



# 2027 Medicare Advantage and Part D Advance Notice

By Brittney Phillips and Tony Pistilli

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The Centers for Medicare and Medicaid Services (CMS) released the CY 2027 Medicare Advantage and Part D Advance Notice on January 26, 2026. The Advance Notice kicks off the annual bid cycle and lays out the methodological changes CMS is proposing for the next payment year. The bid season is already moving quickly, with that infamous first Monday in June already in sight! This article is a payer-oriented summary of proposed changes in Rate Setting, covering what changed, why it matters and what to do.

## Headline Rate Update for CY 2027

### What Changed

The headline number in the Advance Notice is the Effective Growth Rate and resulting Expected Average Change in MA plan payment. These numbers are CMS estimates of the impact that the underlying trend rates used in bids will have on total MA plan payment.

In the Fact Sheet's summary table, CMS shows:

- **Effective Growth Rate (EGR):** 4.97%
- **Risk Model Revision and Normalization:** -3.32%
- **Sources of Diagnoses:** -1.53% (excluding diagnoses from unlinked chart review records)
- **Change in Star Ratings:** -0.03%
- **MA Coding Pattern Adjustment:** 0% (CMS will continue to apply the statutory minimum 5.90% coding pattern adjustment; year-over-year impact is zero)

This totals to an Expected Average Change of 0.09%.

Further down the Fact Sheet, CMS states that they expect MA risk score coding practices and population changes to increase expected average payments by 2.45%. This upward impact to plan revenue is not included in the 0.09% expected average change.

### What It Means

These top-line growth rate numbers are national averages, not a county-specific forecast. They are just a starting point for plans evaluating their specific payment. The trend numbers used in bid templates will vary by county mix and population segments (i.e. ESRD vs. non-ESRD).



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That said, the effective growth rate proposed is significantly lower than the growth rate in the CY 2026 final announcement of 9.04%, but is in line with the average growth rate over the last 5 years. However, the 0.09% headline estimate is net of several large moving components, including material negative adjustments related to changes in the risk adjustment model and the proposed exclusion of diagnoses from unlinked chart review records. These items remain provisional until the Final Notice. As we'll discuss in more detail in the risk adjustment article, many industry voices are raising significant concerns about the impact that provision will have on the risk score accuracy of new-to-plan members.

Plans should treat these open items as scenarios until the April Rate Announcement is released, preparing for their potential impact and for the possibility that the proposals will be recalled.

### What To Do

Many plans will use the CY 2027 bid cycle as an opportunity to pivot from historical maximum growth to more targeted plan strategies such as targeting supplemental benefit offerings, serving unique populations with special needs plans, and balancing aggressive bidding with margin retention.

At the same time, as we'll discuss more fully in the risk adjustment article, CMS has been keen to claw back what some perceive as abuses of the MA risk adjustment program, with CMS Administrator Dr. Mehmet Oz recently saying at the annual J.P. Morgan Healthcare Conference in early January, "risk adjustment wasn't meant to be a plan strategy", emphasizing that the era of "growth at all costs [due to risk adjustment]" was over.

## Proposed Exclusion of Anomalous/Suspect Billing From the Experience Base

### What Changed

CMS proposes a targeted adjustment to the 2027 ratebook to address "significant, anomalous, and highly suspect billing activity" for selected intermittent urinary catheter supplies. CMS states that, in early 2023, it identified a concerning rise in urinary catheter billings attributed to a small group of 15 DMEPOS supply companies that had recently changed ownership, and that CMS investigative work determined beneficiaries did not receive the catheters, physicians did not order them, and the supplies were not needed.

For the CY 2027 ratebook, CMS proposes to exclude all Medicare Parts A and B Fee-For-Service (FFS) payment amounts on Medicare DMEPOS claims associated with specific catheter HCPCS codes from the tabulation of FFS experience used in developing per capita costs:

- CY 2023 FFS experience to exclude payment amounts on DMEPOS claims associated with HCPCS A4352 and A4353.
- CY 2024 FFS experience to exclude Parts A and B FFS payment amounts on DMEPOS claims associated with HCPCS A4353 and A5057.

With the Advance Notice, CMS is releasing proposed impacts of removing this billing activity: county-level impacts for non-ESRD beneficiaries and state-level impacts for dialysis ESRD beneficiaries, available on the CMS "2027 Advance Notice" page.

### What It Means



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This base-period experience adjustment will reduce the underlying FFS experience amounts in the places where these claims were concentrated, which can flow through to county benchmark development and related “growth” inputs used in rate setting.

CMS and OIG investigations have attributed a spike in 2013 with a reduced effect in 2014 to a small number of suppliers, so the impact of this adjustment is likely to depress county-level growth rates, and have uneven effects in different geographies (i.e., some counties and ESRD state aggregates will show larger effects than others)

### What To Do

Plans should pull the CMS impact file and flag the counties in their footprint with the largest proposed adjustments. As benchmark narratives emerge during the bid process, this one-time experience base period adjustment should be isolated when material, rather than attributing the movement to “trend.”

CMS notes that it previously implemented a similar adjustment for Shared Savings Program financial calculations (via a September 27, 2024 final rule), potentially heading off plan objections to this change. Nevertheless, it may be prudent for plans to run early scenarios with and without this change for the few most-impacted counties.



Lewis & Ellis and Axene Health Partners (LEAHP) are partnering to support Medicare Advantage organizations with concierge actuarial analytics and strategy needed to navigate the Medicare bid season and take the next leap forward in achieving their goals in the Medicare market. LEAHP provides bid development, risk and revenue optimization, risk model and coefficient impact studies, Part D formulary and pricing strategy under expanding MFPs and emerging CMMI models, and broader market-level bid strategy to respond to continued funding tightening.

If you'd like to discuss your CY 2027 priorities and where you see the greatest bid and execution risk, we'd welcome a working session to chart the course to a concrete plan of action so you can leap ahead of the competition and achieve your CY 2027 Medicare market goals.

