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For 2026, CMS Finalizes Changes Resulting in a 5.06 Percent Increase in Medicare Advantage Plan Payments and Implements Inflation Reduction Act Provisions on Part D Redesign

On April 7, 2025, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2026 Announcement of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, which finalizes proposals to update program policies for Medicare Advantage (MA) and Part D beginning in 2026. CMS also issued its Final 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 Rate Announcement and Part D Redesign Program Instructions, were also released.

CMS finalizes proposals to:

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

CMS anticipates a 5.06 percent, or over $25 billion, increase in MA plan payments from 2025 to 2026. This is an increase of 2.83 percent from the CY 2026 Advance Notice, largely due to an increase in the effective growth rate.

CMS FINALIZES EFFECTIVE GROWTH RATE OF 9.04 PERCENT AND 5.06 PERCENT INCREASE IN MA PLAN PAYMENTS FOR CY 2026

The Effective Growth Rate reflects the current estimates of the growth rates of benchmarks utilized in determining payment for 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 will 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 results in an effective growth rate of 9.04 percent in CY 2026, with a net impact of $25.06 billion. This figure exceeds the 5.93 percent estimate in the CY 2026 Advance Notice, primarily due to the incorporation of additional FFS expenditure data, including payment information through the fourth quarter of 2024, that was not available at the time of the Advance Notice.

Due to the increase in the effective growth rate, CMS finalizes an increase of 5.06 percent in MA payments to plans in CY 2026.

MA RISK SCORE TREND METHODOLOGY FOR CY 2026 UPDATED USING TWO-YEAR DATA; PLANS RETURN TO THREE-YEAR APPROACH IN 2027

CMS updates its MA risk score trend methodology for CY 2026 to better reflect current market conditions. Rather than using three years of data, CMS is using a two-year trend based on 2022 and 2023 risk scores, citing the unreliability of 2021 data due to pandemic-related service disruptions. CMS intends to return to a three-year methodology in CY 2027 once a sufficient post-pandemic data set is available.

CHANGES FINALIZED TO PART D BENEFIT REDESIGN UNDER IRA

The IRA requires several changes to the Part D benefit. Key changes in the Final CY 2026 Part D Redesign Program Instructions are outlined below. These final 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 "Final Part D Benefit Parameters for 2026 Plan Year" on pages 9-10 of this summary for the defined standard benefit for 2026.

Creditable Coverage (Section 30)
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 finalizes 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)
Part D sponsors can offer non-Defined Standard (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)
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 proposed a 15 percent differential between a PDP organization's basic and EA plans for CY 2026 but finalizes a 10 percent differential. 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)
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)
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 finalizes policies related to the implementation of this subsidy, including policies for drugs not subjected to the DS deductible, selected drug subsidy prospective payments, 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). CMS finalizes its proposal to identify these regulations as the 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 in practice, this means that the corresponding drug is not included on the final formulary reference file (FRF) update that CMS releases prior to the bid submission deadline.

Given 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 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.

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

FULL IMPLEMENTATION OF 2024 HCC RISK ADJUSTMENT MODEL FINALIZED FOR MA PLANS IN CY 2026

CMS finalizes several updates to the CMS-HCC risk adjustment model to improve payment accuracy and reflect current clinical and coding practices. Most notably, for non-PACE MA organizations, CMS will fully implement the 2024 CMS-HCC model, completing the three-year phase-in that began with the CY 2024 Advance Notice. As a result, 100 percent of risk scores for MA plans will be calculated using the 2024 model beginning in CY 2026.

In terms of data sources, CMS will continue its existing policy for non-PACE organizations by calculating risk scores solely from risk adjustment-eligible diagnoses obtained through encounter data and FFS claims.

To maintain consistency in payment benchmarks, CMS also finalizes normalization factors for the risk adjustment models. For CY 2026, the normalization factor is 1.067 for the 2024 CMS-HCC model and 1.187 for the 2017 model. Additionally, CMS will apply the statutory minimum MA coding pattern adjustment of 5.90 percent to account for differences in diagnostic coding between MA and FFS populations.

CMS BEGINS TRANSITION TO 2024 HCC MODEL FOR PACE IN CY 2026 WITH BLENDED RISK SCORE AND DATA APPROACH

For PACE organizations, CMS will begin a gradual transition to the 2024 model. In CY 2026, risk scores will be calculated using a blended approach, with 10 percent derived from the 2024 CMS-HCC model and 90 percent from the older 2017 model. Frailty scores will likewise be calculated accordingly.

For PACE organizations, CMS will use a blended data approach, with 10 percent of the risk score based on encounter and FFS data alone, and 90 percent incorporating data from the Risk Adjustment Processing System (RAPS), encounter data, and FFS claims.

CMS FINALIZES UPDATED RxHCC MODEL REFLECTING IRA CHANGES FOR PART D PLANS; PACE TO USE BLENDED APPROACH IN CY 2026

For Part D risk adjustment (RxHCC models), CMS will implement an updated model calibrated using 2022 diagnoses and 2023 drug expenditures, which reflects changes required by the IRA. This updated model will be applied to non-PACE MA-PD plans and stand-alone Part D plans.

For PACE organizations, CMS will again use a blended approach, calculating risk scores using 10 percent from the updated 2026 RxHCC model and 90 percent from an earlier version calibrated on 2018 diagnoses and 2019 expenditures. Corresponding normalization factors for the 2026 RxHCC model are 1.194 for MA-PD plans, 0.887 for PDPs, and 1.202 for the PACE-only version.

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

For CY 2026, CMS maintains separate ESRD risk adjustment models for MA plans and PACE organizations. MA plans will 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 finalized proposal to blend risk scores from CMS-HCC models for PACE organizations, CMS will use a blend of ESRD risk adjustment models to calculate ESRD risk scores for PACE organizations. This will initiate a four-year transition from the 2019 ESRD CMS-HCC model, which calculates risk scores based on diagnoses from the 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 will 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
- 10 percent of the risk score calculated with the 2023 ESRD CMS-HCC models and diagnoses from encounter data and FFS claims only.

CMS CHANGES CALCULATION OF 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 finalized proposals regarding transitioning risk adjustment to the 2024 CMS-HCC model for PACE organizations, CMS will blend the frailty factors associated with the 2017 CMS-HCC model and 2024 CMS-HCC model to calculate frailty scores for PACE organizations for CY 2026 payment.

Specifically, CY 2026 PACE organization frailty scores will 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 change will be the first of a four-year transition of the PACE organizations' frailty factors to the 2024 CMS-HCC model frailty factors.

For FIDE SNPs, CMS will continue to use the frailty factors finalized in CY 2024 in alignment 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 beneficiary dual status. However, for CY 2026, CMS will return to historical methods and rely 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.

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).

AGENCY TO CONTINUE ADJUSTING FFS PER CAPITA COSTS IN PUERTO RICO

For CY 2026, CMS will apply a 4.1 percent increase to Puerto Rico's FFS rates used in MA benchmark calculations. This adjustment reflects the higher share of zero-claim beneficiaries in Puerto Rico compared to the national average. CMS bases the update on 2019–2023 data and will continue to use actual FFS costs from beneficiaries enrolled in both Part A and Part B to ensure accuracy, as required by law.

CMS CONSIDERS 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 VI-1 of the Rate Announcement.[2]

[2] See pages 99-101 of the Rate Announcement.

New Measure Concepts and Methodological Enhancements

Key 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 several potential measures.

New measures that CMS is considering for future years include:

- Diabetes Foot Exam and Follow-Up (Part C);
- Colorectal Cancer Screening Follow-Up (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 also announces significant planned updates to the Health Equity Index (HEI) reward, including renaming the index to the Excellent Health Outcomes for all (EHO4all) reward. Beginning with the 2027 Star Ratings, the EHO4all will include enrollees who are dually eligible, receive a low-income subsidy, or have a disability. CMS is removing the current reward factor when it is implemented beginning in 2027, with the goal of incentivizing improved performance across all enrollees.

In the CY 2026 Advance Notice, CMS indicated it was considering adding social risk factors (SRFs), such as geography (e.g., rural or urban), to the HEI reward. The agency was interested in preliminary feedback on the addition of geography to the HEI reward and how to define this. Commenters shared mixed feedback, and CMS reiterates that all potential changes would need to be made through rulemaking.

Feedback Received on Simplifying and Refocusing 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 sought 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);
- Plan Makes Timely Decisions about Appeals (Part C);
- Reviewing Appeals Decisions (Part C);
- 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

CMS received mixed feedback from stakeholders and only identified one measure with a consensus (Reviewing Appeals Decisions – Part C) where most commenters did not support retirement. CMS acknowledges these comments and reiterates that any future changes would need to undergo the rulemaking process.

FINAL 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
Deductibles *Beneficiary is responsible for 100 percent of drug costs.*	$590	$615
Out-of-Pocket Threshold *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.*	$2,000	$2,100 *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 2025 and resources ≤ $15,720 (individuals, 2025) or ≤ $31,360 (couples, 2025)** • Generic/Preferred Multi-Source Drug • Other	 $4.90 $12.15	 $5.10 $12.65

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