Category	Change
Stars Program Changes	**Removal of 12 measures across Part C and D, including:** • Administrative and operational measures such as appeals timeliness, appeals review, SNP care management, call center interpreter/TTY availability and plan complaint metrics. • Select clinical or process measures, including diabetes eye exam and statin therapy for patients with CVD. • CAHPS experience measures including customer service and rating of health care quality.
	Addition of one clinical measure: Depression Screening and Follow-Up (Part C), reinforcing CMS's growing focus on behavioral health.
	Elimination of the Health Equity Index (HEI) or EHO4All and reinstatement of the historical Reward Factor for contract performance.
	Faster, more flexible measure removal, allowing CMS to retire measures through rulemaking when low reliability, misaligned with current clinical guidance, or retired by the steward.
Administrative Simplification and Targeted Deregulation	Modify the SEP for provider terminations, creating a straightforward SEP for Provider Terminations that begins when enrollees are notified
	Rescind communication and reporting requirements, including: • Mid-Year Supplemental Benefits Notice • Multi-Language Insert or Notice of Availability • UM Committee health equity requirements • Quality Improvement Program health disparities requirement
	Loosen TPMO and marketing constraints, including: • Removing the 48-hour waiting period between Scope of Appointment and personal marketing appointment. • Allowing marketing events to immediately follow educational events in the same location. • Permitting SOA forms to be obtained at educational events. • Moving the required disclaimer from "first minute" to "before benefits discussion. • Allowing superlatives as long as statements are accurate. • Shortening recorded call retention to 6 years, or possibly 3, while keeping enrollment record retention at 10 years.
D-SNPs, C-SNPs, I-SNPs, and the Next Phase of Integration	**Passive Enrollment for Integrated D-SNPs** • Removes the requirement for "substantially similar" networks and instead requires 120 days of continuity of care and adequate care coordinator staffing.
	Continuity of Enrollment for Full-Benefit Duals • Allows D-SNPs in HIDE or coordination-only structures to maintain enrollment for full-benefit duals in Medicaid FFS.
	RFI on C-SNP/I-SNP Oversight • Possible SMAC requirements for C-SNPs and I-SNPs with high dual enrollment. • Extension of D-SNP look-alike contracting limits. • New care coordination expectations and focus on mental health and substance use disorder management.
Future of Risk Adjustment and Stars QBPS	While no new risk adjustment model is proposed for 2027, CMS devotes significant attention to an RFI on modernizing risk adjustment and Quality Bonus Payments, with an explicit focus on competition, embracing technology and leveling the playing field for smaller and regional plans.
SNP MOC Updates	SNP MOC Submission moves earlier in June with two off-cycle update windows (Jan–Mar, Oct–Dec).
Part D PDE Audit Appeals	Part D PDE Audit Appeals gains a new three-level process with defined rights and timelines