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Summary of CY 2027 Final Rate Announcement

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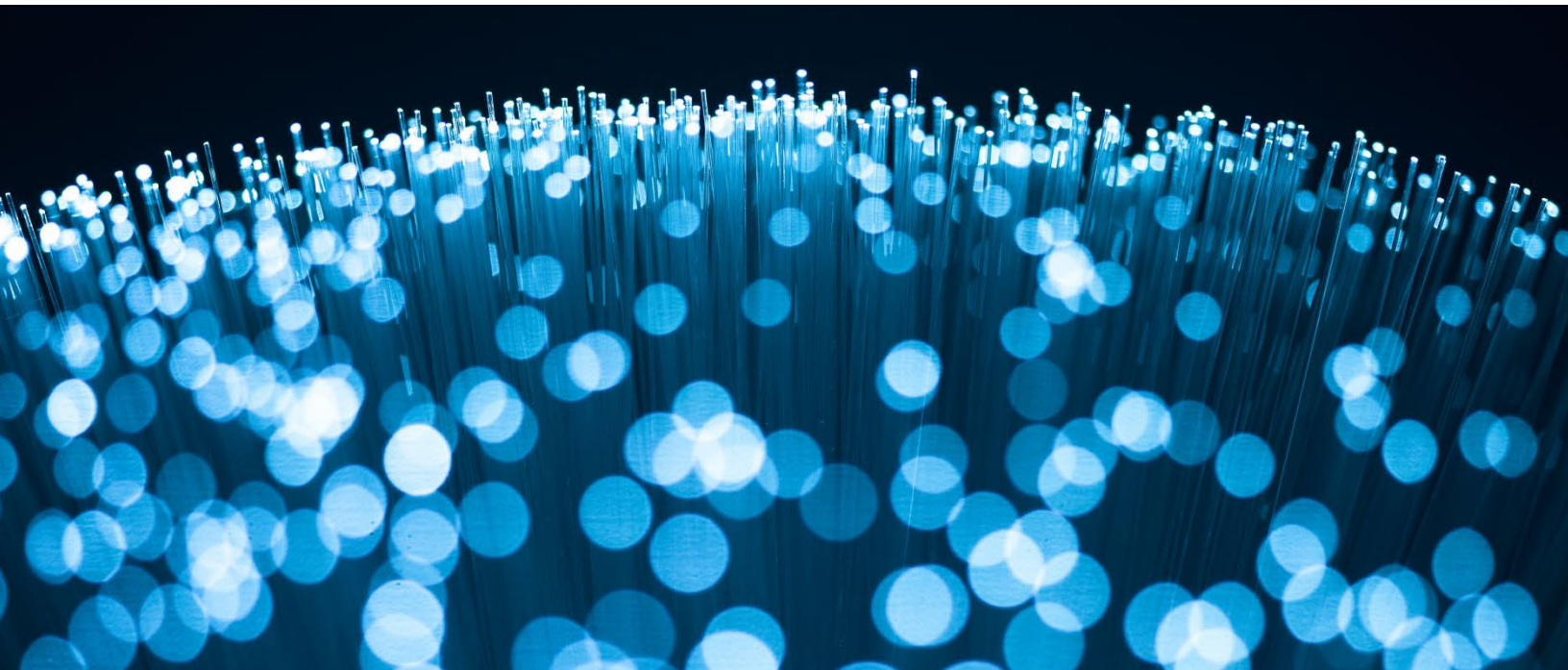

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EXECUTIVE SUMMARY

On April 6, 2026, the Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2027 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Final Announcement), which finalize various proposals from the January 26, 2026 Advance Notice.

In general, most policies proposed in the Advance Notice will be adopted without change. The most impactful changes compared with the Advance Notice are the decision by CMS to not adopt the 2027 CMS-HCC risk adjustment model, an exception to exclude diagnoses from unlinked chart review records only for members with the plan in the diagnosis year, and the upward revision to the fee-for-service (FFS) growth rate. Together, CMS estimates that these changes increased the average risk-adjusted growth rate by 239 basis points compared with the Advance Notice provisions.

Overall MA Payment Impact

Wakely estimates that, on average, 2027 Part C standardized benchmarks will increase 5.06% over 2026 nationwide. This reflects the impact of the growth rate, rebasing/repricing, change in Star Ratings and changes to applicable percentages (i.e., quartile rankings). We also estimate that the change in risk-adjusted benchmark revenue for 2027 versus 2026 is expected to be 2.29%. This accounts for changes in Part C risk score adjustments, including the FFS normalization factor, the MA coding pattern adjustment, and an assumption of no trend in plan risk scores.

Plans should be aware that the changes in the benchmarks can differ considerably (and typically are greater in magnitude) than the change in CMS revenue to the plan. Plans are paid 100% of their Part C basic bid (assuming they bid below the benchmark), which is unaffected by the benchmark for most plans, plus a percentage of the remaining difference of the excess of the benchmark above the bid. Therefore, an increase in the benchmark will impact plans differently based on the disparity of the plan's bid compared to the benchmark (i.e., the "savings") and the star-based percentage of the savings retained by the plan (i.e., Part C "rebate").

Our analysis of county specific benchmarks and plan revenue was aggregated using March 2026 CMS published MA enrollment and star ratings for payment years 2026 and 2027.

Wakely Analysis –Estimated Impact of Growth Rates and Payment Reform

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

- Increase by 5.06% on a standardized (i.e., 1.00) risk score basis. This incorporates changes driven by FFS growth rate, rebasing/repricing, graduate medical education (GME), kidney acquisition costs (KAC), VA Department of Defense (DoD), indirect medical education (IME), credibility, applicable percentage by county, average change in star ratings and quality bonus, and the impact of benchmark.
- Increase by 2.29% on a risk-adjusted basis. The risk-adjusted increase incorporates the year-over-year impact of FFS normalization factors and the impact of removing unlinked chart reviews. There is no change in the MA coding pattern or risk adjustment model from 2026. It does not include MA risk score coding trend.

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

- Change in 1.00 benchmarks
- Impact of change in FFS normalization factor and removal of unlinked chart reviews
- Assumption of no trend in raw risk scores
- Average change in star ratings based on March 2026 enrollment

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

Table 1. Change in Blended Risk-Adjusted Benchmarks [1]

	2026 to 2027
Growth Rate	5.51%
Rebasing/Repricing	0.04%
Applicable %	-0.19%
Star Rating/Quality Bonus	-0.25%
Benchmark Cap	-0.03%
Total Benchmark Change	**5.06%**
FFS Normalization and Risk Model Revision	-2.63%
MA Coding Pattern	0.00%
Total Risk Score Change	**-2.63%**
TOTAL	**2.29%**

[1] Based on March 2026 MA enrollment and Fall 2025 Star Ratings

Below is a brief definition of each of the elements in **Table 1**.

Growth Rate. This is the impact of the FFS (+5.46%) growth rate and the following adjustment factors:

- *Direct GME.* CMS is required to remove costs directly related to graduate medical education. The change to this adjustment from 2026 to 2027 had minimal impact (-0.04%). Note, this adjustment is attributable to FFS beneficiaries only. The adjustment for MA beneficiaries is made to the United State Per Capita Costs (USPCC) before the county-level rates are calculated.

- *VA and DoD.* The change in these carve-out factors from 2026 to 2027 had a minimal impact (0.12%).

- *Credibility.* As FFS enrollment decreases, credibility adjustments are necessary when developing the rates used for MA payment. We anticipate more counties will require a credibility adjustment in future years. The change from 2026 to 2027 was immaterial (0.00%).

- *KAC.* Due to the 21st Century Cures Act, CMS is required to remove KAC from the development of the MA payment rates. The change from 2026 to 2027 was immaterial (-0.01%).

- *IME.* Costs attributable to IME are also removed from the payment rates. The change from 2026 to 2027 was immaterial (-0.04%). Note, this adjustment is attributable to FFS beneficiaries only. The adjustment for MA beneficiaries is made to the USPCC before the county-level rates are calculated.

Rebasing/Repricing. The Average Geographic Adjustment (AGA) factors are derived via the compilation of five years of historical Medicare Parts A and B claim costs at the county level. For payment year 2027, historical claims from 2020 to 2024 are repriced to reflect the most current wage indices (Fiscal year 2026). Wakely calculated the overall impact to MA plans nationwide is 0.04%. The impact of the rebasing and repricing for 2027 payment rates varies significantly by region. This is in part driven by the adjustments made for Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) and the decision to not reprice the skin substitute claims.

Applicable %. Average nationwide change in applicable percentage, based on the enrollment by MA contract and county.

Star Rating/Quality Bonus. Difference in quality bonus impact on benchmarks due to star rating changes between payment year 2026 and 2027. This is based on a static enrollment mix, so it only reflects changes in average star ratings by contract, and not a shift in enrollment toward plans with higher or lower star ratings. In addition, it does not include terminated contracts or contracts without a star rating.

Benchmark Cap. The Affordable Care Act (ACA) formula requires that the final blended benchmark can be no greater than the pre-ACA benchmark. The impact of this cap can year-to-year as plans change star ratings, and as the National Per Capita MA Growth Percentage (NPCMAGP) trend differs from the FFS trend.

Part C FFS Normalization Factor and Risk Model Revision. Consistent with PY2026, PY2027 risk scores will be based on the current 2024 v28 CMS-HCC model. For 2025, CMS updated the FFS normalization methodology to use a multiple regression model which identifies years 2020 through 2023 as COVID affected years. Based on the Fact Sheet, CMS estimates the overall change to both the risk adjustment model and FFS normalization will be -2.63%.

Change in Coding Pattern Adjustment. The coding pattern adjustment for 2026 will be kept at - 5.90%, which is the minimum adjustment required by the Affordable Care Act. There will be no change from 2026.

Change in Bid and Rebate Amounts

The actual revenue change for individual MA 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.

To properly estimate the impact of the various MA payment components addressed in the Final Rate Announcement, Medicare Advantage plans must consider the aggregate 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 2.29%. If we assume that both 2026 and 2027 bids are 78% of the benchmark, then we estimate the change in Part C payments from 2026 to 2027 to be an increase of 2.20% (see **Table 2**).

This estimate is based on the following assumptions:

- Plans bid at 78% of the benchmark in 2027. This is based on the published bid-to-benchmark ratios in the 2027 Final Rate Announcement.
- Annual risk score coding trend is 0% for a static population.
- Nationwide average star ratings, which result in an average rebate percentage of 65.9% in 2026 and 65.5% for 2027.
- No consideration for sequestration.

Table 2 shows the calculations underlying our estimates.

Table 2. Change in Risk-Adjusted MA Bid Revenue

Item	2026	2027	2027/2026
1.0 MA Benchmark [1]	$1,277.94	$1,342.57	5.06%
Raw Risk Adjustment Factor [2]	1.0000	1.0000	0.00%
Risk Score Model Change	1.0000	1.0000	0.00%
Removal of Unlinked Chart Reviews	1.0000	0.9847	-1.53%
FFS Normalization	1.0669	1.0790	-1.12%
MA Coding Pattern Adjustment	0.9410	0.9410	0.00%
RAF after FFS Norm & Coding Pattern	0.8820	0.8588	-2.63%
Risk-Adjusted Benchmark	$1,127.14	$1,152.95	2.29%
Assumed Risk-Adjusted Bid [3]	**$879.17**	**$899.30**	**2.29%**
Savings (Benchmark less bid)	$247.97	$253.65	2.29%
Rebate [4]	$163.35	$166.12	1.70%
Risk-Adjusted Bid + Rebate	**$1,042.52**	**$1,065.42**	**2.20%**

[1] Based on nationwide average MA enrollment by county as of March 2026

[2] Assumed no trend in risk scores

[3] Bid set at 78% of risk-adjusted benchmark

[*4] 65.9% for 2026 and 65.5% for 2027*

Risk Scores and FFS Normalization

For CY 2027, CMS will use the 2024 CMS-HCC model (v28) for all non-Program of All-Inclusive Care for the Elderly (PACE), non-end-stage renal disease (ESRD) beneficiaries. CMS declined to implement the proposed 2027 CMS-HCC model from the Advance Notice, citing the need to allow stakeholders additional time to adjust to the 2024 model. PACE plans will use a 50/50 blend of the 2024 and 2017 CMS-HCC models.

The non-PACE, non-ESRD FFS normalization factor will be 1.079, based on a linear regression of historical risk scores from 2022–2025. This represents a -1.12% change in normalized risk scores relative to CY 2026. Normalization factors for ESRD and PACE beneficiaries changed modestly from the Advance Notice.

The shift to a linear regression reflects CMS's view that all years in the dataset reflect a post-COVID environment, eliminating the need for a separate pre/post-COVID adjustment.

The MA coding pattern adjustment remains at the statutory minimum of 5.90%, unchanged from CY 2026.

For Part D RxHCC models in CY 2027:

- Non-PACE organizations will use the model proposed in the Advance Notice, which relies on 2023 diagnoses to predict 2024 payments, incorporating adjustments for maximum fair price (MFP) drugs.
- PACE organizations will use a 50/50 blend of the CY 2027 RxHCC model and the model based on 2018 diagnoses to predict 2019 payments.

CMS will continue using separate RxHCC FFS normalization factors for Part D plans in 2027: 1.005 for PDPs and 1.109 for MA-PDs. For PACE plans, the RxHCC normalization factors will be 1.237 for the 2018/2019 model and 1.109 for the 2027 model.

CMS finalized the proposal to exclude diagnoses from unlinked chart review records, but modified the proposal to not apply the exclusion to members who switch from one MA plan in the diagnosis to another in the payment year.

Star Rating Changes

CMS finalized several changes to star rating calculations for Star Rating Year (SY) 2027 and for SY2028 and beyond. Changes included modifications to measure definitions, changes to weights, addition of new measures and removal of some measures.

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

The final 2027 MA and FFS growth rates are shown in **Table 3** and are compared with the Advance Notice and the 2026 growth rates.

Table 3. Comparison of 2026 and 2027 Growth Rates

Component	2027 Final	2027 Advance Notice	2026 Final
MA (Including FFS and MA) – Non-ESRD Growth %	5.46%	5.10%	8.81%
Non-ESRD FFS Growth %	5.41%	4.04%	10.72%
ESRD FFS Growth %	6.96%	6.17%	6.79%

The MA (FFS and MA), Non-ESRD FFS and ESRD dialysis-only growth rates increased from the Advance Notice. The data reflected in the Advance Notice was through 2Q2025 for Part A and 3Q2025 for Part B and MA. The data reflected in the Final Rate Announcement is through 4Q2025 for Parts A and B. The update in data was the primary driver of the increase in growth rate. However, we do note that the increase in growth rate was driven by an increase in the 2026 and 2027 USPCC, whereas the 2025 baseline decreased from the Advance Notice.

As has been the case in past years, the year-over-year change in Part C benchmarks can vary significantly depending on geographic area, plan star rating and applicable percentage. **Table 4** (next page) shows the top five and bottom five growth rates by State (these changes include changes due to repricing/rebasing, direct GME, KAC, IME, VA and DOD, credibility factors, star rating, double bonus status, applicable percentage, and the benchmark cap.

Table 4. States with Highest and Lowest Benchmark Change

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%

ATTACHMENT II: KEY ASSUMPTIONS AND FINANCIAL INFORMATION

As in past years, CMS published projections for the total USPCCs by year. Projections are provided for all Medicare services combined as well as more detailed projections by service category within Part A and Part B.

Table 5 shows the restatements, from the Announcement of Calendar Year 2026, of the estimated Part A + Part B non-ESRD FFS costs for 2025 through 2027. FFS non-ESRD growth rate is 5.46%, a slight increase over the 5.10% in the Advance Notice.

Table 5. Non-ESRD FFS Cost Estimates – CY 2027 Final Announcement vs. CY 2026 Final Announcement

Year	CY 2027 Final Announcement	CY 2026 Final Announcement	Restatement
2025	$1,194.31	$1,179.93	1.2%
2026	$1,231.22	$1,230.52	0.1%
2027	$1,297.74	$1,303.06	-0.4%

In the CY 2027 projections by service category for non-ESRD (Aged + Disabled), current estimates show a wide range of changes compared to last year. The top 3 categories for which current estimates increased the most compared with last year's estimates are Part B carrier lab (+13.0%), Part A Skilled Nursing Facility (SNF) (+5.0%) and Part B other intermediary (+4.6%). The top 3 categories that decreased the most versus last year's estimates are Part B physician administered drugs (-17.6%), Part B DMEPOS (-8.0%) and Part A Home Health Agency (-5.1%). The DME and physician administered drug changes are significantly affected by the removal of anomalous DME procedures and the repricing of skin substitutes, respectively.

CMS continues to project that MA enrollment will exceed the growth rate of total Medicare beneficiaries from 2026 through 2028. However, projected increases in 2029 are markedly lower across all categories compared to prior years. **Table 6** shows the annual changes in CMS's projected enrollment for these years.

Table 6. Projected Annual Percentage Change in Medicare Enrollment (non-ESRD, Part A)

Year	Total	FFS	MA
2027	2.2%	1.2%	3.2%
2028	2.3%	0.8%	3.7%
2029	0.4%	0.4%	0.4%

ATTACHMENT III: RESPONSES TO PUBLIC COMMENTS ON PART C PAYMENT POLICY

Section A. Estimates of the MA and FFS Growth Percentages for CY 2027

CMS finalized the CY 2027 growth rate methodology largely as proposed, continuing to rely on FFS per capita cost estimates under current law and incorporating updated experience through 4Q2025.

Key Updates and Considerations

Growth rates reflect updated FFS experience, economic assumptions, and finalized 2026 payment rules. CMS did not phase in or adjust policy changes (including skin substitutes and 340B-related updates), and continued reliance on the statutory framework limits flexibility in rate setting.

FFS cost trends are based on the most recent available data, including updated claims and enrollment experience. Economic assumptions reflect market basket updates, CPI adjustments, and other inflation-related factors embedded in Medicare payment systems. Growth rates also incorporate the impact of finalized policy changes, including physician fee schedule updates and changes to skin substitute payments. Compared to the Advance Notice, the final rates reflect more complete 2025 experience (through Q4), as well as updated projection factors.

Comment Themes

Commenters expressed concern that growth rates may understate current utilization, acuity, and inflation trends, which could create pressure on plan margins, benefits, and premiums. Several stakeholders noted potential data lag and requested incorporation of more recent experience. Others highlighted the impact of multiple policy changes embedded in the growth rates and recommended phasing in significant changes to reduce volatility. Commenters also requested greater transparency into assumptions, methodologies, and key trend drivers.

CMS Responses

CMS maintained its established methodology, emphasizing that growth rates must be based on FFS per capita costs under current law and cannot reflect anticipated legislative changes. CMS indicated that the final rates incorporate the best available data at the time of release, including updated experience and projections. While acknowledging stakeholder feedback, CMS stated that existing documentation, including the Rate Announcement and supplemental trend exhibits, provides sufficient transparency.

Growth rates for CY 2027 were finalized, consistent with prior methodology, with updates for more recent data and finalized policies. Despite stakeholder concerns regarding adequacy and volatility, CMS did not adopt suggested adjustments, citing statutory constraints and adherence to current law

Section B: MA Benchmark, Quality Bonus Payments, and Rebate

Commenters urged CMS to remove or relax the statutory benchmark cap, based on pre-ACA rules, arguing that it can limit quality bonus payments. CMS responded that it does not have the authority to eliminate or modify the cap, as it is mandated by statute (Section 1853(n)(4)). Because the benchmark cap is tied to legally defined payment formulas, CMS lacks administrative discretion to change this policy.

Section C: Calculation of Fee-for-Service Costs

CMS largely maintains its existing methodologies, emphasizing statutory constraints, stability through multi-year averaging, and targeted adjustments (e.g., removal of suspect billing and inclusion of Rural Emergency Hospital [REH] payments).

Data transparency & files: Commenters requested greater transparency and continued publication of certain data files (e.g., *FFSyyPR.xlsx*). CMS responded that it already provides extensive county-level FFS data and announced that the *FFSyyPR.xlsx* file will be discontinued due to system and data integration changes.

Methodology for calculating FFS costs: CMS uses a five-year rolling average of FFS claims to calculate geographic adjustments (AGAs). This methodology helps smooth volatility and mitigate the impact of anomalies. CMS reaffirmed this approach and made no changes.

Adjustments and inclusions in FFS costs: FFS cost calculations include certain adjustments, such as Rural Emergency Hospital (REH) payments. At the same time, CMS excludes fraudulent or suspect billing and payments not funded by Medicare trust funds (e.g., CMMI payments). CMS finalized adjustments of approximately -$3.6 billion for 2023 and -$2.3 billion for 2024 related to suspect DMEPOS claims.

Treatment of Part B drugs (e.g., skin substitutes): Commenters requested repricing of historical Part B drug data at the county level. CMS stated that it does not have the systems or data required to support such repricing and will therefore continue its current methodology without repricing Part B drugs, including skin substitutes.

Population used for benchmarks (Part A/B eligibility issue): Commenters recommended limiting benchmark calculations to beneficiaries enrolled in both Part A and Part B. CMS responded that its current methodology, which includes beneficiaries enrolled in Part A and/or Part B, is consistent with statutory requirements and will remain unchanged. The only exception continues to be Puerto Rico, where a specific adjustment is applied due to unique enrollment patterns.

Rural and market concerns: Commenters raised concerns about payment adequacy in rural areas and the financial sustainability of smaller plans. CMS acknowledged these concerns but emphasized that it must adhere to statutory requirements, under which benchmarks are based on FFS costs.

Section D. Direct Graduate Medical Education (DGME)

CMS intends to continue with the methodology finalized in the CY 2025 Rate Announcement for DGME carve-outs.

Section E. Organ Acquisition Costs for Kidney Transplants

CMS intends to continue with the methodology finalized in the CY 2026 Rate Announcement for the KAC carve-out.

Section F. IME Phase Out

CMS intends to continue with the methodology finalized in the CY 2025 Rate Announcement for IME.

Section G MA ESRD Rates

As indicated in the CY 2027 Advance Notice, the methodology for the development of the MA ESRD rates will be similar to prior years.

Section H. MA EGWPs

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

CMS intends to continue to use the current methodology to establish MA EGWP payment amounts.

Section I. CMS-HCC Risk Adjustment Model

For CY 2027, CMS will not implement the 2027 CMS-HCC model as proposed in the Advance Notice. Instead, CMS will continue to use the 2024 CMS-HCC risk adjustment model to calculate

risk scores for CY 2027 in order to allow the MA market more time to adjust to the completed phase-in of the 2024 CMS-HCC risk adjustment model.

While some commenters supported the proposed 2027 CMS-HCC risk adjustment model, many commenters had concerns about the changes. One specific concern was related to skin substitutes and how the 2027 CMS-HCC risk adjustment model as proposed did not adjust for the higher spending. Although the model was not finalized, CMS assessed the impact of reducing the costs of skin substitutes and found that the raw MA risk score would have only been 0.1% lower.

CMS-HCC Risk Adjustment Model for PACE Organizations

CMS finalized the 50/50 blend as proposed in the CY 2027 Advance Notice. For CY 2027, PACE risk scores will be a 50/50 blend of:

- 2017 CMS-HCC model using Risk Adjustment Processing System (RAPS) + Encounter + FFS data
- 2024 CMS-HCC model using Encounter + FFS only

Section J. 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 finalized using a 50/50 blend of:

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

Section K. Frailty Adjustment for FIDE SNPs & PACE Organizations

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

Frailty factors are unique to each version of the CMS-HCC risk adjustment model. Consequently, as CMS did not implement the 2027 CMS-HCC risk adjustment model, CMS will use the frailty factors associated with the 2024 CMS-HCC risk adjustment model to calculate frailty scores for CY 2027. **Table 7** shows the frailty factors associated with the 2024 CMS-HCC model.

Table 7. Frailty Factors Associated with the 2024 CMS-HCC Model

ADL	Non-Medicaid	Partial Medicaid	Full Medicaid
0	-0.066	-0.070	0.158
1–2	0.103	0.203	0.230
3–4	0.201	0.203	0.230
5–6	0.201	0.217	0.248

For FIDE SNPs to qualify for frailty payments in CY 2027, they must contract with a CMS-approved survey vendor to field the 2026 HOS or HOS-M 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 8**, and
- 50% of the frailty score calculated with the 2024 CMS-HCC model frailty factors as shown in **Table 7**

Table 8. 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 L. 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 M. Normalization Factors for the CMS-HCC Risk Adjustment Models

CMS is revising the normalization factor calculation proposed in the Advance Notice for all CMS-HCC models to exclude 2021 risk scores (2020 dates of service) due to the impact of COVID-19 on those risk scores. The previously included trend from 2021 to 2022 risk scores was artificially high due to the pandemic shut down and that high trend is now deemed unreasonable to be used for expectations of 2025 to 2027 FFS risk score trends. The proposed normalization factor for the 2024 CMS-HCC (v28) model was therefore revised from 1.083 to 1.079.

For both non-ESRD and ESRD models, CMS will use a four-year simple linear regression model using risk scores for 2022–2025. The resulting normalization factors for all models and populations are listed in **Table 9**.

Table 9. CY 2027 Normalization Factors

Model	Normalization Factor
2024 CMS-HCC (v28)	1.079
2017 CMS-HCC (v22)	1.202
2023 ESRD Dialysis	1.072
2019 ESRD Dialysis	1.145
2023 ESRD Functioning Graft	1.119
2019 ESRD Functioning Graft	1.209

Section N. Sources of Diagnoses for Risk Score Calculation

CMS is finalizing the proposal to exclude diagnoses from audio-only encounters from the risk score calculation using the 2024 CMS-HCC model (v28) and provided an estimated average impact of 0.00% for these exclusions.

CMS is modifying the proposal to exclude diagnoses from unlinked chart review records by adding an exception for beneficiaries who switch between MA organizations from one year to the next. Specifically, organizations will be able to submit unlinked chart reviews for beneficiaries who were enrolled in MA with a different parent organization the year prior, but not if the beneficiary was in FFS.

For non-PACE plans for CY 2027 CMS will continue to use the eligible encounter data and FFS claims.

PACE plan risk scores will be calculated as proposed, with 50% of the risk score for non-ESRD beneficiaries using the 2024 CMS-HCC model (v28) while using only encounter data and FFS claims and the remaining 50% portion of PACE beneficiaries risk scores will continue to use RAPS, encounter data, and FFS claims under the 2017 CMS-HCC model (v22). Diagnoses from all types of unlinked chart review records will be included when calculating risk scores for PACE organizations.

ATTACHMENT IV. RESPONSES TO PUBLIC COMMENTS ON PART D PAYMENT POLICY

Section A. Annual Adjustments To Medicare Part D Benefit Parameters In 2027

CMS addressed concerns regarding increases in the deductible and other benefit thresholds that may affect beneficiary affordability by noting that Part D benefit parameter updates strictly follow statute. Benefit parameters are indexed by the Annual Percentage Index (API), using the calculation methodology specified in section 1860D-2(b)(6) of the Act, and CMS does not have flexibility to change the API calculation.

Section B. Part D Premium Stabilization

CMS received several comments expressing support for continuation of the voluntary Part D premium stabilization demonstration due to significant structural changes in the Part D benefit, including elimination of beneficiary cost sharing in the catastrophic phase, increased plan liability, and the growth of high-cost specialty drugs (e.g., GLP-1s). CMS also received comments opposing continuation of this demonstration, arguing that doing so may complicate bid development, shift cost burdens toward enrollees, or delay necessary pricing adjustments under the redesigned Part D benefit structure.

CMS has not committed to extending (or not extending) premium stabilization for CY 2027 without first reviewing CY 2027 bids. CMS will announce any additional premium stabilization for participating PDPs for CY 2027 no later than the release of the National Average Monthly Bid

Amount (NAMBA), Part D base beneficiary premium (BPP), and related Part D bid information in the summer of 2026.

CMS also received comments expressing concern about additional market volatility related to the planned start of the Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) model but noted that the design and implementation of CMS Innovation Center models is outside the scope of this Rate Announcement.

Section C. Part D Calendar Year EGWP Prospective Reinsurance Amount

No changes from the Advance Notice. CMS plans to announce the CY 2027 prospective reinsurance payment amount for Part D Calendar Year EGWPs with the annual release of the NABMA, Part D BPP, and related Part D bid information in summer 2026.

Section D. Part D Risk Sharing

No changes from the Advance Notice. CMS received requests to narrow Part D risk corridors to address increased uncertainty due to Part D redesign, specialty drug trends, and concurrent program changes in Medicare (e.g., maximum fair price (MFP) drugs taking effect, CMS Innovation Center models), however, statute does not permit CMS to narrow the corridors relative to the CY 2011 thresholds.

Section E. Retiree Drug Subsidy Amount

No comments or changes from the Advance Notice.

Section F. RxHCC Risk Adjustment Model

No changes from the Advance Notice. CMS is finalizing the proposed RxHCC model changes that reflect the CY 2027 Part D benefit (inclusive of 2026 MFPs, but exclusive of 2027 MFPs). Changes include updating the calibration to use 2023 diagnoses and 2024 drug spending, separate continuing enrollee model segments for MA-PD plans and stand-alone PDPs, and the exclusion of diagnoses from audio-only services.

CMS received comments expressing concern that the proposed model did not include an adjustment for the agreement upon MFPs for IPAY 2027 but reiterated that the release of these MFPs in November 2025 did not allow for their incorporation. CMS anticipates incorporating these MFPs into the RxHCC model calibration for CY 2028.

CMS also declined requests to adjust the model for expected future utilization or new drugs entering the market, based on the belief that modeling future behavior would result in accurate predictions of relative costs.

Part D Risk Adjustment Models for PACE Organizations: No changes to the Advance Notice. CMS will implement a blend of RxHCC models as proposed for CY 2027 by calculating risk scores as a blend of 50% of the risk score calculated using the MA-PD relative factors of the 2023/2024 RxHCC model and 50% of the risk score calculated using the 2028/2019 RxHCC model.

Section G. Normalization For The RxHCC Risk Adjustment Models

No changes from the Advance Notice. CMS is finalizing the proposal to apply separate normalization factors for PDPs and MA-PD plans using the proposed multiple linear regression methodology.

CMS received comments suggesting alternate calculation methodologies such as calculating separate normalization factors based on the risk score trend or diagnosis trend in each sector or applying a demographic adjustment to the separate normalization factors to account for potential differences between the two populations over time. CMS responded that 2024 gross drug costs (per capita for continuing enrollees) were similar for MA-PD plans and PDPs, and because of a variety of market-based variables they believe assuming equal risk between sectors in 2027 will ensure a level playing field and allow for fairer competition. CMS will continue to monitor risk score trends and conduct analyses using 2025 data to determine normalization methodology that results in the most reasonable predictions of the payment year risk scores.

CMS also received comments requesting that CMS switch to a single normalization factor like was used prior to CY 2025, arguing that CMS is unfairly subsidizing PDPs at the expense of MA-PD plans and that applying separate normalization factors is inconsistent with Part C. CMS responded that applying a single normalization factor would lead to risk adjusters that do not appropriately account for the variation in costs between MA-PD and PDP enrollees because of differences in coding practices between sectors.

Section H. Source Of Diagnoses For Part D Risk Score Calculation

Refer to Attachment III, Section N, for comments and responses regarding sources of diagnoses for risk score calculation. For non-PACE organizations, CMS will calculate CY 2027 risk scores using eligible diagnoses derived from encounter data and FFS claims, excluding diagnoses from audio-only services, and from unliked CRRs (with an exception for beneficiaries who switch between MA organizations from one year to the next). For PACE organizations, CMS will calculate CY 2027 risk scores using 50% of the risk score calculated using eligible diagnoses from RAPS, encounter data, and FFS claims, and 50% of the risk score calculated using eligible diagnoses derived exclusively from encounter data and FFS claims, excluding diagnoses from audio-only services. Diagnoses from unliked CRRs will be included if otherwise eligible.

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

Table 10. Updated API and CPI for 2027

	Annual Percentage Trend for 2026	Prior Year Revisions	API for 2027
API	9.37%	3.92%	13.65%
September CPI (all items, US city average)	2.31%	0.67%	3.00%

Table 11. Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy (LIS), and Retiree Drug Subsidy

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]		

Part D Benefit Parameters	2026	2027
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	$14,000

Section A. Annual Percentage Increase in Consumer Price Index (CPI)

The copayments for full benefit dually eligible beneficiaries are increased from $1.60 to $1.65 per generic, preferred drug that is a multi-source drug, or biosimilar, and from $4.90 to $5.00 for all other drugs.

Section B. Calculation Methodology

For the CY 2027 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 Events (PDEs) 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 C. Annual Percentage Increase in Average Expenditures for Part D Drugs Per Eligible Beneficiary

The defined standard deductible is updated by multiplying the 2026 amount of $615 by the 2027 API and rounding to the nearest multiple of $5, resulting in a 2027 deductible amount of $700.

The annual out-of-pocket (OOP) threshold is updated by multiplying the 2026 amount of $2,100 by the 2027 API and rounding to the nearest multiple of $50, resulting in a 2027 annual OOP of $2,400.

Section D. Retiree Drug Subsidy Amounts.

The cost threshold and cost limit for qualified retiree prescription drug plans are updated using the API. The cost threshold is rounded to the nearest multiple of $5, increasing from $615 to $700. The cost limit is rounded to the nearest multiple of $50, increasing from $12,650 to $14,000.

ATTACHMENT VI: 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 (weight of 1)
- 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 receives EUC status due to wildfires in January 2025 and several counties in Texas (primarily in and around city of Austin) receive 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: Will be removed from Star Ratings in MY 2026/SY 2028 due to a substantive change to the eligible population. No plan for this measure to return to star ratings.
- 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. CMS did not finalize this change.
- Transitions of Care: CMS considered multiple 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. CMS finalized the non-substantive change (1) but not the other proposed changes.
- 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 been finalized with 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 continues 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. CMS received many comments and shared the feedback with National Committee for Quality Assurance (NCQA) and other measure stewards.

ATTACHMENT VII. ECONOMIC INFORMATION FOR THE CY 2027 RATE ANNOUNCEMENT

Section A. Changes in the Payment Methodology for MA and PACE for CY 2027

A1. Medicare Advantage and PACE non-ESRD Ratebook For CY 2027, the FFS and MA growth rates are 5.46% and 4.40%, respectively. The MA non-ESRD ratebook update carries an estimated net impact of $23.16B to the Medicare Trust Funds, after accounting for the benchmark rate cap, MA rebate, EGWP policies, bid savings, and Part B premium offsets. The PACE non-ESRD update reflects the same 4.40% growth rate and contributes an estimated $160M net impact. Separately, implementation of the zero-claims adjustment in Puerto Rico is projected to increase Trust Fund expenditures by $350M.

A2. Medicare Advantage and PACE ESRD Ratebooks The FFS growth rate for MA ESRD is 6.96% for CY 2027. Updating the MA and PACE ESRD ratebooks is expected to result in a net impact of $2.27B to the Medicare Trust Funds, after Part B premium offsets.

A3. Sources of Diagnoses for CY 2027 CMS will exclude diagnoses from audio-only services and unlinked chart review records (CRRs) from risk score calculations, with an exception for beneficiaries switching between MA organizations. This is projected to generate net savings of $6.84B to the Medicare Trust Funds, reflecting the government's retained share of the benchmark-bid difference and Part B premium offsets.

A4. ESRD Risk Adjustment Model CMS is carrying forward the CY 2026 ESRD risk adjustment models without modification. No economic impact.

A5. Frailty Adjustment for FIDE SNPs CMS is retaining the CY 2026 frailty factors from the 2024 CMS-HCC model. No economic impact.

A6. MA Coding Pattern Difference Adjustment CMS will continue applying the statutory minimum coding pattern difference adjustment of 5.90%, consistent with CY 2026. No year-over-year impact.

A7. Part C Normalization Normalization factors will be calculated using a four-year simple linear regression on historical FFS risk scores from 2022–2025. As normalization holds the average FFS risk score at 1.0 year-over-year, there is no economic impact.

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

B1. Annual Percentage Increase for Part D Parameters The CY 2027 update methodology is largely unchanged from CY 2026. Levels changes to the Part D benefit structure could affect payment levels; however, the Trust Fund impact remains uncertain as the effect of parameter updates depends on plan sponsor behavior and bidding assumptions.

B2. Part D Risk Adjustment Model CMS is implementing updated RxHCC models for CY 2027 to reflect statutory changes to the Part D benefit design, calibrated on 2023 diagnoses and 2024 expenditures with separate segments for MA-PD plans and PDPs. PACE organizations remain on the 2018/2019 calibration. Risk scores are derived from dollar coefficients scaled against average predicted per capita expenditures in the denominator year, anchoring the program-wide average at 1.0. While recalibration may shift individual and plan-level risk scores, normalization preserves the 1.0 average in the payment year, resulting in no net economic impact.

B3. Part D Normalization CMS will calculate separate normalization factors for MA-PD and PDP plans under the 2023/2024 RxHCC calibration using a multiple linear regression methodology with historical risk scores from 2020–2024. PACE organizations under the 2018/2019 calibration will use a historical linear slope methodology and average historical risk scores from 2016–2020. As normalization is designed to maintain a program-wide average risk score of 1.0 year-over-year, there is no net economic impact.

DISCLOSURES AND LIMITATIONS

Responsible Actuary

Tim Courtney is the actuary responsible for this communication. He is a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. He meets the Qualification Standards of the American Academy of Actuaries to issue this report.

Scope of Services

Unless otherwise explicitly indicated, Wakely's work is limited to actuarial estimates and related consulting services. Wakely is not providing accounting or legal advice. Readers should retain their own experts in these areas.

Intended Users

The purpose of this summary is to provide financial and actuarial perspective on the provisions of the Final Rate Announcement (FRA). Comments are typically from a national average perspective, and effects of the FRA will vary for different stakeholders.

Risks and Uncertainties

Users of the comments in this report should be qualified to understand the results and the inherent uncertainty. Actual results will likely vary, potentially materially, for different stakeholders. Wakely does not warrant or guarantee that results discussed will be attained for readers of the report.

Conflict of Interest

The responsible actuary is financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. Wakely performs consulting services for clients nationwide. Wakely adheres to conflict of interest standards consistent with the Actuarial Code of Professional Conduct.

Data and Reliance

We have relied on others for data and assumptions used in our report. We have reviewed the data for reasonableness but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be affected, potentially significantly.

Subsequent Events

There are no known relevant events subsequent to the date of information received that would impact the results of this report.

Unanticipated events subsequent to the date of this report is beyond the scope of our work.

Contents of Actuarial Report

This document and the supporting exhibits/files constitute the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPS

Wakely completed the analysis using sound actuarial practice. To the best of my knowledge, the report and methods used in the analysis are in compliance with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations.

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 experience across all sectors of the healthcare industry, collaborating with payers, providers, and government agencies.

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