



2027 Medicare Advantage and Part D Advance Notice

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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 Risk Adjustment, covering what changed, why it matters and what to do.

2027 CMS-HCC Risk Adjustment Model

What Changed

CMS updated the Medicare Adjustment (MA) risk adjustment model using more recent underlying Fee-For-Service (FFS) data (2023 diagnoses to predict 2024 costs, vs. 2018 diagnoses predicting 2019 costs), leading to significant changes in some coefficients and other model parameters. CMS estimates the model revision and related normalization effects as a -3.32% impact on MA risk scores revenue relative to CY 2026.

Initial analysis shows the MA recalibration shifts weight across condition groups in a way that may reduce relative emphasis on some chronic categories while increasing weight on select acute conditions.

One specific coefficient change CMS calls out is the removal of a prior constraint that forced HCC 328 (chronic kidney disease (CKD) Stage 3B) and HCC 329 (CKD Stage 3, except 3B) to share the same coefficient; CMS says there is now sufficient post-2021 data (and clinician input) to support separate, distinct coefficients reflecting different relative costs for those two categories.

CMS made a similar FFS underlying data update to the Part D model, though only moving forward one year from 2023 to 2024. No adjustment was made to account for the historically high trends many Part D plans have seen in 2025, however.

For the first time, CMS calculated separate coefficients for MAPD and PDP plans, potentially resulting in significant changes to Part D risk scores for many plans. Recall that as a result of the Inflation Reduction Act (IRA), a much higher proportion of Part D revenue is risk-adjustable, so while Part D risk adjustment historically had a small impact on total plan performance, it is now a key revenue driver. CMS estimates that MAPD risk scores will break even, with an overall drop in coefficients offset by changes in the MAPD Part D normalization factor. However, plan-level performance could vary significantly.

What It Means

Plans should model the impact these coefficient changes would have on their specific populations and MAPD vs. PDP plans to evaluate what these changes mean for their plan specifically. These changes will likely have highly volatile impacts across different plans.

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What To Do

Plans should treat the model changes as “business as usual” in many operational respects - coefficients change every year. At the same time, plan-specific financial impacts could become material inputs to bids and demand a reconsideration of bid strategy.

Plans should account for risk-adjustment tightening as a fixed headwind that will persist in the near term. In practice, this means bid strategies that factored in coding improvement to offset other payment pressures may need to be re-evaluated, especially under the tightening diagnosis-source rules discussed below.

Diagnosis-Source Tightening: Audio-Only Encounters and unlinked Chart Review Records

What Changed

CMS proposes two significant exclusions from the Part C risk score calculation, effective in CY 2027. First, CMS proposes to exclude diagnoses obtained from audio-only encounters (submitted with modifier “93” or “FQ,” where applicable) from the risk score calculation when no other line on the encounter record, chart review record, or FFS claim is risk adjustment eligible.

Second, and even more impactful, CMS proposes to exclude all diagnoses submitted on unlinked chart review records (CRRs) from risk score calculation beginning in CY 2027. CMS describes unlinked CRRs as those in which the MA organization does not identify a previously accepted encounter data record (EDR) to associate diagnoses with specific items or services. CMS frames this as a data integrity and program integrity issue and proposes requiring diagnoses to be linked to an actual service record for risk-score consideration.

CMS estimates the impact of excluding diagnoses from unlinked CRRs as -1.53% relative to CY 2026. CMS includes supporting context that, while the population affected is small, the practice is not rare at the contract level. CMS’s analysis shows that in service years 2018–2022, about half or more of MA contracts had enrolled beneficiaries with a final accepted unlinked CRR and no final accepted EDR, even though the share of enrolled beneficiaries meeting that condition was approximately 0.04% – 0.05% . CMS also notes stakeholder concerns and cites analyses from OIG and MedPAC related to chart reviews and HRAs as drivers of differential coding.

What It Means

Chart review is not going away. Still, the elimination of unlinked chart review records poses a significant problem for plans: the inability to impact the retrospective risk scores of new-to-plan members. In-year chart reviews to impact current-year payment have always been difficult for these members because the receiving plan did not see the patient’s medical history under their former plan, though the use of MOR data, PCP outreach, and other plans could make some headway here. Eliminating unlinked chart reviews will make these activities impossible because even if the plan can find a way to review a medical record for an event covered by another payer, it will have no mechanism to submit an EDR for that event.

What To Do

Plans that have historically relied heavily on risk adjustment to ensure revenue integrity may need to reconsider their bidding strategies, as membership growth could now become a key margin liability.

More granularly, plans need to validate their encounter and chart review operations around linkage where linkage is possible. If your chart review processes and vendors are not systematically producing linkable records, this gap must be closed before CY 2027.

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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.

