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CMS Finalizes CY 2027 Changes to Medicare Advantage and Part D to Implement Part D Redesign, Update Star Ratings, and Reduce Administrative Burden

On April 2, 2026, the Centers for Medicare & Medicaid Services (CMS) released its Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program Final Rule, which contains finalized policies for Medicare Advantage (MA) and Medicare Part D plans in contract year (CY) 2027. See the press release here and the fact sheet here. In this rule, CMS finalizes proposals:

- Codifying Part D redesign under the Inflation Reduction Act (IRA),
- Manufacturer Discount Program changes, with minor modifications,
- Updating third-party marketing organization (TPMO) practices, with modification,
- Updating Star Ratings measures, including removing the Health Equity Index reward,
- Clarifying that cannabis products illegal under applicable federal or state law cannot be offered as Special Supplemental Benefits for the Chronically Ill (SSBCI), and
- Making regulatory changes aimed at reducing administrative burden in MA and Part D programs.

The agency also addresses proposals from the Contract Year 2026 Proposed Rule[1] related to SSBCI that were not finalized in the Contract Year 2026 Final Rule.[2]

CMS is not finalizing its proposal to revise the Special Enrollment Period (SEP) for Significant Change in Provider Network intended to simplify plan changes for enrollees affected by provider terminations.

This final rule is scheduled to be published in the *Federal Register* on April 6, 2026. Finalized policies are effective June 1, 2026, and are applicable to coverage beginning January 1, 2027.

[1] https://www.federalregister.gov/d/2024-27939
[2] https://www.federalregister.gov/d/2025-06008

MEDICARE PART D REDESIGN UNDER IRA

FINALIZED AS PROPOSED

Pages 9-56 of the Unpublished Final Rule

The IRA of 2022 implemented changes to the Medicare Part D benefit, referred to as the Medicare Part D redesign. The redesign changes the payment obligations of beneficiaries, Part D plan sponsors, manufacturers, and CMS. CMS has released guidance outlining implementation of these policies for 2024, 2025, and 2026, as directed by statute.[3,4,5]

CMS finalizes proposals revising the regulatory text for Part D benefit redesign changes related to the:

- **Deductible:** CMS finalizes its proposal to add clarifying language that the deductible does not apply to ACIP-recommended vaccines or covered insulin products.
- **Initial Coverage Limit and Coverage Gap:** CMS finalizes revisions to reflect the elimination of the initial coverage limit and the coverage gap beginning in 2025.
- **Annual Out-of-Pocket (OOP) Threshold:** Under the IRA, the annual OOP threshold for 2025 is $2,000. This figure is updated annually for inflation and is $2,100 for 2026, as outlined in the CY 2026 Rate Announcement. CMS finalizes revisions to address how these thresholds change from year to year.
- **Alternative Prescription Drug Coverage Options:** CMS finalizes policies to address changes under the IRA that remove certain features previously available under basic alternative Part D plans.

CMS also finalizes its proposals to codify certain policies in the CY '25 and CY '26 Part D Redesign Program Guidance[6], including:

- **TrOOP policies** established in the Final Part D Redesign Program Instructions for CY 2025 and CY 2026, **without modification.**
- **Policies for drugs not subject to the defined standard deductible** that are in effect for 2026 and 2026, **without modification.**
- **Gross covered prescription drug costs (GCPDC) and allowable reinsurance cost definitions to include costs paid by the Manufacturer Discount Program**, with limited modifications, including a modification to revise the regulatory definition of GCPDC to include "all amounts paid by manufacturers under the Manufacturer Discount Program (as defined at § 432.100)."
- **Reinsurance methodology policies** established in the Final Part D Redesign Program Instructions for CY 2025 and CY 2026, **without modification.**

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[3] CY 2024 Advance Notice and Rate Announcement. https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf
[4] Final CY 2025 Part D Redesign Program Instructions. https://www.cms.gov/files/document/final-cy-2025-part-d-redesign-program-instructions.pdf
[5] Final CY 2026 Part D Redesign Program Instructions. https://www.cms.gov/files/document/final-cy-2026-part-d-redesign-program-instruction.pdf
[6] Id.

- **Selected drug policies** established in the Final Part D Redesign Program Instructions for CY 2026, **without modification.**
- **Medical loss ratio (MLR) policies** established in the Final Part D Redesign Program Instructions for CY 2025 and CY 2026, related to excluding MDP payments, IRA subsidy amount (IRASA), and selected drug subsidy program payments for MLR purposes.

Additionally, CMS finalizes conforming edits to the retiree drug subsidy; updates to the low-income cost-sharing subsidy to align with the IRA, including those related to the Federal Poverty Limit (FPL); updates to the base beneficiary premium; and codifies statutory amendments related to the base beneficiary premium.

CMS also finalizes changes to its specialty-tier regulations and annual indexing of Part D benefit parameters using the annual percentage increase in drug expenditures (API) and Consumer Price Index (CPI) related to calculations CMS will make. For the specialty-tier regulations, this includes updating the CY 2026 specialty-tier coinsurance thresholds to reflect the maximum allowable specialty-tier coinsurance percentages. The calculation methodology aligns with the prior Part D benefit redesign instructions.

PART D MANUFACTURER DISCOUNT PROGRAM

FINALIZED WITH MODIFICATION

Pages 59-131 of the Unpublished Final Rule

CMS is largely finalizing its proposal to codify in regulations the sunsetting of the Coverage Gap Discount Program and the termination of all Coverage Gap Discount Program agreements as of January 1, 2025, in alignment with the changes made under the IRA. The Coverage Gap Discount Program, which provided manufacturer discounts at the point of sale for non-low-income subsidy (LIS) Part D enrollees in the coverage gap, has been replaced by the Manufacturer Discount Program, which requires manufacturers to provide discounts during the initial and catastrophic coverage phases for applicable Part D drugs.

The final rule formally terminates all Coverage Gap Discount Program agreements, establishes applicability dates for the program, and codifies requirements for the Manufacturer Discount Program, including conforming changes throughout Part D regulations. **The final rule largely finalizes most of the proposals with minor revisions to regulatory language to allow for the potential of future remote manufacturer audits of third-party administrator (TPA) data. It also clarifies the 60 calendar days' notice required for agreement holders to audit the TPA and the supporting documentation expected from the manufacturer for any timely recalculation request for the phase-in eligibility determination.**

These changes, along with those related to the Medicare Part D redesign, align with the approach taken for other sections of the IRA, where policies are initially implemented through guidance and subsequently revised or codified through rulemaking. With these updates, CMS is generally maintaining existing policies rather than making substantive changes.

TPMO PRACTICE UPDATES

FINALIZED WITH MODIFICATION

Pages 225, 284, 536 of the Unpublished Final Rule

CMS finalizes several changes related to TPMO practices:

- **Disclaimer Requirement:** CMS finalizes its proposal to modify the TPMO disclaimer requirement found in §§422.2267(e)(41) and 423.2267(e)(41), which currently establishes the TPMO's scope of representation, and identify additional information sources for the beneficiary, and require this information to be provided within the first minute of a call. TPMOs must read this disclaimer before discussing any benefits during a call with a beneficiary, and State Health Insurance Assistance Programs (SHIPs) are removed as a source of information.

- **Record Retention Requirements:** CMS finalizes its proposal, with modification, to shorten the required retention period for marketing and sales call recordings by MAOs and Part D sponsors from 10 years to 6 years. **Under the final policy, plans must retain audio recordings for the first 3 years, after which they may keep either audio recordings or complete transcripts for the remaining 3 years.**

- **Limitation on Dual Eligible Special Needs Plan (D-SNP)-Only Contracts Submitting Materials under the Multi-Contract Entity (MCE) Process:** CMS finalizes to require MAOs offering D-SNPs with "exclusively aligned enrollment" subject to §422.107(e) to submit all relevant materials in the Health Plan Management System (HPMS) under the MAO's contract number. In the final rule, CMS corrects a technical error and clarifies the fact that MAOs may not submit materials for the contract under the MCE number, while TPMOs may not submit materials under the multi-plan number as described in §422.2262(d)(2)(i) and §423.2262(d)(2)(i).

These changes reflect CMS's interest in modernizing and updating practices related to TPMOs and related requirements on the side of MAOs and Part D sponsors.

SPECIAL ENROLLMENT PERIOD CHANGES

NOT FINALIZED

Page 7 of the Unpublished Final Rule

CMS is not finalizing its proposals to modify the SEP for provider terminations and is not addressing comments in this final rule, though the agency indicates it may revisit the issue in future rulemaking. In the proposed rule, CMS had outlined changes to the SEP for Significant Change in Provider Network intended to simplify plan changes for enrollees affected by provider terminations by removing the requirement that the change be deemed "significant" by CMS or the MA organization. The proposal would have also required MA organizations to provide clear notification of SEP eligibility to affected enrollees within the required provider termination notice, along with details on the Annual Coordinated Election

Period and the MA Open Enrollment Period, Medigap guaranteed issue rights, and guidance for individuals with employer-based coverage.

FINALIZED AS PROPOSED

Page 176 of the Unpublished Final Rule

CMS codifies existing policy that certain SEPs require prior CMS approval, including those related to contract violations, CMS sanctions, loss of creditable coverage, and other exceptional circumstances. Beneficiaries may continue to receive assistance from agents or brokers when using CMS-operated election mechanisms, but MA organizations will not be able to submit elections for these SEPs without CMS approval.

STAR RATINGS UPDATES

FINALIZED WITH MODIFICATION

Pages 377-461 of the Unpublished Final Rule

CMS finalizes updates to MA Part C and Part D Plan Star Ratings, including:

- **Removal of 11 Star Ratings Measures:** CMS is removing 11 measures across Part C and D star ratings.[7] All measure removals will take effect for the 2029 Star Ratings, with the exception of the Call Center – Foreign Language Interpreter and TTY Availability (Part C and D) and the Statin Therapy for Patients with Cardiovascular Disease (Part C) measures, which will be removed starting with the 2028 Star Ratings.
- **Addition of Depression Screening and Follow-Up Measure:** This new Part C Star Ratings measure will be added for the 2029 Star Ratings/2027 measurement year.
- **Request for Information:** The agency responds to feedback on the Star Ratings, particularly the addition of new outcome measures aligned with Make America Healthy Again (MAHA) priorities. Commenters generally supported CMS's effort to simplify the Star Ratings and focus on outcome-based, prevention-oriented measures, but warned that rapid changes could destabilize plans and harm high-need populations. CMS states it will consider comments as it seeks to streamline the methodology and review the measure set.
- **Removal of the Health Equity Index Reward and Continuation of the Historical Reward Factor:** CMS finalizes its proposal to not implement the Health Equity Index (HEI) reward (also called the Excellent Health Outcomes for All (EHO4all reward)) and continue the previous historical reward factor it was set to replace.

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[7] **Proposed Policy:** In response to stakeholder feedback, CMS is not finalizing its proposal to remove the Diabetes Care – Eye Exam measure.

CMS also clarifies language regarding the timely retirement of measures and codifies current practices of providing sample measure data to MA organizations and Part D plans.

These changes reflect the Trump administration's focus on restructuring quality programs in line with the MAHA agenda and broader regulatory reform initiatives.

CLARIFICATION THAT ILLEGAL CANNABIS PRODUCTS MAY NOT BE OFFERED AS SSBCI

FINALIZED WITH MODIFICATION

Pages 161-167 of the Unpublished Final Rule

CMS finalizes its proposal, with a minor modification, to clarify that cannabis products that are illegal under federal or state law cannot be offered as SSBCI. **CMS makes a minor technical modification to the regulatory text by removing the explicit reference to the Federal Food, Drug, and Cosmetic Act.** With this final rule, MA organizations will, however, be allowed to offer certain hemp-derived ingredients, such as hulled hemp seed, hemp seed protein powder, and hemp seed oil, as supplemental benefits, provided they comply with applicable law and demonstrate a reasonable expectation of health benefit. FDA-approved drugs, such as Epidiolex, will remain under the Part D benefit and cannot be offered as a Part C supplemental benefit. Products with delta-9 THC above 0.3 percent, or those that do not meet the amended federal hemp definition as of November 12, 2026,[8] remain prohibited.

This clarification aligns supplemental benefit policies with federal and state law while allowing plans to safely offer certain hemp-derived products that may benefit chronically ill beneficiaries.

POLICIES AIMED AT REDUCING ADMINISTRATIVE BURDEN AND STREAMLINING MA AND PART D PROGRAMS

Pages 543-579 of the Unpublished Final Rule

FINALIZED AS PROPOSED

Consistent with President Trump's Executive Order, "Unleashing Prosperity through Deregulation,"[9] CMS is finalizing regulatory changes to reduce administrative burden and streamline MA and Medicare Part D programs. Key policies include:

- **Account-Based Plans**: CMS finalizes its proposal to exempt health reimbursement arrangements (HRA) and similar account-based plans from reporting whether their coverage is creditable.

[8] As revised under the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026.

[9] 90 FR 9065 https://www.federalregister.gov/d/2025-02345

- **Annual Health Equity Analysis**: CMS finalizes its proposal to remove the requirement that utilization management committees conduct and publicly post an annual health equity analysis of prior authorization use, as CMS believes it is burdensome and does not provide meaningful additional information.

- **Quality Improvement Program:** CMS rescinds the requirement that quality improvement programs include activities specifically addressing health disparities, while maintaining all other quality improvement obligations.

The agency also finalizes several other proposals, including changes to mid-year notices of unused benefits, cultural competency regulations, enrollment sanctions for non-compliant D-SNPs, and customer call center requirements for the Limited Income Newly Eligible Transition (LI NET) program. These changes collectively aim to simplify regulations, reduce administrative burdens, and maintain access to high-quality care for Medicare beneficiaries.

Overall, these new policies reflect the administration's priority on deregulation, reducing complexity, and focusing regulatory oversight on core program requirements rather than equity-driven mandates.

NOT FINALIZED

- **Dual-Eligible Supplemental Benefits Pathway**: **In response to comments, CMS is not finalizing its proposal to remove the regulatory pathway that allows D-SNPs to offer supplemental benefits.**

SUPPLEMENTAL BENEFITS PROVISIONS PROPOSED IN CY 2026 PROPOSED RULE

Eligibility for SSBCI

FINALIZED WITH MODIFICATION

Pages 324-340 of the Unpublished Final Rule

CMS finalizes updates to the SSBCI eligibility determination process, with modification. These updates were initially proposed in the Contract Year 2026 Proposed Rule but were not finalized. CMS will now require MA organizations to publicly post their objective eligibility criteria for both determining chronically ill enrollees and for SSBCI on a public-facing website. The agency clarifies that plans must use objective processes, rather than self-attestation, to verify that enrollees meet all three statutory criteria defining a chronically ill. **Additionally, CMS finalizes technical and structural modifications clarifying how plans must list and maintain these written policies and objective criteria throughout the coverage year.**

Administration of SSBCI Through Debit Cards

Pages 340-376 of the Unpublished Final Rule

CMS addresses several proposals from the Contract Year 2026 Proposed Rule that were not finalized:

- ***FINALIZED AS PROPOSED:*** CMS finalizes requirements for MA plans to disclose all supplemental benefits and applicable conditions and limitations, as well as eligible over-the-counter items and benefits accessed through debit cards.
- ***FINALIZED WITH MODIFICATION:*** CMS also finalizes, with modification, that plans offering benefits through debit cards must maintain an alternative reimbursement process when the debit card cannot be used, such as in cases of technical malfunctions or out-of-network circumstances.
- ***NOT FINALIZED:*** The agency does not finalize proposals that would have limited acceptable methods for administering cost-sharing reductions by removing "or other means," nor does it finalize its proposal to prohibit MA organizations from marketing the dollar value of supplemental benefits or describing how those benefits are administered, including the use of debit cards.

REQUESTS FOR INFORMATION

- **C-SNP & I-SNP Growth and Dually Eligible Individuals (Pages 537-542 of the Unpublished Final Rule):** Enrollment in Chronic Condition Special Needs Plan (C-SNP) and Institutional Special Needs Plan (I-SNP), particularly among dually eligible individuals, has grown substantially, raising concerns about potential impacts on Medicare-Medicaid integration and care coordination. CMS requested public comment on these trends, including establishing a State Medicaid agency contract (SMAC) requirement similar to existing requirements for D-SNPs, increasing care coordination, applying D-SNP look-alike contracting limitations, and serving special populations such as individuals with serious mental illness or substance use disorders. The agency does not respond to comments but indicates it will use feedback to inform future rulemaking.

- **Future Directions in MA (Pages 580-590 of the Unpublished Rule):** In light of significant growth of MA over the past two decades, CMS sought feedback on potential reforms to the program, including improving risk adjustment accuracy and fairness, reforming Star Ratings and Quality Bonus Payments, and promoting well-being, preventive care, and nutrition to support long-term health outcomes. Commenters broadly supported these goals, emphasizing more accurate and transparent risk adjustment, refinements to Star Ratings to better reflect outcomes and reduce lag, and an expanded focus on nutrition and holistic, preventive services. CMS does not formally respond to comments but will use the input to shape future rulemaking and potential Innovation Center model tests.

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