Issue Brief

FEDERAL ISSUE BRIEF

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

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CMS Posts Calendar Year (CY) 2026 Advance Notice for Medicare Advantage (MA); Capitation Rates; and Part C and Part B Payment Policies

The Centers for Medicare & Medicaid Services (CMS) have released the Calendar Year (CY), 2026 Advance Notice of Methodological Changes for Medicare Advantage (MA), Capitation Rates and Part C and Part B Payment Policies.

A comment period ending February 10 is provided. A copy of the 181-page document is available at: https://www.cms.gov/files/document/2026-advance-notice.pdf.

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. If finalized, the proposed policies in the CY 2026 Advance Notice are projected to result in a net increase of 4.33 percent, or over $21 billion, in MA payments to plans on average year-over-year in CY 2026.

Net Payment Impact

The chart below indicates the expected impact of the proposed policy changes on MA plan payments relative to last year. The chart is from CMS' fact sheet accompanying the notice.

Year-to-Year Percentage Change in Payment

Impact	2025 Advance Notice	**2026 Advance Notice**
Effective Growth Rate	2.44 percent	5.93 percent
Rebasing/Re-pricing	TBD	TBD
Change in Star Ratings	-0.15 percent	-0.69 percent
MA Coding Pattern Adjustment	0.00 percent	0.00 percent
Risk Model Revision and FFS Normalization	-2.45 percent	-3.01 percent
MA risk score trend	3.86 percent	2.10 percent
Expected Average Change in Revenue	3.70 percent	**4.33 percent**

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Attachment I of the 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.

Comment

There was and continues to be significant discussion about the size of the Medicare risk adjustment. Many are concerned it has been too low and MA plans are being paid too much. Such numbers are not in the millions of dollars, but in the billions of dollars. One must question why HHS and CMS, as well as the Congress have not initiated any actions.

Most of the material below is excerpted from notice's fact sheet, which is available at: https://www.cms.gov/newsroom/fact-sheets/2026-medicare-advantage-and-part-d-advance-notice-fact-sheet.

Expected Average Change in Revenue

Growth Rates

The Effective Growth Rate reflects the current estimate of the growth in benchmarks used to determine payment for MA plans. This growth rate is largely driven by the growth in Medicare Fee-For-Service (FFS) per capita costs, as estimated by the Office of the Actuary.

Included in the 2026 growth rate estimate is a technical adjustment to the per capita cost calculations related to indirect and direct medical education costs associated with services furnished to MA enrollees. In CY 2026, CMS is proposing to complete the three-year phase-in of this technical adjustment and apply 100 percent of the adjustment in CY 2026. Pausing the technical adjustment to growth rates regarding medical education costs would result in additional payments of $7.0 billion to MA plans in 2026 that are not necessary to support stability in the program.

Part C Risk Adjustment Model

CMS finalized an updated Part C Risk Adjustment Model in the CY 2024 Rate Announcement and began a three-year phase-in of the use of that model, referred to as the 2024 CMS-HCC (Hierarchical Condition Categories) model, starting with CY 2024. For CY 2026 CMS is proposing to complete the three-year phase-in.

MA Risk Score Trend

The MA risk score trend is the average increase across plans in MA risk scores, not accounting for normalization and coding pattern adjustments to MA risk scores. The trend reflects increases in MA risk scores, which can be due to several factors, including changes in demographics and coding patterns.

For CY 2026, under the full phase-in of the 2024 CMS-HCC model and using the most recent two years of data, the CY 2026 MA risk score trend is projected to be 2.10 percent.

For CY 2026, CMS calculated the MA risk score trend as the average annual change in MA risk scores over a two-year period (from 2022 to 2023).

Inflation Reduction Act (IRA) Updates for 2026

Part D benefit-related IRA updates will be in place for CY 2026 and are described in the CY 2026 Advance Notice and the related Draft CY 2026 Part D Redesign Program Instructions, including the establishment of the selected drug subsidy program and guidance on the successor regulation exception to the IRA's formulary inclusion requirement for selected drugs under the Medicare Drug Price Negotiation Program.

Other previously implemented IRA benefits will continue, including no cost sharing for enrollees in the catastrophic phase, which begins after the annual out-of-pocket threshold of $2,100 is reached; a cap on enrollee cost sharing for a month's supply of each covered insulin product, which, beginning in CY 2026, is the lesser of $35.00, 25 percent of the maximum fair price established under the Medicare Drug Price Negotiation Program, or 25 percent of the negotiated price under the prescription drug plan (PDP) or Medicare Advantage prescription drug (MA-PD) plan; no cost sharing for adult vaccines recommended by the Advisory Committee on Immunization Practices that are covered under Part D; and the requirement for Part D sponsors to offer the Medicare Prescription Payment Plan.

Part D Risk Adjustment

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

Part C and D Star Ratings

In the Advance Notice, CMS provides information and updates in accordance with the Star Ratings regulations at §§ 422.164, 422.166, 423.184, and 423.186. In addition, CMS solicits input on future measures and concepts as we continue to enhance the Star Ratings over time.

Star Ratings updates in the CY 2026 Advance Notice include providing the list of eligible disasters for adjustment, non-substantive measure specification updates, and the list of measures included in the Part C and D Improvement measures and Categorical Adjustment Index for the 2026 Star Ratings.

CMS is also soliciting initial feedback on substantive measure specification updates and comments on new measure concepts. As the Part C and D Star Ratings program continues to evolve and align with the measures included in the Universal Foundation, CMS is considering additional ways to simplify and refocus the measure set to focus more on clinical care, outcomes, and patient experience of care measures. CMS is also seeking comments on updates to display measures, which it publicly reports but do not include in the Star Ratings. CMS is also soliciting preliminary feedback on adding geography to the Health Equity Index reward. All substantive measure specification changes, the addition of new measures, and methodological changes must go through rulemaking.

Frequently Asked Questions (FAQs) on the 2026 Medicare Advantage and Part D Advance Notice

CMS' fact sheet discusses changes via questions as shown below.

Medicare Advantage

1. **How would the proposed changes in the CY 2026 Advance Notice impact payments to MA plans?**

MA payments are expected to increase by 4.33 percent on average from 2025 to 2026, as proposed. This is over a $21 billion increase in expected MA payments to MA plans for next year. This expected increase includes consideration of the various elements that impact MA payment, such as growth rates of underlying costs, 2025 Star Ratings for 2026 quality bonus payments, continued phase-in of risk adjustment model updates that were implemented in CY 2024 and CY 2025 and increases to risk scores because of MA risk score trend, which can be driven by a number of factors including MA demographics and coding patterns. This increase represents the average expected payment update across plans, and thus, there will be variation among plans in terms of their plan-specific payment impacts, including plans that would see a larger or smaller impact year-over-year. As in past years, the projected change in payment can change between the Advance Notice and Rate Announcement, to be published no later than April 7, 2025. If the expected 3-year phase-in of the updated risk adjustment model and the technical adjustment to MA growth rates regarding medical education costs were paused, it would add an additional $10.4 billion to the increase in expected MA payments to plans for next year, making the total increase over $31 billion.

2. What is total MA spending expected to be in 2026?

The 2024 Trustees Report projects that federal payments to MA plans in 2026 will be $590.9 billion. Additionally, the federal government is expected to spend $9.2 trillion over the next decade on MA payments to plans. The final 2026 amount will be impacted by the final policies and updates in the 2026 Rate Announcement.

3. How will the proposed payment updates impact individuals' MA premiums and benefits in 2026 if finalized?

If finalized, CMS anticipates stable premiums and benefits for individuals for CY 2026, as was the case for offerings in CY 2024 and CY 2025, when the updated risk adjustment model was being phased in. For CY 2024, the MA average monthly plan premium remained stable from CY 2023 with a slight increase of $0.64, and rebate dollars, used for supplemental benefits and premium buydowns, were stable. Additionally, in CY 2024, enrollment in MA went up by about 7 percent from CY 2023. For CY 2025, the MA average monthly plan premium remained stable with a decrease of $1.23 from CY 2024, rebate dollars remained stable with a slight increase from CY 2024, and enrollment is expected to increase in CY 2025.

4. What are the updates for MA risk adjustment for CY 2026?

CMS proposes to complete the three-year phase-in of the updated MA Risk Adjustment model (non-PACE), referred to as the 2024 CMS-HCC model, finalized in the CY 2024 Rate Announcement. In CY 2025, CMS continued the phase-in by calculating risk scores for non-PACE organizations as a blend of 67 percent of the risk score calculated using the updated 2024 CMS-HCC model and 33 percent of the risk score calculated using the 2020 CMS-HCC model. CY 2026 will be the third and final year of the phase-in, and CMS proposes to calculate 100 percent of the risk score using the 2024 CMS-HCC model.

The 2024 CMS-HCC model included important technical updates to improve the predictive accuracy of the model. Updates included 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), and an updated "denominator year" to determine the average per capita predicted expenditures used to create relative factors in the model. Updates also included our longstanding principles to make revisions focused on conditions that are subject to more coding variation.

For more information on the 2024 CMS-HCC model, please see the CY 2024 Advance Notice (specifically, Section G pages 43-56) and Fact Sheet and FAQs and CY 2024 Rate Announcement (specifically, Section J pages 65-112) and Fact Sheet with FAQs. Additional information is also included in the CY 2025 Advance Notice (specifically, Section G pages 51-52), Fact Sheet, and FAQs, and the CY 2025 Rate Announcement (specifically, Section J pages 72-80).

5. Is the new risk adjustment model more accurate?

The new 2024 CMS-HCC risk adjustment model is more accurate than the 2020 model because it reflects more recent FFS diagnosis and cost data (2018 diagnoses/2019 costs compared to 2014 diagnoses/2015 costs) and includes clinically meaningful conditions that predict costs developed from experience with ICD-10 and with clinician input. Based on multiple different accuracy analyses, the new model performs better than the old model. The most appropriate way to assess model performance is to examine predictive ratios, which measure accuracy across subgroups of beneficiaries; predictive ratios show that the new model is more accurate. Though the R-squared value – which measures how well the model predicts costs at the individual level – is not the most appropriate measure of performance for the risk adjustment model, nevertheless, the 2024 model has an improved R-squared compared to the 2020 model. Additionally, the new model has better predictive accuracy for all demographic segments, including Full-Benefit dually eligible individuals.

6. What has been the impact of the phase-in to the updated risk adjustment model?

The vast majority of the impact on risk scores and revenue of the new model was the remapping to ICD-10 and updating to newer FFS data years. The third step of clinical updates based on principle 10 (discussed here: https://www.cms.gov/files/document/2025-advance-notice-fact-sheet-and-faq.pdf) had a much smaller impact. The transition from ICD-9 to ICD-10 accounted for roughly 97 percent of the codes removed from payment, the remaining codes were removed due to clinical updates, where CMS changed the payment status of certain codes where there is wider variation in diagnosing and coding, leading to lower predictive accuracy of the model. This may occur because clinical indicators are broad, the clinical indicators need significant interpretation, the condition is being diagnosed and documented in situations where it has no clinical significance, or where the condition does not require or affect patient care, treatment, or management as required by the ICD-10 Coding Guidelines. These diagnoses do not predict costs as well as a result of the variation in their coding. Ultimately, these steps are about paying more for the sickest patients and spreading relative weights for HCCs, and therefore payments, to plans accurately.

7. What are the updates for PACE risk adjustment for CY 2026?

CMS had previously been unable to transition PACE organizations to the updated 2024 CMS-HCC model because PACE organizations have not been submitting comprehensive diagnoses to the encounter data system, which is needed to calculate 2024 CMS-HCC model risk scores.

CMS is proposing to calculate risk scores for PACE organizations using a 10 percent blend of the 2024 CMS-HCC model and a 90 percent blend of the 2017 CMS-HCC model to begin the transition. CMS is also providing a tentative timeline for fully transitioning PACE organizations to an updated risk adjustment model with risk scores calculated only using encounter data and FFS claims in CY 2029.

8. What is CMS proposing regarding the FFS normalization calculation methodology for CY 2026?

For CY 2025, CMS developed and finalized a more sophisticated multiple linear regression methodology for calculating normalization factors for CMS-HCC models. The new 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 more reasonable projections of what the actual average FFS risk score will be in the payment year.

For CY 2026, CMS is proposing to continue using the multiple linear regression methodology that incorporates historical FFS risk scores from the most recent five years of average FFS risk scores (2020-2024). This methodology allows CMS to represent the historical FFS risk score trend more accurately and calculate a factor without excluding the years impacted by the COVID-19 pandemic.

9. How do the risk adjustment model updates and FFS normalization interact to result in a negative 3.01 percent?

When CMS updates a CMS-HCC risk adjustment model for a year, it may make a variety of updates. The 2024 CMS-HCC model was updated to include more recent underlying FFS diagnosis and expenditure data, which allows the model coefficients to reflect more recent costs and coding trends, revised Condition Categories that improved the predictive accuracy of the model, and an updated denominator year, which brought the year in which the 1.0 FFS risk score is set to a more recent year.

Both the model updates – the updated data years and any revisions to Condition Categories – and the updated denominator year can result in changes in risk scores. Average MA risk scores may decrease since the 1.0 is set in FFS, not MA, and plan-level risk scores can change given the clinical profile of each plan's enrollees.

The denominator update will have a direct impact on the normalization factor, which serves the purpose of keeping the average FFS risk score at 1.0 in each payment year. After a risk model is implemented, there will be a trend in the risk scores calculated with that model over a period of years due to changes in population and coding practice compared to the denominator year. Therefore, for each payment year, CMS calculates a normalization factor for each model to project the average FFS risk score from the denominator year to the payment year. CMS applies this normalization factor to all risk scores from that model to account for underlying trends in FFS coding and population from the denominator year to the payment year and keep the average FFS risk score at the same average (1.0).

Because updating the denominator year brings the 1.0 year closer to the payment year, there are fewer years of change to account for through normalization, and the normalization factor will typically be smaller than the normalization factor used (in the prior year) with a risk model with an older denominator year. As a result, a model update is intertwined with the normalization factor, and CMS has included the combined impact in the fact sheet.

To break out the model impacts from the normalization impacts, CMS provides the change in raw (not normalized) risk scores under the risk adjustment models, along with the impact of the normalization factor. Raw risk scores do not measure actual payment impacts, and a good proportion of the difference in risk scores between models is due to differences in trend. The bottom-line impact of normalization is positive, offsetting the downward impact of the 2024 CMS-HCC model, because the normalization factor for the 2024 CMS-HCC model is lower than the normalization factor for the 2020 CMS-HCC model – and fully phasing in a lower factor will reduce risk scores by less. Note, however, that for the 2024 CMS-HCC model, first implemented in 2024, the normalization factor is higher for 2026 than it was for 2025.

If the raw risk adjustment model impact and the impact of the updated normalization factor for 2026 are broken out from one another, the impact of the raw risk adjustment model revisions phase-in is -4.31 percent, and FFS normalization is +1.30 percent. For plans to analyze their specific payment impact, they must both calculate their raw risk score impact of the model revisions with the phase-in and then net it with the FFS normalization impacts with the phase-in.

10. What is the technical adjustment being phased in related to medical education costs?

CMS finalized a technical adjustment to the growth rates related to medical education costs in the CY 2024 Rate Announcement and began phasing in the adjustment starting with CY 2024. Historically, prior to the CY 2024 MA rates, the tabulation of per capita costs for FFS individuals had included indirect medical education and graduate medical education costs paid by CMS to inpatient facilities associated with services furnished to MA enrollees because CMS had not been able to separately identify these payments from those made for services furnished to FFS individuals. The baseline modeling supporting the growth rate calculations was updated to enable CSM to identify the historical and projected costs of medical education paid by CMS for MA admissions. As described in the Fact Sheet, CMS is proposing to follow the approach described in the CY 2024 Rate Announcement. CMS proposes to apply 100 percent of the adjustment for MA-related medical education costs in CY 2026**.**

11. What drives the Medicare Advantage payment Growth Rates?

As required by statute, the growth rates used in the calculation of the MA rates reflect the growth in per capita costs for non-ESRD individuals enrolled in either FFS or Medicare health plans. The growth rates are based on the expected change in United States Per Capita Costs in Fee-For-Service (FFS USPCC) and in Medicare overall (both FFS and MA). The Effective Growth Rate in the Fact Sheet is a national average of expected change in the benchmarks used to determine payment for MA plans based on the growth in per capita costs year over year. The main driver of the Effective Growth Rate is the FFS USPCC, with the Total USPCC used to calculate the benchmark cap for each county. As a result, the Effective Growth Rate is largely driven by trends in per capita costs for individuals in Medicare FFS.

12. Why is the MA risk score trend so important to understanding year-over-year impacts?

The intent of the net payment impact table ("bottom line table") in the Fact Sheet is to give the public a measure of the all-in impacts of the policies CMS is proposing regarding MA payment for CY 2026. While not a policy proposal, the MA risk score trend is a key factor in the level of overall MA payments. The MA risk score trend accounts for the average annual increase in MA risk scores and is driven by MA demographics and diagnosis coding patterns. It represents the estimate, based on historical data, of how much MA risk scores will increase from 2025 to 2026, which will result in higher payments to plans. It is calculated using the risk adjustment model CMS is proposing for the payment year and is an important piece of information CMS provides to the public. Like all aspects of the bottom-line table, the risk score trend is an industry-wide average, and thus, individual MA plans may have a different experience. Historically, the risk score trend has steadily increased over time, even in years when CMS implemented updated risk adjustment models.

13. How does CMS calculate the MA risk score trend?

CMS calculated the MA risk score trend for CY 2026 as the average annual change in MA risk scores using the 2024 CMS-HCC model over a two-year period from 2022 to 2023 (based on 2021 and 2022 dates of service).

CMS historically calculated the MA risk score trend by using MA risk scores over three prior years and then calculating the average annual change in risk scores across those three years. However, CMS did not update the data years used to calculate the MA risk score trend for the 2024 or 2025 Advance Notice and Rate Announcement due to the effects of the pandemic on MA risk scores. 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 not affected by the COVID-19 pandemic. CMS now has two years of risk scores available from after the onset of the COVID-19 pandemic (2022 to 2023 risk scores based on 2021 and 2022 dates of service), and CMS believes it is important to reflect more recent MA experience. However, because we do not have our traditional three years with which to estimate the MA risk score trend, for CY 2026, CMS calculated the MA risk score trend as the average annual change in MA risk scores over a two-year period (from 2022 to 2023). CMS anticipate returning to calculating the trend using the three most recent years of MA risk scores when the data are available for the CY 2027 Advance Notice.

Medicare Part D

14. What proposals are included for the Part D Benefit in the CY 2026 Advance Notice?

In the CY 2026 Advance Notice, CMS provides information on the Part D benefit parameters that are to be updated or eliminated because of amendments to the Social Security Act made by ***the Inflation Reduction Act of 2022*** (IRA). CMS also provides information on proposed updates to the Medicare Part D (RxHCC) risk adjustment model used to calculate direct subsidy payments for Part D benefits offered by stand-alone Part D prescription drug plans (PDPs) and Medicare Advantage prescription drug (MA-PD) plans. The proposed model is updated to reflect the benefit changes under the IRA, including the increase in plan liability given the cap on annual beneficiary out-of-pocket spending and the new Manufacturer Discount Program. These Part D risk adjustment model updates are essential for plan sponsors in developing accurate bids for 2026.

Part D benefit-related updates under the IRA that will be in place for CY 2026 and that are described in the CY 2026 Advance Notice and related Draft CY 2026 Part D Redesign Program Instructions include the establishment of the selected drug subsidy program. Additionally, annual out-of-pocket costs will be capped at $2,100, which is the 2025 out-of-pocket cap of $2,000, adjusted based on the API. As was instituted in CY 2024 and continued in CY 2025, for CY 2026, there will be no cost sharing for enrollees in the catastrophic phase of the benefit, enrollee cost sharing for covered insulin products will be capped, and there will be no enrollee cost sharing for adult vaccines recommended by the Advisory Committee on Immunization Practices and covered under Part D. For more information on these items, see the CY 2026 Advance Notice, Attachment III, and the related Draft CY 2026 Part D Redesign Program Instructions.

15. What updates are being proposed for the Part D risk adjustment model for CY 2026?

The proposals in the CY 2026 Advance Notice include an update to the Part D risk adjustment model that reflects the 2026 Part D benefit design as required by the ***Inflation Reduction Act***. This update reflects changes such as the continued implementation of the Manufacturer Discount Program and the updated out-of-pocket threshold, as well as the new Medicare Drug Price Negotiation Program. Additionally, the updated model being proposed uses the most recent available data for model calibration, which CMS believes best reflects what the patterns in drug spending will be in 2026. Finally, similar to the proposal discussed above for Part C, CMS is proposing to calculate Part D risk scores for PACE organizations using a blend of the model being proposed for non-PACE organizations.

16. How is the Part D risk adjustment model reflecting Maximum Fair Prices negotiated as part of the Medicare Drug Price Negotiation Program?

The Medicare Drug Price Negotiation Program allows 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 covered under Part D for negotiation, and the proposals in the CY 2026 Advance Notice include an update to the Part D risk adjustment model to substitute gross drug costs for the ten selected drugs with their agreed-upon maximum fair prices (MFPs), as adjusted for inflation to the calibration year. 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. CMS is also presenting alternative versions of the Part D risk adjustment model that do not substitute agreed-upon MFPs for gross drug costs for comment**.**

17. Which years of data did CMS use to calibrate the Part D risk adjustment model?

For MA-PD plans and standalone PDPs, the proposed Part D risk adjustment model is calibrated using 2022 diagnoses to predict 2023 expenditures. For PACE organizations, the proposed Part D risk adjustment model is calibrated using 2018 diagnoses to predict 2019 expenditures.

18. What changes is CMS proposing for Part D normalization?

For CY 2026, for MA-PD plans and PDPs, CMS is proposing to use the multiple linear regression methodology that CMS first developed and finalized for the CMS-HCC model in CY 2025. This methodology incorporates historical risk scores from the most current five years of average risk scores (2019-2023). Separate calculations will be done for MA-PD plans and PDPs. Applying separate normalization factors to risk scores used to pay MA-PD plans and PDPs 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, lack of an ability of PDPs to affect the submission of diagnoses in FFS, and available strategies used to manage costs.

For PACE organizations, CMS is proposing to maintain the existing linear slope methodology for calculating Part D model normalization factors—which is to calculate a slope using five years of risk scores (2016-2020) and then projecting the slope by the number of years between the denominator year to the payment year. Like for non-PACE organizations, this calculation will be done separately for MA-PD plans and PDPs, with CMS proposing to use the normalization factor that would be used to calculate risk scores for MA-PD plans since PACE organizations function more similarly to MA-PD plans, compared to PDPs.

19. Does the revised Part D risk adjustment model accurately predict for individuals with higher predicted risk, meaning likely to have higher-cost medications?

Yes, CMS presents predictive ratios for the proposed Part D risk adjustment model in the Advance Notice, and its analysis found that the new model generally predicts well for individuals with the highest predicted risk, including many individuals taking high-cost medications.

The Part D risk adjustment model is not intended to predict costs for specific drugs. Part D plan sponsors submit bids that account for the projected revenue needed to cover the expected per-beneficiary costs of their enrollee population. Risk adjustment is used to adjust these plan bids, and payment is based on health status and demographic characteristics such that plans are paid more for individuals predicted to have higher drug costs on average. Plan sponsors are expected to manage the risk of their enrolled populations, and the Part D risk adjustment model is not intended to influence decisions about drugs prescribed to individuals.

20. Will software or risk scores be posted to the CMS website so that plans can evaluate the impact of the new Part D risk adjustment model?

Yes, model software and risk scores for the proposed Part D risk adjustment model will be posted when the Advance Notice is published. Specifically, CMS will post software for the Part D risk adjustment models presented in the Advance Notice and risk scores for three versions of the Part D model for MA-PDs and PDPs: 1) the current Part D model (first implemented for payment in 2025), 2) the proposed 2026 Part D model (2022/2023 calibration), and 3) an alternate calibration of the 2026 Part D model (2022/2023 calibration) presented for comment in the Advance Notice that does not incorporate maximum fair price data from the Medicare Drug Price Negotiation Program. CMS will also include risk scores for three versions of the RxHCC model for PACE organizations: 1) the current Part D model (first implemented for payment in 2025), 2) the proposed 2026 Part D model (2018/2019 calibration), and 3) an alternate calibration of the 2026 Part D model (2018/2019 calibration) presented for comment in the Advance Notice that does not incorporate maximum fair price data from the Medicare Drug Price Negotiation Program.

Comment

We have been critical of CMS' failure to provide tables of contents and page numbers. This notice, like the 2005 notice demonstrates that CMS can do such.

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Final Thought

The Medicare Advantage program and number of plans continues to grow each year. Once again, the update factor also continues to grow. For CY 2026 it is now projected to be 4.33 percent. Compare this to FY and CY 2025 provider increases of less than 3.0 percent. Bottom line is MA is growing because there is profit in the payments.

Questions? Contact Andrew Wheeler, MHA's Vice President of Federal Finance, at 573-893-3700 | ext. 1336 or awheeler@mhanet.com.

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