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Wakely Summary: Advance Notice of Methodological Changes for CY 2027 MA Capitation Rates and Part C and Part D Payment Policies

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FEBRUARY 2026

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EXECUTIVE SUMMARY

On January 26, 2026, the Centers for Medicare & Medicaid Services (CMS) released the CY 2027 Advance Notice, which details planned changes to the Part C and Part D capitation and risk adjustment methodology for calendar year (CY) 2027. The comment period for the Advance Notice ends February 25, 2026, and the final rating provisions will be announced no later than April 6, 2026.

The growth rate and risk model changes together resulted in a substantially lower estimated benchmark trend than the industry was expecting.

Part C Benchmark Growth Rate

The CY 2027 fee-for-service (FFS) Growth Rate, which is the major driver of Part C benchmark rates, is estimated at 5.10%. All growth rates for CY2027 are summarized in Table 1.

Table 1. Estimated Benchmark Growth Rates, CY2027

Part C Services	Percentage
FFS: Non-End-Stage Renal Disease (ESRD)	5.10%
MA Growth Percentage (including FFS and MA): – Non-ESRD	4.04%
Dialysis-only ESRD	6.17%

When changes to county applicable percentages, Star Ratings, and the pre-Affordable Care Act (ACA) cap on benchmark rates are included, the net growth rate is 4.77%.

For CY2027, CMS is proposing to update the Part C and Part D risk adjustment models, and new policy for how the agency will accept diagnosis codes.

Risk Adjustment Model Changes

The Part C risk adjustment model will continue to use hierarchical condition categories (HCCs) from v28, the data underlying the model will be updated to reflect diagnoses from 2023 to predict 2024 claims. In addition, CMS is proposing to exclude all diagnoses submitted on unlinked chart review records from the risk score calculation. CMS also proposes to exclude diagnoses from audio-only services.

The Part D risk adjustment model will be updated in much the same way as the Part C model. The diagnosis and cost data will be updated for 2023 diagnoses and 2024 payment year, and diagnoses from unlinked chart reviews and audio-only services will be excluded from risk score

calculations. It is important to note that CMS will not reflect adjusted drug costs for the new maximum fair price (MFP) selected drugs for CY2027 because the MFPs were not available in time for model calibration. CMS anticipates including MFPs for these drugs in the RxHCC model calibration in future years.

For CY2027, CMS is again changing the risk adjustment calculations for MA-PD plans versus Prescription Drug Plan (PDP) organizations. Two separate models are proposed with different RxHCC coefficients. Note that the demographic factors for the two plan types are the same.

CMS is proposing to accelerate the phase in of encounter-based risk adjustment for Program of All-inclusive Care for the Elderly (PACE) plans (both Part C and Part D). The proposed blend for CY2027 Part C risk adjustment is 50% 2017 CMS-HCC and 50% 2027 CMS-HCC. Diagnoses from unlinked chart review will continue to be used to calculate risk scores.

CMS proposes to continue using the multiple linear regression method for calculating Part C and D FFS normalization. The CY2027 factor is 1.058 for Part C. In the Fact Sheet,[1] CMS estimates that the combined effect of FFS normalization factor changes, revised HCC coefficients and limitations on diagnosis sources is about a 4.8% reduction in risk-adjusted benchmark payments. For Part D, CMS will continue to use the multiple linear regression model separately for MA-PD and PDP. The CY2027 RxHCC FFS normalization factors 1.109 and 1.005 for MA-PD and PDP, respectively.

Employer Group Waiver Plans (EGWPs)

Plans will not need to file EGWP bid pricing tools (BPTs) for CY 2027, as was the case in CY 2026.

CMS proposes to continue calculating separate HMO and PPO bid-to-benchmark ratios based on individual 2026 bids and then re-weighted with January 2026 EGWP enrollment. The preliminary 2027 bid-to-benchmark ratios are similar to the 2026 rates. Table 2 (next page) compares 2026 and preliminary 2027 ratios.

Table 2. Estimated Bid-to-Benchmark Ratios

Applicable Percentage	2026 Ratios	2027 Estimates
0.95	78.7%	78.6%
1.00	77.8%	77.8%
1.075	77.3%	77.8%
1.15	77.7%	77.7%

[1] https://www.cms.gov/newsroom/fact-sheets/2027-medicare-advantage-part-d-advance-notice

Part D Defined Standard Benefit Changes

Part D benefit parameter changes for 2027 resulting from the Inflation Reduction Act (IRA) of 2022[2] are generally larger than CY 2026. The key IRA changes for 2027 are as follows:

Continued phase in of the Manufacturer Discount Program for certain manufacturer meeting criteria set out in the IRA.

The base beneficiary premium growth will be held to no more than 6% over the CY 2026 level (i.e., CY2025 was $38.99 per member per month (PMPM), so CY2026 can be no higher than $41.33).

Consistent with the past two years, CMS will announce whether it will continue or modify the voluntary Part D premium stabilization demonstration program available to stand alone PDPs.

Part D Parameters and Risk Sharing

The beneficiary maximum out-of-pocket (MOOP) threshold amount for CY 2027 is $2,400 and the preliminary update to the Part D DS deductible for CY 2027 is $700.

CMS proposes to maintain the same risk sharing corridor parameters as have been in place for several years. The narrowed risk corridors available to PDPs participating in the voluntary demonstration program were eliminated for CY2026.

Star Rating Changes

Various updates for the Star Rating measures are proposed. New measures, concepts, and methodological enhancements for future years are also introduced, along with several potential changes for CY2028 and future years.

The following attachments summarize the key changes and proposals in the Advance Notice.

[2] H.R.5376 - 117th Congress (2021-2022): Inflation Reduction Act of 2022 | Congress.gov | Library of Congress

ATTACHMENT I: PRELIMINARY ESTIMATES OF THE NATIONAL PER CAPITA MA GROWTH PERCENTAGE AND THE NATIONAL MEDICARE FEE-FOR-SERVICE GROWTH PERCENTAGE FOR CALENDAR YEAR 2027

Wakely Analysis: Estimated Impact of Growth Rates Combined with Payment Reform

Wakely estimates that, on a nationwide average basis, and as compared with 2026, nationwide average 2027 Part C benchmarks will:

- Increase by 4.77% on a standardized (i.e., 1.00) risk score basis. This incorporates the FFS growth rate, changes in applicable percentage by county, average change in Star Ratings and quality bonus, and the impact of benchmark cap. It does not include changes to the county-level Indirect Graduate Medical Education (IME)/Direct Graduate Medical Education (DGME) adjustment factors, VA and Department of Defense (DoD) adjustment factor, credibility factors or county rebasing and repricing.
- Increase by -0.29% on a risk-adjusted basis. The risk-adjusted change incorporates the year-over-year impact of FFS normalization factors, MA Coding Pattern adjustment and the risk model revision (i.e., the proposed risk adjustment model including the removal of unlinked chart reviews).

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

- Change in 1.00 benchmarks
- Impact of change in Part C risk adjustment model (including the proposal to no longer allow diagnoses from unlinked chart reviews) and change in FFS normalization factor
- Assumption of no trend in raw risk scores (note that CMS estimates MA risk score annual trend at about 2.5%)
- Average change in Star Ratings based on December 2025 enrollment

Table I-1 (next page) shows our estimates of the components that make up this change.

Table I-1. Change in Blended Risk-Adjusted Benchmarks 2026 to 2027

Component	2026 to 2027 Change
Growth Rate [1]	5.10%
Applicable %	-0.19%
Star Rating/Quality Bonus	-0.11%
Benchmark Cap	-0.01%
Total Benchmark Change	4.77%
FFS Normalization & Risk Model Revision [2]	-4.83%
MA Coding Pattern	0.00%
Total Risk Score Change	-4.83%
TOTAL	-0.29%
[1] Based on December 2025 MA enrollment and 2026 Star Ratings	
[2] Includes the removal of unlinked chart reviews	

Following is a brief definition of each of the elements in Table I-1.

- **Growth Rate.** This is the impact of the FFS (+5.10%) growth rate.
- **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 2026 and 2027. We calculate this using December 2025 enrollment.
- **Benchmark Cap.** The ACA formula requires that the final blended benchmark can be no greater than the pre-ACA benchmark. The impact of this cap can vary year-to-year as plans change Star Ratings, and as the MA trend differs from the FFS trend. Note, for CY2027 the proposed MA growth rate is lower than the FFS growth rate, which results in more counties being affected by the benchmark cap.

- **Part C FFS Normalization Factor and Risk Model Revision.** For CY2027 CMS is proposing to update the v28 model using 2023 diagnoses and 2024 expenditures (as compared to 2019/2020 in the 2024 CMS-HCC v28 model). Consistent with last year, CMS is using the multiple linear methodology to calculate the FFS normalization factor. The proposed PY2027 FFS Normalization factor is 1.058. In addition, CMS is proposing to eliminate chart review encounters that are unlinked to a prior claim record in the risk score calculation.
- **Change in Coding Pattern Adjustment.** The coding pattern adjustment for 2027 will be -5.90%, which is the minimum adjustment required by the ACA. There will be no change from 2026.

Change in Bid and Rebate Amounts

The actual revenue change for individual Medicare Advantage 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.

Note, the CMS Fact Sheet only estimates the impact on risk-adjusted benchmark payments. To properly estimate the impact of the various MA payment components addressed in the Advance Notice, Medicare Advantage plans must consider the total 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 -0.29%. If we include estimated changes in bid and rebate levels, then the impact on Part C revenue is -0.35%. This estimate is based on the following assumptions:

- Plans bid at 78% of the benchmark in 2027. This is based on the proposed bid-to-benchmark ratios for MA EGWP plans published in the 2027 Advance Notice.
- Annual risk score coding trend is 0% for a static population.
- Nationwide average Star Ratings, which result in an average rebate percentage of 65.4% in 2026 and 65.2% for 2027.
- No consideration for sequestration.

Table I-2 (next page) shows the calculations underlying our estimates.

Table I-2. Estimated Change in Risk-Adjusted Bid and Rebate, 2026 to 2027

	2026	2027	2027/2026
1.0 MA Benchmark [1]	$1,274.31	$1,335.05	4.77%
Raw Risk Adjustment Factor [2]	1.0000	1.0000	0.00%
Risk Score Model Change	1.0000	0.9589	-4.11%
FFS Normalization & Risk Model Revision	1.0000	0.9842	-1.58%
Removal of Unlinked Chart Reviews	1.0669	1.0580	0.84%
MA Coding Pattern Adjustment	0.9410	0.9410	0.00%
Total Risk Adjustment Factor (RAF) Adjustments	0.8820	0.8394	-4.83%
Risk-Adjusted Benchmark	$1,123.93	$1,120.62	-0.29%
Assumed Risk-Adjusted Bid [3]	$876.67	$874.09	-0.29%
Savings (Benchmark less Bid)	$247.26	$246.54	-0.29%
Rebate [4]	$161.76	$160.71	-0.65%
Risk-Adjusted Bid + Rebate	$1,038.43	$1,034.79	-0.35%

[1] Based on nationwide average MA enrollment by county as of December 2025
[2] Assumed 1.0 risk scores with no trend
[3] Bid set at 78% of risk-adjusted benchmark
[4] Rebate set at 65.4% for 2026 and 65.2% for 2027

As in past years, CMS did not yet reflect the rebasing and repricing for the Average Geographic Adjustment (AGA) factors. These updates may result in dramatically different changes in FFS benchmarks by county.

Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for CY 2027

Section A. Data and Assumptions Supporting USPCCs

In 2024, CMS began a three-year phase-in to remove the MA-related IME and DGME costs from the historical and projected non-ESRD USPCCs. In CY 2026, the technical adjustment was fully phased in. For CY2027, CMS will continue to remove these expenditures which is expected to have minimal impact on the change in non-ESRD USPCCs (US Per Capita Costs).

Section B. 2027 Growth Percentage Estimates

The preliminary estimate of the Total growth rate is +4.04% (last year the rate was +10.72%). The non-ESRD FFS growth rate is estimated at +5.10% (last year rate was +8.81%).

Section C. USPCC Estimates

In the notice, CMS noted that the USPCC estimates include consideration for the following:

- COVID-19
- Part B Provisions of the IRA
- 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022

The restatements in the Centers for Medicare & Medicaid Services (CMS) FFS USPCC estimates from the prior estimates in the CY 2026 Final Announcement are summarized in the Table I-3.

Table I-3. Restatement in Estimated FFS USPCC Costs

Year	Current/Prior
2028	-0.3%
2027	-0.8%
2026	-0.3%
2025	1.9%
2024	-0.9%
2023	-0.2%

As discussed in the section titled "Wakely Estimated Impact of Growth Rates Combined with Payment Reform," we estimate that the nationwide average change in blended standardized (non-risk-adjusted) MA benchmarks from 2026 to 2027 will be 4.77% and the nationwide average change in the blended risk-adjusted benchmark will be -0.29%.

While not discussed in the Advance Notice, it is important to note that the downward restatements for 2026, 2027, and 2028 are significantly driven by a change in CMS payment policy for "skin substitute" procedures. Beginning in 2026, CMS will pay for these procedures under the Physician Fee Schedule as "incident-to supplies." Previously, they were paid as biologicals, with payments up to $2,000 per square centimeter. CMS estimates spending for these products will decrease by nearly 90%[3].

As has been the case in past years, the change in benchmarks can vary significantly depending on geographic area, plan Star Rating and applicable percentage. While CMS will not publish the final geographic relativities (i.e., AGA factors) until the Final Announcement, we can still estimate the impact of changing county quartiles and average Star Ratings.

Table I-4. Highest and Lowest Benchmark Changes by State

Rank	State	Change
1	UT	7.1%
2	MA	7.1%
3	OH	7.1%
4	NH	6.6%
5	ID	6.5%
47	ND	3.3%
48	AL	3.2%
49	WV	3.2%
50	KS	3.1%
51	OK	2.5%

[3] https://www.cms.gov/newsroom/press-releases/cms-modernizes-payment-accuracy-significantly-cuts-spending-waste

Section D. Loading for Claims Processing Costs

Consistent with last year, CMS is proposing to adjust the USPCC to include administrative costs incurred by the Medicare Administration Contractors (MACs) as described in the ACA. The adjustments are consistent with those made in prior years.

ATTACHMENT II: CHANGES IN THE PART C PAYMENT METHODOLOGY FOR MEDICARE ADVANTAGE AND PACE FOR CY2027

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

CMS intends to rebase county FFS rates for CY 2027 using FFS claims data from 2020 through 2024, consistent with annual rebasing since 2012. The rebasing updates FFS per capita costs which serve as the basis for MA county benchmarks.

County benchmark rates are capped at the Applicable Amount. CMS interprets statute to require that the Quality Bonus Payment (QBP) be included before applying the benchmark cap.

Key components of the Part C benchmark calculation include:

- Applicable Amount (pre-ACA): The greater of (1) the county's 2027 FFS cost or (2) the 2026 Applicable Amount increased by the CY 2027 National Per Capita MA Growth Percentage.
- Specified Amount (FFS benchmark): 2027 FFS cost minus IME phase-out and kidney acquisition costs) multiplied by (Applicable Percentage plus QBP).
- Applicable Percentage: Based on 2026 county FFS cost rankings by quartile, as shown in Table II-1.

Table II-1. FFS Quartile Assignment

Quartile	Applicable Percentage
4th (highest)	95.0%
3rd	100.0%
2nd	107.5%
1st (lowest)	115.0%

- QBP, or "applicable percentage quality increase": The QBP is 5% for 4-, 4.5- and 5-Star Medicare Advantage Organizations (MAOs) and is 0% for plans with less than a 4-Star Rating. For new plans under a new parent organization and low enrollment plans, a 3.5% QBP applies.
- The QBP percentage is doubled in qualifying counties meeting statutory population, penetration, and spending criteria.
- Benchmarks are capped at the Applicable Amount after QBP.

Rebates: Rebate levels are based on plan Star Ratings as follows in Table II-2.

Table II-2. MA Rebate Percentages

Star Rating	2024
4.5+ Stars	70%
3.5 to < 4.5 Stars	65%
< 3.5 Stars	50%

The percentage is applied to the amount by which the risk-adjusted service area benchmark exceeds the risk-adjusted bid. New MA contracts under a new parent organization and low enrollment plans are treated as having 3.5 Stars for rebate purposes.

Section B. Calculation of Fee-for-Service Cost

2027 FFS County Cost

The FFS County cost for CY2027 is calculated as the USPCC x AGA, where:

USPCC = the National Average FFS Cost, called the U.S. Per Capita Cost

AGA = County-level Geographic Index, called the Average Geographic Adjustment

With the Advance Notice, CMS is releasing county-level 2024 FFS cost data used to develop 2027 rates: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data.html

Proposed Update to Reimbursement for Rural Emergency Hospitals

Rural Emergency Hospitals (REH) receive payment rates that are 5% higher than the Hospital Outpatient Prospective Payment System (OPPS) rates for specified services. Starting in CY2023, REH facilities receive additional facility payments in 12 monthly installments which are not included in the National Claims History (NCH). CMS is proposing to adjust the 2023 and 2024 FFS experience to reflect these additional payments.

Tabulation of Ratebook FFS Experience Beginning in 2023

Starting in CY2026, CMS replaced the retired denominator file with Common Medicare Environment data beginning in 2023. CMS is proposing to continue this methodology for CY2027.

CMS proposes excluding anomalous durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) claims with Healthcare Common Procedure Coding System (HCPCS) codes A4352 and A4353 from 2023–2024 experience.

AGA Development Overview

The AGA development uses a five-year rolling average of non-hospice FFS claims from 2020–2024, repriced to current wage and geographic indices. Costs for hospice and Cost plans are excluded.

CMS will re-price 2020 to 2024 claims to the most current (i.e., FY2026) wage and geographic practice cost indices and adjust historical FFS claims for legislative changes.

- This includes the repricing of the Medicare DMEPOS claims in accordance with the payment rules in effect during the temporary gap period for the DMEPOS Competitive Bidding Program starting 1/1/2026.
- The January 2026 fee schedules for repricing DMEPOS claims are accessible here: https://www.cms.gov/medicare/payment/fee-schedules/dmepos/dmepos-fee-schedule
- Part B drugs will not be repriced, irrespective of the 340B remedy rule provision. (Many CY2022 340B drug claims have been processed/reprocessed at the higher 340B payment rate already).

There are two additional adjustments included in the development of the AGAs:

1. The first adjustment incorporates shared savings and losses or episode savings and losses experienced under the Medicare Shared Savings Program and Innovation Center models into historical FFS experience. CMS is proposing to use more recent experience years to calculate this adjustment. A similar adjustment has been applied in prior years.
2. The second adjustment is new and is related to Advanced Alternative Payment Models (APM). Qualifying APM participants receive an incentive payment equal to 5% of their estimated aggregate payments for covered professional services furnished between 2019 through 2024 (2025: 3.5%; 2026: 1.88%). Payments are made in the year after the base year, beginning in 2019. CMS is proposing to incorporate the APM incentive payments made in 2020 through 2024 into the historical Ratebook experience.

An additional adjustment is being considered for Puerto Rico. Puerto Rico data only includes beneficiaries with Part A and B eligibility for all five years of the base period. CMS is considering whether to apply an adjustment to Puerto Rico FFS costs to reflect Puerto Rico's high proportion of zero-claimant members versus the national average. Such an adjustment has been applied in prior years.

After the AGA has been calculated, the following additional adjustments are made:

- DGME and IGME are removed from FFS county costs.
- Counties with less than 1,000 members are blended with other counties in the market area for credibility.
- Adjustments are made for beneficiaries who are dually enrolled in Veteran Affairs and DoD health programs.
- Organ acquisition costs for kidney transplants are removed.

Section C. Additional Adjustments

Additional adjustments are applied after the AGA is calculated. The methodology employed for the exclusion of the Direct Graduate Medical Education (DGME or GME), Organ Acquisition for Kidney Transplant (including the coverage of living donor expenses) and the IME phase-out is consistent with the methodology discussed in the 2026 Advance Notice.

Alternate methodologies for the additional adjustments that relate to hospitals participating in the Maryland Total Cost of Care (TCOC) Model will continue to be consistent with the methodology that began with the CY 2025 rates.

Section D. MA ESRD Rates

The 2020-2024 FFS expenditures and enrollment data based on beneficiaries in dialysis for each state will be used to develop the CY 2027 MA ESRD rates. The methodology will be similar to prior years.

Section E. Location of Network Areas for Private Fee-for-service (PFFS) Plans in Plan Year 2028

Non-employer MA PFFS plans offered in a network area must meet certain access standards through written contracts with providers. Network area is defined as an area that the Secretary identifies as having at least two network-based plans with enrollment. CMS will include the list of network areas for plan year 2028 with the CY2027 Rate Announcement.

Section F. Employer Group Waiver Plans (EGWP)

For 2027, CMS intends to continue to waive bid pricing tool requirements for EGWPs.

CMS is also proposing to continue to use the same methodology that was used for 2026 in establishing MA EGWP payment amounts, which is to use 2026 bid-to-benchmark ratios weighted by February 2026 enrollment.

For 2027, CMS has published preliminary bid-to-benchmark ratios for EGWPs. These preliminary ratios are not final and are based on January 2026 enrollment instead of the intended February 2026 enrollment.

Table II-3. EGWP Bid-to-Benchmark Ratios

Applicable Percentage	Bid-to-Benchmark Ratio
0.95	78.6%
1	77.8%
1.075	77.8%
1.15	77.7%

CMS will continue to allow MA EGWPs to use a portion of Part C payment to buy-down enrollee Part B premium. CMS will continue to collect Part B premium buy-down amounts in the EGWP PBP submission. EGWPs that choose to use a portion of their payment to buy-down Part B premium will have that amount reduced from their capitated payment. The Part B buy-down amount cannot vary among beneficiaries within a plan and is subject to the same maximum Part B buy-down amount as non-EGWP plans.

Section G. CMS-HCC Risk Adjustment Model

CMS is proposing to implement a new 2027 CMS-HCC model. This model in similar in its core to the prior risk score model (2024 CMS-HCC model) but has several key differentiators; both are described below.

Section G1. Similarities Between the 2027 CMS-HCC Model and the 2024 CMS-HCC Model

The new model will:

- Have consistent model segmentation for new enrollees, continuing community enrollees, and continuing institutionalized enrollees
- Use the same HCCs and demographic variables
- Use version 28 (v28) of the clinical classification of HCCs

Section G2. Key Updates in the 2027 CMS-HCC Model

- The model calibration is based on more recent data: 2023 diagnosis codes/2024 expenditures compared to 2018/2019
- The denominator year used to create relative factors which are used in the risk score calculation has been updated from 2020 in the 2024 CMS-HCC model to 2024 in the 2027 CMS-HCC model.
- Diagnosis codes from audio-only services are now excluded – this is consistent with diagnosis submission policy
- The CMS-HCC model has historically included constraints that hold coefficients of HCCs to be of equal weight if there is no data to differentiate the HCCs. The new model will remove this constraint for HCC 328 Chronic Kidney Disease, Moderate (Stage 3B) and HCC 329 Chronic Kidney Disease, Moderate (Stage 3, Except 3B) as there is sufficient data with the update to the underlying calibration data.

Section G3. PACE Risk Adjustment Approach

CMS proposes to continue transitioning PACE risk adjustment to the same encounter-based models used for MA. For CY2027, PACE risk scores will be a 50%/50% blend of:

- 2017 CMS-HCC model using Risk Adjustment Processing System (RAPS) + encounter + FFS data
- Proposed 2027 CMS-HCC model using encounter + FFS only

This proposal is a faster phase in than previously announced in the CY 2026 Advance Notice. Specifically, in the CY 2026 Advance Notice, the blend for CY 2027 was proposed to be 75%/25%. Consistent with prior announcements, CMS intends to fully transition PACE organizations, but

a new transition plan was not provided in the CY2027 Advance Notice that coincides with the 50%/50% proposed blend.

Section H. ESRD CMS-HCC Risk Adjustment Models

For CY 2027, CMS will continue to use the 2023 ESRD risk adjustment models for dialysis, transplant, and post-graft beneficiaries for non-PACE organizations.

For PACE organizations, CMS is proposing a 50%/50% blend of:

- 2019 ESRD CMS-HCC model using RAPS + encounter + FFS data
- 2023 ESRD CMS-HCC model using encounter + FFS only

Similar to non-ESRD PACE organizations, this proposal is a faster phase-in than the 75%/25% blend proposed for CY 2027 in the CY 2026 Advance Notice.

Section I. Frailty Adjustment for FIDE SNPs & PACE Organizations

Frailty adjustments compensate plans where functional impairments not captured by diagnoses in the CMS-HCC model drive higher expected costs. This frailty adjustment is included in the capitation payments for PACE organizations as well as FIDE SNPs when the average level of frailty in the FIDE SNP is similar to a PACE organization.

For CY 2027, CMS is proposing to update the frailty factors to be recalibrated to align with the updated 2027 CMS-HCC model. Table II-4 shows the proposed frailty factors for the CY 2027 CMS-HCC model.

Table II-4. Frailty Factors Associated with the Proposed 2027 CMS-HCC Model

ADL	Non-Medicaid	Partial Medicaid	Full Medicaid
0	-0.055	-0.055	-0.070
1-2	0.141	0.141	0.126
3-4	0.168	0.168	0.407
5-6	**0.186**	**0.186**	**0.407**

For FIDE SNPs to qualify for frailty payments in CY2027, they must contract with a CMS-approved survey vendor to field the 2026 Health Outcomes Survey (HOS) or HOS-Modified and meet the PACE minimum frailty score as estimated by CMS.

For PACE organizations, similar to the risk score model phase-in, the frailty scores will be calculated as the sum of:

- 50% of the frailty score calculated with the 2017 CMS-HCC model frailty factors, as shown in Table II-5
- 50% of the frailty score calculated with the proposed 2027 CMS-HCC model frailty factors, as shown in Table II-4

Table II-5. Frailty Factors Associated with the 2017 CMS-HCC Model

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

Section J. MA Coding Pattern Difference Adjustment

CMS will continue to apply the statutory minimum MA coding pattern adjustment of 5.90% for CY 2027 risk scores.

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

For CY2027, the same multiple linear regression methodology used in CY2026 will once again be used. The FFS normalization factor calculations were updated to use the data period 2021 to 2025 (2020 to 2024 dates of service). Since all data used are now considered post-COVID, the regression coefficient β_2 is now equal to 0. This effectively changes the multiple linear regression methodology into the linear slope methodology used prior to CY2025.

Section K1. CMS-HCC Model Normalization Factors

The proposed normalization factor for the proposed 2027 CMS-HCC model is 1.058.

The proposed normalization factor for the 2017 CMS-HCC model used for PACE organizations is 1.207.

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

The proposed normalization factor for the 2023 ESRD Dialysis CMS-HCC model is 1.070.

The proposed normalization factor for the 2019 ESRD Dialysis CMS-HCC model used for PACE organizations is 1.144.

ATTACHMENT III: BENEFIT PARAMETERS FOR THE DEFINED STANDARD BENEFIT AND CHANGES IN THE PAYMENT METHODOLOGY FOR MEDICARE PART D FOR CY 2027

Section A. Annual Adjustments to Medicare Part D Benefit Parameters in 2027

Section A1. Updating the Medicare Part D Benefit Parameters

Beginning in CY2026, the applicable copayment amount for covered insulin products is the lesser of $35, an amount equal to 25% of the maximum fair price (MFP) established for the covered insulin product under the Medicare Drug Price Negotiation Program, or an amount equal to 25% of the negotiated price of the covered insulin product under the PDP or MA-PD plan.

The Inflation Reduction Act (IRA) eliminated the coverage gap phase and set the annual out-of-pocket (OOP) threshold at $2,000, effective as of CY25. Beginning in CY 2026, this threshold is updated annually using the annual percentage increase (API).

Consistent with the IRA redesign, defined standard Part D prescription drug coverage in CY2027 consists of a three-phase benefit, with an annual deductible, initial coverage phase, and catastrophic coverage phase.

CMS updated the deductible and OOP thresholds using the calculated API of 13.65% for CY2027, reflecting a 9.37% increase in the CY 2026 annual percentage trend and a multiplicative adjustment of 3.92% for prior year revisions.

CY2027 Part D Defined Standard benefit thresholds are as follows:

Table III-1. CY2027 Part D Benefit Parameters & Subsidies

Part D Benefit Parameters	2026	2027
Standard Benefit		
Deductible	$615	$700
Out-of-Pocket Threshold	$2,100	$2,400
Full Subsidy-Full Benefit Dual Eligible (FBDE) Individuals		
Deductible	$0.00	$0.00

Copayments for Institutionalized Beneficiaries [category code 3]	$0.00	$0.00
Copayments for Beneficiaries Receiving Home and Community-Based Services [category code 3]	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL [category code 2], Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$1.60	$1.65
Other	$4.90	$5.00
Over 100% FPL [category code 1], Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$5.10	$5.80
Other	$12.65	$14.40
Full Subsidy-Non-FBDE Individuals		
Applied or eligible for QMB/SLMB/QI or SSI and income at or below 150% FPL and resources ≤ $16,590 (individuals, 2026) or ≤ $36,100 (couples, 2026) [category code 1]		
Deductible	$0.00	$0.00
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$5.10	$5.80
Other	$12.65	$14.40
Retiree Drug Subsidy Amounts		
Cost Threshold	$615	$700
Cost Limit	$12,650	$14,400

Section A2. Calculation Methodologies for the Annual Percentage Increase (API) and Consumer Price Index (CPI)

For the CY2027 benefit parameters, CMS used Part D program data to calculate the annual percentage trend of 9.37% by comparing the ratio of the average per capita cost for August 2025–July 2026 (use Prescription Drug Event (PDE) through December 2025 projected through July 2026) and the average per capita cost for August 2024–July 2025. An adjustment of 3.92% is applied to reflect the impact of prior year revisions, for a total annual percentage increase for 2027 of 13.65%.

The annual percentage increase in CPI for September 2027 is the combination of the projected trend for September 2026 (2.31%) and a multiplicative prior year revision of 0.67% for a total annual percentage increase of 3.00%.

Section B. Part D Premium Stabilization

As described in the CY2027 proposed rule, which appeared in the *Federal Register* on November 28, 2025, the Base Beneficiary Premium (BBP) for CY2027 will not be greater than CY2026 BBP, which was $36.78 (as released in the July 28, 2025, Health Plan Management System memorandum) increased by 6%, or $41.33.

Consistent with CY 2024, 2025, and 2026, the direct subsidy amount will change depending on the impact of premium stabilization on the BBP calculation and, thereby, a plan's basic Part D beneficiary premium. As a result, the portion of the plan's bid for basic Part D coverage not funded by basic Part D premiums will continue to be paid through the direct subsidy.

Section C. Part D Calendar Year EGWP Prospective Reinsurance Amount

The methodology used to calculate the prospective reinsurance payments to all Part D Calendar Year EGWP sponsors was updated with the CY2025 Part D Redesign Program. For CY2027, CMS will apply the updated methodology first applied for CY2025. Specifically, for CY2027, CMS will calculate the prospective reinsurance payments to all Part D Calendar Year EGWP sponsors using the weighted average of PMPM prospective reinsurance amounts submitted by Part D sponsors for enhanced alternative (EA) plans.

As in CY2025 and CY2026, CMS plans to announce the CY2027 prospective reinsurance payment amount for Part D Calendar Year EGWPs with the annual release of the Part D National Average Bid Amount (NAMBA), Part D BPP, and related Part D bid information in the summer of 2026.

Section D. Part D Risk Sharing

There are no changes to the Part D risk corridor calculations for CY2027.

Section E. Retiree Drug Subsidy Amounts

See the Part D Benefit Parameters Table for a comparison of the cost threshold and cost limit between CY2026 and CY2027. Both parameters increase consistently with the CY 2027 API.

Section F. RxHCC Risk Adjustment Model

Section F1. Background on the RxHCC Model

The RxHCC model adjusts plan payments based on expected drug spending for each beneficiary. The model uses beneficiary demographic characteristics and diagnosis information from a base year to predict plan spending for drug costs under the standard Part D benefit in the following year. Demographic information such as age, sex, disability, low-income status, and long-term institutional status is obtained from CMS administrative data, and diagnosis information is obtained from MA encounter data and FFS claims for MA and FFS beneficiaries enrolled in the Part D program. Diagnoses are grouped into RxHCCs based on severity and cost.

PDE data used to develop the model are from years prior to the payment year, but each PDE in the model sample is adjusted to have payments reallocated to the standard benefit structure for the applicable payment year. The RxHCC model predicts plan liability – it excludes costs paid for by the government (reinsurance and the low-income subsidy) or the beneficiary.

Section F2. Proposed Updates to the RxHCC Model

CMS is proposing to update the RxHCC models by incorporating the following changes to the Part D benefit related to the IRA:

Increasing manufacturer discounts for specified manufacturers and specified small manufacturers to reflect CY 2027 amounts. For specified manufacturers, the plan liability proportion of cost-sharing for applicable drugs dispensed to low-income subsidy (LIS) beneficiaries was changed for CY 2027 to 70% during the initial coverage phase and 75% during the catastrophic phase. For specified small manufacturers, the plan liability proportion of cost-sharing for applicable drugs dispensed to all beneficiaries was changed for CY 2027 to 70% during the initial coverage phase and 75% during the catastrophic phase.

Updating adult vaccine and insulin National Drug Control (NDC) codes to reflect codes applicable as of May 2025.

Continuing to adjust gross drug costs to account for the MFPs of the selected drugs for IPAY 2026 as part of the Medicare Drug Price Negotiation Program. **CMS is unable to adjust gross**

drug costs to account for the MFPs of selected drugs for IPAY 2027 because the MFPs were not available in time for model calibration, however CMS anticipates incorporating MFPs for these drugs in the RxHCC model calibration for future years.

CMS is also proposing the following additional updates:

- Updating the underlying data to diagnoses from 2023 FFS claims and MA encounter data records and gross drug costs from 2024 PDEs
- Updating the model denominator year from 2023 to 2024
- Excluding diagnoses from audio-only services (using modifiers 93 or FQ) and those submitted on unliked chart review records
- Separating continuing enrollee model segments for beneficiaries in MA-PD plans and PDPs

CMS has previously presented analysis showing that while the RxHCC model does well at predicting across levels of risk, MA-PD plan costs tend to be overpredicted, and PDP plan costs tend to be underpredicted. This difference is due to underlying differences in the MA-PD and PDP sectors, including the lack of an ability of PDPs to affect the submission of diagnoses in FFS and available strategies used to manage Part D costs. CMS is proposing to address this by using separate continuing enrollee model segments for MA-PD plans and PDPs. No changes to model segments for new enrollees are proposed because risk scores for these enrollees are calculated using only demographic information.

Table III-2. CY2027 RxHCC Proposed Model Segments

Proposed Model Segments for 2027 RxHCC Model Calibration	
Proposed Model	**Previous Model**
Ten segments for continuing enrollees:	Five segments for continuing enrollees:
Community, Non-Low Income, Age 65+ (MA-PD) Community, Non-Low Income, Age 65+ (PDP) Community, Non-Low Income, Age <65 (MA-PD) Community, Non-Low Income, Age <65 (PDP) Community, Low Income, Age 65+ (MA-PD) Community, Low Income, Age 65+ (PDP) Community, Low Income, Age <65 (MA-PD) Community, Low Income, Age <65 (PDP) Institutional (MA-PD) Institutional (PDP)	Community, Non-Low Income, Age 65+ Community, Non-Low Income, Age <65 Community, Low Income, Age 65+ Community, Low Income, Age <65 Institutional
Three segments for new enrollees:	Three segments for new enrollees:
Non-Low Income Low Income Institutional	Non-Low Income Low Income Institutional

For PACE organizations, CMS proposes to calculate blended risk scores for CY2027 using the following approach:

- 50% weight on the proposed RxHCC model for CY2027 calibrated using 2018/2019 data and diagnoses from RAPS, encounter data, and FFS claims
- 50% weight on the proposed RxHCC model for CY2027 calibrated using 2023/2024 data and diagnoses from encounter data and FFS claims only

Section F3. Predictive Ratios for the Proposed 2027 RxHCC Model (2023/2024 Calibration)

The predictive accuracy of the RxHCC model is measured by how accurately it predicts costs over subgroups of beneficiaries. This accuracy is measured by the predictive ratio – the ratio of predicted cost to actual cost. A predictive ratio of 1.0 means that the model perfectly predicts cost on average for a subgroup of beneficiaries, and a ratio between 0.90 and 1.10 is generally considered accurate.

By using separate model segments for MA-PD plans and PDPs, the overall average predictive ratio is 1.0 for both groups. Without segmentation, the predictive ratio is 1.0 for Part D overall but is 1.066 for MA-PD plans and 0.898 for PDPs. This creates a systemic bias in payment where MA-PD plans receive more revenue than they should compared to PDPs. The proposed 2023/2024 RxHCC model also improves accuracy for most deciles of predicted risk compared to the previous model.

Section G. Normalization Factors for the RxHCC Models

Similar to previous years, CMS is proposing to separate normalization factors for MA-PD plans and PDPs due to a trend of growing divergence in risk scores and the increased prominence of risk adjustment in Part D payment due to the significant change in plan liability under the IRA redesign of the Part D benefit. The average MA-PD risk score increased by 16.6% from 2018 to 2024, while the average PDP decreased by 5.7% over this same period. Separate normalization factors account for this trend and ensure that risk scores more accurately reflect Part D costs in each sector of the Part D market in the payment year. As was done for CY 2026, the multiple linear regression method used to calculate the normalization factors for CY 2027 includes a flag for pre-COVID-19 risk scores versus post-COVID-19 risk scores.

The proposed normalization factors for the proposed 2027 RxHCC model (2023/2024 calibration) are as follows:

- MA-PDs: 1.109 (2026: 1.194)
- PDPs: 1.005 (2026: 0.887)

For PACE organizations, CMS is proposing to continue using the linear slope methodology to calculate normalization factors for the 2018/2019 calibration of the 2027 RxHCC model, using risk scores from 2016 through 2020. The proposed normalization factor is 1.237.

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

For non-PACE organizations, for CY2027, CMS will continue to calculate Part D risk scores using only risk adjustment-eligible diagnoses from encounter data and FFS claims.

For PACE organizations, for CY 2027, CMS is proposing to calculate risk scores as a blend of risk scores calculated with two different RxHCC models, as follows:

- 50% weight on the proposed 2018/2019 RxHCC model for CY 2027 using pooled RAPS, encounter data, and FFS claims
- 50% weight on the proposed 2023/2024 RxHCC model for CY 2027 (the MA-PD model segment) using encounter data and FFS claims

As with Part C, the exclusion of diagnoses from unlinked chart review records for risk score calculation does not apply to PACE organizations for CY 2027.

ATTACHMENT IV: UPDATES FOR PART C AND D STAR RATINGS

Measure Changes for Star Rating Year (SY) 2027

- Colorectal Cancer Screening: Substantive change causing measure to be treated as a new measure for SY 2027
- Care for Older Adults – Functional Status Assessment: Returning measure with a weight of 1
- Concurrent Use of Opioids and Benzodiazepines: New measure with a weight of 1
- Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults – New measure with a weight of 1
- Care for Older Adults – Pain Assessment: Measure being removed
- Medication Reconciliation Post-Discharge: Measure being removed
- Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR): Measure being removed

Note that the 5% cut point guardrails will not apply to any new measures for the first three years, SY 2027 through SY 2029

Extreme and Uncontrollable Circumstances (EUC) for SY 2027

- For plans that qualify for disaster adjustments, the adjustment will result in the higher of their raw/unadjusted measure-level rating from measurement year (MY) 2024/SY 2026 and MY 2025/SY 2027 being used.
- For SY 2027, Los Angeles County in California received EUC status due to wildfires in January 2025 and several counties in Texas (primarily in and around city of Austin) received EUC status due to severe storms in July 2025.
- CMS-approved exemptions from the Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey can be requested if at least 25% of a contract's enrollees resided in a FEMA-designated Individual Assistance area at the time of a qualifying EUC and the required survey sample cannot be contacted due to displacement from the disaster. If an exemption is granted, the CAHPS measure-level Star Ratings from the prior year are used. The Los Angeles County wildfires met these criteria.

Changes to Star Rating Measures and Methodologies for Future Years (SY 2028 and later)

Note that measures with substantive specification changes described in this section must be added or updated through rulemaking and must remain on the display page for at least two years prior to becoming a Star Ratings measure.

- Plan Makes Timely Decisions about Appeals and Reviewing Appeals Decisions: Data from the Part C Reporting Requirements will start being used to check completeness of data in SY 2027.
- Categorical Adjustment Index (CAI): Starting in SY 2027, consolidated contracts' percentage of LIS/dual eligible (DE) and disabled enrollees will use the surviving contract for the first two years following consolidation followed by the combined December enrollment.
- Statin Therapy for Patients with Cardiovascular Disease: Proposing to remove this measure from Star Ratings in MY 2026/SY 2028 due to a substantive change to the eligible population. Measure will be on the 2028 display page.
- MTM Program Completion Rate for CMR: Returns to Star Ratings as a new measure in MY 2027/SY 2029. Measure will be on the 2027 and 2028 display pages.
- Plan All-Cause Readmissions: Considering a substantive update to include denied claims and planning to update the risk adjustment models for MY 2028 / SY 2030.
- Transitions of Care: There are a few potential upcoming changes to this measure including (1) a non-substantive change in MY 2027/SY 2029, (2) a consideration of shortening the timeframe and adding a long-term institution (LTI) flag in MY 2028 / SY 2030, and 3) an intention to develop an ECDS-reported version of this measure for addition to Star Ratings in MY 2029 / SY 2031.
- Diabetes Care – Blood Sugar Controlled: Developing an ECDS-reported version of this measure for addition to Star Ratings in MY 2029/SY 2031.
- The following measures have non-substantive changes for MY 2026/SY 2028:
    - Statin Use in Persons with Diabetes
    - Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults

Potential Measure and Methodological Changes for Future Years

CMS is continuing to seek feedback on new measures or concepts that would incentivize plans from providing unnecessary, inappropriate, and low-value care or measures related to medical errors or misdiagnoses.

CMS is also considering changes in Star Ratings methodology to simplify calculations and make them easier to understand, including changes to cut points. An example of using percentile distribution cut points to assign measure stars instead of the clustering methodology was provided.

ATTACHMENT V: ECONOMIC INFORMATION FOR THE CY 2027 ADVANCE NOTICE

Attachment V outlines the economic information relevant to significant provisions in the Advance Notice. Any provision that is not mentioned below is assumed to follow CY 2026 guidelines and, therefore, have no resulting impact.

Section A. Changes in Payment Methodology for Medicare Advantage and PACE for CY 2027

Section A1. Medicare Advantage and PACE non-ESRD Ratebook

- Growth rate for 2027 FFS non-ESRD rates estimate: 5.10%.
- Growth rate for 2027 MA non-ESRD rates estimate: 4.04%:
    - Net Impact $22.86 billion cost to Medicare Trust Funds
- MA growth percentage used to calculate the 2027 PACE non-ESRD is estimated to be 4.04%.
    - Net Impact $140 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 $350 million cost to Medicare Trust Funds.

Section A2. Medicare Advantage and PACE non-ESRD Ratebook

- FFS growth percentage for the 2027 MA ESRD rates is estimated to be 6.17%.
    - Net impact $2.14 billion cost to Medicare Trust Funds.

Section A3. CMS-HCC Risk Adjustment Model

- CMS is proposing the CY 2027 risk scores be calculated entirely with 2027 CMS-HCC model.
    - Anticipated impact on MA risk scores: -3.32% relative to the blend in CY 2026
    - Represents $15.22 billion net savings to the Medicare Trust Fund in 2027.
    - Since the 2024 and 2027 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 (2024 and 2027) was appropriately normalized to remove the impact of FFS risk score trend.
- The CY 2027 impact on MA risk scores via excluding diagnosis from unlinked Chart Review Records (CRRs) is projected to be -1.53%, which represents a $7.12 billion net savings to the Medicare Trust Funds.

Section A4. ESRD Risk Adjustment Model

- CMS is proposing continuing the use of the ESRD risk adjustment models used for CY 2026.
  - No economic impact

Section A5. Frailty Adjustment for FIDE SNPs

- CMS is proposing the CY 2027 frailty scores for FIDE SNPs be calculated with the 2027 CMS-HCC model frailty factors, consistent with the risk adjustment model proposed.
- CMS estimates that the transition to the updated frailty factors will result in the following changes (relative to CY 2026).
  - The resulting change in frailty score is 4.89%
  - Represents a net impact of $30 million to the Medicare Trust Funds in 2027

Section A6. MA Coding Pattern Difference Adjustment

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

Section 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. CMS is proposing to calculate the normalization factors using a five-year multiple linear regression methodology and average historical FFS risk scores from 2021 through 2025 for the CY 2027 model.
  - The impact of normalization is zero

Section B. Changes in the Payment Methodology for Medicare Part D for CY 2027

Section B1. Annual Percentage Increase for Part D Parameters

- Unchanged from CY 2026
- At this time, impacts on the Medicare Trust Fund are uncertain.

- The impacts of these parameters are dependent on plan bid assumptions.

Section B2. Part D Risk Adjustment Model

- CMS is proposing a new updated RxHCC risk adjustment model to reflect statutory changes in Part D.
- 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. Part D 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 2027, for the RxHCC models, CMS is proposing to calculate normalization factors using the multiple linear regression methodology and average historical risk scores from 2020 through 2024 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 VI: HCC & RXHCC RISK ADJUSTMENT FACTORS AND PREDICTIVE RATIO TABLES

The proposed 2027 CMS-HCC risk adjustment model introduces recalibrated coefficients that shift relative payment weights across demographic groups and clinical categories. Although the structure remains aligned with the CY2024 v28 model, the updated weights reflect new claims experience and coding patterns. A clear theme is the broad reduction in demographic factors across age and population cohorts (aged, disabled, dual-eligible, community, and institutional).

Beyond demographic changes, we organized the HCCs into CMS CSNP categories as well as all other categories and note the following key changes in each category.

- **Substance Use Disorders:** Weights for chronic alcohol and drug dependence decline across most cohorts.
- **Autoimmune Disorders:** Generally decreasing for community age-ins; mixed elsewhere. HCC114 (variable/combined immunodeficiencies) is a major outlier with substantial increases.
- **Cancer:** Mixed changes with HCC19 showing one of the largest increases in the category.
- **Cardiovascular Disease:** Mixed movement; HCC263 (severe peripheral vascular disease) receives a significant increase.
- **Chronic Heart Failure:** Generally decreasing except HCC221 (heart transplant status), which increases.
- **Dementia:** Flat for age-ins; decreasing for disabled populations.
- **Diabetes:** Mostly decreasing, except increases for partial-dual age-ins, full-dual age-ins, and institutional members.
- **End-Stage Liver Disease:** Mostly decreasing, with HCC63 increasing for partial- and full-dual age-ins.
- **Chronic Kidney Disease:** Increases for HCC326 (Stage 5) and HCC328 (Stage 3B); decreases for HCC327 (Stage 4) and HCC329 (Stage 3 except 3B).
- **Hematologic Disorders**: Broad increases, with HCC111 showing some of the largest jumps (e.g., Full-Dual Disabled rising from 31 to 52).
- **HIV/AIDS:** Weights generally decreasing.
- **Chronic Lung Disorders:** Mostly decreasing across cohorts.
- **Mental Health Conditions:** Chronic and disabling mental health HCCs show broad decreases.
- **Neurologic Disorders:** Mixed increases and decreases across paralysis, neurodegenerative, and seizure-related HCCs.

- **Stroke:** Weights generally increasing.
- **Other:** Outside the traditional C-SNP categories, the model continues to show mixed directional changes. Ulcer-related HCCs (HCC379–HCC383) uniformly increase, as does Sepsis (HCC2), reflecting higher acuity and cost. Conversely, Morbid Obesity (HCC48) and Crohn's Disease (HCC80) are showing decreases.

Finally, CMS reduces weights for disease interaction terms and HCC count variables.

The proposed 2027 CMS-RxHCC (Prescription Drug Hierarchical Condition Category) risk adjustment model introduces recalibrated coefficients that shift relative payment weights across demographic groups and clinical categories. Although the structure remains aligned with the previous model, the updated weights reflect new claims experience and coding patterns. A clear theme, similar to the HCC model, is the broad reduction in demographic factors across age and population cohorts (aged, disabled, dual-eligible, community, and institutional).

Beyond demographic changes, we organized the RxHCCs into clinical categories and noted the following key changes in each:

Cardiovascular Disease: Weights are increasing across all demographic cohorts. The most significant jump is seen in the community non-low-income members under 65, rising from 8.046 to 10.424.

Dermatological Conditions: Mixed movement; weights are decreasing for non-low-income community members aged 65 and older but increasing for low-income and institutional members.

Endocrine & Metabolic: Generally decreasing for community senior populations (both low and non-low income), while showing notable increases for community members under 65 and institutional members.

Gastrointestinal & Hepatology: Mostly decreasing for non-low-income community seniors, but trending upward for low-income seniors and institutional populations.

Hematology & Immunology: Dramatic decreases across all community-based cohorts, contrasting with a sharp increase for institutional members (rising from 5.223 to 6.822).

Infectious Disease: Weights are generally decreasing for community cohorts but show a significant increase for institutional members.

Neurological & Neurocognitive: This category, which includes dementia and Parkinson's, is generally decreasing for community senior populations while remaining relatively flat or slightly increasing for younger community and institutional cohorts.

Oncology: Broad and significant increases are observed across every demographic cohort. This category represents some of the largest risk weight jumps in the model, particularly for non-low-income seniors where the weight rises from 27.189 to 31.679.

Ophthalmological Conditions: Weights for glaucoma-related conditions are decreasing across nearly all demographic cohorts.

Psychiatric & Behavioral: Mixed results; non-low-income community cohorts see a decline, while institutional members see a substantial weight increase from 1.060 to 1.551.

Renal & Kidney Transplant: Weights appear to be zeroed out or removed across all cohorts for the 2027 model year.

Respiratory Disease: Highly volatile movement; weights are increasing for non-low-income members under 65 and low-income seniors, but decreasing significantly for non-low income seniors and institutional members.

Rheumatological & Autoimmune: Generally increasing across all cohorts, with the institutional population seeing a major gain from 5.312 to 7.916.

Specialized Transplants: Weights are increasing for all community-based cohorts but showing a slight decrease for institutional members.

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ABOUT WAKELY

Founded in 1999, Wakely Consulting Group, an HMA Company, is well known for its top-tier healthcare actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive

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