APPLIED POLICY®

For 2026, CMS Proposes Changes Resulting in a 4.33 Percent Increase in Plan Payments and Implements Inflation Reduction Act Provisions on Part D Redesign

On January 10th, 2025, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2026 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, which makes proposals to update program policies for Medicare Advantage (MA) and Part D beginning in 2026. CMS also issued its Draft CY 2026 Part D Redesign Program Instructions, which center on implementing provisions of the Inflation Reduction Act of 2022 (IRA) related to the Part D benefit for 2026. A press release, along with fact sheets for the Advance Notice and Part D Redesign Program Instructions, were also released.

CMS proposes the following:

- Changes to the Effective Growth Rate and benchmark rate for MA payments,
- Changes related to implementing the IRA Part D benefit redesign for 2026,
- Completion of the three-year phase-in of the 2024 CMS-HCC risk adjustment model,
- Beginning to transition to the 2024 CMS-HCC risk adjustment model for Program of All-Inclusive Care for the Elderly (PACE) Organizations,
- To continue the Part D risk adjustment model with plans for 2026 IRA-related changes,
- To continue the End Stage Renal Disease risk adjustment model,
- To continue the frailty adjustment for Fully Integrated Dually Eligible (FIDE) Special Needs Plans (SNPs) and changes to adjustments for PACE, and
- To continue the adjustments to Fee-for-Service (FFS) per capita costs in Puerto Rico.

The agency also solicits feedback on MA star ratings measure concepts for future years.

If these proposals are finalized, CMS anticipates a 4.33 percent, or over $21 billion, increase in MA plan payments from 2025 to 2026.

Public comments on the Advance Notice and Draft Part D Redesign Program Instructions must be submitted by 11:59 PM Eastern Time on Monday, February 10, 2025. The CY 2026 Rate Announcement and the CY 2026 Part D Redesign Program Instructions will be published no later than April 7, 2025.

CMS PROPOSES EFFECTIVE GROWTH RATE OF 5.93 PERCENT AND BENCHMARK RATE DECREASE OF 2.23 PERCENT FOR CY 2026

The Effective Growth Rate reflects the current estimates of the growth rates of benchmarks utilized in determining payment for Medicare Advantage (MA) plans. Growth in Medicare FFS per capita costs, as assessed by the CMS Office of the Actuary, have been the main driver for these growth rates.

The growth rate estimates for 2026 incorporate a technical adjustment to the per capita cost calculations related to indirect and direct medical education costs associated with services provided to MA enrollees. For CY 2026, CMS proposes to complete its three-year phase-in of the technical adjustment outlined in the CY 2024 Rate Announcement, implementing 100 percent of the technical adjustment during CY 2026. This would result in a growth rate of 5.93 percent in CY 2026, with a net impact of $25.06 billion.

Pausing the growth rate adjustment for medical education costs would add $7 billion to MA plan payments in 2026 without affecting program stability.

The MA benchmark rate is the difference between CMS's expected change in revenue, 4.33 percent, and the average risk score trend, 2.10 percent. Therefore, in CY 2026, there will be a 2.23 percent decrease, if finalized as proposed.

CMS PROPOSES CHANGES TO PART D BENEFIT REDESIGN UNDER IRA

The IRA requires several changes to the Part D benefit. Key changes in the Draft CY 2026 Part D Redesign Program Instructions are outlined below. These draft program instructions only include policies updated or modified from CY 2025 and new policies for CY 2026. Unless otherwise stated in the draft instructions, policies outlined in the Final CY 2025 Program Instructions also apply. The Final CY 2025 Program Instructions are available here.

Modifications to Final CY 2025 Program Instructions

Redesigned Part D Benefit in CY 2026 (Section 20)

See section "Proposed Part D Benefit Parameters for 2026 Plan Year" on pages 5-6 of this summary for the defined standard benefit for 2026.

Creditable Coverage (Section 30, in the Final CY 2025 Program Instructions as Section 90)
Medicare beneficiaries may incur a late enrollment penalty if there is a continuous period of 63 days or more at the end of the individual's Part D initial enrollment period where the individual was eligible for Part D but not enrolled and was not covered under creditable coverage. CMS proposes a revised determination methodology that better reflects actuarial equivalence with the Part D defined standard benefit for the purposes of making creditable coverage determinations.

Definition of Enhanced Alternative Benefit Design (Section 40, in the Final CY 2025 Program Instructions as Section 120)
Part D sponsors can offer non-DS plans, including two types of basic plans and Enhanced Alternative (EA) plans. Coverage of drugs specifically excluded as Part D drugs and/or reduction or elimination of the DS deductible or reduction of cost sharing in the initial coverage phase are the possible enhancement features for CY 2026. The IRA did not modify the list of permissible supplemental benefits to include a reduction in the annual OOP threshold, so Part D plans may not lower this threshold beyond $2,100 for CY 2026.

PDP Meaningful Differences (Section 50, in the Final CY 2025 Program Instructions as Section 130)
As the IRA caps enrollees' annual OOP costs, eliminates the coverage gap phase, and eliminates cost-sharing in the catastrophic phase, CMS adopted a new approach to assessing meaningful difference between an EA plan and a basic plan for standalone PDPs in CY 2025. CMS maintains a 15 percent differential between a PDP organization's basic and EA plans for CY 2026 but will evaluate whether this threshold is appropriate in subsequent years. CMS will also continue to conduct a sub-analysis to determine the proportion of meaningful differences derived from formulary robustness.

Non-Calendar Year (NCY) Employer Group Waiver Plans (EGWPs) (Section 60, in the Final CY 2025 Program Instructions as Section 140)
Under a CMS waiver, Part D plans offering EGWPs can establish NCY plan benefit packages that allow employer groups to determine benefits on an NCY basis. A small proportion of EGWPs have NCY plan benefit packages, meaning their plan year will start in 2025 and continue in 2026. CMS outlines how policies under the Part D benefit redesign will apply to these plans as the plans carry over from one year to another.

Medical Loss Ratio (MLR) (Section 80, in the Final CY 2025 Program Instructions as Section 160)
Per statute, MA organizations are subject to penalties if they fail to have an MLR of 85 percent or greater. This rule also applies to Part D sponsors. MA organizations and Part D plans are required to report their MLR for each contract year. Selected drug subsidies will be excluded from the denominator of the MLR calculation, and associated spending is excluded from the numerator of the calculation. The exclusion of these payments is consistent with the exclusion of other payments such as the Discount Program payments from the MLR as they are pass-through payments to the plan, rather than revenue.

New Policies for CY 2026

Selected Drug Subsidy (Section 70)

Under the selected drug subsidy program created by the IRA, Part D sponsors will receive a government subsidy for selected drugs that is equivalent to 10 percent of the drug's negotiated price. This subsidy lowers a Part D sponsor's liability on the negotiated price of the selected drug after the enrollee incurs costs exceeding the annual deductible under the defined standard benefit. CMS proposes policies related to the implementation of this subsidy, including policies for drugs not subjected to the defined standard deductible, selected drug subsidy prospective payments, medical loss ratio, and the reinsurance methodology.

Successor Regulation Exception Permitting Formulary Substitutions of Selected Drugs (Section 90)

Part D sponsors are required to include drugs selected for negotiation on their formularies while maximum fair price (MFP) is in effect. However, the IRA also includes an exception where Part D sponsors can remove coverage of a selected drug based on the currently in effect regulation or "any successor regulation."

When the IRA was enacted, § 423.120(b)(5)(iv) permitted a plan to immediately substitute a newly available generic drug for its brand name drug on the formulary if certain notice and timing requirements were met. Approval requirements for immediate substitutions are now at § 423.120(e)(2)(i), and the corresponding notice requirements for such formulary changes are now codified at § 423.120(f)(2), (3), and (4). These draft program instructions identify this successor regulation rather than the regulation in effect when the IRA was enacted.

These regulations expand on currently permitted formulary substitution and permit a Part D plan sponsor to also remove a selected drug that is a reference product and replace it with an interchangeable biological product as an immediate substitution, so long as the plan adds the corresponding drug to its formulary on the same or lower cost sharing tier and with the same or less restrictive prior authorization, step therapy, or quantity limit requirements. The corresponding drug must also not have been on the market at the time of the plan's initial formulary submission.[1] CMS states that allowing removal of selected drugs that are reference products and replacement with interchangeable biological products as immediate substitutions would be similar and consistent with the original regulation identified for exception.

Noting concerns that the definition of "corresponding drug" in regulation could incorrectly suggest to plan sponsors that it could remove a selected drug if it adds an authorized generic of the brand name drug or an unbranded biological product marketed under the same BLA as the brand name biological product, CMS clarifies that this would be inconsistent with the IRA's requirement that the selected drug be included on formularies in all dosage forms and strengths of the drug to which MFP applies. Additionally, as an authorized generic of a brand name drug that is a selected drug or an unbranded biologic product marketed under the same

[1] Pages 31-33 of the draft guidance includes timing clarification for immediate substitutions in 2025 and 2026.

BLA as a brand name biological product that is a selected drug also qualify as the selected drug, plans would be required to include each authorized generic or unbranded biological product on their formulary while MFP is in effect. As such, CMS amends the definition of "corresponding drug" to make it clear that this term does not include a selected drug.

CMS seeks feedback on its approach to identifying the successor regulation, as well as alternative approaches in which it could identify the successor regulation to also include maintenance changes for generic drugs and interchangeable biological products that are corresponding drugs.

FOR CY 2026, CMS PROPOSES TO COMPLETE ITS THREE-YEAR PHASE-IN OF THE 2024 CMS-HCC RISK ADJUSTMENT MODEL

In CY 2024, CMS introduced the CMS-HCC risk adjustment model, with plans to fully implement it by 2026. The model includes updates such as restructuring condition categories, using ICD-10 codes, and incorporating more recent data. For the 2024 payment year, risk scores were calculated as a blend of the 2020 CMS-HCC model and the updated 2024 model.

For CY 2025, CMS finalized its proposal to continue the phase-in, with risk scores calculated as a blend of 33 percent from the 2020 model and 67 percent from the 2024 model. The MA risk score trend for 2025 was calculated by blending the trends from the 2020 and 2024 CMS-HCC models. The blended trend, at 3.86 percent, reflected the average change in population and coding practices across all MA plans, with variations possible among individual plans in terms of payment impacts.

For CY 2026, CMS proposes to complete the three-year phase-in of the 2024 CMS-HCC risk adjustment model, as described in the CY 2024 Rate Announcement, by calculating 100 percent of the risk scores using only the 2024 CMS-HCC model.

CMS highlights that pausing the proposed risk adjustment model phase-in would result in $3.4 billion in additional payments to MA plans in 2026, which the agency indicates is not necessary to support stability in the program. The agency emphasizes the importance of ensuring these payments are accurate "to prevent wasteful spending."

CMS indicates that it has been working to calibrate the risk adjustment model using MA encounter data (diagnosis, cost, and use data submitted to CMS by MA plans) and may start phasing in an encounter data-based risk adjustment model as early as CY 2027.

CMS PROPOSES BEGINNING TRANSITION TO THE 2024 CMS-HCC RISK ADJUSTMENT MODEL FOR PACE ORGANIZATIONS

In the CY 2025 Advance Notice, CMS indicated its intention to transition PACE organizations to encounter data submissions and the 2024 CMS-HCC risk adjustment model. Since then, CMS has worked to support these transitions through various activities including monitoring

PACE encounter data submissions, participation in the National PACE Association's annual conference, and technical assistance for PACE organizations to support the transition.

For CY 2026, CMS is proposing to begin this transition to the 2024 CMS-HCC risk adjustment model by calculating risk scores for PACE organizations as a blend of 10 percent of the risk score calculated using the 2024 CMS-HCC model and 90 percent of the risk score calculated using the 2017 CMS-HCC model. CMS views the 2024 CMS-HCC model as an improvement in payment accuracy since it is based on more recent cost and diagnosis data and is based on ICD-10 codes. In this Advance Notice, CMS also provides a proposed timeline in Table II-8 for fully transitioning PACE organizations to an updated MA risk adjustment model with risk scores calculated using only diagnoses from encounter data and FFS claims in CY 2029.[2]

PART D RISK ADJUSTMENT MODEL TO BE FURTHER UPDATED IN ALIGNMENT WITH CHANGES FROM IRA

In alignment with the IRA's changes to the Part D benefit for CY 2026, CMS proposes updates to the Part D risk adjustment model. The changes reflect the continued implementation of the Manufacturer Discount Program, the updated out-of-pocket threshold, the new Medicare Drug Price Negotiation Program, and recalibration of the model using more recent data years (2022 diagnoses and 2023 costs).

EXISTING END-STAGE RENAL DISEASE RISK ADJUSTMENT MODELS PROPOSED TO BE MAINTAINED FOR CY 2026

For CY 2026, CMS proposes to maintain separate End-Stage Renal Disease (ESRD) risk adjustment models for MA plans and PACE organizations. Under this proposal, MA plans would continue using the 2023 ESRD risk adjustment models, as outlined in the CY 2023 Advance Notice, to determine risk scores for beneficiaries in dialysis, transplant, and post-graft status.

For PACE organizations, in alignment with the current proposal to blend risk scores from CMS-HCC models for PACE organizations, CMS is also proposing to use a blend of ESRD risk adjustment models to calculate ESRD risk scores for PACE organizations. This would initiate a four-year transition from the 2019 ESRD CMS-HCC model, which calculates risk scores based on diagnoses from the Risk Adjustment Processing System (RAPS) data, encounter data, and FFS claims, to the 2023 ESRD CMS-HCC model, which relies solely on encounter data and FFS claims for risk score calculations.

Specifically, for CY 2026, blended risk scores for PACE organizations would be 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

[2] See page 58 of the Advance Notice.

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

A tentative schedule for phasing out the 2019 ESRD risk adjustment models is provided in Table II-9.[3]

CMS PROPOSES CHANGES TO CALCULATING FRAILTY SCORES FOR PACE ORGANIZATIONS, BUT WILL CONTINUE CURRENT FRAILTY ADJUSTMENT APPROACH FOR FIDE SNPS

CMS utilizes a frailty adjustment for PACE organizations and FIDE SNPs to better predict Medicare expenditure for frail community populations whose functional impairments are unexplained by the CMS-HCC model. CMS is statutorily required to consider frailty when establishing capitated payments for PACE organizations and is allowed to adjust for frailty in FIDE SNPs that display similar frailty to that that seen in the PACE program.

In alignment with other CMS proposals regarding transitioning risk adjustment to the 2024 CMS-HCC model for PACE organizations, CMS proposes a 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, CY 2026 PACE organization frailty scores would be 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.

This proposed changed would be the first of a four-year transition of the PACE organizations' frailty factors to the 2024 CMS-HCC model frailty factors. The 2017 and 2024 CMS-HCC model frailty factors are outlined in Table II-11 and Table II-10, respectively.[4]

For FIDE SNPs, CMS proposes to continue to use the frailty factors finalized in CY 2024 which are aligned with the 2024 CMS-HCC model.

CMS highlights that per 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" starting with contract year 2025. This means that enrollment in FIDE SNPs is limited to full-benefit dually eligible individuals beginning January 1, 2025. For CY 2025, CMS used the full Medicaid factors to calculate all frailty scores for FIDE SNPs, regardless of

[3] See page 59 of the Advance Notice.
[4] See pages 61-62 of the Advance Notice.

beneficiary dual status. However, for CY 2026, CMS proposes returning to historical methods by relying on data submitted via the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) State files, Point-of-Sale data, and the Commonwealth of Puerto Rico monthly Medicaid file to determine a beneficiary's dual status for frailty score calculations. Details on the 2024 CMS-HCC model frailty factors can be found in Table II-10.[5]

CMS plans to 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 way it 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).

CMS PROPOSES TO CONTINUE ADJUSTING FFS PER CAPITA COSTS IN PUERTO RICO

In Puerto Rico, a significantly higher proportion of Medicare beneficiaries receive benefits through MA rather than FFS compared to other states or territories. To maintain stability for the MA program in Puerto Rico in CY 2026, CMS proposes to set MA county rates based on the relatively higher costs of individuals in FFS with both Medicare Parts A and B and offer an adjustment for individuals with zero claims.

CMS SEEKS FEEDBACK ON STAR RATINGS CONCEPTS FOR FUTURE YEARS

Star Ratings are a quality rating system for Medicare Advantage (Part C) and Medicare Part D prescription drug plans. These ratings are released annually and consist of a one-to-five-point scale (with five indicating excellent performance). Measures used to calculate 2026 Star Ratings are included in Table IV-1 of the Advance Notice.[6]

Proposed New Measure Concepts and Methodological Enhancements

Key proposed updates include changes to measure specifications for several measures, the retirement of one display measure (Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) (Part D)), and potential new measure concepts and methodological changes in future years for ten potential measures.

New measures that CMS is considering for future years include:

- Adult COVID-19 Immunization (Part C);
- Diabetes Foot Exam and Follow-Up (Part C);
- Colorectal Cancer Screening Follow-Up (Part C);

[5] See page 61 of the Advance Notice.
[6] See pages 112-114 of the Advance Notice.

- Intimate Partner Violence (IPV) (Part C);
- Disability Equity (Part C);
- End-Stage Renal Disease (ESRD) (Part C);
- Person-Centered Outcomes (Part C) (three measures);
- Respiratory Syncytial Virus (RSV) Immunization Indicator for Adult Immunization Status (Part C).

CMS is also considering adding social risk factors (SRFs), such as geography (e.g., rural or urban), to the Health Equity Index (HEI) reward. The agency is 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.

Feedback Requested to Simplify and Refocus the Measure Set

As the Part C and Part D Star Rating programs continue to evolve and align with measures included in the Universal Foundation, CMS is exploring ways to streamline and refocus the measure set. To support this effort, the agency is seeking feedback on retiring specific measures from the Star Ratings program, including:

- Medicare Plan Finder Price Accuracy (Part D);
- Complaints About the Health and Drug Plan (Part C and D);
- Call Center – Foreign Language Interpreter and TTY Availability (Part C and D);
- Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR) (Part D);
- Special Needs Plan (SNP) Care Management (Part C);
- Care for Older Adults – Medication Review;
- Care for Older Adults – Functional Status Assessment

PROPOSED PART D BENEFIT PARAMETERS FOR 2026 PLAN YEAR

CMS updates the Medicare Part D benefit parameters for the defined standard drug benefit on an annual basis. Given IRA changes for CY 2026, only the defined standard benefit and low-income subsidy (LIS) benefit parameters have been updated by the methodology provided under the Social Security Act. The IRA set the annual out-of-pocket threshold at $2,100 for CY 2026. Additionally, under the IRA, beneficiaries who were previously eligible for the partial LIS benefit will now be eligible for the full LIS benefit in CY 2026. Lastly, parameters for maximum or minimum beneficiary cost-sharing in the coverage gap or above the annual out-of-pocket threshold did not need to be updated for CY 2026, as the coverage gap phase and beneficiary cost-sharing above the annual out-of-pocket threshold have been eliminated.

Standard Benefit	2025	2026 (Draft)
Deductibles *Beneficiary is responsible for 100 percent of drug costs.*	$590	$615
Out-of-Pocket Threshold	$2,000	$2,100

Beneficiary does not have cost-sharing after out-of-pocket spending reaches $2,100. The Coverage Gap Discount Program was sunset effective January 1, 2025, and was replaced with the Manufacturer Discount Program. For applicable drugs, plans will be responsible for 60 percent of drug costs, Medicare will be responsible for 20 percent, and manufacturers will be responsible for 20 percent. For non-applicable drugs, plans will be responsible for 60 percent of drug costs and Medicare will be responsible for 40 percent. An applicable drug is a drug approved under a New Drug Application or Biologics License Application.		*Statutorily set under the IRA.*
Maximum Copayments for Non-Institutionalized Dual Eligibles		
Full Subsidy-Full Benefit Dual Eligible (FBDE) Beneficiaries **Up to 100 percent of federal poverty level (FPL)** • Generic/Preferred Multi-Source Drug • Other	 $1.60 $4.80	 $1.60 $4.90
Full Subsidy-FBDE Beneficiaries **Between 100 percent and 150 percent of FPL** • Generic/Preferred Multi-Source Drug • Other	 $4.90 $12.15	 $5.10 $12.65
Full Subsidy-Non-FBDE Beneficiaries **Applied or eligible for QMB/SLMB/QI or SSI, income at or below 150 percent FPL for 2024 and resources ≤ $15,720 (individuals, 2024) or ≤ $31,360 (couples, 2024)** • Generic/Preferred Multi-Source Drug • Other	 $4.90 $12.15	 $5.10 $12.65

***

This Applied Policy® Summary was prepared by Caitlyn Bernard with support from the Applied Policy team of health policy experts. If you have any questions or need more information, please contact her at CBernard@appliedpolicy.com or at (202) 558-5272.