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CMS 2027 Advance Notice:

A Continuously Shifting Landscape for Medicare Advantage

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CMS 2027 Advance Notice:
Introduction

We're still early in 2026, but we can already see it's a pivotal year for Medicare Advantage (MA).

We started the year with V28 of CMS-HCCs fully in effect, fewer $0 premium plans, and shifts from open access PPOs to narrow network HMOs.

We saw large payers exiting rural markets, a decline in non-Special Needs Plans, and the Inflation Reduction Act (IRA) creating industry headwinds.

As margins tighten for payers and providers, regulatory scrutiny continues to increase with continued OIG audits and CMS announcing the return of RADV audits firing back up.

At the same time, the current administration appears committed to the embattled program, which it believes is a superior alternative to Traditional Medicare, but with a few caveats—notably necessary reimbursement modifications, reporting changes, and increased monitoring.

This tug of war makes it critical to understand the anticipated changes in the *2027 Advance Notice for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies* (2027 Advance Notice).

We are pleased to bring you the following highlights and summary. Note these are *proposed* changes. We won't know what is certain until the MA Capitation Rates and Final Payment Policies are released in early April (expected no later than 4/6, per CMS); but, historically, CMS adopts more than 90% of its proposals.

Let's dive in!

High Prevalence, Chronic Conditions Targeted

As a reminder, MA payments are prospective and 2026 visits determine 2027 reimbursement. Once the proposed rule is finalized, it is retrospectively applied to encounters as of January 1 of this year, which drives 2027 contract year payments.

Overall, CMS projects MA payments will result in a net average year-over-year increase of 0.09% (representing $700M in MA plan payments), and upwards of a 2.54% increase when coding pattern and population changes are considered. Either way, the number is significantly lower than the projected 5.06% increase published in the 2026 Final Rate Announcement.

However, you may recall from last year that numbers can swing widely between the Advanced Notice and the Final Rate Announcement (last year swung from 2.23% to 5.06%, for example).

How does this occur?

It can be the outcome of concerns brought forward in the public comment period; notably, this is how we often end up phasing in larger changes(e.g., V24 to V28, RAPS to EDPS, et al).

Additionally, CMS continues to update data utilized in the actuarial models between the Advance Notice and Final Rate Announcement.

It's important to keep in mind that the numbers used in the Advance Notice and Final Rate Announcement are based on the national average.

There can be significant differences by organization based on payer/member mix, membership volume, geography, and organizational maturity of the risk adjustment program.

That takes us to the other side of the coin—because each year, there are both puts and takes.

And for every 10,000 patients in a MA risk plan, the 2027 proposed rule will cut about $1.2M in risk score care funding.

Most of this comes in the form of the proposed 2027 CMS-HCC Model.

While CMS did not grossly change the structure of V28, it utilized more current data and diminished coefficient weights.

Overall, 65 HCCs **decreased** in coefficient values. In particular, several high prevalence conditions have significant negative impacts. These include:

- **Diabetes: 6.6% decrease**
- **Morbid Obesity: 19.4% decrease**
- **Rheumatoid Arthritis: 17.3% decrease**
- **Major depression: 13.7% decrease**
- **Heart Failure: 10.8% decrease**
- **COPD: 18.8% decrease**
- **CKD 3A: 50.4% decrease**
- **Drug Use Disorder:**
  - **24.3% decrease moderate/severe;**
  - **46.6% decrease mild**

While 50 HCCs experienced a care funding **increase**, many of these are acute in nature, including pressure ulcers, sepsis, some cancers and CKD stage 3B (with stage 3 being "unconstrained" resulting in different coefficients for Stage 3A and 3B).

Here are 5 CMS-HCCs with Higher Proposed Weights in the CY 2027 Advance Notice vs the Current CY 2024 CMS-HCC Model

using the Continuing Enrollee – Community, NonDual, Aged column (i.e., the first coefficient in each HCC row).

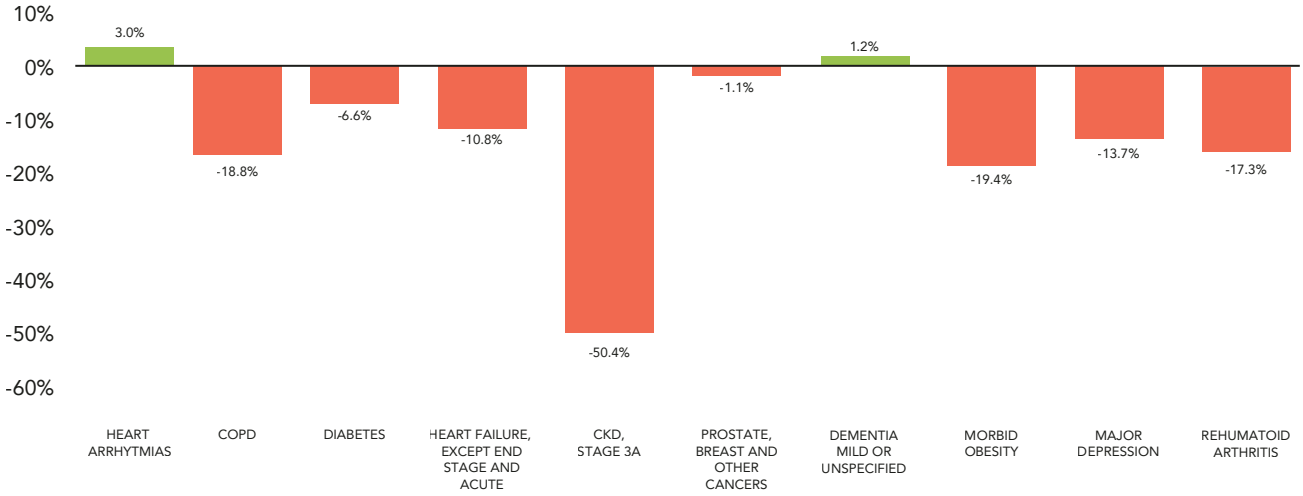
CMS-HCC	Current Weight (CY 2024)	Proposed Weight (CY 2027)	Variance (2027-2024)
HCC 2 – Septicemia/Sepsis/SIRS/Shock	0.500	0.578	+0.078
HCC 18 – Metastatic to bone/other; acute leukemia (except myeloid)	2.341	2.476	+0.135
HCC 19 – Myelodysplastic syndromes / multiple myeloma / other cancers	1.798	2.476	+0.678
HCC 22 – Bladder/colorectal/other cancers	0.363	0.407	+0.044
HCC 50 – Amyloidosis/porphyria/other specified metabolic disorders	0.648	0.778	+0.130

What also stands out as we look at just a few of these HCCs including sepsis and cancers is that they are also OIG target audit areas – making them likely RADV targets, too.

Coefficient Shifts Lead To Funding Reduction

Our math shows that the top 10 conditions (see following chart) by prevalence account for 41% of the total risk score value. When many people have a condition, a small shift leads to big impacts across an organization.

In fact, the shift in weights for these conditions account for a $2.3M decrease in care funding per 10,000 patients.



Of the top 10 conditions shown in the above chart, eight of them went down in the aged, non-dual risk score which accounts for the majority of MA patients. These are all common conditions often seen and addressed by primary care practices.

As noted above, the proposed, actuarially adjusted model includes updated data timing. The 2024 CMS-HCC model used 2018 diagnoses dates of service and 2019 expenditures—notably, pre-COVID. The proposed 2027 model uses (post-COVID) 2023 diagnoses dates and 2024 expenditures. We have also seen a surge in AI focused technology surfacing risk conditions, a greater focus on risk adjustment via shared savings contracts, and the use of outpatient CDI—including prospective chart reviews and more concurrent review.

And for those that either shifted toward SNP plans or treat complex seniors, there is also a notable decrease in the alternative payment condition count coefficient values that further impacts revenue for the cost of care.

In addition to timing changes proposed, the Advanced Notice outlines the statutory required coding pattern adjustment (5.90%), calibration, normalization, and the exclusion of certain claims/charts.

(more on that below).

Other Impactful Changes: Elimination of Unlinked Conditions, Audio-only Telehealth

The other big news in the rule is CMS' intent to exclude certain claims/charts from RAF score calculations.

CMS specifically stated that it is "proposing to exclude diagnosis information from unlinked Chart Review Records (CRRs) – diagnosis information not associated with a specific beneficiary encounter – from risk score calculation starting in CY 2027."

It adds that MA organizations may continue to submit diagnoses using unlinked CRRs; however, those diagnoses will no longer be used for calculating risk scores.

CMS notes that OIG audits and its own analysis have found that half or more of MA contracts enrolled beneficiaries have an unlinked CRR and no encounter data record (EDR). "This raises data integrity concerns as some MA organizations may be continuing to submit unlinked CRRs in lieu of EDR for some service records despite the ability to submit EDRs," the rule states.

While error rates have improved over time, CMS estimates this change alone will reduce payments by 1.53% (more than $7 billion dollars).

With this proposed change, CMS continues to signal that **merely reporting conditions is not enough.** Face-to-face care with complete documentation, accurate coding of the bill/claim, and timely submission are all paramount in justifying care funding.

The Advance Notice also proposes to exclude diagnoses based solely on audio only telehealth, further narrowing the scope of reimbursable documentation. While certain face-to-face (F2F) equivalent visits (inclusive of audio and video) still qualify, the list of services is smaller than allowed during the pandemic.

Depending on geographical internet/broadband options and the technical savvy of the individual enrollee, F2F equivalent visits are not always an option.

Payers and providers servicing enrollees in rural geographies should consider how to best address this change.

Part D Pharmacy Benefits and Star Ratings Programs

As part of the CY2027 Advance Notice, the implemented Inflation Reduction Act changes largely continue.

These include annual TrOOP increase, continued coverage of insulin and adult vaccines, ongoing MAPD and PDP coefficient differences, and many similar components of Part C including normalization, calibration, and updated data dates.

Similarly, the Star Ratings program continue to emphasize a patient-centric experience through the use of HEDIS® which tracks specific clinical metrics (e.g., blood pressure control, cancer screenings), patient experience through CAHPS® and HOS surveys—which collect information on enrollee physical and mental health, plus daily activities—and administrative data.

For more significant insights, we recommend reading the Contract Year 2027 Medicare Advantage and Part D Proposed Rule from CMS dated11/25/25.

Summary & Takeaways

1. The CMS risk adjustment program continues to push toward providing care to the most vulnerable by lowering the weight of chronic conditions in the Community population and increasing the weights of acute conditions.
2. It places increased financial pressure on MA plans and first-tier downstream entities and continues to have a ripple effect on the industry. For example, MA payer stocks tumbled on the Advance Notice, with UnitedHealth Group stock down 10%.
3. Provider organizations (hospitals, physician practices, etc.) will be impacted by diminished capitation or Shared Savings and may continue to create tighter networks, further reducing access.
4. With constant year-over-year program changes, CMS continues to apostolize that every reportable condition must be accurate and complete and meet program requirements of face-to-face (or equivalent) visits.
5. Established visit linkage is critical. Documentation has to be part of the record of care. CMS wants to pay for improved patient care, not improved coding.
6. The cuts in risk adjustment may drive patients toward a new focus on quality. Even though beneficiaries have access to Star Ratings, most do not use them for plan selection. We may be at the tipping point, where HEDIS/Stars performance drives patient choice, which is a good thing.

References & Resources

- CMS, 2027 Advance Notice for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies: https://www.cms.gov/files/document/2027-advance-notice.pdf
- CMS, 2027 Advance Notice Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/2027-medicare-advantage-part-d-advance-notice
- Norwood webinar, CMS 2027 Advance Notice: A New Era in Risk Adjustment: https://my.demio.com/ref/i0iwOpSGeLt01xTp
- RISE, Advance Notice fallout: What MA plans need to know: https://www.risehealth.org/insights-articles/article/advance-notice-fallout-what-ma-plans-need-to-know/

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