2027 Medicare Advantage and Part D Advance Notice

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The Advance Notice of Methodological Changes for Calendar Year (CY) 2027 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Advance Notice) was recently released. The Advance Notice updates MA payment rates and conducts technical updates supporting MA payment accuracy.

At a Glance

- The average expected change in revenue is 2.54%, which is significantly lower than the 7.16% change estimated in the 2026 Rate Announcement.
- The preliminary growth rate is 4.97%, down from 9.04% in the CY2026 Rate Announcement
- CMS is proposing a new Part C Risk Adjustment Model. The new model is calibrated using more recent data, 2023 diagnoses and 2024 expenditures, compared to the prior model which used 2018 diagnoses and 2019 expenditures.
    - The proposed model continues to use version 28 of the clinical classification system, which was first implemented in the 2024 risk adjustment model.
    - It includes refinements to exclude diagnoses from audio-only encounters.
    - CMS is also proposing to exclude diagnoses from unlinked chart review records – diagnosis information not associated with a specific beneficiary encounter.

REVENUE: 2.54%
PRIOR YEAR: 7.16%
GROWTH RATE: 4.97%
PRIOR YEAR: 9.04%

- CMS is also proposing changes to the Part D risk adjustment model to reflect Inflation Reduction Act (IRA) changes to the Part D benefit in effect in 2027, such as the increased manufacturer discount for specified small manufacturers whose discounts are being phased-in over time.

o The proposed model is being calibrated using more recent data, 2023 diagnoses and 2024 expenditures.
o Consistent with the MA model, diagnoses from audio-only encounters and unlinked chart review records are excluded.
o The proposed model is being calibrated separately for MA-PD and PDP populations, as well as continuing to apply separate normalization factors for MA-PD plans and PDPs.

Year-to-Year Percentage Change in Payment

The chart below compares the expected impact of the policy changes and updates of the most recent MA plan payments released recently. Following this comparison, each impact category is further discussed.

Impact	2025 Rate Announcement	2026 Rate Announcement	2027 Advance Notice
Effective Growth Rate	2.33%	9.04%	4.97%
Rebasing / Re-pricing	0.07%	-0.28%	TBD
Change in Star Ratings	-0.11%	-0.69%	-0.03%
Medicare Advantage Coding Pattern Adjustment	0.00%	0.00%	0.00%
Risk Model Revision and Normalization	-2.45%	-3.01%	-3.32%
Sources of Diagnoses	N/A	N/A	-1.53%
MA Risk Score Trend	3.86%	2.10%	2.45%
Expected Average Change in Revenue	3.70%	7.16%	2.54%

Fee-for-Service (FFS) Effective Growth Rate

This represents the average change in the FFS costs from the prior year and is the primary driver of the change in Benchmarks. Benchmarks represent the maximum amount CMS will pay for Medicare covered claims in the service area and is a key component in determining the capitation rate from CMS for MA plans. The trend from 2026 to 2027 at 4.97% is a material decrease from the 2026 Rate Announcement but is higher than the growth rate in recent years prior to 2026.

FFS Growth Rate	2023	2024	2025	2026	2027
Advance Notice	4.84%	2.09%	2.44%	5.93%	4.97%
Final Notice	4.88%	2.28%	2.33%	9.04%	TBD

Rebasing/Re-Pricing

Rebasing is the impact of CMS reassessing the expected costs of traditional Medicare on a county-by-county basis. The FFS Medicare costs are the underlying data driving the calculation of MA benchmarks, and CMS annually recalculates these values since the implementation of the ACA. This ensures that the most recent set of data is being used to calculate the expected FFS costs. This impact would include movement in quartiles for counties with significant FFS cost changes, as well as other up and down adjustments based on expected geographic cost. This amount will not be determined until the release of the Rate Announcement and final Benchmark amounts in early April. Note that for 2027, CMS intends to rebase the county FFS cost data in the development of geographic factors using data from 2020 through 2024, which was released on page 21 of the Advance Notice.

Change in Star Ratings

The Change in Star Ratings shows the revenue impact due to changes in the Star rating methodology. CMS changes and edits the measures and thresholds used in calculating the average Star Rating for MA organizations. The adjustments in Star Ratings reflect how changes impact the Quality Bonus Payments for the following payment year. These payments for 2027 are determined by the number of stars achieved in 2026, which, in turn, is based on performance across various measures during 2025. Specific MA organizations may have significant variable performance in this metric.

Coding Pattern Adjustment

The Coding Pattern Adjustment is a reduction in risk scores for MA plans based on the higher levels of coding seen in the MA membership relative to FFS. This has become a cumulative 5.90% reduction and hasn't changed in several years (no new impact from 2026 to 2027). We expect the conversation and specific adjustments coming from the Risk Model Revision have captured the desired normalization and leveling of the playing field in MA risk enhancement that had been discussed for several years in rate announcements, and we expect this factor to continue to remain stable (or at least universal for all of MA).

Risk Model Revision & Normalization

The Risk Model Revision adjustment reflects the changes in the risk score model. CMS proposed a new risk score model for 2027 (colloquially the 2027 model), which is calibrated with more recent data. The 2027 model will be calibrated with 2023 diagnoses and 2024 expenditures, as compared to the prior 2024 model, which was calibrated with 2018 diagnoses and 2019 expenditures. The new model will continue to use the same segmentation and structure as the prior model and will rely on the same version 28 (V28) of the clinical classification of HCCs.

The Normalization change impacts MA risk scores to account for trend observed in the FFS population risk score. The total risk score in the FFS population has increased slightly each year due to changes in demographics, provider coding patterns, ICD-10 implementation, etc. In order to maintain an average FFS risk score of 1.0 in years other than the denominator year used in the model calibration, a scaling adjustment is applied. For 2027, the proposed normalization factor is 1.058.

While the normalization factors are industry wide, there will be variance in the MA model impact by carrier, often dramatically. Last year the risk model and normalization changes produced a -3.01% change in expected total MA revenue, this year is expected to yield a -3.32% decrease. This accounts for the impacts of the Part C normalization factor and the new 2027 CMS-HCC model. There is considerable interaction between the impact of the MA risk adjustment model updates and the normalization factor update. However, CMS estimates that the normalization factor update would be -1.50% without the risk adjustment model changes.

Sources of Diagnoses

In addition to the risk model revisions noted above, CMS is proposing two changes to the sources of diagnoses that are eligible for risk adjustment:

1. Exclusion of diagnoses from audio-only services. Diagnoses from telehealth services will continue to be eligible for inclusion when those services include an interactive audio and video telecommunications system that permits real-time interactive communication. However, those that include audio-only and do not include a video component will be excluded. These are identified by CPT Code Modifiers of "93" or "FQ" where applicable, which indicate services provided via audio only.
2. Exclusion of diagnoses from Unlinked Chart Review Records. MA organizations must report all items and services they provide to enrollees to the encounter data system (EDS). Additional risk adjustment data may be submitted to the EDS as a Chart Review Record (CRR). CRRs may be submitted in two ways: linked to an encounter data record (EDR) or unlinked. Linking to an EDR allows the organization to associate risk adjustment eligible diagnoses to specific items or services provided to the beneficiary. Under this proposal, diagnoses submitted on CRRs that remain unlinked to an EDR will no longer be eligible for risk adjustment. CMS sites that over half of contracts have submitted unlinked CRRs for beneficiaries with no EDRs, though the number of beneficiaries impacted is small. This raises data integrity concerns as some MA organizations may be submitting unlinked CRRs in lieu of EDRs for some service records.

CMS has estimated that this change will reduce revenue 1.53% for 2027, though this number may vary significantly for MA carriers.

MA Risk Score Trend

CMS has estimated the average plan coding trend for MA carriers and included in the fact sheet. This impact will vary dramatically based on carrier, provider network and sophistication, plan coding efforts and programs, membership duration and lapses, etc. This 2.45% trend is similar to last year's trend of 2.10% but is a decrease from years prior to 2026 which has reduced each year since the introduction and phase-in of the 2024 CMS-HCC model.

Other Advance Notice Highlights

Part D Risk Adjustment and Normalization Methodology

CMS is also implementing a new Rx-HCC model for CY2027, which incorporates the changes to the Part D program made under the IRA, such as the increased manufacturer discount for specified small manufacturers whose discounts are being phased-in over time. In addition, CMS is proposing separate calibration for MA-PD plans and PDPs. Previous models included a single calibration for both populations. Per the Advance Notice, CMS analysis has showed that MA-PD costs tend to be overpredicted, while PDP costs tend to be underpredicted in prior versions of the model. In order to address this, they are proposing to add segments for continuing enrollees, which apply separate calibration for MA-PD members and PDP members. New enrollee segments will continue to be combined between MA-PD plans and PDPs.

In addition, CMS is proposing updates to the allowable sources of diagnoses eligible for risk adjustment. Consistent with the changes proposed to the Part C risk adjustment model, diagnoses from audio-only encounters and unlinked chart review records will be excluded.

CMS will also continue to apply separate normalization factors to risk scores used to pay MA-PD plans and PDPs, consistent with the approach taken since CY2025. The proposed normalization factor for MA-PD plans is 1.109 and for PDPs is 1.005.

Annual Adjustments to Part D Benefit Parameters

Certain parameters of the Part D benefit are updated annually to ensure that the actuarial value of the benefit remains consistent with changes in Part D expenditures. As a result, the Part D defined standard benefits have been updated as follows:

- Deductible will increase to $700 in 2027 from $615 in 2026
- Out-of-pocket threshold will increase to $2,400 in 2027 from $2,100 in 2026

Part C and D Star Ratings

CMS is proposing changes to the Part C and D Star Ratings which include providing the list of eligible disasters for adjustment, non-substantive measure specification updates, and the list of measures included in the Part C and Part D Improvement measures and Categorical Adjustment Index for the 2027 Star Ratings. There are four new or updated measures being added for the 2027 Star Ratings for Colorectoral Cancer Screening, Care for Older Adults – Functional Status Assessment, Concurrent Use of Opioids and Benzodiazepines (COB), and Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH). In addition, three measures are being removed for Care for Older Adults – Pain Assessment, Medication Reconciliation Post-Discharge, and Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR).

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.