April 7, 2025

NOTE: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties

Announcement of Calendar Year (CY) 2026 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

In accordance with section 1853(b)(1) of the Social Security Act ("the Act"), we are notifying you of the annual capitation rate for each Medicare Advantage (MA) payment area for CY 2026 and the risk and other factors to be used in adjusting such rates.

In response to our request for comments on the Advance Notice of Methodological Changes for CY 2026 MA Capitation Rates and Part C and Part D Payment Policies (CY 2026 Advance Notice), published on January 10, 2025, CMS received submissions from professional organizations, MA and Part D sponsors, advocacy groups, physicians, pharmaceutical manufacturers, pharmacy benefit managers, pharmacies, and interested persons. The Announcement of CY 2026 MA Capitation Rates and Part C and Part D Payment Policies (CY 2026 Rate Announcement) describes and responds to all of the substantive comments received.

After considering all comments received, we are finalizing policies in the CY 2026 Rate Announcement.

The capitation rate tables for CY 2026 and supporting data are posted on the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html. The statutory component of the regional benchmarks, qualifying counties, and each county's applicable percentage are also posted on this section of the CMS website.

Attachment I of the CY 2026 Rate Announcement shows the final estimates of the National Per Capita MA Growth Percentage for CY 2026 and the National Medicare Fee-for-Service (FFS) Growth Percentage for CY 2026, used to calculate the CY 2026 capitation rates. As discussed in Attachment I, the final estimate of the National Per Capita MA Growth Percentage for combined aged and disabled beneficiaries is 10.72 percent, and the final estimate of the FFS Growth Percentage is 8.81 percent. Attachment II provides a set of tables that summarizes the key Medicare assumptions used in the calculation of the growth percentages.

Section 1853(b)(4) of the Act requires CMS to release county specific per capita FFS expenditure information on an annual basis, beginning with March 1, 2001. In accordance with this requirement, FFS data for CY 2023 were posted on the above website with the CY 2026 Advance Notice.

Attachment II details the key assumptions and financial information behind the growth percentages presented in Attachment I.

Attachment III presents responses to Part C payment-related comments on the CY 2026 Advance Notice.

Attachment IV presents responses to Part D payment-related comments on the CY 2026 Advance Notice.

Attachment V provides the final Part D benefit parameters and details how they are updated.

Attachment VI presents responses to comments on updates for MA and Part D Star Ratings.

Attachment VII contains economic information for significant provisions in the CY 2026 Rate Announcement.

Attachment VIII contains the RxHCC model risk adjustment factors and predictive ratio tables.

Key Updates from the CY 2026 Advance Notice

Growth Percentages: Attachment I provides the final estimates of the National Per Capita MA Growth Percentage and the FFS Growth Percentage, upon which the capitation rates are based, and information on deductibles for Medical Savings Accounts. Each year for the Rate Announcement, CMS updates the growth rates to be based on the most current estimate of per capita costs, based on the available historical program experience and projected trend assumptions at that time. The growth rates change between proposed and final as CMS incorporates updated data and assumptions. This year, the change in growth rates from the Advance Notice to the Rate Announcement is due primarily to incorporation of additional payment data, including through the fourth quarter of 2024.

Calculation of FFS Cost: Episode savings / losses for two of the Innovation Center models listed in the CY 2026 Advance Notice Table II-5 are not available for CY 2023 and, therefore, will not be represented in the calculation of the CY 2026 non-End Stage Renal Disease (ESRD) MA ratebooks. The two affected models are the Oncology Care Model and the Enhancing Oncology Model.

Policies Adopted as Described

As in past years, policies in the Advance Notice that are not modified or retracted in the Rate Announcement become effective for the upcoming payment year. Clarifications in this CY 2026 Rate Announcement supersede information in the Advance Notice and prior Rate Announcements.

Technical Update to Medical Education Payments in the Non-ESRD USPCC Baseline: We are finalizing the completion of the three-year phase-in schedule as proposed in the CY 2026

Advance Notice by applying 100 percent of the medical education technical adjustment for CY 2026.

Calculation of FFS Costs: As has been the case for the last nine years, the Secretary has directed the CMS OACT to adjust the FFS experience for beneficiaries enrolled in Puerto Rico to reflect the nationwide propensity of beneficiaries with zero claims. For future years, CMS plans to continue to evaluate the methodology for calculating rates for Puerto Rico plans to ensure the rates are based on the best estimates of Medicare FFS per capita costs in Puerto Rico and reassess the need for ongoing special adjustments.

MA Benchmark, Quality Bonus Payments, and Rebate: We will continue to implement the methodology, as described in the CY 2026 Advance Notice, used to derive the benchmark county rates, how the qualifying bonus counties are identified, and the applicability of the Star Ratings.

Location of Network Areas for Private Fee-for-Service (PFFS) Plans in Plan Year 2027: The list of network areas for plan year 2027 is available on the CMS website at https://www.cms.gov/medicare/health-drug-plans/private-fee-for-service-plans/network-requirements.

Direct Graduate Medical Education (DGME) Carve-out Applied to Average Geographic Adjustments (AGAs): As in past years, we will continue carving out FFS DGME amounts from the MA capitation rates as described in the CY 2026 Advance Notice. (This is different than the technical update related to medical education payments on behalf of MA enrollees in the non-ESRD USPCC baseline discussed above.)

Indirect Medical Education (IME) Phase Out Applied to AGAs: We will continue phasing out FFS IME amounts from the MA capitation rates as described in the CY 2026 Advance Notice.

Organ Acquisition Costs for Kidney Transplants: As in past years, we will continue carving out Kidney Acquisition Costs from the MA capitation rates. As described in the CY 2026 Advance Notice, we will use a different data source and methodology to develop the Kidney Acquisition Cost amounts to carve out for hospitals participating in the Maryland Total Cost of Care Model.

MA ESRD Rates: We will continue to set MA ESRD rates on a state basis. We will apply the $6.00 per month Network withhold amount to the ESRD rates beginning in CY 2026.

MA Employer Group Waiver Plans (EGWPs): We will continue to use the payment methodology as described in the Advance Notice, but with finalized bid-to-benchmark ratios for CY 2026 MA EGWP payment rates as indicated in the table below.

Applicable Percentage	Bid to Benchmark Ratio
0.95	78.8%
1	77.7%
1.075	77.2%
1.15	77.6%

CMS-Hierarchical Condition Category (CMS-HCC) Risk Adjustment Model:

- For non-PACE organizations: CMS is completing the phase-in of the 2024 CMS-HCC model as proposed in the CY 2026 Advance Notice by using 100 percent of the risk score calculated using the 2024 CMS-HCC risk adjustment model.

- For PACE organizations: For CY 2026, CMS will begin phasing out the 2017 CMS-HCC model as proposed by calculating risk scores as a blend of 10 percent of the risk score calculated using the 2024 CMS-HCC risk adjustment model and 90 percent of the risk score calculated using the 2017 CMS-HCC risk adjustment model.

CMS-HCC ESRD Risk Adjustment Models:

- For non-PACE organizations: For CY 2026, CMS will continue to use the 2023 CMS-HCC ESRD risk adjustment models to calculate risk scores for beneficiaries in dialysis, transplant, and post-graft status.

- For PACE organizations: For CY 2026, CMS will begin phasing out the 2019 CMS-HCC ESRD model as proposed by calculating risk scores as a blend of 10 percent of the risk score calculated with the 2023 CMS-HCC ESRD models and 90 percent of the risk score calculated using the 2019 CMS-HCC ESRD models.

Frailty Adjustment:

- For Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs): For CY 2026, CMS will use the frailty factors associated with the 2024 CMS-HCC model to calculate frailty scores for FIDE SNPs. FIDE SNP frailty scores will be compared to the PACE minimum frailty score calculated in the same manner to determine whether FIDE SNPs have a similar average level of frailty as the PACE program.

- For PACE organizations: For CY 2026, CMS will calculate frailty scores using a blend of 90 percent of the frailty score calculated with the 2017 CMS-HCC model frailty factors and 10 percent of the frailty score calculated with the 2024 CMS-HCC model frailty factors. This is consistent with the blend CMS will use to calculate risk scores for PACE organizations.

MA Coding Pattern Difference Adjustment: For CY 2026, CMS will apply the statutory minimum MA coding pattern difference adjustment of 5.90 percent.

CMS-HCC Risk Adjustment Model Normalization Factors: For CY 2026, for all CMS-HCC risk adjustment models, CMS calculated the normalization factors using a five-year multiple linear regression methodology and average historical FFS risk scores from 2020 through 2024.

- 2024 CMS-HCC Part C Model: 1.067
- 2017 CMS-HCC Part C Model: 1.187
- 2023 CMS-HCC ESRD Dialysis Model: 1.062
- 2019 CMS-HCC ESRD Dialysis Model: 1.129
- 2023 CMS-HCC ESRD Functioning Graft Model: 1.104
- 2019 CMS-HCC ESRD Functioning Graft Model: 1.203

Sources of Diagnoses for Risk Scores Calculated with CMS-HCC Risk Adjustment Models:

- For non-PACE organizations: CMS will continue the policy first adopted for CY 2022 to calculate all 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: CMS will calculate risk scores using 10 percent of the risk score calculated using diagnoses from encounter data and FFS claims only (under the 2024 CMS-HCC model and the 2023 CMS-HCC ESRD models) and 90 percent of the risk score calculated using diagnoses from RAPS, encounter data, and FFS claims (under the 2017 CMS-HCC model and the 2019 CMS-HCC ESRD models).

RxHCC Risk Adjustment Models: For CY 2026, CMS will implement the updated version of the RxHCC risk adjustment model proposed in the CY 2026 Advance Notice that reflects changes made to the Part D benefit for CY 2026 as a result of the Inflation Reduction Act of 2022 (IRA).

- For non-PACE organizations: CMS will implement the RxHCC model calibrated on 2022 diagnoses and 2023 expenditure data that adjusts gross drug costs for maximum fair prices as proposed in the CY 2026 Advance Notice.
- For PACE organizations: CMS will implement a blend of the RxHCC model being finalized for non-PACE organizations (i.e., 2022/2023 calibration) and the RxHCC model calibrated on 2018 diagnoses and 2019 expenditure data (i.e., 2018/2019 calibration) that adjusts gross drug costs for maximum fair prices by calculating risk scores as a blend of 10 percent of the risk score calculated using the 2022/2023 calibration and 90 percent of the risk score calculated using the 2018/2019 calibration.

RxHCC Risk Adjustment Model Normalization Factors: For CY 2026, for the RxHCC models, CMS calculated separate normalization factors for Medicare Advantage prescription drug (MA-PD) plans and stand-alone Medicare Part D prescription drug plans (PDPs). For the model

calibrated on 2022/2023 data, we used the multiple linear regression methodology and average historical risk scores from 2019 through 2023. For the RxHCC model we are using solely for PACE organizations, we will continue to use the historical linear slope methodology and average risk scores from 2016-2020.

- 2026 RxHCC model (2022/2023 calibration):
    - MA-PD plans: 1.194
    - PDPs: 0.887
- 2026 RxHCC model (2018/2019 calibration) for PACE organizations only: 1.202

Sources of Diagnoses for Risk Scores calculated with the RxHCC Risk Adjustment Models:

- For non-PACE organizations: CMS will continue the policy first adopted for CY 2022 to calculate all risk scores for payment to Part D sponsors using only risk adjustment-eligible diagnoses from encounter data and FFS claims.
- For PACE organizations: CMS will calculate risk scores using 10 percent of the risk score calculated using encounter data and FFS claims only (under the 2026 RxHCC model (2022/2023 calibration)) and 90 percent of the risk score calculated using diagnoses from RAPS, encounter data, and FFS claims (under the 2026 RxHCC model (2018/2019 calibration).

Annual Adjustments to Medicare Part D Benefit Parameters in CY 2026: As described in the CY 2026 Advance Notice, we will update the defined standard benefit deductible amount and the annual out-of-pocket threshold by multiplying the CY 2025 amounts by the CY 2026 Annual Percentage Increase and rounding as specified by the statute.

Part D Calendar Year EGWP Prospective Reinsurance Amount: As finalized in the Final CY 2026 Part D Redesign Program Instructions published concurrently with this CY 2026 Rate Announcement[1], we will continue to use the updated methodology finalized in the Final CY 2025 Part D Redesign Program Instructions to calculate the prospective reinsurance payments to all Part D Calendar Year EGWPs.

Part D Risk Sharing and Additional Premium Stabilization: As discussed in the CY 2026 Advance Notice, we will apply no changes to the current threshold risk percentages for MA-PDs for CY 2026.

Given the significant changes in the Part D benefit in 2025, CMS is conducting a voluntary demonstration that provides additional premium stabilization and narrowed risk corridors for participating PDPs in CY 2025. Since changes to the Part D benefit will be relatively modest in

[1] Refer to CMS' Draft CY 2026 Part D Redesign Program Instructions and Final CY 2026 Part D Redesign Program Instructions.

2026 and PDPs will have some experience with the 2025 changes that will help inform their 2026 bids, CMS anticipates that the factors contributing to the design and magnitude of the CY 2025 demonstration parameters will be significantly mitigated for CY 2026. CMS will take these factors into account in determining the appropriate level of additional premium stabilization and/or narrowed risk corridors for participating PDPs in CY 2026 if necessary to continue to stabilize premiums. We also remind Part D plan sponsors that, per section 1860D–11 of the Act, the Secretary has the authority to negotiate the terms and conditions of proposed bids and does not have to accept any or every Part D bid submitted. Following the submission of bids for CY 2026, CMS will announce any additional premium stabilization and narrowed risk corridors no later than the annual release of the National Average Monthly Bid Amount (NAMBA), Part D base beneficiary premium (BBP), and related Part D bid information in the summer of 2025.

Retiree Drug Subsidy Amounts: As discussed in the CY 2026 Advance Notice, we will use the same methodology as in prior years to update the cost threshold and cost limit for qualified retiree prescription drug plans.

/ s /
John Brooks
Chief Policy and Regulatory Officer & Deputy Administrator

I, Jennifer Wuggazer Lazio, am a Member of the American Academy of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained in this Rate Announcement. My opinion is limited to the following sections of this Rate Announcement: The growth percentages and United States per capita cost estimates provided and discussed in Attachments I, II and III; the qualifying county determination, calculations of Fee-for-Service cost, direct graduate medical education carve-out, kidney acquisition cost carve-out, IME phase out, MA benchmarks, EGWP rates, and ESRD rates discussed in Attachment III; the Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2026 described in Attachments IV and V; and the economic information contained in Attachment VII.

/ s /
Jennifer Wuggazer Lazio, F.S.A., M.A.A.A.
Director
Parts C & D Actuarial Group
Office of the Actuary

Attachments

2026 RATE ANNOUNCEMENT

Attachment I. Final Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for CY 2026

Table I-1 below shows the National Per Capita MA Growth Percentage (NPCMAGP) for CY 2026. An adjustment of 3.53 percent for the combined aged and disabled cohort is included in the NPCMAGP to account for corrections to prior years' estimates as required by section 1853(c)(6)(C). The combined aged and disabled change is used in the development of the ratebook.

Table I-1. Increase in the NPCMAGP for CY 2026

	Prior increases	Current increases			NPCMAGP for 2026 with § 1853(c)(6)(C) adjustment[1]
	2003 to 2025	2003 to 2025	2025 to 2026	2003 to 2026	
Aged + Disabled	117.505%	125.191%	6.943%	140.826%	10.72%

[1] Current increases for 2003-2026 divided by the prior increases for 2003-2025.

Table I-2 below provides the change in the FFS United States Per Capita Cost (USPCC), which was used in the development of the county benchmarks. The percentage change in the FFS USPCC is shown as the current projected FFS USPCC for CY 2026 divided by projected FFS USPCC for CY 2025 as estimated in the CY 2025 Rate Announcement released on April 1, 2024.

Table I-2. FFS USPCC Growth Percentage for CY 2026

	Aged + Disabled	*Dialysis–only ESRD*
Current projected 2026 FFS USPCC	$1,230.52	$10,372.92
Prior projected 2025 FFS USPCC	$1,130.85	$9,713.00
Percent change	8.81%	6.79%

Table I-3 below shows the monthly actuarial value of the Medicare deductible and coinsurance for CYs 2025 and 2026. In addition, for CY 2026, the actuarial value of deductibles and coinsurance is being shown for non-ESRD only, since MA plan bids for CY 2026 exclude costs for ESRD enrollees. These data were furnished by the Office of the Actuary.

Table I-3. Monthly Actuarial Value of Medicare Deductible and Coinsurance for CYs 2025 and 2026

	2025	2026	Change	2026 non-ESRD
Part A Benefits	$36.68	$41.82	14.0%	$40.25
Part B Benefits[1]	170.32	191.17	12.2%	183.40
Total Medicare	207.00	232.99	12.6%	223.65

[1] Includes the amounts for outpatient psychiatric charges.

Medical Savings Account (MSA) Plans. The maximum deductible for MSA plans for CY 2026 is $18,100.

Attachment II. Key Assumptions and Financial Information

The USPCCs are the basis for the National Per Capita MA Growth Percentage. Below is a table that compares last year's estimates of USPCCs with current estimates for 2003 to 2027. In addition, this table shows the current projections of the USPCCs through 2028. We are also providing a set of tables that summarize the key Medicare assumptions used in the calculation of the USPCCs. Most of the tables include information for the years 2003 through 2028.

Most of the tables in this attachment present combined aged and disabled non-ESRD data. The ESRD information presented is for the combined aged-ESRD, disabled-ESRD, and ESRD only.

All of the information provided in this attachment applies to the Medicare Part A and Part B programs. Caution should be employed in the use of this information. It is based upon nationwide averages, and local conditions can differ substantially from conditions nationwide.

None of the data presented here pertain to the Medicare Part D prescription drug benefit.

On March 12, 2025, CMS announced an earlier termination schedule for several Innovation Center models. CMS aims to conclude the Maryland Total Cost of Care, Primary Care First, ESRD Treatment Choices, and Making Care Primary models by December 31, 2025. The geographic adjustments for the five year historical experience period (2019-2023) used for CY 2026 ratebook development are unaffected by the earlier model terminations. Given the time constraints of the statutory announcement of the CY 2026 MA rates and the timing of the model termination announcement, we have not assessed whether the earlier model terminations would impact the assumptions used for USPCC projections for 2026 and thereafter. As such, we expect that any impacts on USPCC assumptions will be first incorporated in the CY 2027 Advance Notice.

Table II-1. Comparison of Current & Previous Estimates of the Total USPCC – non-ESRD

	Part A		Part B		Part A + Part B		
Calendar year	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Ratio
2003	$296.18	$296.18	$247.66	$247.66	$543.84	$543.84	1.000
2004	314.08	314.08	271.06	271.06	585.14	585.14	1.000
2005	334.83	334.83	292.86	292.86	627.69	627.69	1.000
2006	345.30	345.30	313.70	313.70	659.00	659.00	1.000
2007	355.44	355.44	330.68	330.68	686.12	686.12	1.000
2008	371.90	371.90	351.04	351.04	722.94	722.94	1.000
2009	383.91	383.91	367.49	367.49	751.40	751.40	1.000
2010	383.93	383.93	376.34	376.34	760.27	760.27	1.000
2011	387.73	387.73	385.30	385.30	773.03	773.03	1.000
2012	377.37	377.37	391.96	391.93	769.33	769.30	1.000

	Part A		Part B		Part A + Part B		
Calendar year	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Ratio
2013	380.20	380.03	398.89	398.72	779.09	778.75	1.000
2014	370.20	370.23	418.46	418.20	788.66	788.43	1.000
2015	374.02	373.86	435.20	434.84	809.22	808.70	1.001
2016	377.55	377.61	444.84	444.05	822.39	821.66	1.001
2017	383.01	383.10	460.66	459.01	843.67	842.11	1.002
2018	388.22	388.25	494.19	492.57	882.41	880.82	1.002
2019	401.80	400.79	526.48	525.05	928.28	925.84	1.003
2020	403.94	404.09	524.95	525.19	928.89	929.28	1.000
2021	409.54	410.03	573.62	572.47	983.16	982.50	1.001
2022	434.61	433.89	607.19	607.46	1,041.80	1,041.35	1.000
2023	456.39	449.85	663.87	657.69	1,120.26	1,107.54	1.011
2024	469.10	458.16	702.55	683.05	1,171.65	1,141.21	1.027
2025	484.86	466.52	739.82	716.36	1,224.68	1,182.88	1.035
2026	506.51	479.63	803.20	760.94	1,309.71	1,240.57	1.056
2027	530.86	503.41	857.27	809.11	1,388.13	1,312.52	1.058
2028	555.93		902.51		1,458.44		

Table II-2. Comparison of Current & Previous Estimates of the FFS USPCC – non-ESRD

	Part A		Part B		Part A + Part B		
Calendar year	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Ratio
2010	$371.20	$371.20	$374.30	$374.30	$745.50	$745.50	1.000
2011	371.15	371.15	383.17	383.17	754.32	754.32	1.000
2012	356.97	356.97	390.74	390.70	747.71	747.67	1.000
2013	363.99	363.75	394.75	394.49	758.74	758.24	1.001
2014	364.16	364.20	409.30	408.91	773.46	773.11	1.000
2015	369.53	369.31	428.33	427.78	797.86	797.09	1.001
2016	371.56	371.51	434.69	433.28	806.25	804.79	1.002
2017	373.61	373.86	450.48	448.00	824.09	821.86	1.003
2018	378.07	378.12	481.74	479.09	859.81	857.21	1.003
2019	385.42	383.83	508.59	506.20	894.01	890.03	1.004
2020	375.59	375.84	478.06	478.49	853.65	854.33	0.999
2021	390.06	390.92	559.39	557.20	949.45	948.12	1.001
2022	409.14	407.73	578.31	578.70	987.45	986.43	1.001
2023	422.14	419.82	626.15	628.51	1,048.29	1,048.33	1.000
2024	442.08	431.23	682.01	654.25	1,124.09	1,085.48	1.036

	Part A		Part B		Part A + Part B		
Calendar year	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Ratio
2025	457.96	441.68	721.97	689.17	1,179.93	1,130.85	1.043
2026	465.49	446.80	765.03	731.88	1,230.52	1,178.68	1.044
2027	487.18	468.46	815.88	777.17	1,303.06	1,245.63	1.046
2028	509.41		858.14		1,367.55		

Table II-3. Comparison of Current & Previous Estimates of the ESRD Dialysis-only FFS USPCC

	Part A		Part B		Part A + Part B		
Calendar year	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Ratio
2010	$2,952.75	$2,952.75	$3,881.39	$3,881.39	$6,834.14	$6,834.14	1.000
2011	2,862.38	2,862.38	3,908.01	3,908.01	6,770.39	6,770.39	1.000
2012	2,774.49	2,774.49	3,944.59	3,944.59	6,719.08	6,719.08	1.000
2013	2,794.19	2,794.19	4,088.66	4,088.66	6,882.85	6,882.85	1.000
2014	2,784.52	2,784.52	4,115.70	4,115.70	6,900.22	6,900.22	1.000
2015	2,775.84	2,775.84	4,060.87	4,060.87	6,836.71	6,836.71	1.000
2016	2,895.91	2,895.91	4,081.27	4,081.27	6,977.18	6,977.18	1.000
2017	2,883.27	2,883.27	4,102.66	4,102.66	6,985.93	6,985.93	1.000
2018	2,952.21	2,952.21	4,526.09	4,526.09	7,478.30	7,478.30	1.000
2019	3,040.74	3,040.74	4,614.18	4,614.18	7,654.92	7,654.92	1.000
2020	3,082.55	3,082.55	4,542.51	4,542.51	7,625.06	7,625.06	1.000
2021	3,295.54	3,295.54	4,786.27	4,786.27	8,081.81	8,081.81	1.000
2022	3,428.51	3,428.51	4,834.89	4,834.89	8,263.40	8,263.40	1.000
2023	3,675.90	3,576.05	5,030.00	5,146.20	8,705.90	8,722.25	0.998
2024	3,893.89	3,799.72	5,245.62	5,259.82	9,139.51	9,059.54	1.009
2025	4,156.63	3,999.61	5,656.96	5,713.39	9,813.59	9,713.00	1.010
2026	4,441.46	4,254.81	5,931.46	5,986.57	10,372.92	10,241.38	1.013
2027	4,720.20	4,519.44	6,214.25	6,279.35	10,934.45	10,798.79	1.013
2028	5,004.32		6,493.39	6,279.35	11,497.71		

Table II-4. Basis for ESRD Dialysis-only FFS USPCC Trend

Calendar year	Part A			Part B			Part A & Part B		
	All ESRD cumulative FFS trend	Adjustment factor for dialysis-only	Adjusted dialysis-only cumulative trend	All ESRD cumulative FFS trend	Adjustment factor for dialysis-only	Adjusted dialysis-only cumulative trend	All ESRD cumulative FFS trend	Adjustment factor for dialysis-only	Adjusted dialysis-only cumulative trend
2024	1.04812	1.01067	1.05930	1.03839	1.00431	1.04287	1.04250	1.00701	1.04981
2025	1.10703	1.02146	1.13078	1.11501	1.00864	1.12464	1.11164	1.01403	1.12723
2026	1.17040	1.03235	1.20826	1.16409	1.01299	1.17922	1.16675	1.02119	1.19148
2027	1.23072	1.04337	1.28409	1.21435	1.01736	1.23544	1.22126	1.02843	1.25598
2028	1.29102	1.05450	1.36139	1.26345	1.02175	1.29093	1.27509	1.03575	1.32068

Table II-5. Summary of Key Projections

Part A[1]

Year	Calendar year CPI percent change	Fiscal year (FY) inpatient PPS update factor	FY Part A total reimbursement (incurred)
2003	1.4%	3.0%	3.5%
2004	2.1	3.4	8.4
2005	2.7	3.3	8.8
2006	4.1	3.7	5.9
2007	3.3	3.4	5.7
2008	2.3	2.7	7.6
2009	5.8	2.7	6.7
2010	0.0	1.9	3.0
2011	0.0	0.6	4.5
2012	3.6	0.1	0.4
2013	1.7	2.8	4.7
2014	1.5	0.9	0.6
2015	1.7	1.4	3.2
2016	0.0	0.9	4.3
2017	0.3	0.2	4.0
2018	2.0	1.8	4.0
2019	2.8	1.9	9.6
2020	1.6	3.1	5.4
2021	1.3	2.9	3.3
2022	5.9	2.5	7.1
2023	8.7	4.3	6.8
2024	3.2	3.1	6.1
2025	2.5	2.9	7.2
2026	2.8	2.5	7.5
2027	2.5	2.8	7.3
2028	2.4	2.8	7.3

Part B[2]

Calendar year	Physician fee schedule		Outpatient hospital	ESRD dialysis update factor[5]	Total
	Fees[3]	Residual[4]			
2003	1.4%	4.5%	4.4%		6.8%
2004	3.8	5.9	11.1		9.8
2005	2.1	3.2	10.8		7.0
2006	0.2	4.6	5.1		6.1
2007	-1.4	3.5	8.2		4.3
2008	-0.3	4.0	6.3		4.8
2009	1.4	2.3	5.4		3.9
2010	2.3	2.1	6.6		2.4
2011	0.8	2.3	7.1	2.5%	2.3
2012	-1.2	0.8	7.2	2.1	1.7
2013	-0.1	0.2	7.2	2.3	0.8
2014	0.4	0.6	12.6	2.8	3.4
2015	-0.3	-0.3	7.4	0.0	2.7
2016	-0.4	-0.3	5.2	0.15	1.8
2017	0.1	1.1	7.4	0.55	2.8
2018	0.5	1.1	11.4	0.3	6.2
2019	1.2	2.8	5.2	1.3	5.8
2020	0.2	-11.5	-5.8	1.7	-1.3
2021	4.8	13.0	19.7	1.6	8.8
2022	-1.1	2.9	4.7	1.9	4.9
2023	-0.5	4.5	8.4	3.0	8.0
2024	0.0	3.1	9.4	2.1	5.7
2025	-3.4	3.3	9.4	2.2	5.0
2026	0.4	3.0	9.2	1.8	8.0
2027	0.4	2.5	9.5	1.9	6.4
2028	0.4	2.9	7.6	2.0	5.0

[1] Percent change over prior year.

[2] Percent change in charges per aged Part B enrollee.

[3] Reflects the physician update and legislation affecting physician services—for example, the addition of new preventive services enacted in 1997, 2000, and 2010.

[4] Residual factors are factors other than price, including volume of services, intensity of services, and age/sex changes.

[5] The ESRD Prospective Payment System was implemented in 2011.

Table II-6. Medicare Enrollment Projections (In millions)

non-ESRD – Total Part A

Calendar year	Aged	Disabled	Hospice Adj.	Net Part A
2003	34.437	5.961	0.000	40.399
2004	34.849	6.283	0.000	41.132
2005	35.257	6.610	0.000	41.867
2006	35.795	6.889	0.000	42.683
2007	36.447	7.167	0.000	43.614
2008	37.378	7.362	0.000	44.739
2009	38.257	7.574	0.000	45.831
2010	39.091	7.832	0.000	46.923
2011	39.950	8.171	0.000	48.121
2012	41.687	8.411	0.000	50.098
2013	43.087	8.629	0.000	51.716
2014	44.533	8.776	0.000	53.309
2015	45.911	8.853	0.000	54.764
2016	47.370	8.862	0.000	56.232
2017	48.893	8.940	0.000	57.832
2018	50.457	8.696	0.000	59.152
2019	52.119	8.530	0.000	60.650
2020	53.683	8.319	0.000	62.002
2021	55.040	8.069	0.000	63.109
2022	56.518	7.774	0.000	64.292
2023	58.206	7.480	-0.194	65.493
2024	59.588	7.089	-0.188	66.489
2025	61.829	6.756	-0.191	68.394
2026	63.482	6.635	-0.191	69.927
2027	64.998	6.764	-0.191	71.571
2028	66.432	6.921	-0.191	73.162

non-ESRD –Total Part B

Calendar year	Aged	Disabled	Hospice Adj.	Net Part B
2003	33.038	5.215	0.000	38.253
2004	33.294	5.486	0.000	38.780
2005	33.621	5.776	0.000	39.397
2006	33.975	6.017	0.000	39.991
2007	34.465	6.245	0.000	40.710
2008	35.140	6.438	0.000	41.578
2009	35.832	6.664	0.000	42.496
2010	36.516	6.938	0.000	43.454
2011	37.247	7.254	0.000	44.501
2012	38.546	7.502	0.000	46.048
2013	39.779	7.732	0.000	47.511
2014	41.063	7.894	0.000	48.957
2015	42.311	7.977	0.000	50.288
2016	43.623	7.990	0.000	51.614
2017	44.944	8.007	0.000	52.952
2018	46.310	7.861	0.000	54.171
2019	47.765	7.735	0.000	55.499
2020	49.224	7.572	0.000	56.797
2021	50.517	7.361	0.000	57.878
2022	51.889	7.102	0.000	58.992
2023	53.426	6.860	-0.188	60.098
2024	54.927	6.584	-0.183	61.328
2025	56.720	6.255	-0.184	62.791
2026	58.345	6.151	-0.184	64.313
2027	59.879	6.303	-0.184	65.998
2028	61.333	6.449	-0.184	67.598

non-ESRD – FFS Part A

Calendar year	Aged	Disabled	Hospice Adj.	Net Part A
2003	29.593	5.628	0.000	35.221
2004	29.946	5.931	0.000	35.878
2005	30.014	6.178	0.000	36.192
2006	29.362	6.149	0.000	35.511
2007	28.838	6.225	0.000	35.063
2008	28.613	6.241	0.000	34.853
2009	28.563	6.288	0.000	34.852
2010	28.903	6.455	0.000	35.358
2011	29.210	6.659	0.000	35.868
2012	29.960	6.693	0.000	36.653
2013	30.330	6.691	0.000	37.021
2014	30.603	6.618	0.000	37.221
2015	30.947	6.488	0.000	37.435
2016	31.629	6.378	0.000	38.007
2017	31.916	6.299	0.000	38.214
2018	32.167	5.867	0.000	38.034
2019	32.466	5.466	0.000	37.931
2020	32.220	4.952	0.000	37.172
2021	31.438	4.424	0.000	35.862
2022	30.857	3.927	0.000	34.784
2023	30.404	3.483	-0.194	33.693
2024	29.881	3.054	-0.188	32.746
2025	30.829	2.639	-0.191	33.277
2026	31.023	2.352	-0.191	33.184
2027	31.049	2.290	-0.191	33.148
2028	31.099	2.271	-0.191	33.179

non-ESRD – FFS Part B

Calendar year	Aged	Disabled	Hospice Adj.	Net Part B
2003	28.097	4.875	0.000	32.972
2004	28.300	5.128	0.000	33.427
2005	28.287	5.339	0.000	33.626
2006	27.459	5.270	0.000	32.729
2007	26.782	5.297	0.000	32.079
2008	26.301	5.311	0.000	31.612
2009	26.071	5.374	0.000	31.444
2010	26.261	5.556	0.000	31.816
2011	26.440	5.736	0.000	32.176
2012	26.744	5.779	0.000	32.523
2013	26.948	5.790	0.000	32.738
2014	27.060	5.732	0.000	32.792
2015	27.274	5.609	0.000	32.883
2016	27.814	5.503	0.000	33.317
2017	27.882	5.361	0.000	33.243
2018	27.926	5.027	0.000	32.953
2019	28.016	4.665	0.000	32.682
2020	27.665	4.202	0.000	31.867
2021	26.820	3.713	0.000	30.533
2022	26.135	3.253	0.000	29.388
2023	25.533	2.860	-0.188	28.205
2024	25.138	2.521	-0.183	27.475
2025	25.640	2.134	-0.184	27.590
2026	25.826	1.864	-0.184	27.507
2027	25.870	1.825	-0.184	27.511
2028	25.938	1.796	-0.184	27.550

ESRD

	ESRD - Total		ESRD - FFS	
Calendar year	Total Part A	Total Part B	Total Part A	Total Part B
2003	0.340	0.331	0.319	0.309
2004	0.353	0.342	0.332	0.321
2005	0.366	0.355	0.344	0.332
2006	0.382	0.370	0.353	0.340
2007	0.396	0.383	0.361	0.347
2008	0.411	0.397	0.367	0.353
2009	0.426	0.412	0.374	0.360
2010	0.442	0.428	0.388	0.373
2011	0.429	0.416	0.371	0.358
2012	0.441	0.429	0.379	0.366
2013	0.454	0.441	0.385	0.372
2014	0.469	0.456	0.390	0.377
2015	0.482	0.468	0.393	0.379
2016	0.496	0.481	0.400	0.384
2017	0.511	0.495	0.404	0.386
2018	0.525	0.507	0.405	0.387
2019	0.538	0.520	0.407	0.388
2020	0.542	0.524	0.398	0.379
2021	0.534	0.515	0.331	0.312
2022	0.530	0.510	0.294	0.273
2023	0.534	0.513	0.266	0.245
2024	0.539	0.523	0.247	0.231
2025	0.545	0.529	0.242	0.226
2026	0.556	0.539	0.239	0.222
2027	0.570	0.553	0.238	0.221
2028	0.584	0.567	0.237	0.220

Table II-7a. Part A Projections for non-ESRD (Aged+Disabled)*

Calendar year	Inpatient hospital	SNF	Home health agency	Managed care	Hospice: Total reimbursement (in millions)
2003	$2,594.79	$370.67	$124.29	$457.87	$5,733
2004	2,714.54	413.45	133.87	500.73	6,832
2005	2,818.17	450.52	140.87	602.29	8,016
2006	2,764.81	475.11	141.27	757.25	9,368
2007	2,707.53	504.27	143.75	905.73	10,518
2008	2,695.89	536.69	150.98	1,074.98	11,404
2009	2,651.47	551.63	153.85	1,246.01	12,274
2010	2,626.99	571.75	155.17	1,249.70	13,126
2011	2,560.03	617.62	137.21	1,332.03	13,986
2012	2,463.26	535.99	129.76	1,393.02	15,163
2013	2,460.19	534.49	127.31	1,434.17	15,356
2014	2,395.63	528.11	122.66	1,389.87	15,429
2015	2,378.20	524.09	124.77	1,455.70	16,239
2016	2,393.07	497.84	120.12	1,515.64	17,213
2017	2,367.47	476.87	115.69	1,632.20	18,310
2018	2,344.71	457.48	112.50	1,740.06	19,643
2019	2,341.87	440.77	107.92	1,927.66	21,300
2020	2,157.79	447.70	94.96	2,143.82	22,389
2021	2,146.84	417.46	92.81	2,254.51	22,909
2022	2,119.83	443.82	89.79	2,558.87	23,979
2023	2,104.56	409.91	88.65	2,870.37	26,105
2024	2,104.11	415.66	90.19	3,016.06	28,814
2025	2,138.27	439.30	93.53	3,143.96	31,726
2026	2,091.20	459.62	97.21	3,426.66	34,585
2027	2,125.60	477.03	102.21	3,661.91	37,649
2028	2,190.32	476.76	102.20	3,898.13	41,070

*Average annual reimbursement per enrollee on an incurred basis.

Table II-7b. Part A Projections for non-ESRD (Aged+Disabled)*

Calendar year	Inpatient hospital	SNF	Home health agency	Managed care
2003	$248.02	$35.43	$11.88	$297.71
2004	259.34	39.50	12.79	326.66
2005	271.67	43.43	13.58	370.30
2006	276.94	47.59	14.15	375.52
2007	280.65	52.27	14.90	384.98
2008	288.38	57.41	16.15	405.41
2009	290.56	60.45	16.86	433.45
2010	290.52	63.23	17.16	422.53
2011	286.21	69.05	15.34	435.96
2012	280.57	61.05	14.78	432.54
2013	286.39	62.22	14.82	420.62
2014	285.92	63.03	14.64	383.80
2015	289.92	63.89	15.21	383.38
2016	295.05	61.38	14.81	389.70
2017	298.57	60.14	14.59	400.97
2018	303.88	59.29	14.58	406.17
2019	312.04	58.73	14.38	428.85
2020	299.93	62.23	13.20	446.10
2021	314.83	61.22	13.61	435.15
2022	326.51	68.36	13.83	464.61
2023	340.91	66.40	14.36	492.63
2024	356.02	70.33	15.26	495.26
2025	366.23	75.24	16.02	510.27
2026	367.22	80.71	17.07	543.46
2027	382.45	85.83	18.39	568.43
2028	402.48	87.61	18.78	594.41

*Average monthly reimbursement per enrollee on an incurred basis. Excludes cost plan expenditures included in National Claims History file. The denominator of the calculation for all fields except Managed Care is Part A FFS enrollment. The denominator of the calculation for Managed Care field is Part C enrollment.

Table II-8a. Part B Projections for non-ESRD (Aged+Disabled)*

Calendar year	Physician fee schedule	Outpatient hospital	Durable medical equipment
2003	$1,226.51	$364.77	$196.96
2004	1,344.01	418.85	195.61
2005	1,397.43	477.65	196.83
2006	1,396.40	497.47	197.78
2007	1,368.35	526.92	195.68
2008	1,367.83	555.09	200.92
2009	1,386.03	587.61	183.61
2010	1,429.74	623.13	183.76
2011	1,457.04	649.93	175.56
2012	1,410.16	683.23	173.39
2013	1,368.61	719.40	152.19
2014	1,350.96	803.48	128.20
2015	1,336.50	853.32	132.33
2016	1,320.18	886.06	120.26
2017	1,308.69	925.00	111.86
2018	1,302.46	1,007.46	126.57
2019	1,318.63	1,042.24	128.70
2020	1,117.17	928.98	122.87
2021	1,281.77	1,045.72	120.32
2022	1,208.61	1,020.99	126.50
2023	1,170.72	1,042.21	131.55
2024	1,159.77	1,094.26	146.54
2025	1,139.97	1,186.96	156.22
2026	1,145.75	1,264.84	160.97
2027	1,147.51	1,351.60	165.46
2028	1,158.08	1,423.98	169.75

Calendar year	Carrier lab	Physician administered drugs	Other carrier	Intermediary lab
2003	$73.73	$182.58	$147.21	$75.18
2004	78.48	195.20	158.78	80.47
2005	82.71	178.77	184.02	84.16
2006	85.59	185.41	175.66	84.51
2007	90.65	186.97	176.55	84.38
2008	94.50	184.43	182.19	85.78
2009	101.60	196.19	178.46	79.19
2010	103.81	196.41	178.67	80.23
2011	103.85	209.50	179.44	83.31
2012	111.73	209.34	185.17	84.64
2013	111.79	216.91	177.08	81.74
2014	117.60	224.56	173.55	55.45
2015	113.99	252.11	174.94	55.26
2016	100.91	271.45	172.90	56.21
2017	100.65	280.51	177.43	54.99
2018	107.29	304.36	176.15	52.94
2019	108.36	329.56	173.72	50.29
2020	108.77	325.19	165.80	51.22
2021	122.34	339.27	165.03	56.05
2022	108.30	357.13	187.40	52.19
2023	105.60	420.77	215.17	46.34
2024	109.23	523.53	190.40	45.69
2025	113.05	550.71	204.81	45.96
2026	115.56	558.04	213.82	45.95
2027	124.81	585.44	222.08	47.47
2028	128.18	586.38	229.12	47.59

*Average reimbursement per enrollee on an incurred basis.

Calendar year	Other intermediary	Home health agency	Managed care
2003	$113.99	$136.75	$421.40
2004	119.58	156.45	471.37
2005	139.78	179.44	560.31
2006	142.09	202.88	769.94
2007	151.16	232.33	931.18
2008	158.20	252.43	1,104.26
2009	187.44	282.09	1,203.78
2010	193.08	283.25	1,221.28
2011	198.15	253.26	1,293.37
2012	205.08	238.05	1,387.28
2013	194.43	232.65	1,518.34
2014	200.51	226.14	1,726.63
2015	210.37	223.00	1,856.33
2016	214.14	217.10	1,966.38
2017	220.58	206.85	2,129.66
2018	228.20	204.32	2,408.95
2019	236.01	200.51	2,719.34
2020	207.47	186.28	3,075.99
2021	219.43	181.71	3,342.19
2022	214.05	172.31	3,829.27
2023	218.71	165.04	4,439.66
2024	225.85	161.54	4,763.15
2025	231.21	167.82	5,069.86
2026	237.21	173.87	5,710.24
2027	243.78	182.24	6,203.84
2028	251.52	191.03	6,630.82

* Average annual reimbursement per enrollee on an incurred basis.

Table II-8b. Part B Projections for non-ESRD (Aged+Disabled)*

Calendar year	Physician fee schedule	Outpatient hospital	Durable medical equipment
2003	$118.58	$35.27	$19.04
2004	129.94	40.49	18.91
2005	136.42	46.64	19.22
2006	142.18	50.65	20.14
2007	144.72	55.72	20.69
2008	149.92	60.84	22.02
2009	156.09	66.18	20.68
2010	162.72	70.92	20.91
2011	167.93	74.91	20.23
2012	166.38	80.61	20.46
2013	165.51	87.00	18.41
2014	168.07	99.96	15.95
2015	170.33	108.75	16.86
2016	170.43	114.39	15.52
2017	173.71	122.79	14.85
2018	178.43	138.01	17.34
2019	186.61	147.49	18.21
2020	165.92	137.98	18.25
2021	202.49	165.19	19.01
2022	202.09	170.79	21.16
2023	207.87	185.06	23.36
2024	215.71	203.54	27.26
2025	216.20	225.11	29.63
2026	223.24	246.44	31.36
2027	229.41	270.20	33.08
2028	236.80	291.17	34.71

Calendar year	Carrier lab	Physician administered drugs	Other carrier	Intermediary lab
2003	$7.13	$17.65	$14.23	$7.27
2004	7.59	18.87	15.35	7.78
2005	8.08	17.45	17.97	8.22
2006	8.72	18.88	17.89	8.60
2007	9.59	19.77	18.67	8.92
2008	10.36	20.22	19.97	9.40
2009	11.44	22.10	20.10	8.92
2010	11.82	22.35	20.34	9.13
2011	11.97	24.15	20.68	9.60
2012	13.18	24.70	21.85	9.99
2013	13.52	26.23	21.42	9.89
2014	14.63	27.94	21.59	6.90
2015	14.53	32.13	22.29	7.04
2016	13.03	35.04	22.32	7.26
2017	13.36	37.23	23.55	7.30
2018	14.70	41.69	24.13	7.25
2019	15.33	46.64	24.58	7.12
2020	16.16	48.30	24.63	7.61
2021	19.32	53.59	26.07	8.85
2022	18.12	59.74	31.35	8.73
2023	18.75	74.71	38.21	8.23
2024	20.32	97.38	35.42	8.50
2025	21.44	104.44	38.84	8.72
2026	22.52	108.73	41.66	8.95
2027	24.95	117.04	44.40	9.49
2028	26.21	119.90	46.85	9.73

*Average monthly reimbursement per enrollee on an incurred basis. Excludes cost plan expenditures included in National Claims History file. The denominator of the calculation for all fields except Managed Care is Part A FFS enrollment. The denominator of the calculation for Managed Care field is Part C enrollment.

Calendar year	Other intermediary	Home health agency	Managed care
2003	$11.02	$13.22	$254.39
2004	11.56	15.12	284.58
2005	13.65	17.52	318.75
2006	14.47	20.66	353.34
2007	15.99	24.57	366.01
2008	17.34	27.67	383.90
2009	21.11	31.77	385.73
2010	21.98	32.24	380.01
2011	22.84	29.19	389.17
2012	24.20	28.09	393.60
2013	23.51	28.14	406.92
2014	24.95	28.13	435.78
2015	26.81	28.42	446.95
2016	27.65	28.03	462.25
2017	29.28	27.46	476.81
2018	31.26	27.99	512.52
2019	33.40	28.38	551.19
2020	30.81	27.67	583.99
2021	34.66	28.70	589.51
2022	35.81	28.82	635.88
2023	38.84	29.31	697.16
2024	42.01	30.05	719.08
2025	43.85	31.83	753.64
2026	46.22	33.88	831.47
2027	48.73	36.43	886.54
2028	51.43	39.06	932.68

* Average reimbursement per enrollee on an incurred basis.

Table II-9. 2026 Projections by Service Category for non-ESRD (Aged+Disabled)*

Service type	Current estimate	Last year's estimate	Ratio
Part A			
Inpatient hospital	$2,091.20	$1,989.92	1.051
SNF	459.62	439.46	1.046
Home health agency	97.21	101.58	0.957
Managed care	3,426.66	3,221.23	1.064
Part B			
Physician fee schedule	1,145.75	1,127.23	1.016
Outpatient hospital	1,264.84	1,224.04	1.033
Durable medical equipment	160.97	149.87	1.074
Carrier lab	115.56	112.40	1.028
Physician Administered Drugs	558.04	474.79	1.175
Other carrier	213.82	158.24	1.351
Intermediary lab	45.95	46.53	0.988
Other intermediary	237.21	229.72	1.033
Home health agency	173.87	183.83	0.946
Managed care	5,710.24	5,412.57	1.055

* Average reimbursement per enrollee on an incurred basis.

Table II-10. Claims Processing Costs as a Fraction of Benefits

Calendar year	FFS Part A	FFS Part B	Total Part A	Total Part B
2003	0.001849	0.011194	0.001849	0.011194
2004	0.001676	0.010542	0.001676	0.010542
2005	0.001515	0.009540	0.001515	0.009540
2006	0.001245	0.007126	0.001245	0.007126
2007	0.000968	0.006067	0.000968	0.006067
2008	0.000944	0.006414	0.000944	0.006414
2009	0.000844	0.005455	0.000844	0.005455
2010	0.000773	0.005055	0.000773	0.005055
2011	0.000749	0.004396	0.000749	0.004396
2012	0.001008	0.003288	0.001008	0.003288
2013	0.000994	0.002846	0.000994	0.002846
2014	0.001003	0.002884	0.001003	0.002884
2015	0.000952	0.002730	0.000952	0.002730
2016	0.000852	0.002348	0.000852	0.002348
2017	0.000833	0.002111	0.000833	0.002111
2018	0.000836	0.001953	0.000836	0.001953
2019	0.000699	0.001644	0.000699	0.001644
2020	0.000625	0.001536	0.000625	0.001536
2021	0.001038	0.002708	0.000600	0.001399
2022	0.001094	0.002801	0.000582	0.001310
2023	0.001102	0.002916	0.000579	0.001330
2024	0.001059	0.002662	0.000566	0.001260
2025	0.001059	0.002662	0.000566	0.001260
2026	0.001059	0.002662	0.000566	0.001260
2027	0.001059	0.002662	0.000566	0.001260
2028	0.001059	0.002662	0.000566	0.001260

Approximate Calculation of the USPCC, the National MA Growth Percentage for Combined (Aged+Disabled) Beneficiaries, and the FFS USPCC (Aged+Disabled)

The following procedure will approximate the actual calculation of the USPCCs from the underlying assumptions for the contract year for both Part A and Part B.

Part A: The Part A USPCC can be approximated by using the assumptions in the tables titled "Part A Projections for non-ESRD (Aged+Disabled)" and "Claims Processing Costs as a Fraction of Benefits." Information in the "Part A Projections" table is presented on a calendar year per capita basis. First, add the per capita amounts over all types of providers (excluding hospice). Next, multiply this amount by 1 plus the loading factor for administrative expenses from the "Claims Processing Costs" table. Then, divide by 12 to put this amount on a monthly basis.

Part B: The Part B USPCC can be approximated by using the assumptions in the tables titled "Part B Projections for non-ESRD (Aged+Disabled)" and "Claims Processing Costs as a Fraction of Benefits." Information in the "Part B Projections" table is presented on a calendar year per capita basis. First, add the per capita amounts over all types of providers. Next, multiply by 1 plus the loading factor for administrative expenses from the "Claims Processing Costs" table and then divide by 12 to put this amount on a monthly basis.

The National Per Capita MA Growth Percentage: The National Per Capita MA Growth Percentage for CY 2026 (before adjusting for prior years' over/under estimates) is calculated by adding the USPCCs for Part A and Part B for CY 2026 and then dividing by the sum of the current estimates of the USPCCs for Part A and Part B for CY 2025.

The FFS USPCC: The tables used to calculate the total USPCC can also be used to approximate the calculation of the FFS USPCC. The per capita data presented by type of provider in the projection tables for both Part A and Part B are based on total enrollment. To approximate the FFS USPCCs, first add the corresponding provider types under Part A and Part B separately. For the FFS calculations, do not include the managed care provider type. Next, rebase the sum of the per capita amounts for FFS enrollees, i.e., multiply the sum by total enrollees and divide by FFS enrollees. (The enrollment tables in this attachment now also include FFS enrollment). Then, multiply by 1 plus the loading factor for administrative expenses and divide by 12.

Attachment III. Responses to Public Comments on Part C Payment Policy

Section A. General Comments

Comment: CMS received many comments in response to the CY 2026 Advance Notice, with some supporting the direction of the proposals in the Advance Notice and others expressing concerns about the impacts of the proposed updates. Commenters who supported the proposals in the Advance Notice believed that the policies would promote access to care, improve health outcomes, and reduce beneficiary costs. The commenters also expressed support for the policy proposals and updates in the Advance Notice because they believed they will advance coordinated care, reduce administrative burden, and ensure payment rates accurately reflect the cost of care. Many commenters expressed general support for MA and believed that MA provides better care at lower costs than fee-for-service and enables plans to offer supplemental benefits. A few of these commenters believed that MA is a more efficient use of government funds compared to fee-for-service. A commenter expressed support for MA as a facilitator of value-based care. Another commenter expressed support for MA as important for delivery system reform.

Response: CMS appreciates commenters' support.

Comment: Many of the commenters who did not support the proposed changes included in the Advance Notice felt that payment updates they considered unfavorable in the previous two years have put financial pressure on plans, providers, and beneficiaries. Some commenters expressed concerns that the proposed payment update in the Advance Notice is insufficient to keep pace with utilization and costs. Most of the commenters who opposed Advance Notice policies expressed concern about the impact on beneficiary access, including fewer plan options, limited benefits, and higher out-of-pocket costs. A few commenters expressed concern that the policy proposals in the Advance Notice could decrease competition in the MA market. A commenter suggested that this decreased competition would disadvantage small, nonprofit, and community-based MA plans and organizations.

Several commenters expressed general opposition to MA, expressing concern over wasteful government spending. A few of these commenters were concerned about MA fraud, upcoding, and impact to the Medicare Trust Funds. One of these commenters also expressed concern that MA plans use deceptive marketing schemes and aggressive and inappropriate care denials.

A commenter emphasized the importance of encouraging broader stakeholder input in the Advance Notice. They suggested developing less technical and dense materials for community-based organizations and Medicare beneficiaries. These suggestions include publishing a plain language primer on MA payment and proposed changes and asking the public specific questions about access and quality issues to gather information about what is happening on the ground. A commenter requested that all key information be included in the Advance Notice document, rather than referencing to published supporting files and Fact Sheets and providing information

during stakeholder calls, and stated that it is challenging to interpret and use the information provided. Another commenter suggested that CMS release additional explanatory narrative to accompany supporting data and files, to help stakeholders better understand how CMS uses the data.

Response: CMS thanks commenters for their thoughts and input regarding payments made under the MA program. CMS has a fiduciary duty to be a steward of the Medicare program. Protecting and strengthening Medicare for the 68 million Americans who have it now, and all the beneficiaries in the future, is a key priority for CMS. The policies finalized for CY 2026 are projected to increase average per capita payments to MA organizations by 5.06 percent in CY 2026, which will provide continued stability for the MA market and MA beneficiaries. We are finalizing policies that will ensure payments to MA organizations are up to date and reflect current diagnostic and expenditure trends. Further, the updates included in the CY 2026 Rate Announcement ensure accurate, appropriate payments to MA organizations and prevent wasteful Medicare spending. These policies were developed using careful analyses. Further, we note that MA payments, though different than FFS payments, are closely tied to FFS payment levels and are reflective of payment and utilization trends in that market.

We respectfully disagree with the comments claiming that this update to payments in MA will result in increased costs or fewer benefits for beneficiaries. Although the projected 3.70 percent payment increase finalized in the CY 2025 Rate Announcement was a lower increase than in recent years, plan availability, choice, enrollment, and benefit offerings remained stable or grew in 2025. For CY 2025, as with previous years, access to MA plans with prescription drug coverage remains nearly universal, with about 99% of people enrolled in Medicare having access to at least one MA health plan in their area.[2] In 2025, 98% of people with Medicare have access to ten or more MA plan choices when including Special Needs Plans (SNPs). Furthermore, the average number of MA plan choices per county remains robust, with 34 plan offerings for non-SNP MA plans with prescription drug coverage and 65 plan offerings in 2025 for all MA plans (including SNPs). Availability of SNPs is also at its highest level historically, with the number of SNP offerings growing by 9% from 2024 to 2025. Overall MA enrollment has similarly not been negatively impacted by the projected 3.70 percent payment increase we finalized in the CY 2025 Rate Announcement and increased by more than 3.1 percent from January 2024 to January 2025.[3] In CY 2025, average rebate payments to plans, which fund supplemental benefits, remain stable. Additionally, in 2025, 97 percent of MA plans offer hearing and/or dental supplemental benefits and 99 percent of MA plans offer vision benefits.

Given the stability seen in the MA program following the changes announced in the CY 2025 Rate Announcement, CMS expects this year's estimated 5.06 percent payment increase to provide continued stability in beneficiary access, choice, and benefits. CMS reminds readers that

[2] See Medicare Advantage and Medicare Prescription Drug Programs projections for 2025.

[3] See Medicare Advantage/Part D Contract and Enrollment data.

the updates and the continued planned phase-in of the risk adjustment model proposed in the CY 2026 Advance Notice are technical, data-driven, and clinically-based updates that improve the accuracy of payments to MA organizations, as required under the statute governing the MA program.

Additionally, CMS acknowledges that the Advance Notice and Rate Announcement documents are highly technical, given their focus on methodological updates to the MA capitation and payment rates. Each year, we also release a Press Release and Fact Sheet that summarize key proposed updates, and the impact of those changes, to support the public's understanding. Throughout the Rate Announcement, CMS provides links to additional resources as much as possible, so readers can refer to the primary sources of information that can provide more specific detail than can be included in the Rate Announcement itself.

Finally, CMS thanks the commenter for expressing their concern that MA plans use deceptive marketing schemes and aggressive and inappropriate care denials but notes that these topics are outside the scope of the Rate Announcement.

Section B. Estimates of the MA and FFS Growth Percentages for CY 2026

Phase-in of Technical Adjustment to the non-ESRD USPCC Baseline Regarding MA-Related Medical Education Expenses

Comment: A commenter expressed support for CMS' efforts to remove MA-related medical education payments from the non-ESRD FFS USPCC estimates, CMS' ongoing efforts to improve the accuracy of rates, and the transparency of those efforts.

Response: We appreciate the support.

Comment: A large number of commenters requested that CMS consider pausing the continued phase-in of the technical adjustment for CY 2026, extending the phase-in period (e.g., apply 75 percent of the technical adjustment for CY 2026 and 100 percent in CY 2027), in order to further mitigate the impact of the technical adjustment and to allow further evaluation of the impact of the policy to ensure alignment with the Administration's priorities and goals for MA beneficiaries. Several of these commenters suggested that implementing the remaining 48% of the adjustment over two years (i.e., CYs 2026 and 2027), rather than as a one-time correction in CY 2026, would more reasonably align with the initial phase-in schedule of approximately 33% annual impact put forth in the CY 2024 Rate Announcement. Several commenters indicated that increasing the adjustment from 52% to 100% for CY 2026 would not provide an adequately gradual phase-in.

Response: We appreciate the concerns raised by the commenters. We are finalizing the completion of the three-year phase-in schedule as proposed in the CY 2026 Advance Notice by applying 100 percent of the medical education technical adjustment for CY 2026. Completing

the phase-in for CY 2026 is consistent with the three-year phase-in schedule that CMS announced in the CY 2024 Rate Announcement.

Comment: A couple of commenters requested greater transparency of additional information regarding the calculation of the technical adjustment.

Response: The CY 2024, CY 2025, and CY 2026 Advance Notices indicated that the baseline development and modeling supporting the USPCCs had been updated to separately identify the historical and projected costs of IME and DGME paid to hospitals by CMS associated with services furnished to MA enrollees. This update in the modeling stems from separate projections of IME and DGME by FFS versus MA coverages.

We provided the preliminary impacts on the growth rates of the technical adjustment in the CY 2026 Advance Notice, and we now provide the final impacts of the technical adjustment in this CY 2026 Rate Announcement, for the FFS growth rate and the MA growth rate, so that stakeholders can understand how the technical adjustment will impact the county rates in their plan service area.

In the table below, we provide the updated impact of the technical adjustment for medical education costs on the final estimate of the 2026 non-ESRD FFS USPCC (being released in this CY 2026 Rate Announcement). Note that the 2026 Part B non-ESRD FFS USPCC is unaffected by the technical adjustment for medical education costs. As such, the following table illustrates the development of the 2026 Part A non-ESRD FFS USPCC including the technical adjustment.

Projection for Contract Year 2026	With 52% implementation of technical update (*informational*)	With full (100%) implementation of technical update *for CY 2026 rates*
a. Part A FFS Enrollment (annual, in millions)	33.184	33.184
Reimbursements (in millions):	$199,826.05	$199,826.05
b. Part A reimbursements including all MA medical education		
c. MA medical education amount (as a negative number)	($7,623.32)	($14,660.24)
d. Part A reimbursements excluding MA medical education *d = (b + c)*	$192,202.73	$185,165.81

Projection for Contract Year 2026	With 52% implementation of technical update (*informational*)	With full (100%) implementation of technical update *for CY 2026 rates*
e. Part A FFS Admin loading	1.001059	1.001059
f. 2026 Part A non-ESRD FFS USPCC *f = [(d * e) / a / 12]*	$483.18	$465.49
g. 2026 Part B non-ESRD FFS USPCC	$765.03	$765.03
h. 2026 non-ESRD FFS USPCC *h = f + g*	$1,248.21	$1,230.52
i. 2025 non-ESRD FFS USPCC from CY 2025 Rate Announcement	$1,130.85	$1,130.85
j. CY 2026 FFS growth rate *j = h/i – 1 (rounded to hundredth of a percent)*	10.38%	8.81%
k. Impact of increase in phase-in on CY 2026 FFS growth rate (additive impact, compared with 52% phase-in)	n/a	-1.57%

As stated earlier, we provided the preliminary impacts on the growth rates of the technical adjustment in the CY 2026 Advance Notice, and we now provide the final impacts of the technical adjustment in this CY 2026 Rate Announcement. For the MA growth rate, the updated impact of the technical adjustment for MA-related medical education expenses on the final estimate of the 2026 non-ESRD Total USPCC (being released in this CY 2026 Rate Announcement) is as follows: the impact of the increase in the phase-in on the final estimate of the 2026 MA growth rate being released in this CY 2026 Rate Announcement (based on the change in the non-ESRD Total USPCC, which includes both FFS and Part C projections) compared to the 2026 growth rate assuming a 52 percent phase-in is -0.83 percent for 100 percent implementation of the medical education change in CY 2026.

Estimates of non-ESRD USPCCs and Growth Rates

Comment: A commenter expressed appreciation that CMS continues to provide stakeholders with explanatory information about the process used to project the USPCCs and FFS costs,

specifically CMS' commitment to providing stakeholders greater visibility into the general methodology, data sets, and other technical components involved in deriving the USPCCs and calculating the FFS costs including the supporting data and files.

Another commenter appreciated the publication of the components of the growth rates and encouraged CMS to continue this practice with future rate notices.

Some commenters appreciated that the growth rate estimates were higher than the previous two years.

Response: We appreciate the support and feedback.

Comment: A large number of commenters encouraged CMS to incorporate the most recently available cost and utilization data (including 2024 experience) to ensure that the CY 2026 MA benchmarks reflect higher utilization and cost trends and inflation observed by commenters. Some commenters characterized the CY 2026 growth rate estimates as "inadequate," particularly when following the lower growth rates of the past two years.

A couple of these commenters cited published analyses of estimated accelerating cost trends varying geographically in Medicare FFS, MA, and the commercial health plan market. Many commenters cited analyses of ACO REACH model data which suggested that FFS costs grew at a higher rate between 2023 and 2024 than CMS' FFS trend estimates, with one of these commenters acknowledging that the ACO REACH population is a subset of FFS. A large number of commenters noted that MA and Medicare Supplement (i.e., Medigap) data analyses indicated that medical costs and trends (e.g., for 2023-2024) were higher than CMS' FFS estimated trend, specifically noting increases in MA utilization. Several commenters expressed concern that if the growth rates did not reflect higher utilization and cost trends in the U.S. health care market and the impacts of inflation, the rates would be insufficient to cover the cost of care for Medicare beneficiaries in CY 2026 which could lead to higher beneficiary premiums and/or reduced supplemental benefits.

Several commenters expressed concern that restated estimates of FFS and Total USPCCs for recent years demonstrates consistent underestimation and bias toward under-forecasting of Medicare costs, with another commenter stating that this may be "suggesting the process is not immune to errors or deficiencies." A commenter expressed concern regarding volatility in CMS' projections of FFS spending. Another commenter believed that CMS should incorporate feedback from stakeholders who are seeing trends in care delivery, with less delay than annual restatements, including for experience periods where CMS has not yet received or analyzed complete information.

A few commenters expressed concern that CMS is underestimating the Part B FFS USPCC trend given recent FFS experience. Another commenter noted that the restated 2024 FFS USPCC for Part B in the CY 2026 Advance Notice was higher than the estimate in the CY 2025 Rate

Announcement due to emerging actual 2024 claims experience, including for physician administered drug costs, which they believe demonstrates the need to use as much actual experience as possible for data accuracy. A few commenters cited specific drivers of expected increases in utilization and costs, including increased use of GLP-1 (Glucagon-like peptide-1) drugs and ongoing utilization recovery following the COVID-19 pandemic. A couple of commenters stated that the forward-looking trends (for 2024-2025 and 2025-2026), after adjusting for the technical update for medical education payments, are lower than the average trends observed for 2022-2023 and 2023-2024 without evidence or support that the trend drivers are being mitigated or decreasing (citing as one example the trends in physician administered drug costs). Another commenter expressed concern with using 2023 experience data as the base year for projections.

A couple of commenters urged CMS to use consistent experience periods for the Advance Notice and Rate Announcement each year and across each data source used in a given year and communicate the experience periods used (e.g., incurred and paid-through dates). A couple of other commenters requested that CMS adjust the growth rate estimates for CY 2026 to be consistent with OACT's estimates in the Medicare Trustees Report. Another commenter suggested that CMS give more credibility to recent trends that demonstrate an acceleration of trend.

Several commenters believe it would be actuarially appropriate for CMS to incorporate an assumption that Congress will likely alter Medicare physician fee schedule reductions before they are scheduled to take effect in 2026, based on 2021-2024 Congressional actions and considering rate adjustments made for CYs 2014-2016, as a more reasonable expectation than the scheduled reductions.

A commenter expects that CMS will update the growth rates to incorporate actual claims experience through the fourth quarter of 2024. Another commenter urged CMS to review fourth quarter 2023 data to help refine trend projections, since several health plan sponsors had publicly reported higher-than-average medical utilization and cost trends.

Response: Section 1853 of the Act requires that FFS per capita cost estimates be used in developing MA rates and sets the general approach to updating the USPCCs and growth rates. Additionally, the projections are consistent with the law as it exists on the date of the Rate Announcement.

The USPCC modeling approach used by CMS reflects projected changes in the factors used to update Medicare FFS payment rates. The projected expenditures for some of the Medicare payment systems include the expectation of inflation, including projected market basket changes for inpatient, SNF, home health agency, and outpatient hospital projections and consumer price index (CPI) updates for durable medical equipment projections.

The growth percentages are based on CMS' best estimate of historical program experience and projected trend at the time those values are announced. We continue to consider it best practice to base the growth rates on the most recent data and assumptions available at the time those values are announced. Therefore, for each release of the growth rates, CMS updates historical enrollment and claims, as well as projection factors, based on the most recent data.

The baseline supporting the USPCCs and growth rates has been revised since the CY 2026 Advance Notice to incorporate additional program experience. The updated non-ESRD FFS USPCCs for both Part A and Part B are based on program experience through 4th quarter 2024 and incurred dates through 3rd quarter 2024. The CY 2026 Advance Notice non-ESRD FFS USPCCs were based on program experience through 4th quarter 2023 for Part A and through 2nd quarter 2024 for Part B.

Additional updates since the CY 2026 Advance Notice include reflection of final 2025 FFS payment regulations, updates to economic forecasts, and revised projection factors.

Comment: A couple of commenters expressed concern regarding the level of transparency regarding the analysis and assumptions used to calculate the growth percentages. Many commenters requested greater transparency related to the data, methodologies, and assumptions supporting the development of the USPCCs, with some commenters citing the Actuarial Standards of Practice, such as utilization and unit cost trends by type of service, key driving factors of trend changes, and sensitivity analyses of trend estimates to changes in data.

Specific areas mentioned by commenters requesting additional transparency included the following:

- Incurred and paid through dates of the experience data supporting the USPCCs for the Advance Notice and Rate Announcement.
- Explanation of why more recent experience was not used in the FFS USPCCs in the Advance Notice, in particular 2024 Part A experience.
- Details on how CMS will incorporate trend data from 2024 into the final CY 2026 growth rates.
- Explanation of how the 2026 USPCCs account for the prior two years of lower growth rates and the proposed 2026 total payment impact.
- Details regarding how IPPS and OPPS finalized payment rates were incorporated into the 2026 USPCCs (e.g., impacts to trends in utilization and unit costs by type of service).
- Greater insight regarding how utilization trends for 2021-2023, and the long-term costs associated with COVID-19, were incorporated into the USPCCs.
- USPCC tables without the medical education adjustment and 340B adjustment.
- Explanation and impacts of the enrollment projection assumptions whereby the projected number of aged beneficiaries as a percent of the Social Security area population age 65 and older have decreased compared to the CY 2025 Advance Notice.

- Explanation of how Medicare Secondary claims are handled when developing USPCCs and AGAs (e.g., any adjustments factors applied).
- Details of projection methodology for Part B physician-administered drug spending, in particular any adjustments for changes to population morbidity and at what level of detail historical trends are analyzed and projections are calculated (e.g., by drug class).

Response: We discussed in the CY 2026 Advance Notice the methodology, sources of data, assumptions, and trends underlying the MA capitation rates at a level of detail consistent with past practice.

In support of the MA ratebook growth rates, CMS has, as required under section 1853(b)(3) of the Act, included an explanation of the assumptions and changes in methodology used in the CY 2026 Rate Announcement; see the key economic assumptions underlying the USPCCs included in Attachment II of this CY 2026 Rate Announcement. Consistent with prior years, with this CY 2026 Rate Announcement we have published additional information regarding trends for the prior five years and unit cost increases to the contract year at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Trends.html. This information includes additional details of drivers of historical and projected trends. For example, for inpatient prospective payment system (IPPS) experience, the exhibit includes experience and assumptions for unit costs, utilization, case mix, and the impact of COVID-19 morbidity.

Additionally, the USPCC projections reflect payment levels based on the most recent Medicare final rules for fiscal year 2025 or calendar year 2025.

The non-ESRD FFS USPCCs in the CY 2026 Advance Notice were based on actual spending and incurred experience through 4th quarter 2023 for Part A and 2nd quarter 2024 for Part B. The non-ESRD FFS USPCCs in the CY 2026 Rate Announcement are based on program experience through 4th quarter 2024 and incurred dates through 3rd quarter 2024.

The estimate of excess morbidity on aggregate per capita Medicare FFS costs due to COVID-19 remain the same as the CY 2025 Rate Announcement USPCC baseline. The estimated impacts by year are:

2021	2022	2023	2024	2025	2026
-2.50%	-4.00%	-4.40%	-4.40%	-3.90%	-2.30%

The CY 2026 Advance Notice description of the development of Medicare enrollment assumptions from Social Security population projections are based on a more current baseline compared to the baseline supporting the CY 2025 Advance Notice. The underlying enrollment projections were not affected by the reported change in assumptions.

Medicare secondary payer claims are included in the tabulation of non-ESRD USPCCs and AGAs.

Projections for Part B physician-administered drugs are in aggregate and reflect the projected impact of changes in the demographic profile of the FFS population.

We believe that the information in the CY 2026 Advance Notice and now this CY 2026 Rate Announcement provides the necessary support for understanding USPCC levels and trends.

ESRD Dialysis-Only USPCC and Growth Rate

Comment: A few commenters expressed concern regarding volatility in ESRD growth rates, including restatements of prior year estimates. One of these commenters requested greater transparency regarding the methodology and assumptions used to develop the ESRD USPCCs. Another commenter requested that cost and trend data, including utilization, be published for the ESRD beneficiary population, given the increase in ESRD enrollment in MA.

Response: As discussed in past Rate Announcements[4], we believe it is important to update the FFS per capita cost estimates using the most current FFS data available at the time those values are announced and apply repricing adjustments to reflect changes in FFS payment rules. Similar to prior Rate Announcements, the method for calculating the county-level non-ESRD rates and the state-level ESRD rates includes AGAs based on a five-year rolling average of historical claims experience, which provides some measure of stability in the rates.

The published 2024-2026 "Medicare Unit Cost Increases" by service category (available at https://www.cms.gov/files/document/ffs-trends-2024-2026.pdf) apply to provider payments for both ESRD and non-ESRD beneficiaries. Starting with the CY 2024 Rate Announcement posting, we have added trends for the ESRD Prospective Payment System (ESRD PPS) base rate.

The ESRD dialysis USPCCs are derived from the total ESRD USPCC baseline but are adjusted for recent trend differences between the total ESRD and dialysis ESRD populations. Thus, the ESRD dialysis USPCCs are projected using a base year USPCC trended to 2026 using total ESRD growth with an "adjustment factor for dialysis only." The utilization and intensity assumptions supporting the ESRD trends are based on multiple years of historical experience. The applicable trends are found in the table in Attachment II, "Basis for ESRD Dialysis-only FFS USPCC Trend."

[4] Prior Rate Announcements are available at: https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/announcements-and-documents

Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022

Comment: A commenter supported CMS's approach to account for the reduction for non-drug items and services to OPPS providers in MA rate calculations starting in 2026.

Response: CMS appreciates the support.

Comment: A couple of commenters expressed concern about CMS's approach to account for the 0.5 percent reduction in non-drug items and services to OPPS providers in the MA rate calculations, which CMS has previously referred to as the "340B adjustment." (*See, e.g.,* 82 FR 59353 through 59371.) They urged that CMS' MA rate announcement policies have not sufficiently accounted for Part B remedy payments to 340B hospitals for drugs furnished between 2018 and 2022. The commenters believe that CMS's approach would benefit MA plans and result in MA plans underpaying hospitals for 340B drugs between 2018 and 2022 and again underpaying hospitals for non-drug items and services beginning in CY 2026, and they urged CMS to take alternate measures. A commenter provided the following specific suggestions for CMS to consider:

(1) For CMS to directly pay lump sum settlements to 340B hospitals on behalf of MA plans;

(2) For CMS to increase the rates paid to MA plans and mandate that the increased payments flow directly from MA plans to 340B hospitals; or

(3) For CMS to create a pricer that does not include the decreased conversion factor for non-drug outpatient items and services to be used starting in CY 2026 for approximately 16 years, and to mandate that the pricer be used by MA plans for payments to non-contracted hospitals.

Response: CMS appreciates commenters' feedback on this issue, particularly the specific alternative suggestions. CMS's approach to developing the CY 2026 MA rates using the 2026 OPPS FFS rate that reflects the 340B Remedy Rule's 0.5 percent budget neutrality adjustment is consistent with how CMS develops prospective MA rates each year for the Advance Notice and Rate Announcement. CMS is not remedying through this MA rate announcement the policy regarding Medicare Part B payments for 340B-acquired drugs made to providers that it had implemented from 2018-2022. Rather, the Remedy Rule adjusts the CY 2026 FFS rates from what they would be otherwise, which impacts CMS's estimate of the CY 2026 FFS per capita costs used to develop MA rates. As required by section 1853 of the statute, CMS estimates the per capita FFS costs for CY 2026 to develop MA benchmarks, as preliminarily discussed in the CY 2026 Advance Notice and finalized through this CY 2026 Rate Announcement. Specifically, section 1853(n)(2) of the Act requires that, in determining the payment amount, CMS use the base amount described in section 1853(c)(1)(D), based on 100 percent of FFS costs with adjustments for a rebasing year.

In response to the alternatives presented by the commenter, we note that the 340B Remedy Rule (88 FR 77150) remedied the payment amounts made to 340B providers and facilities under FFS Medicare from 2018-2022 in two ways. First, under sections 1833(t)(14) and (t)(2) and, as necessary, section 1871(e)(2), CMS paid 340B-covered entities the difference between what they received for 340B-acquired drugs from 2018-2022 and what they would have received for 340B-acquired drugs if the 340B adjustment had not been in place (81 FR 77161). Second, under sections 1833(t)(14)(H), (t)(9)(B), and (t)(2)(E), and, as applicable, the equitable adjustment or common-law and inherent recoupment authorities, CMS unwound the $7.8 billion in payment increases for non-drug services and items in the 340B payment adjustment from 2018-2022 (82 FR 59482) in order to place providers in as close to a situation as they would have been if that policy never existed (88 FR 77174). CMS implemented the latter budget neutrality offset through a 0.5 percent reduction beginning in 2026 to the hospital outpatient prospective payment system conversion factor for hospitals enrolled in Medicare before January 2, 2018, over an estimated 16-year time period until a total of $7.8 billion is offset (88 FR 77181).

Under the Medicare Advantage program, CMS provides a capitated prospective payment to Medicare Advantage organizations (MAOs) to provide coverage to enrollees, and the MA organizations pay the providers for this care. CMS calculated and paid CY 2018-2022 MA rates under the Advance Notice and Rate Announcement for those years, and those MA rates reflected the FFS policies as of the time they were finalized. The statutory and regulatory provisions of the MA program constitute a broader bidding and payment structure that is distinct from the Medicare FFS program. MA plan bids are an estimate of projected costs that plans expect to incur, in part based on policies under the Medicare FFS program that are generally established each year before MA benchmarks are finalized and bids are submitted.

Applying those general principles here, we generally disagree with commenters' alternatives. We disagree with the commenter's suggestion that CMS should either directly pay MA organizations to distribute to affected 340B hospitals or direct in this Rate Announcement that MA organizations must account for what providers allege were prior inadequate MA payments from MA organizations. We understand from commenters that FFS rates, including the 340B adjustment, could potentially have downstream effects on how much MA organizations pay providers under their MA contracts. But the commenter cites no statutory authority requiring or even authorizing CMS to make direct payments to providers to account for allegedly inadequate payments by MA organizations. MA capitation rates released through the Advance Notice and Rate Announcement process do not set the amounts that MA organizations pay their contracted providers. In fact, section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in how much MA organizations pay contracted providers or direct how MA plans pay providers for particular items or services, like 340B-acquired drugs. We therefore do not agree that this Rate Announcement is the proper venue to re-negotiate payment amounts for particular items or services in provider contracts with MA organizations.

We also disagree with the commenter's suggestion that we should not incorporate into MA rates the 0.5 percent adjustment to Part B payments beginning in 2026 in our calculation of the adjusted average per capita cost for 2026 under section 1853(c)(1)(D) of the statute. That provision instructs that in a rebasing year, CMS calculates MA capitation rates based on "the adjusted average per capita cost for the year involved," which is "determined under section 1876(a)(4)" of the statute. Section 1876(a)(4), in turn, defines "the term 'adjusted average per capita cost'" to mean "the average per capita amount that the Secretary estimates in advance . . . would be payable in any contract year for services covered under parts A and B, or part B only." Because the 340B remedy rule added 42 C.F.R. § 419.32(b)(1)(iv)(B)(12), which reduces by 0.5 percent the amount "payable" under Part B for hospitals enrolled in Medicare before January 2, 2018, we must account for that in the "average per capita amount." That is different from the lump sum payments CMS made in 2024, which do not change the amount "payable" in 2026 for Medicare Part B. We read section 1876(a)(4) to require the use of actuarial principles to estimate the average per capita amount. In applying those actuarial principles, we determine when an amount is "payable" based on underlying utilization. For example, we base our estimate on the amount actually "payable" in 2026 on service utilization in 2026 (and not 2018-2022), as reflected in the 2026 USPCC.

As for the third alternative, section 1852(a)(2) of the Social Security Act mandates that MA organizations reimburse non-contract providers at least the amount they would have received under Medicare FFS. The 340B Remedy Rule finalized that providers that enrolled in Medicare after January 1, 2018 are excluded from the prospective rate reduction starting in CY 2026. We expect that MA organizations will comply with the statutory requirements at section 1852(a)(2) of the Social Security Act. The commenter has not explained why the procedures in section 1852(a)(2) of the Social Security Act to challenge such non-contract payments are inadequate to protect their interests here, and we therefore decline in this announcement either to accept the commenter's suggestion that we prejudge the outcome of such challenges or else set up an extra-statutory method to adjudicate them.

Section C. MA Benchmark, Quality Bonus Payments, and Rebate

Comment: A commenter thanked CMS for including 2023 FFS data with the release of the CY 2026 Advance Notice. The commenter encouraged CMS to continue to release this data at the county level going forward with each Advance Notice, as this data allows MA organizations to plan for the rebasing impact for the county benchmarks released with the Rate Announcement.

Response: We appreciate the support and feedback submitted by the commenter.

Comment: A few commenters urged CMS to use its administrative authority to lift the statutory cap on benchmarks or exclude the quality bonus payment from the benchmark cap. Commenters noted that the MA benchmarks are capped at what the benchmark would have been using the

pre-ACA formula, which results in some plans not receiving the full quality bonus if the benchmark exceeds the cap.

Response: As we have stated in response to similar comments in prior Rate Announcements,[5] while we appreciate the commenters' concerns, we have not identified discretion under section 1853(n)(4) of the Act to eliminate application of the pre-Patient Protection and Affordable Care Act (ACA) (Pub. L. 111-148) rate cap or exclude the bonus payment or quartile adjustment from the cap calculation. The applicable amount (i.e., "benchmark cap") is the rate established under section 1853(k)(1) of the Act.

Section D. Calculation of Fee-for-Service Costs

Comment: A couple of commenters requested that CMS provide more transparency into its methodology for rebasing, given the regional variations in pandemic impacts. Commenters requested that CMS provide further detail explaining the year-over-year changes in FFS spending, the key factors driving these changes, and the relative sensitivity of these estimates to changes in underlying source data.

Response: We appreciate the request for transparency and believe that we have been responsive to stakeholders' interest in understanding and analyzing the rebasing methodology. As noted on page 30 of the CY 2026 Advance Notice, CMS released the 2023 FFS cost data by county used for rebasing county rates in the development of the 2026 ratebook. This data is available on the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data.html. Due to timing constraints, this publicly posted data did not reflect adjustments for Innovation Center models and demonstrations and the Medicare Shared Savings Program and Advanced Alternative Payment Models when posted, and the publicly posted data did not reflect adjustments for claim repricing for the most current available Medicare FFS payment rules and parameters. However, those adjustments are included in the data we used for the MA ratebook.

Starting with the CY 2020 Advance Notice, CMS has published with each Advance Notice the latest FFS cost data by county used in the development of the non-ESRD ratebooks. For the CY 2019 Advance Notice and prior, this FFS cost data was released at the same time as the Rate Announcement on the CMS webpage at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data. The accelerated release of the FFS experience allows stakeholders to conduct basic analyses of the impact of recent program experience on the geographic adjustments supporting the rates.

[5] Please refer to previous Rate Announcements for years 2016 through 2024 available at https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/announcements-and-documents

Comment: A commenter urged CMS to make an adjustment to the Average Geographic Adjustments (AGAs) methodology to account for downward pressure of COVID-19 on FFS costs.

A commenter expressed concern that CMS limits its adjustment of the AGAs for Innovation Center demonstrations and payment models to those listed in the Advance Notice and that CMS excludes Innovation Center payments that are not funded from the Trust Funds. The commenter recommended CMS reconsider this policy and include advance payment of shared savings in the calculation of FFS costs. The commenter also recommended CMS publish the amounts paid to FFS providers through the Innovation Center but not included in the benchmark calculations in the Rate Announcement.

Response: As explained on pages 36-37 of the CY 2026 Advance Notice, we considered adjusting the FFS claims experience for care management fees, per-beneficiary-per-month fees, and/or advance payment of shared savings paid using the Innovation Center appropriation instead of the Medicare Part A or B Trust Funds for other Innovation Center models conducted in the 2019–2023 period. However, we intend to continue prior policy and will not take fees of this type into account in our adjustments to historical FFS experience when they were not funded under Medicare Part A or B Trust Funds.

As we discussed on page 20 of the CY 2018 Advance Notice, the fees paid from administrative accounts authorized by section 1115A of the Act are not from the Parts A and B Trust Funds, from which Medicare claims are disbursed, so we do not consider those payments to be part of FFS costs. Per section 1853(c)(1)(D)(i) and (n)(2)(F) of the Act, CMS uses the "adjusted average per capita cost for the year involved, determined under section 1876(a)(4) [of the Act]" as the base payment amount for setting MA rates. Section 1876(a)(4) indicates that FFS costs used for MA rates are based on the estimated amount that would be payable for services covered under Parts A and B, and types of expenses otherwise reimbursable under Parts A and B (including administrative costs incurred by organizations described in sections 1816 and 1842). As these costs described in section 1876(a)(4) of the Act are paid from the Trust Funds, excluding costs paid from another appropriation is appropriate to determine FFS costs. *See also* sections 1817 and 1841 of the Act. In addition, section 1853(f) of the Act indicates that payments to MA organizations shall be made from the Trust Funds "in such proportion as the Secretary determines reflects the relative weight that benefits under Part A and under Part B represents of the actuarial value of the total benefits under this title." Therefore, we will not make an adjustment to historical FFS claims to account for payments made from the funds appropriated under section 1115A(f).

Comment: Several commenters urged CMS to use only beneficiaries eligible for MA (those with both Part A and Part B) in the calculation of MA benchmarks, instead of including Part A-only and Part B-only beneficiaries. Commenters cited various concerns such as actuarial principles

and the share of Part A-only beneficiaries growing over time. Commenters offered policy suggestions such as making the Puerto Rico benchmark adjustment nationwide.

Response: We refer commenters to the detailed response that we provided in the CY 2020 Rate Announcement regarding use of FFS data for costs of all Medicare beneficiaries, whereby CMS concluded that it finds the current ratebook methodology (our longstanding policy of considering costs of beneficiaries with Part A and/or Part B) to be consistent with section 1853(c)(1)(D) of the Act. We continue to believe that it is not necessary to change the methodology at this time, nor is it required as the statutory language clearly permits CMS to include Medicare beneficiaries who have Part A only or Part B only. While we recognize that calculating rates based on data that excludes beneficiaries entitled only to Part A would yield different results than calculating rates based on our current methodology, that fact alone does not determine which methodology should be employed.

With respect to Puerto Rico, we have discussed in past Advance Notices and Rate Announcements that while most Medicare beneficiaries are automatically enrolled in Part B and must opt out to decline it, beneficiaries in Puerto Rico must take affirmative action to opt in to Part B coverage. As a result, we will finalize for CY 2026 an adjustment to the FFS rate calculation for Puerto Rico used to determine MA rates so that it is based only on the Medicare costs for beneficiaries with both Part A and Part B.

For CY 2026 we will continue to calculate FFS spending for the purpose of establishing MA benchmarks using FFS claims and utilization data for beneficiaries in Part A and/or Part B. We appreciate the suggestions submitted by commenters, and we will continue to analyze this issue and consider whether any adjustments to the methodology on this point may be warranted in future years.

Comment: Commenters were concerned with the proposal regarding the retirement of the Denominator file used in the tabulation of FFS experience. Commenters indicated that multiple adjustments will reduce the MA benchmarks below projected costs for MA enrollees and that the change in FFS enrollment tabulation methodology will adversely impact certain geographic areas. Commenters requested that CMS provide additional information on the expected impact of the change. Commenters also urged CMS to mitigate any impacts on the MA rates. One commenter requested CMS share the source of enrollment data underlying the 2023 legacy FFS costs.

Response: CMS appreciates the concerns raised by commenters. As discussed in past Rate Announcements,[6] given that MA county rates are based on FFS costs, we believe it is important to update the FFS per capita cost estimates using the most current FFS data available. Projected

[6] Please refer to previous Rate Announcements available at https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/announcements-and-documents.

average FFS per capita costs for the payment year for each area are the basis for MA rates, as required by the statute.

Published in conjunction with the CY 2026 Advance Notice are two files with 2023 ratebook experience. The first file reflects an approximation of experience using the legacy approach based on the "Denominator methodology." The second file includes experience from the proposed approach, in which beneficiary statuses are pulled directly from the Common Medicare Environment (CME). Stakeholders can use these two published datasets to assess the geographic impact of the CME approach to the tabulation of 2023 non-ESRD ratebook experience.

A description of the differences between the Denominator and CME approaches is on pages 30-31 of the CY 2026 Advance Notice. The key differences in the Denominator and CME approaches are as follows:

- There are two key changes in the determination of ratebook fee-for-service (FFS) enrollment:
    - The beneficiary county of residence in the Denominator system was determined annually as of March 1 of the following year. For example, the county of residence for CY 2022 experience was based on the beneficiary's county of residence as of March 1, 2023. Under the proposed CME approach, the county of residence is determined monthly. The Enrollment Database is the source for the beneficiary county of residence for both the Denominator and CME approaches.
    - ESRD status in the Denominator was determined annually as of March 1 of the following year based on the beneficiary's Medicare Status Code (MSC). Under the proposed CME approach, the beneficiary's ESRD status is determined monthly from the transplant and dialysis tables.
- The county of residence and ESRD status for Denominator claims is from claim records in the National Claims History (NCH) system. In the proposed CME approach, the beneficiary's county of residence and ESRD status for claims is based on the applicable values in the CME for the month of service.
- Enrollment and non-hospice claims for FFS beneficiaries in hospice status are included in the Denominator experience and excluded in the CME experience.

Table II-4 on page 31 of the CY 2026 Advance Notice illustrates the dollar impact of the update to tabulate ratebook FFS experience beginning in 2023. The corresponding impact of the revision on the non-ESRD USPCC trend is -0.06% for 2024, -0.07% for 2025, and -0.04% for 2026.

The enrollment for both the legacy and revised approach is derived from the same source, the Medicare Enrollment Database (EDB).

Comment: A commenter requested that CMS address how much of the $4.2 billion in suspended catheter claims was included in the non-ESRD 2023 FFS Part B USPCC published in the CY 2025 Rate Announcement.

Response: Experience supporting the 2023 non-ESRD USPCC reflected $2.5 billion in submitted urinary catheter claims in the CY 2025 Rate Announcement. An adjustment of -$1.8 billion was made to the 2023 USPCC published within the CY 2025 Rate Announcement; this adjustment was made to account for the suspension of payments for a portion of these claims. Likewise, this CY 2026 Rate Announcement reflects $3.5 billion in submitted urinary catheter claims for 2023, due to higher than anticipated fourth quarter claims submission for these services. The 2023 USPCC within this CY 2026 Rate Announcement includes a revised adjustment of -$3.5 billion to account for the suspended payment of claims, largely based on more complete financial reporting on CMS program integrity activities.

Comment: A few commenters urged CMS to incorporate changes to the Medicare wage index implemented in the FY 2024 IPPS into the CY 2026 county-level FFS costs. These commenters indicated that changes to the hospital wage index made between the proposed and final FY 2024 IPPS rule resulted in significant payment increases to hospitals in certain regions of Upstate New York and California that were not reflected in payments to plans, straining MA plans in those areas. The commenters recommended that CMS use its authority under section 1853(c)(6) and 1853(c)(2) of the Act to adopt an area-specific approach for correcting prior year rates, including those for CY 2025, for under- and over-projections of growth. A couple of these commenters also requested that CMS provide information in the Rate Announcement describing how CMS has addressed this concern and the impact of any adjustments on MA benchmarks, such as how changes made to the index as part of the IPPS are reflected in the proposed 2026 county-level FFS costs.

Additionally, a commenter suggested that CMS should consider the broader impact that wage index changes have had on hospital rural reclassification.

Response: CMS appreciates the concerns raised by commenters. As discussed in past Rate Announcements,[7] given that MA county rates are based on FFS costs, we believe it is important to update the FFS per capita cost estimates using the most current FFS data available at the time those values are announced and apply repricing adjustments to reflect changes in FFS payment rules. The CY 2026 USPCC projections reflect payment levels based on the most recent Medicare final rules for FY 2025 or CY 2025. Section 1853(b)(1) of the Act prescribes the timing of the release of the MA capitation rates for the contract year and the risk and other factors to be used in adjusting such rates.

[7] Please refer to previous Rate Announcements available at https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/announcements-and-documents.

As noted on page 30 of the CY 2026 Advance Notice, CMS released the 2023 FFS cost data by county used in the development of the CY 2026 ratebook. The data is published on the CMS website at https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics. With the Rate Announcement, CMS annually publishes a tool and corresponding glossary, *Medicare FFS County 20YY web.xlsm*, which provides stakeholders with means to replicate the FFS rate development, and publishes information regarding county-level geographic indices and repricing adjustments. Using this information, stakeholders are able to analyze the drivers of changes in FFS per capita costs for specific counties from one ratebook to another. CMS appreciates the concerns raised regarding potential impacts of wage index changes on hospital rural reclassification.

Puerto Rico

Comment: Commenters supported continuing the adjustment of the calculation of benchmarks in Puerto Rico using only claims data for beneficiaries enrolled in both Parts A and B, the adjustment to the FFS experience for beneficiaries enrolled in Puerto Rico to reflect the nationwide propensity of beneficiaries with zero claims, and expanded eligibility for double bonuses. A commenter stated that these adjustments remain necessary to help plans in Puerto Rico maintain benefits for the low-income populations they serve. Some commenters also stated that these adjustments produce a more accurate projection of FFS costs per capita in Puerto Rico.

However, stakeholders also recommended a number of additional proposals for calculating MA rates in Puerto Rico. Many commenters stated that they are concerned about the large disparity in payment rates between Puerto Rico and the U.S. mainland and requested additional increases to the Puerto Rico rates. Several commenters observed that MA rates in Puerto Rico are 39% lower than the national average and 21% lower than the MA rates in the U.S. Virgin Islands (USVI) due to differences in Medicare payment formulas, population, economic factors, and data sources. A commenter further asserted that payment in Puerto Rico does not adequately cover the costs of providing care in Puerto Rico relative to the U.S. mainland and could jeopardize MA plans' ability to provide services in Puerto Rico. One commenter asserted that, despite these disparities, Puerto Rico consistently outperforms the rest of the nation in health care quality outcomes.

Commenters requested that CMS make additional and continuous adjustments to MA payments in Puerto Rico to account for these dynamics and to achieve greater parity with FFS rates on the mainland. Some commenters supported the use of a proxy as a method to control payment rates. Commenters specifically recommended applying the AGA from a comparable geography, such as the USVI. Other commenters specifically asked CMS to establish a minimum AGA of 0.7 either as a national MA benchmark floor or specifically for Puerto Rico. Commenters recommended a minimum AGA of 0.7 because it would be a level similar to the current 0.70 AGA factor of the USVI. A few commenters suggested that CMS tether Puerto Rico rates to the national average AGA. Some commenters also recommended that CMS make an adjustment to

MA benchmarks in Puerto Rico to reflect the disproportionate representation of dually eligible beneficiaries in the Puerto Rico FFS population. Commenters made other suggestions including considering the Part B premium buy-downs in Dual Eligible Special Needs Plans (D-SNPs) to be part of A/B bids for Puerto Rico plans and adopting alternative methods for applying the quartile adjustment to reduce disparities caused by tying the adjustment to FFS spending at the county level.

Response: CMS thanks the commenters for their thoughtful comments. We appreciate the suggestions and recommendations submitted by commenters. However, we note that section 1853 of the Act prescribes the general approach that FFS per capita costs be used in developing MA rates and CMS has limited discretion to incorporate targeted adjustments or exceptions.

As noted in prior Advance Notices, the law requires that MA benchmarks be based on a county's average Medicare FFS per capita costs, and there is no evidence that FFS costs in Puerto Rico are higher than the costs observed in the FFS claims data and, thus, no basis for overhauling Puerto Rico's MA benchmarks. Section 1853(c)(1)(D) requires an estimate of the per capita costs for services covered under Parts A and B for individuals who are not enrolled in an MA plan. We believe that using data pertaining to actual Medicare FFS costs in Puerto Rico is the best approach to developing the estimate of FFS per capita costs for the contract year, and we have not seen evidence to suggest that Medicare FFS costs in another jurisdiction are a reliable proxy. As we stated in the CYs 2017 and 2018 Rate Announcements and based on the number of FFS beneficiaries used in development of the ratebook FFS rate, we have determined that the FFS data in Puerto Rico is sufficient for establishing accurate MA benchmarks. As noted on page 39 of the CY 2026 Advance Notice, the credibility adjustment is used for counties that have certain levels of FFS beneficiaries.

For the past nine years, the Secretary has directed OACT to adjust the FFS experience for beneficiaries in Puerto Rico to reflect the propensity of nationwide propensity of beneficiaries with zero claims. For the CY 2026 ratebook development, the Secretary has directed OACT to adjust the FFS experience for beneficiaries in Puerto Rico to reflect the nationwide propensity of beneficiaries with zero claims. For purposes of making this adjustment, consistent with the Secretary's instructions, OACT evaluated experience exclusively for beneficiaries that are enrolled in both Part A and Part B and are not also eligible for VA coverage.

The updated study analyzed experience for calendar years 2019 through 2023, using the cohort of FFS beneficiaries enrolled mid-year (i.e., enrolled in both Part A and Part B as of the mid-year dates used for the study) to approximate the average enrollment for the year. On average, 13.8 percent of Puerto Rico FFS beneficiaries with both Part A and Part B were found to have no Medicare claim reimbursements per year. This compares to a nationwide, non-territory proportion of 6.0 percent of FFS beneficiaries without Medicare spending. These results were applied to the Puerto Rico FFS experience by adjusting the weighting of the enrollment and risk scores for the zero-claim cohort to reflect the nationwide proportion of zero-claim beneficiaries.

The resulting impact was an average increase in the standardized FFS costs in Puerto Rico of 4.1 percent for 2019 through 2023. Accordingly, a 4.1 percent adjustment was applied to the pre-standardized Puerto Rico FFS rates supporting the CY 2026 ratebook development.

For future years, CMS plans to continue to evaluate the methodology for calculating rates for Puerto Rico plans to ensure the rates are based on the best estimates of Medicare FFS per capita costs in Puerto Rico and reassess the need for ongoing special adjustments.

Section E. Direct Graduate Medical Education

Maryland TCOC Model

See Comments and Responses in the section titled "Organ Acquisition Costs for Kidney Transplants."

Section F. Organ Acquisition Costs for Kidney Transplants

Maryland TCOC Model

Note: On March 12, 2025, CMS announced an earlier termination schedule for several Innovation Center models. CMS aims to conclude the Maryland Total Cost of Care, Primary Care First, ESRD Treatment Choices, and Making Care Primary models by December 31, 2025. The geographic adjustments for the five year historical experience period (2019-2023) used for CY 2026 ratebook development are unaffected by the earlier model terminations. Given the time constraints of the statutory announcement of the CY 2026 MA rates and the timing of the model termination announcement, we have not assessed whether the earlier model terminations would impact the assumptions used for USPCC projections for 2026 and thereafter. As such, we expect that any impacts on USPCC assumptions will be first incorporated in the CY 2027 Advance Notice.

Comment: Commenters expressed concerns with the Maryland TCOC Model DGME, IME, and KAC carve-outs, stating that the proposed KAC methodology will create added challenges for Maryland MA organizations already facing a suboptimal MA market. Commenters stated that sustaining the adjustment methodology for DGME and IME, as finalized in the CY 2025 Rate Announcement, and proceeding with the proposed KAC adjustment will continue to cause rate reductions for Maryland counties. A few commenters discussed the unique challenges faced by Maryland MA plans due to the interactions between the MA benchmark methodology and the Maryland TCOC Model, emphasizing the need to ensure that payment policies adequately reflect the expected costs of providing covered services.

Commenters highlighted that the adjustments particularly impact Baltimore City and Baltimore County, which have a higher-than-average number of low-income beneficiaries and individuals facing disparities in care and social risk factors related to income, education, and health status. Commenters indicated that for CY 2026, 22 out of Maryland's 24 counties are in the 95 percent

quartile (including Baltimore City and Baltimore County) and adjusting payments to plans downward relative to FFS will further exacerbate the already challenging financial environment for MA plans operating in Maryland.

Response: We appreciate the concerns raised by the commenters. The methodological change will result in more accurate projections of FFS per capita costs for Maryland, in order to adhere to the statutory requirements under sections 1851(i)(3), 1852(a)(1)(B)(i)-(iv), 1853(c)(1)(D)(i), 1853(k)(4)-(5), and 1853(n)(2)(F)-(G) of the Act. In the CY 2025 Rate Announcement, CMS finalized the methodology change for DGME and IME carve-outs to use data from the MAC and Maryland's Heath Services Cost Review Commission (HSCRC) for hospitals participating in the Maryland TCOC Model. The CY 2025 Advance Notice (page 41) stated that CMS would explore the use of KAC data provided by the MAC to the HSCRC to develop a KAC carve-out adjustment specifically for Maryland hospitals. However, this data was not available to be used for the CY 2025 and prior years' ratebook development. For the CY 2026 ratebook, CMS is finalizing the proposal to use KAC data provided by the MAC to the HSCRC to develop a KAC carve-out adjustment specifically for Maryland hospitals with a kidney transplant program. Even with these changes, MA rates in Maryland continue to be among the highest in the country compared to the average MA rates of other states.

Comment: Several commenters recommended CMS not finalize the proposed methodology change for 2026 and delay implementation or phase in the implementation of the KAC adjustment methodological change, to mitigate the impact on enrollees and allow health plans operating in Maryland additional time to analyze the impacts of this change, consider alternatives, and adjust to this additional revenue impact. Commenters stated that sufficient lead time to prepare for this type of change allows for better bid planning, thereby easing potential enrollee impact.

A commenter urged CMS to also discontinue the adjustments to the DGME and IME carve-outs to limit the disruption caused to an already suboptimal Maryland MA market.

Response: CMS is finalizing the methodology change for KAC carve-outs and will continue to use the methodology finalized in the CY 2025 Rate Announcement for the DGME and IME carve-outs, as proposed in the CY 2026 Advance Notice. The change in the data source and methodology for calculating the MA rates in Maryland will more accurately reflect FFS per capita costs and will result in developing more accurate estimates of the FFS per capita costs for the payment year that are the basis for MA rates as required by the statute. We estimate the preliminary impact of this change on MA rates in Maryland and neighboring states, based on last year's CY 2025 MA rates, to be relatively minor.

Section G. IME Phase Out

Maryland TCOC Model

See Comments and Responses in the section titled "Organ Acquisition Costs for Kidney Transplants."

Section H. MA ESRD Rates

Comment: The majority of commenters on this topic expressed concerns that ESRD rates are not sufficient to cover the cost of care for beneficiaries with ESRD. The commenters requested that CMS continue regular evaluations of ESRD rates to improve the adequacy and accuracy of MA ESRD benchmarks and payment, particularly given the increasing number of beneficiaries with ESRD in MA plans. A commenter requested that CMS share more information about its analysis of ESRD payments and costs. Commenters highlighted the potential consequences of inadequate rates, including impacts to all MA beneficiaries through increased premiums and cost-sharing, reduced benefits, and fewer plan options.

Response: CMS appreciates the comments regarding MA ESRD payment adequacy given the increased enrollment into MA plans by beneficiaries with ESRD. CMS continues to analyze these issues and consider whether, consistent with the statutory requirements for setting ESRD rates in section 1853(a)(1)(H) of the Act, any refinements to the methodology may be warranted in future years to ensure appropriate ESRD payment rates.

Comment: A majority of commenters on this topic expressed concern that the state-based rate-setting methodology results in rates that are inadequate to cover costs in certain markets. Many commenters stated that state-based rate setting masks within-state variations in ESRD costs and noted that expenditures for ESRD care in metropolitan areas can deviate from the state average, indicating the need for a more localized approach in setting payment rates. Commenters suggested CMS should continue to consider the use of smaller geographic areas as the basis for calculating MA ESRD benchmarks, and a few commenters stated CMS should provide more underlying data associated with the analysis of core-based statistical areas as an alternative to state-based payments. Commenters acknowledged that certain areas, such as rural and medically underserved areas, could receive lower rates under a new methodology and suggested CMS consider adjustments to these areas to ensure continued access to services.

Response: CMS appreciates the comments regarding ESRD rate setting and refers commenters to the analyses of sub-state ESRD rates provided in the CY 2023 and CY 2024 Advance Notices. In the CY 2024 Advance Notice, CMS provided details of our analysis of potential changes in ESRD rates by Core-Based Statistical Areas (CBSA), showing that CBSAs representing the 40 percent of enrollment with the 68 highest area deprivation index (ADI) measures were expected to receive CY 2022 ESRD rates that were an average of 2.13 percent lower under the CBSA-level approach. CMS believes our longstanding rate-setting approach is fair and reasonable, and CMS agrees with commenters that significant changes to the current methodology should be fully examined prior to implementation. CMS will continue taking into consideration commenters' concerns and recommendations.

Comment: Several commenters stated concerns that the Maximum Out-Of-Pocket (MOOP) limit is a factor contributing to underpayment for beneficiaries with ESRD. Commenters suggested that CMS update the MA benchmark to incorporate the difference between FFS Medicare out-of-pocket costs and the MA MOOP to support accurate payments for beneficiaries with ESRD.

Response: While CMS appreciates the suggestions of commenters, CMS does not find the suggestions to revise the ESRD rate-setting methodology to be consistent with our interpretation of section 1853 of the Act. As explained in the CY 2012 Advance Notice and CY 2012 Rate Announcement, CMS interprets the statutory changes made by the ACA to MA payment to indicate that all MA payment rates, including the separate rates of payment for ESRD enrollees, should closely align with FFS Medicare costs. As provided in section 1853(a)(1)(H) of the Act, CMS establishes separate rates of payment to MA organizations for ESRD beneficiaries enrolled in MA plans. See also §§ 422.254 and 422.304 through 422.308. The rates used for enrollees in dialysis or transplant status are based on statewide average FFS Medicare costs for ESRD beneficiaries in dialysis status. For enrollees with functioning graft status, the MA county benchmark rates are the payment rates. The rates for those in dialysis, transplant, and functioning graft status are also adjusted using a risk adjustment methodology that is specific to the health care costs for beneficiaries with ESRD in dialysis, transplant, or functioning graft status. CMS understands the concern about potential underpayment of ESRD costs leading to increases in costs for all MA enrollees, including those without ESRD; however, the data CMS uses to calculate the CY 2026 MOOP limits includes out-of-pocket expenses from beneficiaries with and without diagnoses of ESRD because the MOOP limits will apply to enrollees with and without diagnoses of ESRD in CY 2026. This practice avoids discriminating against beneficiaries with diagnoses of ESRD — or any group of beneficiaries with a particular high-cost condition or health status — that would result if there were higher premiums, cost sharing, or MOOP amounts applicable only to those individuals with a certain chronic condition. Additional detail on how CMS finalized MOOP limits calculations, including the data used and the percentiles of FFS Medicare data projections that should be used in those calculations is available in the final rule titled “Medicare Program; Maximum Out-of-Pocket (MOOP) Limits and Service Category Cost Sharing Standards” (CMS-4190-FC4) (87 FR 22290) published April 14, 2022.

Comment: A few commenters recommended CMS make changes to the Bid Pricing Tool (BPT) to reclassify the ESRD subsidy to be a Medicare-covered service rather than an A/B Mandatory Supplemental benefit. The commenters suggested that in the short term, CMS should make the ESRD and non-ESRD service categories consistent and merge the ESRD and MA BPT format, and in the long-term, CMS should eliminate the ESRD BPT filing altogether as CMS receives the same information through encounter, rebate, and MLR data.

Response: CMS appreciates the suggestions submitted by the commenters related to the BPT. Section 1853(a)(1)(H) of the Act requires the Secretary to establish “separate rates of payment” with respect to beneficiaries with ESRD enrolled in MA plans and does not require that a competitive bidding methodology be used for CMS capitation payments for ESRD enrollees. In

setting such separate rates, CMS has established an approach for paying MA organizations for enrollees with ESRD that directly use the rates, rather than bids. As such, the ESRD rates are intended to be the payment rate for Medicare-covered services for enrollees with ESRD, and the ESRD subsidy cannot be paid under the rates used in the bids to determine payment for non-ESRD beneficiaries. Therefore, the ESRD subsidy that is permitted in plan bids for non-ESRD beneficiaries will remain as a mandatory supplemental benefit. MA plans do not bid on ESRD beneficiaries. At this time, CMS does not find it necessary to require that MA plans submit a separate A/B bid for beneficiaries with ESRD. Regarding the commenters' request that CMS eliminate the ESRD BPT filing requirement, please refer to the final CY 2026 MA bid pricing tool instructions for more information, which will be released in spring 2025.

Section I. MA EGWPs

Comment: Several commenters expressed their support for EGWPs as an important healthcare option. A few commenters expressed support for the continuation of the current payment methodology for CY 2026, and most commenters expressed appreciation for the inclusion of the preliminary bid-to-benchmark ratios for EGWPs in the Advance Notice to facilitate more accurate benefit and premium information for employers and beneficiaries.

Response: CMS appreciates the support.

Comment: A commenter requested that CMS provide updated bid-to-benchmark ratios based on February enrollment data in advance of the Rate Announcement release to reduce operational pressures on MA plans with short windows for the negotiation and finalization of bids.

Response: CMS appreciates this recommendation. In response to feedback from the industry, CMS began publishing preliminary bid-to-benchmark ratios for EGWPs based on January enrollment data with the CY 2023 Advance Notice. Due to timing and operational constraints, CMS was unable to provide bid-to-benchmark ratios based on February enrollment data in advance of the release of the Rate Announcement.

Comment: Some commenters recommended CMS exclude negative margin plans from the calculation of estimated bid-to-benchmark ratios for EGWPs to avoid undermining the availability of supplemental benefits and limiting EGWPs' ability to expand.

Response: As CMS has stated in past Rate Announcements,[8] CMS does not believe that there is a reasonable rationale to exclude these plans from the calculation of the bid-to-benchmark ratios because the ratios are intended to be representative of the market. Negative margin plans are included in the non-EGWP market as well, so the bids of such plans are included when the bid-to-benchmark ratios are developed. CMS does adjust for factors which would otherwise result in

[8] Please see the CY 2025 Rate Announcement (https://www.cms.gov/files/document/2025-announcement.pdf), CY 2024 Rate Announcement (https://www.cms.gov/files/document/2024-announcement-pdf.pdf), and CY 2023 Rate Announcement (https://www.cms.gov/files/document/2023-announcement.pdf).

significant differences between the EGWP and non-EGWP market. More specifically, while the majority of plans in the EGWP market are PPO plans, the non-EGWP market is predominantly HMO plans. EGWP individual market bid-to-benchmark ratios are calculated separately for HMO and PPO plan types by quartile. Unlike the HMO/PPO difference between EGWPs and non-EGWPs, there is no data to suggest that a similar difference exists between EGWPs and non-EGWPs regarding negative margin plans upon which CMS can judge the reasonableness of adjusting the bid-to-benchmark ratios to account for negative margin plans.

Comment: A few commenters expressed support for the continuation of the policy permitting EGWPs to buy down Part B premiums.

Response: CMS appreciates the support.

Comment: A few commenters suggested adjusting current rate setting to capture differences in the use of HMO and PPO plans between the EGWP and non-EGWP markets. Commenters stated that it would be more accurate for CMS to segment the benchmark calculation by HMO and PPO products and adjust the bid-to-benchmark ratio for the differing products accordingly.

Response: CMS appreciates this suggestion; however, CMS is continuing to apply current methodology for paying EGWPs in CY 2026. Consistent with how CMS has developed EGWP payments since 2019, the CY 2026 EGWP payment methodology takes into account the prevalence of HMO and PPO enrollment in the EGWP market by calculating CY 2026 individual market bid-to-benchmark ratios separately for HMO and PPO plan types by quartile. CMS then takes into account the prevalence of HMO and PPO enrollment in the EGWP market to combine the ratios by quartile. This methodology is more consistent with the county rates for individual market plans, which are also not calculated separately for HMO and PPO plan types.

Comment: A few commenters encouraged facilitating greater access to EGWPs in rural markets. Commenters noted that implementing additional flexibilities around telehealth for provider network requirements could address factors that inhibit the formation of direct contract networks and enable more EGWPs to be offered in rural markets.

Response: CMS notes this comment is unrelated to our proposals in the CY 2026 Advance Notice. CMS interprets this comment to be an issue related to service areas and network adequacy considerations, rather than EGWP payment policy. Therefore, this comment is outside the scope of this document. Of note, to enable employers/unions to offer coordinated care plans to all their Medicare-eligible members wherever they reside, CMS has waived certain service area requirements for EGWPs; CMS encourages readers to review Chapter 9 of the Medicare Managed Care Manual for more information on EGWP waivers.

Comment: A few commenters stated that CMS should work with membership organizations such as the U.S. Chamber of Commerce to enable professional or group associations to pool membership to enroll in EGWPs.

Response: CMS notes that membership in EGWPs is outside the scope of this document.

Section J. CMS-HCC Risk Adjustment Model for CY 2026

Comment: Many commenters were generally supportive or neutral on finalizing the phase-in of the 2024 CMS-Hierarchical Condition Category (HCC) model, stating it improves payment accuracy and program integrity and helps address excess payments to MA organizations that have negatively affected taxpayers and beneficiaries. Additional examples of support included the following comments:

- Continued implementation of the revised model helps to reduce incentives for MA plans to code intensively.
- Belief that the model will improve risk adjustment across the industry and promote more responsible and equitable risk adjustment practices.
- A commenter noted that finalizing one model significantly reduces administrative burden for payers, providers, and CMS.
- Multiple commenters believe the model improves competition in the MA program so that plans compete on price and benefit design rather than coding.
- A commenter cited research suggesting that concerns the model will substantially cut benefits for beneficiaries and harm disadvantaged beneficiaries are unfounded. The commenter noted that the MA market has remained stable, and that enrollment and plan options, especially SNPs, have increased, and that MA organizations have rebate levels that are at record highs.

Response: We thank the commenters for their support. CMS is finalizing the phase-in of the 2024 CMS-HCC model as proposed in the CY 2026 Advance Notice such that 100 percent of the risk scores are calculated using the 2024 CMS-HCC risk adjustment model. We think that finalizing this model at 100 percent will improve payment accuracy and reduce burden for CMS and MA organizations.

Comment: Many commenters expressed concern with the 2024 CMS-HCC model, including concerns that organizations that serve beneficiaries with complex chronic conditions, dually eligible beneficiaries, and certain beneficiary populations, locations (e.g., Puerto Rico), and plan types are disproportionately impacted. Some commenters are concerned that the model has resulted in higher costs and/or reduced access to providers or benefits for beneficiaries, increasing disparities among MA organizations. Commenters believed there are decreases in zero premium plans and increased deductibles, arguing that these trends will remain or worsen with finalizing the phase-in of the model.

Response: Revisions to the CMS-HCC risk adjustment model improve payment accuracy, but as with every update of the risk adjustment model, the impact on each plan can vary, depending on the demographic and health characteristics of their enrollees. The CMS-HCC model is a national model, that captures average variation in costs between population subgroups. The goal of risk adjusted payments is to pay accurately using the appropriate relative risk across subgroups of beneficiaries.

Comment: Some commenters requested that CMS provide more transparency in model development through the publishing of white papers, establishing technical expert panels, and overall increasing engagement with stakeholders or additional time to review. A commenter requested that CMS provide at least 60-day notice for changes to the risk adjustment model. Another commenter recommended that any major risk adjustment model changes be finalized two years before implementation to allow time for plans and providers to make necessary operational changes.

Response: We acknowledge the commenters' request for additional transparency and an extended comment period when updates are made to the CMS-HCC risk adjustment model. Per section 1853(b)(2) of the Act, the Advance Notice of proposed changes to the methodology and assumptions used to determine annual MA capitation rates and the risk and other factors used in adjusting MA capitation rates under section 1853(a)(1)(C) is required to have a minimum 30-day comment period. The CY 2026 Advance Notice was released on January 10th, 2025, and comments were accepted through 11:59 PM Eastern Time on Friday February 10, 2025 (30 days). The only exception to this statutory minimum was another statutory requirement for a 60-day comment period, as first described in Part I of the CY 2019 Advance Notice,[9] that applied only to proposals to implement certain changes to the CMS-HCC model (based on section 1853(a)(1)(I) of the Act), in accordance with requirements in the 21st Century Cures Act (Pub.L. 114-255).

CMS is finalizing the full implementation of the 2024 CMS-HCC risk adjustment model, which is the expected continuation of the three-year phase-in first proposed in the CY 2024 Advance Notice. CMS provided the required 30-day period for comments on the CY 2026 Advance Notice. In setting these timelines, we seek to achieve multiple goals, including providing the statutory-required amount of time for public comment while also releasing the Advance Notice using more current data to calibrate the model and ensuring that the Rate Announcement is published by the statutory deadline. We provided the public with sufficient information to review the proposals since we informed the industry that the evaluation to reclassify the model was underway as far back as 2018, and we provided a number of resources to evaluate the updated model. In addition, the model updates are in line with typical model updates for which CMS has provided a similar or shorter comment period per the existing statutory requirement at the time. We will continue to consider additional ways in which we can engage with stakeholders as we

[9] See Part I of the CY 2019 Advance Notice.

consider future updates to the CMS-HCC risk adjustment model for future years and appreciate commenter input.

Comment: Commenters suggested several proposals for model revisions that they believe would improve the model, such as including additional sources of clinical and non-clinical data or removing data or conditions that they believe lead to more variation in coding between MA and FFS.

Response: We appreciate the extensive and thoughtful comments and feedback we received on improving the CMS-HCC risk adjustment model.

Comment: Many commenters recommended CMS either stop, delay, or lengthen the phase-in period of the 2024 CMS-HCC model to allow stakeholders more time to assess the impact of full implementation, with multiple commenters noting that pausing would allow the new administration additional time to evaluate the model.

Response: The three-year phase-in of the 2024 CMS-HCC risk adjustment model is consistent with how CMS has approached other instances in which model updates have been phased in over time (e.g., the 2014 model was phased in over three years and the 21st Century Cures Act model requirements were phased in over four years, with the final model adopted in the CY 2020 Rate Announcement and phased in over three years). We also note that MA organizations have had over a year of risk scores calculated under the 2024 CMS-HCC model, including CY 2024 and the initial risk scores in CY 2025. MA organizations that conduct analyses on the risk scores are already aware of the 2025 mid-year risk scores. Given this experience, we do not think it is necessary to further delay the full implementation of the updated model for the purpose of stakeholders gaining more experience. CMS appreciates the concerns raised by the commenters on the timeline for finalizing the implementation of the 2024 risk adjustment model. However, it is important to maintain or improve the accuracy of the risk adjustment model by updating it to reflect more recent relative costs, treatment and utilization patterns, and coding practices. We have previously noted that as a model ages and is used to predict expenditures for more recent enrollees in MA plans, that predictive accuracy begins to decline. Delaying the phase-in of a risk adjustment model that is based on more recent underlying data will prolong the use of an older risk adjustment model that, though still accurate according to CMS' measures (i.e., having a predictive ratio between 0.90 and 1.10), is waning in its ability to predict current costs. We also note that the 2024 CMS-HCC model changes are a combination of routine data updates (e.g., updating the years of data used when calibrating the model) and clinical updates to the HCCs that were required to develop a model using the ICD-10 diagnosis codes implemented in 2015 needed to keep MA payments up-to-date and to improve payment accuracy to MA plans. For CY 2026, 100 percent of the risk scores for MA plans and certain demonstrations will be calculated using the 2024 CMS-HCC model.

MA Risk Score Trend

Comment: Some commenters expressed concerns that the CY 2026 Advance Notice did not provide adequate transparency on the methodology, assumptions, and data used for developing the MA risk score trend. Several commenters do not believe CMS has released enough information for their organizations to adequately comment on the MA risk score trend. Commenters requested that CMS publish more information about how the MA risk score trend is calculated and detail of how the MA risk score trend is used by CMS.

Response: Each year, CMS releases a Fact Sheet that shows the year-to-year percentage change in payment associated with the proposed (in the Advance Notice) or finalized (in the Rate Announcement) policies. The Fact Sheet shows the overall average impact on MA revenue, as well as the average impact of key individual updates or policy proposals. As part of the impacts released in the Fact Sheet, CMS also estimates the average growth of MA risk scores in the payment year, known as the MA risk score trend. The MA risk score trend is the average increase in MA risk scores, not accounting for normalization and the MA coding pattern adjustment (which are included separately).

As discussed in the CY 2026 Advance Notice, CMS calculated the MA risk score trend by calculating the increase in MA risk scores over two prior years and then calculating the average annual year-over-year change. The two years of risk scores are calculated using the risk adjustment model to be used in the upcoming payment year. This average annual change is the MA risk score trend provided in the Advance Notice and Rate Announcement Fact Sheet. The trend is an industry average and individual plans' experience will vary.

Comment: Some commenters stated the belief that the MA risk score trend published by CMS does not accurately reflect the current state of the MA program. A few commenters are concerned that the use of two years of risk scores is not appropriate and relying on a single year-over-year data point is inadequate. The commenters stated that CMS should be consistent and continue to use the historical methodology of incorporating three years of data points to calculate the MA risk score trend. A commenter, noting that there is a two-year lag in the data years used to produce the MA risk score trend, believes CMS should consider an adjustment to the methodology to calculate the MA risk score trend reflecting current utilization trends which they cite as rapidly increasing across the market.

Response: CMS appreciates the commenters' concerns and recommendation regarding the approach to calculating the MA risk score trend as the average annual change in risk scores over two years, as opposed to over three years as historically done.

Historically, CMS has calculated the MA risk score trend using the three most recently available years of risk scores to measure the average annual change in MA risk scores. Since CY 2023, CMS has used 2018 through 2020 MA risk scores for this calculation, as these were the most recent three years of continuous data unaffected by the COVID-19 pandemic. However, CMS

recognizes that continued reliance on pre-pandemic risk scores would not adequately reflect current trends in MA risk scores and coding practices.

For CY 2026, CMS is using a two-year risk score trend calculation using 2022 and 2023 MA risk scores. This reflects the most recent post-pandemic data available and aligns with CMS' approach of ensuring that the MA risk score trend estimates are based on the most up-to-date information. CMS determined that 2021 risk scores, which reflect 2020 dates of service, were significantly affected by underutilization due to the pandemic as discussed in prior Rate Announcements, and therefore, including 2021 in the calculation would not provide a reasonable measure of typical risk score growth.

While CMS acknowledges that this approach differs from prior years, it remains consistent with the underlying methodology used historically to estimate the MA risk score trend. CMS anticipates returning to a three-year approach for CY 2027, when three years of post-pandemic MA risk scores will be available for trend estimation.

Risk Adjustment Model Development Using MA Encounter Data

Comment: Many commenters expressed a range of perspectives on a potential transition to an encounter data-based risk adjustment model. Some commenters, citing growing MA enrollment and their own investments in encounter data submission, supported the development of an encounter data-based risk adjustment model. Other commenters, including those neutral or open to the transition, emphasized the need for robust stakeholder engagement, transparency, and additional time before a model is proposed so that stakeholders can meaningfully provide feedback. Some commenters expressed concerns relating to data accuracy and completeness, operational challenges across plan types, and potential geographic disparities. Many commenters recommended a phased-in implementation, continued segmentation to reflect differences between FFS and MA populations, and further research on potential impacts to complex populations. Some commenters also noted the need for continued coding pattern adjustments, despite statutory constraints. A few requested a longer comment period, stating the belief the typical timeframe is insufficient for meaningful stakeholder input.

Response: CMS appreciates the thoughtful feedback, support, and concerns from stakeholders regarding the potential for an encounter data-based model for a future year. We acknowledge commenters' request for an extended comment period. CMS remains committed to evaluating these concerns carefully while we continue engaging with stakeholders as part of the model development process. We are committed to evaluating the feasibility, transparency, and timing of a future transition to an encounter data-based risk adjustment model, as we've done with previous risk adjustment model updates.

CMS-HCC Risk Adjustment Model for PACE Organizations for CY 2026

Comment: All commenters who commented on the risk adjustment model proposal for PACE organizations supported the phase out of the 2017 CMS-HCC model and phasing in of the model currently used for MA organizations (the 2024 CMS-HCC model). A couple of commenters were pleased that dementia would be recognized for PACE as CMS migrates to the 2024 CMS-HCC model.

Response: We thank the commenters for their support. For CY 2026, CMS will blend 10 percent of the risk score calculated using the 2024 CMS-HCC risk adjustment model with 90 percent of the risk score calculated using the 2017 CMS-HCC risk adjustment model.

Section K. ESRD Risk Adjustment Models for CY 2026

For Non-PACE Organizations

Comment: One commenter supported the continued use of the 2023 CMS-HCC ESRD models for CY 2026. The commenter also expressed concern that the model does not fully account for the higher costs of ESRD beneficiaries and requested that CMS take this into consideration for future updates, as well as providing at least 60 days to comment.

Response: We thank the commenter for their support. Payments for enrollees in dialysis or transplant status are calculated using the appropriate ESRD risk scores and a separate state-level ratebook; this separate ratebook comprises much higher rates than the county ratebook used in bidding. While the county ratebook is used for functioning graft enrollees, ESRD functioning graft risk scores, which are based on the non-ESRD model, are higher than risk scores for non-ESRD enrollees. Please see the CY 2023 Advance Notice and Rate Announcement for more information on the risk scores for dialysis and functioning graft enrollees.[10] For CY 2026, we will continue to calculate risk scores for payment of beneficiaries with ESRD in MA plans and certain demonstrations using the 2023 CMS-HCC ESRD risk adjustment models as proposed in the CY 2026 Advance Notice.

For PACE Organizations

CMS did not receive comments on the CMS-HCC ESRD risk adjustment models for PACE organizations for CY 2026. CMS will calculate blended risk scores for PACE participants with ESRD using a sum of 90 percent of the risk score calculated with the 2019 ESRD CMS-HCC models and 10 percent of the risk score calculated with the 2023 ESRD CMS-HCC models as proposed in the CY 2026 Advance Notice.

[10] Refer to CMS' CY 2023 Advance Notice and CY 2023 Rate Announcement.

Section L. Frailty Adjustment for PACE Organizations and FIDE SNPs

Frailty for FIDE SNPs

Comment: A few commenters supported the continued use of the 2024 CMS-HCC model frailty factors.

Response: CMS appreciates the support. As proposed, CMS will continue use of the 2024 CMS-HCC model frailty factors in CY 2026.

Comment: A commenter expressed support for CMS' CY 2025 methodology which considered all 2024 HOS-M respondents to be full-benefit dually eligible individuals and requested that CMS extend this methodology for CY 2026.

Response: CMS appreciates the comment. As required by the CY 2023 final rule (CMS-4192-F, 87 FR 27741) titled "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency," FIDE SNPs must have "exclusively aligned enrollment" beginning for contract year 2025, which means that enrollment in FIDE SNPs is limited to full-benefit dually eligible individuals beginning January 1, 2025. In the CY 2025 Advance Notice, we made clear that only for CY 2025, we would use the full Medicaid factors regardless of beneficiary dual status to calculate all frailty scores for FIDE SNPs; this policy decision was secondary to differences in the enrollment requirements for FIDE SNPs during the survey data collection period (CY 2024) and the calendar year in which frailty adjustments would be made (CY 2025). For CY 2026, CMS will rely on the data as submitted on the State Medicare Modernization Act (MMA) files, the Point of Sale data, and the Commonwealth of Puerto Rico monthly Medicaid file to determine the dual status of a beneficiary for frailty score calculation as has been done historically, with the exception of CY 2025. As noted in the CY 2025 Advance Notice, we anticipate that all 2025 enrollees considered for survey collection used for Activities of Daily Living (ADL) assessment for calculating CY 2026 frailty scores will be reported as full-benefit dually eligible individuals in compliance with 42 CFR § 422.2. As such, CMS anticipates that the CY 2026 frailty scores will exclusively use the full Medicaid factors, consistent with the outcome of the approach used for CY 2025.

MA organizations that are planning to sponsor a FIDE SNP and wish to be considered for frailty payments in CY 2026 must contract with a CMS-approved survey vendor to field the 2025 HOS or HOS-M at the PBP level so that the necessary information to calculate a frailty adjustment for the FIDE SNP's risk scores is available, as described in the January 17, 2025, HPMS memorandum, "Participation in 2025 HOS/HOS-M for MA Organizations Planning to Sponsor FIDE SNPs in 2026 – Notification of Upcoming Release of the HPMS HOS/HOS-M Survey Participation Module for Frailty Consideration." For FIDE SNPs, CMS uses plan-level ADL

information obtained from the HOS or HOS-M in one year to calculate frailty scores for the following year by applying the frailty factors that correspond to the ADL information gathered from the HOS or HOS-M data.

Comment: Commenters expressed concerns regarding a number of aspects of frailty adjustment they believe result in underpayment for beneficiaries with the highest need including general concerns about the decline in frailty scores, the disproportionate impacts of lower frailty scores on vulnerable and high-need populations (e.g., dually eligible enrollees) due to payment decreases, concerns about low response rates and HOS/HOS-M survey administration. These commenters made a variety of recommendations, including:

- *Survey protocol modifications.* One commenter recommended modifications to the current survey protocol such as CMS allowing FIDE SNPs to survey only enrollees who are at a nursing home level of care so that the level of frailty of enrollees being surveyed are on par with PACE participants.
- *Application to expanded beneficiaries.* One commenter requested that CMS apply the frailty adjustment to D-SNP enrollees in Puerto Rico.
- *Monitoring and evaluation*. Another commenter requested CMS continue to monitor payment to FIDE SNPs to assess the impact that reduced frailty factors will have on dually eligible enrollees and any impact this may have on risk adjusted payments and access to benefits.
- *Collaboration with stakeholders.* A commenter requested that CMS collaborate with stakeholders on additional approaches to better measure frailty as well as how the HOS and HOS-M surveys are applied.

Response: CMS acknowledges the concerns regarding several aspects of the frailty payment process. The HOS and HOS-M surveys are sufficient for a frailty adjustment to payment at the plan level because ADL data are collected to calculate frailty scores in the same manner that data are collected and used to calculate frailty factors for model calibration (i.e., limitations in activities of daily living collected from self-reported surveys). In addition, data are collected consistently across respondents, such that frailty scores are calculated using data collected in the same manner across plans, thereby allowing survey results to be compared across plans and relative to PACE (a requirement for determining whether FIDE SNPs receive a frailty adjustment in payment) and thus resulting in frailty payments that are comparable.

Regarding the requests to apply the frailty adjustment to certain populations, CMS is only authorized by statute to apply frailty adjustment to payments to PACE organizations and is permitted to apply frailty to the payments to certain FIDE SNPs. CMS has explored ways of incorporating frailty into the risk adjustment model in order to account for frailty when making risk adjusted payments to all plans and found challenges with a number of approaches. We also note that, because the frailty factors are calculated using the residual of the CMS-HCC risk adjustment model (the difference between the predicted expenditure amounts and the actual

expenditure amounts), and frailty scores have an average value of zero, the application of a frailty adjustment to all MA plans would result in many plans receiving a negative frailty adjustment.

As noted in the CY 2026 Advance Notice, CMS is continuing to evaluate the underlying patterns driving the changes in the 2024 CMS-HCC model frailty factors and welcomes feedback on improving the HOS/HOS-M survey administration process.

Frailty for PACE Organizations

Comment: A commenter expressed support for the proposal to blend the frailty factors associated with the 2017 CMS-HCC model and 2024 CMS-HCC model to calculate frailty scores for PACE organizations for CY 2026 payment.

Response: CMS appreciates the support. CMS is finalizing the proposed blend of frailty factors associated with the 2017 CMS-HCC model at 90 percent and 2024 CMS-HCC model at 10 percent to calculate frailty scores for CY 2026 for PACE organizations.

Comment: A few commenters expressed concern about the transition of PACE from the 2017 CMS-HCC model to the 2024 CMS-HCC model and suggested CMS maintain frailty factors associated with the 2017 CMS-HCC model for 5 or more ADLs to ensure PACE receives adequate funding to support its most complex and frail participants.

Response: The transition of PACE organizations to the CMS-HCC risk adjustment model used for MA payment will take place over multiple years. CMS has laid out a tentative schedule that would fully transition PACE organizations to the model used for MA organizations and its associated frailty factors over four years, as described in the CY 2026 Advance Notice. For CY 2026, CMS will calculate risk scores using a blend of 90 percent of the risk score calculated using the 2017 CMS-HCC model and 10 percent of the risk scores calculated using the 2024 CMS-HCC model. Consequently, CMS will also use a corresponding blend of the frailty factors associated with the 2017 CMS-HCC model and 2024 CMS-HCC model to calculate frailty scores for PACE organizations for CY 2026 payment.

Comment: A few commenters raised concerns that the frailty factors associated with the 2024 CMS-HCC model do not adequately reflect the frequency and severity of dementia. Commenters expressed concerns with using the HOS-M survey to estimate frailty because of low response rates (especially amongst those with dementia), and that reliance on the HOS-M for frailty adjustment does not consider the challenges faced by people with dementia in completing the survey. Commenters suggested that CMS allow PACE organizations to serve as proxies that can complete the survey on behalf of those with dementia, providing a more accurate reflection of the PACE participant's ADL status.

Response: Because the CMS-HCC risk adjustment model predicts total expenditures for Part A and Part B benefits, for beneficiaries with conditions such as dementia that are not directly incorporated in the 2017 CMS-HCC model, the associated costs can be predicted by comorbid conditions and demographic factors that are included in the model. To the extent that these costs are not predicted by the model, they are likely to be reflected in the frailty factors. CMS estimates frailty factors to explain additional costs not explained by diagnoses in the CMS-HCC model used to calculate risk adjusted payments for the organization in the payment year. CMS calibrates the frailty factors by regressing the residual, or unexplained, costs from the CMS-HCC risk adjustment model, onto counts of ADLs. Although total costs are included in the calibration of the 2017 CMS-HCC risk adjustment model, and the associated frailty factors help predict overall costs where diagnoses are not fully predictive, results for individual organizations may differ due to differences between the sample used for model calibration and the populations enrolled in individual plan.

CMS acknowledges the concerns related to the response rates for the HOS-M for PACE participants, particularly among participants with dementia. The responses from this survey are used to determine limitations in ADLs that are accounted for in the calculation of a PACE contract's frailty score. We collect survey data in a consistent manner for all PACE organizations, as this helps to ensure equitable frailty results for payment. In addition, ADL data are collected to calculate frailty scores in the same manner that these data are collected and used to calculate frailty factors for model calibration (i.e., limitations in activities of daily living collected from self-reported surveys). Permitting variation in how the survey is administered for participants with specific conditions may disproportionately affect frailty scores for certain organizations, depending on what proportion of an organization's participants have that condition and which organizations provide the assistance.

There are existing proxy allowances in the survey administration protocol. For the HOS-M survey, a proxy response is at the discretion of the PACE participant, but PACE staff may inform the family member or caregiver of their right to request a proxy if participants with dementia need assistance completing the survey.

Section M. MA Coding Pattern Difference Adjustment

Comment: Several commenters supported CMS' proposed 5.9 percent MA coding pattern adjustment factor for CY 2026.

Response: CMS appreciates the support of the commenters. CMS is finalizing the proposed MA coding pattern adjustment factor of 5.9 percent for CY 2026.

Comment: Several commenters opposed CMS' proposed 5.9 percent MA coding pattern adjustment factor for CY 2026 and provided alternative recommendations to the statutory minimum adjustment factor of 5.9 percent, as summarized below:

Higher Adjustment Factor:

Several commenters recommended a higher adjustment factor than the statutory minimum. These commenters expressed concern that the statutory minimum does not account for the full impact of coding pattern differences between MA and FFS, and a few commenters highlighted analyses from MedPAC that the MA coding pattern adjustment factor should be several percentage points higher. A few commenters who recommended a higher adjustment factor expressed concern that the current application of the minimum adjustment and the HCC-based risk adjustment model incentivize plan sponsors to code their enrollees with as many conditions as possible, driving up payments.

Specific Methodological Recommendations:

- Targeted Approaches: Several commenters requested that CMS consider an approach that addresses variation in coding by targeting plans with higher coding intensity.
    - General comments supporting targeted approaches. Several commenters expressed concern that there is wide variety in coding patterns across the industry and applying an across-the-board MA coding pattern adjustment factor fails to recognize differences across plans which could result in an inequitable outcome. A few commenters recommended targeted approaches, aimed at plans that tend to code more intensely. This was based on their concern that certain MA organizations code much more aggressively than others, with higher levels of coding intensity due to various structural payment incentives, including payments between MA organizations and their contracted providers.
    - Segmented/tiered approach. Several commenters suggested that CMS consider a segmented or tiered approach to estimating the MA coding pattern adjustment factor that recognizes different levels of coding patterns among organizations such that the lowest factor is applied to lower coding organizations while the highest factor is applied to higher coding organizations. The commenters believe that a tiered approach could ensure the MA coding pattern adjustment accounts for differences in coding patterns without negatively affecting plans that adhere to proper coding guidelines.
    - Contract-specific approach. A few commenters recommended tailoring the MA coding pattern adjustment factor to the relative level of coding intensity seen in individual MA contracts – rather than the across-the-board adjustment that CMS applies today to all MA contracts.
    - One commenter stated their belief that the 2024 CMS-HCC model reduced coding differences by eliminating or constraining certain HCCs but deemed it inadequate to fully address growing MA coding intensity. One commenter recommended a

multipronged approach to addressing coding pattern differences between MA and FFS. Their recommendation included three parts: 1) develop a risk adjustment model that uses two years of FFS and MA diagnostic data; 2) exclude diagnoses that are documented only on health risk assessments from either FFS or MA; and then 3) apply an MA coding pattern adjustment factor that fully accounts for the remaining differences in coding between FFS Medicare and MA plans.

Response: We appreciate commenters' feedback. Section 1853(a)(1)(C)(ii) of the Act establishes a minimum MA coding pattern adjustment, which was originally adopted beginning with 2014 payment. The current statutory minimum coding pattern adjustment is 5.9 percent. In accordance with statute, CMS analyzes coding pattern differences and determines what the coding pattern adjustment factor should be on an annual basis. Based on our analysis, we have found that for CY 2026, the minimum adjustment, applied uniformly is sufficient to reflect differences in coding patterns between MA plans and providers under FFS Parts A and B. Therefore, we are finalizing our proposed MA coding pattern adjustment factor for CY 2026.

We appreciate the comprehensive and thoughtful comments and feedback we received on this proposal. Ensuring that the coding pattern adjustment policy appropriately addresses differences in coding patterns between the FFS program and MA is essential, and we will consider these recommendations in the development of future proposals regarding the coding pattern adjustment.

Comment: One commenter requested sufficient time and information to comment on any potential changes to the MA coding pattern adjustment in the future.

Response: CMS appreciates the comment. Section 1853(b)(2) of the Act requires that CMS provide notice of proposed changes in the methodology and assumptions for setting MA capitation rates and risk and other factors used to adjust the capitation payments, with a comment period of at least 30 days to comment on the proposed changes. We will continue to consider additional ways in which we can engage with stakeholders should we consider changes to the MA coding pattern adjustment.

Comment: A couple of commenters provided suggestions for what they referred to as "over-coding" or "upcoding." One commenter suggested that CMS target RADV audits on health plans with significant variation from industry or regional risk score averages. Another commenter recommended that CMS exclude the use of diagnoses from chart reviews and health risk assessments for risk adjustment.

Response: We appreciate the suggestions and are regularly evaluating ways to improve the accuracy of the data we receive and the payments that we make. With respect to the commenters' suggestion regarding over-coding , it is important to note that the coding pattern adjustment is not an adjustment for inaccurate or fraudulent coding, but rather is a program-wide adjustment designed to account for the impact on MA risk scores of the differential coding patterns between

MA and FFS, whereas the primary goal of RADV audits is to address improper payments to MA organizations. The coding pattern difference adjustment does not absolve MA organizations of the longstanding obligation to ensure compliance with risk adjustment requirements.

CMS has issued guidance regarding the longstanding requirements regarding the accuracy of risk adjustment data submitted to CMS, including the April 15, 2022, HPMS memorandum, "Reminder of Existing Obligation to Submit Accurate Risk Adjustment Data." All diagnoses submitted for risk adjustment must meet CMS requirements that diagnoses are documented in the medical record as a result of a face-to-face visit and coded in accordance with the International Classification of Diseases, Clinical Modification (ICD-CM) guidelines for coding and reporting,[11] which apply equally to diagnoses resulting from health risk assessments and chart reviews. In addition, organizations that submit risk adjustment data are required to certify as a condition of receiving monthly payment that the data submitted under 42 CFR 422.310 are accurate, complete, and truthful based on best knowledge, information, and belief (*see* 42 CFR 422.504(l)). And if an organization receives information about inaccurate diagnoses, the organization must correct its data. The Part C/D Overpayment Rule, 42 CFR 422.326, implements the overpayment requirements of section 1128J(d) of the Act and "establishes that, if a Medicare Advantage insurer has received a payment increment for a beneficiary's diagnosis and discovers that there is no basis for that payment in the underlying medical records, that is an overpayment that the insurer must correct by reporting it to CMS within sixty days for refund." *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867, 869, 870 (D.C. Cir. 2021) (upholding relevant portions of the C/D Overpayment Rule).

We also appreciate the commenter's suggestion that CMS exclude the use of diagnoses from chart reviews and health risk assessments for risk adjustment and will consider this and other suggestions as we evaluate risk adjustment changes in the future.

Comment: A few commenters requested confirmation that CMS conducted the annual analysis of coding pattern differences and requested release of analyses with all underlying data.

Response: Section 1853(a)(1)(C)(ii) of the Act requires the Secretary to "annually conduct an analysis of the differences" ". . . in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences" and to reflect such analysis in the risk scores. Further, the statute provides for a minimum coding pattern difference adjustment factor of 5.9 percent for 2019 and each year after. As required by the Act, CMS conducted the annual analysis of the differences in coding patterns between MA and FFS for CY 2026 and assessed the impact of these differences in coding patterns on MA risk scores. In accordance with section 1853(b)(1) of the Act, in the CY 2026 Advance Notice, CMS provided notice of proposed changes to the methodology used to calculate the risk and other factors used in adjusting rates, and we included an explanation of the changes being proposed in

[11] Medicare Managed Care Manual Chapter 7 – Risk Adjustment, Section 120.

the methodology for CY 2026 relative to CY 2025. With the statute in mind, CMS considers each year what information to provide as part of our proposals, and because no changes to the MA coding pattern adjustment were proposed for CY 2026, the underlying data and analyses were not provided.

Section N. Normalization Factors for the CMS-HCC Risk Adjustment Models

Comment: A few commenters expressed support for the methodology as proposed. A commenter believed that the proposed methodology better captures more recent demographic changes in the Medicare population. Another stated that the proposed regression factors fit actual FFS risk scores reasonably well, including for post-COVID years.

Response: CMS appreciates the support of the commenters. CMS is finalizing the methodology for the normalization factors for the CMS-HCC and CMS-HCC ESRD risk adjustment models as proposed using the multiple linear regression methodology and 2020 to 2024 average FFS risk scores.

Comment: Many commenters were opposed to the multiple linear regression methodology that CMS proposed to continue using for CMS-HCC models. Some commenters supported using a multiple linear regression method in general but suggested alternative methods such as using different years of data in the trend or applying the COVID flag to different years. Many alternative methods were suggested by commenters including other regression methods and the method CMS historically used to calculate normalization factors for the CMS-HCC models prior to CY 2025. Most of these commenters believed the Part C normalization factors proposed for CY 2026 are overstated because they put too much weight on the rebound in risk scores from 2021 to 2022. These commenters pointed out that alternative methods would result in lower normalization factors than the current proposed method.

Response: CMS thanks the commenters for their feedback and for suggestions for alternative approaches to calculating the normalization factors. By using a multiple linear regression methodology, we can most appropriately take into account the significant change in the risk scores observed at the onset of the COVID-19 pandemic when risk scores dropped significantly due to atypically low utilization. This methodology enables CMS to incorporate the most recent years of data in the FFS risk score trend in order to reflect current risk and to project a risk score that best estimates the average FFS risk score in the payment year given the currently available data. We believe that the proposed multiple regression approach is reasonable given the variability in the observed data and the uncertainty inherent in any forecast.

As stated above, CMS received a significant number of alternative recommendations from commenters about how to calculate Part C normalization factors. There was not an industry-wide consensus; the recommended alternatives were varied, sometimes conflicting, and produced different normalization factors with varying degrees of magnitude. Alternative methods suggested by commenters resulted in normalization factors that ranged from 4 percent higher

than CMS' proposal to 7.4 percent lower. The range of normalization factors derived from these alternative methods illustrate the inherent uncertainty when predicting future trends. CMS does not believe these alternatives are more reasonable estimates of the average 2026 FFS risk score.

CMS is finalizing the proposed normalization factors that were developed using the multiple linear regression methodology that accounts for the different trends in the FFS risk scores between the pre-COVID-19 period and the period during and after by including a COVID-19 indicator for time periods before and after the onset of the COVID-19 pandemic in the regression. This COVID-19 indicator accounts for the distinct difference in the level and year-over-year change in the average FFS risk score between the pre- and post-COVID-19 periods in a way that does not necessitate the need to exclude any years of data. The COVID-19 indicator itself is a categorical and binary variable that identifies in the regression whether an average FFS risk score is based on dates of service before or after the onset of the COVID-19 pandemic. Many commenters based their recommendations on the assumption that the post-COVID-19 trend will return to pre-COVID-19 levels. CMS does not think there is sufficient post-COVID-19 FFS risk score data to support this assumption. The most recent data suggests the FFS risk score trend remains elevated. CMS believes the use of a categorical variable provides valuable transparency in that it is a clear and replicable approach for accounting for the impact of the COVID-19 pandemic in the regression and relies on basic information without the need to make inferences about the impact of certain years in the historical data on future trends. While CMS is finalizing the normalization factors for MA and PACE developed using the multiple linear regression methodology as proposed in the CY 2026 Advance Notice, we will continue to assess trends and the appropriateness of alternate methods for future years.

Comment: A commenter stated that their plan experienced a disparate impact during the COVID-19 pandemic compared to others due to their unique population. The commenter recommended that CMS consider the disparate impact of normalization changes and provide stakeholders, especially smaller insurers, additional analyses of the impacts and additional time for consideration of the changes being proposed.

Response: We appreciate the request. While CMS acknowledges that individual plan experience and capabilities differ in important ways, the normalization factor is a technical adjustment that accounts for the FFS risk score trend between the denominator year of a model and the payment year. The average FFS risk score changes each year due to an underlying trend that reflects changes in the health status, demographic characteristics, and coding practices in the Medicare FFS population. CMS applies a normalization factor to risk scores in the payment year to account for this trend in the average FFS risk score between the denominator year and the payment year. CMS must predict an average FFS risk score that is a reasonably accurate projection of the FFS risk score in the payment year to maintain an average FFS risk score of 1.0 across the entire FFS population. An appropriate prediction is essential for payment accuracy program wide. Maintaining an appropriate normalization methodology helps to ensure payment stability as routine and necessary updates to the risk adjustment models are made over time. For

these reasons, CMS continues to believe that a uniform normalization factor is the best approach for achieving the goal of this technical adjustment to risk scores, which, as stated previously, is to account for the trend in FFS risk scores between the denominator year and the payment year.

Per section 1853(b)(2) of the Act, the Advance Notice of proposed changes to the methodology and assumptions used to determine annual MA capitation rates and the risk and other factors used in adjusting MA capitation rates under section 1853(a)(1)(C) is required to have a minimum 30-day comment period. The CY 2026 Advance Notice was released on January 10th, 2025, and comments were accepted through 11:59 PM Eastern Time on Friday, February 10, 2025 (30 days). CMS provided the required 30-day period for comments on the CY 2026 Advance Notice. In setting these timelines, we seek to achieve multiple goals, including providing the statutory-required amount of time for public comment while also releasing the Advance Notice using more current data and ensuring that the Rate Announcement is published by the statutory deadline. We note that CMS proposed to continue using the multiple linear regression methodology that was first implemented for CY 2025 but using the most recent five years of FFS risk scores available. Additionally, we provided the public with sufficient information to review the proposal, including the publication of the average FFS risk scores used to calculate the normalization factors in the CY 2026 Advance Notice and the public availability of model software[12] that can be used by plans to assess the impact of a policy change such as this on their risk scores.

Section O. Sources of Diagnoses for Risk Score Calculation for CY 2026

Non-PACE Organizations

CMS did not receive comments regarding sources of diagnoses for non-PACE organizations for CY 2026.

CMS will continue the policy as proposed in the CY 2026 Advance Notice, first 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.

PACE Organizations

Comment: Among commenters who addressed our PACE proposal, all applauded CMS' commitment to work closely with PACE organizations as they transition to submitting complete encounter data. Some of these commenters requested that CMS recognize the operational and administrative challenges faced by PACE organizations with encounter data reporting and to provide ample support and guidance to make this transition as straightforward as possible.

Response: CMS thanks the commenters for supporting the transition to submitting all risk adjustment data to the encounter data system (EDS). As proposed, for CY 2026 CMS will

[12] https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/risk-adjustment.

calculate risk scores for PACE organizations using 10 percent of the risk score calculated using diagnoses from encounter data and FFS claims only (under the 2024 CMS-HCC model and the 2023 CMS-HCC ESRD models) and 90 percent of the risk score calculated using diagnoses from RAPS, encounter data, and FFS claims (under the 2017 CMS-HCC model and the 2019 CMS-HCC ESRD models.

PACE organizations should continue following the instructions for submitting risk adjustment data to the EDS.[13] These submission instructions balance the priority to move PACE submissions to the EDS while allowing for a simpler submission for diagnoses from PACE center services during the transition. As we have previously stated, we cannot fully move PACE to the updated CMS-HCC risk adjustment model until all diagnoses are submitted to the EDS. Although CMS has laid out a transition schedule to move PACE organizations from submissions to RAPS to fully submitting their diagnostic data to the EDS, we reiterate that PACE organizations can stop submitting data to RAPS as soon as they submit fulsome diagnostic data to the EDS, regardless of the transition schedule that CMS follows. Essentially, if PACE organizations are able to improve their submissions to the EDS, then the transition can be accomplished more quickly. By submitting fulsome data to the EDS and stopping submissions to RAPS, PACE organizations will simplify their submission process and reduce their submission burden. Further, a shorter transition period will move PACE organizations to the new CMS-HCC risk adjustment model faster.

CMS acknowledges the operational challenges and capacity limitations associated with moving to the EDS for some PACE organizations. CMS is committed to working closely with PACE organizations and continuing to provide technical assistance and guidance to support the successful submission of the necessary data. In furthering this work, between the release of the CY 2026 Advance Notice and this CY 2026 Rate Announcement, CMS released a dedicated webpage for PACE organizations on the Customer Service and Support Center (CSSC) website.[14] This new webpage provides technical resources to support PACE organizations' submission of encounter data and serves as a central resource for information on HPMS memos and announcements, technical guides, and other relevant resources to assist PACE organizations with the submission of risk adjustment data to the EDS. CMS plans to continue updating the webpage to include additional resources as they become available. We encourage all PACE organizations to visit the CSSC webpage to familiarize themselves with the resources provided and to continue monitoring the page for updates. CMS will continue to provide technical support and to monitor and discuss successes and challenges PACE organizations have experienced with submitting encounter data.

[13] See: https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-5-january-29-31.

[14] CSSC Operations - Encounter Data Submission Resources for PACE Organizations.

Comment: Commenters offered differing views regarding the transition timeline. A few commenters encouraged CMS to continue being patient and cautiously optimistic as PACE organizations progress through the entire proposed four-year transition period and requested that CMS consider the operational challenges that PACE organizations face. A commenter was supportive of the tentative four-year transition while another commenter believed the proposed four-year transition period to be lengthy and would result in longer operational disruption and increased costs to the organization, suggesting for CMS to closely monitor first year transitions by PACE organizations, and if the first year of transition is smooth, to accelerate the transition.

Response: CMS appreciates both the support, and the concerns raised, by the commenters on the timeline for the transition to the 2024 CMS-HCC risk adjustment model over time. CMS is finalizing the proposal in the CY 2026 Advance Notice to calculate 10 percent of the risk scores for PACE using the 2024 CMS-HCC model and will continue to provide guidance and assistance to support this transition.

Attachment IV. Responses to Public Comments on Part D Payment Policy

Section A. Annual Adjustments to Medicare Part D Benefit Parameters in 2026

No in-scope comments received.

Section B. Part D Premium Stabilization

Comment: A commenter asked that CMS release information related to the BBP calculation earlier in the bidding process. The commenter stated that greater visibility into BBP projections ahead of bid submission would be highly beneficial, given the complexity of Part D bid submissions and the need to balance plan design, affordability, and financial sustainability. The commenter also recommended that CMS consider providing illustrative scenarios to guide plan sponsors in their forecasting efforts.

Response: CMS thanks the commenter for their input. Because the BBP is calculated based on the NAMBA, CMS is not able to provide the BBP calculation prior to bid submission.

Section C. Part D Calendar Year EGWP Prospective Reinsurance Amount

Comment: A commenter supported the continued use of prospective reinsurance payments for EGWPs and the continued use of the CY 2025 methodology for CY 2026.

Response: CMS appreciates the support.

Section D. Part D Risk Sharing

Comment: Several commenters agreed with CMS' assessment that risk in the Part D program varies widely and supported CMS' proposal not to widen the risk corridors.

Response: CMS thanks the commenters for their support.

Comment: Several commenters requested that CMS announce before the bid submission deadline, ideally with the CY 2026 Rate Announcement, the premium stabilization and risk corridor parameters for CY 2026 under the voluntary demonstration program for standalone PDPs announced by CMS in July 2024.

Response: CMS thanks the commenters for their input. Without first receiving and analyzing bids submitted for CY 2026, CMS cannot assess the need for, or effectiveness of, the elements of the demonstration in achieving the goals of the demonstration and whether market conditions suggest that Part D sponsors have adequate data on the Part D market following implementation of the Part D benefit changes under the IRA to have stable actuarial information on which to base their PDP bids in the absence of additional premium stabilization. Without such information, CMS would not be able to determine either the need or the appropriate parameters for each element of the demonstration for CY 2026.

It is important to note that since changes to the Part D benefit will be relatively modest in 2026, and PDPs will have some experience with the 2025 changes that will help inform their 2026 bids, CMS anticipates that the factors contributing to the design and magnitude of the CY 2025 demonstration parameters will be significantly mitigated for CY 2026. CMS will take these factors into account in determining the appropriate level of premium stabilization and/or narrowed risk corridors for participating PDPs in CY 2026 if necessary to continue to stabilize premiums. We also remind Part D plan sponsors that, under the statute per section 1860D–11 of the Act, the Secretary has the authority to negotiate the terms and conditions of proposed bids and does not have to accept any or every Part D bid submitted.

Therefore, consistent with the terms of the demonstration as announced in July 2024, CMS will announce any additional premium stabilization and the risk corridors for participating PDPs for CY 2026 no later than the annual release of the NAMBA, Part D BBP, and related Part D bid information in the summer of 2025.

Section E. Retiree Drug Subsidy Amount

No comments received.

Section F. RxHCC Risk Adjustment Model

Comment: Several commenters expressed support for updating the RxHCC models to account for changes in the Part D standard benefit design for CY 2026. Some commenters specifically expressed support for reflecting maximum fair prices (MFPs) under the Medicare Drug Price Negotiation Program in the model calibration. A commenter said that MFPs are a known amount for the 2026 plan year, and that a model that does not account for the MFPs would create an adverse incentive for plans to prefer members using selected drugs over those with conditions

not using these drugs. Another commenter agreed that incorporating MFPs would ensure accuracy of the model but encouraged CMS to blend this model with the CY 2025 RxHCC model to limit volatility of risk score changes.

Response: CMS thanks the commenters for their support and, for CY 2026, is finalizing the updates that reflect the CY 2026 Part D benefit, including MFPs, for both RxHCC models (i.e., the model being implemented for non-PACE organizations and the model being implemented solely for PACE organizations), as proposed. We agree that if the models did not use the agreed-upon MFPs, inaccurate estimates of relative plan liability for CY 2026 would likely result. We believe that a phase-in of the proposed updated RxHCC risk adjustment models would not be appropriate because the payments to Part D sponsors in CY 2026 would less accurately reflect the expected changes in relative plan costs under the 2026 Part D benefit design.

Comment: Nearly all commenters who commented specifically on the proposal to update the underlying data used in the model for non-PACE, and in part for PACE, supported the proposal to use diagnoses from 2022 FFS claims and MA encounter data and gross drug costs from 2023 PDEs, as well as to update the denominator year to 2023. These commenters believed that more recent data is likely to better reflect cost and utilization patterns expected in 2026, with one commenter requesting that CMS update the model to reflect 2025 data as soon as possible to reflect beneficiary diagnoses and expenditures under the IRA. A commenter expressed concern about the use of 2022 diagnoses to calibrate the model, saying that diagnoses from that year were deflated due to the ongoing impacts of the COVID-19 pandemic on utilization.

Response: While we acknowledge the commenter's concern with using diagnoses from 2022 dates of service, we continue to believe that the value of more recent data outweighs concerns about any potential continued impact of the pandemic on utilization in 2022 and are finalizing the data year update for the RxHCC model being finalized for non-PACE organizations (and in part for PACE organizations) that is calibrated on 2022 diagnoses and 2023 expenditure data. The RxHCC model is constructed such that spending associated with unreported diagnoses is instead reflected in demographic coefficients or in correlated RxHCC coefficients (such as for comorbidities), even if the model is calibrated on data with fewer diagnoses than is typical.

Comment: Several commenters expressed concern with reflecting MFPs in the calibration, suggesting that the data not be included at all or that MFP incorporation be delayed until the model makes structural changes to incorporate rebates or until the effects of MFPs on enrollee utilization and formulary design can be studied further. A few of these commenters specifically commented that substituting gross drug costs with MFPs without accounting for prior rebate data could result in distorted plan liability estimates, with one commenter requesting that CMS clarify whether direct and indirect remuneration (DIR) allocated to drugs with substituted MFPs was also removed from the calibration, while others said that CMS has not had time to assess the impact of MFPs on Part D spending and liability, with one saying that reduced cost-sharing for

selected drugs would incentivize higher utilization, which the commenter believed would result in misaligned costs for plans.

Response: CMS appreciates the commenters' concerns about the impact of MFPs on plan liability estimates. With regard to the comments about use of rebates in the data, as stated in the CY 2026 Advance Notice, we substituted the gross drug costs for the ten selected drugs with their agreed-upon MFPs (prior to any additional price concessions for CY 2026, if applicable[15]), adjusted for inflation to the calibration year. For purposes of re-mapping PDEs in the model, the MFP is used as an effective new gross drug cost. Using the agreed-upon MFPs that CMS published rather than the gross drug costs on the PDE records for these drugs allows the model to more accurately reflect plan liability for CY 2026. Substituting MFPs for gross drug costs for 2026 creates stability as the PDE records reflecting these prices will eventually be incorporated as we continue to update the data years. We can account for MFPs because the amount for 2026 is known in advance. Rebates for non-selected drugs in 2026 are not known and will likely differ from rebates in the data currently available to CMS. We will continue to consider if and how to make adjustments for rebates and similar accountancies in future recalibrations.

With regard to the comments about the impact of MFPs on utilization, we do not believe it is appropriate to model expected changes in behavior for incorporation into the model. We believe that modeling future behavior would result in error in the model and inaccurate predictions of relative costs. Instead, we believe it is prudent to calibrate on the most recent available data and wait to account for changes in utilization in future iterations of the model. We believe that it is still more appropriate to reflect MFPs in the model calibration than to not reflect them. If the model did not use the agreed-upon MFPs, it would likely overestimate the expected plan liability for conditions that are treated with these drugs. This would not only overestimate relative costs for RxHCCs with conditions that are prevalently treated using these drugs, but it would also likely underestimate relative costs for RxHCCs for which treatment for the conditions is not associated with these drugs. As a result, we are finalizing the models reflecting MFPs as proposed.

Comment: A few commenters expressed concern about the updated RxHCC model's impact on beneficiaries taking high-cost specialty drugs. Some of these commenters expressed appreciation for CMS providing predictive ratios for the model, but also expressed a belief that the model does not fully predict costs or risk for beneficiaries by using historical data. One of these commenters said that the IRA benefit changes increase the proportion of revenue from risk-adjusted payments, so the financial impact on mismatches between risk scores and expected costs could become greater, which the commenter believed could result in plans being disincentivized to cater to populations with high variability in drug costs. Another of these commenters suggested that the model should be refined to address high-cost RxHCCs,

[15] Please see the Medicare Drug Price Negotiation Program: Revised Guidance for further discussion of MFP methodology for initial price applicability year 2026, including how agreed-upon MFPs are prior to any additional price concessions.

expressing a belief that the model results in insufficient payment under the Part D redesign when plans take on more liability in the catastrophic phase. One additional commenter recommended that CMS incorporate a high-cost threshold into the model to account for outlier expenditures.

Response: CMS recognizes the commenters' concerns. We note that HCC-based risk adjustment models, including both the CMS-HCC and RxHCC models, are intended to predict expected relative expenditures across key subgroups of beneficiaries. As measured by our predictive ratios, the RxHCC model does well at predicting across levels of risk, including enrollees in the highest deciles of predicted risk, meaning beneficiaries broken out into groups based on their predicted drug costs. The models are not intended to predict the costs of individual beneficiaries, nor are they intended to have any influence on drug prescribing and uptake. Overall expected costs for a plan's expected enrolled population are reflected in the bid, and the risk adjustment model is intended to ensure that the payments to the plan adequately reflect its expected relative cost, compared to the national average.

CMS regularly updates the diagnostic and expenditure data underlying the RxHCC model so that the model is calibrated based on the most recent data available, which at this time is 2022 diagnoses and 2023 expenditures. For CY 2026, we are finalizing a model that uses those data years to reflect more recent utilization and cost patterns.

Comment: Some commenters expressed concern about the model's impact on low-income beneficiaries, including those enrolled in SNPs. A commenter believed that the proposed model's risk scores for low-income beneficiaries did not account for the expected plan liability for these beneficiaries compared to non-low income beneficiaries. This commenter further stated their belief that because low-income beneficiaries generally have zero or minimal cost sharing, and many use protected class drugs, plans with high proportions of low-income or dually eligible beneficiaries have few methods for steering beneficiaries toward cost-efficient drugs.

Response: CMS appreciates the commenters' concerns about the impact of the model on low-income beneficiaries, including those in SNPs. While plan liability is increasing across all groups of beneficiaries, the average Part D risk score remains at 1.0, reflecting the average enrollee across the entire Part D market. Because the average Part D risk score remains 1.0, even if plan liability increases, risk scores may change in order to reflect how plan liability changes relative to the new overall average. Since the goal of risk adjustment is to ensure that payments to plans for beneficiaries who are expected to cost relatively more than average are higher than for beneficiaries who are expected to cost less than average, the role of the risk adjustment model is to ensure that the payments reflect these relative differences.

We note that the diagnoses and costs of all low-income beneficiaries, including those enrolled in SNPs, are included in the RxHCC model calibration and accounted for with separate low-income segments, so any unique patterns of costs and utilization due to zero or minimal cost sharing among this group of beneficiaries will be reflected in the model relative factors. Further, we

published predictive ratios in the CY 2026 Advance Notice showing that the model tends to predict well for low-income beneficiaries across all deciles of risk, including in the highest deciles of predicted risk.

Comment: A few commenters suggested that CMS examine modifying the underlying data and structure of the RxHCC model, such as incorporating prescription drug claims into the model to supplement medical diagnoses and incorporating concurrent data markers for drug conditions. Another commenter suggested that CMS incorporate patient-reported outcomes and social drivers of health into the RxHCC model, expressing a belief that these measures would better address the realities of underserved populations by offering insights into beneficiary experience.

Response: CMS thanks the commenters for their suggestions but notes that these suggestions are outside the scope of the information presented in the CY 2026 Advance Notice.

Comment: One commenter suggested that CMS include an RxHCC for chronic kidney disease stage 3 into the payment model as is done in the CMS-HCC model. The commenter believed that including this RxHCC would encourage Part D plans to promote early chronic kidney disease intervention.

Response: CMS appreciates the comment. While we regularly review the RxHCC model for improvements, it is important to note that the RxHCC model specifically predicts plan costs for prescription drugs, not medical costs. As a result, payment RxHCCs may not always be identical to payment CMS-HCCs if the conditions are not strong predictors of both drug and medical costs, respectively.

Comment: Several commenters expressed concern about the impact of the proposal in the CY 2026 MA and Part D proposed rule to cover anti-obesity medications on the RxHCC model. These commenters stated a belief that the proposed coverage of these medications would result in increases in expected utilization and costs that the model does not account for. The commenters requested that CMS update the model to account for these expected cost increases from beneficiary utilization.

Response: CMS is not finalizing the proposal to expand coverage of anti-obesity medications in Part D, as noted in the final rule titled, Contract Year (CY) 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-F).

Comment: Some commenters asked that CMS allow for a 60-day comment period for the RxHCC model so that plans have more time to evaluate the methodological changes. Some of these commenters further asked CMS to collaborate more with stakeholders prior to the publication of the Advance Notice regarding model changes. Several commenters requested that CMS publish additional analyses or provide more data to stakeholders regarding model impacts prior to publication of the Advance Notice. Some of these commenters specifically mentioned

providing analyses of risk model impacts for SNP plans, while other commenters believed CMS should continue to monitor effects of the model updates on the market, such as tracking beneficiary out-of-pocket costs and formulary changes, which these commenters believe could result in financial burdens for certain high-cost, high-need populations. A commenter further asked CMS to provide guidance and training resources such as case studies and best practices related to risk adjustment changes. Some additional commenters asked CMS to publish model software alongside the proposed model update.

Response: CMS appreciates the commenters' feedback. Regarding the commenters' request for more time to review the policy proposals, per section 1853(b)(2) of the Act, the Advance Notice of proposed changes to the methodology and assumptions used to determine annual MA capitation rates and the risk and other factors used in adjusting MA capitation rates under section 1853(a)(1)(C) is required to have a minimum 30-day comment period. Section 1860D-15(c)(1)(D) of the Act requires that CMS publish the risk adjustment factors for Part D at the time of publication of risk adjustment factors for Part C, which we propose in the Advance Notice and finalize in the Rate Announcement for the applicable year, per § 423.329(b)(4).

CMS believes that the period provided for comments on the CY 2026 Advance Notice is sufficient. In setting these timelines, we seek to achieve multiple goals, including providing the statutory-required amount of time for public comment while also releasing the Advance Notice using more current data to calculate the risk and other factors used to adjust MA capitation rates and ensuring that the Rate Announcement is published by the statutory deadline.

CMS acknowledges the commenters' requests for more analyses, resources, and stakeholder engagement and will take these into consideration. When the CY 2026 Advance Notice was published, CMS provided model software on the CMS risk adjustment webpage[16] and posted estimated plan-level risk scores under the RxHCC models discussed in the CY 2026 Advance Notice to provide opportunity to assist in the evaluation of the proposed model update. Additionally, CMS provides risk adjustment resources on the CSSC operations webpage,[17] including FAQs, computer-based trainings, and processing guides, and when changes are made to the model that require changes in reporting, we provide guidance through the Health Plan Management System (HPMS). While CMS engages with stakeholders on a regular basis through various lines of communication, physicians should not adjust their diagnostic or coding practices in response to model changes; rather they should adhere to ICD coding guidelines in order to accurately diagnose and code for patients' diagnoses.

Section G. Normalization for the RxHCC Risk Adjustment Models

CMS did not receive comments specifically regarding the normalization factor methodology for the RxHCC model calibrated on 2018 and 2019 data that is being finalized for use in payment

[16] CMS Risk Adjustment website
[17] CSSC Operations website

solely for PACE organizations and will continue to use the historical linear slope methodology and average risk scores from 2016 through 2020 as proposed.

Comment: Multiple commenters supported continuing to apply separate normalization factors for PDPs and MA-PD plans but opposed the proposed multiple linear regression methodology for calculating the factors. Commenters suggested that CMS phase in the proposed methodology or adopt alternative methodologies that they believe are more supportable or that maintain a similar degree of difference between the PDP and MA-PD normalization factors as exists under the methodology adopted for CY 2025 (i.e., approximately 12 percent).

Response: As with the CMS-HCC model normalization factors, the RxHCC model normalization factors are technical adjustments applied to risk scores in the payment year and are intended to maintain an average risk score at 1.0. The average Part D risk score changes each year due to underlying trends that reflect changes in the health status and demographic characteristics of the population, and coding practices, compared to the denominator year. Therefore, when a risk adjustment model predicts expenditures in years other than the denominator year, the average Part D risk score may no longer be 1.0, as it was in the denominator year. Accordingly, a technical adjustment must be applied to risk scores to account for the risk score changes between the denominator year and payment year that are attributable to changes in demographic characteristics of the population, and reported health status, in order to maintain the average Part D risk score at a 1.0.

Maintaining an average risk score of 1.0 across the Part D program in the payment year is essential to help keep the beneficiary premium at the appropriate proportion of aggregate plan payment and is a longstanding goal of Part D normalization.[18] The most recent risk score data (provided in Table III-12 in the CY 2026 Advance Notice) suggests that continuing to use the historical linear slope method or another method with similar results would lead to normalization factors that underestimate the average MA-PD risk score and overestimate the average PDP risk score in 2026. This under- and over-normalization would reduce the accuracy of Part D payments and be inconsistent with the long-standing goal of Part D normalization.

We are finalizing the multiple linear regression methodology (described in detail in Attachment III, Section G of the CY 2026 Advance Notice) because we believe it results in a more reasonable prediction of PDP and MA-PD risk scores in the payment year, making it more likely that the average payment year risk score across the Part D program will be 1.0. As commenters noted, the historical linear slope methodology did not account for risk score differences between PDPs and MA-PD plans in the denominator year because the calculation applies the trend to a denominator year risk score of 1.0. The multiple linear regression methodology more reasonably reflects the differences between PDP and MA-PD risk scores in the denominator year, projecting

[18] See for example the CY 2010 Advance Notice p 7: https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/advance2010.pdf.

these differences to the payment year. Additionally, as discussed for the CMS-HCC model normalization factors (see Attachment III, Section N), CMS believes that, by using a multiple linear regression methodology, we can more appropriately take into account the significant change in the risk scores observed at the onset of the COVID-19 pandemic, when risk scores dropped significantly due to atypically low utilization. This methodology enables CMS to incorporate the most recent years of data in the risk score trends in order to reflect current risk and project a risk score that best estimates the average Part D risk score in the payment year given the currently available data.

As noted in the CY 2025 Advance Notice and Rate Announcement and the CY 2026 Advance Notice, we did not propose the multiple linear regression methodology for RxHCC models for CY 2025 because we did not have the average 2023 Part D risk score available to evaluate whether the multiple linear regression approach was appropriate. For CY 2026, we have the 2023 Part D risk scores and find that the normalization factors calculated with the historical linear slope methodology are not consistent with recent trends. Our analysis showed that the normalization factor for PDPs is 7 percent higher than the 2023 PDP risk score when most recently the average PDP risk score has been decreasing, and the MA-PD normalization factor is 2 percent lower than the 2023 average MA-PD risk score when most recently MA-PD risk scores have been increasing.

Comment: Many commenters opposed applying separate normalization factors for PDPs and MA-PD plans and suggested CMS switch back to a single factor like was used prior to CY 2025 instead. Commenters raised a number of concerns with implementing separate normalization factors, including that applying separate factors calculated using the multiple linear regression methodology inappropriately adjusts for coding and population differences between market sectors in a way that is inconsistent with how CMS has described the purpose of normalization before, and that more information and/or time is needed to evaluate the impacts of the IRA and the proposed factors before implementing such a change.

Several commenters noted concerns about the disproportionate impacts on specific types of MA plans, such as those serving low-income beneficiaries, and perverse incentives for EGWPs to separate their enrollment into MA-only and PDP products when combined medical and drug benefits would be better. Commenters also suggested that applying separate normalization factors will adjust for differences between market sectors on average and will not capture variation, which may still lead to over- or under-payments for certain plans. A commenter suggested addressing the over- and under-prediction highlighted by CMS through separate models for PDPs and MA-PD plans rather than separate normalization factors. Many commenters who opposed applying separate factors stated that if CMS finalized separate factors, a different methodology should be used, such as an MA-PD normalization factor calculated without special needs plan enrollees, the linear slope methodology implemented for CY 2025, or an alternative that removes what the commenters argue is an additional adjustment for coding differences between PDPs and MA-PD plans from the calculation, thereby resulting in a similar

degree of difference between the PDP and MA-PD normalization factors as exists under the method implemented for CY 2025.

Response: We appreciate the concerns and suggestions expressed by commenters regarding the use of separate normalization factors. We are finalizing the separate normalization factors for PDPs and MA-PD plans because we believe separate normalization factors will lead to risk scores that more accurately reflect Part D costs in each sector of the Part D market that are driven by a variety of market-based variables, including the overall benefits that plan sponsors are able to manage, the strategies available for managing Part D costs, and the inability of PDPs to affect the submission of diagnoses in FFS. Our use of separate PDP and MA-PD normalization factors is because, although the statute treats Part D as one market, these two segments of the market operate quite differently. CMS believes that this policy will best address growing disparities between PDPs and MA-PD plans in order to ensure a level playing field, allowing for fairer competition between PDPs and MA-PD plans so that beneficiary options for Part D coverage are sustained. Finally, we do not think it is appropriate to exclude any populations from the calculation of the normalization factors, since the expected average risk score of 1.0 is necessarily set across the entire Part D market, regardless of their role in setting the NAMBA.

CMS acknowledges that there is inherent uncertainty in our normalization factors because they are projections of the payment year risk scores, and any projection can be imprecise. However, we base our normalization factors on the data available to us at the time and whether or not the risk score projected (i.e., the normalization factor) is a reasonable estimate of the payment year risk score based on observed historical risk scores. By applying separate normalization factors calculated with the proposed multiple linear regression methodology, the relative risk scores will more accurately reflect the relative cost in each market sector compared to the historical methodology applied in 2025 or another methodology that does not account for the difference between PDP and MA-PD plan risk scores. CMS will continue to monitor PDP and MA-PD risk score trends and conduct analyses to determine the normalization methodology that results in the most reasonable predictions of the payment year risk scores, and how best to capture diverging risk score trends between PDPs and MA-PD plans in future years to more accurately reflect Part D costs in each of these two sectors of the Part D market.

Comment: One commenter suggested that CMS did not have the authority to apply separate normalization factors to PDPs and MA-PD plans. The commenter suggested that CMS had acknowledged in a footnote in the CY 2026 Advance Notice that its authority to apply normalization in Part D stems from its specific authority related to risk adjustment, and specific direction for CMS to use "similar methodologies" to those used under section 1853(a)(3) of the Act. The commenter posited that applying separate normalization factors for PDPs and MA-PD plans constitutes a separate risk adjustment methodology that is impermissible because section 1853(a)(3)(D) of the Act states that the risk adjustment "methodology shall be applied uniformly without regard to the type of plan." The commenter asserted that, by requiring that the Secretary "establish *an* appropriate methodology" (emphasis added) for adjusting standardized bids to take

into account variation in costs for basic prescription drug coverage among PDPs and MA-PD plans based on the differences in actuarial risk of different enrollees being served, the statute "direct[s] CMS to apply a singular methodology" to address differences in actuarial risk between PDPs and MA-PD plans. Finally, the commenter suggested that CMS' proposal to establish separate normalization factors for PDPs and MA-PD plans reflected a reinterpretation of the statute as authorizing separate methodologies for PDPs and MA-PD plans and was an unjustified departure from CMS' longstanding approach of applying a single normalization factor in Part D risk adjustment.

Response: CMS respectfully disagrees with the commenter and believes that we do have authority to utilize separate Part D normalization factors for PDPs and MA-PD plans.

Section 1860D-15(c)(1)(A) of the Act directs the Secretary to establish risk adjustors based on an appropriate methodology for adjusting the standardized bid amount to take into account variation in costs for basic prescription drug coverage among PDPs and MA-PD plans based on the differences in actuarial risk of different enrollees being served without changing the aggregate amounts payable. Section 1860D-15(c)(1)(B) of the Act states that the "Secretary *may* take into account the similar methodologies used under section 1853(a)(3) to adjust payments to MA organizations for benefits under the original Medicare fee-for-service program option" (emphasis added). CMS does not understand this to be a "specific direction" to take into account the methodologies used under section 1853(a)(3) of the Act; to the contrary, CMS understands the statute's use of "*may*" to mean that the Secretary is *permitted* – but not *required* – to take into account the "similar methodologies" used to adjust MA payments under section 1853(a)(3) of the Act.

Specifically, while CMS may consider the methodologies used to adjust MA payments under section 1853(a)(3) of the Act, those adjustments are not required and do not supersede the directive at section 1860D-15(c)(1)(A) of the Act to develop an appropriate methodology for adjusting the standardized bid amount to take into account variation in costs for basic prescription drug coverage among PDPs and MA-PD plans based on the differences in actuarial risk of different enrollees being served. The statute does not specify that, if CMS takes into account "the similar methodologies" used to adjust MA payments under section 1853(a)(3), the Secretary is required to apply those methodologies uniformly without regard to plan type. In developing the Part D risk adjustment methodology, CMS has relied in large part on our approach to risk adjustment in Part C. For example, the RxHCC model is developed using condition categories (RxHCCs) and segments based on age, disability, institutional residence, and participation in the low income subsidy program, similar to how the CMS-HCC model is developed using condition categories (HCCs) and segments based on age, disability, institutional residence, and dual eligibility for Medicare and Medicaid. However, Part D has unique features which require considerations that do not exist in Part C. The RxHCC risk adjustment model predicts Part D costs, and our development of the RxHCC model takes into account differences in the Part D benefit, and Part D costs, as well as the profiles of Part D costs of the populations

enrolled in Part D. Further, because Part D payment parameters are set across the enrolled population, in contrast with how Part C payment parameters are set across the FFS population, we set the 1.0 risk score across the entire enrolled population, including both the denominator of the model and the normalization factor(s).

The Part D risk adjustment model and Part D normalization factors are developed and applied consistent with section 1860D-15(c)(1)(A) of the Act. The Part D model and normalization factor(s) together account for variation in costs between PDPs and MA-PD plans based on the differences in actuarial risk of different enrollees being served without changing the aggregate amounts payable. Calculating separate normalization factors for PDPs and MA-PD plans does not imply a different methodology as long as those factors are designed to maintain an average risk score of 1.0 across the Part D program, which has been a long-standing goal of normalization. Section 1860D-15(c)(1)(A) of the Act clearly permits CMS to modify the risk adjustment methodology to account for differences in the actuarial risk of enrollees being served by the PDP and MA-PD plan market – a requirement that does not exist for Part C.

In this vein, applying a single normalization factor, as we do for the Part C risk scores, would lead to risk adjustors that do not appropriately account for the variation in costs between MA-PD and PDP enrollees. The risk score and normalization factor combined account for the expected risk of a Part D enrollee relative to the expected average across Part D in the payment year. A single normalization factor results in a risk adjustor that overestimates actuarial risk for MA-PD plans and underestimates actuarial risk for PDPs. As stated previously in this section of the CY 2026 Rate Announcement, and in the CY 2026 Advance Notice, CMS' goal in applying separate normalization factors is to improve the predictive accuracy of PDP and MA-PD plan risk scores. The intent of normalization is to keep risk scores at consistent levels year over year so that the level of payment is driven by the bid, not the risk scores, and normalization adjusts for any and all drivers of risk score trends. Applying separate normalization factors calculated with the multiple linear regression methodology will reflect the change in population and health status from the denominator year to the payment year similar to how a single normalization factor would but will better account for differences in costs between PDPs and MA-PD plans. Accurately predicting the relative risk for PDPs and MA-PD plans is a long-standing goal of the Part D risk adjustment methodology. Similar changes to the Part D risk adjustment methodology were made in 2016 when CMS incorporated both FFS and MA-PD data into the Part D model to allow MA-PD coding and utilization patterns to be accurately reflected in the Part D relative costs and improve the predictive accuracy of the RxHCC model.[19]

While the differences between the PDP and MA-PD plan sectors are longstanding, the degree to which PDP and MA-PD risk scores have diverged is more recent. CMS analysis finds that PDP and MA-PD risk scores have been growing farther apart since 2015 but that the difference has been increasing more quickly in recent years. The percent difference between PDP and MA-PD

[19] https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/advance2016.pdf.

risk scores was about 16 percent in 2022 and 2023, which is nearly twice the difference between PDP and MA-PD risk scores in 2020 (about 8 percent). Risk scores are intended to predict the expected cost of Part D enrollees relative to the average. The actual cost of providing benefits to enrollees in each sector of the Part D market is similar (average expenditures in 2023 were $2,780.77 for PDPs and $2,697.22 for MA-PD plans) despite the divergence in risk scores. Further, this accelerating divergence in risk scores between sectors is made more acute by the IRA's changes to the Part D benefit, which greatly increased the risk borne by plan sponsors for the Part D benefit. Failing to account for differences in actuarial risk between PDPs and MA-PD plans as directed by the Act would lead to instability in the PDP market and fewer coverage options for enrollees.

Comment: A couple of commenters agreed that the proposed method to apply separate normalization factors for PDPs and MA-PD plans appropriately accounts for the underlying risk score trend, which has been diverging for PDPs and MA-PD plans. A commenter stated this growing divergence suggests systematic differences in coding intensity and/or utilization patterns between PDPs and MA-PD plans that could lead to systematic, destabilizing underpayments for PDPs if not addressed. The commenter stated that separate normalization factors for the two sectors of the Part D market could help level the playing field between PDPs and MA-PD plans.

Response: CMS thanks the commenters for their support. We are finalizing our proposal to apply separate normalization factors for standalone PDPs and MA-PD plans calculated with the multiple linear regression methodology as proposed.

Section H. Source of Diagnoses for Part D Risk Score Calculation for CY 2026

CMS did not receive comments regarding sources of diagnoses for Part D risk scores for CY 2026 and is finalizing the policies as proposed.

For non-PACE organizations, CMS will continue the policy first adopted for CY 2022 to calculate all risk scores for payment to Part D sponsors using only risk adjustment-eligible diagnoses from encounter data and FFS claims.

For PACE organizations, CMS will calculate risk scores using 10 percent of the risk score calculated using encounter data and FFS claims only (under the 2026 RxHCC model (2022/2023 calibration)) and 90 percent of the risk score calculated using diagnoses from RAPS, encounter data, and FFS claims (under the 2026 RxHCC model (2018/2019 calibration)).

Refer to Attachment III, Section O for comments and responses regarding sources of diagnoses for PACE risk scores.

Attachment V. Final Updated Benefit Parameters for the Defined Standard Benefit and Changes in the Payment Methodology for Medicare Part D for CY 2026

Table V-1. Updated API and CPI for 2026

	Annual percentage trend for 2025	Prior year revisions	API for 2026
API	5.69%	-1.34%	4.27%
September CPI (all items, U.S. city average)	2.33%	-0.17%	2.16%

Table V-2. Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy (LIS) and Retiree Drug Subsidy

	2025	2026[20]
Standard Benefit		
Deductible	$590	$615
Out-of-Pocket Threshold	$2,000	$2,100
Full Subsidy-Full Benefit Dual Eligible (FBDE) Beneficiaries (1)		
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] (2)	$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
Between 100% and 150% of FPL [category code 1]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$4.90	$5.10
Other	$12.15	$12.65

[20] These parameters reflect additional plan coverage required for covered insulin products under section 1860D-2(b)(9) of the Act, as added by section 11406 of the IRA, and ACIP-recommended adult vaccines under section 1860D-2(b)(8) of the Act, as added by section 11401 of the IRA.

	2025	2026[20]
Full Subsidy-Non-FBDE Beneficiaries (1)		
Applied or eligible for QMB/SLMB/QI or SSI, income at or below 150% FPL for 2025 and resources ≤ $16,100 (individuals, 2025) or ≤ $32,130 (couples, 2025) [category code 1] (3)		
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

(1) The LIS eligibility categories and corresponding cost-sharing benefits are sometimes referred to using category codes as follows:

- Category Code 1 – Non-institutionalized FBDE beneficiaries with incomes between 100% and 150% of FPL and full-subsidy-non-FBDE beneficiaries.
- Category Code 2 – Non-institutionalized FBDE beneficiaries with incomes up to 100% of the FPL.
- Category Code 3 – FBDE beneficiaries who are institutionalized or would be institutionalized if they were not receiving home and community-based services.

(2) Per section 1860D-14(a)(1)(D)(i) of the Act, FBDE beneficiaries who are receiving certain home and community-based services qualify for zero cost sharing if the individuals (or couple) would have been institutionalized otherwise.

(3) The resource limits for CY 2026 will be provided via the annual HPMS memo entitled "Calendar Year (CY) 2026 Resource and Cost-Sharing Limits for Low-Income Subsidy (LIS)" that is expected to be released during the usual timeframe after the September 2025 CPI has been made available by the Bureau of Labor Statistics. Additionally, these amounts are adjusted for beneficiaries that notified the SSA of their intent to use a portion of their resources for burial expenses. The CY 2025 resource limits, including $1,500 per person for burial expenses, are $17,600 ($35,130 if married). Also, beneficiaries that would have been eligible for the partial LIS benefit had the IRA not been enacted will be eligible for the full LIS benefit if they meet the resource standard described at section 1860D-14(a)(3)(E) of the Act. Note that under 42 CFR 423.773(c)(2), full subsidy-eligible beneficiaries deemed eligible between January 1 and June 30 of a calendar year are deemed eligible for the remainder of the calendar year. Full subsidy-eligible beneficiaries deemed eligible between July 1 and December 31 of a calendar year are deemed eligible for the remainder of the calendar year and the following calendar year.

Section A. Annual Percentage Increase in Consumer Price Index (CPI)

Annual Percentage Increase in Consumer Price Index, September (September CPI)

Section 1860D-14(a)(4) of the Act requires CMS to use the annual percentage increase in the CPI for the 12-month period ending in September 2025 to update the maximum copayments up to the annual OOP threshold for full-benefit dually eligible beneficiaries with incomes not exceeding 100 percent of the FPL for CY 2026. These copayments are increased from $1.60 per generic, preferred drug that is a multi-source drug, or biosimilar, and from $4.80 for all other drugs in CY 2025 and rounded to the nearest multiple of $0.05 and $0.10 respectively.[21]

Section B. Calculation Methodology

Annual Percentage Increase in Average Expenditures for Part D Drugs per Eligible Beneficiary (API)

For contract years 2006 and 2007, the APIs, as defined in section 1860D-2(b)(6) of the Act, were based on the National Health Expenditure (NHE) prescription drug per capita estimates because sufficient Part D program data was not available. Beginning with contract year 2008, the APIs are based on Part D program data. For the CY 2026 benefit parameters, Part D program data will be used to calculate the annual percentage trend as follows:

$$\frac{August\ 2024 - July\ 2025}{August\ 2023 - July\ 2024} = \frac{\$5{,}566.70}{\$5{,}267.07} = 1.0569$$

In the formula, the average per capita cost for August 2023 – July 2024 is calculated from actual Part D PDE data, and the average per capita cost for August 2024 – July 2025 is calculated based on actual Part D PDE data for prescription drug claims with service dates from August 2024 – December 2024 and projected through July 2025.

The 2026 benefit parameters reflect the 2025 annual percentage trend, as well as updates for revision to prior year estimates for API. Based on updated NHE prescription per capita costs and PDE data, the annual percentage increases are now calculated as summarized by Table V-3.

Table V-3. Revised Prior Years' Annual Percentage Trends

Year	Prior Estimates of Annual Percentage Trend	Revised Annual Percentage Trend
2006	7.30%	7.30%
2007	5.92%	5.92%
2008	4.69%	4.69%

[21] Per section 1860D-14(a)(4)(A) of the Act, the copayments are increased from the unrounded 2025 values of $1.59 for multi-source generic or preferred drugs, and $4.77 for all other drugs.

Year	Prior Estimates of Annual Percentage Trend	Revised Annual Percentage Trend
2009	3.14%	3.14%
2010	2.36%	2.36%
2011	2.15%	2.15%
2012	2.53%	2.53%
2013	-3.14%	-3.14%
2014	10.12%	10.12%
2015	9.89%	9.89%
2016	4.02%	4.02%
2017	1.87%	1.87%
2018	4.06%	4.06%
2019	4.92%	4.92%
2020	5.06%	5.06%
2021	4.69%	4.68%
2022	7.36%	7.36%
2023	9.57%	9.54%
2024	5.46%	4.07%

Accordingly, the CY 2026 benefit parameters reflect a multiplicative update of -1.34 percent for prior year revisions. In summary, the 2025 parameters outlined in Section A are updated by 4.27 percent for 2026, as summarized by Table V-4.

Table V-4. Annual Percentage Increase

Annual percentage trend for July 2025	5.69%
Prior year revisions	-1.34%
Annual percentage increase for 2026	4.27%

Note: Percentages are multiplicative, not additive. Values are carried to additional decimal places and may not agree to the rounded values presented above.

Annual Percentage Increase in Consumer Price Index, September (September CPI)

To ensure that plan sponsors and CMS have sufficient time to incorporate cost-sharing requirements into the development of the benefit, any marketing materials, and necessary systems, CMS includes in its methodology to calculate the annual percentage increase in the CPI for the 12-month period ending in September 2025, an estimate of the September 2025 CPI based on projections from the President's FY2026 Budget.

The September 2025 value is from the Bureau of Labor Statistics. The annual percentage trend in the September CPI for CY 2026 is calculated as follows:

$$\frac{Projected\ September\ 2025\ CPI}{Actual\ September\ 2024\ CPI} = \frac{\$322.60}{\$315.30} = 1.0233$$

(Source: President's FY2026 Budget and Bureau of Labor Statistics, Department of Labor)

The CY 2026 benefit parameters reflect the CY 2025 annual percentage trend in the September CPI of 2.33 percent, as well as a -0.17 percent multiplicative correction for the revision to last year's estimate. The CY 2025 annual percentage trend in the CPI can be found in Table V-5 below.

Table V-5. Cumulative Annual Percentage Increase in September CPI

Annual percentage trend for September 2025	2.33%
Prior year revisions	-0.17%
Annual percentage increase for 2026	2.16%

Note: Percentages are multiplicative, not additive. Values are carried to additional decimal places and may not agree to the rounded values presented above.

Section C. Annual Percentage Increase in Average Expenditures for Part D Drugs Per Eligible Beneficiary

Section 1860D-2(b)(6) of the Act defines the API as "the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States for Part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the Secretary shall specify." The following defined standard Part D prescription drug benefit parameters are updated using the "annual percentage increase":

For CY 2026, the defined standard deductible amount is updated by multiplying the 2025 amount of $590 by the 2026 API and rounding to the nearest multiple of $5. Under section 1860D-2(b)(4)(B) of the Act, for CY 2026, the annual OOP threshold is updated by multiplying the CY 2025 amount of $2,000 by the 2026 API and rounding to the nearest multiple of $50.

Table V-6. Part D Benefit Parameters for Defined Standard Benefit for CY 2025 and CY 2026 for Non-LIS Beneficiaries[22]

	2025		2026	
Deductible Phase	Cost sharing: 100%		Cost sharing: 100%	
	Deductible: $590		Deductible: $615	
Initial Coverage Phase	Applicable Drugs Cost sharing: 25%	Non-applicable Drugs Cost sharing: 25%	Applicable Drugs Cost sharing: 25%	Non-applicable Drugs and Selected Drugs Cost sharing: 25%
	Out-of-Pocket Threshold: $2,000		Out-of-Pocket Threshold: $2,100	

Section D. Retiree Drug Subsidy Amounts

While the IRA significantly redesigned the Part D benefit for 2025, the IRA did not change the statutory requirements for retiree drug subsidy plans (as defined in section 1860D-22 of the Act). Specifically, the IRA did not change the requirements related to the methodology for calculating the cost limit and threshold for the CY 2026 retiree drug subsidy amounts for retiree drug subsidy plans.[23]

Per section 1860D-22(a)(3)(B) of the Act and § 423.886(b)(3), the cost threshold and cost limit for qualified retiree prescription drug plans are updated using the API, as defined previously in this document.[24] The updated cost threshold is rounded to the nearest multiple of $5 and the updated cost limit is rounded to the nearest multiple of $50. The cost threshold and cost limit are defined as $590 and $12,150, respectively, for plans that end in CY 2025, and as $615 and $12,650 for plans that end in CY 2026, as noted in Table V-7.

Table V-7. Updated Retiree Drug Subsidy Amounts in CY 2026

	2025	2026
Retiree Drug Subsidy Amounts		
Cost Threshold	$590	$615
Cost Limit	$12,150	$12,650

[22] These parameters reflect additional plan coverage required for covered insulin products under section 1860D-2(b)(9) of the Act, as added by section 11406 of the IRA, and ACIP-recommended adult vaccines under section 1860D-2(b)(8) of the Act, as added by section 11401 of the IRA.

[23] Please see the Final CY 2025 Part D Redesign Program Instructions: https://www.cms.gov/files/document/final-cy-2025-part-d-redesign-program-instructions.pdf.

[24] The cost threshold is the amount of gross retiree costs that a retiree must incur before the retiree drug subsidy applies. The cost limit is the maximum amount of gross retiree costs that the retiree drug subsidy will cover after a retiree hits the cost threshold.

Attachment VI. Updates for Part C and D Star Ratings

Section A. Part C and D Star Ratings and Future Measurement Concepts

The Part C and D Star Ratings measure the quality of and reflect the experiences of beneficiaries in MA and Prescription Drug Plans (PDPs or Part D plans), assist beneficiaries in finding the best plan for their needs, and determine eligibility for MA Quality Bonus Payments. The Star Ratings assess MA and PDP contract efforts on prevention, wellness, and chronic disease, and support CMS's efforts to make all of our programs patient-centric.

The methodology for the Star Ratings system for the Part C and D programs is codified at §§ 422.160 - 422.166 and 423.180 - 423.186. In the Advance Notice, we provided information and updates as required by §§ 422.164(c)(2), (d), (e)(2), and (f)(1); 422.166(f)(2); 423.184(c)(2), (d), (e)(2), and (f)(1); and 423.186(f)(2). We reviewed the comments and will consider them as we identify future enhancements to the Star Ratings program.

Section B. Reminders for 2026 Star Ratings and Beyond

As a reminder, the Star Ratings plan previews codified at §§ 422.166(h)(2) and 423.186(h)(2) are an opportunity for Part C and D sponsors to preview their Star Ratings data in HPMS and raise any questions prior to display on the Medicare Plan Finder. The two plan preview periods allow for any necessary corrections to be made prior to the Star Ratings data being public. During the first plan preview in August, we expect Part C and D sponsors to closely review the Star Ratings methodology and their posted numeric data for each measure. The second plan preview in September includes any revisions made as a result of the first plan preview and provides a preview of the preliminary Star Ratings for each measure, domain, summary score, and overall score. During the second plan preview, we expect Part C and D sponsors to again closely review the methodology and their posted data for each measure, as well as their preliminary Star Rating assignments. Please note that any questions asked during the plan preview periods are not part of the formal appeals process under § 422.260.

Prior to the preview periods, various datasets and reports are available for sponsors to review their underlying measure data as detailed in the annual HPMS memo "Information to Review Data Used for Medicare Part C and D Star Ratings and Display Measures." Sponsors should review the data detailed in this memo and alert CMS of potential errors or anomalies in advance of CMS's plan preview periods to allow sufficient time to investigate and resolve any issues.

Under § 422.260, CMS has made an administrative review process available to MA organizations for payment determinations based on the quality bonuses. MA organizations can request a formal appeal of their Quality Bonus Payment (QBP) rating after CMS releases the preliminary QBP ratings in HPMS, typically in November of each year. CMS anticipates that issues addressed during the preview periods will reduce the need for MA organizations to request an administrative review of QBP determinations. The administrative review is a two-step process

that begins with a request for reconsideration. This review is not intended to repeat the preview periods in giving contracts another opportunity to raise general questions about how CMS calculates the Star Ratings, nor is it intended to review how every measure was calculated. Instead, this review affords an MA organization the opportunity to request review of specific measure values and stars that may affect the calculation of the contract's QBP status.

As described at §§ 422.164(h) and 423.184(h), CMS annually sets and announces a deadline for MA and Part D organizations to request that CMS or the Independent Review Entity (IRE) review its appeals data or CMS review its Complaints Tracking Module (CTM) data.

For the 2026 Star Ratings, CMS is announcing the following deadlines:

- May 30, 2025 for all contracts to request a review of 2024 CTM data. Sponsors should refer to the January 6, 2025, HPMS memorandum, "Updated Complaints Tracking Module Standard Operating Procedures," for instructions on submitting a Plan Request in HPMS to request a review of CTM complaint(s).

- June 30, 2025 for all contracts to request a review of 2024 appeals data. Sponsors can view and monitor their Part C appeals timeliness and effectuation compliance data on the Medicare Appeal Search website.

For the 2027 Star Ratings:

- CMS finalized a deadline of May 18, 2026[25] for all contracts to request a review of their administrative data used for the Part D Patient Safety Star Ratings measures[26] for the 2025 measurement year for the 2027 Star Ratings. CMS reports the Patient Safety measures through the Patient Safety Analysis Web Portal each month to Part D sponsors. Sponsors should review their underlying measure data in the monthly reports and alert CMS if any potential issues are identified in the rate calculations per the measure specifications. Sponsors should refer to the annual HPMS memorandum released each April, "Information to Review Data Used for Medicare Part C and D Star Ratings and Display Measures," which describes the process of submitting the requests.[27] We also encourage sponsors to submit requests for review of their administrative data for the Part

[25] Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescription-drug-benefit.

[26] Includes Medication Adherence for Cholesterol (Statins) (ADH-Statins), Medication Adherence for Hypertension (RAS Antagonists) (ADH-RAS), Medication Adherence for Diabetes Medications (ADH-Diabetes), Statin Use in Persons with Diabetes (SUPD), Concurrent Use of Opioids and Benzodiazepines (COB), and Polypharmacy: Use of Multiple Anticholinergics (ACH) Medications in Older Adults (Poly-ACH) measures.

[27] April 11, 2024 HPMS memorandum, *Information to Review Data Used for Medicare Part C and D Star Ratings and Display Measures*.

D Patient Safety Display measures on the 2027 display page (2025 measurement year) by May 18, 2026.

- CMS is announcing a deadline of March 31, 2026 for all contracts to request a review of 2025 CTM data for the 2027 Star Ratings. We are announcing this deadline in advance due to the timing of the publication of the Advance Notice and Rate Announcement.

As a reminder, there is one new measure being added beginning with the 2026 Star Ratings, Kidney Health Evaluation for Patients with Diabetes.[28] There are also two measures, Improving or Maintaining Physical Health and Improving or Maintaining Mental Health, returning to the 2026 Star Ratings after substantive specification changes.[29] The Improving or Maintaining Physical Health and Improving or Maintaining Mental Health measures have a weight of 1 for the 2026 Star Ratings and then a weight of 3 beginning with the 2027 Star Ratings. The weight of patient experience and complaint measures and access measures decreases from 4 to 2 beginning with the 2026 Star Ratings.[30] Additionally, starting with the 2026 Star Ratings we are no longer removing the numeric values for affected contracts with 60 percent or more of their enrollees in Federal Emergency Management Agency (FEMA) designated Individual Assistance areas at the time of an extreme and uncontrollable circumstance from the cut points clustering algorithm for non-CAHPS measures and from the reward factor calculations.[31]

Section C. Measure Updates for 2026 Star Ratings

The measures that will be used to calculate the 2026 Star Ratings are listed in Table VI-1 with information about the measure type, weight, and measurement year.

[28] Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program.

[29] Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. https://www.federalregister.gov/documents/2021/01/19/2021-00538/medicare-and-medicaid-programs-contract-year-2022-policy-and-technical-changes-to-the-medicare.

[30] Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program.

[31] Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program.

Table VI-1. 2026 Star Ratings Measures

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2026 CAI Values
C	Breast Cancer Screening	Process Measure	1	1/1/2024 – 12/31/2024	**Yes**	**Yes**
C	Colorectal Cancer Screening	Process Measure	1	1/1/2024 – 12/31/2024	**Yes**	**Yes**
C	Annual Flu Vaccine	Process Measure	1	3/2025 – 6/2025	**Yes**	**Yes**
C	Improving or Maintaining Physical Health	Outcome Measure	1*	7/2024 – 11/2024	**No**	**No**
C	Improving or Maintaining Mental Health	Outcome Measure	1*	7/2024 – 11/2024	**No**	**No**
C	Monitoring Physical Activity	Process Measure	1	7/2024 – 11/2024	**Yes**	**Yes**
C	Special Needs Plan (SNP) Care Management	Process Measure	1	1/1/2024 – 12/31/2024	**Yes**	**No**
C	Care for Older Adults – Medication Review	Process Measure	1	1/1/2024 – 12/31/2024	**Yes**	**No**
C	Care for Older Adults– Pain Assessment	Process Measure	1	1/1/2024 – 12/31/2024	**Yes**	**No**
C	Osteoporosis Management in Women who had a Fracture	Process Measure	1	1/1/2024 – 12/31/2024	**Yes**	**Yes**
C	Diabetes Care – Eye Exam	Process Measure	1	1/1/2024 – 12/31/2024	**Yes**	**Yes**
C	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3	1/1/2024 – 12/31/2024	**Yes**	**Yes**
C	Kidney Health Evaluation for Patients with Diabetes	Process Measure	1	1/1/2024 – 12/31/2024	**No**	**No**
C	Controlling Blood Pressure	Intermediate Outcome Measure	3	1/1/2024 – 12/31/2024	**Yes**	**Yes**
C	Reducing the Risk of Falling	Process Measure	1	7/2024 – 11/2024	**Yes**	**Yes**
C	Improving Bladder Control	Process Measure	1	7/2024 – 11/2024	**Yes**	**Yes**

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2026 CAI Values
C	Medication Reconciliation Post-Discharge	Process Measure	1	1/1/2024 – 12/31/2024	**Yes**	**Yes**
C	Plan All-Cause Readmissions	Outcome Measure	3	1/1/2024 – 12/31/2024	**Yes**	**Yes**
C	Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1	1/1/2024 – 12/31/2024	**Yes**	**Yes**
C	Transitions of Care	Process Measure	1	1/1/2024 – 12/31/2024	**Yes**	**Yes**
C	Follow-up after Emergency Room Visit	Process Measure	1	1/1/2024 – 12/31/2024	**Yes**	**Yes**
C	Getting Needed Care	Patients' Experience and Complaints Measure	2	3/2025 – 6/2025	**Yes**	**No**
C	Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	2	3/2025 – 6/2025	**Yes**	**No**
C	Customer Service	Patients' Experience and Complaints Measure	2	3/2025 – 6/2025	**Yes**	**No**
C	Rating of Health Care Quality	Patients' Experience and Complaints Measure	2	3/2025 – 6/2025	**Yes**	**No**
C	Rating of Health Plan	Patients' Experience and Complaints Measure	2	3/2025 – 6/2025	**Yes**	**No**
C	Care Coordination	Patients' Experience and Complaints Measure	2	3/2025 – 6/2025	**Yes**	**No**
C	Complaints about the Health Plan	Patients' Experience and Complaints Measure	2	1/1/2024 – 12/31/2024	**Yes**	**No**
C	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2	1/1/2024 – 12/31/2024	**Yes**	**No**
C	Health Plan Quality Improvement	Improvement Measure	5	NA	**No**	**No**
C	Plan Makes Timely Decisions about Appeals	Measures Capturing Access	2	1/1/2024 – 12/31/2024	**Yes**	**No**

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2026 CAI Values
C	Reviewing Appeals Decisions	Measures Capturing Access	2	1/1/2024 – 12/31/2024	**Yes**	**No**
C	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2	2/2025 – 5/2025	**Yes**	**No**
D	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2	2/2025 – 5/2025	**Yes**	**No**
D	Complaints about the Drug Plan	Patients' Experience and Complaints Measure	2	1/1/2024 – 12/31/2024	**Yes**	**No**
D	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2	1/1/2024 – 12/31/2024	**Yes**	**No**
D	Drug Plan Quality Improvement	Improvement Measure	5	NA	**No**	**No**
D	Rating of Drug Plan	Patients' Experience and Complaints Measure	2	3/2025 – 6/2025	**Yes**	**No**
D	Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	2	3/2025 – 6/2025	**Yes**	**No**
D	MPF Price Accuracy	Process Measure	1	1/1/2024 – 9/30/2024	**Yes**	**No**
D	Medication Adherence for Diabetes Medications	Intermediate Outcome Measure	3	1/1/2024 – 12/31/2024	**Yes**	**Yes**
D	Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measure	3	1/1/2024 – 12/31/2024	**Yes**	**Yes**
D	Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measure	3	1/1/2024 – 12/31/2024	**Yes**	**Yes**
D	MTM Program Completion Rate for CMR	Process Measure	1	1/1/2024 – 12/31/2024	**Yes**	**Yes**
D	Statin Use in Persons with Diabetes	Process Measure	1	1/1/2024 – 12/31/2024	**Yes**	**Yes**

*Measure has a weight of 1 for the 2026 Star Ratings because it is considered a new measure.

Section D. Improvement Measures (Part C & D) for the 2026 Star Ratings

Under §§ 422.164(f) and 423.184(f), improvement measures are calculated using performance measures that meet specific conditions. Table VI-1 includes information about which measures will be used to calculate the improvement measures for the 2026 Star Ratings. As stated in §§ 422.164(f)(4)(i) and 423.184(f)(4)(i), CMS will only include measures in the improvement calculations at the contract level if numeric value scores are available for both the current and prior year.

Section E. Categorical Adjustment Index for the 2026 Star Ratings

The methodology for the Categorical Adjustment Index (CAI) is described at §§ 422.166(f)(2) and 423.186(f)(2), as well as in the annual Medicare Part C & D Star Ratings Technical Notes available on CMS's Part C and D Star Ratings website. As finalized at §§ 422.166(f)(2) and 423.186(f)(2), all measures identified as candidate measures will be included in the determination of the 2026 CAI values. The measure set for the 2026 CAI (for both Part C and D) is identified in Table VI-1.

In keeping with our commitment to transparency, a summary of the analysis of the candidate measure set that includes the minimum, median, and maximum values for the within-contract variation for the low-income subsidy (LIS)/dual eligible (DE) differences are posted with the 2026 CAI values on CMS's Part C and D Star Ratings website.

Section F. Extreme and Uncontrollable Circumstances Policy for the 2026 Star Ratings

Extreme and uncontrollable circumstances such as natural disasters can directly affect Medicare beneficiaries and providers, as well as the Parts C and D organizations that provide beneficiaries with important medical care and prescription drug coverage. An affected contract is identified based on these criteria:

(1) Its service area is within an "emergency area" during an "emergency period" as defined in section 1135(g)(1) of the Act;
(2) Its service area is within a geographic area designated in a major disaster declaration under the Stafford Act and the Secretary exercised authority under section 1135 of the Act based on the same triggering event(s); and
(3) A certain minimum percentage (25 percent) of the enrollees under the contract must reside in a Federal Emergency Management Agency (FEMA)-designated Individual Assistance area at the time of the extreme and uncontrollable circumstance. (See §§ 422.166(i) and 423.186(i)).

We use the start date of the incident period to determine which year of Star Ratings could be affected, regardless of whether the incident period extends to another calendar year (§§ 422.166(i) and 423.186(i)).

Under the 25 percent rules at §§ 422.166(i)(2)–(6) and 423.186(i)(2)–(4), contracts with at least 25 percent of enrollees in a FEMA-designated Individual Assistance area in 2024 will receive the higher of their measure-level rating from the current and prior Star Ratings years for purposes of calculating the 2026 Star Ratings (thus, for 2026 Star Ratings, affected contracts will receive the higher of their measure-level ratings from the 2025 rating or 2026 rating for the applicable measures). Table VI-2 lists the emergency areas affected by emergency declarations first issued in 2024, as defined in section 1135 of the Act, and the exercise of the Secretary's authority under section 1135 of the Act.

Table VI-2. List of Section 1135 Waivers Issued in Relation to the FEMA Major Disaster Declarations

Section 1135 Waiver Date Issued	Waiver or Modification of Requirements Under Section 1135 of the Social Security Act	FEMA Incident Type	Affected State	Incident Start Date
July 12, 2024	Hurricane Beryl	Hurricane Beryl	Texas	July 5, 2024
August 6, 2024	Hurricane Debby	Hurricane Debby	Florida	August 1, 2024
August 7, 2024	Hurricane Debby	Tropical Storm Debby	Georgia	August 4, 2024
September 12, 2024	Hurricane Francine	Hurricane Francine	Louisiana	September 9, 2024
September 26, 2024	Hurricane Helene	Hurricane Helene	Florida	September 23, 2024
September 27, 2024	Hurricane Helene	Hurricane Helene	Georgia	September 24, 2024
September 28, 2024	Hurricane Helene	Tropical Storm Helene	North Carolina	September 25, 2024
September 30, 2024	Hurricane Helene	Tropical Storm Helene	Tennessee	September 26, 2024
September 30, 2024	Hurricane Helene	Hurricane Helene	South Carolina	September 25, 2024
October 8, 2024	Hurricane Milton	Hurricane Milton	Florida	October 5, 2024

Table VI-3 lists the states and territories with Individual Assistance designations from the FEMA major disaster declarations.

Table VI-3. Individual Assistance Counties and County-Equivalents in FEMA Major Disaster Declared States/Territories

FEMA Declaration	State	FEMA Individual Assistance Counties or County Equivalents
DR-4798-TX	Texas	Austin, Bowie, Brazoria, Chambers, Fort Bend, Galveston, Harris, Jackson, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Nacogdoches, Orange, Polk, San Jacinto, Shelby, Trinity, Walker, Waller, Wharton
DR-4806-FL	Florida	Alachua, Baker, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hillsborough, Jefferson, Lafayette, Levy, Madison, Manatee, Pinellas, Sarasota, Suwannee, Taylor
DR-4821-GA	Georgia	Bryan, Bulloch, Chatham, Effingham, Evans, Liberty, Long, Screven
DR-4817-LA	Louisiana	Ascension, Assumption, Jefferson, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary, Terrebonne
DR-4828-FL	Florida	Alachua, Baker, Bradford, Charlotte, Citrus, Collier, Columbia, DeSoto, Dixie, Duval, Franklin, Gilchrist, Gulf, Hamilton, Hernando, Hillsborough, Jefferson, Lafayette, Lee, Leon, Levy, Madison, Manatee, Pasco, Pinellas, Putnam, Sarasota, Suwannee, Taylor, Union, Wakulla
DR-4830-GA	Georgia	Appling, Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Bryan, Bulloch, Burke, Butts, Camden, Candler, Charlton, Chatham, Clinch, Coffee, Colquitt, Columbia, Cook, Dodge, Echols, Effingham, Elbert, Emanuel, Evans, Fulton, Glascock, Glynn, Hancock, Irwin, Jeff Davis, Jefferson, Jenkins, Johnson, Lanier, Laurens, Liberty, Lincoln, Long, Lowndes, McDuffie, McIntosh, Montgomery, Newton, Pierce, Rabun, Richmond, Screven, Stephens, Taliaferro, Tattnall, Telfair, Thomas, Tift, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler, Wilkes
DR-4827-NC	North Carolina	Alexander, Alleghany, Ashe, Avery, Buncombe, Burke, Cabarrus, Caldwell, Catawba, Cherokee, Clay, Cleveland, Eastern Band of Cherokee Indians of North Carolina, Forsyth, Gaston, Graham, Haywood, Henderson, Iredell, Jackson, Lee, Lincoln, Macon, Madison, McDowell, Mecklenburg, Mitchell, Nash, Polk, Rowan, Rutherford, Stanly, Surry, Swain, Transylvania, Union, Watauga, Wilkes, Yadkin, Yancey
DR-4832-TN	Tennessee	Carter, Cocke, Greene, Hamblen, Hawkins, Johnson, Unicoi, Washington

FEMA Declaration	State	FEMA Individual Assistance Counties or County Equivalents
DR-4829-SC	South Carolina	Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Catawba Indian Reservation, Cherokee, Chester, Edgefield, Fairfield, Greenville, Greenwood, Hampton, Jasper, Kershaw, Laurens, Lexington, McCormick, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Union, York
DR-4834-FL	Florida	Brevard, Charlotte, Citrus, Clay, Collier, DeSoto, Duval, Flagler, Glades, Hardee, Hendry, Hernando, Highlands, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Miccosukee Indian Reservation, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, Sarasota, Seminole, St. Johns, St. Lucie, Sumter, Volusia

Further, as part of our Part C and D Star Ratings disaster policy at §§ 422.166(i)(2)(ii) and 423.186(i)(2)(ii), we codified that if at least 25 percent of a contract's enrollees resided in a FEMA-designated Individual Assistance area at the time of a qualifying extreme and uncontrollable circumstance, the contract may be exempt from administering the MA and PDP CAHPS survey if it demonstrates that the required sample for the survey cannot be contacted because a substantial number of the contract's enrollees are displaced due to the qualifying disaster in the calendar year prior to the relevant Star Ratings year and requests and receives a CMS-approved exemption. If an affected contract meeting the criteria requests and receives this exemption, the contract receives the MA and PDP CAHPS measure-level Star Ratings and scores from the prior year. The January 2025 wildfires in Los Angeles County are a qualifying disaster for purposes of §§ 422.166(i)(2)(ii) and 423.186(i)(2)(ii). Therefore, eligible contracts that requested and received an exemption from the 2025 MA and PDP CAHPS survey as a result of the Los Angeles County wildfires will not have the 2025 MA and PDP CAHPS surveys administered and will receive the CAHPS stars and measure scores from the 2025 Star Ratings for the 2026 Star Ratings CAHPS measures.

For all contracts affected by the 2025 Los Angeles County wildfires (i.e., at least 25 percent of their enrollees resided in Los Angeles County at the time of the disaster), the CAHPS measure-level better-of policy codified at §§ 422.166(i)(2)(iv) and 423.186(i)(2)(iv) will be implemented for the 2026 and 2027 Star Ratings. That is, each year we will compare the CAHPS measure-level stars to the prior year and give these contracts impacted by the Los Angeles County wildfires the higher CAHPS measure star and associated score. For example, for eligible contracts that requested and received an exemption from the 2025 MA and PDP CAHPS survey as a result of the Los Angeles County wildfires, the 2025 CAHPS measure-level Star Ratings

will become the 2026 measure-level CAHPS Star Ratings. The 2027 CAHPS measure-level Star Ratings would be the better of the 2027 and 2026 CAHPS measure-level Star Ratings.

Table VI-4 lists the emergency areas affected by emergency declarations first issued in 2025, as defined in section 1135 of the Act, and the exercise of the Secretary's authority under section 1135 of the Act that apply for MA and PDP CAHPS adjustments for the 2026 Star Ratings.

Table VI-4. List of Section 1135 Waivers Issued in Relation to the FEMA Major Disaster Declarations that Apply for MA and PDP CAHPS Adjustments for the 2026 Star Ratings

Section 1135 Waiver Date Issued	Waiver or Modification of Requirements Under Section 1135 of the Social Security Act	FEMA Incident Type	Affected State	Incident Start Date
January 10, 2025	Wildfires	Wildfires and Straight-line Winds	California	January 7, 2025

Table VI-5 lists the states and territories with Individual Assistance designations from the FEMA major disaster declarations that apply for MA and PDP CAHPS adjustments for the 2026 Star Ratings.

Table VI-5. Individual Assistance Counties and County-Equivalents in FEMA Major Disaster Declared States/Territories that Apply for MA and PDP CAHPS Adjustments for the 2026 Star Ratings

FEMA Declaration	State	FEMA Individual Assistance Counties or County-Equivalents
DR-4856-CA	California	Los Angeles

Section G. Changes to Existing Star Ratings Measures for the 2026 Measurement Year and Beyond

CMS solicits feedback on new measure concepts as well as measure updates through the annual Advance Notice and Rate Announcement process. We also provide advance notice regarding measures considered for implementation as future Star Ratings measures. As codified at §§ 422.164(c)(2)(4), 423.184(c)(2)(4), 422.164(d)(2), and 423.184(d)(2), new measures and measures with substantive specification changes 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 uses the Advance Notice and Rate Announcement process to announce non-substantive specification changes as described at §§ 422.164(d)(1) and 423.184(d)(1) and to remove measures as described at §§ 422.164(e) and 423.184(e).

We also encourage interested parties to provide comments directly to measure developers during their public comment periods. For example, the National Committee for Quality Assurance (NCQA) and the Pharmacy Quality Alliance (PQA) regularly solicit public comments on new measures, changes to existing measures, and measure retirements.

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

As the Part C and D Star Rating program continues to evolve and align with the measures included in the Universal Foundation, we are considering additional ways to simplify and refocus the measure set. This is consistent with recommendations from MedPAC and other interested parties that CMS consider having fewer measures in the Part C and D Star Ratings program.

To support the CMS National Quality Strategy, CMS is continuing to move towards a building-block approach to streamline quality measures across CMS quality and value-based care programs. Across our programs, where applicable, we are considering including the Universal Foundation[32] of quality measures, which is a core set of measures that are aligned across CMS programs. CMS is committed to aligning a core set of measures across all our quality and value-based care programs and ensuring we measure quality across the entire care continuum in a way that promotes high quality care for all individuals. Improving alignment of measures across federal programs and with private payers would reduce provider burden while also improving the effectiveness and comparability of measures. Using the Universal Foundation of quality measures would focus provider attention, reduce burden, identify care issues, prioritize development of interoperable, digital quality measures, allow for cross-comparisons across programs, and help identify measurement gaps. The Universal Foundation is a building block to which programs can add program-specific measures. This core set of measures will evolve over time to meet the needs of individuals served across CMS programs. We will continue to consider if additional Universal Foundation measures should be included in the Star Ratings program. We are no longer considering adding the Social Need Screening and Intervention (Part C) measure to the display page or proposing it through rulemaking to add to the Star Ratings program. Any additional Universal Foundation measures would need to be proposed through the rulemaking process.

The Universal Foundation attempts, among other things, to focus attention on measures that are meaningful for the health of broad segments of the population and to reduce provider burden by streamlining and aligning measures – in other words, to focus the measure set on clinical care, outcomes, and patient experience of care measures. There are various measures currently in the Part C and D Star Ratings measure set that focus on operational performance or on completion of required administrative processes. While these measures have been invaluable to CMS's efforts to monitor and improve plan performance and compliance in critical operational areas, they may

[32] https://www.nejm.org/doi/full/10.1056/NEJMp2215539.

be better suited as measures to monitor plan performance and compliance rather than as quality measures in the Part C and D Star Ratings program, especially since ratings for many of these measures are sensitive to small changes in performance. Additionally, we have seen improvement in the measures focused on operational performance and on completion of administrative processes since the inception of the Part C and D Star Ratings program and rates currently are fairly high.[33] For example, measures such as Medicare Plan Finder Price Accuracy (Part D), Complaints about the Health and Drug Plan (Part C and D), and Call Center – Foreign Language Interpreter and TTY Availability (Part C and D) could be proposed for retirement from the Star Ratings program and used, instead, by CMS to monitor plan performance and compliance if applicable. If these measures were removed, the CAHPS Survey measures included in the Star Ratings program would still capture similar issues related to customer service, getting needed information, and overall plan performance.

As performance has increased over time for the Plan Makes Timely Decisions about Appeals (Part C) and Reviewing Appeals Decisions (Part C) measures,[34] we could also consider retiring these measures. Because the appeals process is critical to monitor as it impacts access to care, CMS would continue to monitor plan performance and issue compliance actions based on appeals data as needed and would continue to monitor access issues through the CAHPS Survey.

We currently include in the Star Ratings program two measures using plan-reported data from the Part C and D Reporting Requirements: Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR) (Part D) and Special Needs Plan (SNP) Care Management (Part C). Both of these measures are process measures that indicate how often a contract completed a CMR for MTM program enrollees or how often the contract completed the required health risk assessments. CMS is ultimately interested in the outcomes of these two assessments, and not only their completion rates. CMS solicited feedback on the retirement of these measures from the Star Ratings program.

To simplify and refocus the measure set and the calculation of the Star Ratings program, we also solicited feedback about retiring the other SNP-specific measures. The Care for Older Adults – Pain Assessment measure (Part C) is being retired by NCQA for the 2025 measurement year and will be removed from the Star Ratings program starting with the 2027 Star Ratings.[35] The two remaining measures included in the Star Ratings for contracts with SNP plan benefit packages are: Care for Older Adults – Medication Review and Care for Older Adults – Functional Status

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[33] The average scores for the 2025 Star Ratings for MA contracts were as follows: Part C Call Center – Foreign Language Interpreter and TTY Availability was 94 percent, Part D Call Center – Foreign Language Interpreter and TTY Availability was 94 percent, Complaints about the Health/Drug Plan was 0.23, and Medicare Plan Finder Price Accuracy was 98 percent. Similarly, the average scores for the 2025 Star Ratings for PDP contracts were as follows: Part D Call Center – Foreign Language Interpreter and TTY Availability was 97 percent, Complaints about the Drug Plan was 0.04, and Medicare Plan Finder Price Accuracy was 97 percent.

[34] Scores have increased from 90 percent for the 2015 Star Ratings to 96 percent for the 2025 Star Ratings for Plan Makes Timely Decisions about Appeals measure, and from 88 percent to 95 percent during the same time period for the Reviewing Appeals Decisions measure.

[35] CY 2025 Rate Announcement.pdf (cms.gov) – see page 147.

Assessment. We specifically asked for feedback on whether to retire SNP-specific measures since these measures focus on processes of care and are only applicable to a subset of contracts and enrollees.

Our Star Ratings contractor, RAND Corporation, convened a Technical Expert Panel in late October 2024 to obtain feedback related to making enhancements to the Part C and D Star Ratings measure set. The TEP did not recommend making the measurement set smaller given the high stakes nature of the Part C and D Star Ratings program, but the TEP did support rethinking the measures included. Overall, there was support for the current HEDIS, CAHPS, HOS, and some of the operational measures. Suggestions included the following: adding more evidence-based clinical outcomes measures or redesigning current measures to assess patient outcomes (such as medication adherence); considering relevance, reliability, and the small denominator for some measures; considering "gameability," attribution issues, provider burden, and the sensitivity of measures to small changes; and considering measures focused on trust with the plan and network issues.

We asked for feedback from all interested parties on ways to simplify and refocus the measure set. Commenters provided mixed support for simplifying the overall measure set and focusing more on clinical care, outcomes, and patient experience. Some commenters were supportive of removing some or all of the measures focused on operational performance, while other commenters raised concerns about reducing the number of measures, retiring measures where plans do well, and removing measures where plans have more control over their performance.

There was mixed reaction to removing the Part C and D call center measures. For the call center measures, a few commenters mentioned limitations of the current measures due to a small number of calls causing significant shifts in performance, other commenters suggested increasing the number of calls made or removing the TTY component of the call center measures, and some commenters opposed removing these measures since they promote access for people with limited English proficiency and people with disabilities. We received mixed support for retiring the complaints measure, with some commenters noting that the complaints measure is an integral component of the program and is within the control of Part C and D contracts. The majority of commenters did not support retiring the Part C appeals measures, noting that these measures safeguard patients and promote accountability and transparency. There was mixed feedback on retiring the Medicare Plan Finder Price Accuracy measure, with some commenters saying that it helps ensure that consumers have accurate information about drug prices and others stating that the measure is effectively topped out.

We received mixed feedback on the retirement of the MTM measure. Although some commenters supported the retirement of this measure, the majority of commenters were opposed to retirement until CMS adopts an outcomes-based MTM measure as a replacement. Similarly, we received mixed support for retiring the SNP Care Management measure. Those in support of

retiring this measure noted that removing it would help focus the overall measure set on outcomes measures and reduce reporting burden, while other commenters thought this was an important measure to retain for consumers and plans. There was mixed reaction to removing the SNP-specific measures, such as the Care for Older Adults measures. Some commenters supported keeping the Care for Older Adults measures in the Star Ratings due to their importance for enrollees in SNPs, in particular for I-SNP enrollees, while other commenters noted removing these measures would help reduce burden.

We will take these comments into consideration as we contemplate proposing future changes to the measures. Any changes to the measure set would need to be proposed and finalized through the rulemaking process.

Statin Therapy for Patients With Cardiovascular Disease (Part C). NCQA is reevaluating this measure for the 2026 measurement year. First introduced for the 2015 measurement year, it assesses whether patients with atherosclerotic cardiovascular disease (ASCVD) received appropriate statin therapy and achieved a medication adherence rate of 80 percent. The adherence rate for this measure is not part of the Star Ratings program. Based on a review of recent literature and clinical guidelines, as well as preliminary input from the Cardiovascular Measurement Advisory Panel, NCQA is considering modifying the measure's age ranges and denominator inclusion and exclusion criteria. NCQA is considering removing the existing sex-specific age bands and increasing the upper age limit. NCQA is also examining the current value sets and method used to identify members with ASCVD for any potential updates, as well as evaluating the potential for transitioning this measure to the electronic clinical data systems (ECDS)-reporting method. Changes made to this measure that expand the eligible population would be considered a substantive change. As codified at § 422.164(d)(2), a measure with substantive specification changes 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. The majority of commenters supported the potential changes to this measure; however, there was mixed feedback regarding the age band adjustments, the inclusion and exclusion criteria, and the transition to ECDS-reporting. We have shared this feedback with NCQA for their consideration.

Transitions of Care (Part C). NCQA is reevaluating the Transitions of Care measure, which includes four indicators related to care coordination after a patient is discharged from an inpatient setting to home. The first two indicators relate to notification of inpatient admission and receipt of discharge information and currently use the hybrid reporting method only. The second two indicators, patient engagement after discharge and medication reconciliation, utilize hybrid and administrative reporting methods. NCQA intends to develop a new ECDS-reported version of the measure that will also consider changes from the current specification based on expert feedback and testing. NCQA plans to conduct measure testing in 2025 and implement the new ECDS-reported measure for the 2027 measurement year. NCQA plans to maintain the current Transitions of Care measure alongside the new measure for a period of time to allow for transition to the new measure. If the changes are substantive, we would keep the legacy measure

in Star Ratings while the updated measure is proposed through rulemaking and included on the display page for at least two years as codified at § 422.164(d)(2). Commenters expressed mixed reaction to the development of a new ECDS-reported version of the measure. The comments focused on timing of these potential changes, having the legacy and new measures collected concurrently, ensuring feedback by interested parties as this work progresses, and having widespread testing of the measure to capture potential challenges. We have shared these comments with NCQA for their consideration.

Care for Older Adults (COA): Functional Status Assessment and Medication Review (Part C). NCQA is reevaluating the COA measures with the goal of considering measure modifications and transitioning the measures to the ECDS-reporting method to align with NCQA's strategic direction. This effort may result in new ECDS-reported measures for the functional status assessment and medication review indicators. Any potential new measures are planned for implementation in measurement year 2027 at the earliest, and NCQA plans to maintain the current COA measures alongside any new measures for a period of time to allow for transition. Commenters provided mixed feedback on transitioning these measures to ECDS-reporting method. Comments related to ensuring sufficient time for the transition, expanding the measures to include all Medicare Advantage enrollees, and making sure there is sufficient testing. We shared the feedback we received with NCQA for their review. CMS will provide more updates on NCQA's work as more information is available.

Monitoring Physical Activity, Reducing the Risk of Falling, and Improving Bladder Control (Part C). These are three HEDIS measures collected through the HOS. NCQA refers to these measures as Physical Activity in Older Adults, Fall Risk Management, and Management of Urinary Incontinence in Older Adults. NCQA is planning to reevaluate these for measurement year 2027 at the earliest, focusing on evaluating the relevance and evidence supporting use of these measures in Medicare patients under 65 years of age. If these measures are updated, it would be considered a substantive change as codified at § 422.164(d)(2). CMS would keep the legacy measures in Star Ratings while the updated measures are on the display page and the updated measures are proposed through rulemaking. There was mixed support related to expanding the age range, including comments related to combining the under 65 population with the over 65 population. We have shared this feedback with NCQA for their consideration.

Diabetes Care – Blood Sugar Controlled (Part C). NCQA calls this measure Glycemic Status Assessment for Patients With Diabetes.[36] This measure is part of the former Comprehensive Diabetes Care measure set. The HEDIS measure captures the percentage of members 18-75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: glycemic status <8.0% or glycemic status >9.0%. In the Star Ratings program

[36] https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/announcements-and-documents/371979854/2024 –see pages 156-158.

we include the indicator that captures the percentage of diabetic MA enrollees 18-75 years of age whose most recent HbA1c level is greater than 9%, or who were not tested during the measurement year. This measure for CMS public reporting is reverse scored, such that higher scores are better. Thus, to calculate this measure, CMS subtracts the submitted rate from 100. This is currently a hybrid measure. NCQA is developing a new ECDS-reported version of this measure for measurement year 2027 and plans to conduct testing for ECDS feasibility in 2025, prior to implementation. NCQA plans to maintain the hybrid measure in HEDIS, in parallel with the ECDS measure, during a two-year transition period, until the hybrid measure is replaced with the new ECDS measure in measurement year 2029. This change would be considered non-substantive since removing hybrid reporting and transitioning to ECDS will not change the eligible population for the measure or the data sources that contracts can use; the change is to the reporting method only. Most of the comments related to ensuring adequate time to transition to ECDS reporting. We have shared the comments with NCQA for their review.

Concurrent Use of Opioids and Benzodiazepines (COB) (Part D). The PQA updated the COB measure specifications in the 2025 PQA Measure Manual to exclude beneficiaries with cancer-related pain treatment diagnosis during the measurement year to align with the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain (2022 CDC Guideline).[37] CMS plans to exclude beneficiaries with cancer-related pain treatment diagnosis from the COB measure beginning with the 2025 measurement year (2027 Star Ratings). This would be a non-substantive update under § 423.184(d)(1)(iii) because it updates the clinical codes with no change in the target population or the intent of the measure. Commenters supported updating the COB measure to exclude beneficiaries with cancer-related pain treatment diagnosis. Therefore, this exclusion will be applied for the 2025 measurement year.

Medication Adherence for Diabetes Medications/ Medication Adherence for Hypertension (RAS Antagonists)/ Medication Adherence for Cholesterol (Statins)/ Statin Use in Persons with Diabetes (SUPD)/ COB/ Polypharmacy: Use of Anticholinergic Medications in Older Adults (Poly-ACH) (Part D). CMS excludes contracts with 30 or fewer enrolled members in the denominator from the Star Ratings; in other words, only contracts with 31 or more enrolled members receive a measure rate. The PQA recommends excluding contracts with fewer than 30 enrolled members from the measure rate calculations since it is an insufficient sample size for measurement purposes. Therefore, CMS plans to align with the PQA to exclude contracts with fewer than 30 enrolled members from the measure rate calculations, and contracts with 30 or more enrolled members will be included in the measure rate calculation starting with the 2025 measurement year (2027 Star Ratings). This would be a non-substantive update under § 423.184(d)(1).

All commenters supported this update to these measures to include contracts with 30 or more members in the denominator for the measure rate calculation. Commenters noted that this update

[37] https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm

promotes consistency across many of the other measures in the Star Ratings. Additionally, this change would align with the PQA's recommendation that a denominator less than 30 members is an insufficient sample size for measurement purposes and could lead to unreliable or invalid results. We will implement this update to these measures for the 2025 measurement year.

Section I. Display Measures

Display measures on CMS.gov are published separately from the Star Ratings and include measures that are transitioned from inclusion in the Star Ratings, new or updated measures before inclusion into the Star Ratings, and informational-only measures. Organizations and sponsors have the opportunity to preview the data for their display measures prior to release on CMS.gov. The sections below focus on the current 2025 display measures and feedback CMS received on potential measure changes.

Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation (Part C). Currently on the display page we include Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid and Pharmacotherapy Management of COPD Exacerbation – Bronchodilator. NCQA is exploring potential updates or replacements to this measure given recent clinical guideline updates. This effort may result in new measures for HEDIS if NCQA finds there are gaps in COPD measurement. Any updates or new measures would be available for the 2027 measurement year at the earliest. All commenters supported updates to align with current clinical guidelines. We have shared the comments with NCQA.

Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS) (Part D). The PQA updated the Poly-CNS measure specifications in the 2025 PQA Measure Manual to add the skeletal muscle relaxant class of medications to align with the 2023 updated American Geriatrics Society (AGS) Beers Criteria's recommendation[38] to avoid concurrent use of three or more CNS-active medications in older adults because of the increased risk of falls, fractures, and confusion. The 2023 AGS Beers Criteria for Potentially Clinically Important Drug-Drug Interactions That Should be Avoided in Older Adults (Table 5) to identify any combination of three or more CNS-active medications to avoid was revised to include skeletal muscle relaxants in the medication list. Therefore, the six new skeletal muscle relaxants that will be added to the Poly-CNS measure in 2025 are carisoprodol, chlorzoxazone, cyclobenzaprine, metaxalone, methocarbamol, and orphenadrine. CMS will align with the PQA measure specification updates and add the new skeletal muscle relaxant class of medications to the Poly-CNS measure for the 2025 measurement year (2027 display page).

Most commenters supported adding the skeletal muscle relaxants as a new class of medications to the Poly-CNS measure. A couple of commenters opposed adding the skeletal muscle class to

[38] American Geriatrics Society 2023 updated AGS Beers Criteria for potentially inappropriate medication use in older adults at https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.18372.

the Poly-CNS measure, and one commenter believed this would be a substantive change per the rules to update Star Ratings measures. As a reminder, as discussed in the April 2024 final rule,[39] the Poly-CNS measure was not added to the Star Ratings and will remain on the display page. Therefore, since the Poly-CNS measure is not in the Star Ratings, measure specification updates are not subject to rulemaking, but CMS did announce this measure specification update in advance of the measurement year through the Advance Notice. Additionally, we received comments to expand the exclusion diagnoses and add significant mental health illnesses to the Poly-CNS measure since beneficiaries are in clinical care for these conditions and most likely receiving MTM. We appreciate this feedback and will forward the comments to the measure steward. The skeletal muscle class of medications will be added to the Poly-CNS measure for the 2025 measurement year.

Use of Opioids at High Dosage in Persons Without Cancer (OHD)/ Initial Opioid Prescribing for Long Duration (IOP-LD) (Part D). The PQA also updated the OHD and IOP-LD measure specifications in the 2025 PQA Measure Manual to exclude beneficiaries with cancer-related pain treatment diagnosis during the measurement year to align with the 2022 CDC Guideline. CMS will incorporate this update beginning with the 2025 measurement year (2027 display page).

Similar to the COB measure, commenters were supportive of updating the OHD and IOP-LD measures to exclude beneficiaries with cancer-related pain treatment. Likewise, we will apply the exclusion for the 2025 measurement year to align with the PQA measure specifications.

Medication Adherence for Statins with Risk Adjustment (RA) (ADH-Statins RA)/ Medication Adherence for RAS Antagonists with RA (ADH-RAS RA)/ Medication Adherence for Diabetes Medications with RA (ADH-Diabetes RA)/ Antipsychotic Use in Persons with Dementia (APD)/ Antipsychotic Use in Persons with Dementia – for Long-Term Nursing Home Residents (APD-LTNH)/ OHD/ Poly-CNS/ IOP-LD/ Persistence to Basal Insulin (PST-INS)/ Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR) (Part D). CMS excludes contracts with 30 or fewer enrolled members in the denominator from the display page; only contracts with 31 or more enrolled members receive a measure rate. The PQA recommends excluding contracts with fewer than 30 enrolled members from the measure rate calculations since it is an insufficient sample size for measurement purposes. Therefore, CMS plans to align with the PQA to exclude contracts with fewer than 30 enrolled members from the measure rate calculations, and contracts with 30 or more enrolled members will be included in the measure rate calculation starting with the 2025 measurement year (2027 display page).

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[39] Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024 - Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE) at https://www.govinfo.gov/content/pkg/FR-2024-04-23/pdf/2024-07105.pdf.

Similarly, as mentioned above, all commenters supported this update to the display page measures to include contracts with 30 or more members in the denominator for the measure rate calculation. We will implement this update to these measures for the 2025 measurement year.

Initial Opioid Prescribing for Long Duration (IOP-LD) (Part D). The PQA refined the definition for negative medication history to improve clarity in the 2025 PQA Measure Manual. For a beneficiary to have a negative medication history, there should be no prescription claims for opioids "with a date of service" in the lookback period. CMS does not anticipate this clarification impacting the IOP-LD measure operationally. Therefore, CMS will integrate the revised definition of negative medication history into the IOP-LD measure for the 2025 measurement year (2027 display page). Commenters were supportive of the clarification made to the negative medication history definition, and it will be implemented for the 2025 measurement year.

Financial Reasons for Disenrollment (Part C & D). This measure captures a variety of reasons related to the cost or affordability of services for leaving a plan. CMS is considering replacing one general cost-related leave reason (found a plan that costs less) with three more specific cost-related reasons to leave health or drug plans: 1) found a plan with a lower copayment for prescription drugs (MA & PDP); 2) found a plan with a lower copayment for doctors' visits (MA); and 3) found a plan with a lower monthly premium (MA & PDP). The updated measure is currently being tested and will be available for the 2026 Display Page that covers the 2024 measurement year. Most commenters supported this change, noting the new measure will be useful, more accurate, and help MA plans better understand how different types of cost sharing contribute to disenrollment.

Section J. Retirement of Display Measures

Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) (Part D). The PQA membership voted in favor of retiring the OMP measure for the 2025 measurement year due to low measure rates, resulting in minimal opportunities for improvement. All commenters were supportive of retiring the OMP measure. The OMP measure will be retired starting with the 2025 measurement year.

Section K. Potential New Measure Concepts and Methodological Enhancements for Future Years

CMS's process for adding any new measures to the Star Ratings system includes developing and testing new measures, soliciting feedback on potential new measures, submitting the measures for approval under the PRMR process, and undertaking notice and comment rulemaking to propose and finalize new measures. CMS solicited comments on new measure concepts and methodological changes to inform future changes to the Star Ratings, as described in §§ 422.164(c) and 423.184(c).

Excellent Health Outcomes for All (Part C and D). CMS plans to update the Health Equity Index (HEI) reward defined at §§ 422.166(f)(3) and 423.186(f)(3) to call it the Excellent Health Outcomes for All (EHO4all) reward because this name better captures the goal of ensuring exceptional care for all enrollees. The enrollees to be included in the EHO4all when it is implemented beginning with the 2027 Star Ratings include those that are dually eligible, receive a low-income subsidy, or are disabled because these groups are at risk for poor health outcomes and Star Ratings data show gaps in the quality of care for these enrollees. While the EHO4all reward incentivizes improved performance among specified groups of enrollees at risk for poor health outcomes, CMS is also incentivizing improved performance across all enrollees by removing the current reward factor when the EHO4all reward is implemented beginning with the 2027 Star Ratings. This is consistent with the goal of achieving excellent health outcomes for all enrollees.

CMS is considering adding factors beyond dual eligibility, receipt of low-income subsidy, and disability to the EHO4all reward. One factor we are considering adding is geography (e.g., rural or urban). We solicited preliminary feedback on the addition of geography to the reward and how to define this. There was mixed support for adding geography as an additional factor in the EHO4all reward (also called the HEI reward). Some commenters asked for more details on the definition of geography that would be used, while a few commenters suggested possible definitions of geography. CMS will continue to consider adding geography as an additional factor in the EHO4all reward. Adding geography to the EHO4all reward would need to be proposed and finalized through rulemaking, and a definition of geography would also be proposed as part of this process. Additionally, CMS will propose updates to §§ 422.166(f)(3) and 423.186(f)(3) in future rulemaking to reflect the updated name, EHO4all reward. CMS may also consider additional changes regarding the EHO4all reward and any further changes would need to be proposed through rulemaking.

Diabetes Foot Exam and Follow-Up (Part C). NCQA is developing a new measure that assesses comprehensive foot examinations (neurological, vascular, visual) and appropriate follow-up for abnormal findings (sensory loss, poor circulation, visible wounds/ulceration, skin or structural changes) or for those with existing amputation risk (prior deformity, ulceration, or amputation; glycemic status >9%, smoking, retinopathy, nephropathy, ESRD, dialysis) among adults with diabetes. The measure will be implemented as an ECDS-reported measure that leverages multiple data sources (i.e., claims, electronic health records, health information exchanges, registries). The measure may be included in HEDIS starting with the 2027 measurement year at the earliest. There was mixed reaction to this measure, with commenters wanting additional information to evaluate it. We have shared this feedback with NCQA for their consideration.

Colorectal Cancer Screening Follow-Up (Part C). NCQA is exploring the development of a measure to assess follow-up after colorectal cancer screening. When identified early, colorectal cancer is one of the most treatable forms of cancer. However, the current Colorectal Cancer

Screening measure is limited to screening only and does not assess appropriate and timely follow-up after abnormal results from an initial screening. This measure concept will be developed and tested using the ECDS-reporting method that leverages multiple data sources (i.e., claims, electronic health records, health information exchanges, registries). The measure is being targeted for inclusion in HEDIS starting with the 2027 measurement year. There was mixed feedback on this potential new HEDIS measure although more than half of commenters supported further work in this area taking into consideration the variety of FDA-authorized screening technologies, the window for follow-up, and testing across a variety of EHR vendors. Some commenters suggested that I-SNP enrollees be included. We have shared these comments with NCQA for their review.

End-Stage Renal Disease (ESRD) (Part C). NCQA has completed preliminary analyses to identify MA members with chronic kidney disease (CKD) stage 4 or with ESRD as part of a feasibility assessment of a future measure focused on ESRD in MA. NCQA is obtaining feedback on potential measure concepts from a newly convened kidney expert working group. A measure is planned for measurement year 2027. Although a few commenters expressed support for developing measures related to ESRD, most commenters requested more information. There was some interest in focusing measure development on early intervention and prevention. We have shared this feedback with NCQA for their consideration.

Person-Centered Outcomes (Part C). NCQA is developing three measures focused on identifying, measuring, and tracking goals over time. The person-centered outcome measures incorporate what matters most (person-centered outcome goals) to individuals with complex care needs into care planning and quality measurement. The first measure, Goal Identification, assesses whether a person-centered outcome goal was identified, documented using either a patient-reported outcome measure (PROM) or goal attainment scaling (GAS), and an action plan developed. The second measure, Goal Follow-up, assesses if the person-centered outcome goal was followed up on within two weeks to six months of when the goal and PROM/GAS were identified. The third measure, Goal Achievement, assesses whether the person-centered outcome goal was achieved. NCQA began measure testing in fall 2024 for a potential SNP only measure to include in HEDIS. The measures are planned for the 2027 measurement year at the earliest. We welcomed comments on this measurement concept and whether SNP-specific measures should be considered given our goal of trying to simplify and refocus the Star Ratings measure set. There was mixed reaction to this measurement concept and concerns raised about the additional burden of this type of measure, as well as whether this type of measure should be limited to SNP enrollees. We have shared this feedback received with NCQA.

Respiratory Syncytial Virus (RSV) Immunization Indicator for Adult Immunization Status (Part C). As guidelines continue to develop around RSV vaccination for adults, NCQA is assessing and determining the appropriateness of incorporating this vaccine indicator in the Adult Immunization Status measure. Any potential updates would likely be included no earlier

than the 2027 measurement year. Most commenters requested additional details from NCQA on this measurement concept. We have shared this feedback with NCQA.

Attachment VII. Economic Information for the CY 2026 Rate Announcement

Below, we provide the economic information for significant provisions in the Rate Announcement. Provisions not specifically addressed below are intended to represent a continuation of the policies established for CY 2025 and, as a result, do not have an impact associated with them.

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

A1. Medicare Advantage and PACE non-ESRD Ratebook

The FFS growth percentage for the 2026 MA non-ESRD rates is estimated to be 8.81 percent, and the MA growth percentage for the 2026 MA non-ESRD rates is estimated to be 10.72 percent. The MA non-ESRD ratebook impact summarized here is calculated by comparing 2026 Part C expenditures reflecting these growth rate assumptions to the expected 2026 Part C expenditures assuming the MA non-ESRD ratebook remains unchanged from that finalized for 2025. The net impact on the Medicare Trust Funds for CY 2026 is expected to be $38.73 billion. This figure accounts for the impact of the benchmark rate cap, MA rebate, and MA EGWP policies, as well as the portion of the difference between benchmarks and bids that the government retains, and the portion of the program costs covered by Part B premiums.

The MA growth percentage, used to calculate the 2026 PACE non-ESRD rates as well as in development of the applicable amount used in setting MA non-ESRD rates, is estimated to be 10.72 percent. The PACE non-ESRD ratebook impact is calculated by comparing the 2026 PACE expenditures reflecting this growth rate assumption to the expected 2026 PACE expenditures assuming that the PACE non-ESRD ratebook remains unchanged from the CY 2025 PACE non-ESRD ratebook. The net impact on the Medicare Trust Funds for CY 2026 for the PACE ratebook change is expected to be $280 million. This figure accounts for the portion of the program costs covered by Part B premiums.

The net impact on the Medicare Trust Funds for CY 2026 of implementing the zero-claims adjustment in Puerto Rico is expected to be $320 million.

A2. Medicare Advantage and PACE ESRD Ratebooks

The FFS growth percentage for the 2026 MA ESRD rates is estimated to be 6.79 percent. The impact on the MA and PACE ESRD ratebooks is calculated by comparing projected 2026 Part C expenditures with this growth rate assumption to the expected 2026 Part C expenditures with the assumption that the MA and PACE ESRD ratebooks would have been unchanged from those finalized for CY 2025. The net impact on the Medicare Trust Funds for CY 2026 is expected to be $2.15 billion. This figure accounts for the portion of the program costs covered by Part B premiums.

A3. CMS-HCC Risk Adjustment Model

For CY 2026, CMS is calculating risk scores for MA organizations entirely with the 2024 CMS-HCC model. The CY 2026 impact on MA risk scores, relative to the blend in CY 2025, is projected to be –3.01 percent, which represents a $12.88 billion net savings to the Medicare Trust funds in CY 2026. The 2020 CMS-HCC model (2015 denominator) and the 2024 CMS-HCC model (2020 denominator) have different denominator years (i.e., number of years of risk score trend). Therefore, risk scores under the models are not comparable when determining impacts due to the different number of years of risk score trend. In order to isolate the impact of the model transition, the risk scores being compared were each appropriately normalized to remove the impact of FFS risk score trend. When estimating the impact of fully transitioning to the 2024 CMS-HCC model, the impact takes into account the portion of the difference between benchmarks and bids that the government retains, and the portion of the program costs covered by Part B premiums.

A4. ESRD Risk Adjustment Model

For CY 2026, CMS is continuing the use of the ESRD risk adjustment models used for MA payment in CY 2025. Therefore, no economic impact is applicable.

A5. Frailty Adjustment for FIDE SNPs

For CY 2026, CMS is calculating frailty scores for FIDE SNPs with the 2024 CMS-HCC model frailty factors, consistent with Part C risk adjustment. Additionally, CMS is determining the dual status of a beneficiary using data from systems of record (i.e., the MMA State files, the Point of Sale data, and the Commonwealth of Puerto Rico monthly Medicaid files), as has been done historically, rather than using full Medicaid factors for all beneficiaries, as was done for CY 2025 secondary to differences in the enrollment requirements for FIDE SNPs during the survey data collection period (CY 2024) and the calendar year (CY 2025). The CY 2026 impact of transitioning to frailty scores calculated using the 2024 CMS-HCC model frailty factors entirely, relative to the blend used for CY 2025, and using frailty factors for beneficiaries based on systems of record rather than only full Medicaid factors for all beneficiaries, is a change in frailty scores of -0.58 percent, which represents a net savings of less than $10 million dollars to the Medicare Trust Funds in CY 2026. This impact takes into account the portion of the difference between benchmarks and bids that the government retains, and the portion of the program costs covered by Part B premiums.

A6. MA Coding Pattern Difference Adjustment

For CY 2026, we will continue to apply the statutory minimum coding pattern difference adjustment (5.90 percent). There is no change in policy from CY 2025 and therefore, the year-over-year impact is zero and no economic impact is applicable.

A7. Part C Normalization

The normalization factors serve to offset the trend in risk scores and maintain a 1.0 average FFS risk score for the CMS-HCC models. For CY 2026, for all CMS-HCC risk adjustment models, CMS is calculating the normalization factors using a five-year multiple linear regression methodology and average historical FFS risk scores from 2020-2024. Since normalization is applied to risk scores to maintain the same average risk score year-over-year, the economic 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

The methodology for updating other Part D parameters for CY 2026 generally remains unchanged from that used for CY 2025. However, statutory changes may result in potential payment impacts for CY 2026. At this time, the impact on the Medicare Trust Fund is uncertain since the impact of such parameter updates is generally dependent on the behavior and bid assumptions of Part D plan sponsors.

B2. Part D Risk Adjustment Model

For CY 2026, we are implementing RxHCC risk adjustment models with updates that include revisions to reflect the statutory changes in the Part D benefit structure for CY 2026. CMS is using a model calibrated on 2022 diagnoses and 2023 expenditures for non-PACE organizations and a model that continues to be calibrated on 2018 diagnoses and 2019 expenditures for PACE organizations. In order to calculate risk scores for payment, the dollar coefficients must be denominated to create relative factors. The denominator is the average predicted per capita expenditure predicted by the payment model for a given year. To calculate the denominator, we use the recalibrated model and diagnosis data for Medicare beneficiaries enrolled in both MA-PD plans and PDPs, which results in an average risk score of 1.0 for the enrolled Part D population in the denominator year. Recalibration of the RxHCC model can result in changes in risk scores for individual beneficiaries and for plan level risk scores; however, the average risk score in the denominator year remains 1.0, and the application of the normalization factor functions to maintain the 1.0 in the payment year. Since the average risk score is 1.0 under the existing model and the recalibrated model, the economic impact of the recalibrated model is zero.

B3. Part D Normalization

The 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 model. For CY 2026, CMS is calculating separate MA-PD and PDP normalization factors for the RxHCC model (2022/2023 calibration) being finalized for MA (and partially for PACE organizations) using the

multiple linear regression methodology and average historical risk scores from 2019 through 2023 and, for the 2018/2019 calibration being finalized solely for PACE organizations, using the historical linear slope methodology and average historical risk scores from 2016 through 2020. Since normalization is applied to risk scores to maintain the same average risk score of 1.0 year-over-year, the impact of normalization is zero.

Attachment VIII. RxHCC Risk Adjustment Factors and Predictive Ratio Tables

Table VIII-1. 2026 RxHCC Model Relative Factors for Continuing Enrollees (2022/2023 Calibration; HCPCS-based Filtering Logic; Reflects MFPs)

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
Female						
0-34 Years		-	0.328	-	0.690	2.656
35-44 Years		-	0.363	-	0.837	2.400
45-54 Years		-	0.334	-	0.772	1.543
55-59 Years		-	0.242	-	0.497	1.455
60-64 Years		-	0.165	-	0.257	1.098
65-69 Years		0.122	-	0.108	-	1.211
70-74 Years		0.035	-	0.108	-	0.923
75-79 Years		0.035	-	0.108	-	0.628
80-84 Years		0.035	-	0.108	-	0.328
85-89 Years		0.035	-	0.108	-	0.187
90-94 Years		0.035	-	0.108	-	0.010
95 Years or Over		0.035	-	0.108	-	0.010
Male						
0-34 Years		-	0.181	-	0.715	2.151
35-44 Years		-	0.241	-	0.689	1.847
45-54 Years		-	0.217	-	0.541	1.451
55-59 Years		-	0.194	-	0.380	1.130

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
60-64 Years		-	0.188	-	0.229	0.882
65-69 Years		0.175	-	0.329	-	0.896
70-74 Years		0.146	-	0.240	-	0.698
75-79 Years		0.049	-	0.171	-	0.482
80-84 Years		0.049	-	0.038	-	0.282
85-89 Years		0.049	-	0.038	-	0.084
90-94 Years		0.049	-	0.038	-	0.084
95 Years or Over		0.049	-	0.038	-	0.084
Originally Disabled Interactions with Sex						
Originally Disabled Female		0.042	-	0.376	-	0.298
Originally Disabled Male		-	-	0.169	-	0.298
Disease Coefficients						
RXHCC1	HIV/AIDS	8.325	9.961	9.677	9.773	7.179
RXHCC5	Opportunistic Infections	0.654	0.564	0.828	0.537	0.323
RXHCC15	Chronic Myeloid Leukemia	4.907	4.016	14.570	22.052	9.021
RXHCC16	Multiple Myeloma and Other Hematologic Cancers	11.150	10.209	12.238	11.536	5.396
RXHCC17	Secondary Cancer of Bone and Kidney	4.907	4.016	12.083	10.952	5.396

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC18	Secondary Cancer of Lung, Liver, Brain, and Other Sites	2.456	2.192	4.530	3.803	1.275
RXHCC19	Leukemias and Other Hematologic Cancers	2.456	2.192	3.712	3.413	1.275
RXHCC20	Lung, Kidney, and Other Cancers; Secondary Cancer of Lymph Nodes and Other Sites	0.595	0.471	1.347	0.962	0.397
RXHCC21	Lymphomas and Other Hematologic Cancers	0.595	0.267	0.749	0.359	0.255
RXHCC22	Prostate, Breast, Bladder, and Other Cancers and Tumors	0.123	0.072	0.436	0.359	0.206
RXHCC30	Diabetes with Complications	0.567	0.682	0.983	1.530	0.756
RXHCC31	Diabetes without Complication	0.248	0.281	0.429	0.695	0.326
RXHCC40	Alpha-1-Antitrypsin Deficiency	2.571	6.735	7.006	8.774	1.117
RXHCC41	Lysosomal Storage Disorders	4.668	10.426	6.058	20.506	0.033
RXHCC42	Acromegaly and Other Endocrine and Metabolic Disorders	2.401	3.395	2.778	5.559	0.905

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC43	Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders	0.038	0.143	-	0.142	0.033
RXHCC44	Thyroid Disorders	0.068	0.161	0.152	0.339	0.157
RXHCC47	Disorders of Lipoid Metabolism	-	-	0.047	0.096	0.022
RXHCC54	Chronic Viral Hepatitis C	0.253	0.317	0.267	0.073	0.536
RXHCC55	Acute or Unspecified Viral Hepatitis C	0.253	0.317	0.267	0.073	0.536
RXHCC56	Chronic Viral Hepatitis B and Other Specified Chronic Viral Hepatitis	0.264	0.604	1.274	0.806	0.641
RXHCC59	Primary Biliary Cirrhosis	1.003	1.345	1.597	2.139	1.530
RXHCC65	Chronic Pancreatitis	0.375	0.612	0.771	1.260	0.644
RXHCC66	Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis	0.279	0.612	0.689	1.260	0.395
RXHCC67	Inflammatory Bowel Disease	0.425	0.600	1.156	2.678	0.390
RXHCC80	Aseptic Necrosis of Bone	0.170	0.244	0.192	0.433	-
RXHCC81	Psoriatic Arthropathy	0.755	0.494	6.280	9.094	3.418
RXHCC82	Systemic Sclerosis	1.282	1.247	1.607	2.157	0.500
RXHCC83	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	0.161	0.230	1.227	2.157	0.500

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC84	Systemic Lupus Erythematosus and Other Systemic Connective Tissue Disorders	0.136	0.230	0.340	0.501	0.128
RXHCC87	Osteoporosis, Vertebral and Pathological Fractures	0.044	0.170	0.207	0.496	0.037
RXHCC95	Sickle Cell Anemia	-	0.908	-	1.584	-
RXHCC96	Acquired Hemolytic, Aplastic, and Sideroblastic Anemias	0.880	0.525	1.020	1.126	0.192
RXHCC98	Hereditary Angioedema and Other Defects in the Complement System	9.161	46.954	12.558	51.801	2.960
RXHCC99	Immune Disorders	0.449	0.440	0.755	1.248	0.364
RXHCC100	Immune Thrombocytopenic Purpura	0.478	0.341	2.471	3.003	1.707
RXHCC111	Alzheimer's Disease	-	-	-	-	-
RXHCC112	Dementia, Except Alzheimer's Disease	-	-	-	-	-
RXHCC130	Schizophrenia and Other Psychosis	0.261	0.316	0.905	1.574	0.511
RXHCC131	Bipolar Disorders	0.254	0.160	0.659	0.768	0.435
RXHCC132	Depression	0.040	0.018	0.102	0.225	0.114

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC133	Anxiety and Other Psychiatric Disorders	0.032	0.018	0.035	0.131	-
RXHCC146	Profound or Severe Intellectual Disability/Developmental Disorder	0.525	0.127	0.546	0.275	-
RXHCC147	Moderate Intellectual Disability/Developmental Disorder	0.525	-	0.347	0.132	-
RXHCC148	Mild or Unspecified Intellectual Disability/Developmental Disorder	0.525	-	0.111	-	-
RXHCC153	Myasthenia Gravis and Other Myoneural Disorders	1.972	3.410	2.279	3.891	0.423
RXHCC154	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	4.754	4.995	3.456	4.382	1.002
RXHCC155	Spinal Cord Disorders	0.057	0.146	0.027	0.171	0.111
RXHCC157	Chronic Inflammatory Demyelinating Polyneuritis	4.666	9.323	6.578	10.309	0.729
RXHCC158	Inflammatory and Toxic Neuropathy	-	-	-	-	0.139
RXHCC159	Multiple Sclerosis	1.113	1.277	3.299	5.810	1.850

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC160	Huntington Disease	1.896	1.412	5.311	6.837	4.749
RXHCC161	Parkinson Disease	0.480	0.875	0.687	1.178	0.911
RXHCC163	Intractable Epilepsy	0.120	0.368	0.388	2.741	0.013
RXHCC164	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy	-	-	-	0.026	-
RXHCC166	Migraine Headaches	0.118	0.194	0.541	0.714	0.454
RXHCC168	Trigeminal and Postherpetic Neuralgia	0.063	0.149	0.184	0.443	0.220
RXHCC183	Pulmonary Arterial Hypertension	1.832	6.752	2.391	8.532	0.540
RXHCC184	Pulmonary Hypertension, Except Arterial, and Other Pulmonary Heart Disease	0.177	0.358	0.197	0.416	0.196
RXHCC186	Heart Failure	0.135	0.066	0.197	0.187	0.146
RXHCC187	Hypertension	0.046	0.029	0.103	0.147	0.016
RXHCC188	Coronary Artery Disease	0.061	-	0.177	-	-
RXHCC191	Ventricular Septal Defect and Major Congenital Heart Disorders	0.185	0.541	0.087	-	0.345
RXHCC193	Atrial Arrhythmias	0.214	0.058	0.154	0.020	0.175
RXHCC207	Spastic Hemiplegia	-	0.081	-	0.103	-

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC215	Venous Thromboembolism	0.219	0.242	0.216	0.250	0.146
RXHCC225	Cystic Fibrosis	10.360	37.612	4.932	49.694	6.120
RXHCC226	Idiopathic Pulmonary Fibrosis and Systemic Sclerosis with Lung Involvement	3.683	2.918	6.057	5.993	1.117
RXHCC227	Pulmonary Fibrosis, Except Idiopathic	0.335	0.452	0.515	1.141	0.405
RXHCC228	Severe Persistent Asthma	0.978	0.668	3.048	3.463	1.303
RXHCC229	Chronic Obstructive Pulmonary Disease, Bronchiectasis, and Other Asthma	0.214	0.130	0.406	0.336	0.405
RXHCC243	Glaucoma, Open-Angle or Moderate/Severe Stage	0.136	0.227	0.406	0.571	0.340
RXHCC244	Other Non-Acute Glaucoma	-	-	0.066	-	0.074
RXHCC260	Kidney Transplant Status	-	-	-	-	0.056
RXHCC261	Dialysis Status, Including End Stage Renal Disease	0.009	-	0.007	-	-
RXHCC262	Chronic Kidney Disease Stage 5	0.009	-	0.007	-	-
RXHCC263	Chronic Kidney Disease Stage 4	0.009	-	0.007	-	-

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC311	Chronic Ulcer of Skin, Except Pressure	0.135	0.138	0.116	0.071	0.076
RXHCC314	Pemphigus, Pemphigoid, and Other Bullous Skin Disorders	0.280	0.509	0.748	1.665	0.243
RXHCC316	Psoriasis, Except with Arthropathy	0.198	0.278	1.969	3.361	1.170
RXHCC317	Discoid Lupus Erythematosus	0.076	0.026	0.156	-	-
RXHCC355	Narcolepsy and Cataplexy	0.922	2.360	1.926	4.666	0.932
RXHCC395	Stem Cell, Including Bone Marrow, Transplant Status/Complications	3.425	2.836	5.752	4.181	3.189
RXHCC396	Heart, Lung, Liver, Intestine, or Pancreas Transplant Status	-	-	-	-	0.056
Non-Aged Disease Interactions						
NonAged_RXHCC1	NonAged * HIV/AIDS	-	-	-	-	1.491
NonAged_RXHCC130	NonAged * Schizophrenia and Other Psychosis	-	-	-	-	1.054
NonAged_RXHCC131	NonAged * Bipolar Disorders	-	-	-	-	0.705
NonAged_RXHCC132	NonAged * Depression	-	-	-	-	0.354

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
NonAged_RXHCC133	NonAged * Anxiety and Other Psychiatric Disorders	-	-	-	-	0.126
NonAged_RXHCC159	NonAged * Multiple Sclerosis	-	-	-	-	2.386
NonAged_RXHCC163	NonAged * Intractable Epilepsy	-	-	-	-	0.348

NOTE: The Part D Denominator used to calculate relative factors is $2,597.22. This Part D Denominator is based on the combined PDP and MA-PD populations.
SOURCE: RTI Analysis of 100% 2022-2023 Medicare Enrollment Data, 2023 Prescription Drug Event (PDE) Data, 2022 Professional Claims (Carrier), 2022 Inpatient Claims, 2022 Outpatient Claims, and 2022 Medicare Advantage Encounter Data.

Table VIII-2. 2026 RxHCC Model Relative Factors for New Enrollees, Non-Low Income (2022/2023 Calibration; HCPCS-based Filtering Logic; Reflects MFPs)

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
Female				
0-34 Years	1.693	1.693	-	-
35-44 Years	1.693	1.693	-	-
45-54 Years	1.306	1.306	-	-
55-59 Years	1.306	1.306	-	-

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
60-64 Years	1.306	1.306	-	-
65 Years	0.388	1.019	1.030	1.019
66 Years	0.414	1.019	0.991	1.019
67 Years	0.414	1.019	0.842	1.019
68 Years	0.458	1.019	0.879	1.019
69 Years	0.458	1.019	0.921	1.019
70-74 Years	0.483	1.019	1.005	1.019
75-79 Years	0.515	1.019	0.845	1.019
80-84 Years	0.547	1.019	0.650	1.019
85-89 Years	0.420	1.019	0.420	1.019
90-94 Years	0.249	1.019	0.249	1.019
95 Years or Over	0.249	1.019	0.249	1.019
Male				
0-34 Years	1.069	1.069	-	-
35-44 Years	1.069	1.069	-	-
45-54 Years	1.251	1.251	-	-
55-59 Years	1.251	1.251	-	-
60-64 Years	1.251	1.251	-	-
65 Years	0.478	1.269	1.061	1.269
66 Years	0.507	1.269	1.145	1.269
67 Years	0.527	1.269	1.145	1.269

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
68 Years	0.541	1.269	1.049	1.269
69 Years	0.594	1.269	1.012	1.269
70-74 Years	0.599	1.269	0.889	1.269
75-79 Years	0.706	1.269	0.706	1.269
80-84 Years	0.706	1.269	0.706	1.269
85-89 Years	0.858	1.269	0.858	1.269
90-94 Years	0.858	1.269	0.858	1.269
95 Years or Over	0.858	1.269	0.858	1.269

NOTES:

1. The Part D Denominator used to calculate relative factors is $2,597.22. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).
3. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

SOURCE: RTI Analysis of 100% 2022-2023 Medicare Enrollment Data, 2023 Prescription Drug Event (PDE) Data, 2022 Professional Claims (Carrier), 2022 Inpatient Claims, 2022 Outpatient Claims, and 2022 Medicare Advantage Encounter Data.

Table VIII-3. 2026 RxHCC Model Relative Factors for New Enrollees, Low Income (2022/2023 Calibration; HCPCS-based Filtering Logic; Reflects MFPs)

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
Female				
0-34 Years	2.835	2.835	-	-
35-44 Years	2.835	2.835	-	-
45-54 Years	2.835	2.835	-	-
55-59 Years	2.516	2.516	-	-
60-64 Years	2.516	2.516	-	-
65 Years	1.254	2.387	2.120	2.387
66 Years	0.882	2.387	1.250	2.387
67 Years	0.851	2.387	1.092	2.387
68 Years	0.825	2.387	1.073	2.387
69 Years	0.787	2.387	1.073	2.387
70-74 Years	0.772	2.387	1.073	2.387
75-79 Years	0.720	2.387	0.902	2.387
80-84 Years	0.686	2.387	0.686	2.387
85-89 Years	0.686	2.387	0.686	2.387
90-94 Years	0.415	2.387	0.415	2.387
95 Years or Over	0.415	2.387	0.415	2.387
Male				
0-34 Years	2.066	2.066	-	-

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
35-44 Years	2.066	2.066	-	-
45-54 Years	2.066	2.066	-	-
55-59 Years	2.100	2.207	-	-
60-64 Years	2.000	2.371	-	-
65 Years	1.172	2.183	1.685	2.183
66 Years	0.832	2.183	1.132	2.183
67 Years	0.832	2.183	1.132	2.183
68 Years	0.775	2.183	0.815	2.183
69 Years	0.731	2.183	0.769	2.183
70-74 Years	0.672	2.183	0.672	2.183
75-79 Years	0.672	2.183	0.672	2.183
80-84 Years	0.652	2.183	0.652	2.183
85-89 Years	0.652	2.183	0.652	2.183
90-94 Years	0.406	2.183	0.406	2.183
95 Years or Over	0.406	2.183	0.406	2.183

NOTES:

1. The Part D Denominator used to calculate relative factors is $2,597.22. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).
3. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

SOURCE: RTI Analysis of 100% 2022-2023 Medicare Enrollment Data, 2023 Prescription Drug Event (PDE) Data, 2022 Professional Claims (Carrier), 2022 Inpatient Claims, 2022 Outpatient Claims, and 2022 Medicare Advantage Encounter Data.

Table VIII-4. 2026 RxHCC Model Relative Factors for New Enrollees, Institutional (2022/2023 Calibration; HCPCS-based Filtering Logic; Reflects MFPs)

Variable	Not Concurrently ESRD	Concurrently ESRD
Female		
0-34 Years	3.447	2.481
35-44 Years	3.447	2.481
45-54 Years	3.447	2.481
55-59 Years	2.690	2.481
60-64 Years	2.490	2.481
65 Years	2.651	2.481
66 Years	2.651	2.481
67 Years	1.929	2.481
68 Years	1.929	2.481
69 Years	1.451	2.481
70-74 Years	1.451	2.481
75-79 Years	1.451	2.481
80-84 Years	0.925	2.481
85-89 Years	0.925	2.481
90-94 Years	0.491	2.481
95 Years or Over	0.491	2.481
Male		
0-34 Years	2.974	2.316

Variable	Not Concurrently ESRD	Concurrently ESRD
35-44 Years	2.974	2.316
45-54 Years	2.651	2.316
55-59 Years	2.318	2.316
60-64 Years	1.996	2.316
65 Years	2.052	2.316
66 Years	2.052	2.316
67 Years	1.759	2.316
68 Years	1.759	2.316
69 Years	1.547	2.316
70-74 Years	1.547	2.316
75-79 Years	1.155	2.316
80-84 Years	1.155	2.316
85-89 Years	1.155	2.316
90-94 Years	0.752	2.316
95 Years or Over	0.399	2.316

NOTES:

1. The Part D Denominator used to calculate relative factors is $2,597.22. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

SOURCE: RTI Analysis of 100% 2022-2023 Medicare Enrollment Data, 2023 Prescription Drug Event (PDE) Data, 2022 Professional Claims (Carrier), 2022 Inpatient Claims, 2022 Outpatient Claims, and 2022 Medicare Advantage Encounter Data.

Table VIII-5. 2026 RxHCC Model Relative Factors for Continuing Enrollees (2018/2019 Calibration; Specialty-based Filtering Logic; Reflects MFPs)

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
Female						
0-34 Years		-	0.218	-	0.499	2.382
35-44 Years		-	0.327	-	0.694	2.673
45-54 Years		-	0.358	-	0.714	2.023
55-59 Years		-	0.322	-	0.558	1.670
60-64 Years		-	0.248	-	0.346	1.385
65-69 Years		0.122	-	0.299	-	1.453
70-74 Years		0.114	-	0.045	-	1.106
75-79 Years		0.040	-	0.045	-	0.794
80-84 Years		0.040	-	0.045	-	0.546
85-89 Years		0.040	-	0.045	-	0.353
90-94 Years		0.040	-	0.045	-	0.196
95 Years or Over		0.040	-	0.045	-	0.039
Male						
0-34 Years		-	0.178	-	0.598	2.504
35-44 Years		-	0.225	-	0.646	2.215
45-54 Years		-	0.286	-	0.585	1.876
55-59 Years		-	0.298	-	0.479	1.420
60-64 Years		-	0.282	-	0.359	1.094
65-69 Years		0.168	-	0.309	-	1.097
70-74 Years		0.144	-	0.226	-	0.793
75-79 Years		0.061	-	0.133	-	0.641
80-84 Years		0.061	-	0.029	-	0.458
85-89 Years		0.061	-	0.029	-	0.278
90-94 Years		0.061	-	0.029	-	0.167
95 Years or Over		0.061	-	0.029	-	0.031
Originally Disabled Interactions with Sex						
Originally Disabled Female		0.064	-	0.314	-	0.238
Originally Disabled Male		-	-	0.175	-	0.238
Disease Coefficients						
RXHCC1	HIV/AIDS	8.523	10.433	9.763	10.270	6.530

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC5	Opportunistic Infections	0.468	0.611	0.662	0.541	0.509
RXHCC15	Chronic Myeloid Leukemia	6.175	5.271	15.008	20.324	10.151
RXHCC16	Multiple Myeloma and Other Hematologic Cancers	14.205	15.685	12.359	13.011	4.514
RXHCC17	Secondary Cancer of Bone and Kidney	6.175	5.271	9.943	9.097	4.514
RXHCC18	Secondary Cancer of Lung, Liver, Brain, and Other Sites	1.949	1.977	3.430	3.371	0.950
RXHCC19	Leukemias and Other Hematologic Cancers	1.949	1.746	2.574	2.483	0.950
RXHCC20	Lung, Kidney, and Other Cancers; Secondary Cancer of Lymph Nodes and Other Sites	0.491	0.388	1.025	0.750	0.312
RXHCC21	Lymphomas and Other Hematologic Cancers	0.410	0.135	0.372	0.267	0.142
RXHCC22	Prostate, Breast, Bladder, and Other Cancers and Tumors	0.124	0.135	0.279	0.267	0.142
RXHCC30	Diabetes with Complications	0.495	0.537	0.941	1.426	0.903
RXHCC31	Diabetes without Complication	0.171	0.162	0.329	0.498	0.350
RXHCC40	Alpha-1-Antitrypsin Deficiency	3.730	8.556	7.759	10.698	1.452
RXHCC41	Lysosomal Storage Disorders	3.081	13.907	2.583	19.382	0.283
RXHCC42	Acromegaly and Other Endocrine and Metabolic Disorders	2.110	4.246	2.718	6.251	0.717
RXHCC43	Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders	0.063	0.154	-	0.153	0.102
RXHCC44	Thyroid Disorders	0.070	0.160	0.154	0.296	0.148
RXHCC47	Disorders of Lipoid Metabolism	-	-	0.033	0.112	0.057
RXHCC54	Chronic Viral Hepatitis C	0.714	0.843	1.004	0.821	1.129
RXHCC55	Acute or Unspecified Viral Hepatitis C	0.714	0.843	1.004	0.821	1.129
RXHCC56	Chronic Viral Hepatitis B and Other Specified Chronic Viral Hepatitis	0.351	0.666	1.238	0.765	0.339
RXHCC59	Primary Biliary Cirrhosis	1.081	1.440	1.492	2.322	1.341
RXHCC65	Chronic Pancreatitis	0.351	0.650	0.600	0.930	0.583

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC66	Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis	0.245	0.650	0.480	0.930	0.357
RXHCC67	Inflammatory Bowel Disease	0.494	0.505	1.127	2.316	0.450
RXHCC80	Aseptic Necrosis of Bone	0.204	0.211	0.193	0.365	0.201
RXHCC81	Psoriatic Arthropathy	0.758	0.603	4.614	7.449	2.552
RXHCC82	Systemic Sclerosis	0.975	0.640	1.811	1.959	0.471
RXHCC83	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	0.222	0.311	1.113	1.959	0.471
RXHCC84	Systemic Lupus Erythematosus and Other Systemic Connective Tissue Disorders	0.113	0.239	0.249	0.351	0.127
RXHCC87	Osteoporosis, Vertebral and Pathological Fractures	0.055	0.196	0.228	0.432	-
RXHCC95	Sickle Cell Anemia	-	0.575	-	1.809	0.012
RXHCC96	Acquired Hemolytic, Aplastic, and Sideroblastic Anemias	0.722	0.550	0.820	1.033	0.223
RXHCC98	Hereditary Angioedema and Other Defects in the Complement System	12.046	57.445	18.171	57.829	0.555
RXHCC99	Immune Disorders	0.943	0.622	1.471	1.330	0.852
RXHCC100	Immune Thrombocytopenic Purpura	0.304	0.160	1.510	1.738	0.979
RXHCC111	Alzheimer's Disease	-	-	-	-	-
RXHCC112	Dementia, Except Alzheimer's Disease	-	-	-	-	-
RXHCC130	Schizophrenia and Other Psychosis	0.240	0.269	0.732	1.432	0.353
RXHCC131	Bipolar Disorders	0.240	0.135	0.585	0.758	0.353
RXHCC132	Depression	0.070	0.049	0.183	0.254	0.160
RXHCC133	Anxiety and Other Psychiatric Disorders	0.035	0.049	0.079	0.168	0.074
RXHCC146	Profound or Severe Intellectual Disability/Developmental Disorder	0.526	0.122	0.424	0.386	-
RXHCC147	Moderate Intellectual Disability/Developmental Disorder	0.526	-	0.202	0.126	-
RXHCC148	Mild or Unspecified Intellectual	0.526	-	0.030	0.020	-

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
	Disability/Developmental Disorder					
RXHCC153	Myasthenia Gravis and Other Myoneural Disorders	1.094	2.428	1.728	2.579	0.390
RXHCC154	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	0.776	1.492	0.446	1.698	0.183
RXHCC155	Spinal Cord Disorders	0.086	-	0.075	-	-
RXHCC157	Chronic Inflammatory Demyelinating Polyneuritis	3.783	6.891	5.666	8.430	1.947
RXHCC158	Inflammatory and Toxic Neuropathy	0.074	0.146	0.028	0.237	0.156
RXHCC159	Multiple Sclerosis	3.733	5.468	5.383	9.464	2.832
RXHCC160	Huntington Disease	3.223	4.019	3.544	5.699	3.495
RXHCC161	Parkinson Disease	0.549	0.793	0.615	0.871	0.621
RXHCC163	Intractable Epilepsy	0.312	0.468	0.797	2.875	0.456
RXHCC164	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy	0.068	-	0.052	0.183	-
RXHCC166	Migraine Headaches	0.100	0.125	0.289	0.335	0.406
RXHCC168	Trigeminal and Postherpetic Neuralgia	0.094	0.276	0.265	0.418	0.283
RXHCC183	Pulmonary Arterial Hypertension	1.158	4.027	1.670	6.338	0.616
RXHCC184	Pulmonary Hypertension, Except Arterial, and Other Pulmonary Heart Disease	0.151	0.294	0.195	0.381	0.223
RXHCC186	Heart Failure	0.110	0.020	0.195	0.105	0.223
RXHCC187	Hypertension	0.056	0.005	0.113	0.084	0.076
RXHCC188	Coronary Artery Disease	0.052	-	0.183	-	-
RXHCC191	Ventricular Septal Defect and Major Congenital Heart Disorders	0.150	0.703	0.514	0.307	0.254
RXHCC193	Atrial Arrhythmias	0.215	0.021	0.139	-	0.122
RXHCC207	Spastic Hemiplegia	0.148	0.098	0.170	-	-
RXHCC215	Venous Thromboembolism	0.228	0.238	0.237	0.247	0.148
RXHCC225	Cystic Fibrosis	4.774	26.401	2.663	31.668	1.420
RXHCC226	Idiopathic Pulmonary Fibrosis and Systemic	4.862	3.788	4.995	4.151	1.490

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
	Sclerosis with Lung Involvement					
RXHCC227	Pulmonary Fibrosis, Except Idiopathic	0.398	0.576	0.527	1.352	0.431
RXHCC228	Severe Persistent Asthma	0.855	0.612	1.907	1.909	1.354
RXHCC229	Chronic Obstructive Pulmonary Disease, Bronchiectasis, and Other Asthma	0.237	0.102	0.491	0.396	0.431
RXHCC243	Glaucoma, Open-Angle or Moderate/Severe Stage	0.196	0.223	0.469	0.543	0.406
RXHCC244	Other Non-Acute Glaucoma	0.067	-	0.107	-	0.049
RXHCC260	Kidney Transplant Status	-	-	-	-	-
RXHCC261	Dialysis Status, Including End Stage Renal Disease	0.017	-	-	-	-
RXHCC262	Chronic Kidney Disease Stage 5	0.017	-	-	-	-
RXHCC263	Chronic Kidney Disease Stage 4	0.017	-	-	-	-
RXHCC311	Chronic Ulcer of Skin, Except Pressure	0.175	0.136	0.201	0.304	0.066
RXHCC314	Pemphigus, Pemphigoid, and Other Bullous Skin Disorders	0.317	0.836	0.530	0.746	0.328
RXHCC316	Psoriasis, Except with Arthropathy	0.167	0.183	1.198	2.285	0.811
RXHCC317	Discoid Lupus Erythematosus	0.113	0.239	0.043	-	-
RXHCC355	Narcolepsy and Cataplexy	1.080	2.410	1.452	3.591	0.814
RXHCC395	Stem Cell, Including Bone Marrow, Transplant Status/Complications	4.379	2.326	6.061	3.944	2.412
RXHCC396	Heart, Lung, Liver, Intestine, or Pancreas Transplant Status	-	-	-	-	-
Non-Aged Disease Interactions						
NonAged_RXHCC1	NonAged * HIV/AIDS	-	-	-	-	2.770
NonAged_RXHCC130	NonAged * Schizophrenia and Other Psychosis	-	-	-	-	0.756
NonAged_RXHCC131	NonAged * Bipolar Disorders	-	-	-	-	0.756
NonAged_RXHCC132	NonAged * Depression	-	-	-	-	0.363

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
NonAged_RXHCC133	NonAged * Anxiety and Other Psychiatric Disorders	-	-	-	-	0.015
NonAged_RXHCC159	NonAged * Multiple Sclerosis	-	-	-	-	3.509
NonAged_RXHCC163	NonAged * Intractable Epilepsy	-	-	-	-	0.711

NOTE: The Part D Denominator used to calculate relative factors is $2,108.33. This Part D Denominator is based on the combined PDP and MA-PD populations.

SOURCE: RTI Analysis of 100% 2018-2019 Medicare Enrollment Data, 2019 Prescription Drug Event (PDE) Data, 2018 Professional Claims (Carrier), 2018 Inpatient Claims, 2018 Outpatient Claims, and 2018 Medicare Advantage Encounter Data.

Table VIII-6. 2026 RxHCC Model Relative Factors for New Enrollees, Non-Low Income (2018/2019 Calibration; Specialty-based Filtering Logic; Reflects MFPs)

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
Female				
0-34 Years	1.447	1.447	-	-
35-44 Years	1.447	1.447	-	-
45-54 Years	1.255	1.255	-	-
55-59 Years	1.255	1.255	-	-
60-64 Years	1.255	1.255	-	-
65 Years	0.381	1.299	1.104	1.299
66 Years	0.409	1.299	1.255	1.299
67 Years	0.420	1.299	1.255	1.299
68 Years	0.441	1.299	1.023	1.299
69 Years	0.473	1.299	1.023	1.299
70-74 Years	0.496	1.299	1.023	1.299
75-79 Years	0.557	1.299	0.828	1.299
80-84 Years	0.521	1.299	0.521	1.299
85-89 Years	0.521	1.299	0.521	1.299
90-94 Years	0.396	1.299	0.396	1.299
95 Years or Over	0.396	1.299	0.396	1.299

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
Male				
0-34 Years	1.139	1.139	-	-
35-44 Years	1.139	1.139	-	-
45-54 Years	1.177	1.177	-	-
55-59 Years	1.177	1.177	-	-
60-64 Years	1.177	1.177	-	-
65 Years	0.465	1.542	1.008	1.542
66 Years	0.486	1.542	0.965	1.542
67 Years	0.510	1.542	0.965	1.542
68 Years	0.522	1.542	0.940	1.542
69 Years	0.522	1.542	0.940	1.542
70-74 Years	0.596	1.542	0.940	1.542
75-79 Years	0.668	1.542	0.668	1.542
80-84 Years	0.668	1.542	0.668	1.542
85-89 Years	0.668	1.542	0.668	1.542
90-94 Years	0.368	1.542	0.368	1.542
95 Years or Over	0.368	1.542	0.368	1.542

NOTES:

1. The Part D Denominator used to calculate relative factors is $2,108.33. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).
3. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

SOURCE: RTI Analysis of 100% 2018-2019 Medicare Enrollment Data, 2019 Prescription Drug Event (PDE) Data, 2018 Professional Claims (Carrier), 2018 Inpatient Claims, 2018 Outpatient Claims, and 2018 Medicare Advantage Encounter Data.

Table VIII-7. 2026 RxHCC Model Relative Factors for New Enrollees, Low Income (2018/2019 Calibration; Specialty-based Filtering Logic; Reflects MFPs)

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
Female				
0-34 Years	1.761	2.090	-	-
35-44 Years	2.516	2.516	-	-
45-54 Years	2.498	2.498	-	-
55-59 Years	2.050	2.403	-	-
60-64 Years	1.963	2.106	-	-
65 Years	1.119	2.150	1.638	2.150
66 Years	0.790	2.150	1.213	2.150
67 Years	0.708	2.150	1.013	2.150
68 Years	0.708	2.150	1.013	2.150
69 Years	0.731	2.150	1.013	2.150
70-74 Years	0.765	2.150	0.950	2.150
75-79 Years	0.688	2.150	0.688	2.150
80-84 Years	0.688	2.150	0.688	2.150
85-89 Years	0.688	2.150	0.688	2.150
90-94 Years	0.424	2.150	0.424	2.150
95 Years or Over	0.424	2.150	0.424	2.150
Male				
0-34 Years	1.507	2.202	-	-
35-44 Years	1.979	1.979	-	-
45-54 Years	1.964	1.964	-	-
55-59 Years	1.964	1.964	-	-
60-64 Years	1.633	2.082	-	-
65 Years	1.122	2.226	1.446	2.226
66 Years	0.775	2.226	0.939	2.226
67 Years	0.743	2.226	0.914	2.226
68 Years	0.705	2.226	0.815	2.226
69 Years	0.667	2.226	0.815	2.226
70-74 Years	0.627	2.226	0.753	2.226
75-79 Years	0.639	2.226	0.639	2.226
80-84 Years	0.639	2.226	0.639	2.226
85-89 Years	0.639	2.226	0.639	2.226

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
90-94 Years	0.333	2.226	0.333	2.226
95 Years or Over	0.333	2.226	0.333	2.226

NOTES:

- The Part D Denominator used to calculate relative factors is $2,108.33. This Part D Denominator is based on the combined PDP and MA-PD populations.
- Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).
- For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

SOURCE: RTI Analysis of 100% 2018-2019 Medicare Enrollment Data, 2019 Prescription Drug Event (PDE) Data, 2018 Professional Claims (Carrier), 2018 Inpatient Claims, 2018 Outpatient Claims, and 2018 Medicare Advantage Encounter Data.

Table VIII-8. 2026 RxHCC Model Relative Factors for New Enrollees, Institutional (2018/2019 Calibration; Specialty-based Filtering Logic; Reflects MFPs)

Variable	Not Concurrently ESRD	Concurrently ESRD
Female		
0-34 Years	4.051	2.555
35-44 Years	3.705	2.555
45-54 Years	3.569	2.555
55-59 Years	2.868	2.555
60-64 Years	2.824	2.555
65 Years	2.824	2.555
66 Years	2.427	2.555
67 Years	2.427	2.555
68 Years	1.726	2.555
69 Years	1.726	2.555
70-74 Years	1.614	2.555
75-79 Years	1.614	2.555
80-84 Years	1.055	2.555
85-89 Years	1.055	2.555
90-94 Years	0.658	2.555

Variable	Not Concurrently ESRD	Concurrently ESRD
95 Years or Over	0.658	2.555
Male		
0-34 Years	3.586	2.358
35-44 Years	3.108	2.358
45-54 Years	2.872	2.358
55-59 Years	2.744	2.358
60-64 Years	2.379	2.358
65 Years	2.379	2.358
66 Years	1.952	2.358
67 Years	1.952	2.358
68 Years	1.740	2.358
69 Years	1.740	2.358
70-74 Years	1.740	2.358
75-79 Years	1.341	2.358
80-84 Years	1.341	2.358
85-89 Years	1.019	2.358
90-94 Years	0.712	2.358
95 Years or Over	0.712	2.358

NOTES:

1. The Part D Denominator value used to calculate relative factors is $2,108.33. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

SOURCE: RTI Analysis of 100% 2018-2019 Medicare Enrollment Data, 2019 Prescription Drug Event (PDE) Data, 2018 Professional Claims (Carrier), 2018 Inpatient Claims, 2018 Outpatient Claims, and 2018 Medicare Advantage Encounter Data.

Table VIII-9. 2026 RxHCC Model with Disease Hierarchies (previously published in the 2023 Rate Announcement[40])

RxHCC	If the Disease Group is listed in this column…	…Then drop the RxHCC(s) listed in this column
	RxHCC Model Hierarchical Condition Category Label	
15	Chronic Myeloid Leukemia	17, 18, 19, 20, 21, 22
16	Multiple Myeloma and Other Hematologic Cancers	17, 18, 19, 20, 21, 22
17	Secondary Cancer of Bone and Kidney	18, 19, 20, 21, 22
18	Secondary Cancer of Lung, Liver, Brain, and Other Sites	19, 20, 21, 22
19	Leukemias and Other Hematologic Cancers	20, 21, 22
20	Lung, Kidney, and Other Cancers; Secondary Cancer of Lymph Nodes and Other Sites	21, 22
21	Lymphomas and Other Hematologic Cancers	22
30	Diabetes with Complications	31
40	Alpha-1-Antitrypsin Deficiency	43
41	Lysosomal Storage Disorders	43
42	Acromegaly and Other Endocrine and Metabolic Disorders	43
54	Chronic Viral Hepatitis C	55
65	Chronic Pancreatitis	66
81	Psoriatic Arthropathy	83, 84, 316
82	Systemic Sclerosis	83, 84
83	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	84
84	Systemic Lupus Erythematosus and Other Systemic Connective Tissue Disorders	317
111	Alzheimer's Disease	112
130	Schizophrenia and Other Psychosis	131, 132, 133
131	Bipolar Disorders	132, 133
132	Depression	133
146	Profound or Severe Intellectual Disability/Developmental Disorder	147, 148
147	Moderate Intellectual Disability/Developmental Disorder	148

[40] Refer to CMS' CY 2023 Rate Announcement.

RxHCC	If the Disease Group is listed in this column…	…Then drop the RxHCC(s) listed in this column
	RxHCC Model Hierarchical Condition Category Label	
157	Chronic Inflammatory Demyelinating Polyneuritis	158
163	Intractable Epilepsy	164
183	Pulmonary Arterial Hypertension	184, 186, 187
184	Pulmonary Hypertension, Except Arterial, and Other Pulmonary Heart Disease	186, 187
186	Heart Failure	187
225	Cystic Fibrosis	229
226	Idiopathic Pulmonary Fibrosis and Systemic Sclerosis with Lung Involvement	227, 229
227	Pulmonary Fibrosis, Except Idiopathic	229
228	Severe Persistent Asthma	229
243	Glaucoma, Open-Angle or Moderate/Severe Stage	244
260	Kidney Transplant Status	261, 262, 263, 396
261	Dialysis Status, Including End Stage Renal Disease	262, 263
262	Chronic Kidney Disease Stage 5	263

NOTES:

1. This table applies to all of the RxHCC models in the CY 2026 Rate Announcement.

How Payments are Made with a Disease Hierarchy:

EXAMPLE: If a beneficiary triggers RxHCCs 163 (Intractable Epilepsy) and 164 (Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy), then RxHCC 164 will be dropped. In other words, payment will always be associated with the RxHCC in column 1 if an RxHCC in column 3 also occurs during the same collection period. Therefore, the organization's payment will be based on RxHCC 163 rather than RxHCC 164.

SOURCE: RTI International.

Table VIII-10. 2026 RxHCC Model Predictive Ratios by Deciles of Predicted Risk (sorted low to high): Continuing Enrollee Model Segments, Proposed 2022/2023 Calibration Sample (HCPCS-filtered diagnoses; Reflects MFPs)

Deciles	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
Entire sample	1.000	1.000	1.000	1.000	1.000
First (lowest) decile	0.627	1.087	0.858	0.984	0.559
Second decile	1.174	1.291	1.160	1.380	0.874
Third decile	1.353	1.036	1.112	1.179	1.030
Fourth decile	1.264	1.046	1.031	1.103	1.055
Fifth decile	0.998	1.020	1.026	1.056	1.072
Sixth decile	0.965	1.003	1.027	0.976	1.060
Seventh decile	0.978	0.981	0.981	0.952	1.043
Eighth decile	0.958	0.945	0.967	0.940	1.020
Ninth decile	0.944	0.971	0.980	0.972	0.998
Tenth (highest)	1.017	1.004	0.998	0.997	0.973
Top 5%	1.020	1.005	1.000	1.008	0.978
Top 1%	1.009	0.994	1.009	1.044	0.999
Top 0.1%	0.971	1.009	1.012	1.001	1.018

Table VIII-11. 2026 RxHCC Model Predictive Ratios by Deciles of Predicted Risk (sorted low to high): New Enrollee Model Segments, Proposed 2022/2023 Calibration Sample (HCPCS-filtered diagnoses; Reflects MFPs)

Deciles	Non-Low Income	Low Income	Institutional
Entire sample	1.000	1.000	1.000
First (lowest) decile	0.994	1.002	1.007
Second decile	0.982	0.999	0.962
Third decile	1.017	1.017	1.023
Fourth decile	1.004	0.983	1.011
Fifth decile	0.998	1.002	1.018
Sixth decile	0.990	1.006	0.973
Seventh decile	1.015	1.003	0.976
Eighth decile	1.003	0.991	1.033
Ninth decile	1.001	1.001	0.970
Tenth (highest)	0.999	1.001	1.021
Top 5%	0.992	0.975	0.992
Top 1%	0.992	1.044	0.986