use of Opioids and Benzodiazepines (COB)	Process Measure	1	1/1/2025 – 12/31/2025	No	No
Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)	Process Measure	1	1/1/2025 – 12/31/2025	No	No

Section D. Improvement Measures (Part C & D) for the 2027 Star Ratings [P. 110]

Improvement measures are calculated using performance measures that meet specific conditions. Table VI-1 includes information about which measures will be used to calculate the improvement measures for the 2027 Star Ratings. CMS will only include measures in the improvement calculations at the contract level if numeric value scores are available for both the current and prior year.

Section E. Categorical Adjustment Index for the 2027 Star Ratings [P.110]

All measures identified as candidate measures will be included in the determination of the 2027 Categorical Adjustment Index (CAI) values. The measure set for the 2027 CAI (for both Part C and D) is identified in Table VI-1.

In keeping with CMS's commitment to transparency, a summary of the analysis of the candidate measure set that includes the minimum, median, and maximum values for the within-contract variation for the low-income subsidy (LIS)/dual eligible (DE) differences are posted with the 2027 CAI values on CMS's [Part C and D Star Ratings](#) website.

Section G. Changes to Existing Star Ratings Measures for the 2027 Measurement Year and Beyond [P. 112]

Statin Use in Persons with Diabetes (SUPD) (Part D). The PQA updated the SUPD measure specifications in the 2026 PQA Measure Manual to add a denominator exception for those individuals with diabetes who do not have a prescription claim for a statin but do have one or more prescription claims for either a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor or bempedoic acid. The PQA revised the measure specifications to align with the 2024 American Diabetes Association (ADA) Standards of Care in Diabetes updates on primary and secondary prevention of atherosclerotic cardiovascular disease (ASCVD).

According to the ADA Standards of Care, for primary prevention (10.24), the guidelines recommend that patients who are intolerant to statin therapy be treated with bempedoic acid as an alternative cholesterol-lowering drug to reduce cardiovascular event rates. Additionally, for secondary prevention (10.28), the guidelines recommend that for patients with diabetes and ASCVD who are intolerant to statin therapy, either a PCSK9 inhibitor therapy with monoclonal antibody treatment, bempedoic acid therapy, or a PCSK9 inhibitor therapy with inclisiran siRNA be considered as an alternative cholesterol-lowering therapy.

Therefore, the PQA updated the SUPD measure specifications to add a denominator exception for beneficiaries from the eligible population without one or more prescription claims for a statin medication and with one or more prescription claims for either bempedoic acid or one or more prescription claims for a PCSK9 inhibitor during the measurement year; a beneficiary is removed from the denominator after determining whether the numerator criteria are met and whether the beneficiary meets the exception criteria. However, if a beneficiary has one or more prescription claims for a statin medication during the measurement year, the beneficiary is still included in the denominator and numerator and is not eligible for the denominator exception.

This measure specification update was approved by both the PQA's Measure Update Panel (MUP) and the PQA's Quality Metrics Expert Panel (QMEP).

CMS's analysis found that including the exception criteria had a negligible impact on the year of service (YOS) 2024 SUPD rates overall across all contract types. Most contracts with a denominator of 30 or more beneficiaries had zero to minimal change. For MA-PD contracts with a denominator of 30 or more beneficiaries, there was an increase in rates of about 0.57 percentage points, while the difference in rounded rates was zero percentage points. For PDP contracts with a denominator of 30 or more beneficiaries, there was an increase in rates of about 0.85 percentage points, while the difference in rounded rates was around 1 percentage point.

This change is a non-substantive update because it is expected to slightly narrow the denominator population covered by the SUPD measure. **CMS plans to add the denominator exception to the SUPD measure beginning with the 2026 measurement year (2028 Star Ratings).**

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- Commenters supported updating the SUPD measure to add a denominator exception for beneficiaries with diabetes who do not have a statin claim but have one or more claims for a PCSK9 inhibitor or bempedoic acid. **Therefore, this update will be applied for the 2026 measurement year.**
- A few suggested additional updates, such as adding additional exceptions for institutionalized beneficiaries or other conditions where statin therapy may be contraindicated or including other data source claims.
 - CMS will investigate these ideas and share these comments with the measure steward.

Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH) (Part D). The PQA added clarity in the 2026 Measure Manual for identifying beneficiaries in the eligible population with two or more prescription claims for the same target medication on different dates of service during the measurement period. The same target medication refers to medications with the same anticholinergic active ingredient. This is a non-substantive update since it does not change the measure calculation. **CMS plans to make this update to the Poly-ACH measure beginning with the 2026 measurement year (2028 Star Ratings).**

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- Commenters supported this clarification to the Poly-ACH measure, and it will be implemented for the 2026 measurement year.

Section H. Efforts to Simplify and Refocus the Measure Set to Improve the Impact of the Star Ratings Program [P. 116]

As the Star Ratings program continues to evolve, CMS solicited feedback on new measures or measurement concepts that would incentivize plans from providing unnecessary, inappropriate, or low-value care. CMS stated it is also interested in measures related to medical errors or misdiagnoses. This could include measures focused on the clinical appropriateness of care or measures focused on ensuring diagnoses are not missed.

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- There was mixed reaction to development of measures in these areas.
- Many commenters emphasized the importance of careful measure design, robust testing, and proper risk adjustment to avoid unintended consequences and ensure clinical appropriateness.
- A few commenters noted that plans often lack direct visibility into the clinical nuances needed to determine appropriateness.
- In considering new measures aimed at discouraging low-value care, commenters recommended that CMS ensure measures are grounded in strong clinical evidence and incorporate appropriate exclusions and risk adjustment for medical complexity.
- Some commenters expressed caution about misdiagnosis and medical error measures, citing limited standardized data and concerns about accurately attributing outcomes.
- CMS will take these comments into consideration as it considers future enhancements to the Star Ratings program.

Section I. Display Measures [P. 116]

Display measures on CMS.gov are published separately from the Star Ratings and include measures that are transitioned from inclusion in the Star Ratings, new or updated measures before inclusion into the Star Ratings, and informational-only measures. Organizations and sponsors have the opportunity to preview the data for their display measures prior to release on CMS.gov. CMS anticipates all 2026 display measures will continue to be shown on CMS.gov in 2027 unless noted below. As CMS looks for ways to simplify the program and reduce reporting burden, it also solicited feedback on display measures that could be removed.

Antipsychotic Use in Persons with Dementia (APD) (Part D). Currently, brexpiprazole is included in the PQA Value Set and National Drug Codes (NDCs) for the APD measure. However, in 2023, the FDA approved a new indication for brexpiprazole for treatment of agitation associated with dementia due to Alzheimer's disease. Based on current measure specifications, beneficiaries in the denominator who receive a prescription for brexpiprazole for the new indication would be included in the numerator, despite using brexpiprazole for an indicated condition. In 2025, the PQA's MUP and QMEP approved the removal of brexpiprazole, an atypical antipsychotic, from the medication lists of drugs that are included for the APD measure. Additionally, brexpiprazole will be removed from the measure algorithm in determining whether a beneficiary is taking an antipsychotic medication indicated for the treatment of major

depression. **CMS plans to remove brexpiprazole from the APD measure beginning with the 2026 measurement year (2028 display page).**

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- Commenters supported removing brexpiprazole from the APD measure list, and CMS will implement this update for the 2026 measurement year.
- A few commenters noted that some use of antipsychotics among residents with dementia living in a nursing facility may be appropriate and requested additional updates, such as excluding beneficiaries who are receiving hospice care, or commented about the use of antipsychotics among residents with dementia living in a nursing facility.
- CMS will share this feedback with the measure steward.

Use of Opioids at High Dosage in Persons without Cancer (OHD) (Part D). The PQA updated the OHD measure specifications in the 2026 PQA Measure Manual to revise the methodology for daily morphine milligram equivalent (MME) calculation and to update the MME conversion factors. Daily MME is calculated for each opioid prescription claim with a date of service during each opioid episode for the OHD measure. The daily MME is calculated by the following equation as updated by the PQA:

$$MME/day = (\# \text{ of opioid dosage units per day}) \times (\text{opioid strength per unit}) \times (MME \text{ conversion factor})$$

The number of opioid dosage units per day is equal to the claim quantity dispensed divided by the claim days' supply. The opioid strength per unit and updated MME conversion factor are provided for each NDC in the PQA's Value Set, Opioids. When applying this updated formula to transdermal fentanyl patches, the opioid dosage units per day should always be 1, regardless of the claim's quantity dispensed or days' supply. Additionally, the PQA's Value Set, Opioids expresses weight-based strengths in milligrams, while the Centers for Disease Control and Prevention (CDC) MME conversion factors are based on micrograms. Thus, the PQA uses an adjusted MME conversion factor of 2,400 for transdermal fentanyl patches reported in milligrams (conversion factor of 2.4 for transdermal fentanyl patches reported in micrograms). This conversion factor accounts for the change in unit compared to the CDC and should be applied directly in the PQA's formula for calculating daily MME. Finally, this methodology aligns with opioid MME calculation methodology used in the CMS Part D Opioid Drug Utilization Review (DUR) policy and Overutilization Monitoring System (OMS), described in the [OMS technical guidance](#).

The PQA QMEP voted to approve these changes in 2025. **CMS plans to incorporate the updated MME calculation methodology beginning with the 2026 measurement year (2028 display page) at the earliest.**

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- Most commenters supported updating the MME calculation and conversion factors, and CMS will implement the updates to the OHD measure for the 2026 measurement year (2028 display page).
- A few commenters raised concerns that the measure was duplicative of other Part D opioid-related policies or would cause unintended consequences. The Part D opioid-related policies were carefully developed to balance the need to address opioid misuse with the need to maintain a positive patient-doctor relationship, preserve access to medically necessary drug regimens, and reduce the potential for unintended consequences. The OHD measure complements existing policies, such as drug management programs (DMPs) and point-of-sale opioid safety edits.
- CMS will continue to monitor the impact of these policies and measures. As a reminder, the OHD measure is not a prescribing limit and should not replace clinical judgment.

Section J. Retirement of Display Measures [P. 119]

Antipsychotic Use in Persons with Dementia for Long-Term Nursing Home Residents (APD-LTNH) (Part D). CMS plans to retire the APD-LTNH measure and retain the consensus-based APD measure that focuses on all enrollees regardless of setting. CMS previously retired the APD for Community-Only Residents (APD-COMM) measure.

Based on CMS's analysis of the APD and APD-LTNH measure rates from measurement years 2020 to 2023, the APD-LTNH mean rates were better than the APD mean rates across all contracts and when stratified by MA-PDs and PDPs. Since retiring the APD-COMM measure in 2020, the MA-PD and PDP rates for the overall APD measure have been gradually increasing (worsening), while the APD-LTNH measure rates have been generally decreasing (improving). Therefore, CMS can attribute the worsening performance to the APD community population.

CMS plans to retire the APD-LTNH measure from the 2028 display page (measurement year 2026) to reduce administrative burden and potential duplication of efforts. The APD-LTNH measure is a CMS-developed measure, whereas the PQA-endorsed APD measure is a standardized measure developed through a consensus-based process. The APD-LTNH measure rates are improving, and all beneficiaries in the APD-LTNH measure are captured in the APD measure. Therefore, CMS can refocus on the community population and maintain focus on the long-term nursing home population with the APD measure.

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- All commenters supported retiring the APD-LTNH measure, and this measure will be retired for the 2026 measurement year (2028 display page).

Section K. Potential Methodological Enhancements for Future Years [P. 120]

As CMS continues efforts to simplify the Star Ratings program, it is considering methodological enhancements to make the calculations easier to understand and implement, such as changes to simplify the methodology for determining measure thresholds. For example, one such approach could involve using percentile distribution cut offs to assign measure stars instead of the current clustering methodology for non-CAHPS measures.

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- Some commenters expressed support for moving away from clustering and adopting percentile-based methods for Star Ratings, emphasizing the potential for improved transparency, predictability, and interpretability.
- Others opposed replacing clustering, expressing concerns about arbitrary cut point shifts, artificial distinctions between similar plans, and possible confusion for beneficiaries.
- Many commenters recommended that CMS offer more detailed methodological information and conduct impact analyses before implementing changes, proposing a transparent, phased-in approach with opportunities for feedback.
- Additional suggestions included using pre-determined cut points, simplifying scoring for narrowly distributed measures, and considering alternative statistical methods to enhance stability and predictability.
- CMS will take these comments into consideration as it considers ways to simplify the Star Ratings methodology. Any changes to the methodology would need to be made through notice and comment rulemaking.