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Summary of 2026 Advance Notice

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Executive Summary

On January 10, 2025, the Centers for Medicare and Medicaid Services (CMS) released the CY 2026 Advance Notice, which details planned changes to the Part C and Part D capitation and risk adjustment methodology for calendar year (CY) 2025. The comment period for the Advance Notice ends February 10, 2025, and the final rating provisions will be announced no later than April 7, 2025.

The CY 2025 fee-for-service (FFS) Growth Rate, which is the major driver of Part C benchmark rates, is estimated at 5.67%. The continued phase in removing Medicare Advantage (MA) related indirect medical education (IME) and direct graduate medical education (DGME) amounts results in a -1.42% impact on the growth rate. The implied total impact of the IME and DGME removal has become larger (i.e., a bigger decrease) as compared with the estimate from the CY 2025 Advance Notice.

CMS is maintaining the non-ESRD Part C risk model and will implement the final phase-in of the 2024 CMS-HCC model from the 2020 CMS-HCC models for CY 2026.

CMS proposes to continue using the multiple linear regression method for calculating Part C FFS normalization, and also to now use it for Part D normalization as well. The CY2026 factor is 1.067 for Part C. When taken together with the change in blend percentages from 2025 to 2026 and the differences in risk score models, the year over year effect of FFS normalization is -3.01%.

The proposed coding intensity adjustment factor remains at the statutory minimum of 5.9%.

Due to further changes in the Part D program for CY2026 resulting from the IRA, CMS is proposing a revised 2026 RxHCC model. The new model is based on 2022 diagnoses and 2023 prescription drug expenditure data. No clinical update to the RxHCC definitions is proposed.

In addition to the revised RxHCC model, CMS is also proposing to continue to calculate separate RxHCC FFS normalization factors for MA-PD plans and PDPs. The multiple regression method results in CY2026 RxHCC FFS normalization factors of 1.193 and 0.887 for MA-PD and PDP, respectively. This compares with factors of 1.073 and 0.955 for CY2025, so the spread between the two has widened significantly.

Following is a summary of the key changes and proposals in the Advance Notice.

Part C Growth Rates

The following table shows the estimated growth rates for 2025.

Table 1: Estimated 2025 Growth Rates

Growth Rate	Percentage
FFS – Non-ESRD	5.67%
MA Growth Percentage (including FFS and MA) – Non-ESRD	7.70%
Dialysis-only ESRD	6.31%

For the non-ESRD rates, CMS is continuing the phase in to remove the MA-related IME and DGME from the United States Per Capita Cost (USPCC) calculations. The impact of the continued phase in lowers the 2026 non-ESRD FFS USPCC and corresponding non-ESRD FFS growth percentage by 1.42 percent. In addition, mechanical changes in the tabulation of claims and enrollment stemming from a transition in data sources from the Denominator file and National Claims History to the "Common Medicare Environment" is causing a 0.57% decrease in the non-ESRD FFS growth rate.

Part C Risk Scores

In the CY 2024 Advance Notice, CMS proposed to a new Part C non-ESRD risk score model, to be called the 2024 CMS-HCC model. The model was phased in over 2024 and 2025 and is proposed to be fully phased in as of CY2026. The blend of the new model with the old 2020 CMS-HCC model followed the following schedule:

Table 2: Non-ESRD Part C Risk Score Model Phase-In Schedule

Year	2024 CMS-HCC v28	2020 CMS-HCC v24
2024	33%	67%
2025	67%	33%
2026	100%	0%

For CY 2026, CMS is proposing to continue a multiple linear regression methodology it introduced for CY2025 to calculate FFS normalization factors for all CMS-HCC models. The stated goal of this method is to properly capture the impact of the COVID pandemic on risk scores. The resulting CY2026 FFS normalization factor for the 2024 CMS-HCC model is 1.067, which is a significant increase over the CY 2024 factor of 1.045.

In the Advance Notice Fact Sheet[1], CMS estimates that 2025 over 2024 blended impact of the new normalization factors and risk model updates for non-PACE plans is -3.01% (i.e., CY 2026 normalized, blended risk scores will be 3.01% lower than CY 2025, all other factors equal).

[1] https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-advance-notice-fact-sheet

For PACE plans, CMS is proposing to begin phasing in the 2024 CMS-HCC model, based on encounter and FFS claim data with the currently used 2017 CMS-HCC data, based on the risk-adjusted payment system (RAPS) diagnosis data.

The CY 2026 coding pattern adjustment is set at the statutory minimum of 5.90%, which represents no change compared with CY 2025.

Part D Risk Scores

Due to changes in Defined Standard benefit parameters, manufacturer discounts, and the Medicare Drug Price Negotiation program, CMS is proposing to recalibrate current RxHCC risk model. The new model is recalibrated on 2022 diagnoses for 2023 expenditures. CMS is further proposing to continue using separate FFS normalization factors for MA-PD enrollees compared with PDP enrollees. The MA-PD factor is proposed to be 1.193, and the PDP factor is 0.887.

CMS is also proposing an alternative model that did not adjust drug costs for Maximum Fair Price as part of the Medicare Drug Price negotiation program for 2026 and is seeking comment on the appropriateness of this alternative model compared with the proposed model.

For PACE organizations, CMS is similarly proposing to blend the proposed 2026 RxHCC model with the existing PACE model based on 2018 diagnoses and 2019 costs. The PACE RxHCC FFS normalization factor for CY 2026 is proposed to be 1.202, which is based on a linear regression method applied to MA-PD risk scores from 2016 through 2020 using a 2026 RxHCC model calibrated to 2018/2019.

Employer Group Waiver Plans (EGWPs)

Plans will not need to file EGWP bid pricing tools (BPTs) for CY 2026, as was the case in CY 2024.

CMS proposes to continue calculating separate HMO and PPO bid-to-benchmark ratios based on individual 2025 bids and then re-weighted with February 2025 EGWP enrollment. The preliminary 2026 bid-to-benchmark ratios are about 1% higher than the 2025 rates except for the 0.95 quartile. Table 3 compares 2025 and preliminary 2026 ratios.

Table 3: Estimated Bid-to-Benchmark Ratios

Applicable Percentage	2025 Ratios	2026 Estimates
0.95	78.5%	78.7%
1.00	76.8%	77.8%
1.075	76.2%	77.3%
1.15	76.6%	77.7%

Part D Defined Standard Benefit Changes

Part D changes for 2026 resulting from the Inflation Reduction Act (IRA) of 2022[2] are less dramatic than CY 2025, but are still material. The key IRA changes for 2026 are as follows:

- Continued phase-in of the Manufacturer Discount Program for certain manufacturer meeting criteria set out in the IRA.
- Implementation a drug subsidy program where CMS pays a 10% subsidy in the initial coverage phase for selected drugs affected by the Medicare Drug Price Negotiation Program (MDPNP).
- The base beneficiary premium growth will be held to no more than 6% over the CY 2025 level (i.e., CY2025 was $36.78 PMPM, so CY2026 can be no higher than $38.99).
- Insulin cost sharing will be the lesser of $35, 25% of the maximum fair price in the MDPNP, and 25% of the price negotiated by the MA-PD plan or PDP.

A separate document titled "Draft CY 2026 Part D Redesign Program Instructions" was released at the same time of the Advance Notice. It contains detailed descriptions of how the Defined Standard benefit design changes will be implemented in CY 2026.

Part D Parameters and Risk Sharing

The beneficiary maximum out-of-pocket (MOOP) maximum amount for CY 2026 is $2,100 and the preliminary update to the Part D DS deductible for CY 2026 is $615.

CMS proposes to maintain the same risk sharing corridor parameters as have been in place for several years; however, PDPs participating in the voluntary demonstration program introduced in July 2024 will have more favorable risk sharing terms as summarized in Table 4.

Table 4: Part D Risk Corridors for PDPs Participating in Voluntary Demonstration

Ratio to Target Amount	CMS	PDP
105%+	90%	10%
102.5%-105%	50%	50%
95%-102.5%	0%	100%
90%-95%	50%	50%
<90%	80%	20%

[2] H.R.5376 - 117th Congress (2021-2022): Inflation Reduction Act of 2022 | Congress.gov | Library of Congress

Star Rating Changes

Various updates for the Star Rating measures are proposed. New measures, concepts, and methodological enhancements for future years are also introduced, along with several potential changes for CY2027 and future years.

The general themes of the changes were a desire to continue to align the Star Rating program with the Universal Foundation measure set and simplification of the program.

Attachment I

Wakely Analysis - Wakely Estimated Impact of Growth Rates Combined with Payment Reform

Wakely estimates that, on a nationwide average basis, and as compared with 2024, nationwide average 2026 Part C benchmarks will:

- Increase by 5.02 % on a standardized (i.e., 1.00) risk score basis. This incorporates the FFS growth rate, changes in applicable percentage by county, average change in star ratings and quality bonus, and the impact of benchmark cap. It does not include changes to the county level IME/DGME adjustment factors, VA and DoD adjustment factor, credibility factors or county rebasing and repricing.

- Increase by 1.86% on a risk-adjusted basis. The risk-adjusted change incorporates the year-over-year impact of FFS normalization factors, MA Coding Pattern adjustment and the risk model revision (i.e., the continued phase-in of the 2024 CMS-HCC risk adjustment model).

The Wakely risk-adjusted estimate is based on the following components:

- Change in 1.00 benchmarks
- Impact of change in FFS normalization factor
- Assumption of no trend in raw risk scores
- Average change in star ratings based on December 2024 enrollment

Table 5 shows our estimates of the components that make up this change:

Table 5: Change in Blended Risk-Adjusted Benchmarks 2025 to 2026

Component	2025 to 2026 Change
Growth Rate [2]	5.67%
Applicable %	-0.16%
Star Rating/Quality Bonus	-1.06%
Benchmark Cap	0.60%
Total Benchmark Change	**5.02%**
FFS Normalization & Risk Model Revision	-3.01%
MA Coding Pattern	0.00%
Total Risk Score Change	**-3.01%**
TOTAL	**1.86%**

[1] Based on December 2024 MA enrollment and Fall 2024 Star Ratings
[2] Includes -1.42% adjustment for the removal of MA-related IME and DGME costs

Below is a brief definition of each of the elements in Table 5.

Growth Rate. This is the impact of the FFS (+5.67%) growth rate.

Applicable %. Average nationwide change in applicable percentage, based on the enrollment by Medicare Advantage contract and county.

Star Rating/Quality Bonus. Difference in quality bonus impact on benchmarks due to star rating changes between 2025 and 2026. We calculate this using December 2024 enrollment (January 2025 enrollment was not yet available).

Benchmark Cap. The ACA formula requires that the final blended benchmark can be no greater than the pre-ACA benchmark. The impact of this cap can vary year-to-year as plans change star ratings, and as the MA trend differs from the FFS trend. Note, for CY2026 the proposed MA growth rate is greater than the FFS growth rate, which results in a positive impact to the benchmarks.

Part C Fee-for-Service (FFS) Normalization Factor and Risk Model Revision. The 2025 Part C FFS normalization was a 67%/33% blend of 1.045 (v28) and 1.153 (v24). For 2026, CMS is proposing to continue the full phase-in of the v28 model. The proposed FFS normalization factor for 2026 is 1.067 (v28). We can infer the CY2026 v24 factor using the coefficients published in the CY2025 Advance Notice as 1.179. CMS is continuing to use a multiple regression model to the impact of COVID-19 for 2021 and subsequent years. Based on the Fact Sheet, CMS estimates the overall change to the risk adjustment model and FFS normalization will be -3.01%. They also state the impact due to the risk adjustment model revision phase in is -4.31% and the impact due to the new FFS normalization factors is +1.30%.

Change in Coding Pattern Adjustment. The coding pattern adjustment for 2026 will be -5.90%, which is the minimum adjustment required by the Affordable Care Act (ACA). There will be no change from 2025.

CHANGE IN BID AND REBATE AMOUNTS

The actual revenue change for individual Medicare Advantage plans will depend on the trend in bids, and will further vary depending on star rating, counties served, risk score trends, population changes, and many other factors.

If we assume that both 2025 and 2026 bids are 78% of the benchmark (comparable to the bid to benchmark ratios for MA EGWPs published in the CY2026 Advance Notice), then we estimate the change in Part C payments from 2025 to 2026 to be an increase of 1.59% (see Table 6).

To properly estimate the impact of the various MA payment, components addressed in the Advance Notice, Medicare Advantage plans must consider the aggregate effect on actual payments from CMS, which is not necessarily the same as the change in benchmarks. As noted above, we estimate the change in risk-adjusted benchmarks to be 1.86%. If we include estimated changes in bid and rebate levels, then the impact to Part C revenue is 1.59%. This estimate is based on the following assumptions:

- Plans bid at 78% of the benchmark in 2026. This is based on the published bid-to-benchmark ratios in the 2026 Advance Notice.
- Annual risk score coding trend is 0% for a static population
- Nationwide average star ratings, which result in an average rebate percentage of 65.7% in 2025 and 64.6% for 2026
- No consideration for sequestration or insurer fee

Table 6 shows the calculations underlying our estimates.

Table 6: Estimated Change Risk-Adjusted Bid and Rebate 2025 to 2026

	2025	2026	2026/2025
1.0 MA Benchmark [1]	$1,177.33	$1,236.40	5.02%
Raw Risk Adjustment Factor [2]	1.0000	1.0000	0.00%
Risk Score Model Change	1.0000	0.9576	-4.24%
FFS Normalization & Risk Model Revision	1.0806	1.0669	1.29%
MA Coding Pattern Adjustment	0.9410	0.9410	0.00%
Total RAF Adjustments	0.8708	0.8446	-3.01%
Risk-Adjusted Benchmark	$1,025.20	$1,044.23	1.86%
Assumed Risk-Adjusted Bid [3]	**$799.65**	**$814.50**	1.86%
Savings (Benchmark less bid)	$225.54	$229.73	1.86%
Rebate	**$148.21**	**$148.40**	0.13%
Risk-Adjusted Bid + Rebate	**$947.86**	**$962.89**	**1.59%**

[1] Based on nationwide average MA enrollment by county as of December 2024
[2] Assumed no trend in risk scores
[3] Bid set at 78% of risk-adjusted benchmark

Please note, CMS's stated positive impact due to the FFS normalization change is driven by a shift in the weighting on the v24 and v28 models. The FFS normalization factors for each model have increased from 2025 to 2026, as discussed above. However, because the weighting is shifting from 67%/33% (v28/v24) to 100% v28 the blended FFS normalization factor appears to be a positive change.

As in past years, CMS did not release county-specific benchmarks that reflect re-basing. The re-basing that CMS intends to perform prior to the Final Rate Announcement may result in dramatically difference changes in FFS benchmarks by county.

Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for CY 2026

SECTION A. DATA AND ASSUMPTIONS SUPPORTING USPCC'S

Proposed Technical Update: CMS is proposing a continuation of the phase in of the technical update to remove additional Medical Education Payments in the Non-ESRD USPCC Baseline. For CY 2026, the adjustment will be fully (100%) phased in.

Background

Section 1886(d)(11) of the ACA directs the Secretary to provide inpatient prospective payment system hospitals with an additional payment amount for indirect medical education (IME) costs for discharges of Medicare Advantage (MA) enrollees, and section 1886(h)(3)(D) of the Act directs the Secretary to provide hospitals with an additional payment amount for direct graduate medical education (DGME) costs associated with services furnished to MA enrollees.

CMS states that prior non-ESRD USPCC have included IME and DGME costs attributable to MA enrollees because the supporting data did not separately identify these payments from those made on behalf of FFS enrollees. CMS states that MA organizations (MAOs) had been effectively paid for these admission-related costs, even though CMS, and not MAOs, had been paying these costs associated with MA enrollees directly to hospitals.

In 2024, CMS finalized a three-year phase in to remove the MA-related IME and DGME costs from the historical and projected non-ESRD USPCCs. For CY 2026, CMS is proposing to remove the full amount of the adjustment. Table 7 displays the phase in of the technical adjustment, the reduction to the growth rate, and the full adjustment for each calendar year. Note the full impact has become more negative each year. The incremental impact of changing from a 52% phase into 100% phase in is -1.42%.

Table 7: IME/DGME Adjustment

Year	Phase in %	Applied Adj	Full Adj
2024	33%	-0.85%	-2.58%
2025	52%	-1.45%	-2.79%
2026	100%	-2.96%	-2.96%

SECTION B. 2023 GROWTH PERCENTAGE ESTIMATES

The preliminary estimate of the Total growth rate is +7.70% (last year the rate was +2.31%).

The non-ESRD FFS growth rate is estimated at +5.67% (last year rate was +2.33%).

SECTION C. USPCC ESTIMATES

In the Notice, CMS noted that the USPCC estimates include consideration for the following:

- COVID-19

- Part B Provisions of the IRA
- 340B- Acquired Drug Payment Policy for Calendar Years 2018-2022

The restatements in CMS's FFS USPCC estimates from the prior estimates in the CY 2025 Final Announcement are summarized in the Table 8.

Table 8: Restatement in Estimated FFS USPCC Costs

Year	Current/Prior
2027	1.2%
2026	1.4%
2025	1.6%
2024	1.5%
2023	0.2%
2022	-0.7%
2021	-0.1%

As discussed in the Section "Wakely Estimated Impact of Growth Rates Combined with Payment Reform," we estimate that the nationwide average change in blended standardized (non-risk adjusted) MA Benchmarks from 2025 to 2026 will be 5.02% and the nationwide average change in the blended risk adjusted benchmark will be 1.86%.

As has been the case in past years, the change in benchmarks can vary significantly depending on geographic area, plan star rating and applicable percentage. While CMS will not publish the final geographic relativities (aka Average Geographic Adjustment (AGA) factors) until the Final Announcement, we can still estimate the impact of changing county quartiles and average star ratings.

Table 9: Highest and Lowest Benchmark Changes by State

Rank	State	Change
1	ME	7.1%
2	SD	6.9%
3	WA	6.9%
4	OR	6.7%
5	ND	6.6%
47	HI	3.6%
48	KY	3.5%
49	ID	3.3%
50	UT	2.9%
51	WY	2.7%

SECTION D. LOADING FOR CLAIMS PROCESSING COSTS.

Consistent with last year CMS is proposing to adjust the USPCC to include administrative costs incurred by the Medicare Administration Contractors (MAC's) as described in the ACA. The adjustments are consistent with those made in prior years.

Attachment II

Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2026

SECTION A. MA BENCHMARK, QUALITY BONUS PAYMENTS, AND REBATE

CMS intends to rebase county FFS rates in 2026 (which is the basis of the "Specified Amount", defined below) using FFS claims data from 2019 through 2023 This is consistent with prior years as CMS has rebased the rates every year since 2012 and anticipates continuing this in the future.

County benchmark rates are capped at the Applicable Amount (defined below). CMS interprets that the comparison occurs after the Quality Bonus Payment Percentage ("QBP") has been included. CMS acknowledged stakeholders' concerns that the benchmark cap may diminish

incentives for MA plans to continuously improve care; however, CMS believes that "section 1853(n)(4) of the Act prevents elimination of the rate cap or excluding the bonus payment from the cap calculation."

Below are the key components of the Part C benchmark calculation:

Below are the key components of the Part C benchmark calculation:

- 2026 "Applicable Amount" (pre-ACA amount): The greater of a county's 2026 FFS cost and the 2025 Applicable Amount increased by the CY 2026 National Per Capita MA Growth Percentage.
- 2026 "Specified Amount" (FFS benchmark): 2026 FFS Cost less IME phase-out less kidney acquisition costs multiplied by the "Applicable Percentage" plus the QBP.
- "Applicable Percentage": Varies by county and is based on the county's rank of 2025 per capita FFS rate, assigned by quartiles, as shown in Table 10.

Table 10: FFS Quartile Assignment

Quartile	Applicable Percentage
4th (highest)	95.0%
3rd	100.0%
2nd	107.5%
1st (lowest)	115.0%

If a county's quartile changed from last year, the Applicable Percentage is the average of the current and prior year's applicable percentage. The applicable percentages for CY 2026 county rates will use 2025 rankings and will continue to be adjusted to exclude the IME phase out and payments for kidney acquisition costs.

- QBP, or "applicable percentage quality increase": The QBP is 5% for 4, 4.5, and 5-star MAOs, and is 0% for plans with a star rating below 4. For new plans under a new parent organization and low enrollment plans, a 3.5% QBP applies.

  Double QBP percentages are awarded to "qualifying plans" located in qualifying or "double bonus" counties. Double bonus counties must:

  1) Have a population of over 250,000 (as of 2004).
  2) Have at least 25% of MA-eligible beneficiaries enrolled in MA plans (as of December 2009).
  3) Have 2026 per capita FFS spending lower than the national average.

The final 2026 rate notice will contain a list of all double bonus counties, as the third criterion above is not yet known.

- Cap on Benchmarks: The QBP-adjusted benchmark for a county cannot exceed the applicable amount.
- Rebates: Rebate levels are based on plan Star Ratings as follows in Table 11:

Table 11: MA Rebate Percentages

Star Rating	2024
4.5+ Stars	70%
3.5 to < 4.5 Stars	65%
< 3.5 Stars	50%

The percentage is applied to the amount by which the risk-adjusted service area benchmark exceeds the risk-adjusted bid. New MA contracts under a new parent organization and low enrollment plans are treated as having 3.5 Stars.

SECTION B. CALCULATION OF FEE FOR SERVICE COST

2026 FFS County Cost

The FFS County cost for CY2026 is calculated as the USPCC x AGA, where:

USPCC = the National Average FFS Cost, called the U.S. Per Capita Cost

AGA = County-level Geographic Index, called the Average Geographic Adjustment

- With the Advance Notice, CMS is releasing county-level 2023 FFS cost data used to develop 2026 rates:

https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data.html

Proposed Update to Tabulation of Ratebook FFS Experience Beginning in 2023

CMS is proposing several mechanical changes to the tabulation of ratebook FFS experience and non-ESRD USPCCs. In general, enrollment from the Denominator file and claims from the National Claims History file are no longer being updated. A replacement system using the "Common Medicare Environment" (CME) will be adopted starting with 2023 experience.

Collectively, these changes result in the following impacts on growth rates:

- Non-ESRD FFS: -0.57%
- Total (FFS + MA): -0.19%

The specific mechanical changes are as follows:

- Use CME dialysis and transplant tables to identify claims for beneficiaries in non-ESRD status.
- Use state and county code from the CME.
- Exclude claims for beneficiaries with MA coverage.
- Exclude FFS enrollment and non-hospice claims for FFS beneficiaries in hospice status.

AGA Development Overview:

- A five-year average of FFS costs from 2019 to 2023 is initially calculated (last year was 2018 to 2022) and is then adjusted.
- Costs for hospice and Cost plans are excluded.
- CMS will re-price 2019 to 2023 claims to the most current (i.e., FY2025) wage and geographic practice cost indices and adjust historical FFS claims for legislative changes.

There are two additional adjustments included in the development of the AGAs:

Adjustments for Medicare Shared Savings Program and Innovation Center Models and Demonstrations, and Advanced Alternative Payment Models

The first adjustment incorporates shared savings and losses or episode savings and loses experienced under the Medicare Shared Savings Program and Innovation Center models and demonstrations into historical FFS experience. CMS is proposing to use more recent experience years to calculate this adjustment. A similar adjustment has been applied in prior years.

CMS is proposing a new adjustment related to Advanced Alternative Payment Models. Qualifying APM participants receive an incentive payment equal to 5% of their estimated aggregate payments for covered professional services furnished during the base year. Payments are made in the year after the base year, beginning in 2019. CMS is proposing to incorporate the APM incentive payments made in 2019 through 2023 into the historical ratebook experience.

Additional Adjustment to FFS per Capita Costs in Puerto Rico

An additional adjustment is being considered for Puerto Rico. Puerto Rico data only includes beneficiaries with Part A & B for all five years of the base period. (Puerto Ricans

are not auto enrolled into Part B, they must opt in). CMS is considering whether to apply an adjustment to Puerto Rico FFS costs to reflect Puerto Rico's high proportion of zero-claimant members versus the national average. Such an adjustment has been applied in prior years.

After the AGA has been calculated, the following additional adjustments are made:

- GME and IME costs are removed.
- Counties with less than 1,000 members are blended with other counties in the market area for credibility.
- Adjustments are made for beneficiaries who are dually enrolled in Veteran Affairs and/or the Department of Defense health programs.
- Organ acquisition costs for kidney transplants are removed.

SECTION C. ADJUSTMENTS TO THE AGA'S

SECTION C1. DIRECT GRADUATE MEDICAL EDUCATION

Consistent with the CY 2025 Rate Announcement CMS is continuing to use the alternative data and methodology used to develop the DGME carveout for hospitals participating in the Maryland Total Cost of Care (TCOC) Model.

SECTION C2. ORGAN ACQUISITION COSTS FOR KIDNEY TRANSPLANTS

Kidney acquisition costs (KAC), first removed in 2021, will continue to be carved out for non-PACE plans in 2026. Similar to the DGME exclusion, CMS changed the KAC calculation methodology in 2023 and will continue to use the new methodology in 2026, which once again uses the PSF as the source for carve-out percentage development. The 2026 KAC carve-out factors will be published with the 2025 Final Rate Announcement.

For CY 2026, CMS is proposing the use of KAC data provided by the MAC to the Health Services Cost Review Commission to develop a KAC carve-out adjustment specifically for Maryland hospitals. This data was not available for the CY 2025 rate development. This change is due to a waiver that exempted Maryland from IPPS and OPPS affects the CMS system data used to develop the KAC carve-out.

SECTION C3. IME PHASE OUT

Indirect Medical Education costs are being phased out of MA capitation rates. For 2026, CMS will first calculate FFS rates including IME. The maximum reduction for any county in 2026 is 10.2% of the FFS rate. As in prior years, CMS will publish rates with and without the IME reduction.

Consistent with the CY2025 Rate Announcement, CMS will continue to use the alternative data and methodology used to develop the IME carveout for hospitals participating in the Maryland TCOC Model.

SECTION D. MA ESRD RATES

There are no proposed changes to the methodology used to calculate the ESRD benchmark rates. Like the non-ESRD rates:

- The state AGA will be based on the weighted average of state ESRD FFS dialysis costs for 2019 to 2023 divided by the national average for the same timeframe normalized for risk score.
- CMS plans to reprice historical inpatient, outpatient, SNF, and ESRD PPS claims for 2019 to 2023 to reflect the most recent wage indices (in this case FY2025) and reprice physician claims with the most recent Geographic Practice Cost Indices (CY 2025).
- ESRD state rates for PACE plans will include kidney acquisition costs.

CMS continues to acknowledge MAO concerns regarding ESRD payment adequacy considering the 21st Century Cures Act, which allows ESRD beneficiaries to enroll in MA plans. In the 2023 and 2024 Advance Notice, CMS provided details regarding an analysis of ESRD rates developed at a geographic level smaller than state. The analysis suggested potentially concerning impacts on specific geographic areas. This year, CMS referenced another analysis using 2021 and 2022 data from Worksheet 1 of the ESRD BPT. For most plans, the revenue was adequate to cover the corresponding net medical expenses. Therefore, they do not plan to revise the methodology for CY 2026.

As a part of the Act, ESRD rates are reduced by $0.50 per dialysis treatment in an average ESRD Network Program. CMS updated the study with CY 2022 and C 2023 FFS data finding that FFS beneficiaries received an average of 12 dialysis treatments per month. Therefore, for CY2026, CMS is proposing to increase the withhold amount from $5.25 to $6.00 per month.

SECTION E. LOCATION OF NETWORK AREAS FOR PFFS PLANS IN PLAN YEAR 2027

Non-employer MA PFFS plans offered in a network area must meet certain access standards through written contracts with providers. Network area is defined as an area that the Secretary identifies as having at least two network-based plans with enrollment. CMS will include the list of network areas for plan year 2027 with the CY2026 Rate Announcement.

SECTION F. EMPLOYER GROUP WAIVER PLANS (EGWP)

For 2026, CMS plans to continue to waive bid pricing tool requirements.

CMS is also proposing to continue to use the same methodology that was used for 2025 in establishing MA EGWP payment amounts, which is to use 2025 bid-to-benchmark ratios weighted by February 2025 enrollment.

For 2026, CMS has published preliminary bid-to-benchmark ratios for EGWPs. These preliminary ratios are not final and are based on January 2025 enrollment instead of the intended February 2025 enrollment.

Table 12: Bid to Benchmark Ratios for EGWPs

Applicable Percentage	Bid to Benchmark Ratio
0.95	78.7%
1.00	77.8%
1.075	77.3%
1.15	77.7%

CMS will continue to allow MA EGWPs to use a portion of Part C payment to buy down enrollee Part B premium. CMS will continue to collect Part B premium buy-down amounts in the EGWP PBP submission. EGWPs that choose to use a portion of their payment to buy-down Part B premium will have that amount reduced from their capitated payment. The Part B buy-down amount cannot vary among beneficiaries within a plan and is subject to the same maximum Part B buy-down amount as non-EGWP plans.

SECTION G. CMS-HCC RISK ADJUSTMENT MODEL FOR CY 2026

The phase in of the 2024 CMS -HCC risk model will be final for CY 2026. CMS proposes to fully implement the 2024 CMS-HCC model with 100 percent of the CY 2026 risk scores calculated using the 2024 CMS-HCC risk model.

MA Risk Score Trend: For purposes of estimating overall payment impact for Medicare Advantage (MA) plans in the Fact Sheet, CMS estimates MA-specific risk score trend. For the CY2026 estimate, CMS switched from using a three-year historical period to using the MA risk scores for 2022 and 2023 only, thus avoiding the pandemic years and using the most recent data available. The resulting risk score trend for CY 2026 is 2.1 percent under the 2024 CMS-HCC model.

Risk Adjustment Model using MA Encounter Data: CMS may start phasing in an MA risk adjustment model calibrated on MA encounter data as soon as CY 2027. If pursued, this has the potential to dramatically change payment levels for MA plans in the future, so this is a critical item to watch.

CMS-HCC Model for PACE Organizations: CMS proposes a four-year transition period for PACE organizations to move to an encounter-based risk adjustment model (2024 CMS-HCC, the same model used for non-PACE organizations, referred to as V28). The tentative schedule for the phase out of the 2017 CMS-HCC model is below.

Table 13: Phase-out Schedule of PACE CMS-HCC Risk Score Model

CY	2017 CMS-HCC Model	CMS-HCC Model used for Non-PACE Organizations
2026	90%	10%
2027	75%	25%
2028	50%	50%
2029	0%	100%

SECTION H. END STAGE RENAL DISEASE (ESRD) RISK ADJUSTMENT MODELS FOR CY 2026

In CY 2026, CMS will continue to use the updated 2023 ESRD risk adjustment models for dialysis, transplant, and post-graft beneficiaries.

For CY 2026, CMS proposes to blend ESRD risk scores for PACE organizations over four years. The tentative phase-out schedule of the 2019 ESRD CMS -HCC models:

Table 14: Phase-out Schedule of ESRD CMS-HCC Risk Score Model

CY	2019 ESRD CMS-HCC Model	ESRD CMS-HCC Model used for Non-PACE Organizations
2026	90%	10%
2027	75%	25%
2028	50%	50%
2029	0%	100%

SECTION I. FRAILTY ADJUSTMENT FOR PACE ORGANIZATIONS AND FIDE SNPS

In the CY 2024 Rate Announcement, CMS updated frailty factors to align with 2024 CMS-HCC Model. A continuation of the frailty factors proposed for CY 2024 is proposed for CY 2026. CMS anticipates a multi-year analysis will be needed to evaluate underlying patterns driving changes in frailty factors.

FIDE-SNPS: Beginning CY 2025, enrollment in FIDE SNPs was limited to full-benefit dually eligible individuals, a.k.a. 'exclusively aligned enrollment'. In CY 2026, for the dual status of a beneficiaries for frailty score calculation, CMS will rely on the MMA State files, the Point-of-Sale data, and the Commonwealth of Puerto Rico monthly Medicaid file. Continuing from CY 2025, Frailty factors for non-dual and partial-benefit dually eligible individuals will not be applicable to beneficiaries enrolled in FIDE SNPs in CY 2026.

PACE Organizations: For PACE organizations, CMS proposes blending the 2017 CMS-HCC model with the 2024 CMS HCC model based on a 90%/10% blend. CMS is proposing a similar blend of the frailty factors associated with the 2017 CMS-HCC model (90%) and 2024 CMS HCC model (10%) to calculate the frailty scores for PACE organization in CY 2026.

Table 15: Frailty Factors Associated with the 2017 CMS-HCC Model

Activities of Daily Living (ADL)	Non-Medicaid	Medicaid
0	-0.083	-0.093
1-2	0.124	0.105
3-4	0.248	0.243
5-6	0.248	0.420

Table 16: Frailty Factors Associated with the 2024 CMS-HCC Model

Activities of Daily Living (ADL)	Non-Medicaid	Partial Medicaid	Medicaid
0	-0.086	-0.070	0.158
1-2	0.103	0.203	0.230
3-4	0.201	0.203	0.230
5-6	0.201	0.217	0.248

SECTION J. MEDICARE ADVANTAGE CODING PATTERN DIFFERENCE ADJUSTMENT

For CY 2026, CMS will continue to apply the statutory minimum MA coding pattern difference adjustment factor of 5.90 percent.

SECTION K. NORMALIZATION FACTORS

Between CY 2007 and CY 2024, CMS largely used the same linear slope methodology for calculating normalization factors. However, The FFS trends from 2021 to 2023 are higher than FFS risk score trends before the pandemic. For payment years CY 2023 and CY 2024, CMS continued long-standing normalization methodology with modifications to account for the effects of the pandemic on the trend.

For CY 2024, CMS considered the average 2021 FFS risk score and the average 2022 FFS risk score and continue using the 2016-2020 data years for models with a 2015 denominator.

For CY 2025, CMS introduced a multiple linear regression methodology to calculate all FFS normalization factors for CMS-HCC models, which incorporated historical FFS risk scores from the most current five years of average FFS risk scores (2019-2023) and included a flag that identifies whether an average FFS risk score is based on dates of service before or after the onset of the COVID-19 pandemic. CMS considered FFS risk scores prior to 2021 (dates of service before 2020) as the “pre-COVID-19” period, and FFS risk scores from 2021 onward (dates of service starting in 2020) as the “post-COVID-19” period.

For CY 2026, CMS proposes to continue using the same multiple linear regression model with recalculated regression coefficient weights using updated data. CMS intends to fully phase in the Part C 2024 CMS-HCC (v28) model. PACE plans will continue to have the normalization factor be based on the Part C 2017 CMS-HCC (v21) model.

Below is a description of the proposed multiple linear regression methodology for calculating CY 2026 normalization factors for the CMS-HCC models.

The multiple linear regression equation is: $Y = \beta_0 + \beta_1 x_1 + \beta_2 x_2$, where

Y = Predicted FFS risk score for a given year (i.e., Normalization Factor)

β_0 = Intercept

β_1 = Regression coefficient for the average annual change in FFS risk scores

x_1 = The specific year to be predicted

β_2 = Regression coefficient for the impact of the COVID-19 pandemic on FFS risk scores

x_2 = COVID-19 flag (0 for years before CY 2021, 1 for CY 2021 and onwards)

SECTION K1. NORMALIZATION FACTORS FOR THE PART C CMS-HCC MODELS

Table 17 shows the regression coefficients CMS used to calculate the proposed CY 2026 normalization factors for each of the two-Part C CMS-HCC risk adjustment models. The resulting normalization factors are also shown.

Table 17: Part C CMS-HCC Model Normalization Factor Regression Coefficients

	2024 CMS-HCC Model	2017 CMS-HCC Model
Intercept (β0)	-38.1880	-52.0410
Average Change in FFS Risk Scores (β1)	0.0194	0.0263
COVID-19 Flag (β2)	-0.0495	-0.0560
Proposed 2026 normalization factor	**1.067**	**1.187**

SECTION K2. NORMALIZATION FACTORS FOR THE ESRD DIALYSIS CMS-HCC MODELS

Table 18 shows the regression coefficients CMS used to calculate the proposed CY 2026 normalization factors for both ESRD Dialysis CMS-HCC models. The CY 2026 normalization factors are also shown.

Table 18: ESRD Dialysis Model Normalization Factor Regression Coefficients

Coefficient	2023 ESRD Dialysis Model	2019 ESRD Dialysis Model
Intercept (β0)	-26.0610	-32.6670
Average Change in FFS Risk Scores (β1)	0.0134	0.0167
COVID-19 Flag (β2)	-0.0250	-0.0280
Proposed 2026 normalization factor	1.062	1.129

SECTION K3. NORMALIZATION FACTORS FOR THE ESRD FUNCTIONING GRAFT CMS-HCC MODELS

Table 19 shows the regression coefficients CMS used to calculate the proposed CY 2026 normalization factors for both ESRD Functioning Graft CMS-HCC models. The 2026 normalization factors are also shown.

Table 19: ESRD Functioning Graft Model Normalization Factor Regression Coefficients

Coefficient	2023 ESRD Functioning Graft Model	2019 ESRD Functioning Graft Model
Intercept (β0)	-49.6910	-58.9060
Average Change in FFS Risk Scores (β1)	0.0251	0.0297
COVID-19 Flag (β2)	-0.0580	-0.0635
Proposed 2026 normalization factor	**1.104**	**1.203**

SECTION L. SOURCES OF DIAGNOSES FOR RISK SCORE CALCULATION FOR CY 2025

For non-PACE organizations, for CY 2026, CMS proposes to continue the policy adopted in the CY 2022 Rate Announcement to calculate risk scores for payment to MA organizations and certain demonstrations using only risk adjustment-eligible diagnoses from encounter data and FFS claims.

For PACE organizations, for CY 2026, CMS proposes to blend the Part C 2024 CMS-HCC (v28) and the Part C 2017 CMS-HCC (v21) models. Table 20 outlines the four-year phase-in period for fully transitioning PACE plans to the Part C 2024 CMS-HCC (v28) model.

Table 20: PACE Risk Score Model Phase-in Period

CY	2024 CMS-HCC Model	2017 CMS-HCC Model
2026	10%	90%
2027	25%	75%
2028	50%	50%
2029	100%	0%

Attachment III

Benefit Parameters for the Defined Standard Benefit and Changes in the Payment Methodology for Medicare Part D for CY 2026

SECTION A. ANNUAL ADJUSTMENTS TO MEDICARE PART D BENEFIT PARAMETERS IN 2026

SECTION A1. UPDATING THE MEDICARE PART D BENEFIT PARAMETERS

Beginning in CY 2026, the applicable copayment amount for covered insulin products is the lesser of $35, an amount equal to 25 percent of the maximum fair price established for the covered insulin product under the Medicare Drug Price Negotiation Program, or an amount equal to 25 percent of the negotiated price of the covered insulin product under the PDP or MA-PD plan.

Beginning in CY 2025, the IRA eliminated the coverage gap phase and set the annual MOOP threshold at $2,000. This threshold will be updated using the annual percentage increase (API) in 2026.

Given the IRA changes, defined standard Part D prescription drug coverage in CY 2026 consists of a three-phase benefit as follows:

- Annual deductible - Updated using the API for 2026.
- Initial coverage phase – Because the coverage gap phase is eliminated, this phase now extends to the maximum annual OOP threshold.
- Catastrophic coverage phase - Beneficiaries will continue to pay no cost sharing for covered Part D drugs in the catastrophic coverage phase.

While the annual OOP threshold was set at $2,000 by statute for CY 2025, it has been updated using the API starting in CY 2026.

For CY2026, the annual percentage increase (API) applied to the applicable CMS Defined Standard Part D parameters is 4.27%, reflecting a 5.69% increase in the CY 2025 annual percentage trend and a multiplicative adjustment of -1.34% for prior year revisions.

The proposed CY2026 Part D Defined Standard benefit parameters are as follows:

- $615 deductible ($590 in 2025)
- $2,100 TrOOP ($2,000 in 2025)
- $1.60/$5.10 copays for full subsidy full benefit duals ($1.60/$4.90 in 2025)

Table 21: Proposed Part D Benefit Parameters for Defined Standard Benefit

Part D Benefit Parameters	2025	2026
Standard Benefit		
Deductible	$590	$615
Out-of-Pocket Threshold	$2,000	$2,100
Full Subsidy-Full Benefit Dual Eligible (FBDE) Individuals		
Deductible	$0.00	$0.00
Copayments for Institutionalized Beneficiaries [category code 3]	$0.00	$0.00
Copayments for Beneficiaries Receiving Home and Community-Based Services [category code 3]	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL [category code 2]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$1.60	$1.60
Other	$4.80	$4.90
Over 100% FPL [category code 1]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$4.90	$5.10
Other	$12.15	$12.65
Full Subsidy-Non-FBDE Individuals		
Applied or eligible for QMB/SLMB/QI or SSI and income at or below 150% FPL and resources ≤ $16,100 (individuals, 2025) or ≤ $32,130 (couples, 2025) [category code 1]		
Deductible	$0.00	$0.00
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$4.90	$5.10
Other	$12.15	$12.65
Retiree Drug Subsidy Amounts		
Cost Threshold	$590	$615
Cost Limit	$12,150	$12,650

SECTION A2. CALCULATION METHODOLOGIES FOR THE ANNUAL PERCENTAGE INCREASE (API) AND CONSUMER PRICE INDEX (CPI)

For the CY2026 benefit parameters, Part D program data will be used to calculate the annual percentage trend of 5.69% by comparing the ratio of the average per capita cost for August 2024 – July 2025 (use PDE through December 2024 projected through July 2025) and the average per capita cost for August 2023 – July 2024. An adjustment of -1.34% is applied to reflect the impact of prior year revisions, for a total annual percentage increase for 2025 of 4.27%.

The annual percentage increase in consumer price index (CPI) for September 2026 is the combination of the projected trend for September 2025 (2.33%) and a multiplicative prior year revision of -.017% for a total annual percentage increase of 2.16%.

SECTION A3. ANNUAL ADJUSTMENTS FOR PART D BENEFIT PARAMETERS IN CY 2026

See Table 21 above for the annual benefit parameters. The deductible and out-of-pocket maximum were derived by multiplying the CY2025 deductible and out-of-pocket maximum by the CY 2026 API and rounding.

SECTION B. PART D PREMIUM STABILIZATION

As enacted by the IRA, the base beneficiary premium (BBP) for CY 2026 cannot be greater than CY 2025 BBP, which was $36.78 (as released in the July 29, 2024, HPMS memorandum) increased by 6%, or $38.99.

Consistent with CY 2025, the direct subsidy amount will change depending on the impact of premium stabilization on the BBP calculation and, thereby, a plan's basic Part D beneficiary premium. As a result, the portion of the plan's bid for basic Part D coverage not funded by basic Part D premiums will continue to be paid through the direct subsidy.

SECTION C. PART D CALENDAR YEAR EGWP PROSPECTIVE REINSURANCE AMOUNT

The methodology used to calculate the prospective reinsurance payments to all Part D Calendar Year EGWP sponsors was updated with the CY 2025 Part D Redesign Program. For additional information regarding the reinsurance and Calendar Year EGWP prospective reinsurance amount changes, see the Final CY 2025 Part D Redesign Program Instructions.

As noted in the Draft CY 2026 Part D Redesign Program Instructions, CMS plans to announce the CY 2026 prospective reinsurance payment amount for Part D Calendar Year EGWPs with the

annual release of the Part D National Average Bid Amount (NAMBA), Part D BPP, and related Part D bid information in the summer of 2025.

SECTION D. PART D RISK SHARING

There are no changes to the Part D risk corridor parameters for CY 2026. However, in July 2024, CMS announced a voluntary demonstration program for standalone PDPs to test premium stabilization. As part of that program, CMS revised risk corridors for participating PDPs. The program, beginning in 2025 and running for at least two additional years, narrows CY 2025 risk corridor thresholds to 2.5% and 5% above the target amount and increases the government's share of losses beyond the 5% threshold to 90%. CMS will evaluate and adjust the parameters annually based on market conditions and prior outcomes, with details for CY 2026 to be announced in summer 2025. PDPs not participating in the demonstration will continue under the standard risk corridors.

SECTION E. RETIREE DRUG SUBSIDY AMOUNTS

See the Part D Benefit Parameters Table 21 for a comparison of the cost threshold and cost limit between CY2025 and CY2026.

SECTION F. RXHCC RISK ADJUSTMENT MODEL

For CY 2026, CMS is making further updates to align the RxHCC model with benefit updates for this coming year. They are proposing to update the RxHCC models for CY 2026 by incorporating the following changes to the Part D benefit related to the IRA:

- Adjusting the annual OOP thresholds for pre-IRA data years to estimate what the threshold would have been in the prior year if the IRA were in place at the time.
- Increasing manufacturer discounts for specified manufacturers and specified small manufacturers according to the phase-in schedules under sections 1860D-14C(g)(4)(B) and (C) of the Act.
- Adjusting gross drug costs to account for the Maximum Fair Prices (MFPs) of the selected drugs for which an MFP is in effect for initial price applicability year 2026 as part of the Medicare Drug Price Negotiation Program.

CMS is also considering an alternative RxHCC model that excludes adjustments for gross drug costs to account for the MFPs of the selected ten drugs. CMS is soliciting comments from stakeholders as to the value of either option.

Other changes included in the RxHCC models proposed for CY 2026 are the following technical updates:

- Updating the underlying data used in the model calibration to more recent years, specifically using diagnoses from 2022 FFS claims and MA encounter data records and gross drug costs from 2023 PDEs (the RxHCC model being proposed solely for PACE organizations will continue to use 2018 diagnoses and 2019 costs)
- Updating the denominator year from 2022 to 2023 (the RxHCC model being proposed solely for PACE organization will continue to use a 2020 denominator)

PACE Organizations

The 2026 RxHCC model is being proposed to calculate risk scores as part of a blended risk score model approach for PACE organizations. Because RAPS data is still the primary source of diagnoses for PACE organizations, CMS is proposing the 2018/2019 calibration period to still be used but to be phased out over time, as it represents the most recent data years that still has MA-PDs submitting RAPS data while also avoiding using data that is most affected by the COVID-19 pandemic. Specifically, CMS proposes to calculate blended risk scores for CY 2026 for PACE organizations using the sum of:

- 90 percent of the risk score calculated with the proposed RxHCC model for CY 2026 calibrated using 2018/2019 data and diagnoses from RAPS, encounter data, and FFS claims; and
- 10 percent of the risk score calculated with the proposed RxHCC model for CY 2026 calibrated using 2022/2023 data and diagnoses from encounter data and FFS claims only.

Table 22 defines the proposed phase-out schedule.

Table 22: Proposed Phase-out of PACE RxHCC Risk Score Model

CY	RxHCC Model for PACE Organizations*	RxHCC Model for Non-PACE Organizations**
2026	90%	10%
2027	75%	25%
2028	50%	50%
2029	0%	100%

* Sources of diagnoses: RAPS, encounter data, and FFS claims
** Sources of diagnoses: Encounter data and FFS claims

Predictive Ratios

CMS found that the proposed 2022/2023 RxHCC model that reflects agreed-upon MFPs for initial price applicability year 2026 tends to underpredict spending for the lowest decile of predicted risk, overpredicts for the second through fourth deciles, and generally remains around 1.0 for higher deciles. For the alternative version of the 2022/2023 RxHCC model that does not reflect the MFPs, CMS found the pattern of predicative ratios to be generally similar.

SECTION G. NORMALIZATION FACTORS FOR THE RXHCC MODELS

CMS is proposing to once again apply separate normalization factors for MA-PD plans vs PDPs and notes further divergence between MA-PD and PDP risk scores based on more recent data.

CMS reviewed the five-year linear trend methodology used for CY2025 and observed unreasonable results for MA-PD and PDP risk score predictability no matter which years were included or excluded from 2019 to 2023. CMS is instead proposing to use the same multiple linear regression methodology that was first introduced with the CY2025 MA HCC model normalization factor calculation, which includes a flag for pre-COVID-19 and post-COVID-19 risk scores throughout the 2019 to 2023 historical period. The calculation is performed separated for MA-PD and PDP products.

The proposed 2022/2023 calibration model normalization factors (reflects MFPs):

- MA-PDs: 1.194
- PDPs: 0.887

While not explicitly stated, the proposed 2022/2023 calibration model normalization factors excluding MFPs can be calculated as follows:

- MA-PDs: 1.189
- PDPs: 0.903

In an apparent change from the approach used for CY2025, CMS is proposing to set the normalization factors to be 1.0 separately for the MA-PD and PDP market sectors. No mention of this approach was present in the CY2025 Advance Notice, and it appears that the requirement that Part D scores are maintained at 1.0 across the system was applied only across MA-PD and PDP market sectors for CY2025, and not within each one independently. We believe this change contributes to a much larger differences between the MA-PD and PDP normalization factors.

For PACE organizations, CMS is proposing to use the historical linear slope methodology to calculate normalization factors for the 2018/2019 calibration of the 2026 RxHCC model, using risk scores from years 2016 through 2020. For the 2022/2023 calibration model also used for PACE

organizations, the same normalization factors used for non-PACE MA-PD organizations is proposed to be used, as follows:

- Proposed PACE 2022/2023 Calibration Model Normalization Factor: 1.194
- Proposed PACE 2018/2019 Calibration Model Normalization Factor: 1.202

While not explicitly stated, the proposed PACE organization model normalization factors excluding MFPs can be calculated as follows:

- Proposed PACE 2022/2023 Calibration Model Normalization Factor: 1.189
- Proposed PACE 2018/2019 Calibration Model Normalization Factor: 1.202

SECTION H. SOURCE OF DIAGNOSES FOR PART D RISK SCORE CALCULATIONS FOR CY 2026

For non-PACE organizations, for CY 2026, CMS will continue to calculate Part D risk scores using only risk adjustment-eligible diagnoses from encounter data and FFS claims.

For PACE organizations, for CY 2026, CMS proposed to calculate risk scores as a blend of risk scores calculated with two different RxHCC models, as follows:

- 90 percent of the risk score calculated with the proposed 2018/2019 RxHCC model for CY 2026 using pooled RAPS, encounter data, and FFS claims; and
- 10 percent of the risk score calculated with the proposed 2022/2023 RxHCC model for CY 2026 using encounter data and FFS claims.

Attachment IV

Updates for Part C and D Star Ratings

EXTREME AND UNCONTROLLABLE CIRCUMSTANCES FOR 2026 STAR RATINGS

- For plans that qualify for disaster adjustments, the adjustment will result in the higher of their raw/unadjusted measure-level rating from 2025 (2023 performance) and 2026 (2024 performance) being used.

- Contracts with at least 60% of enrollees in FEMA-designated Individual Assistance areas at the time of an extreme and uncontrollable circumstance will no longer be removed from the cut points clustering algorithm or reward factor calculations.
- Several counties in Texas, Florida, Georgia, Louisiana, North Carolina, Tennessee, and South Carolina received EUC status due to hurricanes (Hurricanes Beryl, Debby, Francine, Helene, and Milton).

CHANGES TO EXISTING MEASURES FOR 2026 STAR RATINGS

- Kidney Health Evaluation for Patients with Diabetes – New measure with a weight of 1
- Improving or Maintaining Physical Health – Returning measure with a weight of 1 for SY 2026 and a weight of 3 thereafter
- Improving or Maintaining Mental Health – Returning measure with a weight of 1 for SY 2026 and a weight of 3 thereafter
- Patients' Experience and Complaints and Access measures – Weights decreasing from 4 to 2

CHANGES TO EXISTING STAR RATING MEASURES FOR FUTURE YEARS (2027 AND LATER)

Note that measures with substantive specification changes described in this section must be added or updated through rulemaking and must remain on the display page for at least two years prior to becoming a Star Ratings measure.

- CMS is continuing to align the Star Rating program with the Universal Foundation measure set. Pending future rulemaking, all Universal Foundation measures are expected to become a part of the Part C and D Star Ratings.
    - Of the Universal measures not currently in the Star Rating program, one was proposed to be included in SY 2028 (Initiation and Engagement of Substance Use Disorder Treatment (Part C)) and three are being considered for future rulemaking (Adult Immunization Status (Part C), Depression Screening and Follow-Up (Part C), and Social Need Screening and Intervention (Part C)).
- CMS is considering ways to simplify the measure set, including potentially having fewer measures in the program. This could mean focusing the measures on clinical care, outcomes, and patient experience by retiring other types of measures.
    - Operational and administrative measures may shift to monitoring and compliance purposes instead of quality through the Star Rating program. Suggested examples of these measures include:
        - Medicare Plan Finder Price Accuracy (Part D),

        - Complaints about the Health and Drug Plan (Part C and D), Call Center – Foreign Language Interpreter and TTY Availability (Part C and D),
        - Plan Makes Timely Decisions about Appeals (Part C), and
        - Reviewing Appeals Decisions (Part C).
    - Process measures may be retired from the Star Rating program. Suggested examples of these measures include:
        - Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR) (Part D) and
        - Special Needs Plan (SNP) Care Management (Part C).
    - Remaining SNP-specific measures may be retired from the Star Rating program. These measures are Care for Older Adults – Medication Review (Part C) and Care for Older Adults – Functional Status Assessment (Part C).

- Statin Therapy for Patients with Cardiovascular Disease (Part C) – NCQA is considering removing the existing sex-specific age bands and increasing the upper age limit, modifying the denominator inclusion and exclusion criteria, reviewing the current method used to identify relevant members for any potential updates, and evaluating the potential for transitioning to the electronic clinical data systems (ECDS) reporting method.
- Transitions of Care (Part C) – NCQA intends to develop a new ECDS-reported version of this measure.
- Care for Older Adults: Functional Status Assessment and Medication Review (Part C) – NCQA is considering measure modifications and transitioning these measures to the ECDS-reporting method.
- Monitoring Physical Activity, Reducing the Risk of Falling, and Improving Bladder Control (Part C) – NCQA is planning to reevaluate the relevance of these measures in Medicare patients under 65 years old.
- The following measures have non-substantive changes in 2027 Star Ratings and later:
    - Diabetes Care – Blood Sugar Controlled (Part C)
    - Concurrent Use of Opioids and Benzodiazepines (Part D)
    - Medication Adherence for Diabetes Medications / Medication Adherence for Hypertension (RAS Antagonists) / Medication Adherence for Cholesterol (Statins) / Statin Use in Persons with Diabetes / Concurrent Use of Opioids and Benzodiazepines / Polypharmacy: Use of Anticholinergic Medications in Older Adults (Part D)

Potential New Measure Concepts and Methodological Enhancements for Future Years

CMS is considering the following new measure concepts and methodological enhancements to the Star Rating program and is requesting feedback.

- Health Equity (Part C and D) – CMS is considering adding additional social risk factors to the Health Equity Index (HEI) reward (e.g., geography).
- Adult COVID-19 Immunization (Part C) – NCQA is developing a measure that assesses whether adults are up to date on their annual COVID-19 vaccination.
- Diabetes Foot Exam and Follow-Up (Part C) – NCQA is developing a measure that assesses comprehensive foot examinations and appropriate follow-up for abnormal findings for adults with diabetes.
- Colorectal Cancer Screening Follow-Up (Part C) – NCQA is developing a measure that assesses follow-up after a colorectal cancer screening.
- Intimate Partner Violence (IPV) (Part C) – NCQA is developing a measure that assesses screening and intervention for IPV.
- Disability Equity (Part C) – NCQA is developing a measure of completeness and quality of disability status data.
- End-Stage Renal Disease (ESRD) (Part C) – NCQA is considering a future measure focused on ESRD.
- Person-Centered Outcomes (Part C) – NCQA is developing three SNP-specific measures focused on identifying, measuring, and tracking person-centered outcome goals over time.
- Respiratory Syncytial Virus (RSV) Immunization Indicator for Adult Immunization Status (Part C) – NCQA is considering incorporating the RSV vaccine indicator in the Adult Immunization Status measure.

Attachment V

Economic Information for the CY 2026 Advance Notice

Attachment V outlines the economic information relevant to significant provisions in the Advance Notice. Any provision that is not mentioned below is assumed to follow CY 2025 guidelines and, therefore, have no resulting impact.

SECTION A – CHANGES IN PAYMENT METHODOLOGY FOR MEDICARE ADVANTAGE AND PACE FOR CY 2026.

- A1. Medicare Advantage and PACE non-ESRD Ratebook.
    - Growth rate for 2026 FFS non-ESRD rates estimate: 5.67%.
    - Growth rate for 2026 MA non-ESRD rates estimate: 7.7%.
        - Net Impact $25.06 billion cost to Medicare Trust Funds.
    - MA growth percentage used to calculate the 2026 PACE non-ESRD is estimated to be 7.7%.
        - Net Impact $180 million cost to Medicare Trust Funds.
    - If CMS continues the adjustment to the calculation of county benchmarks in Puerto Rico for the number of beneficiaries with zero claims.
        - Net impact $300 million cost to Medicare Trust Funds.
- A2. Medicare Advantage and PACE non-ESRD Ratebook.
    - FFS growth percentage for the 2026 MA ESRD rates is estimated to be 6.31%.
        - Net impact $1.92 billion cost to Medicare Trust Funds.
- A3. CMS-HCC Risk Adjustment Model
    - CMS is proposing the CY 2026 risk scores be calculated entirely with 2024 CMS-HCC model.
        - Anticipated impact on MA risk scores: -3.01% relative to the blend in CY 2025
        - Represents $12.77 billion net savings to the Medicare Trust Fund in 2026.
        - Since the 2020 and 2024 models have different numbers of years their denominators, the two models are not comparable when determining the effect of the number of years on the risk score trend.
        - Each model (2020 and 2024) was appropriately normalized to remove the impact of FFS risk score trend.
- A4. ESRD Risk Adjustment.
    - CMS is proposing a continuing the use of the ESRD risk adjustment models used for CY2025.

    - No economic impact

- A5. Frailty Adjustment for FIDE SNPs
    - CMS is proposing the CY 2026 frailty scores for FIDE SNPs be calculated with the 2024 CMS-HCC model frailty factors, consistent with the risk adjustment model proposed.
    - CMS is proposing to also determine the dual status of beneficiaries using data from systems records, rather than using full Medicaid factors for all beneficiaries as was done for CY2025.
        - The resulting change in frailty score is -0.58%
        - Represents a net cost of less than $10 million to the Medicare Trust Funds in 2026
- A6. MA Coding Pattern Difference Adjustment
    - Continue to apply statutory minimum coding patter difference adjustment: 5.9%.
    - No year-over-year impact.
- A7. Part C Normalization
    - Normalization factors serve to offset the trend in risk scores and maintain a 1.0 average FFS risk score for CMS-HCC models. CMS is proposing to calculate the normalization factors using a five-year multiple linear regression methodology and average historical FFS risk scores from 2020 through 2024 for the CY 2026 model.
        - The impact of normalization is zero.

SECTION B – CHANGES IN THE PAYMENT METHODOLOGY FOR MEDICARE PART D FOR CY 2026

- B1. Annual Percentage Increase for Part D Parameters
    - Generally unchanged from CY 2025
    - At this time, impacts on the Medicare Trust Fund are uncertain.
        - The impacts of these parameters are dependent on plan bid assumptions.
- B2. Part D Risk Adjustment Model
    - CMS is proposing a new updated RxHCC risk adjustment model to reflect statutory changes in Part D.

- CMS is proposing a model calibrated on 2022 diagnoses and 2023 expenditures for non-PACE organizations and a model calibrated on 2018 diagnoses and 2019 expenditures for PACE organizations.
    - This is reflected in Attachment III
- The denominator is the average predicted per capita expenditure predicted by the payment model for a given year.
    - The denominator was obtained from MA-PD and PDP diagnosis data to create an average risk score of 1.0 for the Part D population in the denominator year.
- Recalibration can result in changes in risk scores on the plan and individual level.
    - The average risk score in the denominator year remains 1.0.
    - Due to the average risk score being 1.0 in the existing and recalibrated model, the impact of recalibration is zero.

- B3. Normalization
    - Normalization factors serve to offset the trend in risk scores and maintain a 1.0 average risk score across the Part D program (MA-PD plans and PDPs) for the RxHCC models.
    - For CY 2026, for the RxHCC models, CMS is proposing to calculate normalization factors using the multiple linear regression methodology and average historical risk scores from 2019 through 2023 for the model proposed for non-PACE organizations, and using the historical five-year linear slope methodology and average historical risk scores from 2016 through 2020 for the model proposed for PACE organizations.
        - The impact of normalization is $0.

Attachment VI

RxHCC Risk Adjustment Factors and Predictive Ratio Tables

Comparing the proposed CY 2026 RxHCC model to the CY 2025 RxHCC model, the demographic component of continuing enrollee risk scores is moderately reduced for most LI age cohorts and moderately increased for most NLI age cohorts. The RxHCC coefficients are generally higher for most conditions in the proposed CY 2026 model than the CY 2025 model, with a more pronounced increase for LI members than NLI members. New enrollee coefficients are generally higher in the proposed CY 2026 model than the CY 2025 model, with a more pronounced increase for LI members than NLI members.

The proposed CY 2026 RxHCC model includes adjusted gross drug costs to account for the MFPs of the selected drugs for which an MFP is in effect as part of the Medicare Drug Price Negotiation Program. An alternative model without MFP adjustments was also provided. As expected, the RxHCC coefficients for conditions associated with MFP drugs are generally lower in the proposed model than the alternative model to account for the reduced drug costs of the MFP, while RxHCC coefficients for conditions unaffected by MFP drugs are generally higher in the proposed model than the alternative model in order to maintain the average risk score at a 1.0 baseline.