Wakely
An HMA Company

Summary of CY2026 Final Rate Announcement & CY2026 Final Part D Redesign Instructions

Calendar Year 2026

Medicare Advantage Capitation Rates and Part C and Part D Payment Policies

April 2025

Prepared by:

Wakely Consulting Group, an HMA Company

Table of Contents

Executive Summary

On April 7, 2025, the Centers for Medicare and Medicaid Services (CMS) released the CY2026 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Final Announcement), which finalizes various proposals from the January 10, 2025, Advance Notice.

In general, most policies proposed in the Advance Notice will be adopted without change. Notably, all risk adjustment models, and the related fee-for-service (FFS) normalization factors are not changing from the Advance Notice proposals.

The key changes from the Advance notice include changes to the non-End Stage Renal Disease (ESRD) growth rate and a minor decrease in the phase-in percentage for the indirect medical education (IME)/ direct graduation medical education (DGME) reductions applied to Part C benchmark rates:

- The CY2026 FFS growth rate is calculated at 8.81%, which is 314 basis points higher than the proposed rate in the Advance Notice. The increase is primarily driven by CMS's use of additional data as compared with the data available for the Advance Notice.
- The CY2026 Total FFS United States Per Capita Costs (USPCC) Growth Percentage (Also called the National Per Capital Growth Percentage or NPCMAGP) is finalized at 10.72% (302 basis points higher than the 7.70% estimate in the Advance notice). This percentage drives the pre-ACA benchmark, which caps the calculation of the benchmark. The higher total growth rate causes fewer benchmarks to be capped, particularly for rates that include a quality bonus payment increase.

Overall MA Payment Impact

Wakely estimates that, on average, 2026 Part C standardized benchmarks will increase 7.98% over 2025 nationwide. This reflects the impact of the growth rate, rebasing/repricing, change in star ratings and changes to applicable percentages (i.e., quartile rankings). We also estimate that the change in risk adjusted benchmark revenue for 2026 versus 2025 is expected to be 4.73%. This takes into account changes in Part C risk score adjustments, including the FFS normalization factor, the MA Coding Pattern adjustment, and an assumption of no trend in plan risk scores.

Plans should be aware that the changes in the benchmarks can be considerably different (and typically are greater in magnitude) than the change in CMS revenue to the plan. Plans are paid 100% of their Part C basic bid (assuming they bid below the benchmark), which is unaffected by the benchmark for most plans, plus a percentage of the remaining difference of the excess of the benchmark above the bid. Therefore, an increase in the benchmark will impact plans differently based on the disparity of the plan's bid compared to the benchmark (i.e., the "savings") and the star-based percentage of the savings retained by the plan (i.e., Part C "rebate").

Our analysis of county specific benchmarks and plan revenue was aggregated using March 2025 CMS published MA enrollment and star ratings for payment years 2025 and 2026.

Details regarding our calculations and assumptions are provided in the Wakely Analysis in the follow section this summary.

The remainder of this summary includes many details discussed at length in the Notice.

Risk Scores and FFS Normalization

The CMS-Hierarchical condition category (HCC) model used for CY2026 non- Program of All-Inclusive Care for the Elderly (PACE) non-ESRD will be 100% based on the 2024 CMS-HCC model (v28). FFS Normalization factors and the multiple regression model underlying their calculation remain unchanged from the Advance Notice. The factor will be 1.067.

The coding pattern adjustment is set at the statutory minimum of 5.90%, which represents no change compared with CY2025.

All changes for ESRD and PACE risk adjustment and normalization factors were finalized as proposed in the Advance Notice. This includes a 10% blend of the encounter-based 2024 CMS-HCC model for PACE plans.

The RxHCC models for 2026 will use the following:

- For non-PACE organizations, the model proposed in the 2026 Advance Notice using 2022 diagnoses to predict 2023 payments with adjustments for maximum fair price drugs.
- For PACE organizations, CMS will use a blended approach with 10% weight on the RxHCC model for non-PACE organizations and 90% weight on the model using 2018 diagnoses to predict 2019 payments.

CMS is finalizing the use of separate RxHCC FFS normalization factors for Part D Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug (MA-PD) plans in 2026. The factors will be 0.887 for PDPs and 1.194 for MA-PDs. The PACE RxHCC FFS normalization factor will be 1.202 for the 2018/2019 model and 1.194 for the 2026 RxHCC model, as proposed.

EGWPs

CMS finalized the Employer Group Waiver Plans (EGWP) Bid-to-Benchmark Ratios with very minor adjustments from the Advance Notice.

Star Rating Changes

CMS finalized rules related to plans affected by extreme and uncontrollable circumstances.

In general, there were mixed comments related to various CMS proposals for Existing Star Rating Measures for 2027 and future years, with one exception that most commenters did not favor retiring the Part C appeals measures.

Part D Redesign Instructions

Two proposed changes in the draft CY2026 Part D Redesign instructions were not finalized.

First, CMS has decided not to change the definition of enhanced coverage and is continuing to consider a plan as Enhanced Alternative if the only benefit enhancement is coverage for excluded drugs. Furthermore, CMS includes waiving the deductible on a subset of tiers as an enhancement.

Second, CMS will not proceed with a proposed minimum 15% OOPC meaningful difference between an organization's PDP enhanced and basic plans was not finalized. Instead, CMS will apply a reduced OOPC threshold of 10%.

Wakely Analysis –Estimated Impact of Growth Rates and Payment Reform

Wakely estimates that, on a nationwide average basis, and as compared with 2025, nationwide average 2026 Part C benchmarks will:

- Increase by 7.98% on a standardized (i.e., 1.00) risk score basis. This incorporates changes driven by FFS growth rate, rebasing/re-pricing, applicable percentage by county, average change in star ratings/quality bonus, the impact of pre-ACA benchmark cap, and adjustments related to GME, kidney acquisition cost (KAC), Veteran's Affairs (VA), Department of Defense (DoD), IME, and credibility.
- Increase by 4.73% on a risk-adjusted basis. The risk-adjusted increase incorporates the year-over-year impact of FFS normalization factors, MA Coding Pattern adjustment and the risk model revision. It does not include MA risk score coding trend.

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

- Change in 1.00 benchmarks.
- Impact of change in fee-for-service normalization factor and change in blend percentage for the two CMS-HCC risk adjustment models (i.e. v24 and v28).

- Assumption of no trend in raw risk scores.
- Average change in star ratings based on March 2025 enrollment.

Table 1 shows our estimates of the components that make up this change.

Table 1 – Change in Blended Risk-Adjusted Benchmarks [1]

	2025 to 2026
Growth Rate	8.94%
Rebasing/Re-pricing	-0.21%
Applicable %	-0.15%
Star Rating/Quality Bonus	-1.06%
Benchmark Cap	0.54%
Total Benchmark Change	7.98%
FFS Normalization and Risk Model Revision	-3.01%
MA Coding Pattern	0.00%
Total Risk Score Change	-3.01%
TOTAL	4.73%
[1] Based on March 2025 MA enrollment and Fall 2024 Star Ratings	

Below is a brief definition of each of the elements in Table 1.

Growth Rate. This is the impact of the FFS (+8.81%) growth rate and the following adjustment factors:

- *Direct Graduate Medical Education (GME).* CMS is required to remove costs directly related to graduate medical educate. The change to this adjustment from 2025 to 2026 had minimal impact (-0.02%). Note, this adjustment is attributable to FFS beneficiaries only. The adjustment for MA beneficiaries is made to the USPCC before the county level rates are calculated.
- *Veteran's Affairs and Department of Defense (VA and DoD).* The change in these carve out factors from 2025 to 2026 had minimal impact (0.18%).
- *Credibility.* As FFS enrollment decreases, credibility adjustments are necessary when developing the rates used for MA payment. We anticipate more counties will require a credibility adjustment in future years. The change from 2025 to 2026 was immaterial (0.00%).

- *Kidney Acquisition Costs (KAC).* Due to the 21st Century Cures Act, CMS is required to remove kidney acquisition costs from the development of the MA payment rates. The change from 2025 to 2026 was immaterial (-0.02%).
- *Indirect Medical Education (IME).* Costs attributable to indirect medical education are also removed from the payment rates. The change from 2025 to 2026 was immaterial (-0.03%). Note, this adjustment is attributable to FFS beneficiaries only. The adjustment for MA beneficiaries is made to the USPCC before the county level rates are calculated.

Rebasing/Re-pricing. The Average Geographic Adjustment (AGA) factors are derived via the compilation of five years of historical Medicare Parts A&B claim costs at the county level. For payment year 2026, historical claims from 2019 to 2023 are repriced to reflect the most current wage indices (Fiscal year 2025). Wakely calculated the overall impact to MA plans is -0.21%. The impact of the rebasing and re-pricing for 2026 payment rates varies significantly by region. This is in part driven by the change to the risk adjustment model for payment year (PY) 2026.

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

Star Rating/Quality Bonus. Difference in quality bonus impact on benchmarks due to star rating changes between payment year 2025 and 2026. This is based on a static enrollment mix, so it only reflects changes in average star ratings by contract, and not a shift in enrollment toward plans with higher or lower star ratings. In addition, it does not include terminated contracts or contracts without a star rating.

Benchmark Cap. The Affordable Care Act (ACA) formula requires that the final blended benchmark can be no greater than the pre-ACA benchmark. The impact of this cap can year-to-year as plans change star ratings, and as the NPCMGP trend differs from the FFS trend.

Part C FFS Normalization Factor and Risk Model Revision. PY2026 risk scores will be fully transitioned to the v28 CMS-HCC model. For 2025, CMS updated the FFS normalization methodology to use a multiple regression model which identifies years 2020 through 2023 as COVID affected years. Based on the Fact Sheet, CMS estimates the overall change to both the risk adjustment model and FFS normalization will be -3.01%. Please note, Wakely observed significant variation across Medicare Advantage Organizations (MAOs) due to the impact of the new risk adjustment model.

Change in Coding Pattern Adjustment. The coding pattern adjustment for 2026 will be kept at –5.90%, which is the minimum adjustment required by the ACA. There will be no change from 2025.

Change in Bid and Rebate Amounts

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

In order to properly estimate the impact of the various MA payment, components addressed in the Final Rate Announcement, MA plans must consider the aggregate effect on actual payments from CMS, which is not necessarily the same as the change in benchmarks. As noted above, we estimate the change in risk-adjusted benchmarks to be 4.73%. If we assume that both 2025 and 2026 bids are 78% of the benchmark, then we estimate the change in Part C payments from 2025 to 2026 to be an increase of 4.52% (see Table 2).

This estimate is based on the following assumptions:

- Plans bid at 78% of the benchmark in 2026. This is based on the published bid-to-benchmark ratios in the 2026 Final Rate Announcement.
- Annual risk score coding trend is 0% for a static population.
- Nationwide average star ratings, which result in an average rebate percentage of 66.2% in 2025 and 65.3% for 2026.
- No consideration for sequestration.

Table 2 shows the calculations underlying our estimates.

Table 2 – Change in Risk Adjusted MA Bid Revenue

Item	2025	2026	2026/2025
1.0 MA Benchmark [1]	$1,179.72	$1,273.88	7.98%
Raw Risk Adjustment Factor [2]	1.0000	1.0000	0.00%
Risk Score Model Change	1.0000	0.9576	-4.24%
FFS Normalization	1.0806	1.0669	-1.29%
MA Coding Pattern Adjustment	0.9410	0.9410	0.00%
RAF after FFS Norm & Coding Pattern	0.8708	0.8446	-3.01%
Risk-Adjusted Benchmark	$1,027.28	$1,075.88	4.73%
Assumed Risk-Adjusted Bid [3]	$801.27	$839.18	4.73%
Savings (Benchmark less bid)	$226.00	$236.69	4.73%

Rebate [4]	$149.60	$154.67	3.39%
Risk-Adjusted Bid + Rebate	$950.87	$993.85	4.52%

[1] Based on nationwide average MA enrollment by county as of March 2025

[2] Assumed no trend in risk scores

[3] Bid set at 78% of risk-adjusted benchmark

[4] 66.2% for 2025 and 65.3% for 2026

Attachment I: Final Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2026

The final 2026 MA and FFS growth rates are shown in Table 3 and are compared with the Advance Notice and the 2025 growth rates.

Table 3 – Comparison of 2025 and 2026 Growth Rates

Component	2026 Final	2026 Advance Notice	2025 Final
MA (Including FFS and MA) – Non-ESRD Growth %	8.81%	5.67%	2.31%
Non-ESRD FFS Growth %	10.72%	7.70%	2.33%
ESRD FFS Growth %	6.79%	6.31%	1.76%

The MA (FFS and MA), Non-ESRD FFS and ESRD dialysis-only growth rates increased from the Advance Notice. The data reflected in the Advance notice was through 2023Q4 for Part A and 2024Q4 for Part B. The data reflected in the Final Rate announcement reflects data through 2024Q4. The update in data was the primary driver of the increase in trends.

As has been the case in past years, the year over year change in Part C benchmarks can vary significantly depending on geographic area, plan star rating and applicable percentage. Table 4 shows the top five and bottom five growth rates by State (these changes include changes due to repricing/rebasing, GME, KAC, IME, (VA & DoD), credibility factors, star rating, double bonus status, applicable percentage, and the benchmark cap.

Table 4 – States with Highest and Lowest Benchmark Change

Rank	State	Change
1	DC	11.8%
2	IN	10.8%
3	IA	9.9%
4	AZ	9.8%
5	MD	9.5%
47	UT	6.5%
48	NJ	6.4%
49	CA	5.5%
50	ID	5.5%
51	HI	4.2%

Attachment II: Key Assumptions and Financial Information

As in past years, CMS published projections for the total USPCCs by year. Projections are provided for all Medicare services combined as well as more detailed projections by service category within Part A and Part B. The impact of earlier model terminations of Center for Medicare and Medicaid Innovation (CMMI) has not assessed for the assumptions used for 2026 USPCC projections and thereafter. CMS expects any such impacts will be first incorporated in CY2027 Advance Notice.

Table 6 shows the restatements, from the Announcement of Calendar Year 2026, of the estimated Part A + Part B non-ESRD FFS costs for 2024 through 2026. The FFS non-ESRD growth rate is 8.81%, a big increase over the 5.67% in the Advance Notice.

Table 6 – Non-ESRD FFS Cost Estimates – CY2026 Final Announcement versus CY2025 Final Announcement

Year	CY2026 Final Announcement	CY2025 Final Announcement	Restatement
2024	$1,124.09	$1,085.48	3.6%
2025	$1,179.93	$1,130.85	4.3%
2026	$1,230.52	$1,178.68	4.4%

In the CY2026 projections by service category for non-ESRD (Aged + Disabled), current estimates are higher than last year's estimates for all categories except for Part A Home health agency (-4.3%), Intermediary lab (-1.2%) and Part B Home health agency (-5.4%). The top 3 categories that where estimates increased most from last year's estimates are Other Carrier (+35.1%), Physician Administered Drugs (+17.5%) and Durable Medical Equipment (+7.4%).

It is also interesting to note that CMS is continuing to project that Medicare Advantage enrollment will outpace the change in total Medicare beneficiaries for 2025 through 2028. In fact, FFS enrollment has been consistently decreasing from 2018 to 2024. Table 7 shows the annual changes in CMS's projected enrollment for these years.

Table 7 – Projected Annual Percentage Change in Medicare Enrollment (non-ESRD, Part A)

Year	Total	FFS	MA
2026	2.2%	-0.3%	4.6%
2027	2.4%	-0.1%	4.6%
2028	2.2%	-0.1%	4.1%

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

Section E. Direct Graduate Medical Education

See Section F. Organ Acquisition Costs for Kidney Transplants for impacts to DGME.

Section F. Organ Acquisition Costs for Kidney Transplants

The impact of the early termination of Maryland Total Cost of Care (TCOC), Primary Care First, ESRD Treatment Centers and Making Care Primary Models has not been assessed. CMS expects impacts on USPCC projections will be incorporated in the CY 2027 Advance Notice.

As proposed in the Advance Notice, CMS will continue to use the methodology finalized in the CY 2025 Rate Announcement for DMGE and IME carve-outs.

Section G. IME Phase Out

See Section F. Organ Acquisition Costs for Kidney Transplants for impacts to IME Phase Out.

Section H. MA ESRD Rates

The current rate-setting methodology for ESRD will continue. Final CY 2026 MA bid pricing tool instructions will provide additional information concerning the ESRD Bid Pricing Tool (BPT) filing requirements.

Section I. Employer Group Waiver Plans (EGWP)

Plan sponsors will not need to file EGWP BPTs for CY2026, as was the case in CY2025. CMS finalized the EGWP Bid-to-Benchmark Ratios with slight changes from the Advance Notice.

Table 8 – EGWP Bid-to-Benchmark Ratios

Applicable Percentage	Advance Notice Bid to Benchmark Ratio	Final Notice Bid to Benchmark Ratio
0.950	78.7%	78.8%
1.000	77.8%	77.7%
1.075	77.3%	77.2%
1.150	77.7%	77.6%

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

The phase in of the 2024 CMS-HCC risk model completes in CY 2026. CMS will fully implement the 2024 CMS-HCC model with 100 percent of the CY 2026 risk scores calculated using the 2024 CMS-HCC risk model (v28).

CY 2026 will begin a four-year transition period for PACE organizations to have beneficiaries scored on the 2024 CMS-HCC model (v28). For CY 2026, beneficiaries risk scores will be 10% based on the 2024 CMS-HCC risk model (v28) and 90% 2017 CMS-HCC Model (v22).

CMS's stated risk score trend is based on two-years' worth of data (2023 and 2022 beneficiaries) and will revert to three years' worth of data once COVID does not influence trend.

Section K. ESRD Models for CY 2026

For CY 2026, CMS will continue to use the 2023 CMS-HCC ESRD model for ESRD beneficiaries.

For ESRD beneficiaries, CMS will use a similar approach as non-ESRD PACE beneficiaries and blend risk scores 10% on the 2023 CMS-HCC ESRD model and 90% on the 2019 CMS-HCC ESRD model.

Section L. Frailty Adjustment for PACE Organizations and FIDE SNPs

Frailty factors will continue for CY 2026.

Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs): CMS will continue to use the frailty factors associated with the 2024 CMS-HCC Model (v28) for FIDE-SNPS.

PACE Organizations: For PACE organizations, CMS will blend frailty factors on the same basis as the beneficiaries are scored, 10% based on the 2024 CMS-HCC risk model (v28) and 90% on the 2017 CMS-HCC Model (v22).

Section M. MA Coding Pattern Difference Adjustment

For CY 2026, CMS will continue to use the statutory minimum amount of 5.9% MA coding pattern adjustment.

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

For both non-ESRD and ESRD models, CMS will use the model linear regression models proposed in the advanced notice that remove the impact of COVID year (years prior to 2021). The resulting normalization factors for all models and populations are listed in Table 9.

Table 9 – CY 2026 Normalization Factors

Model	Normalization Factor
2024 CMS-HCC (v28)	1.067
2017 CMS-HCC (v22)	1.187
2023 ESRD Dialysis	1.062
2019 ESRD Dialysis	1.129
2023 ESRD Functioning Graft	1.104
2019 ESRD Functioning Graft	1.203

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

For non-PACE plans for CY 2026 CMS will continue to use the eligible encounter data and FFS claims.

PACE plan beneficiaries risk scores will be 10% based on the 2024 CMS-HCC risk model (v28) and PACE plans will submit risk adjustment data to the encounter data system (EDS). PACE plans should follow guidance in the HPMS memo released on January 29, 2024, and monitor the Customer Service and Support Center (CSSC) website for additional guidance on submitting encounter data to EDS. The remaining 90% portion of PACE beneficiaries risk scores will continue to use RAPS, encounter data, and FFS claims under the 2017 CMS-HCC model (v22).

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

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

No comments or changes to the Advance Notice.

Section B. Part D Premium Stabilization

A commenter requested CMS release Base Beneficiary Premium (BBP) estimates ahead of bid submission. CMS responded that they cannot do that as the BBP is calculated based on the National Average Monthly Bid Amount (NAMBA).

Section C. Part D Calendar Year EGWP Prospective Reinsurance Amount

No changes to the Advance Notice.

Section D. Part D Risk Sharing

Several commenters requested that CMS announce the Prescription Drug Plan (PDP) premium stabilization and risk corridor parameters for CY 2026 under the voluntary demonstration program well before the bid submission deadline. CMS stated that they cannot assess the need for or the effectiveness of the elements of the demonstration program without first receiving and analyzing the CY 2026 bid submissions. CMS expects the changes to the Part D benefit will have relatively modest impact for 2026 and so the factors that contributed to the design and magnitude of the CY 2025 demonstration parameters should be significantly mitigated for 2026. CMS also reminds plans that the Secretary has the authority to negotiate the terms and conditions of proposed bids and does not have to accept any or every Part D bid submitted. CMS will announce any additional premium stabilization and the risk corridors for participating PDPs for 2026 no later than the annual release of the NAMBA.

Section E. Retiree Drug Subsidy Amount

No comments or changes to the Advance Notice.

Section F. RxHCC Risk Adjustment Model

Some commenters opposed the inclusion of Maximum Fair Price (MFP) drug cost adjustments in the development of the 2026 RxHCC model, stating that the full scope of plan liability is not captured unless you also include direct and indirect renumeration (DIR). Some commentors suggested that the MFP drugs may expect further utilization increases that are not captured within the 2023 data.

CMS responded by stating it is appropriate to account for MFPs because their gross drug cost in CY2026 is known in advance and that DIR amounts in 2026 are not known and will likely differ from the data currently available to CMS. CMS also mentioned that they do not believe it appropriate to model expected changes in behavior when developing the RxHCC model as it would result in error in the model and inaccurate predictions of relative costs.

Section G. Normalization for the RxHCC Risk Adjustment Models

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

CMS received numerous comments opposing the CY 2026 normalization factor methodology and responded that they believe the new approach results in a more reasonable prediction of PDP and MA-PD risk scores in the payment year, making it more likely that the average payment year risk score across the Part D program will be 1.0.

CMS acknowledged that the prior methodology did not account for risk score differences between PDPs and MA-PD plans in the denominator year and that the new methodology more reasonably reflects these differences in the denominator year and projects those differences to the payment year.

Some commenters believe that the CY 2026 normalization factor methodology is capturing risk score coding differences between PDPs and MA-PD plans rather than risk score trend.

CMS responded by saying they believe the methodology results in relative risk scores that will more accurately reflect the relative cost in each market sector as compared to historical or other methodologies and that CMS will continue to monitor risk score trends between MA-PD plans and PDPs, as well as continue to conduct analyses to determine the most appropriate normalization methodology.

One commenter suggested that CMS does not have the authority to develop separate normalization factors by plan type. CMS disagreed and pointed to Section 1860D-15(C)(1)(A) of the Social Security Act for permission to modify risk adjustment methodology to account for differences in the actuarial risk of enrollees being served by the PDP and MA-PD plan market.

CMS also mentioned that average expenditures in 2023 were $2,780.77 for PDPs and $2,697.22 for MA-PD plans, while MA-PD plan risk scores were about 16% higher than PDPs. They further stated that by not accounting for these differences in actuarial risk between PDPs and MA-PD plans would lead to instability in the PDP market and fewer coverage options for enrollees.

Section H. Source of Diagnoses for Part D Risk Score Calculation for CY2026

CMS did not receive comments regarding sources of diagnoses for Part D risk scores for CY 2026 and is finalizing the policies as proposed. Refer to Attachment III, Section O for comments and responses regarding sources of diagnoses for PACE risk scores.

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

Two annual percentage adjustments are calculated to develop the CY 2026 benefit parameters: the annual percentage increase (API) and the annual Consumer Price Index (CPI) increase. These adjustments are described below.

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

The CPI is defined as the annual percentage increase in the CPI for All Urban Consumers (All Items, U.S. City Average) as of September of the previous year. For CY 2026, the maximum copayments up to the annual out-of-pocket (OOP) threshold for full-benefit dually eligible beneficiaries with incomes at or below 100% of the Federal Poverty Level (FPL) are updated by applying the CPI to the CY 2025 amounts. In CY 2025, these copayments were $1.60 for generic or preferred multi-source drugs (including biosimilars), and $4.80 for all other drugs. The unrounded 2025 copayment amounts were multiplied by the CPI and then rounded to the nearest $0.05 or $0.10, resulting in updated copayments of $1.60 and $4.90 for CY 2026, respectively.

Section B. Calculation Methodology

For the CY 2026 benefit parameters, Part D program data will be used to calculate the annual percentage trend of 5.69% by comparing the ratio of the average per capita cost for August 2024 – July 2025 (use Prescription Drug Events (PDE) through December 2024 projected through July 2025) and the average per capita cost for August 2023 – July 2024. An adjustment of -1.34% is applied to reflect the impact of prior year revisions, for a total annual percentage increase for 2026 of 4.27%.

The annual percentage increase in CPI for September 2026 is the combination of the projected trend for September 2025 (2.33%) and a multiplicative prior year revision of -0.17% for a total annual percentage increase of 2.16%.

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

The API is defined as the yearly percentage growth in average per capita Part D expenditures for the 12-month period ending in July of the previous year. For CY 2026, the defined standard deductible is updated by applying the 2026 API to the CY 2025 amount of $590 and rounding to the nearest $5, resulting in a deductible of $615. Similarly, the annual OOP threshold is updated

by applying the API to the CY 2025 amount of $2,000 and rounding to the nearest $50, resulting in an updated threshold of $2,100.

Section D. Retiree Drug Subsidy Amounts

The retiree drug subsidy cost threshold and cost limit for CY 2026 are calculated by applying the CY 2026 API to the CY 2025 amounts of $590 and $12,150, respectively. The updated cost threshold is then rounded to the nearest $5, and the updated cost limit is rounded to the nearest $50, resulting in a cost threshold of $615 and a cost limit of $12,650 for CY 2026.

Attachment VI: Updates for Part C and D Star Ratings

Extreme and Uncontrollable Circumstances for 2026 Star Ratings

Contracts with at least 25% of enrollees residing in a FEMA-designated Individual Assistance area at the time of a qualifying extreme and uncontrollable circumstance may request exemption from administering the MA and PDP CAHPS survey.

- The plans must demonstrate that the required sample for the survey cannot be contacted due to displacement from the qualifying disaster.
- If the exemption is approved, the contract receives the MA and PDP CAHPS measure-level Star Ratings and scores from the prior year.

The January 2025 wildfires in Los Angeles County are a qualifying disaster for the 2025 MA and PDP CAHPS survey / 2026 Star Ratings CAHPS measures.

- Contracts that received an exemption will receive the 2025 CAHPS measure-level Star Ratings for the 2026 CAHPS measure-level Star Ratings.
- The 2027 CAHPS measure-level Star Ratings will be the better-of the 2027 and 2026 CAHPS measure-level Star Ratings.

Changes to Existing Star Rating Measures for Future Years (2027 and later)

CMS is continuing to align the Star Rating program with the Universal Foundation measure set. However, the Social Need Screening and Intervention (Part C) measure is no longer being considered for addition to the display page or Star Ratings program.

CMS received mixed opinions on the majority of the ideas to simplify the Star Ratings measure set described in the Advance Notice, including the removal or retirement of the following measures: some or all of the measures based on operational performance, Part C and D call center measures, complaints measure, Medicare Plan Finder Price Accuracy measure, MTM measure, SNP Care

Management measure, and SNP-specific measures. There was, however, majority dissent for retiring the Part C appeals measures.

CMS received mixed feedback on the Statin Therapy for Patients with Cardiovascular Disease (Part C), Transitions of Care (Part C), Care for Older Adults: Functional Status Assessment and Medication Review (Part C), and Monitoring Physical Activity, Reducing the Risk of Falling, and Improving Bladder Control (Part C) potential changes.

Excellent Health Outcomes for All (Part C and D) – CMS plans to update the Health Equity Index (HEI) reward to call it the Excellent Health Outcomes for All (EHO4all) reward. CMS received mixed support for adding geography as an additional factor in the reward.

Attachment VII: Economic Information for the CY 2026 Rate Announcement

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

Section A – Changes in Payment Methodology for MA and PACE for CY 2026

A1. Medicare Advantage and PACE non-ESRD Ratebook.

- Growth rate for 2026 FFS non-ESRD rates estimate: 8.81%.
- Growth rate for 2026 MA non-ESRD rates estimate: 10.72%.
  - Net Impact $38.73 billion cost to Medicare Trust Funds.
- MA growth percentage used to calculate the 2026 PACE non-ESRD is estimated to be 10.72%.
  - Net Impact $280 million cost to Medicare Trust Funds.
- If CMS continues the adjustment to the calculation of county benchmarks in Puerto Rico for the number of beneficiaries with zero claims.
  - Net impact $320 million cost to Medicare Trust Funds.

A2. Medicare Advantage and PACE non-ESRD Ratebook.

- FFS growth percentage for the 2026 MA ESRD rates is estimated to be 6.79%.
  - Net impact $2.15 billion cost to Medicare Trust Funds.

A3. CMS-HCC Risk Adjustment Model

- For CY 2026, CMS is calculating risk scores entirely with 2024 CMS-HCC model.
  - Anticipated impact on MA risk scores: -3.01% relative to the blend in CY 2025
  - Represents $12.88 billion net savings to the Medicare Trust Fund in 2026.
  - Since the 2020 and 2024 models have different numbers of years their denominators, the two models are not comparable when determining the effect of the number of years on the risk score trend.
  - Each model (2020 and 2024) was appropriately normalized to remove the impact of FFS risk score trend.

A4. ESRD Risk Adjustment.

- CMS is continuing the use of the ESRD risk adjustment models used for CY2025.
  - No economic impact

A5. Frailty Adjustment for FIDE SNPs

- For CY 2026, CMS is calculating frailty scores for FIDE SNPs with the 2024 CMS-HCC model frailty factors, consistent with Part C risk adjustment.
- CMS is also determining the dual status of beneficiaries using data from systems of records, rather than using full Medicaid factors for all beneficiaries as was done for CY2025.
  - The resulting change in frailty score is -0.58%
  - Represents a net cost of less than $10 million to the Medicare Trust Funds in 2026

A6. MA Coding Pattern Difference Adjustment

- Continue to apply statutory minimum coding patter difference adjustment: 5.9%.
- No year-over-year impact.

A7. Part C Normalization

- Normalization factors serve to offset the trend in risk scores and maintain a 1.0 average FFS risk score for CMS-HCC models. For CY 2026, CMS is calculating the normalization factors using a five-year multiple linear regression methodology and average historical FFS risk scores from 2020 through 2024.
  - The impact of normalization is zero

Section B – Changes in the Payment Methodology for Medicare Part D for CY 2026

B1. Annual Percentage Increase for Part D Parameters

- Generally unchanged from CY 2025
- At this time, impacts on the Medicare Trust Fund are uncertain.
    - The impacts of these parameters are dependent on plan bid assumptions.

B2. Part D Risk Adjustment Model

- For CY 2026, CMS is implementing a new updated RxHCC risk adjustment model to reflect statutory changes in Part D.
- CMS is using a model calibrated on 2022 diagnoses and 2023 expenditures for non-PACE organizations and a model calibrated on 2018 diagnoses and 2019 expenditures for PACE organizations.
- The denominator is the average predicted per capita expenditure predicted by the payment model for a given year.
    - The denominator was obtained from MA-PD and PDP diagnosis data to create an average risk score of 1.0 for the Part D population in the denominator year.
- Recalibration can result in changes in risk scores on the plan and individual level.
    - The average risk score in the denominator year remains 1.0.
    - Due to the average risk score being 1.0 in the existing and recalibrated model, the impact of recalibration is zero.

B3. Normalization

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

Attachment VIII: RxHCC Risk Adjustment Factors and Predictive Ratio Tables

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

model than the CY 2025 model, with a more pronounced increase for LI members than NLI members.

The CY 2026 RxHCC model includes adjusted gross drug costs to account for the MFPs of the selected drugs for which an MFP is in effect as part of the Medicare Drug Price Negotiation Program.

CY2026 Final Part D Redesign Summary

Changes from draft instructions. Please see Wakely's 'Summary of Draft CY 2026 Part D Redesign Program Instructions' for our summary of the draft instructions.

Section 20. Redesigned Part D Benefit in CY 2026

No change from draft instructions.

Section 30. Creditable Coverage

CMS will permit non-Retiree Drug Subsidy (RDS) group health plans to use either the existing simplified determination methodology or the revised simplified determination methodology (plan pays at least 72% of drug expenses).

Section 40. Definition of Enhanced Alternative Benefit Design

In the draft CY2026 Part D Redesign instructions, CMS proposed removing coverage of excluded drugs as one of the definitions to meet Enhanced Alternative coverage. In the Final instructions, CMS has decided to not change the definition of enhanced coverage and is continuing to consider a plan as Enhanced Alternative if the only benefit enhancement is coverage for excluded drugs.

Furthermore, CMS includes waiving the deductible on a subset of tiers as an enhancement.

CMS is finalizing their proposal of a 15% benefit richness threshold for Enhanced Alternative (EA) plans between their EA benefit and the defined standard (DS) benefit. CMS is also finalizing their proposal to exclude PACE organizations, EGWPs, DSNPs and MMPs from OOPC testing. Further, this threshold will not be applied to any SNP required to change from a DS to EA benefit during rebate reallocation to address negative basic premium from meeting OOPC differential tests.

Section 50. PDP Meaningful Difference

In the draft CY2026 Part D Redesign Instructions, CMS proposed a 15% threshold between an organization's enhanced and basic plans' OOPC values. After receiving comments, particularly with respect to concerns that the inclusion of MFP drugs in the OOPC model will make it more difficult to meet the 15% threshold, CMS is finalizing a reduced OOPC threshold of 10% between an organization's enhanced and basic plans.

CMS is finalizing the proposal that 50% of the OOPC differential needs to be attributed to benefit design/tier placement and at least 0% from formulary robustness.

Section 60. Non-Calendar Year (NCY) EGWPs

No change from draft instructions.

CMS cites NCY EGWP pricing guidance from the "Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter" and Section 20.13 of Chapter 12 of the Prescription Drug Benefit Manual.

CMS also reiterates that the Manufacturer Discount Program phase-in for small and specified small manufacturers must be applied on a calendar year basis for NCY EGWPs.

Section 70. Selected Drug Subsidy

No change from draft instructions.

A beneficiary will be an applicable beneficiary for selected drug subsidy once the defined standard deductible has been met. A beneficiary is not applicable for the selected drug subsidy if they have met the plan deductible but has not satisfied the defined standard deductible.

CMS will provide monthly prospective payments for the selected drug subsidy estimate, like other pass-through expenses, and the selected drug subsidy will be reconciled with the other Part D reconciliation payments.

Related to reinsurance methodology, CMS provides a numerical example of how selected drugs will be factored into the calculation. Claims in the catastrophic for selected drugs & non-applicable drugs will be aggregated, as they both have a reinsurance subsidy of 40%.

Section 80. Medical Loss Ratio (MLR)

No change from draft instructions.

CMS is finalizing the removal of selected drug subsidy from both the numerator and denominator of the MLR, like other pass-through payments, e.g. LICS, CGDP, etc.

Section 90. Successor Regulation Exception to the Formulary Inclusion Requirement for Selected Drugs

No changes from draft instructions.

CMS confirms that, consistent with existing rules that allow for removal or down-tiering of brand drugs for cases in which a newly available, therapeutically equivalent generic alternative is added to the formulary, plans can apply this action of mid-year removal/down-tiering of a brand drug for a therapeutically equivalent generic or interchangeable biosimilar alternative to the selected drug. However, in the odd case(s) for which the generic/interchangeable alternative comes to market *after April 1* but *before the submission deadline for the initial 2026 formulary*, the plan would be permitted to remove or down-tier the selected drug from its 2025 formulary but would have to keep the selected drug on its 2026 formulary, with no opportunity to remove or down-tier the selected drug at any point during the 2026 plan year.

CMS additionally confirms that for selected drugs, authorized generics of the selected brand drug or unbranded biologic products marketed under the same biologics license application (BLA) as the brand name selected biologic drugs cannot be considered generic/interchangeable biosimilar alternatives, since per the IRA these drugs also qualify as the selected drug, and the addition of a version of a selected drug to a plan's formulary cannot be used to justify the removal or down-tiering of the original brand name or biologic drug.