

January 10, 2025

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

**SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies**

In accordance with section 1853(b)(2) of the Social Security Act (the Act), we are notifying you of planned changes in the Medicare Advantage (MA) capitation rate methodology and risk adjustment methodology applied under Part C of the Medicare statute for CY 2026. Also included with this Advance Notice is a discussion of the annual adjustments for CY 2026 to the Medicare Part D benefit parameters for the defined standard benefit, including those necessitated by the Inflation Reduction Act of 2022 (IRA) (Pub. L. 117-169). CMS will announce the MA capitation rates and final payment policies for CY 2026 no later than Monday, April 7, 2025, in accordance with section 1853(b) of the Act, as established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) and amended by the Securing Fairness in Regulatory Timing Act of 2015 (Pub. L. 114-106). The Advance Notice of Methodological Changes is published no fewer than 60 days before the publication of the final Announcement of CY 2026 MA Capitation Rates and Part C and Part D Payment Policies (Rate Announcement) and provides a minimum 30-day period for public comment.

Attachment I of this document shows the preliminary estimates of the national per capita MA growth percentage and the national Medicare Fee-for-Service (FFS) growth percentage, which are key factors in determining the MA capitation rates. Attachment II sets forth changes in the Part C payment methodology for CY 2026. Attachment III presents the annual adjustments to the Medicare Part D benefit parameters for the defined standard benefit and sets forth the changes in the Part D payment methodology for CY 2026, including those necessitated by the IRA, such as an update to the Part D risk adjustment (RxHCC) model. For additional information about Part D policies related to the IRA for 2026, such as policies related to the selected drug subsidy program, see the Draft CY 2026 Part D Redesign Program Instructions being released concurrently with this Advance Notice. Attachment IV applies standards for certain updates for the MA and Part D Star Ratings and solicits feedback on potential new measures, substantive and non-substantive updates to existing measures, and potential measure concepts. Attachment V contains economic information for significant provisions in the Advance Notice. Attachment VI presents the risk adjustment factors for the proposed RxHCC models.

As with prior Advance Notices and Rate Announcements, we are releasing a Fact Sheet and Frequently Asked Questions (FAQs), available through the Newsroom webpage on the CMS.gov website, to accompany this CY 2026 Advance Notice. The Fact Sheet provides additional information on the impact of the policies and updates on individual payment factors, such as the

growth rates and risk adjustment changes, including the MA risk score trend, and also the overall average impact of the factors on MA revenue.

CMS invites comments on the Advance Notice. To submit comments or questions electronically, go to <https://www.regulations.gov>, enter the docket number “CMS-2024-0360” in the “Search” field, and follow the instructions for “submitting a comment.”

Comments will be made public, so submitters should not include any confidential or personal information. It should be noted that CMS will not post on Regulations.gov public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. In order to receive consideration prior to the release of the Rate Announcement, comments on this Advance Notice must be received by 11:59 PM Eastern Time on February 10, 2025.

/ s /

Meena Seshamani, M.D., Ph.D.  
Director, Center for Medicare

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 Advance Notice. My opinion is limited to the following sections of this Advance Notice: The growth percentages and United States per capita cost estimates provided in Attachment I; 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, Employer Group Waiver Plan (EGWP) rates, and ESRD rates discussed in Attachment II; Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2026 described in Attachment III; and the economic information contained in Attachment V.

/ s /

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

Attachments

**2026 ADVANCE NOTICE  
TABLE OF CONTENTS**

Attachment I. Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2026 .....	7
Section A. Data and Assumptions Supporting USPCCs .....	8
Section B. 2026 Growth Percentage Estimates.....	15
Section C. USPCC Estimates.....	16
Section D. Loading for Claims Processing Costs .....	21
Attachment II. Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2026 .....	23
Section A. MA Benchmark, Quality Bonus Payments, and Rebate .....	23
A1. Applicable Amount .....	23
A2. Specified Amount .....	23
A3. Quality Bonus Payment Percentage.....	25
A4. Qualifying County Bonus Payment .....	27
A5. Cap on Benchmarks .....	28
A6. Rebate.....	28
Section B. Calculation of Fee-for-Service Cost.....	29
B1. Introduction .....	29
B2. Proposed Update to Tabulation of Ratebook FFS Experience Beginning in 2023 .....	30
B3. AGA Methodology.....	31
B4. Adjustments for Medicare Shared Savings Program and Innovation Center Models and Demonstrations, and Advanced Alternative Payment Models.....	34
B5. Additional Adjustment to FFS per Capita Costs in Puerto Rico.....	38
B6. Additional Adjustments after the AGA is Calculated.....	39
Section C. Additional Adjustments.....	39
C1. Direct Graduate Medical Education.....	40
C2. Organ Acquisition Costs for Kidney Transplants .....	42
C3. IME Phase Out .....	45
Section D. MA ESRD Rates .....	47
Section E. Location of Network Areas for Private Fee-for-Service (PFFS) Plans in Plan Year 2027 .....	49
Section F. MA Employer Group Waiver Plans (EGWP) .....	49
F1. Bid-to-Benchmark Ratio.....	50
F2. MA Rebates and Part B Premium Buy-Down.....	52
F3. Additional Adjustments .....	53
Section G. CMS-HCC Risk Adjustment Model for CY 2026.....	54
G1. CMS-HCC Risk Adjustment Models for PACE Organizations for CY 2026.....	56
Section H. End Stage Renal Disease (ESRD) Risk Adjustment Models for CY 2026 .....	59

H1. ESRD Risk Adjustment Models for PACE Organizations for CY 2026.....	59
Section I. Frailty Adjustment for FIDE SNPs and PACE Organizations.....	60
Section J. Medicare Advantage Coding Pattern Difference Adjustment.....	63
Section K. Normalization Factors.....	63
K1. CMS-HCC Model Normalization Factors .....	66
K2. Normalization Factors for the ESRD Dialysis CMS-HCC Models.....	67
K3. Normalization Factors for the ESRD Functioning Graft CMS-HCC Models .....	68
Section L. Sources of Diagnoses for Risk Score Calculation for CY 2026.....	69
L1. Sources of Diagnoses for Risk Score Calculation for CY 2026 PACE .....	69
Attachment III. Benefit Parameters for the Defined Standard Benefit and Changes in the Payment Methodology for Medicare Part D for CY 2026.....	72
Section A. Annual Adjustments to Medicare Part D Benefit Parameters in 2026 .....	75
A1. Updating the Medicare Part D Benefit Parameters .....	76
A2. Calculation methodologies for the Annual Percentage Increase (API) and Consumer Price Index (CPI) .....	79
A3. Annual Adjustments for Part D Benefit Parameters in CY 2026 .....	82
Section B. Part D Premium Stabilization.....	86
Section C. Part D Calendar Year EGWP Prospective Reinsurance Amount .....	86
Section D. Part D Risk Sharing.....	87
D1. Risk sharing when a plan’s adjusted allowable risk corridor costs (AARCC) exceed the target amount.....	88
D2. Risk sharing when a plan’s adjusted allowable risk corridor costs (AARCC) are below the target amount .....	89
Section E. Retiree Drug Subsidy Amounts.....	91
Section F. RxHCC Risk Adjustment Model.....	91
F1. Background on the RxHCC Risk Adjustment Model.....	91
F2. Updates to the RxHCC Models Proposed for CY 2026 .....	94
F3. Predictive Ratios for CY 2026 RxHCC Models.....	99
Section G. Normalization Factors for the RxHCC Models.....	100
G1. Proposed CY 2026 Normalization Factors for the 2026 RxHCC Risk Adjustment Model (2022/2023 Calibration).....	103
G2. Proposed CY 2026 Normalization Factors for the 2026 RxHCC Risk Adjustment Model (2018/2019 Calibration) used for PACE Organizations .....	106
Section H. Source of Diagnoses for Part D Risk Score Calculation for CY 2026 .....	108
Attachment IV. Updates for Part C and D Star Ratings .....	109
Section A. Part C and D Star Ratings and Future Measurement Concepts .....	109
Section B. Reminders for 2026 Star Ratings and Beyond.....	109
Section C. Measure Updates for 2026 Star Ratings.....	111
Section D. Improvement Measures (Part C & D) for the 2026 Star Ratings.....	115
Section E. Categorical Adjustment Index for the 2026 Star Ratings.....	115

Section F. Extreme and Uncontrollable Circumstances Policy for the 2026 Star Ratings .....	115
Section G. Changes to Existing Star Ratings Measures for the 2026 Measurement Year and Beyond.....	118
Section H. Efforts to Simplify and Refocus the Measure Set to Improve the Impact of the Star Ratings Program .....	118
Section I. Display Measures .....	123
Section J. Retirement of Display Measures .....	125
Section K. Potential New Measure Concepts and Methodological Enhancements for Future Years .....	125
Attachment V. Economic Information for the CY 2026 Advance Notice.....	128
Section A. Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2026.....	128
A1. Medicare Advantage and PACE non-ESRD Ratebook .....	128
A2. Medicare Advantage and PACE ESRD Ratebooks .....	128
A3. CMS-HCC Risk Adjustment Model .....	129
A4. ESRD Risk Adjustment Model .....	129
A5. Frailty Adjustment for FIDE SNPs.....	129
A6. MA Coding Pattern Difference Adjustment .....	130
A7. Part C Normalization .....	130
Section B. Changes in the Payment Methodology for Medicare Part D for CY 2026 .....	130
B1. Annual Percentage Increase for Part D Parameters .....	130
B2. Part D Risk Adjustment Model .....	130
B3. Part D Normalization .....	131
Attachment VI. RxHCC Risk Adjustment Factors and Predictive Ratio Tables.....	132
Table VI-1. 2026 RxHCC Model Relative Factors for Continuing Enrollees (2022/2023 Calibration; HCPCS-based Filtering Logic; Reflects MFPs).....	132
Table VI-2. 2026 RxHCC Model Relative Factors for New Enrollees, Non-Low Income (2022/2023 Calibration; HCPCS-based Filtering Logic; Reflects MFPs) .....	141
Table VI-3. 2026 RxHCC Model Relative Factors for New Enrollees, Low Income (2022/2023 Calibration; HCPCS-based Filtering Logic; Reflects MFPs) .....	143
Table VI-4. 2026 RxHCC Model Relative Factors for New Enrollees, Institutional (2022/2023 Calibration; HCPCS-based Filtering Logic; Reflects MFPs) .....	145
Table VI-5. 2026 RxHCC Model Relative Factors for Continuing Enrollees (2022/2023 Calibration; HCPCS-based Filtering Logic; Does Not Reflect MFPs).....	147
Table VI-6. 2026 RxHCC Model Relative Factors for New Enrollees, Non-Low Income (2022/2023 Calibration; HCPCS-based Filtering Logic; Does Not Reflect MFPs) ....	156
Table VI-7. 2026 RxHCC Model Relative Factors for New Enrollees, Low Income (2022/2023 Calibration; HCPCS-based Filtering Logic; Does Not Reflect MFPs) ....	157
Table VI-8. 2026 RxHCC Model Relative Factors for New Enrollees, Institutional (2022/2023 Calibration; HCPCS-based Filtering Logic; Does Not Reflect MFPs) ....	158

Table VI-9. 2026 RxHCC Model Relative Factors for Continuing Enrollees (2018/2019 Calibration; Specialty-based Filtering Logic; Reflects MFPs) .....160

Table VI-10. 2026 RxHCC Model Relative Factors for New Enrollees, Non-Low Income (2018/2019 Calibration; Specialty-based Filtering Logic; Reflects MFPs)....165

Table VI-11. 2026 RxHCC Model Relative Factors for New Enrollees, Low Income (2018/2019 Calibration; Specialty-based Filtering Logic; Reflects MFPs).....166

Table VI-12. 2026 RxHCC Model Relative Factors for New Enrollees, Institutional (2018/2019 Calibration; Specialty-based Filtering Logic; Reflects MFPs).....167

Table VI-13. 2026 RxHCC Model Relative Factors for Continuing Enrollees (2018/2019 Calibration; Specialty-based Filtering Logic; Does Not Reflect MFPs).....169

Table VI-14. 2026 RxHCC Model Relative Factors for New Enrollees, Non-Low Income (2018/2019 Calibration; Specialty-based Filtering Logic; Does Not Reflect MFPs) .....173

Table VI-15. 2026 RxHCC Model Relative Factors for New Enrollees, Low Income (2018/2019 Calibration; Specialty-based Filtering Logic; Does Not Reflect MFPs) ..175

Table VI-16. 2026 RxHCC Model Relative Factors for New Enrollees, Institutional (2018/2019 Calibration; Specialty-based Filtering Logic; Does Not Reflect MFPs) ..176

Table VI-17. 2026 RxHCC Model with Disease Hierarchies (previously published in the 2023 Rate Announcement).....177

Table VI-18. 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) .....179

Table VI-19. 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) .....179

Table VI-20. 2026 RxHCC Model Predictive Ratios by Deciles of Predicted Risk (sorted low to high): Continuing Enrollee Model Segments, Alternative 2022/2023 Calibration Sample (HCPCS-filtered diagnoses; Does Not Reflect MFPs) .....180

Table VI-21. 2026 RxHCC Model Predictive Ratios by Deciles of Predicted Risk (sorted low to high): New Enrollee Model Segments, Alternative 2022/2023 Calibration Sample (HCPCS-filtered diagnoses; Does Not Reflect MFPs) .....181

## **Attachment I. Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2026**

Each year in the Advance Notice, CMS updates its historical estimates of per capita Medicare costs based on recent data and provides an estimate for an additional projection year. Specifically, CMS provides estimates of three separate United States Per Capita Costs (USPCCs) for each calendar year:

- **Non-ESRD**
  - **FFS USPCC:** the USPCC for FFS aged/disabled beneficiaries except those beneficiaries who are in End Stage Renal Disease (ESRD) status for payment purposes, i.e., those beneficiaries who are in dialysis, transplant, or functioning graft status. The FFS USPCC is used in the calculation of the specified amount in years in which CMS elects to rebase the adjusted average FFS per capita cost. CMS intends to rebase as part of the calculation of the rates for 2026. The specified amount is described in Attachment II Section A2 and is sometimes referred to as the “post Affordable Care Act (ACA)” rate methodology. The FFS USPCC is also used in the calculation of the applicable amount, as described in Attachment II Section A1.
  - **Total USPCC:** the USPCC for Medicare Part C and FFS aged/disabled beneficiaries except those beneficiaries who are in ESRD status for payment purposes. The Total USPCC is used to calculate the national per capita growth percentage, also known as the national per capita MA growth percentage, which is used in the calculation of the applicable amount. See Attachment II Section A1 for details regarding the calculation of the applicable amount, which is sometimes referred to as the “pre-ACA” rate methodology used to determine the “benchmark cap” for each county, as described in Attachment II Section A5.
- **ESRD**
  - **FFS Dialysis ESRD USPCC:** the USPCC for beneficiaries in FFS with ESRD who are in dialysis status (i.e., “Dialysis ESRD”).<sup>1</sup>

Based on these estimates, CMS calculates the change, or growth, in each of the USPCCs for the upcoming year. In this Advance Notice, we provide growth percentages from 2025 to 2026. These growth percentages represent the year-over-year changes to the USPCCs used to calculate the MA payment rates, or benchmarks, as discussed below. Throughout this document, we use the terms “benchmark” and “county rate” interchangeably, and the term “service area benchmark” indicates the bidding benchmark for an MA plan based on its specific service area.

---

<sup>1</sup> Dialysis ESRD USPCCs are trended from a base year using the trend in total ESRD net of an adjustment factor for dialysis-only.

The MA county rates are based on the specified amount as described in Attachment II Section A2 below. Section 1853(n)(2)(A) of the Act defines the specified amount as the base amount multiplied by the applicable percentage for the area (set under section 1853(n)(2)(B) through (D)). Section 1853(n)(4) requires that the benchmark for an area for a year (including increases for quality bonus percentages) be capped at the level of the applicable amount, as defined at section 1853(k)(1) and described in Attachment II Section A1.

The county rates for Programs of All-Inclusive Care for the Elderly (PACE) are established using the applicable amount as determined under section 1853(k)(1). This amount is calculated without excluding indirect medical education (IME) amounts under section 1853(k)(4) (as required by section 1894(d)(3)), or organ acquisition costs for kidney transplants, as discussed in Attachment II Section C of this document.

## **Section A. Data and Assumptions Supporting USPCCs**

### ***Background***

In this section of the CY 2026 Advance Notice, we provide details and descriptions regarding the development of the USPCCs. Unless otherwise stated, the data and methodologies described in this section are a continuation of the data and methodologies used in the prior year. The historical and projected USPCCs are based on the most recent program experience and actuarial projections prepared by the CMS Office of the Actuary. The data is tabulated and projected separately for Medicare Part A and Medicare Part B on a quarterly basis. Enrollment and expenditures are summarized on an incurred basis.

### ***Historical Enrollment***

Historical total Medicare enrollment is developed on a quarterly basis from CMS's administrative records. Historical MA enrollment is tabulated from the Monthly Membership Report (MMR<sup>2</sup>) data files. Medicare FFS enrollment is the difference between total Medicare enrollment and MA enrollment.

MA enrollment is further divided based on beneficiary's ESRD status into non-ESRD MA enrollment and ESRD MA enrollment. ESRD MA enrollment includes beneficiaries with ESRD who are in dialysis, transplant, and post-transplant statuses. The ESRD status is consistent with the risk adjustment classification.<sup>3</sup> Non-ESRD MA enrollment is the difference between total MA enrollment and ESRD MA enrollment.

---

<sup>2</sup> For more information on the MMR, refer to the Plan Communication User Guide available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/maphelpdesk/Plan\\_Communications\\_User\\_Guide](https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/maphelpdesk/Plan_Communications_User_Guide).

<sup>3</sup> See Section H of the CY 2023 Advance Notice for more information regarding ESRD risk adjustment: <https://www.cms.gov/files/document/2023-advance-notice.pdf>.



Medicare FFS enrollment is also divided based on the beneficiary's ESRD status into non-ESRD FFS enrollment and ESRD FFS enrollment. ESRD FFS enrollment includes beneficiaries with ESRD who are in dialysis status, transplant status, and post-transplant beneficiaries with functioning graft for up to 36 months. Non-ESRD FFS enrollment is the difference between Medicare total FFS enrollment and ESRD FFS enrollment.

### ***Projected Enrollment***

Total Medicare enrollment projections are generally based on certain percentages of the Social Security Administration's (SSA's) population projections. The percentages used to project total Medicare enrollment as percentages of SSA's population projections have been stable over time. For Part A, the projected number of aged beneficiaries averages 93 percent of the Social Security area population<sup>4</sup> aged 65 and older. The disabled enrollment projection is slightly more than the portion of SSA's disabled beneficiary population that has been on the rolls for at least 2 years, because an individual is eligible for Part A even if they have had 2 non-consecutive years of disability. For Part B, the aged enrollment averages 87 percent of the Social Security area population aged 65 and older. The Part B disabled enrollment is 92 percent of the Part A disabled enrollment.

The increase in the MA projected enrollment is based on an enrollment model which incorporates the historical growth in penetration rates to estimate the MA enrollment growth rates for future years. Projected FFS enrollment is calculated as the difference between projected total Medicare enrollment and projected MA enrollment.

### ***Historical Benefit Expenditures***

The primary source for historical FFS claims is the National Claims History (NCH) file.<sup>5</sup> Additional sources of FFS expenditures include payments to providers based on cost reports, payments for pass through costs, and payment adjustments authorized by law or in connection with participation in the Medicare Shared Savings Program or Innovation Center models or demonstrations or Advanced Alternative Payment Models. Using completion factors developed from recent program experience, historical experience for more recent years is grossed up to account for claims incurred but not paid.

Historical MA expenditures are tabulated from the MMR files, which is the same source as for MA historical enrollment. The historical experience for more recent years is grossed up to reflect estimated outstanding risk adjustment reconciliations.

---

<sup>4</sup> Social Security area population is defined in the Glossary of the 2023 OASDI Trustees Report (The 2023 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds) available at [https://www.ssa.gov/OACT/TR/2023/VI\\_I\\_glossary.html](https://www.ssa.gov/OACT/TR/2023/VI_I_glossary.html)

<sup>5</sup> For more information on the NCH, refer to the System of Records Notice available at <https://www.hhs.gov/foia/privacy/sorns/09700558/index.html>

### *Projected Benefit Expenditures*

Projected expenditures for FFS beneficiaries are developed separately for each type of service reflected in the NCH file, cost report settlements, pass through costs, and payments in the Medicare Shared Savings Program or Innovation Center models or demonstrations or Advanced Alternative Payment Models.<sup>6</sup>

The projection of NCH costs is based on reimbursements or allowed charges incurred per beneficiary during the base calendar year. For the CY 2026 Advance Notice USPCCs, the base year for expenditures is 2023 for most services.

The projections take into account various trends, including:

- Unit cost changes tied to market baskets and productivity adjustments, fee schedule updates, or the consumer price index (CPI). These updates are based on economic assumptions provided by the Office of Management and Budget (OMB).
- Utilization and intensity of services, which are generally based on historical trends.
- Impact of changes in population mix as measured by age, sex, and time-to-death.
- Changes in Medicare coverage due to legislation, regulation, and national coverage determinations (NCDs).

Projected cost report settlements and pass through costs are developed as a percentage add-on basis to the NCH costs and are projected to remain at the same percentage level throughout the projection.

Innovation Center model or demonstration payments are projected based on the estimates developed for each model or demonstration and any historical experience of each model or demonstration.

MA per capita historical bids, rebates, and benchmarks are summarized on an incurred basis by Medicare Status Code, insurance market (EGWP, individual/non-EGWP), and coverage/plan type (Health Maintenance Organization (HMO), Local Preferred Provider Organization (LPPO), Regional Preferred Provider Organization (RPPO), Special Needs Plan (SNP), etc.). Projections are performed separately for payments from the Part A and Part B Trust Funds.<sup>7</sup> Aggregate projected MA payments are calculated as the projected MA per capita costs times the projected enrollment.

Calendar Year 2023 is the base year for expenditures for the MA experience reflected in the CY 2026 Advance Notice. The 2024 and 2025 risk-adjusted benchmarks, bids, and rebates are estimated based on the growth rates that are derived from the summarized 2024 and 2025 bids

---

<sup>6</sup> Attachment II Section B contains additional information regarding the Medicare Shared Savings Program and Innovation Center models and demonstrations, and Advanced Alternative Payment Models.

<sup>7</sup> MA and PACE plans receive prospective capitated payments for enrollees from the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust fund accounts.

and using plans' projections of enrollment and risk scores. Trends in per capita bids for 2026 and later are tied to the per capita FFS growth rates, calculated using the non-ESRD FFS USPCCs and the per capita benchmark increases. Trends in the MA benchmarks reflect the FFS growth rates, adjustment to MA risk scores for differences in diagnosis coding between MA and FFS beneficiaries, projected changes in quality bonus (county-specific), and projected phase-out of IME (county-specific).

Two documents are published on this website in support of the non-ESRD USPCCs: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Trends>. The first document represents the current estimate of the FFS unit cost increases for 2024 - 2026 and the second is an illustration of the components of the growth rates for 2020 - 2026.

### ***Adjustments from the Program Baseline to Develop the USPCC Baseline***

There are several adjustments made to the program baseline to develop the USPCC projection. Given that MA bids do not include coverage for hospice, payments to hospices are excluded from the USPCCs. Also, per section 1853(c)(1)(D)(i) of the Act, incentive payments under sections 1848(o) and 1886(n) of the Act<sup>8</sup> for adoption and meaningful use of certified EHR technology are not included in the USPCCs. Additionally, claim expenditures in the NCH for cost plan enrollees are removed from the non-ESRD FFS USPCC. Finally, the MA ratebook and MA bids are presented on a pre-sequestration basis and, accordingly, the historical and projected sequestration reduction is added back to the USPCC baseline.

### ***Technical Update to Medical Education Payments in the Non-ESRD USPCC Baseline***

Section 1886(d)(11) of the Act directs the Secretary to provide inpatient prospective payment system hospitals with an additional payment amount for IME costs for discharges of MA enrollees, and section 1886(h)(3)(D) of the Act directs the Secretary to provide hospitals with an additional payment amount for direct graduate medical education (DGME) costs associated with services furnished to MA enrollees. These MA medical education expenditures are not costs for FFS beneficiaries.

Prior to the CY 2024 ratebook, the tabulation of non-ESRD FFS USPCCs had included both IME and DGME costs paid to inpatient facilities on behalf of MA enrollees because the inpatient cost report experience supporting the baseline modeling did not separately identify these payments from those made on behalf of FFS enrollees. Consequently, MA rates had included

---

<sup>8</sup> Sections 1848(o) and 1886(n) of the Act provide for incentive payments under the Medicare FFS program for eligible professionals and eligible hospitals, respectively, for meaningful use of certified EHR technology (CEHRT). 2016 was the final year that eligible professionals, as well as eligible hospitals outside of Puerto Rico, could earn incentive payments under these provisions; eligible hospitals in Puerto Rico could earn incentive payments for meaningful use of CEHRT through 2021. Sections 1848(a)(7) and 1886(b)(3)(B)(ix) require a reduction in Medicare FFS payments for eligible professionals and eligible hospitals that are not meaningful users of certified EHR technology, starting in 2015 for eligible professionals and eligible hospitals outside of Puerto Rico and in 2022 for eligible hospitals in Puerto Rico. 2018 was the final year that eligible professionals who were not meaningful users of CEHRT could be subject to negative payment adjustments under section 1848(a)(7).

these admissions-related costs, even though CMS and not MA organizations, had been paying these costs associated with MA enrollees directly to hospitals.

Beginning with the CY 2024 ratebook, the baseline development and modeling supporting the USPCCs has been updated to separate these payments and identify the historical and projected costs of IME and DGME paid to inpatient facilities by CMS associated with services furnished to MA enrollees.

On pages 10-11 of the CY 2024 Advance Notice,<sup>9</sup> we proposed to remove these MA-related IME and DGME costs from the historical and projected expenditures supporting the non-ESRD FFS USPCCs beginning with the CY 2024 ratebook. In the CY 2024 Rate Announcement,<sup>10</sup> we finalized the technical update to remove MA-related IME and DGME costs from the historical and projected expenditures supporting the non-ESRD FFS USPCCs. The Secretary directed the CMS Office of the Actuary to phase in this technical update to the USPCCs over a 3-year period beginning with the CY 2024 ratebook, with 33% of the MA-related medical education adjustment applied to the USPCCs in 2024.

We indicated on page 3 of the CY 2024 Rate Announcement that we intended to continue the phase-in by increasing to 67% for the 2025 MA-related medical education adjustment to be applied in 2025 and 100% of the 2026 value to be applied in 2026. However, as indicated on pages 3 and 35-36 of the CY 2025 Rate Announcement, based on the Secretary's direction, we applied 52% of the MA-related medical education adjustment for CY 2025. In this CY 2026 Advance Notice, we propose that the historical and projected expenditures supporting the estimates of the 2026 USPCCs which are used to determine the 2026 growth percentages reflect the full (100%) phase-in of the MA-related medical education technical update. The proposed full (100%) phase-in for CY 2026 is consistent with the three-year phase-in schedule announced in the CY 2024 Rate Announcement.

The effects of the full (100%) phase-in of the MA-related medical education adjustment on the USPCCs reflected in Section B of this document include:

- First, the technical change lowers the 2026 non-ESRD FFS USPCC and the corresponding non-ESRD FFS growth percentage by 1.42 percent (compared to the 2026 growth percentage with 52% phase-in). This growth percentage is used in the calculation of the specified amount for all counties.
- Second, the technical change lowers the 2026 non-ESRD Total USPCC and the corresponding MA growth percentage by 0.78 percent (compared to the 2026 growth percentage with 52% phase-in). This growth percentage is used in the calculation of the

---

<sup>9</sup> The CY 2024 Advance Notice is available at <https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf>

<sup>10</sup> The CY 2024 Rate Announcement is available at <https://www.cms.gov/files/document/2024-announcement-pdf.pdf>

applicable amounts which serve as a cap on the specified amount for a subset of affected counties.

This technical change is not expected to have any impact on the 2026 dialysis ESRD USPCC.

The changes described in this section have no impact on the exclusion of medical education costs from the Average Geographic Adjustments (AGAs) used to create the ratebook, because the adjustment proposed in this section is limited to the USPCCs. Refer to Attachment II, Sections C1 (Direct Graduate Medical Education) and C3 (Indirect Medical Education) for descriptions of the adjustments to the AGAs pertaining to the FFS experience and projections used to develop the ratebook. As we explained on page 31 of the CY 2024 Rate Announcement, the adjustments to the USPCCs and AGAs pertain to two different groups of Medicare beneficiaries: the technical update to the non-ESRD FFS USPCC pertains to excluding IME and DGME costs associated with *MA enrollees* (paid directly by CMS to hospitals), whereas the county level adjustment to the AGA pertains to IME and DGME costs associated with *FFS beneficiaries* (paid directly by CMS to hospitals) to determine MA capitation rates using FFS per capita costs as required by section 1853 of the Act.

In addition, the AGA adjustments are developed using different sources of FFS data that are better suited to the separate calculations. Prior to the CY 2024 ratebook, IME and DGME payments included in the non-ESRD FFS USPCCs were sourced from historical inpatient cost reports that had included amounts paid on behalf of both FFS and MA enrollees. The cost reports are used as a source for the projections of the USPCCs since the data contains more detail of the various components of hospital payments that are projected separately, including capital, bad debt, and ancillary pass-through payments. In contrast, the IME and DGME payments used to calculate the ratebook IME and DGME carve-out factors applied to the AGAs are sourced from the FFS claims records and, as such, the adjustment in the county FFS rate calculation has always been limited to the payments for FFS admissions. The claim records are used in the ratebook medical education exclusion because the claim records include the beneficiary's county of residence. Therefore, no corresponding adjustment is required to the IME phase-out and DGME carve-out adjustments to the AGAs in the county ratebook calculation to remove costs associated with MA enrollees. Thus, the technical update to the USPCC has no impact on the exclusion of medical education costs from the AGAs used to develop the ratebook.

The following table illustrates the development of the current estimate of the CY 2026 Part A non-ESRD FFS USPCC with the implementation of the technical update.

**Table I-1. CY 2026 Part A non-ESRD FFS USPCC Estimate Development**

	With 52% implementation of technical update <i>(informational)</i>	With full (100%) implementation of technical update <i>for CY 2026 rates</i>
<b>Projection for Contract Year 2026</b>		
a. Part A FFS Enrollment (annual, in millions)	32.822	32.822
<u>Reimbursements (in millions):</u>		
b. Part A reimbursements including all MA medical education	\$188,732.80	\$188,732.80
c. MA medical education amount (as a negative number)	(\$6,848.92)	(\$13,171.00)
d. Part A reimbursements excluding MA medical education $d = (b + c)$	\$181,883.88	\$175,561.80
e. Part A FFS Admin loading	1.001059	1.001059
f. 2026 Part A non-ESRD FFS USPCC $f = [(d * e) / a / 12]$	\$462.28	\$446.21
g. 2026 Part B non-ESRD FFS USPCC	\$748.78	\$748.78
h. 2026 non-ESRD FFS USPCC $h = f + g$	\$1,211.06	\$1,194.99
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)	7.09%	5.67%
k. Impact of increase in phase-in on CY 2026 FFS growth rate (compared with 52% phase-in)	n/a	-1.42%

As indicated in line k of table I-1, the impact of the increase in the phase-in on the CY 2026 FFS growth percentage (based on the change in the non-ESRD FFS USPCC) compared to the 2026 growth percentage with 52% phase-in is -1.42% for full (100%) implementation of the medical education change in CY 2026.

The impact of the increase in the phase-in on the CY 2026 MA growth percentage (based on the change in the non-ESRD Total USPCC, which includes both FFS and Part C projections) compared to the 2026 growth percentage with 52% phase-in is -0.78% for full (100%) implementation of the medical education change in CY 2026.

### **Section B. 2026 Growth Percentage Estimates**

The MA growth percentage, as defined at section 1853(c)(6), reflects the growth in per capita costs for non-ESRD beneficiaries enrolled in either FFS or Medicare health plans,<sup>11</sup> excluding expenditures attributable to sections 1848(a)(7), 1848(o), 1886(b)(3)(B)(ix), and 1886(n) of the Act, based upon estimates of the Total USPCC. The MA growth percentage is also referred to as the total growth percentage and the National Per Capita MA Growth Percentage. The MA growth percentage is used in calculating the applicable amount for a county, as required under section 1853(k)(1).

The non-ESRD FFS growth percentage reflects the growth in per capita costs based upon estimates of the non-ESRD FFS USPCC. As required by section 1853(n)(2)(E)(ii)(II) of the Act, the FFS USPCC calculated under section 1853(c)(1)(D) is used to calculate the specified amount in years in which CMS elects to rebase the adjusted average FFS per capita cost. CMS intends to rebase as part of the calculation of the rates for 2026.

The ESRD growth percentage reflects the growth in per capita costs based on the ESRD FFS USPCC. MA ESRD rates are determined by applying a historical average geographic adjustment to a projected FFS dialysis-only ESRD USPCC.

Table I-2 below provides the current estimate of the change in the three USPCC estimates. The percentage change in each USPCC is shown as the current projected USPCC for 2026 divided by the prior projected USPCC for 2025.

---

<sup>11</sup> “Medicare health plans” include MA plans, Cost plans, PACE organizations, and Medicare-Medicaid Plans (MMPs) operating in the capitated financial alignment model demonstrations under the Financial Alignment Initiative.

**Table I-2. Increase in the USPCC Growth Percentage for CY 2026<sup>12</sup>**

	Total USPCC – Non-ESRD	FFS USPCC – Non-ESRD	FFS Dialysis-only ESRD USPCC
Current projected 2026 USPCC	\$1,273.92	\$1,194.99	\$10,325.41
Prior projected 2025 USPCC	\$1,182.88	\$1,130.85	\$9,713.00
Percent increase	7.70%	5.67%	6.31%

The current estimate of the MA growth percentage\* (or change in the Total USPCC non-ESRD) for aged and disabled enrollees combined in CY 2026 is 7.70%. This estimate reflects an underlying trend change for CY 2026 in per capita cost of 5.65% and, as required under section 1853(c)(6)(C) of the Act, adjustments to the estimates for prior years as indicated in the table below.

Table I-3 below provides additional detail on the estimates for the change in the Total USPCC non-ESRD or national per capita MA growth percentage for aged/disabled beneficiaries.

**Table I-3. Increase in the MA Growth Percentage for 2026**

	Prior Increases	Current Increases			MA Growth Percentage for 2026 with § 1853(c)(6)(C) Adjustment**
	2003 to 2025	2003 to 2025	2025 to 2026	2003 to 2026	
Aged+Disabled	117.505%	121.714%	5.652%	134.245%	7.70%

\* The MA growth percentage is also known as the National Per Capita MA growth percentage and is equal to change in the Total USPCC non-ESRD.

\*\* (1 + current increases for 2003 to 2026) divided by (1 + prior increases for 2003 to 2025) minus 1.

### Section C. USPCC Estimates

Table I-4 compares last year's estimate of the Total non-ESRD USPCC with current estimates for 2003 to 2028; Table I-5 compares last year's FFS non-ESRD USPCC estimates with current estimates; and Table I-6 compares last year's dialysis-only ESRD USPCC estimates with current estimates. In addition, these tables show the current projections of the USPCCs through 2028.

<sup>12</sup> Growth rates and USPCC estimates reflect impact of proposed changes described in Attachment II, section B2. *Proposed Update to Tabulation of Ratebook FFS Experience Beginning in 2023.*



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 prescription drug benefit.

The tabulation of FFS costs supporting the USPCCs includes payments made outside the FFS claim systems, such as provider settlements via cost reports, Innovation Center model and demonstration payments, Medicare Shared Savings Program shared savings settlements, Advanced Alternative Payment Model incentive payments, and other adjustments. Also included in the USPCCs are the cost impacts of program changes enacted through known legislation, regulation, and NCDs applicable for the contract year (2026). Attachment II Section B contains additional information regarding the calculation of FFS costs used in setting MA rates and benchmarks.

### ***COVID-19***

Our estimates for the USPCCs for 2020 and subsequent years reflect the projected cost impacts related to the COVID-19 pandemic, including estimates for applicable costs related to COVID-19 vaccination and changes in utilization of health care services. These USPCCs also reflect estimated cost impacts of changes in MA coverage created by legislation in section 3713 of the CARES Act, which amended section 1852(a)(1)(B) of the Act to prohibit MA organizations from requiring cost-sharing in excess of FFS cost-sharing (which is zero) for a COVID-19 vaccine and its administration described in section 1861(s)(10)(A) of the Act; this limitation on cost sharing is not limited to the Public Health Emergency (PHE) and, therefore, will apply in 2026.

### ***Part B Provisions of the Inflation Reduction Act***

Our estimates for the USPCCs for 2022 and subsequent years reflect the projected cost impacts related to the Part B provisions of the IRA that are effective in those years. For example, section 11101 of Subtitle B of the IRA requires manufacturers of a “Part B rebatable drug”<sup>13</sup> to pay a rebate if 106% of the lesser of the drug’s average sales price or wholesale acquisition cost (or, for biosimilars, 100% of the biosimilar’s average sales prices +6% of the reference product’s average sales price) for a calendar quarter exceeds the inflation-adjusted payment amount;<sup>14</sup> this provision applies for each calendar quarter beginning on or after January 1, 2023. In addition, if 106% of the lesser of the drug’s average sales price or wholesale acquisition cost (or, for biologicals, 100% of the biosimilar’s average sales prices +6% of the reference product’s

---

<sup>13</sup> Per section 1847A(i)(2) of the Act, a “Part B rebatable drug” is defined as a single source drug or biological including biosimilars (excluding a qualifying biosimilar biological product as defined in 1847A(b)(8)(B)(iii)); a drug or biological with average annual spending less than \$100 per individual user (as determined by the Secretary) and preventive Part B vaccines are excluded from this definition.

<sup>14</sup> The inflation-adjusted amount is the payment amount in the benchmark quarter (in general, the calendar quarter beginning July 1, 2021) increased by CPI-U from the benchmark period CPI-U (in general, January 2021) through the first month of the calendar quarter that is two calendar quarters prior to the applicable calendar quarter.

average sales price) for a calendar quarter exceeds the inflation-adjusted payment amount, then, beginning April 1, 2023, beneficiary coinsurance is reduced to be based on the inflation-adjusted payment amount. Also, section 11407 of the IRA requires that, beginning July 1, 2023, the Medicare Part B deductible does not apply for insulin furnished through an item of durable medical equipment covered under Medicare's durable medical equipment benefit, and beneficiary cost sharing for a month's supply of insulin is not to exceed \$35.

Section 11407 of the IRA is projected to increase Part B FFS expenditures for 2023 and subsequent years because Medicare will pay for the reduced beneficiary financial responsibility for insulins. Section 11101 is projected to have negligible downward impact on Part B FFS expenditures for 2023 and subsequent years.

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

In light of the Supreme Court's decision in *American Hospital Association v. Becerra* on June 15, 2022, and the district court's remand to the agency, CMS issued the Hospital Outpatient Prospective Payment System Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 Final Rule, CMS-1793-F, on November 2, 2023.<sup>15</sup> CMS made a one-time lump sum payment to each affected provider that reflects the difference between what covered entities were paid for 340B drugs (generally ASP minus 22.5%) and what they would have been paid had the 340B payment policy not been applied (generally ASP plus 6%) from 2018 through September 27, 2022. CMS is complying with the budget neutralization requirement under sections 1833(t)(2)(E) and 1833(t)(14)(H) of the Act, and, alternatively, under the agency's inherent or common-law recoupment authorities, by reducing non-drug outpatient item and service prospective payments beginning in 2026. For more information on the remedy, please see: <https://www.cms.gov/newsroom/fact-sheets/hospital-outpatient-prospective-payment-system-remedy-340b-acquired-drug-payment-policy-calendar>.

The FFS USPCCs are developed consistent with the Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 Final Rule (CMS-1793-F), as we previously described on pages 17 and 18 of the CY 2025 Advance Notice and as finalized in the CY 2025 Rate Announcement. That is, in this Advance Notice, the restatements ("current estimates") of the FFS USPCCs for years 2018 - 2022 reflect the lump sum 340B-acquired drug remedy payments for services rendered from January 1, 2018 through September 27, 2022 for each affected 340B covered entity. The lump sum remedy payments are reflected in the USPCCs of the respective year associated with the service experience. The USPCCs projected for years 2026 and later reflect a reduction for all non-drug items and services to all OPSS providers, except any provider that enrolled in Medicare after January 1, 2018, by 0.5 percent each year until the entire 340B-acquired drug offset is reached. Accounting for this reduction in the USPCC projections

---

<sup>15</sup> The final rule appeared in the Federal Register on November 8, 2023 and is available online here: <https://www.federalregister.gov/documents/2023/11/08/2023-24407/medicare-program-hospital-outpatient-prospective-payment-system-remedy-for-the-340b-acquired-drug>.

reflects the fee-for-service projections for 2026 which, under section 1853(c)(1)(D) of the Act, must be reflected in the FFS per capita costs used for developing the MA ratebook. We welcome comments on this proposal and any alternate approaches that may be appropriate.

*USPCC Estimates*<sup>16</sup>

**Table I-4. Comparison of Current & Previous Estimates of the Total USPCC – Non-ESRD**

Calendar year	Part A		Part B		Part A + Part B		
	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	391.93	391.93	769.30	769.30	1.000
2013	380.03	380.03	398.72	398.72	778.75	778.75	1.000
2014	370.23	370.23	418.20	418.20	788.43	788.43	1.000
2015	373.86	373.86	434.84	434.84	808.70	808.70	1.000
2016	377.61	377.61	444.05	444.05	821.66	821.66	1.000
2017	383.10	383.10	459.01	459.01	842.11	842.11	1.000
2018	388.25	388.25	492.56	492.57	880.81	880.82	1.000
2019	400.78	400.79	525.03	525.05	925.81	925.84	1.000
2020	404.07	404.09	525.10	525.19	929.17	929.28	1.000
2021	410.01	410.03	572.18	572.47	982.19	982.50	1.000
2022	433.81	433.89	604.01	607.46	1,037.82	1,041.35	0.997
2023	453.71	449.85	666.11	657.69	1,119.82	1,107.54	1.011
2024	460.38	458.16	696.34	683.05	1,156.72	1,141.21	1.014
2025	471.60	466.52	734.17	716.36	1,205.77	1,182.88	1.019
2026	486.01	479.63	787.91	760.94	1,273.92	1,240.57	1.027
2027	509.15	503.41	835.83	809.11	1,344.98	1,312.52	1.025
2028	533.44		866.84		1,400.28		

<sup>16</sup> Growth rates and USPCC estimates reflect impact of proposed changes described in Attachment II, section B2. *Proposed Update to Tabulation of Ratebook FFS Experience Beginning in 2023.*

**Table I-5. Comparison of Current & Previous Estimates of the FFS USPCC – Non-ESRD**

Calendar year	Part A		Part B		Part A + Part B		
	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	390.70	390.70	747.67	747.67	1.000
2013	363.75	363.75	394.49	394.49	758.24	758.24	1.000
2014	364.20	364.20	408.91	408.91	773.11	773.11	1.000
2015	369.31	369.31	427.78	427.78	797.09	797.09	1.000
2016	371.51	371.51	433.28	433.28	804.79	804.79	1.000
2017	373.86	373.86	448.00	448.00	821.86	821.86	1.000
2018	378.12	378.12	479.08	479.09	857.20	857.21	1.000
2019	383.83	383.83	506.19	506.20	890.02	890.03	1.000
2020	375.84	375.84	478.38	478.49	854.22	854.33	1.000
2021	390.92	390.92	556.71	557.20	947.63	948.12	0.999
2022	407.73	407.73	572.02	578.70	979.75	986.43	0.993
2023	417.47	419.82	633.41	628.51	1,050.88	1,048.33	1.002
2024	428.47	431.23	672.75	654.25	1,101.22	1,085.48	1.015
2025	441.80	441.68	707.01	689.17	1,148.81	1,130.85	1.016
2026	446.21	446.80	748.78	731.88	1,194.99	1,178.68	1.014
2027	466.80	468.46	793.35	777.17	1,260.15	1,245.63	1.012
2028	488.41		821.76		1,310.17		

**Table I-6. Comparison of Current & Previous Estimates of the ESRD Dialysis-only FFS USPCC**

Calendar year	Part A		Part B		Part A + Part B		
	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

Calendar year	Part A		Part B		Part A + Part B		
	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Ratio
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	3,580.06	3,576.05	5,191.99	5,146.20	8,772.05	8,722.25	1.006
2024	3,809.81	3,799.72	5,378.84	5,259.82	9,188.65	9,059.54	1.014
2025	4,033.40	3,999.61	5,774.25	5,713.39	9,807.65	9,713.00	1.010
2026	4,279.98	4,254.81	6,045.43	5,986.57	10,325.41	10,241.38	1.008
2027	4,535.10	4,519.44	6,329.94	6,279.35	10,865.04	10,798.79	1.006
2028	4,800.89		6,584.46	6,279.35	11,385.35		

These estimates are preliminary and could change when the final rates are announced in the Rate Announcement of CY 2026 MA Capitation Rates and MA and Part D Payment Policies. Further details on the derivation of the national per capita MA growth percentage and the FFS growth percentage will also be presented in the Rate Announcement.

#### **Section D. Loading for Claims Processing Costs**

Per section 1853(n)(2)(E) of the Act, the base amount used in setting MA county rates is the amount specified in section 1853(c)(1)(D) for each year that CMS rebases the MA rates. Section 1853(c)(1)(D) of the Act provides that the adjusted average per capita cost (AAPCC) for the year involved, which is the basis for the calculation of the USPCC, is determined under section 1876(a)(4) of the Act. As defined in section 1876(a)(4) of the Act, the AAPCC (and accordingly the USPCCs) include administrative costs incurred by the Medicare Administrative Contractors (MACs) described in sections 1816 and 1842 of the Act, which are incorporated into the calculation as an adjustment. Consistent with past practice, this “loading” adjustment is developed as the ratio of MAC administrative costs to Medicare benefit payments for the most recent completed fiscal year. Consistent with past years, we will continue the methodology that the loading for the non-ESRD Total USPCC include both FFS and Part C expenditures in the denominator of the calculation. In order to better align the costs included in the numerator and denominator, we will continue to include, as adopted for the 2023 rates, only FFS expenditures (as opposed to both FFS and Part C expenditures) in the denominator of the loading adjustment calculation for the non-ESRD FFS and ESRD FFS USPCCs. Table I-7 contains the proposed 2026 USPCC loading adjustment for claims processing costs.

**Table I-7. USPCC Loading Adjustment for Claims Processing Costs**

Expenditure Category	Cash Benefits FY 2024 (000)	MAC Expenses FY 2024 (000)	Claims Processing Loading	USPCC basis
<u>PART A</u>				
FFS	\$211,420,682	\$223,934	0.001059	FFS USPCC
Part C	\$184,503,172	n/a	n/a	n/a
Total	\$395,923,854	\$223,934	0.000566	Total USPCC
<u>PART B</u>				
FFS	\$244,437,761	\$650,590	0.002662	FFS USPCC
Part C	\$272,048,071	n/a	n/a	n/a
Total	\$516,485,832	\$650,590	0.001260	Total USPCC

## **Attachment II. Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2026**

### **Section A. MA Benchmark, Quality Bonus Payments, and Rebate**

Section 1853(n)(2)(E) of the Act requires that, in determining the specified amount, CMS use as the base amount the amount described in section 1853(c)(1)(D) for a rebasing year or, for years that are not a rebasing year, the base amount from the previous year increased by the national per capita MA growth percentage. Section 1853(c)(1)(D)(ii) requires CMS to rebase the county FFS rates, which form the basis of the specified amount described in Section A2 below, periodically but not less than once every three years. When the rates are rebased, CMS updates its estimate of each county's FFS costs using more current FFS claims information. CMS intends to rebase the county FFS rates for 2026 using FFS claims data from 2019 through 2023. CMS has rebased the rates every year since 2012 and has discussed in previous Rate Announcements that we anticipate rebasing the rates each year. Given that MA rates are based on FFS costs, CMS believes it is important to update the FFS per capita cost estimates using the most current FFS data available. (Please note that throughout this document, the terms "benchmark" and "county rate" are used interchangeably, and the term "service area benchmark" indicates the bidding target for an MA plan based on its specific service area.) Section 1853(n)(4) requires that the benchmark for an area for a year (including increases for quality bonus percentages) be capped at the level of the applicable amount, as defined at section 1853(k)(1).

PACE payment rates are not developed using the specified amount, per section 1853(n)(5) of the Act, but are developed using the applicable amount, as defined at section 1853(k)(1), as discussed below.

#### ***A1. Applicable Amount***

The applicable amount is the rate established under section 1853(k)(1) of the Act. As CMS intends to rebase the rates in 2026, the applicable amount for 2026 is the greater of: (1) the county's 2026 FFS cost (that is, the 2026 FFS USPPC adjusted for the county) or (2) the 2025 applicable amount increased by the CY 2026 National Per Capita MA Growth Percentage. As discussed in Section A5, section 1853(n)(4) of the Act requires that the benchmark (determined taking into account the application of the quality bonus payment (QBP) percentage) for each county must be capped at the county's applicable amount.

#### ***A2. Specified Amount***

Under section 1853(n)(2)(A) of the Act, the specified amount is based upon the following formula:

(2026 FFS cost minus (IME phase-out amount and kidney acquisition costs)) × (applicable percentage + applicable percentage quality increase)

Where:

FFS cost is the FFS per capita cost for the area for the year, adjusted to exclude costs attributable to payments under sections 1848(o), 1886(n), and 1886(h), as described in more detail below in Section B;

IME phase-out amount is the amount of indirect costs of medical education that is required to be phased out as specified at section 1853(k)(4) and section 1853(n)(2)(A)(i) and (F);

Kidney acquisition costs are the standardized costs for payments for organ acquisitions for kidney transplants that are required to be excluded, beginning 2021, as specified at section 1853(k)(5) and section 1853(n)(2)(A)(i) and (G);

Applicable percentage is a statutory percentage applied to the county's base payment amount, as described at section 1853(n)(2)(B); and

Applicable percentage quality increase, referred to in this document as the QBP percentage, is a percentage point increase to the applicable percentage for a county in a qualifying plan's service area as provided in section 1853(o).

Section 1853(n)(2)(B) and (C) of the Act requires CMS to determine applicable percentages for a year based on county FFS rate rankings for the most recent year that was a rebasing year. To determine the CY 2026 applicable percentages for counties in the 50 States and the District of Columbia, CMS ranks counties from highest to lowest based upon their 2025 average per capita FFS rate adjusted to exclude the IME phase out and payments for kidney acquisition for transplant. The 2025 rates are used because 2025 is the most recent rebasing year prior to 2026. CMS then places the rates into four quartiles. For the territories, CMS assigns an applicable percentage to each territory county based on where the territory county rate falls in the quartiles established for the 50 States and the District of Columbia.

CMS is publishing the 2026 applicable percentages by county with the Advance Notice at <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html>. Each county's applicable percentage is assigned based upon its quartile ranking, as follows:



**Table II-1. FFS Quartile Assignment**

Quartile	Applicable Percentage
4 <sup>th</sup> (highest)	95%
3 <sup>rd</sup>	100%
2 <sup>nd</sup>	107.5%
1 <sup>st</sup> (lowest)	115%

Section 1853(n)(2)(D) of the Act provides that, beginning in 2013, if there is a change in a county's quartile ranking for a payment year compared to the county's ranking in the previous year, the applicable percentage for the area for the year shall be the average of: (1) the applicable percentage for the previous year and (2) the applicable percentage for the current year. For both years, CMS calculates the applicable percentage that would otherwise apply for the area for the year in the absence of this transitional provision. For example, if a county's ranking changed from the second quartile to the third quartile, the applicable percentage would be 103.75 percent for the year of the change – the average of 107.5 percent and 100 percent (see Table II-1 above).

### ***A3. Quality Bonus Payment Percentage***

The Act provides for CMS to make quality bonus payments to MA organizations that meet quality standards measured under a five-star quality rating system. In this document, we refer to this quality bonus as the *QBP percentage* instead of using the statutory term *applicable percentage quality increase*. The QBP percentage is a percentage point increase to the applicable percentage for each county in a qualifying plan's service area, before multiplying the percentage by the FFS rate for the year to determine the specified amount.

Table II-2 shows the QBP percentage for each Star Rating. Plans with fewer than four stars will not receive a QBP percentage increase to the county rates and plans with four or more stars will receive a QBP percentage increase in the calculation of the county rates, as set forth in sections 1853(n) and 1853(o) of the Act. See Section A6 for rebate percentages.

**Table II-2. Percentage Add-on to Applicable Percentage  
for Quality Bonus Payments**

Star Rating	QBP Percentage
Fewer than 4 stars	0%
4, 4.5, and 5 stars	5%

An MA plan's Star Rating is the rating assigned to its contract applying the 5-star rating system (based on the data collected under section 1852(e) of the Act) specified in §§ 422.160 through

422.166.<sup>17</sup> The contract rating is applied to each plan offered under that contract. MA plans with a Star Rating of four or more stars will bid against their service area benchmarks that include the 5-percentage point QBP add-on to the applicable percentage for the benchmark in each county in the service area, subject to the benchmark cap for the county. MA plans with a Star Rating of fewer than four stars will bid against service area benchmarks that do not include QBP add-ons to the county rates, with the exceptions of new MA plans and low enrollment plans. As discussed below, all benchmarks (determined after application of the QBP percentage) are capped at the section 1853(k)(1) applicable amount per section 1853(n)(4) of the Act.

### **New MA Plans**

New MA plans are treated as qualifying plans that are eligible to receive a QBP percentage increase to the county rates, except that the QBP percentage will be 3.5 percentage points, per section 1853(o)(3)(A)(iii)(I)(cc) of the Act and §§ 422.166(d)(2)(v) and 422.258(d)(7)(v)(C). That is, new MA plans will bid against a service area benchmark that reflects a 3.5 percentage point increase to the applicable percentage used to set the benchmark for each county in the plan's service area. Per section 1853(o)(3)(A)(iii)(II) of the Act and § 422.252, for the purpose of determining a QBP percentage, the term "new MA plan" refers to an MA plan offered by a parent organization that has not had another MA contract in the preceding three-year period.

Per § 422.166(d)(2)(vi), for a parent organization that has had a contract with CMS in the preceding three-year-period, any new MA contract (and MA plans under that contract) under that parent organization will receive an enrollment-weighted average of the Star Ratings earned by the parent organization's existing MA contracts.

### **Low Enrollment Plans**

Low enrollment plans do not receive a quality Star Rating under the 5-star rating system (specified in §§ 422.160 through 422.166) but are treated as qualifying plans for purposes of the QBP. *See* 42 CFR §§ 422.166(d)(2)(v) and 422.258(d)(7)(iv). Section 1853(o)(3)(A)(ii)(II) of the Act, as implemented at § 422.258(d)(7)(iv)(B), provides that for 2013 and subsequent years, CMS shall develop a method for determining whether an MA plan with low enrollment is a qualifying plan for purposes of receiving an increase in payment under section 1853(o). We apply this determination at the contract level, and thus determine whether a contract (meaning all plans under that contract) is a qualifying contract. Pursuant to § 422.252, a low enrollment contract is one that could not undertake Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcome Survey (HOS) data collections because of a lack of a sufficient number of enrollees (that is, fewer than 500 enrollees) to reliably measure the performance of the health plan.

---

<sup>17</sup> All regulatory cites are to Title 42 of the Code of Federal Regulations unless otherwise noted.

Section 1853(o)(3)(A)(ii) of the Act does not address the amount of the increase for low enrollment contracts. We intend to continue the current policy that low enrollment contracts be included as qualifying contracts that receive the QBP percentage of 3.5 percentage points, similar to the QBP percentage increase applied to new MA plans. We discussed the basis of this policy in detail in the 2018 Advance Notice (pages 12-13) (<https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2018.pdf>).

### **Contract Consolidations and QBP**

Section 1853(o)(4) of the Act was amended by the Bipartisan Budget Act of 2018 to add subparagraph (D) regarding the determination of Star Ratings for consolidating MA plans, which is implemented for MA plans at § 422.162(b)(3) for contract consolidations approved on or after January 1, 2019. When two or more contracts for health and/or drug services of the same plan type under the same legal entity are combined into a single contract at the start of a contract year, the rating used to determine QBP status (“QBP rating”) for the first year following the consolidation will be the enrollment weighted average of what would have been the QBP ratings of the surviving and consumed contracts, using the contract enrollment in November of the year the Star Ratings were released (§ 422.162(b)(3)(ii)). For the second year after consolidation, CMS will determine QBP status based on the consolidated contract’s Star Ratings displayed on Medicare Plan Finder, which will be calculated as provided in § 422.162(b)(3)(iv)(B).

#### ***A4. Qualifying County Bonus Payment***

Beginning with contract year 2012, pursuant to section 1853(o)(2) of the Act and § 422.258(d)(7)(ii), the QBP percentage is doubled for a qualifying plan located in a “qualifying county.” A qualifying county is a county that meets all of the following three criteria:

- (1) has an MA capitation rate that, in 2004, was based on the amount specified in section 1853(c)(1)(B) for a Metropolitan Statistical Area with a population of more than 250,000;
- (2) as of December 2009, had at least 25 percent of MA-eligible beneficiaries residing in the county enrolled in a MA plan; and
- (3) has per capita FFS County spending for the year (2026) that is less than the national monthly per capita cost for FFS for the year (2026).

See section 1853(o)(3)(B) of the Act and § 422.258(d)(7)(ii).

Example: As described in Section A3, a plan with a rating of 4.5 stars will have 5 QBP percentage points added to the applicable percentage of each county in its service area. For each county that meets the three criteria stated above in that plan’s service area, that percentage will be doubled so that an additional 5 percentage points will be added to that county’s applicable percentage for a total increase of 10 percentage points. If this qualifying county otherwise has an applicable percentage of 95 percent, this is increased to 105 percent to reflect the quality bonus

payment percentage for that county. As discussed in Section A5 below, all benchmarks are capped at the section 1853(k)(1) applicable amount (determined after application of the QBP percentage) per section 1853(n)(4) of the Act.

CMS will publish a complete list of qualifying counties with the final CY 2026 Rate Announcement. The listing will contain all counties that meet all three criteria stated above. Two of the three elements for determining a qualifying county (2004 urban floors (Y/N) for each county, and 2009 MA penetration rates) can be found in the 2025 Rate Calculation Data file (columns AB and AD) on the CMS website at <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html>. The 2026 FFS rates, which are necessary for the third criterion, are not available at the time this Advance Notice is published. The FFS rates and the national average FFS spending amount will be published in the final CY 2026 Rate Announcement.

#### ***A5. Cap on Benchmarks***

Section 1853(n)(4) of the Act requires that the benchmark (determined by taking into account the application of the QBP percentage) for a county must be capped at the level of the county's applicable amount determined under section 1853(k)(1). This provision requires that the QBP increase be included in the benchmark before the comparison is made to determine if the cap is applied. Thus, for all counties, post-QBP percentage rates are capped at the section 1853(k)(1) applicable amount.

While we appreciate the concerns stakeholders have raised in connection with the cap on benchmarks, CMS believes that section 1853(n)(4) of the Act prevents elimination of the cap or excluding the bonus payment from the cap calculation.

#### ***A6. Rebate***

Under section 1854(b)(1)(C)(v) of the Act, except for Medical Savings Account (MSA) plans, the level of rebate for each plan is based on the plan's Star Rating. Rebates for each plan are calculated as a percentage of the amount by which the risk-adjusted service area benchmark exceeds the risk-adjusted bid. Under § 422.266(b), plans may use rebates to pay for mandatory supplemental benefits (such as reduced cost sharing compared to the cost sharing that is actuarially equivalent to Medicare FFS coverage per section 1852(a)(1)(B) of the Act and additional items and services that are not covered by Medicare Parts A and B) and/or to buy down beneficiary premiums for Part B and/or Part D prescription drug coverage. Pursuant to section 1854(b)(1)(C)(v), which is implemented in § 422.266(a)(2)(ii), the rebate percentages apply based on a plan's Star Rating, as shown in Table II-3.

**Table II-3. MA Rebate Percentages**

<b>Star Rating</b>	<b>Rebate Percentage</b>
4.5+ Stars	70%
3.5 to < 4.5 stars	65%
< 3.5 stars	50%

Section 1854(b)(1)(C)(vi)(II) of the Act requires that, for purposes of determining the rebate percentage, a new MA contract under a new parent organization will be treated as having a Star Rating of 3.5 stars for 2012 and subsequent years. *See also* § 422.266(a)(2)(iv). The statute is silent on the rebate percentage to assign to low enrollment plans in years after 2012. We view this as a gap in the statute, particularly in light of the direction in section 1853(o)(3)(A)(ii) to treat low enrollment plans as qualifying plans for purposes of the QBP percentage. As we have in prior years beginning with CY 2015, CMS intends to treat low enrollment plans as having a Star Rating of 3.5 stars for purposes of determining the rebate percentage; therefore, rebates for each low enrollment plan are calculated as 65% of the amount by which the risk-adjusted service area benchmark exceeds the risk-adjusted bid.

## **Section B. Calculation of Fee-for-Service Cost**

### ***B1. Introduction***

The FFS per capita cost for each county is the product of (1) the national FFS per capita cost, or USPCC, and (2) a county-level geographic index called the average geographic adjustment (AGA). Each year, CMS strives to improve the development of the AGAs and estimated FFS per capita costs with refinements to how these figures are calculated.

We will continue to incorporate refinements developed and used in prior years to update the claims data used to calculate the AGAs and to continue the repricing of historical data in the AGA calculation to reflect changes in FFS payment rules. CMS will reprice historical hospital inpatient, hospital outpatient, skilled nursing facility, and home health claims to reflect the most currently available wage indices, and retabulate physician claims with the most currently available Geographic Practice Cost Index. (See sections B3 through B6 for more details.) We will also reprice historical claims to account for legislative and regulatory changes made to uncompensated care payments. Repricing historical claims used for the AGAs, in conjunction with rebasing rates, ensures that the FFS rates for each county reflect the most current FFS fee schedules and payment rules.

We will continue a refinement to the methodology used in the ratebook development to include Health Professional Shortage Areas (HPSAs) bonus payments. Specifically, we will tabulate the HPSA bonuses by county of residence for years 2019–2023 and add these values to our ratebook

FFS expenditures. The HPSA bonuses are disbursed quarterly to providers and are not reflected in the standard claim files.

With this Advance Notice, we are releasing the 2023 FFS cost data by county used 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>. These data do not reflect adjustments for Innovation Center models and demonstrations and the Medicare Shared Savings Program and Advanced Alternative Payment Models, and do not reflect adjustments for claim repricing for the most current available FFS payment final rules and parameters.

### ***B2. Proposed Update to Tabulation of Ratebook FFS Experience Beginning in 2023***

For more than 20 years, the Denominator file has been the source for FFS enrollment used in the tabulation of non-ESRD ratebook experience. The Denominator file is an abbreviated version of the Enrollment Database (EDB)<sup>18</sup> with key enrollment-related fields including beneficiary identification code, state code, county code, Medicare status code (MSC), months of enrollment, Part A coverage indicator, Part B coverage indicator, and HMO coverage indicator. The Denominator file fields for state code, county code, and MSC for each experience year are populated from the EDB using data as of March following the calendar year.

Non-ESRD ratebook claims are tabulated from the National Claims History (NCH) file. The tabulation excludes claims for beneficiaries in ESRD status as determined by MSC of 11, 21, or 31 on the NCH record. The claims experience is summarized by state and county code using the information on the NCH record.

Note that the tabulation of FFS enrollment from the Denominator file and claims from the NCH are independent processes for the tabulation of ratebook FFS experience through 2022.

The Denominator file is being retired and was last created for calendar year 2022. Accordingly, a replacement system and data will be adopted for the tabulation of ratebook FFS experience starting with 2023. Beginning with 2023 ratebook experience, we are proposing to replace the data derived from the Denominator file with comparable information from the Common Medicare Environment (CME). Similar to the Denominator file, the CME data originates from the EDB. However, the CME data reflects monthly determination of state/county code and MSC instead of the annual determination reflected in the Denominator file. This proposed approach is consistent with the data and methodology used in tabulation of ESRD dialysis experience.

---

<sup>18</sup> The EDB is CMS's database of record for Medicare beneficiary enrollment information; the primary source for beneficiary information is SSA's Master Beneficiary Record. For more information on the EDB, see: <https://aspe.hhs.gov/centers-medicare-medicaid-services>.

Specifically, we are proposing the following changes to the tabulation of ratebook FFS experience based on the updated data source based on the monthly status of each field:

1. Use CME dialysis and transplant tables to identify claims for beneficiaries in non-ESRD status. Historically, the MSC on the Denominator file enrollment record and NCH claim record were used to determine ESRD status.
2. Use the state code and county code from the CME to summarize NCH claim experience by state and county. The state and county code originate with records from the SSA.
3. Exclude claims for beneficiaries with MA coverage.
4. Exclude FFS enrollment and non-hospice claims for FFS beneficiaries in hospice status. As noted previously, payments to hospices are excluded from the development of the USPCCs.

Additionally, we are proposing to make corresponding changes to the non-ESRD USPCCs supporting the CY 2026 growth rates.

The impact of the changes on the USPCCs is as follows:

**Table II-4. Impact of Changes to the Tabulation of Ratebook FFS Experience on USPCCs**

Calendar year	Non-ESRD FFS USPCC			Non-ESRD total USPCC		
	Part A	Part B	Part A + Part B	Part A	Part B	Part A + Part B
2023	(\$2.67)	(\$1.30)	(\$3.97)	\$0.58	\$0.99	\$1.57
2024	(3.13)	(1.66)	(4.79)	0.54	0.97	1.51
2025	(3.63)	(2.10)	(5.73)	0.53	0.98	1.51
2026	(4.03)	(2.36)	(6.39)	(1.81)	(0.40)	(2.21)
2027	(4.38)	(2.65)	(7.03)	(2.01)	(0.57)	(2.58)
2028	(4.73)	(2.89)	(7.62)	(2.24)	(0.73)	(2.97)

As such, the corresponding impacts on the 2026 non-ESRD growth rates are -0.57% for FFS and -0.19% for total. As noted earlier, the growth rates and USPCC estimates in Attachment I of this document reflect these impacts.

### ***B3. AGA Methodology***

In the first step of the AGA methodology, CMS will add the 2023 cost and enrollment data to, and drop the 2018 cost and enrollment data from, the historical claims experience used to develop new geographic cost indices for each county. As a result, the five-year rolling average will be based on non-hospice FFS claims data from 2019-2023. CMS will then perform a series of adjustments to the historical FFS data to estimate FFS rates per county, explained below as successive steps.

For Puerto Rico, CMS will continue to include five years (2019-2023) of historical claims and enrollment only for beneficiaries with Part A and Part B enrollment at the time of the dates of service for the FFS claim. 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. CMS continues to believe it is appropriate to adjust the FFS rate calculation in Puerto Rico used to determine MA rates so that it is based on beneficiaries who are enrolled in both Part A and Part B in order to produce a more accurate projection of FFS costs per capita in Puerto Rico.

In the second step, CMS will reprice the historical inpatient, hospital outpatient, skilled nursing facility, and home health claims from 2019-2023 to reflect the most current (i.e., FY 2025) wage indices, re-tabulate physician claims with the most current Geographic Practice Cost Indices, and reprice Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims in accordance with the payment rules in effect during the temporary gap period for the DMEPOS Competitive Bidding Program<sup>19</sup>, which began January 1, 2024. The repricing of Inpatient Prospective Payment System (IPPS) claims will be based on the wage index and related payment policies adopted under CMS-1808-IFC.<sup>20</sup> The repricing of Outpatient Prospective Payment System (OPPS) claims will be based on the wage index corresponding to regulation CMS-1808-CN. In former competitive bidding areas (CBAs), adjusted fees are based on the single payment amounts updated by the projected percentage change in the Consumer Price Index for All Urban Consumers (CPI-U) from January 2023 to January 2024. In non-CBAs, the adjusted fees are based on fully adjusted rates per the applicable methodology under § 414.210(g). The January 2025 fee schedules for repricing DMEPOS claims are accessible on the CMS website at: <https://www.cms.gov/medicare/payment/fee-schedules/dmepos/dmepos-fee-schedule>.

As noted on page 35 of the CY 2022 Rate Announcement,<sup>21</sup> and consistent with prior years, we do not reprice Part B drugs, and we have not developed the data and systems to support such repricing. Therefore, we do not reprice Part B drugs as part of our adjustments to the AGAs irrespective of the 340B remedy rule provision for lump sum remedy payments for services rendered from January 1, 2018 through September 27, 2022 for each 340B covered entity. On September 28, 2022, the District Court for the District of Columbia vacated the differential

---

<sup>19</sup> For more information on the DMEPOS Competitive Bidding Program Temporary Gap Period, please see: <https://www.cms.gov/files/document/mln764994-dmepos-competitive-bidding-program-temporary-gap-period.pdf>

<sup>20</sup> While the interim final action with comment period (IFC) (CMS-1808-IFC) eliminated the low wage index hospital policy for FY 2025 and established new IPPS rates for FY 2025 that do not reflect the continuation of the low wage index hospital policy, CMS also created a transitional payment exception for FY 2025 equivalent to applying a 5 percent cap on the reduction to the FY 2024 wage index for hospitals that had benefitted from the low wage index hospital policy, which serves to mitigate the impacts on low wage hospitals that had been receiving increased payments under the policy, including those in Puerto Rico. Additionally, CMS also published the 2025 OPPS final rule (CMS-1809-FC), which continues the low wage index hospital policy for the OPPS wage index, whereby the OPPS wage index will use the wage index values included in the IPPS CN (CMS-1808-CN). The USPCCs projected in the CY 2026 Advance Notice reflect the provisions of the IPPS IFC and the OPPS FC.

<sup>21</sup> <https://www.cms.gov/files/document/2022-announcement.pdf>



payment rates for 340B-acquired drugs going forward. As a result, all CY 2022 claims for 340B-acquired drugs paid on or after September 28, 2022, were paid at the default rate (generally ASP plus 6%). As such, many CY 2022 340B drug claims have been processed, or reprocessed through standard claims processing procedures, at the higher 340B payment rate (generally ASP plus 6%) as described in the Hospital Outpatient Prospective Payment System Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 Final Rule, CMS-1793-F, (88 FR 77150–94), issued on November 2, 2023. The processing, or reprocessing through standard claims processing procedures, at the higher 340B payment rate (generally ASP plus 6%) for these aforementioned CY 2022 claims will be included in 2022 FFS experience supporting the ratebook AGAs.

We will continue to adjust the uncompensated care payments (UCP) represented in the 2019–2023 claims to reflect the requirements of the most recent final rule (here, the FY 2025 Inpatient Prospective Payment System (IPPS) final rule). The repricing will include the supplemental payment for certain hospitals in Puerto Rico and certain Indian Health Service / Tribal hospitals that was adopted in the FY 2023 IPPS final rule. Repricing for Puerto Rico inpatient claims will continue to reflect the Consolidated Appropriations Act, 2016 (Pub. L. 114-113, Division O, section 601), which amended section 1886(d)(9)(E) of the Act.

We will continue to use, as the source of the county designation of beneficiaries used in the summarization of the risk scores, the county assignment used for the ratebook FFS claims and enrollment. For contract years 2016 and earlier, the county assignment for each FFS beneficiary was based on the ZIP code associated with the beneficiary’s mailing address. Beginning with the 2017 ratebook, we used the county of residence sourced from the SSA, which is the same county assignment as the ratebook FFS claims and enrollment. The statutory component of the Regional MA benchmarks for RPPOs will also continue to be based on this county designation of beneficiaries. Under our implementation of section 1858(f)(2) of the Act, the standardized RPPO benchmark for each MA region includes a statutory component consisting of the weighted average of the county capitation rates across the region for each appropriate level of Star Rating. The enrollment weights for the statutory component will reflect this county designation of beneficiaries.

As in prior years, (1) CMS will make additional adjustments to the FFS costs described below, and (2) the average of each county’s five-year geographic indices, based on the adjusted claims data, will be divided by the county’s average five-year risk score in order to develop the AGA for that county. Consistent with the development of prior years’ ratebooks, the risk scores used to standardize the non-ESRD and ESRD ratebooks will be based on the risk adjustment model(s) and risk adjustment policies used for the applicable contract year (2026) payment.

***B4. Adjustments for Medicare Shared Savings Program and Innovation Center Models and Demonstrations, and Advanced Alternative Payment Models***

***Medicare Shared Savings Program and Innovation Center Models and Demonstrations***

As indicated in Table II-5, we will continue to adjust historical FFS experience to incorporate shared savings and losses or episode savings and losses experienced under the Medicare Shared Savings Program and Innovation Center models and demonstrations. We will update the experience years used for this adjustment as noted on Table II-5. All adjustments of this type apply to only the non-ESRD ratebook except the model(s) noted as ESRD in Table II-5.

**Table II-5. The Medicare Shared Savings Program and Innovation Center Models and Demonstrations with Ratebook Adjustments**

Program/Models and Demonstrations	Experience Years		Payment Type
	2025 Ratebook	2026 Ratebook	
Medicare Shared Savings Program	2018-2022	2019-2023	Shared savings / shared losses
Comprehensive Care for Joint Replacement (CJR)	2018-2021	2019-2022	Episode savings / episode losses
Next Generation ACO (NGACO)	2018-2021	2019-2021	Shared savings / shared losses
Oncology Care Model (OCM)	2018-2022	2019-2023	Episode savings / episode losses
Enhancing Oncology Model (EOM)	n/a	7/1/2023-12/31/2023	Episode savings / episode losses
Bundled Payments for Care Improvement (BPCI)	2018	n/a	Episode savings / episode losses
Bundled Payment for Care Improvement Advanced (BPCI Advanced)	10/1/2018-2022	2019-2023	Episode savings / episode losses
Medicare-Medicaid Financial Alignment Initiative Managed FFS Model	2018-2020	2019-2020	Shared savings
Vermont Medicare ACO Initiative	2018-2022	2019-2023	Shared Savings / shared losses
Maryland Primary Care Program	2019-2022	2019-2023	Performance-based Incentive Payment
Million Hearts: Cardiovascular Disease Risk Reduction Model	n/a	2019-2021	Incentive payment
Global and Professional Direct Contracting / ACO Realizing Equity, Access, and Community Health (GPDC/ACO REACH)	4/1/2021-2022	4/1/2021-2023	Shared savings / shared losses
Kidney Care Choices / Comprehensive Kidney Care Contracting Option	n/a	2022	Shared savings / shared losses

Program/Models and Demonstrations	Experience Years		Payment Type
	2025 Ratebook	2026 Ratebook	
Next Generation ACO (NGACO)	2018-2021	2019-2021	Population-based payment
Vermont Medicare ACO Initiative	2018-2022	2019-2023	Population-based payment
Maryland Primary Care Program	2019-2022	2019-2023	Population-based payment
Primary Care First	2021-2022	2021-2023	Population-based payment
Primary Care First	2022	2022-2023	Performance-based Incentive Payment
Global and Professional Direct Contracting / ACO Realizing Equity, Access, and Community Health (GPDC/REACH)	4/1/2021-2022	4/1/2021-2023	Population-based payment
Comprehensive Primary Care Plus (CPC+)	2018-2021	2019-2021	Comprehensive Primary Care Payments
Comprehensive Primary Care Plus (CPC+)	2018-2021	2019-2021	Performance-based Incentive Payment
Comprehensive Primary Care Plus (CPC+)	2018-2021	2019-2021	Care Management Fees
Maryland Primary Care Program	2019-2022	2019-2023	Care Management Fees
Maryland Primary Care Program	n/a	2022-2023	Health Equity Advancement Resource and Transformation payments
Kidney Care Choices / Comprehensive Kidney Care Contracting Option	2022	2022-2023	Population-based payment
<b><u>ESRD</u></b>			
Comprehensive ESRD Care (CEC)	2018-3/31/2021	2019-3/31/2021	Shared savings / shared losses
Next Gen ACO (NGACO)	2018-2021	2019-2021	Population-based payment
Vermont Medicare ACO Initiative	2018-2022	2019-2023	Population-based payment
Global and Professional Direct Contracting / ACO Realizing Equity, Access, and Community Health (GPDC/REACH)	4/1/2021-2022	4/1/2021-2023	Population-based payment
Kidney Care Choices / Comprehensive Kidney Care Contracting Option	n/a	2022	Shared savings / shared losses

The key aspects of these adjustments are:

- The adjustments reflect an allocation of the savings and losses based on the distribution of the participating entity’s aligned beneficiaries by county of residence. The adjustments applied to the non-ESRD ratebook exclude experience for beneficiaries in ESRD status as of July 1 of the experience year. (The adjustments for the model(s) noted as ESRD in Table II-5, which are applied to the ESRD ratebook in a similar manner as the non-ESRD cohort, include experience for beneficiaries in ESRD status.)
- Under the models noted as using “population-based payments” in Table II-5, participants receive a monthly fee that ultimately offsets a percentage reduction in FFS payments to certain providers and suppliers aligned with participants over the same year. For each affected claim, the reduction amount represents the portion of the payment that has effectively been rerouted to the Accountable Care Organization (ACO) via the population-based payment and is therefore added back to the reduced FFS amount so that the total reimbursement amount is represented.
- Under the CPC+ model, participants received quarterly payments that replaced a percentage of FFS claim amounts for each affected claim. The “comprehensive primary care payments” are included with claim costs to compile the total reimbursement amount.
- In the ratebooks for contract years 2020 and earlier, the allocation of the Medicare Shared Savings Program and Innovation Center model and demonstration payment adjustments between the Part A and Part B Trust Funds was based on the Part A and Part B proportion of the FFS USPCC for each calendar year. Consistent with the actual payments by the Trust Fund, we intend to continue with the approach started for CY 2021 ratebook to allocate the entire amount of the following payments for all experience years to the Part B Trust Fund: (i) Oncology Care Model episode savings / losses, (ii) Comprehensive Primary Care Plus comprehensive primary care payments, performance-based incentive payments, and care management fees, (iii) Maryland Primary Care Program care management fees and population-based payments, and (iv) Primary Care First population-based payments and performance-based incentive payments. The remaining Medicare Shared Savings Program and Innovation Center model and demonstration payment adjustments will continue to be allocated in the MA ratebook calculations between the Part A and Part B Trust Funds based on the Part A and Part B proportion of the FFS USPCC for each calendar year.

Further information on the Medicare Shared Savings Program may be found at:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram>.

Further information on the Innovation Center models and demonstrations may be found at:

<https://innovation.cms.gov/>.

Although we considered whether to adjust the FFS claims experience for care management fees, per-beneficiary-per-month fees, and/or advance payment of shared savings paid to providers for

other Innovation Center models conducted in 2019-2023 period,<sup>22</sup> we intend to continue prior policy and will not take fees of this type into account in our adjustments to historical FFS experience when such fees or payments were not funded from Medicare Parts A or B Trust Funds.

### Advanced Alternative Payment Models

Section 1833(z)(1) of the Act requires payment of an incentive for physicians and other eligible clinicians who become qualifying APM participants (QPs) through sufficient participation in an Advanced Alternative Payment Model (A-APM) for payment years from 2019 through 2026.<sup>23</sup>

A-APMs can include: 1) models under section 1115A of the Act (other than a health care innovation award), 2) certain two-sided models under the Shared Savings Program under section 1899 of the Act, 3) demonstrations under section 1866C of the Act, and 4) demonstrations required by federal law when these alternative payment models meet the criteria specified in § 414.1415, including requiring the use of Certified Electronic Health Record Technology (CEHRT), making payment based on quality measures, and requiring assumption of a more than nominal amount of financial risk. The QP performance period occurs two years prior to payment of the APM incentive. QP determinations are made for each eligible clinician (National Provider Identifier (NPI)), and may be made at either a group or individual eligible clinician level. The first QP performance year was 2017, and the first APM incentive payments were made to QPs in 2019.

APM incentive payments are calculated and paid as specified in § 414.1450. The amount of the APM incentive payment for payment years 2019 through 2024 is equal to 5 percent, for 2025 is equal to 3.5 percent, and for 2026 is equal to 1.88 percent of the QP's estimated aggregate payments for covered professional services as defined in 1848(k)(3)(A) of the Act furnished during a base year which is the calendar year immediately preceding the payment year. Base year estimated aggregate payments and the corresponding APM incentive payment are calculated for each QP using all of their NPI combinations.

The applicable periods for APM incentive payments made to date are:

**Table II-6. Applicable Periods for APM Incentive Payments**

QP performance year	2017	2018	2019	2020	2021	2022
Base year	2018	2019	2020	2021	2022	2023
Payment year	2019	2020	2021	2022	2023	2024

<sup>22</sup> Information about the various Innovation Center models is available in the Report to Congress available at: <https://innovation.cms.gov/data-and-reports/2021/rtc-2020>

<sup>23</sup> [Consolidated Appropriations Act, 2024 \(Pub. L. 118-42\)](#).

We are proposing to include with the ratebook historical experience the APM incentive payments disbursed in years 2019 through 2023. The APM incentive payments will be added to ratebook FFS experience for the payment year. For example, the APM incentive payments made in 2019 will be added to 2019 ratebook FFS experience. The APM incentive payment adjustment will be allocated based on the distribution of claim expenditures by county of beneficiary residence for the base year expenditures for each NPI. Excluded from the adjustment will be the small proportion, less than 0.50 percent, of incentive payments for providers with no base period experience, given there is no basis for allocation of payments by beneficiary residence for such providers. The adjustment will apply to both non-ESRD and dialysis populations.

Further information on the Advanced Alternative Payment Models may be found at: <https://qpp.cms.gov/apms/advanced-apms>.

#### ***B5. Additional Adjustment to FFS per Capita Costs in Puerto Rico***

For the past nine years, the Secretary has directed the CMS Office of the Actuary to adjust the FFS experience for beneficiaries enrolled in Puerto Rico to reflect the nationwide propensity of beneficiaries with zero claims. For the CY 2017–2025 Rate Announcements, the CMS Office of the Actuary evaluated experience exclusively for beneficiaries who were enrolled in both Parts A and B (“A&B beneficiaries”) and were not dually eligible for Veterans Affairs (VA) coverage. The study for setting the CY 2025 rates analyzed experience for calendar years 2018 through 2022 and only considered FFS beneficiaries enrolled mid-year. On average over this period, 13.9 percent of A&B Puerto Rico FFS beneficiaries were found to have no Medicare Part A or Part B claim reimbursements per year. This compares to a nationwide non-territory proportion of 6.0 percent of A&B FFS beneficiaries found to have no Medicare Part A claim reimbursements and no Medicare Part B claim reimbursements per year over the same period. Based on the Secretary’s direction, the Puerto Rico FFS weighting of enrollment and risk scores for the zero-claim cohort was adjusted to reflect the nationwide proportion of zero-claim beneficiaries. The resulting impact was measured as an average increase in the standardized per-capita FFS costs in Puerto Rico of 4.2 percent for 2018 through 2022. Accordingly, a 4.2 percent adjustment was then applied to the pre-standardized Puerto Rico FFS rates supporting the CY 2025 ratebook development.

We are considering whether a similar adjustment should be applied for CY 2026. The CMS Office of the Actuary will perform an analysis that is similar to the prior analysis but with an updated five years of data: 2019-2023. We welcome comments regarding a similar update to Puerto Rico’s experience in the development of the 2026 FFS rates. We will review the results of this study and any comments that we receive, and we will specify in the final Rate Announcement any adjustment that we determine may be necessary based on those results and comments.

Concerns have been raised in the past by stakeholders regarding the FFS data used to establish MA benchmarks in Puerto Rico. As discussed in the CY 2017 Advance Notice, the law requires that MA benchmarks be based on a county's average FFS per-capita cost, 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. As we stated originally in the CY 2017 Rate Announcement and in Rate Announcements for several years since, our actuarial analyses have indicated that the FFS data in Puerto Rico is sufficient for establishing accurate MA benchmarks.

### ***B6. Additional Adjustments after the AGA is Calculated***

The following adjustments are made after the AGA is calculated:

- Direct Graduate Medical Education: removed from FFS county costs (as directed by section 1853(c)(1)(D)(i) of the Act), described in more detail in Section C1.
- Credibility: for counties with fewer than 1,000 beneficiaries, blend county experience with that of others in the market area to ensure credibility.
- VA and Department of Defense (DoD): apply an adjustment to FFS per capita costs for beneficiaries dually enrolled in VA and/or the DoD health programs (the Uniformed Services Family Health Plan (USFHP) and/or the Veterans Health Administration (VHA)) pursuant to section 1853(c)(1)(D)(iii) of the Act. The VA/DoD adjustment for the 2026 rates will be based upon an updated study that uses FFS data from calendar years 2018-2022. The methodology for the study and adjustment is described in more detail in the CY 2022 Advance Notice Part II (pages 27-28).
- Organ Acquisition Costs for Kidney Transplants: removed from FFS costs (as directed by section 1853(n)(2)(G) and section 1853(k)(5) of the Act), described in more detail in Section C2.
- Indirect Medical Education: removed from FFS county costs (as directed by section 1853(n)(2)(F) and section 1853(k)(4) of the Act), described in more detail in Section C3.

Note that incentive payments for adoption and meaningful use of certified electronic health record (EHR) technology are not included in the claims used to develop the FFS costs and, therefore, no explicit adjustment is needed to exclude these payments from the FFS costs to comply with section 1853(c)(1)(D) of the Act.

### **Section C. Additional Adjustments**

As noted in Section B6, additional adjustments are applied after the AGA is calculated. Subsections C1, C2, and C3 below describe in more detail the separate adjustment factors developed for DGME, Kidney Acquisition Costs, and IME (respectively).

### ***CI. Direct Graduate Medical Education***

See Attachment I Section A regarding medical education expenses in USPCCs.

Section 1853(c)(1)(D)(i) of the Act requires the exclusion of costs attributable to payments under section 1886(h), that is payments for DGME, from the FFS per capita costs used for developing the MA ratebooks.

Please note that some ratebook files and other CMS data reference “graduate medical expenses,” or GME. In the context of the MA ratebooks, DGME and GME refer to the same item and are used interchangeably.

The steps involved in the calculation of the DGME carve-out for CY 2026 for non-Maryland facilities are the same as used for CY 2025 and are as follows:

- a. Identify on the Medicare cost reports (Form CMS-2552-10) those expenditures to be excluded from the MA ratebooks (that is, those costs on the report that are attributable to payments made under section 1886(h)):
  1. Part A DGME: Cost report worksheet E-4, line 49, column 1
  2. Part B DGME: Cost report worksheet E-4, line 50, column 1
- b. Identify cost report fields reflected on the Direct Medical Education per diem field on the Provider Specific File (PSF) for each Provider State based on the jurisdiction of each MAC. This data is available on the CMS website at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents>. The two-digit state code corresponds to the first two digits of the inpatient provider ID.
- c. Using the information from “a” and “b,” tabulate for each provider and calendar year:
  1. Expenditures to be removed from MA rates (item a)
  2. Expenditures represented in DGME field in the PSF (item b)
  3. Proportion of DGME PSF values to be excluded from rates (c1 / c2)
  4. The ratio in step c3 will be set to 0.00 for providers with cost report fields Part A DGME = \$0.00 and Part B DGME = \$0.00.
- d. Accumulate DGME PSF values by county and calendar year:
  1. Multiply the DGME per diem amount on PSF times the number of covered days for each inpatient admission from the FFS claims files.
  2. Accumulate d1 by county of beneficiary residence.
- e. Calculate DGME exclusion for each county and calendar year:  $d2 \times c3$



*DGME Carve-out for Maryland Total Cost of Care (TCOC) Model*

Consistent with the CY 2025 Rate Announcement (pages 64-66), we will continue to use the alternative data and methodology used to develop the DGME carveout for hospitals participating in the Maryland TCOC Model.

The Maryland TCOC Model sets a per capita limit on Medicare total cost of care in Maryland and is the first Innovation Center model to hold a state fully at risk for the total cost of care for Medicare beneficiaries. The Maryland TCOC Model builds upon the Innovation Center's Maryland All-Payer Model, which had set a limit on per capita hospital expenditures in the State. Maryland operates an all-payer hospital rate regulation system. This system is made possible, in part, by a Medicare waiver (codified in section 1814(b) of the Act) that exempted Maryland from the IPPS and the OPSS and allowed Maryland to set rates for these services. This exemption affects the CMS system data used to develop the DGME, IME, and kidney acquisition cost (KAC) carve-outs, and as such we have worked with the MAC and Maryland's Health Services Cost Review Commission (HSCRC) to identify data that can be used to develop the DGME, IME, and KAC carve-outs for hospitals participating in the Maryland TCOC Model. The KAC is addressed in more detail in section C2 below, and IME is addressed in more detail in section C3 below.

The adjustment is based on the Provider Statistical & Reimbursement Report (PS&R) figures for MA admissions for each Maryland hospital with a graduate medical program for each calendar year. The PS&R includes for each Maryland provider the fiscal year MA DGME expenditures and MA days of admission, which are used to calculate the DGME per diem for MA admissions. This MA experience is used as the basis for the FFS DGME amounts since DGME payments for FFS admissions are not included in the inpatient Provider Specific File for providers participating in the Maryland TCOC model.

The adjustment is as follows:

1. Calculate average per diem DGME amount for each TCOC facility and corresponding fiscal year (FY) ending in June as: DGME amount from the PS&R divided by days of admission from the PS&R.
  - a. Actual PS&Rs and DGME experience are available through FY 2023. The DGME amounts are represented in the "From Intermediary Total IME & DME Payments" field on the Calculation of Medicare GME Discounts spreadsheets on HSCRC's Policy Clarifications and Regulations Updates web page.<sup>24</sup>

---

<sup>24</sup> [https://hscrc.maryland.gov/Pages/pdr\\_clarifications.aspx](https://hscrc.maryland.gov/Pages/pdr_clarifications.aspx)

- b. Estimated DGME per diem amounts for each facility for FY 2024 to be calculated as FY 2023 per diem amount multiplied by (1 + HSCRC’s Proposed Inflation Update<sup>25</sup> for rate year 2024) i.e. (1 + 0.0335).
2. DGME for each FFS claim in the NCH is tabulated as: per diem from step 1 applicable to facility and date of admission multiplied by number of covered days for each inpatient admission. This tabulation only applies to providers participating in the TCOC model.
3. Amounts from step 2 are accumulated by county of beneficiary residence.

The DGME carve-out factors for the 2026 rates will be published with the CY 2026 Rate Announcement.

### ***C2. Organ Acquisition Costs for Kidney Transplants***

Section 17006(b) of the 21st Century Cures Act amended section 1853(k) and (n) of the Act to exclude CMS’s estimate of the standardized costs for payments for organ acquisition for kidney transplants from MA benchmarks starting in 2021. Section 1853(k)(5) of the Act, implemented in § 422.306(d), provides for the exclusion of these costs from the applicable amount and section 1853(n)(2)(A)(i), implemented in § 422.258(d), provides for the exclusion from the base amount (used to calculate the specified amount). Further, section 17006(c) of the 21st Century Cures Act amended sections 1851(i) and 1852(a)(1)(B); the amendments, implemented<sup>26</sup> in §§ 422.100(c)(1) and 422.322, require FFS coverage of organ acquisition costs for kidney transplants incurred by MA enrollees and exclude coverage of organ acquisitions for kidney transplants from the benefits that MA plans must provide to their enrollees. As discussed in the CY 2021 final rule (CMS-4190-F) (85 FR 33825) and CY 2021 Advance Notice, we apply the carve-out from the FFS costs when developing ESRD MA rates as well.

The 21st Century Cures Act did not require FFS coverage of organ acquisition costs for kidney transplants received by PACE participants. Therefore, as noted in the CY 2021 final rule (85 FR 33824–25), PACE organizations must continue to cover organ acquisition costs for kidney transplants consistent with the requirement in section 1894(b)(1)(A)(i) of the Act that PACE organizations provide all Medicare-covered items and services. Accordingly, CMS will continue to include the costs for kidney acquisitions in PACE payment rates—both the PACE county rates and the PACE ESRD rates—unlike for MA benchmarks.

---

<sup>25</sup> HSCRC’s Final Recommendation for the Update Factors for Rate Year 2024, available at: [https://hscrc.maryland.gov/Documents/Strong%20als%20Folder/AUUR%20-%20Unit%20Rates%20and%20GBR/FY%202024/Ry24%20Amended%20Final%20UF%20Recommendation%2006142023%20%20with%20comment%20letters%20\(1\).pdf](https://hscrc.maryland.gov/Documents/Strong%20als%20Folder/AUUR%20-%20Unit%20Rates%20and%20GBR/FY%202024/Ry24%20Amended%20Final%20UF%20Recommendation%2006142023%20%20with%20comment%20letters%20(1).pdf).

<sup>26</sup> See the CY 2021 final rule (CMS-4190-F) (85 FR 33796, 33824–26) titled “Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program.”

The steps involved in the calculation of the KAC carve-out for CY 2026 are the same as used for CY 2025 and are as follows:

- a. Identify on the Medicare Cost Reports (Form CMS-2552-10) those expenditures that are related to organ acquisition costs. This will be used in the next step to calculate the proportion of organ acquisition costs that represents kidney acquisition costs (that is, the proportion of costs on the report that is attributable to payments made under section 1881(d) of the Act), which is to be excluded from the MA ratebooks:
  1. Cost report worksheet D-4 (Heart), line 69, column 1
  2. Cost report worksheet D-4 (Intestine), line 69, column 1
  3. Cost report worksheet D-4 (Islet), line 69, column 1
  4. Cost report worksheet D-4 (Kidney), line 69, column 1
  5. Cost report worksheet D-4 (Liver), line 69, column 1
  6. Cost report worksheet D-4 (Lung), line 69, column 1
  7. Cost report worksheet D-4 (Pancreas), line 69, column 1
- b. Using information from “a,” tabulate for each provider and calendar year the proportion of organ acquisition costs<sup>27</sup> that are applicable to kidneys:  $a4 / (a1 + a2 + a3 + a4 + a5 + a6 + a7)$ .
- c. Identify the Organ Acquisition Cost (OAC) per diem field on the inpatient PSF for each Provider State based on each MAC’s jurisdiction (this data is available on the CMS website at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents>) and date of admission. The two-digit state code corresponds to the first two digits of the inpatient provider ID.
- d. Accumulate KAC PSF values by county and calendar year:
  1. Calculate the per admission KAC carveout as the OAC per diem amount on the PSF (item “c”)  $\times$  KAC proportion of OACs (item “b”)  $\times$  number of covered days for each inpatient admission.
  2. Accumulate d1 by county of beneficiary residence.

The KAC carve-out factors for the 2026 rates will be published with the CY 2026 Rate Announcement.

---

<sup>27</sup> Note that the sum of a1 through a7 is the same value as reported on Cost Report Worksheet E, Part A, line 55. Therefore, the proportion of organ acquisition costs that are applicable to kidneys could alternatively be computed by dividing a4 by Cost Report Worksheet E, Part A, line 55.

*KAC Carve-Out for Maryland Total Cost of Care Model*

As previously noted, a Medicare waiver that exempted Maryland from the IPPS and OPSS affects the CMS system data used to develop the KAC carve-out. In the CY 2025 Advance Notice (page 41), we stated that we 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. The KAC data provided by the MAC to the HSCRC is an appropriate data source to calculate the KAC carve-out for Maryland hospitals. This data was not available to be used for the CY 2025 ratebook development and prior years. For the CY 2026 ratebook, we propose 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.

As such, we are proposing to revise the data and methodology used to develop the KAC carve-out for hospitals participating in the Maryland TCOC Model with a kidney transplant program. See section C1 for more information on the Maryland TCOC Model.

The proposed adjustment will be based on the inpatient cost report figures for MA admissions for each Maryland hospital with a kidney transplant program for each calendar year. The inpatient cost report includes for each Maryland provider the fiscal year MA KAC expenditures and MA days of admission, which are used to calculate the KAC per diem for MA admissions. This MA experience is used as the basis for the FFS KAC amounts since KAC payments for FFS admissions are not included in the inpatient PSF for providers participating in the Maryland TCOC Model.

The proposed adjustment is as follows:

1. Calculate average per diem KAC amount for each TCOC facility and corresponding FY ending in June as: KAC amount from the inpatient cost report divided by days of admission from the inpatient cost report.
  - a. Completed KAC expenditures are available for FY 2023 and preliminary tabulation of KAC amounts are available for FY 2024. The KAC amounts are provided to CMS by the MAC (Novitas).<sup>28</sup>
2. The KAC amount for each CY 2023 FFS claim in the NCH is tabulated as: per diem from step 1 applicable to facility and date of admission multiplied by number of covered days for each inpatient admission. This tabulation only applies to providers participating in the TCOC model.
3. Amounts from step 2 are accumulated by county of beneficiary residence.

The estimated impacts of the proposed change to the KAC adjustment for the Maryland TCOC Model, based on last year's published MA rates for CY 2025, are available at:

---

<sup>28</sup> [https://hscrc.maryland.gov/Pages/pdr\\_clarifications.aspx](https://hscrc.maryland.gov/Pages/pdr_clarifications.aspx)

<https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents>.

The KAC carve-out factors for the 2026 rates will be published with the CY 2026 Rate Announcement.

### *Living Donor Expenses*

As described above, the approach to exclude costs for kidney acquisitions from MA benchmarks by county and from MA ESRD rates utilizes data from the Medicare cost reports and the inpatient PSF. These data sources do not include section 1881(d) expenditures for coverage of living donor expenses beyond what is reflected in the kidney acquisition cost center and paid on a pass-through basis in the FFS program. Per section 1853(k)(5) and (n)(2)(G) of the Act, the 1881(d) expenses are required to be included in the carve out of kidney acquisition costs from the benchmark amounts. Accordingly, we will tabulate from the FFS claim records the living donor expenses associated with kidney transplants and add those amounts to the KAC amounts derived from the cost reports. Per statute and as codified in §§ 422.100(c)(1) and 422.322(d), beginning in 2021, MA organizations are not responsible for coverage of organ acquisition costs for kidney transplants incurred by MA enrollees, including coverage under section 1881(d) of living kidney donor expenses, which will be reimbursed by the FFS program.

When developing the CY 2026 rates, we will continue to apply the KAC adjustment subsequent to the application of the IME adjustment, consistent with the adjustment order used beginning with the CY 2022 ratebook.

### ***C3. IME Phase Out***

See Attachment I Section A regarding medical education expenses in USPPCs.

Section 161 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275) amended section 1853(k)(4) of the Act to require CMS to phase out IME amounts from MA capitation rates. Section 1853(n)(2)(F) applies the same phase-out to FFS costs in the calculation of the specified amount in setting MA rates. Payment to teaching facilities for IME expenses associated with MA plan enrollees will continue to be paid directly by CMS to hospitals. Section 1894(d)(3) provides that the IME payment phase-out does not apply to PACE capitation rates.

We will first calculate the FFS rates including the IME amount; this initial amount will serve as the basis for calculating the IME reduction that we will carve out of the MA rates. The absolute effect of the IME phase-out on each county will be determined by the amount of IME included in the initial FFS rate. Under section 1853(k)(4)(B)(ii) of the Act, the maximum reduction for any specific county in 2026 is 10.2 percent of the FFS rate. Consistent with past practice, in order to

help plans identify the impact of the IME reduction, CMS will separately identify the amount of IME for each county rate in the 2026 MA ratebook.

As in prior years, for purposes of making this adjustment for non-Maryland facilities, the IME amounts are tabulated using the Indirect Medical Education Amount field included on inpatient records in the NCH file.

*IME Carve-out for Maryland TCOC Model*

Consistent with the CY 2025 Rate Announcement, we will continue to use the alternative data and methodology used to develop the IME carveout for hospitals participating in the Maryland TCOC Model. See section C1 for more information on the Maryland TCOC Model. The adjustment is based on IME included in the PS&R for MA admissions for each participating provider for each calendar year. The PS&R includes for each Maryland provider the fiscal year MA IME expenditures and MA days of admission, which are used to calculate the IME per diem for MA admissions. This MA experience is used as the basis for FFS IME amounts since IME payments for FFS admissions are not separately identified in the NCH for providers participating in the Maryland TCOC model.

The adjustment is as follows:

1. Calculate average per diem IME amount for each TCOC facility and corresponding fiscal year ending in June as: IME amount from PS&R divided by days of admission from PS&R.
  - a. Actual PS&Rs and IME experience is available through FY 2023. The IME amounts are represented in the “From Intermediary Total IME & DME Payments” field on the Calculation of Medicare GME Discounts spreadsheets on HSCRC’s Policy Clarifications and Regulations Updates web page.
  - b. Estimated IME per diem amounts for each facility for FY 2024 to be calculated as FY 2023 per diem amount multiplied by (1 + HSCRC’s Proposed Inflation Update<sup>29</sup> for rate year 2024) i.e. (1 + 0.0335).
2. IME for each FFS claim in the NCH is tabulated as: per diem from step 1 applicable to facility and date of admission multiplied by number of covered days for each inpatient admission. This tabulation only applies to providers participating in the TCOC model.
3. Amounts from step 2 are accumulated by county of beneficiary residence based on the claims files.

---

<sup>29</sup> HSCRC’s Final Recommendation for the Update Factors for Rate Year 2024, available at: [https://hscrc.maryland.gov/Documents/Strong%20als%20Folder/AUUR%20-%20Unit%20Rates%20and%20GBR/FY%202024/R%20Y24%20Amended%20Final%20UF%20Recommendation%2006142023%20with%20comment%20letters%20\(1\).pdf](https://hscrc.maryland.gov/Documents/Strong%20als%20Folder/AUUR%20-%20Unit%20Rates%20and%20GBR/FY%202024/R%20Y24%20Amended%20Final%20UF%20Recommendation%2006142023%20with%20comment%20letters%20(1).pdf).

The IME factors for the 2026 rates will be published with the CY 2026 Rate Announcement.

#### **Section D. MA ESRD Rates**

Pursuant to section 1853(a)(1)(H) of the Act, CMS establishes “separate rates of payment” with respect to ESRD beneficiaries enrolled in MA plans. As we stated in the CY 2012 Rate Announcement (page 32), it is in keeping with our understanding of the legislative intent to more closely align MA payment rates with FFS costs that the MA ESRD rates are also based on FFS costs. We currently set MA ESRD rates on a state basis (that is, at the state level instead of the county level), using updated FFS costs each year, and intend to continue that policy and our existing methodology for setting MA ESRD rates.

We will use the 2019-2023 FFS expenditures and enrollment data for beneficiaries in dialysis status for each state to develop the CY 2026 MA ESRD rates. For each year, we compute the FFS dialysis per capita costs (for Part A and Part B items and services for beneficiaries in dialysis status) by state. The geographic indices for each year are calculated by dividing the state per capita cost by the national per capita cost. The five-year weighted average of the geographic indices is standardized by dividing by the five-year average risk scores (calculated using the risk adjustment model for CY 2026 payment). This standardized five-year weighted average is the AGA, which represents the ratio of historical FFS dialysis per capita costs by state to national FFS dialysis per capita costs. We calculated the 2023 FFS ESRD dialysis USPCC based on the 2023 data described above in Attachment I, Section A, and, using trend factors, develop the prospective 2026 FFS ESRD dialysis USPCC. The 2026 MA ESRD rates are determined by multiplying the 2026 FFS ESRD dialysis USPCC by the state AGA.

We will continue to incorporate refinements developed and used in prior years regarding the repricing of historical data in the AGA calculation for the MA ESRD rates. Similar to the non-ESRD rate methodology, we intend to reprice the ESRD historical inpatient, hospital outpatient, skilled nursing facility, and ESRD PPS claims from 2019-2023 to reflect the most current (i.e., FY 2025) wage indices, and re-tabulate physician claims with the most current (i.e., CY 2025) Geographic Practice Cost Indices. We will continue to adjust the UCPs represented in the 2019-2023 claims to reflect the requirements of the most recent final rule. The adjustments will also include shared savings and shared losses performance-based payments made under the CEC model and the Kidney Care Choices / Comprehensive Kidney Care Contracting Option, and population-based payments under the Next Gen ACO, Vermont Medicare ACO Initiative, and GPDC/REACH as described in section B of this document, as well as incentive payments under Advanced Alternative Payment Models. Pursuant to section 1853(k)(5), (n)(2)(A)(i) and (n)(2)(G), MA benchmarks for 2021 and subsequent years exclude organ acquisition costs for kidney transplants (described in detail in Section C above). As noted in the CY 2021 final rule (CMS-4190-F) (85 FR 33796, 33825) and in the CY 2021 Rate Announcement, the exclusion of KACs is also applied to the MA ESRD rates for 2021 and subsequent years. In addition, the 2026 MA ESRD rate is adjusted by removing the GME expenses and the gradual phase-out of



IME expenses, consistent with adjustments made for the non-ESRD MA rates that are discussed in Sections B and C of this document.

We will publish a file with the CY 2026 Rate Announcement that includes the key components of the rate development, similar to the rate calculation data supporting the MA non-ESRD county rates.

As stated in Section C, CMS will continue to include organ acquisition costs for kidney transplants in the PACE rates, including PACE ESRD rates, and the IME payment phase-out does not apply to PACE capitation amounts. Therefore, for 2026, the ESRD rates for PACE organizations will continue to include KACs and IME amounts.

We are aware that stakeholders have raised concerns regarding ESRD payment adequacy and accuracy in prior years, in light of the increase in ESRD enrollment in MA plans as a result of the 21st Century Cures Act, which allows beneficiaries with ESRD to enroll in MA plans starting in 2021. In the CY 2023 and CY 2024 Advance Notices, we provided details of our analyses regarding potential changes to our development of the MA ESRD rates, including the impact of rates at geographic levels smaller than the state by how geographic areas measured on the area deprivation index (ADI). The results of these analyses suggested some potentially concerning impacts on specific geographic areas if we were to change the geographic level at which we apply our methodology for developing the MA ESRD rates. CMS has analyzed the actual experience for ESRD enrollees for 2021 and 2022 as reported on Worksheet 1 of the CY 2023 and CY 2024 MA Bid Pricing Tools (BPTs). Our analysis indicates that 2021 and 2022 revenues for ESRD enrollees exceed the corresponding net medical expenses for most plans. Based on the analyses to date, we plan to continue our use of statewide MA ESRD rates for CY 2026.

As stated in section 1853(a)(1)(H) of the Act, and as implemented in § 422.304(c)(1)(iv), the seventh sentence of section 1881(b)(7) shall apply to payments under this section covering the provision of renal dialysis treatment. CMS will continue to withhold from the MA ESRD rates an amount equivalent to reducing each composite rate payment 50 cents for the ESRD Network Program.<sup>30</sup> In the CY 2000 Rate Announcement (page 1), the equivalent withhold amount was determined to be \$5.25 per month.<sup>31</sup> CMS continued to apply the \$5.25 withhold (sometimes referred to as the “user fee”) in subsequent contract years by reducing the monthly payment rate for ESRD beneficiaries by \$5.25, but recently reviewed this withhold amount to determine whether it remains equivalent to the 50 cent per dialysis treatment requirement in the statute. CMS conducted an updated analysis of CY 2022 and CY 2023 FFS data to calculate the average number of paid dialysis sessions per month for FFS beneficiaries and the corresponding average monthly ESRD Network withhold for FFS beneficiaries. This analysis found that in CY 2022

---

<sup>30</sup> For more information on the ESRD Network Program, visit <https://www.cms.gov/training-education/open-door-forums/end-stage-renal-disease-clinical-laboratories-esrd/network>

<sup>31</sup> The CY 2000 Rate Announcement is available at <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Announcement2000.pdf>



and CY 2023, FFS beneficiaries received an average of 12 paid treatments per patient month. Applying the statutory 50 cent withhold to each paid dialysis treatment results in an average ESRD Network withhold for FFS beneficiaries of \$6.00 per month. Therefore, for the CY 2026 ESRD ratebook, we propose to update the withhold amount from \$5.25 to \$6.00 per month, which would be applied by reducing the monthly payment rate for ESRD beneficiaries by \$6.00. The ESRD rates published with the CY 2026 Rate Announcement would be shown both before and after the deduction of the \$6.00 Network withhold (if finalized).

### **Section E. Location of Network Areas for Private Fee-for-Service (PFFS) Plans in Plan Year 2027**

Section 1852(d)(4) of the Act requires MA organizations offering certain non-employer MA PFFS plans in network areas to enter into signed contracts with a sufficient number of providers to meet the access standards applicable to coordinated care plans. Specifically, non-employer MA PFFS plans that are offered in a network area (as defined in section 1852(d)(5)(B)) must meet the access standards described in section 1852(d)(4)(B) through written contracts with providers. These PFFS plans may not meet access standards by establishing payment rates that are at least the rates that apply under FFS and having providers deemed to be contracted as described in § 422.216(f).

Network area is defined in section 1852(d)(5)(B) of the Act, for a given plan year, as an area that the Secretary identifies (in the announcement of the proposed payment rates for the previous plan year under section 1853(b)(1)(B)) as having at least two network-based plans (as defined in section 1852(d)(5)(C)) with enrollment as of the first day of the year in which the Rate Announcement is made. We intend to publish the list of network areas for plan year 2027 with the CY 2026 Rate Announcement. We will make this list available on the CMS website at: <https://www.cms.gov/Medicare/Health-Plans/PrivateFeeforServicePlans/NetworkRequirements>.

### **Section F. MA Employer Group Waiver Plans (EGWP)**

We intend to continue to waive the Bid Pricing Tool bidding requirements for all MA employer/union-only group waiver plans (EGWPs) for 2026.<sup>32</sup> As a condition of this waiver of the bidding requirements and the waivers otherwise provided to MA EGWPs, CMS will establish MA EGWP payment amounts using the same methodology for 2026 as was used for 2025. As has been the case since 2017, for 2026, Part C entities offering EGWPs will not be required to submit Part C bid pricing information in the Part C Bid Pricing Tool. CMS has authority under section 1857(i) of the Act to waive or modify requirements that hinder the design of, the offering of, or the enrollment in employment-based Medicare plans offered by employers and unions to their members. Waiving the requirement to submit Part C bid pricing information facilitates the

---

<sup>32</sup> As stated in the Medicare Managed Care Manual, Ch. 9, § 10.2, in addition to EGWPs, employer/union group health plan sponsors may choose to enroll their Medicare beneficiaries in individual MA plans. These MA plans do not qualify for the employer/union group health plan waiver of bidding requirements described in this section.

offering of Part C plans for employers and unions seeking to establish high quality coverage for their Medicare-eligible retirees by avoiding the cost and administrative burden of submitting the complex bids required from non-EGWPs. We refer the reader to the detailed discussion of our rationale and responses to commenters' questions in the CY 2017 Rate Announcement, Attachment III, Section F (pages 27–44) for additional information, and to the responses to questions received by the Office of the Actuary that are available at:

<https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/ActuarialBidQuestions>.

### ***F1. Bid-to-Benchmark Ratio***

In connection with the continuation of this waiver, for 2026, CMS will continue to use the payment methodology for MA EGWPs that was finalized in the CY 2025 Rate Announcement. For 2026, we will use bid-to-benchmark (B2B) ratios based on 2025 bids and weighted by February 2025 enrollment, which is generally consistent with how we have developed these EGWP payments since 2019. With the exception of the 2022 B2B ratios which were weighted by January 2021 enrollment, the B2B ratios for each year since 2019 have been weighted by enrollment figures for February of the preceding year. For 2026, the B2B ratios will be weighted by February 2025 enrollment.

As a result of feedback from the industry on the CY 2022 bid cycle, CY 2023 was the first year that CMS published preliminary B2B ratios for EGWPs in the Advance Notice. MA organizations indicated that having this information early provides valuable information in their negotiations with employer/union groups to create more accurate benefit and premium quotes for their MA EGWP enrollees. However, the preliminary ratios in Table II-7 are based on 2025 bids and weighted by January 2025 enrollment instead of the February 2025 enrollment that we intend to use for the final ratios; therefore, they could differ from the final ratios that are ultimately published in the Rate Announcement, and we recommend that caution be used in reviewing them. The preliminary B2B ratios are as follows:

**Table II-7. Preliminary Bid-to-Benchmark Ratios**

<b>Applicable Percentage</b>	<b>Bid to Benchmark Ratio</b>
0.95	78.7%
1	77.8%
1.075	77.3%
1.15	77.7%

The payment methodology for MA EGWPs relies on B2B ratios, as described below, that reflect average bid amounts, weighted by plan enrollment. The calculations for the B2B ratios for CY 2026 would therefore be as follows:

First: [(Weighted Average of the Intra-Service Area Rate Adjustment (ISAR) Adjusted County Bid Amounts for 2025 Individual Market Plan Bids by February 2025 Actual

Enrollment)/(Weighted Average of the County Standardized Benchmarks for 2025 Individual Market Plans by February 2025 Actual Enrollment)] = 2025 Individual Market B2B Ratios by Quartile.<sup>33</sup>

Second: The 2025 individual market B2B ratios will be calculated separately for HMO plan types and PPO plan types by quartile.<sup>34</sup> The PPO B2Bs by quartile will be weighted by the total proportion of EGWP PPO plan type enrollment, and the HMO B2Bs by quartile will be weighted by the total proportion of EGWP HMO plan type enrollment to result in the final B2B ratios for 2026 by quartile.

As has been in effect since 2017, for 2026:

- The B2B ratios will be applied to each of the published 5%, 3.5%, and 0% quality bonus percentage county ratebook rates for the payment year to establish Part C base payment amounts for EGWPs based on their Star Rating, for each county.
- In order to calculate a county rebate payment, each county-level EGWP Part C base payment amount will be compared to the corresponding published 5%, 3.5%, and 0% quality bonus percentage county benchmarks for the payment year (2026), which include adjustments for qualifying counties, to determine the amount of savings. The savings amount will be multiplied by the corresponding rebate percentage to determine the Part C EGWP county-level rebate amount.
- The EGWP Part C base payment amount will be added to the Part C EGWP rebate amount to establish the county-level local EGWP total payment amount.
- The total payment amount will be risk adjusted using beneficiary-specific risk scores. Therefore, the formula applied for local EGWP payment on a per-beneficiary basis would be: (Base County Payment Rate + County Rebate) × Beneficiary-Level Risk Score.

For RPPO EGWPs, the weighted-average B2B ratios will continue to be calculated as described above. To establish the Part C base RPPO EGWP payment amount, we will then also continue to apply the same methodology as described above.

---

<sup>33</sup> As in prior years, territories will not be included in the weighted average B2B ratios, but they will be assigned the weighted average of the quartile within which their counties fall. To determine the CY 2026 applicable percentages, CMS ranks counties from highest to lowest based on their 2025 average per capita FFS costs and places the rates into four quartiles. When calculating the 2025 B2B ratios, CMS will group counties by the 2025 unblended quartiles and will then apply these B2B ratios to the 2026 unblended quartiles.

<sup>34</sup> Consistent with how we have developed EGWP payments since 2019, HMO and HMOPOS plans have been combined into an “HMO plan type” and LPPO and RPPO plans have been combined into a “PPO plan type.” “HMO” Health Maintenance Organization, “HMOPOS” Health Maintenance Organization Point of Service, “PPO” Preferred Provider Organization, “LPPO” Local Preferred Provider Organization, “RPPO” Regional Preferred Provider Organization. “PFFS” Private Fee-for-Service individual market plans are excluded from these calculations.

In order to calculate the RPPO EGWP rebate amounts, these percentages will continue to be applied for each county within a region to the published payment year regional benchmarks to establish the savings amount and rebate amounts by Star Rating and quartile.

The RPPO EGWP Payment Formula continues to be  $(\text{Base County Payment Rate} + \text{Regional Rebate}) \times \text{Beneficiary-Level Risk Score}$ , where each is calculated as follows:

- Base County Payment Rate = Bid to Benchmark Ratio  $\times$  2026 MA Monthly Capitation Rate
- Regional Rebate =  $(1 - \text{Bid to Benchmark Ratio}) \times 2026 \text{ Regional Rate} \times \text{Rebate Percentage}$
- The 2026 Regional rate is based on a blend of the statutory and bid component. As with non-EGWPs, if there is no bid component of the 2026 Regional rate (i.e., no individual bids in a region), then the EGWP rate will be based solely on the statutory component.

As has been the case since 2017, for 2026, there will be no Part C Regional PPO EGWP bids to include in the calculation of the MA regional benchmarks. The statutory components of the regional standardized A/B benchmarks will continue to be published each year as part of the Announcement of MA Payment Rates. CMS will also continue to publish the final MA regional standardized A/B benchmarks in late summer, which will reflect the average bid component of the regional benchmark based on non-EGWP bid submissions.

### ***F2. MA Rebates and Part B Premium Buy-Down***

As part of the waiver of the requirement for EGWPs to submit bid pricing information, CMS will continue to waive the requirement that MA EGWPs must specify how they are allocating MA rebate dollars (other than the buy-down of the Part B premium) for 2026. However, the limits set forth in § 422.266 regarding how the MA rebate may be used have not been waived and therefore continue to apply for EGWPs. CMS does not distinguish the amount to be allocated for rebates in calculating payments to MA EGWPs; however, if the MA EGWP elects to treat part of the payment as an MA rebate, how the rebate portion of the payment may be used is subject to the requirements at § 422.266. Thus, an EGWP could designate no part of its payment from CMS as MA rebates, or it could designate a portion of its payment as MA rebates and apply these designated rebate amounts to pay for mandatory supplemental benefits in accordance with § 422.266(b)(1) or to buy down Part B or Part D premiums in accordance with § 422.266(b)(2) and (3). However, the MA EGWP could not use MA rebates to pay for optional supplemental benefits, as this is prohibited by § 422.266(b)(1).

For 2026, we will also continue the existing policy permitting MA EGWPs to buy down Part B premiums for their enrollees using a portion of the Part C payment that the MA EGWP has designated as MA rebates.

As has been the case since 2020, MA EGWPs will be subject to the same maximum Part B buy-down amount as non-EGWPs. That is, EGWPs may only buy down the Part B premium up to the maximum amount displayed in the CY 2026 MA Bid Pricing Tool Worksheet 6. Additionally, as with non-EGWPs, the Part B premium buy-down amount cannot vary among beneficiaries enrolled in an EGWP. The Part B buy-down amount applies to every beneficiary under the plan ID. Therefore, if an EGWP would like to reduce the Part B premium for one employer group under the plan ID by \$5 and reduce the Part B premium for another employer group by \$10, then the MA organization must establish two separate EGWP plan IDs (i.e., two separate Plan Benefit Packages (PBPs)), each with the specific amount to buy-down the Part B premium. In this example, the PBP for plan 801 would contain a \$5 buy-down amount, and the PBP for plan 802 would contain a \$10 buy-down amount.

We will continue to collect a Part B premium buy-down amount in the EGWP's PBP submission to CMS. Any MA EGWP that chooses to use a portion of its payment to buy down the Part B premium must apply such Part B premium buy-down amount consistently to every beneficiary enrolled in the EGWP in accordance with uniformity of benefit rules, which are not waived for EGWPs in connection with buy-downs of Part B premiums. Those MA EGWPs that choose to designate a portion of their payment as MA rebates to buy down the Part B premium for their enrollees will have that amount reduced from their capitated payment. For example, if an MA EGWP determines that under its benefit offering there will be a \$5 reduction to each enrollee's Part B premium, \$5 per member per month will be entered into the requisite field in the PBP, and then \$5 will be subtracted from the monthly capitated amount. For local MA EGWPs, this is reflected in the payment formula described above as follows:

$$\text{Total Payment} = (\text{Base County Payment Rate} + \text{County Rebate}) \times \text{Beneficiary Level Risk Score} - \text{Part B Buy Down Amount.}$$

MA EGWPs will continue to be prohibited from separately refunding Part B premiums for their enrollees outside of this process.

### ***F3. Additional Adjustments***

The following rules will continue to apply as they have since 2017 under the EGWP payment methodology:

- MA EGWPs will not receive capitation payments for hospice care. For more information about how an MA enrollee electing hospice affects payments to MA plans, please see § 422.320.
- MA EGWPs will continue to be paid using the ESRD ratebook for their ESRD beneficiaries in Transplant and Dialysis status and the individual market MA ratebook for those beneficiaries in Functioning Graft status, in keeping with the current payment policy for non-EGWP MA organizations.

- Consistent with how CMS pays capitation for Part B-only enrollees in the non-EGWP context, Part B-only MA EGWPs will continue to receive only the Part B portion of the EGWP payment amount, which is determined by multiplying it by the Part B percentage of the MA rate.
- MA EGWP MSA plans will continue not to submit Bid Pricing Tools for 2026, but the 2026 local EGWP payment rates will continue to not be applied to EGWP MSA plans. The monthly prospective payments for EGWP MSAs will be based on the following formula: 2026 MA Monthly Capitation County Rate  $\times$  beneficiary risk score  $- 1/12$  of the Annual MSA Deposit Amount. The 2026 Annual MSA Deposit Amount must be submitted in the appropriate PBP field. Consistent with individual market MSA plans, MA EGWP MSA plans are not able to use a portion of the Part C payment to buy down the Part B premium.

Notwithstanding the payment policies described above, entities offering MA EGWPs must continue to meet all of the CMS requirements that are not otherwise specifically waived or modified, including, but not limited to, submitting information related to plan service areas, PBPs, and formularies in accordance with the rules for 2026. MA organizations must continue to make a good faith effort in projecting CY 2026 member months for each plan and place the amount in the appropriate section of the CY 2026 PBP submissions to CMS.

### **Section G. CMS-HCC Risk Adjustment Model for CY 2026**

In the 2024 Rate Announcement, CMS finalized an updated risk adjustment model for organizations other than PACE, referred to as the 2024 CMS-HCC model, with the intention to phase it in over three years, with full implementation of the model in payment year 2026.<sup>35</sup> The 2024 CMS-HCC model included important technical updates to improve the predictive accuracy of the model, including restructured condition categories using the International Classification of Diseases (ICD)-10 classification system (instead of the ICD-9 classification system), updated underlying FFS data years (from 2014 diagnoses and 2015 expenditures to 2018 diagnoses and 2019 expenditures), an updated “denominator year” in determining the average per capita predicted expenditures to create relative factors in the model, as well as applying our longstanding principles to make revisions focused on conditions that are subject to more coding variation. These updates help to ensure that higher payments are available to plans that serve beneficiaries who are expected to be more costly.

For CY 2024 payment, risk scores were calculated as a blend of 67 percent of the risk scores calculated with the 2020 CMS-HCC model and 33 percent of the risk scores calculated with the updated 2024 CMS-HCC model. For CY 2025 payment, risk scores are being calculated as a blend of 33 percent of the risk scores calculated with the 2020 model and 67 percent of the risk

---

<sup>35</sup> Refer to the [CY 2024 Rate Announcement](#)

scores calculated with the 2024 model.<sup>36</sup> Consistent with the phase in schedule discussed in the 2024 Rate Announcement for CY 2026, CMS proposes to fully implement the 2024 CMS-HCC risk adjustment model such that 100 percent of the risk scores are calculated using the 2024 CMS-HCC risk adjustment model.

### *MA Risk Score Trend*

We also provide information here regarding the MA risk score trend that we include in the CY 2026 Advance Notice Fact Sheet and FAQs that accompany the release of this document. CMS annually estimates the MA risk score trend, which is the estimated industry average annual change in MA risk scores in the payment year relative to the prior year. CMS provides the MA risk score trend as an essential element for understanding the full revenue picture for MA organizations in the payment year.

The MA risk score trend is calculated using the model(s) proposed for the payment year and has historically been calculated as the average annual change in MA risk scores (i.e., the slope) over a rolling three years of MA risk scores, such that the most recent MA risk scores available were used for estimation. Since CY 2023, however, CMS has not updated the data years used to calculate the MA risk score trend; rather, the trend was calculated using average MA risk scores from 2018 through 2020, which were the most recent three years of continuous MA risk scores based on diagnoses prior to the onset of the COVID-19 pandemic. For CY 2025, in addition to the use of 2018 through 2020 MA risk scores, CMS' published MA risk score trend was calculated using 67 percent of the MA risk score trend under the 2024 CMS-HCC model and 33 percent under the 2020 CMS-HCC model, consistent with CMS' proposal and finalized policy for CY 2025 risk score calculation. The blended MA risk score trend for CY 2025 was 3.86 percent.

If CMS were to continue to rely on risk scores from 2018 through 2020 for CY 2026, it would result in an MA risk score trend of 3.35 percent. However, we believe it is more appropriate to use more recent data to calculate the trend in order to reflect more recent changes in population and coding practices. CMS now has two consecutive years of MA risk scores available from after the onset of the COVID-19 pandemic with which to measure MA risk score change (i.e., 2022 and 2023 MA risk scores). Because 2021 risk scores (based on 2020 dates of service) were impacted by decreased utilization during the pandemic, CMS does not believe that year's average MA risk score should be included in the estimate of the MA risk score trend because the increase in MA risk scores from 2021 to 2022 may not be representative of a typical year's risk score change. However, we believe it is important to use more recent MA risk scores to estimate the MA risk score change from CY 2025 to CY 2026. Since we only have two years of risk scores available from after the onset of the COVID-19 pandemic, instead of our traditional three years with which to estimate the MA risk score trend, we calculated the trend as the average

---

<sup>36</sup> Refer to the [2024 and 2025 Rate Announcements](#).

annual change in MA risk scores over a two-year period from 2022 to 2023 (based on 2021 and 2022 dates of service). Aside from the use of one less year of risk score data, this method aligns with the historical method of calculating the MA risk score trend (i.e., slope) using the most recently available data. For CY 2027, we intend to calculate the MA risk score trend over a three-year period as we have done historically. Such a calculation would appear in the CY 2027 Advanced Notice.

For CY 2026, the MA risk score trend is being calculated using the fully (100%) phased-in 2024 CMS-HCC risk adjustment model and using the most recent two years of data (risk scores from 2022 through 2023). The resulting risk score trend is 2.10 percent for CY 2026, which is lower than the CY 2025 MA risk score trend of 3.86 percent (which reflected a blend of the MA risk score trend under both the 2020 CMS-HCC risk adjustment model and the 2024 CMS-HCC risk adjustment model and used risk scores from 2018 through 2020). This MA risk score trend accounts for the average change in population and coding practices across all MA plans; these trends can vary among individual MA plans in terms of their plan-specific payment impacts.

#### *Risk Adjustment Model Development Using MA Encounter Data*

CMS has been working on calibrating the risk adjustment model using MA encounter data (diagnosis, cost and use data submitted to CMS by MA plans), and CMS may be able to start phasing in an MA encounter data-based model as early as CY 2027. Use of an MA encounter data-based risk adjustment model is consistent with section 1853(a)(1)(C)(ii) of the Act. Given that MA encounter data is likely a better predictor of relative costs in MA than FFS claims data from Traditional Medicare and would remove the need to make the adjustment for coding pattern differences under this provision, we believe moving to a risk adjustment model based on encounter data will be an important improvement to MA payment accuracy.

CMS notes that in response to prior Advance Notices, some commenters have cited wide variation in coding differences between MA plans and recommended that CMS develop a non-uniform adjustment approach to account for different coding behavior in MA and FFS as a way to improve payment accuracy and address differential coding between MA plans. CMS has evaluated a variety of non-uniform approaches but determined that more targeted approaches to adjust for coding pattern differences raise unique technical and methodological challenges..

#### ***G1. CMS-HCC Risk Adjustment Models for PACE Organizations for CY 2026***

Since CY 2020, the 2017 CMS-HCC risk adjustment model has been used to calculate payments to PACE organizations.<sup>37</sup> CMS had not been able to apply the updated risk adjustment models used for MA organizations to PACE organizations because, as CMS has noted in the past,<sup>38</sup> the models used for MA organizations were calibrated using FFS diagnoses selected using the

<sup>37</sup> Refer to the [2020 Rate Announcement](#).

<sup>38</sup> For examples, see the [2024 and 2025 Rate Announcements](#).



filtering method applied to encounter data. These models are intended to calculate risk scores using diagnoses from encounter data (that is, data submitted to the encounter data system (EDS)) and FFS claims (for beneficiaries who switch from FFS to MA) filtered in the same manner as encounter data.

PACE organizations have historically only been required to submit encounter data for Medicare-covered items and services for which the organization collects claims.<sup>39</sup> Because PACE organizations had not been required to submit encounters for all the services furnished to their participants, we did not have complete encounter data from PACE organizations and, therefore, we did not have a complete diagnostic profile for PACE participants in the EDS. Without a complete diagnostic profile, we could not rely solely on encounter data to calculate PACE risk scores. Instead, CMS used diagnoses from encounter data as a supplement to Risk Adjustment Processing System (RAPS) data when calculating risk scores for payment to PACE organizations using the 2017 CMS-HCC risk adjustment model, which is the most recent version of the model calibrated using FFS diagnoses selected using the filtering method applied to RAPS data. As described in Chapter 7 of the Medicare Managed Care Manual, RAPS is a system in which MA organizations and PACE organizations submit abbreviated risk adjustment data to CMS from which diagnoses are used for risk score calculation. The organizations are responsible for verifying that the data came from an acceptable data source in accordance with the risk adjustment data submission requirements in Chapter 7.<sup>40</sup> In the CY 2022 Rate Announcement, CMS finalized the policy to calculate risk scores for organizations other than PACE using diagnoses solely from MA encounter data and FFS claims.<sup>41</sup> Consequently, MA organizations have not been required to submit RAPS data for payment since 2021 dates of service; however, the RAPS system remains available to PACE organizations and for the reporting of data corrections prior to 2021 for organizations other than PACE.

In recent years, CMS has received comments on risk adjustment policies proposed for PACE organizations in Advance Notices,<sup>42</sup> as well as feedback through other engagements with stakeholders, recommending that CMS align PACE with the MA program with respect to the use of a more recent version of the CMS-HCC model to calculate risk scores. We understand the desire to move PACE organizations to the updated model and are committed to aligning PACE with the MA program, which entails fully transitioning PACE organizations to encounter data-based risk scores using the same CMS-HCC risk adjustment models used for MA organizations.

In previous Rate Announcements, CMS noted its intention to transition PACE organizations to fully submitting risk adjustment data to the EDS (i.e., encounter data), and its plans to use a more

---

<sup>39</sup> See the November 1, 2013 HPMS memo titled, “Clarification to Encounter Data Submissions Memo for PACE Organizations.”

<sup>40</sup> Refer to the [Medicare Managed Care Manual, Chapter 7 – Risk Adjustment](#).

<sup>41</sup> Refer to the [2022 Rate Announcement](#).

<sup>42</sup> Refer to the [2024 and 2025 Rate Announcements](#).

recently updated model to pay PACE organizations as soon as practicable. The CY 2025 Advance Notice<sup>43</sup> expressed our belief that calculating PACE risk scores solely using diagnoses from encounter data and FFS claims was achievable soon based on findings from stakeholder engagement and analysis. In January of 2024, CMS released technical instructions to PACE organizations on the submission of risk adjustment data to the EDS for PACE center services for which a claim is not generated.<sup>44</sup> With the release of these technical instructions, CMS now expects that PACE organizations are submitting fulsome diagnosis data to the EDS.

While CMS anticipates that PACE organizations will be able to submit a full diagnostic profile to the EDS for their beneficiaries for 2025 dates of service for use for CY 2026 risk adjustment, CMS is proposing to calculate a blended risk score for CY 2026, with the intention for there to be a four-year transition to the CMS-HCC model used for non-PACE organizations. For CY 2026 payments to PACE organizations, CMS proposes to calculate risk scores using a blend of the risk scores calculated using the 2017 CMS-HCC model, which we began using for CY 2020 payments to PACE organizations, and the risk scores calculated using the 2024 CMS-HCC model (i.e., sometimes referred to as V28).<sup>45</sup>

Specifically, CMS proposes to calculate blended risk scores for CY 2026 for PACE organizations using the sum of:

- 90 percent of the risk score calculated with the 2017 CMS-HCC model and diagnoses from RAPS, encounter data, and FFS claims and
- 10 percent of the risk score calculated with the 2024 CMS-HCC model and diagnoses from encounter data and FFS claims only.

CMS intends to fully transition PACE organizations to the CMS-HCC model used for organizations other than PACE and to calculate risk scores only using diagnoses from encounter data and FFS claims over four years. A tentative schedule for the phase-out of the 2017 CMS-HCC model is described in Table II-8.

**Table II-8. Tentative Phase-out Schedule of the 2017 CMS-HCC Model**

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

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

\*\* Sources of diagnoses: Encounter data and FFS claims

<sup>43</sup> Refer to the [CY 2025 Rate Announcement](#).

<sup>44</sup> Refer to the January 2024 CMS memo, titled "[PACE Organization Risk Adjustment Submissions to the Encounter Data System](#)".

<sup>45</sup> Refer to the [CY 2020 Rate Announcement](#) and [CY 2024 Rate Announcement](#).

Refer to Attachment II, Section L1 for more information about sources of diagnoses used for PACE risk score calculation and details on CMS' ongoing outreach efforts to assist PACE organizations in the transition to submitting fulsome diagnosis data to the EDS.

## **Section H. End Stage Renal Disease (ESRD) Risk Adjustment Models for CY 2026**

CMS uses separate models to calculate the risk scores applied in payment for the Part A and Part B benefits provided to beneficiaries in ESRD status when enrolled in MA organizations or PACE organizations.

For CY 2026, for MA organizations, CMS will continue to use the 2023 ESRD CMS-HCC models, which are described in the CY 2023 Advance Notice,<sup>46</sup> to calculate risk scores for beneficiaries in dialysis, transplant, and post-graft status.

### ***H1. ESRD Risk Adjustment Models for PACE Organizations for CY 2026***

For CY 2026, for PACE organizations, in alignment with the proposal to blend risk scores from CMS-HCC models for PACE organizations, discussed in Attachment II, Section G1, CMS is also proposing to use a blend of ESRD risk adjustment models to calculate ESRD risk scores for PACE organizations.

Specifically, CMS proposes to calculate blended risk scores for CY 2026 for PACE organizations using the sum of:

- 90 percent of the risk score calculated with the 2019 ESRD CMS-HCC models and diagnoses from RAPS, encounter data, and FFS claims and
- 10 percent of the risk score calculated with the 2023 ESRD CMS-HCC models and diagnoses from encounter data and FFS claims only.

CMS intends to fully transition PACE organizations to the ESRD risk adjustment models used for organizations other than PACE and to calculate risk scores only using diagnoses from encounter data and FFS claims over four years. A tentative schedule for the phase-out of the 2019 ESRD risk adjustment models is described in Table II-9.

**Table II-9. Tentative Phase-out Schedule of the 2019 ESRD CMS-HCC Models**

<b>CY</b>	<b>2019 ESRD CMS-HCC Models*</b>	<b>ESRD CMS-HCC Models used for Non-PACE Organizations **</b>
2026	90%	10%
2027	75%	25%
2028	50%	50%
2029	0%	100%

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

\*\* Sources of diagnoses: Encounter data and FFS claims

<sup>46</sup> CY 2023 Advance Notice (Section H): <https://www.cms.gov/files/document/2023-advance-notice.pdf>

Refer to Attachment II, Section L1 for more information about sources of diagnoses used for PACE risk score calculation and details on CMS' ongoing outreach efforts to assist PACE organizations in the transition to submitting fulsome diagnosis data to the EDS.

### **Section I. Frailty Adjustment for FIDE SNPs and PACE Organizations**

While the CMS-HCC model predicts future Medicare expenditures of individuals based on their demographic and clinical characteristics, the model may not explain all of the variation in expenditures for frail community populations. The purpose of the frailty adjustment is to predict the Medicare expenditures of community populations with functional impairments that are unexplained by the diagnoses in the CMS-HCC model.

Section 1894(d)(2) of the Act requires CMS to take into account the frailty of the PACE population when establishing the capitated payment amounts for PACE organizations. In addition, section 1853(a)(1)(B)(iv) of the Act allows CMS to make an additional payment adjustment that takes into account the frailty of beneficiaries enrolled in Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs), if the average level of frailty in the FIDE SNP is similar to that in the PACE program. For PACE organizations and eligible FIDE SNPs, we make this adjustment by adding a frailty score to a beneficiary's risk score.

CMS calibrates the frailty factors by regressing the residual, or unexplained, costs from the CMS-HCC risk adjustment model onto counts of activities of daily living (ADLs). Residual costs are unique to each version of the CMS-HCC model, and consequently, so are the frailty factors. For this reason, CMS must update the frailty factors whenever the CMS-HCC model changes. The frailty factors are calibrated to align with the CMS-HCC risk adjustment model using data regarding limitations on ADLs from the FFS Consumer Assessment of Health Providers & Systems (CAHPS) survey. There are six ADLs: 1) bathing and showering, 2) dressing, 3) eating, 4) getting in or out of bed or chairs, 5) walking, and 6) using the toilet.

By using the FFS CAHPS results to calibrate the frailty factors, CMS uses methodologically-similar surveys to estimate the frailty factors and to calculate annual frailty scores (which use ADLs from the Health Outcomes Survey (HOS) and the Health Outcomes Survey – Modified (HOS-M)). To calculate frailty scores for payment, CMS uses the number of functional limitations represented by the ADL scale to determine the relative frailty of those in the community who are 55 years of age and older.

#### FIDE SNPs

For CY 2026, CMS will continue using the frailty factors finalized in CY 2024. In the CY 2024 Rate Announcement, CMS updated the frailty factors to align with the 2024 CMS-HCC model. We continue to consider the recalibrated factors finalized in the CY 2024 Rate Announcement to be an appropriate measure of predicted residual costs from the model for the survey population. As first noted in the CY 2024 Rate Announcement, when CMS recalibrated the frailty factors for

the 2024 CMS-HCC model, we noticed differences in the frailty factor patterns relative to prior years. In prior Advance Notices and Rate Announcements, we noted our intention to research the pattern changes. The evaluation of the underlying patterns driving the changes in the frailty factors in recent years is an ongoing effort. We anticipate a multi-year analysis will be necessary to isolate the underlying pattern drivers. It remains our intention to take the findings under consideration when making future updates to the frailty factors.

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 1/1/2025.<sup>47</sup> 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 (CY 2025). For CY 2026, CMS is proposing to rely on the data as submitted on the MMA State 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. As noted in the CY 2025 Advance Notice, we anticipate that all 2025 enrollees considered for survey collection used for ADL assessment for calculating CY 2026 frailty scores will be reported as full-benefit dually eligible individuals in compliance with 42 CFR § 422.2.

The 2024 CMS-HCC model frailty factors are in Table II-10.

**Table II-10. Frailty Factors Associated with the 2024 CMS-HCC Model – FIDE SNPs**  
(Previously published and finalized in the CY 2024 Rate Announcement<sup>48</sup>)

<b>ADL</b>	<b>Non-Medicaid</b>	<b>Partial Medicaid</b>	<b>Full Medicaid</b>
0	-0.066	-0.070	0.158
1-2	0.103	0.203	0.230
3-4	0.201	0.203	0.230
5-6	0.201	0.217	0.248

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. For FIDE SNPs, CMS uses plan-level ADL information

<sup>47</sup> See definition of Fully integrated dual eligible special needs plan at 42 CFR § 422.2, paragraphs 5 and 6.

<sup>48</sup> [CY 2024 Rate Announcement](#), Section L.

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.

CMS will estimate the PACE minimum frailty score used as the threshold to establish whether a FIDE SNP qualifies to receive a frailty adjustment in CY 2026 in the same manner proposed to calculate FIDE SNP frailty scores (i.e., using the MMA State files, the Point of Sale data, and the Commonwealth of Puerto Rico monthly Medicaid file to determine the dual status of a beneficiary).

### PACE Organizations

As discussed in Attachment II, section G.1, for CY 2026, CMS proposes calculating risk scores using a blend of the 90% of the risk scores calculated using the 2017 CMS-HCC model and 10% of the risk scores calculated using the 2024 CMS-HCC model. Consequently, CMS is also proposing 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.

Specifically, CMS proposes that for CY 2026 PACE organization frailty scores will be calculated as the sum 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.

CMS intends to fully transition PACE organizations to the frailty factors associated with the CMS-HCC model used for organizations other than PACE over four years, as described in Attachment II, Section G1.

The 2017 and 2024 CMS-HCC model frailty factors are in Table II-11 and Table II-10, respectively.

**Table II-11. Frailty Factors Associated with the 2017 CMS-HCC Model**

(Previously published and finalized in the 2017 Rate Announcement<sup>49</sup>)

ADL	Non-Medicaid	Medicaid
0	-0.083	-0.093
1-2	0.124	0.105
3-4	0.248	0.243
5-6	0.248	0.420

<sup>49</sup> [CY 2017 Rate Announcement, Section J.](#)

## **Section J. Medicare Advantage Coding Pattern Difference Adjustment**

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

## **Section K. Normalization Factors**

The CMS-HCC risk adjustment models are calibrated with diagnostic and cost information from a past period for beneficiaries enrolled in FFS. The risk adjustment models are prospective in that they use health status in a base year (i.e., data collection year) to estimate incremental costs for a variety of beneficiary characteristics (e.g., age and gender) and health conditions in the following year (i.e., the payment year). To create relative factors, each model variable's incremental cost estimate, referred to as a dollar coefficient, is divided by the predicted average per capita expenditure for beneficiaries in the FFS program in a given year (i.e., the denominator year). Risk scores are the sum of relative factors assigned to each beneficiary based on their demographic characteristics and health status from the prior year. The average risk score is 1.0 among FFS beneficiaries in the denominator year.

The average FFS risk score changes each year due to an underlying trend that reflects 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 FFS risk score may no longer be 1.0, as it was in the denominator year. Accordingly, an adjustment must be applied to account for the FFS risk score trend between the denominator year and payment year. For example, the 2024 CMS-HCC model (non-PACE, non-ESRD) has a denominator year of 2020. 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. The normalization factor is a projection of the average FFS risk score based on the trend, and we apply it by dividing each individual risk score in the payment year by the normalization factor. Doing so effectively keeps the average FFS risk score at 1.0 in the payment year.<sup>50</sup> For the normalization factor to work as intended, CMS must predict an average FFS risk score that is a reasonably accurate projection of the future payment year's average FFS risk score, given the historical FFS information available at the time the normalization factor is calculated.

There has been increased uncertainty regarding the FFS risk score trend in the immediate few years after the onset of the pandemic. FFS risk scores decreased from 2020 to 2021, which we believe was driven in large part by reduced utilization in 2020 due to the pandemic, while the FFS risk score changes from 2021 to 2022, 2022 to 2023, and 2023 to 2024 were higher than year-over-year changes in FFS risk scores before the pandemic. Specifically, from 2020 to 2021,

---

<sup>50</sup> See section 1853(a)(1)(C)(i) of the Act, which authorizes use of additional adjustment factors to improve the determination of actuarial equivalence, and section 1853(a)(1)(C)(ii)(I) of the Act, which requires that the risk adjustment used in MA payment reflects changes in treatment and coding practices in the fee-for-service sector.



the average FFS risk score (calculated using the 2024 CMS-HCC model) decreased by 3.2 percent; then, from 2021 to 2022, the average FFS risk score increased by 2.5 percent. The year-over-year change in average FFS risk scores was similar from 2022 to 2023 and 2023 to 2024, with an increase in the average risk score of 1.7 percent and 1.8 percent, respectively. These recent risk score increases continue to be higher than the average year-over-year increase of approximately one percent seen prior to the pandemic from 2017 to 2020.<sup>51</sup>

Since CY 2007 and until CY 2024, CMS largely used the same methodology for calculating normalization factors, which was to project the slope from the denominator year to the payment year using the most recent five years of average FFS risk scores available calculated using the payment year model. After calculating the slope, we applied the equation  $(1+X)^n$  – where X is the slope calculated from the five-year trend of historical FFS risk scores, and the exponent, n, is the number of years between the denominator year and the payment year. The CY 2023 and CY 2024 normalization factors were calculated using the linear slope methodology, necessitating the exclusion of FFS risk scores affected by the pandemic in order for the normalization factors to be reasonable projects of future risk scores. For CY 2025, CMS developed, proposed, and finalized a more sophisticated multiple linear regression methodology for calculating normalization factors for CMS-HCC models.<sup>52</sup> This methodology allows CMS to incorporate the most recent average FFS risk scores in the calculation, without excluding any years of FFS risk scores, while making reasonable projections of what the actual average FFS risk score will be in the payment year. For CY 2025, this updated methodology incorporated historical FFS risk scores from the most recent five years of average FFS risk scores at the time (2019-2023) and included a flag that identified whether an average FFS risk score was based on dates of service before or after the onset of the COVID-19 pandemic.

The multiple linear regression methodology, first implemented for CY 2025 payment, continues to allow CMS to incorporate the most recent average FFS risk scores in the calculation, without excluding any years of FFS risk scores, while making reasonable projections of what the actual average FFS risk score will be in the payment year. As stated in the CY 2025 Rate Announcement, the multiple linear regression methodology with a COVID-19 indicator allows us to take into account the different slopes for pre- and post-COVID-19 affected years, capturing the impact of the pandemic on FFS risk scores in our projections.<sup>53</sup> This methodology considers the distinct slopes and FFS risk score levels that exist before and after the onset of COVID-19, without requiring any exclusion of risk scores. The inclusion of a COVID-19 indicator and performing a multiple linear regression will ensure our projections align more closely with the trend observed in the most recent FFS risk score data available. CMS continues to believe that

---

<sup>51</sup> See Table II-10 Average FFS Risk Scores for Part C CMS-HCC Models in the [2025 Advance Notice](#).

<sup>52</sup> Refer to Section K of the 2025 [Advance Notice](#) and [Rate Announcement](#).

<sup>53</sup> Pages 92 – 93 of the [2025 Rate Announcement](#).



this approach is the best way to more reasonably normalize, given the variability in the years since the onset of the COVID-19 pandemic.

### **Proposed CY 2026 Normalization Methodology for CMS-HCC Risk Adjustment Models**

For CY 2026, CMS is proposing to continue to use a multiple linear regression methodology using the most recent five years of FFS risk scores available to calculate all FFS normalization factors for CMS-HCC models, which is the same approach that was used to calculate CY 2025 normalization factors. Similar to CY 2025, for CY 2026, this methodology incorporates historical FFS risk scores from the most recent five years of average FFS risk scores (2020-2024) and includes a flag that identifies whether an average FFS risk score is based on dates of service before or after the onset of the COVID-19 pandemic. For the COVID-19 flag used to calculate the proposed CY 2026 normalization factors, we considered FFS risk scores prior to 2021 (dates of service before 2020) as the “pre-COVID-19” period, and FFS risk scores from 2021 onward (dates of service starting in 2020) as the “post-COVID-19” period.

For a more detailed review and explanation of the multiple linear regression methodology that we propose to use for calculating CY 2026 normalization factors for the CMS-HCC models, please refer to pages 62 and 63 of the CY 2025 Advance Notice and pages 91 to 101 of the CY 2025 Rate Announcement.<sup>54</sup>

The multiple linear regression equation is:

$$Y = \beta_0 + \beta_1x_1 + \beta_2x_2$$

The variables in the multiple linear regression equation for the CY 2025 normalization factors are:

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

$\beta_0$  = Intercept

$\beta_1$  = Regression coefficient for the average annual change in FFS risk scores

$x_1$  = The specific year to be predicted

$\beta_2$  = Regression coefficient for the impact of the COVID-19 pandemic on FFS risk scores

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

The proposed CY 2026 normalization factors calculated using the multiple linear regression methodology and the multiple linear regression coefficients for each of the CMS-HCC risk adjustment models are in subsections K1 through K3.

---

<sup>54</sup> [2025 Advance Notice](#) and [Rate Announcement](#).

### ***K1. CMS-HCC Model Normalization Factors***

The FFS risk scores for the trend using the 2017 CMS-HCC model and the FFS risk scores for the trend using the 2024 CMS-HCC model are calculated using FFS beneficiaries who are entitled to Part A, enrolled in Part B, who do not have ESRD, and are not in hospice status. The CMS-HCC model normalization factors are applied to the community non-dual aged, community non-dual disabled, community full benefit dual aged, community full benefit dual disabled, community partial benefit dual aged, community partial benefit dual disabled, institutional, new enrollee, and C-SNP new enrollee risk scores.

Table II-12 shows the average FFS risk scores, under the risk adjustment models proposed for use in payment for CY 2026 (the 2024 CMS-HCC model and the 2017 CMS-HCC model (PACE only)), calculated for years 2020 through 2024. Table II-13 shows the regression coefficients that were used to calculate the proposed CY 2026 normalization factors for both models.

**2024 CMS-HCC Model:** The proposed 2026 normalization factor calculated using the multiple linear regression method and 2020-2024 average FFS risk scores for the 2024 CMS-HCC model is 1.067.

**2017 CMS-HCC Model:** The proposed 2026 normalization factor calculated using the multiple linear regression method and 2020-2024 average FFS risk scores for the 2017 CMS-HCC model used for PACE organizations is 1.187.

**Table II-12. Average FFS Risk Scores for CMS-HCC Models**

<b>Year</b>	<b>2024 CMS-HCC Model</b>	<b>2017 CMS-HCC Model</b>
2020	1.000	1.085
2021	0.968	1.053
2022	0.992	1.085
2023	1.009	1.108
2024	1.027	1.133

**Table II-13. CMS-HCC Model Normalization Factor Regression Coefficients**

<b>Coefficient</b>	<b>2024 CMS-HCC Model</b>	<b>2017 CMS-HCC Model</b>
Intercept ( $\beta_0$ )	-38.1880	-52.0410
Average Change in FFS Risk Scores ( $\beta_1$ )	0.0194	0.0263
COVID-19 Flag ( $\beta_2$ )	-0.0495	-0.0560

## ***K2. Normalization Factors for the ESRD Dialysis CMS-HCC Models***

The trends for the ESRD Dialysis CMS-HCC models are calculated using FFS beneficiaries who are entitled to Part A, enrolled in Part B, are not in hospice status, and are receiving dialysis treatment. The normalization factors for the ESRD Dialysis CMS-HCC models are applied to the risk scores for enrollees in the dialysis, dialysis new enrollee, and transplant segments.

Table II-14 shows the average FFS risk scores calculated for years 2020 through 2024 using the 2019 and 2023 ESRD Dialysis CMS-HCC models and Table II-15 shows the regression coefficients that were used to calculate the proposed CY 2026 normalization factors for both ESRD Dialysis CMS-HCC models.

**2023 ESRD Dialysis CMS-HCC Model:** The proposed 2026 normalization factor calculated using the multiple linear regression method and 2020-2024 average FFS risk scores for the 2023 ESRD Dialysis CMS-HCC model is 1.062.

**2019 ESRD Dialysis CMS-HCC Model:** The proposed 2026 normalization factor calculated using the multiple linear regression method and 2020-2024 average FFS risk scores for the 2019 ESRD Dialysis CMS-HCC model used for PACE organizations is 1.129.

**Table II-14. Average FFS Risk Scores for ESRD Dialysis CMS-HCC Models**

<b>Year</b>	<b>2023 ESRD Dialysis CMS- HCC Model</b>	<b>2019 ESRD Dialysis CMS- HCC Model</b>
2020	1.007	1.057
2021	0.997	1.047
2022	1.006	1.060
2023	1.023	1.080
2024	1.036	1.096

**Table II-15. ESRD Dialysis CMS-HCC Model Normalization Factor Regression Coefficients**

<b>Coefficient</b>	<b>2023 ESRD Dialysis CMS- HCC Model</b>	<b>2019 ESRD Dialysis CMS- HCC Model</b>
Intercept ( $\beta_0$ )	-26.0610	-32.6770
Average Change in FFS Risk Scores ( $\beta_1$ )	0.0134	0.0167
COVID-19 Flag ( $\beta_2$ )	-0.0250	-0.0280

### ***K3. Normalization Factors for the ESRD Functioning Graft CMS-HCC Models***

The trends for the ESRD Functioning Graft CMS-HCC models are calculated using FFS beneficiaries who are entitled to Part A, enrolled in Part B, do not have ESRD, and are not in hospice status. The normalization factors for the ESRD Functioning Graft CMS-HCC models are applied to the risk scores for enrollees in the functioning graft community, functioning graft institutional, and functioning graft new enrollee segments.

Table II-16 shows the average FFS risk scores calculated for years 2020 through 2024 using the 2019 and 2023 ESRD Functioning Graft CMS-HCC models and Table II-17 shows the regression coefficients that were used to calculate the proposed CY 2026 normalization factors for both ESRD Functioning Graft CMS-HCC models.

**2023 ESRD Functioning Graft CMS-HCC Model:** The proposed 2026 normalization factor calculated using the multiple linear regression method and 2020-2024 average FFS risk scores for the 2023 ESRD Functioning Graft CMS-HCC model is 1.104.

**2019 ESRD Functioning Graft CMS-HCC Model:** The proposed 2026 normalization factor calculated using the multiple linear regression method and 2020-2024 average FFS risk scores for the 2019 ESRD Functioning Graft CMS-HCC model used for PACE organizations is 1.203.

**Table II-16. Average FFS Risk Scores for ESRD Functioning Graft CMS-HCC Models**

<b>Year</b>	<b>2023 ESRD Functioning Graft CMS-HCC Model</b>	<b>2019 ESRD Functioning Graft CMS-HCC Model</b>
2020	1.011	1.088
2021	0.976	1.054
2022	1.006	1.086
2023	1.029	1.110
2024	1.052	1.145

**Table II-17. ESRD Functioning Graft CMS-HCC Model Normalization Factor Regression Coefficients**

<b>Coefficient</b>	<b>2023 ESRD Functioning Graft CMS-HCC Model</b>	<b>2019 ESRD Functioning Graft CMS-HCC Model</b>
Intercept ( $\beta_0$ )	-49.6910	-58.9060
Average Change in FFS Risk Scores ( $\beta_1$ )	0.0251	0.0297
COVID-19 Flag ( $\beta_2$ )	-0.0580	-0.0635

For information on the Part D RxHCC model normalization factors, please see Attachment III, Section G.

## **Section L. Sources of Diagnoses for Risk Score Calculation for CY 2026**

### Non-PACE Organizations

For non-PACE organizations, for CY 2026, CMS will continue the policy 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.

#### ***L1. Sources of Diagnoses for Risk Score Calculation for CY 2026 PACE***

CMS is proposing to blend risk scores for PACE organizations in CY 2026 using the 2024 CMS-HCC model and the 2017 CMS-HCC model, as described in the CMS-HCC risk adjustment model section (Attachment II, Section G1). CMS is also proposing to blend ESRD risk scores in CY 2026 using the 2023 ESRD CMS-HCC models and the 2019 ESRD CMS-HCC models, as described in the ESRD risk adjustment models section (Attachment II, Section H1). CMS intends to fully transition PACE organizations to the CMS-HCC model and ESRD risk adjustment models used for organizations other than PACE over time, as described in Table II-8 and Table II-9, respectively.

As CMS has noted in response to previous comments from PACE organizations,<sup>55</sup> fulsome submission of diagnosis data to the EDS are necessary for moving PACE organizations to an updated version of the CMS-HCC model because more recent versions of the CMS-HCC model have been calibrated using the encounter data diagnosis filtering methodology for diagnoses submitted through encounter data,<sup>56</sup> and, in order for payments to be appropriate, the diagnosis filtering used to calculate risk scores needs to align with the diagnosis filtering used to calibrate a model.

On January 29, 2024, CMS released an HPMS memo providing technical instructions to begin transitioning PACE organizations to submitting all risk adjustment data to the EDS rather than RAPS.<sup>57</sup> Historically, the identification and submission of risk-adjustment-eligible diagnoses to the RAPS for risk score calculation have been done by MA organizations and other submitters, such as PACE organizations. Starting in 2012, MA organizations and other submitters (except

---

<sup>55</sup> Refer to the 2023 Rate Announcement, the 2024 Rate Announcement, and the 2025 Rate Announcement: <https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/announcements-and-documents>.

<sup>56</sup> The most recent versions of the CMS-HCC model (i.e., 2020 CMS-HCC model and 2024 CMS-HCC model) were calibrated using the filtering logic applied to encounter data. Refer to the [2020 and 2024 Advance Notices and Rate Announcements](#) and the [Final Encounter Data Diagnosis Filtering Logic HPMS Memo](#).

<sup>57</sup> Refer to the January 2024 CMS memo, titled "[PACE Organization Risk Adjustment Submissions to the Encounter Data System](#)".

for PACE) began submitting encounter data. In November 2013, CMS released an HPMS memo titled, “Clarification to Encounter Data Submissions Memo for PACE Organizations,” clarifying that PACE organizations are only required to submit encounter data for services for which the organization collects claims. Because PACE organizations were only required to submit a subset of encounters in circumstances where they have a claim for a service, we did not have a complete diagnostic profile for PACE participants in the encounter data. Now, PACE organizations are instructed to submit diagnoses for services from which they do not collect a claim, via an encounter data record or an unlinked chart review record. Chart review records are submitted on the same format as encounter data records, and CMS provided instructions with submission flexibilities to account for the unique PACE center setting. In order to move PACE organizations to risk scores calculated using the updated risk adjustment model, risk adjustment-eligible diagnoses must be pulled from encounter data submitted to the EDS. Risk adjustment-eligible diagnoses are extracted from the EDS based on the encounter data diagnosis filtering methodology.<sup>58</sup>

Consequently, CMS continues to work with PACE organizations to fully transition from RAPS to the EDS so that the EDS can be the source of risk adjustment data for PACE. In 2022, CMS began engaging with some PACE organizations to discuss successes and challenges they have experienced with submitting encounter data. CMS also conducted encounter data technical user group calls for PACE organizations.<sup>59</sup> In the CY 2024 Rate Announcement,<sup>60</sup> we noted our intention to conduct analyses to assess the state of encounter data submissions for PACE organizations. In addition, we stated our commitment to continue working closely with PACE organizations to develop further guidance and provide technical assistance with transitioning PACE organizations fully to encounter data in anticipation of future implementation of a more recent version of the CMS-HCC risk adjustment model for PACE that is calibrated using encounter data. CMS conducted a technical assistance user group call in June 2024 for PACE organizations and their contracted third-party submitters where we provided support for PACE submission by providing scenarios and a questions and answers session. Our analysis shows that all PACE organizations have completed necessary encounter data submission onboarding and connectivity requirements and have successfully submitted encounter data to the EDS. As a result of our findings from stakeholder engagement and analysis, CMS believes that calculating PACE risk scores solely using diagnoses from encounter data and FFS claims is achievable soon. While CMS believes PACE organizations can successfully transition to submitting all risk adjustment data to the EDS for CY 2025 dates of service, CMS understands the operational challenges and capacity limitations associated with moving to the EDS for some PACE

---

<sup>58</sup> Refer to the [Final Encounter Data Diagnosis Filtering Logic](#).

<sup>59</sup> On April 7, 2022, CMS conducted a user group call to provide background on the encounter data format, encounter data processing, and filtering for risk adjustment eligible diagnoses, as well as encounter data reports. On June 13, 2024 CMS conducted another user group call to review technical instructions for encounter data submission, Encounter Data System processing, and the review of scenarios to support PACE organization in encounter data submission.

<sup>60</sup> Refer to Section J. of the [2024 Rate Announcement](#).

organizations. Therefore, consistent with requests we have received from PACE organizations and other stakeholders, CMS intends for a phased-in transition similar to the MA organization encounter data transition.

For CY 2026, CMS proposes to calculate risk scores for PACE organizations by summing 10 percent of the risk score calculated with encounter data and FFS diagnoses using the CMS-HCC models used for organizations other than PACE (i.e., the 2024 CMS-HCC model and the 2023 ESRD CMS-HCC models) with 90 percent of the risk score calculated with pooled diagnoses from RAPS, encounter data, and FFS using the CMS-HCC models that have recently been used to calculate risk scores for PACE organizations (i.e., the 2017 CMS-HCC model and the 2019 ESRD CMS-HCC models).

For subsequent years, in alignment with the tentative phase-out schedule of the 2017 CMS-HCC model and the 2019 ESRD CMS-HCC models (see Tables II-8 and II-9), CMS intends for there to be a four-year transition timeline in which, by the fourth year (CY 2029), risk scores for PACE organizations will be calculated solely using diagnoses from encounter data and FFS claims (see Table II-18). While this phase-out schedule provides a stepwise approach to phasing out RAPS, we understand that there are incentives for the updated risk adjustment models to also apply to PACE organizations. CMS will monitor encounter data submissions by PACE organizations to assess whether an accelerated transition timeframe may be possible. CMS will take these factors into account as we consider the remainder of the phase-out schedule in future years.

**Table II-18. Tentative Phase-out Schedule of RAPS Data Submissions**

<b>CY</b>	<b>RAPS*</b>	<b>Encounter Data**</b>
2026	90%	10%
2027	75%	25%
2028	50%	50%
2029	0%	100%

\* Used to calculate risk scores using the 2017 CMS-HCC and 2019 ESRD CMS-HCC models.

\*\* Used to calculate risk scores using the 2017 CMS-HCC and 2019 ESRD CMS-HCC models as a supplement to RAPS, and for the risk adjustment models used for non-PACE organizations.

We remain committed to working closely with PACE organizations to support their transition to EDS submissions and the implementation of the updated risk adjustment model for PACE. We intend to provide ample support and guidance to make this transition as straightforward as possible. To that end, we intend to release additional technical guidance to assist PACE organizations with the transition.

### **Attachment III. Benefit Parameters for the Defined Standard Benefit and Changes in the Payment Methodology for Medicare Part D for CY 2026**

Attachment III proposes revisions to the RxHCC risk adjustment model and provides updates to the Part D benefit parameters for CY 2026. CMS annually updates the Part D benefit parameters, and we provide the CY 2026 updates to these parameters in Sections A through E. We discuss proposed updates to the RxHCC risk adjustment model and related factors and information sources in Sections F through H.

Each year in the Advance Notice, CMS updates the statutory parameters for the defined standard Part D drug benefit and provides information on any changes to the payment methodology for the Part D benefit.

In order to ensure that the actuarial value of the Part D drug benefit remains consistent with changes in Part D drug expenses, certain parameters are updated using one of two indexing methods: the annual percentage increase in average expenditures for Part D drugs per eligible beneficiary (API) or the annual percentage increase in the Consumer Price Index (CPI) (all items, U.S. city average).

In Section A1, CMS provides the API and CPI for 2026, identifies those parameters updated or eliminated by statute, and provides tables outlining the benefit parameters for the standard benefit as well as for low-income subsidy (LIS) beneficiaries. In Section A2, CMS explains the calculation methodologies for the API and CPI. In Section A3, CMS describes the benefit parameters updated in this notice and provides additional tables with information on the updated parameters for both LIS and non-LIS beneficiaries.<sup>61</sup>

In Sections B through E, CMS describes other updates relevant to the Part D benefit parameters for 2026, including Part D premium stabilization, the prospective reinsurance amount for CY EGWPs, retiree drug subsidy amounts, and Part D risk sharing.

In addition, CMS provides information on proposed updates to the RxHCC risk adjustment model used to adjust direct subsidy payments for Part D benefits offered by standalone prescription drug plans (PDPs) and Medicare Advantage-Prescription Drug (MA-PD) plans in Section F, the normalization factors for the proposed RxHCC models in Section G, and information on the sources of diagnoses for the Part D risk score calculation in Section H.

---

<sup>61</sup> Historically, CMS has used the term “applicable beneficiary,” as defined in section 1860D-14A(g)(1) of the Act and § 423.100, to refer to a non-LIS beneficiary enrolled in a stand-alone prescription drug plan (PDP) or Medicare Advantage prescription drug (MA-PD) plan and who is not enrolled in a retiree prescription drug plan, and the term “non-applicable beneficiary” to refer to an LIS beneficiary. As noted below, the CGDP sunset effective January 1, 2025, and was replaced by the new Discount Program. Both LIS and non-LIS beneficiaries are included in the definition of applicable beneficiary under the Discount Program. Therefore, the terms “applicable beneficiary” and “non-applicable beneficiary” are no longer useful for describing how the benefit parameters discussed in the Advance Notice apply to LIS and non-LIS beneficiaries and will no longer be used to distinguish between LIS and non-LIS beneficiaries.



As noted earlier in this document, the IRA made several amendments and additions to the Act that affect the structure of the defined standard Part D drug benefit for CY 2023 and subsequent years. CMS is releasing separate Draft CY 2026 Part D Redesign Program Instructions concurrently with this document that will describe those changes in detail and provide guidance on changes in place for 2026. For reference purposes, we are also including a list of certain IRA provisions in place for 2026 here.

IRA provisions in effect for CY 2026 include:

- Beginning in CY 2025, the coverage gap phase is eliminated and defined standard Part D prescription drug coverage will consist of a three-phase benefit. As such, in CY 2026, there will be no initial coverage limit and the initial coverage phase will extend to the maximum annual OOP threshold, at which point the catastrophic phase will begin.
- As in CY 2024 and 2025, there is no beneficiary cost sharing above the annual OOP threshold in CY 2026.
- The CGDP ended effective January 1, 2025, and was replaced by the Manufacturer Discount Program (Discount Program). Under the Discount Program, the manufacturer will typically pay a 10 percent discount for applicable drugs in the initial coverage phase.<sup>62</sup> In the catastrophic phase, manufacturers will typically pay a 20 percent discount for applicable drugs. In certain circumstances, manufacturer discounts will be phased in and may be less than 10 percent in the initial coverage phase and 20 percent in the catastrophic coverage phase.
- Effective January 1, 2026, the new selected drug subsidy program will begin. Under the selected drug subsidy program, CMS will pay a 10 percent subsidy in the initial coverage phase for selected drugs (as defined in section 1192(c) of the Act) during a price applicability period (as defined in section 1191(b)(2) of the Act) that would otherwise have been applicable drugs if they were not selected under the Medicare Drug Price Negotiation Program.
- As in CY 2025, the reinsurance payment amount for CY 2026 for a Part D beneficiary will be 20 percent of the allowable reinsurance costs incurred after the beneficiary

---

<sup>62</sup> As defined at section 1860D-14C(g)(2) of the Act and in section 40.1 of the Medicare Part D Manufacturer Discount Program Final Guidance, applicable drugs under the Discount Program are all Part D drugs approved under a new drug application under section 505(c) of the Federal Food, Drug, and Cosmetic Act (FDCA) or, in the case of a biologic product, licensed under section 351 of the Public Health Service Act (PHSA), other than a selected drug (as referred to under section 1192(c) of the Act) dispensed during a price applicability period (as defined in section 1191(b)(2) of the Act). Because the statute defines in part an applicable drug as a Part D drug that is approved under an NDA under section 505(c) of the FDCA or is licensed under section 351 of the PHSA, a Part D drug that meets such criteria will be considered an applicable drug regardless of whether the plan sponsor treats such product as a brand name or generic product under its benefit. *See* Medicare Part D Manufacturer Discount Program Final Guidance (November 17, 2023). <https://www.cms.gov/files/document/manufacturer-discount-program-final-guidance.pdf>.

exceeds the annual OOP threshold for applicable drugs or 40 percent for non-applicable drugs<sup>63</sup> and selected drugs (as defined in section 1192(c) of the Act).

- As in CY 2025, the definition of incurred costs at section 1860D-2(b)(4)(C) of the Act includes, among other categories of costs, supplemental coverage and other health insurance, which was previously excluded from the definition of incurred costs. Manufacturer discounts provided under the Discount Program will be excluded from the definition of incurred costs.
- As in CY 2025, the deductible will continue not to apply to covered insulin products and the Part D cost-sharing amount for a month's supply of each covered insulin product must not exceed the statutorily defined "applicable copayment amount." Beginning in CY 2026, the applicable copayment amount is the lesser of \$35, an amount equal to 25 percent of the maximum fair price established for the covered insulin product under the Medicare Drug Price Negotiation Program, or an amount equal to 25 percent of the negotiated price of the covered insulin product under the PDP or MA-PD plan.
- As in CY 2025, the deductible will continue not to apply to any adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). Also, section 1860D-2(b)(8) of the Act requires these vaccines to be exempt from any co-insurance or other cost sharing, including cost sharing for vaccine administration and dispensing fees for such products, when administered in accordance with ACIP's recommendation, for beneficiaries in the initial coverage and coverage gap phases.
- Premium stabilization will continue to be in effect, and the base beneficiary premium (BBP) in CY 2026 will be the lesser of the CY 2025 BBP increased by 6 percent or the BBP as it would have been calculated if the IRA's premium stabilization provision had not been enacted.

Only those IRA policies that directly affect the CY 2026 statutory parameters for the defined standard Part D drug benefit are discussed in Attachment III below. Please see the Draft CY 2026 Part D Redesign Program Instructions for additional information on IRA-related changes. In addition, please see the proposed rule titled "Medicare and Medicaid Programs: Contract Year 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," which was issued on November 26, 2024, for IRA-related changes related to cost sharing for covered insulin products, ACIP-recommended vaccines, and the Medicare Prescription Payment Plan for CY 2026.

---

<sup>63</sup> As defined in section 130 of the Medicare Part D Manufacturer Discount Program Final Guidance, a non-applicable drug is any Part D drug that is not an applicable drug and not a selected drug (as defined in section 1192(c) of the Act) during a price applicability period (as defined in section 1191(b)(2) of the Act) with respect to such drug.

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

Certain parameters are annually updated using one of two indexing methods, the API or the CPI, to ensure that the actuarial value of the benefit remains consistent with changes in Part D drug expenditures. Beginning in CY 2023, the IRA exempted from the deductible and eliminated beneficiary cost sharing for ACIP-recommended adult vaccines and exempted from the deductible and required that cost-sharing amount for a one-month supply of each covered insulin product must not exceed the statutorily-defined “applicable copayment amount.” For 2023, 2024, and 2025, the applicable copayment amount for covered insulin products was \$35. Beginning in CY 2026, the applicable copayment amount for covered insulin products is the lesser of \$35, an amount equal to 25 percent of the maximum fair price established for the covered insulin product under the Medicare Drug Price Negotiation Program, or an amount equal to 25 percent of the negotiated price of the covered insulin product under the PDP or MA-PD plan. Beginning in CY 2024, beneficiary cost sharing in the catastrophic phase of the benefit was eliminated. Beginning in CY 2025, the IRA eliminated the coverage gap phase.

Given these changes, defined standard Part D prescription drug coverage in CY 2026 will consist of a three-phase benefit as follows:

- **Annual deductible:** Beneficiaries will be responsible for all of their Part D prescription drug costs until they reach the defined standard deductible limit, with the exception that the deductible will continue to not apply to any Part D covered insulin product and any ACIP-recommended adult vaccine. The defined standard Part D deductible will be updated using the API for 2026.
- **Initial coverage phase:** In the initial coverage phase, the beneficiary pays 25% coinsurance for most covered Part D drugs.<sup>64</sup> Because the coverage gap phase was eliminated beginning in CY 2025, there will not be an initial coverage limit, and, thus, that parameter will no longer be updated. The initial coverage phase will extend to the maximum annual OOP threshold. The annual OOP threshold will be updated using the API for CY 2026.
- **Catastrophic coverage phase:** Beneficiaries will continue to pay no cost sharing for covered Part D drugs in the catastrophic coverage phase. Therefore, beneficiary cost sharing above the annual OOP threshold will no longer be updated.

Please see the Draft CY 2026 Part D Redesign Program Instructions published concurrently with this Advance Notice for a detailed description of IRA-related changes to the Part D benefit that apply in CY 2026 and guidance related to those changes. IRA changes specific to CY 2023 were

---

<sup>64</sup> The exceptions include ACIP-recommended adult vaccines, for which beneficiaries pay \$0, and covered insulin products, for which the cost sharing is capped. For CY 2026 and each subsequent year, the applicable copayment amount for a month’s supply of each covered insulin product is the lesser of: (1) \$35, (2) an amount equal to 25 percent of the maximum fair price (MFP) established for the covered insulin product in accordance with part E of subchapter XI of the Act, or (3) an amount equal to 25 percent of the negotiated price of the covered insulin product under the PDP or MA-PD plan.

described in separate guidance specific to CY 2023.<sup>65</sup> IRA changes specific to CY 2024 were described in the CY 2024 Rate Announcement. IRA changes specific to CY 2025 were described in the Final CY 2025 Part D Redesign Program Instructions.<sup>66</sup> Additionally, IRA changes related to cost sharing for covered insulin products, ACIP-recommended vaccines, and the Medicare Prescription Payment Plan for CY 2026 are described in the proposed rule titled “Medicare and Medicaid Programs: Contract Year 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,” which was issued on November 26, 2024.

### ***A1. Updating the Medicare Part D Benefit Parameters***

Part D of Title XVIII of the Act directs CMS to update the statutory parameters for the defined standard Part D drug benefit each year. These annual adjustments ensure that the actuarial value of the drug benefit remains consistent with changes in Part D drug expenses. This section provides the methodologies used to update the statutory parameters for CY 2026.

Historically, the statutory parameters have included the defined standard benefit deductible, initial coverage limit, and annual OOP threshold. In addition, CMS is required by statute to update the parameters for the LIS benefit. Given the changes enacted by the IRA, for CY 2026 the defined standard benefit deductible, annual OOP threshold, and LIS benefit parameters will be updated per the methodology provided by the Act.

Finally, it is not necessary to update the parameters for the initial coverage limit, maximum or minimum beneficiary cost sharing in the coverage gap or above the annual OOP threshold for CY 2026 as the coverage gap phase and beneficiary cost sharing above the annual OOP threshold have been eliminated.

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

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.” As noted above, in CY 2025, the only defined standard Part D prescription drug benefit parameter that was updated using the API was the deductible. However, while the annual OOP threshold was set at \$2,000 by statute for CY 2025, it will be updated using the API in CY 2026. The only LIS cost-sharing parameter

<sup>65</sup> Centers for Medicare & Medicaid Services, Contract Year 2023 Program Guidance Related to Inflation Reduction Act Changes to Part D Coverage of Vaccines and Insulin (Sept. 26, 2022). Available at <https://www.cms.gov/files/document/irainsulinvaccinesmemo09262022.pdf>.

<sup>66</sup> 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>.

that is updated using the API is the maximum copayment below the annual OOP threshold for low-income, full-subsidy-eligible beneficiaries with incomes between 100 and 150 percent of the FPL.

The CY 2025 annual percentage trend in the API can be found in Table III-1 below. The percent increase in the benefit parameters indexed to the API for CY 2026 is 4.27 percent. This increase reflects the CY 2025 annual percentage trend of 5.69 percent in the API as well as a multiplicative update of -1.34 percent for prior year revisions. See Section A2 for additional information on the calculation of the API.

*Annual Percentage Increase in Consumer Price Index, 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. CMS uses an estimate of the September 2025 CPI based on projections from the President's FY 2026 Budget for this purpose.

The CY 2025 annual percentage trend in the CPI can be found in Table III-1 below. The percent increase in the maximum copayments indexed to the CPI for CY 2026 is 2.16 percent. The CY 2026 increase reflects the CY 2025 annual percentage trend in the CPI of 2.33 percent as well as a multiplicative update of -0.17 percent for prior year revisions.

See Section A2 for additional information on the calculation of the annual percentage increase in the CPI.

**Table III-1. Updated API and CPI for CY 2026**

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

Table III-2 below summarizes the Part D benefit parameters discussed in this notice, including those that are required by statute to be updated with either the API or CPI each year. The 2025 column shows the CY 2025 values for the Part D benefit parameters. The 2026 column shows the updated parameters for CY 2026. The CY 2026 values will be updated using either the 2026 API of 4.27% percent or CPI of 2.16% percent, as applicable.

The CY 2025 parameters reflect the elimination of beneficiary cost sharing above the annual OOP threshold for all Part D beneficiaries regardless of their LIS status. The CY 2025 parameters also reflect the elimination of the coverage gap phase and the statutorily set annual OOP threshold of \$2,000 for CY 2025, consistent with the amendments to the Act made by

section 11201 of the IRA. We also provide the Part D benefit parameters that remain constant from year-to-year.

For completeness, Table III-2 also includes estimates of the cost threshold and cost limit for the Retiree Drug Subsidy program (discussed in more detail in Section F).

**Table III-2. Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy, and Retiree Drug Subsidy**

	2025	2026 <sup>67</sup>
<b>Standard Benefit</b>		
Deductible	\$590	\$615
Out-of-Pocket Threshold	\$2,000	\$2,100
<b>Full Subsidy-Full Benefit Dual Eligible (FBDE) Beneficiaries (1)</b>		
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
<b>Full Subsidy-Non-FBDE Beneficiaries (1)</b>		
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
<b>Retiree Drug Subsidy Amounts</b>		
Cost Threshold	\$590	\$615
Cost Limit	\$12,150	\$12,650

<sup>67</sup> 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.

(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.

## ***A2. Calculation methodologies for the Annual Percentage Increase (API) and Consumer Price Index (CPI)***

As noted above, the API and CPI are indexing methods used to update certain Part D benefit parameters. This section describes in detail the calculation methodologies used to determine the API and CPI for 2026.

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

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:

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

In the formula, the average per capita cost for August 2023 – July 2024 is calculated from actual Part D prescription drug event (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 annual percentage trend in Table III-3 is based on updated NHE prescription drug per capita costs and PDE data. The years in this table refer to the trend observed in the period of the August of the prior year to July of that year relative to the same interval in preceding years. For example, year 2021 represents the trend observed in August 2020 to July 2021 relative to August 2019 to July 2020.

**Table III-3. Revised Prior Years' Annual Percentage Trends**

<b>Year</b>	<b>Prior Estimates of Annual Percentage Trend</b>	<b>Revised Annual Percentage Trend</b>
<b>2006</b>	7.30%	7.30%
<b>2007</b>	5.92%	5.92%
<b>2008</b>	4.69%	4.69%
<b>2009</b>	3.14%	3.14%
<b>2010</b>	2.36%	2.36%
<b>2011</b>	2.15%	2.15%
<b>2012</b>	2.53%	2.53%
<b>2013</b>	-3.14%	-3.14%
<b>2014</b>	10.12%	10.12%
<b>2015</b>	9.89%	9.89%
<b>2016</b>	4.02%	4.02%
<b>2017</b>	1.87%	1.87%
<b>2018</b>	4.06%	4.06%
<b>2019</b>	4.92%	4.92%
<b>2020</b>	5.06%	5.06%
<b>2021</b>	4.69%	4.68%
<b>2022</b>	7.36%	7.36%
<b>2023</b>	9.57%	9.54%
<b>2024</b>	5.46%	4.07%

Accordingly, the CY 2026 benefit parameters will reflect the CY 2025 annual percentage trend and a multiplicative update for prior year revisions. The CY 2025 annual percentage trend can be found in Table III-4. The 2025 API is updated by 4.27 percent.



**Table III-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)  
Calculation Methodology*

To ensure that Part D 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:

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

(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 III-5 below.

**Table III-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.

### ***A3. Annual Adjustments for Part D Benefit Parameters in CY 2026***

#### ***Defined Standard Part D Prescription Drug Benefit Parameters***

In accordance with section 1860D-2(b) of the Act, CMS updates the statutory parameters for the defined standard Part D prescription drug benefit each year. As mentioned previously, these annual adjustments ensure that the actuarial value of the drug benefit remains consistent with changes in Part D drug expenses. As noted above, the IRA also made several amendments and additions to the Act that affect the structure of the defined standard Part D prescription drug benefit in CY 2026, which are reflected in the discussion below.

As described in section 1860D-2(b) of the Act, as amended by section 11201 of the IRA, the defined standard Part D prescription drug benefit is composed of three sequential coverage phases: deductible, initial coverage, and catastrophic coverage phases. Under section 1860D-2(b) and (c) of the Act, as amended by section 11201 of the IRA, the coverage gap phase was eliminated in CY 2025, meaning a beneficiary will leave the initial coverage phase and enter the catastrophic phase once they incur enough TrOOP-eligible costs to meet the annual OOP threshold, which is \$2,100 in CY 2026. TrOOP is spending on covered Part D drugs by the beneficiary or on their behalf by certain third parties. The categories of payments that count toward TrOOP changed in CY 2025. Specifically, TrOOP includes previously excluded supplemental benefits and excludes Discount Program payments (see sections 1860D-2(b)(4)(C)(iii) and (F) of the Act).<sup>68</sup>

Cost sharing for beneficiaries varies by coverage phase, by LIS status, and whether the drug is a covered insulin product or ACIP-recommended adult vaccine. See Table III-6 below for non-LIS beneficiary cost sharing and the next section for discussion of cost-sharing requirements for LIS beneficiaries.

For CY 2026, under section 1860D-2(b)(1) of the Act, the defined standard benefit deductible amount is updated by multiplying the CY 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 III-6 below summarizes the defined standard benefit parameters and provides the CY 2025 parameter values. The updated parameter values for CY 2026 are obtained by applying the 2026 API and rounding to a specified amount and are summarized in Table III-6.

---

<sup>68</sup> For additional details on IRA-related changes to TrOOP, please see the Final CY 2025 Part D Redesign Programs Instructions and the August 5, 2024, HPMS memorandum titled “Update: Clarification of True Out-of-Pocket (TrOOP) Costs for Calendar Year 2025”.

**Table III-6. Part D Benefit Parameters for Defined Standard Benefit for CY 2025 and CY 2026 for Non-LIS Beneficiaries<sup>69</sup>**

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

*Annual Adjustments for Low-Income Subsidy (LIS) Beneficiary Cost-Sharing Parameters*

The LIS benefit provides Part D cost-sharing assistance to certain low-income Medicare Part D beneficiaries across the same coverage phases described above. Medicare Part D beneficiaries who are eligible for full Medicaid benefits, recipients of Supplemental Security Income (SSI) benefits (*see* § 423.773(c)(1)(ii)), or eligible for a Medicare Savings Programs as a Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), or Qualifying Individual under a State’s Medicaid plan (*see* § 423.773(c)(1)(iii)) are deemed automatically eligible for the full subsidy and do not have to separately apply for the LIS benefit. Other Medicare Part D beneficiaries must apply for the LIS benefit and may receive the full subsidy if they meet certain income and asset requirements, as described in section 1860D-14(a)(3)(E) of the Act.

The cost-sharing benefits for LIS beneficiaries are described in section 1860D-14(a)(1) of the Act. Full subsidy FBDE individuals who are institutionalized or receiving certain home and community-based services, as defined in § 423.772, have a \$0 deductible and \$0 copayments for all covered Part D drugs, regardless of the defined standard benefit phase. Other full subsidy (both FBDE and non-FBDE) beneficiaries also have a \$0 deductible but pay nominal copayments for all covered Part D drugs below the annual OOP threshold as described in sections 1860D-14(a)(1)(D)(ii) and (iii).

The following LIS cost-sharing parameters are updated each year by multiplying the prior year’s value by the API and rounding as specified by the statute:

<sup>69</sup> 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.

**Maximum Copayments up to the Annual OOP Threshold for Certain Low-Income Full Subsidy Eligible Beneficiaries:** From \$4.90 per generic, preferred drug that is a multi-source drug, or biosimilar and \$12.15 for all other drugs in CY 2025, rounded to the nearest multiple of \$0.05.

**Maximum Copayment Amounts up to the Annual OOP Threshold for Full Benefit Dual Eligible Beneficiaries with Incomes Not Exceeding 100 Percent of the Federal Poverty Level:** 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.<sup>70</sup>

Please see Table III-7 below for complete information on the different LIS benefit categories and cost-sharing parameters for CY 2025, as well as the LIS cost-sharing parameters updated for CY 2026 by either using the 2026 API or CPI.

**Table III-7. Updated Part D Low-income Cost-Sharing Parameters for CY 2026<sup>71</sup>**

	2025	2026
<b>Full Subsidy-Full Benefit Dual Eligible (FBDE) Beneficiaries (1)</b>		
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 (3)	\$1.60	\$1.60
Other (3)	\$4.80	\$4.90
Between 100% and 150% of FPL		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	\$4.90	\$5.10
Other	\$12.15	\$12.65

<sup>70</sup> Per section 1860D-14(a)(4)(A) of the Act, the copayments are increased from the unrounded 2024 values of \$1.55 for multi-source generic or preferred drugs, and \$4.65 for all other drugs.

<sup>71</sup> 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
<b>Full Subsidy-Non-FBDE Beneficiaries (1)</b>		
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 (couple, 2025) [category code 1] (4)		
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

- (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 percent of FPL who meet the statutory resource requirements, and full-subsidy-non-FBDE beneficiaries.
  - Category Code 2 – Non-institutionalized FBDE beneficiaries with incomes up to 100 percent of the FPL and who meet the statutory resource requirements.
  - 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 individual (or couple) would have been institutionalized.
- (3) Increases to the maximum copayments for non-institutionalized FBDE beneficiaries with incomes not greater than 100 percent of the FPL are applied to the unrounded CY 2025 values of \$1.59 for generic/preferred multi-source drugs and \$4.77 for all other drugs.
- (4) 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 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). In addition, beneficiaries that would have been eligible for the partial LIS benefit had the IRA not been enacted are eligible for the full LIS benefit if they meet the resource standard described at section 1860D-14(a)(3)(E) of the Act.

## **Section B. Part D Premium Stabilization**

As described in the 2024 Advance Notice and the July 29, 2024, HPMS memorandum, titled “Annual Release of Part D National Average Monthly Bid Amount and Other Part C & D Bid Information,”<sup>72</sup> under section 1860D-13 of the Act, as added by section 11201 of the IRA, the Base Beneficiary Premium (BBP) for CY 2024 through CY 2029 is equal to the lesser of the prior year’s BBP increased by 6 percent, or the BBP as it would have been calculated if the IRA’s premium stabilization provision had not been enacted.

Therefore, the BBP for CY 2026 will not be greater than CY 2025 BBP, which was \$36.78 (as released in the July 29, 2024, HPMS memorandum) increased by 6%, or \$38.99. We will provide more information on the BBP calculation for CY 2026 during the usual timeframe after CY 2026 bids have been submitted. Please note that the BBP is calculated at the national level and that premiums for individual plans may increase by more than 6%.<sup>73</sup>

It is important to note that the Part D premium stabilization policy impacts the direct subsidy payments for Part D benefits offered by PDPs and MA-PD plans. CMS provides a capitated direct subsidy payment for each Part D beneficiary equal to the Part D plan’s approved standardized bid, risk adjusted for the beneficiary’s health status, and reduced by the plan’s basic Part D premium, as defined at § 423.329. Consistent with CY 2024 and CY 2025, the direct subsidy amount will change depending on the impact of premium stabilization on the BBP calculation and, thereby, a plan’s basic Part D beneficiary premium. As a result, the portion of the plan’s bid for basic Part D coverage not funded by basic Part D premiums will continue to be paid through the direct subsidy.

## **Section C. Part D Calendar Year EGWP Prospective Reinsurance Amount**

From 2017 through 2024, CMS made prospective reinsurance payments to all Part D Calendar Year EGWP sponsors based on the average per member-per month (PMPM) actual (final) reinsurance amounts paid to Part D Calendar Year EGWP sponsors for the most recently reconciled payment year.

---

<sup>72</sup> [Annual Release of Part D National Average Monthly Bid Amount and Other Part C & D Bid Information](#)

<sup>73</sup> In July 2024, CMS announced a voluntary demonstration program for standalone PDPs that includes elements designed to test whether additional premium stabilization and revised risk corridors increase the efficiency and economy of services under the Medicare Part D program as the benefit improvements and changes to plan liability for beneficiary costs under the IRA go into effect. The demonstration was designed for one year (i.e., CY 2025) and at least two subsequent demonstration years with parameters to be adjusted to reflect market conditions in those years. Note that the demonstration does not affect the calculation of the BBP under the formula established at section 1860D-13(a)(2) of the Act and the BBP for 2026 will be calculated based on the CY 2025 BBP prior to the application of the demonstration parameters. Please see the July 29, 2024, HPMS memorandum “Annual Release of Part D National Average Monthly Bid Amount and Other Part C & D Bid Information” for additional information.

In 2025, given that the reinsurance percentages and methodology changed significantly, as discussed in the Final CY 2025 Part D Redesign Program Instructions,<sup>74</sup> the methodology used to calculate the prospective reinsurance payments to all Part D Calendar Year EGWP sponsors was also updated. For additional information regarding the reinsurance and Calendar Year EGWP prospective reinsurance amount changes, please see the Final CY 2025 Part D Redesign Program Instructions. As established in the Draft CY 2026 Part D Redesign Program Instructions, the program instructions for Part D Calendar Year EGWP prospective reinsurance contained in the Final CY 2025 Part D Redesign Program Instructions will also apply to CY 2026. As in CY 2025, CMS plans to announce the prospective reinsurance payment amount for Part D Calendar Year EGWPs with the annual release of the Part D National Average Monthly Bid Amount (NAMBA), Part D BBP, and related Part D bid information; for CY 2026, the release of such information will occur in the summer of 2025.

#### **Section D. Part D Risk Sharing**

The risk sharing payments provided by CMS limit Part D sponsors' exposure to unexpected drug expenses. Pursuant to section 1860D-15(e)(3)(C) of the Act and § 423.336(a)(2)(ii), CMS may establish a risk corridor with higher threshold risk percentages for Part D risk sharing beginning in CY 2012. Widening the risk corridor would increase the risk associated with providing the Part D benefit and reduce the risk sharing amounts provided (or recouped) by CMS. While CMS may widen the risk corridors, the statute does not permit CMS to narrow the corridors relative to the CY 2011 thresholds.

CMS has evaluated the risk sharing amounts for CYs 2008–2023 to assess whether they have decreased or stabilized. A steady decline or stabilization in the Part D risk sharing amounts would suggest that Part D sponsors have significantly improved their ability to predict Part D expenditures. However, CMS has found that risk sharing amounts continue to vary significantly in aggregate from year to year and among Part D sponsors in any given year. We do not believe it is appropriate to adjust the parameters in the manner allowed by the statute at this time, and we will apply no changes to the current threshold risk percentages for CY 2026. We will continue to evaluate the risk sharing amounts each year to determine if wider corridors should be applied for Part D risk sharing.

Thus, the risk percentages and payment adjustments for Part D risk sharing are unchanged from CY 2025. The risk percentages for the first and second thresholds remain at +/- 5 percent and +/- 10 percent of the target amount, respectively, for CY 2026.<sup>75</sup> The payment adjustments for the

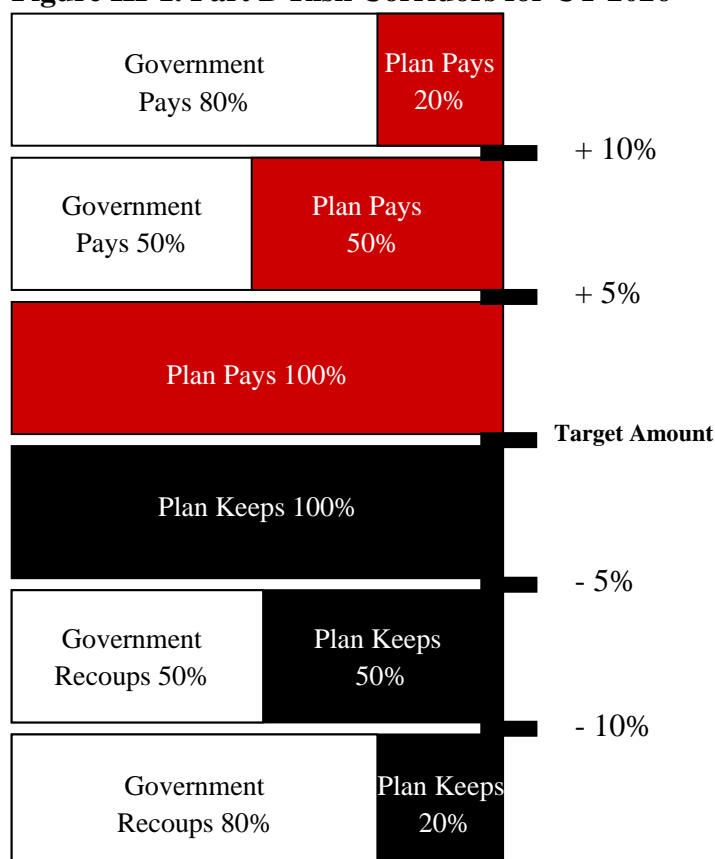
---

<sup>74</sup> Please see the Final CY 2025 Part D Redesign Program Instructions.

<sup>75</sup> Per section 1860D-15(e)(3)(B) of the Act, the target amount is the total amount of payments (from both CMS and by or on behalf of enrollees) to a Part D plan for the coverage year based on the standardized bid amount, less the administrative expenses assumed in the standardized bid.

first and second corridors are 50 percent and 80 percent, respectively. Figure III-1 below illustrates the risk corridors for CY 2026.

**Figure III-1. Part D Risk Corridors for CY 2026**



***D1. Risk sharing when a plan's adjusted allowable risk corridor costs (AARCC) exceed the target amount***

For the portion of a plan's adjusted allowable risk corridor costs (AARCC<sup>76</sup>) that is between the target amount and the first threshold upper limit (105 percent of the target amount), the Part D sponsor pays 100 percent of this amount. For the portion of the plan's AARCC that is between the first threshold upper limit and the second threshold upper limit (110 percent of the target amount), the government pays 50 percent, and the plan pays 50 percent. For the portion of the plan's AARCC that exceeds the second threshold upper limit, the government pays 80 percent, and the plan pays 20 percent.

<sup>76</sup> Per § 423.336(a), the "adjusted allowable risk corridor costs" for a Part D plan are the allowable risk corridor costs for a Part D plan for the coverage year, reduced by the sum of the total reinsurance payments and total low-income cost-sharing subsidies paid to the sponsor of the Part D plan for the coverage year.



Example: If a plan's AARCC is \$120 and its target amount is \$100, the Part D sponsor and the government cover \$9.50 and \$10.50, respectively, of the \$20 in unanticipated costs. The sponsor's responsibility is calculated as follows:

$$100\% \text{ of } (\$105 - \$100) + 50\% \text{ of } (\$110 - \$105) + 20\% \text{ of } (\$120 - \$110).$$

***D2. Risk sharing when a plan's adjusted allowable risk corridor costs (AARCC) are below the target amount***

If a plan's AARCC is between the target amount and the first threshold lower limit (95 percent of the target amount), the plan keeps 100 percent of the difference between the target amount and the plan's AARCC. If a plan's AARCC is between the first threshold lower limit and the second threshold lower limit (90 percent of the target amount), the government recoups 50 percent of the difference between the first threshold lower limit and the plan's AARCC. The plan would keep 50 percent of the difference between the first threshold lower limit and the plan's AARCC, as well as 100 percent of the difference between the target amount and first threshold lower limit. If a plan's AARCC is less than the second threshold lower limit, the government recoups 80 percent of the difference between the plan's AARCC and the second threshold lower limit, as well as 50 percent of the difference between the first and second threshold lower limits. In this case, the plan would keep 20 percent of the difference between the plan's AARCC and the second threshold lower limit, 50 percent of the difference between the first and second threshold lower limits, and 100 percent of the difference between the target amount and the first threshold lower limit.

Example: If a plan's AARCC is \$80 and its target amount is \$100 of the \$20 in unexpected savings generated, the Part D sponsor keeps \$9.50, and the government recoups \$10.50. The sponsor's share is calculated as follows:

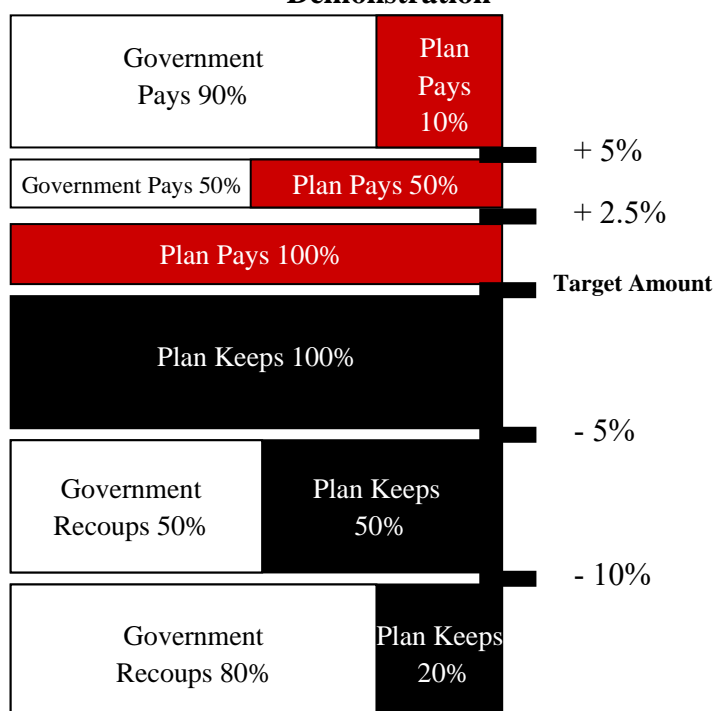
$$100\% \text{ of } (\$100 - \$95) + 50\% \text{ of } (\$95 - \$90) + 20\% \text{ of } (\$90 - \$80).$$

In July 2024, CMS announced a voluntary demonstration program for standalone PDPs to test whether additional premium stabilization and revised risk corridors increase the efficiency and economy of services under the Medicare Part D program as the benefit improvements and changes to plan liability for beneficiary costs under the IRA go into effect. The demonstration is designed for one year (i.e., CY 2025) and at least two subsequent demonstration years with parameters to be adjusted to reflect market conditions and variations in those years. Under this demonstration, the upper thresholds (see Attachment III, Section D1) for the CY 2025 risk corridors were narrowed to 2.5 percent and 5 percent above the target amount for participating PDPs. In addition, for CY 2025, CMS increased the share of losses assumed by the government once the demonstration 5 percent threshold is reached; the government's share of any losses beyond this threshold increased to 90 percent for CY 2025. Please see the July 29, 2024, HPMS

memorandum “Annual Release of Part D National Average Monthly Bid Amount and Other Part C & D Bid Information.”<sup>77</sup>

Figure III-2 below shows the CY 2025 risk corridors for PDPs participating in the voluntary demonstration. For CY 2026, CMS will determine the additional premium stabilization and risk corridors for participating PDPs for CY 2026 under the demonstration following submission of bids for CY 2026 and will announce the additional premium stabilization and risk corridors no later than the annual release of the NAMBA, Part D BBP, and related Part D bid information in the summer of 2025. For each subsequent year, CMS will assess each element of the demonstration separately to determine appropriate parameters for such subsequent plan year, considering the success of each element in achieving the goals of the demonstration in prior years and whether market conditions suggest that Part D sponsors have adequate data on the Part D market to have stable actuarial information on which to base their PDP bids in the absence of additional premium stabilization. The value of one or more of the parameters may be reduced for a subsequent demonstration year to equal its value absent the demonstration. For PDPs not participating in the demonstration, the risk corridors in Figure III-1 will apply.

**Figure III-2. Part D Risk Corridors for CY 2025 for PDPs Participating in the Voluntary Demonstration**



<sup>77</sup> See [www.cms.gov/files/document/july-29-2024-parts-c-d-announcement.pdf](https://www.cms.gov/files/document/july-29-2024-parts-c-d-announcement.pdf).

## Section E. Retiree Drug Subsidy Amounts

While the IRA significantly redesigned the Part D benefit starting in CY 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 retiree drug subsidy amounts for retiree drug subsidy plans.<sup>78</sup>

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.<sup>79</sup> 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 III-8.

**Table III-8. Updated Retiree Drug Subsidy Amounts in CY 2026**

	2025	2026
<b>Retiree Drug Subsidy Amounts</b>		
Cost Threshold	\$590	\$615
Cost Limit	\$12,150	\$12,650

## Section F. RxHCC Risk Adjustment Model

### *F1. Background on the RxHCC Risk Adjustment Model*

The prescription drug hierarchical condition category (RxHCC) risk adjustment model is used to help ensure that payments to Part D plans reflect the plans' expected drug costs given their enrolled population. The model is used to calculate beneficiary risk scores, which represent the expected plan liability for a beneficiary's drug costs relative to the average-cost beneficiary. If the enrolled population is expected to be more or less costly than average, the risk adjustment model ensures that plan payments account for that difference in risk.

- The RxHCC model uses beneficiary demographic characteristics and diagnosis information from a base year (i.e., data collection year) to predict expected plan spending for drug costs in the following year (i.e., the payment year) under the basic Part D drug benefit. Demographic information, such as beneficiary age, sex, disability status, low income, and long-term institutional status, is obtained from CMS administrative data.

<sup>78</sup> 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>.

<sup>79</sup> 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.

- Diagnosis information is obtained from MA encounter data and FFS claims for MA and FFS beneficiaries enrolled the Part D program. Diagnoses are grouped into RxHCCs based on severity and cost.
- Gross prescription drug expenditures are collected from PDE data.

PDEs used to develop the model are always from years prior to the payment year. Individual PDEs reflect costs paid by plans, beneficiaries, and the government for the benefit structure in place for a given year. However, because the RxHCC model is used to predict plan spending in a future year when the benefit will be different, each PDE in the model sample needs to have payments reallocated to the standard benefit structure for the applicable payment year. The spending totals used to calibrate the model reflect how much a plan would have spent for a drug if the future payment year’s basic benefit structure was in place when the PDE occurred. The model includes costs for which the plan is financially liable; in other words, the model excludes costs paid for entirely by the government (reinsurance and the low-income subsidy) or the beneficiary. It also excludes enhanced benefits provided above and beyond the defined standard benefit structure. For additional details and examples of the PDE re-mapping process, consult the CY 2025 Advance Notice.<sup>80</sup>

The re-mapped PDE expenditures are used to predict plan spending for each model factor (diagnosis groups, or RxHCCs, and demographic characteristics). These values are then divided by the average predicted per capita expenditure – referred to as the denominator – for a given year to generate relative factors for each model factor. The relative factors represent the marginal, or additional, expected plan spending for drug costs for each model factor relative to the average, holding all else the same. Relative factors are used to calculate risk scores for each beneficiary to use for preparing plan bids and for calculating direct subsidy payments.

### *Model Segments*

The RxHCC model comprises separate relative factors for different subsets of Part D beneficiaries based on community versus institutional status, low-income status, and aged versus disabled status. There are eight unique beneficiary subsets (“model segments”):

- Five segments are for continuing enrollees, who are defined as beneficiaries who had 12 months of enrollment in Part B in the base year (when diagnosis information is collected). (12 months of Part B is used as a way to identify beneficiaries who have an adequate amount of diagnoses to calculate a risk score.)
  - Community, Non-Low Income, Age 65+
  - Community, Non-Low Income, Age <65
  - Community, Low Income, Age 65+

---

<sup>80</sup> Refer to the [CY 2025 Advance Notice, Attachment III, Section G1](#).

- Community, Low Income, Age < 65
- Institutional
- Three segments are for new enrollees, who are beneficiaries with fewer than 12 months of enrollment in Part B in the base year.
  - Non-Low Income
  - Low-Income
  - Institutional

The RxHCC model sample comprises all beneficiaries who were in FFS or Medicare Advantage (MA-PD or MA-only) for all 12 months of the base year (the year from which diagnoses were used for model calibration) and were enrolled in a PDP or an MA-PD plan for at least one month in the prediction year (the year from which costs were used for model calibration). CMS regressed the plan liability for the Part D defined standard benefit for each beneficiary onto their demographic factors and condition categories, as indicated by their diagnoses, to estimate dollar coefficients. Resulting dollar coefficients represent the marginal (additional) cost of the condition or demographic factor (for example, age and sex groups). Beneficiaries are segmented based on low-income status, disability status, and residence setting (community vs. institutional), and whether they are new enrollees (have less than 12 months of Part B in the data collection period). Age groups are defined for beneficiaries based on their age on February 1 of the prediction year. Beneficiaries who age into Medicare after February 1 of the prediction year are treated as 65 years old in model calibration. LIS and institutional status are determined on a month-by-month basis. Plan liability figures for each beneficiary are annualized and weighted based on the proportion of months beneficiaries are eligible for each model segment in the prediction year.

To create the relative factors used to calculate risk scores for payment, the dollar coefficients are divided by the average predicted plan liability across all model segments (the denominator). Denominators for the recalibrated RxHCC risk adjustment models are calculated using data from 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.

When the RxHCC model is recalibrated to reflect updated data years and/or an updated benefit structure, it can result in changes to coefficients for the factors in the model. Changes in the relative (denominated) factors can occur when the marginal cost attributable to a demographic factor or an RxHCC changes differently than the average beneficiary cost. Recalibration of the RxHCC model can result in changes in risk scores for individual beneficiaries and for plan average risk scores, depending on each individual beneficiary's combination of diagnoses.

Relative factors for the proposed RxHCC models for CY 2026 are presented in Attachment VI.

## ***F2. Updates to the RxHCC Models Proposed for CY 2026***

The IRA has made substantial changes to the Part D benefit and gross plan liability. For CY 2025, CMS recalibrated the RxHCC models to account for changes made to the Part D benefit structure for that year, thereby improving the model's accuracy under the revised standard benefit.<sup>81</sup> For CY 2026, CMS is making further updates to align the RxHCC model with benefit updates for this coming year.

We are proposing to update the RxHCC models for CY 2026 by incorporating the following changes to the Part D benefit related to the IRA:

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

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

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

### *IRA-related RxHCC Model Updates*

Adjusting the Annual OOP Thresholds. Because the RxHCC model is calibrated using historical data, the annual OOP threshold must be adjusted to the appropriate amount, relative to the \$2,000 annual OOP threshold established for CY 2025 by the IRA; in other words, given the lower annual OOP threshold set by the IRA, we need to reflect what this lower annual OOP threshold would have been in the year of data we are using to calibrate the CY 2026 model (i.e., 2023 for non-PACE and 2019 for PACE). Without an adjustment, a higher proportion of costs would be allocated to the initial coverage phase than would be appropriate. For the RxHCC model proposed for CY 2026, the annual OOP threshold is adjusted using the final published APIs from the CY 2019 to CY 2025 Rate Announcements, shown in Table III-9 below. The

---

<sup>81</sup> For more details, see [CY 2025 Advance Notice, Attachment III, Section G2](#).

annual OOP threshold is divided by the published API for each year and rounded to the nearest \$50. This is the same approach that is used annually to increase the benefit parameters in Part D to account for inflation in drug costs.

**Table III-9. Published API and Adjusted OOP**

<b>Data Year</b>	<b>Published API</b>	<b>Adjusted OOP</b>
2025	1.0858	\$2,000
2024	1.0801	\$1,850
2023	1.0508	\$1,700
2022	1.0731	\$1,600
2021	1.0285	\$1,500
2020	1.0521	\$1,450
2019	1.0194	\$1,400

Increasing Manufacturer Discounts. The IRA provides for lower applicable discounts for certain manufacturers' applicable drugs marketed as of August 16, 2022, during a multi-year phase-in period, which concludes by 2031. A list of NDC-9 codes eligible for phased-in manufacturer discounts was published in May 2024.<sup>82</sup> This list of eligible drugs is based on ownership information submitted by manufacturers to HPMS and whether the manufacturers entered into a Discount Program agreement by the statutory deadline of March 1, 2024. The phased-in discount percentages in the RxHCC models being proposed for CY 2026 reflect the May 2024 list and the CY 2026 benefit structure.<sup>83</sup> Specifically, for specified manufacturers, the plan liability proportion of cost-sharing for applicable drugs dispensed to low-income beneficiaries was changed for CY 2026 to 73 percent during the initial coverage phase and 78 percent during the catastrophic phase. For specified manufacturers, no changes were made to the plan liability proportion of cost-sharing for applicable drugs dispensed to non-LIS beneficiaries because these drugs are not eligible for the phased-in manufacturer discount. For specified small manufacturers, the plan liability proportion of cost-sharing for applicable drugs dispensed to all beneficiaries was changed for CY 2026 to 73 percent during the initial coverage phase and 78 percent during the catastrophic phase.

Adjusting Gross Drug Costs for the Maximum Fair Price (MFP). Sections 11001 and 11002 of the IRA establish the Medicare Drug Price Negotiation Program and authorize Medicare to directly negotiate drug prices for certain high expenditure, qualifying single source drugs and biological products covered under Medicare Part B or Part D. For the first year of the Medicare Drug Price Negotiation Program (initial price applicability year 2026), CMS selected ten drugs

<sup>82</sup> For more information, see <https://www.cms.gov/medicare/coverage/prescription-drug-coverage/part-d-information-pharmaceutical-manufacturers>.

<sup>83</sup> Due to the timing of the RxHCC model calibration, CMS is not able to incorporate any changes made to the list after May 2024 into the CY 2026 RxHCC model.

covered under Part D for negotiation,<sup>84</sup> as shown in Table III-10 below. For the participating manufacturers of the ten selected drugs for initial price applicability year 2026, the negotiated MFPs will apply beginning in CY 2026 to the selected drugs covered under Medicare Part D. In August 2024, CMS posted the MFP data file for selected drugs for initial price applicability year 2026 where an MFP was agreed upon.<sup>85</sup>

**Table III-10. Selected Drugs and Commonly Treated Conditions for Initial Price Applicability Year 2026**

<b>Drug Name</b>	<b>Commonly Treated Conditions</b>
Eliquis	Prevention and treatment of blood clots
Jardiance	Diabetes; Heart failure; Chronic kidney disease
Xarelto	Prevention and treatment of blood clots; Reduction of risk for patients with coronary or peripheral artery disease
Januvia	Diabetes
Farxiga	Diabetes; Heart failure; Chronic kidney disease
Entresto	Heart failure
Enbrel	Rheumatoid arthritis; Psoriasis; Psoriatic arthritis
Imbruvica	Blood cancers
Stelara	Psoriasis; Psoriatic arthritis; Crohn's disease; Ulcerative colitis
Fiasp; Fiasp FlexTouch; Fiasp PenFill; NovoLog; NovoLog FlexPen; NovoLog PenFill	Diabetes

For the CY 2026 models, we are proposing to substitute the gross drug costs for the ten selected drugs with their agreed-upon MFPs, as adjusted for inflation to the calibration year. Essentially, 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. 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.

<sup>84</sup> [Medicare Drug Price Negotiation Program: Selected Drugs for Initial Price Applicability Year 2026](#)

<sup>85</sup> For more information about the Medicare Drug Price Negotiation Program and the MFPs for initial price applicability year 2026, see <https://www.cms.gov/inflation-reduction-act-and-medicare/medicare-drug-price-negotiation>. See “File for Negotiated Prices, also known as Maximum Fair Prices in Statute.”



Because the MFPs reflect prices for CY 2026, but we use historical data for model calibration, an adjustment must be applied to the gross drug costs to reflect what the MFPs would have been in the data year used to calibrate the model. We estimated what the MFPs for each of the ten selected drugs would have been in prior years had they been in place for those years (i.e., had the selected drug's first initial price applicability year been earlier than CY 2026, thereby requiring adjustments for inflation for each year subsequent to that first initial price applicability year of the price applicability period in accordance with section 1195(b)(1) of the Act), similar to the adjustment made for the \$2,000 annual OOP threshold for CY 2025, as described earlier in this section. To do this, we first divided the published and agreed-upon MFP for initial price applicability year 2026 by an early estimate of the annual percentage increase in the September CPI for 2026. Then, for each year going back to CY 2019, we divided the resulting simulated MFP by the posted increase in the September CPI from the corresponding Rate Announcement.<sup>86</sup> This approach avoids overstating the relative magnitude of the MFPs in our 2026 simulation using 2023 or 2019 data while also minimizing complexity and uncertainty in the calculation. Additionally, it is similar to the methodology set forth in section 1195(b)(1) of the Act that will be used annually to adjust MFPs for inflation for each year subsequent to the selected drug's first initial price applicability year of the price applicability period, in which the updated price will be equal to the MFP that was published for such drug for the previous year, increased by the annual percentage increase in the Consumer Price Index for all urban consumers, also known as the CPI-U (United States city average).

#### *Updates to Data Years Used to Calibrate the Model and to Calculate the Denominator*

CMS is proposing an RxHCC model for CY 2026 with the previously discussed changes and updated data years to reflect more recent utilization and cost patterns – the diagnosis and cost data are updated from 2021 diagnoses and 2022 costs to 2022 diagnoses and 2023 costs. The denominator for this proposed model is updated from 2022 to 2023. As noted previously, we did not similarly update the data years and denominator year for the model being proposed solely for PACE organizations.

Though CMS is proposing RxHCC risk adjustment models for CY 2026 that reflect agreed-upon MFPs for initial price applicability year 2026, we also present versions of both the 2022/2023 and 2018/2019 RxHCC risk adjustment model calibrations that include the same updates as the models being proposed (e.g., changes in the benefit and other technical updates), but without substituting gross drug costs for the ten selected drugs with agreed-upon MFPs. We welcome comment from stakeholders on the value and benefit of using MFPs in the model calibration.

---

<sup>86</sup> The CMS Office of the Actuary provided an early estimate of the annual increase in the September CPI for 2026 because the published increase was not available at the time of model calibration. This methodology is similar to how CMS will adjust MFPs for inflation for each year subsequent to the selected drug's first initial price applicability year of the price applicability period.

### *Methodology for Calculating non-PACE and PACE Organizations Risk Scores*

The 2026 RxHCC model (2022/2023 calibration) is being proposed to calculate risk scores for CY 2026 payment for PDPs and MA-PD plans and as part of a blended risk score for PACE organizations, as detailed below.

Because RAPS data have long been the primary source of diagnoses for risk scores used to pay PACE organizations, the RxHCC risk adjustment model used for PACE has historically been calibrated using the specialty-based filtering logic that aligns with how PACE organizations determine which risk adjustment-eligible diagnoses to submit to RAPS. The RxHCC model used to calculate risk scores for PACE organizations finalized for CY 2025 was calibrated using 2018 diagnoses and 2019 costs. For CY 2026 for PACE organizations, CMS is proposing an RxHCC model calibrated using specialty-based filtering to be used in a Part D risk score blend. This proposed RxHCC model includes the updates previously described above but continues to be based on 2018 diagnoses and 2019 costs (like it is for CY 2025). These data years are the most recent available data that both 1) still have MA-PD plans submitting RAPS data<sup>87</sup> and 2) avoid using data that is most affected by the COVID-19 pandemic. For this reason, CMS is unable to update the data years used to calibrate this model any further.

In alignment with the proposal to blend risk scores from the CMS-HCC and ESRD risk adjustment models for PACE organizations, discussed in Attachment II, Sections G1 and H1, CMS is also proposing to use a blend of RxHCC risk scores for PACE organizations.

Specifically, CMS proposes to calculate blended risk scores for CY 2026 for PACE organizations using the sum of:

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

As with the CMS-HCC and ESRD risk adjustment models, CMS intends to fully transition PACE organizations to the RxHCC risk adjustment model used for organizations other than PACE and to calculate risk scores only using diagnoses from encounter data and FFS claims over four years. A tentative schedule for the phase-out of the RxHCC risk adjustment model used solely for PACE organizations is described in Table III-11.

---

<sup>87</sup> For payment in CY 2022 (2021 dates of service), we did not use RAPS data to calculate risk scores for non-PACE organizations. See the [CY 2022 Advance Notice, Part II, Attachment II, Section N](#) for more details.

**Table III-11. Tentative Phase-out Schedule of the RxHCC Model used Solely for PACE Organizations**

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

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

\*\* Sources of diagnoses: Encounter data and FFS claims

### ***F3. Predictive Ratios for CY 2026 RxHCC Models***

The predictive accuracy of the RxHCC model is measured by how accurately it predicts costs over subgroups of beneficiaries. Because the goal of the risk adjustment model is not to predict the costs of individual beneficiaries, but to predict accurately over subgroups of beneficiaries, we rely on subgroup-level measures of predictive accuracy. Specifically, predictive accuracy in the RxHCC models is measured by the predictive ratio – the ratio of predicted cost to actual cost – for a group of beneficiaries. A predictive ratio of 1.0 means that the model perfectly predicts plan spending on average for a subgroup of beneficiaries. When evaluating the predictive power of the model, a predictive ratio between 0.90 and 1.10 is generally considered accurate.<sup>88</sup>

Attachment VI of this Advance Notice presents predictive ratios for the 2022/2023 model calibration by the decile of predicted risk for each model segment. These predictive ratios reflect the ratio of plan spending predicted by the model for CY 2023 to the actual Part D plan expenditures for that year. Actual expenditure amounts are calculated using the remapped PDEs that reflect the CY 2026 Part D benefit structure, and that are described in Section F2 above.

We find that the proposed 2022/2023 RxHCC model that reflects agreed-upon MFPs for initial price applicability year 2026 tends to underpredict spending for the lowest decile of predicted risk, overpredicts for the second through fourth deciles, and generally remains around 1.0 for higher deciles. We also include predictive ratios in Attachment VI for the reference version of the 2022/2023 RxHCC model that does not substitute gross drug costs for agreed-upon MFPs, and we find that the pattern is generally similar. Because higher deciles reflect the highest risk in terms of expected spending, we believe that the prevalence of predictive ratios between 0.90 and 1.10 for these deciles reflect a model that predicts cost well for beneficiaries with higher predicted costs. We also find similar patterns for the 2018/2019 calibrations for PACE organizations, so predictive ratios for this calibration are not presented in this Advance Notice.

<sup>88</sup> [Report to Congress: Risk Adjustment in Medicare Advantage, December 2021](#), p. 42.

## Section G. Normalization Factors for the RxHCC Models

The RxHCC risk adjustment models, as described in Section F of Attachment III, are calibrated with diagnostic and cost information for beneficiaries enrolled in MA-PD plans and PDPs. The risk adjustment models are prospective in that they use health status in a base year (i.e., data collection year) to estimate incremental costs for which Part D plans will be at risk (“plan liability”) for key beneficiary characteristics, such as age and gender and health conditions, in the following year (i.e., the payment year). To create relative factors, each model variable’s incremental cost estimate, referred to as a dollar coefficient, is divided by the predicted average per capita Part D expenditure for beneficiaries in both the Medicare FFS and MA program for which the Plan sponsors are liable in a given year (i.e., the denominator year). Risk scores are the sum of relative factors assigned to each beneficiary based on their demographic characteristics and health status as determined by diagnosis coding reported to CMS for each enrollee.

The diagnoses that determine health status for beneficiaries enrolled in MA-PD plans are submitted by MA organizations, whereas diagnoses for beneficiaries enrolled in standalone PDPs are reported on FFS claims. (When we calculate risk scores, we take diagnoses from whichever source reported the diagnoses for the beneficiary in the data collection year. If a beneficiary was enrolled in both an MA-PD plan and a PDP during the year, we will use risk adjustment-eligible diagnoses submitted by either or both the MA organization(s) and FFS providers.) The average Part D risk score is 1.0 in the denominator year across beneficiaries enrolled in MA-PD plans and PDPs. When a risk adjustment model predicts expenditures in years other than the denominator year, the average risk score may no longer be 1.0 due to an underlying trend that reflects changes, such as those in coding and population characteristics, between the denominator year and other years. We maintain an average 1.0 risk score across the entire Part D program in the payment year through the normalization factor, which we have done since early in the Part D program.<sup>89</sup> The normalization factor is a projection of the underlying risk score trend to the payment year and is applied by dividing each individual risk score in the payment year by the relevant normalization factor.

CMS has historically used one normalization factor across both MA-PD plans and PDPs to set the 1.0. Given the increased prominence of risk adjustment in Part D payment due to the significant change in plan liability under the IRA redesign of the Part D benefit, and a trend of growing divergence in risk scores between MA-PD plans and PDPs, for CY 2025 payment we finalized separate normalization factors for MA-PD plans and PDPs.<sup>90</sup> Separate factors help ensure that risk scores more accurately reflect Part D costs in each of these two sectors of the

---

<sup>89</sup> See section 1853(a)(1)(C)(ii)(I) of the Act, which requires that the risk adjustment used in MA payment reflects changes in treatment and coding practices in the fee-for-service sector. In establishing the factors used to risk adjust Part D payment, section 1860D-15(c)(1)(B) of the Act permits the Secretary to 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.

<sup>90</sup> Refer to the [2025 Advance Notice and 2025 Rate Announcement](#).

Part D market. We must maintain an average 1.0 risk score across the entire Part D program in the payment year, which we achieved by setting the 1.0 within each market sector.

For CY 2026, we observe that MA-PD and PDP risk score trends continue to diverge and, therefore, in order to “take into account variation in costs for basic prescription drug coverage among prescription drug plans and MA-PD plans based on the differences in actuarial risk of different enrollees being served,” as directed by section 1860D-15(c)(1)(A) of the Act, we will continue calculating separate normalization factors for risk scores used to pay MA-PD plans and PDPs. We calculated the risk score trend separately for MA-PD plans and PDPs using the proposed 2026 RxHCC model and found that between 2017 and 2023, the average MA-PD plan risk score calculated with the proposed 2026 RxHCC model increased 17.9 percent while the average PDP risk score calculated with the same model decreased 8.2 percent. Using the proposed 2026 RxHCC model, the average MA-PD plan risk score for 2023 was 22.1 percent higher than the average PDP risk score for 2023. We also assessed how well the proposed 2026 RxHCC model predicts costs for MA-PD plans and PDPs. Across all model segments in the entire market for the proposed 2022/2023 model calibration, both the average predicted expenditures and the average actual expenditures were \$2,731.88, a predictive ratio of 1.000. However, this ratio differed for MA-PD plans and PDPs. For MA-PD plans, the average predicted expenditures were \$2,955.89, while the average actual expenditures were \$2,697.22, resulting in a predictive ratio of 1.096. For PDPs, the average predicted expenditures were \$2,415.94, while the average actual expenditures were \$2,780.77, resulting in a predictive ratio of 0.869. These results show that MA-PD plan costs tend to be overpredicted, while PDP costs tend to be underpredicted. (See Section F3 above for more information on predictive ratios.)

Just as for CY 2025, continued use of separate normalization factors for MA-PD plans and PDPs will ensure that risk scores will more accurately reflect Part D costs in each of these two sectors of the Part D market that are driven by a variety of market-based variables, including the overall benefits that they 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.

Historically, CMS has largely used a linear slope methodology for calculating normalization factors in Part D, which is to calculate a slope using the five most recent years of risk scores – each year being an average of the risk scores of beneficiaries enrolled in MA-PD plans and PDPs – using the RxHCC model for the payment year, then projecting the slope by the number of years between the denominator year to the payment year. For CY 2025, we maintained the linear slope methodology but calculated a slope using the five most recent years of risk scores available at the time (2018 to 2022), excluding the 2021 risk score that was based on 2020 dates of service (the year the COVID-19 pandemic began), for MA-PD plans and PDPs separately, then projected each slope from the denominator year to the payment year.<sup>91</sup> To calculate the normalization factors using this method, we first calculate the slope from the five-year trend of historical risk

---

<sup>91</sup> Refer to the [2025 Advance Notice and 2025 Rate Announcement](#).

scores for each sector after which we apply the equation  $(1+X)^n$  – where X is the slope, and the exponent, n, is the number of years between the denominator year and the payment year.

For CY 2025 for CMS-HCC models, CMS finalized a more sophisticated multiple linear regression methodology for calculating normalization factors, which allowed CMS to incorporate the most recent average risk scores (2019 to 2023) in the calculation of the normalization factor, without excluding any years of risk scores, such as those affected by the COVID-19 pandemic.<sup>92</sup> CMS did not believe it was prudent to apply the multiple linear regression methodology to calculate the normalization factors for the RxHCC models for CY 2025 because the most recent final RxHCC risk score was for CY 2022 (using diagnoses from 2021 dates of service), unlike the CMS-HCC model for which the most recent final risk score was for CY 2023 (using diagnoses from 2022 dates of service). The one-year data lag is due to the normalization factors for the RxHCC risk adjustment models including both MA and FFS risk scores, distinct from the CMS-HCC models, which only use FFS risk scores. Because the “post-COVID” portion of the trend would have only reflected the risk score change from 2021 to 2022, we believed the multiple linear regression methodology could distort the resulting normalization factors if used as the sole basis for the “post-COVID” portion of the trend since the risk score change from 2021 to 2022 included the rebound of risk scores after the pandemic when utilization began to increase. Without having more “post-COVID” data to determine whether the multiple regression methodology was appropriate for determining the Part D normalization factor for CY 2025, we maintained the historical linear slope methodology until another year of risk scores was available and used risk scores from 2018 through 2022, excluding 2021, consistent with the calculation of the CMS-HCC model normalization factors when 2022 was the most recent year available.<sup>93</sup>

The normalization factor finalized for the RxHCC model for PACE organizations for CY 2025 was calculated using the MA-PD risk score trend, not the PDP risk score trend, given that PACE organizations function more similarly to MA-PD plans, compared with PDPs. Also, as we did for CYs 2023 and 2024, we used risk scores from 2016 through 2020 to calculate the CY 2025 normalization factor for PACE organizations because, in addition to the 2021 risk score, the 2022 risk score had to be excluded.<sup>94</sup> This is because the risk score trends used to calculate the 2025 normalization factors for the RxHCC models are based on a non-PACE population, and the 2025 RxHCC model (2018/2019) finalized for PACE organizations for CY 2025 is calibrated using diagnoses from RAPS and FFS. Beginning with CY 2022 payment, non-PACE organizations were no longer required to submit data to the RAPS system<sup>95</sup> and, therefore, the 2022 risk score in the trend of the 2025 RxHCC model finalized for PACE organizations was not

---

<sup>92</sup> Refer to the [2025 Advance Notice and 2025 Rate Announcement](#).

<sup>93</sup> Refer to the [2024 Advance Notice and 2024 Rate Announcement](#).

<sup>94</sup> Refer to the [2025 Advance Notice and 2025 Rate Announcement](#).

<sup>95</sup> Refer to the [2022 Rate Announcement](#).



believed to be representative of the actual average 2022 MA-PD risk score, but rather a reflection of decreased submission of data to the RAPS system. Including the 2022 risk score for the RxHCC model for PACE would have grossly underestimated what the average risk score was likely to be for MA-PD plans in CY 2025.

***G1. Proposed CY 2026 Normalization Factors for the 2026 RxHCC Risk Adjustment Model (2022/2023 Calibration)***

With the 2023 average risk score now available for the RxHCC models, CMS assessed the risk score trends using the historical linear slope methodology to calculate the MA-PD and PDP normalization factors for the proposed 2026 RxHCC model (2022/2023 calibration) for CY 2026. We considered whether it remained supportable to continue to use the historical methodology, as we did for CY 2025, for determining the normalization factors, moving up the data years to 2019 to 2023 (the most recent year for which Part D risk scores are available) from 2018 to 2022 and excluding 2021 risk scores. Our analysis showed that when the CY 2026 normalization factor is calculated using a slope with the most recent average risk scores, the resulting normalization factor for PDPs is 7 percent higher than the 2023 PDP risk score calculated using the proposed 2026 RxHCC model, a risk score growth that is not reasonable given the declining PDP risk score trends. For MA-PD plans, the normalization factor is 2 percent lower than the most recent average MA-PD risk score calculated with the 2026 RxHCC model (2022/2023 calibration), predicting a decreasing average MA-PD risk score that is similarly not reasonable given the MA-PD risk score trend both pre- and post-pandemic. Given that this approach to predict PDP and MA-PD risk scores is not supportable, CMS explored using the historical linear slope approach for the 2022/2023 calibration of the 2026 RxHCC model, but excluding other years of risk scores (e.g., including 2019, 2020, and 2023 but excluding 2021 and 2022 or including 2022 and 2023 but excluding 2019, 2020, and 2021), as we did for the CMS-HCC models for CY 2025 when 2023 was the most recent risk score available.<sup>96</sup> As with the analysis conducted for the CY 2025 CMS-HCC model normalization factors, whether we exclude more “post-COVID” risk scores or exclude “pre-COVID” risk scores, the resulting normalization factors are not reasonable predictions of the CY 2026 average MA-PD or PDP risk score given the historical risk score trends for these sectors.

Because excluding data years under the linear slope methodology does not produce reasonable projections for MA-PD plans or PDPs, it is no longer supportable to use with updated data. For this reason, CMS assessed the use of the more sophisticated multiple linear regression methodology to calculate separate MA-PD and PDP normalization factors for the proposed 2022/2023 calibration of the RxHCC model for CY 2026 using risk scores from 2019 to 2023. This methodology of calculating normalization factors is the same as the methodology used to calculate the Part C normalization factors for the CMS-HCC models starting with CY 2025

---

<sup>96</sup> Refer to the [2025 Advance Notice and 2025 Rate Announcement](#).

payment, and we believe is supportable in predicting CY 2026 RxHCC model (2022/2023 calibration) MA-PD and PDP risk scores.

The multiple linear regression methodology includes a flag that identifies whether an average risk score is based on dates of service before or after the onset of the COVID-19 pandemic. For the COVID-19 flag used to calculate the proposed CY 2026 normalization factor, we considered risk scores prior to 2021 (dates of service before 2020) as the “pre-COVID-19” period, and risk scores from 2021 onward (dates of service starting in 2020) as the “post-COVID-19” period. As with the Part C normalization factors, this methodology similarly allows CMS to incorporate the most recent average RxHCC risk scores into the calculation, without excluding any years of risk scores, while making reasonable projections of what the actual average MA-PD and PDP risk scores will be in the payment year.

The multiple linear regression equation is:

$$Y = \beta_0 + \beta_1 x_1 + \beta_2 x_2$$

The variables in the multiple linear regression equation for the CY 2026 normalization factor are:

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

$\beta_0$  = Intercept

$\beta_1$  = Regression coefficient for the average annual change in risk scores

$x_1$  = The specific year to be predicted

$\beta_2$  = Regression coefficient for the impact of the COVID-19 pandemic on risk scores

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

Using the historical average risk scores from 2019-2023 and the corresponding flag for years before and after the onset of the COVID-19 pandemic, CMS used multiple linear regression to calculate regression coefficients for  $\beta_0$  (intercept, separately for MA-PD plans and PDPs),  $\beta_1$  (average annual change in risk scores, separately for MA-PD plans and PDPs), and  $\beta_2$  (impact of the COVID-19 pandemic on risk scores, separately for MA-PD plans and PDPs), which are the outputs of the multiple linear regression model. The regression coefficients are model specific and are constants. CMS used the model-specific regression coefficients, rounded to the fourth decimal place, to calculate the CY 2026 normalization factor for the RxHCC risk adjustment model. For an example of how to calculate the normalization factor using the regression coefficients, refer to Section K of the CY 2025 Advance Notice.<sup>97</sup>

---

<sup>97</sup> Refer to the [CY 2025 Advance Notice](#).



*CY 2026 Proposed Normalization Factors for the 2026 RxHCC Model (2022/2023 Calibration)*

The proposed normalization factors for the proposed 2026 RxHCC model (2022/2023 calibration) using the multiple linear regression methodology and average risk scores for MA-PD plans and PDPs from 2019 to 2023 are 1.194 for MA-PD plans and 0.887 for PDPs. CMS' proposal for calculating normalization factors for the 2026 RxHCC model (2022/2023) better reflects the historical PDP and MA-PD risk score trends by incorporating the most recent data and accounting for the impact of the pandemic on the normalization factor projection.

Table III-12 shows the historical average MA-PD and PDP risk scores, and Table III-13 shows the regression coefficients that were used to calculate the proposed CY 2026 normalization factors for the proposed RxHCC model (2022/2023 calibration). Table III-14 shows the historical average MA-PD and PDP risk scores, and Table III-15 shows the regression coefficients that were used to calculate the normalization factors for the alternative RxHCC model (2022/2023 calibration). We have also included the overall Part D historical risk scores and regression coefficients for informational purposes.

**Table III-12. Average Risk Scores for the Proposed 2026 RxHCC Model (2022/2023 Calibration, Reflects MFPs)**

<b>Year</b>	<b>Proposed 2026 RxHCC Model (2022/2023 calibration) MA-PD</b>	<b>Proposed 2026 RxHCC Model (2022/2023 calibration) PDP</b>	<b>Proposed 2026 RxHCC Model (2022/2023 calibration) Overall</b>
2019	1.002	0.954	0.975
2020	1.030	0.941	0.983
2021	1.011	0.883	0.948
2022	1.062	0.892	0.983
2023	1.085	0.889	1.000

**Table III-13. Proposed 2026 RxHCC Model (2022/2023 Calibration, Reflects MFPs) Normalization Factor Regression Coefficients**

<b>Coefficient</b>	<b>Proposed 2026 RxHCC Model (2022/2023 Calibration) MA-PD</b>	<b>Proposed 2026 RxHCC Model (2022/2023 Calibration) PDP</b>	<b>Proposed 2026 RxHCC Model (2022/2023 Calibration) Overall</b>
Intercept ( $\beta_0$ )	-70.0704	1.3514	-44.2578
Average Change in Risk Scores ( $\beta_1$ )	0.0352	-0.0002	0.0224
COVID-19 Flag ( $\beta_2$ )	-0.0513	-0.0590	-0.0580

**Table III-14. Average Risk Scores for the Alternative 2026 RxHCC Model (2022/2023 Calibration, Does Not Reflect MFPs)**

<b>Year</b>	<b>Alternative 2026 RxHCC Model (2022/2023 calibration) MA-PD</b>	<b>Alternative 2026 RxHCC Model (2022/2023 calibration) PDP</b>	<b>Alternative 2026 RxHCC Model (2022/2023 calibration) Overall</b>
2019	0.999	0.948	0.970
2020	1.026	0.937	0.979
2021	1.008	0.882	0.945
2022	1.058	0.893	0.982
2023	1.082	0.892	1.000

**Table III-15. Alternative 2026 RxHCC Model (2022/2023 Calibration, Does Not Reflect MFPs) Normalization Factor Regression Coefficients**

<b>Coefficient</b>	<b>Proposed 2026 RxHCC Model (2022/2023 Calibration) MA-PD</b>	<b>Proposed 2026 RxHCC Model (2022/2023 Calibration) PDP</b>	<b>Proposed 2026 RxHCC Model (2022/2023 Calibration) Overall</b>
Intercept ( $\beta_0$ )	-69.6700	-2.6926	-47.0896
Average Change in Risk Scores ( $\beta_1$ )	0.0350	0.0018	0.0238
COVID-19 Flag ( $\beta_2$ )	-0.0507	-0.0580	-0.0583

***G2. Proposed CY 2026 Normalization Factors for the 2026 RxHCC Risk Adjustment Model (2018/2019 Calibration) used for PACE Organizations***

The risk score trends used to calculate the normalization factors for the RxHCC models are based on a non-PACE population, and the 2026 RxHCC model (2018/2019) being proposed for PACE organizations is calibrated using diagnoses from RAPS and FFS. CMS fully transitioned to using diagnoses solely from encounter data for CY 2022 payment for non-PACE organizations, so there was no longer a requirement for MA plans to submit data to the RAPS system.<sup>98</sup> For this reason, we must exclude 2022 and 2023 average risk scores from the risk score trend because including them in the normalization factor calculation for the 2026 RxHCC model (2018/2019 calibration) would grossly underestimate what the average Part D risk score is likely to be in CY 2026. Because 2021 risk scores (based on 2020 dates of service) were impacted by decreased utilization during the pandemic, CMS has not included average 2021 risk scores in the calculation of normalization factors using the linear slope methodology. The average 2021 risk

<sup>98</sup> Refer to the [CY 2022 Rate Announcement](#).

score is being used to calculate the proposed normalization factor for the 2026 RxHCC model (2022/2023) using the multiple linear regression methodology because the particular methodology we are using allows us to take into account pre- and post-pandemic trends, and there are two additional years of “post-COVID” risk scores available for that model. With the average 2021 risk score (based on 2020 dates of service) being the most recent risk score CMS can use to calculate a normalization factor for the 2018/2019 calibration of the 2026 RxHCC model, and being the only risk score available from after the onset of the COVID-19 pandemic, we do not believe that the multiple linear regression approach is prudent.

Therefore, for CY 2026, CMS is proposing to use the historical linear slope methodology to calculate normalization factors for the 2018/2019 calibration of the 2026 RxHCC model being proposed for PACE organizations, continuing to use average risk scores from 2016 to 2020, as we have done in payment since CY 2023. To calculate the normalization factor using this method, we first calculate the slope from the five-year trend of historical risk scores after which we apply the equation  $(1+X)^n$  – where X is the slope, and the exponent, n, is the number of years between the denominator year and the payment year. The 2026 RxHCC model being proposed for PACE organizations has a 2020 denominator and there are six years of trend between the denominator year and the payment year.

*CY 2026 Proposed Normalization Factors for the 2026 RxHCC Model (2018/2019 Calibration) used for PACE Organizations*

The proposed MA-PD normalization factor using the historical linear slope methodology and historical average risk scores from 2016 to 2020 for the 2026 RxHCC model (2018/2019 calibration) being proposed for PACE organizations is 1.202. We are proposing to use the normalization factor that would be used to calculate risk scores for MA-PD plans under this proposed model for purposes of calculating risk scores for PACE organizations, since they function more similarly to MA-PD plans, compared with PDPs.

Table III-16 and Table III-17 show the historical average MA-PD risk scores for the proposed and alternative RxHCC models (2018/2019 calibration), respectively, for PACE organizations for CY 2026. We have also included the PDP and overall Part D historical risk scores, for informational purposes. As described in the CY 2025 Advance Notice, normalization factors for the RxHCC model proposed for PACE organizations must exclude average risk scores for 2022 and beyond, in addition to excluding the 2021 risk score due to the impact of the COVID-19 pandemic. This is because CMS fully transitioned to using diagnoses solely from encounter data for CY 2022 payment for non-PACE organizations, so these scores would not be representative of the actual average MA-PD risk score, but rather a reflection of decreased submission of data to the RAPS system.<sup>99</sup>

---

<sup>99</sup> For more information, see Attachment III, Section H of the CY 2025 Advance Notice.

**Table III-16. Average Risk Scores for the Proposed 2026 RxHCC Model (2018/2019 Calibration, Reflects MFPs)**

<b>Year</b>	<b>Proposed 2026 RxHCC Model (2018/2019 Calibration) MA-PD</b>	<b>Proposed 2026 RxHCC Model (2018/2019 Calibration) PDP</b>	<b>Proposed 2026 RxHCC Model (2018/2019 Calibration) Overall</b>
2016	0.920	0.989	0.962
2017	0.943	0.985	0.967
2018	0.978	0.982	0.981
2019	1.014	0.976	0.993
2020	1.040	0.964	1.000

**Table III-17. Average Risk Scores for the Alternative 2026 RxHCC Model (2018/2019 Calibration, Does Not Reflect MFPs)**

<b>Year</b>	<b>Proposed 2026 RxHCC Model (2018/2019 Calibration) MA-PD</b>	<b>Proposed 2026 RxHCC Model (2018/2019 Calibration) PDP</b>	<b>Proposed 2026 RxHCC Model (2018/2019 Calibration) Overall</b>
2016	0.920	0.983	0.958
2017	0.944	0.982	0.966
2018	0.979	0.980	0.980
2019	1.014	0.975	0.992
2020	1.040	0.965	1.000

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

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

For PACE organizations, for CY 2026, we propose to calculate risk scores as a blend of risk scores calculated with two different RxHCC models. Specifically, CMS proposes to calculate risk scores for PACE organizations using the sum of:

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

Refer to Attachment II, Section L1 above for additional information about sources of diagnoses for PACE risk scores.

## **Attachment IV. 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 support CMS's efforts to make all of our programs patient-centric, and to incentivize eliminating health disparities.

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 provide 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).

### **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<sup>100</sup> for all contracts to request a review of their administrative data used for the Part D Patient Safety Star Ratings measures<sup>101</sup> 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.<sup>102</sup> We also encourage sponsors to submit requests for review of their administrative data for the Part

---

<sup>100</sup> 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>.

<sup>101</sup> 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.

<sup>102</sup> 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.<sup>103</sup> 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.<sup>104</sup> 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.<sup>105</sup> 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.<sup>106</sup>

### Section C. Measure Updates for 2026 Star Ratings

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

---

<sup>103</sup> 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>.

<sup>104</sup> 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-medicare-advantage-programs-contract-year-2022-policy-and-technical-changes-to-the-medicare>.

<sup>105</sup> 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>.

<sup>106</sup> 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 IV-1. 2026 Star Ratings Measures**

<b>Part C or D</b>	<b>Measure</b>	<b>Measure Type</b>	<b>Weight</b>	<b>Measurement Year</b>	<b>Improvement Measure</b>	<b>Included in the 2026 CAI Values</b>
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



<b>Part C or D</b>	<b>Measure</b>	<b>Measure Type</b>	<b>Weight</b>	<b>Measurement Year</b>	<b>Improvement Measure</b>	<b>Included in the 2026 CAI Values</b>
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

<b>Part C or D</b>	<b>Measure</b>	<b>Measure Type</b>	<b>Weight</b>	<b>Measurement Year</b>	<b>Improvement Measure</b>	<b>Included in the 2026 CAI Values</b>
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 IV-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' [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 IV-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 or 60 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 IV-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 IV-2. List of Section 1135 Waivers Issued in Relation to the FEMA Major Disaster Declarations**

<b>Section 1135 Waiver Date Issued</b>	<b>Waiver or Modification of Requirements Under Section 1135 of the Social Security Act</b>	<b>FEMA Incident Type</b>	<b>Affected State</b>	<b>Incident Start Date</b>
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 IV-3 lists the states and territories with Individual Assistance designations from the FEMA major disaster declarations.

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

<b>FEMA Declaration</b>	<b>State</b>	<b>FEMA Individual Assistance Counties or County-Equivalents</b>
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, Tattall, 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

### **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<sup>107</sup> 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 the best, safest, and most equitable 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 disparities in care, 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 submitted the following Universal Foundation measures to the 2024 Pre-Rulemaking Measure Review (PRMR) process: Adult Immunization Status (Part C), Depression Screening and Follow-up (Part C), and Social Need Screening and Intervention (Part C).<sup>108</sup> We are considering proposing these measures to be included in the Star Ratings program through future rulemaking. We have also proposed to include the Initiation and Engagement of Substance Use Disorder Treatment measure (Part C) in the 2028 Star Ratings in the 2026 Part C and D proposed rule.<sup>109</sup> These measures will increase focus on behavioral health and health equity and expand the current immunization measure.

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 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 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.<sup>110</sup> For

---

<sup>107</sup> <https://www.nejm.org/doi/full/10.1056/NEJMp2215539>

<sup>108</sup> <https://mmshub.cms.gov/sites/default/files/2024-MUC-List.xlsx>

<sup>109</sup> <https://www.federalregister.gov/documents/2024/12/10/2024-27939/medicare-and-medicaid-programs-contract-year-2026-policy-and-technical-changes-to-the-medicare>

<sup>110</sup> 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

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,<sup>111</sup> 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. We are interested in feedback about retiring these measures from the Star Ratings program.

To simplify and refocus the measure set and the calculation of the Star Ratings program, we are interested in 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.<sup>112</sup> 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 Assessment. We are interested in 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

---

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.

<sup>111</sup> 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.

<sup>112</sup> [CY 2025 Rate Announcement.pdf \(cms.gov\)](#) – see page 147.



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 are interested in feedback from all interested parties on ways to simplify and refocus the measure set. Any changes 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. 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.

**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).

**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. 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.

**Diabetes Care – Blood Sugar Controlled (Part C).** NCQA calls this measure Glycemic Status Assessment for Patients With Diabetes.<sup>113</sup> 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 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.

---

<sup>113</sup> <https://www.cms.gov/medicare/health-plans/medicareadvtspecratestats/announcements-and-documents/371979854/2024> – see pages 156-158.

**Concurrent Use of Opioids and Benzodiazepines (COB) (Part D).** The PQA updated the COB measure specifications in the draft 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).<sup>114</sup> 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.

**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).

## 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. We anticipate all 2025 display measures will continue to be shown on CMS.gov in 2026 unless noted below.

**Social Need Screening and Intervention (Part C).** This measure captures the percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive. NCQA's analysis of data from the first year demonstrated that performance was low and there were challenges for contracts reporting the measure. To help increase performance, NCQA is considering potential measure updates across all product lines to include G and Z codes for the screening indicators. Currently, the screening indicators only allow for the capture of LOINC codes mainly used in electronic medical records. The inclusion of G and Z codes would help overall performance for screening as health plans

<sup>114</sup> <https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm>

could also pull administrative data. These changes will be considered for inclusion at the earliest in the 2026 measurement year.

**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.

**Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS) (Part D).**

The PQA updated the Poly-CNS measure specifications in the draft 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<sup>115</sup> 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).

**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 draft 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).

**Medication Adherence for Statins with Sociodemographic Status Adjustment (ADH-Statins SDS)/ Medication Adherence for RAS Antagonists with SDS (ADH-RAS SDS)/ Medication Adherence for Diabetes Medications with SDS (ADH-Diabetes SDS)/ 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 of Basal Insulin (PST-INS)/ Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR) (Part D).** CMS excludes contracts with

---

<sup>115</sup> 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>.

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).

**Initial Opioid Prescribing for Long Duration (IOP-LD) (Part D).** The PQA refined the definition for negative medication history to improve clarity in the draft 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).

**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.

## **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. Therefore, CMS will retire the OMP measure from the 2027 display page (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 is soliciting 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).

**Health Equity (Part C and D).** CMS is considering adding social risk factors (SRFs) to the Health Equity Index (HEI) reward. One SRF we are currently considering adding is geography (e.g., rural or urban). We are interested in preliminary feedback on the addition of geography to the HEI reward and how to define this. Any changes to the HEI would be proposed through future rulemaking.

**Adult COVID-19 Immunization (Part C).** NCQA is exploring the development of a new ECDS-reported measure that assesses whether adults are up to date on their annual COVID-19 vaccination. The proposed draft measure specification assesses the percentage of people 19 and older who received their annual COVID-19 vaccine between July 1 of the year prior to the measurement period to June 30 of the measurement period. The numerator time period aligns with the influenza indicator in the Adult Immunization Status measure. The measure is specified and will be tested in fall 2024 as an ECDS-reported measure that leverages electronic clinical data sources such as claims, electronic health records, health information exchanges, immunization registries, and case management systems. NCQA is targeting this measure for inclusion in HEDIS reporting for the 2026 measurement year.

**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 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.

**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.

**Intimate Partner Violence (IPV) (Part C).** NCQA is developing a separate measure from the current Social Need Screening and Intervention measure to assess screening and intervention for IPV. IPV is associated with worsened health outcomes such as depression/anxiety, suicidality, and substance use. Women and lesbian, gay, bisexual, transgender, and queer populations experience IPV at higher rates than non-marginalized groups. The larger social determinants of health measurement field has included IPV as a social need domain and NCQA is interested in aligning with the industry and national guidelines for capturing screening and intervention of IPV. NCQA is developing this measure for measurement year 2027 at the earliest.

**Disability Equity (Part C).** NCQA is developing a measure of completeness and quality of disability status data. This work aligns with current efforts in disability research to promote standardized and purposeful collection of disability data. Development of a disability status data measure will inform multiple routes for advancing disability equity through potential future measures of access to primary and preventative care for individuals with disabilities, perinatal care and birth equity for individuals with disabilities, and a targeted measure for individuals with intellectual and developmental disabilities. NCQA is seeking input on this measure concept from advisory panels, a focus group, and public listening sessions. This measure is planned for measurement year 2026 at the earliest.

**End-Stage Renal Disease (ESRD) (Part C).** NCQA is exploring the feasibility of a future measure focused on ESRD in MA. Currently, NCQA is conducting preliminary analyses to identify MA members with chronic kidney disease (CKD) stage 4 or ESRD to help inform the development of a measure focused on this population.

**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 will begin measure testing in fall 2024 for a potential SNP only measure to include in HEDIS starting with the 2027 measurement year. We welcome 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.

**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.

## **Attachment V. Economic Information for the CY 2026 Advance Notice**

Below, we provide the economic information for significant provisions in the Advance Notice. 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. We note that the information provided below is likely to change as the rates and underlying assumptions are updated; we will provide revised impact estimates in the Rate Announcement that reflect the payment methodologies being finalized and the latest data available.

### **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 5.67 percent, and the MA growth percentage for the 2026 MA non-ESRD rates is estimated to be 7.70 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 \$25.06 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 7.70 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 \$180 million. This figure accounts for the portion of the program costs covered by Part B premiums.

If we continue the adjustment to the calculation of county benchmarks in Puerto Rico for the number of beneficiaries with zero claims, then the net impact on the Medicare Trust Funds for CY 2026 of implementing the zero-claims adjustment in Puerto Rico is expected to be \$300 million.

#### ***A2. Medicare Advantage and PACE ESRD Ratebooks***

The FFS growth percentage for the 2026 MA ESRD rates is estimated to be 6.31 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 \$1.92 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 proposing to calculate 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 \$12.77 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 the proposal to fully transition 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 proposing to calculate frailty scores for FIDE SNPs with the 2024 CMS-HCC model frailty factors, consistent with the Part C risk adjustment model proposal in Attachment II, Section G. Additionally, CMS is proposing to determine 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 we applied the same factor for CY 2025, therefore the year-over-year impact is zero.

### ***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 proposing to calculate 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 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 proposing to implement RxHCC risk adjustment models with updates that include revisions to reflect the statutory changes in the Part D benefit structure for CY 2026. As described in Attachment III, CMS is proposing 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 for the enrolled Part D population in the denominator year of 1.0. 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, for the RxHCC models, CMS is proposing to calculate normalization factors using the multiple linear regression methodology and average historical risk scores from 2019 through 2023 for the model being proposed for MA (and partially for PACE organizations), and using the historical linear slope methodology and average historical risk scores from 2016 through 2020 for the model proposed for PACE organizations. 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 VI. RxHCC Risk Adjustment Factors and Predictive Ratio Tables**

**Table VI-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
<b>Female</b>						
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
<b>Male</b>						
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
60-64 Years		-	0.188	-	0.229	0.882
65-69 Years		0.175	-	0.329	-	0.896

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
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
<b>Originally Disabled Interactions with Sex</b>						
Originally Disabled Female		0.042	-	0.376	-	0.298
Originally Disabled Male		-	-	0.169	-	0.298
<b>Disease Coefficients</b>						
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
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

<b>Variable</b>	<b>Description Label</b>	<b>Community, Non-Low Income, Age≥65</b>	<b>Community, Non-Low Income, Age&lt;65</b>	<b>Community, Low Income, Age≥65</b>	<b>Community, Low Income, Age&lt;65</b>	<b>Institutional</b>
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
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

<b>Variable</b>	<b>Description Label</b>	<b>Community, Non-Low Income, Age≥65</b>	<b>Community, Non-Low Income, Age&lt;65</b>	<b>Community, Low Income, Age≥65</b>	<b>Community, Low Income, Age&lt;65</b>	<b>Institutional</b>
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
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	-

<b>Variable</b>	<b>Description Label</b>	<b>Community, Non-Low Income, Age≥65</b>	<b>Community, Non-Low Income, Age&lt;65</b>	<b>Community, Low Income, Age≥65</b>	<b>Community, Low Income, Age&lt;65</b>	<b>Institutional</b>
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
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	0.525	-	0.111	-	-



<b>Variable</b>	<b>Description Label</b>	<b>Community, Non-Low Income, Age≥65</b>	<b>Community, Non-Low Income, Age&lt;65</b>	<b>Community, Low Income, Age≥65</b>	<b>Community, Low Income, Age&lt;65</b>	<b>Institutional</b>
	Disability/Developmental Disorder					
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
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

<b>Variable</b>	<b>Description Label</b>	<b>Community, Non-Low Income, Age≥65</b>	<b>Community, Non-Low Income, Age&lt;65</b>	<b>Community, Low Income, Age≥65</b>	<b>Community, Low Income, Age&lt;65</b>	<b>Institutional</b>
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	-
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

<b>Variable</b>	<b>Description Label</b>	<b>Community, Non-Low Income, Age≥65</b>	<b>Community, Non-Low Income, Age&lt;65</b>	<b>Community, Low Income, Age≥65</b>	<b>Community, Low Income, Age&lt;65</b>	<b>Institutional</b>
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	-	-
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

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
RXHCC396	Heart, Lung, Liver, Intestine, or Pancreas Transplant Status	-	-	-	-	0.056
<b>Non-Aged Disease Interactions</b>						
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
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 VI-2. 2026 RxHCC Model Relative Factors for New Enrollees, Non-Low Income (2022/2023 Calibration; HCPCS-based Filtering Logic; Reflects MFPs)**

<b>Variable</b>	<b>Not Concurrently ESRD, Not Originally Disabled</b>	<b>Concurrently ESRD, Not Originally Disabled</b>	<b>Not Concurrently ESRD, Originally Disabled</b>	<b>Concurrently ESRD, Originally Disabled</b>
<b>Female</b>				
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	-	-
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
<b>Male</b>				
0-34 Years	1.069	1.069	-	-
35-44 Years	1.069	1.069	-	-
45-54 Years	1.251	1.251	-	-

<b>Variable</b>	<b>Not Concurrently ESRD, Not Originally Disabled</b>	<b>Concurrently ESRD, Not Originally Disabled</b>	<b>Not Concurrently ESRD, Originally Disabled</b>	<b>Concurrently ESRD, Originally Disabled</b>
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
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 VI-3. 2026 RxHCC Model Relative Factors for New Enrollees, Low Income (2022/2023 Calibration; HCPCS-based Filtering Logic; Reflects MFPs)**

<b>Variable</b>	<b>Not Concurrently ESRD, Not Originally Disabled</b>	<b>Concurrently ESRD, Not Originally Disabled</b>	<b>Not Concurrently ESRD, Originally Disabled</b>	<b>Concurrently ESRD, Originally Disabled</b>
<b>Female</b>				
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
<b>Male</b>				
0-34 Years	2.066	2.066	-	-
35-44 Years	2.066	2.066	-	-
45-54 Years	2.066	2.066	-	-

<b>Variable</b>	<b>Not Concurrently ESRD, Not Originally Disabled</b>	<b>Concurrently ESRD, Not Originally Disabled</b>	<b>Not Concurrently ESRD, Originally Disabled</b>	<b>Concurrently ESRD, Originally Disabled</b>
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 VI-4. 2026 RxHCC Model Relative Factors for New Enrollees, Institutional (2022/2023 Calibration; HCPCS-based Filtering Logic; Reflects MFPs)**

<b>Variable</b>	<b>Not Concurrently ESRD</b>	<b>Concurrently ESRD</b>
<b>Female</b>		
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
<b>Male</b>		
0-34 Years	2.974	2.316
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

<b>Variable</b>	<b>Not Concurrently ESRD</b>	<b>Concurrently ESRD</b>
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 VI-5. 2026 RxHCC Model Relative Factors for Continuing Enrollees (2022/2023 Calibration; HCPCS-based Filtering Logic; Does Not Reflect 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
<b>Female</b>						
0-34 Years		-	0.308	-	0.638	2.351
35-44 Years		-	0.342	-	0.771	2.183
45-54 Years		-	0.310	-	0.704	1.427
55-59 Years		-	0.221	-	0.459	1.367
60-64 Years		-	0.152	-	0.246	1.042
65-69 Years		0.112	-	0.320	-	1.146
70-74 Years		0.037	-	0.008	-	0.882
75-79 Years		0.037	-	0.008	-	0.618
80-84 Years		0.037	-	0.008	-	0.345
85-89 Years		0.037	-	0.008	-	0.209
90-94 Years		0.037	-	0.008	-	0.015
95 Years or Over		0.037	-	0.008	-	0.015
<b>Male</b>						
0-34 Years		-	0.169	-	0.653	1.917
35-44 Years		-	0.230	-	0.642	1.685
45-54 Years		-	0.208	-	0.522	1.358
55-59 Years		-	0.188	-	0.390	1.077
60-64 Years		-	0.191	-	0.256	0.865
65-69 Years		0.176	-	0.318	-	0.875
70-74 Years		0.151	-	0.231	-	0.692

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
75-79 Years		0.112	-	0.158	-	0.485
80-84 Years		0.004	-	0.013	-	0.300
85-89 Years		0.004	-	0.013	-	0.092
90-94 Years		0.004	-	0.013	-	0.092
95 Years or Over		0.004	-	0.013	-	0.092
<b>Originally Disabled Interactions with Sex</b>						
Originally Disabled Female		0.021	-	0.276	-	0.267
Originally Disabled Male		-	-	0.157	-	0.267
<b>Disease Coefficients</b>						
RXHCC1	HIV/AIDS	7.174	8.599	8.284	8.358	6.147
RXHCC5	Opportunistic Infections	0.544	0.476	0.649	0.388	0.219
RXHCC15	Chronic Myeloid Leukemia	4.231	3.473	12.589	18.953	7.739
RXHCC16	Multiple Myeloma and Other Hematologic Cancers	9.624	8.809	10.523	9.898	4.614
RXHCC17	Secondary Cancer of Bone and Kidney	4.231	3.473	10.334	9.363	4.614
RXHCC18	Secondary Cancer of Lung, Liver, Brain, and Other Sites	2.393	2.056	3.871	3.313	1.210
RXHCC19	Leukemias and Other Hematologic Cancers	2.393	2.056	3.871	3.313	1.210
RXHCC20	Lung, Kidney, and Other Cancers; Secondary	0.523	0.406	1.140	0.800	0.307

<b>Variable</b>	<b>Description Label</b>	<b>Community, Non-Low Income, Age≥65</b>	<b>Community, Non-Low Income, Age&lt;65</b>	<b>Community, Low Income, Age≥65</b>	<b>Community, Low Income, Age&lt;65</b>	<b>Institutional</b>
	Cancer of Lymph Nodes and Other Sites					
RXHCC21	Lymphomas and Other Hematologic Cancers	0.523	0.244	0.678	0.299	0.246
RXHCC22	Prostate, Breast, Bladder, and Other Cancers and Tumors	0.108	0.061	0.367	0.299	0.161
RXHCC30	Diabetes with Complications	0.616	0.716	1.107	1.618	0.830
RXHCC31	Diabetes without Complication	0.278	0.291	0.485	0.716	0.362
RXHCC40	Alpha-1-Antitrypsin Deficiency	2.204	5.795	6.007	7.465	0.861
RXHCC41	Lysosomal Storage Disorders	3.992	8.970	5.165	17.572	-
RXHCC42	Acromegaly and Other Endocrine and Metabolic Disorders	2.053	2.913	2.307	4.668	0.706
RXHCC43	Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders	0.025	0.105	-	0.053	-
RXHCC44	Thyroid Disorders	0.062	0.145	0.141	0.294	0.132
RXHCC47	Disorders of Lipoid Metabolism	-	-	0.048	0.100	0.031
RXHCC54	Chronic Viral Hepatitis C	0.183	0.244	0.166	-	0.410
RXHCC55	Acute or Unspecified Viral Hepatitis C	0.183	0.244	0.166	-	0.410

<b>Variable</b>	<b>Description Label</b>	<b>Community, Non-Low Income, Age≥65</b>	<b>Community, Non-Low Income, Age&lt;65</b>	<b>Community, Low Income, Age≥65</b>	<b>Community, Low Income, Age&lt;65</b>	<b>Institutional</b>
RXHCC56	Chronic Viral Hepatitis B and Other Specified Chronic Viral Hepatitis	0.207	0.508	1.107	0.678	0.539
RXHCC59	Primary Biliary Cirrhosis	0.847	1.200	1.310	1.747	1.246
RXHCC65	Chronic Pancreatitis	0.310	0.553	0.630	1.111	0.544
RXHCC66	Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis	0.247	0.553	0.602	1.111	0.327
RXHCC67	Inflammatory Bowel Disease	0.599	1.035	1.410	3.881	0.381
RXHCC80	Aseptic Necrosis of Bone	0.129	0.202	0.119	0.363	-
RXHCC81	Psoriatic Arthropathy	0.787	0.489	6.064	8.728	3.294
RXHCC82	Systemic Sclerosis	1.082	1.034	1.353	2.177	0.515
RXHCC83	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	0.173	0.223	1.289	2.177	0.515
RXHCC84	Systemic Lupus Erythematosus and Other Systemic Connective Tissue Disorders	0.108	0.206	0.266	0.405	0.107
RXHCC87	Osteoporosis, Vertebral and Pathological Fractures	0.034	0.142	0.196	0.420	0.009
RXHCC95	Sickle Cell Anemia	-	0.742	-	1.314	-
RXHCC96	Acquired Hemolytic, Aplastic, and Sideroblastic Anemias	0.777	0.457	0.837	0.914	0.110

<b>Variable</b>	<b>Description Label</b>	<b>Community, Non-Low Income, Age≥65</b>	<b>Community, Non-Low Income, Age&lt;65</b>	<b>Community, Low Income, Age≥65</b>	<b>Community, Low Income, Age&lt;65</b>	<b>Institutional</b>
RXHCC98	Hereditary Angioedema and Other Defects in the Complement System	7.877	40.278	10.741	44.406	2.559
RXHCC99	Immune Disorders	0.439	0.427	0.718	1.227	0.310
RXHCC100	Immune Thrombocytopenic Purpura	0.415	0.295	2.103	2.548	1.424
RXHCC111	Alzheimer's Disease	-	-	-	-	-
RXHCC112	Dementia, Except Alzheimer's Disease	-	-	-	-	-
RXHCC130	Schizophrenia and Other Psychosis	0.196	0.248	0.701	1.296	0.388
RXHCC131	Bipolar Disorders	0.196	0.111	0.493	0.621	0.346
RXHCC132	Depression	0.019	-	0.051	0.180	0.085
RXHCC133	Anxiety and Other Psychiatric Disorders	0.017	-	-	0.090	-
RXHCC146	Profound or Severe Intellectual Disability/Developmental Disorder	0.493	0.094	0.437	0.211	-
RXHCC147	Moderate Intellectual Disability/Developmental Disorder	0.493	-	0.285	0.092	-
RXHCC148	Mild or Unspecified Intellectual Disability/Developmental Disorder	0.493	-	0.082	-	-

<b>Variable</b>	<b>Description Label</b>	<b>Community, Non-Low Income, Age≥65</b>	<b>Community, Non-Low Income, Age&lt;65</b>	<b>Community, Low Income, Age≥65</b>	<b>Community, Low Income, Age&lt;65</b>	<b>Institutional</b>
RXHCC153	Myasthenia Gravis and Other Myoneural Disorders	1.688	2.908	1.931	3.301	0.335
RXHCC154	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	4.069	4.286	2.915	3.736	0.818
RXHCC155	Spinal Cord Disorders	0.032	0.117	-	0.100	0.062
RXHCC157	Chronic Inflammatory Demyelinating Polyneuritis	4.012	7.992	5.609	8.828	0.635
RXHCC158	Inflammatory and Toxic Neuropathy	-	-	-	-	0.103
RXHCC159	Multiple Sclerosis	0.955	1.080	2.765	4.922	1.557
RXHCC160	Huntington Disease	1.607	1.219	4.499	5.838	3.995
RXHCC161	Parkinson Disease	0.396	0.741	0.577	0.987	0.748
RXHCC163	Intractable Epilepsy	0.078	0.299	0.276	2.319	-
RXHCC164	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy	-	-	-	-	-
RXHCC166	Migraine Headaches	0.091	0.155	0.413	0.584	0.381
RXHCC168	Trigeminal and Postherpetic Neuralgia	0.047	0.122	0.161	0.370	0.197
RXHCC183	Pulmonary Arterial Hypertension	1.642	5.857	2.165	7.376	0.542
RXHCC184	Pulmonary Hypertension, Except Arterial, and	0.233	0.386	0.311	0.468	0.262



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
	Other Pulmonary Heart Disease					
RXHCC186	Heart Failure	0.215	0.147	0.311	0.310	0.190
RXHCC187	Hypertension	0.052	0.030	0.122	0.132	0.018
RXHCC188	Coronary Artery Disease	0.068	0.014	0.201	-	-
RXHCC191	Ventricular Septal Defect and Major Congenital Heart Disorders	0.168	0.479	0.097	-	0.284
RXHCC193	Atrial Arrhythmias	0.485	0.201	0.509	0.268	0.447
RXHCC207	Spastic Hemiplegia	0.021	0.088	-	0.073	-
RXHCC215	Venous Thromboembolism	0.379	0.367	0.412	0.460	0.391
RXHCC225	Cystic Fibrosis	8.874	32.259	4.175	42.581	5.173
RXHCC226	Idiopathic Pulmonary Fibrosis and Systemic Sclerosis with Lung Involvement	3.141	2.484	5.178	4.955	0.913
RXHCC227	Pulmonary Fibrosis, Except Idiopathic	0.267	0.363	0.409	0.913	0.342
RXHCC228	Severe Persistent Asthma	0.827	0.558	2.589	2.950	1.125
RXHCC229	Chronic Obstructive Pulmonary Disease, Bronchiectasis, and Other Asthma	0.165	0.095	0.324	0.266	0.342
RXHCC243	Glaucoma, Open-Angle or Moderate/Severe Stage	0.123	0.202	0.375	0.508	0.297

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
RXHCC244	Other Non-Acute Glaucoma	-	-	0.053	-	0.050
RXHCC260	Kidney Transplant Status	-	-	-	-	-
RXHCC261	Dialysis Status, Including End Stage Renal Disease	-	-	-	-	-
RXHCC262	Chronic Kidney Disease Stage 5	-	-	-	-	-
RXHCC263	Chronic Kidney Disease Stage 4	-	-	-	-	-
RXHCC311	Chronic Ulcer of Skin, Except Pressure	0.133	0.145	0.106	0.081	0.080
RXHCC314	Pemphigus, Pemphigoid, and Other Bullous Skin Disorders	0.269	0.374	0.640	1.735	0.226
RXHCC316	Psoriasis, Except with Arthropathy	0.189	0.274	1.814	3.158	1.078
RXHCC317	Discoid Lupus Erythematosus	0.058	-	0.048	-	-
RXHCC355	Narcolepsy and Cataplexy	0.786	2.037	1.619	3.980	0.789
RXHCC395	Stem Cell, Including Bone Marrow, Transplant Status/Complications	2.884	2.414	4.809	3.464	2.713
RXHCC396	Heart, Lung, Liver, Intestine, or Pancreas Transplant Status	-	-	-	-	-
<b>Non-Aged Disease Interactions</b>						

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_RXHCC1	NonAged * HIV/AIDS	-	-	-	-	1.258
NonAged_RXHCC130	NonAged * Schizophrenia and Other Psychosis	-	-	-	-	0.934
NonAged_RXHCC131	NonAged * Bipolar Disorders	-	-	-	-	0.643
NonAged_RXHCC132	NonAged * Depression	-	-	-	-	0.325
NonAged_RXHCC133	NonAged * Anxiety and Other Psychiatric Disorders	-	-	-	-	0.101
NonAged_RXHCC159	NonAged * Multiple Sclerosis	-	-	-	-	2.036
NonAged_RXHCC163	NonAged * Intractable Epilepsy	-	-	-	-	0.244

**NOTE:** The Part D Denominator used to calculate relative factors is \$3,025.10. 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 VI-6. 2026 RxHCC Model Relative Factors for New Enrollees, Non-Low Income (2022/2023 Calibration; HCPCS-based Filtering Logic; Does Not Reflect MFPs)**

<b>Variable</b>	<b>Not Concurrently ESRD, Not Originally Disabled</b>	<b>Concurrently ESRD, Not Originally Disabled</b>	<b>Not Concurrently ESRD, Originally Disabled</b>	<b>Concurrently ESRD, Originally Disabled</b>
<b>Female</b>				
0-34 Years	1.529	1.529	-	-
35-44 Years	1.529	1.529	-	-
45-54 Years	1.248	1.248	-	-
55-59 Years	1.248	1.248	-	-
60-64 Years	1.200	1.200	-	-
65 Years	0.380	1.027	0.966	1.027
66 Years	0.412	1.027	0.933	1.027
67 Years	0.412	1.027	0.892	1.027
68 Years	0.461	1.027	0.892	1.027
69 Years	0.478	1.027	0.892	1.027
70-74 Years	0.478	1.027	0.892	1.027
75-79 Years	0.547	1.027	0.832	1.027
80-84 Years	0.604	1.027	0.674	1.027
85-89 Years	0.448	1.027	0.448	1.027
90-94 Years	0.448	1.027	0.448	1.027
95 Years or Over	0.448	1.027	0.448	1.027
<b>Male</b>				
0-34 Years	1.274	1.274	-	-
35-44 Years	1.274	1.274	-	-
45-54 Years	1.274	1.274	-	-
55-59 Years	1.193	1.193	-	-
60-64 Years	1.193	1.193	-	-
65 Years	0.502	1.285	1.063	1.285
66 Years	0.537	1.285	1.063	1.285
67 Years	0.560	1.285	1.063	1.285
68 Years	0.579	1.285	1.063	1.285
69 Years	0.630	1.285	1.044	1.285
70-74 Years	0.649	1.285	0.936	1.285
75-79 Years	0.780	1.285	0.780	1.285
80-84 Years	0.780	1.285	0.780	1.285
85-89 Years	0.780	1.285	0.780	1.285
90-94 Years	0.780	1.285	0.780	1.285
95 Years or Over	0.780	1.285	0.780	1.285

**NOTES:**

1. The Part D Denominator used to calculate relative factors is \$3,025.10. 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 VI-7. 2026 RxHCC Model Relative Factors for New Enrollees, Low Income (2022/2023 Calibration; HCPCS-based Filtering Logic; Does Not Reflect MFPs)**

<b>Variable</b>	<b>Not Concurrently ESRD, Not Originally Disabled</b>	<b>Concurrently ESRD, Not Originally Disabled</b>	<b>Not Concurrently ESRD, Originally Disabled</b>	<b>Concurrently ESRD, Originally Disabled</b>
<b>Female</b>				
0-34 Years	2.240	2.240	-	-
35-44 Years	2.240	2.240	-	-
45-54 Years	2.592	2.592	-	-
55-59 Years	2.592	2.592	-	-
60-64 Years	2.592	2.592	-	-
65 Years	1.215	2.478	2.036	1.979
66 Years	0.861	1.979	1.203	1.979
67 Years	0.839	1.979	1.110	1.979
68 Years	0.812	1.979	1.110	1.979
69 Years	0.787	1.979	1.110	1.979
70-74 Years	0.777	1.979	0.992	1.979
75-79 Years	0.737	1.979	0.940	1.979
80-84 Years	0.723	1.979	0.723	1.979
85-89 Years	0.723	1.979	0.723	1.979
90-94 Years	0.466	1.979	0.466	1.979
95 Years or Over	0.466	1.979	0.466	1.979
<b>Male</b>				
0-34 Years	1.577	2.292	-	-
35-44 Years	1.976	2.256	-	-
45-54 Years	2.083	2.083	-	-
55-59 Years	2.083	2.083	-	-
60-64 Years	2.083	2.083	-	-
65 Years	1.171	2.078	1.641	2.078
66 Years	0.839	2.078	1.084	2.078
67 Years	0.839	2.078	1.084	2.078

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
68 Years	0.785	2.078	0.826	2.078
69 Years	0.735	2.078	0.748	2.078
70-74 Years	0.713	2.078	0.662	2.078
75-79 Years	0.656	2.078	0.656	2.078
80-84 Years	0.656	2.078	0.656	2.078
85-89 Years	0.656	2.078	0.656	2.078
90-94 Years	0.451	2.078	0.451	2.078
95 Years or Over	0.451	2.078	0.451	2.078

**NOTES:**

1. The Part D Denominator used to calculate relative factors is \$3,025.10. 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 VI-8. 2026 RxHCC Model Relative Factors for New Enrollees, Institutional (2022/2023 Calibration; HCPCS-based Filtering Logic; Does Not Reflect MFPs)**

Variable	Not Concurrently ESRD	Concurrently ESRD
<b>Female</b>		
0-34 Years	3.268	2.391
35-44 Years	3.229	2.391
45-54 Years	3.229	2.391
55-59 Years	2.556	2.391
60-64 Years	2.521	2.391
65 Years	2.521	2.391
66 Years	2.521	2.391
67 Years	1.907	2.391
68 Years	1.907	2.391
69 Years	1.444	2.391
70-74 Years	1.444	2.391
75-79 Years	1.444	2.391
80-84 Years	1.035	2.391

<b>Variable</b>	<b>Not Concurrently ESRD</b>	<b>Concurrently ESRD</b>
85-89 Years	1.035	2.391
90-94 Years	0.570	2.391
95 Years or Over	0.570	2.391
<b>Male</b>		
0-34 Years	2.728	2.239
35-44 Years	2.728	2.239
45-54 Years	2.554	2.239
55-59 Years	2.290	2.239
60-64 Years	2.025	2.239
65 Years	2.025	2.239
66 Years	2.025	2.239
67 Years	1.867	2.239
68 Years	1.714	2.239
69 Years	1.588	2.239
70-74 Years	1.588	2.239
75-79 Years	1.233	2.239
80-84 Years	1.233	2.239
85-89 Years	1.233	2.239
90-94 Years	0.777	2.239
95 Years or Over	0.777	2.239

**NOTES:**

1. The Part D Denominator used to calculate relative factors is \$3,025.10. 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 VI-9. 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
<b>Female</b>						
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
<b>Male</b>						
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
<b>Originally Disabled Interactions with Sex</b>						
Originally Disabled Female		0.064	-	0.314	-	0.238
Originally Disabled Male		-	-	0.175	-	0.238
<b>Disease Coefficients</b>						
RXHCC1	HIV/AIDS	8.523	10.433	9.763	10.270	6.530
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



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
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
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

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
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 Disability/Developmental Disorder	0.526	-	0.030	0.020	-
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

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
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 Sclerosis with Lung Involvement	4.862	3.788	4.995	4.151	1.490
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	-	-	-	-

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
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	-	-	-	-	-
<b>Non-Aged Disease Interactions</b>						
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
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 VI-10. 2026 RxHCC Model Relative Factors for New Enrollees, Non-Low Income (2018/2019 Calibration; Specialty-based Filtering Logic; Reflects MFPs)**

<b>Variable</b>	<b>Not Concurrently ESRD, Not Originally Disabled</b>	<b>Concurrently ESRD, Not Originally Disabled</b>	<b>Not Concurrently ESRD, Originally Disabled</b>	<b>Concurrently ESRD, Originally Disabled</b>
<b>Female</b>				
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
<b>Male</b>				
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 VI-11. 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
<b>Female</b>				
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
<b>Male</b>				
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

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

**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 VI-12. 2026 RxHCC Model Relative Factors for New Enrollees, Institutional (2018/2019 Calibration; Specialty-based Filtering Logic; Reflects MFPs)**

Variable	Not Concurrently ESRD	Concurrently ESRD
<b>Female</b>		
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

<b>Variable</b>	<b>Not Concurrently ESRD</b>	<b>Concurrently ESRD</b>
85-89 Years	1.055	2.555
90-94 Years	0.658	2.555
95 Years or Over	0.658	2.555
<b>Male</b>		
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 VI-13. 2026 RxHCC Model Relative Factors for Continuing Enrollees (2018/2019 Calibration; Specialty-based Filtering Logic; Does Not Reflect 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
<b>Female</b>						
0-34 Years		-	0.205	-	0.487	2.236
35-44 Years		-	0.309	-	0.668	2.533
45-54 Years		-	0.333	-	0.674	1.928
55-59 Years		-	0.298	-	0.524	1.605
60-64 Years		-	0.231	-	0.321	1.343
65-69 Years		0.118	-	0.292	-	1.406
70-74 Years		0.110	-	0.042	-	1.083
75-79 Years		0.044	-	0.042	-	0.781
80-84 Years		0.044	-	0.042	-	0.539
85-89 Years		0.044	-	0.042	-	0.344
90-94 Years		0.044	-	0.042	-	0.180
95 Years or Over		0.044	-	0.042	-	0.013
<b>Male</b>						
0-34 Years		-	0.171	-	0.571	2.331
35-44 Years		-	0.215	-	0.619	2.087
45-54 Years		-	0.271	-	0.563	1.797
55-59 Years		-	0.283	-	0.462	1.376
60-64 Years		-	0.272	-	0.345	1.069
65-69 Years		0.170	-	0.306	-	1.069
70-74 Years		0.147	-	0.224	-	0.778
75-79 Years		0.064	-	0.130	-	0.633
80-84 Years		0.064	-	0.019	-	0.449
85-89 Years		0.064	-	0.019	-	0.265
90-94 Years		0.064	-	0.019	-	0.099
95 Years or Over		0.064	-	0.019	-	0.099
<b>Originally Disabled Interactions with Sex</b>						
Originally Disabled Female		0.048	-	0.303	-	0.224
Originally Disabled Male		-	-	0.171	-	0.224
<b>Disease Coefficients</b>						
RXHCC1	HIV/AIDS	7.769	9.527	8.876	9.330	5.911
RXHCC5	Opportunistic Infections	0.412	0.548	0.587	0.456	0.449
RXHCC15	Chronic Myeloid Leukemia	5.654	4.840	13.724	18.549	9.213
RXHCC16	Multiple Myeloma and Other Hematologic Cancers	12.975	14.329	11.264	11.858	4.091
RXHCC17	Secondary Cancer of Bone and Kidney	5.654	4.840	9.049	8.265	4.091

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	2.150	1.964	3.112	3.049	0.982
RXHCC19	Leukemias and Other Hematologic Cancers	2.150	1.964	2.969	2.768	0.982
RXHCC20	Lung, Kidney, and Other Cancers; Secondary Cancer of Lymph Nodes and Other Sites	0.449	0.352	0.922	0.669	0.259
RXHCC21	Lymphomas and Other Hematologic Cancers	0.392	0.128	0.360	0.239	0.121
RXHCC22	Prostate, Breast, Bladder, and Other Cancers and Tumors	0.115	0.123	0.249	0.239	0.121
RXHCC30	Diabetes with Complications	0.539	0.589	1.042	1.577	1.020
RXHCC31	Diabetes without Complication	0.197	0.182	0.378	0.546	0.404
RXHCC40	Alpha-1-Antitrypsin Deficiency	3.394	7.805	7.086	9.713	1.287
RXHCC41	Lysosomal Storage Disorders	2.802	12.659	2.358	17.628	0.184
RXHCC42	Acromegaly and Other Endocrine and Metabolic Disorders	1.915	3.866	2.469	5.703	0.642
RXHCC43	Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders	0.048	0.133	-	0.099	0.045
RXHCC44	Thyroid Disorders	0.068	0.154	0.145	0.280	0.135
RXHCC47	Disorders of Lipoid Metabolism	-	-	0.038	0.119	0.065
RXHCC54	Chronic Viral Hepatitis C	0.630	0.750	0.888	0.714	0.996
RXHCC55	Acute or Unspecified Viral Hepatitis C	0.630	0.750	0.888	0.714	0.996
RXHCC56	Chronic Viral Hepatitis B and Other Specified Chronic Viral Hepatitis	0.321	0.589	1.154	0.702	0.279
RXHCC59	Primary Biliary Cirrhosis	0.978	1.332	1.341	2.079	1.207
RXHCC65	Chronic Pancreatitis	0.309	0.589	0.531	0.878	0.519
RXHCC66	Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis	0.218	0.589	0.437	0.878	0.313
RXHCC67	Inflammatory Bowel Disease	0.465	0.534	1.116	2.739	0.410
RXHCC80	Aseptic Necrosis of Bone	0.179	0.176	0.135	0.312	0.156
RXHCC81	Psoriatic Arthropathy	0.849	0.655	4.950	7.940	2.735
RXHCC82	Systemic Sclerosis	0.881	0.573	1.641	2.090	0.479
RXHCC83	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	0.244	0.321	1.217	2.090	0.479
RXHCC84	Systemic Lupus Erythematosus and Other Systemic Connective Tissue Disorders	0.094	0.210	0.214	0.306	0.101
RXHCC87	Osteoporosis, Vertebral and Pathological Fractures	0.046	0.181	0.205	0.392	-

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
RXHCC95	Sickle Cell Anemia	-	0.543	-	1.638	-
RXHCC96	Acquired Hemolytic, Aplastic, and Sideroblastic Anemias	0.738	0.522	0.758	0.902	0.198
RXHCC98	Hereditary Angioedema and Other Defects in the Complement System	10.981	52.300	16.503	52.705	0.480
RXHCC99	Immune Disorders	1.013	0.621	1.525	1.338	0.868
RXHCC100	Immune Thrombocytopenic Purpura	0.303	0.161	1.379	1.546	0.852
RXHCC111	Alzheimer's Disease	-	-	-	-	-
RXHCC112	Dementia, Except Alzheimer's Disease	-	-	-	-	-
RXHCC130	Schizophrenia and Other Psychosis	0.207	0.233	0.637	1.269	0.289
RXHCC131	Bipolar Disorders	0.207	0.112	0.513	0.669	0.289
RXHCC132	Depression	0.056	0.038	0.156	0.225	0.135
RXHCC133	Anxiety and Other Psychiatric Disorders	0.027	0.038	0.059	0.145	0.055
RXHCC146	Profound or Severe Intellectual Disability/Developmental Disorder	0.583	0.105	0.366	0.334	-
RXHCC147	Moderate Intellectual Disability/Developmental Disorder	0.583	-	0.173	0.103	-
RXHCC148	Mild or Unspecified Intellectual Disability/Developmental Disorder	0.583	-	0.028	-	-
RXHCC153	Myasthenia Gravis and Other Myoneural Disorders	0.993	2.202	1.566	2.332	0.346
RXHCC154	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	0.701	1.358	0.388	1.530	0.128
RXHCC155	Spinal Cord Disorders	0.068	-	0.039	-	-
RXHCC157	Chronic Inflammatory Demyelinating Polyneuritis	3.442	6.282	5.167	7.654	1.786
RXHCC158	Inflammatory and Toxic Neuropathy	0.049	0.119	-	0.193	0.143
RXHCC159	Multiple Sclerosis	3.402	4.981	4.873	8.587	2.557
RXHCC160	Huntington Disease	2.919	3.647	3.186	5.158	3.111
RXHCC161	Parkinson Disease	0.492	0.723	0.544	0.780	0.540
RXHCC163	Intractable Epilepsy	0.271	0.417	0.701	2.594	0.365
RXHCC164	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy	0.049	-	0.020	0.140	-
RXHCC166	Migraine Headaches	0.086	0.107	0.249	0.284	0.368
RXHCC168	Trigeminal and Postherpetic Neuralgia	0.087	0.258	0.242	0.367	0.253

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
RXHCC183	Pulmonary Arterial Hypertension	1.072	3.681	1.537	5.771	0.582
RXHCC184	Pulmonary Hypertension, Except Arterial, and Other Pulmonary Heart Disease	0.163	0.295	0.207	0.374	0.236
RXHCC186	Heart Failure	0.129	0.048	0.207	0.132	0.236
RXHCC187	Hypertension	0.059	0.008	0.111	0.081	0.075
RXHCC188	Coronary Artery Disease	0.051	-	0.181	-	-
RXHCC191	Ventricular Septal Defect and Major Congenital Heart Disorders	0.145	0.641	0.482	0.257	0.217
RXHCC193	Atrial Arrhythmias	0.388	0.106	0.345	0.111	0.283
RXHCC207	Spastic Hemiplegia	0.153	0.102	0.165	-	-
RXHCC215	Venous Thromboembolism	0.325	0.318	0.366	0.399	0.331
RXHCC225	Cystic Fibrosis	4.332	24.067	2.393	28.858	1.252
RXHCC226	Idiopathic Pulmonary Fibrosis and Systemic Sclerosis with Lung Involvement	4.415	3.436	4.537	3.660	1.335
RXHCC227	Pulmonary Fibrosis, Except Idiopathic	0.349	0.513	0.468	1.200	0.383
RXHCC228	Severe Persistent Asthma	0.770	0.551	1.742	1.727	1.220
RXHCC229	Chronic Obstructive Pulmonary Disease, Bronchiectasis, and Other Asthma	0.204	0.084	0.440	0.347	0.383
RXHCC243	Glaucoma, Open-Angle or Moderate/Severe Stage	0.181	0.214	0.431	0.515	0.374
RXHCC244	Other Non-Acute Glaucoma	0.058	-	0.095	-	0.040
RXHCC260	Kidney Transplant Status	-	-	-	-	-
RXHCC261	Dialysis Status, Including End Stage Renal Disease	-	-	-	-	-
RXHCC262	Chronic Kidney Disease Stage 5	-	-	-	-	-
RXHCC263	Chronic Kidney Disease Stage 4	-	-	-	-	-
RXHCC311	Chronic Ulcer of Skin, Except Pressure	0.166	0.143	0.195	0.319	0.075
RXHCC314	Pemphigus, Pemphigoid, and Other Bullous Skin Disorders	0.308	0.770	0.508	1.000	0.296
RXHCC316	Psoriasis, Except with Arthropathy	0.176	0.190	1.258	2.435	0.836
RXHCC317	Discoid Lupus Erythematosus	0.092	0.210	-	-	-
RXHCC355	Narcolepsy and Cataplexy	0.984	2.190	1.315	3.257	0.761
RXHCC395	Stem Cell, Including Bone Marrow, Transplant Status/Complications	3.940	2.088	5.464	3.545	2.256
RXHCC396	Heart, Lung, Liver, Intestine, or Pancreas Transplant Status	-	-	-	-	-
<b>Non-Aged Disease Interactions</b>						

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_RXHCC1	NonAged * HIV/AIDS	-	-	-	-	2.512
NonAged_RXHCC130	NonAged * Schizophrenia and Other Psychosis	-	-	-	-	0.712
NonAged_RXHCC131	NonAged * Bipolar Disorders	-	-	-	-	0.712
NonAged_RXHCC132	NonAged * Depression	-	-	-	-	0.359
NonAged_RXHCC133	NonAged * Anxiety and Other Psychiatric Disorders	-	-	-	-	0.014
NonAged_RXHCC159	NonAged * Multiple Sclerosis	-	-	-	-	3.167
NonAged_RXHCC163	NonAged * Intractable Epilepsy	-	-	-	-	0.643

**NOTE:** The Part D Denominator used to calculate relative factors is \$2,315.18. 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 VI-14. 2026 RxHCC Model Relative Factors for New Enrollees, Non-Low Income (2018/2019 Calibration; Specialty-based Filtering Logic; Does Not Reflect MFPs)**

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
<b>Female</b>				
0-34 Years	1.354	1.354	-	-
35-44 Years	1.354	1.354	-	-
45-54 Years	1.203	1.203	-	-
55-59 Years	1.203	1.203	-	-
60-64 Years	1.203	1.203	-	-
65 Years	0.379	1.286	1.066	1.286
66 Years	0.410	1.286	1.131	1.286
67 Years	0.422	1.286	1.131	1.286
68 Years	0.442	1.286	1.131	1.286
69 Years	0.475	1.286	1.131	1.286
70-74 Years	0.501	1.286	1.034	1.286
75-79 Years	0.572	1.286	0.798	1.286
80-84 Years	0.561	1.286	0.561	1.286
85-89 Years	0.561	1.286	0.561	1.286
90-94 Years	0.435	1.286	0.435	1.286
95 Years or Over	0.435	1.286	0.435	1.286

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
<b>Male</b>				
0-34 Years	1.072	1.072	-	-
35-44 Years	1.072	1.072	-	-
45-54 Years	1.197	1.356	-	-
55-59 Years	1.151	1.151	-	-
60-64 Years	1.151	1.151	-	-
65 Years	0.483	1.524	1.009	1.524
66 Years	0.510	1.524	0.991	1.524
67 Years	0.537	1.524	0.967	1.524
68 Years	0.550	1.524	0.958	1.524
69 Years	0.550	1.524	0.958	1.524
70-74 Years	0.630	1.524	0.958	1.524
75-79 Years	0.712	1.524	0.712	1.524
80-84 Years	0.712	1.524	0.712	1.524
85-89 Years	0.712	1.524	0.712	1.524
90-94 Years	0.402	1.524	0.402	1.524
95 Years or Over	0.402	1.524	0.402	1.524

**NOTES:**

1. The Part D Denominator used to calculate relative factors is \$2,315.18. 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 VI-15. 2026 RxHCC Model Relative Factors for New Enrollees, Low Income (2018/2019 Calibration; Specialty-based Filtering Logic; Does Not Reflect MFPs)**

<b>Variable</b>	<b>Not Concurrently ESRD, Not Originally Disabled</b>	<b>Concurrently ESRD, Not Originally Disabled</b>	<b>Not Concurrently ESRD, Originally Disabled</b>	<b>Concurrently ESRD, Originally Disabled</b>
<b>Female</b>				
0-34 Years	1.661	1.995	-	-
35-44 Years	2.402	2.402	-	-
45-54 Years	2.417	2.417	-	-
55-59 Years	2.004	2.368	-	-
60-64 Years	1.928	2.104	-	-
65 Years	1.111	2.104	1.609	2.104
66 Years	0.792	2.104	1.164	2.104
67 Years	0.706	2.104	1.024	2.104
68 Years	0.714	2.104	1.024	2.104
69 Years	0.751	2.104	0.944	2.104
70-74 Years	0.769	2.104	0.914	2.104
75-79 Years	0.704	2.104	0.704	2.104
80-84 Years	0.704	2.104	0.704	2.104
85-89 Years	0.704	2.104	0.704	2.104
90-94 Years	0.439	2.104	0.439	2.104
95 Years or Over	0.439	2.104	0.439	2.104
<b>Male</b>				
0-34 Years	1.414	2.068	-	-
35-44 Years	1.995	1.995	-	-
45-54 Years	1.995	1.995	-	-
55-59 Years	1.777	1.929	-	-
60-64 Years	1.623	2.034	-	-
65 Years	1.117	2.161	1.432	2.161
66 Years	0.778	2.161	0.918	2.161
67 Years	0.747	2.161	0.886	2.161
68 Years	0.711	2.161	0.798	2.161
69 Years	0.668	2.161	0.798	2.161
70-74 Years	0.635	2.161	0.750	2.161
75-79 Years	0.648	2.161	0.648	2.161
80-84 Years	0.648	2.161	0.648	2.161
85-89 Years	0.648	2.161	0.648	2.161
90-94 Years	0.343	2.161	0.343	2.161
95 Years or Over	0.343	2.161	0.343	2.161

**NOTES:**

1. The Part D Denominator used to calculate relative factors is \$2,315.18. 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 VI-16. 2026 RxHCC Model Relative Factors for New Enrollees, Institutional (2018/2019 Calibration; Specialty-based Filtering Logic; Does Not Reflect MFPs)**

Variable	Not Concurrently ESRD	Concurrently ESRD
<b>Female</b>		
0-34 Years	3.779	2.552
35-44 Years	3.561	2.552
45-54 Years	3.468	2.552
55-59 Years	2.871	2.552
60-64 Years	2.856	2.552
65 Years	2.760	2.552
66 Years	2.407	2.552
67 Years	2.407	2.552
68 Years	1.756	2.552
69 Years	1.756	2.552
70-74 Years	1.633	2.552
75-79 Years	1.633	2.552
80-84 Years	1.107	2.552
85-89 Years	1.107	2.552
90-94 Years	0.681	2.552
95 Years or Over	0.681	2.552
<b>Male</b>		
0-34 Years	3.379	2.345
35-44 Years	2.961	2.345
45-54 Years	2.818	2.345
55-59 Years	2.702	2.345
60-64 Years	2.318	2.345
65 Years	2.383	2.345
66 Years	1.951	2.345
67 Years	1.951	2.345
68 Years	1.633	2.345
69 Years	1.633	2.345



<b>Variable</b>	<b>Not Concurrently ESRD</b>	<b>Concurrently ESRD</b>
70-74 Years	1.710	2.345
75-79 Years	1.710	2.345
80-84 Years	1.111	2.345
85-89 Years	1.111	2.345
90-94 Years	0.754	2.345
95 Years or Over	0.754	2.345

**NOTES:**

1. The Part D Denominator value used to calculate relative factors is \$2,315.18. 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 VI-17. 2026 RxHCC Model with Disease Hierarchies (previously published in the 2023 Rate Announcement<sup>116</sup>)**

<b>RxHCC</b>	<b>If the Disease Group is listed in this column...</b>	<b>...Then drop the RxHCC(s) listed in this column</b>
	<b>RxHCC Model Hierarchical Condition Category Label</b>	
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

<sup>116</sup> Refer to CMS' [CY 2023 Rate Announcement](#).

<b>RxHCC</b>	<b>If the Disease Group is listed in this column...</b>	<b>...Then drop the RxHCC(s) listed in this column</b>
	<b>RxHCC Model Hierarchical Condition Category Label</b>	
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
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 Advance Notice.

**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 VI-18. 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 VI-19. 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

<b>Deciles</b>	<b>Non-Low Income</b>	<b>Low Income</b>	<b>Institutional</b>
Top 0.1%	0.878	1.324	1.903

**Table VI-20. 2026 RxHCC Model Predictive Ratios by Deciles of Predicted Risk (sorted low to high): Continuing Enrollee Model Segments, Alternative 2022/2023 Calibration Sample (HCPCS-filtered diagnoses; Does Not Reflect MFPs)**

<b>Deciles</b>	<b>Community, Non-Low Income, Age≥65</b>	<b>Community, Non-Low Income, Age&lt;65</b>	<b>Community, Low Income, Age≥65</b>	<b>Community, Low Income, Age&lt;65</b>	<b>Institutional</b>
Entire sample	1.000	1.000	1.000	1.000	1.000
First (lowest) decile	0.598	1.136	0.591	1.045	0.635
Second decile	1.071	1.338	1.268	1.437	0.924
Third decile	1.486	1.035	1.163	1.231	1.028
Fourth decile	1.263	1.045	1.059	1.091	1.063
Fifth decile	1.044	0.997	1.019	1.029	1.057
Sixth decile	0.976	0.986	1.024	0.973	1.036
Seventh decile	0.987	1.001	0.992	0.964	1.021
Eighth decile	0.946	0.940	0.969	0.919	1.017
Ninth decile	0.952	0.980	0.969	0.977	0.992
Tenth (highest)	1.015	1.002	0.999	0.999	0.979
Top 5%	1.020	1.002	1.003	1.010	0.985
Top 1%	1.012	0.994	1.017	1.043	0.996
Top 0.1%	0.975	1.006	1.016	1.001	1.024

**Table VI-21. 2026 RxHCC Model Predictive Ratios by Deciles of Predicted Risk (sorted low to high): New Enrollee Model Segments, Alternative 2022/2023 Calibration Sample (HCPCS-filtered diagnoses; Does Not Reflect MFPs)**

<b>Deciles</b>	<b>Non-Low Income</b>	<b>Low Income</b>	<b>Institutional</b>
Entire sample	1.000	1.000	1.000
First (lowest) decile	1.015	0.995	0.958
Second decile	0.991	1.008	1.016
Third decile	1.006	1.000	1.008
Fourth decile	0.990	1.003	0.994
Fifth decile	0.999	0.995	1.023
Sixth decile	1.005	0.993	0.989
Seventh decile	0.985	1.004	0.998
Eighth decile	1.011	1.001	1.028
Ninth decile	0.998	0.995	0.967
Tenth (highest)	1.001	1.003	1.009
Top 5%	1.007	1.003	1.002
Top 1%	1.003	0.962	1.010
Top 0.1%	0.952	1.067	1.772