



Contract Year (CY) 2027 Medicare Advantage and Part D Proposed Rule ACR Detailed Summary

On November 25th, 2025, Centers for Medicare and Medicaid Services (CMS) released the Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program. Comments on this proposed rule are due to CMS by January 26, 2026.

Implementation of Certain Provisions of the Inflation Reduction Act of 2022 and the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018

Medicare Part D Redesign

The Inflation Reduction Act of 2022 (IRA) introduced major changes to the Medicare Part D prescription drug benefit and gave CMS temporary authority—through 2026—to implement these changes via program instructions. Since this authority will expire, CMS is proposing to formally codify these changes for 2027 and beyond.

The proposed regulations would:

- Eliminate the coverage gap phase.
- Lower the annual out-of-pocket threshold.
- Remove cost sharing for enrollees in the catastrophic phase.
- Implement the Manufacturer Discount Program, which replaced the Coverage Gap Discount Program on January 1, 2025.

Additionally, the proposal would codify operational updates, including changes to True Out-of-Pocket (TrOOP) cost calculations, specialty-tier rules, reinsurance payment methods, and the implementation of the Selected Drug Subsidy.

MA & Part D Quality Rating System (Star Ratings)

The Star Ratings system helps Medicare beneficiaries compare health and drug plan quality and determines Quality Bonus Payments and rebates for MA contracts. Currently, MA-PD contracts are rated at up to 43 measures, MA-only contracts on up to 33 measures, and Part D plans on up to 12 measures across five categories: outcomes, intermediate outcomes, process, patient experience, and access.

Proposed Updates to Star Ratings

CMS proposes two sets of major changes to the Part C and Part D Star Ratings system. Firstly, CMS is proposing not to introduce the “Excellent Health Outcomes for All” reward—which is intended to recognize high measure-level scores among enrollees with certain social risk factors—in the 2027 Star Ratings. Instead, CMS plans to maintain the existing reward factor that promotes consistently strong performance across all quality measures at §§422.166(f)(1) and 423.186(f)(1).



Secondly, CMS proposes to simplify and refocus the measure set for the 2027 measurement year by removing 12 measures that focus on administrative processes or areas where plan performance is uniformly high and shows little variation. Table 1 of the proposed rule lists the measures proposed to be removed from the Star Ratings. CMS proposes to add a new Part C Depression Screening and Follow-Up measure to address behavioral health gaps, starting with the 2027 measurement year to be reflected in the 2029 Star Ratings.

Medicare Trust Fund Impacts

For the Star Ratings updates, the net impact is estimated to be between \$5.02 billion in 2028 and \$0.95 billion in 2036, resulting in a 10-year net impact estimate of \$13.18 billion, which equates to 0.15 percent of the Medicare payments to private health plans for the years 2027 through 2036. Table K3 in the final rule shows the net impacts per year to the Medicare Trust Fund for star ratings updates.

Strengthening Current MA and Medicare Prescription Drug Benefit Program Policies

Improving the Enrollment Experience

CMS is proposing changes to improve the enrollment experience for MA and Part D enrollees.

The proposal includes:

- **New SEP for Provider Terminations**

CMS plans to update the existing SEP that allows enrollees to switch plans when their provider leaves the network. Currently, this SEP applies only if CMS and the MA organization deem the network change “significant.” The proposed change removes that limitation, making it easier for enrollees to stay with their provider by changing plans when any provider they use exits the network.

- **Codifying SEP Approval Policy**

CMS will formalize its long-standing policy that certain SEPs require prior CMS approval. This ensures transparency and consistency by making clear that changes to these SEPs can only occur through rulemaking.

Improvements for Special Needs Plans

Model of Care (MOC) Off-Cycle Submission Window

All Special Needs Plans (SNPs) must implement care management through an NCQA-approved Model of Care (MOC) and related services, with each SNP type requiring its own MOC. CMS allows “off-cycle” revisions to address enrollee needs during the approval process. Starting in 2027, CMS will move the initial and renewal MOC submission deadline to early June and proposes a new timeline for off-cycle updates: January–March and October–December each year. This change splits the current six-month update window to align with operational needs for CMS and NCQA reviews.

Passive Enrollment by CMS

Dually eligible individuals often struggle with navigating Medicare and Medicaid, but integrated care options—such as Dual Special Needs Plans (D-SNPs)—are expanding to improve



coordination. CMS supports passive enrollment from terminating integrated D-SNPs to comparable plans but proposes changes to reduce disruptions. The agency plans to eliminate requirements for substantially similar provider networks and benefits between plans, replacing them with a 120-day continuity-of-care period for active treatments, even with out-of-network providers. Existing integration standards already ensure comparable benefits across D-SNPs within a state.

Reducing Regulatory Burden and Costs in Accordance with Executive Order (E.O.) 14192

CMS is proposing several changes to reduce burden and remove requirements that are duplicative or no longer necessary or applicable.

Proposals include:

- Exempting account-based plans (such as health reimbursement arrangements (HRAs), flexible spending accounts (FSAs), and health savings accounts (HSAs)) from creditable coverage disclosure requirements.
- Rescinding the requirement for MA plans to send mid-year notices about unused supplemental benefits.
- Eliminating the requirement for MA quality improvement programs to include activities that reduce health disparities.
- Eliminating health equity requirements for MA Utilization Management (UM) Committees, including requiring a health equity expert member, conducting annual health equity analyses, and publicly posting these analyses.
- Waiving the requirement for the Limited Income Newly Eligible Transition (LI NET) program to maintain toll-free customer call centers open from 8 a.m. to 8 p.m. in all regions.

Request for Information on Future Directions in Medicare Advantage

The MA program has grown considerably in the past two decades, now covering over half of all Medicare beneficiaries. In light of this growth, CMS is interested in exploring opportunities for modernizing and strengthening the program, including with regard to payment, risk adjustment, and quality policy, with the aim of supporting competition and maximizing the value of the program for beneficiaries and taxpayers.

Risk Adjustment RFI

CMS is focusing on enhancing competition within the MA program by soliciting input on risk adjustment and quality bonus payment changes. CMS recognizes that the current risk adjustment system may disadvantage smaller, newer, and less well-resourced plans and may encourage plans to prioritize investment in coding activities that could lead to MA plans coding more intensely than Original Medicare.

CMS is exploring modernization opportunities including a next-generation risk adjustment model that could leverage artificial intelligence and alternative data sources, as well as ways to streamline the quality measurement timeline and reduce the current two-year lag between measurement and payment.



RFI on Quality Bonus Payments & Star Ratings

CMS solicits comments from stakeholders on strategies to further simplify and modify the Star Ratings program to further drive improved quality of care and reduce regulatory burden, allowing plans to concentrate resources on areas that directly impact patient care and health outcomes.

CMS is gathering input to shape future policies on the MA Quality Bonus Payment (QBP) structure and its effect on rebates. The agency is examining the timelines for introducing new Star Rating measures—covering testing, validation, proposal, and implementation—as well as the current two-year delay between the measurement period and payment adjustments for MA plans. CMS is seeking ideas to shorten both timelines.

CMS is also requesting feedback on whether to pilot a CMMI model that separates Quality Bonus Payments (QBPs) from MA bids. The agency seeks input on what such an alternative policy might entail, its potential benefits and drawbacks, the appropriate timing for finalizing and distributing bonus payments, and strategies to better incentivize cost containment while enhancing care quality within the MA program.

RFI on Dually Eligible Individual Enrollment Growth in C-SNPs and I-SNPs

CMS aims to address the significant growth in chronic condition special needs plans (C-SNPs) enrollment, with particular concern about dually eligible individuals enrolling in these plans rather than dual eligible special needs plans (D-SNPs) that offer integrated Medicare-Medicaid benefits. CMS is exploring potential solutions including adopting a State Medicaid Agency Contract requirement for C-SNPs and/or institutional special needs plans (I-SNPs) with high concentrations of dually eligible individuals, like existing D-SNP requirements.

Well-Being and Nutrition RFI

The MA program offers a unique opportunity to bring high-value interventions designed to support overall well-being and nutrition to patients. This RFI is seeking comments on tools and policies that improve overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connection, purpose, and fulfillment, in addition to tools that would achieve optimal nutrition and improve preventive care in MA, including possible incentives for MAOs to support beneficiaries seeking to improve their nutrition.