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Potential Swings in County-Level Benchmarks: Understanding the Nuanced Impacts of CMS's Proposed Changes for 2027

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Note: This brief assumes the reader has a basic understanding of the average geographic adjustment factors in the county-level Part C benchmark rates used for payment in Medicare Advantage.

BACKGROUND ON AGA FACTORS IN PART C BENCHMARK RATES

The Part C benchmarks are derived from the county-level fee-for-service (FFS) rates. The Centers for Medicare & Medicaid Services (CMS) calculates county-level FFS rates by multiplying the estimated nationwide average non-end-stage renal disease (ESRD) FFS United States per Capita Cost (USPCC) and the county-level average geographic adjustment (AGA) factor, in addition to other minor adjustment factors.

The AGA factor measures the five-year average historical relationship between a county's per capita Medicare expenditures and the national average per capita Medicare expenditures. The five-year average of the geographic indices is divided by the five-year enrollment weighted average risk score to remove the effects of the health status and demographic characteristics of the beneficiaries in the county. For payment year (PY) 2027, the five-year average will be based on expenditures from 2020 through 2024.

CMS uses the following methodology to calculate the five-year average of geographic indices and the five-year weighted average of risk scores in the AGA factors:

- Historical hospital inpatient, hospital outpatient, skilled nursing facility, and home health claims will be repriced to reflect the most currently available wage indices, and CMS will retabulate physician claims with the most recent Geographic Practice Cost Index.
- Risk scores will be calculated using the model to be used in the payment year (i.e., for PY 2027 CMS will use the CMS-Hierarchal Condition Category [HCC] 2027 v28 model if it is finalized).

The bottom line is material changes to county-level expenditures or risk scores will have an impact on the AGA factor and, therefore, the county-level benchmark.

POTENTIAL IMPACT OF PROPOSALS INCLUDED IN THE CY 2027 ADVANCE NOTICE

CMS's Calendar Year (CY) 2027 Advance Notice, released on January 26, 2026, proposed adjustments to the expenditures used in the geographic indices as well as a new risk-adjustment model. These adjustments could result in material changes in AGA factors by county because they vary significantly in different parts of the country. Below we describe three specific adjustments that may cause change in AGAs for 2027.

- **DMEPOS:** CMS proposed excluding anomalous claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) with Healthcare Common Procedure Coding System (HCPCS) codes A4352 and A4353 for 2023 dates of service and A4353 and A5057 for 2024 dates of service.

With the Advance Notice, CMS published the proposed 2023 and 2024 county-level impacts for the DMEPOS removal. The amounts vary drastically by county. For CY 2023, the average per capita cost removed is approximately $10 nationally and county-level amounts ranging from $0 to $190. For CY 2024, the average national per capita cost amount removed is $3.50 and ranges from $0 to $55. **Table 1** shows the states with the highest per capita costs. It is likely that the AGA factor will decrease in these areas as the amount of DMEPOS in the proposed removal is greater than nationwide, effectively decreasing the geographic index for 2023 and 2024.

Table 1. Top Five Proposed DMEPOS Per Capita Amounts by State (weighted average)

Rank	2023		2024	
1	Kansas	$475	Delaware	$115
2	Nevada	$310	Maryland	$110
3	Michigan	$300	Illinois	$90
4	Utah	$365	Arkansas	$85
5	Indiana	$260	District of Columbia	$75

- **REH:** CMS proposed including additional payments to Rural Emergency Hospitals (REH) for 2023 and 2024. Starting in CY 2023, REH facilities are receiving additional facility payments in 12 monthly installments, which are not included in the National Claims History (NCH) used to tabulate the expenditures in the geographic indices.

CMS published the county-level impact of including the additional REH payments. The effect nationwide is minimal, averaging less than $2 per member per month (PMPM) for both years. However, it is likely the geographic indices for 2023 and 2024 will increase for the affected counties (mainly rural counties) where the additional payments are higher than the nationwide average, which could increase the AGA. For CY 2023 the REH amounts by county range from $0 to $460 and from $0 to $485 for CY 2024. **Table 2** displays the states with the highest per capita costs.

Table 2. Top Five Proposed REH Per Capita Amounts by State (weighted average)

Rank	2023		2024	
1	Mississippi	$14	Mississippi	$45
2	Oklahoma	$11	Arkansas	$37
3	Texas	$7	Oklahoma	$27
4	Georgia	$6	Kansas	$24
5	New Mexico	$5	Nebraska	$15

- **Skin Substitutes:** Beginning January 1, 2026, CMS pays for skin substitute procedures under the Medicare Physician Fee Schedule (PFS) as incident-to supplies. Previously, they were paid as biologicals, with payments of up to $2,000 per square centimeter. CMS estimates spending for these products will decrease by nearly 90%. [1]

1 Centers for Medicare & Medicaid Services. CMS Modernizes Payment Accuracy and Significantly Cuts Spending Waste. October 31, 2025. Available at: https://www.cms.gov/newsroom/press-releases/cms-modernizes-payment-accuracy-significantly-cuts-spending-waste.

The change in reimbursement is driving the downward restatements of the 2026 and 2027 USPCC and is reflected in the proposed growth rate; however, the effect on the AGA factors is unclear. On page 31 of the Advance Notice, CMS states, "Consistent with prior years, we do not reprice Part B drugs as a part of our adjustments to the AGAs." Given that skin substitute procedures were considered Part B drugs prior to 2026, it is unclear whether CMS will include these procedures in the repricing exercise used to calculate the geographic indices.

Using the FFS Limited Data Set (LDS) 5% sample, Wakely summarized the spending on the skin substitute procedures relative to total spend. In 2022, the skin substitute procedures represented about 0.35% of total costs; in 2023, it increased to 0.90% and in 2024 increased to 2.00%. **Table 3** displays the highest percentage of skin substitute spending in 2023 and 2024 for the top five states. Depending on how CMS handles the repricing, these areas could see increased volatility in the geographic indices.

Table 3. Observed Skin Substitute Spend as a Percentage of Total Cost

Rank	2023		2024	
1	West Virginia	4.6%	Nevada	9.4%
2	Nevada	4.3%	Virginia	6.6%
3	Arizona	4.2%	West Virginia	6.4%
4	Oklahoma	3.3%	Oklahoma	4.8%
5	Utah	3.2%	Florida	4.1%

In addition to the effect of skin substitute procedures on the costs used in the geographic indices, risk scores are affected. CMS is proposing a new risk-adjustment model that uses 2023 diagnoses and 2024 expenditures to calculate the coefficient factors. We observed a consistent and significant increase in the coefficients for pressure ulcers. These increases are likely the result of updating the expenditure year to 2024, when skin substitute reimbursement was much higher than in the previous CMS-HCC model. This change highlights a disconnect between the process used to recalibrate the risk-adjustment model versus the development of the growth rate and projected costs for the contract year.

As mentioned previously, the prevalence of skin substitute procedures has increased among FFS providers from 2022. In counties where the skin substitute mix is higher than the nationwide average, the FFS risk scores will likely increase. Given all five data years (2020–2024) will be scored the on PY 2027 CMS-HCC model, this could have a material impact. An increase in risk scores would decrease the AGA factors. It is also worth noting that areas with a high prevalence of skin substitutes may experience a double impact on a downward AGA adjustment (the first adjustment reflecting lower claims via the repricing [numerator] and the second adjustment reflecting higher risk scores [denominator]).

CONCLUSION

By April 6, 2026, CMS will release the MA Final Rate Announcement, which will include final guidance on whether the above proposals will be fully implemented, phased-in, or delayed for PY 2027. If these proposals are implemented, the financial impact to MA plans and risk-bearing providers will vary widely.

When estimating the potential impact to plan revenue, MA plan sponsors should consider the impact of the DMEPOS, REH, and skin substitute FFS prevalence in their market. A decrease in county-level FFS expenditures could decrease the AGA factors. In addition, an increase in FFS risk scores could decrease the AGA factors.

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